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THE TENTH ANNIVERSARY OF
Defending Life



Defending Life 2015

CELEBRATING TEN YEARS OF DEFENDING LIFE

*A State-by-State Legal Guide to
Abortion, Bioethics, and the End of Life*



An Educational Publication of
Americans United for Life
655 15th St NW, Suite 410
Washington, DC 20005
202-289-1478
www.AUL.org

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For information, please contact Americans United for Life,
655 15th Street NW, Suite 410, Washington, DC 20005; 202-289-1478



Charmaine Yoest, Ph.D., PRESIDENT & CEO

Editor-in-Chief:

Denise Burke, Esq., VICE PRESIDENT OF LEGAL AFFAIRS

Associate Editors:

Ovide Lamontagne, Esq., GENERAL COUNSEL

Jeanneane Maxon, Esq., VICE PRESIDENT OF EXTERNAL AFFAIRS AND CORPORATE COUNSEL

William Saunders, Esq., SENIOR VICE PRESIDENT OF LEGAL AFFAIRS AND SENIOR COUNSEL

Mailee Smith Esq., STAFF COUNSEL

Contributors:

Clarke Forsythe, Esq., SENIOR COUNSEL

Daniel McConchie, VICE PRESIDENT OF GOVERNMENT AFFAIRS

Mary Harned, Esq., STAFF COUNSEL

Anna Paprocki, Esq., STAFF COUNSEL

Mary Drury, PARALEGAL

Praise for *Defending Life*

AUL'S 2015 LEGAL GUIDE BEING USED ACROSS THE COUNTRY

“*Defending Life* has played a key role in providing tools enabling states to enact constitutionally sound pro-life legislation to protect women and their unborn children and to motivate the states to do so through AUL’s state rankings in *Defending Life*’s “Life List.” I am proud that the State of Louisiana has ranked number one on the “Life List” for several years, and I hope our work inspires leaders in other states to follow suit.” – **Bobby Jindal, Governor of Louisiana**

“Americans United for Life’s legal guide, *Defending Life*, is an extremely useful resource not only domestically for state and federal government leaders but also for pro-life lawmakers worldwide. At its core, *Defending Life*, is a strategic blueprint and best practices guide to tangibly protect women and children from the pain and violence of abortion as well as safeguard all who are weak, frail, vulnerable and unwanted.”

– **Congressman Chris Smith, Co-Chairman of the Congressional Pro-Life Caucus**

“As a pro-life governor, I appreciate good ideas and expert assistance, especially when it comes to doing all we can to protect innocent human life. I can personally attest to the quality of Americans United for Life’s legal and strategic help. As we do everything possible to defend the unborn and protect women’s health, I can say that you will not find a more comprehensive resource for helping states advance this important mission. Congratulations on the 10th anniversary of *Defending Life*.” – **Terry Branstad, Governor of Iowa**

“I believe every life is sacred and that life begins at conception. Throughout my career in public service I’ve maintained a 100 percent pro-life record. As governor I have been proud to sign the pro-life legislation that has come to my desk. I will continue to defend the life of the unborn, and I appreciate the efforts of Americans United for Life to provide lawmakers with the tools they need to craft strong pro-life bills.”

– **Mary Fallin, Governor of Oklahoma**

“Americans United for Life has a long and successful history of fighting to protect our most vulnerable—the unborn. I share that passion for protecting life and have seen the benefits of AUL’s efforts both during my time as a Congressman and now as the Governor of the State of Indiana. I have long believed that a society will be judged by the way it treats its most vulnerable, and I am proud that Indiana is one of the top ten most pro-life states in the country. Congratulations on the 10th anniversary of *Defending Life*, and let it inspire us to renew our efforts to protect the sanctity of every human life.” – **Michael R. Pence, Governor of Indiana**

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FORWARD

*By Governor Bobby Jindal
State of Louisiana, AUL's #1 Life List State*

Yes, America, there is a war on women. It is a war fought by an industry which profits off the continued destruction of human life, and seeks additional funding and leeway from government in order to do so. It is a war with casualties in the tens of millions, which has erased from our history countless young women and men before they had a chance to draw breath, to invent, to write a song, or to fall in love. It is a war prosecuted by those who believe any inconvenient or sickly life should be eradicated against those who believe that our right to life comes not from government but from our Creator – an old-fashioned idea, but one that has the advantage of being true.

The real aim of America's abortion industry and its client groups is not women's health. As their political stance has lost favor, they have become more desperate, revealing their true aims. Once, they called for abortion to be safe, legal, and rare. Now, they are increasingly willing to admit this was always a PR gimmick. Their recent actions show that they are not much concerned about the health and safety of women, and they have a vested interest in ensuring that abortion is anything but rare. They only want it legal. The "safe-legal-rare" mantra was an admission that the vast majority of Americans, including most of those who call themselves "pro-choice," do not like the idea of aborting children. Nor should they.

While the Supreme Court of the United States has limited our ability to roll back the industry of abortion-on-demand, it has endorsed commonsense requirements for purposes of safety. In the normal process of governance, an entity engaged in a medical practice with a large degree of risk would attract significant oversight. Yet for some reason, despite their love for regulation and other requirements in nearly every other arena of health care, state bureaucrats have for decades turned a blind eye toward abortion clinics and providers, ignoring many questions about their practices.

In the wake of the horror of the Kermit Gosnell killings, states are reconsidering these matters. As states across the country have reconsidered how clinics have been regulated, the introduction of sunlight to the practices of the abortion industry has produced new evidence of their hypocrisy. Even cursory oversight has found that abortion clinics often fail the most basic procedures when it comes to sterilization and cleanliness, the most basic infection prevention process, and the most basic criminal and other background checks on their employees.

Most recently in Louisiana, in an overwhelmingly bipartisan fashion, we passed a law introduced by a Democratic legislator which requires doctors practicing at abortion clinics to have admitting privileges at a local hospital. This is the type of basic medical requirement to guard against emergencies – one which ought to make logical sense even to those who claim that they are "pro-choice." Instead, we have had to fight these self-styled proponents of women's health in the media, the legislature, and now in the federal courts. At each turn, they have attempted to let abortion clinics do whatever they wish—because their primary aim is not to safeguard women's health, but to provide for the destruction of human lives—both women and unborn children deemed unwanted, unimportant, or inconvenient.

The declared compassion for women espoused by the abortion industry is, in reality, a flimsy cover for their actual aims to rid the world of those they view as defective or inconvenient. Just as Planned Parenthood founder Margaret Sanger sought to exterminate “human weeds” and wrote that, “The most merciful thing that the large family does to one of its infant members is to kill it,” today prominent atheist Richard Dawkins says that the most ethical approach to learning your unborn child has Down syndrome is to “[a]bort it and try again” because “it would be immoral to bring it into the world.”

More than three decades ago, Ronald Reagan wrote for *The Human Life Review* of similar sentiments found in the testimony of witnesses before the Congress on the practice of abortion. “The many medical and scientific witnesses who testified disagreed on many things, but not on the scientific evidence that the unborn child is alive, is a distinct individual, or is a member of the human species,” Reagan wrote. “They did disagree over the value question, whether to give value to a human life at its early and most vulnerable stages of existence. Regrettably, we live at a time when some persons do not value all human life. They want to pick and choose which individuals have value.”

Increasingly, the American people do not agree with this view. The abortion rate is the lowest it has been since 1973, and polling data indicates that more people self-identify as pro-life. They are moving in the right direction for a number of reasons – in no small part because of the hard and diligent work of organizations like Americans United for Life and the AUL publication, *Defending Life*, the playbook of the pro-life movement. *Defending Life* has played a key role in providing tools enabling states to enact constitutionally sound pro-life legislation to protect women and their unborn children and to motivate the states to do so through AUL’s state rankings in *Defending Life*’s “Life List.” I am proud that the State of Louisiana has ranked number one on the “Life List” for several years, and I hope our work inspires leaders in other states to follow suit.

Americans may be changing their minds because of the science of ultrasounds and because of the shifting understanding of the harms the abortion on-demand regime has wrought. Importantly, they are also moving in that direction for a reason that runs deeper, an understanding which resides at the center of the human heart—the knowledge that life is a precious gift, not to be discarded lightly.

We hope that this war on women and the unborn will someday end. I believe it will end when we as a nation realize that without the right to life, there can be no liberty; and when we learn to value each and every human life as the incredible gift it is. Until that day comes, we will fight against the abortion industry with every tool at our disposal under the Constitution, secure in the knowledge that our cause is just.

As others have noted, there is no higher aim of government than to stand in defense of the helpless and the innocent against those who would destroy them. I am an optimist. I believe the American people, regardless of party affiliation, will rally to defend the defenseless. It is in this spirit that I commend Americans United for Life on the 10th anniversary of the publication of *Defending Life* and urge government leaders at all levels to advance the cause of Life in the manner prescribed in the pages which follow.



Bobby Jindal,
Governor of Louisiana



FROM *the* PRESIDENT

Dear Friends,

Today, Texas has fewer than 10 abortion clinics. Last year, it had 40. That simple fact tells a dramatic story. Seeing dangerous clinics close rather than comply with commonsense health and safety regulations is a trend across the country. And abortion advocates are incensed. After years of enjoying their politically protected lack of regulation and the resulting profits, their exploitive business practices are finally being exposed. And legislators are taking action – equipped with AUL’s model legislation and expertise crafting and defending abortion clinic regulations.

Abortion advocates seem stunned. A recent article in *The Guardian* focused on abortionist Curtis Boyd and his wife Glenna. Boyd is somewhat infamous for having admitted in 2009 to Jim Douglas with the ABC affiliate, KVUE in Austin, Texas, “Am I killing? Yes, I am. I know that.” Even with that cold-blooded admission, the Boyds remain perplexed by our pro-life opposition. They commented to *The Guardian* that after 43 years of legal abortion they thought “there would be no resistance.”

But resistance there has been indeed. The article chronicles the tremendous pro-life gains that we are seeing across the country. According to the abortion lobby’s research arm, the Guttmacher Institute, in 2000, 13 states were considered “hostile to abortion.” By 2013, that number had more than doubled, with 27 states classified as “hostile to abortion.”

In response, Glenna remarks that she can’t think of a time “when it was worse than it is now” and Boyd himself concludes: “We wake up and think, ‘My God what has happened?’”

Well Mr. Boyd, resistance happened. And we are proud to have been among the leaders. With the release of this 10th Anniversary Edition of *Defending Life*, we are marking a decade of crafting what some have called “the pro-life playbook.” In each successive edition, we’ve outlined the contours of a carefully constructed state-based approach to testing – and widening – the cracks in the foundation of *Roe v. Wade*. And each year we’ve been accumulating victories, building momentum, and advancing a culture of life in America.

Writing in a recent op-ed for the *Los Angeles Times*, Caitlin Borgmann, who is a Law Professor at CUNY and on the Board of the National Abortion Federation, bemoans AUL’s strategy as “pursu[ing] a subtle, yet stunningly effective, type of restriction.” In fact, over the ensuing decade after the release of the inaugural edition of *Defending Life*, we’ve seen the passage of over 300 pieces of pro-life legislation passed at the state level.

We launched the inaugural edition of *Defending Life* a decade ago in order to systematize and nationalize our state-based strategy, and to make solid, defensible, constitutionally sound legislative limits on the abortion license more accessible to pro-life legislators. This strategy has its roots in the disappointment in seeing *Roe* endure through the challenge of multiple failed congressional efforts to pass a Human Life Amendment in the decade after *Roe*. In 1984, AUL’s then-President, my friend Paige Cunningham, convened an historic Reversing *Roe* Conference. Through days of discussion in a packed room in Chicago’s Palmer House hotel, the wisdom of a state-based strategy to create a solid challenge to *Roe* developed. The proceedings were published later in 1987 as *Abortion and the Constitution*, a landmark publication that could rightly be viewed as the precursor to *Defending Life*.

That same year, *Valparaiso University Law Review* published an article co-authored by AUL's Senior Counsel, Clarke Forsythe, "Homicide of the Unborn Child: The Born Alive Rule and Other Legal Anachronisms," articulating a powerful argument for defending the personhood of the unborn through state homicide statutes. Subsequently, our AUL legal team developed a state fetal homicide model. AUL's state-based model legislation strategy now had form and substance. And 37 states now have fetal homicide laws.

In 1989, AUL hosted an annual national conference for pro-life legislators, and the AUL legal team was heavily involved in shaping and defending the abortion restrictions that were upheld in the 1989 *Webster v. Reproductive Health Services* and 1992 *Casey v. Planned Parenthood* decisions.

Though disappointed that neither *Webster* nor *Casey* overturned *Roe*, as we had hoped, we continued refining the strategy and testing the limits of the legal challenges we confronted.

The turn into a new century brought another disappointment with the Supreme Court's stunning *Stenberg v. Carhart* decision in 2000, overturning Nebraska's partial-birth-abortion ban and similar bans in 29 other states. That same year, however, AUL's Vice President of Legal Affairs, Denise Burke was appointed a Special Prosecutor to defend "Lou Ann's Law," Arizona's health and safety standards for abortion clinics enacted in response to Lou Ann Herron's tragic death from a botched abortion. Successful defense of this much-needed law took another decade, but eventually saw victory in 2010. The *Stenberg* decision also finally went down in defeat in 2007 after Congress passed a federal partial-birth abortion ban, and the Supreme Court upheld it in *Gonzales v. Carhart*.

In the midst of these challenges and counter-challenges, abortion advocates continued to argue that *Roe* was "settled law." But we worked to ensure it would never be settled. The state-based strategy needed some rocket fuel, and we provided it in *Defending Life*.

By 2004, after working with state legislators for more than 20 years, in response to NARAL's "State Reports," our team launched AUL's first State Report Cards, the precursor to today's Life List. The response was stunning: the following year we saw a new high of 31 pro-life laws passed. This laid the groundwork for the inaugural edition of *Defending Life*, which we released two years later. Passage of state pro-life laws began trending upward—steadily growing.

Until 2010, when the midterm elections produced a robust new class of pro-life legislators in state-houses across the country. *Defending Life 2011* was waiting for them—and the passage of pro-life laws that year hit an all-time high of 92.

All told, the decade of *Defending Life* has seen the passage of 332 pro-life laws across the country. We are proud to have played a role in that sea-change, working to assist the committed and courageous pro-life men and women who serve in state legislatures, often at great personal cost.

I am pleased to introduce the 10th Anniversary Edition of a project that has changed the landscape of abortion law in this country. *Defending Life 2015* continues to press forward into new opportunities with our continued emphasis on how abortion harms women through our *Women's Protection Project*.

And we are deeply grateful for your support and partnership that has enabled this work.



Charmaine Yoest, Ph.D.

President and CEO

Facilitating Roe's Unraveling

THE STRATEGIC SIGNIFICANCE OF *DEFENDING LIFE* ON ITS 10TH ANNIVERSARY

By Clarke D. Forsythe, Senior Counsel, Americans United for Life

There is a 30 year backstory to our 10th anniversary edition of *Defending Life*—that AUL's talented Legal and Government Affairs experts, under the leadership of our Vice President of Legal Affairs Denise Burke, have worked so tirelessly to develop, launch, update, and improve for more than a decade. Without the backstory, the significance of this team's achievement cannot be adequately understood.

In 1983, a decade-long Congressional effort to overturn *Roe v. Wade* and its companion case, *Doe v. Bolton*, through a constitutional amendment came to an end with the vote on the Senate floor against the Hatch-Eagleton Federalism Amendment. The following year, a strategic conference was held in Chicago to map out a strategy to overturn *Roe* through the courts. The conference's deliberations and conclusions were published by AUL in *Abortion and the Constitution: Reversing Roe v. Wade Through the Courts* (Georgetown University Press 1987). As one element of a broader strategy against *Roe*, conference participants endorsed the drafting and adoption of limits on abortion by state legislatures. The goal was carefully drafted laws that could create strategic test cases in the courts.

When initially published, the strategy laid out in *Abortion and the Constitution* could only be partially implemented because of the hostility of the pro-abortion Blackmun majority on the Supreme Court (and of the federal courts generally). However, in 1989, the Court made its second retreat from *Roe* with its decision in *Webster v. Reproductive Health Services* where it upheld restrictions on the use of state funds, facilities, and employees for performing, assisting

with, or counseling on behalf of abortion, and affirmed the right of a state to allocate resources in favor of childbirth over abortion. After *Webster*, AUL went “national” with its public policy strategy.

In 2003, AUL's development and launch of our annual *State Report Cards*, a precursor to *Defending Life* that reported on state laws related to abortion, elevated the professionalism, outreach, and influence of AUL's state legislative strategy. Advancing AUL's goal of comprehensive protection of human life from conception to natural death, the *State Report Cards* later matured into *Defending Life* in 2006 with comprehensive coverage of the entire spectrum of life issues including bioethics and biotechnologies, the end of life, and legal protection for the unborn, and healthcare freedom of conscience.

As *Roe* is a key legal obstacle to full legal protection for both women and the unborn within the context of abortion, *Roe* must be overturned. While that has yet to be achieved, the Court has made several retreats from *Roe* over the years and, with each retreat, the Court has given more deference to the states, allowing them to enact stronger limits on abortion and permitting those limits to be enforced by state officials. As the Supreme Court has retreated from its belief that the mere access to abortion must be protected at all costs to a belief that states should be permitted to act in furtherance of their interests in protecting both maternal health and unborn life, many states have moved forward to fill the vacuum, enacting limitations and regulations on abortion designed to protect both women and their unborn children.

And with each retreat, the policy proposals in *Defending Life* have realized a greater potential for success. Our legal and political experts have written or implemented an increasing number of new policy proposals to protect women and children from the harms inherent in abortion. Year after year, our experts have worked long hours to refine existing policy ideas and to introduce new ones developed by the AUL Legal Team. These proposals – which now inform 31 pieces of AUL model legislation directly related to abortion – form the policy basis for AUL’s mother-child strategy of protecting the child as much as possible and identifying and highlighting abortion’s specific risks to women.

Jack Kemp called politics “the battle of ideas.” To make a difference in law and public policy, well-conceived and considered proposals are necessary. Intellectual and legally sound products like *Defending Life* endure. As AUL Board member and political analyst Yuval Levin, who edits the quarterly *National Affairs*, said in a recent interview,

Politics in the end is moved by arguments. The intellectual work does matter. I think it does absolutely shape outcomes. But it happens in a way that relies on a kind of food chain. Things have to move through our intellectual world and it doesn’t move directly from that kind of work to policymaking; there has to be some time to digest, to think it through. I think that happens on a lot of important issues in our politics. So I am impressed with how ideas move politics but you know it’s not a direct process. Not a simple one.

Through their work on and devotion to *Defending Life*, Denise Burke and the experts at AUL enabled the larger pro-life movement to be ready when the Supreme Court made its most recent and most important retreat for *Roe* in 2007 when, in *Gonzales v. Carhart*, the Court upheld the federal ban on partial-

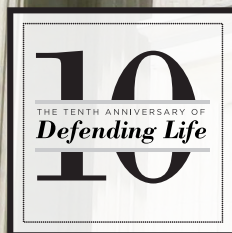
birth abortion and signaled an increasing willingness to endorse any abortion regulations that make good medical sense.

Importantly, this work allowed AUL to be even more prepared and engaged in 2010 when the midterm elections created pro-life majorities in a number of states. Beginning in 2011, AUL has been directly involved with the enactment of 74 new abortion-related state laws, nearly one-third of that total enacted over that period. A significant share of the credit for AUL’s role goes to *Defending Life*, its model legislation, and its tailored state-by-state analysis and recommendations.

Defending Life has become very significant to the cause for life in the United States and an increasingly influential asset in protecting human life. AUL took Denise Burke’s vision for *Defending Life* and made this ambitious blueprint a reality. The focus, commitment, ingenuity, and tireless efforts of a dedicated team at AUL have been inspirational to the broader pro-life movement and to hundreds of state legislators nationwide.



TEN YEARS OF *DEFENDING LIFE*



TEN YEARS OF *DEFENDING LIFE*

Accumulating Victories, Building Momentum, and Advancing a Culture of Life in America

By Ovide M. Lamontagne, General Counsel, Americans United for Life

Denise M. Burke, Vice President of Legal Affairs and Editor-in-Chief of *Defending Life*

“D*efending Life* is AUL’s strategic response to the increasing number of requests that we receive on issues relating to abortion, bioethics, the end of life, and healthcare rights of conscience. Legislators have made it clear to AUL that they need accurate and strategic information on these critical issues. [*Defending Life*] will encourage legislators to fight for life in their states ... outlines proven steps to reduce abortion and what opportunities each state has ... to protect the sanctity of human life. This one-of-a-kind tool encompasses everything legislators need to know to pass pro-life legislation.”

With these words, *Defending Life* was launched in 2006¹. *Defending Life* was—and remains—an ambitious undertaking that demonstrates AUL’s unwavering commitment to providing life-affirming and cutting-edge legislation, information, and analysis to state and federal legislators, the media, and an increasingly pro-life American public. A decade and tens of thousands of copies later, *Defending Life* remains “the pro-life playbook” and the most comprehensive and effective tool for ensuring that everyone is welcomed in life and protected in law.

Defending Life has provided indispensable analysis of current and emerging life issues, predicted legislative and public policy trends and challenges, and contributed to the enactment of hundreds of pro-life laws in states across the country. Through *Defending Life*, AUL has also ranked the states based

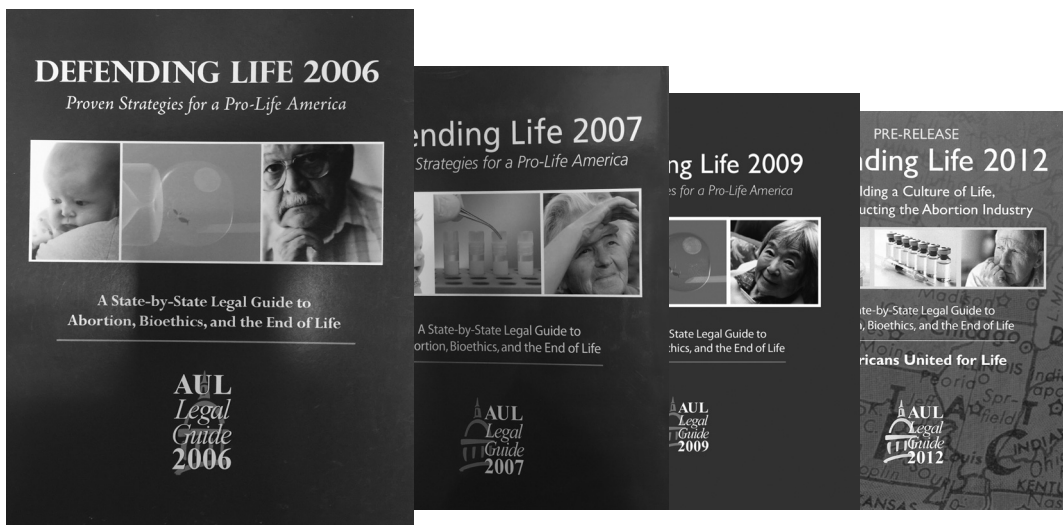
on their commitment to life, introduced new model legislation, and memorialized the contributions of pro-life champions including Representative Henry Hyde and Father Richard John Neuhaus.

DEFENDING LIFE ACCURATELY PREDICTS PUBLIC POLICY TRENDS AND CHALLENGES

By design, *Defending Life* serves as a herald for new and emerging legal and public policy trends in the cause for life. Over the years, it has proven both insightful and prophetic.

Only a few examples are necessary to prove the prescient nature of *Defending Life*. In its inaugural edition and several years before the debate over the federal healthcare law and its coercive HHS Mandate drew attention to the need to protect freedom of conscience, *Defending Life* acknowledged the growing threats to conscience and featured an expansive “Primer on Protecting Healthcare Rights of Conscience.”

Realizing the potentially devastating impact of President Barack Obama’s campaign promise that the “first thing” he would do once in office would be to sign the *Freedom of Choice Act*, *Defending Life* 2009 detailed the history, impact, and threats posed by this extreme pro-abortion legislation and included a resolution opposing this federal “power grab”



promoted by Planned Parenthood, NARAL Pro-Choice America, and their allies.

Later, *Defending Life* warned that the federal healthcare law would be the “biggest expansion of abortion since *Roe v. Wade*” and would pose significant threats to individual conscience.

The 2010 edition of *Defending Life* forecasted the explosion of life-affirming legislation that would follow the November 2010 mid-term elections. In her introduction to the volume, AUL President and CEO Dr. Charmaine Yoest noted that “as the most radically pro-abortion administration in history took shape” requests for AUL’s expert legal assistance and model legislation had increased exponentially. AUL’s expertise and model legislation—the “backbones” of *Defending Life*—made significant contributions to the more than 200 life-affirming laws enacted since 2011.

DEFENDING LIFE SPOTLIGHTS NEW AUL MODEL LEGISLATION

The inaugural edition of *Defending Life* included nine pieces of AUL model legislation, prominently featuring basic abortion-related legislation such as informed

consent, parental notice, and abortion facility regulations. By contrast, this latest version of *Defending Life* features 45 pieces of AUL model legislation, more than half of which concern abortion.

Since its inception in 2006, *Defending Life* has premiered more than 30 pieces of expertly crafted AUL model legislation providing legal guidance on the full spectrum of life issues: abortion, legal recognition and protection of the unborn (in contexts other than abortion), bioethics and biotechnologies, the end of life, and healthcare freedom of conscience. As a result, AUL now provides the nation’s most comprehensive catalogue of pro-life model legislation.

Among the model legislation introduced in *Defending Life* are the *Parental Involvement Enhancement Act*, providing options to strengthen a state’s parental consent or notification law; the *Child Protection Act*, requiring abortion facility employees and volunteers to report all cases of suspected abuse of minors and providing legal remedies against those assisting a minor girl in circumventing her home state’s parental involvement requirement; the *Defunding the Abortion Industry and Advancing Women’s Health Act*, providing options for eliminating state taxpayer funding for abortion providers like Planned Parenthood; and

the *Ensuring Compliance with Healthcare Freedom of Conscience Act*, requiring that recipients of state funding certify compliance with federal and state laws protecting conscience.

DEFENDING LIFE CONTRIBUTES TO ENACTMENT OF NEW PRO-LIFE LAWS

The model legislation featured in *Defending Life* has led to the enactment of innumerable pro-life state laws. As a recent example, *Defending Life* was ready, and distributed to legislators and influencers, when a number of states elected pro-life majorities to their legislatures in November 2010. An explosion of the pro-life legislation—especially the types of legislation championed by AUL—followed. As the pro-abortion

Americans United for Life is “the anti-abortion group perhaps most responsible for the barrage of new state laws.”

– MOTHER JONES, JAN. 16, 2013

Guttmacher Institute has reported, more pro-life laws were enacted during the 2011, 2012, and 2013 state legislative years than in the entire previous decade, with a notable surge of pro-life activity in 2011.

Among the laws enacted over the last four years are abortion facility regulations and admitting privileges requirements which AUL has championed for more than a decade, AUL’s *Abortion-Inducing Drugs Safety Act* regulating the provision of chemical abortions, ultrasound requirements for abortion, and AUL’s cutting-edge ban on abortions performed for reasons of sex-selection or genetic abnormalities such as Down Syndrome.

AUL’s thoughtful development of both its model legislation and the well-researched and targeted

content of each edition of *Defending Life* as well as AUL’s aggressive distribution of this invaluable resource deserve considerable credit for the surge in life-affirming laws being enacted in states across the nation. *Defending Life* challenges every state to improve its record on life and to protect human life from conception to natural death.

DEFENDING LIFE RANKS AND CHALLENGES THE STATES

From its launch in 2006, the “Life List,” AUL’s annual ranking of the states, has easily been the most popular and anticipated part of each edition of *Defending Life*. While the specific criteria used to rank the states have been modified over the years to better reflect emerging areas of the law and to harness momentum on key pro-life legislative and policy issues, the goal of the ranking remains to challenge and encourage pro-life states to continue to advance new and cutting-edge legal protections for life rather than resting on their prior accomplishments, while simultaneously encouraging states with more modest or even poor records on life to strive for better and more protective laws.

As a result, the “Life List” has engendered a healthy sense of competition among the states. AUL’s legal and policy experts routinely answers specific questions from legislators and other allies as to how their state can become “number one” on the “Life List.”

In ten years of ranking the states, *Defending Life* has spotlighted the accomplishments of consistently pro-life states such as Arkansas, Louisiana (which has topped the Life List since 2010), Oklahoma, and Texas. AUL has also pointed out the legal dangers in the policies of anti-life states including California, New York, Oregon, and Vermont.

The true impact of the “Life List” on state law and policy can perhaps best be seen in the steady progress of the small number of states that have moved from the “middle of the pack” to the upper echelons of

AUL's annual state ranking. Arizona provides the most recent example of this life-affirming trend.

In *Defending Life 2009*, AUL ranked Arizona as the 29th most pro-life state. Just three years later, Arizona had risen to number 14 on the “Life List.” Arizona’s progress was marked by the enactment of a variety of pro-life measures, many of which were based on AUL model legislation. For example, the state enhanced its existing informed consent law, instituted new limits on public funding for abortion, limited the performance of abortions to licensed physicians, and implemented better protections for healthcare rights of conscience. By the release of *Defending Life 2013*, Arizona had



cracked the “Top Ten” in the “Life List” for the first time and had enacted AUL’s *Women’s Health Defense Act*, banning abortions at 5 months (i.e., 20 weeks gestation) based on concerns for both maternal health and fetal pain, enacted limits on dangerous “telemed” abortions, required an ultrasound before an abortion, and strengthened its abortion facility regulations.

Notably, Arizona, like a number of other states including Indiana, Mississippi, and Virginia, enacted many of its more recent abortion-related laws and regulations after AUL increased its efforts to expose

the substandard conditions and practices that are all-too-common in the corrupt and parasitic abortion industry more concerned with increasing profits than protecting the lives and safety of the women it claims to serve.

DEFENDING LIFE EXPOSES ABORTION INDUSTRY MALFEASANCE

Beginning with *Defending Life 2009*, AUL took the lead in exposing the truth about America’s abortion industry. In an article entitled “Planned Parenthood: What can be done to stop their radical agenda for America?” Americans United for Life began making the case that Planned Parenthood’s legacy is “a troubling one of ruined lives” and that “[f]or more than 90 years, it has relentlessly pursued an agenda of unapologetic abortion-on-demand, putting profits and ideology above women’s health and safety.” This work also laid the groundwork for AUL’s later, groundbreaking reports on the abortion giant: *The Case for Investigating Planned Parenthood: AUL Looks Behind the Closed Doors of the Nation’s Largest Abortion Provider* (released in 2011) and the *Planned Parenthood Exhibits: The Continuing Case for Investigating the Nation’s Largest Abortion Provider* (released in 2012).

Later, in both *Defending Life 2012* and *Defending Life 2013*, AUL’s legal team provided further evidence in support of its contention that Planned Parenthood is a “scandal-ridden, heavily-subsidized, and abortion-centric organization” whose true legacy must be understood by all Americans, whose radical agenda must be confronted, and whose enormous annual taxpayer subsidies must be ended.

In the wake of the Kermit Gosnell scandal, AUL broadened its focus in *Defending Life 2013* and *Defending Life 2014* to issue a stinging indictment of the entire abortion industry, spotlighting the pervasiveness of substandard care and practices at America’s abortion clinics. AUL’s efforts to expose and remedy abortion

“At its core, *Defending Life* is a strategic blueprint and best practice guide to tangibly protect women and children from the pain and violence of abortion as well as safeguard all who are weak, frail, vulnerable and unwanted.”

– CONGRESSMAN CHRIS SMITH
(R-NJ), Co-Chairman of the Congressional
Pro-Life Caucus.

industry malfeasance and implement our Mother-Child strategy will continue in future editions of *Defending Life* and in a comprehensive, new report slated for release in 2015.

DEFENDING LIFE MARKS THE 40TH ANNIVERSARY OF ROE V. WADE AND INAUGURATES THE WOMEN’S PROTECTION PROJECT

Defending Life 2013 marked the 40th anniversary of *Roe v. Wade* with a collection of essays entitled “*Roe at 40: Evaluating the Regime of Abortion on Demand.*” The essays included a frank analysis of whether and how *Roe* could be overturned, a discussion of the increasing pro-life sentiment among Americans, and an indictment of the radical, anti-woman agenda still being advanced by pro-abortion groups like Planned Parenthood.

Guest writer Dr. Byron Calhoun, joined with AUL Staff Counsel Mailee Smith, to catalogue the medical risks of abortion, highlighting recent and growing research on abortion’s health risks. AUL’s focus on abortion’s negative impact on women remains a common theme in *Defending Life* and the centerpiece of AUL’s extraor-

dinarily effective “mother-child” legislative strategy.

Further, in anticipation of the October 2013 release of AUL Senior Counsel Clarke Forsythe’s book, *Abuse of Discretion*, the *Roe* anniversary edition of *Defending Life* detailed how *Roe v. Wade* became the law of the land and demonstrated that this landmark and controversial decision was, in reality, not a well-reasoned judicial decision, but a “power play by pro-abortion justices.”

In 2014, *Defending Life* focused on AUL’s new initiative, the *Women’s Protection Project* which further highlights abortion’s negative impact on women and recommends specific legislative solutions to the growing concerns regarding abortion’s risks to women and girls. The *Women’s Protection Project* encompasses seven pieces of AUL model legislation designed to protect women and girls from dangerous, late-term abortion procedures, substandard abortion clinics and practices, the misuse of abortion-inducing drugs, and other dangers inherent in how abortion is practiced.

Further, the *Women’s Protection Project* includes an *Enforcement Module* which provides state officials and others with a variety of options for ensuring that protective, abortion-related laws are properly enforced. As the Kermit Gosnell grand jury noted in 2011, to prevent future abortion tragedies, state officials and the general public “must find the fortitude to enact and enforce the necessary regulations. Rules must be more than words on paper.”

DEFENDING LIFE ACCENTUATES IMPORTANCE OF THE COURTS IN ADVANCING PRO-LIFE POLICIES

From its inception, *Defending Life* has spotlighted the importance of federal and state courts in implementing commonsense and medically appropriate policies on abortion and in combating the dangerous regime of abortion-on-demand. The opening salvo in this ongoing educational campaign was the *Defending Life* 2006 article, “Who Will Fix the Supreme Court’s

Defending Life is “built upon AUL’s four decades of professional expertise and insight” and “provides a comprehensive catalog of expertly crafted model legislation dedicated to protecting the unborn and promoting the values of life in a variety of settings.”

– GOVERNOR RICK PERRY (TEXAS), Foreword to *Defending Life* 2014

Mess,” arguing that the Supreme Court’s abortion jurisprudence has damaged women, the ability of states to carry out their responsibilities to protect maternal health, and the needed public discourse over the desirability and availability of abortion.

In 2008, recognizing the underappreciated importance of state courts in policy debates surrounding the life issues, *Defending Life* included an in-depth analysis of each of the 50 state supreme courts and their records on life. Meanwhile, AUL’s analysis of federal and Supreme Court jurisprudence on abortion continued and included *Defending Life* 2013’s frank and eye-opening discussion of how *Roe v. Wade* became the law of the land.

DEFENDING LIFE LOOKS FORWARD TO THE FUTURE

Over the last ten years, *Defending Life* has clearly contributed to the increase in America’s pro-life ethic and to the weakening of the pro-abortion movement. With each future edition of *Defending Life*, AUL will continue to build on that momentum and to take advantage of unique and emerging opportunities to expose and dismantle the tyranny of abortion-on-demand, to challenge our allies to upgrade their efforts in defense of life, and to confront the renegade abortion industry and its supporters. The future looks bright, and AUL and *Defending Life* look forward to celebrating more pro-life victories with each passing year.

ENDNOTES:

¹Past editions of *Defending Life* can be found at the Americans United for Life website, www.aul.org

Accumulating Legislative Victories and Laying the Groundwork for *Roe*'s Demise

By Mary E. Harned, Staff Counsel

Mary Drury, Paralegal, Americans United for Life

After inventing a constitutional “right” to abortion and declaring themselves the “National Abortion Control Board”—with the final word on every federal or state regulation or limitation of abortion¹—certain members of the U.S. Supreme Court may have believed that democratic debate over the issue would dissipate. Instead, legislative gains over the last ten years have demonstrated both the resilience of the pro-life movement and a growing awareness among Americans that every abortion ends at least one human life and can gravely endanger another.

Americans United for Life (AUL) began publishing *Defending Life* at a critical time in the movement to protect women and their unborn children. The Supreme Court’s 2000 decision in *Stenberg v. Carhart*², striking down partial birth abortion limitations in 30 states, left pro-life state legislators—previously emboldened by the Court’s endorsement of various abortion restrictions in *Planned Parenthood v. Casey*³ and other cases—uncertain about what types of life-affirming legislation would continue to pass judicial scrutiny.

AUL recognized the need for solid legislative and policy guidance on the life issues and, through the development and publication of *Defending Life*, AUL increased its effectiveness in helping states to enact strong and effective pro-life laws. Armed with *Defending Life* and its growing catalogue of pro-life model legislation, legislators were prepared in 2007 when the Supreme Court reversed course, upholding the federal

partial birth abortion ban in *Gonzales v. Carhart*⁴, and spurring a flood of new pro-life legislation.

Remarkably, even the election in 2008 (and reelection in 2012) of the most pro-abortion President in history has not derailed the enactment of a substantial number of cutting-edge and comprehensive state laws protecting both maternal health and the unborn. Many of these new laws were based on or inspired by the AUL model legislation featured in *Defending Life*. Moreover, the expert analysis provided by AUL’s legal and policy experts also helped to defeat anti-life measures introduced in Congress.

AUL’S INFLUENCE INCREASES FOLLOWING INTRODUCTION OF *DEFENDING LIFE*

AUL’s promotion of legislation that protects both women and their unborn children and efforts to educate the public through the articles in *Defending Life*, public testimony, and other resources have been extraordinarily successful and, as a result, have received extensive media attention. For example, AUL has been described as “the most powerful right-to-life legal organization in the country,”⁵ “an influential advocacy group that creates model anti-abortion legislation for the states,”⁶ “*de facto* lawmakers,”⁷ “perhaps [the group] most responsible for a barrage of new state [pro-life] laws,”⁸ and “a less confrontational, more pragmatic force.”⁹ In January of 2014, the *Rolling Stone* reported, with alarm, that AUL is

“chiefly responsible for the most recent and highly successful under-the-radar strategy.”¹⁰

Defending Life has been central to AUL’s efforts and has even been referred to as “the pro-life playbook.”¹¹ AUL experts assist state legislators and other allies to customize the model legislation in *Defending Life* to fit their state’s particular needs.

STATE ABORTION RESTRICTIONS: PROTECTING WOMEN AND THEIR UNBORN CHILDREN

In the last four years alone, nearly 220 state laws protecting women and their unborn children from the dangers inherent in abortion have been enacted. Nearly a third of these laws are based on AUL model legislation or were otherwise assisted by AUL professionals. State legislators or policy groups have ready access to AUL’s model legislation through *Defending Life*.

Legislative gains in the last ten years have demonstrated both the resilience of the pro-life movement and a rapidly growing awareness among Americans that every abortion ends at least one human life and gravely endangers another.

Critical to many of AUL’s achievements is our Mother-Child strategy, our emphasis on protecting both women and their unborn children, most recently through our 2013 initiative, the *Women’s Protection Project*¹². Abortion is always deadly for an unborn child. The Supreme Court has repeatedly acknowledged “abortion is inherently different from other medical procedures, because no other procedure involves the purposeful termination of a potential life.”¹³ However, a robust and growing body of evidence documents how dangerous abortion is to a mother’s physical and psychological health.¹⁴

Given the extensive health risks posed by abortion,

which increase substantially with gestation,¹⁵ legislative and educational efforts to limit or prohibit abortions must be based on facts detailing the impact of abortion on both women and their unborn children.

DEFENDING LIFE PRECIPITATES A DECADE OF CONSEQUENTIAL LEGISLATIVE ACTION

Abortion: Abortion Bans or Limitations

Understandably, measures banning or limiting abortions are widely popular with pro-life legislators and their constituents. In 2006, at least 21 states considered measures banning all or most abortions. Nearly a decade later, in 2014, at least 20 states considered measures to ban or limit abortions, demonstrating the resilience of public support for such limitations.

However, driven by the demand for AUL’s innovative legislation, the nature of the abortion bans being considered has evolved. While post-viability bans, partial-birth abortion bans, and nearly complete bans on abortion continue to be introduced and, in some cases, enacted, the most popular abortion bans or limitations today include:

- Based on AUL’s *Women’s Health Defense Act*, limits on abortion at five months (i.e., 20 weeks) based on concerns for women’s health and fetal pain. Arizona was the first state to enact the *Women’s Health Defense Act*, and in 2014, Mississippi became the most recent.
- Based on AUL’s *Prenatal Nondiscrimination Act*, prohibitions on abortions for sex-selection and genetic abnormalities. In the last two years, both North Dakota and South Dakota enacted this protective legislation.

Abortion: Informed Consent and Parental Involvement

Abortion advocates aggressively oppose laws ensuring that women considering abortions are provided with information about the abortion procedure itself, abortion's substantial health risks to women and the pain experienced by their unborn child, as well as parental involvement requirements designed to safeguard minors against both the risks of abortion and the risk of continuing sexual and other abuse at the hands of predators. In contrast, these laws are very popular with the American public and their elected state representatives.

It is indefensible for abortion providers to withhold critical information from their clients. Further, it is particularly dangerous for abortion providers to presume that minors understand risks posed by abortion. The pro-abortion Guttmacher Institute has acknowledged that because minors are less likely than adults to take prescribed antibiotics or follow other regimens of treatment, they are at greater risk for serious long-term complications from abortion.¹⁶ Further, minors face dangers beyond the physical and psychological complications of abortion. When they obtain “secret” abortions, minors often do so at the behest of the older men who impregnated them and then return to abusive situations.

Between 2006 and 2014, each year an average of 20 states considered enacting informed consent laws or enhancements to their existing laws. (Thirty-two states currently maintain enforceable informed consent laws for abortion.) Ultrasound requirements are one of the most popular informed consent “enhancements,” with a median of 18 states considering them each year since 2006. Ultrasound provisions promote the woman's physical and psychological health and advance the state's important and legitimate interest in protecting life.¹⁷ AUL's model ultrasound requirement, which was introduced in *Defending Life* 2007, requires an abortion provider or other qualified practitioner to perform an ultrasound and give the woman the option

of viewing the ultrasound image and hearing the fetal heart tone. Currently, at least 13 states require both the performance of an ultrasound before an abortion and the ability for a woman to view the ultrasound image and have it explained to her.



Interest in parental involvement laws experienced a renaissance in 2011, when at least 28 states considered new or enhanced parental involvement provisions, compared to just 9 states in 2010. Six of these states enacted laws, with Nebraska adopting AUL's *Parental Consent for Abortion Act*, to replace its existing parental notification law. Also, in 2012, with assistance from AUL, New Hampshire overrode a veto to enact a parental notification law.

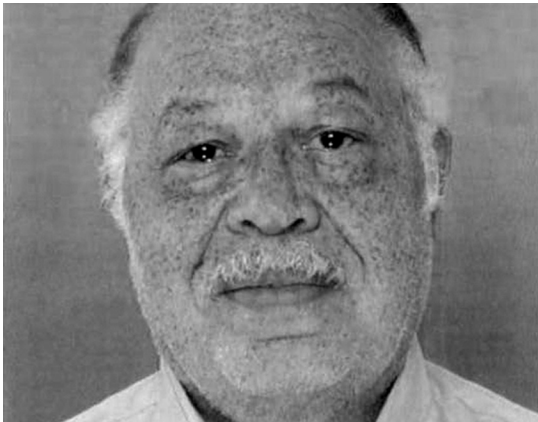
In response to increased state interest in new or improved parental involvement laws, AUL introduced the *Parental Involvement Enhancement Act* in *Defending Life* 2012. This model legislation assists states in closing loopholes that permit abortion providers to sidestep laws requiring parental involvement. In 2013, Montana and Oklahoma enacted enhancements featured in the new AUL model.

Abortion: Health and Safety Standards for Abortion Clinics

The 2010 raid on the Philadelphia clinic operated by notorious late-term abortionist Kermit Gosnell—and his later convictions for involuntary manslaughter in the death of a client and for murder for using scissors to cut the spinal cords of struggling born-alive infants—awakened many Americans to the dangerous

conditions present in many of the nation's abortion clinics. AUL has long advocated for stringent health and safety standards for abortion clinics and the tools needed to adequately enforce these requirements.

In recent years, AUL has led the nationwide effort to require abortion clinics to meet the same medical standards as facilities performing other outpatient surgeries. Most recently, in 2014, AUL assisted Arizona with amending its law to permit unannounced state visits to clinics and helped Oklahoma enact comprehensive health and safety regulations based on AUL's *Women's Health Protection Act*, first developed in 2002.



The Gosnell case brought discussion about abortion regulations into the national spotlight

To augment health and safety standards for abortion facilities, AUL provides model legislation, the *Abortion Providers' Admitting Privileges Act*, to ensure that abortion providers maintain admitting privileges at hospitals near their clinics.

The need for such lifesaving requirements is clear. Relying on the abortion industry's own conservative estimates of complication rates along with the pro-abortion Guttmacher Institute's latest report on induced abortions, in 2011 alone, more than 26,000 women experienced abortion-related complications, and more than 3,000 of these women required hospitalization. Admitting privileges requirements are necessary to ensure that these women receive high-

quality, post-abortive and emergency care.

In the last four years, at least 11 states have enacted admitting privilege requirements for abortion providers, bringing the total number of states that have enacted these protective requirements to 15.

Abortion: Regulation of Abortion-Inducing Drugs

A "chemical abortion revolution" has arrived, posing grave dangers to women and their unborn children. Abortion-inducing drugs such as RU-486 (the Mifeprex regimen) are being dispensed with greater frequency from non-specialized clinics and often in a manner not approved by the U.S. Food and Drug Administration (FDA).

AUL assists states with ensuring that profit-driven abortion providers do not abandon their responsibility to their patients after dispensing life-ending drugs. In *Defending Life 2011*, AUL introduced the *Abortion-Inducing Drugs Safety Act* to ensure that abortion providers follow FDA-approved protocols, examine women before prescribing the Mifeprex regimen, and meet other critical safety standards. In the last four years, at least 18 states have regulated the use of abortion-inducing drugs, including requiring physicians' adherence to the FDA-approved protocols and performance of patient examinations prior to prescribing the drugs.

Abortion: Public Funding and Insurance Coverage of Abortion

Increased public awareness about the breadth of taxpayer subsidization of abortion and growing suspicion about the abortion industry have arguably inaugurated a new era in the use of state funding restrictions to limit or eliminate state taxpayer funding for abortion providers and to, ultimately, protect women and unborn children from a parasitic industry more concerned with profits than the health and safety of women and their unborn children. In the last four years, at least 12 states diverted or withheld federal and/or state family planning funding from abortion providers



including Planned Parenthood, the nation's largest abortion provider. These actions, encouraged by AUL model legislation and other material in *Defending Life* and aided by AUL's legal and policy experts, are having consequential effects on the nation's abortion industry.

Further, the enactment of the *Affordable Care Act* (ACA), also known as "Obamacare," raised awareness about insurance coverage for abortion. Twenty-five states have laws prohibiting or limiting abortion coverage in their state insurance Exchanges required by the ACA. Half of these laws are based on AUL's *Federal Abortion-Mandate Opt-Out Act* or were enacted with AUL's assistance. Further, ten states now have limitations or prohibitions on private insurance plans offering abortion coverage in their state, and at least 16 states restrict abortion coverage for public employees.

Legal Recognition and Protection of Unborn and Newly Born Children

States have embraced opportunities to protect and to provide immediate and effective legal status for unborn children through laws that recognize and protect unborn and newly born children outside the context of abortion. The most popular of these consensus-building laws include criminal and civil penalties for actions that result in the death of or an injury to an unborn child and protections for unborn children who

are born alive during abortions.

Today, states that have previously lagged behind in affording unborn children these basic protections are enacting new laws. For example, in 2014, Alaska enacted AUL's *Unborn Wrongful Death Act* which permits wrongful death lawsuits to be brought on behalf of an unborn child, and Florida enacted a measure removing viability as the point at which a person may be charged with a crime against an unborn child. In 2013, following testimony from AUL President and CEO Dr. Charmaine Yoest, Florida enacted a law requiring that children born alive following an attempted abortion receive appropriate medical care and attention and not be abandoned to die.

States that have not enacted or strengthened these protections are missing an opportunity to have a conversation about the humanity of unborn children, free from the sometimes polarizing debate over abortion.

Bioethics and Biotechnologies

In this "brave new world" of biotechnologies, AUL has focused on providing accurate and up-to-date information on legal advances in biotechnology including human cloning, destructive embryo research (DER), and ethical alternatives to DER such as adult stem cells, induced pluripotent stem (iPS) cells, and

cord blood. AUL provides model legislation to help states promote ethical research and prohibit research that destroys human life.

Tragically, much of the biotechnology legislation considered by states is not life-affirming. For instance, in 2014, only two states considered measures prohibiting human cloning for all purposes, and only two states considered measures opposing destructive embryo research. When states pursue the dream of “miracle cures” through unethical research, they devalue life and draw resources from successful adult stem cell research.

End of Life

The need for laws that respect the lives of sick, elderly, and disabled Americans has never been greater. The most obvious threat to vulnerable populations is the legalization of assisted suicide, or even worse, euthanasia. “Aid in dying” and “death with dignity,” terms preferred by supporters of assisted suicide, are merely euphemisms for physician-assisted suicide. Further, experiences in European countries demonstrate that once assisted suicide becomes legal, the slide towards euthanasia is inevitable.

Oregon was the first state to experiment with legalizing physician-assisted suicide, adopting the practice by ballot initiative in 1994. Washington followed suit in 2008. In 2009, the Montana Supreme Court held that physicians could use the consent defense against a charge of homicide when aiding a suicide. Later, in 2012, Vermont legalized physician-assisted suicide.

However, there is good news. AUL has recently assisted other states—Connecticut, Massachusetts, and New Hampshire—in defeating aggressive efforts to legalize physician-assisted suicide. Importantly, in 2011 Idaho enacted AUL’s *Assisted Suicide Ban Act*, explicitly prohibiting the practice.

Healthcare Freedom of Conscience

Healthcare providers, institutions, and payers should be free to exercise their moral, ethical, and religious beliefs. However, without robust legal protection

Remarkably, even the election ... of the most pro-abortion President in history has not derailed the enactment of a substantial number of state laws protecting women and their unborn children.

for healthcare freedom of conscience, they can face serious repercussions for refusing to provide or pay for services that violate their consciences. The battle over the freedom of conscience has gained great attention because of coercive measures in the federal healthcare law and subsequent litigation seeking to defend Americans’ First Amendment freedoms.

After a 2012 surge in legislation to protect healthcare freedom of conscience (aided significantly by AUL), however, the number of conscience-protecting bills dropped dramatically in 2014—to only roughly one-third of 2013 activity levels, while the number of bills seeking to coerce conscience almost doubled. Overall, the amount of conscience-protective legislation has fluctuated over the last nine years. In some years, coercive measures (e.g., forcing insurance companies to cover contraceptives or forcing pharmacies to dispense contraception) significantly outpace the protective measures.

LIFE-RELATED LEGISLATION IN CONGRESS

Not surprisingly, President Obama and a pro-abortion majority in the United States Senate have blocked most efforts to protect life at the federal level since 2008. However, AUL has helped prevent the enactment of some extreme pro-abortion measures and blunted the impact of others.

With pro-abortion majorities in both the House and the Senate from 2008-2010, abortion advocates pushed for unregulated, unrestricted, and taxpayer-funded abortion-on-demand through the radical *Freedom of*

Choice Act (FOCA) and undertook covert efforts to mainstream abortion as “healthcare” through the *Affordable Care Act* (ACA).

The Freedom of Choice Act

The goal of the *Freedom of Choice Act* (FOCA) is to create a fundamental right to abortion, to eliminate federal and state protections for women and their unborn children, and to bar legislatures from regulating or restricting abortion in the future. Some of the protections that FOCA would have eliminated include parental involvement laws, informed consent laws, and requirements that abortion only be performed by licensed physicians. These commonsense protections are supported by the vast majority of Americans.

Through *Defending Life* and other initiatives, AUL and others were successful at heading off this dangerous legislation by educating the American people about just how radical FOCA is. By early 2009, the abortion lobby switched gears, claiming that FOCA was not an immediate priority and admitting that they did not have the votes for passage.

Women's Health Protection Act (FOCA 2.0)

In November 2013, the abortion lobby launched a new tactic, asserting that its expansive pro-abortion policies are necessary to protect women's health. Senator Richard Blumenthal (D-CT) introduced the disingenuously named federal *Women's Health Protection Act*, which would accomplish the same goal as FOCA: invalidating virtually all abortion-related protections for women and their unborn children. Furthermore, Senator Blumenthal's bill would bar states from enacting future protections. Through this legislation, abortion advocates callously claim that virtually any limitation on access to abortion is unduly burdensome to women and that any regulation of abortion is medically unnecessary.

The pro-life movement continues to meet these disingenuous claims head on. For example, in her testimony before the Senate Judiciary Committee in July 2014, AUL Board member Dr. Monique Chireau effectively

debunked several assumptions underlying this dangerous bill: that abortion is good and healthy for women; that restrictions on and regulations of abortion are “medically unwarranted;” that mere access to abortion



is necessary for women's health; and that the state has no interest in protecting unborn human life.

The Affordable Care Act

If the pro-life movement had not been vigilant, President Obama's signature healthcare law could have explicitly included direct taxpayer funding for abortions and might have been used to mandate abortion coverage in private insurance plans. However, constant pressure by pro-life members of Congress and pro-life groups like AUL helped to blunt pro-abortion efforts to mainstream abortion as “health care.”

Nonetheless, significant anti-life provisions remain, necessitating the law's repeal.

For example, the ACA:

- Fails to comprehensively prohibit the use of federal tax dollars for abortions or insurance coverage for abortion, creating a loophole that can be and has been easily exploited.
- Permits health plans that provide abortion coverage to participate in the Exchanges established in each state under the law and permits those plans to obtain federal subsidies (unless states affirmatively “opt-out” of permitting this).

- Requires Americans in states without opt-out laws who are enrolled in insurance plans that cover abortion to pay an “abortion premium” that is used exclusively to pay for abortions, even if they are enrolled inadvertently or through employment.
- Creates a mechanism whereby insurance plans that cover abortions within state Exchanges will be permitted to directly use federal subsidies to pay for abortions if Congress ever fails to add the Hyde Amendment to the yearly Labor, Health & Human Services (LHHS) Appropriations Bill—an “omission” the abortion lobby actively pursues.
- Includes a “preventive care” mandate that is being used to require insurance plans to cover life-ending drugs and devices inappropriately classified as “emergency contraception.”
- Lacks real conscience protections.

In early September 2014, the non-partisan Government Accountability Office (GAO) released a report showing that federal funds are likely paying for abortions through some insurance plans, in some state Exchanges. The Obama Administration promised the American people that there would be no taxpayer funding of abortion in the ACA, but the GAO report proves that the Obama Administration is not enforcing that promise.

The ACA requires insurers that cover abortion to collect a separate payment for abortions and a separate payment for legitimate healthcare that may be subsidized by taxpayers—in order to keep taxpayer funds from co-mingling with abortion funds. The GAO report revealed that insurers are not collecting a separate “abortion premium,” and that at least some insurers do not have a system for segregating abortion funds from taxpayer funds.

The GAO found 1036 plans that cover abortion on demand in the 2014 Exchanges. Since insurance issuers are not collecting a separate payment for legitimate health care and a separate payment for abortion, taxpayers are effectively paying for abortion coverage

in some or all of these plans. Congressional action is needed to stop this abuse and to hold the Obama Administration accountable.

PROGRESS FOR FEDERAL PRO-LIFE LEGISLATION

In 2010, pro-life Republicans retook the House of Representatives. Under their leadership, the House has passed several pieces of pro-life legislation including:

- *Pain Capable Unborn Child Protection Act* prohibiting abortion after 5 months (i.e., 20 weeks gestation);
- *No Taxpayer Funding for Abortion and Abortion Insurance Full Disclosure Act* applying the restrictions on abortion funding found in the Hyde Amendment to all federal funding streams and requiring that all plans offered through the ACA Exchanges disclose if abortion coverage is included;
- *Prenatal Nondiscrimination Act* prohibiting sex-selective abortions;
- *Protect Life Act* ensuring that no funds appropriated or authorized through the ACA can be used for abortion or insurance plans that provide abortion coverage;
- *H.AMDT. 95*, known as the “Pence Amendment,” which would have prohibited the use of federal funds for Planned Parenthood;
- *H.Cong.Res. 36*, known as the “Black-Roby Resolution to Defund Planned Parenthood,” which would have defunded Planned Parenthood in the Continuing Resolution;
- *H.AMDT. 298*, known as the “Foxy Amendment,” which would prohibit federal funds from being used to train abortion providers.

President Obama and the pro-abortion Senate, however, have blocked these House-passed measures from enactment. While, Republicans have managed

to keep provisions in annual appropriations bills that prevent many sources of federal funds from being used for abortions, these laws will have a better chance of enactment if pro-life Republicans take control of the Senate following the 2014 mid-term elections, and if we elect a pro-life president in 2016.

As we wrote at the outset, legislative gains over the last ten years have demonstrated both the resilience of the

pro-life movement and a growing awareness among Americans that every abortion ends at least one human life and gravely endangers another. As noted above, publishing *Defending Life* continues to be an important and strategic tool at a critical time in the movement to protect women and their unborn children.

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³ 505 U.S. 833 (1992).

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⁹ Jennifer Skalka, *Abortion Opponents Have a New Voice*, THE CHRISTIAN SCIENCE MONITOR (Aug. 13, 2011), available at <http://www.csmonitor.com/USA/Society/2011/0813/Abortion-opponents-have-a-new-voice> (last visited Sept. 3, 2014).

¹⁰ Janet Reitman, *The Stealth War on Abortion*, ROLLING STONE (Jan. 14, 2014), available at <http://www.rollingstone.com/politics/news/the-stealth-war-on-abortion-20140115> (last visited at Oct. 14 2014).

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¹² Women's Protection Project, available at <http://www.aul.org/womens-protection-project/> (last visited Sept. 4, 2014).

¹³ *Harris v. McRae*, 448 U.S. 297, 325 (1980).

¹⁴ For a comprehensive discussion of the medical risks posed by abortion, please see Byron C. Calhoun, M.D. & Mailee R. Smith, Esq., *Significant Potential for Harm: Growing Medical Evidence of Abortion's Negative Impact on Women*, DEFENDING LIFE 2013: DECONSTRUCTING ROE: ABORTION'S NEGATIVE IMPACT ON WOMEN (2013).

¹⁵ See, e.g., L.A. Bartlett et al., *Risk Factors for Legal Induced Abortion—Related Mortality in the United States*, OBSTETRICS & GYNECOLOGY 103(4):729 (2004).

¹⁶ Guttmacher Institute, *Teenage Pregnancy: Overall Trends and State-by-State Information* (Feb. 19, 2004).

¹ *Roe v. Wade*, 410 U.S. 113, 162 (1973).

AUL Educates Americans on Abortion's Harm to Women

By Anna Paprocki, Staff Counsel, Americans United for Life

Abortion advocates work hard to bury the studies and stories that document abortion's negative health—and even deadly—consequences for women because this evidence discredits their politically expedient “myth” that the debate surrounding abortion requires choosing sides between a mother and her child. In 2014, abortion-industry backed politicians in the U. S. Senate even pushed a bill that would eliminate virtually all regulation of abortion under the misleading title: the *Women's Health Protection Act*.

Year after year, *Defending Life* has at length presented data and analysis demonstrating that a growing body of medical and other evidence proves that abortion carries inherent risks that harm mothers and their children including those children conceived in future pregnancies. Further, several editions of *Defending Life* have called attention to the all-too-common substandard conditions and practices in America's abortion clinics – conditions that have thoroughly permeated the profit-hungry abortion industry and have exacerbated abortion's risks to women.

THE FREQUENCY OF ABORTION SHOULD RAISE PUBLIC CONCERN ABOUT EVEN MODEST RISKS

“Harms or benefits associated with such a commonly used procedure, even if rather modest, would ripple through a population and have a large impact,” wrote Dr. John M. Thorp of the Department of Obstetrics and Gynecology, School of Medicine, University of North Carolina in his review of the available abortion-related data on the 40th anniversary of *Roe v. Wade*.¹

Dr. Thorp explains, for example, that “if the hazard ratio for preterm birth associated with [induced abortion] is 1.3, then the population attributed risk would be 3.2%.”² While the numbers 1.3 and 3.2% might sound small, the consequence is profound: “therefore over one-quarter of preterm births in developed countries would be attributable to [induced abortion].”³

Over one million abortions are performed each year in the United States.⁴ For the sake of both public health and the health of individual women, the facts about abortion's harm to women demand attention.

DECADES OF MEDICAL EVIDENCE REVEALS THAT ABORTION CARRIES SIGNIFICANT PSYCHOLOGICAL RISKS, INCLUDING INCREASED RISKS OF DEPRESSION, ANXIETY, AND SUICIDE

Over 100 studies demonstrate the connection between abortion and subsequent mental health problems.⁵ It has been estimated that 10 percent of mental health problems suffered by women are directly attributable to abortion.⁶

Pro-abortion advocates sometimes try to dismiss the evidence by claiming abortion was merely a symptom, rather than a cause, of mental health issues. They flatly refuse to consider that abortion may compound underlying mental health concerns. However, studies controlling for pre-pregnancy psychological state demonstrate a link between induced abortion and depression and anxiety.

One of the leading studies, led by a pro-abortion researcher and controlling for all relevant factors (including prior history of depression, anxiety, and suicide ideation), found that 27 percent of women who aborted reported experiencing suicidal ideation, with as many as 50 percent of minors experiencing suicide or suicidal ideation.⁷ The risk of suicide was three times greater for women who aborted than for women who delivered. The study also found that 42 percent of women who aborted reported major depression by age 25, and 39 percent of post-abortive women suffered from anxiety disorders by age 25.

Over 100 studies demonstrate the connection between abortion and subsequent mental health problems

Another study found that women whose first pregnancies ended in abortions were 65 percent more likely to score in the “high risk” range for clinical depression than women whose first pregnancies resulted in births—even after controlling for age, race, marital status, divorce history, education, income, and pre-pregnancy psychological state.⁸

Of course, abortion advocates sometimes try to dismiss abortion’s negative mental health consequences by hiding behind studies finding women did not cite “regret” as their main emotion.⁹ However, feeling short-term relief from circumstances and feeling regret from abortion or other negative mental health consequences are not mutually exclusive.

Commonsense confirms that a woman could be troubled by her involvement in the taking of human life, even where circumstances made her feel trapped into having an abortion. In virtually any context other than abortion, society openly accepts that the psychological consequences of killing are real and can be lasting. It is uncontroversial that, in the case of an accident or an instance where a member of the military or police has felt his or her duty demanded the taking of a life,

a person can be seriously impacted. Seemingly, only in the instance of abortion is there resistance to the idea that death can have a negative mental health impact.

The reason abortion advocates vehemently oppose the facts regarding abortion’s harmful psychological impact seems obvious. Negative mental health consequences expose the fallacy of their proposition that abortion is comparable to any other elective surgical or medical procedure. Emotional and psychological risks stem from what makes abortion fundamentally different: no other surgical or medical procedure involves the taking of a human life.

HISTORY PROVES THAT LEGAL ABORTION HAS HAD A NEGATIVE—AND EVEN DEADLY—IMPACT ON WOMEN’S PHYSICAL HEALTH.



In 2014 Lakisha Wilson died as a result of her late-term abortion

Recent deaths from legal abortion include that of 22-year-old LaKisha Wilson who was pronounced dead on March 28, 2014, one week after she stopped breathing at an abortion clinic in downtown Cleveland.¹⁰ Jennifer Moribelli’s death in February 2013 was the result of a legal abortion performed by Leroy Carhart, infamous for his late-term abortion practice.¹¹ Tonya Reaves, a young mother, died in July 2012 after her legal abortion in a flagship Chicago Planned Parenthood clinic.¹² Holly Patterson died three weeks after her 18th birthday in 2003 after the chemical abortion pill was given to her legally, though with off-label instructions for its use, by Planned Parenthood.¹³

Death is only one measure of safety. Whether

accomplished by an invasive surgical procedure or by taking a combination of potent drugs, abortion carries many other inherent risks of physical harm for women.

Numerous, well-documented studies in peer-reviewed international medical journals have found increased physical health risks after abortion.¹⁴ Even Planned Parenthood’s website acknowledges undisputed risks of immediate complications from abortion including blood clots, hemorrhage, incomplete abortions, infection, and injury to the cervix and other organs.¹⁵ Abortion can also cause cardiac arrest, respiratory arrest, renal failure, metabolic disorder, or shock.¹⁶ Immediate complications affect approximately ten percent of women undergoing abortions.¹⁷

In an effort to downplay their significance, abortion advocates often declare that the risks are similar to those of other procedures. Certainly some physical risks associated with induced abortion may occur with other elective surgical and medical procedures—for example bleeding, infection, and damage to other organs in the genitourinary and gastrointestinal tracts. Some similarity, however, fails to make the full consideration of these risks any less important for women considering abortions.

1 out of 3 preterm births in the U.S. could be due to induced abortion.

Induced abortion carries “unique risks of incomplete emptying of the uterus and obfuscation of the diagnosis of ectopic pregnancy.”¹⁸ And as explained above, abortion also carries unique negative mental health risks.

It bears remembering that the baby—whose death is intended in an induced abortion—fails to be considered in studies examining abortion’s physical harms. Tragically, that loss of human life goes uncounted.

THE IMPACT ON A WOMAN’S REPRODUCTIVE FUTURE AND THE HEALTH OF SUBSEQUENTLY BORN CHILDREN IS VITAL INFORMATION FOR A WOMAN CONSIDERING ABORTION

The link between having an induced abortion and subsequent preterm birth (a birth occurring three or more weeks before the due date of the baby) has been recognized in over 120 peer-reviewed scientific studies,¹⁹ as well as being listed as an “immutable medical risk factor” by the Institute of Medicine.²⁰ “Mechanical trauma to the cervix, infection, and scarring of the endometrium” are all reasons why an induced abortion could increase the likelihood of a subsequent preterm birth.²¹

One major concern with preterm birth is very low birth weight which can have serious health consequences, including cerebral palsy, cognitive impairment, and chronic health issues.²² Preterm birth is also the leading cause of infant death, both globally and in the United States.²³

In fact, abortion may be a significant contributor to the dangerous and costly pre-term birth phenomenon. “Up to one-third of [preterm births] in contemporary perinatal practice in the U.S. could be due to [induced abortion].”²⁴

Studies have also shown that induced abortion is a risk factor for a woman developing placenta previa in future pregnancies. Placenta previa can cause severe bleeding before or during delivery and can be dangerous for both the mother and the baby.²⁵

A SUBSTANTIAL SHIFT FROM SURGICAL TO CHEMICAL ABORTIONS PRESENTS NEW THREATS TO WOMEN’S HEALTH

Because of its known dangers, the use of the mifepristone and misoprostol chemical abortion drug regimen (also commonly referred to as “RU-486”)

has been strictly regulated by the U.S. Food and Drug Administration (FDA). On its website, the FDA notes, “Since its approval in September 2000, the [FDA] has received reports of serious adverse events, including several deaths, in the United States following medical abortion with mifepristone and misoprostol.”²⁶ A 2011 FDA report accounts for at least 2,207 cases of severe adverse events including hemorrhaging, blood loss requiring transfusions, serious infection, and death.²⁷



RU-486 caused the death of 17-year-old Holly Patterson in 2003

Studies have found chemical abortions can carry even more risk to women than surgical abortions. For example, a major review of nearly 7,000 abortions performed in Australia in 2009 and 2010 found that 3.3 percent of patients who used mifepristone in the first trimester required emergency hospital treatment, in contrast to 2.2 percent of patients who underwent surgical abortions.²⁸ Women receiving chemical abortions were admitted to hospitals at a rate of 5.7 percent following the abortion, as compared with 0.4 percent for patients undergoing surgical abortion. Another study revealed that the overall incidence of immediate adverse events is fourfold higher for chemical abortions than for surgical abortions.²⁹

Planned Parenthood’s own studies acknowledge that its off-label use of chemical abortions has come at the cost of women’s lives and “higher-than-expected” consequences to health. According to a 2009 study produced by Planned Parenthood,

Prompted by the deaths that occurred after medical abortion and internal data that show a higher-than-expected rate of serious infection, [Planned Parenthood Federation of America] changed its medical abortion protocol at the end of March 2006.³⁰

Only after women, including 18 year-old Holly Patterson, died or suffered serious infections did Planned Parenthood stop the vaginal use of misoprostol, an off-label use that was never approved by the FDA.

THE LATER IN PREGNANCY AN ABORTION OCCURS, THE RISKIER IT IS AND THE GREATER THE CHANCE FOR SIGNIFICANT COMPLICATIONS

A well-respected peer-reviewed journal—one which is also frequently cited by abortion advocates—notes that, “Abortion has a higher medical risk when the procedure is performed later in pregnancy. Compared to abortion at eight weeks of gestation or earlier, the relative risk increases exponentially at higher gestations.”³¹

The relative risk of mortality increases by 38 percent for each additional week after 8 weeks gestation.³² That means a woman seeking an abortion at 20 weeks (five months) is 35 times more likely to die from abortion than she was in the first trimester. At 21 weeks or more, she is 91 times more likely to die from abortion than she was in the first trimester.

Researchers have concluded that it may not be possible to reduce the risk of death in later-term abortions because of the “inherently greater technical complexity of later abortions.”³³ This is because later-term

abortions require a greater degree of cervical dilation, with an increased blood flow in a later-term abortion which predisposes the woman to hemorrhage, and because the myometrium is relaxed and more subject to perforation.³⁴

U.S. ABORTION DATA IS INCOMPLETE AND UNRELIABLE, AND ABORTION COMPLICATIONS ARE UNDER-REPORTED

There is no federal requirement for abortion reporting. The U.S. Centers for Disease Control (CDC) has cautioned against making comparative statements between abortion and pregnancy based on CDC data.³⁵

Further, the Alan Guttmacher Institute, a long-time special affiliate of Planned Parenthood, relies on voluntary reporting from the abortion industry.³⁶ Guttmacher's estimates and unsubstantiated theories are, unfortunately, often cited as facts rather than receiving the scrutiny they deserve.

Abortion complications in the United States are known to be under-reported for a variety of reasons. Susan Schewel, the Executive Director of the Women's Medical Fund in Philadelphia, a pro-abortion group, described the obstacles she experienced trying to work with women to file complaints with the Pennsylvania Department of Health: "The women found the complaint process so onerous and the telling of their stories so personally difficult that they failed to complete the paperwork and abandoned the effort."³⁷

According to a "whistleblower" lawsuit filed against Planned Parenthood, former employee Sue Thayer recalls that, lacking the ability to care for these women at their own facilities, Planned Parenthood's "telemedicine" chemical abortion patients (women who were given abortion drugs after a Skype session with an off-location doctor) who later experienced significant bleeding were told "to go to an emergency room and report that they were experiencing a spontaneous miscarriage."³⁸

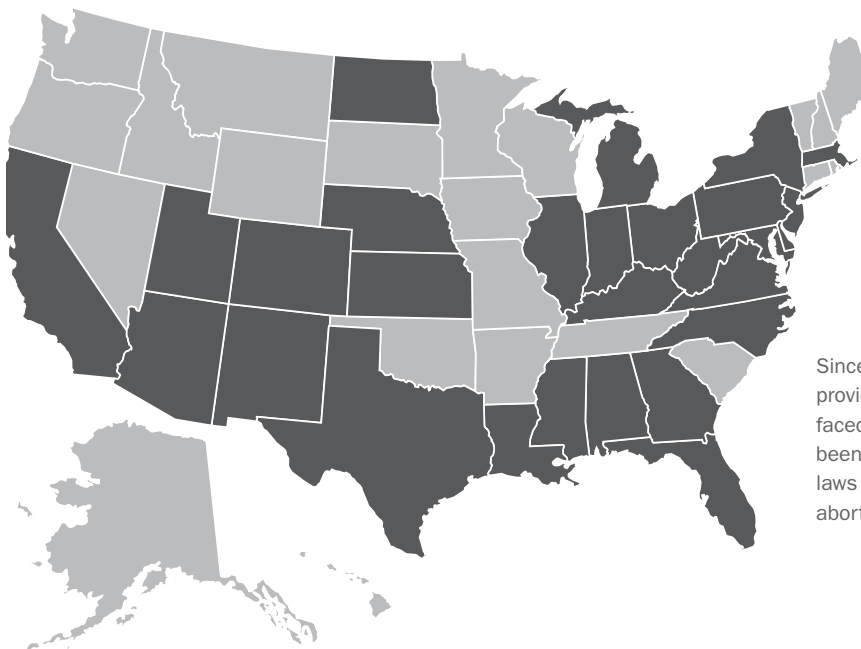
Countless other negative health stories go unreported because they go unconnected to the abortions that caused them. A former Planned Parenthood nurse testified before the Delaware Senate that "the sad thing is that these women may not even realize the fact that Planned Parenthood could be at fault for these medical tragedies even years after they had their abortions at Planned Parenthood."³⁹

Notably, in contrast to the United States, "countries with mandatory reporting and the ability to link birth, abortion, and hospital registries show increased rates of mortality above U.S. estimates and increased relative risk of death after [induced abortion] when compared to women having a child."⁴⁰

FAILURE TO ENACT AND ENFORCE HEALTH AND SAFETY STANDARDS HAS ALLOWED ABORTION INDUSTRY ABUSE TO COMPOUND THE KNOWN HARMS FROM ABORTION.

From the "Abortion Profiteers" of Michigan Avenue profiled by the Chicago Sun Times in 1978, to recently convicted murderer. Kermit Gosnell, to Planned Parenthood clinics nationwide rocked by scandal, experience has indisputably proven that merely turning abortion clinics into legal operations has not diminished the state's significant interest in regulating abortion to safeguard maternal health.

In 2012, two nurses left Planned Parenthood in Delaware, not because of a change of heart regarding abortion, but because of the abortion clinic's deplorable safety conditions including "meat-market-style, assembly-line abortions."⁴¹ In her testimony before the Delaware senate, Jayne Mitchell-Werbrich, a registered nurse for over 26 years and a former employee at a Planned Parenthood abortion clinic, described serious health hazards that she reported to Planned Parenthood officials as well as state agencies, but which were never addressed:



Since 2009, over 100 abortion providers in 29 states have faced investigations or have been cited for violating state laws governing the provision of abortions.

I was forced to resign on August 8, 2012 as the conditions at Planned Parenthood continued to be unsafe and potentially life threatening for the patients despite the numerous reports I provided to Planned Parenthood Administrators, State of Delaware: Division of Professional Regulation, State of Delaware Health and Social Services: Division of Public Health and Occupational Safety and Health Administration (OSHA).⁴²

Since 2009, over 100 abortion providers in 29 states have faced investigations or have been cited for violating state laws governing the provision of abortions.⁴³ These investigations and other adverse actions likely represent only the tip of the proverbial iceberg of the abortion industry's abuses.

STUDIES SHOW THAT, WHERE ABORTION HAS BEEN RESTRICTED, MATERNAL MORTALITY RATES HAVE DECREASED.

A May 2012 study from Chile that examined trends in maternal deaths both when abortion was legal and

after abortion was prohibited found that death rates did not increase after abortion was made illegal.⁴⁴ While abortion was the leading cause of death for a pregnant woman between 1957 and 1989—the time period in which abortion was legal, maternal mortality actually decreased from 41.3 deaths per 100,000 live births when abortion was legal to just 12.7 maternal deaths per 100,000 live births after abortion was made illegal. Today, Chile has a lower maternal mortality rate than the United States and has the lowest maternal mortality rate in all of Latin America.

Another study that compared maternal mortality rates in Ireland (where abortion is illegal) to England and Scotland (where abortion is legal) found that maternal mortality rates were much lower in Ireland than in England or Scotland.⁴⁵ Specifically, in Ireland, there are 1 or 2 maternal deaths per 100,000 live births, whereas in England/Wales there are 10 deaths per 100,000 live births and in Scotland there are 10 to 12 deaths per 100,000 live births.

ABORTION FUNDAMENTALLY DIFFERS FROM NECESSARY MEDICAL TREATMENTS THAT ARE CARRIED OUT TO SAVE THE LIFE OF THE MOTHER, EVEN IF SUCH TREATMENTS RESULT IN THE LOSS OF LIFE OF HER UNBORN CHILD.

The American Association of Pro-Life Obstetricians and Gynecologists (AAPLOG) affirms the Dublin Declaration which states:

As experienced practitioners and researchers in Obstetrics and Gynecology, we affirm that direct abortion is not medically necessary to save the life of a woman. We uphold that there is a fundamental difference between abortion and necessary medical treatments that are carried out to save the life of the mother, even if such treatments results in the loss of life of her unborn child. We confirm that the prohibition of abortion does not affect, in any way, the availability of optimal care to pregnant women.⁴⁶

There is a distinct difference between preterm parturition (separating a mother and her unborn

child for the purposes of saving a mother's life) and direct abortion. There are times when separating the mother and her unborn child may be necessary to save the life of the mother, even if the unborn child is too premature to survive. However, as AAPLOG explains, "In those tragic cases, if possible the life of the baby will be attempted to be preserved, and if not possible, the body of the unborn child is treated with respect, recognizing the humanity of the life which is lost in the separation."⁴⁷

In contrast, induced abortion, where "the focus of the abortion procedure is on killing the unborn child, and the purpose of the abortion is to produce a dead baby," is never necessary to save the life or preserve the health of any woman.⁴⁸

Abortion is by definition deadly for the baby. Moreover, the evidence is overwhelming that legal abortion poses serious medical risks for women. Full and accurate information is necessary for true "choice." With over a million abortions performed in the United States each year, abortion's harm to women remains a significant public health concern—a concern that AUL and *Defending Life* will continue to expose.

ENDNOTES:

¹ John M. Thorp, Jr., *Public Health Impact of Legal Termination of Pregnancy in the US: 40 Years Later*, SCIENTIFICA 2013, available at <http://www.hindawi.com/journals/scientifica/2012/980812/cta/> (last visited Sept. 4, 2014).

² *Id.*

³ *Id.*

⁴ See Jones & Jerman, *Abortion Incidence and Service Availability in the United States 2011*, 46(1) PERSP. ON SEXUAL & REPROD. HEALTH (2014).

⁵ Priscilla K. Coleman, *Abortion and Mental Health: A Quantitative Synthesis and Analysis of Research Published 1995-2009*, 199 THE BRIT. J. OF PSYCHIATRY 180, 180.

⁶ *Id.* at 183.

⁷ D.M. Fergusson et al., *Abortion in young women and subsequent mental health*, J. CHILD PSYCHOLOGY & PSYCHIATRY 47:16 (2006).

⁸ J.R. Coughle et al., *Depression associated with abortion and childbirth: A long-term analysis of the NLSY cohort*, MED. SCI.MONITOR 9(4):CR157 (2003).

⁹ See e.g. Lauren Rankin, *The Seven Most Common Lies About Abortion*, *Rolling Stone*, Feb. 26, 2014, available at <http://www.rollingstone.com/politics/news/the-seven-most-common-lies-about-abortion-20140226> (last visited Sept. 4, 2014).

¹⁰ See Scott Taylor, Preterm clinic: Lakisha Wilson Abortion Death Investigation, *Fox19*, Apr. 3, 2014, available at <http://www.fox19.com/story/25158531/preterm-abortion-clinic-lakisha-wilson-death-investigation> (last visited Sept. 4, 2014).

¹¹ See Authorities: *Woman died from abortion complications*, *USA Today*, June 12, 2013, available at <http://www.usatoday.com/story/news/nation/2013/02/21/woman-late-term-abortion-death/1935799/> (last visited Sept. 4, 2014).

¹² See *Report of Postmortem Examination*, OFF. OF THE MED. EXAMINER, COOK COUNTY, ILL. (July 26, 2012), obtained by Operation Rescue, available at <http://operationrescue.org/pdfs/Reaves%20Autopsy%20Report.pdf> (last visited Oct. 8, 2013).

¹³ See Julian Guthrie, *Monty Patterson learns about RU-486 the hard way*, *SFGate*, Dec. 5, 2011, available at <http://www.sfgate.com/entertainment/article/Monty-Patterson-learns-about-RU-486-the-hard-way-2345757.php> (last visited Sept. 4, 2014).

¹⁴ See Thorp *supra*. See also Mailee R. Smith and Dr. Byron Calhoun, *Significant Potential for Harm: Growing Medical Evidence of Abortion's Negative Impact on Women*, DEFENDING LIFE 2013.

¹⁵ The websites for abortion organizations such as Planned Parenthood and the National Abortion Federation acknowledge these risks of abortion. See, e.g., Planned Parenthood Federation of America, *In-Clinic Abortion Procedures* (2013), available at <http://www.plannedparenthood.org/health-topics/abortion/abortion-procedures-4359.htm> (last visited Sept. 4, 2014); Planned Parenthood, *The Abortion Pill (Medical Abortion)* (2013), available at <http://www.plannedparenthood.org/health-topics/abortion/abortion-pill-medication-abortion-4354.asp> (last visited Sept. 4, 2014); National Abortion Federation, *Abortion Facts*, available at http://www.prochoice.org/about-abortion/facts/safety_of_abortion.html (last visited Sept. 4, 2014).

¹⁶ See Shadigian, Elizabeth, "Reviewing the Medical Evidence: Short and Long-Term Physical Consequences of Induced Abortion," testimony before the South Dakota Task Force to Study Abortion, Pierre, South Dakota September 21, 2005, available at http://www.abortionbreastcancer.com/PHYSICAL_EFFECTS_OF_ABORTION.pdf. (last visited Sept. 4, 2014).

¹⁷ *Id.*

¹⁸ See Thorp *supra* at 4.

¹⁹ A bibliography of studies documenting the association between abortion and preterm birth is available at <http://www.aaplog.org/complications-of-induced-abortion/induced-abortion-and-pre-term-birth/bibliography/> (last visited Sept. 4, 2014).

²⁰ INST. OF MED. OF THE ACADEMIES, *PRETERM BIRTH: CAUSES, CONSEQUENCES, AND PREVENTION*, 625 (Richard E. Behrman and Adrienne Stith Butler, eds., 2007) available at http://books.nap.edu/openbook.php?record_id=11622&page=625 (last visited Sept. 4, 2014).

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²² Mayo Clinic Staff, *PREMATURE BIRTH*, available at <http://mayoclinic.com/health/premature-birth/DS00137> (last visited Sept. 4, 2014).

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²⁵ See John M. Thorp, et al., *Long-Term Physical and Psychological Health Consequences of Induced Abortion: Review of the Evidence*, 58 OBSTETRICAL & GYNECOLOGICAL SURVEY 67, 70 (2002); and Cande V. Anath, et al., *The Association of Placenta Previa with History of Cesarean Delivery and Abortion: A Metaanalysis*, 177 AM. J. OBSTETRICS & GYNECOLOGY 1072, 1075 (1997). See also L.G. Johnson, et al., *The Relationship of Placenta Previa and History of Induced Abortion*, 81 INT'L J. GYNECOLOGY & OBSTETRICS 191, 191 (2002).

²⁶ See *Mifeprex(mifepristone) information*, available at <http://www.fda.gov/drugs/drugsafety/postmarketdrugafetyinformationforpatientsandproviders/ucm111323.htm> (last visited Sept. 4, 2014).

²⁷ The FDA report, "Mifepristone U.S. Postmarketing Adverse Events Summary through 04/30/2011," available at <http://www.fda.gov/downloads/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/UCM263353.pdf> (last visited Sept. 4, 2014).

²⁸ E. Mulligan & H. Messenger, *Mifepristone in South Australia: The First 1343 Tablets*, *Australian Family Physician* 40(5):342-45 (May 2011).

²⁹ M. Niinimäki et al., *Immediate Complications after Medical compared with Surgical Termination of Pregnancy*, *Obstet. Gynecol.* 114:795 (Oct. 2009).

³⁰ Mary Fjerstad, N.P., M.H.S., et al, *Rates of Serious Infection after Changes in Regimens for Medical Abortion*, 361 *NEW. ENG. J. MED.* 145 (2009). Mrs. Fjerstad and Dr. Cullins report having been employed by Planned Parenthood Federation of America (PPFA) at the time of the study. Drs. Lichtensberg and Trussell report serving on the PPFA National Committee. “No other conflict of interest relevant to this article was reported.”

³¹ L.A. Bartlett et al., *Risk factors for legal induced abortion-related mortality in the United States*, *OBSTETRICS & GYNECOLOGY* 103(4):729-37 (2004). “The risk of death associated with abortion increases with the length of pregnancy, from one death for every one million abortions at or before eight weeks gestation to one per 29,000 abortions at sixteen to twenty weeks and one per 11,000 abortions at twenty-one or more weeks.”

³² See *id.* at 729, 731.

³³ *Id.* at 735.

³⁴ *Id.*

³⁵ See e.g., Letter of July 20, 2004 from Julie Louise Gerberding, M.D., M.P.H., Director, Centers for Disease Control, to Walter M. Weber, available at <http://findlawimages.com/efile/supreme/briefs/05-1382/05-1382.mer.ami.aclj.pdf> (last visited Sept. 4, 2014).

³⁶ See e.g., Jones & Jerman, *Abortion Incidence and Service Availability in the United States 2011*, 46(1) *PERSP. ON SEXUAL & REPROD. HEALTH* (2014).

³⁷ Kermit Gosnell and Intelligence Failures, *The Atlantic*, Apr. 17, 2013, available at <http://www.theatlantic.com/politics/archive/2013/04/kermit-gosnell-and-intelligence-failures-contd/275092/> (last visited Sept. 4, 2014).

³⁸ See Second Amended Complaint at 45, *United States and Iowa ex rel Thayer v. Planned Parenthood of the Heartland*, No. CV00129 (S.D. Iowa July 26, 2012).

³⁹ Testimony available at http://sba-list.org/sites/default/files/content/shared/jayne_mitchell-werbrich_testimony.pdf (last visited Sept. 4, 2014).

⁴⁰ See Thorp *supra* at 3.

⁴¹ Testimony available at http://sba-list.org/sites/default/files/content/shared/jayne_mitchell-werbrich_testimony.pdf (last visited Sept. 4, 2014).

⁴² *Id.*

⁴³ Data cited is from Americans United for Life’s forthcoming expose on abortion industry abuses. The report is scheduled for release in 2015

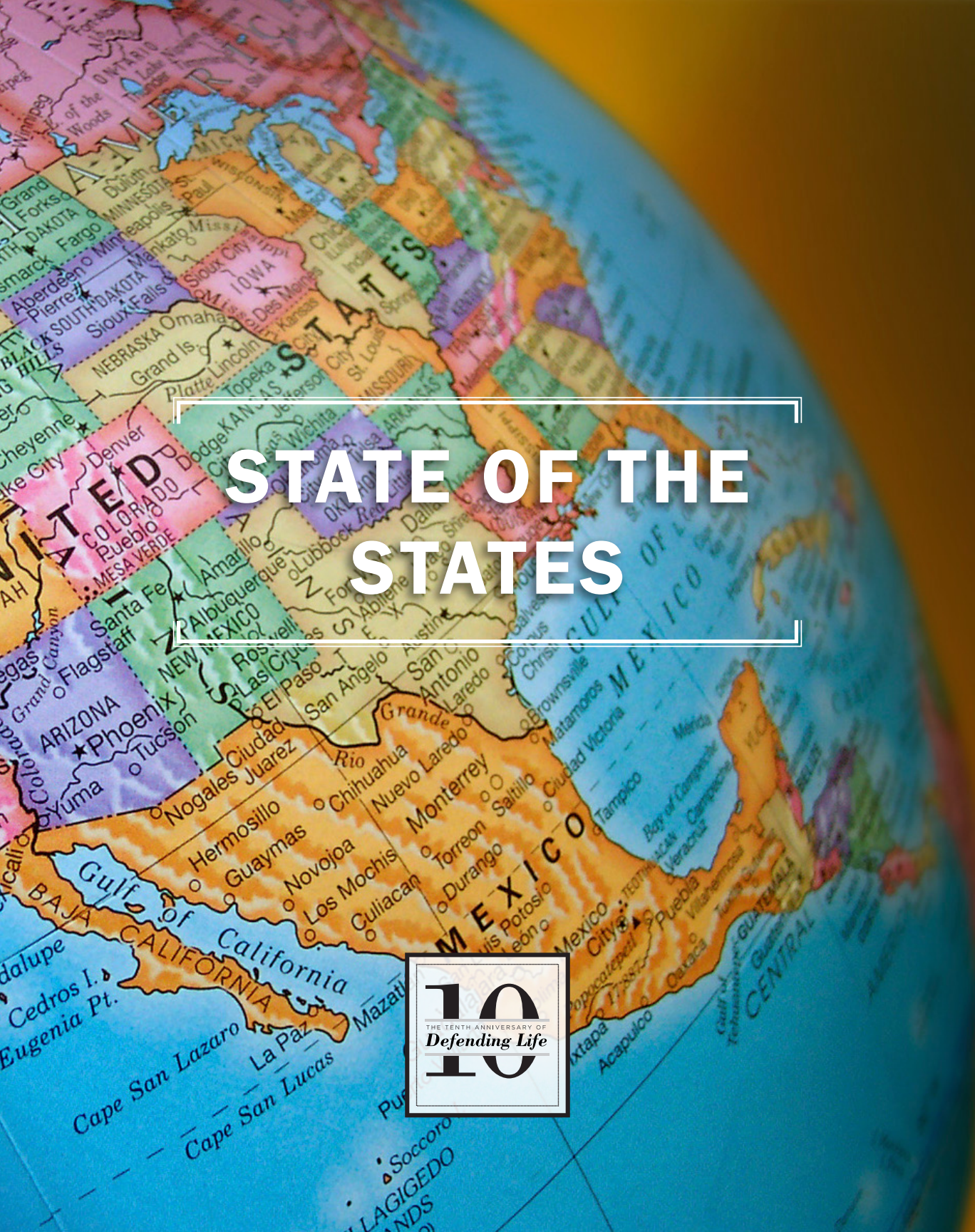
⁴⁴ E. Koch et al., *Women’s Education Level, Maternal Health Facilities, Abortion Legislation and Maternal Deaths: A Natural Experiment in Chile from 1957 to 2007*, *PLOS ONE* 7(5):e36613 (May 4, 2012), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3344918/> (last visited Sept. 4, 2014).

⁴⁵ Carroll, *Ireland’s Gain: The Demographic Impact and Consequences for the Health of Women of the Abortion Laws in Ireland and Northern Ireland since 1968*, at Figure 8 (Dec. 2011), available at http://papiresearch.org/ESW/Files/Irelands_Gain.pdf (last visited Sept. 4, 2014).

⁴⁶ *Premature Delivery is Not Induced Abortion*, American Association of Pro-Life Obstetricians and Gynecologists, available at <http://www.aaplog.org/position-and-papers/premature-delivery-not-induced-abortion/> (last visited Sept. 4, 2014).

⁴⁷ *Id.*

⁴⁸ *Id.*



STATE OF THE STATES

10
THE TENTH ANNIVERSARY OF
Defending Life

STATE OF THE STATES

Every year, we are making progress—state-by-state and law-by-law—toward creating a more pro-life America. The 2014 state legislative year produced significant victories for life, simultaneously laying the groundwork for victories in 2015 and beyond. Last year, at least 56 new life-affirming legal requirements, including at least 41 measures related to abortion, were enacted, while 20 states made notable progress in defending Life.

In 2013, 41 states considered approximately 270 measures related to abortion, and the majority of these measures were life-affirming. A number of states including Indiana, Louisiana, Mississippi, Oklahoma, and South Dakota enacted multiple life-affirming and protective measures. Of particular note, Mississippi, relying on AUL model language, enacted a ban on abortions at five months of pregnancy, relying on both maternal health concerns and evidence of fetal pain.

Recognizing the significance of state laws protecting women and the unborn from the negative impact of abortion, establishing legal recognition and protection of unborn children in contexts other than abortion, prohibiting the illicit and exploitative use of emerging biotechnologies, protecting those at the end of life, and affirming the First Amendment freedom of conscience,

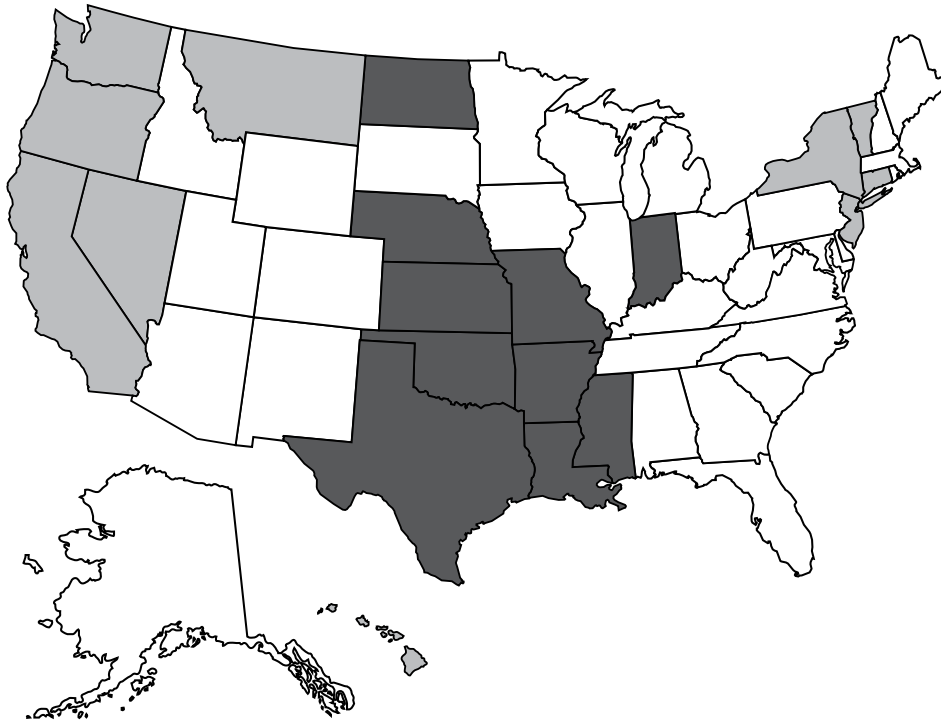
AUL has compiled an individual report card on the life-related laws in each of the 50 states and the District of Columbia.

The AUL State Report Cards summarize and highlight existing state laws on abortion, legal protection and recognition of the unborn, bioethics and biotechnologies, the end of life, and healthcare freedom of conscience. They also specifically discuss advances both in the legislatures and in the courts that have been made over the last year.

Importantly, each report card also includes recommendations for each state, allowing citizens and lawmakers to readily assess each state's progress and to develop a plan to further protect life in their individual states. We have made specific recommendations as to what is needed, what are the best “next steps” toward a renewed culture of life, and what is realistic and feasible for each state to accomplish.

These report cards are designed to encourage state action intended to bring us closer to the day when every person—from conception to natural death—is welcomed in life and protected in law!

Ten Best and Worst States for Life



MOST PROTECTIVE STATES

1. Louisiana (best)
2. Mississippi
3. Kansas
4. Oklahoma
5. Arkansas
6. Missouri
7. Indiana
8. North Dakota
9. Nebraska
10. Texas

LEAST PROTECTIVE STATES

1. Washington (worst)
2. Vermont
3. Oregon
4. California
5. New Jersey
6. Hawaii
7. New York
8. Montana
9. Nevada
10. Connecticut

AUL's 2014 State Rankings

- | | |
|--------------------|-------------------|
| 1. Louisiana | 26. Rhode Island |
| 2. Mississippi | 27. Florida |
| 3. Kansas | 28. Utah |
| 4. Oklahoma | 29. Colorado |
| 5. Arkansas | 30. Minnesota |
| 6. Missouri | 31. Delaware |
| 7. Indiana | 32. Maine |
| 8. North Dakota | 33. Alaska |
| 9. Nebraska | 34. West Virginia |
| 10. Texas | 35. New Hampshire |
| 11. South Dakota | 36. Iowa |
| 12. Arizona | 37. Wyoming |
| 13. Pennsylvania | 38. Massachusetts |
| 14. Michigan | 39. Maryland |
| 15. Georgia | 40. New Mexico |
| 16. Ohio | 41. Connecticut |
| 17. Alabama | 42. Nevada |
| 18. Wisconsin | 43. Montana |
| 19. Virginia | 44. New York |
| 20. Kentucky | 45. Hawaii |
| 21. South Carolina | 46. New Jersey |
| 22. Idaho | 47. California |
| 23. Tennessee | 48. Oregon |
| 24. Illinois | 49. Vermont |
| 25. North Carolina | 50. Washington |



Alabama | RANKING: 17

In recent years, Alabama has made significant progress in protecting women from the harms of abortion. Alabama law requires informed consent and parental consent before abortion, and has prohibited abortion coverage in the state health insurance Exchanges (required under the federal healthcare law). However, the state maintains no laws regarding human cloning, destructive embryo research, fetal experimentation, or human egg harvesting, and it does not promote ethical forms of research.

» ABORTION

- Alabama bans most abortions at or after 5 months (*i.e.*, 20 weeks) on the basis of pain experienced by unborn children.
- Alabama requires that a woman be given a 48-hour reflection period before a physician may perform an abortion and requires that she be informed of the risks of and alternatives to abortion, the probable gestational age of her unborn child, and the probable anatomical and physiological characteristics of the child at that stage of development.
- Alabama also requires an abortion provider to provide the woman with an opportunity to review a state-sponsored videotape and written materials detailing sources of public and private support, adoption agencies, fetal development, abortion methods, and the father's legal responsibilities.
- The state also requires an abortion provider to perform an ultrasound prior to an abortion and to provide the woman with an opportunity to view the ultrasound.
- Alabama requires abortion providers to explain in printed materials that it is illegal for someone to coerce a woman into having an abortion.
- One parent must provide written consent before a physician may perform an abortion on a minor under the age of 18, unless there is a medical emergency or the minor obtains a court order. Further, the state requires proof of relationship between parent(s) and a minor seeking an abortion and prohibits a parent, legal guardian, custodian, or any other person from coercing a minor to have an abortion.
- Abortion clinics must meet the same medically appropriate standards of patient care as other facilities performing outpatient surgeries.
- Only a physician licensed by the state to practice medicine or osteopathy may perform an abortion. A requirement that abortion providers maintain hospital admitting privileges has been challenged by Planned Parenthood and is in litigation.

- The state maintains an enforceable abortion reporting law, but does not require the reporting of information to the Centers for Disease Control (CDC). The measure requires abortion providers to report short-term complications.
- Abortion clinics are required to report suspected child abuse.
- Alabama requires that abortion-inducing drugs be administered by a physician and mandates that the physician examine the woman before providing the drugs.
- Alabama follows the federal standard for Medicaid funding for abortions, only permitting the use of federal or state matching Medicaid funds for abortions necessary to preserve the life of the woman or when the pregnancy is the result of rape or incest.
- The Alabama Office of Women’s Health may not advocate, promote, or otherwise advance abortion or abortion-inducing drugs.
- Alabama prohibits abortion coverage in the state health insurance Exchanges (required under the federal healthcare law) except in cases of life endangerment, rape, incest, or ectopic pregnancy. Further, Alabama voters approved a constitutional amendment that “prohibit[s] any person, employer, or health care provider from being compelled to participate in any health care system.” As a result, if individuals, employers, and healthcare providers are not required to participate in a particular healthcare system, their freedom of conscience to object to providing or paying for certain services that are included in that system (*e.g.*, abortion or life-ending drugs or devices) is protected.
- Alabama offers “Choose Life” license plates, the proceeds of which benefit pregnancy resource centers and/or other organizations providing abortion alternatives.

» **LEGAL RECOGNITION OF UNBORN AND NEWLY BORN**

- Alabama defines a “person” under its homicide laws to include the unborn child *in utero* at any stage of development, regardless of viability.
- Alabama also defines a nonfatal assault on an unborn child as a criminal offense.
- The state allows a wrongful death (civil) action when an unborn child at any stage of development is killed through a negligent or criminal act.
- Alabama has created a specific affirmative duty for physicians to provide medical care and treatment to infants born alive at any stage of development.
- Alabama has enacted a “Baby Moses” law under which a mother or legal guardian who is unable to care for a newborn infant may anonymously and safely leave the infant in the care of a responsible person at a hospital, police station, fire station, or other prescribed location.

» **BIOETHICS LAWS**

- Alabama maintains no laws regarding human cloning, destructive embryo research, fetal experimentation, or human egg harvesting, and it does not promote ethical forms of research.
- The state maintains laws regarding the parentage of children conceived through assisted reproductive technologies.

» **END OF LIFE LAWS**

- Alabama does not have a specific statute criminalizing assisted suicide. However, under the state's common law, assisted suicide remains a crime.

» **HEALTHCARE FREEDOM OF CONSCIENCE**

Participation in Abortion

- Alabama currently provides no protection for the freedom of conscience of healthcare providers.

Participation in Research Harmful to Human Life

- Alabama currently provides no protection for the rights of healthcare providers who conscientiously object to participation in human cloning, destructive embryo research, or other forms of medical research, which violate a provider's moral or religious belief.

» **WHAT HAPPENED IN 2014**

- Alabama amended its informed consent law to include a 48-hour reflection period in place of a previously required 24-hour reflection period.
- Alabama also enacted a measure requiring proof of relationship between parent(s) and a minor seeking an abortion and prohibiting a parent, legal guardian, custodian, or any other person from coercing a minor to have an abortion.
- Alabama considered legislation prohibiting an abortion when an unborn child has a heartbeat and requiring that information on perinatal hospice be given to a woman seeking abortion after receiving a life-limiting diagnosis for her unborn child.
- In *Planned Parenthood v. Bentley*, a federal district court invalidated an Alabama law requiring that abortion providers maintain hospital admitting privileges. The law remains in litigation.
- Alabama modified the physician registration requirements under the *Alabama Pain Management Act*.
- Alabama considered a measure protecting a healthcare provider's right not to participate in certain healthcare services including abortion.

