RESOLVED, That the American Bar Association urges federal, state, local, territorial, and tribal governments not to impose upon medical facilities and healthcare providers that offer reproductive health services to women, licensing or other regulatory requirements that are not medically necessary or that have the purpose or effect of burdening women’s access to such services.
Overview

The right to bodily autonomy and to make personal decisions about one’s family have long been recognized by the Supreme Court of the United States.1 These rights are effectuated through a patient’s right to choose and access reproductive healthcare. For women,2 the right to make personal decisions about reproductive healthcare is under threat. The increase in legislative activity at the state and federal level, coupled with the prospect of further Supreme Court consideration of reproductive health-related laws and regulations, makes the threat imminent and real.

In the first quarter of 2019 alone, over 300 restrictive reproductive healthcare bills affecting contraception, family planning, and abortion were introduced in state legislatures.3 As of 2017, states had already enacted close to a thousand bills restricting access to reproductive healthcare.4 These laws are often passed in the guise of protecting women but have the effect of shutting down medical facilities and making reproductive healthcare more difficult and expensive to obtain.

Laws and Regulations Impeding Reproductive Healthcare

The myriad restrictive bills, passed in the name of protecting women’s health, run the gamut, requiring:

- unnecessary services, such as ultrasounds, when not medically indicated;

1 Meyer v. Nebraska, 262 U.S. 390, 399 (1923) (recognizing family decisions protected by the Fourteenth Amendment); Griswold v. Connecticut, 381 U.S. 479, 484 (1965) (holding that married women have the right to contraception under the Fourteenth Amendment); Eisenstadt v. Baird, 405 U.S. 438, 443 (1972) (expanding the right to contraception to all women, whether married or single); Roe v. Wade, 410 U.S. 113, 129 (1973) (recognizing the right to abortion under the Fourteenth Amendment); Carey v. Population Servs., Int’l, 431 U.S. 678, 684 (1977) (striking down the presumption that only pharmacists could dispense nonprescription contraceptives); Planned Parenthood of Se. Pennsylvania v. Casey, 505 U.S. 833, 848 (1992) (reaffirming the right to abortion and forbidding regulations that impose an undue burden on pre-viability abortion); Cleveland Bd. of Educ. v. LaFleur, 414 U.S. 632, 639 (1974) (upholding that personal choice in matters of family life, in this case to procreate, is a liberty that the Fourteenth Amendment protects); Cruzan v. Dir., Missouri Dep’t of Health, 497 U.S. 261, 279 (1990) (recognizing the right to refuse unwanted medical treatment); Lawrence v. Texas, 539 U.S. 558 (2003) (recognizing constitutional protections for intimate personal decisions and protecting same-sex conduct, along with private sexual activity more broadly). Most recently, in Obergefell v. Hodges, the Court held that the right to marry a person of the same sex, “[l]ike choices concerning contraception, family relationships, procreation, and childrearing, all of which are protected by the Constitution[,]” is protected by the Fourteenth Amendment. 135 S. Ct. 2584, 2588 (2015).

2 Throughout the report, “women” is used for ease and consistency, but it is recognized that not all people seeking reproductive healthcare, including pregnant people, identify as women.

3 These 300-plus bills seek to restrict access to contraception or abortion, to defund providers of comprehensive reproductive healthcare, or to support faith-based crisis pregnancy centers that do not provide medical care.

• biased and medically inaccurate counseling (including inaccurate information about physical or mental side effects of procedures);
• delays before accessing services;
• unreasonable physical plant requirements (such as the size of procedure rooms or the width of corridors); and
• limits on private and public health insurance coverage.5

As noted, the proponents of many of these state restrictions have justified them under the guise of protecting women’s health and safety. For example, some states require providers to gain hospital admitting privileges even though they do not practice at hospitals—overregulation that is contrary to modern medical standards and to which both the American Medical Association (AMA) and the American College of Obstetricians and Gynecologists (ACOG) are publicly opposed.6 Requiring providers to have admitting privileges is unnecessary and puts many providers in an impossible situation. Hospitals often require a minimum number of admissions each year in order to maintain privileges. Nine out of ten abortions take place during the first trimester, and because abortion is so safe, less than 0.05% of these patients experience a complication requiring hospitalization.7 Providers therefore cannot meet admission minimums, are denied privileges, and can no longer serve the women these laws claim to protect.