RECOMMENDATIONS

for ALABAMA

WOMEN'S PROTECTION PROJECT PRIORITIES

- Additional components of the Parental Involvement Enhancement Act
- Components of the Child Protection Act related to evidence retention and remedies for third-party interference with parental rights
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- Defunding the Abortion Industry And Advancing Women's Health Act
- Prenatal Nondiscrimination Act
- Partial-Birth Abortion Ban Act

Legal Recognition and Protection for the Unborn

- Statutory prohibition on wrongful birth lawsuits
- Pregnant Woman's Protection Act

Bioethics

- Prohibition on Public Funding for Human Cloning and Destructive Embryo Research Act
- Human Cloning Prohibition Act
- Destructive Embryo Research Act

End of Life

- Assisted Suicide Ban Act

Healthcare Freedom of Conscience

- Healthcare Freedom of Conscience Act



Alaska | RANKING: 33

Alaska maintains few legal protections for women seeking abortion and does not regulate emerging biotechnologies. However, in 2014, Alaska enacted a measure restricting payments for abortions for women eligible for public assistance. Specifically, the law defines “medically necessary abortions” to limit the number of abortions that state taxpayers must pay for under the state’s Medicaid program. The state also enacted a new law establishing a wrongful death (civil) cause of action in the death of an unborn child at any stage of development.

» ABORTION

- The Alaska Supreme Court has determined that the Alaska Constitution provides for a broader right to abortion than that interpreted in the U.S. Constitution.
- Alaska maintains an abortion information website and requires that a woman seeking an abortion certify in writing that a physician provided her with information on the following: fetal development, various abortion procedures, possible risks and complications associated with abortion and childbirth, eligibility requirements for medical assistance benefits, child support orders, and contraceptive options.
- The state includes information about the abortion-breast cancer link in the educational materials a woman must receive prior to an abortion.
- The state requires that a parent be notified before a minor under the age of 18 obtains an abortion unless the minor is the victim of abuse by a parent or legal guardian, there is a medical emergency, or the minor obtains a court order. The law remains in litigation.
- Alaska limits the performance of abortions to licensed physicians. However, the Alaska Attorney General has issued opinions that laws requiring that only licensed physicians perform abortions and imposing minimal health and safety regulations on abortion clinics are unconstitutional and unenforceable.
- Alaska maintains an enforceable abortion reporting law, but the measure does not require the reporting of information to the Centers for Disease Control (CDC). The measure pertains to both surgical and nonsurgical abortions.
- Alaska taxpayers are required by court order to fund “medically necessary” abortions for women eligible for public assistance. In 2014, the state enacted a measure defining “medically necessary abortions” to limit the number of abortions that state taxpayers must pay for under the State Medicaid program.

- Alaska has authorized “Choose Life” specialty license plates. The proceeds from the sale of the plates benefit pregnancy resource centers.

» **LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN**

- Under Alaska criminal law, an unborn child at any stage of development may be considered a victim of murder, manslaughter, and criminally negligent homicide.
- Alaska also criminalizes nonfatal assaults on the unborn.
- Alaska provides a wrongful death (civil) cause of action when an unborn child at any stage of development is killed through a negligent or criminal act.
- Alaska maintains a “Baby Moses” law, which provides immunity for a parent who leaves an unharmed infant, no more than 21 days old, with police, medical personnel, hospital employees, emergency services personnel, or any person the parent believes will act in the infant’s best interest.
- Alaska requires healthcare professionals to report suspicions of drug use during pregnancy.
- In the case of a stillbirth, Alaska law requires that the mother and the father (if present) must be advised that they may request the preparation of a “Certificate of Birth Resulting in Stillbirth.”

» **BIOETHICS LAWS**

- Alaska maintains no laws regarding human cloning, destructive embryo research, fetal experimentation, human egg harvesting, or assisted reproductive technologies, and it does not promote ethical research alternatives.

» **END OF LIFE LAWS**

- Alaska law specifically prohibits assisted suicide. Under the law, assisted suicide constitutes manslaughter.

» **HEALTHCARE FREEDOM OF CONSCIENCE**

Participation in Abortion

- Alaska law provides that no person or hospital may be required to participate in an abortion.
- Recent court decisions have narrowed the legal protection for hospitals. Currently,

non-sectarian hospitals built or operated with public funds may not refuse to offer or provide abortions.

Participation in Research Harmful to Human Life

- Alaska currently provides no protection for the rights of conscience of healthcare providers who conscientiously object to participation in human cloning, destructive embryo research, or other forms of medical research, which violate a provider's moral or religious belief.

» WHAT HAPPENED IN 2014

- Alaska enacted a measure restricting Medicaid payments for abortions. Specifically, the law defines “medically necessary abortions” to limit the number of abortions that state taxpayers must pay for under the state’s Medicaid program. AUL experts consulted with lawmakers on the legislation, and AUL Action drafted a letter analyzing the measure for the Alaska Senate.
- A case challenging Alaska’s 2010 voter-approved parental notification law remains before the Alaska Supreme Court. Provisions related to the state’s definition of “medical emergency” in the context of state-funded abortions through Medicaid are also in litigation.
- The state enacted *Jackson’s Law*, based on AUL’s *Unborn Wrongful Death Act*, which provides a wrongful death (civil) cause of action in the death of an unborn child at any stage of development. Previously, state law only allowed a wrongful death action when an unborn child was born alive following a negligent or criminal act and died thereafter.
- Alaska considered legislation related to pain management and palliative care.

RECOMMENDATIONS

for ALASKA

WOMEN'S PROTECTION PROJECT PRIORITIES

- Women's Health Defense Act (5 month abortion limitation)
- 24-hour reflection period for abortion
- Abortion Patients' Enhanced Safety Act
- Abortion-Inducing Drugs Safety Act
- Components of the Child Protection Act related to mandatory reporting of abuse and remedies for third-party interference with parental rights
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- Federal Abortion-Mandate Opt-Out Act
- Women's Ultrasound Right to Know Act
- State Constitutional Amendment (providing that there is no state constitutional right to abortion)
- Defunding the Abortion Industry and Advancing Women's Health Act
- Coercive Abuse Against Mother's Prevention Act
- Prenatal Nondiscrimination Act

Legal Recognition and Protection for the Unborn

- Born-Alive Infant Protection Act
- Pregnant Woman's Protection Act

Bioethics

- Prohibition on Public Funding of Human Cloning and Destructive Embryo Research Act

Healthcare Freedom of Conscience

- Healthcare Freedom of Conscience Act



Arizona | RANKING: 12

Arizona has recently garnered national attention for its efforts to protect women from the well-documented harms inherent in abortion and from the substandard care given at some abortion clinics. This trend continued in 2014 when Arizona enacted legislation permitting enhanced inspections of abortion clinics to ensure compliance with the state's abortion-related laws and a measure prohibiting a third-party from interfering with parental rights and assisting a minor in obtaining an abortion without the required parental consent.

» ABORTION

- The Arizona Supreme Court has implicitly recognized a broader state constitutional right to abortion than that interpreted in the U.S. Constitution.
- Arizona's *Women's Health Defense Act*, limiting abortion at or after 5 months (*i.e.*, 20 weeks) gestation based upon the significant risks of later-term abortions to maternal health (and also concerns for fetal pain), has been permanently enjoined by the Ninth Circuit Court of Appeals.
- Arizona prohibits partial-birth abortion.
- Arizona's law making it a felony to perform an abortion in Arizona knowing that the abortion is sought based on the sex or race of the child or the race of a parent is in litigation. Further, it is a felony to use force or the threat of force to intentionally injure or intimidate any person for the purpose of coercing a sex-selection or race-based abortion.
- At least 24 hours prior to an abortion, a woman must receive information about the nature of the procedure, the immediate and long-term risks of abortion, the risks of childbirth, alternatives to abortion, and the probable gestational age and anatomical and physiological characteristics of her unborn child. A woman must also receive information about medical assistance benefits, the father's liability for child support, and the public and private agencies available to assist her. The state also requires abortion providers to inform women about alternatives to abortion.
- Arizona requires that an ultrasound be performed at least 24 hours prior to an abortion.
- A woman who is seeking abortion because of fetal anomalies must be informed that there are perinatal hospice programs.
- Women considering abortion must also be informed that it is illegal for a person to intimidate or coerce her into having an abortion.

- One parent must provide written notarized consent before a physician may perform an abortion on a minor under the age of 18, unless the minor is the victim of incest by someone in her home, there is a medical emergency, or she obtains a court order. The state prohibits a third party from interfering with parental rights and assisting a minor in obtaining an abortion without the requisite parental consent.
- Arizona has enacted comprehensive abortion clinic regulations which are largely based on treatment protocols promulgated by national abortion advocacy groups. Further, Arizona maintains a measure allowing unannounced inspections of abortion facilities (in certain circumstances) to ensure compliance with the state's regulations.
- Only licensed physicians may perform surgical abortions. Further, a physician assistant may not prescribe, dispense, or administer prescription medicine to induce an abortion, and the state board of nursing may not decree that the scope of practice for registered nurse practitioners includes abortions.
- The state maintains an enforceable abortion reporting law, but does not require the reporting of information to the Centers for Disease Control (CDC). The measure pertains to both surgical and nonsurgical abortions and requires abortion providers to report short-term complications. In 2014, the state amended its law to additionally require abortion providers to report any abortions that result in live birth.
- Arizona requires abortion providers to follow the protocol approved by the Federal Drug Administration (FDA) when administering the Mifeprex (RU-486) regimen and other abortion-inducing drugs. The law is currently in litigation.
- In 2002, the Arizona Supreme Court concluded that state taxpayers must fund "medically necessary" abortions for women eligible for public assistance, implicitly recognizing a broader state constitutional right to abortion than that interpreted in the U.S. Constitution. However, a subsequent law (2010) provides that "no public funds nor tax monies of [Arizona] or any political subdivision of [Arizona] nor any federal funds passing through the state treasury or the treasury of any political subdivision of [Arizona] may be expended for payment to any person or entity for the performance of any abortion unless an abortion is necessary to save the life of the woman having the abortion."
- The state requires that Medicaid providers cover family planning services that do not include abortion or abortion counseling.
- Arizona prohibits public funding for training to perform abortions or the use of "monies paid by students as part of tuition or fees to a state university or a community college" for abortions.
- Organizations that receive state funds through Women's Services programs may not use those funds to provide abortions or abortion referrals, and grantees cannot provide the grant money to entities that promote, refer, or perform abortions.
- A state statute permitting a tax credit for voluntary cash contributions by a taxpayer or

on a taxpayer's behalf to charitable organizations does not permit donations to qualify for the credits if the beneficiary organizations provide, pay for, promote, provide coverage of, or provide referrals for abortion or financially support any other entity that does so.

- A woman may not obtain an abortion at any university facility under the jurisdiction of the Arizona Board of Regents unless the procedure is necessary to save her life.
- In addition, Arizona prohibits insurance companies from offering abortion coverage within state insurance Exchanges established pursuant to the federal healthcare law, except in cases involving threats to a woman's life or health.
- Arizona further prohibits the use of state funds "directly or indirectly to pay the costs, premiums or charges associated with a health insurance policy, contract or plan that provides coverage, benefits or services related to the performance of any abortion" except in cases of life endangerment or substantial and irreversible impairment of a major bodily function.
- Arizona has approved "Choose Life" license plates. The proceeds from the sale of the plates benefit organizations providing abortion alternatives.

» **LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN**

- Arizona law defines the killing of an unborn child, at any stage of development, as manslaughter.
- The state defines a nonfatal assault on an unborn child as a criminal offense.
- The state provides enhanced sentencing for domestic violence offenses when the victim is pregnant.
- The state allows a wrongful death (civil) action when a viable unborn child is killed through a negligent or criminal act.
- The state has created a specific affirmative duty of physicians to provide medical care and treatment to infants born alive at any stage of development.
- Arizona maintains a *Dangerous Crimes Against Children Act* which allows for the prosecution of a woman for prenatal drug use or abuse that causes harm or injury to her unborn child. Under the law, the woman can be charged with child abuse and/or drug transfer to a minor under 12 years of age. The state further requires healthcare professionals to report suspected prenatal drug exposure.

» **BIOETHICS LAWS**

- Arizona prohibits destructive embryo research, human cloning, and the creation, transfer, and transportation of human-animal hybrids. The state also prohibits taxpayer funding of human cloning and denies special tax credits to entities engaged in destructive embryo research.

- Arizona requires healthcare professionals to notify patients in the second trimester of pregnancy of post-delivery options related to stem cells contained in umbilical cord blood and options for their donation or storage in a family donor banking program.
- The state also requires that women providing eggs receive information on the risks of human egg harvesting and prohibits payment for human eggs when the eggs are to be used for research purposes.

» **END OF LIFE LAWS**

- In Arizona assisted suicide is considered manslaughter.

» **HEALTHCARE FREEDOM OF CONSCIENCE**

Participation in Abortion

- Arizona law protects healthcare providers who conscientiously object to participation in abortions. Under this law, healthcare providers must object in writing, and objections must be based on moral or religious beliefs.
- A pharmacy, hospital, or healthcare professional is not required to participate in or provide an abortion, abortion medication, “emergency contraception,” or any medicine or device intended to inhibit or prevent implantation of a fertilized egg.
- Arizona also allows a “religiously-affiliated employer” to offer a health plan that does not cover contraceptives based on the religious beliefs of the employer or a beneficiary. “Religiously-affiliated employer” is defined as either a non-profit that primarily employs and serves individuals who share the non-profit’s religious beliefs or as an organization that has incorporating documents that clearly state that religious beliefs are “central to the organization’s operating principles.”

Participation in Research Harmful to Human Life

- Arizona currently provides no protection for the rights of healthcare providers who conscientiously object to participation in human cloning, destructive embryo research, or other forms of medical research, which violate a provider’s moral or religious belief.

» **WHAT HAPPENED IN 2014**

- Arizona enacted legislation enhancing inspections and investigations of abortion facilities to ensure compliance with the state’s abortion-related laws. AUL experts recommended the amendment to Arizona legislators. Additionally, Arizona amended its abortion clinic regulations to require abortion providers to report any abortions that result in live births.
- The state also enacted legislation prohibiting a third-party from interfering with

parental rights and assisting a minor in obtaining an abortion without the required parental consent.

- Conversely, Arizona legislators considered a number of measures that would undermine the state’s strong protection of unborn children and women including: measures removing criminal and civil remedies from its (enjoined) five-month abortion limitation, sex-selection abortion prohibition, partial-birth abortion prohibition, perinatal hospice information requirement, and parental involvement law; legislation repealing a prohibition on physician assistants from performing abortions; a measure repealing the state’s chemical abortion regulation; legislation removing necessary informed consent and ultrasound protections; a measure allowing a minor to provide “informed consent” for abortion without the involvement of parents; and legislation imposing draconian regulations on pregnancy resource centers.
- Arizona considered legislation modifying its existing Physician Orders for Life-Sustaining Treatment (POLST) Paradigm program. The measure would have ensured that an advance directive or power of attorney took precedent over a conflicting POLST form.
- Arizona considered legislation that would require pharmacists and/or pharmacies to dispense so-called “emergency contraception” despite religious or conscience objections.

RECOMMENDATIONS

for ARIZONA

WOMEN'S PROTECTION PROJECT PRIORITIES

- Abortion Patients' Enhanced Safety Act
- Components of the Parental Involvement Enhancement Act
- Child Protection Act
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- Defunding the Abortion Industry and Advancing Women's Health Act
- State Constitutional Amendment (affirming that there is no state constitutional right to abortion)

Legal Recognition and Protection for the Unborn

- Unborn Wrongful Death Act (for a pre-viable child)
- Statutory prohibition on wrongful birth lawsuits
- Pregnant Woman's Protection Act

Bioethics

- Assisted Reproductive Technologies Disclosure and Risk Reduction Act

Healthcare Freedom of Conscience

- Healthcare Freedom of Conscience Act



Arkansas | RANKING: 5

Arkansas has been a leading proponent of life-affirming legal innovations. The state was one of the first states to enact an ultrasound requirement and to require that women be informed about fetal pain. Arkansas is also one of only a small number of states that has completely banned human cloning. While 2014 marked a budget-only session for the legislature, the state continued to prioritize the lives of women and the unborn, enacting three measures continuing the state's policy of not permitting public funding of abortion or abortion referrals in public schools.

» ABORTION

- Arkansas' policy, as explained in Amendment 68, §2 to the state constitution, is to "protect the life of every unborn child from conception until birth, to the extent permitted by the Federal Constitution."
- Arkansas possesses an enforceable abortion prohibition should the U.S. Constitution be amended or certain U.S. Supreme Court decisions be reversed or modified.
- The state prohibits an abortion if an unborn child's heartbeat is detected and the unborn child is at 12 weeks of development or greater. This law is in litigation.
- Arkansas also prohibits abortion at or after 5 months development (*i.e.*, 20 weeks) based upon the pain felt by the unborn child.
- Arkansas prohibits partial-birth abortion.
- Arkansas requires that, 24 hours prior to an abortion, a physician provide a woman with information about the risks of abortion, the risks of continued pregnancy, and the probable gestational age of her unborn child. Further, state-prepared materials must be made available to her. These materials include pictures or drawings of the probable anatomical and physiological characteristics of the unborn child at 2-week gestational increments and a list of private and public agencies providing counseling and alternatives to abortion.
- An abortion provider must check for the unborn child's heartbeat prior to abortion and must inform the woman if a heartbeat is detected. The state also requires that women considering abortion receive information about fetal pain.
- Arkansas requires that an abortion provider offer a woman the opportunity to see the ultrasound image if an ultrasound is used in preparation for the abortion.
- A woman must also be informed that a spouse, boyfriend, parent, friend, or other person cannot force her to have an abortion.

- A physician may not perform an abortion on an unemancipated minor under the age of 18 without notarized written consent or in-person consent (with photo identification) from a parent or legal guardian, unless the minor states by affidavit that she is the victim of physical or sexual abuse and her only living parent or guardian is the perpetrator, a medical emergency exists, or the minor obtains a court order.
- Arkansas prohibits the intentional causing, aiding, abetting, or assisting a child to obtain an abortion without parental consent and requires the collection of forensic samples when an abortion is performed on a minor under the age of 14.
- Arkansas' comprehensive abortion clinic regulations apply to "any facility in which the primary function is the willful termination of pregnancy." The regulations prescribe minimum health and safety standards for the facility, staffing, and clinic administration.
- All facilities performing ten or more abortions per month must be licensed by the state Department of Health. Abortion providers must also maintain hospital admitting privileges.
- Only a person licensed to practice medicine in the State of Arkansas may perform an abortion.
- The state has an enforceable abortion reporting law, but does not require the reporting of information to the Centers for Disease Control (CDC). The measure pertains to both surgical and nonsurgical abortions and requires abortion providers to report short-term complications.
- When an abortion is performed, an abortion provider must report information related to the post-fertilization age of the unborn child.
- Employees and volunteers at "reproductive health facilities" are included in the list of mandatory reporters of suspected sexual abuse of minors.
- The Arkansas Constitution provides that no public funds will be used to pay for any abortion, except to save the mother's life. However, Arkansas follows the federal standard for Medicaid funding for abortions, permitting the use of federal or state matching Medicaid funds for abortions necessary to preserve the life of the woman or when the pregnancy is the result of rape or incest.
- The state prohibits the use of public funds for abortions, abortion referrals, or the purchase or dispensing of abortion-inducing drugs in public schools.
- Arkansas prohibits abortion coverage in the state health insurance Exchanges (required under the federal healthcare law), except in cases of rape, incest, or when the mother's life is in danger.
- Arkansas has implemented a "Choose Life" license plate program, directing the proceeds to organizations providing abortion alternatives.

» LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN

- Under Arkansas law, the killing of an unborn child at any stage of gestation is defined as a form of homicide.
- The state also criminalizes nonfatal assaults on an unborn child.
- Arkansas permits women to use force to defend their unborn children from criminal violence.
- Arkansas allows a parent or other relative to bring a wrongful death (civil) lawsuit when a viable unborn child is killed through a negligent or criminal act.
- *Under the Child Maltreatment Act*, “neglect” includes prenatal drug use that causes the child to be born with an illegal substance in his or her system or a drug-related health problem. Moreover, test results may be used as evidence of neglect in subsequent proceedings.
- Arkansas requires healthcare providers to report the birth of an infant who suffers from fetal alcohol syndrome.
- Arkansas allows a woman who loses a child after 5 months (*i.e.*, 20 weeks) gestation to seek a “Certificate of Birth Resulting in Stillbirth,” which is filed with the state registrar.

» BIOETHICS LAWS

- Arkansas bans both cloning-to-produce-children and cloning-for-biomedical-research.
- The state maintains no laws regarding destructive embryo research. Moreover, the state’s fetal experimentation statute only prohibits research on a born alive child—thereby allowing research on a child born dead (*i.e.*, aborted) with the permission of the mother.
- The state’s *Newborn Umbilical Cord Initiative Act* has established a network to collect and store postnatal tissue and fluid.
- Arkansas excludes an “unborn child” from the definition of “person” in the context of assisted reproductive technologies.
- Arkansas mandates that only physicians may perform artificial insemination procedures.
- The state maintains no regulations related to human egg harvesting.

» END OF LIFE LAWS

- Under Arkansas law, assisted suicide is a felony.

» **HEALTHCARE FREEDOM OF CONSCIENCE**

Participation in Abortion

- Arkansas law protects healthcare providers who conscientiously object to participating in abortions.
- Under the law, healthcare providers cannot be subject to civil liability or other recriminatory action for their refusal to participate in abortions.
- In addition, no hospital is required to permit an abortion within its facility.
- Arkansas provides some protection for the conscience rights of pharmacists and pharmacies.

Participation in Research Harmful to Human Life

- Arkansas currently provides no protection for the rights of healthcare providers who conscientiously object to participation in human cloning, destructive embryo research, or other forms of medical research, which violate a provider's moral or religious belief.

» **WHAT HAPPENED IN 2014**

- In a budget-only session, Arkansas enacted three measures continuing the state's policy of not permitting public funding of abortion or abortion referrals in public schools.

RECOMMENDATIONS

for ARKANSAS

WOMEN'S PROTECTION PROJECT PRIORITIES

- Abortion Patients' Enhanced Safety Act
- Abortion-Inducing Drugs Safety Act
- Parental Involvement Enhancement Act
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- Prenatal Nondiscrimination Act
- Defunding the Abortion Industry and Advancing Women's Health Act

Legal Recognition and Protection for the Unborn

- Unborn Wrongful Death Act (for a pre-viable child)
- Born-Alive Infant Protection Act
- Statutory prohibition on wrongful life lawsuits

Bioethics

- Prohibition on Public Funding of Human Cloning and Destructive Embryo Research Act

Healthcare Freedom of Conscience

- Healthcare Freedom of Conscience Act



California | RANKING: 47

The health and welfare of women, minors, and unborn children is increasingly at risk in California. State law protects and advances a “right” to abortion at the expense of both maternal health and unborn children. Further, the state funds destructive embryo research and explicitly allows cloning-for-biomedical-research, making it a “clone-and-kill” state.

» ABORTION

- The California Supreme Court has found that the state constitution provides a broader right to abortion than that interpreted in the U.S. Constitution.
- The state has also adopted a *Freedom of Choice Act* providing a right to abortion even if *Roe v. Wade* is eventually overturned and specifically providing that “[e]very woman has the fundamental right to choose to bear a child or to choose and to obtain an abortion” and “[t]he state may not deny or interfere with a woman’s right to choose or obtain an abortion prior to the viability of the fetus, or when the abortion is necessary to protect the life or health of the woman.”
- California requires that, prior to an abortion, a woman be informed of the nature of the abortion procedure, possible risks and complications, abortion alternatives, post-procedure medical services, and family planning information.
- A law requiring that a physician have the consent of one parent or a court order prior to performing an abortion on a minor under the age of 18 has been declared unconstitutional by the California Supreme Court.
- California requires abortion clinics meet rudimentary standards for patient care, equipment, and staffing. In 2013, California exempted abortion clinics from many generally applicable building code standards.
- Non-physicians, including nurse practitioners, certified nurse-midwives, or physician assistants, may perform surgical abortions or administer abortion-inducing drugs in California.
- The California Supreme Court has mandated that taxpayers pay for “medically necessary” abortions for women eligible for state medical assistance. This requirement essentially equates to funding abortion-on-demand in light of the U.S. Supreme Court’s broad definition of “health” in the context of abortion.
- Grants made by the “Adolescent Family Life Program” may not be expended for abortions, abortion referrals, or abortion counseling.

- Family planning grants may not be used for abortions or services ancillary to abortions.
- California provides direct funding to pregnancy resource centers.
- California protects “freedom of access” to abortion clinics and has established procedures for investigating “anti-reproductive-rights crimes” under its *Reproductive Rights Law Enforcement Act*.

» LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN

- Since 1970, California law has defined the killing of an unborn child after the embryonic stage (7-8 weeks of gestation) as a form of homicide.
- The state allows a wrongful death (civil) action only when an unborn child is born alive following a negligent or criminal act and dies thereafter.
- The state has created a specific affirmative duty of physicians to provide medical care and treatment to infants born alive at any stage of development.
- California maintains a “Baby Moses” law, under which a mother or legal guardian who is unable to care for a newborn infant may anonymously and safely leave the infant in the care of a responsible person at a hospital, police station, fire station, or other prescribed location.
- California funds drug treatment programs for pregnant women and newborns.

» BIOETHICS LAWS

- California funds and protects the “right” to engage in destructive embryo research and human cloning by state constitutional amendment.
- California bans cloning-to-produce-children, but explicitly allows cloning-for-biomedical-research, making it a “clone-and-kill” state.
- California allows research on “fetal remains.”
- The state promotes ethical forms of research, tasking the University of California with developing a plan to establish and administer an “Umbilical Cord Blood Collection Program” for the purpose of collecting units of umbilical cord blood for use in transplantation. The state also conducts an “Umbilical Cord Blood Awareness Campaign” to disseminate information about cord blood banking options.
- California regulates assisted reproductive technologies, including specifically requiring that a patient be provided information on embryo donation.
- The state requires that any advertising for egg donors (for fertility treatments) contain a statement that “there may be risks associated with human egg donation.” Moreover, no human eggs may be sold for “valuable consideration,” which does not include reasonable payment for the removal, processing, disposal, preservation, quality control, and storage of the eggs.

» **END OF LIFE LAWS**

- California expressly prohibits assisted suicide. In 1996, the Ninth Circuit Court of Appeals upheld the felony charge that accompanies this prohibition.
- In 2008, the state enacted a measure that requires physicians to provide end of life counseling to patients.
- California has amended its medical school curriculum requirements to include instruction on pain management and end of life issues.

» **HEALTHCARE FREEDOM OF CONSCIENCE**

Participation in Abortion

- California currently provides legal protection for individual healthcare providers and private healthcare institutions that conscientiously object to participating in abortions. Protection also extends to medical and nursing students. However, this protection does not apply in “medical emergencies.”
- The state provides some protection for the conscience rights of pharmacists and pharmacies.
- Health insurance plans that provide prescription coverage must provide coverage for contraception. The requirement includes an exemption so narrow it precludes the ability of most employers and insurers with moral or religious objections from exercising it.

Participation in Research Harmful to Human Life

- California currently provides no protection for the rights of healthcare providers who conscientiously object to participation in human cloning, destructive embryo research, or other forms of medical research, which violate a provider’s moral or religious belief.

» **WHAT HAPPENED IN 2014**

- California considered legislation requiring parental involvement before a minor obtains an abortion.
- California considered a measure requiring healthcare providers to inform a patient’s agent (under a power of attorney for health care) when the patient is diagnosed with a terminal illness and providing that the patient or the agent has the right to comprehensive information and counseling regarding legal end of life options for the patient. It also considered legislation related to pain management and palliative care.

RECOMMENDATIONS

for CALIFORNIA

WOMEN'S PROTECTION PROJECT PRIORITIES

- Women's Health Defense Act (5 month abortion limitation)
- Reflection period for abortion
- Women's Health Protection Act (abortion clinic regulations)
- Abortion-Inducing Drugs Safety Act
- Parental Notification for Abortion Act (or parental notice initiative)
- Child Protection Act
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- Federal Abortion-Mandate Opt-Out Act
- Coercive Abuse Against Mothers Prevention Act
- State Constitutional Amendment (providing that there is no state constitutional right to abortion)
- Repeal of State FOCA
- Defunding the Abortion Industry and Advancing Women's Health Act
- Women's Ultrasound Right to Know Act
- Prenatal Nondiscrimination Act

Legal Recognition and Protection for the Unborn

- Unborn Wrongful Death Act
- Amend fetal homicide law to protect unborn from conception
- Statutory prohibition on wrongful birth and wrongful life lawsuits
- Pregnant Woman's Protection Act

Bioethics

- Constitutional amendment banning state funding for human cloning and destructive embryo research

Healthcare Freedom of Conscience

- Healthcare Freedom of Conscience Act



Colorado | RANKING: 29

Colorado lacks the most basic protections for maternal health and the unborn. It does not require informed consent for abortion or that abortion clinics meet minimal health and safety standards. It is also in the minority of states that do not maintain a fetal homicide law recognizing an unborn child as a potential crime victim.

» ABORTION

- A physician may not perform an abortion on a minor under the age of 18 until at least 48 hours after written notice has been given to her parents, unless the parents waive the notice requirement, the minor declares she is a victim of abuse or neglect by a party entitled to notice and the abuse has been reported by the physician, there is a medical emergency, or the minor obtains a court order. Substitute notice of a grandparent, aunt, or uncle is permitted if the minor lives with him or her.
- Only licensed physicians using accepted medical procedures may perform abortions.
- Colorado has an enforceable abortion reporting law, but does not require the reporting of information to the Centers for Disease Control (CDC). The measure pertains to both surgical and nonsurgical abortions.
- The Colorado Constitution prohibits public funds from being used to pay for an abortion except when the abortion is necessary to preserve the woman's life. However, a federal court has declared this provision, along with two related statutes, in conflict with federal law. Currently, the state follows the federal standard for Medicaid funding for abortions, permitting the use of federal or state matching Medicaid funds for abortions necessary to preserve the life of the woman or when the pregnancy is the result of rape or incest.
- Organizations that provide abortions are prohibited from receiving state family planning funds.
- School-based health clinics cannot provide abortion services.
- The Colorado Attorney General has issued an opinion stating that group health insurance provided for state employees must exclude coverage for abortion.
- Colorado requires that death certificates indicate whether a woman was pregnant at the time of her death.

» LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN

- Actions by a third party designed to “intentionally, knowingly, recklessly, or with extreme indifference terminate or attempt to terminate a woman’s pregnancy” are a felony in Colorado. The state also imposes enhanced criminal penalties for an assault on a pregnant woman. However, Colorado law does not recognize the unborn child as the second (and separate) victim of a crime.
- Colorado has created a civil action for “unlawful termination of a pregnancy.” However, this “one-victim” measure fails to recognize an unborn child as a separate person.
- Colorado allows a parent or other relative to bring a wrongful death (civil) lawsuit when a viable unborn child is killed through the negligent or criminal act of another.
- In its definition of “child abuse or neglect,” Colorado includes instances where an infant tests positive at birth for a controlled substance. The state also funds substance abuse treatment for pregnant women and prohibits the use of drug tests performed as part of prenatal care in criminal prosecutions.
- Women must be informed of the availability of stillbirth certificates and be given the option to request one following a miscarriage or stillbirth.

» BIOETHICS LAWS

- Colorado maintains no laws regarding human cloning, destructive embryo research, fetal experimentation, human egg harvesting, or assisted reproductive technologies.
- Voluntary financial contributions to the “Adult Stem Cells Cure Fund” may be designated on state income tax forms and an account for the proceeds has been created in the state treasury.
- Colorado has enacted legislation preventing genetic information from being used to deny access to healthcare insurance or Medicare supplement insurance coverage.

» END OF LIFE LAWS

- Colorado law expressly criminalizes assisted suicide. Assisting a suicide is considered manslaughter.
- Colorado protects healthcare providers from liability for manslaughter when prescribing or administering palliative care prescriptions to terminally ill patients. However, the statute does not permit assisted suicide.
- The state maintains a Physician Orders for Life-Sustaining Treatment (POLST) Paradigm Program.

» HEALTHCARE FREEDOM OF CONSCIENCE

Participation in Abortion

- A hospital staff member or person associated with or employed by a hospital who objects in writing and on religious or moral grounds may not be required to participate in medical procedures that result in abortion.
- A hospital is not required to admit a woman for the purpose of performing an abortion.
- Private institutions and physicians, as well as their respective agents, may refuse to provide contraceptives and information about contraceptives based upon religious or conscientious objections. In addition, county and city employees may refuse on religious grounds to provide family planning and birth control services.

Participation in Research Harmful to Human Life

- Colorado currently provides no protection for the rights of healthcare providers who conscientiously object to participation in human cloning, destructive embryo research, or other forms of medical research, which violate a provider's moral or religious belief.

» WHAT HAPPENED IN 2014

- Colorado continued its policy of prohibiting public funding for abortion.
- AUL helped defeat the *Reproductive Health Freedom Act*, a state *Freedom of Choice Act* which was abandoned after significant grassroots opposition. AUL provided legal analysis on the impact of the bill, and AUL Action sent out an Action Alert on the measure.
- Colorado enacted a measure creating a civil action for “unlawful termination of a pregnancy.” However, this “one-victim” measure fails to recognize an unborn child as a separate victim. An additional measure was introduced that would have made Colorado the only state in the country that does not *at least* permit a wrongful death action to be brought on behalf of a child who is injured in the womb, is born, and later dies.
- Legislators appropriated money to the state's *Adult Stem Cells Cure Fund*.

RECOMMENDATIONS

for COLORADO

WOMEN'S PROTECTION PROJECT PRIORITIES

- Women's Health Defense Act (5 month abortion limitation)
- Women's Right to Know Act with reflection period
- Women's Health Protection Act (abortion clinic regulations)
- Parental Consent for Abortion Act
- Parental Involvement Enhancement Act
- Abortion-Inducing Drugs Safety Act
- Child Protection Act
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- Federal Abortion-Mandate Opt-Out Act
- Women's Ultrasound Right to Know Act
- Coercive Abuse Against Mothers Prohibition Act
- Defunding the Abortion Industry and Advancing Women's Health Act
- Prenatal Nondiscrimination Act

Legal Recognition and Protection for the Unborn

- Crimes Against the Unborn Child Act
- Unborn Wrongful Death Act (for a pre-viable child)
- Born-Alive Infant Protection Act
- Pregnant Woman's Protection Act

Bioethics

- Human Cloning Prohibition Act
- Destructive Embryo Research Act
- Prohibition on Public Funding of Human Cloning and Destructive Embryo Research Act

Healthcare Freedom of Conscience

- Healthcare Freedom of Conscience Act



Connecticut | RANKING: 41

Connecticut law evinces a profound disrespect for human life, providing for a broad state constitutional “right” to abortion, failing to adequately protect unborn victims of violence, and permitting cloning-for-biomedical-research and destructive embryo research. Unfortunately, no life-affirming measures were considered by the Connecticut Legislature in 2014.

» ABORTION

- The Connecticut Supreme Court has determined that the state constitution protects the “right” to an abortion as a fundamental right and to a greater extent than that interpreted in the U.S. Constitution.
- The state maintains a *Freedom of Choice Act*. The Act mandates a legal right to abortion even if *Roe v. Wade* is eventually overturned, specifically providing that “[t]he decision to terminate a pregnancy prior to the viability of the fetus shall be solely that of the pregnant woman in consultation with her physician.”
- Connecticut law requires that all women considering abortion receive counseling on the type of abortion procedure to be used and the discomfort and risks involved in that procedure.
- In addition to counseling on the type of abortion procedure and its inherent risks, minors must also receive information on the alternatives to abortion and public and private agencies that can provide them with assistance. Further, a qualified counselor must discuss the possibility of the minor involving a parent or other adult in her decision.
- Connecticut mandates that abortion clinics meet rudimentary health and safety standards. The regulations prescribe minimum standards for the building or facility, patient medical testing, and the maintenance of patient records.
- Connecticut limits the performance of abortions to licensed physicians.
- The state has an enforceable abortion reporting law, but does not require the reporting of information to the Centers for Disease Control (CDC). The measure pertains to both surgical and nonsurgical abortions and requires abortion providers to report short-term complications.
- Connecticut taxpayers are required by court order to fund “medically necessary” abortions for women eligible for public assistance. This requirement essentially

equates to funding abortion-on-demand in light of the U.S. Supreme Court’s broad definition of “health” in the context of abortion.

- Connecticut offers “Choose Life” license plates, the proceeds of which benefit pregnancy resource centers and/or other organizations providing abortion alternatives.

» **LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN**

- Connecticut defines an assault on a pregnant woman resulting in “the termination of pregnancy that does not result in live birth” as a crime. The law recognizes an affirmative defense if the defendant did not know that the victim was pregnant at the time of the assault.
- Connecticut allows a parent or other relative to bring a wrongful death (civil) lawsuit when a viable unborn child is killed through the negligent or criminal act of another.
- The state funds drug treatment programs for pregnant women and newborns.

» **BIOETHICS LAWS**

- Connecticut prohibits cloning-to-produce-children but allows cloning-for-biomedical-research, making it a “clone and kill” state. It also permits destructive embryo research and funds destructive research and human cloning.
- The state does not prohibit fetal experimentation.
- Connecticut requires that a physician provide a woman in the last trimester of pregnancy with information regarding options to bank or donate umbilical cord blood. The Connecticut Umbilical Cord Blood Collection Board has been directed to engage in public education and establish an umbilical cord blood collection program.
- Connecticut regulates assisted reproductive technologies to some degree. For example, only persons certified to practice medicine in the state may perform artificial insemination.
- The state prohibits direct or indirect payment for the donation of human eggs for stem cell research.

» **END OF LIFE LAWS**

- Connecticut has enacted a statutory prohibition on assisted suicide. Assisting a suicide constitutes manslaughter.
- The state has established a Physician Orders for Life-Sustaining Treatment (POLST) Paradigm program.

» HEALTHCARE FREEDOM OF CONSCIENCE

Participation in Abortion

- Under Connecticut law, no person is required to participate in any phase of an abortion against his or her judgment or religious, moral, or philosophical beliefs.
- Health insurance plans that provide prescription coverage must also provide coverage for contraception. Certain conscience exemptions apply to religious employers or organizations.

Participation in Research Harmful to Human Life

- Connecticut currently provides no protection for the rights of healthcare providers who conscientiously object to participation in human cloning, destructive embryo research, or other forms of medical research, which violate a provider's moral or religious belief.

» WHAT HAPPENED IN 2014

- Connecticut enacted a measure which seemingly made only technical changes to current funding mechanisms for unethical research.
- Connecticut established a Physician Orders for Life-Sustaining Treatment (POLST) Paradigm program.
- AUL helped defeat legislation legalizing assisted suicide in Connecticut.

RECOMMENDATIONS

for CONNECTICUT

WOMEN'S PROTECTION PROJECT PRIORITIES

- Women's Health Defense Act (5 month abortion limitation)
- Women's Right to Know Act with reflection period
- Abortion Patients' Enhanced Safety Act
- Abortion-Inducing Drugs Safety Act
- Parental Notification for Abortion Act
- Child Protection Act
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- Federal Abortion-Mandate Opt-Out Act
- State Constitutional Amendment (providing that there is no state constitutional right to abortion)
- Repeal of State FOCA
- Defunding the Abortion Industry and Advancing Women's Health Act
- Women's Ultrasound Right to Know Act
- Coercive Abuse Against Mothers Prevention Act
- Prenatal Nondiscrimination Act

Legal Recognition and Protection for the Unborn

- Crimes Against the Unborn Child Act
- Unborn Wrongful Death Act (for a pre-viable child)
- Born-Alive Infant Protection Act
- Pregnant Woman's Protection Act

Bioethics

- Repeal of existing laws permitting human cloning, destructive embryo research, and the funding of these practices

Healthcare Freedom of Conscience

- Healthcare Freedom of Conscience Act



Delaware | RANKING: 31

Delaware maintains minimal protections for women considering abortion. The state's parental notice law includes major loopholes, and it does not require that abortion clinics meet even minimal health and safety standards. Further, it does not proscribe or limit human cloning, destructive embryo research, fetal experimentation, or human egg harvesting.

» ABORTION

- Delaware's informed consent law requires that a woman be informed of the probable stage of her unborn child's development, the abortion procedure to be used and its inherent risks, alternative abortion procedures, the probable effects of an abortion on future childbearing, and alternatives to abortion. The portion of the law requiring a 24-hour reflection period has been ruled unconstitutional.
- Delaware prohibits some coerced abortions, defining "coercion" as "restraining or dominating the choice of a minor female by force, threat of force, or deprivation of food and shelter." The state emancipates a minor for social assistance purposes if her parents or guardians deny financial support because of her refusal to undergo an abortion.
- Despite a law prohibiting a physician from performing an abortion on an unemancipated minor under the age of 16 until 24 hours after notice has been given to one parent, the Delaware Attorney General has issued a "Statement of Policy" providing that state officials will not prosecute abortion providers who fail to comply with this requirement. The law also permits substitute notice of a grandparent or mental health professional.
- Only licensed physicians may perform abortions.
- Delaware has an enforceable abortion reporting law, but does not require the reporting of information to the Centers for Disease Control (CDC). The measure pertains to both surgical and nonsurgical abortions.
- Delaware follows the federal standard for Medicaid funding for abortions, permitting the use of federal or state matching Medicaid funds for abortions necessary to preserve the life of the woman or when the pregnancy is the result of rape or incest.
- Delaware offers "Choose Life" license plates.

» **LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN**

- Delaware law does not provide for the prosecution of third parties who kill or injure an unborn child.
- Delaware allows a parent or other relative to bring a wrongful death (civil) lawsuit when a viable unborn child is killed through the negligent or criminal act of another.
- The state has created a specific affirmative duty of physicians to provide medical care and treatment to infants born alive at any stage of development.

» **BIOETHICS LAWS**

- Delaware does not proscribe or limit human cloning, destructive embryo research, fetal experimentation, or human egg harvesting. It also does not promote ethical forms of research or regulate assisted reproductive technologies.

» **END OF LIFE LAWS**

- Assisted suicide is a felony in Delaware.

» **HEALTHCARE FREEDOM OF CONSCIENCE**

Participation in Abortion

- Delaware law provides that no person can be required to participate in any medical procedure that results in an abortion.
- Hospitals are not required to permit abortions within their facility.
- If health insurance plans provide coverage for prescription drugs, coverage must also be provided for contraception. A conscience exemption exists for religious employers.

Participation in Research Harmful to Human Life

- Delaware currently provides no protection for the rights of healthcare providers who conscientiously object to participation in human cloning, destructive embryo research, or other forms of medical research, which violate a provider's moral or religious belief.

» **WHAT HAPPENED IN 2014**

- Delaware did not consider any life-related measures related in 2014.

RECOMMENDATIONS

for DELAWARE

WOMEN'S PROTECTION PROJECT PRIORITIES

- Women's Health Defense Act (5 month abortion limitation)
- Women's Right to Know Act with reflection period
- Abortion Patients' Enhanced Safety Act
- Abortion-Inducing Drugs Safety Act
- Parental Consent for Abortion Act
- Parental Involvement Enhancement Act
- Child Protection Act
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- Federal Abortion-Mandate Opt-Out Act
- Women's Ultrasound Right to Know Act
- Defunding the Abortion Industry and Advancing Women's Health Act
- Coercive Abuse Against Mothers Prevention Act
- Prenatal Nondiscrimination Act

Legal Recognition and Protection for the Unborn

- Crimes Against the Unborn Child Act
- Protection for unborn children from nonfatal assaults
- Unborn Wrongful Death Act (for a pre-viable child)
- Pregnant Woman's Protection Act

Bioethics

- Human Cloning Prohibition Act
- Destructive Embryo Research Act
- Prohibition on Public Funding of Human Cloning and Destructive Embryo Research Act

Healthcare Freedom of Conscience

- Healthcare Freedom of Conscience Act



District of Columbia | RANKING: NOT RANKED

The District of Columbia provides virtually no protection for human life, failing to protect women from the harms inherent in abortion, to recognize and protect unborn victims of violence, or to prohibit assisted suicide. The District also fails to protect the fundamental freedom of conscience of healthcare providers.

» ABORTION

- No abortion may be performed after viability unless it is necessary to preserve the woman's life or health.
- In the District of Columbia, abortions may only be performed under the direction of a licensed medical practitioner.
- Taxpayer funds may not be used for abortions unless the abortion is necessary to preserve the woman's life or the pregnancy was the result of rape or incest.

» LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN

- The laws of the District of Columbia do not recognize an unborn child as a potential crime victim.
- The District of Columbia allows a parent or other relative to bring a wrongful death (civil) lawsuit when a viable unborn child is killed through another's negligent or criminal act.

» BIOETHICS LAWS

- The District of Columbia maintains no laws related to human cloning, destructive embryo research, fetal experimentation, human egg harvesting, or assisted reproductive technologies.

» ABORTION

- No abortion may be performed after viability unless it is necessary to preserve the woman's life or health.
- In the District of Columbia, abortions may only be performed under the direction of a licensed medical practitioner.
- Taxpayer funds may not be used for abortions unless the abortion is necessary to preserve the woman's life or the pregnancy was the result of rape or incest.

» **LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN**

- The laws of the District of Columbia do not recognize an unborn child as a potential crime victim.
- The District of Columbia allows a parent or other relative to bring a wrongful death (civil) lawsuit when a viable unborn child is killed through another's negligent or criminal act.

» **BIOETHICS LAWS**

- The District of Columbia maintains no laws related to human cloning, destructive embryo research, fetal experimentation, human egg harvesting, or assisted reproductive technologies.

» **END OF LIFE LAWS**

- The legal status of assisted suicide in the District of Columbia is undetermined. It has not enacted a specific statute prohibiting assisted suicide, and it does not recognize common law crimes. There is no judicial decision stating whether assisted suicide is a form of homicide under the general homicide laws.

» **HEALTHCARE FREEDOM OF CONSCIENCE LAWS**

Participation in Abortion

- The District of Columbia currently provides no protection for the rights of healthcare providers who conscientiously object to participation in abortion.

Participation in Research Harmful to Human Life

- The District of Columbia currently provides no protection for the rights of healthcare providers who conscientiously object to participation in human cloning, destructive embryo research, or other forms of medical research, which violate a provider's moral or religious belief.

» **WHAT HAPPENED IN 2014**

- The District of Columbia did not consider any life-related measures in 2014.



Florida | RANKING: 27

Despite a state Supreme Court decision providing a broader “right” to abortion than that interpreted in the U.S. Constitution, Florida has made strides to protect women and unborn children. Florida maintains informed consent and parental notice for abortion laws, and an ultrasound must be performed before every abortion. While the state does not prohibit destructive embryo research or human cloning, it does maintain a “Public Cord Blood Tissue Bank” to collect, screen, and store umbilical cord blood.

» ABORTION

- The Florida Supreme Court has determined that the state constitution provides a broader right to abortion than that interpreted in the U.S. Constitution. Under the auspices of this decision, Florida courts have struck down prior versions of the state’s informed consent and parental involvement laws.
- Florida prohibits abortion after viability.
- Prior to an abortion, Florida requires that a woman receive oral, in-person counseling regarding the nature and medical risks of abortion, the risk of continued pregnancy, and the gestational age of the unborn child. She must also receive printed materials discussing pregnancy services and abortion alternatives, providing a description of the unborn child, and discussing available medical benefits.
- Florida requires that an ultrasound be performed and that the ultrasound be reviewed with the woman before she gives her consent for the abortion.
- Florida requires that notice be given in person, by telephone, or by mail to one parent at least 48 hours prior to an abortion on a minor aged 17-years old or younger, unless there is a medical emergency or the minor obtains a court order. Parents must be notified about an emergency abortion within 24 hours of the procedure.
- Florida law provides patient care standards for facilities performing abortions after the first trimester.
- Only physicians licensed by the State of Florida in medicine or osteopathy or those physicians practicing medicine or osteopathy and employed by the United States may perform abortions.
- Florida has an enforceable abortion reporting law, but does not require the reporting of information to the Centers for Disease Control (CDC). The measure requires abortion providers to report short-term complications only for post-first trimester abortions.

- Florida follows the federal standard for Medicaid funding for abortions, permitting the use of federal or state matching Medicaid funds for abortions necessary to preserve the life of the woman or when the pregnancy is the result of rape or incest.
- Florida prohibits insurance plans that cover abortions (except in cases of life endangerment, rape, or incest) from receiving federal or state subsidies through a health insurance Exchange established pursuant to the federal healthcare law.
- Florida provides direct funding to pregnancy resource centers, including faith-based centers.
- Florida also offers “Choose Life” license plates, the proceeds of which benefit pregnancy resource centers and/or other organizations providing abortion alternatives.

» **LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN**

- Florida criminalizes the killing of an unborn child at any stage of gestation.
- Any crime that results in the death of an unborn child is subject to the same penalties as a crime that causes the death of another.
- The state allows a wrongful death (civil) action only when an unborn child is born alive following a negligent or criminal act and dies thereafter.
- An infant born alive during or immediately after an attempted abortion is entitled to the same rights, powers, and privileges as any other child born alive in the course of natural birth. Healthcare providers must take reasonable and medically appropriate measures to preserve the life and health of born-alive infants.
- Florida has enacted a “Baby Moses” law under which a mother or legal guardian who is unable to care for a newborn infant may anonymously and safely leave the infant in the care of a responsible person at a hospital, police station, fire station, or other prescribed location.
- The state defines substance abuse during pregnancy as “child abuse” under civil child-welfare statutes and funds drug treatment programs for pregnant women and newborns.

» **BIOETHICS LAWS**

- Florida does not ban human cloning or destructive embryo research, and its ban on fetal experimentation applies only to a live child (and not to an aborted fetus).
- Florida maintains a “Public Cord Blood Tissue Bank” to collect, screen for infectious and genetic diseases, perform tissue tubing, cryopreserve, and store umbilical cord blood. Women admitted to a hospital or birthing facility may be offered the opportunity to donate umbilical cord blood to the Bank (which is a public resource).
- Florida regulates assisted reproductive technologies and includes “embryo adoption” in a statutory list of “fertility techniques.”

- In regard to human egg harvesting, only “reasonable compensation” directly related to the donation of eggs is permitted.

» **END OF LIFE LAWS**

- In Florida, assisted suicide is considered manslaughter.

» **HEALTHCARE FREEDOM OF CONSCIENCE**

Participation in Abortion

- Under Florida law, a hospital staff member, person associated with or employed by a hospital, or physician’s employee, who objects on religious or moral grounds, is not required to participate in any medical procedure that results in an abortion.
- Certain individuals, such as physicians, may refuse to furnish any contraceptive or family planning service, supplies, or information because of religious objections.
- Hospitals are not required to perform abortions.

Participation in Research Harmful to Human Life

- Florida does not expressly protect the rights of conscience of all healthcare providers who conscientiously object to participation in procedures other than abortion, such as destructive embryo research and human cloning.

» **WHAT HAPPENED IN 2014**

- Florida enacted legislation prohibiting abortions after viability.
- It also considered legislation mandating health and safety standards for abortion facilities, delineating qualifications for individual abortion providers, relating to informed consent and parental involvement before abortion, and relating to insurance coverage of abortion.
- Florida enacted a measure providing that any crime that results in the death of an unborn child is subject to the same penalties as a crime that causes the death of another and removing viability as the point when a person may be charged with certain crimes against an unborn child.
- The state considered legislation prohibiting experimentation on live fetuses; however, experimentation on aborted fetuses would have been permitted.
- Florida considered legislation related to pain management and palliative care.

RECOMMENDATIONS

for FLORIDA

WOMEN'S PROTECTION PROJECT PRIORITIES

- Women's Health Defense Act (5 month abortion limitation)
- Reflection period for abortion
- Women's Health Protection Act (including regulation of facilities providing first-trimester abortions)
- Abortion-Inducing Drugs Safety Act
- Parental Consent for Abortion Act
- Parental Involvement Enhancement Act
- Child Protection Act
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- State Constitutional Amendment (providing that there is no state constitutional right to abortion)
- Defunding the Abortion Industry and Advancing Women's Health Act
- Prenatal Nondiscrimination Act

Legal Recognition and Protection for the Unborn

- Crimes Against the Unborn Child Act (protecting a child from conception)
- Unborn Wrongful Death Act
- Born-Alive Infant Protection Act
- Pregnant Woman's Protection Act

Bioethics

- Human Cloning Prohibition Act
- Destructive Embryo Research Act
- Prohibition on Public Funding of Human Cloning and Destructive Embryo Research Act

Healthcare Freedom of Conscience

- Healthcare Freedom of Conscience Act



Georgia | RANKING: 15

Georgia law provides significant legal protections for women and unborn children, including an informed consent law, a requirement for parental involvement for a minor considering abortion, and an ultrasound requirement. In 2014, the state enacted a measure, based on AUL model language, prohibiting abortion coverage for state employees and in the state's health insurance Exchange (established in each state under the federal healthcare law). However, Georgia does not require that abortion clinics meet the same health and safety standards as other facilities performing other invasive, outpatient surgeries, nor does it maintain any laws regulating human cloning, destructive embryo research, fetal experimentation, human egg harvesting, or assisted reproductive technologies.

» ABORTION

- Georgia prohibits abortion at or after 5 months (*i.e.*, 20 weeks) gestation based upon the pain felt by the unborn child, but the law is in litigation. Further, if an abortion is performed at or after 5 months of pregnancy, the abortion provider must report the medical diagnosis that necessitated the procedure.
- Georgia prohibits partial-birth abortions performed after viability.
- Georgia requires that, 24 hours prior to an abortion, a woman receive information on the medical risks of abortion and pregnancy and the gestational age of the unborn child. A woman must also receive information on medical assistance benefits, child support, and the right to review state-prepared material on a state-sponsored website.
- In addition, a woman must be orally informed that information on fetal pain is available on the state-sponsored website.
- A woman must also be offered the opportunity to view any ultrasound performed as part of the preparation for the abortion. State-developed materials must include information on organizations that provide ultrasounds.
- A physician may not perform an abortion on an unemancipated minor under the age of 18 until at least 24 hours after notice has been given in person or over the telephone to one parent, unless notice is waived in person by the parent who also presents photo identification, there is a medical emergency, or the minor obtains a court order.
- Georgia imposes cursory administrative requirements on abortion clinics operating in the state. Further, second- and third-trimester abortions must be performed in hospitals or ambulatory surgical centers.
- Only physicians licensed to practice medicine and surgery in the state may perform abortions.
- The state has an enforceable abortion reporting law, but does not require the reporting

of information to the Centers for Disease Control (CDC). The measure pertains to both surgical and nonsurgical abortions.

- Georgia includes “reproductive healthcare facilities” in the definition of mandatory reporters for suspected child abuse.
- Georgia includes mifepristone (*i.e.*, RU-486) in its definition of “dangerous drugs” which may be dispensed only upon prescription by a “registered practitioner.” However, “practitioner” is defined broadly to include physicians, advance practice nurses, physician assistants, and even veterinarians.
- Georgia follows the federal standard for Medicaid funding for abortions, permitting the use of federal or state matching Medicaid funds for abortions necessary to preserve the life of the woman or when the pregnancy is the result of rape or incest.
- No facility operated on public school property or operated by a public school district and no employee of any such facility acting within the scope of such person’s employment may provide abortions, abortion referrals, or abortion-inducing drugs.
- Georgia prohibits abortion coverage in the state’s health insurance Exchange (established in each state under the federal healthcare law). The state also prohibits abortion coverage for state employees.
- Georgia offers “Choose Life” license plates, the proceeds of which benefit pregnancy resource centers and/or other organizations providing abortion alternatives.

» **LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN**

- Under Georgia criminal law, the killing of an unborn child at any stage of gestation is defined as a form of homicide.
- Georgia also maintains the crime of “feticide-by-vehicle,” making the unborn child at any stage of development a potential victim under the state’s homicide-by-vehicle law.
- Georgia defines a nonfatal assault on an unborn child as a criminal offense.
- Georgia allows a parent or other relative to bring a wrongful death (civil) lawsuit when an unborn child is killed (after “quickening”) through the negligent or criminal act of another.
- The state has created a specific affirmative duty of physicians to provide medical care and treatment to infants born alive at any stage of development.

» **BIOETHICS LAWS**

- Georgia maintains no laws regulating human cloning, destructive embryo research, fetal experimentation, human egg harvesting, or assisted reproductive technologies.
- Georgia maintains the “Newborn Umbilical Cord Blood Bank” for postnatal tissue and

fluid, making them available for medical research and treatment. All physicians and hospitals must inform pregnant patients of the full range of options for donation of postnatal tissue and fluids.

- Georgia law provides for embryo adoption.

» **END OF LIFE LAWS**

- Under Georgia law, assisting in another person's suicide is a felony.
- The state maintains a Physician Orders for Life-Sustaining Treatment (POLST) Paradigm Program.

» **HEALTHCARE FREEDOM OF CONSCIENCE**

Participation in Abortion

- A person who objects in writing to participating in abortions and whose objections are based on moral or religious grounds may not be required to participate in any medical procedure that results in an abortion.
- A hospital, medical facility, or physician is not required to admit a woman for the purpose of performing an abortion.
- The state provides some protection for the conscience rights of pharmacists and pharmacies.
- Health insurance plans that provide prescription coverage must also provide coverage for contraception. There is no conscience exception for religious employers.

Participation in Research Harmful to Human Life

- Georgia currently provides no protection for the rights of healthcare providers who conscientiously object to participation in human cloning, destructive embryo research, or other forms of medical research, which violate a provider's moral or religious belief.

» **WHAT HAPPENED IN 2014**

- Georgia enacted a measure, based on AUL model language, prohibiting abortion coverage for state employees and in the state's health insurance Exchange (established in each state under the federal healthcare law). Conversely, legislators appropriated funding for family planning that could possibly go to abortion providers.
- Georgia considered legislation related to parental involvement before abortion.
- It also considered measures related to advance planning documents and pain management and palliative care.

RECOMMENDATIONS

for GEORGIA

WOMEN'S PROTECTION PROJECT PRIORITIES

- Abortion Patients' Enhanced Safety Act
- Abortion-Inducing Drugs Safety Act
- Parental Consent for Abortion Act
- Parental Involvement Enhancement Act
- Components of the Child Protection Act related to evidence retention and remedies for third-party interference with parental rights
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- Federal Abortion-Mandate Opt-Out Act
- Coercive Abuse Against Mothers Prevention Act
- Defunding the Abortion Industry and Advancing Women's Health Act
- Prenatal Nondiscrimination Act

Legal Recognition and Protection for the Unborn

- Unborn Wrongful Death Act (providing protection from conception)
- Pregnant Woman's Protection Act

Bioethics

- Human Cloning Prohibition Act
- Destructive Embryo Research Act
- Prohibition on Public Funding of Human Cloning and Destructive Embryo Research Act

Healthcare Freedom of Conscience

- Healthcare Freedom of Conscience Act



Hawaii | RANKING: 45

Hawaii lacks the most basic protections for women and unborn children. The state fails to require informed consent for abortion, to mandate parental involvement in a minor's abortion decision, or to ensure that abortion clinics meet minimum health and safety standards. Hawaii also fails to protect unborn victims of violence and to ban destructive embryo research or human cloning.

» ABORTION

- Hawaii has adopted a *Freedom of Choice Act*. The Act provides a “right” to abortion even if *Roe v. Wade* is eventually overturned, specifically providing that “[t]he State shall not deny or interfere with a female’s right to choose or obtain an abortion of a nonviable fetus or an abortion that is necessary to protect the life or health of the female.”
- Hawaii has no informed consent or parental involvement law.
- Hawaii maintains no enforceable abortion clinic regulations; however, only licensed physicians, surgeons, or licensed osteopathic physicians or surgeons may perform abortions.
- The state has an enforceable abortion reporting law, but does not require the reporting of information to the Centers for Disease Control (CDC).
- Hawaiian taxpayers are required by statute to pay for “medically necessary” abortions for women receiving state medical assistance. This requirement essentially equates to funding abortion-on-demand in light of the U.S. Supreme Court’s broad definition of “health” in the context of abortion.
- Hawaii offers “Choose Life” license plates, the proceeds of which benefit pregnancy resource centers and/or other organizations providing abortion alternatives.

» LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN

- Hawaii’s criminal law does not recognize or protect unborn children.
- The state allows a wrongful death (civil) action when a viable unborn child is killed through a negligent or criminal act.
- Hawaii does not require that appropriate medical care be given to an infant who survives an attempted abortion.
- Hawaii has a “Baby Moses” law, which permits a person to leave an unharmed infant

no more than 72-hours old at a hospital, fire station, or police station and be immune from prosecution for child abandonment. The professional receiving the child must inquire into the child's medical history and provide information on social services to the person relinquishing the infant.

» **BIOETHICS LAWS**

- Hawaii does not ban or regulate human cloning, destructive embryo research, or fetal experimentation.
- The state supports ethical research and treatments in a unique way by providing for a leave of absence for stem cell donors.
- The state does not maintain any meaningful regulation of assisted reproductive technologies or human egg harvesting.

» **END OF LIFE LAWS**

- In Hawaii, it is manslaughter if a person intentionally causes another person to commit suicide.
- Hawaii also has a "Pain Patients' Bill of Rights" which directs the Hawaii State Board of Nursing to develop and implement a pain and palliative care policy.

» **HEALTHCARE FREEDOM OF CONSCIENCE**

Participation in Abortion

- Under Hawaiian law, no person or hospital is required to participate in abortions.
- Health insurance plans that provide prescription coverage must also provide coverage for contraception. A conscience exemption exists for religious employers.

Participation in Research Harmful to Human Life

- Hawaii currently provides no protection for the rights of healthcare providers who conscientiously object to participation in human cloning, destructive embryo research, or other forms of medical research, which violate a provider's moral or religious belief.

» **WHAT HAPPENED IN 2014**

- Hawaii considered legislation prohibiting partial-birth abortion, mandating health and safety standards for abortion facilities, and requiring parental involvement before abortion.
- Hawaii considered a measure that included line-item funding for Planned Parenthood.
- The state enacted a unique measure encouraging ethical research and treatments by

providing for a leave of absence for stem cell donors.

- Hawaii considered a measure purportedly making the unauthorized use, implantation, or injection of human sperm, ova, embryos, or stem cells a felony; however, the measure allowed for the use of embryos (or stem cells) if there is consent. The state also considered legislation related to assisted reproductive technologies.
- Hawaii enacted a measure modifying its existing Physician Orders for Life-Sustaining Treatment (POLST) Paradigm program. The state also considered a number of other measures regarding the end of life, including legislation legalizing assisted suicide, expanding healthcare provider signatory authority to include advanced practice registered nurses, and relating to pain management and palliative care.
- The state adopted a resolution honoring the State Commission of the Status of Women for, in part, supporting a coercive measure requiring Hawaii's emergency rooms to dispense so-called "emergency contraception" regardless of religious and moral objections.

RECOMMENDATIONS

for HAWAII

WOMEN'S PROTECTION PROJECT PRIORITIES

- Women's Health Defense Act (5 month abortion limitation)
- Women's Right to Know Act with reflection period
- Abortion Patients' Enhanced Safety Act
- Abortion-Inducing Drugs Safety Act
- Parental Notification for Abortion Act
- Child Protection Act
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- Repeal State FOCA
- Federal Abortion-Mandate Opt-Out Act
- Defunding the Abortion Industry and Advancing Women's Health Act
- Women's Ultrasound Right to Know Act
- Coercive Abuse Against Mothers Prevention Act
- Prenatal Nondiscrimination Act

Legal Recognition and Protection for the Unborn

- Crimes Against the Unborn Child Act
- Unborn Wrongful Death Act (for a pre-viable child)
- Born-Alive Infant Protection Act
- Pregnant Woman's Protection Act

Bioethics

- Human Cloning Prohibition Act
- Destructive Embryo Research Act
- Prohibition on Public Funding of Human Cloning and Destructive Embryo Research Act

RECOMMENDATIONS

for HAWAII (CONT.)

End of Life

- Assisted Suicide Ban Act

Healthcare Freedom of Conscience

- Healthcare Freedom of Conscience Act



Idaho | RANKING: 22

Idaho has taken effective legislative action to protect women and the unborn from abortion and maintains comprehensive legal protection for the conscience rights of healthcare providers. However, the state has not enacted laws regulating human cloning, destructive embryo research, fetal experimentation, or human egg harvesting, nor does Idaho promote ethical alternatives to such destructive research.

» ABORTION

- Idaho has adopted a legislative declaration recognizing “the fundamental importance” of Idaho’s interest in preserving the lives of unborn children and declaring that it is the “public policy of this state that all state statutes, rules, and constitutional provisions shall be interpreted to prefer, by all legal means, live childbirth over abortion.”
- A 1996 decision by the Idaho Supreme Court has been interpreted as creating a state constitutional right to abortion that is broader than that interpreted in the U.S. Constitution.
- Idaho prohibits abortions at or after 5 months (*i.e.*, 20 weeks) on the basis of pain experienced by unborn children. The law is in litigation.
- Under Idaho law, a physician may not perform an abortion until 24 hours after he or she provides a woman with an “accurate and substantially complete” explanation of the abortion procedure to be used; the inherent risks and possible complications of the procedure, including possible effects on future childbearing; and alternatives to abortion and the risks of those alternatives. State-prepared material on fetal development, the availability of assistance from both public and private agencies, and a description of commonly used abortion procedures and their specific risks must also be made available to the woman.
- An abortion provider must offer a woman seeking an abortion the opportunity to view any ultrasound that is conducted in preparation for the procedure. Additionally, the woman has the right to ask for an ultrasound, even if the abortion provider does not routinely conduct one.
- Idaho prohibits anyone from coercing a woman into having an abortion and allows a victim of coercive abuse to bring a civil suit against her abuser.
- Idaho requires written consent from one parent before an abortion is performed on a minor under the age of 18, unless there is a medical emergency, the pregnancy is the result of rape or incest, or a judicial order is obtained.

- Only physicians licensed by the state to practice medicine and surgery or osteopathic medicine and surgery may perform abortions.
- Idaho has an enforceable abortion reporting law, but does not require the reporting of information to the Centers for Disease Control (CDC). The measure pertains to both surgical and nonsurgical abortions.
- Idaho follows the federal standard for Medicaid funding for abortions, permitting the use of federal or state matching Medicaid funds for abortions necessary to preserve the life of the woman or when the pregnancy is the result of rape or incest.
- Idaho also provides that no funds available to the state Department of Health and Welfare, by appropriations or otherwise, may be used to pay for abortions, except when necessary to save the life of the mother or when the pregnancy is the result of rape or incest.
- The state prohibits insurance companies from offering abortion coverage within state insurance Exchanges established pursuant to the federal healthcare law, except in cases of life endangerment, rape, or incest.
- Idaho prohibits private insurance companies from covering abortion, except in cases of life endangerment.

» **LEGAL RECOGNITION OF UNBORN AND NEWLY BORN**

- Idaho defines the killing of an unborn child at any stage of gestation as homicide.
- Idaho defines a nonfatal assault on an unborn child as a criminal offense.
- Idaho allows a wrongful death (civil) action when a viable unborn child is killed through negligent or criminal act.

» **BIOETHICS LAWS**

- Idaho has not enacted laws regulating human cloning, destructive embryo research, fetal experimentation, or human egg harvesting, nor does it promote ethical alternatives to such destructive research.
- Idaho mandates that only physicians may perform artificial insemination and regulates semen donation.

» **END OF LIFE LAWS**

- In Idaho, assisted suicide is a felony.
- The state has implemented a Physicians Order for Life Sustaining Treatment (POLST) Paradigm Program.

» **HEALTHCARE FREEDOM OF CONSCIENCE**

Participation in Abortion

- A physician is not required to perform or assist in abortions. The state protects “health care professionals” (principally, licensed medical providers, including pharmacists) who decline to participate in abortion or the distribution of abortion-inducing drugs.
- Nurses, medical technicians, hospital employees, and employees of physicians who object on religious, moral, or personal grounds are not required to participate in abortions. The objection must be in writing.
- A hospital, upon an objection of its governing board, is not required to admit a woman or permit the use of its facilities for the purposes of performing an abortion.

Participation in Research Harmful to Human Life

- The state protects “health care professionals” (principally, licensed medical providers, including pharmacists) who decline to participate in human cloning, embryo research, and destructive stem-cell technologies.

» **WHAT HAPPENED IN 2014**

- Idaho considered legislation requiring abortion providers to maintain admitting privileges and regulating the provision of abortion-inducing drugs.

RECOMMENDATIONS

for IDAHO

WOMEN'S PROTECTION PROJECT PRIORITIES

- Abortion Patients' Enhanced Safety Act
- Parental Involvement Enhancement Act
- Abortion-Inducing Drugs Safety Act
- Child Protection Act
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- State Constitutional Amendment (providing that there is no state constitutional right to abortion)
- Defunding the Abortion Industry and Advancing Women's Health Act
- Prenatal Nondiscrimination Act

Legal Recognition and Protection for the Unborn

- Born-Alive Infant Protection Act
- Pregnant Woman's Protection Act

Bioethics

- Human Cloning Prohibition Act
- Destructive Embryo Research Act
- Prohibition on Public Funding of Human Cloning and Destructive Embryo Research Act



Illinois | RANKING: 24

Illinois provides minimal protection for women considering abortion, failing to maintain even an informed consent law. The state attempted to remedy this deficiency in 2014 when, in response to the tragic death of Tonya Reeves (who died of complications related to a botched abortion performed at a Planned Parenthood facility in Chicago), the state considered comprehensive informed consent requirements, including a 24-hour reflection period, and comprehensive health and safety regulations for abortion clinics.

» ABORTION

- Illinois prohibits a physician from performing an abortion on a minor under the age of 18 without providing 48-hours' notice to one parent or other adult family member. The law provides exceptions in cases of rape, incest, child abuse by an adult family member, or in a medical emergency, and permits a minor to seek a court order to bypass the notice requirement.
- Illinois' abortion clinic regulations are not uniformly applied to all of the state's abortion clinics.
- Only physicians licensed by the State of Illinois may perform abortions. A chiropractor's 1978 challenge to this requirement was rejected.
- Illinois has an enforceable abortion reporting law, but does not require the reporting of information to the Centers for Disease Control (CDC). The measure requires abortion providers to report short-term complications.
- Illinois requires abortion providers, as well as those who provide abortion referrals, to report suspected child abuse or neglect.
- Illinois taxpayers are required by court order to fund "medically necessary" abortions for women eligible for public assistance. This requirement essentially equates to funding abortion-on-demand in light of the U.S. Supreme Court's broad definition of "health" in the context of abortion.
- Illinois Department of Children and Family Services grants may be made to non-profit agencies and organizations which do not use such grants to refer for, counsel for, or perform abortions.
- In the state health plan, Illinois provides abortion coverage only when a woman's life is endangered.

» **LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN**

- Under Illinois criminal law, the killing of an unborn child at any stage of gestation is defined as a form of homicide.
- Illinois defines a nonfatal assault on an unborn child as a crime.
- Illinois allows a wrongful death (civil) action when an unborn child at any stage of development is killed through a third-party's negligent or criminal act.
- The state has created a specific affirmative duty of physicians to provide medical care and treatment to infants born alive at any stage of development.
- Illinois maintains an Abandoned Newborn Infant Protection Act, or "Baby Moses" law, which includes a prohibition preventing persons accepting an infant under the Act from publicly discussing the circumstances surrounding the infant's legal surrender.
- The state defines substance abuse during pregnancy as "child abuse" under civil child welfare statutes. Illinois also requires healthcare professionals to report suspected prenatal drug exposure and funds drug treatment programs for pregnant women and newborns.

» **BIOETHICS LAWS**

- Under the Stem Cell Research and Human Cloning Prohibition Act, Illinois permits and funds destructive embryo research. While the Act prohibits cloning-to-produce-children, it specifically allows for "therapeutic cloning," making it a "clone-and-kill" state.
- The state Department of Public Health has been directed to establish a network of human cord blood banks. The Department also encourages healthcare providers to distribute a state-produced publication on umbilical cord blood banking, and encourages all licensed hospitals to offer pregnant women the option to donate cord blood.
- Illinois provides no meaningful regulation of assisted reproductive technologies, does not regulate human egg harvesting, and permits gestational surrogacy.

» **END OF LIFE LAWS**

- In Illinois, assisted suicide is a felony.
- Illinois maintains a Physicians Order for Life-Sustaining Treatment (POLST) Paradigm Program.

» **HEALTHCARE FREEDOM OF CONSCIENCE**

Participation in Abortion

- By statute, Illinois protects the civil rights of all healthcare providers, whether

individuals, institutions, or payers (public or private), who conscientiously object to participating in any healthcare services, including abortion. The law includes protection for medical and nursing students, counselors, and social workers.

- A state appellate court has ruled that an Illinois rule forcing pharmacists to dispense “emergency contraception” violates the Illinois Healthcare Rights of Conscience Act.
- Health insurance plans that provide prescription coverage must also provide coverage for contraception. A conscience exemption is provided for religious employers.

Participation in Research Harmful to Human Life

- By statute, Illinois protects the civil rights of all healthcare providers who conscientiously object to participating in procedures such as human cloning or destructive embryo research.

» WHAT HAPPENED IN 2014

- In response to the tragic death of Tonya Reeves, who died of complications related to a botched abortion performed at a Planned Parenthood facility in Chicago, Illinois considered comprehensive informed consent requirements, including a 24-hour reflection period (based on AUL model language). Required state-prepared materials would have included information on abortion-related coercion, and abortion providers would have been required to provide information on the pain felt by the unborn child.
- Illinois also considered a comprehensive law (also based on AUL model language) requiring that abortion facilities be licensed as surgical treatment centers and that an abortion provider who has admitting privileges at a local hospital remain in the abortion clinic during and after abortion procedures are performed.
- The state considered legislation requiring an ultrasound 24 hours before an abortion (if a facility had the necessary equipment).
- Illinois considered a measure criminalizing the unlawful delivery of a controlled substance to a woman known to be pregnant or the injecting, inhaling, absorbing, or ingesting any amount of that controlled substance by the woman, if her unborn child dies as a result. In addition, the state considered legislation permitting women to be prosecuted for alcohol or drug abuse while pregnant, as well as permitting the prosecution of a third-party who intentionally provides controlled substances to a pregnant woman, resulting in injury to or the death of her unborn child.
- Illinois considered legislation funding unethical research.
- The state considered legislation modifying its Physician Orders for Life-Sustaining Treatment (POLST) Paradigm program and relating to pain management and palliative care.

RECOMMENDATIONS

for ILLINOIS

WOMEN'S PROTECTION PROJECT PRIORITIES

- Women's Health Defense Act (5 month abortion limitation)
- Women's Right to Know Act with reflection period
- Women's Health Protection Act (abortion clinic regulations)
- Abortion-Inducing Drugs Safety Act
- Parental Involvement Enhancement Act
- Components of the Child Protection Act related to evidence retention and remedies for third-party interference with parental rights
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- Federal Abortion-Mandate Opt-Out Act
- Abortion Complication Reporting Act
- Women's Ultrasound Right to Know Act
- Coercive Abuse Against Mothers Prevention Act
- Defunding the Abortion Industry and Advancing Women's Health Act

Legal Recognition and Protection for the Unborn

- Pregnant Woman's Protection Act

Bioethics

- Human Cloning Prohibition Act
- Destructive Embryo Research Act
- Prohibition on Public Funding of Human Cloning and Destructive Embryo Research Act



Indiana | RANKING: 7

Indiana has made significant strides in recent years to protect women and unborn children from the harms inherent in abortion and from substandard abortion clinics. This trend continued in 2014 with the enactment of measures requiring state officials to inspect abortion clinics annually and prohibiting insurance coverage of abortion.

» ABORTION

- Abortions may be performed at or after 5 months (i.e., 20 weeks) gestation only for “medical necessity.”
- Indiana prohibits partial-birth abortion.
- Indiana law requires that, at least 18 hours before an abortion, a woman receive information about the type of abortion procedure to be used, the risks of and alternatives to that particular procedure (including the risks of chemical abortion), the probable gestational age of the unborn child, the risks associated with carrying the pregnancy to term, and the name of the physician who will perform the abortion. Further, the woman must be told about state medical assistance benefits, the father’s liability for child support, and abortion alternatives.
- A 2011 state law requires that informed consent information include the fact that human physical life begins when a human ovum is fertilized by a human sperm. Further, before an abortion, women must be informed that “objective scientific information shows that a fetus can feel pain” at or before 5 months (i.e., 20 weeks) gestation, but that portion of the law has been declared invalid as applied to women in the first trimester.
- Indiana requires an ultrasound before abortion. The image must be displayed unless the woman signs a form indicating that she does not desire to see the image. Further, the auscultation of fetal heart tone must be made audible, if possible, unless the woman signs a form indicating that she does not wish to hear the heart tone.
- A physician may not perform an abortion on a minor under the age of 18 without the written consent of one parent unless there is a medical emergency or the minor obtains a court order.
- All facilities performing surgical abortions must be licensed by the state Department of Health and meet comprehensive health and safety standards. State officials are required to inspect abortion clinics once a year. Indiana also requires that post-first-trimester abortions be performed in a hospital or ambulatory outpatient surgical

center. A law requiring clinics providing chemical abortions to meet the same patient care standards as facilities providing surgical abortions has been challenged in federal court.

- Only physicians licensed to practice medicine in Indiana may perform abortions. Abortion providers must have admitting privileges in the county where they provide abortions or in a contiguous county. In 2014, the state amended its law to remove the option of contracting with another physician that has admitting privileges, instead requiring that an abortion provider personally maintain local admitting privileges.
- The state has an enforceable abortion reporting law, but does not require the reporting of information to the Centers for Disease Control (CDC). The measure pertains to both surgical and nonsurgical abortions and requires abortion providers to report short-term complications.
- Every medical facility where abortions may be performed must be supplied with reporting forms provided by the state that require the reporting of, among other things, the post-fertilization age (of the unborn child) and, if an abortion is performed at or after 5 months (i.e., 20 weeks) gestation, the medical reason for the abortion.
- If an abortion is performed on a female who is less than 14 years of age, the physician who performed the abortion must transmit an informational form to both the state Department of Health and Department of Child Services within a specified time period.
- Indiana requires that a physician examine a woman before providing abortion-inducing drugs, effectively preventing the dangerous practice of “telemed abortion.” The law also provides that the drugs cannot be administered past nine weeks post-fertilization unless the FDA has approved them for such use.
- Indiana funds abortions for women eligible for public assistance when necessary to preserve the woman’s life or physical health or when the pregnancy is the result of rape or incest. It further provides that neither the state nor any political subdivision of the state may make a payment from any fund under its control for the performance of an abortion unless the abortion is necessary to preserve the life of the pregnant woman.
- The state Office of Women’s Health director and employees are not permitted to advocate, promote, refer for, or otherwise advance abortion or abortion-inducing drugs.
- In 2011, Indiana enacted a law prohibiting state agencies from contracting with or making grants (of state or state-administered federal funds) to entities that perform abortions or maintain or operate facilities where abortions are performed, and cancelling current contracts with such entities. However, the Seventh Circuit enjoined the law as it applies to Medicaid funding.

- The state prohibits insurance companies from offering abortion coverage within the state insurance Exchanges established pursuant to the federal healthcare law, except in cases of life endangerment, substantial and irreversible impairment of a major bodily function, rape, or incest.
- Indiana prohibits insurance coverage of abortion, with exceptions protecting the mother's life, guarding against substantial threats to the mother's health, and applying in cases of rape and incest. The measure is based on AUL's *Abortion Coverage Prohibition Act*.
- Indiana offers "Choose Life" license plates, the proceeds of which benefit pregnancy resource centers and/or other organizations providing abortion alternatives.

» **LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN**

- Under Indiana criminal law, the killing of an unborn child after viability is defined as a form of homicide.
- A person who causes the death of a child in utero while committing murder or felony murder may be sentenced to an additional fixed term of imprisonment that is equal to the advisory sentence for murder. This provision applies at any stage of gestation.
- An assault on a viable unborn child is a prosecutable crime.
- Additionally, Indiana defines criminal assaults on a pregnant woman that result in miscarriage, stillbirth, or "damage to pregnancy" as an enhanced offense for sentencing purposes.
- The state allows a wrongful death (civil) action only when an unborn child is born alive following a negligent or criminal act and dies thereafter.
- Indiana has created a specific affirmative duty of physicians to provide medical care and treatment to infants born alive at any stage of development.
- The state defines substance abuse during pregnancy as "child abuse" under civil child welfare statutes. In 2013 the state allocated funds for "prenatal substance use and prevention" for pregnant women.
- The state Department of Health has been directed to develop a system of registry for stillbirth information.

» **BIOETHICS LAWS**

- Indiana bans human cloning for any purpose and prohibits funding of human cloning.
- While the state does not explicitly ban destructive embryo research, it does prohibit research on embryos created from ova initially provided for use in in vitro fertilization (IVF) procedures as well as experimentation on aborted fetuses. However, the state's

prohibition on experimentation on embryos created for use in IVF explicitly excludes fetal stem-cell research from its application.

- Indiana has established a public umbilical cord blood bank and an educational initiative to promote public awareness of the importance of donating. Participating facilities must offer patients the option of donating cord blood following delivery.
- The state has also directed the Board of Trustees at Indiana University to establish an adult stem-cell research center.
- Indiana prohibits the purchase or sale of human ova, but does not prohibit certain transactions between a woman and a qualified IVF clinic for certain expenses (e.g., earnings lost, travel expenses, medical expenses, or recovery time).
- The state does not otherwise regulate assisted reproductive technologies, but does prohibit gestational surrogacy contracts.

» **END OF LIFE LAWS**

- Assisting a suicide constitutes a felony.
- The state maintains a Physicians Order for Life Sustaining Treatment (POLST) Paradigm Program.

» **HEALTHCARE FREEDOM OF CONSCIENCE**

Participation in Abortion

- A physician, hospital, facility employee, or staff member who objects on religious, moral, or ethical grounds is not required to participate in abortions.
- A private or religiously affiliated hospital is not required to permit the use of its facilities for the performance of an abortion.
- Indiana has a “contraceptive equity” law, requiring health insurance coverage for contraception. No exemption is provided for employers or insurers with a moral or religious objection to contraception.

Participation in Research Harmful to Human Life

- Indiana currently provides no protection for the rights of healthcare providers who conscientiously object to participation in human cloning, destructive embryo research, or other forms of medical research, which violate a provider’s moral or religious belief.

» **WHAT HAPPENED IN 2014**

- Indiana enacted a measure requiring state officials to annually inspect abortion clinics and amended its admitting privileges law to remove the option of contracting with

another physician who has admitting privileges (instead of requiring that an abortion provider personally maintain local admitting privileges).

- Indiana also enacted a measure, largely based on AUL's Abortion Coverage Prohibition Act, prohibiting insurance coverage of abortion. It includes life and substantial health exceptions, as well as exceptions in cases of rape and incest.
- The state considered legislation aimed at protecting women from coerced abortions.
- Indiana considered a measure requiring an individual's treating physician to evaluate an individual's mental capacity before executing a Physician Order for Life-Sustaining Treatment (POLST).

RECOMMENDATIONS

for INDIANA

WOMEN'S PROTECTION PROJECT PRIORITIES

- Abortion Patients' Enhanced Safety Act
- Parental Involvement Enhancement Act
- Components of the Child Protection Act related to evidence retention and remedies for third-party interference with parental rights
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- Prenatal Nondiscrimination Act

Legal Recognition and Protection for the Unborn

- Unborn Wrongful Death Act
- Pregnant Woman's Protection Act

Bioethics

- Promotion of ethical research alternatives

Healthcare Freedom of Conscience

- Healthcare Freedom of Conscience Act



Iowa | RANKING: 36

Iowa made headlines in 2014 when a state trial court upheld an Iowa Board of Medicine rule prohibiting the use of webcams for chemical abortions. While litigation over the rule is likely to continue, the trial court's decision clearly demonstrates that physicians (who comprised the Board of Medicine) agree that providing abortion-inducing drugs in violation of the FDA's restrictions is dangerous and puts women's lives and health at risk.

» ABORTION

- In 2002, Iowa issued an “Information, Not Criminalization” directive. The directive purportedly makes information on family planning, abortion, adoption, and other reproductive health information available to women at their request. However, the information is not mandated, and there are no penalties for failure to supply the information or to otherwise provide access to the information.
- A physician may not perform an abortion on an unmarried or never married minor under the age of 18 until at least 48 hours after written notice has been provided to a parent or grandparent, unless the minor is the victim of rape, incest, or child abuse, there is a medical emergency, or a court order is issued.
- Only physicians licensed to practice medicine and surgery in the State of Iowa or osteopathic physicians and surgeons may perform abortions.
- Iowa has an enforceable abortion reporting law, but does not require the reporting of information to the Centers for Disease Control (CDC). The measure pertains to both surgical and nonsurgical abortions.
- The Iowa State Board of Medicine requires that a physician physically examine a woman and document (in her medical record) the age and location of the pregnancy prior to administering abortion-inducing drugs. The rule also requires the physician to be present when the drugs are dispensed. The rule has been challenged by Planned Parenthood and is in litigation, but a state trial court has upheld the rule.
- Iowa taxpayers are required to pay for abortions for women eligible for state medical assistance if the continued pregnancy endangers the woman's life, the unborn child is physically deformed, mentally deficient, or afflicted with a congenital condition, or the pregnancy is the result of reported rape or incest.
- The state requires abortion providers to meet certain informed consent requirements before performing abortions for which they plan to seek reimbursement from the state.

» **LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN**

- Iowa does not protect unborn children from criminal violence.
- Iowa law provides that an attack on a pregnant woman that results in a stillbirth or miscarriage is a criminal assault. It also requires an investigation into a newborn's death when 1) the death is believed to have occurred during or after delivery and when the delivery was only attended by the mother; or 2) the medical examiner otherwise believes an investigation is warranted.
- The state allows wrongful death (civil) actions only when an unborn child is born alive following a negligent or criminal act and dies thereafter.
- Iowa has created a specific affirmative duty of physicians to provide medical care and treatment to infants born alive after viability.
- The state defines substance abuse during pregnancy as "child abuse" under its civil child welfare statutes. Iowa also requires healthcare professionals to report suspected prenatal drug exposure and to test newborns for drug exposure when there is suspicion of prenatal drug use or abuse.
- Iowa has authorized stillbirth certificates.

» **BIOETHICS LAWS**

- Under the Stem Cell Research and Cures Initiative, Iowa allows cloning-for-biomedical-research and destructive embryo research, while prohibiting cloning-to-produce-children, making it a "clone-and-kill" state.
- The state does not prohibit fetal experimentation or promote ethical forms of research.
- Iowa does not regulate assisted reproductive technologies or human egg harvesting.

» **END OF LIFE LAWS**

- Assisting a suicide constitutes a felony in Iowa.
- Iowa maintains a Physician Orders for Life-Sustaining Treatment (POLST) Paradigm Program.

» **HEALTHCARE FREEDOM OF CONSCIENCE**

Participation in Abortion

- An individual who objects on religious or moral grounds is not required to participate in an abortion unless that abortion constitutes "emergency medical treatment" of a serious physical condition necessary to save the woman's life.

- A private or religiously affiliated hospital is not required to perform or permit abortions that are not necessary to save the woman's life.
- Health insurance plans that provide prescription coverage must also provide coverage for contraception. No conscience exemption is provided for religious employers.

Participation in Research Harmful to Human Life

- Iowa currently provides no protection for the rights of healthcare providers who conscientiously object to participation in human cloning, destructive embryo research, or other forms of medical research, which violate a provider's moral or religious belief.

» WHAT HAPPENED IN 2014

- Iowa considered legislation regulating the provision of abortion-inducing drugs and relating to the insurance coverage of abortion.
- In *Planned Parenthood of the Heartland v. Iowa Board of Medicine*, a state trial court upheld an Iowa Board of Medicine rule prohibiting the use of "telemedicine" for chemical abortions. The law remains in litigation.
- Iowa considered fetal homicide legislation protecting an unborn child from the time of conception. It also considered legislation extending wrongful death protections to unborn children after viability.
- In response to the coercive federal mandates in the Affordable Care Act, Iowa considered legislation attempting to provide conscience protections for employers regarding the provision of health insurance that includes abortion, abortion-inducing drugs, and certain contraceptive services.
- Iowa considered legislation related to pain management and palliative care.

RECOMMENDATIONS

for IOWA

WOMEN'S PROTECTION PROJECT PRIORITIES

- Women's Health Defense Act (5 month abortion limitation)
- Women's Right to Know Act with reflection period
- Abortion Patients' Enhanced Safety Act
- Abortion-Inducing Drugs Safety Act
- Parental Consent Act for Abortion
- Parental Involvement Enhancement Act
- Components of the Child Protection Act related to evidence retention and remedies for third-party interference with parental rights
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- Federal Abortion-Mandate Opt-Out Act
- Defunding the Abortion Industry and Advancing Women's Health Act
- Women's Ultrasound Right to Know Act
- Coercive Abuse Against Mothers Prevention Act
- Prenatal Nondiscrimination Act

Legal Recognition and Protection for the Unborn

- Crimes Against the Unborn Child Act
- Unborn Wrongful Death Act
- Pregnant Woman's Protection Act

Bioethics

- Human Cloning Prohibition Act
- Destructive Embryo Research Act
- Prohibition on Public Funding of Human Cloning and Destructive Embryo Research Act

Healthcare Freedom of Conscience

- Healthcare Freedom of Conscience Act



Kansas | RANKING: 3

Under the leadership of Governor Sam Brownback and other pro-life leaders, Kansas has aggressively implemented a life-affirming legal strategy for protecting women and their unborn children. Since 2011, Kansas has, among other measures, limited the availability of abortion, adopted protective health and safety standards for abortion clinics, and ensured that taxpayer dollars are not used to subsidize abortions or abortion providers like Planned Parenthood. In 2014, the Tenth Circuit dealt a major win to Kansas—and major defeat to abortion providers—when it upheld a Kansas law effectively preventing abortion providers from receiving federal Title X funding.

» ABORTION

- Kansas bans abortions at or after 5 months (*i.e.*, 20 weeks) on the basis of the pain experienced by unborn children.
- Kansas prohibits partial-birth abortion.
- Kansas prohibits sex-selection abortions.
- Kansas permits abortions after viability only when an abortion provider has the documented referral from another physician not legally or financially affiliated with the abortion provider and both physicians determine that (1) the abortion is necessary to preserve the life of the pregnant woman, or (2) the continuation of the pregnancy will cause a substantial and irreversible impairment of a major bodily function of the pregnant woman. For the “medical emergency” exception to apply, the underlying condition must be physical in nature and not resulting from the woman’s own behavior.
- The state maintains a “delayed enforcement” provision prohibiting abortion should *Roe v. Wade* be overturned.
- The state’s “medical emergency” exception for abortion-related laws is limited to situations where a woman’s life is endangered or her physical health is severely compromised.
- Under Kansas law, a physician may not perform an abortion until at least 24 hours after a woman has received complete and accurate information on the proposed abortion method, the risks of the proposed method, the probable gestational age of the unborn child, the probable anatomical and physiological development of the unborn child, the medical risks of carrying the pregnancy to term, and the name of the physician who will perform the abortion. Further, a woman must be informed that “abortion will terminate the life of a whole, separate, unique, living human being” and be provided written information on medical assistance benefits, agencies offering alternatives to

abortion, the father's legal liability, and the development of the unborn child. In 2013, the state amended the law to include information on fetal pain and the right to view an ultrasound image, as well as the risks of breast cancer and pre-term birth following abortion.

- Kansas requires an ultrasound evaluation for all women seeking abortions. Further, the physician or other healthcare professional must, at the request of the patient, review and explain the ultrasound results including the probable gestational age of the unborn child before the abortion procedure is performed.
- Women must also be informed that the state-mandated written materials are also available online and provided a list of organizations providing free ultrasound examinations.
- All women in “medically challenging pregnancies” must be given a list of websites for national perinatal assistance including information regarding which entities provide these services free of charge. Similarly, the state has authorized grants, contracts, or cooperative agreements to help a family after they learn that their child has Down syndrome or other conditions.
- The state requires abortion providers to state in their printed materials that it is illegal for someone to coerce a woman into having an abortion. Clinics must also post signs stating that it is illegal to force a woman to have an abortion.
- A physician may not perform an abortion on an unemancipated minor under the age of 18 without the written, notarized consent of two parents, unless there is a medical emergency or the minor obtains a court order. The consent of only one parent is required when the parents are not married to each other, one cannot be found, or the minor is the victim of incest by her father (which must be reported).
- Any physician who performs an abortion on a minor under the age of 14 must retain fetal tissue extracted during the procedure and send it to the Kansas Bureau of Investigation. The tissue is to be submitted “for the purpose of DNA testing and examination” and will be used to investigate (and potentially prosecute) incidents of child rape and sexual abuse.
- In 2011, Kansas enacted comprehensive health and safety regulations for abortion clinics which include a requirement that the clinic be licensed by the state. This law is currently in litigation in state court.
- The state requires that a physician performing abortions have admitting privileges at an accredited hospital located within 30 miles of the abortion facility.
- Kansas has an enforceable abortion reporting law, but does not require the reporting of information to the Centers for Disease Control (CDC). The measure pertains to both surgical and nonsurgical abortions.
- Kansas also requires reporting of the medical reasons supporting the termination of a late-term pregnancy.

- Kansas mandates that the state Department of Social and Rehabilitation Services produce and distribute a report on the number of child abuse reports received from abortion providers.
- When RU-486 or any drug is used for the purpose of inducing an abortion, the drug must be administered by or in the same room and in the physical presence of the physician who prescribed, dispensed, or otherwise provided the drug to the patient.
- Kansas follows the federal standard for Medicaid funding for abortions, permitting the use of federal or state matching Medicaid funds for abortions necessary to preserve the life of the woman or when the pregnancy is the result of rape or incest.
- A Kansas law effectively preventing abortion providers from receiving federal Title X funding was upheld by the Tenth Circuit Court of Appeals.
- No state funds may be expended for any abortion, and tax benefits for abortion or abortion providers are specifically prohibited.
- Contracts with the Kansas Department of Health and Environment’s pregnancy maintenance program may not be granted to groups that promote, refer for, or educate in favor of abortion.
- Abortions may not be performed in any facility, hospital, or clinic owned, leased, or operated by the University of Kansas Hospital Authority unless necessary to preserve a woman’s life or prevent “a serious risk of substantial and irreversible impairment of a major bodily function.”
- Kansas prohibits abortions in state-run or state-leased facilities except when necessary to save the woman’s life.
- School districts, district employees or volunteers, and educational service providers are prohibited from contracting with a school district to provide abortion services (except when necessary to save the woman’s life).
- Kansas prohibits insurance companies from offering abortion coverage within state insurance Exchanges established pursuant to the federal healthcare law, except in cases of life endangerment.
- Kansas prohibits private insurance companies from covering abortion, except in cases of life endangerment. Further, the state employee health benefits plan may not provide coverage for abortion except in cases of life endangerment. The state has also removed any tax benefit for insurance coverage of abortion.
- Public health benefits coverage for children cannot be used for abortions or abortion coverage.
- The state provides direct funding to pregnancy resource centers and other organizations promoting abortion alternatives.

» LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN

- Under Kansas law, an “unborn child” (from fertilization to birth) is a potential victim of murder, manslaughter, vehicular manslaughter, and battery.
- Kansas defines criminal assaults on a pregnant woman that result in miscarriage, stillbirth, or “damage to pregnancy” as an enhanced offense for sentencing purposes.
- The state allows a wrongful death (civil) action when a viable unborn child is killed through negligent or criminal act.
- The state prohibits wrongful birth and wrongful life lawsuits.
- Kansas law requires that an attending physician take “all reasonable steps necessary to maintain the life and health” of a child (at any stage of development) who survives an attempted abortion.
- The state maintains a provision related to fetal death or stillborn certificates.

» BIOETHICS LAWS

- Kansas maintains no laws banning human cloning, destructive embryo research, or fetal experimentation.
- The state has enacted a measure promoting morally responsible growth in the biotechnology industry. The state has specifically indicated that the terms “bioscience,” “biotechnology,” and “life sciences” shall not be construed to include 1) induced human abortions or the use of cells or tissues derived therefrom, and 2) any research the funding of which would be contrary to federal law. The law effectively prohibits funding of human cloning and destructive embryo research.
- Kansas has directed the state Department of Health and Environment to develop and make available education and training (for healthcare providers) in the basic procedures and requirements for collecting and maintaining umbilical cords, cord blood, amniotic fluid, and placenta donations. A healthcare provider giving health services to a pregnant woman must advise her of post-delivery options to donate the umbilical cord.
- Kansas maintains no meaningful regulation of assisted reproductive technologies or human egg harvesting.

» END OF LIFE LAWS

- In Kansas, assisting a suicide is a felony.
- Kansas maintains a “Pain Patient’s Bill of Rights,” which, among other provisions, allows physicians to prescribe a dosage of opiates deemed medically necessary to relieve pain. The law does not expand the scope of medical practice to allow physician-assisted suicide or euthanasia.

» **HEALTHCARE FREEDOM OF CONSCIENCE**

Participation in Abortion

- No person may be required to participate in medical procedures that result in abortion.
- No hospital may be required to perform abortions in its facilities.
- Kansas permits an individual or healthcare facility to refuse to perform, make referrals for, or participate in abortion services or services that the individual or facility “reasonably believes” would end a pregnancy.
- The state provides some protection for the conscience rights of pharmacists and pharmacies.

Participation in Research Harmful to Human Life

- Kansas currently provides no protection for the rights of healthcare providers who conscientiously object to participation in human cloning, destructive embryo research, or other forms of medical research, which violate a provider’s moral or religious belief.

» **WHAT HAPPENED IN 2014**

- Kansas enacted a measure clarifying that the state’s “medical emergency” exception for abortion-related laws is limited to situations where a woman’s life is endangered or her physical health is severely compromised.
- Kansas also enacted legislation removing any tax benefit for insurance coverage of abortion.
- The state considered a ban on sex-selective abortions.
- The Tenth Circuit upheld a Kansas law effectively preventing abortion providers from receiving federal Title X funding.
- Kansas appropriated \$9,000 to its Midwest Stem Cell Therapy Center. The state also considered a measure declaring surrogacy against public policy and criminalizing involvement in a compensated surrogacy contract.
- The state considered legislation legalizing assisted suicide and measure establishing a Physician Orders for Life-Sustaining Treatment (POLST) Paradigm program.

RECOMMENDATIONS

for KANSAS

WOMEN'S PROTECTION PROJECT PRIORITIES

- Abortion Patients' Enhanced Safety Act
- Parental Involvement Enhancement Act
- Components of the Child Protection Act related to mandatory reporters of suspected child sexual abuse and remedies for third-party interference with parental rights
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- Prenatal Nondiscrimination Act

Legal Recognition and Protection for the Unborn

- Unborn Wrongful Death Act (for a pre-viable child)

Bioethics

- Human Cloning Prohibition Act
- Destructive Embryo Research Act
- Prohibition on Public Funding of Human Cloning and Destructive Embryo Research Act

Healthcare Freedom of Conscience

- Healthcare Freedom of Conscience Act



Kentucky | RANKING: 20

Kentucky has laid the groundwork for more aggressive efforts to protect women and their unborn children through its informed consent law, parental involvement law, and abortion clinic regulations. The state also provides legal recognition and protection for unborn children in its homicide laws and protects the freedom of conscience of some healthcare providers. However, more can be done to advance the goals of the *Women's Protection Project* and to regulate emerging biotechnologies.

» ABORTION

- Kentucky's legislature has declared its opposition to abortion, stating that if the U.S. Constitution is amended or certain judicial decisions are reversed or modified, the legal recognition and protection of the lives of all human beings "regardless of their degree of biological development shall be fully restored."
- Under Kentucky law, a physician may not perform an abortion until at least 24 hours after a woman has received information about the probable gestational age of her unborn child, the nature and risks of the proposed abortion procedure, alternatives to abortion, and the medical risks of carrying the pregnancy to term. She must also be told that state-prepared materials are available for her review, that medical assistance may be available, and that the father is liable for child support even if he offered to pay for the abortion.
- A physician may not perform an abortion on an unemancipated minor under the age of 18 without the written consent of one parent, unless there is a medical emergency or a court order is issued.
- Kentucky requires abortion clinics to meet licensing requirements and minimum health and safety standards, including maintaining written policies and procedures, conducting appropriate patient testing, ensuring proper staffing, maintaining necessary equipment and medication, and providing medically appropriate post-operative care.
- Kentucky limits the performance of abortions to licensed physicians, and all abortion providers must maintain hospital admitting privileges.
- Kentucky has an enforceable abortion reporting law, but does not require the reporting of information to the Centers for Disease Control (CDC). The measure pertains to both surgical and nonsurgical abortions.
- The state follows the federal standard for Medicaid funding for abortions, permitting

the use of federal or state matching Medicaid funds for abortions necessary to preserve the life of the woman or when the pregnancy is the result of rape or incest.

- Kentucky otherwise prohibits the use of public funds for abortions unless necessary to save the life of the mother.
- Kentucky restricts the use of some or all state facilities for the performance of abortion.
- Kentucky prohibits school districts from operating a family resource center or a youth services center that provides abortion counseling or makes referrals to a healthcare facility for the purpose of seeking an abortion.
- Hospitals with emergency room services may not counsel victims of reported sexual offenses on abortion.
- All private health insurance contracts, plans, and policies must exclude coverage for abortion unless the procedure is necessary to preserve the woman's life.
- Kentucky also prohibits insurance coverage of abortions for public employees.
- The state offers "Choose Life" license plates, the proceeds of which benefit pregnancy resource centers and/or other organizations providing abortion alternatives.

» **LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN**

- The definition of "person" for purposes of Kentucky homicide laws includes "an unborn child from the moment of conception."
- Kentucky allows a parent or other relative to bring a wrongful death (civil) lawsuit when a viable unborn child is killed through the negligent or criminal act of another.
- Kentucky has enacted a "Baby Moses" law, under which a mother or legal guardian who is unable to care for a newborn infant may anonymously and safely leave the infant in the care of a responsible person at a hospital, police station, fire station, or other prescribed location.
- Healthcare professionals must test newborns for prenatal drug exposure when there is suspicion of maternal drug abuse.
- Kentucky has allocated \$1.4 million for substance abuse prevention and treatment for pregnant women.

» **BIOETHICS LAWS**

- Kentucky maintains no laws regarding human cloning or destructive embryo research, and it does not promote ethical alternatives to such destructive research.
- The state does not fully prohibit fetal experimentation, instead prohibiting only the sale or use of a live or viable aborted child.
- Kentucky does not regulate assisted reproductive technologies or human egg harvesting.

» **END OF LIFE LAWS**

- In Kentucky, assisting a suicide is a felony.

» **HEALTHCARE FREEDOM OF CONSCIENCE**

Participation in Abortion

- A physician, nurse, hospital staff member, or hospital employee who objects in writing and on religious, moral, or professional grounds is not required to participate in an abortion. Kentucky law also protects medical and nursing students.
- Private healthcare facilities and hospitals are not required to permit the performance of abortions if such performance violates the established policy of that facility or hospital.

Participation in Research Harmful to Human Life

- Kentucky currently provides no protection for the rights of healthcare providers who conscientiously object to participation in human cloning, destructive embryo research, or other forms of medical research, which violate a provider's moral or religious belief.

» **WHAT HAPPENED IN 2014**

- Kentucky considered measures limiting abortion at 5 months (i.e., 20 weeks) development, prohibiting abortion when an unborn child has a heartbeat, relating to abortion reporting, regulating the provision of abortion-inducing drugs, requiring a reflection period before abortion, giving women the opportunity to hear the heartbeat of their unborn children, requiring an ultrasound before an abortion, and enhancing parental involvement.
- Kentucky considered establishing a Physician Orders for Life-Sustaining Treatment (POLST) Paradigm program and considered legislation related to pain management and palliative care.

RECOMMENDATIONS

for KENTUCKY

WOMEN'S PROTECTION PROJECT PRIORITIES

- Women's Health Defense Act (5 month abortion limitation)
- Abortion Patients' Enhanced Safety Act
- Parental Involvement Enhancement Act
- Abortion-Inducing Drugs Safety Act
- Child Protection Act
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- Federal Abortion-Mandate Opt-Out Act
- Women's Ultrasound Right to Know Act
- Defunding the Abortion Industry and Advancing Women's Health Act
- Coercive Abuse Against Mothers Prevention Act
- Prenatal Nondiscrimination Act

Legal Recognition and Protection for the Unborn

- Unborn Wrongful Death Act (for a pre-viable child)
- Born-Alive Infant Protection Act
- Pregnant Woman's Protection Act

Bioethics

- Human Cloning Prohibition Act
- Destructive Embryo Research Act
- Prohibition on Public Funding of Human Cloning and Destructive Embryo Research Act

Healthcare Freedom of Conscience

- Healthcare Freedom of Conscience Act



Louisiana | RANKING: 1

Louisiana maintains some of the nation's most comprehensive laws protecting the health and safety of women seeking abortions and providing legal recognition and protection for the unborn. In 2014, the state enhanced its informed consent law, clarifying that the law applies to both surgical and chemical abortions and requiring that certain information on psychological risk, human trafficking, and abuse be provided before abortion. The state also enacted a measure requiring abortion providers to have admitting privileges at a hospital within 30 miles of the abortion facility.

» ABORTION

- Louisiana has declared that “the unborn child is a human being from the time of conception and is, therefore, a legal person for purposes of the unborn child’s right to life and is entitled to the right to life from conception under the laws and Constitution of this state.”
- The state prohibits abortions at or after 5 months (i.e., 20 weeks) gestation based on the pain felt by an unborn child.
- Louisiana bans partial-birth abortion throughout pregnancy except when necessary to save the life of the woman. The measure creates a civil cause of action for violations of the ban and includes more stringent criminal penalties than the related federal law, imposing a sentence of hard labor or imprisonment for one to ten years and/or a fine of \$10,000 to \$100,000.
- Louisiana has enacted a measure banning abortion once *Roe v. Wade* is overturned. While the ban includes an exception for life endangerment, there is no exception for rape or incest.
- A physician may not perform an abortion until at least 24 hours after a woman has been provided information about the proposed abortion procedure, the alternatives to abortion, the probable gestational age of the unborn child, the risks associated with abortion, and the risks associated with carrying the child to term. She must also be told about available medical assistance benefits, the father’s legal responsibilities, and that her consent for an abortion may be withdrawn or withheld without any loss of government benefits. Women must also be provided information on psychological risk, human trafficking, and abuse. The Legislature has explicitly stated that informed consent requirements apply to both surgical and chemical abortions.
- Importantly, to ensure that informed consent information focuses on a woman’s individual circumstances and that she has an adequate opportunity to ask questions,

the required information must be provided to the woman individually and in a room that protects her privacy.

- Louisiana maintains a website providing the required informed consent information, as well as information on abortion alternatives. Abortion providers must give women the website’s address following their first contact.
- Louisiana also provides a booklet describing the development of the unborn child; detailing abortion methods and their risks; providing a list of public and private agencies, including adoption agencies, that are available to provide assistance; providing information about state medical assistance benefits; and describing a physician’s liability for failing to obtain a woman’s informed consent prior to an abortion.
- In addition, a woman considering an abortion must receive information about fetal pain; specifically, she must be told about the availability of anesthesia or analgesics to prevent pain to the unborn child. Further, the mandatory informed consent materials state that by 5 months (*i.e.*, 20 weeks) gestation, an unborn child can experience and respond to pain and that anesthesia is routinely administered to unborn children for prenatal surgery at 20 weeks gestation or later.
- Louisiana mandates that an ultrasound be performed before an abortion and requires that the person performing the ultrasound read a “script” that includes offering the woman a copy of the ultrasound print. In 2012, the state supplemented this requirement, mandating that the ultrasound images be displayed and an audible heartbeat be provided to a woman before an abortion.
- Printed materials must include a comprehensive list of facilities that offer obstetric ultrasounds free of charge.
- The state requires abortion providers to state in their printed materials that it is illegal for someone to coerce a woman into having an abortion. Further, abortion providers must post signs declaring that “it is unlawful for anyone to make you have an abortion against your will, even if you are a minor.” Clinics must also post the phone number of the National Human Trafficking Resource Center hotline.
- A woman seeking an abortion following rape or incest and using state funds to pay for the abortion must be offered the same informed consent information (without the 24-hour reflection period) as is required for other abortions in the state.
- A physician may not perform an abortion on an unemancipated minor under the age of 18 without notarized, written consent from one parent unless there is a medical emergency or the minor obtains a court order.
- Further, the definition of “child abuse” includes coerced abortion. The state has authorized a court to issue a temporary restraining order prohibiting activities associated with a coerced abortion.

- Louisiana requires the licensing of abortion clinics and imposes minimum health and safety standards in a variety of areas, including clinic administration, professional qualifications, patient testing, physical plant, and post-operative care. Abortion providers must also maintain hospital admitting privileges.
- Louisiana law allows state officials to close an abortion clinic for any violation of state or federal law.
- Only physicians licensed to practice medicine in Louisiana may perform abortions. Abortion providers must have admitting privileges at a hospital within 30 miles of the abortion facility, but this provision is currently in litigation. Additionally, a person cannot perform an abortion unless that person is currently enrolled in or has completed a residency in obstetrics and gynecology or family medicine.
- The state has an enforceable abortion reporting law, but does not require the reporting of information to the Centers for Disease Control (CDC). The measure requires abortion providers to report short-term complications and the name and address of the hospital or facility where treatment was provided for the complications. Drug-induced abortions and any complications arising from an abortion must be reported.
- The state requires the presence of a physician when abortion-inducing drugs are administered or dispensed and requires the scheduling of a follow-up appointment for the woman.
- Louisiana follows the federal standard for Medicaid funding for abortions, only permitting the use of federal or state matching Medicaid funds for abortions necessary to preserve the life of the woman or when the pregnancy is the result of rape or incest.
- Public funds may not be used “for, to assist in, or to provide facilities for an abortion, except when the abortion is medically necessary to prevent the death of the mother.”
- No individual or organization that performs elective abortions (or an affiliate of that individual or organization) may provide instruction or materials in public schools.
- The state prohibits insurance companies from offering abortion coverage within state insurance Exchanges established pursuant to the federal healthcare law.
- Louisiana funds programs providing direct support for groups and organizations promoting abortion alternatives.
- Louisiana also offers “Choose Life” license plates, the proceeds of which benefit pregnancy resource centers and/or other organizations providing abortion alternatives.

» **LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN**

- Under Louisiana criminal law, the killing of an unborn child at any stage of gestation is defined as a form of homicide. In addition, an “unborn child” is a victim of a

“feticide” if killed during the perpetration of certain crimes, including robbery and cruelty to juveniles.

- Louisiana defines a nonfatal assault on an unborn child as a criminal offense.
- The state allows a wrongful death (civil) action when an unborn child at any stage of development is killed through a negligent or criminal act.
- The state has created a specific affirmative duty of physicians to provide medical care and treatment to infants born alive at any stage of development.
- Under the Louisiana Children’s Code, “neglect” includes instances when a newborn is identified by a healthcare provider as having been affected by prenatal drug use or exhibiting symptoms of drug withdrawal.
- Louisiana has also expanded the definition of “prenatal neglect” to include 1) “exposure to chronic or severe use of alcohol,” 2) the use of any controlled dangerous substance “in a manner not lawfully prescribed” that results in symptoms of withdrawal to the newborn, 3) the presence of a controlled substance or related metabolite in the newborn, or 4) observable and harmful effects in the newborn’s appearance or functioning.
- The state also funds drug treatment programs for pregnant women and newborns.

» **BIOETHICS LAWS**

- Louisiana prohibits destructive embryo research and the funding of human cloning (although it does not explicitly ban human cloning).
- Louisiana does not fully ban fetal experimentation, instead prohibiting only experimentation on live-born human beings or fetuses in utero.
- Louisiana bans the creation of chimeras (human-animal hybrids).
- The state has established the Umbilical Cord Blood Banking Program to promote public awareness of the potential benefits of cord blood banking, to encourage research into the uses of cord blood, to facilitate pre-delivery arrangements for cord blood donations, and to promote professional education programs.
- The state regulates assisted reproductive technologies.
- Louisiana law allows for embryo adoption.

» **END OF LIFE LAWS**

- In Louisiana, assisted suicide is a felony.

» **HEALTHCARE FREEDOM OF CONSCIENCE**

Participation in Abortion

- Any person has the right not to participate in or be required to participate in any healthcare service that violates his or her conscience (including abortion and the provision of abortion-inducing drugs) to the extent that “access to health care is not compromised.” The person’s conscientious beliefs must be in writing and patients must be notified. The law is not to be construed as relieving any healthcare provider from providing “emergency care.”
- A healthcare facility must ensure that it has sufficient staff to provide patient care in the event an employee declines to participate in any healthcare service that violates his or her conscience.

Participation in Research Harmful to Human Life

- Any person has the right not to participate in or be required to participate in any healthcare service that violates his or her conscience (including human embryonic stem-cell research, human embryo cloning, euthanasia, or physician-assisted suicide) to the extent that “access to health care is not compromised.” The person’s conscientious beliefs must be in writing and patients must be notified. The law is not to be construed as relieving any healthcare provider from providing “emergency care.”
- A healthcare facility must ensure that it has sufficient staff to provide patient care in the event an employee declines to participate in any healthcare service that violates his or her conscience.

» **WHAT HAPPENED IN 2014**

- Louisiana enacted legislation strengthening its informed consent requirements and clarifying that informed consent requirements apply to both surgical and chemical abortions. It also enacted a measure requiring that certain information on psychological risk, human trafficking, and abuse be provided before abortion. Further, abortion clinics must now post the phone number of the National Human Trafficking Resource Center hotline.
- The state enacted a measure requiring abortion providers to have admitting privileges at a hospital within 30 miles of the abortion facility. Abortion advocates immediately challenged the provision, and it remains in litigation.
- Louisiana enacted a provision requiring that drug-induced abortions and any complications arising from abortion be reported.
- In a busy and productive legislative session, Louisiana also enacted a measure providing that no individual or organization that performs elective abortions (or an affiliate of that individual or organization) may provide instruction or materials in public schools.

- The state also considered an abortion-related amendment to its state constitution.
- Governor Bobby Jindal vetoed a measure allowing gestational surrogacy, while state legislators also considered legislation criminalizing gestational surrogacy or enticing a minor into surrogacy.
- Louisiana enacted a measure prohibiting the termination of life-sustaining procedures for pregnant women.
- Legislators requested a study by and recommendations from the Louisiana State Board of Medical Examiners concerning the over-prescription of pain medication.

RECOMMENDATIONS

for LOUISIANA

WOMEN'S PROTECTION PROJECT PRIORITIES

- Abortion Patients' Enhanced Safety Act
- Abortion-Inducing Drugs Safety Act
- Parental Involvement Enhancement Act
- Child Protection Act
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- Defunding the Abortion Industry and Advancing Women's Health Act
- Prenatal Nondiscrimination Act

Legal Recognition and Protection for the Unborn

- Prohibition on wrongful birth and wrongful life lawsuits
- Pregnant Woman's Protection Act

Bioethics

- Human Cloning Prohibition Act
- Assisted Reproductive Technologies Disclosure and Risk Reduction Act



Maine | RANKING: 32

Maine provides minimal protection for women seeking abortions. For example, its parental involvement law contains a major loophole, allowing abortion providers to veto a parent's right to grant or withhold consent. Further, Maine is in the minority of states failing to provide meaningful legal recognition and protection to unborn victims of criminal violence.

» ABORTION

- Maine has enacted a *Freedom of Choice Act* providing for a legal right to abortion even if *Roe v. Wade* is eventually overturned and stating that it is the public policy of Maine not to restrict access to abortion before viability.
- A physician may not perform an abortion on a woman until after advising her of the probable gestational age of the unborn child; the risks associated with continued pregnancy and the proposed abortion procedure; and, at the woman's request, alternatives to abortion and information about and a list of public and private agencies that will provide assistance if the woman chooses to carry her pregnancy to term.
- A physician may not perform an abortion on a minor under the age of 18 until after advising her about the alternatives to abortion, prenatal care, agencies providing assistance, and the possibility of involving her parents or other adult family members in her decision. Moreover, the physician must have the written consent of one parent or an adult family member unless he or she determines that the minor is "mentally and physically competent" to give consent or has secured a court order.
- Only physicians licensed to practice medicine or osteopathy by the State of Maine may perform abortions.
- Maine has an enforceable abortion reporting law, but does not require the reporting of information to the Centers for Disease Control (CDC). The measure governs both surgical and nonsurgical abortions.
- Maine follows the federal standard for Medicaid funding for abortions, permitting the use of federal or state matching Medicaid funds for abortions necessary to preserve the life of the woman or when the pregnancy is the result of rape or incest.

» LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN

- Maine does not currently recognize an unborn child as a potential victim of homicide or assault.

- Maine provides for an enhanced sentence for the homicide of a pregnant woman and has created a new crime of “elevated aggravated assault” on a pregnant woman.
- The state requires healthcare providers to report all deaths of infants less than one year of age, as well as deaths of women during pregnancy and maternal deaths within 42 days of giving birth, to the Maternal Infant Death Review Panel.
- The state allows a wrongful death (civil) action only when an unborn child is born alive following a negligent or criminal act and dies thereafter.
- Maine has created a specific affirmative duty of physicians to provide medical care and treatment to infants born alive at any stage of development.
- Maine has a “Baby Moses” law, establishing a safe haven for mothers to legally leave their infants at designated places and ensuring that the infants receive appropriate care and protection.
- The state requires a healthcare provider involved in the delivery or care of an infant suspected to have been exposed to drugs *in utero* to report the suspected exposure to the state Department of Health and Human Services.
- Maine provides for the issuance of a “Certificate of Birth Resulting in Stillbirth” when requested by a parent.

» **BIOETHICS LAWS**

- Maine does not maintain laws regarding human cloning, but its ban on fetal experimentation applies to live fetuses either intrauterine or extrauterine. Thus, its fetal experimentation statute could be read to prohibit harmful experimentation on human embryos.
- Maine does not promote ethical forms of research.
- Maine maintains no meaningful regulation of assisted reproductive technologies or human egg harvesting.

» **END OF LIFE LAWS**

- In Maine, assisted suicide is a felony.

» **HEALTHCARE FREEDOM OF CONSCIENCE**

Participation in Abortion

- The conscientious objection of a physician, nurse, or other healthcare worker to performing or assisting in the performance of an abortion may not be the basis for civil liability, discrimination in employment or education, or other retaliatory action. Medical and nursing students are also protected.

- The conscientious objection of a hospital or other healthcare facility to permitting an abortion on its premises may not be the basis for civil liability or recriminatory action.
- Private institutions, physicians, or their agents may refuse to provide family planning services based upon religious or conscientious objections.
- The state provides some protection for the conscience rights of pharmacists and pharmacies.
- Health insurance plans that provide prescription coverage must also provide coverage for contraception. The provision includes an exemption so narrow that it excludes the ability of most employers and insurers with moral or religious objections from exercising the exemption.

Participation in Research Harmful to Human Life

- Maine currently provides no protection for the rights of healthcare providers who conscientiously object to participation in human cloning, destructive embryo research, or other forms of medical research, which violate a provider's moral or religious belief.

» WHAT HAPPENED IN 2014

- Governor Paul LePage vetoed legislation which would have expanded Medicaid family planning funding to individuals at or below 200 percent of the federal poverty line. While not directly related to abortion funding, the measure would have made more money available to abortion providers.
- In *Fitzgerald v. Portland*, a pro-life family challenged a local ordinance placing a "no pro-life speech" zone around abortion clinics. The ordinance was reportedly repealed in the wake of the Supreme Court's decision in *McCullen v. Coakley*, which struck down a similar ordinance in Massachusetts, but another similar zone is being contemplated in Portland.
- Maine considered legislation related to pain management and palliative care.

RECOMMENDATIONS

for MAINE

WOMEN'S PROTECTION PROJECT PRIORITIES

- Women's Health Defense Act (5 month abortion limitation)
- Women's Right to Know Act with reflection period
- Abortion Patients' Enhanced Safety Act
- Abortion-Inducing Drugs Safety Act
- Parental Consent for Abortion Act
- Parental Involvement Enhancement Act
- Child Protection Act
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- Repeal State FOCA
- Federal Abortion-Mandate Opt-Out Act
- Defunding the Abortion Industry and Advancing Women's Health Act
- Women's Ultrasound Right to Know Act
- Coercive Abuse Against Mothers Prevention Act
- Prenatal Nondiscrimination Act

Legal Recognition and Protection for the Unborn

- Crimes Against the Unborn Child Act
- Unborn Wrongful Death Act
- Pregnant Woman's Protection Act

Bioethics

- Human Cloning Prohibition Act
- Destructive Embryo Research Act
- Prohibition on Public Funding of Human Cloning and Destructive Embryo Research Act

Healthcare Freedom of Conscience

- Healthcare Freedom of Conscience Act



Maryland | RANKING: 39

Maryland provides virtually no protection for women and unborn children. The state does not have an informed consent law, its parental notice law contains a loophole that eviscerates the protection this requirement typically provides, and it does not provide meaningful legal recognition and protection to unborn victims of criminal violence. It is also one of a small number of states that allows and funds destructive embryo research.

» ABORTION

- The state maintains a *Freedom of Choice Act*. The Act mandates a right to abortion even if *Roe v. Wade* is eventually overturned, specifically providing that the state may not “interfere with the decision of a woman to terminate a pregnancy” before the fetus is viable, if the procedure is necessary to protect the life or health of the woman, or if the unborn child is afflicted by a genetic defect or serious deformity.
- Under current Maryland law, an unmarried minor under the age of 18 who lives with a parent may not undergo an abortion unless one parent has been notified by the physician. However, the law contains a significant loophole: a minor may obtain an abortion without parental notification if, in the professional judgment of the physician, notice to the parent may lead to physical or emotional abuse of the minor, the minor is mature and capable of giving informed consent to an abortion, or notice would not be in the “best interests” of the minor.
- In July 2012, the state Department of Health and Mental Hygiene announced that abortion clinics will have to be licensed and meet minimum health and safety standards modeled after existing standards for outpatient surgical centers.
- Only licensed physicians may perform abortions.
- Maryland taxpayers are required by statute to pay for “medically necessary” abortions for women eligible for public assistance. This requirement essentially equates to funding abortion-on-demand in light of the U.S. Supreme Court’s broad definition of “health” in the context of abortion.
- Maryland offers “Choose Life” license plates, the proceeds of which benefit pregnancy resource centers and/or other organizations providing abortion alternatives.

» LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN

- Maryland recognizes a “viable fetus” as a distinct victim of murder, manslaughter, or unlawful homicide. However, the law explicitly states that its enactment should not be construed as conferring “personhood” on the fetus.

- The state allows a wrongful death (civil) action when a viable unborn child is killed through a negligent or criminal act.
- Maryland law does not require physicians to provide appropriate medical care to an infant who survives an abortion.
- Maryland has a “Baby Moses” law, establishing a safe haven for mothers to legally leave their infants up to 10 days of age at designated places and ensuring that the infants receive appropriate care and protection.
- Maryland law provides that a child is not receiving proper care if he or she is born exposed to methamphetamine or if the mother tests positive for methamphetamine upon admission to the hospital for delivery of the infant. It funds drug treatment programs for pregnant women and newborns.
- A healthcare provider must report the delivery of an infant exposed to controlled substances to a local social services office. The report alone will not automatically trigger a child abuse or neglect investigation.

» **BIOETHICS LAWS**

- Maryland prohibits cloning-to-produce-children, but not cloning-for-biomedical-research, making it a “clone-and-kill” state.
- Maryland maintains a “Stem Cell Research Fund,” and allows and funds destructive embryonic research. However, funds may also be used for adult stem-cell research.
- Maryland does not prohibit fetal experimentation.
- Umbilical cord blood donation educational materials are to be distributed to all pregnant patients.
- Maryland does not regulate assisted reproductive technologies, but does maintain provisions related to the parentage of children conceived using such technologies.
- Maryland appears to prohibit the sale or transfer of human eggs for “valuable consideration.” It proscribes the use of sperm or eggs from a “known donor” if the donor receives any remuneration for the donation. The prohibition does not apply to anonymous donation to a tissue or sperm bank or to a fertility clinic.

» **END OF LIFE LAWS**

- In Maryland, assisted suicide is considered a felony.
- The state maintains a Physician Orders for Life-Sustaining Treatment (POLST) Paradigm program.

» HEALTHCARE FREEDOM OF CONSCIENCE

Participation in Abortion

- Under Maryland law, no person may be required to participate in or refer to any source for medical procedures that result in an abortion.
- A hospital is not required to permit the performance of abortions within its facilities or to provide referrals for abortions.
- Health insurance plans that provide prescription coverage must also provide coverage for contraception. There is a conscience exemption for religious employers.

Participation in Research Harmful to Human Life

- Maryland currently provides no protection for the rights of healthcare providers who conscientiously object to participation in human cloning, destructive embryo research, or other forms of medical research, which violate a provider's moral or religious belief.

» WHAT HAPPENED IN 2014

- Maryland continued its policy of paying for abortions for women on public assistance (Medicaid).
- Maryland considered a measure limiting abortion at 5 months (*i.e.*, 20 weeks) development. AUL provided support for the measure. The state also considered legislation related to ultrasound and abortion reporting.
- In *Centro Tepeyac v. Montgomery County*, pregnancy resource centers (PRCs) were victorious in defeating a Montgomery County ordinance placing draconian regulations on PRCs in an effort to stymie their life-affirming message. Litigation over a similar Baltimore ordinance is ongoing.
- Maryland enacted (without the governor's signature) legislation appropriating funds to the Maryland Stem Cell Fund. The state considered legislation amending its stem cell research fund to include certain reporting requirements.
- The state considered establishing a study of assisted suicide and legislation related to pain management and palliative care.

RECOMMENDATIONS

for MARYLAND

WOMEN'S PROTECTION PROJECT PRIORITIES

- Women's Health Defense Act (5 month abortion limitation)
- Women's Right to Know Act with reflection period
- Abortion Patients' Enhanced Safety Act
- Abortion-Inducing Drugs Safety Act
- Meaningful parental involvement law
- Child Protection Act
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- Repeal State FOCA
- Federal Abortion-Mandate Opt-Out Act
- Defunding the Abortion Industry and Advancing Women's Health Act
- Women's Ultrasound Right to Know Act
- Coercive Abuse Against Mothers Prevention Act
- Prenatal Nondiscrimination Act

Legal Recognition and Protection for the Unborn

- Crimes Against the Unborn Child Act (protecting the child from conception)
- Unborn Wrongful Death Act (for a pre-viable child)
- Born-Alive Infant Protection Act
- Pregnant Woman's Protection Act

Bioethics

- Human Cloning Prohibition Act
- Destructive Embryo Research Act
- Prohibition on Public Funding of Human Cloning and Destructive Embryo Research Act

Healthcare Freedom of Conscience

- Healthcare Freedom of Conscience Act



Massachusetts | RANKING: 38

Massachusetts has failed to make significant progress in protecting women and the unborn from the harms inherent in abortion, instead recognizing a broader constitutional right to abortion than that interpreted in the U.S. Constitution. The State has also failed to adequately limit and regulate emerging biotechnologies and has considered measures to approve assisted suicide and endanger those at the end of life.

» ABORTION

- The Massachusetts Constitution has been interpreted as providing a broader right to abortion than that interpreted in the U.S. Constitution.
- The state's informed consent law is enjoined.
- Any person who provides prenatal care, postnatal care, or genetic counseling to parents with an unborn child diagnosed with Down syndrome must provide up-to-date information about Down syndrome. Mandated information includes information about physical, developmental, educational, and psychosocial outcomes; life expectancy; intellectual and functional development; treatment options; and information on educational and support groups.
- A physician may not perform an abortion on an unmarried minor under the age of 18 without the written consent of one parent unless there is a medical emergency or the minor obtains a court order.
- The state's requirement that abortions after the 12th week of pregnancy be performed in hospitals is, under current U.S. Supreme Court precedent, unenforceable.
- Only physicians authorized to practice medicine in the State of Massachusetts may perform abortions.
- Massachusetts has an enforceable abortion reporting law, but does not require the reporting of information to the Centers for Disease Control (CDC). The measure pertains to both surgical and nonsurgical abortions and requires abortion providers to report short-term complications.
- Massachusetts taxpayers are required by court order to pay for "medically necessary" abortions for women eligible for public assistance. This requirement essentially equates to funding abortion-on-demand in light of the U.S. Supreme Court's broad definition of "health" in the context of abortion.
- State employee health insurance provides coverage of abortion only when a woman's

life or health is endangered or in cases of rape, incest, or fetal abnormality, and may not cover partial-birth abortions. Further, health maintenance organizations (HMOs) may not be required to provide payment or referrals for abortion unless necessary to preserve the woman's life.

» **LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN**

- The Massachusetts Supreme Court has determined that the state's homicide law applies to the killing of an unborn child who has attained viability.
- The state allows a wrongful death (civil) action when a viable unborn child is killed through a negligent or criminal act.
- The state requires healthcare professionals to report suspected prenatal drug exposure.

» **BIOETHICS LAWS**

- While Massachusetts prohibits cloning-to-produce-children, it statutorily permits cloning-for-biomedical-research and destructive embryo research, making it a "clone-and-kill" state.
- The Massachusetts Public Health Council has reversed a rule put in place during the gubernatorial administration of Mitt Romney that prohibited scientists from creating human embryos for the purpose of destroying them for research.
- The state funds destructive embryo research and allows tax credits for "life sciences," including "stem cell research."
- The state does not maintain a comprehensive ban on fetal experimentation, prohibiting only experimentation on live fetuses and allowing experimentation on dead fetuses with consent of the parents.
- Massachusetts has established an umbilical cord blood bank for the purpose of collecting and storing umbilical cord blood and placental tissues. All licensed hospitals are required to inform pregnant patients of the opportunity to donate the umbilical cord and placental tissue following delivery.
- Massachusetts requires a degree of informed consent before a physician can harvest human eggs for purposes of assisted reproductive technologies. In the research setting, the state also prohibits the purchase of human eggs for "valuable consideration."
- Massachusetts requires any person who provides prenatal care, postnatal care, or genetic counseling to parents with an unborn child diagnosed with Down syndrome to provide up-to-date information about Down syndrome. Mandated information includes information about physical, developmental, educational, and psychosocial outcomes; life expectancy; intellectual and functional development; treatment options; and information on educational and support groups.

» END OF LIFE LAWS

- In Massachusetts, assisted suicide remains a common law crime.

» HEALTHCARE FREEDOM OF CONSCIENCE

Participation in Abortion

- A physician or person associated with, employed by, or on the medical staff of a hospital or health facility who objects in writing and on religious or moral grounds is not required to participate in abortions. Medical and nursing students are also protected.
- A private hospital or health facility is not required to admit a woman for an abortion.
- Health insurance plans that provide prescription coverage must also provide coverage for contraception. The provision includes a conscience exemption so narrow it excludes the ability of most employers and insurers with moral or religious objections from exercising the exemption.

Participation in Research Harmful to Human Life

- Massachusetts currently provides no protection for the rights of healthcare providers who conscientiously object to participation in human cloning, destructive embryo research, or other forms of medical research, which violate a provider's moral or religious belief.

» WHAT HAPPENED IN 2014

- Massachusetts considered legislation prohibiting sex-selective abortions, prohibiting partial-birth abortions, requiring a reflection period before an abortion, and related to abortion funding.
- In *McCullen v. Coakley*, the U.S. Supreme Court struck down a draconian Massachusetts “no pro-life speech zone” law which hampered the First Amendment speech rights of sidewalk counselors seeking to offer assistance to women entering or leaving abortion facilities.
- Massachusetts considered fetal homicide legislation protecting an unborn child from the time of conception.
- Massachusetts considered legislation related to assisted reproductive technologies and embryo adoption.
- The state also considered a number of measures related to end of life issues, including legislation explicitly legalizing assisted suicide; forbidding any facility from withholding or withdrawing life-sustaining care from a patient or discharging a patient from the facility if there is a reason to believe that such an action is contrary to the patient's religious beliefs; involving advance planning documents; giving patients

certain rights (such as the right to accept or refuse treatment); and pertaining to pain management and palliative care.

RECOMMENDATIONS

for MASSACHUSETTS

WOMEN'S PROTECTION PROJECT PRIORITIES

- Women's Health Defense Act (5 month abortion limitation)
- Women's Right to Know Act with reflection period
- Abortion Patients' Enhanced Safety Act
- Abortion-Inducing Drugs Safety Act
- Parental Involvement Enhancement Act
- Child Protection Act
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- State Constitutional Amendment (providing that there is no state constitutional right to abortion)
- Federal Abortion-Mandate Opt-Out Act
- Defunding the Abortion Industry and Advancing Women's Health Act
- Women's Ultrasound Right to Know Act
- Coercive Abuse Against Mothers Prevention Act
- Prenatal Nondiscrimination Act

Legal Recognition and Protection for the Unborn

- Crimes Against the Unborn Child Act (to protect an unborn child from conception)
- Unborn Wrongful Death Act (for a pre-viable child)
- Born-Alive Infant Protection Act
- Pregnant Woman's Protection Act

Bioethics

- Human Cloning Prohibition Act
- Destructive Embryo Research Act
- Prohibition on Public Funding of Human Cloning and Destructive Embryo Research Act

RECOMMENDATIONS

for MASSACHUSETTS (CONT.)

End of Life

- Assisted Suicide Ban Act

Healthcare Freedom of Conscience

- Healthcare Freedom of Conscience Act



Michigan | RANKING: 14

Michigan has an enviable record of protecting women and the unborn from the harms inherent in abortion, including imposing medically appropriate health and safety standards on abortion facilities, regulating the provision of chemical abortions, and limiting taxpayer funding of abortion and abortion providers. However, the state's record on emerging biotechnologies is more suspect. Michigan specifically allows destructive embryo research and the funding of such research, and fails to regulate assisted reproductive technologies or human egg harvesting.

» ABORTION

- Michigan possesses an enforceable abortion prohibition should the U.S. Constitution be amended or certain U.S. Supreme Court decisions be reversed or modified.
- Michigan prohibits partial-birth abortion.
- A physician may not perform an abortion on a woman until at least 24 hours after the woman receives information on the probable gestational age of her unborn child, along with state-prepared information or other material on prenatal care and parenting, the development of the unborn child, a description of abortion procedures and their inherent complications, and assistance and services available through public agencies.
- Women must be informed of the availability of ultrasounds and be given the opportunity to view the results of an ultrasound prior to abortion.
- A physician is required to screen patients for coercion before performing an abortion. The Department of Community Health has been instructed to develop a notice concerning coerced abortions to be posted in abortion facilities.
- A physician may not perform an abortion on an unemancipated minor under the age of 18 without the written consent of one parent unless there is a medical emergency or the minor obtains a court order.
- The Michigan Attorney General has issued opinions that the state's informed consent and parental consent statutes apply both to surgical abortions and to the use of mifepristone (RU-486).
- Under Michigan law, abortion clinics (where more than 50 percent of the patients served undergo abortions) are regulated as "freestanding surgical outpatient facilities." The regulations provide for minimum health and safety standards in such areas as clinic administration, staff qualifications, and physical plant.
- Michigan limits the performance of abortions to licensed physicians.

- Michigan has an enforceable abortion reporting law, but does not require the reporting of information to the Centers for Disease Control (CDC). The measure pertains to both surgical and nonsurgical abortions and requires abortion providers to report short-term complications.
- Michigan requires that a woman be examined and specifically prohibits physicians from utilizing an internet web camera for chemical abortions. The physician must also be present when the drugs are dispensed.
- Michigan follows the federal standard for Medicaid funding for abortions, permitting the use of federal or state matching Medicaid funds for abortions necessary to preserve the life of the woman or when the pregnancy is the result of rape or incest.
- Michigan prohibits organizations that receive state funds from using those funds to provide abortion counseling or to make referrals for abortion, and only permits ultrasound grants if they will not be used for assisting in the performance of elective abortions.
- Family planning funds are prioritized for organizations which do not perform elective abortions within a facility owned or operated by the organization, make referrals for abortions, or have written policies which consider abortion a method of family planning.
- Insurance companies participating in the state insurance Exchanges established pursuant to the federal healthcare law cannot offer policies that provide abortion coverage within the Exchanges.
- Michigan prohibits insurance plans from covering abortions, except by optional rider.
- In 2014, Michigan allocated \$800,000 for a pregnancy and parenting support services program, which must provide childbirth, alternatives to abortion, and grief counseling.

» **LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN**

- Under Michigan law, the killing of an unborn child at any stage of gestation is defined as a form of homicide.
- Michigan defines a criminal assault on a pregnant woman that results in miscarriage, stillbirth, or “damage to pregnancy” as an enhanced offense for sentencing purposes.
- Michigan defines a nonfatal assault on an unborn child as a crime.
- Michigan has applied the affirmative defense of “defense of others” to cases where a woman uses force (including deadly force) to protect her unborn child.
- The state allows a wrongful death (civil) action when an unborn child at any stage of development is killed through a negligent or criminal act.
- The state has created a specific affirmative duty of physicians to provide medical care and treatment to infants born alive at any stage of development.

- Michigan requires healthcare professionals to report suspected prenatal drug exposure.

» **BIOETHICS LAWS**

- In November 2008, Michigan voters passed a Stem Cell Initiative, amending the state constitution to legalize destructive embryo research and to allow the funding of research on human embryos.
- Michigan does not maintain a comprehensive ban on fetal experimentation, prohibiting only experimentation on live fetuses and allowing research on dead fetuses with the consent of the mother.
- The Michigan Legislature has directed the state to establish a state-wide network of cord blood stem-cell banks and to promote public awareness and knowledge about the banks and banking options, if funds are available.
- Michigan does not maintain any meaningful regulation of assisted reproductive technologies or human egg harvesting.

» **END OF LIFE LAWS**

- In Michigan, assisted suicide is a felony.

» **HEALTHCARE FREEDOM OF CONSCIENCE**

Participation in Abortion

- A physician, nurse, medical student, nursing student, or individual who is a member of, associated with, or employed by a hospital, institution, teaching institution, or healthcare facility who objects on religious, moral, ethical, or professional grounds is not required to participate in abortions.
- A hospital, institution, teaching institution, or healthcare facility is not required to participate in abortion, permit an abortion on its premises, or admit a woman for the purposes of performing an abortion.

Participation in Research Harmful to Human Life

- Michigan currently provides no protection for the rights of healthcare providers who conscientiously object to participating in human cloning, destructive embryo research, or other forms of medical research which violate a provider's moral or religious belief.

» **WHAT HAPPENED IN 2014**

- Michigan enacted legislation prohibiting insurance plans from covering abortions, except by optional rider.

- Michigan also adopted a budget bill that allocates \$800,000 for a pregnancy and parenting support services program, which must provide childbirth, alternatives to abortion, and grief counseling.
- The state considered legislation related to abortion reporting and “Choose Life” license plates.
- Michigan considered legislation purporting to protect employees against discrimination for “reproductive health decision making.” The legislation appeared to adopt a disingenuous narrative—that employees face potential discrimination or lack of access to contraception stemming from their employers’ religious liberty and conscience claims against the coercive “HHS Mandate” (which would require many employers to pay for or facilitate coverage for drugs and devices with life-ending mechanisms of action).
- The state considered legislation related to pain management and palliative care.

RECOMMENDATIONS

for MICHIGAN

WOMEN'S PROTECTION PROJECT PRIORITIES

- Women's Health Defense Act (5 month abortion limitation)
- Abortion Patients' Enhanced Safety Act
- Parental Involvement Enhancement Act
- Child Protection Act
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- Federal Abortion-Mandate Opt-Out Act
- Defunding the Abortion Industry and Advancing Women's Health Act
- Coercive Abuse Against Mothers Prevention Act
- Prenatal Nondiscrimination Act

Bioethics

- Repeal of constitutional amendment permitting and funding destructive embryo research
- Promotion of ethical forms of research
- Assisted Reproductive Technologies Disclosure and Risk Reduction Act

Healthcare Freedom of Conscience

- Healthcare Freedom of Conscience Act



Minnesota | RANKING: 30

Although the Minnesota Constitution has been interpreted to protect abortion to a greater extent than that interpreted in the U.S. Constitution, Minnesota has made some meaningful progress toward protecting women and unborn children. For example, it requires informed consent before abortion that includes information on the abortion-breast cancer link, as well as information about perinatal hospice options for families facing life-limiting fetal anomalies.

» ABORTION

- The Minnesota Constitution protects the “right to an abortion” as a fundamental right and to a greater extent than that interpreted in the U.S. Constitution.
- Minnesota’s informed consent law requires that a woman be given information on the risks of and alternatives to abortion at least 24 hours prior to undergoing an abortion.
- Minnesota requires that a physician or his or her agent advise a woman seeking an abortion after 5 months (*i.e.*, 20 weeks) gestation of the possibility that anesthesia will alleviate fetal pain.
- The state also explicitly requires a physician to inform a woman seeking abortion of the abortion-breast cancer link.
- Minnesota maintains a law prohibiting coerced abortions, defining “coercion” as “restraining or dominating the choice of a minor female by force, threat of force, or deprivation of food and shelter.” The provision only applies to employees in government-run social programs and prohibits threatening to disqualify eligible recipients of their financial assistance if they do not obtain abortion, and is applied to older women as well as minors.
- Minnesota law provides that a physician may not perform an abortion on an unemancipated minor under the age of 18 until at least 48 hours after written notice has been delivered to both parents (unless one cannot be found after a reasonable effort) unless one of the following applies: the minor is the victim of rape, incest, or child abuse, which must be reported; there is a medical emergency; or the minor obtains a court order.
- Minnesota requires abortions after the first trimester to be performed in a hospital or “abortion facility.”
- Only physicians licensed to practice medicine by the State of Minnesota or physicians-in-training supervised by licensed physicians may perform abortions.

- The state has an enforceable abortion reporting law, but does not require the reporting of information to the Centers for Disease Control (CDC). The measure pertains to both surgical and nonsurgical abortions and requires abortion providers to report short-term complications.
- Minnesota taxpayers are required by court order to fund “medically necessary” abortions for women eligible for public assistance. This requirement essentially equates to funding abortion-on-demand in light of the U.S. Supreme Court’s broad definition of “health” in the context of abortion.
- Minnesota prohibits special grants from being awarded to any non-profit corporation which performs abortions. Further, grantees may not provide state funds to any non-profit corporation which performs abortions.
- Pregnancy alternative grants may not be used to encourage or affirmatively counsel a woman to have an abortion not necessary to prevent her death, to provide her with an abortion, or to directly refer her to an abortion provider for an abortion.
- The Minnesota Care public insurance program prohibits public funds from being used to cover abortions except when the mother’s life is in danger, she faces a serious health risk, or in cases of rape or incest.

» **LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN**

- Under Minnesota law, the killing of an unborn child at any stage of gestation is defined as a form of homicide.
- Minnesota has established a penalty for injuring an unborn child as a result of operating a motor vehicle in a grossly negligent manner or while under the influence of alcohol or drugs.
- Minnesota defines a nonfatal assault on an unborn child as a criminal offense.
- Minnesota allows a wrongful death (civil) action when a viable unborn child is killed through a negligent or criminal act.
- The state has created a specific affirmative duty of physicians to provide medical care and treatment to infants born alive after attaining viability.
- Minnesota has a “Baby Moses” law allowing emergency service personnel to accept a relinquished infant who is seven days old or younger.
- A court may order a pregnant woman into an early intervention treatment program for substance abuse.
- Professionals, such as healthcare providers and law enforcement officers, must report suspected abuse of a controlled substance by pregnant women. In addition, healthcare professionals must test newborns for drug exposure when there is suspicion of prenatal drug use.

- The state also funds drug treatment programs for pregnant women and newborns.

» **BIOETHICS LAWS**

- Minnesota does not explicitly prohibit human cloning or destructive embryo research.
- In 2011, the state allowed a former prohibition on the funding of human cloning to expire.
- Minnesota bans experimentation on a “living human conceptus,” meaning that experimentation on an aborted fetus is not prohibited.
- The state does not promote ethical alternatives to destructive embryo research.
- Minnesota maintains no meaningful regulation of assisted reproductive technologies or human egg harvesting.

» **END OF LIFE LAWS**

- In Minnesota, assisted suicide is a felony.

» **HEALTHCARE FREEDOM OF CONSCIENCE**

Participation in Abortion

- Minnesota law provides that no person, hospital, or institution may be coerced, held liable for, or discriminated against in any way for refusing to perform, accommodate, or assist in an abortion. However, this provision has been held unconstitutional as applied to public hospitals and institutions. Thus, public hospitals may be required to perform, accommodate, or assist in abortions.
- State employees may refuse to provide family planning services if contrary to their personal beliefs.
- Health plan companies and healthcare cooperatives are not required to provide abortions or coverage of abortions.

Participation in Research Harmful to Human Life

- Minnesota currently provides no protection for the rights of healthcare providers who conscientiously object to participation in human cloning, destructive embryo research, or other forms of medical research, which violate a provider’s moral or religious belief.

» **WHAT HAPPENED IN 2014**

- Minnesota considered a measure prohibiting a physician from charging a fee or receiving any compensation, either directly or indirectly, for performing an abortion, including payments made by a health plan company or a patient’s employer. It also

considered legislation limiting abortion at 5 months (*i.e.*, 20 weeks) development, delineating qualifications for individual abortion providers, requiring abortion reporting, regulating the provision of abortion-inducing drugs, and related to insurance coverage of abortion.

- Minnesota enacted a measure establishing a penalty for injuring an unborn child as a result of operating a motor vehicle in a grossly negligent manner or while under the influence of alcohol or drugs.
- Minnesota enacted a measure providing improved access to health care delivered by advanced practice registered nurses.

RECOMMENDATIONS

for MINNESOTA

WOMEN'S PROTECTION PROJECT PRIORITIES

- Women's Health Defense Act (5 month abortion limitation)
- Abortion Patient's Enhanced Safety Act
- Abortion-Inducing Drugs Safety Act
- Parental Consent for Abortion Act
- Parental Involvement Enhancement Act
- Child Protection Act
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- State Constitutional Amendment (providing that there is no state constitutional right to abortion)
- Federal Abortion-Mandate Opt-Out Act
- Defunding the Abortion Industry and Advancing Women's Health Act
- Women's Ultrasound Right to Know Act
- Prenatal Nondiscrimination Act

Legal Recognition and Protection for the Unborn

- Unborn Wrongful Death Act (for a pre-viable child)
- Pregnant Woman's Protection Act

Bioethics

- Human Cloning Prohibition Act
- Destructive Embryo Research Act
- Prohibition on Public Funding of Human Cloning and Destructive Embryo Research Act

Healthcare Freedom of Conscience

- Healthcare Freedom of Conscience Act



Mississippi | RANKING: 2

Over the last several years, AUL has worked with Mississippi to enact numerous life-affirming laws, such as its informed consent law and comprehensive protection for healthcare freedom of conscience. In 2014, Mississippi enacted a measure, based on AUL model legislation, limiting abortions at 5 months (i.e., 20 weeks) of pregnancy based on the health risks to a woman from late-term abortions and the pain experienced by an unborn child. Mississippi also maintains one the nation's most protective laws, based on AUL model legislation, for healthcare freedom of conscience.

» ABORTION

- In *Pro-Choice Mississippi v. Fordice*, the Mississippi Supreme Court found that the state constitution's right of privacy includes "an implicit right to have an abortion." However, the court still upheld the state's informed consent law, 24-hour reflection period before an abortion, and a two-parent consent requirement before a minor may obtain an abortion.
- Mississippi limits abortions at 5 months (i.e., 20 weeks) of pregnancy based on the health risks to women caused by a later-term abortion, as well as the pain to the unborn child.
- Mississippi prohibits partial-birth abortion.
- Mississippi has enacted legislation banning abortion, except in cases of life endangerment, should *Roe v. Wade* be overturned.
- A physician may not perform an abortion on a woman until at least 24 hours after the woman receives counseling on the medical risks of abortion including the link between abortion and breast cancer, the medical risks of carrying the pregnancy to term, the probable gestational age of the unborn child, medical assistance benefits, and the legal obligations of the child's father. Mississippi also provides written material describing the development of the unborn child, the medical risks of abortion, available state benefits, and public and private agencies offering alternatives to abortion.
- In addition, an abortion provider is required to perform an ultrasound on a woman seeking abortion. The woman must be offered the opportunity to view the ultrasound image, receive a copy of the image, and listen to the unborn child's heartbeat. Abortion facilities must purchase ultrasound equipment.
- An abortion provider must inform a woman seeking abortion due to a life-limiting diagnosis for her unborn child at or after 5 months (i.e., 20 weeks) development of certain supportive services available to her should she decide to carry the child

to term. These services include counseling and care from maternal-fetal medical specialists, obstetricians, neonatologists, anesthesia specialists, clergy, social workers, and specialty nurses who focus on alleviating fear and ensuring that the woman and her family experience the life and death of their child in a comfortable and supportive environment.

- A physician may not perform an abortion on an unemancipated minor under the age of 18 without the written consent of both parents unless there is a medical emergency, the minor is the victim of incest by her father (in such circumstances, the consent of the minor’s mother is sufficient), or the minor obtains a court order. The two-parent consent requirement has been upheld by both a federal appellate court and the Mississippi Supreme Court.
- Mississippi mandates minimum health and safety regulations for abortion clinics performing more than 10 abortions per month and/or more than 100 abortions per year. The regulations prescribe minimum health and safety standards for the building or facility, clinic administration, staffing, and pre-procedure medical evaluations.
- Further, Mississippi requires second-trimester abortions be performed in hospitals, ambulatory surgical facilities, or a licensed Level I abortion facility (as defined by state statute).
- Only practicing physicians licensed by the State of Mississippi may perform abortions. A 2012 law requiring abortion providers to maintain hospital admitting privileges is in litigation, but a portion of that law requiring physicians to be board certified in obstetrics and gynecology is in effect. Prior to the enactment of the 2012 law, Mississippi required that abortion facilities have only a transfer agreement with a local hospital, a written agreement for backup care with a physician with admitting privileges, and at least one affiliated doctor with admitting privileges.
- The *Abortion Complication Reporting Act* requires abortion providers to report any incident where a woman dies or needs further medical treatment as a result of an abortion. The measure applies to both surgical and nonsurgical abortions and requires hospitals to report the number of patients treated for complications resulting from abortions.
- The state also requires that deaths resulting from criminal abortions, self-induced abortions, or abortions performed because of sexual abuse be reported to the medical examiner.
- Mississippi includes “reproductive healthcare facilities” in the definition of mandatory reporters for suspected child sexual abuse.
- Mississippi requires that a physician examine a woman before providing abortion-inducing drugs. Further, the physician must follow “the standard of care,” and the provider or his or her agent must also schedule a follow-up appointment for the woman.

- Mississippi funds abortions for women eligible for public assistance when necessary to preserve the woman's life, the pregnancy is the result of rape or incest, or in cases involving fetal abnormalities.
- No money in the Mississippi Children's Trust Fund, established to assist child abuse and neglect programs, may be used for abortion counseling.
- Mississippi restricts the use of state facilities for the performance of abortions.
- Public school nurses are prohibited from providing abortion counseling or referring any student to abortion counseling or an abortion clinic.
- Insurance companies participating in the state insurance Exchanges established pursuant to the federal healthcare law cannot offer policies that provide abortion coverage within the Exchanges, except in cases of life endangerment, rape, or incest.
- Further, health insurance funds for state employees may not be used for insurance coverage of abortion unless an abortion is necessary to preserve the life or physical health of the mother.
- Mississippi offers "Choose Life" and "We Love Life" license plates, the proceeds of which benefit pregnancy resource centers and/or other organizations providing abortion alternatives.

» **LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN**

- The killing of an unborn child at any stage of gestation is a form of homicide.
- Mississippi defines a nonfatal assault on an unborn child as a criminal offense.
- Further, Mississippi law also provides that an attack on a pregnant woman resulting in a stillbirth or miscarriage is a criminal assault.
- Mississippi authorizes a wrongful death (civil) action when an unborn child (after quickening) is killed through violence or negligence.
- The state has created a specific affirmative duty of physicians to provide medical care and treatment to infants born alive at any stage of development.
- Mississippi law protects the anonymity of the parent relinquishing a newborn under the state's infant abandonment statute.

» **BIOETHICS LAWS**

- Mississippi maintains no laws regarding human cloning, destructive embryo research, fetal experimentation, assisted reproductive technologies, or human egg harvesting.
- The state promotes ethical forms of research through an umbilical cord blood banking program.
- In each of the last four years, Mississippi has enacted appropriations measures

prohibiting state funds from being used in research in which a human embryo is killed or destroyed.

» **END OF LIFE LAWS**

- In Mississippi, assisted suicide is a felony.
- The state has created a Physicians Orders for Life-Sustaining Treatment (POLST) Paradigm program.

» **HEALTHCARE FREEDOM OF CONSCIENCE**

Participation in Abortion

- The Mississippi *Healthcare Rights of Conscience Act*, based on AUL model legislation, provides comprehensive freedom of conscience protection for healthcare providers, institutions, and insurance companies (including pharmacists and pharmacies) who conscientiously object to participating in any healthcare service including abortion.

Participation in Research Harmful to Human Life

- Mississippi protects the civil rights of all healthcare providers who conscientiously object to participating in any healthcare services, including destructive embryo research and human cloning.

» **WHAT HAPPENED IN 2014**

- Mississippi enacted a measure limiting abortions at 5 months (*i.e.*, 20 weeks) of pregnancy, which is substantially based on AUL's *Women's Health Defense Act*. The law is predicated on the health risks to women from late-term abortions and the pain experienced by an unborn child.
- Along with the five-month abortion limitation, Mississippi enacted a perinatal hospice information requirement, mandating that a woman whose unborn child has received a life-limiting diagnosis be informed of certain supportive services available to her if she decides to carry the child to term. These services include counseling and care from maternal-fetal medical specialists, obstetricians, neonatologists, anesthesia specialists, clergy, social workers, and specialty nurses who focus on alleviating fear and ensuring that the woman and her family experience the life and death of their child in a comfortable and supportive environment.
- The state also considered legislation prohibiting sex-selective abortions, mandating additional health and safety standards for abortion facilities, and regulating abortion-inducing drugs.
- In *Jackson Women's Health Organization v. Currier*, the Fifth Circuit struck down Mississippi's 2012 admitting privileges requirement (leaving in place a similar, earlier requirement).

- Mississippi considered legislation permitting women to be prosecuted for alcohol or drug abuse while pregnant. The measure also permitted the prosecution of a third-party who intentionally provides controlled substances to a pregnant woman, resulting in injury to or the death of the unborn child.
- Mississippi established an umbilical cord blood banking program. The state also adopted three appropriations measures providing that state funds may not be used at state institutions of higher learning for research in which a human embryo is killed or destroyed.
- The state also considered legislation prohibiting human cloning for all purposes and a measure that would have established a research committee to examine the state of embryo and cloning research in the state.
- Finally, the state established a Physicians Orders for Life-Sustaining Treatment (POLST) Paradigm program and enacted measures related to pain management and palliative care.

RECOMMENDATIONS

for MISSISSIPPI

WOMEN'S PROTECTION PROJECT PRIORITIES

- Women's Health Defense Act (5 month abortion limitation)
- Abortion-Inducing Drugs Safety Act
- Parental Involvement Enhancement Act
- Component of the Child Protection Act providing remedies for third-party interference with parental rights
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- State Constitutional Amendment (providing that there is no state constitutional right to abortion)
- Prenatal Nondiscrimination Act

Legal Recognition and Protection for the Unborn

- Unborn Wrongful Death Act (for a pre-viable child)
- Pregnant Woman's Protection Act

Bioethics

- Human Cloning Prohibition Act
- Destructive Embryo Research Act
- Prohibition on Public Funding of Human Cloning and Destructive Embryo Research Act



Missouri | RANKING: 6

Missouri was the first state to mandate that abortion clinics meet the same stringent patient care standards as facilities performing other outpatient surgeries, protecting women from an increasingly substandard and predatory abortion industry and setting the “gold standard” for other states to follow. However, the state provides little protection to human embryos outside the womb, having amended the state constitution to allow cloning-for-biomedical-research.

» ABORTION

- The legislature has found that the life of each human being begins at conception.
- As applied to its abortion-related laws, Missouri maintains a narrow definition of “medical emergency.” A medical emergency is deemed to exist only in situations where a woman’s life or a “major bodily function” is at risk.
- Missouri prohibits partial-birth abortion.
- Missouri has a post-viability abortion ban that allows an abortion only when the life of the mother is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself, or when continuation of pregnancy will create a serious risk of substantial and irreversible physical impairment of a major bodily function of the pregnant woman. The law also requires a determination of gestational age according to specified standards, includes specific reporting requirements, and requires a second physician to concur that an abortion is “medically necessary.”
- At least 24 hours prior to abortion, a woman must be advised of the risks of abortion, given information about the development of her unborn child, and provided information on resources available to assist her in bringing her child to term. The law also requires that she be informed that abortion ends the “life of a separate, unique, living human being.”
- Women seeking abortions at or after 22 weeks gestation must be counseled on fetal pain.
- Abortion providers must offer an ultrasound to every woman seeking an abortion.
- Abortion clinics must provide a woman with confidential access to a telephone and a list of protective resources if she indicates that she is being coerced by a third party into seeking an abortion.

- A physician may not perform an abortion on an unemancipated minor under the age of 18 without the informed, written consent of one parent or a court order. Further, only a parent or guardian can transport a minor across state lines for an abortion.
- Missouri requires abortion clinics to meet the same patient care standards as other facilities performing surgeries in an ambulatory setting.
- Only physicians licensed by the state, practicing in Missouri, and having surgical privileges at a hospital within a 30-mile radius of the facility where the abortion is performed and that offers obstetrical or gynecological care may perform abortions. The Eighth Circuit Court of Appeals has upheld this requirement.
- Missouri law provides that no person shall perform or induce a “medical abortion” unless such person has proof of medical malpractice insurance with coverage amounts of at least \$500,000.
- The state has an enforceable abortion reporting law, but does not require the reporting of information to the Centers for Disease Control (CDC). The measure pertains to both surgical and nonsurgical abortions and requires abortion providers to report short-term complications.
- Missouri requires that the initial dose in an abortion-inducing drug regimen be administered in the presence of a physician. The physician or an agent of the physician must also make all reasonable efforts to ensure that the woman comes back for a follow-up appointment.
- Missouri follows the federal standard for Medicaid funding for abortions, permitting the use of federal or state matching Medicaid funds for abortions necessary to preserve the life of the woman or when the pregnancy is the result of rape or incest.
- Missouri law provides that it is unlawful for any public funds to be expended for the purpose of performing or assisting an abortion not necessary to save the life of the mother or for the purpose of encouraging or counseling a woman to have an abortion not necessary to save her life.
- The state has an extensive list of additional limitations on abortion funding, including the following: public facilities may not be used for performing, assisting in, or counseling a woman on abortion unless it is necessary to preserve her life; a state employee may not participate in an abortion; no school district or charter school or personnel or agents of these schools may provide abortion services or permit instruction by providers of abortion services; family planning services may not include abortions unless it is certified by a physician that the life of the mother is in danger; Missouri Alternatives to Abortions Services Program funding may not be granted to organizations or affiliates of organizations that perform or induce, assist in the performance or induction of, or refer for abortions; research grants may not be used in research projects that involve abortion services, human cloning, or prohibited human research, and cannot share costs with another prohibited study; and no money from the legal expense fund may be used to defend abortion.

- Insurance companies participating in the state insurance Exchanges established pursuant to the federal healthcare law cannot offer policies that provide abortion coverage within the Exchanges, except in cases of life endangerment. There is a state constitutional amendment prohibiting the establishment, creation, or operation of a health insurance Exchange unless it is created by a legislative act, a ballot initiative, or referendum.
- Private health insurance policies are prohibited from including coverage for abortion unless an abortion is necessary to preserve the life of the woman or an optional rider is purchased. Missouri also prohibits abortion coverage for state employees except in cases of life endangerment. Further, Missouri protects individual and group insurance consumers from paying for insurance coverage that violates their moral or religious beliefs.
- State health insurance for uninsured children cannot be used to encourage, counsel, or refer for abortions, with exceptions for life endangerment or in cases of rape or incest.
- Missouri provides direct taxpayer funding to pregnancy resource centers and prohibits organizations that receive this funding from using those funds to provide abortion counseling or to make referrals for abortion.
- Missouri also provides tax credits for donations to pregnancy resource centers that do not perform or refer women for abortions.
- Missouri has appropriated federal and state funds for women “at or below 200 percent of the Federal Poverty Level” to be used to encourage women to carry their pregnancies to term, to pay for adoption expenses, and/or to assist with caring for dependent children.

» **LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN**

- Under Missouri law, the killing of an unborn child at any stage of development is defined as a form of homicide.
- Missouri has enacted AUL’s *Pregnant Woman’s Protection Act*, which provides an affirmative defense to women who use force to protect their unborn children from criminal assaults.
- The state allows a wrongful death (civil) action when an unborn child at any stage of development is killed through a negligent or criminal act.
- The state has created a specific affirmative duty of physicians to provide medical care and treatment to infants born alive at any stage of development.
- Missouri has a “Baby Moses” law, establishing a safe haven for mothers to legally leave their infants at designated places and ensuring that the infants receive appropriate care and protection.
- The state funds drug treatment programs for pregnant women and newborns.

» BIOETHICS LAWS

- In November 2006, Missouri voters approved a ballot initiative amending the state constitution to allow cloning-for-biomedical research (while banning cloning-to-produce-children) and destructive embryo research. This constitutional amendment may mean that the state's ban on public funding relates only to cloning-to-produce-children, making it a "clone-and-kill" state.
- The state's prohibition on fetal experimentation applies only to a fetus aborted alive.
- Missouri has created a program funding the establishment of umbilical cord blood banks. The state Department of Health and Senior Services is to post resources regarding umbilical cord blood on its website including information on the potential value and uses of cord blood. State law authorizes a licensed physician giving care to a pregnant woman to provide information about this website.
- Missouri maintains no laws regarding assisted reproductive technologies or human egg harvesting.

» END OF LIFE LAWS

- In Missouri, assisted suicide constitutes manslaughter.

» HEALTHCARE FREEDOM OF CONSCIENCE

Participation in Abortion

- A physician, nurse, midwife, or hospital is not required to admit or treat a woman for the purpose of abortion if such admission or treatment is contrary to religious, moral, or ethical beliefs or established policy. Protection is also provided to medical and nursing students.
- A law requiring insurance coverage for obstetrical and gynecological care provides: "Nothing in this chapter shall be construed to require a health carrier to perform, induce, pay for, reimburse, guarantee, arrange, provide any resources for, or refer a patient for an abortion."

Participation in Research Harmful to Human Life

- Missouri currently provides no protection for the rights of healthcare providers who conscientiously object to participation in human cloning, destructive embryo research, or other forms of medical research, which violate a provider's moral or religious belief.

» WHAT HAPPENED IN 2014

- Missouri enacted legislation specifically excluding funding for "abortion services."
- Governor Jay Nixon vetoed a measure amending the state's informed consent law to

require a 72-hour reflection period. The Governor also line-item vetoed \$500,000 from the state's alternatives to abortion fund, lowering the amount appropriated to just over \$1.5 million.

- Missouri considered legislation prohibiting a physician from performing an abortion on a woman for the purpose of providing fetal organs or tissue for medical transplantation to the woman or to others. The state also considered a measure, based on AUL model language, that would prohibit an abortion performed solely because of the unborn child's sex or because the unborn child had been diagnosed with a genetic abnormality or Down syndrome.
- AUL provided support for a measure, based on AUL model legislation, that would have enhanced the state's parental involvement law by requiring notarized written consent, proof of paternal identification and relationship to the minor, a post-emergency notification, a venue restriction for judicial bypass proceedings, and a clear and convincing evidence standard and mental health evaluation in judicial bypass proceedings.
- Further, Missouri considered measures related to health and safety standards for abortion facilities; qualifications for individual abortion providers; ultrasounds; abortion reporting; abortion coercion; information on fetal pain; insurance coverage of abortion; use of state facilities and/or actors for abortion; supporting pregnancy resource centers; the definition of "medical emergency" as used in abortion-related statutes; the state constitution; and the prohibition of school-based healthcare clinics from performing or referring for abortion services, contraceptive drugs, or contraceptive devices.
- Conversely, Missouri also considered legislation aimed at undermining or stigmatizing the work of pregnancy resource centers.
- Missouri considered a constitutional amendment providing that it would not recognize or enforce any federal action legalizing or funding destructive embryo research.
- The Missouri House passed a measure protecting individuals and institutions from participating in specific services including abortion, abortion-inducing drugs, contraception (which includes drugs and devices with known life-ending effects, but misleadingly labeled as "contraception"), human cloning, human embryonic stem cell research, and fetal tissue research. Conversely, the state considered legislation that would require pharmacists and/or pharmacies to dispense so-called "emergency contraception" despite religious or conscience objections.
- Missouri considered measures related to advance planning documents, pain management, and palliative care.

RECOMMENDATIONS

for MISSOURI

WOMEN'S PROTECTION PROJECT PRIORITIES

- Women's Health Defense Act (5 month abortion limitation)
- Abortion-Inducing Drugs Safety Act
- Parental Involvement Enhancement Act
- Abortion-Inducing Drugs Safety Act
- Component of the Child Protection Act mandating evidence retention
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- Prenatal Nondiscrimination Act
- Defunding the Abortion Industry and Advancing Women's Health Act

Legal Recognition and Protection for the Unborn

- Law criminalizing nonfatal assaults on the unborn

Bioethics

- Assisted Reproductive Technologies Disclosure and Risk Reduction Act

Healthcare Freedom of Conscience

- Healthcare Freedom of Conscience Act



Montana | RANKING: 43

A Montana state court has held that the state constitution provides a broader “right” to abortion than that interpreted in the federal constitution, making it difficult for the state to enact comprehensive, commonsense regulations that protect maternal health. For example, the state maintains no informed consent law, and provisions related to parental consent are currently in litigation. In fact, the state does not even maintain a physician-only law, instead allowing physician assistants to perform abortions.

» ABORTION

- State courts have held that the Montana Constitution provides a broader right to abortion than that interpreted in the U.S. Constitution. Under the auspices of these decisions, several state laws have been declared unconstitutional, including laws limiting taxpayer funding for abortions, requiring parental notice prior to a minor undergoing an abortion, requiring a 24-hour reflection period prior to an abortion, mandating that state-prepared informed consent information be offered to a woman prior to an abortion, and requiring that only a licensed physician perform an abortion.
- Montana prohibits partial-birth abortion after the child attains viability.
- Montana “prohibits a physician from performing an abortion on a minor under 16 years of age unless a physician notifies a parent or legal guardian of the minor at least 48 hours prior to the procedure. Notice is not required if: (1) there is a medical emergency; (2) it is waived by a youth court in a sealed proceeding; or (3) it is waived by the parent or guardian. A person who performs an abortion in violation of the act, or who coerces a minor to have an abortion, is subject to criminal prosecution and civil liability.” In 2013, the state amended the law to require notarized parental consent and proof of identification. Both laws are in litigation.
- Montana specifically allows physician assistants to perform abortions.
- The state has an enforceable abortion reporting law, but does not require the reporting of information to the Centers for Disease Control (CDC). The measure pertains to both surgical and nonsurgical abortions.
- Montana taxpayers are required by court order to fund “medically necessary” abortions for women eligible for public assistance. This requirement essentially equates to funding abortion-on-demand in light of the U.S. Supreme Court’s broad definition of “health” in the context of abortion.
- The state offers “Choose Life” license plates, the proceeds of which benefit pregnancy resource centers and/or other organizations providing abortion alternatives.

- Montana maintains a “Freedom of Clinic Access” (FACE) law, making it a crime to block access to an abortion facility and restricting how close sidewalk counselors and demonstrators can be to the facility.

» **LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN**

- Montana permits the prosecution of a third party who intentionally kills an unborn child who has reached at least eight weeks development.
- Under Montana law, a person commits an offense if he “purposefully, knowingly, or negligently causes the death of a premature infant born alive, if such infant is viable.”
- The state allows a wrongful death (civil) action when a viable unborn child is killed through negligent or criminal act.
- The state has created a specific affirmative duty of physicians to provide medical care and treatment to infants born alive at any stage of development.
- Montana has a “Baby Moses” law, establishing a safe haven for mothers to legally leave their infants at designated places and ensuring the infants receive appropriate care and protection.
- Specific professionals are required to report any infant affected by drug exposure.
- Montana maintains a measure allowing a woman who loses a child after 20 weeks gestation to obtain a “Certificate of Birth Resulting in Stillbirth.”

» **BIOETHICS LAWS**

- Montana bans cloning-to-produce-children, but not cloning for all purposes, making it a “clone-and-kill” state.
- The state does not prohibit destructive embryo research, and its prohibition on fetal experimentation applies only to children born alive (*i.e.*, it does not apply to aborted fetuses).
- Montana does not promote ethical forms of research.
- The state maintains no meaningful regulation of assisted reproductive technologies or human egg harvesting.

» **END OF LIFE LAWS**

- The Montana Supreme Court has stated that it finds nothing in Montana Supreme Court precedent or state statutes indicating that physician-assisted suicide is against public policy—thus potentially paving the way for physician-assisted suicide in the state.

» **HEALTHCARE FREEDOM OF CONSCIENCE**

Participation in Abortion

- On the basis of religious or moral beliefs, an individual, partnership, association, or corporation may refuse to participate in an abortion or to provide advice concerning abortion.
- A private hospital or healthcare facility is not required, contrary to religious or moral tenets or stated religious beliefs or moral convictions, to admit a woman for an abortion or to permit the use of its facilities for an abortion.
- Montana has a “contraceptive equity” requirement, meaning that health insurance coverage must include coverage for contraception. There is no conscience exemption for employers or insurers with a religious or moral objection to contraception.

Participation in Research Harmful to Human Life

- Montana currently provides no protection for the rights of healthcare providers who conscientiously object to participation in human cloning, destructive embryo research, or other forms of medical research, which violate a provider’s moral or religious belief.

» **WHAT HAPPENED IN 2014**

- Montana did not hold a regular legislative session in 2014.
- In *Planned Parenthood v. State of Montana*, the state appealed to the Montana Supreme Court a trial court’s decision invalidating its parental involvement provisions.

RECOMMENDATIONS

for MONTANA

WOMEN'S PROTECTION PROJECT PRIORITIES

- Women's Health Defense Act (5 month abortion limitation)
- Women's Right to Know Act with reflection period
- Women's Health Protection Act (abortion clinic regulations)
- Abortion-Inducing Drugs Safety Act
- Parental Involvement Enhancement Act
- Child Protection Act
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- State constitutional amendment (providing that there is no state constitutional right to abortion)
- Federal Abortion-Mandate Opt-Out Act
- Defunding the Abortion Industry and Advancing Women's Health Act
- Women's Ultrasound Right to Know Act
- Coercive Abuse Against Mothers Prevention Act
- Prenatal Nondiscrimination Act

Legal Recognition and Protection for the Unborn

- Crimes Against the Unborn Child Act (to protect a child from conception)
- Unborn Wrongful Death Act
- Pregnant Woman's Protection Act

Bioethics

- Human Cloning Prohibition Act
- Destructive Embryo Research Act
- Prohibition on Public Funding of Human Cloning and Destructive
- Embryo Research Act

RECOMMENDATIONS

for MONTANA (CONT.)

End of Life

- Assisted Suicide Ban Act

Healthcare Freedom of Conscience

- Healthcare Freedom of Conscience Act



Nebraska | RANKING: 9

Nebraska maintains a number of regulations protecting women and unborn children, including a limitation on abortion at 5 months (*i.e.*, 20 weeks) development, a prohibition of “telemed abortions,” and defining the killing of an unborn child at any stage of gestation as homicide. However, the state does not regulate human cloning, destructive embryo research, assisted reproductive technologies, or human egg harvesting.

» ABORTION

- Nebraska bans abortions at or after 5 months (*i.e.*, 20 weeks) gestation on the basis of the pain experienced by unborn children.
- Under Nebraska law, a physician may not perform an abortion on a woman until at least 24 hours after counseling the woman on the risks of abortion, the risks of continued pregnancy, and the probable gestational age of the unborn child. Nebraska also provides materials describing the development of the unborn child, the medical and psychological risks of abortion, available state benefits, and public and private agencies offering alternatives to abortion.
- An abortion provider who conducts an ultrasound prior to performing an abortion must display the ultrasound image of the unborn child so that the woman may see it.
- Nebraska prohibits coercing a woman to have an abortion and provides that such coercion is a Class III misdemeanor.
- A physician may not perform an abortion on an unemancipated minor under the age of 18 without the written, notarized consent of one parent, unless there is a medical emergency or the minor obtains a court order. If the minor is a victim of rape, incest, or abuse by a parent, she may obtain the consent of a grandparent.
- Nebraska mandates minimum health and safety standards for abortion clinics which, at any point during a calendar year, perform 10 or more abortions during a single calendar week. The regulations prescribe minimum health and safety standards for the building or facility, staffing, and medical testing of clinic employees.
- Only physicians licensed by the State of Nebraska may perform abortions.
- The state has an enforceable abortion reporting law, but does not require the reporting of information to the Centers for Disease Control (CDC). The measure pertains to both surgical and nonsurgical abortions and requires abortion providers to report short-term complications.

- Nebraska bans so-called “telemed abortions” by requiring that a physician be present in the same room with a patient when he or she performs, induces, or attempts to perform or induce an abortion.
- Nebraska follows the federal standard for Medicaid funding for abortions, permitting the use of federal or state matching Medicaid funds for abortions necessary to preserve the life of the woman or when the pregnancy is the result of rape or incest.
- State-funded prenatal services may not be used for abortion counseling, referral for abortion, or funding for abortion.
- No funds appropriated or distributed under the *Nebraska Health Care Funding Act* may be used for abortions, abortion counseling, or referrals for abortions.
- No funding from the Woman’s Health Initiative Fund may be used to pay for abortions.
- Nebraska prohibits organizations that receive public funds from using those funds to provide abortions, abortion counseling, or to make referrals for abortions.
- The state prohibits insurance companies from offering abortion coverage within state insurance Exchanges established pursuant to the federal healthcare law, except in cases of life endangerment.
- Nebraska prohibits private insurance companies from covering abortion, except in cases of life endangerment. Further, group health insurance contracts or health maintenance agreements paid for with public funds may not include abortion coverage unless an abortion is necessary to preserve the life of a woman.

» **LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN**

- Under Nebraska law, the killing of an unborn child at any stage of gestation is defined as a form of homicide. Nebraska law also provides penalties for the vehicular homicide of an unborn child.
- Nebraska criminalizes nonfatal assaults on an unborn child.
- State law maintains that any person who commits certain enumerated criminal offenses against a pregnant woman shall be punished by the imposition of the next higher penalty classification.
- The state allows a wrongful death (civil) action when an unborn child at any stage of development is killed through a third party’s negligent or criminal act.
- Nebraska law requires that “all reasonable steps, in accordance with the sound medical judgment of the attending physician, shall be employed to preserve the life of a child” who is born alive following an attempted abortion at any stage of development.
- Nebraska has a “Baby Moses” law, prohibiting the criminal prosecution of someone who relinquishes a child to an on-duty hospital employee.
- The state funds drug treatment programs for pregnant women and newborns.

» **BIOETHICS LAWS**

- Nebraska does not prohibit human cloning or destructive embryo research, but no state facilities or funds can be used for the performance of human cloning or destructive embryo research.
- Nebraska prohibits experimentation only on an infant aborted alive and, therefore, does not prohibit experimentation on dead fetuses.
- Funds appropriated or distributed under the *Nebraska Health Care Funding Act* may not be used for research or activity using fetal tissue obtained from induced abortion or human embryonic stem cells or for the purpose of obtaining other funding for such use.
- The state provides funding for ethical forms of stem-cell research. Nebraska has also appropriated funds for biomedical research that excludes research on fetal tissue from aborted babies or human embryonic stem cells.
- Nebraska does not regulate assisted reproductive technologies or human egg harvesting.

» **END OF LIFE LAWS**

- In Nebraska, assisting a suicide is a felony.

» **HEALTHCARE FREEDOM OF CONSCIENCE**

Participation in Abortion

- A person is not required to participate in an abortion.
- A hospital, institution, or other facility is not required to admit a woman for an abortion or to allow the performance of an abortion within its facility.

Participation in Research Harmful to Human Life

- Nebraska currently provides no protection for the rights of healthcare providers who conscientiously object to participation in human cloning, destructive embryo research, and other forms of medical research, which violate a provider's moral or religious belief.

» **WHAT HAPPENED IN 2014**

- Governor Dave Heineman signed AUL's *Pregnancy Center Proclamation*, supporting the work of pregnancy resource centers.
- Nebraska considered legislation requiring abortion facilities to post signs concerning coerced abortions. AUL drafted a letter in support of the bill.
- AUL assisted the state in defeating legislation repealing the state's parental consent requirement and otherwise weakening existing parental involvement requirements.

- Nebraska considered a measure establishing an interim study to evaluate the potential uses of the Physician Orders for Life-Sustaining Treatment (POLST) Paradigm program and out-of-hospital “Do Not Resuscitate” protocols.

RECOMMENDATIONS

for NEBRASKA

WOMEN'S PROTECTION PROJECT PRIORITIES

- Abortion Patients' Enhanced Safety Act
- Parental Involvement Enhancement Act
- Child Protection Act
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- Defunding the Abortion Industry and Advancing Women's Health Act
- Prenatal Nondiscrimination Act

Legal Recognition and Protection for the Unborn

- Prohibition on wrongful birth and wrongful life lawsuits
- Pregnant Woman's Protection Act

Bioethics

- Human Cloning Prohibition Act
- Destructive Embryo Research Act
- Prohibition on Public Funding of Human Cloning and Destructive Embryo Research Act

Healthcare Freedom of Conscience

- Healthcare Freedom of Conscience Act



Nevada | RANKING: 42

Nevada enacted a *Freedom of Choice Act* in 1990, providing for a legal right to abortion in the state even if *Roe v. Wade* is eventually overturned. As a result, Nevada has failed to enact commonsense laws designed to protect women and unborn children from the harms inherent in abortion.

» ABORTION

- Nevada maintains a *Freedom of Choice Act*. It mandates a legal right to abortion even if *Roe v. Wade* is eventually overturned, specifically providing that abortions may be performed within 24 weeks after the commencement of a pregnancy. Because Nevada voters approved a ballot initiative providing this state “right” to abortion, the statute will remain in effect and cannot be amended, repealed, or otherwise changed except by a direct vote of the people.
- A physician may not perform an abortion on a woman until after the physician or other qualified person informs her of the probable gestational age of the unborn child, describes the abortion procedure to be used and its risks, and explains the physical and emotional consequences of abortion.
- Nevada’s parental notification law has been declared unconstitutional. The law sought to prohibit a physician from performing an abortion on an unemancipated minor under the age of 18 until notice had been given to one parent or a court order had been secured.
- Only physicians licensed by the State of Nevada or employed by the United States and using accepted medical practices and procedures may perform abortions. Chiropractic physicians and osteopathic medical professionals are explicitly prohibited from performing abortions.
- The state has an enforceable abortion reporting law, but does not require the reporting of information to the Centers for Disease Control (CDC).
- Nevada follows the federal standard for Medicaid funding for abortions, permitting the use of federal or state matching Medicaid funds for abortions necessary to preserve the life of the woman or when the pregnancy is the result of rape or incest.

» LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN

- Nevada criminal law defines the killing of an unborn child after “quickening” (discernible movement in the womb) as a form of homicide.

- The state allows a wrongful death (civil) action when a viable unborn child is killed through a negligent or criminal act.
- Under Nevada law, all reasonable steps must be taken to preserve the life and health of an infant “whenever an abortion results in the birth of an infant capable of sustained survival by natural or artificial supportive systems.”
- The state defines substance abuse during pregnancy as “child abuse” under civil child welfare statutes.

» **BIOETHICS LAWS**

- Nevada does not ban human cloning, destructive embryo research, or fetal experimentation, nor does it promote ethical forms of research.
- The state does not regulate assisted reproductive technologies or human egg harvesting.
- In 2013, the state enacted a measure permitting gestational surrogacy.

» **END OF LIFE LAWS**

- The legal status of assisted suicide in Nevada is undetermined. The state has not enacted a specific statute prohibiting assisted suicide, and it does not recognize common law crimes (including assisted suicide). Further, there is no judicial decision stating whether assisted suicide is a form of homicide under Nevada’s general homicide laws.
- The state maintains a Physician Orders for Life-Sustaining Treatment (POLST) Paradigm Program.

» **HEALTHCARE FREEDOM OF CONSCIENCE**

Participation in Abortion

- Except in a medical emergency, an employer may not require a nurse, nursing assistant, or other employee to participate directly in the performance of an abortion if that person has previously signed and provided a written statement indicating a religious, moral, or ethical basis for conscientiously objecting to participation in abortions.
- Except in a medical emergency, a private hospital or licensed medical facility is not required to permit the use of its facilities for the performance of an abortion.
- Health plans providing prescription coverage must provide coverage for contraception. A conscience exemption applies to certain insurers affiliated with religious organizations.

Participation in Research Harmful to Human Life

- Nevada currently provides no protection for the rights of healthcare providers who conscientiously object to participation in human cloning, destructive embryo research, and other forms of medical research, which violate a provider's moral or religious belief.

» WHAT HAPPENED IN 2014

- Nevada did not hold a regular legislative session in 2014.

RECOMMENDATIONS

for NEVADA

WOMEN'S PROTECTION PROJECT PRIORITIES

- Women's Health Defense Act (5 month abortion limitation)
- Reflection period before abortion
- Abortion Patients' Enhanced Safety Act
- Abortion-Inducing Drugs Safety Act
- Parental Notification for Abortion Act
- Child Protection Act
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- Repeal State FOCA
- Federal Abortion-Mandate Opt-Out Act
- Defunding the Abortion Industry and Advancing Women's Health Act
- Women's Ultrasound Right to Know Act
- Coercive Abuse Against Mothers Prevention Act
- Prenatal Nondiscrimination Act

Legal Recognition and Protection for the Unborn

- Crimes Against the Unborn Child Act (protecting an unborn child from conception)
- Unborn Wrongful Death Act (for a pre-viable child)
- Pregnant Woman's Protection Act

Bioethics

- Human Cloning Prohibition Act
- Destructive Embryo Research Act
- Prohibition on Public Funding of Human Cloning and Destructive Embryo Research Act

End of Life

- Assisted Suicide Ban Act

Healthcare Freedom of Conscience

- Healthcare Freedom of Conscience Act



New Hampshire | RANKING: 35

Pro-life legislators in New Hampshire have made repeated attempts to enact life-affirming laws and regulations over the last several years and have enjoyed some limited success. However, much work remains to be done. New Hampshire allows abortion after viability, even in cases where the mother's life or health is not in danger, and the state does not maintain any informed consent requirements. Moreover, New Hampshire does not criminalize the killing of an unborn child outside the context of abortion.

» ABORTION

- New Hampshire prohibits partial-birth abortion.
- New Hampshire law allows abortions after viability, even in cases where the mother's life or health is not endangered.
- A physician may not perform an abortion on an unemancipated minor under the age of 18 until at least 48 hours after written notice has been delivered to one parent, except when there is a medical emergency or when the minor obtains a court order.
- The state Department of Health is required to collect, compile, and maintain abortion statistics and to prepare and submit an annual report to the general court.
- New Hampshire follows the federal standard for Medicaid funding for abortions, permitting the use of federal or state matching Medicaid funds for abortions necessary to preserve the life of the woman or when the pregnancy is the result of rape or incest.

» LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN

- New Hampshire does not criminalize the killing of an unborn child outside the context of abortion. However, it does provide that an attack on a pregnant woman which results in a stillbirth or miscarriage is a criminal assault.
- The state allows a wrongful death (civil) action when a viable unborn child is killed through a negligent or criminal act.
- New Hampshire has a "Baby Moses" law, establishing a safe haven for mothers to legally leave their infants at designated places and ensuring the infants receive appropriate care and protection.
- New Hampshire has approved stillbirth certificates.

» BIOETHICS LAWS

- New Hampshire does not ban human cloning, destructive embryo research, or fetal experimentation.
- The state does not promote ethical forms of research.
- New Hampshire has enacted regulations applicable to practitioners and participants in assisted reproductive technologies.

» END OF LIFE LAWS

- In New Hampshire, assisting suicide is a felony.

» HEALTHCARE FREEDOM OF CONSCIENCE

Participation in Abortion

- New Hampshire currently provides no protection for the freedom of conscience of healthcare providers.
- New Hampshire law requires group or blanket health insurance policies issued or renewed by insurers, health service corporations, and health maintenance organizations to provide coverage for contraceptives if they otherwise provide coverage for outpatient services or other prescription drugs. The law contains no conscience exemptions for religious or other employers with ethical or moral objections to these drugs.

Participation in Research Harmful to Human Life

- New Hampshire currently provides no protection for the rights of healthcare providers who conscientiously object to participation in human cloning, destructive embryo research, and other forms of medical research, which violate a provider's moral or religious belief.

» WHAT HAPPENED IN 2014

- New Hampshire enacted a measure creating a “buffer zone” around abortion clinics, hampering the First Amendment speech rights of sidewalk counselors seeking to offer assistance to women entering or leaving abortion facilities. Following the U.S. Supreme Court's decision in *McCullen v. Coakley* striking down a similar “no pro-life speech zone” in Massachusetts, the New Hampshire law was challenged in federal court. The case, *Reddy v. Foster*, was voluntarily dismissed when the law was put on indefinite hold.
- New Hampshire considered legislation, based on AUL model language, mandating comprehensive health and safety standards for abortion facilities and imposing licensing requirements.

- New Hampshire considered fetal homicide legislation criminalizing the killing of an unborn child after eight weeks development.
- AUL assisted the state in defeating a measure legalizing assisted suicide.
- In addition, the state considered measures related to its Physician Orders for Life-Sustaining Treatment (POLST) Paradigm program, pain management, and palliative care.

RECOMMENDATIONS

for NEW HAMPSHIRE

WOMEN'S PROTECTION PROJECT PRIORITIES

- Women's Health Defense Act (5 month abortion limitation)
- Women's Right to Know Act with reflection period
- Abortion Patients' Enhanced Safety Act
- Abortion-Inducing Drugs Safety Act
- Parental Consent for Abortion Act
- Parental Involvement Enhancement Act
- Child Protection Act
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- Federal Abortion-Mandate Opt-Out Act
- Defunding the Abortion Industry and Advancing Women's Health Act
- Women's Ultrasound Right to Know Act
- Coercive Abuse Against Mothers Prevention Act
- Prenatal Nondiscrimination Act

Legal Recognition and Protection for the Unborn

- Crimes Against the Unborn Child Act
- Unborn Wrongful Death Act (for a pre-viable child)
- Born-Alive Infant Protection Act
- Pregnant Woman's Protection Act

Bioethics

- Human Cloning Prohibition Act
- Destructive Embryo Research Act
- Prohibition on Public Funding of Human Cloning and Destructive Embryo Research Act

Healthcare Freedom of Conscience

- Healthcare Freedom of Conscience Act



New Jersey | RANKING: 46

New Jersey provides no meaningful protection for women considering abortion or for unborn victims of violence. Further, the state directly supports the destruction of nascent human life by permitting and funding destructive embryo research. While the state considered a number of life-affirming measures in 2014, none were enacted.

» ABORTION

- The New Jersey Supreme Court has ruled that the state constitution provides a broader right to abortion than that interpreted in the U.S. Constitution. Pursuant to this ruling, the New Jersey Supreme Court has struck down the state's parental notification requirement and restrictions on the use of taxpayer funds to pay for abortions.
- New Jersey does not have an informed consent law or an enforceable parental involvement law for abortion.
- New Jersey requires that abortions after the first trimester be performed in licensed ambulatory care facilities or hospitals.
- Only physicians licensed to practice medicine and surgery in New Jersey may perform abortions.
- New Jersey provides court-ordered coverage for all "medically necessary" abortions for women eligible for public assistance. This requirement essentially equates to funding abortion-on-demand in light of the U.S. Supreme Court's broad definition of "health" in the context of abortion.
- Under the State Health Benefits plan, any contracts entered into by the State Health Benefits Commission must include coverage of abortion.

» LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN

- New Jersey law does not recognize an unborn child as a potential victim of homicide or assault.
- The state allows a wrongful death (civil) action only when an unborn child is born alive following a negligent or criminal act and dies thereafter.
- New Jersey does not require infants who survive an abortion to be given appropriate, potentially life-saving medical care.

- New Jersey has a “Baby Moses” law, establishing a safe haven for mothers to legally leave their infants at designated places and ensuring the infants receive appropriate care and protection.

» **BIOETHICS LAWS**

- New Jersey prohibits cloning-to-produce-children, but not cloning-for-biomedical-research, making it a “clone-and-kill” state.
- The state allows and funds destructive embryo research and does not prohibit fetal experimentation.
- General hospitals are to advise every pregnant patient of the option to donate umbilical cord blood or placental tissue. Healthcare professionals are to provide pregnant women with state-prepared materials on umbilical cord blood donation and storage “as early as practicable,” and preferably in the first trimester of pregnancy.
- State funding earmarked for “stem cell research” may also be available for adult stem-cell research.
- While the state does not maintain any meaningful regulation of assisted reproductive technologies, state law requires that informed consent materials include information on embryo donation.

» **END OF LIFE LAWS**

- In New Jersey, assisting a suicide is a felony.
- The state has a “bill of rights” for patients/residents of healthcare facilities including the right for competent patients/residents to “refuse treatment.”

» **HEALTHCARE FREEDOM OF CONSCIENCE**

Participation in Abortion

- A person is not required to perform or assist in the performance of an abortion.
- A hospital or healthcare facility is not required to provide abortions. The New Jersey Supreme Court has determined that the law is unconstitutional as applied to nonsectarian or nonprofit hospitals.
- New Jersey requires individual, group, and small-employer health insurance policies, medical or hospital service agreements, health maintenance organizations, and prepaid prescription service organizations to provide coverage for contraceptives if they also provide coverage for other prescription drugs. The provision includes a conscience exemption so narrow it excludes the ability of most employers and insurers with moral or religious objections from exercising it.

Participation in Research Harmful to Human Life

- New Jersey currently provides no protection for the rights of healthcare providers who conscientiously object to participation in human cloning, destructive embryo research, and other forms of medical research, which violate a provider's moral or religious belief.

» WHAT HAPPENED IN 2014

- New Jersey considered legislation prohibiting certain abortions, involving abortion reporting, providing ultrasound requirements, requiring parental involvement, relating to abortion funding, and amending the state constitution.
- New Jersey considered legislation prohibiting “wrongful birth” and “wrongful life” lawsuits and defining prenatal drug and alcohol exposure as “child abuse.”
- In addition, New Jersey considered a measure requiring that the details of the death of an unborn child occurring 20 or more weeks after gestation be entered into a state electronic birth certificate and perinatal database.
- New Jersey considered legislation promoting ethical forms of research and restricting the use of state funds for unethical forms of research, as well as legislation related to assisted reproductive technologies and gestational surrogacy.
- New Jersey considered legislation that would require pharmacists and/or pharmacies to dispense so-called “emergency contraception” regardless of religious and moral objections.
- The state also considered legislation explicitly legalizing assisted suicide.

RECOMMENDATIONS

for NEW JERSEY

WOMEN'S PROTECTION PROJECT PRIORITIES

- Women's Health Defense Act (5 month abortion limitation)
- Women's Right to Know Act with reflection period
- Abortion Patients' Enhanced Safety Act
- Abortion-Inducing Drugs Safety Act
- Parental Notification for Abortion Act
- Components of the Child Protection Act related to evidence retention and remedies for third-party interference with parental rights
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- State Constitutional Amendment (providing that there is no state constitutional right to abortion)
- Federal Abortion-Mandate Opt-Out Act
- Defunding the Abortion Industry and Advancing Women's Health Act
- Women's Ultrasound Right to Know Act
- Coercive Abuse Against Mothers Prevention Act
- Prenatal Nondiscrimination Act

Legal Recognition and Protection for the Unborn

- Crimes Against the Unborn Child Act
- Unborn Wrongful Death Act
- Born-Alive Infant Protection Act
- Pregnant Woman's Protection Act

Bioethics

- Human Cloning Prohibition Act
- Destructive Embryo Research Act
- Prohibition on Public Funding of Human Cloning and Destructive Embryo Research Act

Healthcare Freedom of Conscience

- Healthcare Freedom of Conscience Act



New Mexico | RANKING: 40

New Mexico does not adequately protect the health and safety of women seeking abortions. New Mexico lacks an informed consent law, an enforceable parental involvement law, and comprehensive health and safety regulations for facilities performing abortions. Further, New Mexico fails to protect nascent human life from potential abuses of biotechnology.

» ABORTION

- The New Mexico Supreme Court has held that the Equal Rights Amendment to the state constitution provides a broader right to abortion than that interpreted in the U.S. Constitution. Under this ruling, the court has struck down restrictions on the use of taxpayer funding to pay for abortions.
- New Mexico prohibits partial-birth abortion after the child has attained viability.
- New Mexico does not have an informed consent law.
- New Mexico has enacted a parental notice law that may be constitutionally problematic. The state Attorney General has issued an opinion that the law does not provide the constitutionally required judicial bypass procedure and is unenforceable.
- New Mexico maintains no regulations mandating that abortion clinics meet minimum patient care standards.
- Only physicians licensed in New Mexico may perform abortions.
- The state has an enforceable abortion reporting law, but does not require the reporting of information to the Centers for Disease Control (CDC). The measure pertains to both surgical and nonsurgical abortions.
- New Mexico provides court-ordered coverage for all “medically necessary” abortions for women eligible for public assistance. This requirement essentially equates to funding abortion-on-demand in light of the U.S. Supreme Court’s broad definition of “health” in the context of abortion.

» LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN

- New Mexico law does not recognize an unborn child as a potential victim of homicide or assault.
- New Mexico defines criminal assaults on a pregnant woman that result in miscarriage, stillbirth, or “damage to pregnancy” as enhanced offenses for sentencing purposes.
- The state allows a wrongful death (civil) action when a viable unborn child is killed through a negligent or criminal act.

- New Mexico does not require that an infant who survives an abortion be given appropriate medical care.
- New Mexico has a “Baby Moses” law, establishing a safe haven for mothers to legally leave their infants at designated places and ensuring that the infants receive appropriate care and protection.
- The state provides for both reports of “spontaneous fetal death” (for an unborn child who has reached at least 20 weeks development) and for certificates of stillbirth.

» BIOETHICS LAWS

- New Mexico does not prohibit human cloning or destructive embryo research, and its prohibition on fetal experimentation applies only to experimentation that might be harmful to a live fetus (*i.e.*, it does not apply to aborted fetuses).
- All healthcare providers are to advise pregnant patients of the option to donate umbilical cord blood following delivery.
- New Mexico maintains no meaningful regulation of assisted reproductive technologies or human egg harvesting, but the *Uniform Parentage Act* includes “donation of embryos” in its definition of “assisted reproduction.”

» END OF LIFE LAWS

- In New Mexico, assisting a suicide is a felony.

» HEALTHCARE FREEDOM OF CONSCIENCE

Participation in Abortion

- A person associated with, employed by, or on the staff of a hospital who objects on religious or moral grounds is not required to participate in an abortion.
- A hospital is not required to admit a woman for the purpose of performing an abortion.
- Health insurance plans that provide prescription coverage must also provide coverage for contraception. There is a conscience exemption for religious employers.

Participation in Research Harmful to Human Life

- New Mexico currently provides no protection for the rights of healthcare providers who conscientiously object to participation in human cloning, destructive embryo research, and other forms of medical research, which violate a provider’s moral or religious belief.

» WHAT HAPPENED IN 2014

- New Mexico considered legislation related to abortion funding.

RECOMMENDATIONS

for NEW MEXICO

WOMEN'S PROTECTION PROJECT PRIORITIES

- Women's Health Defense Act (5 month abortion limitation)
- Women's Right to Know Act with reflection period
- Abortion Patients' Enhanced Safety Act
- Abortion-Inducing Drugs Safety Act
- Parental Notification for Abortion Act
- Child Protection Act
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- State Constitutional Amendment (providing that there is no state constitutional right to abortion)
- Federal Abortion-Mandate Opt-Out Act
- Defunding the Abortion Industry and Advancing Women's Health Act
- Women's Ultrasound Right to Know Act
- Coercive Abuse Against Mothers Prevention Act
- Prenatal Nondiscrimination Act

Legal Recognition and Protection for the Unborn

- Crimes Against the Unborn Child Act
- Unborn Wrongful Death Act (for a pre-viable child)
- Born-Alive Infant Protection Act
- Pregnant Woman's Protection Act

Bioethics

- Human Cloning Prohibition Act
- Destructive Embryo Research Act
- Prohibition on Public Funding of Human Cloning and Destructive Embryo Research Act

Healthcare Freedom of Conscience

- Healthcare Freedom of Conscience Act



New York | RANKING: 44

New York lags far behind the majority of states in protecting maternal health or its taxpayers. The state does not have either an informed consent or parental involvement law, and does not provide effective limits on public funding for abortion. However, New York has twice rejected Governor Andrew Cuomo's *Women's Equality Act* which would have elevated abortion to a fundamental legal right in the state, eliminating all existing protections for women considering abortion, rescinding protections for unborn victims of violence, and compromising the conscience rights of healthcare providers.

» ABORTION

- In *Hope v. Peralles*, the due process provision of the New York Constitution was interpreted as protecting a woman's right to an abortion.
- New York does not have an informed consent law for abortion and does not protect the right of parents to be involved in the abortion decisions of their minor daughters.
- Under current legal precedent, New York's requirement that abortions after the first trimester be performed in hospitals is unenforceable.
- The state limits the performance of abortions to licensed physicians.
- The state has an enforceable abortion reporting law, but does not require the reporting of information to the Centers for Disease Control (CDC). The measure pertains to both surgical and nonsurgical abortions.
- New York taxpayers are required by statute to fund "medically necessary" abortions for women receiving public assistance. This essentially equates to funding abortion-on-demand in light of the U.S. Supreme Court's broad definition of "health" in the context of abortion.
- New York provides funding to pregnancy resource centers and other abortion alternatives.
- New York maintains the crime of "aggravated interference with health care services" in the first and second degrees. The statute provides, in pertinent part, that "a person is guilty of the crime of aggravated interference with health care services... when he or she... causes physical injury to such other person who was obtaining or providing, or was assisting another person to obtain or provide reproductive health services."

» LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN

- Under New York law, the killing of an unborn child after the 24th week of pregnancy is defined as a homicide.
- The state allows a wrongful death (civil) action only when an unborn child is born alive following a negligent or criminal act and dies thereafter.
- New York law states that the “opportunity to obtain medical treatment of an infant prematurely born alive in the course of an abortion shall be the same as the rights of an infant born spontaneously.” Thus, the state has created a specific affirmative duty of physicians to provide medical care and treatment to infants born alive at any stage of development.
- New York has a “Baby Moses” law, establishing a safe haven for mothers to legally leave their infants at designated places and ensuring the infants receive appropriate care and protection.
- The state funds drug treatment programs for pregnant women and newborns.

» BIOETHICS LAWS

- New York does not prohibit human cloning, destructive embryo research, or fetal experimentation.
- New York has a state board that disburses state monies for destructive embryo research. The monies may not fund cloning-to-produce-children.
- The state does not regulate assisted reproductive technologies.
- New York is the first state to publicly fund the dangerous procedure of human egg harvesting.

» END OF LIFE LAWS

- New York expressly prohibits assisted suicide which is defined as a form of manslaughter. This prohibition has been upheld by the U.S. Supreme Court.

» HEALTHCARE FREEDOM OF CONSCIENCE***Participation in Abortion***

- A person who objects in writing and on the basis of religious beliefs or conscience is not required to perform or assist in an abortion.
- Staff members of the state Department of Social Services may refuse to provide family planning services if it conflicts with their cultural values, conscience, or religious convictions.
- Health plans that provide prescription coverage must provide coverage for

contraception. The provision includes a conscience exemption so narrow it excludes the ability of most employers and insurers with moral or religious objections from exercising it.

Participation in Research Harmful to Human Life

- New York currently provides no protection for the rights of healthcare providers who conscientiously object to participation in human cloning, destructive embryo research, and other forms of medical research, which violate a provider's moral or religious belief.

» WHAT HAPPENED IN 2014

- Both chambers of the New York legislature passed legislation requiring the state Department of Health to create and maintain a "women's health initiatives" website that will "promote" the items and services that are required as preventive care coverage under the federal *Affordable Care Act*. That list explicitly includes all FDA labeled "contraceptives," including so-called "emergency contraception."
- New York considered measures prohibiting sex-selective abortions (based on AUL model language), mandating health and safety standards for abortion facilities, requiring reporting on abortions, providing comprehensive informed consent protection and a 24-hour reflection period (based on AUL model language), instituting ultrasound requirements, requiring parental involvement (based on AUL Model language), concerning insurance coverage of abortion, and requiring the consent of a parent or guardian before school health services can prescribe or distribute so-called "emergency contraception."
- Conversely, New York considered legislation repealing existing abortion-related regulations, including a provision requiring abortions to be performed by physicians, and also considered the *Women's Equality Act*, which would have permitted unrestricted and unregulated abortion-on-demand and eliminated the possibility of a criminal investigation or prosecution of an abortion provider for causing a woman's death or injury.
- Along similar lines, it considered draconian legislation aimed at undermining or stigmatizing the work of pregnancy resource centers, as well as legislation defining taking photographs of people entering or leaving a "reproductive health care service facility" as aggravated harassment in the third degree.
- New York considered fetal homicide legislation protecting an unborn child from the time of conception, while simultaneously introducing legislation removing unborn children from the protection of the state's homicide statute.
- New York appropriated funds to the *Empire State Stem Cell Research Act*, which funds unethical research. Conversely, the state also considered legislation prohibiting human cloning for all purposes and promoting ethical forms of research.

- New York considered legislation regulating the process of consent prior to *in vitro* fertilization, as well as legislation concerning gestational surrogacy.
- New York considered making it unlawful to provide valuable consideration for the “donation” of human eggs for research. However, payment of “actual expenses” would have been allowed.
- New York considered a measure that would have limited the state’s requirement that a healthcare provider continue to provide life-sustaining treatment to a patient at the request of a patient’s surrogate, pending transfer or judicial review, if an adult patient has made a decision about the care expressed either orally during hospitalization in the presence of two adult witnesses (at least one of whom is a health or social services practitioner affiliated with the hospital) or in writing. It also considered a measure that would permit some persons with developmental disabilities to make their own decisions concerning life-sustaining care.
- New York considered measures related to advance planning documents, pain management and palliative care.
- Finally, New York considered legislation purporting to protect employees against discrimination for “reproductive health decision making.” The legislation appeared to adopt a disingenuous narrative that employees face potential discrimination or lack of access to contraception stemming from their employers’ religious liberty and conscience claims against the coercive “HHS Mandate” (which would require many employers to pay for or facilitate coverage for drugs and devices with life-ending mechanisms of action). In addition, New York considered legislation that would require pharmacists and/or pharmacies to dispense so-called “emergency contraception” despite religious or conscience objections.

RECOMMENDATIONS

for NEW YORK

WOMEN'S PROTECTION PROJECT PRIORITIES

- Women's Health Defense Act (5 month abortion limitation)
- Women's Right to Know Act with reflection period
- Abortion Patients' Enhanced Safety Act
- Abortion-Inducing Drugs Safety Act
- Parental Notification for Abortion Act
- Child Protection Act
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- State Constitutional Amendment (providing that there is no state constitutional right to abortion)
- Federal Abortion-Mandate Opt-Out Act
- Defunding the Abortion Industry and Advancing Women's Health Act
- Women's Ultrasound Right to Know Act
- Coercive Abuse Against Mothers Prevention Act
- Prenatal Nondiscrimination Act

Legal Recognition and Protection for the Unborn

- Crimes Against the Unborn Child Act
- Unborn Wrongful Death Act
- Pregnant Woman's Protection Act

Bioethics

- Human Cloning Prohibition Act
- Destructive Embryo Research Act
- Prohibition on Public Funding of Human Cloning and Destructive Embryo Research Act

Healthcare Freedom of Conscience

- Healthcare Freedom of Conscience Act



North Carolina | RANKING: 25

North Carolina has recently enacted a number of provisions aimed at protecting the health and welfare of women and unborn children, including a prohibition on sex-selective abortions and an informed consent law. Further, the state protects unborn victims of violence from conception until birth. However, North Carolina maintains no laws regarding human cloning, destructive embryo research, fetal experimentation, assisted reproductive technologies, or human egg harvesting.