One particular type of restrictive bill, which has been introduced with great frequency in recent years, imposes onerous and medically unnecessary regulations on the physical plant of reproductive health clinics. These laws are based upon the pretext that reproductive care is inherently dangerous, and facilities must mimic hospitals in order to be safe. Nothing could be further from the truth.

Reproductive healthcare is extremely safe. Contraception is well established to be safe and effective at reducing unintended pregnancy,8 and has been called by the Centers for Disease Control (“CDC”) one of the ten greatest public health achievements of the

---

twentieth century. In addition, as the CDC has observed: “Access to family planning and contraceptive services has altered social and economic roles of women. Family planning has provided health benefits such as smaller family size and longer intervals between the birth of children; increased opportunities for preconceptional [sic] counseling and screening; fewer infant, child, and maternal deaths; and the use of barrier contraceptives to prevent pregnancy and transmission of human immunodeficiency virus and other STDs.”

Abortion is likewise, in the recent words of the Supreme Court surveying the medical evidence, “extremely safe.” The risk of death in childbirth is 14 times higher than for abortion procedures. In fact, there are dozens of common medical procedures that are considered to be very safe but that are more risky than abortion. The mortality rates are higher for gallbladder removal, knee replacement surgery, bariatric surgery, and hernia surgery. According to the former president of the American College of Obstetricians and Gynecologists, the mortality rate of colonoscopy is 40 times greater than of abortion.

Research also demonstrates that states that have passed 10 or more reproductive healthcare restrictions also tend to be states where women and children have worse health outcomes than states with fewer restrictions on access to reproductive healthcare. According to the Guttmacher Institute, a leading research and policy organization in reproductive healthcare, despite exceptionally low complication rates for patients undergoing abortion, “24 states have laws or policies that regulate abortion providers [in ways that] go beyond what is necessary to ensure patients’ safety.” These laws have not improved the abortion procedure, but rather have made it more difficult to access not only abortion, but also other basic preventative care co-located in some clinics, including breast exams, cholesterol screening, diabetes screening, flu shots, employment and sports physicals, pregnancy care, menopause testing and treatment, and cervical cancer screenings.

---

10 Id.
11 Whole Woman’s Health v. Hellerstedt, 136 S. Ct. 2292, 2296 (2016); see also, e.g., DAVID A. GRIMES & LINDA G. BRANDON, EVERY THIRD WOMAN IN AMERICA: HOW LEGAL ABORTION TRANSFORMED OUR NATION 35 (2014).
14 Targeted Regulation of Abortion Providers, GUTTMACHER INST. (Mar. 1, 2019), https://www.guttmacher.org/state-policy/explore/targeted-regulation-abortion-providers. Fewer than 0.5% of abortion patients in the United States experience a major complication that requires hospitalization. Id.
15 See, e.g., Women’s Services, PLANNED PARENTHOOD, https://www.plannedparenthood.org/get-care/our-services/womens-services (last visited Mar. 29, 2019) (noting that in addition to abortions, Planned Parenthood centers also provide a variety of health services including pap tests, breast exams, and cervical cancer screenings).
At the federal level, there have been similar efforts to thwart access to a spectrum of reproductive health services. In one of his first acts as president, Donald Trump reinstated and expanded the Global Gag Rule, a destructive policy that restricts access to safe abortion services for women worldwide. The rule dictates that overseas groups receiving any health funds from the U.S. – not just family planning funding – may not use U.S. funds or even their own funds from other sources to provide safe and legal abortion services, provide information about or referrals for abortion, or provide funds to any groups that provide or discuss abortion. Multiple academic studies have found that the Global Gag Rule decreases healthcare services, including the dissemination of contraception, and thus, ironically, that it is associated with an increase in abortions.\(^{16}\)

Similarly, the administration’s recent regulation governing the Title X family planning program implements a “Domestic Gag Rule” that prohibits entities receiving Title X funding from providing referrals for or information about abortion. For example, Title X-funded health centers serve more than 4 million people and provide a critical entry point – at times the only entry point – into the health care system for many low-income, uninsured, and underserved clients.\(^{17}\) In fact, six in ten women receiving Title X services reported that a Title X-funded health center was their usual source of medical care,\(^{18}\) and four in ten reported it was their only source of care.\(^{19}\)

The “Domestic Gag Rule” also requires physical and financial separation between Title X services and abortion care and imposes strict limitations on the use of Title X funds. According to research by the Kaiser Family Foundation, the total cost for bringing organizations into compliance would equal $66.25 million, a quarter of the Title X program’s annual budget.\(^{20}\) Reallocation of these monies for compliance translates into reductions in quality of care and services for millions of women and their families.\(^{21}\) Many Title X funded health centers may also stop providing abortion services altogether.\(^{22}\) As

---


\(^{19}\) Id.