» ABORTION

- North Carolina prohibits sex-selective abortions.
- A physician may not perform an abortion on a woman until at least 24 hours after the woman has been informed of particular medical risks associated with the particular abortion procedure to be employed (including psychological risks), the probable gestational age of the unborn child, medical risks associated with carrying the child to term, whether the physician who is to perform the abortion has liability insurance for malpractice, the location of the hospital that offers obstetrical or gynecological care located within 30 miles of the location where the abortion is performed or induced and at which the physician performing or inducing the abortion has clinical privileges, and if the physician performing the abortion does not have local hospital admitting privileges. Additional information about medical assistance benefits, alternatives to abortion, and the father's liability for child support must also be provided.
- An abortion provider is required to provide, display, and describe ultrasound images to a woman seeking an abortion and offer her the opportunity to hear the fetal heart tones. Portions of the law requiring display and explanation of the image have been challenged and are in litigation, but the provision mandating the ultrasound itself has not been challenged.
- A physician may not perform an abortion on an unemancipated minor under the age of 18 without the written consent of one parent or a grandparent with whom the minor has lived for at least six months, unless there is a medical emergency or the minor obtains a court order.
- North Carolina has enacted comprehensive regulations establishing minimum health and safety standards for abortion clinics. Among the areas regulated are clinic administration, staffing, patient medical evaluations, and post-operative care.
- In 2013, the state Department of Health was given discretion to apply ambulatory

surgical center standards to abortion facilities. The impact of the new law is undetermined.

- Only physicians licensed to practice medicine in North Carolina may perform abortions. The physician must be present during the performance of the entire (surgical) abortion procedure.
- The state has an enforceable abortion reporting law, but does not require the reporting of information to the Centers for Disease Control (CDC). The measure pertains to both surgical and nonsurgical abortions.
- A physician must be present during the administration of the first drug in an abortion-inducing drug regimen.
- North Carolina follows the federal standard for Medicaid funding for abortions, permitting the use of federal or state matching Medicaid funds for abortions necessary to preserve the life of the woman or when the pregnancy is the result of rape or incest.
- In 2012, the state enacted a law defunding abortion providers. A similar 2011 law had been enjoined.
- North Carolina prohibits abortion coverage for public employees except in cases of life endangerment, rape, or incest.
- The state has limited funding for abortion through the health insurance plans offered through the health insurance Exchanges required by the federal healthcare law or offered through local governments.
- In 2014, the state appropriated \$250,000 to Carolina Pregnancy Care Fellowship.
- The state has authorized “Choose Life” license plates, the proceeds of which benefit entities providing abortion alternatives. A federal district court has ruled that the plates are unconstitutional because the North Carolina legislature did not offer a pro-abortion version of the plates. The law remains in litigation.

» LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN

- North Carolina protects unborn victims of violence from conception until birth. *Lily’s Law* provides that the crime of homicide also includes situations where a child is born and dies from injuries received *in utero*.
- North Carolina defines a criminal assault on a pregnant woman that results in miscarriage, stillbirth, or “damage to pregnancy” as an enhanced offense for sentencing purposes.
- The state allows for a wrongful death (civil) action when a viable unborn child is killed through a negligent or criminal act.
- North Carolina does not require that infants who survive an abortion be given appropriate medical care.

- North Carolina has a “Baby Moses” law, establishing a safe haven for mothers to legally leave their infants at designated places and ensuring the infants receive appropriate care and protection.
- The state funds drug treatment programs for pregnant women and newborns.

» **BIOETHICS LAWS**

- North Carolina maintains no laws regarding human cloning, destructive embryo research, fetal experimentation, assisted reproductive technologies, or human egg harvesting.
- North Carolina requires the state Department of Health and Human Services to make publicly available publications on umbilical cord stem cells and umbilical cord blood banking. The Department also encourages healthcare professionals to provide the publications to their pregnant patients.

» **END OF LIFE LAWS**

- North Carolina’s treatment of assisted suicide is unclear. While the state has statutorily adopted the common law of crimes, it has also abolished the common law crime of suicide. Assisted suicide may still be a common law crime.

» **HEALTHCARE FREEDOM OF CONSCIENCE**

Participation in Abortion

- An individual healthcare provider who objects on religious, moral, or ethical grounds is not required to participate in abortions.
- A hospital or other healthcare institution is not required to provide abortions.
- The state provides some protection for the conscience rights of pharmacists and pharmacies.
- Health insurance plans that provide prescription coverage must also provide coverage for contraception. The provision includes a conscience exemption so narrow that it excludes the ability of most employers and insurers with moral or religious objections from exercising it.

Participation in Research Harmful to Human Life

- North Carolina currently provides no protection for the rights of healthcare providers who conscientiously object to participation in human cloning, destructive embryo research, or other forms of medical research, which violate a provider’s moral or religious belief.

» WHAT HAPPENED IN 2014

- North Carolina appropriated \$250,000 to Carolina Pregnancy Care Fellowship.
- In *Stuart v. Camnitz*, a federal district court struck down portions of North Carolina’s ultrasound regulation requiring a display and explanation. The case has been appealed to the Fourth Circuit.
- North Carolina considered a measure making assisted suicide unlawful; however, the measure did not provide a criminal penalty. It also considered legislation related to pain management and palliative care.
- North Carolina considered legislation purporting to protect employees against discrimination for “reproductive health decision making.” The legislation appeared to adopt a disingenuous narrative that employees face potential discrimination or lack of access to contraception stemming from their employers’ religious liberty and conscience claims against the coercive “HHS Mandate” (which would require many employers to pay for or facilitate coverage for drugs and devices with life-ending mechanisms of action).

RECOMMENDATIONS

for NORTH CAROLINA

WOMEN'S PROTECTION PROJECT PRIORITIES

- Abortion-Inducing Drugs Safety Act
- Parental Involvement Enhancement Act
- Components of the Child Protection Act related to evidence retention and remedies for third-party interference with parental rights
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- Federal Abortion-Mandate Opt-Out Act
- Prenatal Nondiscrimination Act

Legal Recognition and Protection for the Unborn

- Unborn Wrongful Death Act (for a pre-viable child)
- Born-Alive Infant Protection Act
- Pregnant Woman's Protection Act

Bioethics

- Human Cloning Prohibition Act
- Destructive Embryo Research Act
- Prohibition on Public Funding of Human Cloning and Destructive Embryo Research Act

End of Life

- Assisted Suicide Ban Act

Healthcare Freedom of Conscience

- Healthcare Freedom of Conscience Act



North Dakota | RANKING: 8

North Dakota maintains some of the strongest legal protections for women considering abortion. Among many protective measures, the state limits abortion at 5 months (i.e., 20 weeks) development, maintains comprehensive informed consent requirements, requires abortion providers to have admitting privileges at a local hospital, and funds organizations that promote abortion alternatives. Additionally, North Dakota is one of only a handful of states that effectively bans human cloning for all purposes.

» ABORTION

- North Dakota prohibits abortion at 5 months (i.e., 20 weeks) development.
- A state law prohibiting an abortion when there is a detectible heartbeat—as early as six weeks development—is currently in litigation.
- North Dakota prohibits partial-birth abortion.
- North Dakota prohibits abortions sought solely on account of a child’s sex or because the child has been diagnosed with a genetic abnormality.
- North Dakota has enacted a measure banning abortion should *Roe v. Wade* be overturned.
- A physician may not perform an abortion on a woman until at least 24 hours after the woman has been informed of the medical risks associated with abortion, the medical risks of carrying the pregnancy to term, the probable gestational age of the unborn child, state assistance benefits, the father’s legal obligations, the availability of state-prepared information on the development of the unborn child, and a list of agencies that offer alternatives to abortion. The woman must also be informed that “the abortion will terminate the life of a whole, separate, unique, living human being” and be provided information about the abortion-breast cancer link.
- Abortion providers must offer a woman the opportunity to view an ultrasound image of her unborn child.
- North Dakota prohibits anyone from coercing a woman into abortion. Further, abortion facilities must post a notice stating that no one can force a woman to have an abortion.
- A physician may not perform an abortion on an unmarried minor under the age of 18 without the written consent of both parents (or the surviving parent, custodial parent, or guardian) unless there is a medical emergency or the minor obtains a court order.

- Only physicians licensed by North Dakota to practice medicine or osteopathy or employed by the United States may perform abortions.
- The state also requires abortion providers to have admitting privileges at a local hospital and to be board certified in obstetrics/gynecology, and abortion clinics must maintain a transfer agreement with a local hospital to assist in the treatment of abortion-related complications. Further, abortion clinics must have a staff member trained in cardiopulmonary resuscitation.
- The state has an enforceable abortion reporting law, but does not require the reporting of information to the Centers for Disease Control (CDC). The measure pertains to both surgical and nonsurgical abortions.
- Physicians performing an abortion must report the post-fertilization age of the aborted child.
- North Dakota bans “webcam abortions” by requiring that abortion-inducing drugs be administered by or in the same room and in the physical presence of the physician who prescribed, dispensed, or otherwise provided the drug or chemical to the patient. The law is in litigation.
- North Dakota follows the federal standard for Medicaid funding for abortions, permitting the use of federal or state matching Medicaid funds for abortions necessary to preserve the life of the woman or when the pregnancy is the result of rape or incest.
- North Dakota law also provides that no state funds or funds from any agency, county, municipality, or any other subdivision thereof and no federal funds passing through the state treasury or a state agency may be used to pay for the performance or for promoting the performance of an abortion unless the abortion is necessary to prevent the death of the woman.
- No funds, grants, gifts, or services of an organization receiving funds distributed by the Children’s Services Coordinating Committee may be used for the purposes of direct provision of contraception services, abortion, or abortion referrals to minors.
- An abortion may not be performed in hospitals owned or operated by the state, unless the abortion is necessary to preserve the life of the woman.
- State health insurance contracts, policies, and plans must exclude coverage for abortion unless the abortion is necessary to preserve the woman’s life.
- Private insurance companies are also prohibited from covering abortion except in cases of life endangerment.
- North Dakota funds organizations that promote abortion alternatives.

» **LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN**

- Under North Dakota criminal law, the killing of an unborn child at any stage of gestation is defined as homicide.

- North Dakota defines a nonfatal assault on an unborn child as a criminal offense.
- The state allows a wrongful death (civil) action when a viable unborn child is killed through a third party's negligent or criminal act.
- The state has created a specific affirmative duty of physicians to provide medical care and treatment to infants born alive after viability.
- North Dakota requires healthcare professionals to report suspected prenatal drug exposure. In addition, healthcare professionals must test newborns for prenatal drug exposure when there is adequate suspicion of prenatal use by the mother.

» BIOETHICS LAWS

- North Dakota prohibits both human cloning and fetal experimentation; however, it does not prohibit destructive embryo research.
- North Dakota allows healthcare professionals to inform pregnant patients of options relating to umbilical cord blood, and hospitals are to allow pregnant patients to arrange for such donations.
- The *Uniform Parentage Act* includes "donation of embryos" in its definition of "assisted reproduction," but the state maintains no meaningful regulation of assisted reproductive technologies or human egg harvesting.

» END OF LIFE LAWS

- In North Dakota, assisting a suicide is a felony.

» HEALTHCARE FREEDOM OF CONSCIENCE

Participation in Abortion

- A hospital, physician, nurse, hospital employee, or any other person is not under a legal duty or contractual obligation to participate in abortions.

Participation in Research Harmful to Human Life

- North Dakota currently provides no protection for the rights of healthcare providers who conscientiously object to participation in human cloning, destructive embryo research, and other forms of medical research, which violate a provider's moral or religious belief.

» WHAT HAPPENED IN 2014

- North Dakota did not hold a regular legislative session in 2014.

RECOMMENDATIONS

for NORTH DAKOTA

WOMEN'S PROTECTION PROJECT PRIORITIES

- Abortion Patients' Enhanced Safety Act
- Parental Involvement Enhancement Act
- Child Protection Act
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- Federal Abortion-Mandate Opt-Out Act
- Defunding the Abortion Industry and Advancing Women's Health Act

Legal Recognition and Protection for the Unborn

- Unborn Wrongful Death Act
- Born-Alive Infant Protection Act (for a pre-viable child)
- Pregnant Woman's Protection Act

Bioethics

- Promotion of ethical forms of medical research

Healthcare Freedom of Conscience

- Healthcare Freedom of Conscience Act



Ohio | RANKING: 16

Ohio maintains fairly comprehensive protections for women considering abortion and their unborn children, and it was the first state to regulate the provision of abortion-inducing drugs. However, the state does not adequately protect vulnerable patients at the end of life, failing to prohibit assisted suicide, and it maintains no protective laws regarding human cloning or destructive embryo research.

» ABORTION

- Ohio prohibits partial-birth abortion.
- Post-viability abortions are only permitted when the abortion is necessary to avoid the death of the pregnant woman or there is a serious risk of substantial and irreversible impairment of a major bodily function of the pregnant woman. Two physicians must verify the medical necessity.
- A physician may not perform an abortion on a woman until at least 24 hours after the physician informs her of the nature of the proposed abortion procedure and its risks, the probable gestational age of the unborn child, and the medical risks of carrying the pregnancy to term. The physician must also provide state-prepared materials describing the development of the unborn child, public and private agencies providing assistance, state medical assistance benefits, and the father's legal obligations.
- Ohio requires an abortion provider to offer a woman the opportunity to view an ultrasound and to obtain a copy of the image when an ultrasound is performed as part of the preparation for an abortion.
- As part of a budgetary measure, Ohio has mandated that before an abortion, the physician must attempt to determine if there is a fetal heartbeat. If a fetal heartbeat is detected, the abortion provider may not perform the abortion until 24 hours after he or she has informed the pregnant woman in writing that her baby has a heartbeat and of the statistical probability of bringing the baby to term based on the child's stage of development. The provision is in litigation in state court.
- Abortion facilities must post signs informing a woman that no one can force her to have an abortion. The law increases the penalty for domestic violence if the offender knew the woman was pregnant, while also permitting the recovery of compensatory and exemplary damages when mandatory reporters fail to report suspected coercive abuse.
- A physician may not perform an abortion on an unemancipated minor under the age of 18 until receiving the consent of one parent or guardian unless there is a medical emergency or the minor obtains a court order.

- Ohio licenses and regulates abortion clinics as a subset of ambulatory surgical centers.
- Ohio limits the performance of abortions to licensed physicians, and all providers must maintain hospital admitting privileges.
- In addition, abortion providers must maintain a written transfer agreement with a hospital to facilitate care for women experiencing abortion complications. A 2013 requirement prohibiting publicly funded hospitals from entering into transfer agreements with abortion providers is in litigation.
- The state has an enforceable abortion reporting law, but does not require the reporting of information to the Centers for Disease Control (CDC). The measure pertains to both surgical and nonsurgical abortions and requires abortion providers to report short-term complications.
- Ohio has a law regulating the provision of RU-486 and creating criminal penalties for those providing the drug without following FDA-approved guidelines. The law also requires abortion providers to inform the state medical board whenever RU-486 leads to “serious complications.”
- Ohio follows the federal standard for Medicaid funding for abortions, permitting the use of federal or state matching Medicaid funds for abortions necessary to preserve the life of the woman or when the pregnancy is the result of rape or incest.
- Ohio maintains a “tiering system” for the allocation of family planning funding including funding for which abortion providers might be eligible. Under the system, first priority for funding is given to public entities that are operated by state or local government entities. Most abortion providers fall into the lowest priority category of this system.
- Ohio law also generally provides that state or local public funds shall not be used to subsidize an abortion, except in cases of life endangerment, rape, or incest.
- Several state funding sources include abortion-related limitations. For example, women’s health services grants may not be used to provide abortion services and may not be used for counseling or referrals for abortions, except in cases of medical emergency. Services using these grants must be physically and financially separate from abortion-providing and abortion-promoting activities. Additionally, generic services funds may not be used to counsel or refer for abortions, except in cases of medical emergency, and the Breast Cancer Fund of Ohio may not use money for abortion information, counseling, or services, or for any abortion-related activities.
- State employee health insurance may not provide coverage for abortion unless the abortion is necessary to preserve the woman’s life, the pregnancy is the result of rape or incest, or an additional premium is paid for an optional rider.
- Ohio permits motorists to pay a \$30 fee for “Choose Life” specialty license plates, with \$20 from the proceeds of each plate designated for non-profit groups that encourage adoption.

» **LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN**

- Under Ohio criminal law, the killing of an unborn child at any stage of gestation is homicide.
- Ohio defines a nonfatal assault on an unborn child as a crime.
- Ohio allows a wrongful death (civil) action when a viable unborn child is killed through a negligent or criminal act.
- Ohio has a “Baby Moses” law, establishing a safe haven for mothers to legally leave their infants at designated places and ensuring the infants receive appropriate care and protection.
- The state funds drug treatment programs for pregnant women and newborns.
- Under the *Grieving Parents Act*, the state permits a fetal death certificate and burial in the death of an unborn child.

» **BIOETHICS LAWS**

- Ohio maintains no laws regarding human cloning or destructive embryo research; however, it bans fetal experimentation.
- The Ohio Department of Health has been directed to place printable information on umbilical cord blood banking and donation on its website. It also encourages healthcare professionals to provide this information to pregnant women.
- Ohio maintains no comprehensive regulations of assisted reproductive technologies or human egg harvesting.
- The state maintains laws regarding the parentage of donated embryos.

» **END OF LIFE LAWS**

- Ohio has declared that assisted suicide is against public policy; however, state law does not criminalize assisted suicide. Under existing Ohio law, an injunction may be issued to prevent a healthcare professional from participating in a suicide, and assisting a suicide is grounds for professional discipline.

» **HEALTHCARE FREEDOM OF CONSCIENCE**

Participation in Abortion

- No person is required to participate in medical procedures that result in an abortion.
- A hospital is not required to permit its facilities to be used for abortions.

Participation in Research Harmful to Human Life

- Ohio currently provides no protection for the rights of healthcare providers who conscientiously object to participation in human cloning, destructive embryo research, or other forms of medical research, which violate a provider’s moral or religious belief.

» WHAT HAPPENED IN 2014

- Ohio considered legislation prohibiting abortion when an unborn child has a heartbeat and requiring that a woman be informed that her unborn child has a heartbeat and mandating health and safety standards for abortion facilities. It also considered a resolution, based on AUL's model language, honoring the work of pregnancy resource centers.
- In addition, Ohio considered a requirement that would take effect upon the reversal of *Roe v. Wade*, allowing its Attorney General to seek a declaration or the lifting of any injunction against any previously invalidated abortion-related restriction or regulation. The measure would allow county prosecutors to pursue such actions if the Attorney General declines.
- Ohio enacted two measures concerning the provision of certain medication for pain management or palliative care. It also considered a measure ensuring that an individual's statutory priority to decide whether to withhold or withdraw life-sustaining treatment for a relative is forfeited if that individual is charged with causing the terminal condition of his or her relative.

RECOMMENDATIONS

for OHIO

WOMEN'S PROTECTION PROJECT PRIORITIES

- Abortion Patients' Enhanced Safety Act
- Parental Involvement Enhancement Act
- Child Protection Act
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- Defunding the Abortion Industry and Advancing Women's Health Act
- Prenatal Nondiscrimination Act

Legal Recognition and Protection for the Unborn

- Unborn Wrongful Death Act (for a pre-viable child)
- Pregnant Woman's Protection Act

Bioethics

- Human Cloning Prohibition Act
- Destructive Embryo Research Act
- Prohibition on Public Funding of Human Cloning and Destructive Embryo Research Act

End of Life

- Assisted Suicide Ban Act

Healthcare Freedom of Conscience

- Healthcare Freedom of Conscience Act



Oklahoma | RANKING: 4

Protecting women and their unborn children remains a primary focus of Oklahoma legislators. Even in the face of threatened litigation by abortion advocates, Oklahoma continues to enact comprehensive and protective laws and regulations, counting it more important to protect women from an abusive abortion industry that values profits over women's lives. In 2014, it enacted a number of protective provisions, including comprehensive regulation of abortion-inducing drugs and health and safety standards for abortion facilities.

» ABORTION

- Oklahoma bans abortions at or after 5-months of pregnancy (*i.e.*, 20 weeks) on the basis of pain experienced by unborn children.
- Oklahoma prohibits partial-birth abortions and sex-selection abortions.
- Oklahoma possesses an enforceable abortion prohibition should the U.S. Constitution be amended or certain U.S. Supreme Court decisions be reversed or modified.
- Oklahoma has amended its definition of “abortion” to include the use of abortion-inducing drugs. It has also amended the definition of “medical emergency” as applied to all of its abortion laws, narrowing the exception to exclude “mental health” and applying it only to cases where a physical condition could cause the major impairment of a bodily function or death.
- Oklahoma requires that, 24 hours before an abortion, a woman receive counseling on the medical risks of abortion and pregnancy, the name of the physician performing the abortion, and the gestational age of the unborn child. The woman must also receive information on anatomical and physiological characteristics of fetuses at different stages of development and her right to receive state-prepared materials on potential government benefits, child support, and a list of support agencies and their services.
- Oklahoma has supplemented its informed consent requirements, mandating that women seeking abortions at five months gestation or later receive information about fetal pain.
- A woman (at six weeks or later gestation) must be given an opportunity to hear the heartbeat of her unborn child.
- The state requires an ultrasound evaluation of all patients who elect to have abortions.
- A woman considering abortion after a life-limiting diagnosis for her unborn child must receive information on perinatal hospice services.

- Abortion clinics must post signs indicating that a woman cannot be coerced into an abortion.
- A physician may not perform an abortion on an unemancipated minor without the written, notarized consent of a parent or guardian. A parent or guardian must provide government-issued proof of identification, and the abortion provider must also sign a document attesting to the quality of the identification provided. Judicial bypass proceedings must be initiated in the county where the minor resides, and judges must consider certain enumerated factors in assessing the maturity of the minor and the specific circumstances of the case. In a medical emergency, abortion providers must notify a parent or guardian of the minor's abortion no less than 24 hours after the procedure, unless the minor obtains a judicial waiver.
- The state maintains a separate parental notice provision that does not include a judicial bypass procedure.
- Oklahoma law mandates that abortion clinics comply with comprehensive health and safety standards. An additional requirement that abortions after the first trimester be performed in a hospital has been ruled unconstitutional.
- Only physicians licensed to practice medicine in Oklahoma may perform abortions. Abortion providers must have admitting privileges at a general medicine surgical hospital within 30 miles of the abortion facility and must remain on the premises in order to facilitate the transfer of emergency cases (until all abortion patients are stable and ready to leave the recovery room).
- Abortion providers must report specific and detailed information about each abortion and abortion patient including aggregate information on the number of women receiving state abortion counseling materials and the number of abortions exempted from the counseling requirement because of a "medical emergency." In addition, abortion providers must report specific and detailed information regarding minors' abortions, including whether they obtained the mandatory parental consent, whether the minors sought judicial bypass of the consent requirement, and whether or not such bypass was granted. The requirements apply to both surgical and nonsurgical abortions, but do not require that any of this information be reported to the Centers for Disease Control (CDC).
- In 2013, Oklahoma amended its abortion reporting statute to require the provision of additional information including a screenshot of the ultrasound image. In 2014, the state added a requirement that any incidents of injury or death must be reported to the state Board of Health.
- Oklahoma maintains comprehensive regulations of abortion-inducing drugs, including a requirement that physicians physically examine a woman before administering the drugs as well as a requirement that the drugs be administered as restricted by the U.S. Food & Drug Administration. An additional 2012 law explicitly prohibits the use of telemedicine to administer abortion-inducing drugs.

- In 2012, Oklahoma enacted a law permitting a woman (or parent or legal guardian, if applicable) to commence a civil action if an abortion provider violates the state’s informed consent law, ultrasound requirement, fetal pain counseling requirement, parental involvement law, or any other law regulating a minor’s abortion.
- Oklahoma follows the federal standard for Medicaid funding for abortions, permitting the use of federal or state matching Medicaid funds for abortions necessary to preserve the life of the woman or when the pregnancy is the result of rape or incest.
- Under Oklahoma law, no public funds can be used to encourage a woman to have an abortion (except to the extent required by federal Medicaid rules).
- Oklahoma prohibits taxpayer funding of any entity associated with another entity that provides, counsels, or refers for abortion.
- The state prohibits the use of research grants provided through the *Oklahoma Health Research Act* for abortion.
- Oklahoma law restricts the use of state facilities for the performance of abortions and provides that no state actor may perform an abortion except in cases of life endangerment, incest, or rape. Healthcare providers who are state employees may not provide abortions, abortion referrals, or abortion counseling.
- The state prohibits insurance companies from offering abortion coverage within state insurance Exchanges established pursuant to the federal healthcare law, except in cases of life endangerment.
- Oklahoma also prohibits private health insurance coverage for abortions, except in cases of life endangerment.
- Oklahoma has directed the state Department of Health to “facilitate funding to nongovernmental entities that provide alternatives to abortion services.” It has also allocated direct taxpayer funding to abortion alternatives.
- The state offers “Choose Life” license plates, the proceeds of which benefit pregnancy resource centers and/or other organizations providing abortion alternatives.

» **LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN**

- Oklahoma criminalizes the unlawful killing of an unborn child from “the moment of conception.”
- Oklahoma also criminalizes a nonfatal assault on an unborn child.
- The *Pregnant Woman’s Protection Act* provides an affirmative defense to a woman who uses force to protect her unborn child from a criminal assault.
- Oklahoma allows a wrongful death (civil) action when an unborn child at any stage of development is killed through a negligent or criminal act.
- The state bans civil causes of action for both “wrongful birth” and “wrongful life.”

- Under Oklahoma law, “the rights to medical treatment of an infant prematurely born alive in the course of an abortion shall be the same as the rights of an infant of similar medical status prematurely born.” Thus, the state has created a specific affirmative duty of physicians to provide medical care and treatment to infants born alive at any stage of development.
- Oklahoma has a “Baby Moses” law, establishing a safe haven for mothers to legally leave their infants at designated places and ensuring that the infants receive appropriate care and protection.
- Oklahoma requires healthcare professionals to report suspected prenatal drug exposure and mandates that the state Department of Human Services investigate when a newborn tests positive for controlled substances.

» **BIOETHICS LAWS**

- Oklahoma bans human cloning for all purposes, destructive embryo research, and fetal experimentation.
- The state Department of Health has been directed to establish, operate, and maintain a public umbilical cord blood bank or cord blood collection operation. The Department has also been directed to establish a related education program, and each physician is to inform pregnant patients of the opportunity to donate to the bank following delivery.
- The state regulates the donation and transfer of human embryos used in assisted reproductive technologies and establishes that donors of embryos relinquish all parental rights with respect to any resulting children.
- Oklahoma regulates assisted reproductive technologies.

» **END OF LIFE LAWS**

- In Oklahoma, assisting a suicide is a felony.

» **HEALTHCARE FREEDOM OF CONSCIENCE**

Participation in Abortion

- Oklahoma’s *Freedom of Conscience Act* provides broad conscience protections for individuals and institutions.
- No person is required to participate in medical procedures that result in or are in preparation for an abortion except when necessary to preserve a woman’s life.
- A private hospital is not required to permit abortions within its facilities.

Participation in Research Harmful to Human Life

- The *Freedom of Conscience Act* provides broad conscience protections for individuals and institutions.

» WHAT HAPPENED IN 2014

- Oklahoma enacted a measure based on AUL's *Women's Health Protection Act* and *Abortion Providers' Admitting Privileges Act*, mandating that abortion clinics comply with comprehensive health and safety standards for women and that abortion providers have admitting privileges at a general medicine surgical hospital within 30 miles of the abortion facility and remain on the premises in order to facilitate the transfer of emergency cases (until all abortion patients are stable and ready to leave the recovery room).
- Oklahoma also enacted a measure drafted by AUL experts which clarifies and strengthens its abortion inducing-drugs safety regulation (also based on AUL model legislation), a previous version of which was invalidated by the Oklahoma Supreme Court. Under the law, a physician must examine a woman before dispensing abortion-inducing drugs, and those drugs must be dispensed according to restrictions outlined by the FDA.
- In addition, the state enacted a measure partially based on AUL's *Perinatal Hospice Information Act*, ensuring that a woman considering an abortion after a life-limiting diagnosis for her unborn child receives information on perinatal hospice services. This measure specifically provides enforcement provisions including a private right of action for the mother, father, or grandparent of the unborn child.
- In a busy legislative session, Oklahoma enacted a measure requiring an ultrasound evaluation of all patients who elect to have abortions and a measure requiring abortion providers to report any injuries or deaths to the state Board of Health.
- Oklahoma removed "deaths due to criminal abortion" from a list of "violent deaths" to be investigated.
- Oklahoma considered legislation that would prohibit minors under the age of 17 from receiving Plan B, a so-called "emergency contraceptive," without a prescription.
- Oklahoma was the only state in 2014 to consider legislation prohibiting destructive embryo research. The state also considered legislation restricting state funds for unethical forms of research.
- The state considered measures related to advance planning documents, pain management, and palliative care.

RECOMMENDATIONS

for OKLAHOMA

WOMEN'S PROTECTION PROJECT PRIORITIES

- Abortion Patient's Enhanced Safety Act
- Components of the Child Protection Act related to evidence retention and remedies for third-party interference with parental rights
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- Defunding the Abortion Industry and Advancing Women's Health Act

Legal Recognition and Protection for the Unborn

- Unborn Wrongful Death Act (for a pre-viable child)

Bioethics

- Egg Provider Protection Act
- Assisted Reproductive Technologies Disclosure and Risk Reduction Act



Oregon | RANKING: 48

Oregon has an abysmal record on life, failing to protect women, the unborn, the sick, and the dying. For example, Oregon does not mandate informed consent or parental involvement before abortion, does not recognize an unborn child as a potential victim of homicide or assault, and does not limit destructive embryo research or human cloning. Sadly, Oregon was the first state in the nation to legalize physician-assisted suicide.

» ABORTION

- Oregon does not provide even rudimentary protection for a woman considering an abortion. Oregon does not have an informed consent law, an ultrasound requirement, a parental involvement law for minors seeking abortion, abortion clinic regulations, or a prohibition on anyone other than a licensed physician performing an abortion.
- The state has an enforceable abortion reporting law, but does not require the reporting of information to the Centers for Disease Control (CDC). The measure pertains to both surgical and nonsurgical abortions and requires abortion providers to report short-term complications.
- Oregon taxpayers fund “medically necessary” abortions for women eligible for state medical assistance for general care. This requirement essentially equates to funding abortion-on-demand in light of the U.S. Supreme Court’s broad definition of “health” in the context of abortion.

» LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN

- Current Oregon law does not recognize an unborn child as a potential victim of homicide or assault.
- The state allows a wrongful death (civil) action when a viable unborn child is killed through a negligent or criminal act.
- Oregon does not require that an infant who survives an abortion be given appropriate, potentially life-saving medical care.
- Oregon has a “Baby Moses” law, establishing a safe haven for mothers to legally leave their infants at designated places and ensuring that the infants receive appropriate care and protection.
- The state funds drug treatment programs for pregnant women and newborns.

» **BIOETHICS LAWS**

- Oregon maintains no laws regarding human cloning, destructive embryo research, or fetal experimentation; nor does it promote ethical forms of research.
- Further, the state does not regulate assisted reproductive technologies or human egg harvesting.

» **END OF LIFE LAWS**

- Oregon permits physician-assisted suicide under statutorily specified circumstances.
- However, Oregon bans the sale of “suicide kits.”

» **HEALTHCARE FREEDOM OF CONSCIENCE**

Participation in Abortion

- A physician is not required to participate in or give advice about abortion if he or she discloses this election to the patient.
- A hospital employee or medical staff member is not required to participate in abortions if he or she has notified the hospital of this election.
- A private hospital is not required to admit a woman for an abortion.
- A state Department of Human Services employee who objects in writing may refuse to offer family planning and birth control services.
- Health plans that provide prescription coverage must also cover prescription contraceptives. Religious employers may refuse coverage if their primary purpose is the inculcation of religious values, if they primarily employ and serve people with the same values, and if they are nonprofit entities under federal law.

Participation in Research Harmful to Human Life

- Oregon currently provides no protection for the rights of healthcare providers who conscientiously object to participation in human cloning, destructive embryo research, or other forms of medical research, which violate a provider’s moral or religious belief.

» **WHAT HAPPENED IN 2014**

- Oregon considered legislation prohibiting sex-selective abortions.

RECOMMENDATIONS

for OREGON

WOMEN'S PROTECTION PROJECT PRIORITIES

- Women's Health Defense Act (5-month abortion limitation)
- Women's Right to Know Act with reflection period
- Abortion Patients' Enhanced Safety Act
- Abortion-Inducing Drugs Safety Act
- Parental Notification for Abortion Act
- Child Protection Act
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- Federal Abortion-Mandate Opt-Out Act
- Defunding the Abortion Industry and Advancing Women's Health Act
- Women's Ultrasound Right to Know Act
- Coercive Abuse Against Mothers Prevention Act
- Prenatal Nondiscrimination Act

Legal Recognition and Protection for the Unborn

- Crimes Against the Unborn Child Act
- Unborn Wrongful Death Act (for a pre-viable child)
- Born-Alive Infant Protection Act
- Pregnant Woman's Protection Act

Bioethics

- Human Cloning Prohibition Act
- Destructive Embryo Research Act
- Prohibition on Public Funding of Human Cloning and Destructive Embryo Research Act

End of Life

- Repeal of law permitting physician-assisted suicide

Healthcare Freedom of Conscience

- Healthcare Freedom of Conscience Act



Pennsylvania | RANKING: 13

Pennsylvania's efforts to protect women and unborn children from the negative consequences of abortion have been ground-breaking, as memorialized in the landmark case *Planned Parenthood v. Casey*. Pennsylvania has led the way for other states by enacting such measures as informed consent, parental consent, and state funding of abortion alternatives. Moreover, Pennsylvania is also one of a small number of states that prohibits destructive embryo research.

» ABORTION

- In the landmark case *Planned Parenthood v. Casey*, Pennsylvania's informed consent requirements, mandated a 24-hour reflection period prior to an abortion, and a parental consent requirement for a minor seeking an abortion were upheld by the U.S. Supreme Court.
- The state requires abortion providers to state in their printed materials that it is illegal for someone to coerce a woman into having an abortion.
- Pennsylvania's parental consent law requires one-parent consent unless there is a medical emergency or a minor obtains a court order. The law permits substitute consent by any adult standing in *loco parentis* if neither parent is available.
- Pennsylvania requires that abortion clinics meet the same patient care standards as facilities performing other outpatient surgeries.
- Only physicians or doctors of osteopathy licensed to practice medicine in Pennsylvania may perform abortions. Abortion providers must also maintain hospital admitting privileges.
- The state has an enforceable abortion reporting law, but does not require the reporting of information to the Centers for Disease Control (CDC). The measure pertains to both surgical and nonsurgical abortions and requires abortion providers to report short-term complications.
- Pennsylvania follows the federal standard for Medicaid funding for abortions, permitting the use of federal or state matching Medicaid funds for abortions necessary to preserve the life of the woman or when the pregnancy is the result of rape or incest.
- Pennsylvania does not provide public funding or public facilities for an abortion unless the abortion is necessary to preserve the woman's life or the pregnancy is the result of rape or incest.

- No public funds for legal services or IOLTA (Interest on Lawyer Trust Account) funds may be used to advocate for or oppose abortion rights.
- Programs receiving funds through the state Department of Public Welfare Women's Services programs may not be used to promote, refer for, or perform abortions, or engage in any counseling to encourage abortion. Physical and financial separation of these programs from abortion services is required.
- Pennsylvania prohibits the use of family planning funds for abortion-related activities, and requires family planning services providers and subcontractors to keep a state-funded family planning project physically and financially separate from abortion-related activities, with exceptions for abortions in cases of life endangerment, rape, or incest.
- Pennsylvania prohibits abortion coverage in its state health insurance Exchanges required under the federal healthcare law.
- Health plans funded by the state may not include coverage for abortion unless the abortion is necessary to preserve a woman's life or the pregnancy is the result of rape or incest.
- Pennsylvania also requires any insurance providers offering healthcare or disability insurance within the state to offer policies that do not cover abortion except when necessary to preserve a woman's life or when the pregnancy is the result of rape or incest.
- Pennsylvania has allocated millions of dollars to pregnancy resource centers and other abortion alternative programs. Entities receiving the funds cannot perform abortions or provide abortion counseling.
- Pennsylvania offers "Choose Life" license plates, the proceeds of which are used to fund adoption and abortion alternatives services.

» **LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN**

- Under Pennsylvania law, the killing of an unborn child at any stage of gestation is defined as homicide.
- Pennsylvania defines a nonfatal assault on an unborn child as a criminal offense.
- The state allows a wrongful death (civil) action when a viable unborn child is killed through a negligent or criminal act.
- The state has created a specific affirmative duty for physicians to provide medical care and treatment to infants born alive at any stage of development.
- Pennsylvania funds drug treatment programs for pregnant women and newborns. The state also ensures adequate care for babies determined to have been prenatally exposed to alcohol or illegal substances.
- Pennsylvania law provides for "fetal death registrations."

» **BIOETHICS LAWS**

- Pennsylvania does not ban human cloning, but it does prohibit destructive embryo research.
- Pennsylvania prohibits experimentation on a live human fetus, but allows experimentation on a dead fetus with the consent of the mother.
- A healthcare professional providing services to a pregnant woman must advise her of the option to donate umbilical cord blood following delivery, and all healthcare facilities and providers must permit the woman to arrange for an umbilical cord donation.
- Pennsylvania requires quarterly reports of assisted reproductive technologies data, including the number of women implanted and the number of eggs fertilized, destroyed, or discarded.

» **END OF LIFE LAWS**

- In Pennsylvania, assisting a suicide is a felony.

» **HEALTHCARE FREEDOM OF CONSCIENCE**

Participation in Abortion

- If an objection is made in writing and is based on religious, moral, or professional grounds, a physician, nurse, staff member, or other employee of a hospital or healthcare facility is not required to participate in abortions and cannot be held liable for refusing to participate. Medical and nursing students are also protected.
- Except for facilities that perform abortions exclusively, each facility that performs abortions must prominently post a notice of the right not to participate in abortions.
- A private hospital or other healthcare facility is not required to perform abortions and may not be held liable for this refusal.
- Pennsylvania also protects healthcare providers who object to providing abortion-inducing drugs.

Participation in Research Harmful to Human Life

- Pennsylvania currently provides no protection for the rights of healthcare providers who conscientiously object to participation in human cloning, destructive embryo research, or other forms of medical research, which violate a provider's moral or religious belief.

» **WHAT HAPPENED IN 2014**

- Pennsylvania adopted a budget which includes \$1,000,000 from the federal Social Services Block Grant to fund alternatives to abortion services.

- The state considered legislation delineating qualifications for individual abortion providers and related to abortion funding.
- Pennsylvania enacted a measure ensuring adequate care for babies determined to have been prenatally exposed to alcohol or illegal substances. The state considered fetal homicide legislation protecting an unborn child from the time of conception.
- In the context of pain management and palliative care, Pennsylvania established a task force on opioid prescription drug proliferation in the state. It also considered legislation explicitly legalizing assisted suicide.

RECOMMENDATIONS

for PENNSYLVANIA

WOMEN'S PROTECTION PROJECT PRIORITIES

- Women's Health Defense Act (5 month abortion limitation)
- Abortion-Inducing Drugs Safety Act
- Parental Involvement Enhancement Act
- Child Protection Act
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- Defunding the Abortion Industry and Advancing Women's Health Act
- Women's Ultrasound Right to Know Act
- Prenatal Nondiscrimination Act

Bioethics

- Human Cloning Prohibition Act
- Prohibition on Public Funding of Human Cloning and Destructive Embryo Research Act

Healthcare Freedom of Conscience

- Healthcare Freedom of Conscience Act



Rhode Island | RANKING: 26

While Rhode Island provides some basic protections for women and minors considering abortion, it allows cloning-for-biomedical-research, making it a “clone-and-kill” state. Moreover, it offers no legal protection for researchers who conscientiously object to such unethical practices.

» ABORTION

- Rhode Island possesses an enforceable abortion prohibition should the U.S. Constitution be amended or certain U.S. Supreme Court decisions be reversed or modified.
- A physician may not perform an abortion on a woman until the physician or the physician’s agent has informed her of the probable gestational age of her unborn child and the nature and risks of the proposed abortion procedure. The woman must also sign a statement indicating she was informed that, if she decides to carry her child to term, she may be able to place the child with either a relative or with another family through foster care or adoption.
- A physician may not perform an abortion on an unemancipated minor under the age of 18 without the consent of one parent unless there is a medical emergency or a minor obtains a court order.
- Rhode Island has a complex system of abortion clinic regulations under which different standards apply at different stages of pregnancy, and different facilities may be used to perform abortions at different stages of gestation.
- “Termination procedures” (non-surgical abortion procedures) must be performed by a licensed physician or “other licensed healthcare practitioner acting within his/her scope of practice.”
- The state has an enforceable abortion reporting law, but does not require the reporting of information to the Centers for Disease Control (CDC). The measure pertains to both surgical and nonsurgical abortions.
- Rhode Island follows the federal standard for Medicaid funding for abortions, permitting the use of federal or state matching Medicaid funds for abortions necessary to preserve the life of the woman or when the pregnancy is the result of rape or incest.
- The state prohibits abortion coverage for public employees (explicitly including city and town employees) except when a woman’s life or health is endangered or in cases of rape or incest.

» **LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN**

- Under Rhode Island law, the killing of an unborn child after “quickening” (discernible movement in the womb) is homicide.
- The state allows a wrongful death (civil) action when a viable unborn child is killed through a negligent or criminal act.
- Any physician, nurse, or other licensed medical provider who knowingly and intentionally fails to provide reasonable medical care and treatment to an infant born alive in the course of an abortion, and as a result the infant dies, is guilty of the crime of manslaughter. Thus, the state has created a specific affirmative duty to provide medical care and treatment to infants born alive at any stage of development.
- The state defines substance abuse during pregnancy as “child abuse” under civil child-welfare statutes. Rhode Island also requires healthcare professionals to report suspected prenatal drug exposure.
- Rhode Island maintains a measure allowing a woman who loses a child after 20 weeks of pregnancy to obtain a “Certificate of Birth Resulting in Still Birth.” The certificate is filed with the state registrar.

» **BIOETHICS LAWS**

- Rhode Island bans cloning-to-produce-children, but not cloning-for-biomedical-research, making it a “clone-and-kill” state. Under a sunset provision in the statute, the prohibition is set to expire on July 7, 2017. The state does not prohibit destructive embryo research.
- Rhode Island bans harmful experimentation on a live human fetus, but allows experimentation on a dead fetus if consent of the mother is obtained.
- Every obstetrical professional or facility is to inform a pregnant woman of the options relating to stem cells that are contained in the umbilical cord blood, and each hospital or other obstetrical facility must cooperate with the collection staff of a cord blood bank designated by the woman and facilitate the donation of the cord blood.
- The state maintains no meaningful regulation of assisted reproductive technologies or human egg harvesting.

» **END OF LIFE LAWS**

- Under Rhode Island law, assisting a suicide is a felony.
- The state maintains a Physician Orders for Life-Sustaining Treatment (POLST) Paradigm Program.

» **HEALTHCARE FREEDOM OF CONSCIENCE**

Participation in Abortion

- A physician or other person associated with, employed by, or on the staff of a healthcare facility who objects in writing and on religious and/or moral grounds is not required to participate in abortions.
- Health insurance plans which provide prescription coverage are also required to provide coverage for contraception. The provision includes a conscience exemption so narrow it excludes the ability of most employers and insurers with moral or religious objections from exercising the exemption.

Participation in Research Harmful to Human Life

- Rhode Island provides no protection for the rights of healthcare providers who conscientiously object to participation in human cloning, destructive embryo research, and other forms of medical research, which violate a provider's moral or religious belief.

» **WHAT HAPPENED IN 2014**

- Rhode Island considered a measure, based on AUL model language, prohibiting sex-selective abortion. It also considered legislation prohibiting partial-birth abortion.
- Rhode Island considered legislation related to coerced or forced abortions, ultrasound requirements, abortion funding, and insurance coverage of abortion.
- Conversely, the state considered draconian legislation aimed at undermining or stigmatizing the work of pregnancy resource centers, as well as legislation protecting the legal "right" to abortion. The state also considered legislation repealing a defunct law requiring spousal notice before abortion.
- Rhode Island established a Palliative Care and Quality of Life Interdisciplinary Advisory Council.

RECOMMENDATIONS

for RHODE ISLAND

WOMEN'S PROTECTION PROJECT PRIORITIES

- Women's Health Defense Act (5 month abortion limitation)
- Reflection period for abortion
- Women's Health Protection Act
- Abortion-Inducing Drugs Safety Act
- Parental Involvement Enhancement Act
- Child Protection Act
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- Federal Abortion-Mandate Opt-Out Act
- Defunding the Abortion Industry and Advancing Women's Health Act
- Women's Ultrasound Right to Know Act
- Coercive Abuse Against Mothers Prevention Act
- Prenatal Nondiscrimination Act

Legal Recognition and Protection for the Unborn

- Crimes Against the Unborn Child Act (providing protection from conception)
- Unborn Wrongful Death Act
- Pregnant Woman's Protection Act

Bioethics

- Human Cloning Prohibition Act
- Destructive Embryo Research Act
- Prohibition on Public Funding of Human Cloning and Destructive Embryo Research Act

Healthcare Freedom of Conscience

- Healthcare Freedom of Conscience Act



South Carolina | RANKING: 21

South Carolina maintains a number of life-affirming laws including comprehensive informed consent requirements and health and safety standards for abortion clinic. In 2014, South Carolina built on previous protections, adopting measures requiring abortion providers to report providers who have hospital admitting privileges and to report abortion complications. However, like many other states, South Carolina has not taken action on human cloning, destructive embryo research, or fetal experimentation.

» ABORTION

- South Carolina prohibits partial-birth abortion.
- South Carolina prohibits abortions after 24 weeks gestation unless the attending physician and another independent physician certify in writing that the abortion is necessary to preserve the woman's life or health. If both physicians certify the abortion is necessary to preserve the woman's mental health, an independent psychiatrist must also certify that the abortion is necessary.
- A physician may not perform an abortion on a woman until 24 hours after she is informed of the probable gestational age of her unborn child, the abortion procedure to be used, and the availability of state-prepared, written materials describing fetal development, listing agencies offering alternatives to abortion, and describing available medical assistance benefits.
- South Carolina requires that a woman be offered an ultrasound and the opportunity to view the image prior to abortion.
- A physician may not perform an abortion on an unemancipated minor under the age of 17 without the informed, written consent of one parent, a grandparent, or any other person who has standing in *loco parentis*, unless there is a medical emergency, the minor is a victim of incest, or the minor obtains a court order.
- South Carolina has enacted comprehensive health and safety regulations for abortion clinics. These regulations are based on national abortion industry standards and cover such areas as clinic administration, physical plant, sanitation standards, patient care, post-operative recovery, and proper maintenance of patient records.
- Only a physician licensed to practice medicine in South Carolina may perform an abortion. Additionally, abortion providers must maintain hospital admitting privileges.
- The state has an enforceable abortion reporting law, but does not require the reporting of information to the Centers for Disease Control (CDC). The law pertains to both

surgical and nonsurgical abortions. In 2014, the state added provisions requiring abortion providers to report whether providers have hospital admitting privileges and to report abortion complications.

- South Carolina follows the federal standard for Medicaid funding for abortions, permitting the use of federal or state matching Medicaid funds for abortions necessary to preserve the life of the woman or when the pregnancy is the result of rape or incest.
- State law provides that no state funds may be expended to perform abortions, except those authorized by Medicaid under federal law. Further, the state maintains the following funding restrictions: money appropriated to the Adolescent Pregnancy Prevention Initiative may not be used for transportation to or from abortion services; state funds appropriated for family planning may not be used to pay for an abortion; the South Carolina Department of Health and Environmental Control and its employees may not provide referral services or counseling for abortion; and funds appropriated under the South Carolina Birth Defects Program may not be used to counsel or refer women for abortions.
- South Carolina prohibits health plans offered through the state's health insurance Exchanges required under the federal healthcare law from including abortion coverage.
- State taxpayer funds appropriated to the State Health Insurance Plan may not be used to pay for an abortion except in cases of rape or incest, or to preserve a woman's life.

» **LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN**

- The *Unborn Victims of Violence Act* provides that the killing of an unborn child at any stage of gestation may be prosecuted as homicide. It also criminalizes a nonfatal assault on an unborn child.
- The state allows a wrongful death (civil) action when a viable unborn child is killed through a negligent or criminal act.
- South Carolina law protects infants who survive abortions.
- South Carolina has a "Baby Moses" law, establishing a safe haven for mothers to legally leave their infants at designated places and ensuring that the infants receive appropriate care and protection.
- The state defines substance abuse during pregnancy as "child abuse" under civil child-welfare statutes.

» **BIOETHICS LAWS**

- South Carolina does not prohibit human cloning, destructive embryo research, or fetal experimentation, nor does it promote ethical forms of research.
- South Carolina does not regulate the provision of assisted reproductive technologies or human egg harvesting.

» END OF LIFE LAWS

- Under South Carolina law, assisted suicide is a felony.

» HEALTHCARE FREEDOM OF CONSCIENCE

Participation in Abortion

- A physician, nurse, technician, or other employee of a hospital, clinic, or physician who objects in writing is not required to recommend, perform, or assist in the performance of an abortion.
- A healthcare provider's conscientious objection to performing or assisting in abortions may not be the basis for liability or discrimination. A person discriminated against in employment may bring a civil action for damages and reinstatement.
- Except in an emergency, a private or nongovernmental hospital or clinic is not required to permit the use of its facilities for the performance of an abortion or to admit a woman for an abortion.
- A hospital's refusal to perform or to permit the performance of abortions within its facility may not be the basis for civil liability.

Participation in Research Harmful to Human Life

- South Carolina currently provides no protection for the rights of healthcare providers who conscientiously object to participation in human cloning, destructive embryo research, and other forms of medical research, which violate a provider's moral or religious belief.

» WHAT HAPPENED IN 2014

- South Carolina adopted a measure requiring abortion providers to report whether they have hospital admitting privileges and to report abortion complications.
- It adopted a budget bill that continues a long-standing provision that prohibits the state employees' health plan from covering abortion except when necessary to save the woman's life or in cases of rape or incest.
- South Carolina considered legislation limiting abortion at 5 months (i.e., 20 weeks) pregnancy and delineating qualifications for individual abortion providers.
- South Carolina introduced a *Pregnant Woman's Protection Act* that included AUL-drafted legislative findings.
- The state considered legislation promoting ethical forms of research.
- South Carolina considered legislation related to pain management and palliative care.

RECOMMENDATIONS

for SOUTH CAROLINA

WOMEN'S PROTECTION PROJECT PRIORITIES

- Women's Health Defense Act (5 month abortion limitation)
- Abortion Patients' Enhanced Safety Act
- Abortion-Inducing Drugs Safety Act
- Parental Involvement Enhancement Act
- Child Protection Act
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- Defunding the Abortion Industry and Advancing Women's Health Act
- Coercive Abuse Against Mothers Prevention Act
- Prenatal Nondiscrimination Act

Legal Recognition and Protection for the Unborn

- Unborn Wrongful Death Act (for a pre-viable child)
- Born-Alive Infant Protection Act
- Pregnant Woman's Protection Act

Bioethics

- Human Cloning Prohibition Act
- Destructive Embryo Research Act
- Prohibition on Public Funding of Human Cloning and Destructive Embryo Research Act

Healthcare Freedom of Conscience

- Healthcare Freedom of Conscience Act



South Dakota | RANKING: 11

South Dakota maintains some of the most comprehensive and protective abortion-related laws in the nation. The state's informed consent requirements, in particular, have received significant national attention. In 2014, South Dakota enacted a prohibition on sex-selective abortions. South Dakota is one of only a small number of states that prohibits destructive embryo research, human cloning for any purpose, and fetal experimentation.

» ABORTION

- South Dakota prohibits partial-birth abortion.
- The state also prohibits sex-selective abortions.
- South Dakota provides that no abortion may be performed after the 24th week of pregnancy unless the procedure is necessary to preserve the woman's life or health.
- South Dakota maintains a law that would "on the date that the states are given the exclusive authority to regulate abortion" ban abortion throughout pregnancy except if necessary to preserve a woman's life. It specifically applies both to surgical and chemical abortions and applies at all stages of pregnancy.
- A physician may not perform an abortion on a woman until at least 72 hours (excluding weekends and holidays) after she has been informed of the probable gestational age of her unborn child, the medical risks of abortion, the medical risks of carrying the pregnancy to term, and the name of the physician who will perform the abortion. She must also be informed about available medical assistance benefits, the father's legal responsibilities, and her right to review additional information prepared by state health department officials.
- South Dakota requires that women be informed that "the abortion will terminate the life of a whole, separate, unique, living human being;" that the woman "has an existing relationship with the unborn human being and that the relationship enjoys protection under the United States Constitution and under the laws of South Dakota;" and that "by having an abortion her existing relationship and her existing constitutional rights with regards to that relationship will be terminated."
- In 2012, the Eighth Circuit upheld *en banc* South Dakota's requirement that a woman be informed of the risk of suicide and suicide ideation following abortion.
- South Dakota requires that a woman be offered an ultrasound and the opportunity to view the image prior to undergoing an abortion. The law also requires that abortion

providers report the number of women who undergo abortions after choosing to view the ultrasound.

- A physician must perform an assessment of a woman's medical and personal circumstances prior to an abortion. Moreover, a woman exhibiting certain risk factors must receive counseling about mental health risks associated with abortion.
- A 2011 law requiring that a woman consult with a "pregnancy help center" before undergoing an abortion is in litigation. In 2012, the law was amended to require pregnancy help centers (or pregnancy resource centers) to have licensed medical and mental health professionals on staff.
- South Dakota law provides that it is a physician's common law duty to determine that the woman's consent is not coerced, and that he or she must assess whether the woman is being coerced into seeking an abortion.
- Abortion providers must also screen women for coercion and inform them that they cannot be forced to have an abortion because of the child's gender. Providers must post signs informing a woman that she cannot be coerced into undergoing a sex-selective abortion.
- State-prepared, written informed consent materials must include information that sex-selective abortions are illegal.
- A physician may not perform an abortion on an unemancipated minor under the age of 18 until at least 48 hours after providing written notice to one parent or after obtaining a court order. South Dakota also requires parental notification within 24 hours after the performance of an "emergency abortion" on a minor; however, an exception to the requirement is permitted if a minor indicates that she will seek a judicial bypass.
- South Dakota requires that all abortion clinics in the state meet minimum health and safety standards. Further, second-trimester abortions (beginning at 14 weeks and 6 days gestation) must "be performed in a hospital, or if one is not available, in a licensed physician's medical clinic or office of practice subject to the requirements of §34-23A-6 [blood supply requirements]."
- Only a physician licensed by the state or a physician practicing medicine or osteopathy and employed by the state or the United States may perform an abortion. Further, the state medical board prohibits physician assistants and nurses from entering into practice agreements under which they may perform abortions.
- No surgical or medical abortion may be scheduled except by a licensed physician and only after the physician physically and personally meets with the pregnant woman, consults with her, and performs an assessment of her medical and personal circumstances.
- For each abortion performed, an abortion provider must complete a reporting form mandated and provided by the South Dakota Department of Health. The required

information includes: (1) the method of abortion; (2) the approximate gestational age of the fetus; (3) the specific reason for the abortion; (4) the entity, if any, that paid for the abortion; (5) a description of any complications from the abortion; (6) the method used to dispose of fetal tissue; (7) the specialty area of the attending physician; (8) whether the attending physician has been subject to license revocation, suspension, or other professional sanction; (9) the number of previous abortions the woman has had; (10) the number of previous live births of the woman; (11) whether the woman received the RH test and tested positive for the RH-negative factor; and (12) the marital and educational status and race of the woman. The provision applies to both surgical and nonsurgical abortions, but does not require that any information be reported to the Centers for Disease Control (CDC). In 2014, the state amended its current law to mandate details on the sex of the unborn child.

- South Dakota prohibits public funding for abortion unless the procedure is necessary to preserve the woman's life (in contravention of federal law).
- South Dakota prohibits health plans offered through the state's health insurance Exchanges required under the federal healthcare law from including abortion coverage.
- The state offers "Choose Life" license plates, the proceeds of which benefit pregnancy resource centers and/or other organizations providing abortion alternatives.
- The state Department of Health must maintain a registry of state "pregnancy help centers." A center seeking to be listed on the registry must certify that it has a licensed medical director and that the center does not perform abortions, has no affiliation with any organization or physician that performs abortion, and that it does not refer women for abortions. The law excludes agencies that place children for adoption from the registry.

» **LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN**

- Under South Dakota law, the killing of an unborn child at any stage of gestation is defined as a form of homicide.
- South Dakota defines a nonfatal assault on an unborn child as a crime.
- The state allows a wrongful death (civil) action when an unborn child at any stage of development is killed through a negligent or criminal act.
- The state has created a specific affirmative duty for physicians to provide medical care and treatment to an infant born alive at any stage of development.
- The state defines substance abuse during pregnancy as "child abuse" under civil child-welfare statutes.
- South Dakota maintains a measure allowing a woman who loses a child after 20 weeks gestation to obtain a "Certificate of Birth Resulting in a Stillbirth."

» **BIOETHICS LAWS**

- South Dakota bans human cloning for any purpose, destructive embryo research, and fetal experimentation.
- The state does not promote ethical forms of research.
- South Dakota maintains no meaningful regulation of assisted reproductive technologies or human egg harvesting.

» **END OF LIFE LAWS**

- Assisted suicide is a felony in South Dakota.

» **HEALTHCARE FREEDOM OF CONSCIENCE**

Participation in Abortion

- South Dakota law protects the rights of physicians, nurses, counselors, social workers, and other persons to refuse to perform, assist in, provide referrals for, or counsel for abortions.
- A healthcare provider's conscientious objection to performing or assisting in an abortion may not be a basis for liability, dismissal, or other prejudicial actions by a hospital or medical facility with which the person is affiliated or employed.
- A counselor, social worker, or other person in a position to address "the abortion question . . . as part of [the] workday routine" who objects to providing abortion advice or assistance may not be held liable to any person or subject to retaliation by an institution with which the person is affiliated or employed.
- No hospital is required to admit a woman for the purpose of abortion. The refusal of a hospital to participate in abortions may not be a basis for liability.
- A pharmacist is not required to dispense medication if there is reason to believe the medication would be used to cause an abortion.

Participation in Research Harmful to Human Life

- South Dakota currently provides no specific protection for the rights of healthcare providers who conscientiously object to participation in human cloning, destructive embryo research, or other forms of medical research, which violate a provider's moral or religious belief.

» **WHAT HAPPENED IN 2014**

- South Dakota enacted a prohibition on sex-selective abortions based on AUL model language, while also considering legislation prohibiting an abortion sought because the unborn child has been diagnosed with Down syndrome.

- As part of the sex-selective abortion prohibition, it enacted a provision mandating reporting on the sex/gender of the unborn child. It also enacted a separate requirement that an abortion provider screen a woman for coercion, inform her that she cannot be forced to have an abortion because of her child's gender, and post signs informing a woman that she cannot be coerced into undergoing a sex-selective abortion and that sex-selective abortions are illegal.
- South Dakota enacted legislation requiring the state Department of Health to maintain a registry of state "pregnancy help centers." A center seeking to be listed on the registry must certify that it has a licensed medical director and that the center does not perform abortions, has no affiliation with any organization or physician that performs abortion, and that it does not refer women for abortions. The law excludes agencies that place children for adoption from the registry.
- It also considered legislation related to abortion funding.

RECOMMENDATIONS

for SOUTH DAKOTA

WOMEN'S PROTECTION PROJECT PRIORITIES

- Women's Health Defense Act (5 month abortion limitation)
- Abortion Patients' Enhanced Safety Act
- Parental Consent for Abortion Act
- Parental Involvement Enhancement Act
- Child Protection Act
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- Defunding the Abortion Industry and Advancing Women's Health Act
- Coercive Abuse Against Mothers Prevention Act

Legal Recognition and Protection for the Unborn

- Crimes Against the Unborn Child Act
- Unborn Wrongful Death Act (for a pre-viable child)
- Born-Alive Infant Protection Act
- Pregnant Woman's Protection Act

Bioethics

- Assisted Reproductive Technologies Disclosure and Risk Reduction Act

Healthcare Freedom of Conscience

- Healthcare Freedom of Conscience Act



Tennessee | RANKING: 23

The Tennessee Supreme Court has read a state constitutional right to abortion into the state constitution, hampering recent efforts to enact many commonsense abortion regulations. Efforts continue to override this judicial fiat and return decisions on abortion law and policy to the citizens of Tennessee and their elected representatives. [Since the time these rankings were established based on data available on August 15, 2014, the voters of Tennessee passed Amendment 1 to the Tennessee Constitution rendering the Constitution “neutral” on abortion and enabling the State to enact commonsense abortion regulations, including health and safety standards to protect women.]

» ABORTION

- The Tennessee Supreme Court has read a constitutional right to abortion into the state constitution [*as of August 15, 2014*]. This right is deemed to be broader than that interpreted in the U.S. Constitution.
- Tennessee prohibits partial-birth abortion.
- No abortion may be performed after viability unless necessary to preserve the woman’s life or health.
- Tennessee’s informed consent law is enjoined.
- Abortion facilities must post signs indicating that a woman cannot be “pressured, forced or coerced” to have an abortion against her will.
- A physician may not perform an abortion on an unemancipated minor under the age of 18 without the written consent of one parent unless there is a medical emergency, the minor is the victim of incest, or the minor obtains a court order.
- A federal district court has declared Tennessee’s abortion clinic regulations unconstitutional (as applied to the particular abortion provider who challenged the law).
- Only a physician licensed or certified by the state may perform an abortion. Tennessee law provides that a nurse practitioner or physician’s assistant may not write or sign a prescription, dispense any drug or medication, or perform any procedure involving a drug or medication whose sole purpose is to cause an abortion.
- Tennessee also requires abortion providers to have admitting privileges at a hospital located in the same county as the abortion facility or in an adjacent county.
- The state has an enforceable abortion reporting law, but does not require the reporting of information to the Centers for Disease Control (CDC).

- No licensed physician may perform or attempt to perform any abortion, including a chemical abortion, or prescribe any drug or device intended to cause a medical abortion, except in the physical presence of the pregnant woman, effectively prohibiting “telemed abortions.”
- Tennessee follows the federal standard for Medicaid funding for abortions, permitting the use of federal or state matching Medicaid funds for abortions necessary to preserve the life of the woman or when the pregnancy is the result of rape or incest.
- Tennessee prohibits the use of funds for abortion or abortion research within the state Genetic Testing Program.
- Tennessee law provides that all federal money sent to the state for family planning services will be used fully by government-run health agencies, and none will be paid to third-party providers or private organizations or entities. This law prevents abortion providers from obtaining family planning funds.
- The state prohibits insurance companies from offering abortion coverage within state insurance Exchanges established pursuant to the federal healthcare law.
- Tennessee provides funding to pregnancy resource centers through a “Choose Life” specialty license plate program.

» **LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN**

- Tennessee law includes an unborn child at any point in gestation as a potential victim of homicide.
- Tennessee law provides for enhanced penalties for murdering a pregnant woman.
- The state allows a wrongful death (civil) action only when an unborn child is born alive following a negligent or criminal act and dies thereafter.
- The state has created a specific affirmative duty for physicians to provide medical care and treatment to an infant born alive at any stage of development.
- Tennessee has a “Baby Moses” law, establishing a safe haven for mothers to legally leave their infants at designated places and ensuring that the infants receive appropriate care and protection.
- Tennessee law provides for the prosecution of women for alcohol or drug abuse while pregnant.
- Tennessee requires publicly-funded substance abuse facilities to give preference to pregnant women and requires any facility capable of accommodating a pregnant woman to provide such treatment. The law also prohibits state officials from filing for protective services for the child if the mother is less than 5 months (*i.e.*, 20 weeks) into her pregnancy and seeks substance abuse treatment as part of her prenatal care.
- Tennessee law provides for a “Certificate of Birth Resulting in Stillbirth.”

» **BIOETHICS LAWS**

- Tennessee does not prohibit human cloning or destructive embryo research. Further, the state allows fetal experimentation with the consent of the mother.
- The state Department of Health encourages healthcare professionals to provide pregnant women with a publication containing information on cord blood banking.
- Tennessee maintains no meaningful regulation of assisted reproductive technologies or human egg harvesting.
- However, the state provides for the relinquishment of rights to an embryo (*i.e.*, embryo adoption).

» **END OF LIFE LAWS**

- Assisted suicide is a felony in Tennessee.
- The state maintains a Physician Orders for Life-Sustaining Treatment (POLST) Paradigm Program.

» **HEALTHCARE FREEDOM OF CONSCIENCE**

Participation in Abortion

- A physician is not required to perform an abortion and no person may be required to participate in the performance of an abortion.
- A hospital is not required to permit the performance of an abortion within its facilities.

Participation in Research Harmful to Human Life

- Tennessee currently provides no protection for the rights of healthcare providers who conscientiously object to participation in human cloning, destructive embryo research, or other forms of medical research, which violate a provider's moral or religious belief.

» **WHAT HAPPENED IN 2014**

- Tennessee enacted a measure permitting women to be prosecuted for alcohol or drug abuse while pregnant.
- It enacted measures regulating pain management clinics and supporting access to patient-centered and family-focused palliative care.
- Tennessee also considered legislation related to advance planning documents.

RECOMMENDATIONS

for TENNESSEE

WOMEN'S PROTECTION PROJECT PRIORITIES

- Women's Health Defense Act (5 month abortion limitation)
- Women's Right to Know Act with reflection period
- Abortion Patients' Enhanced Safety Act
- Abortion-Inducing Drugs Safety Act
- Parental Involvement Enhancement Act
- Components of the Child Protection Act related to mandatory reporting of suspected child abuse and providing remedies for interference with parental rights
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- Women's Ultrasound Right to Know Law
- Prenatal Nondiscrimination Act

Legal Recognition and Protection for the Unborn

- Unborn Wrongful Death Act
- Pregnant Woman's Protection Act

Bioethics

- Human Cloning Prohibition Act
- Destructive Embryo Research Act
- Prohibition on Public Funding of Human Cloning and Destructive Embryo Research Act

Healthcare Freedom of Conscience

- Healthcare Freedom of Conscience Act



Texas | RANKING: 10

As a result of aggressive legislative action over the past several years, Texas has become one of the most protective states in the nation. Recent legislative gains in Texas were affirmed in 2014, when the Fifth Circuit upheld portions of a 2013 omnibus abortion bill requiring abortion providers to have admitting privileges at local hospitals and regulating the administration of abortion-inducing drugs.

» ABORTION

- Texas prohibits abortion at 5 months (i.e., 20 weeks) development based upon medical evidence that an unborn child at that stage can feel pain.
- Another law provides that third-trimester abortion may not be performed on a viable fetus unless necessary to preserve the woman's life or prevent a "substantial risk of serious impairment" to her physical or mental health, or if the fetus has a severe and irreversible abnormality. An additional law provides that a third-trimester abortion may not be performed on a viable fetus unless necessary to prevent "severe, irreversible brain damage" to the woman, paralysis, or if the fetus has a severe and irreversible "brain impairment."
- Texas possesses an enforceable abortion prohibition should the U.S. Constitution be amended or certain U.S. Supreme Court decisions be reversed or modified.
- A physician may not perform an abortion on a woman until at least 24 hours after obtaining her informed consent and after informing her of the nature and risks of the proposed abortion procedure, including the gestational development of the unborn child and available assistance from both public and private agencies. The counseling must be in-person if a woman lives within 100 miles of the abortion facility.
- The state also explicitly requires a physician to inform a woman seeking abortion of the abortion-breast cancer link.
- Texas requires the performance of an ultrasound before an abortion. The abortion provider must display the ultrasound image, make audible the heart auscultation, and provide a medical description of the images depicted in the ultrasound image.
- Texas prohibits insurance companies from coercing a woman's abortion decision through force or by threatening adverse alteration to an insurance plan.
- A physician may not perform an abortion on an unemancipated minor under the age of 18 without the written, notarized consent of one parent or a guardian, unless there is a medical emergency or the minor obtains a court order.

- Abortion clinics must meet the same patient care standards as other facilities performing outpatient surgeries. The law is currently in litigation.
- Only a physician licensed in Texas may perform an abortion. A provision requiring abortion providers to maintain hospital admitting privileges is in litigation.
- The state has an enforceable abortion reporting law, but does not require the reporting of information to the Centers for Disease Control (CDC). The measure pertains to both surgical and nonsurgical abortions and requires abortion providers to report deaths that occur in their facilities as a result of abortion, as well as short-term complications.
- Texas requires that physicians providing “medical abortion” be able to do the following: accurately date a pregnancy, determine that the pregnancy is not ectopic, and provide surgical intervention or provide for the patient to receive a surgical abortion. The patient must be examined by a physician and informed of the risks and benefits of the procedure and the possibility that a surgical abortion may be required. A 2013 law requiring a physician to examine a woman before dispensing abortion-inducing drugs and requiring the physician to follow a certain protocol has been upheld by the Fifth Circuit Court of Appeals.
- Texas follows the federal standard for Medicaid funding for abortions, permitting the use of federal or state matching Medicaid funds for abortions necessary to preserve the life of the woman or when the pregnancy is the result of rape or incest.
- The Texas Supreme Court has upheld a law limiting taxpayer assistance for abortion to cases where the abortion is necessary to preserve a woman’s life or when the pregnancy is the result of rape or incest.
- Funds administered under the Maternal and Infant Health Improvement Program for Women and Children cannot be used for abortions, except in cases of life endangerment.
- State agencies may not contract with entities that perform or promote elective abortions or are affiliates of entities that perform or promote elective abortions under a Women’s Health Care Services project (family planning funding).
- Texas has enacted laws prohibiting state contracts with entities that perform elective abortions. The restrictions have been challenged in state court but remain in force while the lawsuit proceeds.
- Texas continues to allocate millions of dollars to the mission of pregnancy resource centers and others providing abortion alternatives.
- The state maintains a “Choose Life” license plate program, the proceeds of which benefit abortion alternatives.

» LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN

- Under Texas law, the killing of an unborn child at any stage of gestation is defined as a form of homicide.
- Texas defines a nonfatal assault on an unborn child as a criminal offense.
- Texas allows parents and other relatives to bring a wrongful death (civil) lawsuit when an unborn child at any stage of development is killed through the negligence or criminal act of another.
- Under Texas law, a “living human child born alive after an abortion or premature birth is entitled to the same rights, powers and privileges as are granted by the laws of [Texas] to any other child born alive after the normal gestational period.” Thus, the state has created a specific affirmative duty of physicians to provide medical care and treatment to infants born alive at any stage of development.
- The state defines substance abuse during pregnancy as “child abuse” under civil child-welfare statutes. The state has also created a task force charged, in part, with advising on potential criminal liability for a woman who exposes her unborn child to controlled substances.

» BIOETHICS LAWS

- Texas does not prohibit human cloning or destructive embryo research. Further, it does not prohibit fetal experimentation outright, but it does include “fetal tissue” in its ban on the sale or transfer of “human organs.”
- However, in 2009 Texas appropriated \$5 million in state funding for adult stem-cell research, and in 2013 the state created a body to provide grants or funds for ethical research.
- The state Department of State Health Services publishes a brochure related to umbilical cord blood donation, and physicians are to provide the brochure to their pregnant patients.
- Texas law provides that blood obtained by a blood bank may be used for the collection of adult stem cells if the donor consents, and allows hospitals to use adult stem cells if certain conditions are met.
- Texas maintains no meaningful regulation of assisted reproductive technologies or human egg harvesting, but the Uniform Parentage Act includes the “donation of embryos” in its definition of “assisted reproduction.”

» END OF LIFE LAWS

- Assisted suicide is a felony in Texas.

» **HEALTHCARE FREEDOM OF CONSCIENCE**

Participation in Abortion

- A physician, nurse, staff member, or employee of a hospital who objects to participating directly or indirectly in an abortion may not be required to participate in an abortion.
- A healthcare provider's conscientious objection to participating in abortions may not be a basis for discrimination in employment or education. A person whose rights are violated may bring an action for relief, including back pay and reinstatement.
- A private hospital or healthcare facility is not required to make its facilities available for the performance of an abortion unless a physician determines that the woman's life is immediately endangered.

Participation in Research Harmful to Human Life

- Texas currently provides no protection for the rights of healthcare providers who conscientiously object to participation in human cloning, destructive embryo research, or other forms of medical research, which violate a provider's moral or religious belief.

» **WHAT HAPPENED IN 2014**

- Texas did not hold a regular legislative session in 2014.
- In *Planned Parenthood v. Abbott*, the Fifth Circuit upheld a requirement that abortion providers maintain admitting privileges at local hospitals and a provision regulating the administration of abortion-inducing drugs. Planned Parenthood has filed a second challenge to the admitting privileges requirement and a requirement requiring abortion clinics to meet the same health and safety standards as ambulatory surgical centers.

RECOMMENDATIONS

for TEXAS

WOMEN'S PROTECTION PROJECT PRIORITIES

- Parental Involvement Enhancement Act
- Components of the Child Protection Act related to evidence retention and remedies for third-party interference with parental rights
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- Women's Ultrasound Right to Know Law
- Prenatal Nondiscrimination Act

Legal Recognition and Protection for the Unborn

- Unborn Wrongful Death Act
- Pregnant Woman's Protection Act

Bioethics

- Human Cloning Prohibition Act
- Destructive Embryo Research Act
- Prohibition on Public Funding of Human Cloning and Destructive Embryo Research Act

Healthcare Freedom of Conscience

- Healthcare Freedom of Conscience Act



Utah | RANKING: 28

In recent years, Utah has enacted several pieces of commonsense legislation designed to protect women and the unborn from the harms inherent in abortion, fulfilling the public policy of the state “to encourage all persons to respect the right to life.” Much work remains to be done, however, in the field of biotechnologies. Utah does not prohibit human cloning, destructive embryo research, or fetal experimentation, nor does it promote ethical alternatives to destructive embryo research or provide any meaningful regulation of assisted reproductive technologies.

» ABORTION

- The Utah legislature has resolved that “it is the finding and policy of the Legislature... that unborn children have inherent and inalienable rights that are entitled to protection by the state of Utah pursuant to the provisions of the Utah Constitution... The state of Utah has a compelling interest in the protection of the lives of unborn children...It is the intent of the Legislature to protect and guarantee to unborn children their inherent and inalienable right to life....”
- Moreover, the legislature has found and declared that “it is the public policy of this state to encourage all persons to respect the right to life of all other persons, regardless of age, development, condition or dependency, including all...unborn persons.”
- Utah prohibits partial-birth abortion throughout pregnancy under a law which has been litigated and upheld in federal court. Although modeled after the federal ban, Utah’s law provides harsher penalties.
- Utah prohibits post-viability abortions except in cases of life endangerment, “serious risk of substantial and irreversible impairment of a major bodily function,” severe fetal abnormality as certified by two physicians, or rape or incest reported to the police. Performing a prohibited abortion is a felony.
- A physician may not perform an abortion on a woman until at least 72 hours after informing her, in a face-to-face consultation, of the probable gestational age of her unborn child; fetal development; the nature of, risks of, and alternatives to the proposed abortion procedure; that adoptive parents may legally pay the costs of prenatal care; and the medical risks of carrying the pregnancy to term.
- If an ultrasound is performed before an abortion, the abortion provider must offer to show it to the woman. The ultrasound provision is waived if there is a medical emergency or if two physicians who practice maternal-fetal medicine concur, in

writing in the patient's medical record, that the unborn child has a defect that is uniformly diagnosable and uniformly lethal.

- Additionally, Utah requires that a woman seeking abortion at 5 months or 20 weeks gestation or later be offered anesthesia for the unborn child (because of the pain experience by a child by this stage of development).
- Utah prohibits and criminalizes acts intended to coerce a woman into undergoing an abortion. The state also requires abortion providers to affirmatively state in printed materials that it is illegal for someone to coerce a woman into having an abortion.
- A physician may not perform an abortion on a minor until the physician obtains the consent of one parent or guardian, unless there is a medical emergency or a minor obtains a court order.
- Utah mandates comprehensive health and safety regulations and an annual licensing requirement for abortion clinics that provide abortions during the first and second trimesters of pregnancy.
- Only a physician or osteopathic physician licensed by the state to practice medicine may perform an abortion. Further, abortion providers must maintain hospital admitting privileges.
- The state has an enforceable abortion reporting law, but does not require the reporting of information to the Centers for Disease Control (CDC). The measure pertains to both surgical and nonsurgical abortions.
- Utah funds abortions for women eligible for public assistance when necessary to preserve the woman's life, the woman's physical health is threatened by a continued pregnancy, or the pregnancy is the result of rape or incest.
- No agency of the state or its political subdivisions may approve any application for funds of the state or its political subdivisions to directly or indirectly support any organization or healthcare provider that provides abortion services to unmarried minors without written consent of a minor's parent or guardian.
- The state prohibits insurance companies from offering abortion coverage within state insurance Exchanges established pursuant to the federal healthcare law, except in cases of life endangerment, serious risk of substantial and irreversible impairment of major bodily function, lethal defect of the unborn baby, rape, or incest.
- Utah also prohibits private insurance companies from covering abortion, except in cases of life endangerment, serious risk of substantial and irreversible impairment of major bodily function, lethal defect of the unborn baby, rape, or incest.
- Utah has authorized "Choose Life" license plates, the proceeds of which benefit abortion alternatives.

» LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN

- Under Utah law, the killing of an unborn child at any stage of gestation is defined as a form of homicide.
- The state allows a wrongful death (civil) action only when an unborn child is born alive following a negligent or criminal action and dies thereafter.
- Utah has a “Baby Moses” law, establishing a safe haven for mothers to legally leave their infants at designated places and ensuring the infants receive appropriate care and protection.
- Utah requires substance abuse treatment programs receiving public funds to give priority admission to pregnant women and teenagers. The state also requires healthcare professionals to report suspected prenatal drug exposure.
- Utah Human Services, Child and Family Services Agency regulations include exposure to alcohol or other “harmful” substances in utero in the state’s definitions of “abuse,” “neglect,” and “dependency.”
- The state has removed prohibitions (in certain cases) on the prosecution of a woman for killing her unborn child.

» BIOETHICS LAWS

- Utah does not prohibit human cloning, destructive embryo research, or fetal experimentation.
- The state does not promote ethical alternatives to destructive embryo research.
- Utah does not provide any meaningful regulation of assisted reproductive technologies or human egg harvesting. Further, state law contains provisions authorizing gestational agreements.
- The Uniform Parentage Act includes “donation of embryos” in its definition of “assisted reproduction.”

» END OF LIFE LAWS

- Utah does not have a specific statute criminalizing assisted suicide. Thus, the legal status of assisted suicide in Utah is currently indeterminable.

» HEALTHCARE FREEDOM OF CONSCIENCE***Participation in Abortion***

- A healthcare provider who objects on religious or moral grounds is not required to participate in abortions.

- A healthcare facility is not required to admit a woman for the performance of an abortion.
- A healthcare provider or healthcare facility's conscientious objection to participating in abortion may not be a basis for civil liability or other recriminatory action.
- Moral or religious objections to abortion may not be a basis for discrimination including dismissal, demotion, suspension, discipline, harassment, retaliation, adverse change in status, termination of, adverse alteration of, or refusal to renew an association or agreement; or refusal to provide a benefit, privilege, raise, promotion, tenure, or increased status that the healthcare provider would have otherwise received. Importantly, Utah provides a private right of action for discrimination, providing equitable relief including reinstatement and damages.

Participation in Research Harmful to Human Life

- Utah currently provides no protection for the rights of healthcare providers who conscientiously object to participation in human cloning, destructive embryo research, or other forms of medical research, which violate a provider's moral or religious belief.

» WHAT HAPPENED IN 2014

- Utah enacted a measure amending its informed consent law to create exceptions if 1) the treating physician and one other physician concur, in writing, that an abortion is necessary to avert the woman's death or a serious risk of substantial and irreversible impairment of a major bodily function; or 2) two physicians who practice maternal-fetal medicine concur, in writing in the patient's medical record, that the unborn child has a defect that is uniformly diagnosable and uniformly lethal. Similarly, it enacted a measure waiving its ultrasound requirement if 1) the treating physician and one other physician concur, in writing, that an abortion is necessary to avert the woman's death or a serious risk of substantial and irreversible impairment of a major bodily function; or 2) two physicians who practice maternal-fetal medicine concur, in writing in the patient's medical record, that the unborn child has a defect that is uniformly diagnosable and uniformly lethal.
- Utah enacted a measure outlining the fees that abortion facilities (and other entities) must pay to the state government.
- The state enacted a measure related to the provision of health insurance coverage for infertility treatment.

RECOMMENDATIONS

for UTAH

WOMEN'S PROTECTION PROJECT PRIORITIES

- Women's Health Defense Act (5 month abortion limitation)
- Abortion Patients' Enhanced Safety Act
- Abortion-Inducing Drugs Safety Act
- Parental Involvement Enhancement Act
- Child Protection Act
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- Defunding the Abortion Industry and Advancing Women's Health Act
- Prenatal Nondiscrimination Act

Legal Recognition and Protection for the Unborn

- Unborn Wrongful Death Act
- Born-Alive Infant Protection Act

Bioethics

- Human Cloning Prohibition Act
- Destructive Embryo Research Act
- Prohibition on Public Funding of Human Cloning and Destructive Embryo Research Act

Healthcare Freedom of Conscience

- Healthcare Freedom of Conscience Act



Vermont | RANKING: 49

Vermont lacks the most basic legal protections for women considering abortion, for unborn victims of criminal violence, and for nascent human life. Further, Vermont has legalized physician-assisted suicide and is one of only a few states that does not protect healthcare freedom of conscience.

» ABORTION

- The Vermont Constitution has been construed to provide a broader right to abortion than interpreted in the U.S. Constitution.
- Further, the Vermont legislature has resolved that “it is critical for the... personal health and happiness of American women, that the right of women... to make their own personal medical decisions about reproductive and gynecological issues be vigilantly preserved and protected.... This legislative body reaffirms the right of every Vermont woman to privacy, autonomy, and safety in making personal decisions regarding reproduction and family planning....”
- Vermont allows abortions after viability, even in cases where the mother’s life or health is not endangered.
- Vermont does not provide even rudimentary protection for women or minors considering abortions. The state does not have an informed consent law, ultrasound requirement, parental involvement law for minors seeking abortions, abortion clinic regulations, or a prohibition on anyone other than a licensed physician performing an abortion.
- The state has an enforceable abortion reporting law, but does not require the reporting of information to the Centers for Disease Control (CDC). The measure pertains to both surgical and nonsurgical abortions.
- Vermont taxpayers fund “medically necessary” abortions for women receiving public assistance. This requirement essentially equates to funding abortion-on-demand in light of the U.S. Supreme Court’s broad definition of “health” in the context of abortion.

» LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN

- Vermont law does not recognize an unborn child as a potential homicide or assault victim.

- The state allows a wrongful death (civil) action when a viable unborn child is killed through a negligent or criminal act.
- Vermont does not require infants who survive abortions to be given appropriate, potentially life-saving medical care.
- Vermont's *Baby Safe Haven Law* allows mothers to legally leave their infants at designated places and ensures the infants receive appropriate care and protection. The state permits a person or facility receiving an infant to not reveal the identity of the person relinquishing the child unless there is suspected abuse.

» **BIOETHICS LAWS**

- Vermont does not prohibit or limit human cloning, destructive embryo research, or fetal experimentation.
- The state does not promote ethical alternatives to destructive embryo research.
- Vermont does not regulate assisted reproductive technologies or human egg harvesting.

» **END OF LIFE LAWS**

- Physician-assisted suicide is legal in Vermont. Importantly, the law fails to include some of the most basic legal protections for those considering physician-assisted suicide. A physician who has only examined a patient once is permitted to prescribe life-ending drugs to the patient. The physician is not required to refer the patient for an evaluation by a psychiatrist to determine if the patient is depressed or being coerced to end his or her life. Further, the law does not require witnesses to be present when the patient takes a life-ending medication, increasing the possibility that persons who may wish to hasten a patient's death might be with the patient and pressure the patient to end his or her life or even administer the lethal drugs instead of the patient.
- Vermont requires the state Department of Health to provide an annual report on end of life care and pain management. The state also has a "Patient's Bill of Rights for Palliative Care and Pain Management" to ensure that healthcare providers inform patients of all of their treatment options.
- The state maintains a Physician Orders for Life-Sustaining Treatment (POLST) Paradigm Program.

» **HEALTHCARE FREEDOM OF CONSCIENCE**

Participation in Abortion

- Vermont currently provides no protection for the rights of conscience of healthcare providers who conscientiously object to participating or assisting in abortions or any other healthcare procedure.

Participation in Research Harmful to Human Life

- Vermont currently provides no protection for the rights of healthcare providers who conscientiously object to participation in human cloning, destructive embryo research, or other forms of medical research, which violate a provider's moral or religious belief.

» WHAT HAPPENED IN 2014

- Vermont repealed its pre-Roe abortion prohibition and considered further legislation protecting the legal "right" to abortion.
- It established a pain management advisory council.
- Vermont considered a number of other end of life measures including a measure providing immunity to physicians and pharmacists who comply with the state's assisted suicide law; a modification to its Physician Orders for Life-Sustaining Treatment (POLST) Paradigm program; and legislation that would permit a surrogate decision maker to provide informed consent for a "Do Not Resuscitate" order, a clinician order for life-sustaining treatment, or hospice care on behalf of a patient, but not assisted suicide.

RECOMMENDATIONS

for VERMONT

WOMEN'S PROTECTION PROJECT PRIORITIES

- Women's Health Defense Act (5 month abortion limitation)
- Women's Right to Know Act with reflection period
- Abortion Patients' Enhanced Safety Act
- Abortion-Inducing Drugs Safety Act
- Parental Notification for Abortion Act
- Child Protection Act
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- State Constitutional Amendment (providing there is no state constitutional right to abortion)
- Federal Abortion-Mandate Opt-Out Act
- Defunding the Abortion Industry and Advancing Women's Health Act
- Women's Ultrasound Right to Know Act
- Coercive Abuse Against Mothers Prevention Act
- Prenatal Nondiscrimination Act

Legal Recognition and Protection for the Unborn

- Crimes Against the Unborn Child Act
- Unborn Wrongful Death Act
- Born-Alive Infant Protection Act
- Pregnant Woman's Protection Act

Bioethics

- Human Cloning Prohibition Act
- Destructive Embryo Research Act
- Prohibition on Public Funding of Human Cloning and Destructive Embryo Research Act

End of Life

- Repeal Physician Assisted Suicide Law and Enact Assisted Suicide Ban Act

Healthcare Freedom of Conscience

- Healthcare Freedom of Conscience Act



Virginia | RANKING: 19

Virginia provides fairly comprehensive protection for women, the unborn, and newly born children. It is also one of only a small number of states that has enacted meaningful, protective regulations for emerging biotechnologies. For example, the state bans human cloning for all purposes and maintains an umbilical cord blood bank and related educational initiatives. In 2014, Virginia rejected multiple measures that would have weakened the state's ultrasound and informed consent requirements, but, at the behest of Governor McAuliffe, state officials are reviewing and considering changes to the state's requirement that abortion facilities meet the same health and safety standards as other facilities performing outpatient surgeries.

» ABORTION

- Virginia prohibits “partial-birth infanticide” (i.e., partial-birth abortion).
- A third-trimester abortion may not be performed unless the attending physician and two other physicians certify in writing that continuation of the pregnancy is likely to result in the woman’s death or would “substantially and irretrievably impair” the woman’s physical or mental health. Further, measures for life support for the unborn child “must be available and utilized if there is any clearly visible evidence of viability.”
- A physician may not perform an abortion on a woman until at least 24 hours after the woman is provided with in-person counseling, including “a full, reasonable, and comprehensible medical explanation of the nature, benefits, risks of and alternatives to abortion;” the probable gestational age of her unborn child; and descriptions of available assistance and benefits, agencies and organizations providing alternatives to abortion, and the father’s legal responsibilities.
- Virginia requires that a woman undergo an ultrasound and have the opportunity to view the images prior to an abortion.
- A physician may not perform an abortion on an unemancipated minor under the age of 18 until he or she secures written consent from one parent or “authorized person” who has care and control of the minor, unless the minor is the victim of rape, incest, or child abuse; there is a medical emergency; or the minor secures a court order.
- Virginia regulates any facility in which five or more first trimester abortions per month are performed as a category of “hospital.” Regulations implemented by the Virginia Board of Health are in litigation.
- The state also requires that second-trimester abortions be performed in a hospital or

ambulatory surgical center. The U.S. Supreme Court has upheld the constitutionality of this requirement.

- Only a physician licensed by the state to practice medicine and surgery may perform an abortion.
- The state has an enforceable abortion reporting law, but does not require the reporting of information to the Centers for Disease Control (CDC). The measure pertains to both surgical and nonsurgical abortions.
- The state provides funding for women eligible for public assistance for abortions only in cases of rape, incest, fetal abnormality, or when the life of the mother is in jeopardy.
- No expenditures from general or non-general fund sources may be made out of any appropriations by the General Assembly for providing abortion services, except as otherwise required by federal law or state statute.
- No postpartum family planning funds provided to women under the state’s Medicaid program may be used to make direct referrals for abortion.
- The state prohibits insurance companies from offering abortion coverage within state insurance Exchanges established pursuant to the federal healthcare law, except in cases of life endangerment, rape, or incest.
- Benefits provided to state employees through the Commonwealth of Virginia Health Benefits Plan may not provide coverage for abortion unless the procedure is necessary to preserve the woman’s life or health, the pregnancy is the result of rape or incest that has been reported to a law enforcement or public health agency, or a physician certifies that the fetus is believed to have an incapacitating physical deformity or mental deficiency.
- Virginia offers “Choose Life” license plates, the proceeds of which benefit abortion alternatives. Unfortunately, the state also offers a pro-abortion license plate, “Trust Women/Respect Choice.” However, while Planned Parenthood and other abortion providers are eligible to receive the proceeds from the plate, they are specifically prohibited from using the earned revenue for “abortion services.”

» **LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN**

- Under Virginia law, the killing of an unborn child at any stage of gestation is defined as a form of homicide.
- For purposes of “homicide” and “child abuse,” a “human infant who has been born alive and is fully brought forth from the mother has achieved an independent and separate existence, regardless of whether the umbilical cord has been cut or the placenta detached.”
- The state permits recovery for the death of an unborn child at any stage of development in a wrongful death (civil) action.

- Virginia protects infants born alive at any stage of development from “deliberate acts” undertaken by a physician that result in the death of the infant.
- Virginia has enacted a “Baby Moses” law, establishing a safe haven for mothers to legally leave their infants at designated places and ensuring the infants receive appropriate care and protection.
- Virginia requires emergency personnel to report child abuse including cases of in utero exposure to controlled substances, and healthcare providers are required to report to the state Department of Social Services any diagnosis of fetal alcohol spectrum disorders or other medical condition caused by exposure to controlled substances during pregnancy.
- The state also funds drug treatment programs for pregnant women and newborns.

» **BIOETHICS LAWS**

- Virginia prohibits human cloning for any purpose, but it does not prohibit destructive embryo research or fetal experimentation.
- Virginia prohibits tax credits for research on human cells, on tissue derived from induced abortions, and on stem cells obtained from human embryos. This provision is an annual rider.
- Virginia maintains the “Virginia Cord Blood Bank Initiative” as a public resource for advancing basic and clinical research and for the treatment of patients with life-threatening diseases or debilitating conditions. All women admitted to a hospital or birthing facility may be offered the opportunity to donate umbilical cord blood to the initiative. Likewise, every licensed practitioner who renders prenatal care is to provide information to pregnant patients regarding the option of umbilical cord blood banking.
- The state has also created a special fund in the state treasury entitled the “Christopher Reeve Stem Cell Research Fund.” No monies from the fund may be provided to entities that conduct research with stem cells obtained from human embryos.
- Virginia maintains some regulation of assisted reproductive technologies, including requiring a form of informed consent. However, the state does not regulate human egg harvesting.

» **END OF LIFE LAWS**

- Virginia does not have a specific statute criminalizing assisted suicide. However, Virginia has adopted the common law of crimes, which includes the crime of assisted suicide

» HEALTHCARE FREEDOM OF CONSCIENCE***Participation in Abortion***

- Any person who objects in writing and on personal, ethical, moral, and/or religious grounds is not required to participate in abortions.
- A physician, hospital, or medical facility is not required to admit a woman for the purposes of performing an abortion.
- The conscientious objection of an individual healthcare provider, hospital, or medical facility to participating in an abortion may not be a basis for a claim for damages, denial of employment, disciplinary action, or any other recriminatory action.

Participation in Research Harmful to Human Life

- Virginia currently provides no protection for the rights of healthcare providers who conscientiously object to participation in human cloning, destructive embryo research, or other forms of medical research, which violate a provider's moral or religious belief.

» WHAT HAPPENED IN 2014

- Virginia considered legislation prohibiting sex-selective abortions and concerning abortion funding.
- Conversely, Virginia considered multiple measures weakening its current abortion requirements including measures allowing informed consent information to be given over the telephone (rather than in person), repealing or weakening its ultrasound requirement, and repealing the health insurance Exchange opt-out provision.
- Virginia enacted a measure regulating genetic counselors and considered legislation related to embryo adoption.
- In response to the coercive federal mandates in the Affordable Care Act, legislation was introduced in Virginia attempting to provide conscience protections for employers regarding the provision of health insurance that includes abortion, abortion-inducing drugs, and certain contraceptive services.

RECOMMENDATIONS

for VIRGINIA

WOMEN'S PROTECTION PROJECT PRIORITIES

- Women's Health Defense Act (5 month abortion limitation)
- Abortion-Inducing Drugs Safety Act
- Parental Involvement Enhancement Act
- Child Protection Act
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- Defunding the Abortion Industry and Advancing Women's Health Act
- Coercive Abuse Against Mothers Prevention Act
- Prenatal Nondiscrimination Act

Legal Recognition and Protection for the Unborn

- Pregnant Woman's Protection Act

Bioethics

- Destructive Embryo Research Act

End of Life

- Assisted Suicide Ban Act

Healthcare Freedom of Conscience

- Healthcare Freedom of Conscience Act



Washington | RANKING: 50

Washington does not adequately protect women from the negative consequences of abortion, nor does it protect unborn children from criminal violence. Washington has failed to enact commonsense, publicly supported laws such as informed consent, parental involvement, abortion clinic regulations, and fetal homicide, and it does not prohibit human cloning, destructive embryo research, or fetal experimentation. Moreover, Washington explicitly permits physician-assisted suicide.

» ABORTION

- Washington maintains a Freedom of Choice Act. The Act mandates a right to abortion even if *Roe v. Wade* is eventually overturned, specifically providing: “The sovereign people hereby declare that every individual possesses a fundamental right of privacy with respect to personal reproductive decisions. Accordingly, it is the public policy of the [S]tate of Washington that: (1) Every individual has the fundamental right to choose or refuse birth control; (2) Every woman has the fundamental right to choose or refuse to have an abortion...; (3) ... the state shall not deny or interfere with a woman’s fundamental right to choose or refuse to have an abortion; and (4) the state shall not discriminate against the exercise of these rights in the regulation or provision of benefits, facilities, services, or information.”
- A state voter initiative declared: “The state may not deny or interfere with a woman’s right to choose to have an abortion prior to viability of the fetus, or to protect her life or health.”
- No abortion may be performed after viability unless necessary to protect the woman’s life or health.
- Washington does not have an informed consent law for abortion, parental involvement law for minors seeking abortion, or abortion clinic regulations.
- Only a physician licensed in Washington may perform an abortion.
- The state has an enforceable abortion reporting law, but does not require the reporting of information to the Centers for Disease Control (CDC). The measure pertains to both surgical and nonsurgical abortions and requires abortion providers to report short-term complications.
- Washington taxpayers are required by statute to fund “medically necessary” abortions for women receiving state public assistance. It must also provide benefits, services, or information to permit women to obtain abortions if it provides comparable maternity care benefits, services, or information.

- Washington protects physical access to abortion clinics and curtails the First Amendment rights of pro-life sidewalk counselors and demonstrators.

» **LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN**

- Under Washington criminal law, the killing of an unborn child after “quickening” is defined as a form of homicide.
- The state allows a wrongful death (civil) action when a viable unborn child is killed through negligence or a criminal act.
- Under Washington law, “the right of medical treatment of an infant born alive in the course of an abortion procedure shall be the same as the right of an infant born prematurely of equal gestational age.” Thus, the state has created a specific affirmative duty of physicians to provide medical care and treatment to infants born alive at any stage of development.
- Washington has enacted a “Baby Moses” law, establishing a safe haven for mothers to legally leave their infants at designated places and ensuring the infants receive appropriate care and protection.
- The state funds drug treatment programs for pregnant women and newborns.

» **BIOETHICS LAWS**

- Washington law does not prohibit human cloning, destructive embryo research, or fetal experimentation.
- All persons licensed to provide prenatal care or practice medicine must provide information to all pregnant women regarding the differences between public and private umbilical cord blood banking and the opportunity to donate the blood and tissue extracted from the placenta and umbilical cord following delivery.
- Washington maintains no meaningful regulation of assisted reproductive technologies or human egg harvesting.
- The Uniform Parentage Act includes “donation of embryos” in its definition of “assisted reproduction.”

» **END OF LIFE LAWS**

- Washington has legalized physician-assisted suicide by voter initiative. The law creates financial incentives for healthcare insurance companies to deny coverage for life-saving treatment and to pressure vulnerable patients to choose suicide—a practice already occurring in Oregon. Moreover, the law does not provide safeguards for those suffering from mental illness, such as depression, and requires physicians participating in patient suicides to falsify death certificates.
- The initiative superseded a prior law which made assisted suicide a felony. That law had

been upheld in the landmark case of *Washington v. Glucksberg*, where the U.S. Supreme Court refused to recognize a federal constitutional right to assisted suicide.

» **HEALTHCARE FREEDOM OF CONSCIENCE**

Participation in Abortion

- An individual healthcare worker or private medical facility cannot be required by law or contract to participate in the performance of abortions.
- No person may be discriminated against in employment or professional privileges because of participating or refusing to participate in an abortion.
- Overall, Washington protects individual healthcare providers, as well as private hospitals and medical facilities, who conscientiously object to participating in any healthcare procedure. However, this protection does not extend to public hospitals and medical facilities.
- Washington has a “contraceptive equity” law, requiring health insurance coverage for contraception. No exemption is provided for employers or insurers with a moral or religious objection to contraception.

Participation in Research Harmful to Human Life

- Washington currently provides no protection for the rights of healthcare providers who conscientiously object to participation in human cloning, destructive embryo research, or other forms of medical research, which violate a provider’s moral or religious belief.

» **WHAT HAPPENED IN 2014**

- Washington considered legislation requiring parental notice before abortion. AUL submitted written testimony supporting the measure.
- It considered a measure seeking to broaden the ability of abortion providers to be reimbursed for “telemed” abortions.
- Washington considered a requirement that, when a patient died from assisted suicide, the physician who signs a patient’s death certificate designate that assisted suicide was the cause of death.
- It also considered a measure providing immunity from civil, criminal, and professional sanctions for a healthcare provider or facility that participates in good faith in the provision of medical care or in the withholding or withdrawal of life-sustaining treatment in accordance with the directives contained in a Physician Orders for Life-Sustaining Treatment (POLST) form.
- The Washington House passed the Reproductive Parity Act requiring health insurance plans that cover maternity care to also cover abortions. The phony conscience clause in the measure would require plan providers with religious objections to facilitate

abortion coverage for its plan beneficiaries. AUL submitted testimony against and assisted in defeating the measure.

- A challenge to a Washington Board of Pharmacy rule requiring pharmacists and/or pharmacies to dispense “emergency contraception” regardless of moral or conscience objection remains in litigation before the Ninth Circuit.

RECOMMENDATIONS

for WASHINGTON

WOMEN'S PROTECTION PROJECT PRIORITIES

- Women's Health Defense Act (5 month abortion limitation)
- Women's Right to Know Act with reflection period
- Abortion Patients' Enhanced Safety Act
- Abortion-Inducing Drugs Safety Act
- Parental Notification for Abortion Act
- Child Protection Act
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- Repeal of State FOCA
- Federal Abortion-Mandate Opt-Out Act
- Defunding the Abortion Industry and Advancing Women's Health Act
- Women's Ultrasound Right to Know Act
- Coercive Abuse Against Mothers Prevention Act
- Prenatal Nondiscrimination Act

Legal Recognition and Protection for the Unborn

- Crimes Against the Unborn Child Act (protecting a child from conception)
- Unborn Wrongful Death Act (for a pre-viable child)
- Pregnant Woman's Protection Act

Bioethics

- Human Cloning Prohibition Act
- Destructive Embryo Research Act
- Prohibition on Public Funding of Human Cloning and Destructive Embryo Research Act

End of Life

- Limits on the provision of assisted suicide such as family member notification and mental health evaluations

Healthcare Freedom of Conscience

- Healthcare Freedom of Conscience Act



West Virginia | RANKING: 34

Although the West Virginia Supreme Court has ruled that the state constitution provides for a broader right to abortion than that interpreted in the U.S. Constitution, the state does maintain some basic protections for women considering abortion. For example, state materials required under an informed consent law include information about the abortion-breast cancer link. However, little has been done to address emerging biotechnologies.

» ABORTION

- The West Virginia Supreme Court has ruled that the state constitution provides for a broader right to abortion than that interpreted in the U.S. Constitution.
- A physician may not perform an abortion on a woman until at least 24 hours after obtaining her informed consent and after informing her of the nature and risks of the proposed abortion procedure, the risks of carrying the pregnancy to term, and the probable gestational age of the unborn child.
- At least 24 hours prior to an abortion, a woman must also receive information about medical assistance benefits that may be available for prenatal care, childbirth, and neonatal care; the father's liability for child support; and her right to review state-prepared materials describing the development of the unborn child, outlining common methods of abortion, discussing the medical risks of abortion, and listing agencies that offer alternatives to abortion. She may review this information either in print or on the state's website.
- The state includes information about the abortion-breast cancer link in the educational materials that a woman must receive prior to abortion.
- If an ultrasound is performed before an abortion, the abortion provider must offer to show it to the woman. The woman must also be given the opportunity of having the image explained to her.
- A physician may not perform an abortion on an unemancipated minor under the age of 18 until at least 24 hours after actual notice has been provided to one parent, unless there is a medical emergency or the minor secures a court order. The law also allows an abortion to be performed without parental notice if a physician who is not performing the abortion determines that the minor is "mature enough to make the abortion decision independently or that parental notice is not in the minor's best interest."