\(^{22}\) For example, in a rural state like Maine, 16 out of 17 abortion clinics would either close or stop providing abortion services. *Maine Title X Recipients Take Trump Administration to Court*, CTR. FOR REPRODUCTIVE
a result, it will hamper a patient’s ability to receive accurate information from her medical provider about the full range of reproductive healthcare and limit her ability to make informed decisions and access services.\(^{23}\)

Finally, under recent Title X regulations, grantees no longer need to follow evidence-based family planning protocols; Title X funds have been awarded even if a clinic does not offer contraception.\(^{24}\) The Domestic Gag Rule would block the availability of Title X funds to some grantees, redirect funds to faith-based organizations disseminating religious messages, and eliminate the requirement that providers offer information about the full range of available reproductive healthcare. These changes will shrink the network of participating healthcare providers and have major repercussions for women across the country who rely on them.

Currently, more than 80 cases in state and federal courts are being litigated to protect access to a spectrum of reproductive health services that range from access to contraception, funding for medical providers offering contraceptive services, and access to abortion care. Passage of this resolution would put the ABA on record as opposed to medically unwarranted laws and regulations that are intended to make or have the effect of making access to reproductive healthcare more difficult.

**ABA Policy Relevant to the Proposed Resolution**

The ABA has adopted several policies that are consistent with this resolution and that strongly oppose restrictions that would burden women’s access to reproductive health services. The ABA has a long record of supporting personal autonomy in healthcare decision-making and opposing regulations that interfere with access to treatment and quality of care. In 1991, in anticipation of *Rust v. Sullivan* going to the Supreme Court, the ABA passed Resolution 91A10H, which expressed the association’s opposition to “unreasonable government-imposed restrictions on professional relationships [and] governmental intrusion into sensitive and confidential areas of healthcare.”\(^{25}\) In 1992, the ABA recognized individual liberty and bodily autonomy in making personal reproductive health choices with the passage of Resolution 92A12. The Resolution opposes state and federal legislation that would restrict the rights of women to terminate their pregnancies before viability, or after that point when necessary to protect the life or health of the woman.

In 2005, the ABA responded to passage of the Weldon Amendment, which prohibited federal agencies and state or local governments from “discriminating” against any health

---


care entities for refusing to provide, pay for, provide coverage of, or make referrals for abortions under penalty of losing federal funds under the Consolidated Appropriations Act. This at this time, the ABA adopted Resolution 05M104, reaffirming and expanding its 1991 policy, and adding that medical providers must give relevant and medically accurate information for fully informed decision making “whether or not the provider chooses to offer such care.” With the passage of ABA Resolution 93M104, the association also opposed the use of government funding programs to suppress or discourage speech activities by grantees based on the government’s viewpoint. In adopting resolutions 91A10H, 01A118, 05M104 and 93M104, the ABA has made clear its support for the right of patients to receive full and adequate medical advice and referrals for all reproductive health options, and the correlative right of healthcare professionals to advise their patients in accordance with their best medical judgment and professional ethics.

The ABA has also supported the right to access quality reproductive health services irrespective of income and free from discrimination. Resolutions 90M108 and 94M105 support every American’s right to access quality health care regardless of the person’s income and describe the various characteristics required for such access and quality of care. In adopting ABA Resolution 18104C, the association also recognized that the prohibition of sex discrimination by covered health programs or activities includes, by definition, discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, childbirth and related medical conditions.

The ABA has in the past adopted resolutions that are similar to and consistent with the resolution accompanying this report. The instant resolution is being proposed to apply principles the ABA previously endorsed to a wave of reproductive healthcare restrictions of a particular type: limitations that purport to be “women-protective” but are medically unnecessary and have the purpose or effect of reducing access to healthcare.

**Challenges to Statutes Limiting Reproductive Health Care**

Despite long-standing Supreme Court precedent supporting access to reproductive healthcare, including *Roe v. Wade*, *Planned Parenthood of Southeastern Pa. v. Casey*, and *Whole Woman’s Health v. Hellerstedt*, legislatures continue to pass restrictive regulations on medical facilities and healthcare providers that do not improve a woman’s reproductive health outcomes but rather burden her access to information and services.\(^{30}\)

---

29 See ABA House of Delegates Resolution 90M108 (adopted Feb. 1990); ABA House of Delegates Resolution 94M105 (adopted Feb. 1994) (providing for every American to have access to quality healthcare regardless of the person’s income and describing the various characteristics required for access and quality care).
30 The stated purpose of protecting women with these restrictions is belied by the safety of abortion. In *Whole Woman’s Health v. Hellerstedt*, Texas defended these laws as an effort to improve abortion safety. But when the Texas Senate passed the law, the Texas Lieutenant Governor celebrated on Twitter with a map of clinic closures. The map was captioned “If SB5 passes, it would essentially ban abortion statewide,” and the Lieutenant Governor posted “We fought to pass SB5 through the Senate last night, this is why!”
The landmark 2016 decision in *Whole Woman’s Health v. Hellerstedt* struck down two parts of the omnibus 2013 Texas law known as HB2: the “admitting privileges” provision requiring all abortion providers to obtain local hospital admitting privileges, and the “ambulatory surgical center” provision requiring every licensed abortion facility to meet hospital-like building standards. The decision preserved access to healthcare for millions of Texas women, and signaled that laws like Louisiana’s Act 620 are also unconstitutional. The decision reaffirmed that when courts assess benefits, they need to apply heightened scrutiny to the state’s claims about whether and how a law actually advances a valid state interest. The Court held that both the hospital admitting privileges requirement and the ambulatory surgical center requirement imposed undue burdens on abortion access by placing substantial obstacles in the paths of women attempting to obtain a legal abortion. Both of these requirements offered little to no health benefits while increasing the difficulty in receiving care, and reducing the quality of care at the clinics that remain open.

The Court’s application of the undue burden test in *Whole Woman’s Health* is not limited to a particular type of abortion restriction, state, or set of facts. Instead, it instructs what courts need to do each time they apply the undue burden test to evaluate a law that limits women’s fundamental right to choose an abortion. It is important for legislatures as well as courts to apply this precedent. Once clinics close, they face obstacles to reopening and often do not reopen – even if a lawsuit is ultimately successful. Despite the Supreme Court’s ruling in *Whole Women’s Health*, Texas still has just half the number of facilities it had before the law was passed in July 2013, which means it is still affecting access to abortion care and other reproductive health services in Texas today.

A Louisiana law targeting the regulation of abortion providers, identical to the Texas admitting privileges law determined to be unconstitutional in *Whole Woman’s Health v. Hellerstedt*, is the subject of a petition for certiorari in the Supreme Court. *June Medical*
Services v. Gee is a challenge to Louisiana Act 620, which would require any physician providing abortion services in Louisiana to have admitting privileges at a hospital within 30 miles of the procedure. Originally filed in 2014, the case was heard before the Fifth Circuit in 2018. The Fifth Circuit reversed the lower court, holding the law could go into effect, and refused a request for rehearing en banc. In his dissent, Judge Stephen Higginson stated the Fifth Circuit’s decision was issued with blatant disregard for the precedent set in Whole Woman’s Health v. Hellerstedt. Judge Higginson wrote that he is “unconvinced that any Justice of the Supreme Court who decided Whole Woman’s Health would endorse our opinion.” On February 7, 2019, the Supreme Court granted an emergency stay, and on April 17, 2019, a petition of certiorari was filed. The law will remain blocked until the disposition of this petition. Should this law go into effect, it is possible that two of the three remaining clinics in Louisiana will close.