- The state has an enforceable abortion reporting law, but does not require the reporting of information to the Centers for Disease Control (CDC). The measure pertains to both surgical and nonsurgical abortions.
- West Virginia taxpayers are required to fund “medically necessary” abortions for women receiving state medical assistance. This requirement essentially equates to funding abortion-on-demand in light of the U.S. Supreme Court’s broad definition of “health” in the context of abortion.

» **LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN**

- West Virginia law recognizes an unborn child at any stage of gestation as a potential victim of homicide.
- The state also criminalizes nonfatal assaults on the unborn.
- The state allows a wrongful death (civil) action when an unborn child at any stage of development is killed through a negligent or criminal act.
- West Virginia does not require physicians or hospitals to provide appropriate and potentially life-saving care to infants who survive attempted abortions.
- West Virginia has enacted a “Baby Moses” law, establishing a safe haven for mothers to legally leave their infants at designated places and ensuring that the infants receive appropriate care and protection.

» **BIOETHICS LAWS**

- West Virginia does not prohibit human cloning, destructive embryonic research, or fetal experimentation.
- The state does not promote ethical alternatives to destructive embryo research.
- West Virginia does not regulate assisted reproductive technologies or human egg harvesting.

» **END OF LIFE LAWS**

- West Virginia does not have a specific statute criminalizing assisted suicide. However, assisted suicide remains a common law crime.

» **HEALTHCARE FREEDOM OF CONSCIENCE**

Participation in Abortion

- West Virginia protects the civil rights of healthcare providers, including individuals, hospitals, and other medical facilities who/that conscientiously object to participating in abortions.

- West Virginia has a “contraceptive equity” law, requiring health insurance coverage for contraception. The law provides an exemption to employers or insurers with a conscientious objection to contraceptives.

Participation in Research Harmful to Human Life

- West Virginia currently provides no protection for the rights of healthcare providers who conscientiously object to participation in human cloning, destructive embryo research, or other forms of medical research, which violate a provider’s moral or religious belief.

» WHAT HAPPENED IN 2014

- Governor Earl Ray Tomblin vetoed a measure prohibiting abortion at 5 months (*i.e.*, 20 weeks) “post-fertilization” age that also included reporting requirements related to the age of the unborn child. AUL had submitted a letter in support of the measure.
- West Virginia considered legislation prohibiting sex-selective abortions, mandating health and safety standards for abortion facilities, requiring an abortion provider who has admitting privileges at a local hospital be on-site during and after an abortion (based on AUL model language), requiring the administration of anesthesia if an unborn child has reached at least seven weeks development, enhancing parental involvement requirements, concerning funding and insurance coverage of abortion, prohibiting the use of state actors in performing or assisting in abortions, and amending the state constitution to provide that there is no state constitutional right to abortion.
- West Virginia considered two measures providing protection for infants who survive attempted abortions. It also considered a measure permitting parents to receive a certificate of stillbirth, requiring the issuance of a birth certificate for a baby born alive during an abortion, and providing a death certificate if the child survives the abortion but dies a short time later.
- The state considered legislation related to pain management and palliative care.

RECOMMENDATIONS

for WEST VIRGINIA

WOMEN'S PROTECTION PROJECT PRIORITIES

- Women's Health Defense Act (5 month abortion limitation)
- Abortion Patients' Enhanced Safety Act
- Abortion-Inducing Drugs Safety Act
- Parental Consent for Abortion Act
- Parental Involvement Enhancement Act
- Child Protection Act
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- State Constitutional Amendment (providing that there is no state constitutional right to abortion)
- Federal Abortion-Mandate Opt-Out Act
- Defunding Abortion Providers and Advancing Women's Health Act
- Coercive Abuse Against Mothers Prevention Act
- Prenatal Nondiscrimination Act

Legal Recognition and Protection for the Unborn

- Unborn Wrongful Death Act
- Born-Alive Infant Protection Act

Bioethics

- Human Cloning Prohibition Act
- Destructive Embryo Research Act
- Prohibition on Public Funding of Human Cloning and Destructive Embryo Research Act

Healthcare Freedom of Conscience

- Healthcare Freedom of Conscience Act



Wisconsin | RANKING: 18

Wisconsin has made progress toward protecting women from the harms inherent in abortion. However, more could be done to close loopholes in existing laws, such as a provision giving discretion to a psychiatrist or psychologist to waive the state's parental consent requirement. Moreover, the state has done little in the field of biotechnologies, failing to ban human cloning, destructive embryo research, or fetal experimentation.

» ABORTION

- Wisconsin's Attorney General has issued a statement declaring the state's partial-birth abortion law unenforceable and finding it possibly restrictive of other abortion procedures.
- No abortion may be performed after viability unless necessary to preserve the woman's life or health. Moreover, a physician must use the abortion method most likely to preserve the life and health of the unborn child unless that method would increase the risk to the woman.
- Wisconsin possesses an enforceable abortion prohibition should the U.S. Constitution be amended or certain U.S. Supreme Court decisions be reversed or modified.
- A physician may not perform an abortion on a woman until at least 24 hours after the woman is informed of the probable gestational age of her unborn child, the details of the proposed abortion procedure and its inherent risks, the particular medical risks of her pregnancy, her right to view an ultrasound prior to an abortion, available medical assistance benefits, the father's legal responsibilities, and alternatives to abortion.
- Wisconsin requires that an ultrasound be performed before an abortion.
- The state also requires abortion providers to state in their printed materials that it is illegal for someone to coerce a woman into having an abortion.
- A physician may not perform an abortion on an unemancipated minor without the informed, written consent of one parent, grandparent, aunt, uncle, or sibling who is at least 25 years of age, unless the minor is the victim of rape, incest, or child abuse; there is a medical emergency; or the minor obtains a court order. Further, the law gives discretion to a psychiatrist or psychologist to waive consent based on a belief that the minor will commit suicide rather than obtain consent or seek a court order.
- Wisconsin imposes minimal health and safety requirements on abortion clinics. Further, physicians may only perform first-trimester abortions within 30 minutes travel time of a hospital.

- Only a licensed physician may perform an abortion. A law requiring that individual abortion providers maintain admitting privileges at a local hospital is in litigation.
- The state has an enforceable abortion reporting law, but does not require the reporting of information to the Centers for Disease Control (CDC). The measure pertains to both surgical and nonsurgical abortions and requires abortion providers to report short-term complications.
- Wisconsin prohibits the use of telemedicine to administer abortion-inducing drugs and requires that such drugs be provided only by physicians.
- Wisconsin provides state funding for abortions for women eligible for public assistance that are directly and medically necessary to preserve the woman's life, to prevent grave, long-lasting physical health damage to the woman, or when the pregnancy is the result of sexual assault or incest reported to law enforcement authorities.
- Generally, no state, local, or federal funds passing through the state's pregnancy programs, projects, or services may be used to perform, promote, refer for, or counsel for abortion. However, referrals may be made if the abortion is necessary to preserve the woman's life. Further, the law only applies to the extent it is able without losing federal funds.
- Wisconsin's Private Employer Health Care Purchasing Alliance, a voluntary program for private employers, may not include coverage for abortion unless the abortion is needed to preserve the woman's life. Further, coverage for abortions that are "medically necessary" may be obtained only by an optional rider or supplemental coverage provision that is offered and provided on an individual basis and for which an additional premium is paid. Under no circumstances is an employer required to provide coverage for abortion.
- The state prohibits abortion coverage in the state health insurance Exchange required under the federal healthcare law except in cases of life endangerment, rape, incest, or possible "grave, long-lasting physical health damage."

» **LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN**

- Under Wisconsin law, the killing of an unborn child at any stage of gestation is defined as a form of homicide.
- Wisconsin defines a nonfatal assault on an unborn child as a crime.
- The state allows wrongful death (civil) actions when a viable unborn child is killed through a negligent or criminal act.
- The state has created a specific affirmative duty of physicians to provide medical care and treatment to infants born alive at any stage of development.
- Wisconsin has enacted a "Baby Moses" law, establishing a safe haven for mothers

to legally leave their infants at designated places and ensuring the infants receive appropriate care and protection.

- The state defines substance abuse during pregnancy as “child abuse” under civil child-welfare statutes.

» **BIOETHICS LAWS**

- Wisconsin does not ban human cloning, destructive embryo research, or fetal experimentation.
- Wisconsin provides funding for destructive embryo research.
- The state requires that healthcare providers offer pregnant women information on options to donate umbilical cord blood following delivery.
- Wisconsin maintains no comprehensive measures regulating assisted reproductive technologies or human egg harvesting.

» **END OF LIFE LAWS**

- Under Wisconsin law, assisting in a suicide is a felony.

» **HEALTHCARE FREEDOM OF CONSCIENCE**

Participation in Abortion

- A physician or other person associated with, employed by, or on staff with a hospital who objects in writing and on moral or religious grounds is not required to participate in abortions.
- A healthcare provider’s conscientious objection to participating in abortion may not be a basis for damages, discrimination in employment or education, disciplinary action, or other retaliatory action.
- An individual or entity is not required, because of the receipt of any grant, contract, or loan under state or federal law, to participate in or make its facilities available for the performance of an abortion if such action is contrary to stated religious or moral beliefs.
- A hospital’s conscientious objection, based on moral or religious grounds, to permitting or performing an abortion may not be a basis for civil damages.
- No individual or entity may be required to participate in or make its facilities available for abortion contrary to religious beliefs or moral convictions because of the receipt of any grant, contract, or loan under state or federal law.
- Wisconsin has a “contraceptive equity” requirement, meaning health insurance coverage must include coverage for contraception. No exemption is provided for employers or insurers with moral or religious objections to contraception.

Participation in Research Harmful to Human Life

- Wisconsin currently provides no protection for the rights of healthcare providers who conscientiously object to participation in human cloning, destructive embryo research, or other forms of medical research, which violate a provider's moral or religious belief.

» WHAT HAPPENED IN 2014

- Wisconsin considered legislation prohibiting sex-selective abortions, delineating qualifications for individual abortion providers, concerning abortion funding, and creating a "Choose Life" license plate.
- Conversely, it also considered legislation repealing its admitting privileges requirement (which is currently in litigation), a measure repealing its ultrasound requirement and replacing it with a requirement that written informed consent materials include information about ultrasound, and legislation creating a "Support Planned Parenthood" specialty license plate.
- In *Planned Parenthood v. Van Hollen*, a state trial court interpreted Wisconsin law to require a physician to be present when abortion-inducing drugs are provided, but not when the drugs are actually ingested.
- Further, the U.S. Supreme Court rejected a request to hear a legal challenge to Wisconsin's admitting privileges requirement for abortion providers. Litigation over the constitutionality of the requirement continues.
- Wisconsin considered a measure providing for evaluations of infants for fetal alcohol spectrum disorders and providing referral for related services and treatment.
- It also considered legislation related to pain management and palliative care.

RECOMMENDATIONS

for WISCONSIN

WOMEN'S PROTECTION PROJECT PRIORITIES

- Women's Health Defense Act (5 month abortion limitation)
- Women's Health Protection Act (abortion clinic regulations)
- Parental Involvement Enhancement Act
- Child Protection Act
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- Defunding the Abortion Industry and Advancing Women's Health Act
- Prenatal Nondiscrimination Act

Legal Recognition and Protection for the Unborn

- Unborn Wrongful Death Act (for a pre-viable child)
- Pregnant Woman's Protection Act

Bioethics

- Human Cloning Prohibition Act
- Destructive Embryo Research Act
- Prohibition on Public Funding of Human Cloning and Destructive Embryo Research Act

Healthcare Freedom of Conscience

- Healthcare Freedom of Conscience Act



Wyoming | RANKING: 37

Wyoming lacks many basic legal protections for human life. For example, Wyoming does not require informed consent for abortion, mandate minimum health and safety standards for abortion clinics, protect unborn victims of violence, or criminalize assisted suicide.

» ABORTION

- No abortion may be performed after viability unless necessary to protect the woman from “imminent peril that substantially endangers her life or health.”
- Wyoming does not have an informed consent law for abortion.
- A physician may not perform an abortion on an unemancipated minor under the age of 18 who is not in active military service or who has not lived independently and apart from her parents for more than six months without receiving the consent of one parent, unless there is a medical emergency or the minor obtains a court order.
- Only a physician licensed to practice medicine in the state and using accepted medical procedures may perform an abortion.
- The state has an enforceable abortion reporting law, but does not require the reporting of information to the Centers for Disease Control (CDC). The measure pertains to both surgical and nonsurgical abortions and requires abortion providers to report short-term complications.
- Wyoming follows the federal standard for Medicaid funding for abortions, permitting the use of federal or state matching Medicaid funds for abortions necessary to preserve the life of the woman or when the pregnancy is the result of rape or incest.

» LEGAL RECOGNITION AND PROTECTION OF UNBORN AND NEWLY BORN

- Wyoming law does not recognize an unborn child as a potential victim of homicide or assault.
- Wyoming law defines an attack on a pregnant woman resulting in a miscarriage or stillbirth as a criminal assault. The state also provides enhanced penalties for murdering a pregnant woman.
- The state allows a wrongful death (civil) action only when an unborn child is born alive following a negligent or criminal act and dies thereafter.
- Wyoming law requires that the “commonly accepted means of care shall be employed

in the treatment of any viable infant aborted alive with any chance of survival.”

- Wyoming has a “Baby Moses” law, establishing a safe haven for mothers to legally leave their infants at designated places and ensuring the infants receive appropriate care and protection.

» **BIOETHICS LAWS**

- Wyoming has not banned human cloning or destructive embryo research. Further, it does not comprehensively ban fetal experimentation, instead prohibiting only the sale, transfer, or “giving away” of a live or viable aborted child for experimentation. The provision does not apply to children aborted prior to viability.
- The state does not promote ethical alternatives to destructive embryo research.
- Wyoming maintains no comprehensive measures regulating assisted reproductive technologies or human egg harvesting, but it includes “donation of embryos” in the definition of “assisted reproduction.”

» **END OF LIFE LAWS**

- Wyoming has not enacted a statutory prohibition against assisted suicide. Moreover, since the state does not recognize common law crimes (including assisting in suicide), the legal status of assisted suicide in Wyoming is unclear.

» **HEALTHCARE FREEDOM OF CONSCIENCE**

Participation in Abortion and Healthcare Systems

- A person is not required to participate in an abortion or in any act that assists in the performance of an abortion.
- A healthcare provider’s conscientious objection to participation in abortion may not be the basis for civil liability, discrimination in employment, or the imposition of other sanctions by a hospital, person, firm, association, or group. Moreover, a healthcare provider injured because of a violation of his or her right of conscience may bring a civil action for damages or injunctive relief.
- A private hospital, institution, or facility is not required to perform or to admit a woman for the purposes of performing an abortion.
- A private hospital, institution, or facility’s conscientious objection to permitting an abortion within its facility or admitting a patient for an abortion may not be a basis for civil liability.
- In 2012, Wyoming voters approved a state constitutional amendment providing that no one can be compelled to participate in any healthcare system. By doing so, they voted to protect the freedom of conscience of individuals, employers, and healthcare

providers who object to providing or paying for certain services, such as abortion and drugs with life-ending mechanisms of action.

Participation in Research Harmful to Human Life

- Wyoming currently provides no protection for the rights of healthcare providers who conscientiously object to participation in human cloning, destructive embryo research, or other forms of medical research, which violate a provider's moral or religious belief.

» **WHAT HAPPENED IN 2014**

- Wyoming did not consider any life-affirming measures in 2014.

RECOMMENDATIONS

for WYOMING

WOMEN'S PROTECTION PROJECT PRIORITIES

- Women's Health Defense Act (5 month abortion limitation)
- Women's Right to Know Act with reflection period
- Women's Health Protection Act (abortion clinic regulations)
- Abortion-Inducing Drugs Safety Act
- Parental Involvement Enhancement Act
- Components of the Child Protection Act related to evidence retention and remedies for third-party interference with parental rights
- Enhanced penalties and enforcement mechanisms for the state's abortion-related laws

ADDITIONAL PRIORITIES

Abortion

- Federal Abortion-Mandate Opt-Out Act
- Defunding the Abortion Industry and Advancing Women's Health Act
- Women's Ultrasound Right to Know Act
- Coercive Abuse Against Mothers Prevention Act
- Prenatal Nondiscrimination Act

Legal Recognition and Protection for the Unborn

- Crimes Against the Unborn Child Act
- Unborn Wrongful Death Act
- Pregnant Woman's Protection Act

Bioethics

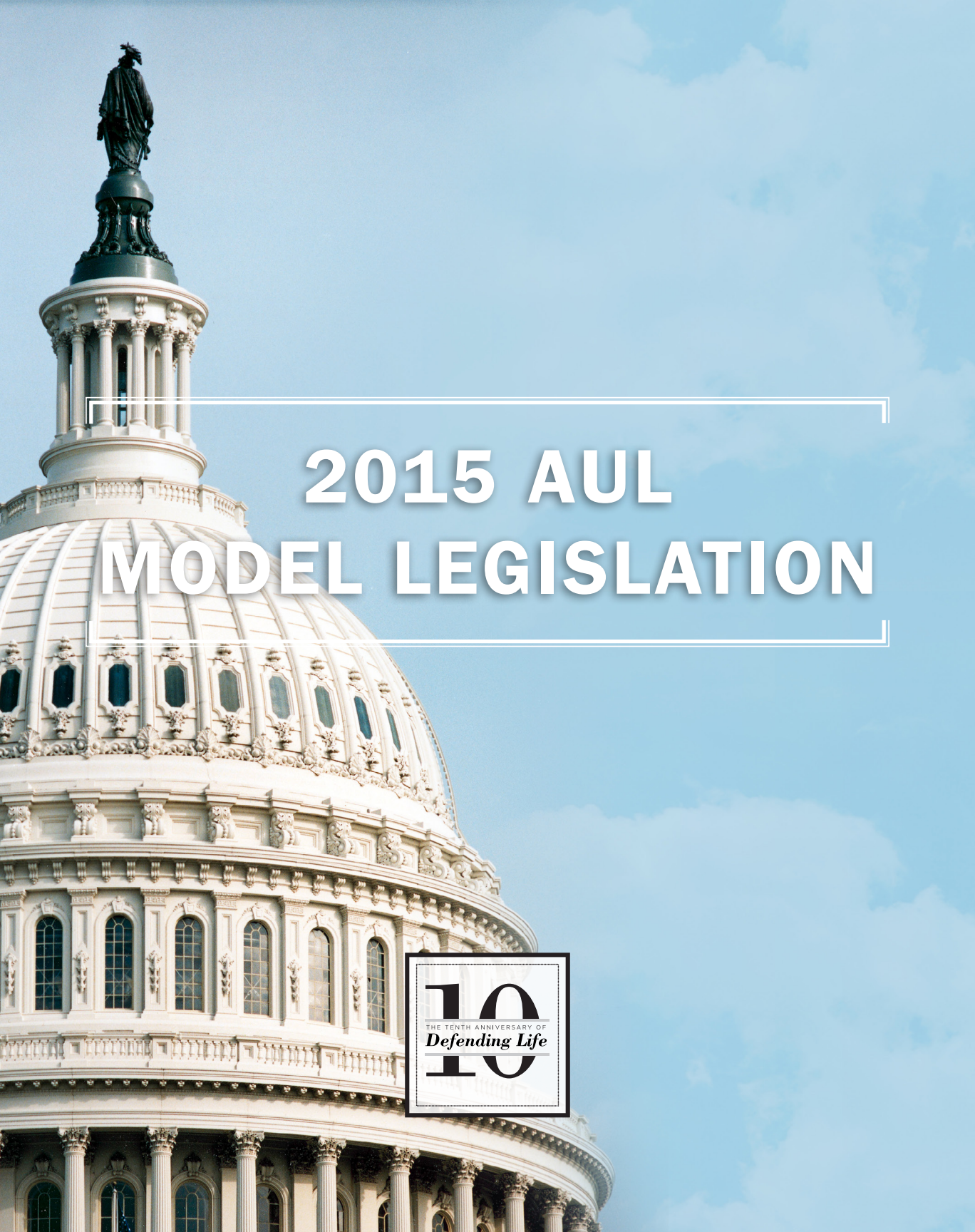
- Human Cloning Prohibition Act
- Destructive Embryo Research Act
- Prohibition on Public Funding of Human Cloning and Destructive Embryo Research Act

End of Life

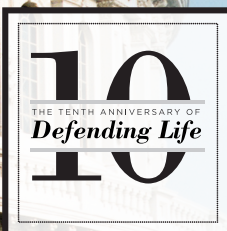
- Assisted Suicide Ban Act

Healthcare Freedom of Conscience

- Healthcare Freedom of Conscience Act



2015 AUL MODEL LEGISLATION



[2015 MODEL LEGISLATION]

Americans United for Life, the legal architects of the pro-life movement, maintains the nation's most comprehensive catalogue of model legislation protecting human life from conception until natural death. AUL legal experts have carefully crafted each model bill to advance legal protection for life and to withstand potential judicial scrutiny.

The model legislation featured in this volume is included in AUL's Women's Protection Project and covers the full spectrum of life issues: abortion, protection for unborn children in contexts other than abortion, emerging biotechnologies, the end-of-life, and healthcare freedom of conscience. Additional information on and resources to support AUL's model legislation are available at AUL's website, www.aul.org/legislative-resources/order-model-legislation/.

The Women's Protection Project

In direct response to the well-documented risks of abortion and the growing epidemic of substandard abortion care in the United States, AUL launched the Women's Protection Project in 2014 which features seven pieces of expertly crafted AUL model legislation:

Women's Health Defense Act: Limits abortions at or after five months of pregnancy based on the substantial risks these abortions pose to women's health and the pain felt by unborn children.

Women's Right to Know Act: Provides a woman, at

least twenty-four (24) hours before an abortion, with detailed information regarding her medical and psychological risks; her child's gestational age, development, and pain capability; and the abortion procedure itself.

Abortion Patients' Enhanced Safety Act: Requires abortion providers to meet the same health and safety standards as other facilities performing outpatient surgeries.

Abortion-Inducing Drugs Safety Act: Protects women from unsafe "telemed" abortions (where abortion-inducing drugs are administered without a face-to-face examination by a physician) and the growing practice within the abortion industry not to follow FDA-approved protocols for the administration of these dangerous drugs.

Parental Involvement Enhancement Act: Strengthens state parental involvement laws with, among other elements, requirements for notarized consent forms and for identification and proof of relationship for a parent or guardian providing the requisite consent, as well as more stringent standards for judicial bypass proceedings.

Child Protection Act: Strengthens requirements that abortion clinics report all cases of suspected statutory rape and sexual abuse, mandates the collection of forensic evidence for certain abortions performed

on minors, and prohibits a third-party from aid or abetting a minor in circumventing her state's parental involvement law.

Enforcement Module: Provides options for the criminal, civil, and administrative enforcement of all abortion-related statutes including the component legislation of the Women's Protection Project and details enhanced inspection requirements for abortion facilities.

Other Abortion Legislation

State Constitutional Amendment: Enunciates a state policy to protect the life of an unborn child from conception until birth that will guide the interpretation of existing and future state laws; prevents any branch of state government from manufacturing a "right" to abortion under the state constitution; and prohibits state funding of abortion to the extent permitted by federal law.

"The Missouri Preamble": Provides guidance for the interpretation and application of state laws and protects unborn children to the fullest extent possible (given existing U.S. Supreme Court precedent on abortion).

Joint Resolution Proposing Constitutional Amendment Returning Determinations on Abortion Law and Policy to the American People: Enables the American people and their elected representatives to express their continuing conviction that, more than 40 years after *Roe v. Wade*, the U.S. Supreme Court's abortion decisions are erroneous and should be overturned, restoring self-government on this issue to the American people.

Partial-Birth Abortion Ban Act: Enacts a state ban on partial-birth abortion.

Prenatal Nondiscrimination Act: Bans sex-selective abortions and abortions performed for genetic abnormalities.

The Woman's Ultrasound Right to Know Act: Requires an abortion provider to perform an ultrasound prior to an abortion and to inform a woman of her right to view the images and have them explained to her.

Perinatal Hospice Information Act: Amends a state's informed consent law to include information about perinatal hospice and other supportive, life-affirming options for families facing lethal fetal anomalies.

Coercive Abuse Against Mothers Prevention Act: Prohibits coercing a woman to undergo an abortion, as well as requires abortion facilities to post signs concerning coercion and to report suspected cases of coercive abuse.

Parental Consent for Abortion Act: Mandates parental consent prior to a minor's abortion.

Parental Notification for Abortion Act: Requires parental notice before a minor's abortion.

Women's Health Protection Act: Requires abortion facilities to meet medically appropriate health and safety standards designed specifically for such facilities.

Abortion Providers' Admitting Privileges Act: Mandates that abortion facilities employ at least one abortion provider with admitting privileges at a local hospital and that a provider with such privileges remain in the facility when abortions are being performed.

Abortion Reporting Act: Requires abortion providers to report demographic information about women undergoing abortions and mandates that any medical provider treating an abortion-related complication report information about the complication to state officials.

Federal Abortion-Mandate Opt-Out Act: Prohibits insurance providers operating within the state health insurance Exchanges (required under the federal healthcare law) from offering coverage for abortion.

Abortion Coverage Prohibition Act: Prohibits all private health insurance coverage for abortion within the state.

Defunding the Abortion Industry and Advancing Women's Health Act: Prohibits the use of public funds, facilities, and personnel for the performance of abortions or the provision of abortion counselling and/or referrals.

Joint Resolution Calling for Investigation and De-funding of Planned Parenthood and Other Abortion Providers: Calls on state authorities to look into the practices of abortion providers and to freeze any state funding allocated for abortion providers, as well as voicing the state legislature's support for similar efforts at the federal level

Joint Resolution Honoring Pregnancy Resource Centers: Honors pregnancy resource centers for their life-affirming work.

Legal Recognition and Protection of the Unborn

Crimes Against the Unborn Child Act: Criminalizes fatal and nonfatal assaults against an unborn child and specifically recognizes an unborn child as a potential crime victim.

Pregnant Woman's Protection Act: Extends state law allowing the use of force to defend another to women who use force to protect their unborn children from third-party violence.

Born-Alive Infant Protection Act: Requires that children who survive attempted abortions be given appropriate medical care and treatment.

Unborn Wrongful Death Act: Provides for a wrongful death (civil) action when an unborn child, at any stage of development, is killed through the criminal or negligent act of a third-party.

(NEW) Dignified Final Disposition Act: Provides for the

proper disposition of fetal remains and for fetal birth and death certificates in specified circumstances.

Bioethics and Biotechnologies

Human Cloning Prohibition Act: Prohibits all forms of human cloning.

Destructive Human Embryo Research Act: Prohibits destructive embryo research.

Prohibition on Public Funding of Human Cloning and Destructive Embryo Research: Prohibits state funding for any form of human cloning or destructive embryo research.

Real Hope for Patients Act: Provides options for states to encourage ethical stem cell research.

Assisted Reproductive Technologies Disclosure and Risk Reduction Act: Regulates assisted reproductive technologies—the “gateway” to unethical embryo research—by requiring detailed informed consent requirements, imposing data collection and reporting requirements, and placing limits on the creation and transfer of embryos in a single reproductive cycle.

Egg Provider Protection Act: Protects women from the health risks and exploitation associated with human egg harvesting.

Embryo Adoption Act: Provides a legal adoption procedure for human embryos.

End of Life

Assisted Suicide Ban Act: Prohibits assisted suicide.

Joint Resolution Opposing Physician-Assisted Suicide: Reaffirms the state's opposition to assisted suicide and provides information to counter any momentum achieved by those asserting that suicide and death are America's answers to illness, disease, disability, or suffering.

Pain Medicine Education Act: Establishes an educational curriculum for pain management and provides guidelines for evaluating, monitoring, and treating pain.

Life Sustaining Care Act: Protects a patient from having life-sustaining care withdrawn or withheld against his or her will.

Healthcare Freedom of Conscience

Healthcare Freedom of Conscience Act: Provides comprehensive protection for the freedom of conscience of individual healthcare providers, institutions, and payers.

Pharmacist Freedom of Conscience Act: Provides comprehensive protection for pharmacists' freedom of conscience.

Ensuring Compliance with Healthcare Freedom of Conscience Act: Requires healthcare institutions receiving taxpayer funding to certify that they are knowledgeable of state and federal laws protecting conscience rights and have policies in place to abide by those laws, providing an incentive to protect—not coerce or discriminate against—healthcare professionals' conscience rights.

Joint Resolution Calling for Rescission of HHS Coercive Mandate & Affirming Freedom of Conscience: Reaffirms the state's opposition to the federal "HHS Mandate" (requiring many employers to purchase health insurance coverage for their employees that covers life-ending drugs and devices) and its commitment to protecting healthcare freedom of conscience.

A black and white photograph of a woman and a young child. The woman is on the left, smiling broadly, showing her teeth. The child is on the right, looking towards the camera with a slight smile. The image is partially obscured by a dark horizontal band that contains the title text.

WOMEN'S PROTECTION PROJECT

Women's Health Defense Act

HOUSE/SENATE BILL NO. _____

By Representatives/Senators _____

Section 1. Title.

This Act may be known and cited as the “Women’s Health Defense Act” [or, alternatively, the “Women’s Late-Term Pregnancy Health Act.”]

Section 2. Legislative Findings and Purposes.

(a) The [Legislature] of the State of [Insert name of State] finds that:

- (1) Abortion can cause serious physical and psychological (both short- and long-term) complications for women, including but not limited to: uterine perforation, uterine scarring, cervical perforation or other injury, infection, bleeding, hemorrhage, blood clots, failure to actually terminate the pregnancy, incomplete abortion (retained tissue), pelvic inflammatory disease, endometritis, missed ectopic pregnancy, cardiac arrest, respiratory arrest, renal failure, metabolic disorder, shock, embolism, coma, placenta previa in subsequent pregnancies, preterm birth in subsequent pregnancies, free fluid in the abdomen, organ damage, adverse reactions to anesthesia and other drugs, psychological or emotional complications including depression, anxiety, sleeping disorders, an increased risk of breast cancer, and death.
- (2) Abortion has a higher medical risk when the procedure is performed later in pregnancy. Compared to an abortion at eight (8) weeks gestation or earlier, the relative risk increases exponentially at higher gestations. L. Bartlett et al., *Risk factors for legal induced abortion-related mortality in the United States*, *Obstetrics & Gynecology* 103(4):729 (2004).
- (3) In fact, the incidence of major complications is highest after twenty (20) weeks of gestation. J. Pregler & A. DeCherney, *Women’s Health: Principles and Clinical Practice* 232 (2002).
- (4) According to the Alan Guttmacher Institute, the risk of death associated with abortion increases with the length of pregnancy, from one death for every one million abortions at or before eight weeks gestation to one per 29,000 abortions at 16 to 20 weeks gestation and one per 11,000 abortions at 21 or more weeks gestation (citing L. Bartlett et al., *Risk factors for legal induced abortion-related mortality in the United States*, *Obstetrics & Gynecology* 103(4):729–737 (2004)).
- (5) After the first trimester, the risk of hemorrhage from an abortion, in particular, is greater, and the resultant complications may require a hysterectomy, other reparative surgery, or a blood transfusion.
- (6) The State of [Insert name of State] has a legitimate concern for the public’s health and safety. *Williamson v. Lee Optical*, 348 U.S. 483, 486 (1955).
- (7) The State of [Insert name of State] “has legitimate interests from the outset of pregnancy in protecting the health of women.” *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 847 (1992). More specifically, the State of [Insert name of State] “has a legitimate concern with the health of women who undergo abortions.” *Akron v. Akron Ctr. for Reproductive Health, Inc.*, 462 U.S. 416, 428–29 (1983).
- (8) In addition, there is substantial and well-documented medical evidence that an unborn child by at least 20 weeks gestation has the capacity to feel pain during an abortion. K. Anand, *Pain and its effects in the human neonate and fetus*, *N.E.J.M.* 317:1321 (1987).

(b) Based on the findings in subsection (a), the [Legislature]’s purposes in promulgating this Act are to

- (1) Based on the documented risks to women’s health, prohibit abortions at or after 20 weeks gestation, except in cases of a medical emergency.
- (2) Prohibit abortions at or after 20 weeks gestation, in part, because of the pain felt by an unborn child.
- (3) Define “medical emergency” to encompass “significant health risks,” namely only those circumstances in which a pregnant woman’s life or a major bodily function is threatened. *Gonzales v. Carhart*, 550 U.S. 124, 161 (2007).

Section 3. Definitions.

For purposes of this Act only:

- (a) **“Abortion”** means the act of using or prescribing any instrument, medicine, drug, or any other substance, device, or means with the intent to terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child. Such use, prescription, or means is not an abortion if done with the intent to:
 - (1) Save the life or preserve the health of the unborn child;
 - (2) Remove a dead unborn child caused by spontaneous abortion; or
 - (3) Remove an ectopic pregnancy.
- (b) **“Attempt to perform”** means an act or omission of a statutorily required act that, under the circumstances as the actor believes them to be, constitutes a substantial step in a course of conduct planned to culminate in the performance or induction of an abortion.
- (c) **“Conception”** means the fusion of a human spermatozoon with a human ovum.
- (d) **“Gestational age”** means the time that has elapsed since the first day of the woman’s last menstrual period.
- (e) **“Major bodily function”** includes, but is not limited to, functions of the immune system, normal cell growth, and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.
- (f) **“Medical facility”** means any public or private hospital, clinic, center, medical school, medical training institution, healthcare facility, physician’s office, infirmary, dispensary, ambulatory surgical treatment center, or other institution or location wherein medical care is provided to any person.
- (g) **“Physician”** means any person licensed to practice medicine in this State. The term includes medical doctors and doctors of osteopathy.
- (h) **“Pregnant”** or **“pregnancy”** means that female reproductive condition of having an unborn child in the [woman’s] uterus.
- (i) **“Probable gestational age”** means what, in reasonable medical judgment, will with reasonable probability be the gestational age of the unborn child at the time the abortion is considered, performed, or attempted.
- (j) **“Reasonable medical judgment”** means that medical judgment that would be made by a reasonably prudent physician [*in the community*], knowledgeable about the case and the treatment possibilities with respect to the medical condition(s) involved.
- (k) **“Unborn child”** means the offspring of human beings from conception until birth.

Section 4. Prohibition.

- (a) Except in the case of a medical emergency as specifically defined in Subsection 4(c) of this Act, no abortion shall be performed, induced, or attempted unless the physician [*or the referring physician*] has first made a determination

of the probable gestational age of the unborn child. In making such a determination, the physician [*or referring physician*] shall make such inquiries of the pregnant woman and perform or cause to be performed all such medical examinations, imaging studies, and tests as a reasonably prudent physician [*in the community*], knowledgeable about the medical facts and conditions of both the woman and the unborn child involved, would consider necessary to perform and consider in making an accurate diagnosis with respect to gestational age.

(b) Except in a medical emergency as specifically defined in Subsection 4(c) of this Act, no physician or person shall knowingly perform, induce, or attempt to perform an abortion upon a pregnant woman when the probable gestational age of her unborn child has been determined to be at least twenty (20) weeks.

(c) **Medical Emergency Exception:** For the purposes of this Act only, “medical emergency” means a condition in which an abortion is necessary to preserve the life of the pregnant woman whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself, or when continuation of the pregnancy will create a serious risk of substantial and irreversible impairment of a major bodily function (as specifically defined in subsection 3(e) of this Act) of the pregnant woman.

Section 5. Reporting.

(a) Any physician who performs an abortion pursuant to subsection 4(c) of this Act shall report, in writing, to the medical facility in which the abortion is performed the reason(s) for the determination that a medical emergency existed. The physician’s written report shall be included in a written report from the medical facility to the [*Insert appropriate state department, department head, or regulatory body*]. If the abortion is not performed in a medical facility, the physician shall report, in writing, the reason(s) for the determination that a medical emergency existed to the [*Insert appropriate state department, department head, or regulatory body*] as part of the written report made by the physician to the [*Insert appropriate state department, department head, or regulatory body*]. The physician and the medical facility shall retain a copy of the written reports required under this Section for not less than five (5) years.

(b) Failure to report under this Section does not subject the physician to criminal or civil penalties under Sections 6 and 7 of this Act.

(c) Subsection 4(b) does not preclude sanctions, disciplinary action, or any other appropriate action by the [*Insert appropriate citation or reference to state Medical Board or other appropriate agency*].

Section 6. Criminal Penalties.

(a) Any person who intentionally or knowingly violates this Act is guilty of a [*Insert appropriate penalty/offense classification*].

(b) Any physician who intentionally or knowingly performs or induces an abortion in violation of this Act and thereby kills an unborn child shall be fined not less than ten thousand (10,000) nor more than one-hundred thousand (100,000) dollars under this Act, or be imprisoned [*at hard labor*] not less than one (1) year nor more than ten (10) years, or both.

Section 7. Civil Remedies.

(a) The woman, the father of the unborn child if married to the mother at the time she receives an abortion in violation of this Act, and/or, if the mother has not attained the age of eighteen (18) years at the time of the abortion, the maternal grandparents of the unborn child may in a civil action obtain appropriate relief, unless the pregnancy resulted from the plaintiff’s criminal conduct or, if brought by the maternal grandparents, the maternal grandparents consented to the abortion.

(b) Such relief shall include:

(1) Money damages for all psychological and physical injuries occasioned by the violation of this Act; and

- (2) Statutory damages equal to *[Insert number]* times the cost of the abortion performed in violation of this Act.

Section 8. Review by State Medical Board *[of Medical Licensure and Supervision]*.

(a) A physician-defendant accused of violating this Act may seek a hearing before the State Medical Board *[or other appropriate state agency]* as to whether the physician's conduct was necessary to save the life of the mother whose life was endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself; and/or as to whether the continuation of the pregnancy would have created a serious risk of substantial and irreversible impairment of a major bodily function (as specifically defined in subsection 3(e) of this Act) of the pregnant woman.

(b) The findings on this issue are admissible at the criminal and civil trials of the physician-defendant. Upon a motion of the physician-defendant, the court shall delay the beginning of the trial(s) for not more than thirty (30) days to permit such a hearing to take place.

Section 9. Penalties for Medical Facilities.

(a) A medical facility licensed pursuant to *[Insert reference(s) to appropriate statute(s) or regulation(s)]* in which an abortion is performed or induced in violation of this Act shall be subject to immediate revocation of its license by the *[Insert name of appropriate department or agency]*.

(b) A medical facility licensed pursuant to *[Insert references to appropriate statute(s) or regulation(s)]* in which an abortion is performed or induced in violation of this Act shall lose all state funding for *[Insert number]* years and will be required to reimburse the State for funds from the calendar *[fiscal]* year in which the abortion in violation of this Act was performed.

Section 10. Prosecutorial Exclusion.

A woman upon whom an abortion in violation of this Act is performed or induced may not be prosecuted under this Act for a conspiracy to violate Section 4 of this Act.

Section 11. Construction.

- (a) Nothing in this Act shall be construed as creating or recognizing a right to abortion.
- (b) It is not the intention of this Act to make lawful an abortion that is currently unlawful.

Section 12. Severability.

Any provision of this Act held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as to give it the maximum effect permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event such provision shall be deemed severable here from and shall not affect the remainder hereof or the application of such provision to other persons not similarly situated or to other, dissimilar circumstances.

Section 13. Right of Intervention.

The *[Legislature]*, by joint resolution, may appoint one or more of its members, who sponsored or cosponsored this Act in his or her official capacity, to intervene as a matter of right in any case in which the constitutionality of this law is challenged.

Section 14. Effective Date.

This Act takes effect on *[Insert date]*.

Women's Right To Know Act

HOUSE/SENATE BILL NO. _____

By Representatives/Senators _____

Section 1. Title.

This Act may be known and cited as the “Women’s Right to Know Act.” [Or, alternatively, as the “Women’s Health Information Act” or the “Informed Consent for Abortion Act.”]

Section 2. Legislative Findings and Purposes.

- (a) The [Legislature] of the State of [Insert name of State] finds that:
- (1) It is essential to the psychological and physical well-being of a woman considering an abortion that she receives complete and accurate information on abortion and its alternatives.
 - (2) The knowledgeable exercise of a woman’s decision to have an abortion depends on the extent to which she receives sufficient information to make an informed choice between two alternatives: giving birth or having an abortion.
 - (3) Adequate and legitimate informed consent includes information which “relat[es] to the consequences to the fetus.” *Planned Parenthood v. Casey*, 505 U.S. 833, 882-883 (1992).
 - (4) [Insert percentage] of all abortions are performed in clinics devoted solely to providing abortions and family planning services. Most women who seek abortions at these facilities do not have any relationship with the physician who performs the abortion, before or after the procedure. They do not return to the facility for post-surgical care. In most instances, the woman’s only actual contact with the physician occurs simultaneously with the abortion procedure, with little opportunity to receive counseling concerning her decision.
 - (5) The decision to abort “is an important, and often a stressful one, and it is desirable and imperative that it be made with full knowledge of its nature and consequences.” *Planned Parenthood v. Danforth*, 428 U.S. 52, 67 (1976).
 - (6) “The medical, emotional, and psychological consequences of an abortion are serious and can be lasting...” *H.L. v. Matheson*, 450 U.S. 398, 411 (1981).
 - (7) Abortion facilities or providers often offer only limited or impersonal counseling opportunities.
 - (8) Many abortion facilities or providers hire untrained and unprofessional “counselors” to provide pre-abortion counseling, but their primary goal is actually to “sell” or promote abortion services.
- (b) Based on the findings in subsection (a), the purposes of this Act are to:
- (1) Ensure that every woman considering an abortion receives complete information on abortion and its alternatives, and that every woman submitting to an abortion does so only after giving her voluntary and fully-informed consent to the abortion procedure;
 - (2) Protect unborn children from a woman’s uninformed decision to have an abortion;
 - (3) Reduce “the risk that a woman may elect an abortion, only to discover later, with devastating psychological consequences, that her decision was not fully informed.” *Planned Parenthood v. Casey*, 505 U.S. 833, 882 (1992); and

- (4) Adopt the construction of the term “medical emergency” accepted by the U.S. Supreme Court in *Planned Parenthood v. Casey*, 505 U.S. 833 (1992).

Section 3. Definitions.

For purposes of this Act only:

- (a) **“Abortion”** means the act of using or prescribing any instrument, medicine, drug, or any other substance, device, or means with the intent to terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child. Such use, prescription, or means is not an abortion if done with the intent to:
- (1) Save the life or preserve the health of the unborn child;
 - (2) Remove a dead unborn child caused by spontaneous abortion; or
 - (3) Remove an ectopic pregnancy.
- (b) **“Complication”** means any adverse physical or psychological condition arising from the performance of an abortion, which includes but is not limited to: uterine perforation, cervical perforation, infection, bleeding, hemorrhage, blood clots, failure to actually terminate the pregnancy, incomplete abortion (retained tissue), pelvic inflammatory disease, endometritis, missed ectopic pregnancy, cardiac arrest, respiratory arrest, renal failure, metabolic disorder, shock, embolism, coma, placenta previa in subsequent pregnancies, preterm birth in subsequent pregnancies, free fluid in the abdomen, adverse reactions to anesthesia and other drugs, any psychological or emotional complications such as depression, anxiety, and sleeping disorders, and any other “adverse event” as defined by the Food and Drug Administration (FDA) criteria provided in the Medwatch Reporting System. The Department may further define “complication.”
- (c) **“Conception”** means the fusion of a human spermatozoon with a human ovum.
- (d) **“Department”** means the Department of *[Insert appropriate title]* of the State of *[Insert name of State]*.
- (e) **“Facility”** or **“medical facility”** means any public or private hospital, clinic, center, medical school, medical training institution, healthcare facility, physician’s office, infirmary, dispensary, ambulatory surgical treatment center, or other institution or location wherein medical care is provided to any person.
- (f) **“First trimester”** means the first twelve (12) weeks of gestation.
- (g) **“Gestational age”** means the time that has elapsed since the first day of the woman’s last menstrual period.
- (h) **“Hospital”** means an institution licensed pursuant to the provisions of the law of this
- (i) **“Medical emergency”** means that condition which, on the basis of the physician’s good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate termination of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function.
- (j) **“Physician”** means any person licensed to practice medicine in this State. The term includes medical doctors and doctors of osteopathy.
- (k) **“Pregnant”** or **“pregnancy”** means that female reproductive condition of having an unborn child in the *[woman’s]* uterus.
- (l) **“Qualified person”** means an agent of the physician who is a psychologist, licensed social worker, licensed professional counselor, registered nurse, or physician.
- (m) **“Unborn child”** means the offspring of human beings from conception until birth.

(n) “**Viability**” means the state of fetal development when, in the judgment of the physician based on the particular facts of the case before him or her and in light of the most advanced medical technology and information available to him or her, there is a reasonable likelihood of sustained survival of the unborn child outside the body of his or her mother, with or without artificial support.

Section 4. Informed Consent Requirement.

No abortion shall be performed or induced without the voluntary and informed consent of the woman upon whom the abortion is to be performed or induced. Except in the case of a medical emergency, consent to an abortion is voluntary and informed if and only if:

(a) At least twenty-four (24) hours before the abortion, the physician who is to perform the abortion or the referring physician has informed the woman, orally and in person, of the following:

- (1) The name of the physician who will perform the abortion;
- (2) Medically accurate information that a reasonable patient would consider material to the decision of whether or not to undergo the abortion, including
 - a. A description of the proposed abortion method;
 - b. The immediate and long-term medical risks associated with the proposed abortion method including, but not limited to, the risks of infection, hemorrhage, cervical or uterine perforation, danger to subsequent pregnancies, and increased risk of breast cancer; and
 - c. Alternatives to the abortion;
- (3) The probable gestational age of the unborn child at the time the abortion is to be
- (4) The probable anatomical and physiological characteristics of the unborn child at performed; the time the abortion is to be performed;
- (5) The medical risks associated with carrying her child to term; and
- (6) Any need for anti-Rh immune globulin therapy if she is Rh negative, the likely consequences of refusing such therapy, and the cost of the therapy.

(b) At least twenty-four (24) hours before the abortion, the physician who is to perform the abortion, the referring physician, or a qualified person has informed the woman, orally and in person, that:

- (1) Medical assistance benefits may be available for prenatal care, childbirth, and neonatal care, and that more detailed information on the availability of such assistance is contained in the printed materials and informational DVD given to her and described in Section 5.
- (2) The printed materials and informational DVD in Section 5 describe the unborn child and list agencies that offer alternatives to abortion.
- (3) The father of the unborn child is liable to assist in the support of the child, even in instances where he has offered to pay for the abortion. In the case of rape or incest, this information may be omitted.
- (4) She is free to withhold or withdraw her consent to the abortion at any time without affecting her right to future care or treatment and without the loss of any state or federally funded benefits to which she might otherwise be entitled.
- (5) The information contained in the printed materials and informational DVD given to her, as described in Section 5, are also available on a state-maintained website.

(c) The information required in subsections 4(a) and 4(b) is provided to the woman individually and in a private room to protect her privacy, to maintain the confidentiality of her decision, and to ensure that the information focuses on her individual circumstances and that she has an adequate opportunity to ask questions.

(d) At least twenty-four (24) hours before the abortion, the woman is given a copy of the printed materials and permitted to view or is given a copy of the informational DVD described in Section 5. If the woman is unable to read the materials, they shall be read to her. If the woman asks questions concerning any of the information or materials, answers shall be provided to her in a language she can understand.

[OPTIONAL Information on Fetal Pain: (e) *At least twenty-four (24) hours prior to an abortion being performed or induced on an unborn child who is twenty (20) weeks gestation or more, the physician performing the abortion on the pregnant woman, the referring physician, or a qualified person assisting the physician shall, orally and in person, offer information on fetal pain to the pregnant woman. This information and counseling shall include, but shall not be limited to, the following:*

- (1) *That, by twenty (20) weeks, the unborn child possesses all anatomical links in its nervous system (including spinal cord, nerve tracts, thalamus, and cortex) that are necessary in order to feel pain;*
- (2) *That an unborn child who is twenty (20) weeks gestation or more is fully capable*
- (3) *A description of the actual steps in the abortion procedure to be performed or of experiencing pain;*
- (4) *That maternal anesthesia typically offers little pain prevention for the unborn induced and at which steps in the abortion procedure the unborn child is capable of feeling pain; child; and*
- (5) *That an anesthetic or analgesic is available in order to minimize and/or alleviate pain to the fetus.]*

[OPTIONAL Information on Chemical Abortion Reversal: (f) *At least twenty-four (24) hours prior to an abortion being performed or induced utilizing abortion-inducing drugs, the physician performing the abortion on the pregnant woman, the referring physician, or a qualified person assisting the physician shall, orally and in person, inform the woman of the following:*

- (a) *That it may be possible to reverse the effects of the abortion should she change*
- (b) *That information on and assistance with reversing the effects of abortion-inducing drugs is available in the state-prepared materials.*

For purposes of this Section, **“abortion-inducing drugs”** means a medicine, drug, or any other substance prescribed or dispensed with the intent of terminating the clinically diagnosable pregnancy of a woman, with knowledge that the termination will with reasonable likelihood cause the death of the unborn child. This includes off-label use of drugs known to have abortion-inducing properties, which are prescribed specifically with the intent of causing an abortion, such as misoprostol (Cytotec), and methotrexate. This definition does not apply to drugs that may be known to cause an abortion, but which are prescribed for other medical indications (e.g., chemotherapeutic agents, diagnostic drugs, etc.).]

[(g)] Prior to the abortion, the woman certifies in writing on a checklist form provided or approved by the Department that the information required to be provided under subsections 5(a), 5(b), 5(c), [and] 5(d), 5(e), and 5(f)] have been provided. All physicians who perform abortions shall report the total number of certifications received monthly to the Department. The her mind, but that time is off the essence; and Department shall make the number of certifications received available to the public on an annual basis.

[(h)] Except in the case of a medical emergency, the physician who is to perform the abortion shall receive and sign a copy of the written certification prescribed in subsection [(g)] of this Section prior to performing the abortion. The physician shall retain a copy of the checklist certification form in the woman’s medical record.

[(i)] In the event of a medical emergency requiring an immediate termination of pregnancy, the physician who performed the abortion shall clearly certify in writing the nature of the medical emergency and the circumstances which necessitated the waiving of the informed consent requirements of this Act. This certification shall be signed

by the physician who performed the emergency abortion, and shall be permanently filed in both the records of the physician performing the abortion and the records of the facility where the abortion takes place.

[(j)] A physician shall not require or obtain payment for a service provided in relation to abortion from a patient who has inquired about an abortion or scheduled an abortion until the expiration of the 24-hour reflection period required in subsections 4(a), 4(b), [and] 4(d)[, 4(e) and 4(f)].

Section 5. Publication of Materials.

The Department shall cause to be published printed materials and an informational DVD in English [*and Spanish and other appropriate language(s)*] within [*Insert appropriate number*] days after this Act becomes law. The Department shall develop and maintain a secure internet website, which may be part of an existing website, to provide the information required by and described in this Section. No information regarding persons using the website shall be collected or maintained. The Department shall monitor the website on a weekly basis to prevent and correct tampering.

On an annual basis, the Department shall review and update, if necessary, the following easily comprehensible printed materials and informational DVD:

(a) Geographically indexed materials that inform the woman of public and private agencies and services available to assist a woman through pregnancy, upon childbirth, and while her child is dependent, including but not limited to adoption agencies.

The materials shall include a comprehensive list of the agencies, a description of the services they offer, and the telephone numbers and addresses of the agencies and shall inform the woman about available medical assistance benefits for prenatal care, childbirth, and neonatal care.

The Department shall ensure that the materials described in this Section are comprehensive and do not directly or indirectly promote, exclude, or discourage the use of any agency or service described in this Section. The materials shall also contain a toll-free, 24-hour-a-day telephone number which may be called to obtain information about the agencies in the locality of the caller and of the services they offer.

The materials shall state that it is unlawful for any individual to coerce a woman to undergo an abortion [*Insert reference to state's anti-coercion statute(s), if any*] and that if a minor is denied financial support by the minor's parents, guardian, or custodian because of the minor's refusal to have an abortion performed, the minor shall be deemed emancipated for the purposes of eligibility for public-assistance benefits, except that such benefits may not be used to obtain an abortion.

The materials shall also state that any physician who performs an abortion upon a woman without her informed consent may be liable to her for damages in a civil action at law and that the law permits adoptive parents to pay costs of prenatal care, childbirth, and neonatal care. The materials shall also include the following statement:

"There are many public and private agencies willing and able to help you to carry your child to term, and to assist you and your child after your child is born, whether you choose to keep your child or to place her or him for adoption. The State of [*Insert name of State*] strongly urges you to contact one or more of these agencies before making a final decision about abortion. The law requires that your physician or his agent give you the opportunity to call agencies like these before you undergo an abortion."

(b) Information on the support obligations of the father of a child who is born alive, including but not limited to the father's legal duty to support his child, which may include child support payments and health insurance, and the fact that paternity may be established by the father's signature on a birth certificate, by a statement of paternity, or by court action. The printed material shall also state that more information concerning establishment of paternity and child support services and enforcement may be obtained by calling state or county public assistance agencies.

(c) Materials that inform the pregnant woman of the probable anatomical and physiological characteristics of the unborn child at two (2) week gestational increments from fertilization to full term, including color photographs of the developing unborn child at two (2) week gestational increments. The descriptions shall include information about brain and heart functions, the presence of external members and internal organs during the applicable stages of development, and any relevant information on the possibility of the unborn child's survival. If a photograph is not available, a picture must contain the dimensions of the unborn child and must be realistic. The materials shall be objective, nonjudgmental, and designed to convey only accurate scientific information about the unborn child at the various gestational ages.

(d) Objective information describing the various surgical and drug-induced methods of abortion, as well as the immediate and long-term medical risks commonly associated with each abortion method including, but not limited to uterine perforation, cervical perforation, infection, bleeding, hemorrhage, blood clots, failure to actually terminate the pregnancy, incomplete abortion (retained tissue), pelvic inflammatory disease, endometritis, missed ectopic pregnancy, cardiac arrest, respiratory arrest, renal failure, metabolic disorder, shock, embolism, coma, placenta previa in subsequent pregnancies, preterm birth in subsequent pregnancies, free fluid in the abdomen, adverse reactions to anesthesia and other drugs, any psychological or emotional complications such as depression, anxiety, and sleeping disorders, and any other "adverse event" as defined by the Food and Drug Administration (FDA) criteria provided in the Medwatch Reporting System; and the medical risks associated with carrying a child to term.

(e) A uniform resource locator (URL) for the state-maintained website where the materials described in Subsections 5(a), 5(b), 5(c), [and] 5(d)[and 5(f)] can be found.

[OPTIONAL Information on Chemical Abortion Reversal: (f) *Information on the potential ability of qualified medical professionals to reverse the effects of abortion obtained through the use of abortion-inducing drugs, such as mifepristone (brand name Mifeprex) and misoprostol, commonly referred to as "RU-486," including information directing women to obtain further information at <http://www.abortionpillreversal.com/> and by contacting (877) 558-0333 for assistance in locating a medical professional that can aide in the reversal of abortion.*]

[(g)] A checklist certification form to be used by the physician or a qualified person under subsection 4[(g)] of this Act, which will list all the items of information which are to be given to the woman by a physician or the agent under this Act.

[(h)] The materials shall be printed in a typeface large enough to be clearly legible.

[(i)] The Department shall produce a standardized DVD that may be used statewide, presenting the information described in Subsections 5(a), 5(b), 5(c), 5(d), [and] 5(e) [, and 5(f),] in accordance with the requirements of those subsections. In preparing the DVD, the Department may summarize and make reference to the printed, comprehensive list of geographically indexed names and services described in subsection 5(a). The DVD shall, in addition to the information described in subsections 5(a), 5(b), 5(c), 5(d), [and] 5(e) [, and 5(f)] show an ultrasound of the heartbeat of an unborn child at four (4) to five (5) weeks gestational age, at six (6) to eight (8) weeks gestational age, and each month thereafter, until viability. That information shall be presented in an objective, unbiased manner designed to convey only accurate scientific information.

[(j)] The materials required under this Section and the DVD described in subsection 5([(i)]) shall be available at no cost from the Department upon request and in appropriate number to any person, facility, or hospital.

Section 6. Medical Emergencies.

When a medical emergency compels the performance of an abortion, the physician shall inform the woman, before the abortion if possible, of the medical indications supporting the physician's judgment that an immediate abortion is necessary to avert her death or that a 24-hour delay will cause substantial and irreversible impairment of a major bodily function.

Section 7. Criminal Penalties.

Any person who intentionally, knowingly, or recklessly violates this Act is guilty of a *[Insert appropriate penalty/offense classification]*.

Section 8. Civil Remedies and Professional Sanctions.

(a) In addition to any and all remedies available under the common or statutory law of this State, failure to comply with the requirements of this Act shall:

- (1) Provide a basis for a civil malpractice action for actual and punitive damages.
- (2) Provide a basis for a professional disciplinary action under *[Medical Malpractice Act]*.

(b) No civil liability may be assessed against the woman upon whom the abortion is performed.

(c) When requested, the court shall allow a woman to proceed using solely her initials or a pseudonym and may close any proceedings in the case and enter other protective orders to preserve the privacy of the woman upon whom the abortion was performed.

(d) If judgment is rendered in favor of the plaintiff, the court shall also render judgment for a reasonable attorney's fee in favor of the plaintiff against the defendant.

(e) If judgment is rendered in favor of the defendant and the court finds that the plaintiff's suit was frivolous and brought in bad faith, the court shall also render judgment for reasonable attorney's fee in favor of the defendant against the plaintiff.

Section 9. Construction.

(a) Nothing in this Act shall be construed as creating or recognizing a right to abortion.

(b) It is not the intention of this law to make lawful an abortion that is currently unlawful.

Section 10. Right of Intervention.

The *[Legislature]*, by joint resolution, may appoint one or more of its members, who sponsored or cosponsored this Act in his or her official capacity, to intervene as a matter of right in any case in which the constitutionality of this law is challenged.

Section 11. Severability.

Any provision of this Act held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as to give it the maximum effect permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event such provision shall be deemed severable here from and shall not affect the remainder hereof or the application of such provision to other persons not similarly situated or to other, dissimilar circumstances.

Section 12. Effective Date.

This Act takes effect on *[Insert date]*.

Abortion Patients' Enhanced Safety Act

HOUSE/SENATE BILL NO. _____

By Representatives/Senators _____

[Drafter's Note: States considering this legislation will need to address several important issues such as whether or not the administration of abortion-inducing drugs such as RU-486 will be specifically covered or excluded. Moreover, states that maintain enforceable abortion clinic regulations may also want to consider whether it is preferable to amend or supplement existing requirements. Please contact AUL for assistance in this regard.]

Section 1. Title.

This Act may be known and cited as the “Abortion Patients’ Enhanced Safety Act.”

Section 2. Legislative Findings and Purposes.

- (a) The Legislature of the State of [Insert name of State] finds that:
- (1) The [vast majority] of all abortions in this State are performed in clinics devoted solely to providing abortions and family planning services. Most women who seek abortions at these facilities do not have any relationship with the physician who performs the abortion either before or after the procedure, and they do not return to the facility for post-surgical care. In most instances, the woman’s only actual contact with the abortion provider occurs simultaneously with the abortion procedure, with little opportunity to ask questions about the procedure, potential complications, and proper follow-up care.
 - (2) For most abortions, the woman arrives at the clinic on the day of the procedure, has the procedure in a room within the clinic, and recovers under the care of clinic staff, all without a hospital admission.
 - (3) “The medical, emotional, and psychological consequences of an abortion are serious and can be lasting” *H.L. v. Matheson*, 450 U.S. 398, 411 (1981).
 - (4) Abortion is an invasive surgical procedure that can lead to numerous and serious medical complications. Potential immediate complications for first-trimester abortions include, among others, bleeding, hemorrhage, infection, uterine perforation, blood clots, cervical tears, incomplete abortion (retained tissue), failure to actually terminate the pregnancy, free fluid in the abdomen, acute abdomen, missed ectopic pregnancies, cardiac arrest, sepsis, respiratory arrest, reactions to anesthesia, and even death.
 - (5) The risks for second-trimester abortions are greater than for first-trimester abortions. The risk of hemorrhage, in particular, is greater, and the resultant complications may require a hysterectomy, other reparative surgery, or a blood transfusion.
 - (6) The State of [Insert name of State] has a legitimate concern for the public’s health and safety. *Williamson v. Lee Optical*, 348 U.S. 483, 486 (1985).
 - (7) The State of [Insert name of State] “has legitimate interests from the outset of pregnancy in protecting the health of women.” *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 847 (1992). More specifically, the State of [Insert name of State] “has a legitimate concern with the health of women who undergo abortions.” *Akron v. Akron Ctr. for Reproductive Health, Inc.*, 462 U.S. 416, 428-29 (1983).
 - (8) Moreover, the State of [Insert name of State] has “a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that ensure maximum safety for the patient.” *Roe v. Wade*, 410 U.S. 113, 150 (1973).

- (9) The *Roe* Court specifically found that the State's legitimate interest in regulating abortion to protect maternal health, "obviously extends at least to [regulating] the performing physician and his staff, to the facilities involved, to the availability of after-care, and to adequate provision for any complication or emergency that may arise." *Id.* at 150.
 - (10) An ambulatory surgical center (ASC) [or other appropriate term as used in existing state statutes, administrative rules, or other regulatory material(s)] is a healthcare facility that specializes in providing surgery services in an outpatient setting. ASCs generally provide a cost-effective and convenient environment that may be less stressful than what many hospitals offer. Particular ASCs may perform surgeries in a variety of specialties or dedicate their services to one specialty.
 - (11) Patients who elect to have surgery in an ASC arrive on the day of the procedure, have the surgery in an operating room, and recover under the care of the nursing staff, all without a hospital admission.
- (b) Based on the findings in subsection (a), it is the purpose of this Act to:
- (1) Define [certain] abortion clinics as "ambulatory surgical centers" [or other appropriate term as used in existing state statutes, administrative rules, or other regulatory material(s)] under the laws of this State and to subject them to licensing and regulation as such;
 - (2) Promote and enforce the highest standard for care and safety in facilities performing abortions in this State;
 - (3) Provide for the protection of public health through the establishment and enforcement of rigorous and medically appropriate standards of care and safety in facilities performing abortions; and
 - (4) Regulate the provision of abortion consistent with and to the extent permitted by the decisions of the Supreme Court of the United States.

Section 3. Definitions.

As used in this Act only:

- (a) **"Abortion"** means the act of using or prescribing any instrument [, *medicine, drug, or any other substance, device, or means*]¹ with the intent to terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child. Such use [, *prescription, or means*] is not an abortion if done with the intent to:
- (1) Save the life or preserve the health of the unborn child;
 - (2) Remove a dead unborn child caused by spontaneous abortion; or
 - (3) Remove an ectopic pregnancy.
- (b) **"Abortion clinic"** means a facility, other than an accredited hospital, in which five (5) or more first-trimester abortions in any month or any second- or third-trimester abortions are performed.
- (c) **"Department"** means the [Insert name of state department or agency that licenses and regulates ambulatory surgical centers or similar state-regulated entities] of the State of [Insert name of State].

¹ Provisions in this model legislation may implicate the *Patient Protection and Affordable Care Act* (the federal healthcare law enacted in 2010) including, specifically, the "HHS Mandate" which requires most insurance plans to cover certain life-ending drugs and devices. Please contact AUL for drafting assistance.

Section 4. Statutory Definition of “Ambulatory Surgical Center” [Or Other Appropriate Term] Modified to Include Certain Facilities Performing Abortions.

(a) The term “ambulatory surgical center” *[or other appropriate term as used in existing state statutes, administrative rules, or other regulatory material(s)]* as used in *[Insert specific citation(s) or reference(s) to state statute(s), administrative rule(s), or other regulatory material(s) governing ambulatory surgical centers or similar state-regulated entities]* shall include abortion clinics which do not provide services or other accommodations for abortion patients to stay more than twenty-three (23) hours within the clinic.

(b) All ambulatory surgical centers *[or other appropriate term as used in existing state statute(s), administrative rule(s), or other regulatory material(s)]* operating in this State including abortion clinics must meet the licensing and regulatory standards prescribed in *[Insert specific reference(s) to state statute(s), administrative rule(s), or other regulatory material(s) providing licensing and regulatory standards for ambulatory surgical centers or similar state-regulated entities]*.

Section 5. Criminal Penalties.

Whoever operates an abortion clinic as defined in this Act without a valid ambulatory surgical center *[or other appropriate term as used in existing state statute(s), administrative rule(s), or other regulatory material(s)]* license issued by the Department is guilty of a *[Insert proper penalty/offense classification]*.

Section 6. Civil Fines.

(a) Any violation of this Act may be subject to a civil penalty or fine up to *[Insert appropriate amount]* imposed by the Department.

(b) Each day of violation constitutes a separate violation for purposes of assessing civil penalties or fines.

(c) In deciding whether and to what extent to impose fines, the Department shall consider the following factors:

- (1) Gravity of the violation including the probability that death or serious physical harm to a patient or individual will result or has resulted;
- (2) Size of the population at risk as a consequence of the violation;
- (3) Severity and scope of the actual or potential harm;
- (4) Extent to which the provisions of the applicable statutes or regulations were violated;
- (5) Any indications of good faith exercised by licensee;
- (6) Duration, frequency, and relevance of any previous violations committed by the licensee; and
- (7) Financial benefit to the licensee of committing or continuing the violation.

(d) Both the Office of the Attorney General and the Office of the District Attorney *[or other appropriate classification]* for the county in which the violation occurred may institute a legal action to enforce collection of civil fines.

Section 7. Injunctive Remedies.

In addition to any other penalty provided by law, whenever in the judgment of the *[Director]* of the *[Insert name of state department or agency that licenses and regulates ambulatory surgical centers or similar state-regulated entities]*, any person has engaged or is about to engage in any acts or practices which constitute, or will constitute, a violation of this Act, the *[Director]* shall make application to any court of competent jurisdiction for an order enjoining such acts and practices, and upon a showing by the *[Director]* that such person has engaged or is about to engage in any such acts or practices, an injunction, restraining order, or such other order as may be appropriate shall be granted by such court without bond.

Section 8. Construction.

- (a) Nothing in this Act shall be construed as creating or recognizing a right to abortion.
- (b) It is not the intention of this Act to make lawful an abortion that is currently unlawful.

Section 9. Right of Intervention.

The [*Legislature*], by joint resolution, may appoint one or more of its members, who sponsored or cosponsored this Act in his or her official capacity, to intervene as a matter of right in any case in which the constitutionality of this Act or any portion thereof is challenged.

Section 10. Severability.

Any provision of this Act held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as to give it the maximum effect permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event such provision shall be deemed severable herefrom and shall not affect the remainder hereof or the application of such provision to other persons not similarly situated or to other, dissimilar circumstances.

Section 11. Effective Date.

This Act takes effect on [*Insert date*].

Abortion-Inducing Drugs Safety Act

HOUSE/SENATE BILL NO. _____

By Representatives/Senators _____

[Drafter's Note: AUL has drafted detailed talking points to assist those interested in introducing this model language in preparing for and countering arguments typically raised by abortion advocates. Those talking points are available upon request by contacting AUL's Legislative Coordinator at (202) 289-1478 or Legislation@AUL.org.]

Section 1. Title.

This Act may be known and cited as the “Abortion-Inducing Drugs Safety Act.”

Section 2. Legislative Findings and Purposes.

[Drafter's Note: Challenges to Mifeprex regulations have demonstrated the necessity of including certain facts related to the Mifeprex regimen in order to make clear the State's intent. It is imperative to include the following findings, as well as the definitions, in the model language, and/or as part of the legislative record.]

- (a) The [Legislature] of the State of [Insert name of State] finds that:
- (1) The Food and Drug Administration (FDA) approved the drug mifepristone (brand name “Mifeprex”), a first-generation [selective] progesterone receptor modulator ([S]PRM), as an abortion-inducing drug with a specific gestation, dosage, and administration protocol.
 - (2) The FDA approved mifepristone (brand name “Mifeprex”) under the rubric of 21 C.F.R. § 314.520, also referred to as “Subpart H,” which is the only FDA approval process that allows for postmarketing restrictions. Specifically, the Code of Federal Regulations (CFR) provides for accelerated approval of certain drugs that are shown to be effective but “can be safely used only if distribution or use is restricted.”
 - (3) The FDA does not treat Subpart H drugs in the same manner as drugs which undergo the typical approval process.
 - (4) As approved by the FDA and as outlined in the Mifeprex final printed labeling (FPL), an abortion by mifepristone consists of three (3) two-hundred (200) mg tablets of mifepristone taken orally, followed by two (2) two-hundred (200) mcg tablets of misoprostol taken orally, through forty-nine (49) days LMP (a gestational measurement using the first day of the woman's “last menstrual period” as a marker). The patient is to return for a follow-up visit in order to confirm that a complete termination of pregnancy has occurred. This FDA-approved protocol is referred to as the “Mifeprex regimen.”
 - (5) The aforementioned treatment requires three (3) office visits by the patient, and the dosages may only be administered in a clinic, medical office, or hospital and under supervision of a physician.
 - (6) The Mifeprex FPL outlines the FDA-approved dosage and administration of both drugs in the Mifeprex regimen, namely mifepristone and misoprostol.
 - (7) When the FDA approved the Mifeprex regimen under Subpart H, it did so with certain restrictions. For example, the distribution and use of the Mifeprex regimen must be under the supervision of a physician who has the ability to assess the duration of pregnancy, diagnose ectopic pregnancies, and provide surgical intervention (or has made plans to provide surgical intervention through other qualified physicians).
 - (8) One of the restrictions imposed by the FDA as part of its Subpart H approval is a written agreement that must be signed by both the physician and patient. In that agreement, the woman, along with the

physician, attests to the following, among other statements:

- a. “I believe I am no more than 49 days (7 weeks) pregnant;”
 - b. “I understand that I will take misoprostol in my provider’s office two days
 - c. “I will do the following... return to my provider’s office in 2 days (Day 3)
- (9) The FDA concluded that available medical data did not support the safety of home use of misoprostol, and it specifically rejected information in the Mifeprex FPL on self-administering misoprostol at home.
 - (10) Court testimony by Planned Parenthood and other abortion providers demonstrates that providers routinely fail to follow the FDA-approved protocol for the Mifeprex regimen, as it is outlined in the Mifeprex FPL. *See, e.g., Planned Parenthood Cincinnati Region v. Taft*, 459 F. Supp. 2d 626 (S.D. Oh. 2006).
 - (11) Specifically, Planned Parenthood and other abortion providers are administering a single oral dose of two-hundred (200) mg of mifepristone, followed by a single vaginal or buccal dose of eight-tenths (.8) mg misoprostol, through sixty-three (63) days LMP, without medical supervision and without follow-up care. *See, e.g., Planned Parenthood Cincinnati Region*, 459 F. Supp. 2d at 630 n.7.
 - (12) The use of mifepristone presents significant medical risks to women, including but not limited to abdominal pain, cramping, vomiting, headache, fatigue, uterine hemorrhage, viral infections, and pelvic inflammatory disease.
 - (13) Abortion-inducing drugs are associated with an increased risk of complications relative to surgical abortion. The risk of complications increases with advancing gestational age, and, in the instance of the Mifeprex regimen, with failure to complete the two-step dosage process.
 - (14) In July 2011, the FDA reported 2,207 adverse events in the U.S. after women used the Mifeprex regimen for the termination of pregnancy. Among those were 14 deaths, 612 hospitalizations, 339 blood transfusions, and 256 infections (including 48 “severe infections”).
 - (15) “Off-label” or so-called “evidence-based” use of the Mifeprex regimen may be deadly. To date, 14 women have reportedly died after administration of the Mifeprex regimen, with eight deaths attributed to severe bacterial infection. All eight of those women administered the regimen in an “off-label” or “evidence-based” manner advocated by abortion providers. The FDA has not been able to determine whether off-label use led to the eight deaths.
 - (16) Medical evidence demonstrates that women who use abortion-inducing drugs incur more complications than those who have surgical abortions.
- (b) Based on the findings in subsection (a), it is the purpose of this Act to:
 - (1) Protect women from the dangerous and potentially deadly off-label use of abortion-inducing drugs, such as, but not limited to the Mifeprex regimen; and
 - (2) Ensure that physicians abide by the protocol tested and approved by the FDA for such abortion-inducing drugs, as outlined in the drug labels.

Section 3. Definitions.

(a) “**Abortion**” means the act of using or prescribing any instrument, medicine, drug, or any other substance, device, or means with the intent to terminate the clinically diagnosable pregnancy of a woman, with knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child. Such use, prescription, or means is not an abortion if done with the intent to:

- (1) Save the life or preserve the health of the unborn child;
- (2) Remove a dead unborn child caused by spontaneous abortion;
- (3) Remove an ectopic pregnancy; or
- (4) Treat a maternal disease or illness for which the prescribed drug is indicated.

(b) **“Abortion-inducing drug”** means a medicine, drug, or any other substance prescribed or dispensed with the intent of terminating the clinically diagnosable pregnancy of a woman, with knowledge that the termination will with reasonable likelihood cause the death of the unborn child. This includes off-label use of drugs known to have abortion-inducing properties, which are prescribed specifically with the intent of causing an abortion, such as misoprostol (Cytotec), and methotrexate. This definition does not apply to drugs that may be known to cause an abortion, but which are prescribed for other medical indications (e.g., chemotherapeutic agents, diagnostic drugs, etc.).

Use of such drugs to induce abortion is also known as **“medical [, and] drug-induced [, and/or chemical] abortion.”**

- (c) **“Department”** means the Department of *[Insert appropriate title]* of the State of *[Insert name of State]*.
- (d) **“Final printed labeling (FPL)”** means the FDA-approved informational document for an abortion-inducing drug which outlines the protocol authorized by the FDA and agreed upon by the drug company applying for FDA authorization of that drug.
- (e) **“LMP” or “gestational age”** means the time that has elapsed since the first day of the woman’s last menstrual period.
- (f) **“Mifeprex regimen”** means the abortion-inducing drug regimen that involves administration of mifepristone (brand name “Mifeprex”) and misoprostol. It is the only abortion-inducing drug regimen approved by the FDA. It is also known as the **“RU-486 regimen”** or simply **“RU-486.”**
- (g) **“Mifepristone”** means the first drug used in the Mifeprex regimen.
- (h) **“Misoprostol”** means the second drug used in the Mifeprex regimen.
- (i) **“Physician”** means any person licensed to practice medicine in this State. The term includes medical doctors and doctors of osteopathy.
- (j) **“Pregnant” or “pregnancy”** means that female reproductive condition of having an unborn child in the mother’s *[woman’s]* uterus.
- (k) **“Unborn child”** means the offspring of human beings from conception until birth.

Section 4. Unlawful Distribution of Abortion-Inducing Drug.

(a) It shall be unlawful to knowingly give, sell, dispense, administer, or otherwise provide or prescribe any abortion-inducing drug to a pregnant woman for the purpose of inducing an abortion in that pregnant woman or enabling another person to induce an abortion in a pregnant woman, unless the person who gives, sells, dispenses, administers, or otherwise provides or prescribes the abortion-inducing drug is a physician and the provision or prescription of the abortion-inducing drug satisfies the protocol authorized by the FDA, as outlined in the final printed labeling (FPL) for the drug or drug regimen. In the case of the Mifeprex regimen, the Mifeprex label includes the FDA-approved dosage and administration instructions for both mifepristone (Mifeprex) and misoprostol.

(b) Because the failure and complication rates from medical abortion increase with advancing gestational age, because the physical symptoms of medical abortion can be identical to the symptoms of ectopic pregnancy, and because abortion-inducing drugs do not treat ectopic pregnancies but rather are contraindicated in ectopic

pregnancies, the physician giving, selling, dispensing, administering, or otherwise providing or prescribing the abortion-inducing drug must first examine the woman and document, in the woman's medical chart, gestational age and intrauterine location of the pregnancy prior to giving, selling, dispensing, administering, or otherwise providing or prescribing the abortion-inducing drug.

(c) Every pregnant woman to whom a physician gives, sells, dispenses, administers, or otherwise provides or prescribes any abortion-inducing drug shall be provided with a copy of the drug's label.

(d) The physician giving, selling, dispensing, administering, or otherwise providing or prescribing the abortion-inducing drug must have a signed contract with a physician who agrees to handle complications and be able to produce that signed contract on demand by the patient or by the Department. The physician who contracts to handle emergencies must have active admitting privileges and gynecological/surgical privileges at a hospital designated to handle any emergencies associated with the use or ingestion of the abortion-inducing drug. Every pregnant woman to whom a physician gives, sells, dispenses, administers, or otherwise provides or prescribes any abortion-inducing drug shall receive the name and phone number of the contracted physician and the hospital at which that physician maintains admitting privileges can handle any emergencies.

(e) The physician giving, selling, dispensing, administering, or otherwise providing or prescribing any abortion-inducing drug, or an agent of said physician, must schedule a follow-up visit for the woman at approximately fourteen (14) days after administration of the abortion-inducing drug to confirm that the pregnancy is completely terminated and to assess the degree of bleeding. Said physician or agent of physician shall make all reasonable efforts to ensure that the woman returns for the scheduled appointment. A brief description of the efforts made to comply with this subsection, including the date, time, and identification by name of the person making such efforts, shall be included in the woman's medical record.

Section 5. Reporting.

(a) If a physician provides an abortion-inducing drug to another for the purpose of inducing an abortion as authorized in Section 4 of this Act, and if the physician knows that the woman who uses the abortion-inducing drug for the purpose of inducing an abortion experiences (during or after the use) an adverse event, the physician shall provide a written report of the adverse event within three (3) days of the event to the FDA via the Medwatch Reporting System [and to the State Medical Board].

[(b). *The State Medical Board shall compile and retain all reports it receives under this Section. All reports the Board receives are public records open to inspection under [Insert citation(s) to or appropriate reference(s) to applicable State code section(s) regarding public records]. In no case shall the State Medical Board release to any person or entity the name or any other personal identifying information regarding a person who uses an abortion-inducing drug for the purpose of inducing an abortion and who is the subject of a report the State Medical Board receives under this provision.*]

[(c)] An “**adverse event**” shall be defined for purposes of this Act according to the FDA criteria given in the Medwatch Reporting System.

[**Drafter's Note:** *Inclusion of the reporting requirements is optional and may be removed without diminishing the effect of the regulation itself.*]

Section 6. Criminal Penalties.

(a) A person who intentionally, knowingly, or recklessly violates any provision of this Act is guilty of a [Insert appropriate penalty/offense classification]. In this Section, “**intentionally**” is defined by Section [Insert section number or other appropriate reference] of the [state penal/criminal code].

(b) No criminal penalty may be assessed against the pregnant woman upon whom the drug-induced abortion is performed.

Section 7. Civil Remedies and Professional Sanctions.

(a) In addition to whatever remedies are available under the common or statutory law of this State, failure to comply with the requirements of this Act shall:

- (1) Provide a basis for a civil malpractice action for actual and punitive damages.
- (2) Provide a basis for a professional disciplinary action under [*Medical Malpractice Act*].
- (3) Provide a basis for recovery for the woman's survivors for the wrongful death of the woman under the [*Wrongful Death Act*].

(b) No civil liability may be assessed against the pregnant woman upon whom the drug-induced abortion is performed.

(c) When requested, the court shall allow a woman to proceed using solely her initials or a pseudonym and may close any proceedings in the case and enter other protective orders to preserve the privacy of the woman upon whom the drug-induced abortion was performed.

(d) If judgment is rendered in favor of the plaintiff, the court shall also render judgment for a reasonable attorney's fee in favor of the plaintiff against the defendant.

(e) If judgment is rendered in favor of the defendant and the court finds that the plaintiff's suit was frivolous and brought in bad faith, the court shall also render judgment for reasonable attorney's fee in favor of the defendant against the plaintiff.

Section 8. Construction.

(a) Nothing in this Act shall be construed as creating or recognizing a right to abortion.

(b) It is not the intention of this Act to make lawful an abortion that is currently unlawful.

Section 9. Right of Intervention.

The [*Legislature*], by joint resolution, may appoint one or more of its members, who sponsored or cosponsored this Act in his or her official capacity, to intervene as a matter of right in any case in which the constitutionality of this law is challenged.

Section 10. Severability.

Any provision of this Act held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as to give it the maximum effect permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event such provision shall be deemed severable here from and shall not affect the remainder hereof or the application of such provision to other persons not similarly situated or to other, dissimilar circumstances.

Section 11. Effective Date.

This Act takes effect on [*Insert date*].

Parental Involvement Enhancement Act

HOUSE/SENATE BILL NO. _____

By Representatives/Senators _____

[Drafter’s Note: *The requirements detailed below may be enacted individually or collectively, depending on the needs of an individual state. Each substantive Section contains a drafter’s note indicating when enactment of the enhancement would be appropriate. For assistance in drafting a complete overhaul of a state’s parental notice or consent law, please see AUL’s Parental Consent for Abortion Act or Parental Notification of Abortion Act.*]

Section 1. Short Title.

This Act may be cited as the “Parental Involvement Enhancement Act.”

Section 2. Legislative Findings and Purposes.

- (a) The Legislature of the State of *[Insert name of State]* finds that:
- (1) Immature minors often lack the ability to make fully informed choices that take into account both immediate and long-range consequences.
 - (2) The medical, emotional, and psychological consequences of abortion are sometimes serious and can be lasting, particularly when the patient is immature.
 - (3) The capacity to become pregnant and the capacity for mature judgment concerning the wisdom of an abortion are not necessarily related.
 - (4) Parents ordinarily possess information essential to a physician’s exercise of his or her best medical judgment concerning the child.
 - (5) Parents who are aware that their minor daughter has had an abortion may better ensure that she receives adequate medical attention after her abortion.
 - (6) Parental consultation is usually desirable and in the best interests of the minor.
- (b) Based on the findings in subsection (a), the *[Legislature]*’s purposes in enacting this enhancement to the State of *[Insert name of State]*’s parental *[consent or notice]* law are to further the important and compelling State interests of:
- (1) Protecting minors against their own immaturity;
 - (2) Fostering family unity and preserving the family as a viable social unit;
 - (3) Protecting the constitutional rights of parents to rear children who are members of their household;
 - (4) Reducing teenage pregnancy and abortion; and
 - (5) In light of the foregoing statements of purpose, allowing for judicial bypasses of the parental *[consent or notice]* requirement to be made only in exceptional or rare circumstances.

Section 3. Definitions.

[Drafter’s Note: *These are recommended definitions, but some may not be compatible with a state’s existing parental involvement law. In drafting a specific bill, care should be taken to select only those definitions that are compatible with existing state law or with the intent of the new bill.*]

For purposes of this Act only:

- (a) **“Abortion”** means the act of using or prescribing any instrument, medicine, drug, or any other substance, device, or means with the intent to terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child. Such use, prescription, or means is not an abortion if done with the intent to:
- (1) Save the life or preserve the health of the unborn child;
 - (2) Remove a dead unborn child caused by spontaneous abortion; or
 - (3) Remove an ectopic pregnancy.
- (b) **“Actual notice”** means the giving of notice directly, in person or by telephone.
- (c) **“Constructive notice”** means notice by certified mail to the last known address of the parent or guardian with delivery deemed to have occurred forty-eight (48) hours after the certified notice is mailed.
- (d) **“Coercion”** means restraining or dominating the choice of a pregnant woman by force, threat of force, or deprivation of food and shelter.
- (e) **“Consent”** means, in the case of a pregnant woman who is less than eighteen (18) years of age, a notarized written statement signed by the pregnant woman and her mother, father, or legal guardian declaring that the pregnant woman intends to seek an abortion and that her mother, father, or legal guardian consents to the abortion; or, in the case of a pregnant woman who is an incompetent person, a notarized written statement signed by the pregnant woman’s guardian declaring that the guardian consents to the performance of an abortion upon the pregnant woman.
- (f) **“Department”** means the Department of *[Insert appropriate title]* of the State of *[Insert name of State]*.
- (g) **“Emancipated minor”** means any person less than eighteen (18) years of age who is or has been married or who has been legally emancipated.
- (h) **“Incompetent”** means any person who has been adjudged a disabled person and has had a guardian appointed for her under the *[state Probate Act or other appropriate state law]*.
- (i) **“Medical emergency”** means a condition that, on the basis of the physician’s good-faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function.
- (j) **“Neglect”** means the failure of a parent or legal guardian to supply a minor with necessary food, clothing, shelter, or medical care when reasonably able to do so or the failure to protect a minor from conditions or actions that imminently and seriously endanger the minor’s physical or mental health when reasonably able to do so.
- (k) **“Physical abuse”** means any physical injury intentionally inflicted by a parent or legal guardian on a minor.
- (l) **“Physician,” “attending physician,” or “referring physician”** means any person licensed to practice medicine in this State. The term includes medical doctors and doctors of osteopathy.
- (m) **“Pregnant woman”** means a woman who is pregnant and is less than eighteen (18) years of age and not emancipated, or who has been adjudged an incompetent person under *[Insert citation(s) or other reference(s) to state statute(s) relating to petition and hearing; independent evaluation, etc.]*.
- (n) **“Sexual abuse”** means any sexual conduct or sexual penetration as defined in *[Insert citation(s) or other reference(s) to appropriate section(s) of the state criminal/penal code or other appropriate law(s)]* and committed against a minor by a parent or legal guardian.

Section [4]. Notarized Consent.

[Drafter's Note: This enhancement is appropriate for a state with a parental consent law that does not already require notarized consent.]

- (a) No person shall perform an abortion upon a pregnant woman unless, in the case of a woman who is less than eighteen (18) years of age, he or she first obtains the notarized written consent of both the pregnant woman and one of her parents or her legal guardian; or, in the case of a woman who is an incompetent person, he or she first obtains the notarized written consent of her guardian.
- (b) The physician shall keep the notarized written consent of the parent or legal guardian in the medical file of the pregnant woman for five (5) years past the majority of the pregnant woman, but in no event less than seven (7) years.

Section [5]. Notarized Waiver of Notice Requirement.

[Drafter's Note: This enhancement is appropriate for a state with a parental notice law that permits the person(s) entitled to notice to waive the requirement.]

- (a) Notice is not required if the physician obtains a notarized written statement by the pregnant woman's parent or legal guardian, dated not more than thirty (30) days before the abortion, waiving the right of the parent or legal guardian to notice of the pregnant woman's abortion.
- (b) The physician shall keep a copy of the notarized written statement of the parent or legal guardian waiving their right to notice in the medical file of the pregnant woman for five (5) years past the majority of the pregnant woman, but in no event less than seven (7) years.

Section [6]. Proof of Identification and Relationship to Pregnant Woman – Consent.

[Drafter's Note: This enhancement is appropriate for a state with a parental consent law that does not require the consenting parent or guardian to provide identification or proof of the parent or guardian's relationship to the pregnant woman.]

- (a) The physician shall obtain from the parent or legal guardian entitled to consent:
 - (1) Government-issued proof of the identity of the parent or legal guardian; and
 - (2) Written documentation that establishes that the parent or legal guardian is the lawful parent or legal guardian of the pregnant woman.
- (b) The physician shall keep a copy of the proof of identification of the parent or legal guardian and the written documentation that establishes the relationship of the parent or legal guardian to the pregnant woman in the medical file of the pregnant woman for five (5) years past the majority of the pregnant woman, but in no event less than seven (7) years.
- (c) A physician receiving parental consent under this Section shall execute for inclusion in the medical record of the pregnant woman an affidavit stating: "I, (Insert name of physician), certify that according to my best information and belief, a reasonable person under similar circumstances would rely on the information presented by both the pregnant woman and her parent or legal guardian as sufficient evidence of identity and relationship."

Section [7]. Proof of Identification and Relationship to Pregnant Woman – Waiver of Notice Requirement.

[Drafter's Note: This enhancement is appropriate for a state with a parental notice law that permits the person(s) entitled to notice to waive the requirement.]

- (a) In lieu of the notice required by this Section, the physician shall obtain from the parent or legal guardian entitled to notice:

- (1) Government-issued proof of the identity of the parent or legal guardian;
- (2) Written documentation that establishes that the parent or legal guardian is the lawful parent or legal guardian of the pregnant woman; and
- (3) A signed statement by the parent or legal guardian that the parent or legal guardian has been notified that an abortion is to be performed on the pregnant woman.

(b) The physician shall keep a copy of the proof of identification of the parent or legal guardian and the written documentation that establishes the relationship of the parent or legal guardian to the pregnant woman in the medical file of the pregnant woman for five (5) years past the majority of the pregnant woman, but in no event less than seven (7) years.

(c) A physician receiving parental notice under this Section shall execute for inclusion in the medical record of the pregnant woman an affidavit stating: “I, (Insert name of physician), certify that according to my best information and belief, a reasonable person under similar circumstances would rely on the information presented by both the pregnant woman and her parent or legal guardian as sufficient evidence of identity and relationship.”

Section [8]. Notice of Post-Emergency.

[Drafter’s Note: This enhancement is appropriate for states with parental consent or parental notification laws.]

(a) [Consent or Notice] shall not be required under Section [Insert Section number] of this Act if the attending physician certifies in the minor or incompetent woman’s medical record that a medical emergency exists and there is insufficient time to [obtain the required consent or provide the required notice]. However, the attending physician shall, within twenty-four (24) hours after completion of the abortion, notify one of the parents or the legal guardian of the minor or incompetent woman in the manner provided in this Section that a medical emergency abortion was performed on the minor or incompetent woman and of the circumstances that warranted invocation of this Section.

(b) Unless the minor or incompetent woman gives notice of her intent to seek a judicial waiver pursuant to Section [Insert number of judicial waiver section] of this [Act], the attending physician shall verbally inform the parent or legal guardian of the minor or incompetent woman within twenty-four (24) hours after the performance of a medical emergency abortion that an abortion was performed on the minor or incompetent woman. The attending physician shall also inform the parent or legal guardian of the basis for the certification of the physician required under paragraph (a) of this Section, and provide details regarding any additional risks to the minor or incompetent woman. The attending physician shall also send a written notice of the performed abortion by certified mail to the last known address of the parent or legal guardian, restricted delivery, return receipt requested.

(c) If the minor or incompetent woman gives notice to the attending physician of her intent to seek a judicial waiver pursuant to Section [Insert number for judicial waiver section] of this [Act], the physician shall file a notice with any judge of a court of competent jurisdiction that the minor has given such notice and shall provide the information the physician would have been required to provide the parent under [paragraph (b)] of this Section if the minor or incompetent woman had not given notice of her intent to seek a judicial waiver.

(d) The court shall expeditiously schedule a confidential conference with notice to the minor or incompetent woman and the physician. If the minor or incompetent woman is able to participate in the proceedings, the court shall advise the minor or incompetent woman that she has the right to court-appointed counsel and shall, upon her request, provide the minor or incompetent woman with such counsel. If the minor or incompetent woman is unable to participate, the court shall appoint counsel on behalf of the minor or incompetent woman.

(e) After an appropriate hearing, the court, taking into account the medical condition of the minor or incompetent woman, shall set a deadline by which the minor or incompetent woman must file a petition or motion pursuant to Section [Insert number for judicial waiver section] of this [Act]. The court may subsequently extend the deadline in

light of the medical condition of the minor or incompetent woman or other equitable considerations. If the minor or incompetent woman does not file a petition or motion by the deadline, either in that court or in another court of competent jurisdiction with a copy filed in that court, the court shall direct that the court clerk provide the notice to a parent or legal guardian.

Section [9]. Venue.

[Drafter's Note: This enhancement is for any state that does not restrict the venue in which a minor may file a petition for judicial waiver of the state's consent or notice requirement.]

The pregnant woman may petition a [circuit] court in the county in which the pregnant woman resides for a waiver of the [consent or notice] requirement

Section [10]. Burden of Evidence for Bypass.

[Drafter's Note: This enhancement is for a state that wishes to define or to provide a heightened evidentiary requirement in judicial waiver proceedings.]

(a) If the court finds, by clear and convincing evidence, that the pregnant woman is both sufficiently mature and well-informed to decide whether to have an abortion, the court shall issue an order authorizing the pregnant woman to consent to the performance or inducement of an abortion without the [consent or notification] of a parent or guardian and the court shall execute the required forms. If the court does not make the finding specified in this subsection or subsection (b) of this Section, it shall dismiss the petition.

(b) If the court finds, by clear and convincing evidence, that the pregnant woman is the victim of physical or sexual abuse by one or both of her parents or her legal guardian, or that [obtaining the consent or providing the notification] of a parent or legal guardian is not in the best interest of the pregnant woman, the court shall issue an order authorizing the pregnant woman to consent to the performance or inducement of an abortion without the [consent or notification] of a parent or guardian. If the court does not make the finding specified in this subsection or subsection (a) of this Section, it shall dismiss the petition.

Section [11]. Judicial Bypass Standards.

[Drafter's Note: This enhancement is for states that want to enact specific standards for courts to use when evaluating judicial waiver petitions.]

(a) If the pregnant woman claims to be mature and well-informed at a proceeding held pursuant to [Insert section number], the pregnant woman must prove by clear and convincing evidence that she is sufficiently mature and capable of giving informed consent without [obtaining consent from or giving notice to] her parent or legal guardian based on her experience level, perspective, and judgment.

(b) In assessing the pregnant woman's experience level, the court may consider, among other relevant factors, the pregnant woman's age and experiences working outside the home, living away from home, traveling on her own, handling personal finances, and making other significant decisions. In assessing the pregnant woman's perspective, the court may consider, among other relevant factors, what steps the pregnant woman took to explore her options and the extent to which she considered and weighed the potential consequences of each option. In assessing the pregnant woman's judgment, the court may consider, among other relevant factors, the pregnant woman's conduct since learning of her pregnancy and her intellectual ability to understand her options and to make an informed decision.

(c) In assessing whether, by clear and convincing evidence, [obtaining the consent or providing notification] of a pregnant woman's parent or guardian is not in her best interest, a court may not consider the potential financial impact on the pregnant woman or the pregnant woman's family if the pregnant woman does not have an abortion.

Section [12]. Mental Health Evaluation.

[Drafter's Note: *This enhancement is for any state that wants to better protect minors from their own immaturity or coercion or abuse by others.*]

(a) Prior to court proceedings addressing a petition for judicial waiver, the court may require the pregnant woman to participate in an evaluation and counseling session with a mental health professional from the [state Health Department] or a staff member from the [state Department of Social Services], or both. Such evaluation shall be confidential and scheduled expeditiously.

(b) Such evaluation and counseling session shall be for the purpose of developing trustworthy and reliable expert opinion concerning the pregnant woman's sufficiency of knowledge, insight, judgment, and maturity with regard to her abortion decision in order to aid the court in its decision and to make the State's resources available to the court for this purpose.

Persons conducting such sessions may employ the information and printed materials referred to in [Insert citation(s) to state informed consent law, if applicable] in examining how well the pregnant woman is informed about pregnancy, fetal development, abortion risks and consequences, and abortion alternatives and should also endeavor to verify that the pregnant woman is seeking an abortion of her own free will and is not acting under coercion, intimidation, threats, abuse, undue pressure, or extortion by any other persons.

(c) The results of such evaluation and counseling shall be reported to the court by the most expeditious means, commensurate with security and confidentiality, to assure receipt by the court prior to a hearing on the pregnant woman's petition.

Section [13]. Disclosure and Consent Form.

[Drafter's Note: *This enhancement is appropriate for states with parental consent laws. It is based on the consent form developed by the Texas Medical Board.*]

(a) A form created by the [Insert appropriate state department or agency] shall be used by physicians to obtain the consent required prior to performing an abortion on a minor who is not emancipated.

(b) A form is not valid and consent is not sufficient, unless:

- (1) A parent or legal guardian initials each page of the form, indicating that he or she has read and understands the information included on that page;
- (2) A parent or legal guardian signs the last page of the form in front of a person who is a notary public;
- (3) The minor initials each list of risks and hazards, detailed in Sections (c)(4)(i)-(iv) below;
- (4) The minor signs a "consent statement," described in Section (c)(6) below; and
- (5) The physician signs the declaration described in Section (c)(7) below.

(c) The form shall include, but is not limited to, the following:

- (1) A description of the minor's rights, including her right to informed consent;
- (2) A description of the parent or legal guardian's rights under [Insert name of State] law;
- (3) A detailed description of the surgical and/or medical procedures that are planned to be performed on the minor;
- (4) A detailed list of the risks and hazards related to the surgical and medical procedures planned for the minor, including, but not limited to, the following:

- a. Risks and hazards that may occur in connection with any surgical, medical, and/or diagnostic procedure: potential for infection; blood clots in veins and lungs; hemorrhage (heavy bleeding); allergic reactions; or death.
 - b. Risks and hazards that may occur with a surgical abortion: hemorrhage (heavy bleeding); a hole in the uterus (uterine perforation) or other damage to the uterus; sterility; injury to the bowel and/or bladder; a possible hysterectomy as a result of complication or injury during the procedure; and failure to remove all products of conception that may result in an additional procedure.
 - c. Risks and hazards that may occur with a medical/non-surgical abortion: hemorrhage (heavy bleeding); failure to remove all products of conception that may result in an additional procedure; sterility; and possible continuation of pregnancy.
 - d. Risks and hazards of the particular procedure planned for the minor: cramping of the uterus or pelvic pain; infection of the female organs (uterus, tubes, and ovaries); cervical laceration; incompetent cervix; and emergency treatment for any of the above named complications.
- (5) A description of additional information that must be provided by the physician to the minor under *[Insert name of State]* law, including, but not limited to *[Insert information required by the state's informed consent law, if applicable (e.g. the probable gestational age of the unborn baby; the availability of medical assistance benefits; the father's responsibilities, etc.)]*
- (6) A "consent statement" which must be signed by the minor. The consent statement must include, but is not limited to, the following points, which must be individually initialed by the minor:
- a. That the minor understands that the doctor is going to perform an abortion on her which will end her pregnancy and will result in the death of her unborn child;
 - b. That the minor is not being forced to have an abortion, and that she has the choice not to have the abortion and may withdraw consent prior to the abortion;
 - c. That the minor gives permission for the procedure;
 - d. That the minor understands that there are risks and hazards that could affect her if she has the planned surgical or medical procedures;
 - e. That the minor has been given the opportunity to ask questions about her condition, alternative forms of treatment, risk of non-treatment, the procedures to be used, and the risks and hazards involved;
 - f. That the minor has been given information required under *[Insert citation(s) to the state's informed consent law, if applicable]*; and
 - g. That the minor has sufficient information to give informed consent.
- (7) A "physician declaration," which must be signed by the physician, stating that the physician or his or her assistant has, as required, explained the procedure and the contents of this form to the minor and her parent or legal guardian and has answered all questions. Further, to the best of the physician's knowledge, the patient and her parent or legal guardian have been adequately informed and have consented to the procedure.
- (8) A "parental consent statement" stating that the signing parent or legal guardian:
- a. Understands that the doctor signing the "physician declaration" is going to perform an abortion on the minor, which will end her pregnancy and result in the death of her unborn child;

- b. That the parent or legal guardian has had the opportunity to read this form or have it read to him or her and has initialed each page;
 - c. That the parent or legal guardian had the opportunity to ask questions to the physician or the physician's assistant about the information in this form and the surgical and medical procedures to be performed on the minor;
 - d. That the parent or legal guardian believes that he or she has sufficient information to give informed consent; and
 - e. That, by the parent or legal guardian's signature, the parent or legal guardian affirms that he or she is the minor's father, mother, or legal guardian.
- (9) A page for the parent or legal guardian's signature that must be notarized by a notary public.
- (10) Any additional information that must be provided to a woman under the laws of *[Insert name of State]* in order for a physician to obtain her informed consent prior to performing an abortion.

Section [14]. Construction.

- (a) Nothing in this Act shall be construed as creating or recognizing a right to abortion.
- (b) It is not the intention of this law to make lawful an abortion that is currently unlawful.

Section [15]. Severability.

Any provision of this Act held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as to give it the maximum effect permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event such provision shall be deemed severable herefrom and shall not affect the remainder hereof or the application of such provision to other persons not similarly situated or to other, dissimilar circumstances.

Section [16]. Right of Intervention.

The *[Legislature]*, by joint resolution, may appoint one or more of its members who sponsored or co-sponsored this Act, as a matter of right and in his or her official capacity, to intervene to defend this law in any case in which its constitutionality is challenged.

Section [17]. Effective Date.

This Act takes effect on *[Insert date]*.

Child Protection Act

HOUSE/SENATE BILL NO. _____

By Representatives/Senators _____

Section 1. Title.

This Act may be cited as the “[*Insert name of State*] Child Protection Act.”

Section 2. Legislative Findings and Purposes.

- (a) The [*Legislature*] of the State of [*Insert name of State*] finds that:
- (1) Children are increasingly being preyed upon, victimized, and coerced into illegal sexual relationships by adults.
 - (2) [*Insert name of State*] law requires [*caretakers, healthcare facilities, healthcare providers, teachers, and other specified individuals*] to report suspected incidents of sexual crimes against children. [*Insert reference(s) to appropriate state statute(s)*].
 - (3) However, many of these suspected criminal acts go unreported, and perpetrators are not investigated or prosecuted.
 - (4) [*Insert name of State*] may better prevent future sexual crimes against children by investigating, prosecuting, incarcerating, and treating those who prey upon and victimize children.
 - (5) To prevent future and continuing sexual crimes against children, all suspected crimes of this nature must be reported to state investigators and agencies that are specifically trained and equipped to professionally, thoroughly, and compassionately investigate cases of suspected crimes against children, appropriately and effectively relieving mandatory reporters of any investigatory responsibility.
 - (6) The physical, emotional, developmental, and psychological impact of sexual crimes on child victims can be severe and long-lasting.
 - (7) The societal costs of these crimes are also significant and affect the entire populace.
 - (8) The collection, maintenance, and preservation of evidence, including forensic tissue samples, furthers [*Insert name of State*]’s interest in protecting children from sexual crimes and provides the State with the tools necessary for successful investigations and prosecutions.
 - (9) Parents and guardians have both the right and responsibility to be involved in medical treatment decisions involving their children, and no one has the right to knowingly or willfully impede or circumvent this right.
 - (10) There are documented cases of individuals other than a parent or guardian aiding, abetting, and assisting minor girls to procure abortions without their parents’ or guardian’s knowledge, consent, or involvement. This includes transporting children across state lines to avoid [*Insert name of State*]’s parental [*involvement, consent, or notice*] requirements for abortion.
 - (11) Such actions violate both the sanctity of the familial relationship and [*Insert name of State*]’s parental [*involvement, consent, or notice*] law for abortion.
- (b) Based on the findings in subsection (a), the [*Legislature*]’s purposes in promulgating this Act are to further the important and compelling state interests of:

- (1) Protecting children from sexually predatory adults;
- (2) Ensuring that adults who are involved in illegal sexual relationships or contact with children are reported, investigated, and, when warranted, prosecuted;
- (3) Relieving medical professionals and other mandatory reporters of suspected sexual crimes against children from any responsibility to personally investigate an allegation or suspicion. Mandatory reporters must simply report allegations, suspicions, and pertinent facts. Trained law enforcement or social services personnel will then be responsible for any investigation and for the ultimate disposition of the allegation(s) or case;
- (4) Reducing the physical, emotional, developmental, and psychological impact of sexual crimes on child victims;
- (5) Reducing the societal and economic burdens on the populace that result from sexual crimes against children;
- (6) Providing law enforcement officials with the tools and evidence necessary to investigate and prosecute child predators; and
- (7) Protecting and respecting the right of parents and guardians to be involved in the medical decisions and treatment of their children and preventing anyone from knowingly or willfully subverting or circumventing these rights.