Legislation Supporting Reproductive Care

Though this report has discussed a number of restrictions on reproductive healthcare, there are also legislators and advocates seeking to expand access to care. At the federal level, the Women’s Health Protection Act (WHPA) is a bill that would prohibit states from imposing restrictions on abortion that apply to no similar medical care, interfere with patient’s personal decision making, and block access to safe, legal abortion care. WHPA was first introduced by Sen. Richard Blumenthal (CT) and Rep. Judy Chu (CA) in November 2013; it has since been reintroduced in each session of Congress. Sen. Tammy Baldwin (WI) is a lead cosponsor in the Senate, and Rep. Marcia Fudge (OH) and Rep. Lois Frankel (FL) are lead cosponsors in the House of Representatives.

At the state level, lawmakers in 12 states introduced a Whole Woman’s Health Act before their state legislatures. Bills were introduced in 17 states to codify the birth control benefits of the Affordable Care Act, and those measures passed in Connecticut, Delaware, Maryland, Rhode Island, Washington, and Washington, D.C. Missouri and Kentucky considered legislation to repeal their mandatory delay requirements, allowing patients to receive abortion care more quickly, and the Arizona legislature considered a bill to repeal the state’s ban on using telemedicine to administer abortions.

Conclusion

The ABA should continue its proud history of support for women’s privacy in making the most intimate decisions about their own healthcare. Passage of this resolution would allow the ABA to speak, whether through legislative advocacy or amicus briefs, against

---

35 June Medical Services, L.L.C. v. Gee, 913 F.3d 573, 585 (5th Cir. 2019) (Higginson, J., dissenting).
36 June Medical Services, L.L.C. v. Gee, 139 S. Ct. 663; see also June Medical Services v. Gee, CTR. FOR REPRODUCTIVE RIGHTS (Mar. 14, 2019), https://www.reproductiverights.org/case/june-medical-services-v-gee-2014 (detailing the path of the case to date).
38 Id. at 21-23.
39 Id. at 21-23.
laws and regulations that use women’s health as a pretext for constraining women’s rights, and to endorse laws that reaffirm the right to privacy in medical decision making.

Respectfully submitted,

Wilson A. Schooley
Chair, Civil Rights & Social Justice
Section
August 2019
GENERAL INFORMATION FORM

Submitting Entity: Civil Rights & Social Justice Section

Submitted By: Wilson A. Schooley

1. Summary of Resolution(s). The ABA urges federal, state, local, territorial, and tribal governments to refrain from imposing upon reproductive healthcare providers requirements that are not medically necessary or have the purpose or effect of burdening women’s access to such services.

2. Approval by Submitting Entity. The Council of the Section of Civil Rights and Social Justice approved sponsorship of this resolution on April 12, 2019.

The Commission on Women in the Profession approved cosponsorship of this resolution on May 28, 2019.

3. Has this or a similar resolution been submitted to the House or Board previously? n/a

4. What existing Association policies are relevant to this Resolution and how would they be affected by its adoption? ABA Resolution 91A10H (1991) expresses the association’s opposition to “unreasonable government-imposed restrictions on professional relationships [and] governmental intrusion into sensitive and confidential areas of healthcare.”\(^{40}\) ABA Resolution 92A12 (1992) recognizes individual liberty and bodily autonomy in making personal reproductive health choices and opposes state and federal legislation that would restrict the rights of women to terminate their pregnancies before viability, or after that point when necessary to protect the life or health of the woman. ABA Resolution 05M104 reaffirms and expands on its 1991 policy and adds that medical providers must give relevant and medically accurate information for fully informed decision making “whether or not the provider chooses to offer such care.”\(^{41}\) ABA Resolution 93M104 opposed the use of government funding programs to suppress or discourage speech activities by grantees based on the government’s viewpoint.\(^{42}\) These adopted resolutions demonstrate the ABA’s support for the right of patients to receive full and adequate medical advice and referrals for all reproductive health options, and the correlative right of healthcare professionals to advise their patients in accordance with their best medical judgment and professional ethics.

In addition, Resolutions 90M108 and 94M105 support every American’s right to access quality health care regardless of the person’s income and describe the various characteristics required for such access and quality of care. ABA Resolution 18104C recognizes that the prohibition of sex discrimination by covered health programs or activities includes, by definition, discrimination based on pregnancy, false pregnancy,

\(^{41}\) ABA House of Delegates Resolution 05M104 (adopted Feb. 2005).
termination of pregnancy, childbirth and related medical conditions.