Section 3. Definitions.

For purposes of this Act only:

(a) **“Abuse”** means *[Insert specific language from existing state statutes concerning the reporting of child abuse, child sexual abuse, or similar offenses]* or *[the involvement of a child in any sexual act with a parent, guardian, or another adult; any sexual activity involving a child under the age of twelve (12); the aiding or toleration of a parent, guardian, or caretaker of the child’s sexual involvement with any other adult; the child’s involvement in pornographic displays; or any other involvement of a child in sexual activity constituting a crime under the laws of this State].*

[Drafter’s Note: Depending on the specific provisions and prohibitions of the state’s criminal/penal code or other statutes, a more definitive exclusion of sexual acts or conduct between two (consenting) children may be appropriate in light of recent federal court decisions. Please consult AUL for specific drafting assistance.]

(b) **“Abortion”** means the act of using or prescribing any instrument, medicine, drug, or any other substance, device, or means with the intent to terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child. Such use, prescription, or means is not an abortion if done with the intent to:

- (1) Save the life or preserve the health of the unborn child;
- (2) Remove a dead unborn child caused by spontaneous abortion; or
- (3) Remove an ectopic pregnancy.

(c) **“Adult”** means one who has attained the age *[of eighteen (18) or the legal age of majority in this State]*.

(d) **“Caretaker”** means any person legally obligated to provide or secure adequate care for the child, including a parent, guardian, tutor, legal custodian, foster home parent, or anyone else providing the child with a residence.

(e) **“Child”** or **“children”** means anyone under the age of *[eighteen (18) or, if appropriate, the state’s age of consent for sexual activity]*.

(f) **“Mandatory reporter”** means any of the following individuals or entities performing their occupational duties:

- (1) *[Insert specific categories and definitions of mandatory reporters from existing state statutes or administrative rules defining “mandatory reporters” for child abuse, child sexual abuse, or similar offenses].*
- (2) **“Reproductive healthcare facility”** means any office, clinic, or any other physical location that provides abortions, abortion counseling, abortion referrals, contraceptives, contraceptive counseling, sex education, or gynecological care and services.

(g) **“Physician”** means a person licensed to practice medicine in the State of *[Insert name of State]*. This term includes medical doctors and doctors of osteopathy.

(h) **“Sexual abuse”** means *[Insert specific language from existing state statutes concerning child sexual abuse or similar offenses]* or *[any sexual conduct, sexual contact, or sexual penetration as defined in [Insert appropriate reference(s) to state criminal/penal code provision(s) or other statutory provision(s)] and committed against a child by an adult or involving a child under the age of twelve (12)].*

Section 4. Mandatory Reporter Requirements.

A mandatory reporter must report *[in writing]* every instance of alleged or suspected abuse, sexual abuse, or sexual crimes against a child as defined by *[Insert appropriate reference(s) to state criminal/penal code or other statutory provision(s)]*. The mandatory reporter may not use his or her discretion in deciding what cases should or should not be reported to the appropriate law enforcement or state agencies.

Section 5. Mandatory Reporting Procedure.

If a mandatory reporter has cause to believe that a child has been abused, sexually abused, or has been the victim of a sexual crime as defined in *[Insert appropriate reference(s) to state criminal code or other statutory provision(s)]*, the mandatory reporter shall make a *[written]* report no later than the forty-eighth (48th) hour after such abuse, sexual abuse, or crime has been brought to his or her attention or he or she suspects such abuse, sexual abuse, or crime. A mandatory reporter may not delegate the responsibility to report such abuse, sexual abuse, or crime to any other person, but must personally make the report. The mandatory reporter must make a report to *[Insert name of designated local or state law enforcement agency and/or other state agency]*.

Section 6. Contents of the Report.

The person making the report must identify the name and address of the child, as well as the name and address of the person(s) who is responsible for the care or custody of the child. The person making the report must also file any pertinent information he or she may have relating to the alleged or suspected abuse, sexual abuse, or crime.

Section 7. Failure to Report.

Any mandatory reporter who has cause to believe that a child has been abused, sexually abused, or has been the victim of a crime as defined in *[Insert appropriate reference(s) to state criminal/penal code or other statutory provision(s)]* and does not report such abuse, sexual abuse, or crime as provided by this Act shall be subject to *[Insert reference(s) to appropriate civil remedy, fine, or other penalty]*.

Section 8. Maintenance of Forensic Samples from Abortion Performed on a Child.

(a) Any physician who performs an abortion on a child who is less than *[fourteen (14)]* years of age at the time of the abortion procedure shall preserve, in accordance with rules and regulations adopted by the *[state Attorney General or other appropriate law enforcement agency charged with the collection and preservation of evidence]* pursuant to this Act, fetal tissue extracted during such abortion. The physician shall submit such tissue to the *[Insert name of proper state agency such as state Department of Public Safety, state Bureau of Investigation, or the state Crime Laboratory]*.

(b) The [state Attorney General or other appropriate law enforcement agency charged or familiar with the forensic collection and preservation of evidence] shall adopt rules and regulations prescribing:

- (1) The amount and type of fetal tissue to be preserved and submitted by a physician pursuant to this Section;
- (2) Procedures for the proper preservation of such tissue for the purpose of DNA testing and examination;
- (3) Procedures for documenting the chain of custody of such tissue for use as evidence;
- (4) Procedures for proper disposal of fetal tissue preserved pursuant to this Section;
- (5) A uniform reporting form [or instrument] mandated to be utilized by physicians when submitting fetal tissue under this Section which shall include the name and address of the physician submitting the fetal tissue and the name and complete address of residence of the parent or legal guardian of the child upon whom the abortion was performed; and
- (6) Procedures for communication with law enforcement agencies regarding evidence and information obtained pursuant to this Section.

(c) **Penalties.** Failure of a physician to comply with any provision of this Section or any rule or regulation adopted thereunder:

- (1) Shall constitute unprofessional conduct for the purposes of [Insert appropriate statutory reference(s)]; and
- (2) Is a [Insert appropriate criminal offense/penalty classification] and a [Insert appropriate higher offense/penalty classification] upon a second or subsequent conviction.

Section 9. Prohibition on Intentionally Causing, Aiding, Abetting, or Assisting a Child to Obtain an Abortion Without Parental [Involvement, Consent or Notification].

(a) No person shall intentionally cause, aid, abet, or assist a child to obtain an abortion without the [consent or notification required by [insert reference(s) to state parental involvement for abortion statute(s)]]].

(b) **Penalties.** A person who violates subsection (a) of this Section shall be civilly liable to the child and to the person or persons required to [give consent/receive notice under [insert reference(s) to state parental involvement for abortion statute(s)]]]. A court may award damages to the person or persons adversely affected by a violation of subsection (a) of this Section, including compensation for emotional injury without the need for personal presence at the act or event, and the court may further award attorneys' fees, litigation costs, and punitive damages. Any adult who engages in or consents to another person engaging in a sexual act with a child in violation of the provisions of [Insert appropriate reference(s) to state criminal/penal code provision(s)], which results in the child's pregnancy, shall not be awarded damages under this Section.

(c) It shall not be a defense to a claim brought under this Section that the abortion was performed or induced pursuant to consent to the abortion given in a manner that was otherwise lawful in the state or place where the abortion was performed or induced.

(d) An unemancipated child does not have capacity to consent to any action in violation of this Section.

(e) A court of competent jurisdiction may enjoin conduct that would be in violation of this Section upon petition by the Attorney General, a prosecuting or [district] attorney, or any person adversely affected or who reasonably may be adversely affected by such conduct, upon a showing that such conduct:

- (1) Is reasonably anticipated to occur in the future; or
- (2) Has occurred in the past, whether with the same child or others, and that it is not unreasonable to expect that such conduct will be repeated.

Section 10. Right of Intervention.

The [*Legislature*], by joint resolution, may appoint one or more of its members, who sponsored or cosponsored this Act in his or her official capacity, to intervene as a matter of right in any case in which the constitutionality of this law is challenged.

Section 11. Severability.

Any provision of this Act held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as to give it the maximum effect permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event such provision shall be deemed severable herefrom and shall not affect the remainder hereof or the application of such provision to other persons not similarly situated or to other, dissimilar circumstances.

Section 12. Effective Date.

This Act takes effect on [*Insert date*].

Enforcement Module: Enforcement Options For State Abortion Laws

[Drafter's Note: AUL should be consulted for drafting assistance with regard to these enforcement options. For example, AUL can assist in the drafting of specific findings of fact that should be adopted in support of the enforcement options legislators decide to pursue. These model provisions may be enacted in whole or in part as stand-alone legislation or as an amendment to existing laws.]

GENERAL CRIMINAL LIABILITY

(a) A [person] who intentionally, knowingly, or recklessly violates any provision of [this Act [or Section] or any rules and regulations adopted under this Act [or Section]]; OR insert specific reference(s) to state abortion-related statute(s), regulations(s), or administrative rule(s)] is guilty of a [Insert appropriate penalty/offense classification].

In this Section, “**intentionally**” is defined by Section [Insert appropriate section number] of the [Criminal/Penal Code].

(b) No criminal penalty may be assessed against the pregnant woman upon whom the abortion is performed for a violation of any provision of [this Act [or Section] or any rules and regulations adopted under this Act [or Section]]; OR insert specific reference(s) to state abortion-related statute(s), regulation(s), or administrative rule(s)].

GENERAL CIVIL LIABILITY

Option 1: Civil Penalties Administered by State Authorities

(a) Any violation of [this Act [or Section] or any rules and regulations adopted under this Act [or Section]]; OR insert specific reference(s) to state abortion-related statute(s), regulation(s), or administrative rule(s)] may be subject to a civil penalty or fine up to [Insert appropriate amount] imposed by [Insert name of appropriate state official(s), department(s), and/or agencies].

(b) No civil penalty may be assessed against the pregnant woman upon whom the abortion is performed for a violation of any provision of [this Act [or Section] or any rules and regulations adopted under this Act [or Section]]; OR insert specific reference(s) to state abortion-related statute(s), regulation(s), or administrative rule(s)].

(c) Each day of violation constitutes a separate violation for purposes of assessing civil penalties or fines.

(d) In deciding whether and to what extent to impose fines, by [Insert name of appropriate state official(s), department(s), or agencies] shall consider the following factors:

- (1) Gravity of the violation(s) including the probability that death or serious physical harm to a patient or individual will result or has resulted;
- (2) Size of the population at risk as a consequence of the violation(s);
- (3) Severity and scope of the actual or potential harm;
- (4) Extent to which the provisions of the applicable statutes or regulations were violated;
- (5) Any indications of good faith exercised by [abortion facility, physician, licensee, and/or other appropriate term];
- (6) Duration, frequency, and relevance of any previous violations committed by the [abortion facility, physician, licensee, and/or other appropriate term]; and
- (7) Financial benefit to the [abortion facility, physician, licensee, and or other appropriate term] of committing or continuing the violation(s).

(e) Both the Office of the Attorney General and the Office of the District Attorney *[or other appropriate term]* for the county in which the violation(s) occurred may institute a legal action to enforce collection of civil penalties or fines.

Option 2: Statutory Cause of Action for Harmed Party

Any *[person]* who violates *[this Act [or Section] or any rules and regulations adopted under this Act [or Section]; OR insert specific reference(s) to state abortion-related statute(s), regulation(s), or administrative rule(s)]* shall be civilly liable to the person or persons adversely affected by the violation(s). A court may award damages to the person or persons adversely affected by any violation(s) of *[this Act [or Section] or any rules and regulations adopted under this Act [or Section]; OR insert specific reference(s) to state abortion-related statute(s), regulation(s), or administrative rule(s)]* including compensation for emotional, physical, and psychological harm; attorneys' fees, litigation costs, and punitive damages.

Option 3: Third-Party's Ability to Initiate Civil [or Administrative] Enforcement Actions¹

(a) Except as provided in subsection (b) of this *[Act or [Section]]*, any person *[or class of persons]* with *[direct]* knowledge of the relevant facts may commence a civil *[or administrative]* action on his or her *[or their]* own behalf:

- (1) Against any physician who is alleged to have violated or to be in violation of *[any provision of this Act [or Section] or any rules and regulations adopted under this Act [or Section]; OR insert specific reference(s) to state abortion-related statute(s), regulation(s), or administrative rule(s)]*;
- (2) Against any *[staff member, employee, and/or volunteer]* at an *[abortion facility]* who is alleged to have violated or to be in violation of *[any provision of this Act [or Section] or any rules and regulations adopted under this Act [or Section]; OR insert specific reference(s) to state abortion-related statute(s), regulation(s), or administrative rule(s)]*;
- (3) Against any *[abortion facility]*, including specifically its *[owner(s) and director(s)]*, that is alleged to have violated or to be in violation of *[any provision of this Act [or Section] or any rules and regulations adopted under this Act [or Section]; OR insert specific reference(s) to state abortion-related statute(s), regulation(s), or administrative rule(s)]*; or
- (4) Against any *[official, department, agency, or agent]* of the State of *[Insert name of State]*, in *[his, her, or its]* official capacity, who *[that]* is alleged to have violated or to be in violation of *[any provision of this Act [or Section] or any rules and regulations adopted under this Act [or Section]; OR insert specific reference(s) to state abortion-related statute(s), regulation(s), or administrative rule(s)]* or who is alleged to have improperly failed to enforce *[any provision of this Act [or Section] or any rules and regulations adopted under this Act [or Section]; OR insert specific reference(s) to state abortion-related statute(s), regulation(s), or administrative rule(s)]* as required by *[this Act [or Section] or any rules and regulations adopted under this Act [or Section]]* OR *insert specific reference(s) to state abortion-related statute(s), regulation(s), or administrative rule(s)]*.

[Drafter's Note: A state choosing to propose subsection (a)(4) will also need to consider a specific waiver of sovereign immunity.]

(b) No civil action may be commenced under subsection (a) prior to thirty (30) days after the plaintiff(s) *[or class of plaintiffs]* has given notice of the violation(s) to the *[official, department, agency, or agent]* of the State of *[Insert name of State]* charged with enforcing *[any provision of this Act [or Section] or any rules and regulations adopted under this Act [or Section]; OR insert specific reference(s) to state abortion-related statute(s), regulation(s), or administrative rule(s)]*.

(c) Nothing in this *[Act [or Section]]* shall restrict any right which any person *[or class of persons]* may have under any statute or at common law to seek enforcement of *[any provision of this Act [or Section] or any rules and regulations*

¹ Adapted from 42 U.S.C. § 7604 (2013).

adopted under this Act [or Section]; OR insert specific reference(s) to state abortion-related statute(s), regulation(s), or administrative rule(s)] or to seek any other legal or equitable relief.

(d) Nothing in this [Act [or Section]] or in any other law of the State of [Insert name of State] shall be construed to prohibit, exclude, or restrict any person [or class of persons] from:

- (1) Bringing any enforcement action or obtaining any judicial remedy or sanction in any state or local court; or
- (2) Bringing any administrative enforcement action or obtaining any administrative remedy or sanction in any state or local administrative agency, department or instrumentality; in any department, agency, or instrumentality thereof; or from any officer, agent, or employee thereof under state or local law respecting [any provision of this Act [or Section] or any rules and regulations adopted under this Act [or Section]; OR insert specific reference(s) to state abortion-related statute(s), regulation(s), or administrative rule(s)].

ADMINISTRATIVE ACTION AGAINST FACILITY LICENSE

The [Insert reference(s) to appropriate state official(s), department(s), and/or agencies] may deny, suspend, revoke, or refuse to renew [a license] in any case in which it finds that there has been a substantial failure of any [person, physician, licensee, applicant, abortion facility, and/or other appropriate term(s)] to comply with the requirements of [this Act [or Section] or any rules and regulations adopted under this Act [or Section]; OR insert specific reference(s) to state abortion-related statute(s), regulation(s), or administrative rule(s)]. In such case, the [Insert reference(s) to appropriate state official(s), department(s), and/or agencies] shall furnish the [person, physician, licensee, applicant, abortion facility, and/or other appropriate term(s)] thirty (30) days notice specifying reasons for the action. Any [person, physician, licensee, applicant, abortion facility, and/or other appropriate term(s)] who [that] feels aggrieved by the action of the [Insert reference(s) to appropriate state official(s), department(s), and/or agencies] in denying, suspending, revoking, or refusing to renew a license may appeal the action in accordance with the [delay, notice, and other] procedures established [Insert reference(s) to applicable agency or administrative appeal procedure(s)].

INJUNCTIVE REMEDY

In addition to any other penalty provided by law, whenever in the judgment of the [Insert reference(s) to appropriate state official(s), department(s), and/or agencies], any [person, physician, licensee, abortion facility, and/or other appropriate term(s)] has engaged, or is about to engage, in any acts or practices which constitute, or will constitute, a violation of [this Act [or Section] or any rules and regulations adopted under this Act [or Section]; OR insert specific reference(s) to state abortion-related statute(s), regulation(s), or administrative rule(s)], the [Insert reference(s) to appropriate state official(s), department(s), and/or agencies] shall make application to any court of competent jurisdiction for an order enjoining such acts and practices, and upon a showing by the [Insert reference(s) to appropriate state official(s), department(s), and/or agencies] that such [person, physician, licensee, abortion clinic, and/or other appropriate term(s)] has engaged or is about to engage in any such acts or practices, an injunction, restraining order, or such other order as may be appropriate shall be granted by such court without bond.

PROFESSIONAL AND DISCIPLINARY REMEDIES

In addition to whatever remedies are available under the common or statutory law of this State, failure to comply with the requirements of [this Act [or Section] or any rules and regulations adopted under this Act [or Section]; OR insert specific reference(s) to state abortion-related statute(s), regulation(s), or administrative rule(s)] shall:

- (a) Provide a basis for a civil malpractice action for actual and punitive damages.
- (b) Provide a basis for a professional disciplinary action under [state Medical Malpractice Act or other appropriate statutory and/or administrative authority].

Inspections and Investigations of Licensed Abortion Facilities

[Drafter's Note: A critical element of ensuring the protection of maternal health and the adequate enforcement of laws, regulations, and administrative rules related to abortion is regular inspections and, when appropriate, administrative and criminal investigations. The model provisions provided below may be used to supplement existing state rules and protocols for the inspection and investigation of abortion facilities.]

(a) The Department shall establish policies and procedures for conducting pre-licensure and re-licensure inspections of abortion facilities. Prior to issuing or reissuing a license, the Department shall conduct an on-site inspection to ensure compliance with the *[minimum standards, applicable regulations, and administrative rules]* promulgated by the Department under *[Insert citation(s) and reference(s) to appropriate authorities including laws, regulations, and administrative rules]*.

(b) The Department shall also establish policies and procedures for conducting inspections and investigations pursuant to complaints received by the Department and made against any abortion facility. The Department shall receive, record, and dispose of complaints in accordance with established policies and procedures.

(c) If the Director determines that there is reasonable cause to believe a licensee, licensed abortion facility, or abortion facility that is required to be licensed pursuant to *[Insert citation(s) and reference(s) to appropriate authorities including laws, regulations, and administrative rules related to abortion]* is not adhering to the requirements of *[Insert citation(s) and reference(s) to appropriate authorities including laws, regulations, and administrative rules related to abortion]*; *[the minimum standards, regulations, and administrative rules promulgated by the Department under the authority of [Insert citation(s) and reference(s) to appropriate authorities including laws, regulations, and administrative rules related to abortion]]* ; or any other law, administrative rule, or regulation relating to abortion, the Director and any duly-designated employee or agent of the Director, including *[county health representatives]* and county or municipal fire inspectors, consistent with standard medical practices, may enter on and into the premises of the licensee, licensed abortion facility, or abortion facility that is required to be licensed pursuant to *[Insert citation(s) and reference(s) to appropriate authorities including laws, regulations, and administrative rules related to abortion]* during regular business hours of the licensee or abortion facility to determine compliance with *[Insert citation(s) and reference(s) to appropriate authorities including laws, regulations, and administrative rules related to abortion]*; *[the minimum standards, regulations, and administrative rules promulgated by the Department under the authority of [Insert citation(s) and reference(s) to appropriate authorities including laws, regulations, and administrative rules related to abortion]]* ; local fire ordinances or rules; and any other law, administrative rule, or regulation relating to abortion.

(d) An application for a license pursuant to *[Insert citation(s) and reference(s) to appropriate authorities including laws, regulations, and administrative rules related to abortion]* constitutes permission for, and complete acquiescence in, an entry or inspection of the premises during the pendency of the application and, if licensed, during the term of the license.

(e) If an inspection or investigation conducted pursuant to this Section 5(c) or 5(d) reveals that a licensee or licensed abortion facility is not adhering to the requirements of *[Insert citation(s) and reference(s) to appropriate authorities including laws, regulations, and administrative rules]*; *[the minimum standards, administrative rules, or regulations promulgated by the Department under the authority of [Insert citation(s) and reference(s) to appropriate authorities including laws, regulations, and administrative rules]]*; local fire ordinances or rules; and any other law, administrative rule, or regulation relating to abortion, the Director may take action to deny, suspend, revoke, or refuse to renew a license to operate an abortion facility.



ABORTION

State Constitutional Amendment

Section 1. The policy of *[Insert name of State]* is to protect the life of every unborn child from conception to birth, to the extent permitted by the federal constitution.

Section 2. Nothing in this Constitution shall be construed to grant or secure any right relating to abortion or the public funding thereof.

Section 3. No public funds shall be used to pay for any abortion, except to save the life of the mother [*or as may be required by federal law*].

The “Missouri Preamble”: A Framework for Defining and Protecting Personhood

HOUSE/SENATE BILL NO. _____

By Representatives/Senators _____

Section 1. Text of Preamble.

The [Legislature] of the State of [Insert name of State] finds that:

- (a) The life of each human being begins at conception;
- (b) Unborn children have protectable interests in life, health, and well-being; and
- (c) The natural parents of unborn children have protectable interests in the life, health, and well-being of their unborn children.

Section 2. Effective Date, Interpretation, and Application.

Effective [Insert effective date], the laws of the State of [Insert name of State] shall be interpreted and construed to acknowledge on behalf of the unborn child at every stage of development, all the rights, privileges, and immunities available to other persons, citizens, and residents of the State of [Insert name of State], subject only to the Constitution of the United States [, and] decisional interpretations thereof by the United States Supreme Court[,] [and specific provisions to the contrary in the statutes and constitution of the State of [Insert name of State]].

Section 3. Definitions.

As used in this [Section, Title, or other appropriate term], the terms “unborn child” or “unborn children” means the offspring of human beings from conception until birth.

Section 4. Exclusions.

Nothing in this [Section, Title, or other appropriate term] shall be interpreted as creating a cause of action against a woman for indirectly harming her unborn child by failing to properly care for herself or by failing to follow any particular program of prenatal care.

Pro-Life State Resolution

JOINT RESOLUTION PROPOSING A CONSTITUTIONAL AMENDMENT RETURNING DETERMINATIONS ON ABORTION LAW AND POLICY TO THE AMERICAN PEOPLE

HOUSE/SENATE BILL NO. _____

By Representatives/Senators _____

WHEREAS, no right to abortion is rooted in the traditions of the American people, and no national right to abortion is conferred by the Constitution of the United States;

WHEREAS, the U.S. Supreme Court's decisions in *Roe v. Wade* and *Doe v. Bolton* have no basis in the text or history of the Constitution of the United States;

WHEREAS, the U.S. Supreme Court's abortion decisions have taken away the American people's right of self-government and have not respected the authority of the American people, through their elected representatives, to establish abortion law and policy;

WHEREAS, the authority of the people of each State to determine public policy and to protect human life and health is fundamental;

WHEREAS, the appropriate forum for the resolution of the abortion issue in a republic is the legislature;

WHEREAS, the U.S. Supreme Court's abortion decisions have resulted in the most extreme abortion policy of any democracy in the world and have resulted in significant damage to the physical and psychological health of American women;

WHEREAS, the State of *[Insert name of State]* has a duty to protect innocent human life;

WHEREAS, human beings possessing inherent and inalienable rights are entitled to the full protection of law and due process, and the U.S. Supreme Court's abortion decisions have failed to protect the lives of unborn children;

WHEREAS, because of the U.S. Supreme Court's abortion decisions, it is impossible for the State of *[Insert name of State]* to protect the life, health, and welfare of women and unborn human life; to adequately protect parental rights; to maintain accurate statistical data to aid in providing proper legal protections for maternal health; and to properly regulate the practice of medicine; and

WHEREAS, the State of *[Insert name of State]* is prevented, by the U.S. Supreme Court, from providing adequate legal remedies to protect the life, health, and welfare of pregnant women and unborn human life.

NOW, THEREFORE, BE IT RESOLVED BY THE LEGISLATURE OF THE STATE OF *[INSERT NAME OF STATE]*:

Section 1. That, because the people in a republic have the only legitimate authority to determine abortion law and policy, the *[Legislature]* of this State, as duly-elected representatives of the people, calls upon the United States Congress to propose a constitutional amendment, pursuant to Article V of the Constitution of the United States, stating that a right to abortion is not conferred by the Constitution of the United States.

Section 2. That the Secretary of State of *[Insert name of State]* transmit a copy of this resolution to the Governor, to the President of the United States, and to the President of the Senate and the Speaker of the House of Representatives of the United States Congress.

Partial-Birth Abortion Ban Act

HOUSE/SENATE BILL NO. _____

By Representatives/Senators _____

Section 1. Title.

This Act may be known and cited as the “Partial-Birth Abortion Ban Act.”

Section 2. Legislative Findings and Purposes.

- (a) The [Legislature] of the State of [Insert name of State] finds that:
- (1) Partial-birth abortion is a gruesome and inhumane procedure that is never medically necessary and, as such, should be prohibited.
 - (2) In 2003, the 108th United States Congress passed the *Partial-Birth Abortion Ban Act of 2003* (18 U.S.C. §1531), and President George W. Bush signed it into law.
 - (3) Later, on April 18, 2007, the U.S. Supreme Court upheld the *Partial-Birth Abortion Ban Act of 2003* (“the federal ban”) in *Gonzales v. Carhart*, 550 U.S. 124 (2007), specifically ruling that a ban on partial-birth abortion need not include a maternal “health” exception to be constitutional.
 - (4) This Act’s language stems from and uses as its primary influence the language of the federal ban as upheld in *Gonzales v. Carhart*.
 - (5) This Act – a state ban on partial-birth abortion – is needed to supplement the federal ban. Importantly, the federal ban was narrowly tailored to reach only those partial-birth abortion procedures that implicate Congress’ power to regulate interstate or foreign commerce. U.S. CONST. art. 1, §8, cl. 3. Without this Act, partial-birth abortions performed, but not affecting these categories of commerce, are not prohibited under the federal ban.
 - (6) Partial-birth abortion poses serious risks to women’s long-term health.
 - (7) There is a substantial evidentiary record upon which the [Legislature] of the State of [Insert name of State] has based its conclusion that a state ban on partial-birth abortion is not constitutionally required to contain a maternal “health” exception.
 - (8) Moreover, the medical evidence clearly supports the informed judgment of the State of [Insert name of State] that a partial-birth abortion is never medically necessary to preserve a woman’s health and instead poses serious health risks to women.
 - (9) Specifically, partial-birth abortion poses serious risks including, but not limited to: an increased risk of cervical incompetence, as a result of cervical dilation that makes it difficult or impossible for a woman to successfully carry a subsequent pregnancy to term; an increased risk of uterine rupture, abruption, amniotic fluid embolus, and trauma to the uterus, as a result of converting the child to a footling breech position – a procedure which, according to a leading obstetrics textbook, “there are very few, if any, indications for other than for delivery of a second twin”; and a risk of lacerations and secondary hemorrhaging, as a result of the physician blindly forcing a sharp instrument into the base of the unborn child’s skull while he or she is lodged in the birth canal – an act which could result in severe bleeding and subsequent shock.
 - (10) There is no credible medical evidence that partial-birth abortions are safer than other abortion procedures. No controlled studies of partial-birth abortion have been conducted nor have any comparative studies

been conducted to demonstrate its safety and efficacy compared to other abortion methods. Furthermore, there have been no articles published in peer-reviewed journals that establish that partial-birth abortions are superior in any way to established abortion procedures.

- (11) In light of this overwhelming evidence, the State of [Insert name of State] has a compelling interest in prohibiting partial-birth abortion. Both *Roe v. Wade*, 410 U.S. 113 (1973), and *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), recognized a governmental interest in protecting the life of a child during the birth [or delivery] process. This interest is specifically implicated during a partial-birth abortion because labor is induced and the birth process is begun before an abortion is attempted or the child is actually aborted [or killed].
 - (12) In fact, partial-birth abortion kills a child who is mere inches away from birth and being considered a “person” under *Roe*. Thus, the State clearly has a heightened interest in protecting the life of the partially-born child.
 - (13) The public’s perception of the appropriate role of a physician during a child’s birth [or delivery] is undermined by aborting a child in the manner that purposefully seeks to kill the child inches from birth [or legal personhood].
 - (14) Partial-birth abortion is disturbingly similar to the killing of a newborn infant and blurs the legal and moral lines between infanticide and abortion. This Act reinforces that line at birth – just as the Supreme Court established in *Roe v. Wade* – while also preserving the integrity of the medical profession and promoting respect for human life.
 - (15) The vast majority of infants killed during partial-birth abortions are alive through the very end of the procedure. Medical science has established that an unborn child can feel pain when subjected to painful stimuli like that inflicted during a partial-birth abortion procedure. Moreover, fetal pain experts believe that an unborn child’s perception of pain can be even more intense than that of newborn infants and older children subjected to the same stimuli.
- (b) Based on the findings in subsection (a), the purposes of the [Legislature] are to:
- (1) Conclusively establish that partial-birth abortion is never medically indicated to preserve the health of the mother and instead poses significant health risks to her;
 - (2) Clearly define the line between abortion and infanticide; and
 - (3) Safeguard the role of a physician during childbirth.

Section 3. Definitions.

- (a) **“Medical facility”** means any public or private hospital, clinic, center, medical school, medical training institution, healthcare facility, physician’s office, infirmary, dispensary, ambulatory surgical treatment center, or other institution or location wherein medical care is provided to any person.
- (b) **“Partial-birth abortion”** means an abortion in which the person performing the abortion
- (1) Deliberately and intentionally vaginally delivers a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or, in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother, for the purpose of performing an overt act that the person knows will kill the partially delivered living fetus; and
 - (2) Performs the overt act, other than completion of delivery, which kills the partially delivered living fetus.
- (c) **“Physician”** means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery

by the State in which the doctor performs such activity, or any other person legally authorized by the State to perform abortions; *provided, however*, that any person who is not a physician or not otherwise legally authorized by the State to perform abortions, but who nevertheless directly performs a partial-birth abortion, shall be subject to the provisions of this Act.

Section 4. Prohibition.

A person shall not knowingly perform or attempt to perform a partial-birth abortion.

Section 5. Limitations.

No person shall perform or induce a partial-birth abortion on a viable fetus unless such person is a physician and has a documented referral from another physician not legally or financially affiliated with the physician performing or inducing the abortion and both physicians determine that the life of the mother is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself.

Section 6. Reporting.

(a) If a physician determines in accordance with the provisions of Section 5 that a partial-birth abortion is necessary and performs a partial-birth abortion on the woman, the physician shall report such determination and the reasons for such determination in writing to the medical facility in which the abortion is performed for inclusion in the report of the medical facility to the *[Insert appropriate state department, department head, or regulatory body]*; or if the abortion is not performed in a medical facility, the physician shall report the reasons for such determination in writing to the *[Insert appropriate state department, department head, or regulatory body]* as part of the written report made by the physician to *[Insert appropriate sState department, department head, or regulatory body]*. The physician shall retain a copy of the written reports required under this Section for not less than five (5) years.

(b) Failure to report under this Section does not subject the physician to criminal or civil penalties.

(c) Subsection (b) does not preclude sanctions, disciplinary action, or any other appropriate action by the *[Insert appropriate citation or reference to state Medical Board or other appropriate agency]*.

Section 7. Criminal Penalties.

(a) Any person who intentionally or knowingly violates this Act is guilty of a *[Insert appropriate offense/penalty classification]*.

(b) Any physician who intentionally or knowingly performs a partial-birth abortion and thereby kills a human fetus shall be fined not less than ten thousand (\$10,000) nor more than one-hundred thousand dollars (\$100,000) under this Act, or be imprisoned *[at hard labor]* not less than one (1) year nor more than ten (10) years, or both.

Section 8. Civil Penalties.

(a) The father, if married to the mother at the time she receives a partial-birth abortion procedure, and, if the mother has not attained the age of eighteen (18) years at the time of the abortion, the maternal grandparents of the fetus may in a civil action obtain appropriate relief, unless the pregnancy resulted from the plaintiff's criminal conduct or the plaintiff consented to the abortion.

(b) Such relief shall include:

- (1) Money damages for all injuries, psychological and physical, occasioned by the violation of this Act; and
- (2) Statutory damages equal to *[Insert number]* times the cost of the partial-birth abortion.

Section 9. Review by State Medical Board *[of Licensure and Supervision]*.

(a) A physician-defendant accused of an offense under this Act may seek a hearing before the State Medical Board [or other appropriate state agency] as to whether the physician's conduct was necessary to save the life of the mother whose life was endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself.

(b) The findings on this issue are admissible at the civil or criminal trial of the physician-defendant. Upon a motion of the physician-defendant, the court shall delay the beginning of the trial for not more than thirty (30) days to permit such a hearing to take place.

Section 10. Penalties for Ambulatory Health Care Facilities.

(a) An ambulatory healthcare [or surgical] facility licensed pursuant to [Insert reference(s) to appropriate state statute(s) or administrative regulation(s)] in which the partial-birth abortion is performed in violation of this Act shall be subject to immediate revocation of its license by the [Insert name of appropriate state department or agency].

(b) An ambulatory healthcare [or surgical] facility licensed pursuant to [Insert references to appropriate state statute(s) or administrative regulation(s)] in which the partial-birth abortion is performed in violation of this Act shall lose all state funding for [Insert number] years and will be required to reimburse the state for funds from the calendar [or fiscal] year in which the partial-birth abortion was performed.

Section 11. Prosecutorial Exclusion.

A woman upon whom a partial-birth abortion is performed may not be prosecuted under this Act for a conspiracy to violate Section 4 of this Act.

Section 12. Construction.

(a) Nothing in this Act shall be construed as creating or recognizing a right to abortion.

(b) It is not the intention of this Act to make lawful an abortion that is currently unlawful.

Section 13. Severability.

Any provision of this Act held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as to give it the maximum effect permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event such provision shall be deemed severable herefrom and shall not affect the remainder hereof or the application of such provision to other persons not similarly situated or to other, dissimilar circumstances.

Section 14. Right of Intervention.

The [Legislature], by joint resolution, may appoint one or more of its members, who sponsored or cosponsored this Act in his or her official capacity, to intervene as a matter of right in any case in which the constitutionality of this law is challenged.

Section 15. Effective Date.

This Act shall take effect on [Insert date].

Prenatal Nondiscrimination Act Of [Insert Year]

HOUSE/SENATE BILL NO. _____

By Representatives/Senators _____

Section 1. Title.

This Act may be cited as the “Prenatal Nondiscrimination Act of [Insert appropriate year].”

Section 2. Legislative Findings.

The [Legislature] of the State of [Insert name of State] finds that:

- (a) With regard to sex-selection abortion:
 - (1) A sex-selection abortion is used to prevent the birth of a child of an undesired sex. The victims of sex-selection abortion are overwhelmingly female.
 - (2) The United States, along with other countries, has petitioned the United Nations General Assembly to declare sex-selection abortion a crime against women.
 - (3) Countries such as India, Great Britain, and China have taken steps to end sex-selection abortion. For example, China and India do not allow doctors to reveal the sex of an unborn child.
 - (4) Women are a vital part of our society and culture and possess the same fundamental human rights as men.
 - (5) The United States prohibits discrimination on the basis of sex in various areas, including employment, education, athletics, and health insurance.
 - (6) It is undesirable to have a sex imbalance within a society, particularly when there is a shortage of women. Countries with high rates of male-preference have experienced ill effects as a result of an increasing number of young, unmarried men.
 - (7) A large population of young, unmarried men can be a cause of increased violence and militancy within a society.
- (b) With regard to abortion and Down syndrome:
 - (1) Various studies have found that between 70 percent and 100 percent of unborn children diagnosed with Down syndrome are aborted.
 - (2) Recent years have seen an increase in the use of amniocentesis and other prenatal testing to diagnose potential health problems in unborn children.
 - (3) Amniocentesis and other prenatal testing often give correct results, but also give many false-positive results.
 - (4) Roughly 1 in every 700 to 1,000 children is born with Down syndrome.
 - (5) Down syndrome is not considered a severe disability.
 - (6) In various circumstances, the United States prohibits discrimination against persons with Down syndrome.
 - (7) In many situations, such as education, the United States requires that concessions be made for the benefit of persons with Down syndrome.

- (8) Persons with Down syndrome contribute to American culture and are a valuable part of our society.
- (9) Many persons with Down syndrome are able to maintain employment, obtain an education, and live with varying degrees of independence.
- (10) As technology advances and as medical treatments and educational methods improve, persons with Down syndrome will increasingly be self-dependent and productive citizens.
- (11) Persons with Down syndrome possess the same fundamental human rights as all other human beings.
- (c) With regard to abortion and genetic abnormalities:
 - (1) Studies have revealed that unborn children who are diagnosed with a genetic abnormality or a potential for a genetic abnormality are often aborted.
 - (2) Various studies have found that between 70 percent and 100 percent of unborn children diagnosed with genetic abnormalities are aborted.
 - (3) Recent years have seen an increase in the use of amniocentesis and other prenatal testing to diagnose potential health problems in unborn children.
 - (4) Amniocentesis and other prenatal testing often give correct results, but also give false-positive results.
 - (5) There are approximately 4,000 known genetic abnormalities.
 - (6) The United States prohibits discrimination against persons with physical or mental deformities or handicaps in various circumstances, such as housing and employment.
 - (7) In many situations, the United States requires that concessions be made for the benefit of persons with physical or mental deformities or handicaps.
 - (8) Persons with physical or mental deformities or handicaps contribute to American culture and are a valuable part of our society.
 - (9) Many persons with physical or mental deformities or handicaps are able to support themselves financially, obtain an education, and live independently.
 - (10) As technology advances and as medical treatments and educational methods improve, persons with physical or mental deformities or handicaps will increasingly be self-dependent and productive citizens.
 - (11) Persons with physical or mental deformities or handicaps possess the same fundamental human rights as all other human beings.

Section 3. Definitions.

As used in this Act only:

- (a) **“Abortion”** means the act of using or prescribing any instrument, medicine, drug, or any other substance, device, or means with the intent to terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child. Such use, prescription, or means is not an abortion if done with the intent to:
 - (1) Save the life or preserve the health of the unborn child;
 - (2) Remove a dead unborn child caused by spontaneous abortion; or
 - (3) Remove an ectopic pregnancy.
- (b) **“Down syndrome”** refers to a chromosome disorder associated either with an extra chromosome 21 (in whole

or in part) or an effective trisomy for chromosome 21. Down syndrome is sometimes referred to as “trisomy 21 syndrome.”

(c) **“Genetic abnormality”** means any defect, disease, or disorder that is inherited genetically. The term genetic abnormality includes, but is not limited to: any physical disability, any mental disability or retardation, any physical disfigurement, scoliosis, dwarfism, Down syndrome, albinism, Amelia, or any other type of physical or mental abnormality or disease.

(d) **“Incompetent”** means any person who has been adjudged a disabled person and has had a guardian appointed for him/her under the *[Insert state Probate Act or other appropriate state law]*.

(e) **“Minor”** means any person under the age of eighteen (18) who is not and has not been married and has not been legally emancipated.

(f) **“Physician”** means any person licensed to practice medicine in this State. The term includes medical doctors and doctors of osteopathy.

(g) **“Pregnant woman”** means any female, including those who have not reached the age of eighteen (18) *[or minors]*, who is in the reproductive condition of having an unborn child in her uterus.

(h) **“Sex-selection abortion”** means an abortion performed solely on account of the sex of the unborn child.

(i) **“Unborn child”** means the offspring of human beings from conception until birth.

Section 4. Prohibition on Sex-Selection Abortion.

(a) No person may intentionally perform or attempt to perform an abortion with the knowledge that the pregnant woman is seeking the abortion solely on account of the sex of the unborn child.

(b) Nothing in this Section shall be construed to proscribe the performance of an abortion because the unborn child has a genetic abnormality or disorder that is linked to the unborn child’s sex.

[Drafter’s Note: If a particular state is also seeking to ban abortions performed because of genetic abnormalities, this subsection (b) may need to be removed or modified.]

(c) If this Section is held invalid as applied to the period of pregnancy prior to viability, then it shall remain applicable to the period of pregnancy subsequent to viability.

Section 5. Prohibition on Abortion for Down Syndrome.

(a) No person may intentionally perform or attempt to perform an abortion with knowledge that the pregnant woman is seeking the abortion solely because the unborn child has been diagnosed with either Down syndrome or a potential for Down syndrome.

(b) If this Section is held invalid as applied to the period of pregnancy prior to viability, then it shall remain applicable to the period of pregnancy subsequent to viability.

Section 6. Prohibition on Abortion for a Genetic Abnormality.

(a) No person may intentionally perform or attempt to perform an abortion with knowledge that the pregnant woman is seeking the abortion solely because the unborn child has been diagnosed with either a genetic abnormality or a potential for a genetic abnormality.

(b) If this Section is held invalid as applied to the period of pregnancy prior to viability, then it shall remain applicable to the period of pregnancy subsequent to viability.

Section 7. Criminal Penalties.

Any physician or other person who intentionally or knowingly performs or attempts to perform an abortion prohibited by this Act shall be guilty of a [Insert appropriate offense/penalty classification], and shall be fined not less than [Insert appropriate amount or possible range of fine] or be imprisoned [at hard labor] not less than [Insert appropriate time period or range], or both.

Section 8. Civil Penalties and Professional Sanctions.

(a) Any physician or person who intentionally or knowingly violates this Act shall be liable for damages and shall, if applicable, have his or her medical license suspended or revoked. He or she may also be enjoined from such acts as provided in this Section.

(b) **Civil Damages.** A pregnant woman upon whom an abortion has been performed in violation of this Act, the parent or legal guardian of the woman if she is an unemancipated minor as defined in [Insert citation(s) or other reference(s) to appropriate state statute(s)], or the legal guardian [or conservator] of the woman if she has been adjudged incompetent under [Insert citation(s) or other reference(s) to state statute(s) relating to petition and hearing, independent evaluation, etc.] may commence a civil action for any knowing or reckless violation of the Act and may seek both actual and punitive damages. Such damages shall include, but are not limited to:

- (1) Money damages for all injuries, psychological and physical, occasioned by the violation(s) of this Act; and
- (2) Statutory damages equal to [Insert number] times the cost of the abortion performed in violation of this Act.

(c) **Action Against a Medical License.** Any physician who performs an abortion in violation of this Act shall be considered to have engaged in unprofessional conduct for which his or her [certificate or] license to provide healthcare services in the State of [Insert name of State] shall be suspended or revoked by the [Insert name of state Medical Board or other appropriate entity].

(d) **Injunctive Relief.** A cause of action for injunctive relief against any physician or other person who has knowingly violated this Act may be maintained by the woman upon whom the abortion was performed or attempted to be performed in violation of this Act; any person who is the spouse, parent, guardian, [conservator], or a current or former licensed healthcare provider of the woman upon whom an abortion has been performed or attempted to be performed in violation of this Act; by the Office of the Attorney General of [Insert name of State]; or by a [District] Attorney with appropriate jurisdiction. The injunction shall prevent the physician or person from performing further abortions in violation of this Act.

(e) **Contempt Proceedings.** Any physician or other person who knowingly violates the terms of an injunction issued in accordance with this Act shall be subject to [civil and/or criminal] contempt and shall be fined not less than [Insert appropriate amount or possible range of fine], or be imprisoned [at hard labor] not less than [Insert appropriate time period or range], or both.

[Drafter's Note: If only civil contempt is selected as the appropriate remedy for failure to comply with a validly-issued injunction, then any reference(s) to imprisonment or other criminal penalties should be removed from subparagraph 8(e).]

Section 9. Exclusion of Liability for Woman Who Undergoes Abortion Prohibited Under this Act.

(a) Any woman upon whom an abortion in violation of this Act is performed or attempted may not be prosecuted under this Act for a conspiracy to violate this Act or otherwise held criminally or civilly liable for any violation.

(b) In any criminal proceeding or action brought under this Act, any woman upon whom an abortion in violation of this Act is performed or attempted is entitled to all rights, protections, and notifications afforded to crime victims under [Insert citation(s) or other reference(s) to state law(s) or administrative policies associated with the state's Victim-Witness Protection or similar program].

(c) In every civil proceeding or action brought under this Act, the anonymity of the woman upon whom an abortion is performed or attempted shall be preserved from public disclosure unless she gives her consent to such disclosure. A court of competent jurisdiction, upon motion or *sua sponte*, shall issue orders to the parties, witnesses, and counsel and shall direct the sealing of the record and exclusion of individuals from courtrooms or hearing rooms, to the extent necessary to safeguard her identity from public disclosure. In the absence of written consent of the woman upon whom an abortion has been performed or attempted, anyone who initiates a proceeding or action under Section 8(b) or Section 8(d) of this Act shall do so under a pseudonym.

Section 10. Construction.

- (a) Nothing in this Act shall be construed as creating or recognizing a right to abortion.
- (b) It is not the intention of this Act to make lawful an abortion that is currently unlawful.

Section 11. Severability.

Any provision of this Act held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as to give it the maximum effect permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event such provision shall be deemed severable herefrom and shall not affect the remainder hereof or the application of such provision to other persons not similarly situated or to other, dissimilar circumstances.

Section 12. Right of Intervention

The [Legislature], by joint resolution, may appoint one or more of its members, who sponsored or cosponsored this Act in his or her official capacity, to intervene as a matter of right in any case in which the constitutionality of this law is challenged.

Section 13. Effective Date.

This Act takes effect on [Insert date].

Women's Ultrasound Right to Know Act

HOUSE/SENATE BILL NO. _____

By Representatives/Senators _____

Section 1. Title.

This Act may be known and cited as the “Woman’s Ultrasound Right to Know Act.”

Section 2. Legislative Findings and Purposes.

- (a) The [Legislature] of the State of [Insert name of State] finds that:
- (1) Ultrasound requirements serve an essential medical purpose in confirming the presence, location, and gestational age of a pregnancy.
 - (2) Ultrasound requirements also serve an essential medical purpose in diagnosing ectopic pregnancies which, if left undiagnosed, can result in infertility or even fatal blood loss.
 - (3) Furthermore, it is critical to the psychological and physical well-being of a woman considering an abortion that she receives complete and accurate information on the reality and status of her pregnancy and of her unborn child.
 - (4) The decision to abort “is an important, and often a stressful one, and it is desirable and imperative that it be made with full knowledge of its nature and consequences.” *Planned Parenthood v. Danforth*, 428 U.S. 52, 67 (1976).
 - (5) The knowledgeable exercise of a woman’s decision to have an abortion depends on the extent to which the woman receives sufficient information to make an informed choice between two alternatives: giving birth or having an abortion.
- (b) Based on the findings in subsection (a), the purposes of this Act are to:
- (1) Protect the physical health and welfare of every woman considering an abortion;
 - (2) Ensure that every woman considering an abortion receives complete information on the reality and status of her pregnancy and of her unborn child and that every woman submitting to an abortion does so only after giving her voluntary and informed consent to the abortion procedure;
 - (3) Protect the unborn child from a woman’s uninformed decision to have an abortion;
 - (4) Reduce “the risk that a woman may elect an abortion, only to discover later, with devastating psychological consequences, that her decision was not fully informed.” *Planned Parenthood v. Casey*, 505 U.S. 833, 882 (1992); and
 - (5) Adopt the construction of the term “medical emergency” accepted by the U.S. Supreme Court in *Planned Parenthood v. Casey*, 505 U.S. 833 (1992).

Section 3. Definitions.

For purposes of this Act only:

- (a) “**Abortion**” means the act of using or prescribing any instrument, medicine, drug, or any other substance, device, or means with the intent to terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child. Such use, prescription, or means is not an abortion if done with the intent to:

- (1) Save the life or preserve the health of the unborn child;
- (2) Remove a dead unborn child caused by spontaneous abortion; or
- (3) Remove an ectopic pregnancy.

(b) **“Auscultation”** means the act of listening for sounds made by internal organs of the fetus, specifically for a fetal heartbeat, utilizing an ultrasound transducer and fetal heart rate (FHR) monitor.

(c) **“Department”** means the Department of *[Insert appropriate title]* of the State of *[Insert name of State]*.

(d) **“Facility”** or **“medical facility”** means any public or private hospital, clinic, center, medical school, medical training institution, healthcare facility, physician’s office, infirmary, dispensary, ambulatory surgical treatment center, or other institution or location wherein medical care is provided to any person.

(e) **“Medical emergency”** means that condition which, on the basis of the physician’s good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate termination of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function.

(f) **“Physician”** means any person licensed to practice medicine in this State. The term includes medical doctors and doctors of osteopathy.

(g) **“Pregnant”** or **“pregnancy”** means that female reproductive condition of having an unborn child in the *[woman’s]* uterus.

(h) **“Qualified person”** means an agent of the physician who is a psychologist, licensed social worker, licensed professional counselor, registered nurse, or physician.

(i) **“Unborn child”** means the offspring of human beings from conception until birth.

(j) **“Ultrasound”** means the use of ultrasonic waves for diagnostic or therapeutic purposes, specifically to monitor a developing fetus.

Section 4. Ultrasound Requirement.

Except in the case of a medical emergency, at least twenty-four (24) hours before the performance of an abortion, the physician who is to perform the abortion on the pregnant woman~~[the referring physician,]~~ or a qualified person assisting the physician shall perform fetal ultrasound imaging and auscultation of fetal heart tone services on the patient undergoing the abortion.

Section 5. Informed Consent.

No abortion shall be performed or induced without the voluntary and informed consent of the woman upon whom the abortion is to be performed or induced. Except in the case of a medical emergency, consent to an abortion is voluntary and informed if and only if:

(a) At least twenty-four (24) hours before the abortion, the physician who is to perform the abortion on the pregnant woman~~[the referring physician,]~~ or a qualified person assisting the physician has offered the woman, orally and in person, the opportunity to:

- (1) View the active ultrasound image of the unborn child and hear the heartbeat of the unborn child if the heartbeat is audible; and
- (2) Receive a physical picture of the ultrasound image of the unborn child.

(b) At the woman’s request, the physician or qualified person assisting the physician, at least twenty-four (24)

hours prior to the performance of the abortion, shall:

- (1) Provide the active ultrasound image to the pregnant woman for her to view and auscultation of fetal heart tone for her to hear; and
 - (2) Provide a physical picture of the ultrasound image of the unborn child.
- (c) At least twenty-four (24) hours prior to the performance of the abortion, a physician or qualified person assisting the physician shall obtain the woman's signature on a certification form stating the following:
- (1) That she has been offered the opportunity to view the active ultrasound image of the unborn child and to hear the heartbeat of the unborn child if the heartbeat is audible;
 - (2) That she has been offered the opportunity to receive the physical picture of the ultrasound image of the unborn child; and
 - (3) That the woman either (A) requested to view the active ultrasound imaging and hear auscultation of fetal heart tone and/or receive the physical picture of the ultrasound image; or (B) that the woman opted not to view the active ultrasound imaging and hear auscultation of fetal heart tone and/or receive the physical picture of the ultrasound image.
- (d) Before the abortion is performed or induced, the physician who is to perform or induce the abortion shall receive a copy of the written certification prescribed by Section 5(c). The physician shall retain a copy of the signed certification form in the woman's medical record.
- (e) The [Department of Health] shall enforce the provisions of this Act at all facilities and medical facilities that provide abortion services.

Section 6. Standard of Medical Practice.

- (a) The active ultrasound image must be of a quality consistent with standard medical practice in the community, shall contain the dimensions of the unborn child, and shall accurately portray the presence of external members and internal organs of the unborn child, if present or viewable.
- (b) The auscultation of fetal heart tone must be of a quality consistent with standard medical practice in the community.

Section 7. Medical Emergencies.

When a medical emergency compels the performance of an abortion, the physician shall inform the woman, before the abortion if possible, of the medical indications supporting the physician's judgment that an immediate abortion is necessary to avert her death or that a twenty-four (24) hour delay will cause substantial and irreversible impairment of a major bodily function.

Section 8. Criminal Penalties.

- (a) Any person who purposefully, knowingly, or recklessly performs or attempts to perform or induce an abortion without complying with Section 4 with this Act is guilty of a [Insert appropriate penalty/offense classification].
- (b) Any person who purposefully, knowingly, or recklessly performs or attempts to perform or induce an abortion without complying with any other provision of this Act is guilty of a [Insert appropriate penalty/offense classification].

Section 9. Civil Penalties and Professional Sanctions.

- (a) In addition to any and all remedies available under the common or statutory law of this State, failure to comply with the requirements of this Act shall:

- (1) Provide a basis for a civil malpractice action for actual and punitive damages. Any intentional violation of this Act shall be admissible in a civil suit as *prima facie* evidence of a failure to obtain informed consent, which, except in the case of a medical emergency as defined by this Act, constitutes medical malpractice.
- (2) Provide a basis for a professional disciplinary action under [Medical Malpractice Act].
- (3) Provide a basis for recovery for the woman for the wrongful death of her unborn child under the [Wrongful Death Act whether or not the unborn child was born alive or was viable at the time the abortion was performed].

[**Drafter's Note:** Subsection 8(c) may need to be modified to correspond with the requirements of the state's wrongful death statutes. Please consult AUL for drafting assistance.]

(b) When requested, the court shall allow a woman to proceed using solely her initials or a pseudonym and may close any proceedings in the case and enter other protective orders to preserve the privacy of the woman upon whom the abortion was performed.

(c) If judgment is rendered in favor of the plaintiff, the court shall also render judgment for a reasonable attorney's fee in favor of the plaintiff against the defendant.

(d) If judgment is rendered in favor of the defendant and the court finds that the plaintiff's suit was frivolous and brought in bad faith, the court shall also render judgment for a reasonable attorney's fee in favor of the defendant against the plaintiff.

Section 10. Construction.

(a) Nothing in this Act shall be construed as creating or recognizing a right to abortion.

(b) It is not the intention of this law to make lawful an abortion that is currently unlawful.

Section 11. Right of Intervention.

The [Legislature], by joint resolution, may appoint one or more of its members, who sponsored or cosponsored this Act in his or her official capacity, to intervene as a matter of right in any case in which the constitutionality of this law is challenged.

Section 12. Severability.

Any provision of this Act held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as to give it the maximum effect permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event such provision shall be deemed severable herefrom and shall not affect the remainder hereof or the application of such provision to other persons not similarly situated or to other, dissimilar circumstances.

Section 13. Effective Date.

This Act takes effect on [Insert date].

Perinatal Hospice Information Act

HOUSE/SENATE BILL NO. _____

By Representatives/Senators _____

Section 1. Title.

This Act may be known as the “Perinatal Hospice Information Act.”

Section 2. Legislative Findings and Purposes.

- (a) The [Legislature] of the State of [Insert name of State] finds that:
- (1) As prenatal diagnosis improves, increasingly more lethal fetal anomalies are diagnosed earlier in pregnancy.
 - (2) Currently, parents are often given minimal options: terminating the pregnancy or simply waiting for their child to die. The majority of parents choose to terminate their pregnancies, while only twenty (20) percent of parents decide to continue their pregnancies.
 - (3) Studies indicate that choosing to terminate the pregnancy can pose severe long-term psychological risks for the woman, including the risk of posttraumatic stress, depression, and anxiety. On the other hand, parents who choose to continue their pregnancy under the supportive, compassionate care of a perinatal hospice team report being emotionally and spiritually prepared for the death of their child.
 - (4) Studies reveal that, when given the option, at least eighty (80) to eighty-seven (87) percent of parents choose to continue their pregnancies in the supportive environment of perinatal hospice care.
- (b) Based on the findings in subsection (a), it is the purpose of this Act to:
- (1) Guarantee that a woman considering an abortion after a diagnosis of a lethal fetal anomaly is presented with information on the option of perinatal hospice care; and
 - (2) Ensure that any abortion choice that a woman makes has been fully informed.

Section 3. Definitions.

For purposes of this Act only:

- (a) **“Abortion”** means the act of using or prescribing any instrument, medicine, drug, or any other substance, device, or means with the intent to terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child. Such use, prescription, or means is not an abortion if done with the intent to:
- (1) Save the life or preserve the health of the unborn child;
 - (2) Remove a dead unborn child caused by spontaneous abortion; or
 - (3) Remove an ectopic pregnancy.
- (b) **“Department”** means the Department of [Insert appropriate title] of the State of [Insert name of State].
- (c) **“Lethal fetal anomaly”** means a fetal condition diagnosed before birth that will with reasonable certainty result in the death of the unborn child within three months after birth.
- (d) **“Medical emergency”** means that condition which, on the basis of the physician’s good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate termination of her

pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function.

(e) **“Perinatal hospice”** means comprehensive support to the pregnant woman and her family that includes support from the time of diagnosis, through the time of birth and the death of the infant, and through the postpartum period. Supportive care may include (but is not limited to) counseling and medical care by maternal-fetal medical specialists, obstetricians, neonatologists, anesthesia specialists, clergy, social workers, and specialty nurses focused on alleviating fear and ensuring that the woman and her family experience the life and death of their child in a comfortable and supportive environment.

(f) **“Physician”** means any person licensed to practice medicine in this State. The term includes medical doctors and doctors of osteopathy.

Section 4. Informed Consent for Abortion to Include Information on Perinatal Hospice.

(a) No abortion shall be performed or induced without the voluntary and informed consent of the woman upon whom the abortion is to be performed or induced. Except in the case of a medical emergency, consent to an abortion is voluntary and informed only if:

- (1) In the case of a woman seeking an abortion of her unborn child diagnosed with a lethal fetal anomaly, at least twenty-four (24) hours before the abortion, the physician who is to perform the abortion [*or the referring physician*] has informed the woman, orally and in person, that perinatal hospice services are available and has offered this care as an alternative to abortion.
- (2) In the case of a woman seeking an abortion of her unborn child diagnosed with a lethal fetal anomaly, at least twenty-four (24) hours before the abortion, the woman is given a list of perinatal hospice programs available both in her state and nationally, prepared by the Department and organized geographically by location.

(b) If perinatal hospice services are declined in favor of abortion, the woman must certify in writing both her decision to forgo such services and proceed with the abortion, and that she received the materials listed in subsection 4(a)(2) of this Section.

Section 5. Publication of Materials.

The Department shall cause to be published the printed materials described in Section 4(a)(2) in English and Spanish [*and/or other appropriate language(s)*] within [*Insert appropriate number*] days after this Act becomes law.

Section 6. Professional Sanctions.

(a) **Unprofessional Conduct.** Any violation of this Act shall constitute unprofessional conduct pursuant to [*Insert appropriate statutes for medical doctors and surgeons and osteopathic doctors*] and shall result in permanent revocation of the violator’s license to practice medicine.

(b) **Trade, Occupation, or Profession.** Any violation of this Act may be the basis for denying an application for, denying an application for the renewal of, or revoking any license, permit, certificate, or any other form of permission required to practice or engage in a trade, occupation, or profession.

Section 7. Severability.

Any provision of this Act held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as to give it the maximum effect permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event such provision shall be deemed severable herefrom and shall not affect the remainder hereof or the application of such provision to other persons not similarly situated or to other, dissimilar circumstances.

Section 8. Right of Intervention.

The [Legislature], by joint resolution, may appoint one or more of its members who sponsored or co-sponsored this Act, as a matter of right and in his or her official capacity, to intervene to defend this law in any case in which its constitutionality is challenged or questioned.

Section 9. Effective Date.

This Act takes effect on [Insert date].

Coercive Abuse Against Mothers Prevention Act

HOUSE/SENATE BILL NO. _____

By Representatives/Senators _____

Section 1. Title.

This Act shall be known as the “Coercive Abuse Against Mothers Prevention Act.”

Section 2. Legislative Findings and Purposes.

- (a) The [Legislature] of the [Insert name of State] finds that:
- (1) Research indicates that violence against pregnant women is a serious problem. Many women report that they were coerced into abortions and have suffered grievous physical, emotional, psychological, and spiritual harm as a result.
 - (2) Reproductive healthcare facilities are often the only and last opportunities of hope for victims of coercive abuse and, as such, are in a unique position to help these women.
 - (3) More cases of coerced or attempted coerced abortions are reported if women are informed of their rights and given information concerning treatment and protection options.
 - (4) More women receive treatment for coercive abuse if they are informed of their rights and given information concerning treatment and protection options.
 - (5) Coercive abuse is a serious women’s health issue because it violates women’s rights to physical and emotional health, freedom of conscience, and to freely choose either pregnancy or abortion.
- (b) Based on the findings in subsection (a), the [Legislature] intends to
- (1) Prohibit actions intended to coerce or otherwise force a woman to abort her unborn child; and
 - (2) Empower all mothers in the State of [Insert name of State] to exercise their freedom of conscience in choosing life for their unborn children, free of violent and abusive coercion.

Section 3. Definitions.

For the purposes of this Act only:

- (a) **“Abortion”** means the act of using or prescribing any instrument, medicine, drug, or any other substance, device, or means with the intent to terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child. Such use, prescription, or means is not an abortion if done with the intent to:
- (1) Save the life or preserve the health of the unborn child;
 - (2) Remove a dead unborn child caused by spontaneous abortion; or
 - (3) Remove an ectopic pregnancy.
- (b) **“Abuser”** means any person who coerces, forces, attempts to coerce, or attempts to force a woman into having an abortion.
- (c) **“Coercing an abortion”** or **“forcing an abortion”** occurs when a person knows of or suspects the pregnancy of a woman and engages or conspires with another to engage in any conduct described below that is intentionally

and purposely aimed at causing or directing the pregnant woman to have an abortion and solely conditioned upon the pregnant woman disregarding or refusing the person's demand that she seek an abortion:

- (1) Committing, attempting to commit, or threatening to commit physical harm to the woman, unborn child, or another person;
- (2) Committing, attempting to commit, or threatening to commit any act prohibited by any statute of this State [*or insert specific citation(s) or reference(s) to state's criminal and civil codes*], (*including any common law tort not codified in a State statute*);
- (3) Revoking, attempting to revoke, or threatening to revoke a scholarship awarded to the woman by a public or private institution of higher education;
- (4) Discharging, attempting to discharge, or threatening to discharge the woman or another person or changing, attempting to change, or threatening to change her or the other person's compensation, terms, conditions, or privileges of employment;
- (5) Denying, attempting to deny, or threatening to deny any social assistance for which a pregnant woman or another person has applied, has been approved for, or has been receiving and for which she or the other person is otherwise eligible; and
- (6) Denying, removing, or threatening to deny or remove financial support or housing from a dependent.

The terms “**coerce**” and “**force**” do not include or encompass constitutionally protected speech, conduct, or expressions of conscience.

(d) “**Coercion**” occurs when, with purpose to restrict a pregnant woman's freedom of action to her detriment, any person engages conduct defined in Section 3(c) of this Act.

(e) “**Course of conduct**” means a pattern of conduct composed of a series of two or more separate acts evidencing a continuity of purpose.

(f) “**Dependent**” means [*Insert definition*] as defined in [*Insert citation(s) to appropriate federal or state law*].

(g) “**Mandatory reporter**” means any individual who provides healthcare services, including a physician, surgeon, physical therapist, psychiatrist, psychologist, medical resident, medical intern, hospital staff member, licensed nurse, nurse's aide, any emergency medical technician, paramedic, and any employee, staff member, or volunteer at a reproductive healthcare facility.

(h) “**Physician**” or “**attending physician**” means any person licensed to practice medicine in this State. The term includes medical doctors and doctors of osteopathy.

(i) “**Pregnant woman**” means any female, including those who have not reached the age of eighteen (18) [*or minors*], who is in the reproductive condition of having an unborn child in her uterus.

(j) “**Reproductive healthcare facility**” or “**facility**” means any office, clinic, or other physical location that provides surgical or medical abortions, abortion counseling, abortion referrals, contraceptives, contraceptive counseling, sex education, or gynecological care and services.

(k) “**Solely**” means the conduct described in Section 4 of this Act must be such that it would not have occurred but for the woman's pregnancy. This does not preclude the possibility that an actor may have multiple motives for engaging in the conduct described in Section 4 of this Act.

(l) “**Threat**” means at least one statement or a course of conduct by an individual that would cause a reasonable person to believe that the individual is likely to act in accordance with the statements or as implied by a course of conduct. A threat does not include constitutionally protected speech or any generalized statement regarding a

lawful pregnancy option, including, but not limited to, an emotional expression by a family or household member of the pregnant woman.

(m) “Unborn child” or “pre-born child” means the offspring of human beings from conception until birth.

Section 4. Coerced or Forced Abortion Prohibited; Criminal Penalties and Civil Remedies.

(a) **Prohibition:** It shall be illegal to coerce or force a pregnant woman to have an abortion.

(b) **Criminal Penalties and Civil Remedies:**

- (1) Anyone who is guilty of engaging in conduct described in and proscribed by this Section is, in addition to any other crimes described in [State’s criminal/penal code], guilty of a [Insert appropriate penalty/offense classification].
- (2) If a violation of this Section is committed by the father or putative father of the unborn child against a pregnant woman who is less than eighteen (18) years of age, and the father or putative father is eighteen (18) years of age or older, the father or putative father is guilty of a [Insert reference to a higher penalty/offense classification].
- (3) A pregnant woman injured by reason of an abuser’s violation of this Act may bring a civil suit for the recovery of damages for such injury, including wrongful death on behalf of an aborted child (as provided for in [Insert citation(s) or other reference(s) to state’s Wrongful Death Act]), whether or not the abuser is criminally prosecuted or convicted and whether or not the pregnant woman has an abortion. In such a civil suit, the pregnant woman shall be entitled to recover, in addition to any other damages, her reasonable attorney’s fees and costs if she is the prevailing party.
- (4) Any minor [or woman] who is threatened with coercion, as defined in Section 3(c) of this Act, may apply to a court of competent jurisdiction for relief. The court shall provide the minor [or woman] with counsel, give the matter expedited consideration, and grant such relief as may be necessary to prevent such coercion.
- (5) If a minor is denied financial support by the minor’s parent(s), guardian(s), or custodian because of the minor’s refusal to have an abortion, the minor must be considered an emancipated minor for the purposes of eligibility for public assistance benefits. Any public assistance benefits may not be used to obtain an abortion.

Section 5. Reproductive Healthcare Facility Requirements; Criminal Penalties, Civil Remedies, and Professional Sanctions.

(a) **Sign Postage Requirements:**

- (1) A reproductive healthcare facility shall conspicuously post signs visible to all who enter so as to be clearly readable, which state: “It is against the law for anyone, regardless of his or her relationship to you, to force you to have an abortion. You have the right to contact any local or state law enforcement or social service agency to receive protection from any actual or threatened physical, emotional, or psychological abuse. It is against the law to perform, induce, prescribe for, or provide you with the means for an abortion without your voluntary consent.”
- (2) Such signs must be posted in the waiting room(s), consultation room(s), and procedure room(s).
- (3) The continued posting of such signs shall be a condition of licensure of any reproductive healthcare facility under [Insert reference(s) to state abortion facility licensure law or other administrative requirements]. The display of such signs does not discharge the duty of a reproductive healthcare facility to have a

physician orally inform the pregnant woman of information required by Sections 5(b)(5) and 5(c) of this (1) Act.

(b) **Mandatory Reporting Requirements:**

- (1) **Requirement:** A mandatory reporter must report every instance of alleged or suspected coerced abortion as defined in and proscribed by Sections 3 and 4 of this Act. The mandatory reporter may not use his or her discretion in deciding what cases should or should not be reported to the appropriate law enforcement or state agency.
- (2) **Standard:** The standard to be applied to a mandatory reporter in determining a reportable suspicion is reasonability in good faith.
- (3) **Procedure:** If a mandatory reporter has cause to believe that a pregnant woman is or was a victim of conduct described in and proscribed by Sections 3 and 4 of this Act, the mandatory reporter shall make a report no later than the forty-eighth (48th) hour after such coercion, force, attempted coercion, attempted force, threatened coercion, or threatened force has been brought to his or her attention or suspicion. A mandatory reporter may not delegate the responsibility to report such coercion, force, attempted coercion, attempted force, threatened coercion, or threatened force to any other person, but must personally make the report. A mandatory reporter must make a report to *[designated local or state law enforcement agency and/or other appropriate social services agency]*.
- (4) **Content of Report:** The person making the report must identify the name and address of the pregnant woman, and, in a case of a minor, the name and address of the person who is responsible for the care or custody of the minor. The person making the report must also file any pertinent information he or she may have relating to the alleged or suspected coercion, force, attempted coercion, attempted force, threatened coercion, or threatened force.
- (5) The attending physician shall orally inform the pregnant woman that no one can force her to have an abortion.
- (6) It shall be unlawful for any reproductive healthcare facility to willfully and knowingly continue to employ a mandatory reporter who has violated Sections 4 or 5 of this Act.

(c) **Private Counseling Requirements:**

- (1) In a private room, the attending physician shall orally ask the pregnant woman if she is being coerced or forced to have an abortion. If it is reasonably suspected that the woman is being coerced or forced into having an abortion, the physician shall inform the woman that such coercion is illegal, that the woman may have legal remedies, and that a request or demand by the father to have an abortion does not relieve his financial support responsibilities.
- (2) The attending physician shall also provide the pregnant woman with information about assistance, counseling, and protective services offered by social programs and local or state law enforcement agencies, as well as access to a telephone where she can make a private call and to an alternate exit from the facility *[so that, if necessary, she can exit the abortion facility without being seen or confronted]*.

(d) **Required Reflection [or Waiting] Period:**

- (1) No person shall perform an abortion upon a pregnant woman who is known or suspected to be a victim of conduct described in and proscribed by Sections 3 and 4 of this Act within twenty-four (24) hours of when this fact or suspicion arises and informing the woman of her rights as provided in Sections 5(b)(5) and 5(c) of this Act.

- (2) The mandatory twenty-four (24) hour reflection period may be waived if, in the physician's best medical judgment, an abortion is necessary to prevent the death of the woman or to prevent substantial and irreversible injury to a major bodily function.

(e) ***Criminal Penalties, Civil Remedies, and Professional Sanctions:***

- (1) Any mandatory reporter who has reason to believe a woman is or has been a victim of conduct described in and proscribed by Sections 3 and 4 of this Act and willfully and knowingly does not report such coercion, force, attempted coercion, attempted force, threatened coercion, or threatened force as required by this Act is guilty of a *[Insert appropriate penalty/offense classification]*.
- (2) Any person who performs an abortion which is inconsistent with Section 5(d) of this Act is guilty of a *[Insert appropriate penalty/offense classification]*.
- (3) Any person who performs, induces, or assists in performing or inducing an abortion on a woman, and is unaware that the woman is or has been a victim of conduct described in and proscribed by Sections 3 and 4 as a result of a willful, knowing, or purposeful failure to comply with the requirements of Section 5(c) of this Act is guilty of a *[Insert appropriate penalty/offense classification]*.
- (4) A pregnant woman injured by reason of a facility's violation of this Act may bring a civil suit for recovery of damages for such injury, including wrongful death on behalf of an aborted child (as provided for in *[Insert citation(s) or reference(s) to state's Wrongful Death Act]*), whether or not the attending physician or the facility is criminally prosecuted or convicted and whether or not the pregnant woman has an abortion. In such a civil suit, the pregnant woman, if she is the prevailing party, shall be entitled to recover, in addition to any other damages, her reasonable attorney's fees and costs.
- (5) Initial and continuing adherence to the requirements of Section 5 of this Act shall be a condition of licensure for any reproductive healthcare facility under *[Insert reference(s) to state abortion facility licensure law or administrative requirements]*.
- (6) A woman receiving an abortion inconsistent with any provision of this Act cannot be prosecuted or held civilly liable.

Section 6. Duties of Law Enforcement [or Other Designated Social Services or Public Agency].

(a) Upon the request of the complainant (including a pregnant woman, a woman who was coerced or forced into having an abortion and later reports the coercion or force, or any woman whose rights under this Act were denied by any physician or facility), a law enforcement agency *[or designated social or other public services agency]* investigating a violation of this Act shall notify the complainant not less than twenty-four (24) hours before initially contacting the person(s) alleged to have violated Sections 4 or 5 of this Act.

(b) This Act does not preclude or prohibit an alleged perpetrator from being charged with, convicted of, or punished for any other crime committed while also violating this Act.

(c) A court of competent jurisdiction may order that a term of imprisonment imposed for violating this Act be served consecutively to a term of imprisonment imposed for any other crime committed while also violating this Act.

Section 7. Construction.

(a) This Act does not create, recognize, endorse, or condone a right to an abortion.

(b) It is not the intention of this Act to make lawful an abortion that is currently unlawful.

Section 8. Severability.

Any provision of this Act held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as to give it the maximum effect permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event such provision shall be deemed severable herefrom and shall not affect the remainder hereof or the application of such provision to other persons not similarly situated or to other, dissimilar circumstances.

Section 9. Right of Intervention.

The [*Legislature*], by a joint resolution, may appoint one or more of its members, who sponsored or cosponsored this Act in his or her official capacity, to intervene as a matter of right in any case in which the constitutionality of this Act is challenged.

Section 10. Effective Date.

This Act takes effect on [*Insert date*].

Parental Consent For Abortion Act

HOUSE/SENATE BILL NO. _____

By Representatives/Senators _____

Section 1. Title.

This Act may be cited as the “Parental Consent for Abortion Act.”

Section 2. Legislative Findings and Purposes.

- (a) The Legislature of the State of *[Insert name of State]* finds that:
- (1) Immature minors often lack the ability to make fully informed choices that take into account both immediate and long-range consequences.
 - (2) The medical, emotional, and psychological consequences of abortion are sometimes serious and can be lasting, particularly when the patient is immature.
 - (3) The capacity to become pregnant and the capacity for mature judgment concerning the wisdom of an abortion are not necessarily related.
 - (4) Parents ordinarily possess information essential to a physician’s exercise of his or her best medical judgment concerning the child.
 - (5) Parents who are aware that their minor daughter has had an abortion may better ensure that she receives adequate medical attention after her abortion.
 - (6) Parental consultation is usually desirable and in the best interests of the minor.
- (b) Based on the findings in subsection (a), the *[Legislature]*’s purposes in enacting this parental consent law are to further the important and compelling State interests of:
- (1) Protecting minors against their own immaturity;
 - (2) Fostering family unity and preserving the family as a viable social unit;
 - (3) Protecting the constitutional rights of parents to rear children who are members of their household;
 - (4) Reducing teenage pregnancy and abortion; and
 - (5) In light of the foregoing statements of purpose, allowing for judicial bypasses of the parental consent requirement only in exceptional or rare circumstances.

Section 3. Definitions.

For purposes of this Act only:

- (a) **“Abortion”** means the act of using or prescribing any instrument, medicine, drug, or any other substance, device, or means with the intent to terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child. Such use, prescription, or means is not an abortion if done with the intent to:
- (1) Save the life or preserve the health of the unborn child;
 - (2) Remove a dead unborn child caused by spontaneous abortion; or
 - (3) Remove an ectopic pregnancy.

- (b) **“Coercion”** means restraining or dominating the choice of a pregnant woman by force, threat of force, or deprivation of food and shelter.
- (c) **“Consent”** means, in the case of a pregnant woman who is less than eighteen (18) years of age, a notarized written statement signed by the pregnant woman and her mother, father, or legal guardian [or alternate person as described in Section 5] declaring that the pregnant woman intends to seek an abortion and that her mother, father, or legal guardian [or alternate person as described in Section 5] consents to the abortion; or, in the case of a pregnant woman who is an incompetent person, a notarized written statement signed by the pregnant woman’s guardian declaring that the guardian consents to the performance of an abortion upon the pregnant woman.
- (d) **“Department”** means the Department of [Insert appropriate title] of the State of [Insert name of State].
- (e) **“Emancipated minor”** means any person less than eighteen (18) years of age who is or has been married or who has been legally emancipated.
- (f) **“Incompetent”** means any person who has been adjudged a disabled person and has had a guardian appointed for her under the [state Probate Act or other appropriate state law].
- (g) **“Medical emergency”** means a condition that, on the basis of the physician’s good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function.
- (h) **“Neglect”** means the failure of a parent or legal guardian to supply a minor with necessary food, clothing, shelter, or medical care when reasonably able to do so or the failure to protect a minor from conditions or actions that imminently and seriously endanger the minor’s physical or mental health when reasonably able to do so.
- (i) **“Physical abuse”** means any physical injury intentionally inflicted by a parent or legal guardian on a minor.
- (j) **“Physician,” “attending physician,” or “referring physician”** means any person licensed to practice medicine in this State. The term includes medical doctors and doctors of osteopathy.
- (k) **“Pregnant woman”** means a woman who is pregnant and is less than eighteen (18) years of age and not emancipated, or who has been adjudged an incompetent person under [Insert citation(s) or other reference(s) to state statute(s) relating to petition and hearing; independent evaluation, etc.].
- (l) **“Sexual abuse”** means any sexual conduct or sexual penetration as defined in [Insert citation(s) or other reference(s) to appropriate section(s) of the state criminal code or other appropriate law(s)] and committed against a minor by a parent or legal guardian.

Section 4. Consent of One Parent Required.

[Drafter’s Note: Please refer to AUL’s Parental Involvement Enhancement Act for additional language to strengthen parental consent requirements.]

No person shall perform an abortion upon a pregnant woman unless, in the case of a woman who is less than eighteen (18) years of age, he or she first obtains the notarized written consent of both the pregnant woman and one of her parents or her legal guardian; or, in the case of a woman who is an incompetent person, he or she first obtains the notarized written consent of her guardian. In deciding whether to grant such consent, a pregnant woman’s parent or guardian shall consider only the pregnant woman’s best interests.

[Section 5. Alternate Consent.

[Drafter’s Note: Because this model language includes a judicial bypass provision through which a court may permit a minor to bypass parental consent when she is the victim of abuse, it is not necessary to include this provision.]

If the pregnant woman declares in a signed written statement that she is a victim of sexual abuse, neglect, or physical abuse by either of her parent(s) or her legal guardian(s), then the attending physician shall obtain the notarized written consent required by this Act from a brother or sister of the pregnant woman who is over twenty-one (21) years of age, or from a stepparent or grandparent specified by the pregnant woman. The physician who intends to perform the abortion must certify in the pregnant woman's medical record that he or she has received the written declaration of abuse or neglect and must report the abuse or neglect pursuant to [Insert reference(s) or citation(s) to appropriate legal authority]. Any physician relying in good faith on a written statement under this Section shall not be civilly or criminally liable under any provisions of this Act for failure to obtain consent.]

Section 6. Exceptions.

[Drafters' Note: Please refer to AUL's Parental Involvement Enhancement Act for additional language to prevent abuse of the required "medical emergency" exception.]

Consent shall not be required under Section 4 [or 5] of this Act if:

- (a) The attending physician certifies in the pregnant woman's medical record that a medical emergency exists and that there is insufficient time to obtain the required consent; or
- (b) Consent is waived under Section 9 of this Act.

Section 7. Coercion Prohibited.

A parent, guardian, or any other person shall not coerce a pregnant woman to have an abortion performed. If a pregnant woman is denied financial support by the pregnant woman's parents or legal guardian because of the pregnant woman's refusal to have an abortion performed, the pregnant woman shall be deemed emancipated for the purposes of eligibility for public assistance benefits, except that such benefits may not be used to obtain an abortion.

[Drafters' Note: Please refer to AUL's Coercive Abuse Against Mothers Prevention Act for more detail regarding coercion and abortion.]

Section 8. Reports.

A monthly report indicating the number of consents obtained under this law, the number of times exceptions were made to the consent requirement under this Act, the type of exception, the pregnant woman's age, and the number of prior pregnancies and prior abortions of the pregnant woman shall be filed with the Department on forms prescribed by it. No patient names are to be used on the forms. A compilation of the data reported shall be made by the Department on an annual basis and shall be available to the public.

Section 9. Procedure for Judicial Waiver of Consent.

[Drafters' Note: Please refer to AUL's Parental Involvement Enhancement Act for enhancements to judicial bypass provisions.]

- (a) The requirements and procedures under this Section are available to a pregnant woman whether or not she is a resident of this State.
- (b) The pregnant woman may petition any [circuit] court for a waiver of the consent requirement and may participate in proceedings on her own behalf. The petition shall include a statement that the pregnant woman is pregnant and is unemancipated. The petition shall also include a statement that consent has not been waived, and that the pregnant woman wishes to abort without obtaining consent under this Act. The court shall appoint a guardian *ad litem* for her. Any guardian *ad litem* appointed under this Act shall act to maintain the confidentiality of the proceedings.

[Drafters' Note: Because of concern for confidentiality, unless a judicial decision or other state law requires it, it might be

better to say: “the court may appoint a guardian ad litem for her.”]

The [circuit] court shall advise her that she has a right to court-appointed counsel and shall provide her with counsel upon her request.

(c) Court proceedings under this Section shall be confidential and shall ensure the anonymity of the pregnant woman. All court proceedings under this Section shall be sealed. The pregnant woman shall have the right to file her petition in the [circuit] court using a pseudonym or using solely her initials. All documents related to this petition shall be confidential and shall not be available to the public. These proceedings shall be given precedence over other pending matters to the extent necessary to ensure that the court reaches a decision promptly. The court shall rule, and issue written findings of fact and conclusions of law, within two (2) business days of the time that the petition was filed, except that the two (2) business day limitation may be extended at the request of the pregnant woman. If the court fails to rule within the two (2) business day period and an extension was not requested, then the petition shall be deemed to have been granted, and the consent requirement shall be waived.

(d) If the court finds, by clear and convincing evidence, that the pregnant woman is both sufficiently mature and well-informed to decide whether to have an abortion, the court shall issue an order authorizing the pregnant woman to consent to the performance or inducement of an abortion without the consent of a parent or guardian, and the court shall execute the required forms. If the court does not make the finding specified in this subsection or subsection (e) of this Section, it shall dismiss the petition.

(e) If the court finds, by clear and convincing evidence, that the pregnant woman is the victim of physical or sexual abuse by one or both of her parents or her legal guardian, or that obtaining the consent of a parent or legal guardian is not in the best interest of the pregnant woman, the court shall issue an order authorizing the pregnant woman to consent to the performance or inducement of an abortion without the consent of a parent or guardian. If the court does not make the finding specified in this subsection or subsection (d) of this Section, it shall dismiss the petition.

(f) A court that conducts proceedings under this Section shall issue written and specific factual findings and legal conclusions supporting its decision and shall order that a confidential record of the evidence and the judge’s findings and conclusions be maintained. At the hearing, the court shall hear evidence relating to the emotional development, maturity, intellect, and understanding of the pregnant woman.

(g) An expedited confidential appeal shall be available, as the [Insert name of State] Supreme Court provides by rule, to any pregnant woman to whom the [circuit] court denies a waiver of consent. An order authorizing an abortion without consent shall not be subject to appeal.

(h) No filing fees shall be required of any pregnant woman who petitions a court for a waiver of parental consent under this Act at either the trial or the appellate level.

Section 10. Appeal Procedure.

The [Insert name of State] Supreme Court is respectfully requested to establish rules to ensure that proceedings under this Act are handled in an expeditious and confidential manner and to satisfy the requirements of federal courts.

[Drafter’s Note: This Section should be drafted to comport with whatever procedure the State uses to establish procedures for legal appeals. If the legislature has this authority, those procedures should be included in the legislation.]

Section 11. Criminal Penalties and Civil Remedies.

(a) Any person who intentionally performs an abortion with knowledge that or with reckless disregard as to whether the person upon whom the abortion is to be performed is an unemancipated minor or an incompetent person without obtaining the required consent is guilty of a [Insert appropriate offense/penalty classification]. In this

Section, “**intentionally**” is defined by [Section] [Insert section number] of the [state criminal/penal code].

It is a defense to prosecution under this Section that the minor falsely represented her age or identity to the physician to be at least eighteen (18) years of age by displaying an apparently valid governmental record of identification such that a careful and prudent person under similar circumstances would have relied on the representation. The defense does not apply if the physician is shown to have had independent knowledge of the minor’s actual age or identity or failed to use due diligence in determining the minor’s age or identity. In this subsection, “**defense**” has the meaning and application assigned by [Section] [Insert section number] of the [state penal/criminal code].

(b) Any person not authorized to provide consent under this Act who provides consent is guilty of a [Insert appropriate offense/penalty classification].

(c) Any person who coerces a pregnant woman to have an abortion is guilty of a [Insert appropriate offense/penalty classification].

(d) Failure to obtain consent from person(s) from whom consent is required under this Act is *prima facie* evidence of failure to obtain consent and of interference with family relations in appropriate civil actions. Such *prima facie* evidence shall not apply to any issue other than failure to obtain consent from the parent or legal guardian and interference with family relations in appropriate civil actions. The civil action may be based on a claim that the act was a result of simple negligence, gross negligence, wantonness, willfulness, intention, or other legal standard of care. The law of this State shall not be construed to preclude the award of exemplary damages in any appropriate civil action relevant to violations of this Act.

(e) Nothing in this Act shall be construed to limit the common law rights of parents or legal guardians.

Section 12. Construction.

(a) Nothing in this Act shall be construed as creating or recognizing a right to abortion.

(b) It is not the intention of this law to make lawful an abortion that is currently unlawful.

Section 13. Severability.

Any provision of this Act held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as to give it the maximum effect permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event such provision shall be deemed severable herefrom and shall not affect the remainder hereof or the application of such provision to other persons not similarly situated or to other, dissimilar circumstances.

Section 14. Right of Intervention.

The [Legislature], by joint resolution, may appoint one or more of its members who sponsored or co-sponsored this Act, as a matter of right and in his or her official capacity, to intervene to defend this law in any case in which its constitutionality is challenged.

Section 15. Effective Date.

This Act takes effect on [Insert date].

Parental Notification Of Abortion Act

HOUSE/SENATE BILL NO. _____

By Representatives/Senators _____

Section 1. Title.

This Act may be cited as the “Parental Notification of Abortion Act.”

Section 2. Legislative Findings and Purposes.

- (a) The [Legislature] of the State of [Insert name of State] finds that:
- (1) Immature minors often lack the ability to make fully informed choices that take into account both immediate and long-range consequences.
 - (2) The medical, emotional, and psychological consequences of abortion are sometimes serious and can be lasting, particularly when the patient is immature.
 - (3) The capacity to become pregnant and the capacity for mature judgment concerning the wisdom of an abortion are not necessarily related.
 - (4) Parents ordinarily possess information essential to a physician’s exercise of his or her best medical judgment concerning their child.
 - (5) Parents who are aware that their minor daughter has had an abortion may better ensure that she receives adequate medical attention after her abortion.
 - (6) Parental consultation is usually desirable and in the best interests of the minor.
- (b) Based on the findings in subsection (a), the [Legislature]’s purposes in enacting this parental notification law are to further the important and compelling State interests of:
- (1) Protecting minors against their own immaturity;
 - (2) Fostering family unity and preserving the family as a viable social unit;
 - (3) Protecting the constitutional rights of parents to rear children who are members of their household;
 - (4) Reducing teenage pregnancy and abortion; and
 - (5) In light of the foregoing statements of purpose, allowing for judicial bypasses to be made only in exceptional or rare circumstances.

Section 3. Definitions.

For purposes of this Act only:

- (a) **“Abortion”** means the act of using or prescribing any instrument, medicine, drug, or any other substance, device, or means with the intent to terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child. Such use, prescription, or means is not an abortion if done with the intent to:
- (1) Save the life or preserve the health of the unborn child;
 - (2) Remove a dead unborn child caused by spontaneous abortion; or
 - (3) Remove an ectopic pregnancy.

- (b) **“Actual notice”** means the giving of notice directly, in person or by telephone.
- (c) **“Constructive notice”** means notice by certified mail to the last known address of the parent or guardian with delivery deemed to have occurred forty-eight (48) hours after the certified notice is mailed.
- (d) **“Coercion”** means restraining or dominating the choice of a minor by force, threat of force, or deprivation of food and shelter.
- (e) **“Department”** means the Department of *[Insert appropriate title]* of the State of *[Insert name of State]*.
- (f) **“Emancipated minor”** means any person less than eighteen (18) years of age who is or has been married or who has been legally emancipated.
- (g) **“Incompetent”** means any person who has been adjudged a disabled person and has had a guardian appointed for her under the *[state Probate Act or other appropriate state law]*.
- (h) **“Medical emergency”** means a condition that, on the basis of the physician’s good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function.
- (i) **“Neglect”** means the failure of a parent or legal guardian to supply a minor with necessary food, clothing, shelter, or medical care when reasonably able to do so or the failure to protect a minor from conditions or actions that imminently and seriously endanger the minor’s physical or mental health when reasonably able to do so.
- (j) **“Physical abuse”** means any physical injury intentionally inflicted by a parent or legal guardian on a minor.
- (k) **“Physician,” “attending physician,” or “referring physician”** means any person licensed to practice medicine in this State. The term includes medical doctors and doctors of osteopathy.
- (l) **“Pregnant woman”** means a woman who is pregnant and is less than (18) years of age and is not emancipated, or who has been adjudged an incompetent person under *[Insert citation(s) or other reference(s) to state statute(s) relating to petition and hearing; independent evaluation, etc.]*.
- (m) **“Sexual abuse”** means any sexual conduct or sexual penetration as defined in *[Insert citation(s) or other reference(s) to appropriate section(s) of the state criminal code or other appropriate law(s)]* and committed against a pregnant woman by a parent or legal guardian.

Section 4. Notice of One Parent Required.

[Drafter’s Note: Please refer to AUL’s Parental Involvement Enhancement Act for additional language to strengthen parental notification requirements.]

No person shall perform an abortion upon a pregnant woman unless that person has given at least forty-eight (48) hours actual notice to one parent or the legal guardian of the pregnant woman of his or her intention to perform the abortion. The notice may be given by a referring physician. The person who performs the abortion must receive the written statement of the referring physician certifying that the referring physician has given notice to the parent or legal guardian of the pregnant woman who is to receive the abortion. If actual notice is not possible after a reasonable effort, the person or his or her agent must give forty-eight (48) hours constructive notice.

[Section 5. Alternate Notification.

[Drafter’s Note: Because this model language includes a judicial bypass provision through which a court may permit a minor to bypass parental notice when she is the victim of abuse, it is not necessary to include this provision.]

If the pregnant woman declares in a signed written statement that she is a victim of sexual abuse, neglect, or physical abuse by

either of her parents or her legal guardian, then the attending physician shall give the notice required by this Act to a brother or sister of the pregnant woman who is over twenty-one (21) years of age or to a stepparent or grandparent specified by the pregnant woman. The physician who intends to perform the abortion must certify in the pregnant woman's medical record that he or she has received the written declaration of abuse or neglect, and must report the abuse or neglect pursuant to [Insert citation(s) or reference(s) to the appropriate statute(s)]. Any physician relying in good faith on a written statement under this Section shall not be civilly or criminally liable under any provisions of this Act for failure to give notice.]

Section 6. Exceptions.

[Drafter's Note: Please refer to AUL's Parental Involvement Enhancement Act for additional language to prevent abuse of the "medical emergency" and waiver exceptions.]

Notice shall not be required under Section 4 [or 5] of this Act if:

- (a) The attending physician certifies in the pregnant woman's medical record that a medical emergency exists and there is insufficient time to provide the required notice; or
- (b) Notice is waived in writing by the person who is entitled to notice; or
- (c) Notice is waived under Section 9 of this Act.

Section 7. Coercion Prohibited.

A parent, legal guardian, or any other person shall not coerce a pregnant woman to have an abortion performed. If a pregnant woman is denied financial support by the pregnant woman's parents or legal guardian because of the pregnant woman's refusal to have an abortion performed, the pregnant woman shall be deemed emancipated for the purposes of eligibility for public assistance benefits, except that such benefits may not be used to obtain an abortion.

[Drafter's Note: Please refer to AUL's Coercive Abuse Against Mothers Prevention Act for more detail regarding coercion and abortion.]

Section 8. Reports.

A monthly report indicating the number of notices issued under this law, the number of times exceptions were made to the notice requirement under this Act, the type of exception, the pregnant woman's age, and the number of prior pregnancies and prior abortions of the pregnant woman shall be filed with the Department on forms prescribed by it. No patient names are to be used on the forms. A compilation of the data reported shall be made by the Department on an annual basis and shall be available to the public.

Section 9. Procedure for Judicial Waiver of Notice.

[Drafter's Note: Please refer to AUL's Parental Involvement Enhancement Act for enhancements to judicial bypass provisions.]

- (a) The requirements and procedures under this Section are available to a pregnant woman whether or not she is a resident of this State.
- (b) The pregnant woman may petition any [circuit] court for a waiver of the notice requirement and may participate in proceedings on her own behalf. The petition shall include a statement that the pregnant woman is pregnant and is unemancipated. The petition shall also include a statement that notice has not been waived and that the pregnant woman wishes to abort without giving notice under this Act. The court shall appoint a guardian *ad litem* for her. Any guardian *ad litem* appointed under this Act shall act to maintain the confidentiality of the proceedings.

[Drafter's Note: Because of concern for confidentiality, unless a judicial decision or other state law requires it, it might be better to say: "the court may appoint a guardian *ad litem* for her."]

The [circuit] court shall advise her that she has a right to court-appointed counsel and shall provide her with counsel upon her request.

(c) Court proceedings under this Section shall be confidential and shall ensure the anonymity of the pregnant woman. All court proceedings under this Section shall be sealed. The pregnant woman shall have the right to file her petition in the [circuit] court using a pseudonym or using solely her initials. All documents related to this petition shall be confidential and shall not be available to the public. These proceedings shall be given precedence over other pending matters to the extent necessary to ensure that the court reaches a decision promptly. The court shall rule, and issue written findings of fact and conclusions of law, within two (2) business days of the time that the petition was filed, except that the two (2) business day limitation may be extended at the request of the pregnant woman. If the court fails to rule within the two (2) business day period and an extension was not requested, then the petition shall be deemed to have been granted, and the notice requirement shall be waived.

(d) If the court finds, by clear and convincing evidence, that the pregnant woman is both sufficiently mature and well-informed to decide whether to have an abortion, the court shall issue an order authorizing the pregnant woman to consent to the performance or inducement of an abortion without the notification of a parent or guardian, and the court shall execute the required forms. If the court does not make the finding specified in this subsection or subsection (e) of this Section, it shall dismiss the petition.

(e) If the court finds, by clear and convincing evidence, that the pregnant woman is the victim of physical or sexual abuse by one or both of her parents or her legal guardian, or that the notification of a parent or guardian is not in the best interest of the pregnant woman, the court shall issue an order authorizing the pregnant woman to consent to the performance or inducement of an abortion without the notification of a parent or guardian. If the court does not make the finding specified in this subsection or subsection (d) of this Section, it shall dismiss the petition.

(f) A court that conducts proceedings under this Section shall issue written and specific factual findings and legal conclusions supporting its decision and shall order that a confidential record of the evidence, and the judge's findings and conclusions be maintained. At the hearing, the court shall hear evidence relating to the emotional development, maturity, intellect, and understanding of the pregnant woman.

(g) An expedited confidential appeal shall be available, as the [Insert name of State] Supreme Court provides by rule, to any pregnant woman to whom the [circuit] court denies a waiver of notice. An order authorizing an abortion without notice shall not be subject to appeal.

(h) No filing fees shall be required of any pregnant woman who petitions a court for a waiver of parental notification under this Act at either the trial or the appellate level.

Section 10. Appeal Procedure.

The [Insert name of State] Supreme Court is respectfully requested to establish rules to ensure that proceedings under this Act are handled in an expeditious and confidential manner and to satisfy the requirements of federal courts.

[Drafter's Note: This Section should be drafted to comport with whatever procedure the State uses to establish procedures for legal appeals. If the legislature has this authority, those procedures should be included in the legislation.]

Section 11. Criminal Penalties and Civil Remedies.

(a) Any person who intentionally performs an abortion with knowledge that or with reckless disregard as to whether the person upon whom the abortion is to be performed is an unemancipated minor or an incompetent female without providing the required notice is guilty of a [Insert appropriate penalty/offense classification]. In this Section, "intentionally" is defined by [Section] [Insert section number] of the [state penal/criminal code].

It is a defense to prosecution under this Section that the minor falsely represented her age or identity to the physician to be at least eighteen (18) years of age by displaying an apparently valid governmental record of identification such that a careful and prudent person under similar circumstances would have relied on the representation. The defense does not apply if the physician is shown to have had independent knowledge of the minor's actual age or identity or failed to use due diligence in determining the minor's age or identity. In this subsection, “**defense**” has the meaning and application assigned by [Section] [Insert section number] of the [state penal/criminal code].

(b) Any person not authorized to receive notice under this Act who signs a waiver of notice under subsection (b) of Section 7 is guilty of a [Insert appropriate penalty/offense classification].

(c) Any person who coerces a pregnant woman to have an abortion is guilty of a [Insert appropriate penalty/offense classification].

(d) Failure to provide person(s) with the notice required under this Act is *prima facie* evidence of failure to provide notice and of interference with family relations in appropriate civil actions. Such *prima facie* evidence shall not apply to any issue other than failure to inform the parents or legal guardian and interference with family relations in appropriate civil actions. The civil action may be based on a claim that the act was a result of simple negligence, gross negligence, wantonness, willfulness, intention, or other legal standard of care. The law of this State shall not be construed to preclude the award of exemplary damages in any appropriate civil action relevant to violations of this Act.

(e) Nothing in this Act shall be construed to limit the common law rights of parents or legal guardians.

Section 12. Construction.

(a) Nothing in this Act shall be construed as creating or recognizing a right to abortion.

(b) It is not the intention of this law to make lawful an abortion that is currently unlawful.

Section 13. Severability.

Any provision of this Act held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as to give it the maximum effect permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event such provision shall be deemed severable herefrom and shall not affect the remainder hereof or the application of such provision to other persons not similarly situated or to other, dissimilar circumstances.

Section 14. Right of Intervention.

The [Legislature], by joint resolution, may appoint one or more of its members who sponsored or co-sponsored this Act, as a matter of right and in his or her official capacity, to intervene to defend this law in any case in which its constitutionality is challenged.

Section 15. Effective Date.

This Act takes effect on [Insert date].

Women's Health Protection Act

HOUSE/SENATE BILL NO. _____

By Representatives/Senators _____

Section 1. Title.

This Act may be known and cited as the “Women’s Health Protection Act.”

Section 2. Legislative Findings and Purposes.

(a) The Legislature of the State of *[Insert name of State]* finds that:

- (1) The *[vast majority]* of all abortions in this State are performed in clinics devoted primarily to providing abortions and family planning services. Most women who seek abortions at these facilities do not have any relationship with the physician who performs the abortion either before or after the procedure. They do not return to the facility for post-surgical care. In most instances, the woman’s only actual with the abortion provider occurs simultaneously with the abortion procedure, with little opportunity to ask questions about the procedure, potential complications, and proper follow-up care.
- (2) “The medical, emotional, and psychological consequences of an abortion are serious and can be lasting...” *H.L. v. Matheson*, 450 U.S. 398, 411 (1981).
- (3) Abortion is an invasive, surgical procedure that can lead to numerous and serious (both short- and long-term) medical complications. Potential complications for abortion include, among others, bleeding, hemorrhage, infection, uterine perforation, uterine scarring, blood clots, cervical tears, incomplete abortion (retained tissue), failure to actually terminate the pregnancy, free fluid in the abdomen, acute abdomen, organ damage, missed ectopic pregnancies, cardiac arrest, sepsis, respiratory arrest, reactions to anesthesia, an increased risk of breast cancer, fertility problems, emotional problems, and even death.
- (4) The risks for second-trimester abortions are greater than for first-trimester abortions. The risk of hemorrhage, in particular, is greater, and the resultant complications may require a hysterectomy, other reparative surgery, or a blood transfusion.
- (5) The State of *[Insert name of State]* has a legitimate concern for the public’s health and safety. *Williamson v. Lee Optical*, 348 U.S. 483, 486 (1985).
- (6) The State of *[Insert name of State]* “has legitimate interests from the outset of pregnancy in protecting the health of women.” *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 847 (1992).
- (7) More specifically, the State of *[Insert name of State]* “has a legitimate concern with the health of women who undergo abortions.” *Akron v. Akron Ctr. for Reproductive Health, Inc.*, 462 U.S. 416, 428-29 (1983).
- (8) The U.S. Supreme Court has specifically acknowledged that a State has “a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient. This interest obviously extends at least to the performing physician and his staff, to the facilities involved, to the availability of after-care, and to adequate provision for any complication or emergency that might arise.” *Roe v. Wade*, 410 U.S. 113, 150 (1973).

(b) Based on the findings in subsection (a), the purposes of this Act are to:

- (1) Regulate abortion clinics consistent with and to the extent permitted by the decisions of the U.S. Supreme Court and other courts; and

- (2) Provide for the protection of public health through the development, establishment, and enforcement of medically appropriate standards of care and safety in abortion clinics.

Section 3. Definitions.