5. If this is a late report, what urgency exists which requires action at this meeting of the House? n/a

6. **Status of Legislation.** (If applicable) A number of bills relevant to this resolution are pending in state legislatures. For example, Oklahoma Senate Bill 857, introduced in February 2019, would require all abortion clinics to be licensed by the State Department of Health. Under this bill, the Commissioner of Health would be empowered to create standards for physical facilities, equipment, personnel, medical screening, and recovery rooms. Note that all of these licensing requirements would be in addition to requirements already applicable to other medical facilities. The bill would allow any Department of Health official to conduct warrantless inspections. All the State Commissioner of Health needs is “reasonable cause” to believe that the facility is not in compliance, which may lead to an action suspending or revoking a clinic’s license to operate.

Louisiana House Bill 484 would require physicians, medical staff—including medical directors and administrators—and owners of abortion facilities to designate one custodian of records for the clinic. The custodian is required to obtain and maintain medical records for each patient who has had an abortion at that facility. Medical records must be retained for at least seven years, longer for minors. The clinic's record retention policy must be approved by the state department of health. The penalty for violating this law would be $1,000 or “imprison[ment] for not more than two years with or without hard labor, or both.” Physicians may also face professional disciplinary actions such as permanent disqualification from providing abortions.

7. **Brief explanation regarding plans for implementation of the policy, if adopted by the House of Delegates.** Passing this resolution will allow the ABA to advocate for the passage of reasonable laws and regulations protecting reproductive health facilities and against onerous and burdensome laws and regulations that have no legitimate medical purpose. It will also allow the filing of amicus briefs in litigation challenging such laws that is sure to come before the U. S. Supreme Court and state appellate courts.

8. **Cost to the Association.** (Both direct and indirect costs) Adoption of this proposed resolution would result in only minor indirect costs associated with staff time devoted to the policy subject matter as part of the staff members’ overall substantive responsibilities.

9. **Disclosure of Interest.** (If applicable) There are no known conflicts of interest.

10. **Referrals.** The Report with Recommendation will be referred to the following entities:
    - Center for Human Rights
    - Coalition on Racial and Ethnic Justice
Commission on Disability Rights
Commission on Domestic & Sexual Violence
Commission on Hispanic Legal Rights and Responsibilities
Commission on Racial and Ethnic Diversity in the Profession
Commission on Sexual Orientation and Gender Identity
Commission on Women in the Profession
Commission on Youth at Risk
Family Law Section
Government and Public Sector Lawyers Division
Health Law Section
Law Student Division
Section of State and Local Government Law
Senior Lawyers Division
Standing Committee on Legal Aid and Indigent Defendants
Young Lawyers Division

11. Contact Name and Address Information.

Estelle H. Rogers, CRSJ Section Delegate
111 Marigold Ln
Forestville, CA 95436-9321
Tel.: (202) 337-3332 (cell)
E-mail: 1estellerogers@gmail.com

Paula Shapiro, Acting Section Director
Section of Civil Rights and Social Justice
1050 Connecticut Avenue NW
Washington, DC 20036
Tel.: (202) 662-1029
E-mail: paula.shapiro@americanbar.org

12. Contact Name and Address Information.

Estelle H. Rogers, CRSJ Section Delegate
111 Marigold Ln
Forestville, CA 95436-9321
Tel.: (202) 337-3332 (cell)
E-mail: 1estellerogers@gmail.com
EXECUTIVE SUMMARY

1. Summary of the Resolution
The ABA urges federal, state, local, territorial, and tribal governments to refrain from imposing upon reproductive healthcare providers requirements that are not medically necessary or have the purpose or effect of burdening women’s access to such services.

2. Summary of the Issue that the Resolution Addresses
The resolution addresses the obstacles that women face in obtaining reproductive health services due to restrictive and unnecessary requirements. Increasingly, states have enacted laws and regulations that make it more difficult to access services on the pretext of protecting women’s health, while scientific data does not support the health-related rationale for these restrictions.

3. Please Explain How the Proposed Policy Position Will Address the Issue
This proposed policy would address this issue by allowing the ABA to lobby in opposition to unnecessary requirements that serve no medical purpose but make it unduly burdensome for women seeking reproductive health care and to file amicus briefs in litigation on the same subject.

4. Summary of Minority Views or Opposition Internal and/or External to the ABA
No minority views or opposition have been identified.