As used in this Act only:

- (a) **“Abortion”** means the act of using or prescribing any instrument[, *medicine, drug, or any other substance, device, or means*] with the intent to terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child. Such use[, *prescription, or means*] is not an abortion if done with the intent to:
 - (1) Save the life or preserve the health of the unborn child;
 - (2) Remove a dead unborn child caused by spontaneous abortion; or
 - (3) Remove an ectopic pregnancy.
- (b) **“Abortion clinic”** means a facility, other than an accredited hospital, in which five (5) or more first-trimester abortions in any month or any second- or third-trimester abortions are performed.
- (c) **“Born-alive,”** with respect to a member of the species homo sapiens, means the complete expulsion or extraction from his or her mother of that member, at any stage of development, who after such expulsion or extraction breathes or has a beating heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, regardless of whether the umbilical cord has been cut, and regardless of whether the expulsion or extraction occurs as a result of natural or induced labor, cesarean section, or induced abortion.
- (d) **“Conception”** and **“fertilization”** each means the fusion of the human spermatozoon with a human ovum.
- (e) **“Department”** means the [*Insert name of state health department or other appropriate agency*].
- (f) **“Director”** means the Director of the [*Insert name of state health department or other appropriate agency*].
- (g) **“Gestation”** means the time that has elapsed since the first day of the woman’s last menstrual period.
- (h) **“Licensee”** means an individual, a partnership, an association, a limited liability company, or a corporation authorized by the [*Insert name of state health department or other appropriate agency*] to operate an abortion clinic.
- (i) **“Physician”** means a person licensed to practice medicine in the State of [*Insert name of State*]. This term includes medical doctors and doctors of osteopathy.
- (j) **“Unborn child”** means the offspring of human beings from conception until birth.

Section 4. Licensure Requirements.

- (a) Beginning on [*Insert effective date*], all abortion clinics shall be licensed by the Department. Any existing abortion clinic, as defined by this Act, shall make application for licensure within ninety (90) days.
- (b) An application for a license shall be made to the Department on forms provided by it and shall contain such information as the Department reasonably requires, which shall include affirmative evidence of ability to comply with such reasonable standards, rules, and regulations as are lawfully prescribed hereunder. Additional information required by the Department shall be supplied on supplemental forms as needed.
- (c) Following receipt of an application for license and if the applicant and the facility meet the requirements established by this Act and the minimum standards, administrative rules, and regulations adopted in pursuance thereof, the Department shall issue a license which is valid for a period of one (1) year.
- (d) A temporary or provisional license may be issued to an abortion clinic for a period of six (6) months in

cases where sufficient compliance with minimum standards, rules, and regulations require an extension of time, if a disapproval has not been received from any other state or local agency otherwise authorized to inspect such facilities. The failure to comply must not be detrimental to the health and safety of the public.

(e) A license shall apply only to the location and licensee stated on the application and such license, once issued, shall not be transferable from one place to another or from one licensee to another. If the location of the facility is changed, the license shall be automatically revoked. A new application form shall be completed prior to all license renewals.

(f) An application for a license or renewal to operate an abortion clinic shall be accompanied by a fee of *[Insert appropriate amount]*, which is hereby levied as the license fee for operation of an abortion clinic for a period of one (1) year. The fees herein levied and collected shall be paid into the *[general fund]*.

(g) Each license issued hereunder shall be for a period of one (1) year from the date of issuance unless sooner revoked, shall be on a form prescribed by the Department, and may be renewed from year to year upon application and payment of the license fee as in the case of procurement of the original license.

(h) The Department may deny, suspend, revoke, or refuse to renew a license in any case in which it finds that there has been a substantial failure of the applicant or licensee to comply with the requirements of this Act or the minimum standards, administrative rules, and regulations adopted by the Department pursuant to this Act. In such case, the Department shall furnish the person, applicant, or licensee thirty (30) days notice specifying the reason(s) for the action.

(i) Any person, applicant, or licensee who feels aggrieved by the action of the Department in denying, suspending, revoking, or refusing to renew a license may appeal the Department's action in accordance with the delay, notice, and other procedures established *[Insert reference(s) to agency/administrative appeal procedure(s) within the Department]*.

(j) Any person, applicant, or licensee who feels aggrieved by the action of the *[appellate board or other appropriate agency or body]* may, within thirty (30) days after notification of such action, appeal suspensively to the *[Insert name of court]*. A record of all proceedings before the *[appellate board or other appropriate agency or body]* shall be made and kept on file with the *[appellate board or other appropriate agency or body]*. The *[appellate board or other appropriate agency or body]* shall transmit a certified copy of the record to the *[Insert name of court]*. The *[Insert name of court]* shall try the appeal de novo.

Section 5. Inspections and Investigations.

(a) The Department shall establish policies and procedures for conducting pre-licensure and re-licensure inspections of abortion clinics. Prior to issuing or reissuing a license, the Department shall conduct an on-site inspection to ensure compliance with the *[minimum standards, applicable regulations, and administrative rules]* promulgated by the Department under *[Insert citation(s) and reference(s) to appropriate authorities including laws, regulations, and administrative rules]*.

(b) The Department shall also establish policies and procedures for conducting inspections and investigations pursuant to complaints received by the Department and made against any abortion clinic. The Department shall receive, record, and dispose of complaints in accordance with established policies and procedures.

(c) If the Director determines that there is reasonable cause to believe a licensee, licensed abortion clinic, or abortion clinic that is required to be licensed pursuant to *[Insert citation(s) and reference(s) to appropriate authorities including laws, regulations, and administrative rules related to abortion]* is not adhering to the requirements of *[Insert citation(s) and reference(s) to appropriate authorities including laws, regulations, and administrative rules related to abortion]*; *[the minimum standards, regulations, and administrative rules promulgated by the Department under the authority of [Insert citation(s) and reference(s) to appropriate authorities including laws, regulations, and administrative rules related*

to abortion]] ; or any other law, administrative rule, or regulation relating to abortion, the Director and any duly-designated employee or agent of the Director, including [county health representatives] and county or municipal fire inspectors, consistent with standard medical practices, may enter on and into the premises of the licensee, licensed abortion clinic, or abortion clinic that is required to be licensed pursuant to [Insert citation(s) and reference(s) to appropriate authorities including laws, regulations, and administrative rules related to abortion] during regular business hours of the licensee or abortion clinic to determine compliance with [Insert citation(s) and reference(s) to appropriate authorities including laws, regulations, and administrative rules related to abortion]; [the minimum standards, regulations, and administrative rules promulgated by the Department under the authority of [Insert citation(s) and reference(s) to appropriate authorities including laws, regulations, and administrative rules related to abortion]] ; local fire ordinances or rules; and any other law, administrative rule, or regulation relating to abortion.

(d) An application for a license pursuant to [Insert citation(s) and reference(s) to appropriate authorities including laws, regulations, and administrative rules related to abortion] constitutes permission for, and complete acquiescence in, an entry or inspection of the premises during the pendency of the application and, if licensed, during the term of the license.

(e) If an inspection or investigation conducted pursuant to this Section 5(c) or 5(d) reveals that a licensee or licensed abortion clinic is not adhering to the requirements of [Insert citation(s) and reference(s) to appropriate authorities including laws, regulations, and administrative rules]; [the minimum standards, administrative rules, or regulations promulgated by the Department under the authority of [Insert citation(s) and reference(s) to appropriate authorities including laws, regulations, and administrative rules]]; local fire ordinances or rules; and any other law, administrative rule, or regulation relating to abortion, the Director may take action to deny, suspend, revoke, or refuse to renew a license to operate an abortion clinic.

Section 6. Minimum Standards, Administrative Rules, and Regulations for Abortion Clinics.

The Department shall establish minimum standards, administrative rules, and regulations for the licensing and operation of abortion clinics. Such minimum standards, administrative rules, and regulations become effective upon approval by the Director.

Section 7. Administrative Rules for Abortion Clinics.

(a) The Director shall adopt rules for an abortion clinic's physical facilities. At a minimum these rules shall prescribe standards for:

- (1) Adequate private space that is specifically designated for interviewing, counseling, and medical evaluations.
- (2) Dressing rooms for staff and patients.
- (3) Appropriate lavatory areas.
- (4) Areas for pre-procedure hand washing.
- (5) Private procedure rooms.
- (6) Adequate lighting and ventilation for abortion procedures.
- (7) Surgical or gynecologic examination tables and other fixed equipment.
- (8) Post-procedure recovery rooms that are supervised, staffed, and equipped to meet the patients' needs.
- (9) Emergency exits to accommodate a stretcher or gurney.
- (10) Areas for cleaning and sterilizing instruments.

(11) Adequate areas for the secure storage of medical records and necessary equipment and supplies.

(12) The display in the abortion clinic, in a place that is conspicuous to all patients, of the clinic's current license issued by the Department.

(b) The Director shall adopt rules to prescribe abortion clinic supply and equipment standards, including supplies and equipment that are required to be immediately available for use in an emergency. At a minimum these rules shall:

- (1) Prescribe required equipment and supplies, including medications, required for the performance, in an appropriate fashion, of any abortion procedure that the medical staff of the abortion clinic anticipates performing and for monitoring the progress of each patient throughout the procedure and recovery period.
- (2) Require that the number or amount of equipment and supplies at the abortion clinic is adequate at all times to assure sufficient quantities of clean and sterilized durable equipment and supplies to meet the needs of each patient.
- (3) Prescribe required equipment, supplies, and medications that shall be available and ready for immediate use in an emergency and requirements for written protocols and procedures to be followed by staff in an emergency, such as the loss of electrical power.
- (4) Prescribe the mandated equipment and supplies for required laboratory tests and the requirements for protocols to maintain laboratory equipment at the abortion clinic or operated by clinic staff.
- (5) Require ultrasound equipment in all abortion clinics.
- (6) Require that all equipment is safe for patients and the staff, meets applicable federal standards, and is checked annually.

(c) The Director shall adopt rules relating to abortion clinic personnel. At a minimum these rules shall require that:

- (1) The abortion clinic designate a medical director who is licensed to practice medicine [and surgery] in the State of *[Insert name of State]*.
- (2) Physicians performing abortions are licensed to practice medicine [*and surgery*] in the State of *[Insert name of State]*, demonstrate competence in the procedure(s) involved, and are acceptable to the medical director of the abortion clinic.
- (3) The employment of at least one (1) physician with admitting privileges at an accredited hospital in this state and within thirty (30) miles of the licensed abortion clinic. Specifically, on any day when any abortion is performed in the abortion clinic, a physician with admitting privileges at an accredited hospital in this State and within thirty (30) miles of the abortion clinic must remain on the premises of the abortion clinic to facilitate the transfer of emergency cases if hospitalization of an abortion patient or a child born alive is necessary and until all abortion patients are stable and ready to leave the recovery room.
- (4) Surgical assistants [*or other appropriate classification(s) of healthcare provider(s)*] receive training in counseling, patient advocacy, and the specific responsibilities of the services the surgical assistants [*or other appropriate classification(s) of healthcare provider(s)*] provide at an abortion clinic.
- (5) Volunteers, if any, receive training in the specific responsibilities of the services that volunteers provide at an abortion clinic, including counseling and patient advocacy, and as provided in the administrative rules adopted by the Director for different types of volunteers based on their responsibilities.

- (d) The Director shall adopt rules relating to the medical screening and evaluation of each abortion clinic patient. At a minimum these rules shall require:
- (1) A medical history including the following:
 - a. Reported allergies to medications, antiseptic solutions, or latex.
 - b. Obstetric and gynecologic history.
 - c. Past surgeries.
 - d. Medication that the patient is currently taking.
 - (2) A physical examination including a bimanual examination estimating uterine size and palpation of the adnexa.
 - (3) The appropriate pre-procedure testing including:
 - a. Urine or blood tests for pregnancy, if ordered by a physician.
 - b. A test for anemia.
 - c. Rh typing, unless reliable written documentation of blood type is available.
 - d. Other tests as indicated from the physical examination.
 - (4) An ultrasound evaluation for all patients who elect to have an abortion. The rules shall require that if a person who is not a physician performs an ultrasound examination, that person shall have documented evidence that he or she completed a course or other acceptable training in the operation of ultrasound equipment as prescribed in rule. *[A physician or other licensed healthcare professional shall review, at the request of the patient, the ultrasound evaluation results with the patient before the abortion procedure is performed, including permitting the patient to view the active ultrasound image and learn the probable gestational age of the unborn child.]*
 - (5) That the physician is responsible for estimating the gestational age of the unborn child based on the ultrasound examination and obstetric standards in keeping with established standards of care regarding the estimation of gestational age as defined in rule and shall write the estimate in the patient's medical record. The physician shall keep original prints of each ultrasound examination of a patient in the patient's medical record.
- (e) The Director shall adopt rules relating to the abortion procedure. At a minimum these rules shall require that:
- (1) Medical personnel are available to all patients throughout the abortion procedure.
 - (2) Standards for the safe conduct of abortion procedures that conform to obstetric standards in keeping with established standards of care regarding the estimation of gestational age as defined in rule.
 - (3) Appropriate use of local anesthesia, analgesia, and sedation if ordered by the physician.
 - (4) The use of appropriate precautions, such as the establishment of intravenous access at least for patients undergoing second- or third-trimester abortions.
 - (5) The use of appropriate monitoring of the vital signs and other defined signs and markers of the patient's status throughout the abortion procedure and during the recovery period until the patient's condition is deemed to be stable in the recovery room.
- (f) The Director shall adopt rules that prescribe minimum recovery room standards for the abortion clinic. At a minimum these rules shall require that:

- (1) Immediate post-procedure care consists of observation in a supervised recovery room for as long as the patient's condition warrants.
 - (2) The clinic arrange hospitalization if any complication beyond the management capability of the staff occurs or is suspected.
 - (3) A licensed healthcare professional who is trained in the management of the recovery area and is capable of providing basic cardiopulmonary resuscitation and related emergency procedures actively monitors patients in the recovery room.
 - (4) A physician with admitting privileges at an accredited hospital in this state and within thirty (30) miles of the abortion clinic remains on the premises of the abortion clinic until all patients are stable and are ready to leave the recovery room and to facilitate the transfer of emergency cases if hospitalization of the patient or a child born alive is necessary. A physician shall sign the discharge order and be readily accessible and available until the last patient is discharged.
 - (5) A physician discusses RhO(d) immune globulin with each patient for whom it is indicated and assures it is offered to the patient in the immediate post-operative period or that it will be available to her within seventy-two (72) hours after completion of the abortion procedure. If the patient refuses, a refusal form approved by the Department shall be signed by the patient and a witness and included in the patient medical record.
 - (6) Written instructions with regard to post-abortion coitus, signs of possible complications and problems, and general aftercare are given to each patient. Each patient shall have specific instructions regarding access to medical care for complications, including a telephone number to call for medical emergencies.
 - (7) There is a specified minimum length of time that a patient remains in the recovery room by type of abortion procedure and duration of gestation.
 - (8) The physician ensures that a licensed healthcare professional from the abortion clinic makes a good faith effort to contact the patient by telephone, with the patient's consent, within twenty-four (24) hours after surgery to assess the patient's recovery.
 - (9) Equipment and services are located in the recovery room to provide appropriate emergency resuscitative and life support procedures pending the transfer of the patient or a child born alive to the hospital.
- (g) The Director shall adopt rules that prescribe standards for follow-up care for abortion patients. At a minimum these rules shall require that:
- (1) A post-abortion medical visit is offered and, if requested, scheduled for two (2) to three (3) weeks after the abortion procedure, including a medical examination and a review of the results of all laboratory tests.
 - (2) A urine [*or blood*] test for pregnancy is obtained at the time of the follow-up visit to rule out continuing pregnancy. If a continuing pregnancy is suspected, the patient shall be appropriately evaluated and a physician who performs abortions shall be consulted.
- (h) The Director shall adopt rules to prescribe minimum abortion clinic incident reporting. At a minimum these rules shall require that:
- (1) The abortion clinic records each incident resulting in a patient's or a born-alive child's [serious] injury occurring at an abortion clinic and shall report these incidents in writing to the Department within ten (10) days after the incident. For the purposes of this paragraph, "serious injury" means an injury that occurs at an abortion clinic and that creates a serious risk of substantial impairment of a major body organ or function.

- (2) If a patient's death occurs, other than the death of an unborn child properly reported pursuant to law, the abortion clinic reports it to the Department not later than the next Department work day.
- (3) Incident reports are filed with the Department and appropriate professional regulatory boards.
- (i) The Department shall not release personally identifiable patient or physician information.
- (j) The rules adopted by the Director pursuant to this Act do not limit the ability of a physician or other healthcare professional to advise a patient on any health issue.
- (k) The provisions of this Act and the rules and regulations adopted pursuant hereto shall be in addition to any other laws, administrative or other rules, and regulations which are applicable to facilities defined as "abortion clinics" under this Act.

Section 8. Criminal Penalties.

- (a) Whoever operates an abortion clinic as defined in this Act without a valid license issued by the Department is guilty of *[Insert proper penalty/offense classification]*.
- (b) Any person who intentionally, knowingly[, or recklessly] violates this Act or any administrative rules or regulations adopted under this Act is guilty of *[Insert proper penalty/offense classification]*.

Section 9. Civil Penalties and Fines.

- (a) Any violation of this Act or any administrative rules or regulations adopted under this Act may be subject to a civil penalty or fine up to *[Insert appropriate amount]* imposed by the Department.
- (b) Each day of violation constitutes a separate violation for purposes of assessing civil penalties or fines.
- (c) In deciding whether and to what extent to impose fines, the Department shall consider the following factors:
 - (1) Gravity of the violation including the probability that death or serious physical harm to a patient or individual will result or has resulted;
 - (2) Size of the population at risk as a consequence of the violation;
 - (3) Severity and scope of the actual or potential harm;
 - (4) Extent to which the provisions of the applicable statutes or regulations were violated;
 - (5) Any indications of good faith exercised by licensee;
 - (6) The duration, frequency, and relevance of any previous violations committed by the licensee; and
 - (7) Financial benefit to the licensee of committing or continuing the violation.
- (d) Both the Office of the Attorney General and the Office of the District Attorney *[or other appropriate classification]* for the county in which the violation occurred may institute a legal action to enforce collection of civil penalties or fines.

Section 10. Injunctive Remedies.

In addition to any other penalty provided by law, whenever in the judgment of the Director, any person has engaged, or is about to engage, in any acts or practices which constitute, or will constitute, a violation of this Act, or any rule or regulation adopted under the provision of this Act, the Director shall make application to any court of competent jurisdiction for an order enjoining such acts and practices, and upon a showing by the Director that such person has

engaged, or is about to engage, in any such acts or practices, an injunction, restraining order, or such other order as may be appropriate shall be granted by such court without bond.

Section 11. Construction.

- (a) Nothing in this Act shall be construed as creating or recognizing a right to abortion.
- (b) It is not the intention of this Act to make lawful an abortion that is currently unlawful.

Section 12. Right of Intervention.

The [Legislature], by joint resolution, may appoint one or more of its members, who sponsored or cosponsored this Act in his or her official capacity, to intervene as a matter of right in any case in which the constitutionality of this Act or any portion thereof is challenged.

Section 13. Severability.

Any provision of this Act held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as to give it the maximum effect permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event such provision shall be deemed severable herefrom and shall not affect the remainder hereof or the application of such provision to other persons not similarly situated or to other, dissimilar circumstances.

Section 14. Effective Date.

This Act takes effect on [Insert date].

Abortion Providers' Admitting Privileges Act

HOUSE/SENATE BILL NO. _____

By Representatives/Senators _____

Section 1. Title.

This Act may be known and cited as the “Abortion Providers’ Admitting Privileges Act.”

Section 2. Legislative Findings and Purposes.

- (a) The Legislature of the State of *[Insert name of State]* finds that:
- (1) The *[vast majority]* of all abortions in this State are performed in clinics devoted primarily to providing abortions and family planning services. Most women who seek abortions at these clinics do not have any relationship with the physician who performs the abortion either before or after the procedure. They do not return to the facility for post-surgical care. In most instances, the woman’s only actual contact with the abortion provider occurs simultaneously with the abortion procedure, with little opportunity to ask questions about the procedure, potential complications, and proper follow-up care.
 - (2) In some cases, abortion providers travel into *[Insert name of State]* from other states *[or locations]* to perform abortions at abortion clinics in this State. These physicians typically do not live in or remain in this State when not providing abortions or abortion-related services.
 - (3) “The medical, emotional, and psychological consequences of an abortion are serious and can be lasting” *H.L. v. Matheson*, 450 U.S. 398, 411 (1981).
 - (4) Abortion is an invasive, surgical procedure that can lead to numerous and serious (both short- and long-term) medical complications. Potential complications for abortion include, among others, bleeding, hemorrhage, infection, uterine perforation, uterine scarring, blood clots, cervical tears, incomplete abortion (retained tissue), failure to actually terminate the pregnancy, free fluid in the abdomen, acute abdomen, organ damage, missed ectopic pregnancies, cardiac arrest, sepsis, respiratory arrest, reactions to anesthesia, and even death.
 - (5) The risks for second-trimester abortions are greater than for first-trimester abortions. The risk of hemorrhage, in particular, is greater, and the resultant complications may require a hysterectomy, other reparative surgery, or a blood transfusion.
 - (6) The State of *[Insert name of State]* has a legitimate concern for the public’s health and safety. *Williamson v. Lee Optical*, 348 U.S. 483, 486 (1985).
 - (7) The State of *[Insert name of State]* “has legitimate interests from the outset of pregnancy in protecting the health of women.” *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 847 (1992).
 - (8) More specifically, the State of *[Insert name of State]* “has a legitimate concern with the health of women who undergo abortions.” *Akron v. Akron Ctr. for Reproductive Health, Inc.*, 462 U.S. 416, 428-29 (1983).
 - (9) The U.S. Supreme Court has specifically acknowledged that a State has “a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient. This interest obviously extends at least to the performing physician and his staff, to the facilities involved, to the availability of after-care, and to adequate provision for any complication or emergency that might arise.” *Roe v. Wade*, 410 U.S. 113, 150 (1973).
 - (10) Among the benefits supporting an admitting privileges requirement for abortion providers are that

it:

- a. Provides a more thorough evaluation mechanism of physician competency which better protects patient safety;
- b. Acknowledges and enables the importance of continuity of care;
- c. Enhances inter-physician communication and optimizes patient information transfer and complication management; and
- d. Supports the ethical duty of care for the operating physician to prevent patient abandonment.

(b) Based on the findings in subsection (a), it is the purpose of this Act to provide for the protection of public health generally and of women's health and safety specifically through the establishment and enforcement of an admitting privileges requirement for physicians providing abortions in *[freestanding]* abortion clinics in this State.

Section 3. Definitions.

As used in this Act only:

(a) **"Abortion"** means the act of using or prescribing any instrument[, *medicine, drug, or any other substance, device, or means*]¹¹ with the intent to terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child. Such use [, *prescription, or means*] is not an abortion if done with the intent to:

- (1) Save the life or preserve the health of the unborn child;
- (2) Remove a dead unborn child caused by spontaneous abortion; or
- (3) Remove an ectopic pregnancy.

(b) **"Abortion clinic"** means a facility, other than an accredited hospital, in which five (5) or more first-trimester abortions in any month or any second- or third-trimester abortions are performed.

(c) **"Admitting privileges"** means the right of a physician[, by virtue of membership with a hospital's medical staff,] to admit patients *[from an abortion clinic]* to a particular hospital for the purposes of providing specific diagnostic or therapeutic services to such patient in that hospital.

(d) **"Physician"** means a person licensed to practice medicine in the State of *[Insert name of State]*. This term includes medical doctors and doctors of osteopathy.

Section 4: Admitting Privileges Requirement.

On any day when any abortion is performed in an abortion clinic, a physician with admitting privileges at an accredited hospital in this State and within thirty (30) miles of the abortion clinic must remain on the premises of the abortion clinic to facilitate the transfer of emergency cases if hospitalization of an abortion patient or a child born alive is necessary and until all abortion patients are stable and ready to leave the recovery room.

Section 5. Civil Penalties and Fines.

(a) Any violation of this Act may be subject to a civil penalty or fine up to *[Insert appropriate amount]* imposed by the *[state Department of Health or other appropriate department or agency]*.

(b) Each day of violation constitutes a separate violation for purposes of assessing civil penalties or fines.

¹¹The bracketed language is used when state officials intend the requirements prescribed herein to apply to the administration or provision of abortion-inducing drugs (such as RU-486).

(c) In deciding whether and to what extent to impose fines, the [state Department of Health or other appropriate department or agency] shall consider the following factors:

- (1) Whether physical harm to a patient or a child born alive has occurred;
- (2) Severity and scope of the actual or potential harm;
- (3) Any indications of good faith exercised by the abortion clinic involved in the violation to comply with the requirements of this Act;
- (4) The duration, frequency, and relevance of any previous violations of this Act by the abortion clinic; and
- (5) Financial benefit to the abortion clinic of committing or continuing the violation.

(d) Both the Office of the Attorney General and the Office of the District Attorney [*or other appropriate title or designation*] for the county in which the violation occurred may institute a legal action to enforce collection of civil penalties or fines.

Section 6. Injunctive Remedies.

In addition to any other penalty provided by law, whenever in the judgment of the [*Director [or other appropriate title or designation] of the Department of Health or other appropriate department or agency*], any person has engaged, or is about to engage, in any acts or practices which constitute, or will constitute, a violation of this Act, the [*Director [or other appropriate title or designation] of the Department of Health or other appropriate department or agency*] shall make application to any court of competent jurisdiction for an order enjoining such acts and practices, and upon a showing by the [*Director [or other appropriate title or designation] of the Department of Health or other appropriate department or agency*] that such person has engaged, or is about to engage, in any such acts or practices, an injunction, restraining order, or such other order as may be appropriate shall be granted by such court without bond.

Section 7. Construction.

- (a) Nothing in this Act shall be construed as creating or recognizing a right to abortion.
- (b) It is not the intention of this Act to make lawful an abortion that is currently unlawful.

Section 8. Right of Intervention.

The [*Legislature*], by joint resolution, may appoint one or more of its members, who sponsored or cosponsored this Act in his or her official capacity, to intervene as a matter of right in any case in which the constitutionality of this Act or any portion thereof is challenged.

Section 9. Severability.

Any provision of this Act held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as to give it the maximum effect permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event such provision shall be deemed severable herefrom and shall not affect the remainder hereof or the application of such provision to other persons not similarly situated or to other, dissimilar circumstances.

Section 10. Effective Date.

This Act takes effect on [*Insert date*].

Abortion Reporting Act

HOUSE/SENATE BILL NO. _____

By Representatives/Senators _____

Section 1. Title.

This Act may be known and cited as the “Abortion Reporting Act.”

Section 2. Legislative Findings and Purposes.

- (a) The [Legislature] of the State of [Insert name of State] finds that:
- (1) The State “has legitimate interests from the outset of pregnancy in protecting the health of women.” *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 847 (1992).
 - (2) Specifically, the State “has a legitimate concern with the health of women who undergo abortions.” *Akron v. Akron Ctr. for Reproductive Health, Inc.* 462 U.S. 416, 428-29 (1983).
 - (3) Abortion is an invasive, surgical procedure that can cause severe physical and psychological (both short- and long-term) complications for women, including but not limited to: uterine perforation, cervical perforation, infection, bleeding, hemorrhage, blood clots, failure to actually terminate the pregnancy, incomplete abortion (retained tissue), pelvic inflammatory disease, endometritis, missed ectopic pregnancy, cardiac arrest, respiratory arrest, renal failure, metabolic disorder, shock, embolism, coma, placenta previa in subsequent pregnancies, preterm delivery in subsequent pregnancies, free fluid in the abdomen, adverse reactions to anesthesia and other drugs, an increased risk for developing breast cancer, psychological or emotional complications such as depression, suicidal ideation, anxiety, sleeping disorders, and death.
 - (4) To facilitate reliable scientific studies and research on the safety and efficacy of abortion, it is essential that the medical and public health communities have access to accurate information both on the abortion procedure and on complications resulting from abortion.
 - (5) Abortion “record keeping and reporting provisions that are reasonably directed to the preservation of maternal health and that properly respect a patient’s confidentiality and privacy are permissible.” *Planned Parenthood v. Danforth*, 428 U.S. 80 at 52, 79-81 (1976).
 - (6) Abortion and complication reporting provisions do not impose an “undue burden” on a woman’s right to choose whether or not to terminate a pregnancy. Specifically, “[t]he collection of information with respect to actual patients is a vital element of medical research, and so it cannot be said that the requirements serve no purpose other than to make abortions more difficult.” *Planned Parenthood v. Casey*, 505 U.S. 833 at 900-901 (1992).
 - (7) To promote its interest in maternal health and life, the State of [Insert name of State] maintains an interest in:
 - a. Collecting certain demographic information on all abortions performed in the State;
 - b. Collecting information on all complications from all abortions performed in the State; and
 - c. Compiling statistical reports based on abortion complication information collected pursuant to this Act for future scientific studies and public health research.
- (b) Based on the findings in subsection (a), it is the purpose of this Act to promote the health and safety of

women, by adding to the sum of medical and public health knowledge through the compilation of relevant data on all abortions performed in the State, as well as on all medical complications and maternal deaths resulting from these abortions.

Section 3. Definitions.

For the purposes of this Act only:

(a) “**Abortion**” means the act of using or prescribing any instrument, medicine, drug, or any other substance, device, or means with the intent to terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child. Such use, prescription, or means is not an abortion if done with the intent to:

- (1) Save the life or preserve the health of the unborn child;
- (2) Remove a dead unborn child caused by spontaneous abortion; or
- (3) Remove an ectopic pregnancy.

(b) “**Complication**” means any adverse physical or psychological condition arising from the performance of an abortion, which includes but is not limited to: uterine perforation, cervical perforation, infection, bleeding, hemorrhage, blood clots, failure to actually terminate the pregnancy, incomplete abortion (retained tissue), pelvic inflammatory disease, endometritis, missed ectopic pregnancy, cardiac arrest, respiratory arrest, renal failure, metabolic disorder, shock, embolism, coma, placenta previa in subsequent pregnancies, preterm delivery in subsequent pregnancies, free fluid in the abdomen, adverse reactions to anesthesia and other drugs, subsequent development of breast cancer, any psychological or emotional complications such as depression, suicidal ideation, anxiety, and sleeping disorders, and any other “adverse event” as defined by the Food and Drug Administration (FDA) criteria provided in the Medwatch Reporting System.

(c) “**Department**” means the Department of [*Insert name of appropriate department or agency*] of the State of [*Insert name of State*].

(d) “**Facility**” means any public or private hospital, clinic, center, medical school, medical training institution, healthcare facility, physician’s office, infirmary, dispensary, ambulatory surgical center, or other institution or location wherein medical care is provided to any person.

(e) “**Hospital**” means any institution licensed as a hospital pursuant to the laws of this State.

(f) “**Physician**” means any person licensed to practice medicine in this State. The term includes medical doctors and doctors of osteopathy.

(g) “**Pregnant**” or “**pregnancy**” means that female reproductive condition of having an unborn child in the [*woman’s*] uterus.

Section 4. Demographic Reporting on Abortion.

(a) For the purpose of promoting maternal health and adding to the sum of medical and public health knowledge through the compilation of relevant data, a report of each abortion performed shall be made to the Department on forms prescribed by it. The reports shall be completed by the hospital or other [*licensed*] facility in which the abortion occurred, signed by the physician who performed the abortion, and transmitted to the Department within fifteen (15) days after each reporting month.

(b) Each report shall include, at minimum, the following information:

- (1) Identification of the physician who performed the abortion, the facility where the abortion was performed, and the referring physician, agency, or service, if any;

- (2) The county and state in which the woman resides;
 - (3) The woman's age and race;
 - (4) The number of the woman's previous pregnancies, number of live births, and number of previous abortions;
 - (5) The probable gestational age of the unborn child;
 - (6) The type of procedure performed or prescribed and the date of the abortion; and
 - (7) Preexisting medical condition(s) of the woman which would complicate her pregnancy, if any.
- (c) Reports required under this subsection shall not contain:
- (1) The name of the woman;
 - (2) Common identifiers such as her social security number or *[motor vehicle operator's license number]*; or
 - (3) Other information or identifiers that would make it possible to identify, in any manner or under any circumstances, a woman who has obtained or seeks to obtain an abortion.
- (d) Every hospital or other *[licensed]* facility in which an abortion is performed within this State during any quarter year shall file with the Department a report showing the total number of abortions performed within the hospital or other *[licensed]* facility during that quarter year. This report shall also show the total abortions performed in each trimester of pregnancy. These reports shall be submitted on a form prescribed by the Department that will enable a hospital or other *[licensed]* facility to indicate whether or not it is receiving any state-appropriated funds. The reports shall be available for public inspection and copying only if the hospital or other *[licensed]* facility receives state-appropriated funds within the twelve (12)-calendar-month period immediately preceding the filing of the report. If the hospital or other *[licensed]* facility indicates on the form that it is not receiving state-appropriated funds, the Department shall regard that hospital or other *[licensed]* facility's report as confidential unless it receives other evidence that causes it to conclude that the hospital or facility receives state-appropriated funds.
- (e) The Department shall prepare a comprehensive annual statistical report for the *[Legislature]* based upon the data gathered from reports under this subsection. The statistical report shall not lead to the disclosure of the identity of any physician or person filing a report under this subsection nor of any woman who is the subject of the report. The aggregated data shall also be made independently available to the public by the Department in a downloadable format.
- (f) The Department shall summarize aggregate data from the reports required under this Act and submit the data to the U.S. Centers for Disease Control and Prevention (CDC) for the purpose of inclusion in the annual Vital Statistics Report. The aggregated data shall also be made independently available to the public by the Department in a downloadable format.
- (g) Reports filed pursuant this subsection shall not be deemed public records and shall remain confidential, except that disclosure may be made to law enforcement officials upon an order of a court after application showing good cause. The court may condition disclosure of the information upon any appropriate safeguards it may impose.
- (h) Absent a valid court order or judicial subpoena, neither the Department, any other state department, agency, or office nor any employees thereof shall compare data concerning abortions or abortion complications maintained in an electronic or other information system file with data in any other electronic or other information system, the comparison of which could result in identifying, in any manner or under any circumstances, a woman obtaining or seeking to obtain an abortion.
- (i) Statistical information that may reveal the identity of a woman obtaining or seeking to obtain an abortion shall

not be maintained by the Department, any other state department, agency, office, or any employee or contractor thereof.

(j) The Department or an employee or contractor of the Department shall not disclose to a person or entity outside the Department the reports or the contents of the reports required under this subsection, in a manner or fashion so as to permit the person or entity to whom the report is disclosed to identify, in any way or under any circumstances, the physician who performed the abortion and filed the report or the woman who is the subject of the report.

(k) Original copies of all reports filed under this subsection shall be available to the [State Medical Board] for use in the performance of its official duties.

(l) The Department shall communicate the reporting requirements in this subsection to all medical professional organizations, licensed physicians, hospitals, emergency rooms, abortion facilities [*or other appropriate term such as “reproductive health center”*], Department [*of Health*] clinics, ambulatory surgical facilities, and other healthcare facilities operating in the State.

Section 5. Abortion Complication Reporting.

(a) A hospital, [*licensed*] healthcare facility, or individual physician shall file a written report with the Department regarding each woman who comes under the hospital, [*licensed*] healthcare facility, or physician's care and reports any complication, requires medical treatment, or suffers death that the attending physician, hospital staff, or facility staff has reason to believe is a primary, secondary, or tertiary result of an abortion. The reports shall be completed by the hospital, [*licensed*] healthcare facility, or attending physician who treated the woman, signed by the attending physician, and transmitted to the Department within thirty (30) days of the discharge or death of the woman treated for the complication.

(b) Each report of a complication, medical treatment, or death following abortion required under this subsection shall contain, at minimum, the following information:

- (1) The age and race of the woman;
- (2) The woman's state and county of residence;
- (3) The number of previous pregnancies, number of live births, and number of previous abortions of the woman;
- (4) The date the abortion was performed, as well as the reason for the abortion and the method used, if known;
- (5) Identification of the physician who performed the abortion, the facility where the abortion was performed, and the referring physician, agency, or service, if any;
- (6) The specific complication(s) that led to the treatment, including, but not limited to, failure to actually terminate the pregnancy, missed ectopic pregnancy, uterine perforation, cervical perforation, incomplete abortion (retained tissue), bleeding, infection, hemorrhage, blood clots, cardiac arrest, respiratory arrest, pelvic inflammatory disease, damage to pelvic organs, endometritis, renal failure, metabolic disorder, shock, embolism, free fluid in the abdomen, acute abdomen, adverse reaction to anesthesia or other drugs, hemolytic reaction due to the administration of ABO-incompatible blood or blood products, hypoglycemia where onset occurs while patient is being cared for in the abortion facility, physical injury associated with therapy performed in the abortion facility, coma, death, and psychological or emotional complications including but not limited to depression, suicidal ideation, anxiety, and sleep disorders; and
- (7) The amount billed to cover the treatment of the specific complication(s), including whether the

treatment was billed to Medicaid, insurance, private pay, or other method. This should include charges for any physician, hospital, emergency room, prescription or other drugs, laboratory tests, and any other costs for the treatment rendered.

(c) Reports required under this subsection shall not contain:

- (1) The name of the woman;
- (2) Common identifiers such as her social security number or *[motor vehicle operator's license number]*; or
- (3) Other information or identifiers that would make it possible to identify, in any manner or under any circumstances, a woman who has obtained or seeks to obtain an abortion.

(d) The Department shall prepare a comprehensive annual statistical report for the *[Legislature]* based upon the data gathered from reports under this subsection. The statistical report shall not lead to the disclosure of the identity of any physician or person filing a report under this subsection nor of a woman about whom a report is filed. The aggregated data shall also be made independently available to the public by the Department in a downloadable format.

(e) The Department shall summarize aggregate data from the reports required under this Act and submit the data to the U.S. Centers for Disease Control and Prevention (CDC) for the purpose of inclusion in the annual Vital Statistics Report. The aggregated data shall also be made independently available to the public by the Department in a downloadable format.

(f) Reports filed pursuant this subsection shall not be deemed public records and shall remain confidential, except that disclosure may be made to law enforcement officials upon an order of a court after application showing good cause. The court may condition disclosure of the information upon any appropriate safeguards it may impose.

(g) Absent a valid court order or judicial subpoena, neither the Department, any other state department, agency, or office, nor any employees or contractors thereof shall compare data concerning abortions or abortion complications maintained in an electronic or other information system file with data in any other electronic or other information system, a comparison of which could result in identifying, in any manner or under any circumstances, a woman obtaining or seeking to obtain an abortion.

(h) Statistical information that may reveal the identity of a woman obtaining or seeking to obtain an abortion shall not be maintained by the Department, any other state department, agency, office, or any employee or contractor thereof.

(i) The Department or an employee or contractor of the Department shall not disclose to a person or entity outside the Department the reports or the contents of the reports required under this subsection in a manner or fashion so as to permit the person or entity to whom the report is disclosed to identify, in any way or under any circumstances, the woman who is the subject of the report.

(j) Original copies of all reports filed under this subsection shall be available to the *[State Medical Board]* for use in the performance of its official duties.

(k) The Department shall communicate this reporting requirement to all medical professional organizations, licensed physicians, hospitals, emergency rooms, abortion facilities *[or other appropriate term such as "reproductive health center"]*, Department *[of Health]* clinics, ambulatory surgical facilities, and other healthcare facilities operating in the State.

Section 6. Reporting Forms.

The Department shall create the forms required by this Act within sixty (60) days after the effective date of this Act. No provision of this Act requiring the reporting of information on forms published by the Department shall

be applicable until ten (10) days after the requisite forms are first created or until the effective date of this Act, whichever is later.

Section 7. Criminal Penalties and Professional Sanctions.

- (a) Any person who willfully delivers or discloses to the Department any report, record, or information required pursuant to this Act and known by him or her to be false is guilty of a *[Insert appropriate offense/penalty classification]*.
- (b) Any person who willfully discloses any information obtained from reports filed pursuant to this Act, other than the disclosure authorized by the Act or otherwise authorized by law, is guilty of a *[Insert appropriate offense/penalty classification]*.
- (c) Any person required under this Act to file a report, keep any records, or supply any information who willfully fails to file such report, keep such records, or supply such information at the time or times required by law or regulation, is guilty of unprofessional conduct, and his or her professional license shall be subject to suspension or revocation in accordance with procedures provided under the *[Insert reference(s) to the state Medical Practice Act or other appropriate statute(s) or administrative rule(s) or procedure(s)]*.
- (d) In addition to the above penalties, any facility that willfully violates any of the requirements of this Act shall upon conviction:
 - (1) Have its license suspended for a period of six (6) months for the first violation.
 - (2) Have its license suspended for a period of one (1) year for the second violation.
 - (3) Have its license revoked upon a third or subsequent violation.

Section 8. Construction.

- (a) Nothing in this Act shall be construed as creating or recognizing a right to abortion.
- (b) It is not the intention of this Act to make lawful an abortion that is currently unlawful.

Section 9. Right of Intervention.

The *[Legislature]*, by joint resolution, may appoint one or more of its members, who sponsored or cosponsored this Act in his or her official capacity, to intervene as a matter of right in any case in which the constitutionality of this law is challenged.

Section 10. Severability.

Any provision of this Act held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as to give it the maximum effect permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event such provision shall be deemed severable herefrom and shall not affect the remainder hereof or the application of such provision to other persons not similarly situated or to other, dissimilar circumstances.

Section 11. Effective Date.

This Act takes effect on *[Insert date]*.

The Federal Abortion-Mandate Opt-Out Act

HOUSE/SENATE BILL NO. _____

By Representatives/Senators _____

Section 1. Title.

This Act may be known and cited as the “Federal Abortion-Mandate Opt-Out Act.”

Section 2. Legislative Findings and Purposes.

- (a) The Legislature of the State of *[Insert name of State]* finds that:
- (1) Under the Patient Protection and Affordable Care Act (ACA), federal tax dollars, via affordability credits (subsidies provided to individuals up to 400% of the federal poverty level), are routed to Exchange-participating health insurance plans, including plans that provide coverage for abortions.
 - (2) Federal funding of insurance plans that provide abortion coverage is an unprecedented change in federal abortion funding policy. The Hyde Amendment, as passed each year in the Labor Health and Human Services Appropriations bill, and the Federal Employee Health Benefits Program (FEHBP) prohibit federal funds from subsidizing health insurance plans that provide coverage for most abortions. Under the ACA, however, Exchange-participating health insurance plans that provide abortions can receive federal funds.
 - (3) The provision of federal funding for health insurance plans that provide abortion coverage is nothing short of taxpayer-funded and government-endorsed abortion.
 - (4) However, the ACA allows a State to “opt-out” of permitting health insurance plans that cover abortions to participate in the Exchanges within that State, and thereby prohibit taxpayer money from subsidizing plans that cover abortions within that State.
 - (5) It is the long-standing policy of the State of *[Insert name of State]* that *[Insert statement(s) about state laws and policies on funding for abortion, use of state resources to promote or perform abortions, and/or restrictions on insurance plans that cover abortions]*.
 - (6) The decision not to fund abortion places no governmental obstacle in the path of a woman who chooses to terminate her pregnancy. *Rust v. Sullivan*, 500 U.S. 173, 201 (1991).
 - (7) Moreover, it is permissible for a State to engage in unequal subsidization of abortion and other medical services to encourage alternative activity deemed in the public interest. *Rust v. Sullivan*, 500 U.S. 173, 198 (1991).
 - (8) Citizens of the State of *[Insert name of State]*, like other Americans, oppose the use of public funds – both federal and state – to pay for abortions. For example, a January 2010 Quinnipiac poll showed that 7 in 10 Americans were opposed to provisions in federal healthcare reform that use federal funds to pay for abortions and abortion coverage.
 - (9) The Guttmacher Institute, which advocates for unfettered and taxpayer-funded access to abortion confirms that more women have abortions when they are covered by public programs.¹
 - (10) It is an accepted principle of economics and public policy, that when you subsidize or pay for a service or product, you increase demand for that service or product. Moreover, it is reasonable to conclude that this

¹ See Heather D. Boonstra, “The Heart of the Matter: Public Funding of Abortion for Poor Women in the United States,” Guttmacher Policy Review, Winter 2007, Vol. 10, No. 1, available at <http://www.guttmacher.org/pubs/gpr/10/1/gpr100112.html> (last visited June 25, 2014).

principle applies to the delivery of medical care in general and to the provision of abortion in particular.

- (11) Given that more women have abortions when they are covered by public programs and that public or private insurance coverage of a procedure generally leads to increased usage of that procedure, the State of *[Insert name of State]* concludes that the incidence of abortion would increase with the subsidization of private insurance plans that cover abortion.

(b) Based on the findings in subsection (a) of this Act, it is the purpose of this Act to affirmatively opt-out of allowing qualified health plans that cover abortions to participate in Exchanges within the State of *[Insert name of State]*.

Section 3. Definition.

As used in this Act, “abortion” means the act of using or prescribing any instrument, medicine, drug, or any other substance, device, or means with the intent to terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child. Such use, prescription, or means is not an abortion if done with the intent to:

- (a) Save the life or preserve the health of the unborn child;
- (b) Remove a dead unborn child caused by spontaneous abortion; or
- (c) Remove an ectopic pregnancy.

Section 4. Opt-Out.

(a) No abortion coverage may be provided by a qualified health plan offered through an Exchange created pursuant to Patient Protection and Affordable Care Act (ACA) within the State of *[Insert name of State]*.

(b) This limitation shall not apply to an abortion performed when the life of the mother is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself *[, or when the pregnancy is the result of an act of rape or incest]*.

Section 5. Construction.

- (a) Nothing in this Act shall be construed as creating or recognizing a right to abortion.
- (b) It is not the intention of this Act to make lawful an abortion that is currently unlawful.

Section 6. Right of Intervention.

The *[Legislature]*, by joint resolution, may appoint one or more of its members, who sponsored or cosponsored this Act in his or her official capacity, to intervene as a matter of right in any case in which the constitutionality of this Act or any portion thereof is challenged.

Section 7. Severability.

Any provision of this Act held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as to give it the maximum effect permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event such provision shall be deemed severable herefrom and shall not affect the remainder hereof or the application of such provision to other persons not similarly situated or to other, dissimilar circumstances.

Section 8. Effective Date.

This Act takes effect on *[Insert date]*.

The Employee Coverage Prohibition Act

HOUSE/SENATE BILL NO. _____

By Representatives/Senators _____

Section 1. Title.

This Act may be known and cited as the “Employee Coverage Prohibition Act.”

Section 2. Legislative Findings and Purposes.

- (a) The Legislature of the State of *[Insert name of State]* finds that:
- (1) The Hyde Amendment, as passed each year in the Labor Health and Human Services Appropriations bill, and the Federal Employee Health Benefits Program (FEHBP) prohibit federal funds from subsidizing health insurance plans that provide abortion coverage. In other words, federal employees cannot enroll in insurance plans that cover abortions (with limited exceptions).
 - (2) It is the long-standing policy of the State of *[Insert name of State]* that *[Insert statement(s) about state policies on funding for abortion, use of state resources to promote or perform abortions, and/or insurance plans that cover abortions]*.
 - (3) Nonetheless, the State of *[Insert name of State]* currently does not explicitly prohibit state employees from receiving subsidized abortion coverage and does not explicitly prohibit the use of state taxpayer funds for abortions for state employees or their dependents.
 - (4) The provision of state government funding for health insurance plans that provide abortion coverage is nothing short of taxpayer-funded and government-endorsed abortion.
 - (5) The decision not to fund abortion places no governmental obstacle in the path of a woman who chooses to terminate her pregnancy. *Rust v. Sullivan*, 500 U.S. 173, 201 (1991).
 - (6) Moreover, it is permissible for a State to engage in unequal subsidization of abortion and other medical services to encourage alternative activity deemed in the public interest. *Rust v. Sullivan*, 500 U.S. 173, 198 (1991).
 - (7) Citizens of the State of *[Insert name of State]*, like other Americans, oppose the use of public funds – both federal and state – to pay for abortions. For example, a January 2010 Quinnipiac poll showed that 7 in 10 Americans opposed provisions in federal health care reform that use federal funds to pay for abortions and abortion coverage.
 - (8) The Guttmacher Institute, which advocates for unfettered and taxpayer-funded access to abortion, confirms that more women have abortions when they are covered by public programs.¹
 - (9) It is an accepted principle of economics and public policy, that when you subsidize or pay for a service or product, you increase demand for that service or product. Moreover, it is reasonable to conclude that this principle applies to the delivery of medical care in general and to the provision of abortion in particular.
 - (10) Given that more women have abortions when they are covered by public programs and that public or private insurance coverage of a procedure generally leads to increased usage of that procedure, the State of *[Insert name of State]* concludes that the incidence of abortion may be higher when insurance coverage of abortion is subsidized for public employees.

¹ See Heather D. Boonstra, The Heart of the Matter: Public Funding of Abortion for Poor Women in the United States, Guttmacher Policy Review, Winter 2007, Vol. 10, No. 1, available at <http://www.guttmacher.org/pubs/gpr/10/1/gpr100112.html> (last visited Aug. 25, 2014).

(b) Based on the findings in subsection 2(a), it is the purpose of this Act to prohibit any insurance contract, plan, or policy provided or offered to employees of the State of [Insert name of State] [and/or a specific county, city, or town] and their dependents from providing coverage for obtaining or performing an abortion and to prohibit the use of state funds [and/or the funds of any specific county, city, or town] for the purpose of obtaining or performing an abortion on behalf of employees of the State of [Insert name of State] [and/or a specific county, city, or town] and their dependents.

Section 3. Definitions.

For the purposes of this Act:

(a) **“Abortion”** means the act of using or prescribing any instrument, medicine, drug, or any other substance, device, or means with the intent to terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child. Such use, prescription, or means is not an abortion if done with the intent to:

- (1) Save the life or preserve the health of the unborn child;
- (2) Remove a dead unborn child caused by spontaneous abortion; or
- (3) Remove an ectopic pregnancy.

(b) **“Employee”** means:

- (1) Any person in the service of the State[, county, city, or town] or of any branch of the State[, county, city, or town] government, of any executive department of the State[, county, city, or town], or of any agency, board, institution, or commission of the State[, county, city, or town] under any contract for hire, express or implied, oral or written, where the State[, county, city, or town] has the power or right to control and direct the employee in the material details of how the work is to be performed;
- (2) State[, county, city, or town] elected officials; or
- (3) Appointed members of governing bodies of the State[, county, city, or town].

Section 4. Prohibition.

(a) Notwithstanding any other provision of law to the contrary, the State of [Insert name of State] [or any county, city, or town within the State of [Insert name of State]] shall not include in any insurance contract, plan, or policy covering employees and their dependents any provision which shall provide coverage for obtaining or performing an abortion nor shall any State[, county, city, or town] funds be used for the purpose of obtaining or performing an abortion on behalf of the State[, county, city, or town] employees or their dependents.

(b) This Section shall be applicable to all contracts, plans, or policies of: ²

- (1) All health insurers subject to [Insert appropriate State[, county, city, or town] code section(s) or other regulatory provision(s)];
- (2) All nonprofit hospital and medical, surgical, dental, and health service corporations subject to [Insert appropriate State[, county, city, or town] code section(s) or other regulatory provision(s)];
- (3) All group and blanket health insurers subject to [Insert appropriate State[, county, city, or town] code section(s) or other regulatory provision(s)];
- (4) All health maintenance organizations subject to [Insert appropriate State[, county, city, or town] code section(s) or other regulatory provision(s)]; and

² This list should be tailored according to the laws of the State.

- (5) Any provision of medical, hospital, surgical, and funeral benefits and of coverage against accidental death or injury, when such benefits or coverage are incidental to or part of other insurance described in *[Insert appropriate State[, county, city, or town] code section(s) or other regulatory provision(s)]*.

(c) This limitation shall not apply to an abortion performed when the life of the mother is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself, *or when the pregnancy is the result of an act of rape or incest*.

Section 5. Construction.

- (a) Nothing in this Act shall be construed as creating or recognizing a right to abortion.
- (b) It is not the intention of this Act to make lawful an abortion that is currently unlawful.

Section 6. Right of Intervention.

The *[Legislature]*, by joint resolution, may appoint one or more of its members, who sponsored or cosponsored this Act in his or her official capacity, to intervene as a matter of right in any case in which the constitutionality of this Act or any portion thereof is challenged.

Section 7. Severability.

Any provision of this Act held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as to give it the maximum effect permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event such provision shall be deemed severable herefrom and shall not affect the remainder hereof or the application of such provision to other persons not similarly situated or to other, dissimilar circumstances.

Section 8. Effective Date.

This Act takes effect on *[Insert date]*.

The Defunding the Abortion Industry and Advancing Women's Health Act

HOUSE/SENATE BILL NO. _____

By Representatives/Senators _____

[Drafter's Note: Provisions in this model may be enacted individually or collectively, depending on the needs of an individual state. The three substantive Parts of the Act include drafter's notes indicating when enactment of each Part would be appropriate for a State and provide language that may be tailored to fit a state's specific needs. Further, AUL will work with states to ensure that the appropriate legislative findings and purposes in Section 2 and definitions in Section 3 are included in their bills.]

Section 1. Title.

This Act may be known and cited as the "Defunding the Abortion Industry and Advancing Women's Health Act."

Section 2. Legislative Findings and Purposes.

[Drafter's Note: Additional findings and purposes may need to be included, depending on how a particular bill is structured.]

(a) The [Legislature] of the State of [Insert name of State] finds that:

- (1) The State of [Insert name of State] voluntarily participates in several federal programs that provide funds for family planning services. Among these programs are Title X of the Public Health Service Act which provides project grants to public and private agencies for family planning services, and Title XX of the Social Security Act which provides block grants to the states for social services, including family planning.
- (2) Title X specifies that funds may not be used to finance abortions or abortion-related activity. Specifically, Title X provides that "none of the funds appropriated ... shall be used in programs where abortion is a method of family planning." 42 U.S.C. §300a-6.
- (3) Title XX funds may not be used for the provision of medical care. Moreover, any Title XX funds used to match Title X funds may not be used to finance abortions or abortion-related activity.
- (4) In addition to federal family planning funds, the State of [Insert name of State] also provides state-originated funds under [Insert reference(s) to any direct state subsidies, grants, or other allocations for family planning services, education, etc.] for family planning.
- (5) The [Insert name of State] [Department of Health or other appropriate state department or agency] appropriates and distributes both federal and state funds for family planning services to ["family planning contractors" or other appropriate term].
- (6) [Insert reference(s) to applicable state law(s)] prohibits the use of public funds for elective abortion: abortions performed in cases not involving threats to the life of the mother [or insert specific exemption language from applicable state statute(s)].
- (7) Left unrestricted or unregulated, federal and state funds for family planning services can, in some cases, effectively and indirectly subsidize contractors, individuals, organizations, or entities performing or inducing abortions, referring for abortions, or counseling in favor of abortions through shared administrative costs, overhead, employee salaries, rent, utilities, and various other expenses.
- (8) When the federal or a state government appropriates public funds to establish a program, it is entitled to

define the limits of that program. *Rust v. Sullivan*, 500 U.S. 173, 194 (1991).

- (9) The decision not to fund abortion places no governmental obstacle in the path of a woman who chooses to terminate her pregnancy. *Rust v. Sullivan*, 500 U.S. 173, 201 (1991).
 - (10) The government may rationally distinguish between abortion and other medical procedures because “no other procedure involves the purposeful termination of a potential life.” *Harris v. McRae*, 448 U.S. 297, 325 (1980).
 - (11) It is permissible for the State of *[Insert name of State]* to engage in unequal subsidization of abortion and other medical services to encourage alternative activity deemed in the public interest. *Rust v. Sullivan*, 500 U.S. 173, 201 (1991).
 - (12) Requiring abortion-related activity to be completely separate from other activities that receive federal and/or state funding in no way denies any right to engage abortion-related activities. *Rust v. Sullivan*, 500 U.S. 173, 198 (1991).
 - (13) Planned Parenthood’s internal surveys show that approximately seventy (70) percent of women who visit their clinics do not follow up with referrals to other medical facilities to have important health needs addressed. As a result, it is better for women to seek birth control and related services from more comprehensive healthcare providers who can address a broad array of health issues that Planned Parenthood clinics are not equipped to handle.
- (b) Based on the findings in subsection (a), the purposes of this Act are to:
- (1) Advance the State’s policy that normal childbirth is in the best interests of the well-being and common good of *[Insert name of State]*’s citizens and should be given preference, encouragement, and support by law and state action;
 - (2) Ensure that public funds are not used to subsidize abortions directly or indirectly;
 - (3) Ensure that no federal family planning funds appropriated or dispersed by the State are used to pay the direct or indirect costs (including, but not limited to, administrative costs or expenses, overhead, employee salaries, rent, and telephone and other utilities) of abortion procedures, abortion referrals, or abortion counseling provided by *[“family planning contractors” or other appropriate term]*,
 - (4) Ensure recipients of federal family planning funds that, as permitted by current law, affiliate with an independent, unsubsidized entity that performs or provides abortions, abortion referrals, or abortion counseling, do not use public funds to subsidize, either directly or indirectly, the provision of abortions, abortion counseling, or abortion referrals; and
 - (5) Guarantee that no state family planning funds appropriated or dispersed pursuant to *[Insert reference(s) to specific state statute(s) regarding family planning funds and/or state family planning policies or programs]*, shall be appropriated to or distributed to individuals, organizations, entities, or affiliates of individuals, organizations, or entities that perform, induce, refer for, or counsel on behalf of elective abortions.

Section 3. Definitions.

As used in this Act only:

- (a) **“Abortion”** means the act of using or prescribing any instrument, medicine, drug, or any other substance, device, or means with the intent to terminate the clinically diagnosable pregnancy of a woman with the knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child. Such use, prescription, or means is not an abortion if done with the intent to:

- (1) Save the life or preserve the health of the unborn child;
- (2) Remove a dead unborn child caused by spontaneous abortion; or
- (3) Remove an ectopic pregnancy.

Further, an **“elective abortion”** means an abortion performed for reasons other than threats to the life of the mother *[or insert a specific definition or exemption language from current state law]*.

(b) **“Affiliate”** means an organization that owns or controls or is owned or controlled, in whole or in part, by the other; related by shareholdings or other means of control; or a subsidiary, parent, or sibling corporation.

(c) **“Facility”** or **“medical facility”** means any public or private hospital, clinic, center, medical school, medical training institution, healthcare facility, physician’s office, infirmary, dispensary, ambulatory surgical treatment center, or other institution or location wherein medical care is provided to any person.

(d) **“Family planning contractor”** and **“contractor”** mean an individual, organization, or entity that enters into a contract or agreement with the *[Department of Health or other responsible department or agency]* to receive funds for and to provide family planning services.

(e) **“Family planning services”** means a range of acceptable methods to prevent, delay, space, or otherwise time pregnancy, including, but not limited to, natural family planning methods and infertility services. Family planning services do not include abortion, abortion referrals, or counseling in favor of abortion.

(f) **“Federal family planning funds”** means any federal money appropriated or dispersed by any state official, branch, department, or agency, in whole or in part, for family planning services, including (but not limited to) funds under Title X and Title XX or other federal money accepted by the State, in whole or in part, for family planning services.

(g) **“Human cloning”** means human asexual reproduction accomplished by (1) introducing the genetic material from one or more human somatic or embryonic cells into a fertilized or unfertilized oocyte whose nuclear material has been removed or inactivated before or after introduction, so as to produce an organism at any stage of development with a human or predominantly human genetic constitution; (2) artificially subdividing a human embryo at any time from the two-cell stage onward, such that more than one human organism results; or (3) introducing pluripotent cells from any source into a human embryo, nonhuman embryo, or artificially manufactured human embryo or trophoblast, under conditions where the introduced cells generate all or most of the body tissues of the developing organism.

(h) **“Physician”** means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which the doctor performs such activity or any other individual legally authorized by the State to perform abortions.

(i) **“Prohibited human research”** means:

- (1) Any medical procedures, scientific or laboratory research, or other kinds of investigation that kill or injure the human subject (at any stage of development) of such research; or
- (2) Any scientific or laboratory research or other kinds of investigation conducted on fetal tissue obtained from an abortion, unless the research is done to obtain forensic or other evidence in a rape or incest investigation.

Prohibited human research does not include:

- (1) *In vitro* fertilization and accompanying embryo transfer to a woman’s body;
- (2) Research in the use of nuclear transfer or other cloning techniques to produce molecules; deoxyribonucleic

acid; or cells other than human embryos, tissues, organs, plants, or animals other than humans; or

(3) Any diagnostic procedure that benefits the human subject of such tests.

(j) **“State family planning funds”** means funds dispersed under *[Insert reference(s) to specific state statute(s) regarding state family planning funds or state family planning policies or programs]*.

(k) **“Unborn child”** means the offspring of human beings from conception until birth.

Part I: Prohibitions on Abortion Funding.

[Drafter’s Note: *Sections 4-11 provide options for reducing or eliminating the provision of public funding for abortion providers and abortion-related activities. These provisions are particularly helpful in states that do not have a comprehensive prohibition on public funding for abortions. AUL can assist states with determining which provisions are needed. These sections may be enacted collectively, individually, or as part of a state Appropriations Act or budgetary rider.*]

Section 4. Comprehensive Prohibition on the Use of Public Funds.

(a) Notwithstanding any other provision of law to the contrary, no public funds made available to any institution, board, commission, department, agency, official, or employee of the State of *[Insert name of State]* or of any local political subdivision thereof, whether such funds are made available by the government of the United States, the State of *[Insert name of State]*, or a local governmental subdivision or are from any other public source, or monies paid by students as part of tuition or fees to a state university or a community college shall be used in any way for, to assist in, or to provide facilities for an abortion or for training to perform an abortion.

(b) It shall be unlawful for any person employed by the State or any agency or political subdivision thereof, within the scope of the person’s employment, to perform or assist an abortion.

(c) No fund or committee authorized by the *[Code]* of *[Insert name of State]* for the special protection of women or children shall be authorized to use or distribute public funds for the payment of abortions, abortion referrals, abortion counseling, or abortion-related services.

(d) No organization that receives funds authorized or appropriated by the State may use those funds to perform or promote abortions, provide counseling in favor of abortion, or to make referrals for abortions.

(e) The limitations in subsections (a) through (d) shall not apply to an abortion performed when the life of the mother is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself *[, or when the pregnancy is the result of an act of rape or incest]*.

Section 5. Use of Public Facilities Prohibited.

(a) It shall be unlawful for any public institution, public facility, public equipment, or other physical asset owned, leased, or controlled by the State or any agency or political subdivision thereof to be used for the purpose of performing or assisting an abortion. This limitation shall not apply to an abortion performed when the life of the mother is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself *[, or when the pregnancy is the result of an act of rape or incest]*.

(b) It shall be unlawful for any public institution or facility to lease or sell its facilities to or property or permit the subleasing of its facilities or property to any physician or health facility for use in the provision or performance of abortion. This limitation shall not apply to an abortion performed when the life of the mother is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself *[, or when the pregnancy is the result of an act of rape or incest]*.

Section 6. Use of Education-Related Fees Prohibited.

No applicant, student, teacher, or employee of any public school or university shall be required to pay any fees that would, in whole or in part, fund an abortion [*or insurance coverage for an abortion*] for any other applicant, student, teacher, or employee of that school or university.

Section 7. Contracts with Abortion Providers Prohibited/Restricted.

No hospital, clinic, or other health facility owned or operated by the State, a county, a city, or other governmental entity (except the government of the United States, another state, or a foreign nation) shall enter into any contract with any physician or health facility under the terms of which such physician or health facility agrees to provide or perform abortions, except when the life of the mother is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself [, *or when the pregnancy is the result of an act of rape or incest*].

Section 8. Research Grants Restricted.

- (a) Public funds shall not be expended, paid, or granted to or on behalf of an existing or proposed research project that involves the performance of abortion, human cloning, or prohibited human research.
- (b) No moneys derived from an award of public funds shall be passed through to any other research project, person, or entity involved with the provision or performance of abortion, human cloning, or prohibited human research.
- (c) A research project that receives an award of public funds shall maintain financial records that demonstrate strict compliance with this subsection.
- (d) Any audit conducted pursuant to any grant or contract awarding public funds shall also certify whether there is compliance with this subsection and shall note any noncompliance as a material audit finding.

Section 9. School-Based Health Clinics.

- (a) No facility operated on public school property or operated by a public school district and no employee of any such facility acting within the scope of such employee's employment shall provide any of the following services to public school students:
 - (1) Provision or performance of an abortion;
 - (2) Counseling in favor of an abortion;
 - (3) Referral for an abortion; or
 - (4) Dispensing drugs classified as "emergency contraception" by the federal Food and Drug Administration (FDA).
- (b) The [*Insert name of State*] [*Department of Education or other appropriate state department or agency*] and local units of administration are prohibited from utilizing state funds for the procurement of abortions or distribution of drugs classified as "emergency contraception" by the federal Food and Drug Administration (FDA).

Section 10. Legal Funds Restricted.

- (a) No federal or state funds which are appropriated by the state for the provision of legal services by private agencies, as authorized by statute previously or subsequently enacted, may be used, directly or indirectly, to:
 - (1) Advocate for a legal "right" to abortion;
 - (2) Provide legal assistance with respect to any proceeding or litigation which seeks to procure any abortion or to procure public funding for any abortion; or

- (3) Provide legal assistance with respect to any proceeding or litigation which seeks to compel the performance or assistance in the performance of any abortion or the provision of facilities for the performance of any abortion.

(b) Nothing in this subsection shall be construed to require or prevent the expenditure of funds pursuant to a court order awarding fees for attorney's services under the *Civil Rights Attorney's Fees Awards Act of 1976* (Public law 94-559, 90 Stat. 2641) nor shall this subsection be construed to prevent the use of public funds to provide court-appointed counsel in any proceeding relating to *[Insert reference to state parental involvement (for abortion) law]*.

Section 11. IOLTA Accounts Restricted.

No Interest on Lawyer Trust Accounts (IOLTA) funds may be used, directly or indirectly, to do any of the following:

- (a) Advocate for a legal "right" to abortion;
- (b) Provide legal assistance with respect to any proceeding or litigation which seeks to procure or procure public funding for any abortion; or
- (c) Provide legal assistance with respect to any proceeding or litigation which seeks to compel the performance or assistance in the performance of any abortion or the provision of facilities for the performance of any abortion.

PART II: Restrictions on Family Planning Funds.

[Drafter's Note: Sections 12-15 may be enacted as a stand-alone law, in conjunction with Part III and/or provisions in Part I, or as a part of a state Appropriations Act or budgetary rider. These Sections, modeled after laws upheld by federal appellate courts, are appropriate for any state that wishes to prevent federal and state family planning funds from subsidizing the abortion industry. It also helps ensure that limited family planning funds are distributed to individuals, organizations, or entities that provide comprehensive care for women.]

Section 12. Prohibitions on Use of Funds.

- (a) No federal or state family planning funds shall be used by contractors of the *[Department of Health or other appropriate department or agency]* to pay the direct or indirect costs (including, but not limited to, administrative costs and expenses, overhead, employee salaries, rent, and telephone and other utilities) of performing, inducing, referring for, or counseling in favor of abortions.
- (b) No state family planning funds shall be granted, appropriated, or distributed to individuals or organizations that perform, induce, refer for, or counsel in favor of abortions, or that have affiliates that perform, induce, refer for, or counsel in favor of elective abortions.

Section 13. Limited Waiver.

If the *[Department of Health or other appropriate department or agency]* concludes that compliance with subsection 12(b) would result in a significant reduction in family planning services in any public health region of the State, the *[Department of Health or other appropriate department or agency]* may waive the requirements of subsection 12(b) for the affected region to the extent necessary to avoid a significant reduction in family planning services to the region. This waiver shall expire on *[Insert appropriate year, date, or time period]*, and no waiver shall extend beyond that date.

Section 14. Mandatory Certification of Compliance.

(a) A family planning contractor, individual, organization, or entity applying for federal family planning funds administered or distributed by the *[Department of Health or other appropriate department or agency]* must certify in writing on forms provided by the *[Department of Health or other appropriate department or agency]* that it will not, directly or indirectly, use the funds to perform, induce, refer for abortion, or counsel in favor of abortions. Recipients of federal family planning funds administered or distributed through the *[Department of Health or other*

appropriate department or agency] will annually submit a written certification of continued compliance. Funds shall not be granted to any family planning contractor, individual, organization, or entity until the required certification has been received.

(b) A family planning contractor, individual, organization, or entity applying for state family planning funds must certify in writing on forms provided by the [*Department of Health or other appropriate department or agency*] that it will not perform, induce, refer for, or counsel in favor of elective abortions, and that it does not have affiliates that perform, induce, refer for, or counsel in favor of elective abortions. Recipients of state family planning funds through the [*Department of Health or other appropriate department or agency*] will submit an annual written certification of continued compliance. Funds shall not be granted to any family planning contractor, individual, organization, or entity until required certification has been received.

(c) The [*Department of Health or other appropriate department or agency*] shall include in its financial audit a review of the use of appropriated federal and state family planning funds to ensure compliance with this Act.

Section 15. Failure to Comply, Recoupment of Funds, and Civil Penalties.

(a) A family planning contractor that receives any federal and/or state family planning funds and is found not to be in compliance with the requirements of Sections 12 and 14 of this Act will be enjoined from receiving any future federal and/or state family planning funds and will be liable to return to the State the full amount of federal and/or state family planning funds received [*may insert specific time period*].

(b) Any violation of this Act may subject the family planning contractor to a civil penalty or fine up to [*Insert appropriate amount*] imposed by the [*Department of Health or other appropriate department or agency*].

(c) Both the Office of the Attorney General and the Office of the District Attorney [*or other appropriate designation*] for the county in which the violation occurred may institute legal action to enforce:

- (1) Recoupment, collection, or reimbursement of federal and/or state family planning funds; and
- (2) Collection of civil penalties or fines.

PART III: Prioritization for Award of Family Planning Funds.

[Drafter's Note: Section 16 may be enacted as a stand-alone law, in conjunction with Part II (so that abortion providers who are awarded family planning funds under Section 16 cannot use the funds to subsidize their abortion practice) or provisions in Part I, or as a part of a state Appropriations Act or budgetary rider. This provision promotes women's health by prioritizing the distribution of public funds for family planning services to healthcare providers who can meet women's comprehensive medical needs.]

Section 16. Family Planning Funding Prioritization.

(a) Notwithstanding any other law, federal family planning funds and state family planning funds shall be awarded to eligible individuals, organizations, or entities applying to be family planning contractors in the following order of descending priority:

- (1) Public entities that provide family planning services, including state, county, and local community health clinics and federally qualified health centers;
- (2) Nonpublic entities that provide comprehensive primary and preventive health services, as described in 42 U.S.C. 254b(b)(1)(A), in addition to family planning services; and
- (3) Nonpublic entities that provide family planning services, but do not provide comprehensive primary and preventive health services.

(b) The [Department of Health or other appropriate department or agency] shall, in compliance with federal law, ensure distribution of federal family planning funds in a manner that does not severely limit or eliminate access to family planning services in any region of the State.

(c) The [Department of Health or other appropriate department or agency] shall submit an annual report to the [Legislature] listing any family planning contractors that fall under category (a)(3), and the amount of federal or state family planning funds they received. The report shall provide a detailed explanation of how the State determined that there were an insufficient number of eligible individuals, organizations, or entities in categories (a)(1) and (a)(2) to prevent a significant reduction in family planning services in each region of the state where (a)(3) contractors are located.

Section 17. Construction.

(a) Nothing in this Act shall be construed as creating or recognizing a right to abortion.

(b) Nothing in this Act shall be construed as creating or recognizing a right to federal and/or state funds for family planning services.

Section 18. Right of Intervention.

The [Legislature] by joint resolution, may appoint one or more of its members, who sponsored or cosponsored this Act in his or her official capacity, to intervene as a matter of right in any case in which the constitutionality of this law is challenged.

Section 19. Severability.

Any provision of the Act held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as to give it the maximum effect permitted by law, unless such holding shall be one of utter invalidity or unenforceability in which event such provision shall be deemed severable herefrom and shall not affect the remainder hereof or the application of such provision to other persons not similarly situated or to other, dissimilar circumstances.

Section 20. Effective Date.

This Act takes effect on [Insert date].

Joint Resolution to Promote Women’s Safety by Investigating and Defunding Planned Parenthood and other Abortion Providers

HOUSE/SENATE BILL NO. _____

By Representatives/Senators _____

WHEREAS, at least [Insert appropriate number] states have recently or are currently investigating abortion clinics and abortion providers for offenses including failure to meet medical standards and licensing requirements, violations of health and safety codes, improper disposal of medical waste and patient records, Medicaid fraud, violations of late-term abortion restrictions, criminal battery, and criminal and civil liability for the deaths of their patients;¹

WHEREAS, a January 2011 Pennsylvania grand jury report investigating abortion provider Kermit Gosnell and the Women’s Medical Society clinic in Philadelphia reveals Gosnell’s utter disregard for the law and documents a pattern of deadly behavior towards women and newborns;

WHEREAS, the Pennsylvania grand jury report reveals that the Women’s Medical Society clinic received government funding;

WHEREAS, the Pennsylvania grand jury report demonstrates a systemic failure to enforce laws designed to protect women’s health and safety, noting there “were several oversight agencies that stumbled upon and should have shut down Kermit Gosnell long ago;”

WHEREAS, video footage recorded at Planned Parenthood affiliates by the organization Live Action shows Planned Parenthood employees recommending that minors patronize abortion facilities that may be willing to violate state laws;

WHEREAS, sex-trafficking is a form of slavery and federal statutes[, including 18 U.S.C. §§ 1591, 2421, 2422, and 2423,] prohibit sex tourism and the interstate and international sex trafficking of adults and children, as well as sex trafficking within a state;

WHEREAS, in 2003, the U.S. State Department estimated that 800,000 to 900,000 human beings are bought, sold, or forced across international borders each year;

WHEREAS, a 2001 report released by the University of Pennsylvania estimated that approximately 293,000 American youth are currently at risk of becoming victims of commercial sexual exploitation;

WHEREAS, the average age at which girls first become victims of prostitution is 12 to 14 years of age;

WHEREAS, video footage recorded at Planned Parenthood affiliates in several states and the District of Columbia shows a willingness by Planned Parenthood employees to aid a man who claims that he is involved in the sex-trafficking of girls as young as 14 years of age;

WHEREAS, video footage recorded at Planned Parenthood affiliates in several states and the District of Columbia shows a willingness by Planned Parenthood employees to circumvent state parental involvement laws concerning abortion;

¹ Legislators and others considering this resolution should contact Americans United for Life for information on on-going investigations of and emerging claims against abortion clinics and individual abortion providers.

WHEREAS, numerous allegations have surfaced concerning the failure of Planned Parenthood affiliates to report the suspected sexual abuse of young girls;

WHEREAS, Planned Parenthood affiliates in a number of states have disregarded state abortion-related laws including parental involvement and informed consent laws and faced adverse administrative actions for those violations;

WHEREAS, some Planned Parenthood clinics have violated state law by performing abortions without a license;

WHEREAS, Planned Parenthood affiliates nationwide admittedly dispense the dangerous abortion drug RU-486 in direct violation of the U.S. Food and Drug Administration (FDA) protocol for the drug as well as the drug's label, endangering women's lives and health;

WHEREAS, audit reports demonstrate that some Planned Parenthood affiliates have overbilled state and federal government healthcare and family planning programs;

WHEREAS, the Planned Parenthood Federation of America (the national parent organization with over 700 affiliated centers across the nation) and its affiliates received \$540,600,000 in government grants and reimbursements for the fiscal year ending in June 2013;

[WHEREAS, Planned Parenthood affiliates in [Insert name of State] receive[d] [Insert appropriate information about source and amount of state grants to or contracts with Planned Parenthood]];

WHEREAS, Planned Parenthood affiliates have performed a significant percentage of the over 50 million abortions performed in the United States since 1973 when *Roe v. Wade* was decided, including [327,166 abortions from October 1, 2011 to September 30, 2012];

WHEREAS, as government funding of Planned Parenthood has doubled, Planned Parenthood has doubled its abortion business;

WHEREAS, Planned Parenthood Federation of America has made clear the centrality of abortion to its mission by recently mandating that every Planned Parenthood affiliate must have at least one clinic performing abortions;

WHEREAS, the decision not to fund abortion places no governmental obstacle in the path of a woman who chooses to terminate her pregnancy. *Rust v. Sullivan*, 500 U.S. 173, 201 (1991);

WHEREAS, when the federal or a state government appropriates public funds to establish a program, it is entitled to define the limits of that program. *Rust v. Sullivan*, 500 U.S. 173, 194 (1991);

[WHEREAS, the established policy of [Insert name of State] provides [Insert appropriate description of and references to any state policies against public funding for abortion and/or abortion providers]];

WHEREAS, the federal Congress' power of inquiry is "an essential and appropriate auxiliary to the legislative function." *McGrain v. Daugherty*, 272 U.S. 135, 174 (1927);

WHEREAS, the Congress' issuance of a subpoena pursuant to an authorized investigation is "an indispensable ingredient of lawmaking." *Eastland v. United States Servicemen's Fund*, 421 U.S. 491, 505 (1975); and

WHEREAS, [Insert name of State] also has the authority under [Insert appropriate statutory or other reference(s)] to investigate recipients of state funding [including state family planning funding].

NOW, THEREFORE, BE IT RESOLVED BY THE LEGISLATURE OF THE STATE OF [INSERT NAME OF STATE]:

Section 1. That the [Legislature] immediately freeze any currently allocated state funding for abortion providers, in particular Planned Parenthood.

Section 2. That the [Legislature] calls on Congress to freeze any currently allocated federal funding for abortion providers, in particular the Planned Parenthood Federation of America (PPFA) and its affiliates.

Section 3. That the [Legislature] calls on the [Insert name of appropriate state authority] to conduct a full-scale investigation of abortion providers, including Planned Parenthood, for potential violations of state laws, including health and safety code violations, misuse of government funding, and [Insert appropriate reference(s) to other state law(s)].

Section 4. That the [Legislature] calls on Congress to conduct a full-scale investigation of abortion providers, including Planned Parenthood, for potential violations of federal laws including aiding and abetting sex-trafficking, misuse of federal funding, and [Insert appropriate reference(s) to other federal law(s)] and urges Congress to use its subpoena power to obtain all business, medical, and other records necessary for a thorough and complete investigation.

Section 5. That the [Legislature] strongly supports the federal [“No Taxpayer Funding of Abortion Act” or similar legislation] to ensure consistency with longstanding federal law and policy [and the laws and policies of this State] prohibiting government funding of abortion.

Section 6. That the [Legislature] strongly supports the federal [“Title X Abortion Provider Prohibition Act” or similar legislation] to ensure that federal family-planning funding does not subsidize the abortion industry by, for example, paying for shared overhead and operational costs.

Section 7. That the Secretary of State of [Insert name of State] transmit a copy of this resolution to the Governor; to the President of the United States; to the President of the Senate and the Speaker of the House of Representatives of the United States Congress; and to each individual member of [Insert name of State]’s Congressional delegation.

Joint Resolution Honoring Pregnancy Resource Centers

HOUSE/SENATE BILL NO. _____

By Representatives/Senators _____

WHEREAS, the life-affirming impact of pregnancy resource centers on the women, men, children, and communities they serve is considerable and growing;

WHEREAS, pregnancy resource centers serve women in *[Insert name of State]* and across the United States with integrity and compassion;

WHEREAS, more than 2,500 pregnancy resource centers across the United States provide comprehensive care to women and men facing unplanned pregnancies, including resources to meet their physical, psychological, emotional, and spiritual needs;

WHEREAS, pregnancy resource centers offer women free, confidential, and compassionate services, including pregnancy tests, peer counseling, 24-hour telephone hotlines, childbirth and parenting classes, referrals to community health care, and other support services;

WHEREAS, many medical pregnancy resource centers offer ultrasounds and other medical services;

WHEREAS, many pregnancy resource centers provide information on adoption and adoption referrals to pregnant women;

WHEREAS, pregnancy resource centers encourage women to make positive life choices by equipping them with complete and accurate information regarding their pregnancy options and the development of their unborn children;

WHEREAS, pregnancy resource centers provide women with compassionate and confidential peer counseling in a nonjudgmental manner regardless of their pregnancy outcomes;

WHEREAS, pregnancy resource centers provide important support and resources for women who choose childbirth over abortion;

WHEREAS, pregnancy resource centers ensure that women are receiving prenatal information and services that lead to the birth of healthy infants;

WHEREAS, many pregnancy resource centers provide grief assistance for women and men who regret the loss of their children from past choices they have made;

WHEREAS, many pregnancy resource centers work to prevent unplanned pregnancies by teaching effective abstinence education in public schools;

WHEREAS, both federal and state governments are increasingly recognizing the valuable services of pregnancy resource centers through the designation of public funds for such organizations; *[and]*

WHEREAS, pregnancy resource centers operate primarily through reliance on the voluntary donations and time of individuals who are committed to caring for the needs of women and promoting and protecting life. *[: and]*

[OPTIONAL (consider adding only in states where PRCs have been publically accused by a legislator, abortion-advocacy group, or another party of false advertising or other deceptive practices): WHEREAS, pregnancy resource centers provide full disclosure, in both their advertisements and direct contact with women, of the types of services they provide.]

NOW, THEREFORE, BE IT RESOLVED BY THE [LEGISLATURE] OF THE STATE OF [INSERT NAME OF STATE]:

Section 1. That the [Legislature] strongly supports pregnancy resource centers in their unique, positive contributions to the individual lives of women, men, and babies—both born and unborn.

Section 2. That the [Legislature] commends the compassionate work of tens of thousands of volunteers and paid staff at pregnancy resource centers in [Insert name of State] and across the United States.

Section 3. That the [Legislature] strongly encourages the Congress of the United States and other federal and state government agencies to grant pregnancy resource centers assistance for medical equipment and abstinence education in a manner that does not compromise the mission or religious integrity of these organizations.

Section 4. That the [Legislature] disapproves of the actions of any national, state, or local groups attempting to prevent pregnancy resource centers from effectively serving women and men facing unplanned pregnancies.

Section 5. That the Secretary of State of [Insert name of State] transmit a copy of this resolution to each pregnancy resource center in [Insert name of State], to the Governor, to the President of the United States, and to the President of the Senate and the Speaker of the House of Representatives of the United States Congress.

A black and white ultrasound image of a fetus, showing the head, torso, and limbs. The image is grainy and has a high-contrast, medical appearance. It serves as the background for the top half of the page.

LEGAL RECOGNITION AND PROTECTION OF THE UNBORN

Crimes Against the Unborn Child Act

HOUSE/SENATE BILL NO. _____

By Representatives/Senators _____

Section 1. Title.

This Act may be known and cited as the “Crimes Against the Unborn Child Act” [or, alternatively, the “Unborn Victims of Violence Act.”]

Section 2. Legislative Findings and Purposes.¹

- (a) The [Legislature] of the State of [Insert name of State] finds that:
- (1) A significant loophole exists in [Insert name of State]’s criminal law, denying adequate legal protection to pregnant women and certain children. Currently, an offender may not be held criminally responsible for the harm caused to a child unless that child has first been born alive. Thus, an unborn child is completely denied protection under current provisions of this State’s criminal law.
 - (2) [Insert name of State] lags behind most states in this area of crime victims’ protection. Thirty-eight (38) states now provide varying degrees of protection and justice for pregnant women and their unborn children who are victims of violence. Importantly, twenty-nine (29) states provide protection for unborn children at any stage of gestation.
 - (3) Recent statistics demonstrate that domestic abuse and violence against women increases during pregnancy. It is estimated that one (1) in five (5) women will be abused during pregnancy. Moreover, a study in the *Journal of the American Medical Association* found that, for example, in the State of Maryland, a pregnant woman is more likely to be a victim of a homicide than to die of any other cause.
 - (4) Compounding this tragedy is the loophole in [Insert name of State]’s current law, which denies effective protection and remedy to women, their children, and their extended families, telling them, in effect, that their loved ones never existed at all.
 - (5) The federal “Unborn Victims of Violence Act,” enacted in April 2004, is limited, applying only to unborn children injured or killed during the course of specified federal crimes of violence. It does not reach many crimes of violence committed against pregnant women and their unborn children: crimes which are most commonly prosecutable only under state criminal laws.
- (b) Based on the findings in subsection (a), the purpose of this Act is to protect the affirmative right of a pregnant woman to carry her child to term be protected and to hold perpetrators of crimes against pregnant women and their unborn children fully accountable for their crimes.

Section 3. Amendment of State Criminal Code.

For purposes of the offenses of homicide, assault, and battery [Designate the specific crime(s) and section(s) of the state criminal code to be amended], the term “person” [or other appropriate term(s) as used in the state’s criminal code] includes an unborn child at every stage of gestation from conception until live birth.

¹ Much of the language in the Legislative Findings and Purposes section is modeled after language in legislation previously introduced in New York. See e.g., NY AB 4897 (2009).

Section 4. Definitions.

For the purposes of this Act only:

- (a) “Conception” means the fusion of a human spermatozoon with a human ovum.
- (b) “Gestation” means the time during which a woman carries an unborn child in her womb, from conception to birth.
- (c) “Unborn child” means the offspring of human beings from conception until birth.

Section 5. Exclusions.

Nothing in this Act shall apply to an act committed by the mother of an unborn child; to a medical procedure performed by a physician or other licensed medical professional at the request of a mother of an unborn child or the mother’s legal guardian; or to the lawful dispensation or administration of lawfully prescribed medication.

Section 6. Right of Intervention.

The [Legislature], by joint resolution, may appoint one or more of its members, who sponsored or cosponsored this Act in his or her official capacity, to intervene as a matter of right in any case in which the constitutionality of this law is challenged.

Section 7. Severability.

Any provision of this Act held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as to give it the maximum effect permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event such provision shall be deemed severable herefrom and shall not affect the remainder hereof or the application of such provision to other persons not similarly situated or to other, dissimilar circumstances.

Section 8. Effective Date.

This Act takes effect on [Insert date].

Pregnant Woman’s Protection Act

HOUSE/SENATE BILL NO. _____

By Representatives/Senators _____

[Drafter’s Note: This model language may need to be specifically tailored to the provisions/requirements of a state’s criminal code. Otherwise, the model language should be carefully duplicated. Please contact AUL for drafting assistance.]

Section 1. Title.

This Act may be known and cited as the “Pregnant Woman’s Protection Act.”

Section 2. Legislative Findings and Purposes.¹

- (a) The [Legislature] of the State of [Insert name of State] finds that:
- (1) Violence and abuse are often higher during pregnancy than during any other period in a woman’s lifetime.
 - (2) According to the Centers for Disease Control, every year in the United States more than 300,000 pregnant women experience some kind of violence involving an intimate partner.
 - (3) According to the March of Dimes, one (1) in six (6) pregnant women has been abused by a partner.
 - (4) Further, one household survey determined that pregnant women are 60.6 percent more likely to be beaten than women who are not pregnant. Battering and Pregnancy, Midwifery Today 19: 1998.
 - (5) Women are more likely to suffer increased abuse as a result of unintended pregnancies, and pregnant women are more likely to be victims of homicide than to die of any other cause.
 - (6) Homicide and other violent crimes are a leading cause of death for women of reproductive age.
 - (7) Husbands, ex-husbands, or boyfriends are often the perpetrators of pregnancy-associated homicide or violence. Moreover, when husbands, ex-husbands, or boyfriends are involved, the violence is often intended to end or jeopardize the pregnancy.
 - (8) Violence against a pregnant woman puts the life and bodily integrity of both the pregnant woman and the unborn child at risk.
- (b) Based on the findings in subsection (a), it is the purpose of this Act is to
- (1) Ensure that the affirmative right of a pregnant woman to carry her child to term is protected.
 - (2) Ensure that affirmative defenses to criminal liability provided for under [Insert name of State]’s criminal code at [Section(s)] [Insert citation(s) to appropriate criminal code section(s)] explicitly provide for a pregnant woman’s right to use force, including deadly force, to protect her unborn child in circumstances where she reasonably believes that unlawful force is threatening her unborn child and that her intervention and use of force are immediately necessary to protect her unborn child.

¹ Specific statistics or examples from a particular state may be included in the findings. Please contact AUL for drafting assistance with adding this information.

- (3) Supplement, but not supersede, the applicability of any other affirmative defenses to criminal liability provided for under *[Insert name of State]*'s criminal code.

Section 3. Definitions.

As used in this Act only:

- (a) “Another” means a person other than the pregnant woman.
- (b) “Deadly force” means *[Insert specific language from and citation(s) to appropriate state criminal code section(s)]* (or “force which, under the circumstances in which it is used, is readily capable of causing death or serious physical harm”).
- (c) “Force” means *[Insert specific language from and citation(s) to appropriate state criminal code section(s)]* (or “violence, compulsion, or constraint exerted upon or against another”).
- (d) “Embryo” means an individual organism of species homo sapiens from the single cell stage to eight (8) weeks development.
- (e) “Pregnant” means the female reproductive condition of having an unborn child in the woman’s *[body]*.
- (f) “Unborn child” means the offspring of human beings from conception until birth.
- (g) “Unlawful force” means *[Insert specific language from and citation(s) to appropriate state criminal code section(s)]* (or “force which is employed without the consent of the pregnant woman and which constitutes an offense under the criminal laws of this State or an actionable tort”).

Section 4. Affirmative Defense to Criminal Liability.

A pregnant woman is justified in using force or deadly force against another to protect her unborn child if:

- (a) Under the circumstances as the pregnant woman reasonably believes them to be, she would be justified under *[Section(s)] [Insert citation(s) to state criminal code section(s) on self-defense and use of deadly force]* of *[Insert name of State]*'s *[criminal/penal]* code in using force or deadly force to protect herself against the unlawful force or unlawful deadly force she reasonably believes to be threatening her unborn child; and
- (b) She reasonably believes that her intervention and use of force or deadly force are immediately necessary to protect her unborn child.

Section 5. Exclusions.

The affirmative defense to criminal liability provided for under this Act does not apply to:

- (a) Acts committed by anyone other than the pregnant woman.
- (b) Acts where the pregnant woman would be obligated under *[Section(s)] [Insert citations to state criminal code section(s) requiring retreat before acting in self-defense, if any]* of *[Insert name of State]*'s *[criminal/penal]* code *[to retreat, to surrender the possession of a thing, or to comply with a demand before using force in self-defense]*. However, the pregnant woman is not obligated to retreat before using force or deadly force to protect her unborn child, unless she knows that she can thereby secure the complete safety of her unborn child.
- (c) The defense of human embryos existing outside of a woman’s body (such as, but not limited to, frozen human embryos stored at fertility clinics or elsewhere).

Section 6. Severability.

Any provision of this Act held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as to give it maximum effect permitted by law, unless such holding shall be one of utter

invalidity or unenforceability, in which event such provision shall be deemed severable herefrom and shall not affect the remainder hereof or the application of such provision to other persons not similarly situated or to other, dissimilar circumstances.

Section 7. Right of Intervention.

The [*Legislature*], by joint resolution, may appoint one or more of its members, who sponsored or cosponsored this Act in his or her official capacity, to intervene as a matter of right in any case in which the constitutionality of this law is challenged.

Section 8. Effective Date.

This Act takes effect on [*Insert date*].

Born-Alive Infant Protection Act

HOUSE/SENATE BILL NO. _____

By Representatives/Senators _____

Section 1. Title.

This Act may be known and cited as the “Born-Alive Infant Protection Act.”

Section 2. Legislative Findings and Purpose.

- (a) The [Legislature] of the State of [Insert name of State] finds that:
- (1) The State of [Insert name of State] has a paramount interest in protecting all human life.
 - (2) If an [attempted] abortion results in the live birth of an infant, the infant is a legal person for all purposes under the laws of this State.
 - (3) It is not an infringement on a woman’s right to terminate her pregnancy for this State to assert its interest in protecting an infant whose live birth occurred as the result of an [attempted] abortion.
 - (4) Without proper legal protection, newly born infants who have survived [attempted] abortions have been denied appropriate life-saving or life-sustaining medical care and treatment and have been left to die.
- (b) Based on the findings in subsection (a), it is the purpose of this Act is to:
- (1) Ensure the protection and promotion of the health and well-being of all infants born alive in this State; and
 - (2) Mandate that healthcare providers give medically appropriate and reasonable life-saving and life-sustaining medical care and treatment to all born-alive infants.

Section 3. Definitions.

For the purposes of this Act only:

- (a) “Abortion” means the act of using or prescribing any instrument, medicine, drug, or any other substance, device, or means with the intent to terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child. Such use, prescription, or means is not an abortion if done with the intent to:
- (1) Save the life or preserve the health of the unborn child;
 - (2) Remove a dead unborn child caused by spontaneous abortion; or
 - (3) Remove an ectopic pregnancy.
- (b) “Born alive” or “live birth” means the complete expulsion or extraction of an infant from his or her mother, regardless of the state of gestational development, that, after expulsion or extraction, whether or not the umbilical cord has been cut or the placenta is attached, and regardless of whether the expulsion or extraction occurs as a result of natural or induced labor, cesarean section, or induced abortion, shows any evidence of life, including, but not limited to, one or more of the following:
- (1) Breathing;
 - (2) A heartbeat;

(3) Umbilical cord pulsation; or

(4) Definite movement of voluntary muscles.

(c) “**Consent**” means the voluntary agreement or acquiescence by a person of age and with the requisite mental capacity who is not under duress or coercion and who has knowledge or understanding of the act or action to which he or she has agreed or acquiesced.

(d) “**Facility**” or “**medical facility**” means any public or private hospital, clinic, center, medical school, medical training institution, healthcare facility, physician’s office, infirmary, dispensary, ambulatory surgical treatment center, or other institution or location wherein medical care is provided to any person.

(e) “**Infant**” means a child of the species homo sapiens who has been completely expulsed or extracted from his or her mother, regardless of the stage of gestational development, until the age of thirty (30) days post birth.

(f) “**Physician**” means a person licensed to practice medicine in the State of *[Insert name of State]*. This term includes medical doctors and doctors of osteopathy.

(g) “**Premature**” or “**preterm**” means occurring prior to the thirty-seventh (37th) week of gestation.

Section 4. Requirements and Responsibilities.

(a) A person shall not deny or deprive an infant of nourishment with the intent to cause or allow the death of the infant for any reason, including, but not limited to:

(1) The infant was born with a handicap;

(2) The infant is not wanted by the parent(s) or guardian(s); or

(3) The infant is born alive by natural or artificial means.

(b) A person shall not deprive an infant of medically appropriate and reasonable medical care and treatment or surgical care.

(c) The requirements of this Section shall not be construed to prevent an infant’s parent(s) or guardian(s) from refusing to give consent to medical treatment or surgical care which is not medically necessary or reasonable, including care or treatment which either:

(1) Is not necessary to save the life of the infant;

(2) Has a potential risk to the infant’s life or health that outweighs the potential benefit to the infant of the treatment or care; or

(3) Is treatment that will do no more than temporarily prolong the act of dying when death is imminent.

(d) The physician performing an abortion must take all medically appropriate and reasonable steps to preserve the life and health of a born-alive infant. If an abortion performed in a hospital results in a live birth, the physician attending the abortion shall provide immediate medical care to the infant, inform the mother of the live birth, and request transfer of the infant to an on-duty resident or emergency care physician who shall provide medically appropriate and reasonable medical care and treatment to the infant.

If an abortion performed in a facility other than a hospital results in a live birth, a physician attending the abortion shall provide immediate medical care to the infant and call 9-1-1 for an emergency transfer of the infant to a hospital that shall provide medically appropriate and reasonable care and treatment to the infant.

(e) If the physician described in subsection (d) of this Section is unable to perform the duties in that paragraph

because he is assisting the woman on whom the abortion was performed, then an attending physician's assistant, nurse, or other healthcare provider must assume the duties outlined in subsection (d) of this Section.

(f) Any born-alive infant including one born in the course of an abortion procedure shall be treated as a legal person under the laws of this State, with the same rights to medically appropriate and reasonable care and treatment, and birth and death (if death occurs) certificates shall be issued accordingly.

(g) If, before the abortion, the mother [, *and if married, her husband,*] has [*or have*] stated in writing that she does [*or they do*] not wish to keep the infant in the event that the abortion results in a live birth, and this writing is not retracted before the [*attempted*] abortion, the infant, if born alive, shall immediately upon birth become a ward of [*Insert name of appropriate state child welfare department or agency*].

(h) No person may use any born-alive infant for any type of scientific research or other kind of experimentation except as necessary to protect or preserve the life and health of the born-alive infant.

[Optional: Section 5. Infanticide. [Consider this Section if the state's criminal code does not include the crime of infanticide, or if the state does not wish to add another definition to the existing crime of infanticide.]

(a) *“Infanticide” means any deliberate act that:*

Is intended to kill an infant who has been born alive; and

That does kill such infant.

(b) *Any physician, nurse, or other healthcare provider who deliberately fails to provide medically appropriate and reasonable care and treatment to a born-alive infant, and, as a result of that failure, the infant dies, shall be guilty of the crime of infanticide.]*

Section [6]. Exceptions.

The parent(s) or guardian(s) of a born-alive infant will not be held criminally or civilly liable for the actions of a physician, nurse, or other healthcare provider that are in violation of this Act and to which the parent(s) or guardian(s) did not give consent.

Section [7]. Criminal Penalties.

(a) Any physician, nurse, or other healthcare provider who intentionally, knowingly, or negligently fails to provide medically appropriate and reasonable care and treatment to a born-alive infant in the course of an [*attempted*] abortion shall be guilty of a [*Insert appropriate classification*] felony and upon conviction shall be fined an amount not exceeding [*Insert appropriate amount*], or imprisoned not less than [*Insert appropriate term*] years and not exceeding [*Insert appropriate term*] years, or both [or “*will be punished according to the sentencing guidelines found in the [Criminal/Penal Code] of [Insert name of State].*”].

[Optional (if Act includes Section on “Infanticide”): (b) *Any person found guilty of the crime of infanticide shall be fined an amount not exceeding [Insert appropriate amount], or imprisoned not less than [Insert appropriate term] years and not exceeding [Insert appropriate term] years, or both [or “will be punished according to the sentencing guidelines found in the [Criminal/Penal Code] of [Insert name of State].”]*

[(c)] Any violation of Section 4, subsection (h) of this Act [*concerning the research use of a born-alive infant*] is a [*Insert appropriate classification*] felony and upon conviction shall be fined an amount not exceeding [*Insert appropriate amount*], or imprisoned not less than [*Insert appropriate term*] years and not exceeding [*Insert appropriate term*] years, or both [or “*will be punished according to the sentencing guidelines found in the [Criminal/Penal Code] of [Insert name of State].*”].

Section [8]. Civil and Administrative Action.

In addition to whatever remedies are available under the statutory [*or common*] law of this State, failure to comply with the requirements of this Act shall:

- (a) Provide a basis for a civil action for compensatory and punitive damages. Any conviction under this Act shall be admissible in a civil suit as prima facie evidence of a failure to provide medically appropriate and reasonable care and treatment to a born-alive infant. Any civil action may be based on a claim that the death of or injury to the born-alive infant was a result of simple negligence, gross negligence, wantonness, willfulness, intentional conduct, or another violation of the legal standard of care.
- (b) Provide a basis for professional disciplinary action under [*Insert appropriate reference(s) to state statute(s) and/or administrative rule(s) concerning the state medicalbBoard's oversight and review authority*] for the suspension or revocation of any license for physicians, licensed and registered nurses, or other licensed or regulated persons. Any conviction of any person for any failure to comply with the requirements of this Act shall result in the automatic suspension of his or her license for a period of at least one (1) year [*or other appropriate penalty*] and said license shall be reinstated after that time only under such conditions as the [*Insert reference(s) to appropriate regulatory or licensing body*] shall require to ensure compliance with this Act.
- (c) Provide a basis for recovery for the parent(s) of the infant or the parent(s) or guardian(s) of the mother, if the mother is a minor, for the wrongful death of the infant under [*Insert reference(s) to state's wrongful death statute(s)*], whether or not the infant was viable at the time the [*attempted*] abortion was performed.

Section [9]. Construction.

- (a) Nothing in this Act shall be construed to affirm, deny, expand, or contract any legal status or legal right applicable to any member of the species homo sapiens at any point prior to being born alive (as defined in this Act).
- (b) Nothing in this Act shall be construed to affect existing federal or state law regarding abortion.
- (c) Nothing in this Act shall be construed as creating or recognizing a right to abortion.
- (d) Nothing in this Act shall be construed to alter generally accepted medical standards.

Section [10]. Severability.

Any provision of this Act held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as to give it the maximum effect permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event such provision shall be deemed severable herefrom and shall not affect the remainder hereof or the application of such provision to other persons not similarly situated or to other dissimilar circumstances.

Section [11] Right of Intervention.

The [*Legislature*], by joint resolution, may appoint one or more of its members, who sponsored or cosponsored this Act in his or her official capacity, to intervene as a matter of right in any case in which the constitutionality of this law is challenged.

Section [12]. Effective Date.

This Act takes effect on [*Insert date*].

Unborn Wrongful Death Act

HOUSE/SENATE BILL NO. _____

By Representatives/Senators _____

Section 1. Title.

This Act may be known and cited as the “Unborn Wrongful Death Act.”

Section 2. Legislative Findings and Purpose.

- (a) The [Legislature] of the State of [Insert name of State] finds that:
- (1) This State has statutorily recognized a wrongful death civil cause of action [Insert appropriate statutory or other reference(s)] since [Insert date].
 - (2) The wrongful death cause of action is intended to correct a flaw in the common law: At common law, no cause of action survived a victim’s death. Thus, a tortfeasor (wrongdoer) could escape liability merely because he or she inflicted injuries so severe that they resulted in the death of the victim.
 - (3) The wrongful death cause of action provides for damages to be paid by a wrongdoer to his or her victim’s survivors, thus deterring tortuous and harmful behavior and providing for restitution to the victim’s estate.
 - (4) This State has an interest in protecting every human being including unborn children from tortuous and harmful acts.
 - (5) Parents of unborn children have protectable interests in the life, health, and well-being of their children.
 - (6) Tortuous behavior which results in the death of an unborn child carries the same social and emotional cost as that which results in the death of a born and living human being including bereavement, a loss to society, and the lawlessness and disregard for life which characterizes negligent, harmful, and wrongful behavior.
- (b) For these reasons, the [Legislature] finds that the exclusion of unborn children from coverage under the State’s wrongful death cause of action is at cross purposes with the justifications for the statute[s], and that a cause of action for the wrongful death of an unborn child at any stage of gestation or development should be permitted under the laws of this State.

Section 3. Definitions.

For the purposes of this Act only:

- (a) “Abortion” means the act of using or prescribing any instrument, medicine, drug, or any other substance, device, or means with the intent to terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child. Such use, prescription, or means is not an abortion if done with the intent to:
- (1) Save the life or preserve the health of the unborn child;
 - (2) Remove a dead unborn child caused by spontaneous abortion; or
 - (3) Remove an ectopic pregnancy.

(b) “**Born-alive**” means the substantial expulsion or extraction of an infant from its mother, regardless of the duration of the pregnancy, that after expulsion or extraction, whether or not the umbilical cord has been cut or the placenta is attached, and regardless of whether the expulsion or extraction occurs as a result of natural or induced labor, cesarean section, or induced abortion, shows any evidence of life, including, but not limited to, one or more of the following:

- (1) Breathing;
- (2) A heartbeat;
- (3) Umbilical cord pulsation; or
- (4) Definite movement of voluntary muscles.

(c) “**Conception**” means the fusion of a human spermatozoon with a human ovum.

(d) “**Physician**” means a doctor legally authorized to practice medicine or surgery in this State or any other individual legally authorized by this State to perform abortions; provided, however, that any individual who is not a physician and not otherwise legally authorized by this State to perform abortions, but who nevertheless performs an abortion shall be subject to the provisions of this Act.

(e) “**Unborn child**” means the offspring of human beings from conception until birth.

Section 4. Cause of Action.

The state or location of gestation or development of an unborn child when an injury is caused, when an injury takes effect, or at death shall not foreclose maintenance of a cause of action under the law of this State arising from the death of the unborn child caused by a wrongful act, neglect, carelessness, lack of skill, or default.

Section 5. Exceptions.

(a) There shall be no cause of action against a physician or a medical institution for the wrongful death of an unborn child caused by an abortion where the abortion was permitted by law and the requisite consent was lawfully given; *provided, however*, that a cause of action is not prohibited where an abortion is performed in violation of state law or where the child is born-alive and subsequently dies.

(b) There shall be no cause of action against a physician or a medical institution for the wrongful death of an unborn child *in utero* based on the alleged misconduct of the physician or medical institution where the defendant did not know and, under standard medical practice in the community, had no medical reason to know of the pregnancy of the woman or the existence of the unborn child.

Section 6. Construction.

(a) This Act does not create, recognize, endorse, or condone a right to an abortion.

(b) It is not the intention of this Act to make lawful an abortion that is currently unlawful.

Section 7. Severability.

Any provision of this Act held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as give it the maximum effect permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event such provision shall be deemed severable herefrom and shall not affect the remainder hereof or the application of such provision to other persons not similarly situated or to other, dissimilar circumstances.

Section 8. Right of Intervention.

The [*Legislature*], by joint resolution, may appoint one or more of its members, who sponsored or cosponsored this Act in his or her official capacity, to intervene as a matter of right to defend this law in any case in which its constitutionality is challenged.

Section 9. Effective Date.

This Act takes effect on [*Insert date*].

Dignified Final Disposition Act

HOUSE/SENATE BILL NO. _____

By Representatives/Senators _____

Section 1. Title.

This Act may be known and cited as the “Dignified Final Disposition Act.”

Section 2. Legislative Findings and Purpose.

- (a) The [Legislature] of the State of [Insert name of State] finds that:
 - (1) Deceased unborn children deserve the same respect as other human beings.
 - (2) The laws of the State of [Insert name of State] do not ensure that miscarried, stillborn, or aborted children receive proper burials.
 - (3) [Insert name of State] also fails to require fetal death reporting and/or the issuance of fetal death certificates except [Insert short description of circumstances when, under existing state law(s), the reporting of fetal deaths is required and/or a fetal death certificate is available].
 - (4) Further, while the loss of a child at any stage of development is often devastating to parents, [Insert name of State] only offers [Certificates of Birth Resulting in Stillbirth] to parents for fetal deaths that occur [Insert short description of existing state law(s)].
- (b) Based on the findings in subsection (a), the purposes of this Act are to:
 - (1) Ensure that the mother of a deceased unborn baby is given the opportunity to bury her child;
 - (2) Require institutions where deceased unborn children are delivered or where unborn children are aborted to provide a dignified final disposition of the fetal remains of these children;
 - (3) Require fetal death reports for all fetal deaths as defined in this Act; and
 - (4) Ensure that parents of all stillborn children are offered the opportunity to obtain a [Certificate of Birth Resulting in Stillbirth].

Section 3. Definitions.

For purposes of this Act only:

- (a) “**Abortion**” means the act of using or prescribing any instrument, medicine, drug, or any other substance, device, or means with the intent to terminate the clinically diagnosable pregnancy of a woman with the knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child. Such use, prescription, or means is not an abortion if done with the intent to:
 - (1) Save the life or preserve the health of the unborn child;
 - (2) Remove a dead unborn child caused by spontaneous abortion; or
 - (3) Remove an ectopic pregnancy.
- (b) “**Authorized representative**” has the same meaning as [Insert appropriate reference(s) and/or citation(s) to state law(s)].
- (c) “**Fetal death**” means death prior to expulsion or extraction from his or her mother of an unborn child who has

reached a stage of development so that there are cartilaginous structures and/or fetal or skeletal parts. The death is indicated by the fact that, after such expulsion or extraction, the unborn child does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.

- (d) “**Final disposition**” means the burial, *[interment]*, cremation, or other legal disposition of a dead unborn child.
- (e) “**Fetal remains**” means the physical remains or corpse of a dead unborn child who has been expelled or extracted from his or her mother and who has reached a stage of development so that there are cartilaginous structures and/or fetal or skeletal parts, whether or not the remains have been obtained by induced, spontaneous, or accidental means. The death is indicated by the fact that, after such expulsion or extraction, the unborn child does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.
- (f) “**Miscarriage**” means the spontaneous or accidental death of an unborn child before he or she is able to survive independently that does not result in the birth of a live baby. The death is indicated by the fact that, after the expulsion of the unborn child, he or she does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.
- (g) “**Physician**” means any person licensed to practice medicine in this State. The term includes medical doctors and doctors of osteopathy.
- (h) “**Pregnant**” or “**pregnancy**” means that female reproductive condition of having an unborn child in the *[mother’s]* uterus.
- (i) “**Stillbirth**” means the birth of a child that has died in the uterus. The death is indicated by the fact that, after the expulsion of the unborn child, he or she does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.
- (j) “**Unborn child**” means the offspring of human beings from conception until birth.

Section 4. Release of Dead Unborn Child to Mother for Final Disposition.

In every instance of fetal death, irrespective of the duration of pregnancy, the individual in charge of the institution where the fetal remains were expelled or extracted, upon request of the mother, shall release to the mother or the mother’s designee the fetal remains for final disposition in accordance with applicable law. Such request may be made by the mother or her authorized representative prior to or shortly after the expulsion or extraction of the fetal remains.

Section 5. Authorization for Final Disposition of Dead Unborn Child.

- (a) Except as provided in Section 6 of this Act, in every instance of fetal death, irrespective of the duration of pregnancy, where a mother does not request the release of her dead unborn child, the funeral director or other person assuming responsibility for the final disposition of the fetal remains shall obtain from the mother or her authorized representative a written authorization for final disposition on a form prescribed and furnished or approved by the state Department of *[Insert name of appropriate department]*. The authorization may allow final disposition to be by a funeral director or the individual in charge of the institution where the fetal remains were expelled or extracted.
- (b) The mother or her authorized representative may direct the final disposition of the fetal remains to be burial, *[interment,]* or cremation as those terms are defined in *[Insert appropriate reference(s) to state law(s)]*. After final disposition, the funeral director, the individual in charge of the institution, or other person making the final disposition shall retain the authorization for not less than seven (7) years.
- (c) Irrespective of the duration of pregnancy, the individual in charge of the institution where the fetal remains

were expelled or extracted must ensure that the final disposition of the fetal remains is by burial, [interment,] or cremation as those terms are defined in [Insert appropriate reference(s) to state law(s)].

(d) If final disposition of the fetal remains is by cremation, the medical examiner of the county in which fetal death occurred shall sign the authorization for final disposition.

(e) If final disposition of the fetal remains is cremation by the institution where the fetal remains were expelled or extracted, the fetal remains must be cremated separately from any medical waste.

(f) Fetal remains may be moved from the place of death to be prepared for final disposition with the consent of the physician or county medical examiner who certifies the cause of death.

(g) A permit for final disposition issued under the laws of another state that accompanies fetal remains brought into this state is authorization for final disposition of the fetal remains in this state.

Section 6. Special Rules for an Unborn Child Who Dies from Abortion.

This Act does not require a physician to discuss with a mother the final disposition of the fetal remains of her dead unborn child prior to performing an abortion, nor does it require a physician to obtain authorization from a mother for the final disposition of fetal remains upon completion of an abortion.

Section 7. Fetal Death Certificates.

(a) A fetal death certificate for each fetal death which occurs in this state shall be filed with the [State Registrar], within three (3) days after such delivery, miscarriage, or abortion.

(b) The funeral director or person assuming responsibility for the final disposition of the fetal remains shall file the fetal death certificate. In the absence of such a person, the physician in attendance at or after the expulsion or extraction of fetal remains shall file the certificate of fetal death. The physician shall obtain the personal data from the next of kin or the best qualified person or source available, complete the certificate as to personal data, and deliver the certificate to the person responsible for completing the medical certification of the cause of death within twenty-four (24) hours after the expulsion or extraction of fetal remains.

(c) The medical certification shall be completed and signed within forty-eight (48) hours after delivery by the physician in attendance at or after the expulsion or extraction, except when inquiry into the cause of death is required by [Insert appropriate reference(s) to state law(s)].

Section 8. Certificate of Birth for Stillborn Child.

The [Insert name of appropriate state department or agency] shall establish a [Certificate of Birth Resulting in Stillbirth] to be offered to the parent(s) of a stillborn child. The medical staff treating the stillbirth shall notify the parent(s) or their authorized representative of the ability to request the certificate. The certificate shall be available to any parent of a stillborn child upon proper application. This certificate shall not be used as evidence of live birth or for identification purposes.

Section 9. Construction.

(a) Nothing in this Act shall be construed to affect existing federal or state law regarding abortion.

(b) Nothing in this Act shall be construed as creating or recognizing a right to abortion.

(c) Nothing in this Act shall be construed to alter generally accepted medical standards.

Section 10. Severability.

Any provision of this Act held to be invalid or unenforceable by its terms, or as applied to any person or circumstance,

shall be construed so as to give it the maximum effect permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event such provision shall be deemed severable herefrom and shall not affect the remainder hereof or the application of such provision to other persons not similarly situated or to other dissimilar circumstances.

Section 11. Right of Intervention.

The [*Legislature*], by joint resolution, may appoint one or more of its members, who sponsored or cosponsored this Act in his or her official capacity, to intervene as a matter of right in any case in which the constitutionality of this law is challenged.

Section 12. Effective Date.

This Act takes effect on [*Insert date*].



BIOETHICS & BIOTECHNOLOGIES

Human Cloning Prohibition Act

HOUSE/SENATE BILL NO. _____

By Representatives/Senators _____

Section 1. Short Title.

This Act may be known and cited as the “Human Cloning Prohibition Act.”

Section 2. Legislative Findings and Purpose.

- (a) The [Legislature] of the State of [Insert name of State] finds that:
- (1) At least one company has announced that it has successfully cloned a human being at an early embryonic stage of life, and others have announced that they will attempt to clone a human being using the technique known as somatic cell nuclear transfer.
 - (2) Efforts to create human beings through cloning mark a new and decisive step toward turning human reproduction into a manufacturing process in which human beings are made in laboratories to preordained specifications and, potentially, in multiple copies.
 - (3) Creating cloned, live-born human children (or “cloning-to-produce-children”) begins by creating cloned human beings at the embryonic stage of life. Some propose that this same process be used to create human embryos for destructive research, specifically as sources of stem cells and tissues for possible treatment of other humans (or “cloning-for-biomedical-research”).
 - (4) Many scientists agree that attempts at “cloning-to-produce-children” pose a massive risk of producing children who are stillborn, unhealthy, or severely disabled and that attempts at “cloning-for-biomedical-research” always result in the destruction of human beings at the embryonic stage of life when their stem cells are harvested.
 - (5) The prospect of creating new human life solely to be exploited (“cloning-to-produce children”) or destroyed (“cloning-for-biomedical-research”) in these ways has been condemned on moral grounds as evincing a profound disrespect for human life.
 - (6) The distinction between so-called “therapeutic” and “reproductive” cloning is a false distinction because both begin with the reproduction of a human being at the embryonic stage of life: one destined for implantation in a womb and one destined for destructive farming of its stem cells. Regardless of their ultimate destiny, science defines all human embryos as human beings.
 - (7) If “cloning-for-biomedical-research” is permitted, it will be nearly impossible to ban only attempts at “cloning-to-produce-children.” Cloning would take place within the privacy of a doctor-patient relationship; the implantation of embryos to begin a pregnancy is a simple procedure; and any government effort to prevent the implantation of an existing cloned embryo or to prevent birth once implantation has occurred would raise substantial moral, legal, and practical issues.
 - (8) Based on the findings in subsection (a), it is the purpose of this Act to prohibit the use of cloning technology to initiate the development of new human beings at the embryonic stage of life for any purpose.

Section 3. Definitions.

For purposes of this Act only:

- (a) **“Human cloning”** means human asexual reproduction, accomplished by (1) introducing the genetic material from one or more human somatic or embryonic cells into a fertilized or unfertilized oocyte whose nuclear material has been removed or inactivated before or after introduction, so as to produce an organism at any stage of development with a human or predominantly human genetic constitution; (2) artificially subdividing a human embryo at any time from the two-cell stage onward, such that more than one human organism results; or (3) introducing pluripotent cells from any source into a human embryo, nonhuman embryo, or artificially manufactured human embryo or trophoblast, under conditions where the introduced cells generate all or most of the body tissues of the developing organism.
- (b) **“Somatic cell”** means a cell having a complete set of chromosomes obtained from a living or deceased human body at any stage of development.
- (c) **“Embryo”** means an organism of the species *homo sapiens* from the single cell stage to eight (8) weeks development.
- (d) **“Fetus”** means an organism of the species *homo sapiens* from eight (8) weeks development until complete expulsion or extraction from a woman’s body or removal from an artificial womb or other similar environment designed to nurture the development of such organism.
- (e) **“Pluripotent cells”** means stem cells possessing the ability to give rise to most or all of the various cell types that make up the body. One demonstration of pluripotency is the ability, even after prolonged existence in culture, to form derivatives of all three embryonic germ layers from the progeny of a single cell.

Section 4. Prohibitions.

It shall be unlawful for any person or entity, public or private, to intentionally or knowingly:

- (a) Perform or attempt to perform human cloning;
- (b) Participate in an attempt to perform human cloning;
- (c) Transfer or receive the product of human cloning for any purpose; or
- (d) Transfer or receive, in whole or in part, any oocyte, embryo, fetus, or human somatic cell for the purpose of human cloning.

Section 5. Exceptions.

Nothing in this Act shall restrict areas of scientific research not specifically prohibited by this Act including in vitro fertilization; the administration of fertility-enhancing drugs; research in the use of nuclear transfer or other cloning techniques to produce molecules, DNA, tissues, organs, plants, animals other than humans, or cells other than human embryos.

Section 6. Criminal Penalties.

- (a) Any person or entity that violates Sections 4(a) or 4(b) of this Act shall be guilty of a *[Insert appropriate penalty/offense classification]*.
- (b) Any person or entity that violates Sections 4(c) or 4(d) of this Act shall be guilty of a *[Insert appropriate penalty/offense classification]*.

Section 7. Civil Penalty.

Any person or entity that violates any provision of this Act and derives a pecuniary gain from such violation shall be fined *[Insert amount]*, twice the amount of gross gain, or, at the discretion of the court, any amount intermediate between the forgoing.

Section 8. Professional Sanctions.

(a) **Unprofessional Conduct.** Any violation of this Act shall constitute unprofessional conduct pursuant to *[Insert appropriate statutes for medical doctors and surgeons and osteopathic doctors]* and shall result in permanent revocation of the violator's license to practice medicine.

(b) **Trade, Occupation, or Profession.** Any violation of this Act may be the basis for denying an application for, denying an application for the renewal of, or revoking any license, permit, certificate, or any other form of permission required to practice or engage in a trade, occupation, or profession.

Section 9. Severability.

Any provision of this Act held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as to give it the maximum effect permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event such provision shall be deemed severable herefrom and shall not affect the remainder hereof or the application of such provision to other persons not similarly situated or to other, dissimilar circumstances.

Section 10. Right of Intervention

The *[Legislature]*, by joint resolution, may appoint one or more of its members who sponsored or co-sponsored this Act, as a matter of right and in his or her official capacity, to intervene to defend this law in any case in which its constitutionality is challenged.

Section 11. Effective Date.

This Act takes effect on *[Insert date]*.

Destructive Human Embryo Research Act

HOUSE/SENATE BILL NO. _____

By Representatives/Senators _____

Section 1. Short Title.

This Act may be known and cited as the “Destructive Human Embryo Research Act.”

Section 2. Legislative Findings and Purpose.

(a) The [Legislature] of the State of [Insert name of State] finds that:

- (1) Human embryos are human beings at the earliest stage of development.
- (2) Some human embryos are being created and then destroyed to obtain stem cells for research.
- (3) Destructive human embryo research to obtain embryonic stem cells raises grave moral, ethical, scientific, and medical issues that must be addressed.
- (4) The moral justification of medical or scientific research cannot be based upon the dehumanizing and utilitarian premise that the ends justify any means. Medical research and treatment does not require the destruction of human life because it can be ethically pursued in other ways, including the use of adult stem cells or induced pluripotent stem cells.

(b) Based on the findings in subsection (a), it is the purpose of this Act to prohibit destructive human embryo research.

Section 3. Definitions.

For purposes of this Act only:

(a) “**Human embryo**” means an organism with a human or predominately human genetic constitution, from a single cell up to eight (8) weeks of development, that is derived by fertilization, parthenogenesis, cloning (also known as “somatic cell nuclear transfer”), or any other means from one or more human gametes or human diploid cells.

(b) “**Gamete**” means a human sperm or unfertilized human ovum.

(c) “**Destructive research**” means medical procedures, scientific or laboratory research, or other kinds of investigation that kill or injure the subject of such research. It does not include:

- (1) *In vitro* fertilization and accompanying embryo transfer to a woman’s body;
- (2) Research in the use of nuclear transfer or other cloning techniques to produce molecules; deoxyribonucleic acid; cells other than human embryos, tissues, organs, plants, or animals other than humans; or
- (3) Any diagnostic procedure that benefits the human embryo subject to such tests, while not imposing risks greater than those considered acceptable for other human research subjects.

Section 4. Prohibitions.

It shall be unlawful for any person to:

(a) Intentionally or knowingly conduct destructive research on a human embryo;

- (b) Buy, sell, receive, or otherwise transfer a human embryo with the knowledge that such embryo will be subjected to destructive research; or
- (c) Buy, sell, receive, or otherwise transfer gametes with the knowledge that a human embryo will be produced from such gametes to be used in destructive research.

Section 5. Criminal Penalties.

- (a) Whoever violates Section 4(a) shall be guilty of a [*Insert appropriate penalty/offense classification*] for each violation.
- (b) Whoever violates Section 4(b) shall be guilty of a [*Insert appropriate penalty/offense classification*] for each violation.
- (c) Whoever violates Section 4(c) shall be guilty of a [*Insert appropriate penalty/offense classification*] for each violation.

Section 6. Severability.

Any provision of this Act held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as to give it the maximum effect permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event such provision shall be deemed severable herefrom and shall not affect the remainder hereof or the application of such provision to other persons not similarly situated or to other, dissimilar circumstances.

Section 7. Right of Intervention.

The [*Legislature*], by joint resolution, may appoint one or more of its members who sponsored or co-sponsored this Act, as a matter of right and in his or her official capacity, to intervene to defend this law in any case in which its constitutionality is challenged.

Section 8. Effective Date.

This Act takes effect on [*Insert date*].

Prohibition on Public Funding of Human Cloning and Destructive Embryo Research Act

HOUSE/SENATE BILL NO. _____

By Representatives/Senators _____

Section 1. Short Title.

This Act may be cited as the “Prohibition on Public Funding of Human Cloning and Destructive Embryo Research Act.”

Section 2. Legislative Findings and Purposes.

- (a) The [Legislature] of the State of [Insert name of State] finds that:
- (1) The prospect of creating new human life solely to be exploited or destroyed has been condemned on moral grounds as displaying a profound disrespect for human life.
 - (2) Destructive human embryo research reduces the status of human beings from ends in themselves to a mere means for another’s possible benefit.
 - (3) The moral justification of medical or scientific research cannot be based upon the dehumanizing and utilitarian premise that the ends justify any means.
 - (4) Ethical research—research not involving human cloning and destructive embryonic stem-cell research—has proven more promising than destructive research. For example, so-called “therapeutic cloning” has, thus far, made no valuable therapeutic advancements, while research with ethically obtained adult stem cells has already improved patient health. Adult stem cell contributions have included heart tissue regeneration; corneal reconstruction; treatment for autoimmune diseases such as diabetes, lupus, Crohn’s disease, and multiple sclerosis; and treatment for leukemia and other bone and blood cancers.
 - (5) Moreover, recent and promising advances in “reprogramming” human cells to behave as if in an embryonic state render controversial cloned human embryos unnecessary for use in embryonic stem cell research.
 - (6) Cloning embryos and destructive embryonic stem cell research require human egg cells which are very expensive to obtain.
 - (7) Harvesting human egg cells also poses significant health risks to women including ovarian hyperstimulation syndrome, damage to internal organs or blood vessels, infertility, depression, and death.
 - (8) Harvesting human egg cells for research, whether women are compensated or not, results in the commoditization and exploitation of women.
 - (9) Public opinion is divided over the deeply conflicting moral and ethical concerns related to payments to women for access to their human egg cells. Providing public funds to be exchanged in these transactions would be a misuse of revenue collected by this State.
 - (10) Public opinion is similarly divided over the moral and ethical concerns surrounding the creation and destruction of human embryos. Providing public funds to such research would be a misuse of revenue collected by this State.
- (b) Based on the findings in subsection (a), the [Legislature]’s purposes in enacting this ban on taxpayer funding is to further the important and compelling state interests of:

- (1) Respecting life and fostering a culture of life;
- (2) Limiting public expenditures;
- (3) Directing public expenditures away from funding research that has not yielded any significant scientific contributions or benefit to patients;
- (4) Directing public expenditures toward funding research that has already made significant contributions to patients;
- (5) Relieving the consciences of taxpayers concerned about the possible exploitation of women that may result from payment for human egg cells; and
- (6) Relieving the consciences of those taxpayers who object to human cloning and destructive embryonic stem cell research.

Section 3. Definitions.

For purposes of this Act only:

- (a) **“Human cloning”** means human asexual reproduction accomplished by (1) introducing the genetic material from one or more human somatic or embryonic cells into a fertilized or unfertilized oocyte whose nuclear material has been removed or inactivated before or after introduction, so as to produce an organism at any stage of development with a human or predominantly human genetic constitution; (2) artificially subdividing a human embryo at any time from the two-cell stage onward, such that more than one human organism results; or (3) introducing pluripotent cells from any source into a human embryo, nonhuman embryo, or artificially manufactured human embryo or trophoblast, under conditions where the introduced cells generate all or most of the body tissues of the developing organism.
- (b) **“Somatic cell”** means a cell having a complete or nearly complete set of chromosomes obtained from a living or deceased human body at any stage of development.
- (c) **“Human embryo”** means an organism with a human or predominately human genetic constitution, from a single cell up to eight (8) weeks of development, that is derived by fertilization, parthenogenesis, cloning (also known as “somatic cell nuclear transfer”), or any other means from one or more human gametes or human diploid cells.
- (d) **“Embryonic stem cell”** means a stem cell obtained from an embryo of the same species.
- (e) **“Destructive research”** means medical procedures, scientific or laboratory research, or other kinds of investigation that kills or injures the subject of such research. It does not include:
 - (1) In vitro fertilization and accompanying embryo transfer to a woman’s body;
 - (2) Research in the use of nuclear transfer or other cloning techniques to produce molecules; deoxyribonucleic acid; cells other than human embryos, tissues, organs, plants, or animals other than humans; or
 - (3) Any diagnostic procedure that benefits the human embryo subject to such tests, while not imposing risks greater than those considered acceptable for other human research subjects.
- (f) **“Pluripotent cells”** means stem cells possessing the ability to give rise to most or all of the various cell types that make up the body. One demonstration of pluripotency is the ability, even after prolonged existence in culture, to form derivatives of all three embryonic germ layers from the progeny of a single cell.
- (g) **“Public funds”** means, but is not limited to:
 - (1) Any monies received or controlled by the state or any official, department, division, agency, or educational

or political subdivision thereof, including but not limited to monies derived from federal, state, or local taxes, gifts, or grants from any source; settlements of any claims or causes of action, public or private; bond proceeds or investment income; federal grants or payments; or intergovernmental transfers; and

- (2) Any monies received or controlled by an official, department, division, or agency of state government or any educational or political subdivision thereof, by any person or entity pursuant to appropriation by the [Legislature], or by the governing body of any political subdivision of this State.

Section 4. Human Cloning and Destructive Embryonic Stem Cell Research Against Public Policy.

The [Legislature] declares that public funding of human cloning and destructive embryonic stem cell research is against public policy.

Section 5. Prohibitions.

(a) No public funds shall be used to finance human cloning or destructive embryonic stem-cell research. The State, a state educational institution, or a political subdivision of the State may not use public funds, facilities, or employees to knowingly destroy human embryos for the purpose of research or knowingly participate in human cloning or attempted human cloning.

(b) No public funds shall be used to buy, receive, or otherwise transfer a human embryo with the knowledge that such embryo will be subjected to destructive research.

(c) No public funds shall be used to buy, receive, or otherwise transfer gametes with the knowledge that a human embryo will be produced from such gametes to be used in destructive research

This Section will go into effect notwithstanding any other law in the State.

Section 6. Exceptions.

Nothing in this Act shall restrict the funding of areas of scientific research not specifically prohibited by this Act, including:

- (a) *In vitro* fertilization and accompanying embryo transfer to a woman's body;
- (b) The administration of fertility-enhancing drugs;
- (c) Research in the use of nuclear transfer or other cloning techniques to produce molecules; deoxyribonucleic acid; cells other than human embryos, tissues, organs, plants, or animals other than humans; and
- (d) Any diagnostic procedure that benefits the human embryo subject to such tests, while not imposing risks greater than those considered acceptable for other human research subjects.

Section 7. Criminal Penalty.

Any person or entity that intentionally or knowingly fails to comply with the provisions of this Act shall be guilty of a [Insert appropriate penalty/offense classification].

Section 8. Civil Penalty.

Any person or entity that intentionally or knowingly fails to comply with the provisions of this Act shall be fined [Insert amount].

Section 9. Professional Sanction.

Any violation of the provisions of this Act may be the basis for denying an application for, denying an application for the renewal of, or revoking any license, permit, certificate, or any other form of permission required to practice or engage in a trade, occupation, or profession.

Section 10. Severability.

Any provision of this Act held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as to give it the maximum effect permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event such provision shall be deemed severable herefrom and shall not affect the remainder hereof or the application of such provision to other persons not similarly situated or to other, dissimilar circumstances.

Section 11. Right of Intervention.

The [Legislature], by joint resolution, may appoint one or more of its members, who sponsored or cosponsored this Act in his or her official capacity, to intervene as a matter of right to defend this law in any case in which its constitutionality is challenged.

Section 12. Standing.

The provisions of this Act shall inure to the benefit of all residents of this State. Any taxpayer of this State or any political subdivision of this State shall have standing to bring suit against the State, any official, department, division, agency, or political subdivision of this State, and any recipient of public funds which is in violation of this Act in [Insert reference(s) to the proper venue(s) to hear legal actions to enforce this Act] to enforce the provisions of this Act.

Section 13. Effective Date.

This Act takes effect on [Insert date].

Real Hope for Patients Act

HOUSE/SENATE BILL NO. _____

By Representatives/Senators _____

Section 1. Short Title.

This Act may be known and cited as the “Real Hope for Patients Act.”

Section 2. Legislative Findings and Purposes.

- (a) The [Legislature] of the State of [Insert name of State] finds and declares that:
- (1) Stem cell research using adult stem cells has already resulted in treatments for anemia, leukemia, lymphoma, lupus, multiple sclerosis, rheumatoid arthritis, sickle cell disease, spinal cord injury, and Crohn’s disease.
 - (2) Unlike human embryonic stem cell research, scientific research utilizing adult stem cells is not controversial, in large part, because it does not require the destruction of human embryos.
 - (3) Unlike human embryonic stem cell research, scientific research utilizing adult stem cells has yielded peer-reviewed and published evidence of treatments or cures for over seventy (70) conditions or diseases. Embryonic stem cell research has not yielded a single treatment for human patients.
 - (4) Researchers are studying umbilical cord blood, also known as cord blood, as a source of adult blood stem cells that can be used to treat life-threatening diseases.
 - (5) The umbilical cord and placenta are rich in adult stem cells that may be used for scientific research and medical treatment without destroying human embryos.
 - (6) For many patients with life-threatening diseases, medical treatments utilizing adult stem cells may be the best and only hope for a cure.
 - (7) Cord blood donations are urgently needed to keep up with the demand for transplants and research.
 - (8) Many women in good health may be eligible to voluntarily donate their children’s cord blood, but are unaware of its unique value or of the existence of donation programs.
 - (9) Because cord blood is collected after the birth of a baby, the collection process is painless and does not affect the baby or mother or change the delivery process.
 - (10) It shall be the public policy of this State to encourage the donation, collection, and storage of stem cells collected from umbilical cord blood and placental tissue and to make such stem cells available for both scientific research and medical treatment.
 - (11) It shall be the public policy of this State to encourage ethical research and medical treatments utilizing adult stem cells.
- (b) Based on the findings in subsection (a), the purposes of this Act are to:
- (1) Require all physicians to inform pregnant women of the opportunity to donate blood and tissue extracted from the umbilical cord and placental tissue following delivery;
 - (2) Create the [Adult Stem Cells Cure Fund] for the purpose of advancing adult stem cell research, treatments, and awareness; and

- (3) Create the [Adult Stem Cells Cure Bank] for the purpose of advancing adult stem cell research and treatments through the collection of cells and tissues.

Section 3. Definitions.

For purposes of this Act only:

- (a) “**Adult stem cell**” means an undifferentiated cell in a human tissue or organ that can renew itself and direct the repair of body tissues or can differentiate to yield some or all of the cell types of the human body.

[Drafter’s Note: If a legislator would like to expand the definition of “adult stem cell” to encompass research on the stem cells of animals for purposes of the adult stem cell bank, etc., the word “human” should be removed from this definition.]

- (b) “**Department**” means the [Department of Health or other appropriate department or agency].
- (c) “**Destructive research**” means medical procedures, scientific or laboratory research, or other kinds of investigation that kill or injure the subject of such research. It does not include:
 - (1) In vitro fertilization and accompanying embryo transfer to a woman’s body;
 - (2) Research in the use of nuclear transfer or other cloning techniques to produce molecules, deoxyribonucleic acid, or cells other than human embryos, tissues, organs, plants, or animals other than humans; or
 - (3) Any diagnostic procedure that benefits the human embryo subject to such tests, while not imposing risks greater than those considered acceptable for other human research subjects.
- (d) “**Placental tissue**” means all blood and other organic tissue derived from the placenta.
- (e) “**Prenatal care**” means the regular monitoring and management of the health status of a pregnant woman and her unborn child during the period of gestation.
- (f) “**Umbilical cord cells**” means cells derived from umbilical cord blood and placental tissue.
- (g) “**Human cloning**” means human asexual reproduction accomplished by (1) introducing the genetic material from one or more human somatic or embryonic cells into a fertilized or unfertilized oocyte whose nuclear material has been removed or inactivated before or after introduction, so as to produce an organism at any stage of development with a human or predominantly human genetic constitution; (2) artificially subdividing a human embryo at any time from the two-cell stage onward, such that more than one human organism results; or (3) introducing pluripotent cells from any source into a human embryo, nonhuman embryo, or artificially manufactured human embryo or trophoblast, under conditions where the introduced cells generate all or most of the body tissues of the developing organism.
- (h) “**Gamete**” means a human sperm or unfertilized human ovum.
- (i) “**Physician**” means any person licensed to practice medicine in this State. The term includes medical doctors and doctors of osteopathy.
- (j) “**Qualified professional**” means a physician, physician assistant, registered nurse, or licensed practical nurse, licensed or registered under [Insert reference(s) to appropriate state statute(s) or administrative regulation(s)] acting within the course and scope of his or her authority as provided by law.

Section 4. Creation by the Department of Informative Pamphlet on Umbilical Cord Donations.

- (a) On or before [Insert date], the Department shall prepare a pamphlet that includes information regarding the following:

- (1) The medical processes involved in the collection of umbilical cord blood and placental tissue;
 - (2) The medical risks of umbilical cord blood and placental collection to the mother and her newborn child;
 - (3) The current and potential future medical uses, risks, and benefits of umbilical cord blood and placental tissue collection to a mother, her newborn child, and her biological family;
 - (4) The current and potential medical uses, risks, and benefits of umbilical cord blood and placental tissue collection to persons who are not biologically related to a mother or her newborn child;
 - (5) Any costs that may be incurred by a pregnant woman who chooses to make an umbilical cord blood and placental tissue donation;
 - (6) Options for ownership and future use of the banked material;
 - (7) The average cost of public and private umbilical cord blood and placental tissue banking; and
 - (8) Ways to initiate and schedule the donation of umbilical cord blood and placental tissue.
- (b) The Department shall review and update the pamphlet prepared pursuant to this Section as necessary.
- (c) The Department shall distribute the pamphlet free of charge to physicians and healthcare institutions upon request and shall make the pamphlet available on its website.

Section 5. Creation of the [Adult Stem Cells Cure Bank].

- (a) On or before [Insert date], the Department, in collaboration with a private blood bank or donor organization, shall establish, operate, and maintain an [Adult Stem Cells Cure Bank] program for the purpose of collecting and storing cells and tissue for use in adult stem cell research and treatments, including but not limited to bone marrow, adipose (fat) tissue, and muscle tissue, as well as umbilical cord blood and placental tissue donated by maternity patients in this State.
- (b) The Department shall promulgate all rules necessary to carry out the establishment, operation, and maintenance of the [Adult Stem Cells Cure Bank] program.

Section 6. Duties of Physicians.

- (a) Notwithstanding any general or special law to the contrary, not later than thirty (30) days from the commencement of the third trimester of pregnancy, every physician or qualified professional acting under the direction of the physician shall inform a pregnant patient to whom he or she is providing prenatal care of the opportunity following delivery of a newborn child to donate blood and tissue extracted from the umbilical cord and placenta to a publicly accessible, certified umbilical cord blood and placental tissue bank.
- (b) In fulfilling his or her obligations under subsection (a) of this Section, the physician or qualified professional shall, at minimum, provide the pregnant patient a copy of the pamphlet prepared by the Department under Section 4 of this Act.
- (c) A licensed hospital that treats a pregnant woman during the delivery of her child shall permit her to arrange for an umbilical cord blood and placental tissue donation if she has made this request unless, in the professional judgment of a physician, the donation would threaten the health of the mother or the newborn child.
- (d) Cord blood donations to a public bank pursuant to this Act shall be made at no expense to the donor. However, nothing in this Section shall prohibit a maternity patient from donating to or storing blood extracted from the umbilical cord or placenta in a private umbilical cord blood and placental tissue bank.

(e) A physician, qualified professional, or hospital acting in good faith pursuant to this Section is not subject to civil or criminal liability or regulatory discipline for the acts prescribed in this Section.

[(f) *This Section does not impose an obligation on a physician to permit umbilical cord blood collection, if the collection conflicts with the physician's bona fide religious beliefs and the physician makes this fact known to the woman as soon as reasonably feasible.*]

Section 7. Creation of the [Adult Stem Cells Cure Fund].

(a) The [Insert name of State] [Adult Stem Cells Cure Fund], referred to in this Section as the “Fund,” shall be created in the state Treasury. The Fund shall consist of monies transferred to the Fund by virtue of [direct public funding provided in subsection (e) of this Section], [the income tax check-off program provided in Section 8], [and] gifts, grants, and donations which the Department is authorized to accept.

(b) The Department may accept gifts, grants, and donations for the purposes of the Fund. The Department shall transfer any gifts, grants, or donations to the Fund to the [state treasurer, comptroller, or other appropriate term] who shall credit the same to the Fund. All interest derived from the deposit or the investment of monies in the Fund shall be credited to the Fund. All monies remaining in the Fund at the end of any fiscal year shall remain in the Fund and shall not be deposited into any other Fund. [The monies in the Fund shall be annually appropriated by the [Legislature] to the Department for the purposes of this Act.]

(c) The Department may use up to five (5) percent [or other appropriate percentage] of the monies appropriated from the [Adult Stem Cells Cure Fund] for administrative costs incurred in the implementation of this Act. The Department may use up to twenty-five (25) percent [or other appropriate percentage] of the monies appropriated to the Department from the Fund for umbilical cord collection awareness, including the preparation, production, and distribution of the pamphlet outlined in Section 4. The Department shall use at least thirty (30) percent [or other appropriate percentage] of the monies appropriated to the Department from the Fund to provide grants to public or private researchers (including, but not limited to, companies, non-profit organizations, or universities) for the purpose of engaging in adult stem cell research. In so doing, the recipients shall be required to adhere to the criteria outlined in subsection (d). The Department shall use any remaining monies appropriated to the Department from the Fund for activities in connection with collection and maintenance of cells and tissue for the [Adult Stem Cells Cure Bank] created in Section 5.

(d) Recipients of grants under this Section shall use all monies received to conduct and support basic and applied research to develop techniques for the isolation, derivation, production, testing, and human clinical use of adult stem cells, including stem cells derived from umbilical cord blood or placental tissue, that may result in improved understanding of or treatments for diseases and other adverse health conditions, prioritizing research with the greatest potential for near-term clinical benefit in human patients, provided that such isolation, derivation, production, testing, or use will not involve:

- (1) Destructive research on a human embryo;
- (2) Human cloning;
- (3) Buying, selling, receiving, or otherwise transferring a human embryo with the knowledge that such embryo will be subjected to destructive research;
- (4) Buying, selling, receiving, or otherwise transferring any gamete with the knowledge that a human embryo will be produced from such gamete to be used in destructive research; or
- (5) Buying, selling, receiving, or otherwise transferring, in whole or in part, any gamete, embryo, fetus, or human somatic cell for the purpose of human cloning.

[*(e)* There is hereby appropriated to the Department from any monies not otherwise appropriated from the [General Revenue Fund of the State Treasury] for the fiscal year ending [Insert date] the sum of [Insert appropriate amount]. The appropriation set forth in this Section shall be transferred to the [Adult Stem Cells Cure Fund].]

[Section 8. Income Tax Check-off Program for Contributions to the [Adult Stem Cells Cure Fund].

(a) In order to provide a means by which an individual taxpayer may designate a portion or all of his or her income tax refund to be withheld and contributed for the purposes set forth in this Act, the [Revenue Division of the Department of Finance and Administration or other appropriate department or agency] shall include on the [Insert name of State] individual income tax forms, including those forms on which a husband and wife file separately on the same form and on all corporate income tax forms, a designation as follows:

If you are entitled to a refund, check if you wish to designate ☐ \$1, ☐ \$5, ☐ \$10, ☐ \$20, ☐ \$_____ (write in amount), or ☐ all refund due from your tax refund for the [Adult Stem Cells Cure Fund]. Your refund will be reduced by this amount.

If you owe an additional amount, check if you wish to contribute an additional ☐ \$1, ☐ \$5, ☐ \$10, ☐ \$20, ☐ \$_____ (write in amount) for the [Adult Stem Cells Cure Fund]. If you wish to make a contribution to the program, you must enclose a separate check for the amount of your contribution, payable to the [Adult Stem Cells Cure Fund].

(b) The [Department of Finance and Administration or other appropriate department or agency] shall certify quarterly to the state [Treasurer, Comptroller, or other appropriate term] the amount contributed to the program through this state income tax check-off during the quarter, as authorized by this Section, and the [Treasurer, Comptroller, or other appropriate term] shall deduct from the:

Individual Income Tax Withholding Fund the amount certified by the [Department of Finance and Administration or other appropriate department or agency] as contributed to the [Adult Stem Cells Cure Fund] on individual income tax forms; and

Corporate Income Tax Withholding Fund the amount certified by the [Department of Finance and Administration or other appropriate department or agency] as contributed to the [Adult Stem Cells Cure Fund] on corporate income tax forms.

(c) It is the intent of the [Legislature] that the income tax check-off program established in this Section is supplemental to any appropriated funding and is not intended to take the place of funding that would otherwise be appropriated for the purposes of this Act.

(d) The Director of the [Department of Finance and Administration or other appropriate department or agency] shall promulgate all rules and all income tax forms, returns, and schedules necessary to carry out the program.]

[Section 9.] Severability.

Any provision of this Act held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as give it the maximum effect permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event such provision shall be deemed severable herefrom and shall not affect the remainder hereof or the application of such provision to other persons not similarly situated or to other, dissimilar circumstances.

[Section 10.] Right of Intervention.

The [Legislature], by joint resolution, may appoint one or more of its members who sponsored or co-sponsored this Act, as a matter of right and in his or her official capacity, to intervene to defend this law in any case in which its constitutionality is challenged.

[Section 11.] Effective Date.

This Act takes effect on [Insert date].

Assisted Reproductive Technology Disclosure and Risk Reduction Act

HOUSE/SENATE BILL NO. _____

By Representatives/Senators _____

Section 1. Short Title.

This Act may be known and cited as the “Assisted Reproductive Technology Disclosure and Risk Reduction Act.”

Section 2. Legislative Findings and Purposes.

- (a) The [Legislature] of the State of [Insert name of State] finds that:
- (1) Infertility is of serious concern to many couples and individuals who want to be parents.
 - (2) Assisted reproductive technology (ART) is a growing, multi-billion dollar annual industry that serves an increasing number of patients.
 - (3) ART procedures are expensive. Each [treatment] cycle can cost [\$10,000 to \$15,000, or more].
 - (4) Full information about the costs and risks of ART is necessary for patients to evaluate ART, including the risks associated with multiple gestations.
 - (5) Only one federal statute, the Fertility Clinic Success Rate and Certification Act of 1992 (42 U.S.C. § 263a-1, et seq.), directly regulates ART procedures by requiring the reporting of clinic success rates.
 - (6) ART is subject to little state regulation.
 - (7) A number of other nations regulate specific aspects of ART, including the number of embryos that can be created. Brazil, Denmark, Germany, Hungary, Saudi Arabia, Singapore, Sweden, and Switzerland limit the number of embryos that can be transferred per treatment cycle. Specifically, Germany, Sweden, Denmark, and Switzerland limit transfers to no more than three (3) embryos per treatment cycle, while the United Kingdom limits the number transferred to two (2) embryos per treatment cycle.
 - (8) Voluntary self-regulation of ART programs is not completely effective. Not all ART programs or facilities are members of professional organizations such as the Society for Assisted Reproductive Technology (SART) or the American Society for Reproductive Medicine (ASRM). Moreover, these professional organizations do not independently confirm that their members follow their voluntary guidelines.
 - (9) In most cases, ART involves the creation of multiple embryos, some of which are not subsequently used in the implantation (transfer) procedure.
 - (10) This State has an interest in ensuring protection for mothers who undergo ART and for the future health of children conceived through ART.
 - (11) Informed consent is one of the core principles of ethical medical practice and every patient has a right to information pertinent to an invasive medical procedure. Further, ART is unique because it produces a third party—the prospective child—who must also be considered and protected.
 - (12) Thorough recordkeeping and reporting are necessary to ensure meaningful public education about the rates of success and the costs, risks, and benefits of ART and to ensure proper accountability.

- (13) One problem associated with ART is high-order multiple pregnancies (three (3) or more embryos implanting) and the associated health risks to mother and children, for which the economic burdens for parents and society are significant.
- (14) Fetal reduction in the event of a high-order multiple pregnancy involves significant risks to the mother and to subsequently born children.
- (b) Based on the findings in subsection (a), the purposes of this Act are to:
 - (1) Protect the safety and well-being of women using ART and the children conceived through ART;
 - (2) Establish standards for obtaining informed consent from couples and individuals seeking ART;
 - (3) Require adequate reporting for facilities providing ART services;
 - (4) Stem the proliferation of cryopreserved human embryos being stored in fertility clinics [*and bring the State of [Insert name of State] into line with international norms*] by limiting the number of embryos that can be created in any reproductive cycle;
 - (5) Reduce the risk of high-order multiple gestations and the risk of pre-maturity and other complications to mothers and children by limiting the number of embryos transferred in any reproductive cycle;
 - (6) Reduce the risks of fetal reduction to mothers and children; and
 - (7) Institute annual reporting requirements on certain aspects of ART to the [*Insert name of state health department or other appropriate agency*].

Section 3. Definitions.

For purposes of this Act only:

- (a) “**Assisted reproductive technology (ART)**” means all clinical treatments and laboratory procedures which include the handling of human eggs, sperm, or embryos with the intent of establishing a pregnancy. It includes in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), and such other specific technologies as the [*Department of Health*] may include in this definition.
- (b) “**ART facility**” or “**facility**” means any public or private organization, corporation, partnership, sole proprietorship, association, agency, network, joint venture, or other entity that is involved in providing assisted reproductive technology, including but not limited to: hospitals, clinics, medical centers, ambulatory surgical centers, private physician’s offices, pharmacies, nursing homes, university medical and nursing schools, medical training facilities, or other institutions or locations wherein assisted reproductive technology is offered to any person.
- (c) “**ART program**” or “**program**” means all treatments or procedures which include the handling of both human eggs and sperm.
- (d) “**Department**” means the [*Insert name of state health department or other appropriate agency*].
- (e) “**Embryo**” means the developing human organism however generated, beginning with the diploid cell resulting from the fusion of the male and female pronuclei, from somatic cell nuclear transfer, or by other means, until approximately the end of the second (2nd) month of development.
- (f) “**Gamete**” means human egg (oocyte) or sperm.
- (g) “**Fetal reduction**” means the induced termination of one or more embryos or fetuses.

Section 4. Informed Consent.

- (a) All ART programs providing assisted reproductive technologies must, at least twenty-four (24) hours prior

to obtaining a signed contract for services, provide patients with the following information in writing and obtain a signed disclosure form before services commence:

- (1) Description of the procedure(s).
- (2) Outcomes and success:
 - a. The likelihood that the patient will become pregnant, based on experience at that particular program with patients of comparable age and medical conditions;
 - b. Statistics on the facility's success rate, including the total number of live births, the number of live births as a percentage of completed retrieval cycles, and the rates for clinical pregnancy and delivery per completed retrieval cycle bracketed by age groups consisting of women under thirty (30) years of age, women aged thirty (30) through thirty-four (34) years, women aged thirty-five (35) through thirty-nine (39) years, and women aged forty (40) years and older;
 - c. The likelihood of the patient having a live-born child based on a forthright assessment of her particular age, circumstances, and embryo transfer options;
 - d. The program's most recent outcome statistics, as reported to the United States Centers for Disease Control and Prevention (CDC);
 - e. The existence of (and availability of data) from the Fertility Clinic Success Rate and Certification Act regarding pregnancy and live-birth success rates of ART programs, as well as a copy of the annual report by the ART program to the CDC pursuant to said Act; and
 - f. Statistics reported by the program to federal and state agencies, reported statistics from all other clinics in the State, and national ART statistics as reported to the CDC, as well as an explanation of the relevance of the statistics.
- (3) Costs:
 - a. The anticipated price (to the patient) of all procedures, including any charges for procedures and medications not covered in the standard fee; and
 - b. Average cost to patients of a successful assisted pregnancy.
- (4) Major known risks:
 - a. All major known risks and side effects to mothers and children conceived, including psychological risks associated with all ART drugs and procedures considered;
 - b. The risks associated with any drugs or fertility-enhancing medications proposed;
 - c. The risks associated with egg retrieval and embryo or oocyte transfer; and
 - d. The risks associated with multiple gestations to mother and children.
- (5) Multiple gestation and fetal reduction:
 - a. The likelihood that fetal reduction might be recommended as a response to multiple gestations;
 - b. A clear explanation of the nature of fetal reduction and the associated risks for mother and any surviving child(ren); and
 - c. Decisions about embryo conception and transfer, including the patient's right to determine the number of embryos or oocytes to conceive and transfer.

- (6) Donor gametes: If relevant, the testing protocol used to ensure that gamete donors are free from known infections, including human immunodeficiency viruses, and free from carriers of known genetic and chromosomal diseases.
- (7) Non-transferred embryos:
 - a. The availability of embryo adoption for non-transferred embryos and information on agencies in the State that process or facilitate embryo adoption;
 - b. The risks of cryopreservation for embryos, including information concerning the current feasibility of freezing eggs rather than embryos, and any influence that may have on the likelihood of a live birth;
 - c. The current law governing disputes concerning excess embryos; and
 - d. Information concerning disposition of non-transferred embryos that may be chosen by the patient, the rights of patients regarding that disposition, and the need to state *[her]* wishes and intentions regarding disposition.
- (8) Changes that may affect the contract:
 - a. The effect on treatment, embryos, and the validity of informed consent of clinic closings, divorce, separation, failure to pay storage fees for excess embryos, failure to pay treatment fees, inability to agree on the fate of embryos, death of patient or others, withdrawal of consent for transfer after fertilization but before cryopreservation, incapacity, unavailability of agreed upon disposition of embryos, or loss of contact with the clinic; and
 - b. The patient's right to revoke consent at any time and that charges will be limited to the services provided, with exceptions possibly made for some shared-risk programs, if relevant.
- (b) This information must be discussed with the patient, and the ART program must provide written documentation that all relevant information required by this Section has been given to the patient.
- (c) Patients shall be informed of the option of additional counseling throughout future procedures, even if counseling was refused in the past.
- (d) Each time a new cycle is undertaken, informed consent must be obtained and information provided to the patient with the latest statistics and findings concerning the patient's status.
- (e) The *[Commissioner of Health or other appropriate office/individual]* is authorized to promulgate additional regulations providing more specific guidance for ensuring fully informed consent to ART.

Section 5. Data Collection and Reporting Requirements.

(a) All ART programs shall confidentially collect and maintain the following information, pertaining to the particular ART program, and confidentially report, on such forms as the Department prescribes, the following information to *[Insert name of state health department or other appropriate agency]*, no later than *[February 1]* following any year such procedures were performed:

- (1) Success rates:
 - a. Rates of success, defined as the total number of live births achieved, the percentage of live births per completed cycle of egg retrieval, and the numbers of both clinical pregnancy and actual delivery as ratios against the number of retrieval cycles completed. These statistics must be broken down into the age group of patients: under thirty (30), thirty to thirty-four (30-34), thirty-five to thirty-seven (35-37), thirty-eight to forty (38-40), forty-one to forty-two (41-42), and forty-three (43) and above;

- b. Rate of live births per transfer; and
 - c. Number of live births per ovarian stimulation, broken down into age groups: under thirty (30), thirty to thirty-four (30-34), thirty-five to thirty-seven (35-37), thirty-eight to forty (38-40), forty-one to forty-two (41-42), and forty-three (43) and above.
- (2) Storage: Information regarding the storage and safekeeping of embryos including:
 - a. Storage location (if stored); or
 - b. Location to which relocated and purpose of relocation (if transferred to another facility); or
 - c. Time and date of disposal of each patient's embryos (if destroyed).
- (3) Technologies: Percentage usage of types of ART, including IVF, GIFT, ZIFT, combination, or other.
- (4) Multiples:
 - a. Percentage of pregnancies resulting in multi-fetal pregnancies, broken down by number of fetuses; and
 - b. Percentage of live births involving multiple infants.
- (5) Fetal Reduction:
 - a. Number of fetal reductions performed, individually reported and identifying the number of embryos transferred before the reduction;
 - b. Percentage of transferred embryos that implant;
 - c. Percentage of premature births per single and multiple births; and
 - d. The use of pre-implantation genetic diagnosis (PGD) in the ART program, including data on its safety and efficacy.
- (6) Prematurity and Other Abnormalities:
 - a. Percentage of birth defects per single and multiple births; and
 - b. Percentage of fetal reductions that resulted in a miscarriage.

(b) The program's medical director shall verify in writing the accuracy of the foregoing data.

(c) The [Commissioner of Health or other appropriate office or individual] is authorized to promulgate further regulations requiring additional or more specific data collection and reporting.

[(d) The Commissioner shall make the data available in such form as the Commissioner prescribes.]

Section 6. Limits on Creation and Transfer of Embryos in Single Reproductive Cycle.

(a) It shall be unlawful for any ART program, ART facility, or its employees to create more than [two (2)] embryos per reproductive cycle.

(b) It shall be unlawful for any ART program, ART facility, or its employees to transfer more than [two (2)] embryos per reproductive cycle.

(c) In subsequent assisted reproductive cycles, transfer shall first be attempted with cryopreserved embryos from previous cycles, if they exist. Only after transfer is attempted with cryopreserved embryos may new embryos be conceived through ART. [Alternatively, subsection 6(b) could require presenting patients with the option of prioritizing

the use of existing cryopreserved embryos in future cycles.]

Section 7. Embryo Donation and Adoption.

No ART program may limit or inhibit the choice by patients of embryo donation or adoption through the employment of psychological evaluations, increased costs or payments, or other conditions.

Section 8. Civil Penalty.

Any person or entity that violates any provision of this Act and derives a pecuniary gain from such violation shall be fined *[Insert amount]*, twice the amount of gross gain, or, at the discretion of the court, any amount intermediate between the foregoing.

Section 9. Professional Sanctions.

(a) **Unprofessional Conduct.** Any violation of this Act shall constitute unprofessional conduct pursuant to *[Insert appropriate state statutes or regulations for medical doctors and surgeons and osteopathic doctors]* and shall result in sanctions increasing in severity from censure to temporary suspension of license to practice medicine to permanent revocation of license to practice medicine.

(b) **Trade, Occupation, or Profession.** Any violation of this Act may be the basis for denying an application for, denying an application for the renewal of, or revoking any license, permit, certificate, or any other form of permission required to practice or engage in a trade, occupation, or profession.

(c) **Facility Licensing.** Any violation of this Act by an individual in the employ and under the control of a licensed healthcare facility and to which the management of said facility consents to, knows about, or should have known about may be the basis for denying an application for, denying an application for the renewal of, temporarily suspending, or permanently revoking any operational license, permit, certificate, or any other form of permission required to operate a healthcare facility.

Section 10. Severability.

Any provision of this Act held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as to give it the maximum effect permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event such provision shall be deemed severable herefrom and shall not affect the remainder hereof or the application of such provision to other persons not similarly situated or to other, dissimilar circumstances.

Section 11. Right of Intervention

The *[Legislature]*, by joint resolution, may appoint one or more of its members who sponsored or co-sponsored this Act, as a matter of right and in his or her official capacity, to intervene to defend this law in any case in which its constitutionality is challenged.

Section 12. Effective Date.

This Act takes effect on *[Insert date]*.

Egg Provider Protection Act

HOUSE/SENATE BILL NO. _____

By Representatives/Senators _____

Section 1. Short Title.

This Act may be known as the “Egg Provider Protection Act.”

Section 2. Legislative Findings and Purposes.

- (a) The [Legislature] of the State of [Insert name of State] finds that:
- (1) Human eggs used for research and fertility treatments are obtained from female human providers.
 - (2) Egg providers tend to be young, single women without children.
 - (3) Egg providers are usually compensated financially for their eggs or for the time, pain, and inconvenience of the extraction procedure.
 - (4) Egg harvesting requires preliminary hormone treatment.
 - (5) This hormone therapy is accompanied by serious health risks including an increased risk of uterine, ovarian, and breast cancers and potential complications with future pregnancies.
 - (6) Many egg providers are not fully informed of the health risks associated with egg harvesting.
 - (7) Many egg providers suffer emotionally and psychologically for extended periods after their eggs are harvested.
 - (8) Many egg providers will desire to have children sometime after having their eggs harvested.
 - (9) There is a substantial lack of knowledge in regard to the effects and risks of the egg harvesting process
- (b) Based on the findings in subsection (a), it is the purpose of this Act to:
- (1) Safeguard the health and welfare of egg providers;
 - (2) Require fully informed consent that ensures that egg providers understand the physical, psychological, and reproductive risks that accompany egg harvesting;
 - (3) Prevent egg harvesting institutions from exploiting women and commodifying women’s bodies; and
 - (4) Establish an egg provider registry in order to contribute to a more accurate and complete understanding of the effects of egg harvesting on the providers.

Section 3. Definitions.

For purposes of this Act only:

- (a) “**Compensation**” means any consideration or payment given to a woman in exchange for the harvesting and use of her eggs. It does not include reimbursement for time and trouble.
- (b) “**Department**” means [Insert reference to appropriate state department or agency responsible for implementing and administering this Act].
- (c) “**Destructive human embryo research**” means medical procedures, scientific or laboratory research, or other kinds of investigation that kill or injure the human embryo. It does not include:

- (1) In vitro fertilization and accompanying embryo transfer to a woman's body;
 - (2) Research in the use of nuclear transfer or other cloning techniques to produce molecules; deoxyribonucleic acid; or cells other than human embryos, tissues, organs, plants, or animals other than humans; or
 - (3) Any diagnostic procedure that benefits the human embryo subject to such tests, while not imposing risks greater than those considered acceptable for other human research subjects.
- (d) **"Egg"** means the unfertilized gamete, or oocyte, of a human female.
- (e) **"Egg harvesting"** means the extraction of an egg or eggs from the reproductive organs of a provider for purposes other than the impregnation of the provider with those same eggs.
- (f) **"Egg provider"** or **"provider"** means any woman who provides or agrees to provide her eggs for purposes other than her own impregnation with those same eggs.
- (g) **"Human cloning"** means human asexual reproduction accomplished by (1) introducing the genetic material from one or more human somatic or embryonic cells into a fertilized or unfertilized oocyte whose nuclear material has been removed or inactivated before or after introduction, so as to produce an organism at any stage of development with a human or predominantly human genetic constitution; (2) artificially subdividing a human embryo at any time from the two-cell stage onward, such that more than one human organism results; or, (3) introducing pluripotent cells from any source into a human embryo, nonhuman embryo, or artificially manufactured human embryo or trophoblast, under conditions where the introduced cells generate all or most of the body tissues of the developing organism.
- (h) **"Licensed physician"** means any person licensed to practice medicine in this State. The term includes medical doctors and doctors of osteopathy.
- (i) **"Medication"** means a hormone, birth control pill, GnRH agonist, GnRH antagonist, gonadotropin, estrogen suppressor, antibiotic, pain medication, or any other drug.
- (j) **"Public funds"** means, but is not limited to:
- (1) Any monies received or controlled by the state or any official, department, division, agency, or educational or political subdivision thereof, including, but not limited to, monies derived from federal, state, or local taxes; gifts or grants from any source; settlements of any claims or causes of action, public or private; bond proceeds or investment income; federal grants or payments; or intergovernmental transfers; and
 - (2) Any monies received or controlled by an official, department, division, or agency of state government or any educational or political subdivision thereof, by any person or entity pursuant to appropriation by the [Legislature], or by governing body of any political subdivision of this state.
- (k) **"Solicitation"** means any advertisement whether written, printed, or spoken, in a newspaper or magazine, on radio, television, or internet, or otherwise published.

Section 4. Professional and Clinical Requirements for Egg Harvesting.

- (a) No person shall harvest eggs unless he or she is a licensed physician.
- (b) No person shall harvest eggs except in a hospital, clinic, or other medical facility that meets the normal licensing standards for such facilities in the State, as detailed in [Insert appropriate state code provision(s) and/or administrative regulation(s)].
- (c) No person or entity shall provide compensation, financial or otherwise, for eggs or the egg harvesting procedure.

(d) Any reimbursement for time and trouble to the provider shall not exceed an amount typically paid to research subjects for their time and trouble in unrelated medical tests at the institution offering the reimbursement or, if no other live-subject medical tests are conducted at that institution, at other medical institutions in the State.

Section 5. Solicitation of Egg Providers.

(a) No solicitation of egg providers shall offer compensation, financial or otherwise, for eggs or the egg harvesting procedure.

(b) Any solicitation of egg providers shall include a summary of any drug or hormone treatments involved, the total number of office or other visits that a provider must make, and the intended use of the eggs to be harvested.

Section 6. Informed Consent.

(a) Before conducting any medical procedures on or prescribing any hormones or other drugs for an egg provider, a physician shall provide the prospective provider with the following information, described in basic terminology and written in a language understood by the prospective provider, and shall obtain the provider's signed consent on a form that the *[Insert name of state health department or other appropriate agency]* shall prescribe.

(1) Procedure.

- a. Description of all hormones and other drugs to be taken by the egg provider, including the dosage, frequency of administration, intended biochemical function of, and the likely physiological response to each medication;
- b. Whether the hormones and other drugs to be taken by the egg provider are being administered as tested and approved by the Food and Drug Administration (FDA);
- c. Whether the hormones and other drugs to be taken by the egg provider are being administered "off-label" or according to an "evidence-based protocol," and if so the original intended purpose of the hormone or drug when it was tested and approved by the FDA;
- d. The number of times the egg provider will be expected to visit the physician, the purpose for each visit, and the duration of each visit, including recovery time;
- e. Description of the procedure to be performed on the egg provider, including all blood tests, ultrasounds, injections, and egg extractions. The description shall include the purpose, duration, and estimated recovery time of each procedure; and
- f. Description of all restrictions the egg provider will be asked to undertake and their duration, including abstinence from alcohol, cigarettes, illegal drugs, prescription drugs, and unprotected sexual intercourse and restrictions on driving following medication and medical procedures.

(2) Nature of Egg Harvesting.

- a. The approximate number of eggs to be harvested; and
- b. The fact that eggs have the potential to develop into live human persons sharing their parents' DNA when fertilized by sperm.

(3) Intended Use of Eggs.

- a. Description of the intended use of the eggs;

- b. Whether the eggs may be fertilized by sperm and, if so, how many days the resulting embryos will be permitted to develop;
 - c. Whether the eggs may be turned into blastocysts through human cloning or some means other than fertilization by sperm and, if so, how many days the resulting entities will be permitted to develop;
 - d. Whether the eggs may be used for destructive human embryo research;
 - e. Whether the eggs may be implanted in other persons for reproductive or other purposes;
 - f. How many separate recipients may be impregnated with the provider's eggs;
 - g. What information the egg provider will be entitled to learn about any children produced with her eggs and what contact she will be allowed to have with such children; and
 - h. Whether the eggs may be multiplied to produce more eggs. If so, the information required by subparts (a) through (g) of this subsection must also be given as to the resulting eggs.
- (4) Side Effects.
- a. Description of any pain that may be experienced as a result of hormones, other drugs, the egg harvesting procedure, or any related procedure, including the likely degree and duration of such pain;
 - b. Description of any other possible physical side effects, including allergic reaction, ovarian hyperstimulation syndrome, ovary rupture, bleeding, infection, blood clots, kidney failure, fluid build-up in the lungs, damage to bowel or bladder, and scarring of the fallopian tubes that may be experienced as a result of hormones, other drugs, the egg harvesting procedure, or any related procedure, including the likely degree and duration of such physical side effects;
 - c. Description of any emotional or psychological side effects, including depression, stress-related symptoms, and mood swings that may be experienced as a result of hormones, other drugs, the egg harvesting procedure, or any related procedure, including the likely degree and duration of such emotional or psychological side effects;
 - d. Information on studies demonstrating an increased likelihood of the egg provider developing uterine, breast, or ovarian cancer or any other type of cancer, after providing eggs, including the percentage of the general female population that develop each type of cancer and the percentage of egg providers that develop each type of cancer;
 - e. The adverse effects that hormones, other drugs, the egg harvesting procedure, and other related procedures may have on future attempts of the egg provider to become pregnant, including scarred fallopian tubes and infection; and
 - f. Acknowledgement that, to date, the process and risks associated with egg harvesting have not been studied and are unknown compared to other medical procedures and treatments, and, therefore, the egg provider cannot be completely informed of all potential risks or effects.
- (b) No person other than the egg provider shall consent on behalf of the provider.

Section 7. Data Collection and Reporting and Maintenance of State Registry.

(a) In order to develop the breadth of knowledge necessary to adequately inform women of the risks involved in egg harvesting and to better understand which demographics are being targeted by researchers for egg harvesting, the Department shall develop and maintain a state registry containing the following information about each woman who provides eggs to any person or institution within the State:

- (1) The age of the egg provider;

- (2) The current annual income of the egg provider;
- (3) The city and state of residence of the egg provider;
- (4) The number of pregnancies of the egg provider;
- (5) The number of live births of the egg provider;
- (6) The number of times the egg provider has previously provided or attempted to provide eggs;
- (7) The number of eggs harvested each time the egg provider has previously provided eggs;
- (8) All hormones and other drugs prescribed or administered to the egg provider, including dosage and frequency of administration, and relating directly or indirectly to the egg harvesting procedure;
- (9) The manner in which the egg provider was instructed to administer the hormones and drugs prescribed;
- (10) Whether the egg provider was told that the medical community has not yet adequately studied the effects of the egg harvesting procedure and, therefore, the egg provider cannot be completely informed of all potential risks or effects;
- (11) Whether the egg provider had a particular physician or other contact person within the institution or facility harvesting the eggs and, if so, the name and position of that physician or other person;
- (12) The name of the institution or facility harvesting the eggs;
- (13) The total number of eggs harvested;
- (14) The particular disposition [*or use*] of the eggs harvested;
- (15) Whether and to what extent the egg provider received any follow-up care;
- (16) Any side effects or adverse events in the health of the egg provider which occurred during the administration of hormones or other drugs, during the harvesting procedure, or up to one year following the ingestion of hormones or drugs and/or the harvesting procedure, whichever is later;
- (17) Any medical treatment or procedure provided to the egg provider as a result of the hormones or other drugs or the egg harvesting procedure;
- (18) The total amount of money paid to the egg provider for time, transportation, discomfort, or other services related to the egg harvesting procedure; and
- (19) An itemized list of the amounts of money paid to the egg provider, the source of each amount, and the consideration for each amount

For purposes of this Act, an “**adverse event**” shall be defined according to the Food and Drug Administration (FDA) criteria given in the Medwatch Reporting System.

(b) Any person or institution that harvests human eggs shall collect and maintain the information required in subsection (a) of this Section and shall report it within fifteen (15) days after the last day of each calendar month to the Department on such forms as the Department shall prescribe.

(c) The Department shall summarize aggregate data from the reports required under this Section and submit the data to the U.S. Centers for Disease Control and Prevention (CDC) for the purpose of inclusion in the annual Vital Statistics Report. The aggregated data shall also be made independently available to the public by the Department in a downloadable format.

(d) In addition to the information enumerated in subsection (a) of this Section, any person or institution that harvests human eggs shall report to the Department the name of the egg provider for which the information was collected and reported. That name shall not be included in the Department’s aggregate report. The

Department shall assign a unique identification number for each egg provider for the purposes of the aggregate report.

(e) The Department shall maintain a separate registry containing the names of the egg providers with their unique identification numbers. This registry will be accessible only by petition to the Department and for good cause, including but not limited to statistical compilation and research on the effects and risks of the egg harvesting procedure.

Section 8. Prohibition on Use of Taxpayer Funds for Human Egg Harvesting.

(a) Notwithstanding any other law, no public funds shall be used to facilitate the harvesting of human eggs, pay for the procedure of egg harvesting, or compensate those who perform or undergo the procedure.

(b) For purposes of this Section, “egg harvesting” (as defined in Section 3(e) of this Act) includes the extraction of human oocytes from a woman’s reproductive organs for the purpose of reproduction.

Section 9. Criminal Penalty.

Any person or entity that intentionally or knowingly violates any provisions or requirement of this Act shall be guilty of a *[Insert appropriate penalty/offense classification]*.

Section 10. Civil Penalty.

Any person or entity that violates any provision of this Act shall be fined *[Insert amount]*, twice the amount of gross pecuniary gain derived from such a violation, or, at the discretion of the court, any amount intermediate between the forgoing.

Section 11. Professional Sanctions.

(a) **Unprofessional Conduct.** Any violation of this Act shall constitute unprofessional conduct pursuant to *[Insert appropriate statutes for medical doctors and surgeons and osteopathic doctors]* and shall result in permanent revocation of the violator’s license to practice medicine.

(b) **Trade, Occupation, or Profession.** Any violation of this Act may be the basis for denying an application for, denying an application for the renewal of, or revoking any license, permit, certificate, or any other form of permission required to practice or engage in a trade, occupation, or profession.

Section 12. Severability.

Any provision of this Act held to be invalid or unenforceable by its terms or as applied to any person or circumstance shall be construed so as to give it the maximum effect permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event such provision shall be deemed severable herefrom and shall not affect the remainder hereof or the application of such provision to other persons not similarly situated or to other, dissimilar circumstances.

Section 13. Right of Intervention.

The *[Legislature]*, by joint resolution, may appoint one or more of its members who sponsored or co-sponsored this Act, as a matter of right and in his or her official capacity, to intervene to defend this law in any case in which its constitutionality is challenged or questioned.

Section 14. Effective Date.

This Act takes effect on *[Insert date]*.

Embryo Adoption Act

HOUSE/SENATE BILL NO. _____

By Representatives/Senators _____

Section 1. Short Title.

This Act may be cited as the “Embryo Adoption Act.”

Section 2. Legislative Findings and Purposes.

- (a) The [Legislature] of the State of [Insert name of State] finds that:
- (1) There are hundreds of thousands of cryopreserved (frozen) human embryos in laboratories and facilities in the United States, and that the number grows annually.
 - (2) There is little guidance from federal or state law for the disposition of frozen embryos. In fact, few states have laws governing the disposition of frozen embryos.
 - (3) Embryo donation can be a haphazard process, providing insufficient protection for the best interests of the child and insufficient certainty for the rights and responsibilities of relinquishing (genetic) and potential adopting parents.
 - (4) Allowing parents who adopt embryos to obtain a court order of adoption creates greater protection for the child, greater certainty for the termination of rights of the relinquishing (genetic) parents, and greater certainty for the rights of the adopting parents.
 - (5) Further, allowing a court order of adoption promotes the psychological health of the child who later will not feel that he or she was “donated” or given away, but was adopted from and by loving parents.
 - (6) Finally, allowing a court order of adoption may allow adopting parents to claim an adoption tax credit that would not be available to them under a typical “embryo donation” scenario, further encouraging the adoption of embryos which might otherwise remain in a state of frozen limbo.
- (b) Based on the findings in subsection (a), the purposes of the [Legislature] are to:
- (1) Clarify the rights of relinquishing (genetic) and adopting parents;
 - (2) Allow for a court order of adoption for adopted frozen embryos; and
 - (3) Promote the best interests of the child.

Section 3. Definitions.

For purposes of this Act only:

- (a) “**Adopting parent**” means the person or persons who receive a relinquished embryo and who accept full legal rights and responsibilities for such embryo and any child that may be born as a result of embryo transfer.
- (b) “**Embryo relinquishment**” means the relinquishment of rights and responsibilities by the relinquishing parent(s) of a human embryo and the acceptance of said rights and responsibilities by adopting parent(s).
- (c) “**Embryo transfer**” means the medical procedure of physically placing an embryo into the uterus of a woman.
- (d) “**Human embryo**” or “**embryo**” means an individual organism of the human species, from the single cell stage to eight (8) weeks development.

(e) “Relinquishing parent” means the person or persons who hold the legal rights and responsibilities for an embryo, regardless of whether the embryo was created with the use of the relinquishing parents’ gametes or through the use of donor gametes, who is seeking to relinquish the embryos to adopting parents.

[Section 4.] Amendment to Definition Section of State Adoption Law.

For purposes of embryo adoption under this Act and the [Insert reference(s) to the definition section(s) of state’s adoption law(s)], “child” [or “minor”] shall include a human embryo.

[Section 5.] Exclusivity.

The relinquishment of human embryos from relinquishing to adopting parents shall be conducted pursuant to the adoption laws of this state, as amended by Sections 6 through 9 of this Act.]

[Drafter’s Note: Amending a state’s adoption law requires input from legal counsel experienced in that particular state’s adoption requirements. Thus, legislators wishing to amend the state’s adoption law as opposed to introducing an analogous procedure for embryo adoption are encouraged to contact AUL, as well as in-state legal counsel before introducing a measure based on Sections 4 and 5 herein.]

[Section 6.] Relinquishment of Rights.

(a) A relinquishing parent may relinquish all rights and responsibilities for an embryo to an adopting parent prior to embryo transfer. Prior to embryo transfer, a written contract shall be entered into between each relinquishing parent and each adopting parent for the legal transfer of rights to an embryo and to any child which may result from the embryo transfer. The contract shall be signed by each relinquishing parent for such embryo and by each adopting parent in the presence of a notary public and a witness. Initials or other designations may be used if the parties desire anonymity. The contract may include a written waiver by the relinquishing parent of notice and service in the legal adoption proceeding which may follow.

(b) If the embryo was created using donor gametes, the sperm or oocyte donors who irrevocably relinquished their rights in connection with in vitro fertilization shall not be entitled to any notice of the embryo relinquishment nor shall their consent to the embryo relinquishment be required.

(c) Upon embryo relinquishment by each relinquishing parent pursuant to subsection (a) of this Section, the legal transfer of rights to an embryo shall be considered complete, and the embryo transfer shall be authorized.

(d) A child born to an adopting parent as the result of embryo relinquishment pursuant to subsection (a) of this Section shall be presumed to be the legal child of the adopting parent.

[Section 7.] Petition for Expedited Order of Adoption.

(a) Prior to the birth of a child or following the birth of a child, an adopting parent may petition the [*superior court*] for an expedited order of adoption. In such cases, the written contract between each relinquishing parent and each adopting parent shall be acceptable in lieu of a surrender of rights.

(b) All petitions under this Section shall be filed in the county in which any petitioner or any respondent resides.

(c) The court shall give effect to any written waiver of notice and service in the legal proceeding for adoption.

(d) In the interest of justice, to promote the stability of embryo transfers, and to promote the interests of children who may be born following such embryo transfers, the court in its discretion may waive such technical requirements as the court deems just and proper.

[Section 8.] Finality of Orders of Adoption.

Upon a filing of a petition for adoption or parentage and the court finding that such petition meets the criteria required by this Act, an expedited order of adoption shall be issued and shall be a final order. Such order shall terminate any future parental rights and responsibilities of any past or present relinquishing parent or gamete donor in a child which results from the embryo transfer and shall vest such rights and responsibilities in the adopting parent.

[Section 9.] Status of Prior Agreements for Disposition of Embryos.

Relinquishment of rights to an embryo pursuant to [Section 6] shall cancel any prior written agreement governing disposition of the embryo.

[Section 10.] Severability.

Any provision of this Act held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as to give it the maximum effect permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event such provision shall be deemed severable herefrom and shall not affect the remainder hereof or the application of such provision to other persons not similarly situated or to other, dissimilar circumstances.

[Section 11.] Right of Intervention.

The [Legislature], by joint resolution, may appoint one or more of its members who sponsored or co-sponsored this Act, as a matter of right and in his or her official capacity, to intervene to defend this law in any case in which its constitutionality is challenged or questioned.

[Section 12.] Effective Date.

This Act takes effect on [Insert date].



END OF LIFE

Assisted Suicide Ban Act

HOUSE/SENATE BILL NO. _____

By Representatives/Senators _____

Section 1. Title.

This Act may be known and cited as the “Assisted Suicide Ban Act.”

Section 2. Legislative Findings and Purposes.

- (a) The [Legislature] of the State of [Insert name of State] finds that:
- (1) “In almost every State—indeed, in almost every western democracy—it is a crime to assist a suicide. The States’ assisted suicide bans are not innovations. Rather they are longstanding expressions of the States’ commitment to the protection and preservation of all human life.” *Washington v. Glucksberg*, 521 U.S. 702, 710 (1997).
 - (2) “Indeed, opposition to and condemnation of suicide—and, therefore, of assisting suicide—are consistent and enduring themes of our philosophical, legal and cultural heritages.” This almost universal tradition has long rejected a right to assisted suicide and the State of [Insert name of State] “continues to explicitly reject it today, even for terminally ill, mentally competent adults.” *Washington v. Glucksberg*, 521 U.S. 702, 711 & 723 (1997). Destructive human embryo research to obtain embryonic stem-cells raises grave moral, ethical, scientific, and medical issues that must be addressed;
 - (3) The State of [Insert name of State] “has an unqualified interest in the preservation of human life, ...in preventing suicide, and in studying, identifying, and treating its causes.” *Washington v. Glucksberg*, 521 U.S. 702, 729-30 (1997).
 - (4) The State of [Insert name of State] “has an interest in protecting vulnerable groups—including the poor, the elderly, and disabled persons—from abuse, neglect, [coercion,] and mistakes.” A ban on assisted suicide reflects and reinforces our well-supported policy “that the lives of the terminally ill, disabled and elderly people must be no less valued than the lives for the young and healthy, and that a seriously disabled [, terminally ill, or elderly] person’s suicidal impulses should be interpreted and treated the same way as anyone else’s.” *Washington v. Glucksberg*, 521 U.S. 702, 731-32 (1997).
 - (5) The State of [Insert name of State] has an interest in protecting the integrity and ethics of the medical profession, including its obligation to serve its patients as healers, as well as to the principles articulated in the Hippocratic Oath to:
 - g. Keep the sick from harm and injustice.
 - h. Refrain from giving anybody a deadly drug if asked for it, nor make a suggestion to this effect.
 - (6) More specifically, the State of [Insert name of State] recognizes the close link between physician-assisted suicide and euthanasia where a “right to die” easily becomes a “duty to die.” A prohibition of assisted suicide is the only reasonable means to protect against foreseeable abuses. *Washington v. Glucksberg*, 521 U.S. 702, 734-35 (1997); *Vacco v. Quill*, 521 U.S. 793, 808-09 (1997).
 - (7) The State of [Insert name of State] also recognizes the distinction between a patient refusing life-sustaining medical treatment (not to include the withdrawal of artificial nutrition and hydration), where he or she dies from the underlying fatal disease or pathology; and a patient ingesting or administering a lethal medication prescribed by a physician, where the medication is the cause of death. *Vacco v. Quill*, 521 U.S.

793, 801 (1997).

- (8) The State of *[Insert name of State]* further recognizes the importance of palliative care and pain management and emphasizes the distinction in the “legal principles of causation and intent” between pain management intended to alleviate pain and assisted suicide intended to cause death. *Vacco v. Quill*, 521 U.S. 793, 801-03 (1997).
- (b) Based on the findings in subsection (a), it is the purpose of this Act to:
 - (1) Provide protection for our most vulnerable citizens by explicitly prohibiting assisted suicide within the State of *[Insert name of State]*’s criminal code.
 - (2) Reinforce and reflect the intended purpose of our medical professions to preserve life and act as healers.

Section 3. Definitions.

As used in this Act only:

- (a) **“Deliberately”** means to consider carefully; done on purpose; intentional.
- (b) **“Healthcare provider”** means any individual who may be asked to participate in any way in a healthcare service, including, but not limited to, the following: a physician; physician’s assistant; nurse; nurses’ aide; medical assistant; hospital employee; clinic employee; nursing home employee; pharmacist; pharmacy employee; researcher; medical or nursing school faculty member, student or employee; counselor; social worker; or any professional, paraprofessional, or any other person who furnishes or assists in the furnishing of healthcare services.
- (c) **“Person”** means any natural person; and when appropriate, an **“organization”** to include:
 - (1) A public or private corporation, company, association, firm, partnership, or joint-stock company;
 - (2) Government or a governmental instrumentality; or
 - (3) A foundation, institution, society, union, club, or church.
- (d) **“Physician”** means a person licensed to practice medicine in the State of *[Insert name of State]*. This term includes medical doctors and doctors of osteopathy.
- (e) **“Suicide”** means the act or instance of taking one’s own life voluntarily and intentionally.
- (f) **“Aid in dying”** means the act or instance of a person providing the means or manner for another to be able to commit suicide.

Section 4. Criminal Penalties.

- (a) Any person who deliberately advises, assists, or encourages another to commit suicide or provides aid in dying is guilty of *[Insert appropriate degree of felony]*.
- (b) Any physician or healthcare provider who:
 - (1) Prescribes any drug, compound, or substance to a patient with the intended purpose to assist in ending the patient’s life; or
 - (2) Assists or performs any medical procedure for the intended purpose to assist in ending the patient’s life is guilty of *[Insert appropriate degree of felony]*.

Section 5. Civil Penalties and Fines.

- (a) Any person, physician, or healthcare provider who intentionally or knowingly violates this Act shall be liable for damages.

(b) If any person assists a suicide resulting in death, any surviving family member, other beneficiary, executor, or administrator of the decedent's estate may bring an appropriate action under *[Insert reference to state's wrongful death statute(s)]*.

(c) Any physician or other healthcare provider who assists a suicide in violation of this Act shall be considered to have engaged in unprofessional conduct for which his or her *[certificate or]* license to provide healthcare services in the State of *[Insert name of State]* shall be suspended or revoked by *[Insert name of State Medical Board or other appropriate entity]*.

Section 6. Construction.

Nothing in this Act shall be construed to prohibit a physician or healthcare provider from:

- (a) Participating in the execution of a person sentenced by a court to death by lethal injection.
- (b) Following a patient's clear, expressed, and documented wishes to withhold or withdraw life-sustaining treatment *[not necessarily inclusive of withdrawing artificial nutrition and hydration]*.
- (c) Prescribing and administering palliative care or pain medication treatment options intended to relieve pain while the patient's illness or condition follows its natural course.

Section 7. Right of Intervention.

The *[Legislature]*, by joint resolution, may appoint one or more of its members, who sponsored or cosponsored this Act in his or her official capacity, to intervene as a matter of right in any case in which the constitutionality of this Act, or any portion thereof, is challenged.

Section 8. Severability.

If any provision, word, phrase, or clause of this Act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect the provisions, words, phrases, clauses, or applications of this Act which can be given effect without the invalid provision, word, phrase, clause, or application and to this end, the provisions, words, phrases, and clauses of this Act are declared severable.

Section 9. Effective Date.

This Act takes effect on *[Insert date]*.

Joint Resolution Opposing Physician-Assisted Suicide

HOUSE/SENATE BILL NO. _____

By Representatives/Senators _____

WHEREAS, [Insert name of State] has an “unqualified interest in the preservation of human life,” and this State’s “prohibition on assisted suicide, like all homicide laws, both reflects and advances its commitment to this;”¹

WHEREAS, neither this State’s constitution nor the U.S. Constitution contains a right to assisted suicide and, thus, no individual has the right to authorize another to kill him or her in violation of federal and state criminal laws;²

WHEREAS, suicide is not a typical reaction to an acute problem or life circumstance, and many individuals who contemplate suicide, including the terminally ill, suffer from treatable mental disorders, most commonly clinical depression, which frequently goes undiagnosed and untreated by physicians;³

WHEREAS, in Oregon, forty-six (46) percent of patients seeking assisted suicide changed their minds when their physicians intervened and appropriately addressed suicidal ideations by treating their pain, depression, and/or other medical problems;⁴

WHEREAS, palliative care continues to improve and is nearly always successful in relieving pain and allowing a person to die naturally, comfortably, and in a dignified manner without a change in the law;⁵

WHEREAS, the experiences in Oregon and the Netherlands explicitly demonstrate that palliative care options deteriorate with the legalization of physician-assisted suicide;⁶

WHEREAS, [Insert name of State] rejects abuses of palliative care through “futility care” protocols and the use of “terminal sedation” without life-sustaining care as seen in the Liverpool Care Pathway;⁷

WHEREAS, a physician’s recommendation for assisted suicide relies on the physician’s judgment—to include prejudices and negative perceptions—that a patient’s life is not worth living, ultimately contributing to the use of “futility care” protocols and euthanasia;⁸

WHEREAS, [Insert name of State] rejects the “sliding-scale approach” which claims certain “qualities of life” are not worthy of equal legal protections;⁹

¹ *Washington v. Glucksberg*, 521 U.S. 702, 728 (1997).

² See *id.* at 735 (upholding Washington’s ban on assisted suicide and finding there is no constitutional right to assisted suicide under the Due Process Clause of the Fourteenth Amendment); *Vacco v. Quill*, 521 U.S. 793, 808-09 (1997) (upholding New York’s statute prohibiting assisted suicide as consistent with the U.S. Constitution in that it did not violate the Equal Protection Clause of the Fourteenth Amendment); *Sampson v. State*, 31 P3d 88, 95 (Alaska 2000) (finding Alaska’s manslaughter statute prohibiting assisted suicide constitutional in that it does not infringe upon their constitutional rights to privacy, liberty, and equal protection); *Donaldson v. Lungren*, 2 Cal. App. 4th 1614, 4 Cal. Rptr. 2d 59, 63-5 (Cal. Ct. App. 1992) (finding no constitutional right to assisted suicide under the California Constitution); and *Krischer v. McIver*, 697 So. 2d 97, 104 (Fla. 1997) (upholding the constitutionality of Florida’s statute prohibiting assisted suicide).

³ New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide And Euthanasia In The Medical Context* 77-82 (May 1994) available at <http://www.health.state.ny.us/nysdoh/provider/death.htm> (last visited Aug. 14, 2014).

⁴ Linda Ganzini et al., *Physicians’ Experiences with the Oregon Death with Dignity Act*, 342 NEW ENG. J. MED. 557, 557 (2000).

⁵ Herbert Hendin & Kathleen Foley, *Physician-Assisted Suicide in Oregon: A Medical Perspective*, 106 MICH. L. REV. 1613, 1634-35 (2008).

⁶ *Id.* at 1615-20 (noting only 13 percent of patients received palliative care consultations after the Oregon law went into effect).

⁷ See *id.* at 1634-35; Kate Devlin, *Sentenced to death on the NHS*, Telegraph, September 2, 2009 at <http://www.telegraph.co.uk/health/healthnews/6127514/Sentenced-to-death-on-the-NHS.html> (last visited Aug. 14, 2014).

⁸ See *Washington v. Glucksberg*, 521 U.S. at 732 (1997).

⁹ *Id.* at 729.

WHEREAS, the legalization of assisted suicide sends a message that suicide is a socially acceptable response to aging, terminal illness, disabilities, and depression and subsequently imposes a “duty to die;”

WHEREAS, the medical profession as a whole opposes physician-assisted suicide because it is contrary to the medical profession’s role as healer and undermines the physician-patient relationship;¹⁰

WHEREAS, assisted suicide is significantly less expensive than other care options, and Oregon’s experience demonstrates that cost constraints can create financial incentives to limit care and offer assisted suicide;¹¹

WHEREAS, as evidenced in Oregon, the private nature of end-of-life decisions makes it virtually impossible to police a physician’s behavior to prevent abuses, making any number of safeguards insufficient;¹² and

WHEREAS, a prohibition on assisted suicide, specifically physician-assisted suicide, is the only way to protect vulnerable citizens from coerced suicide and euthanasia.¹³

NOW THEREFORE, BE IT RESOLVED BY THE [LEGISLATURE] OF THE STATE OF [INSERT NAME OF STATE]:

Section 1. That the [Legislature] strongly opposes and condemns physician-assisted suicide because the [Legislature] has an “unqualified interest in the preservation of human life” [and because “its assisted-suicide ban insists that all persons’ lives, from beginning to end, regardless of physical or mental condition, are under the full protection of the law.”]¹⁴

Section 2. That the [Legislature] strongly opposes and condemns physician-assisted suicide because anything less than a prohibition leads to foreseeable abuses and eventually to euthanasia by devaluing human life, particularly the lives of the terminally ill, elderly, disabled, and depressed whose lives are of no less value or quality than any other citizen of this State.

Section 3. That the [Legislature] strongly opposes and condemns physician-assisted suicide even for terminally ill, mentally competent adults because assisted suicide eviscerates efforts to prevent the self-destructive act of suicide and hinders progress in effective physician interventions including diagnosing and treating depression, managing pain, and providing palliative and hospice care.

Section 4. That the [Legislature] strongly opposes and condemns physician-assisted suicide because assisted suicide undermines the integrity and ethics of the medical profession, subverts a physician’s role as healer, and compromises the physician-patient relationship. For these reasons and others, the medical community summarily rejects it.

Section 5. That the Secretary of State of [Insert name of State] transmit a copy of this resolution to the Governor, the [Insert name of State] [Department of Health and Human Services], and the [Insert name of State] Medical Association.

¹⁰ *Id.* at 731; see also, American College of Physicians, Ethics Manual, available at http://www.acponline.org/running_practice/ethics/manual/ethicman5th.htm#patients (last visited Aug. 14, 2014) (“The College does not support legalization of physician-assisted suicide. After much consideration, the College concluded that making physician-assisted suicide legal raised serious ethical, clinical, and social concerns and that the practice might undermine patient trust and distract from reform in end of life care.”); Royal College of Physicians cannot support legal change on assisted dying – survey results, May 9, 2006, available at <http://www.rcplondon.ac.uk/news-media/press-releases/rcp-cannot-support-legal-change-assisted-dying-survey-results> (last visited Aug. 14, 2014).

¹¹ Susan Donaldson James, *Death Drugs Cause Uproar in Oregon, Terminally Ill Denied Drugs for Life, But Can Opt for Suicide*, ABC News, Aug 6, 2008 available at <http://abcnews.go.com/Health/story?id=5517492&page=1> (last visited Aug. 14, 2014).

¹² Hendin & Foley, *supra* note 10 at 1637-38.

¹³ *Glucksberg*, 521 U.S. at 733-34.

¹⁴ *Id.* at 728-29.

Pain Medicine Education Act

HOUSE/SENATE BILL NO. _____

By Representatives/Senators _____

Section 1. Title.

This Act may be known and cited as the “Pain Medicine Education Act.”

Section 2. Legislative Findings and Purposes.

- (a) The Legislature of the State of *[Insert name of State]* finds that:
- (1) One goal of medicine is to relieve suffering.
 - (2) Inadequate pain relief is a serious public health problem in the United States, especially for those with chronic pain, the terminally ill, or those who are otherwise in the final stages of life. Approximately *[Insert number based on studies or other evidence]* percent of chronic pain patients in this State do not receive adequate treatment for their pain symptoms.
 - (3) Clinical experience demonstrates that adequate pain management leads to enhanced functioning and increased quality of life, while uncontrolled pain contributes to disability and despair.
 - (4) Every person experiences pain, suffers, and dies at some point in his or her life. Diagnosis and treatment of pain is integral to the practice of medicine and appropriate pain management for each patient is the responsibility of the treating physician.
 - (5) Inappropriate pain management and treatment may result from a healthcare provider’s lack of knowledge and professional training.
 - (6) All healthcare providers should become knowledgeable about assessing patients’ pain and effective methods of pain treatment, as well as statutory requirements for prescribing controlled substances.
 - (7) Many healthcare providers are ill-informed about current and effective management techniques for patients’ pain symptoms, in part, because this topic is not adequately addressed in the normal course of professional schools’ curricula.
 - (8) With proper management techniques, chronic pain may be reduced in the overwhelming majority of suffering patients.
 - (9) Controlled substances, including opioid analgesics, may be essential in the courses of treatment for all types of pain and are, therefore, necessary to the public health.
 - (10) Healthcare professionals’ education has not provided appropriate training in the use of opioid medications for chronic pain.
 - (11) Patient pain should be assessed and treated promptly, and the quantity and frequency of doses should be adjusted based upon, among other medically relevant factors, the intensity and duration of the pain and the treatment outcomes being sought.
 - (12) Tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not the same as addiction.
 - (13) The *[Legislature]* recognizes that some types of pain cannot be completely relieved.

(b) The [Legislature's] purpose in promulgating this Act is to further the important and compelling societal interests of:

- (1) Expanding the opportunities for medical students, residents, and other healthcare providers to gain experience in treating severe pain symptoms in suffering patients.
- (2) Ensuring the best possible medical care for all patients suffering from intractable and chronic pain.
- (3) Improving the quality of life for all chronic pain sufferers, especially those in the last stages of life, by ensuring that patients undergo a peaceful, natural, and, as much as possible, pain-free end-of-life experience.
- (4) Reducing patient requests for physician-assisted suicide by addressing issues that may lead to depression and despair which are the root causes and the most-cited motivations for physician-assisted suicide.
- (5) Broadening patient autonomy by presenting the greatest number of possible options for treatment through consultation with knowledgeable physicians.

Section 3. Definitions.

As used in this Act only:

(a) **“Addiction”** means a primary, chronic, neurobiological disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include the following: impaired control over drug use, craving, compulsive use, and continued use despite harm. Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and are not the same as addiction.

(b) **“Classroom instruction”** means education conducted with a licensed instructor present, either by lecture or discussion, as an integrated part of a healthcare provider school course curriculum.

(c) **“Clinical instruction”** means education conducted through interaction with patients suffering from severe chronic or acute pain in hospital-based sites, non-hospital-based ambulatory care settings, and palliative care sites and hospices and under the supervision of a licensed healthcare provider. This can include standardized patient experiences.

(d) **“Double effect”** is a doctrine justifying palliative sedation and requiring three standards for ethical medical treatment: (1) the treatment itself is not morally wrong; (2) the intended benefit to the patient is not achieved by the secondary and unintended effects of the treatment; and (3) proportionality exists between the intended effects and the unintended secondary effects.

(e) **“Healthcare provider”** includes the following professionals:

- (1) **“Nurses”** mean licensees of the [Insert name of the State Board of Nursing], including advanced practice nurses.
- (2) **“Pharmacists”** mean licensees of the [Insert the name of the State Board of Pharmacy].
- (3) **“Physicians”** mean licensees of the [Insert name of the state board(s) licensing medical doctors and doctors of osteopathy].
- (4) **“Physician’s assistants”** mean licensees or registrants of the [Insert the name of the state board regulating physician assistants].
- (5) **“Nurse-practitioners”** mean licensees of the [Insert name of State Board(s) licensing nurse-practitioners].

- (f) **“Intractable pain”** means a state of pain, even if temporary, in which reasonable efforts to remove or remedy the cause(s) of the pain have failed or have proven inadequate.
- (g) **“Opioid”** means a strong pain medication derived from opium or synthesized to behave like opium derivatives. Examples of opioids include but are not limited to: morphine, codeine, oxycodone, methadone, and fentanyl.
- (h) **“Pain”** is an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.
- (1) **“Acute pain”** is the normal, predicted physiological response to a noxious chemical, thermal, or mechanical stimulus and typically is associated with invasive procedures, trauma, and disease. It is generally time-limited.
 - (2) **“Chronic pain”** is a state in which pain persists beyond the usual course of an acute disease or healing of an injury, or that may or may not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over months or years.
- (i) **“Palliative care”** means:
- (1) The active, total care of a patient whose disease or medical condition is not responsive to curative treatment or whose prognosis is limited due to progressive, far-advanced disease; and
 - (2) The evaluation, diagnosis, treatment, and management of primary and secondary pain, whether acute, chronic, persistent, intractable, or associated with the end-of-life, the purpose of which is to diagnose and alleviate pain and other distressing signs and symptoms and to enhance the quality of life.
- (j) **“Palliative sedation”** means the administration of sedatives to a terminally ill, conscious patient whose pain cannot be otherwise relieved to alleviate suffering, but with the effect of inducing unconsciousness. The intent of administering the drug is to relieve pain, not to produce unconsciousness or accelerate death.
- (k) **“Physical dependence”** means a state of adaptation that is manifested by drug class-specific signs and symptoms that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist. Physical dependence by itself does not equate with addiction.
- (l) **“Tolerance”** means a physiologic state resulting from regular use of a drug in which an increased dosage is needed to produce a specific effect, or a reduced effect is observed with a constant dose over time. Tolerance may or may not be evident during opioid treatment and does not equate with addiction.

Section 4. Requirements for Healthcare Provider Education.

- (a) **Objectives.** The instruction required by this Act is designed to meet the following objectives:
- (1) That students will become more comfortable addressing the needs of patients experiencing chronic or severe pain.
 - (2) That students will be trained in the most current methods regarding the use of controlled substances, especially opioid analgesics.
 - (3) That students will realize the importance of developing a pain treatment plan for each patient in chronic or severe pain and learn methods and techniques necessary for developing such a plan.
 - (4) That students will learn objective methods for evaluating pain symptoms in patients.
 - (5) That students will understand the differences between addiction to opioid analgesics and tolerance and dependence on opioid analgesics.
 - (6) That students will understand the principle of double effect, especially with regard to palliative sedation.

- (7) That students will understand the extreme unlikelihood of opioid administration hastening death when properly monitored.
- (8) That students will understand relevant laws applicable to prescription of controlled substances.
- (9) That students will become aware of differences in diverse cultural approaches to pain management and end-of-life care and become comfortable working with patients who may express preferences different than those of the student's own intuitions.

(b) **Curriculum.** The curriculum in each school educating healthcare providers and receiving public funds shall include at least eight (8) hours of classroom instruction and at least four (4) hours of clinical instruction on pain management. The curriculum shall be designed to accomplish all objectives listed in Sections 4(a)(1) through 4(a)(9) of this Act. In developing a curriculum for pain management education, it is recommended that faculty educators are trained in or consult the *Education for Physicians on End-of-Life Care (EPEC) Curriculum* created by the Institute for Ethics at the American Medical Association.

(c) **Procedures for evaluating and monitoring pain.** Students shall be instructed in the following seven-step method for pain treatment:

- (1) **Evaluation of the patient.** A medical history and physical examination must be obtained, evaluated, and documented in the medical record. The medical record should document the nature and intensity of the pain, current and past treatments for pain, underlying and co-existing diseases or conditions, the effect of pain on physical and psychological function, and history of substance abuse. The medical record should also document the presence of one or more recognized medical indications for the use of a controlled substance.
- (2) **Treatment plan.** A written treatment plan should state objectives that will be used to determine treatment access, such as pain relief and improved physical and psychosocial function, and should indicate if any further diagnostic evaluations or other treatments are planned. After treatment begins, the physician should adjust drug therapy to the individual medical needs of each patient. Other treatment modalities or a rehabilitation program may be necessary, depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.
- (3) **Informed consent and agreement for treatment.** The physician should discuss the risks and benefits of the use of controlled substances with the patient, persons designated by the patient, or the patient's [surrogate, guardian, or other appropriate term] if the patient is without medical decision-making capacity. The patient should receive prescriptions from one physician and one pharmacy whenever possible. If the patient is at high risk for medication abuse or has a history of substance abuse, the physician should consider the use of a written agreement between physician and patient outlining patient responsibilities, including:
 - a. Urine/serum medication levels screening when requested;
 - b. Number and frequency of all prescription refills; and
 - c. Reasons for which drug therapy may be discontinued (e.g., violation of agreement).
- (4) **Periodic Review.** The physician should periodically review the course of pain treatment and any new information about the etiology of the pain or the patient's state of health. Continuation or modification of controlled substances for pain management therapy depends on the physician's evaluation of progress toward treatment objectives. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Objective evidence of improved or diminished function should be monitored and information from family members or other caregivers should be considered in determining the patient's response to treatment. If the patient's progress is

unsatisfactory, the physician should assess the appropriateness of the continued use of the current treatment plan and consider the use of other therapeutic modalities.

- (5) **Consultation.** The physician should be willing to refer the patient as needed for additional evaluation and treatment in order to achieve treatment objectives. Special attention should be given to those patients with pain who are at risk for medication misuse, abuse, or diversion. The management of pain in patients with a history of substance abuse or with a comorbid psychiatric disorder may require extra care, monitoring, documentation, and consultation with or referral to an expert in the management of such patients.
- (6) **Medical records.** The physician should keep accurate medical records including:
- The medical history and physical examination;
 - Diagnosis, therapeutic, and laboratory results;
 - Evaluations and consultations;
 - Treatment objectives;
 - Discussion of risks and benefits;
 - Informed consent;
 - Treatments;
 - Medications (including date, type, dosage, and quantity prescribed);
 - Instructions and agreements; and
 - Periodic reviews.

Records should remain current and be maintained in an accessible manner and readily available for review.

- (7) **Compliance with controlled substance laws and regulations.** To prescribe, dispense, or administer controlled substances, the physician must be licensed in the State and comply with applicable federal and state regulations. Physicians are referred to the *Physician's Manual* of the U.S. Drug Enforcement Administration [and any relevant documents issued by the State Medical Board] for specific rules governing controlled substances as well as applicable State regulations.
- (d) **Hours Requirements.** The following requirements apply to the core curriculum of any healthcare provider education program and are in addition to any course content required in elective courses or courses required for discrete areas of medicine. A board issuing a license or certification to any healthcare provider under [Insert relevant reference(s) or citation(s)] shall require that each applicant for initial licensure complete at least:
- Eight (8) hours of classroom instruction; and
 - Four (4) hours of clinical instruction. The requirements of this subsection shall not apply to those seeking licensure from the [State Board of Pharmacy].
- (e) **Application.** The licensure requirements of this Act shall apply to any student beginning healthcare provider education anytime after [Insert date].

Section 5. Pain Management Regulations Encouraged.

The [Legislature] strongly encourages [Insert name of State Medical Licensing Board] to adopt pain management regulations based on the *Pain Management Model Policy of the Federation of State Medical Licensing Boards* and the provisions of this Act.

[**Drafter's Note:** *Include this Section when the State Medical Board has not already adopted pain management regulations or similar standards.*]

Section 6. Severability.

Any provision of this Act held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as to give it the maximum effect permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event such provision shall be deemed severable herefrom and shall not affect the remainder hereof or the application of such provision to other persons not similarly situated or to other, dissimilar circumstances.

Section 7. Right of Intervention.

The [Legislature], by joint resolution, may appoint one or more of its members, who sponsored or cosponsored this Act in his or her official capacity, to intervene as a matter of right in any case in which the constitutionality of this Act or any portion thereof is challenged.

Section 8. Effective Date.

This Act takes effect [Insert date].

Life-Sustaining Care Act

HOUSE/SENATE BILL NO. _____

By Representatives/Senators _____

Section 1. Title.

This Act may be known and cited as the “Life-Sustaining Care Act.”

Section 2. Legislative Findings and Purposes.

(a) The [Legislature] of the State of [Insert name of State] finds that:

- (1) Over the last few decades, services that were once considered basic “humane care” have been redefined as “medical treatment,” and may, therefore, be rejected by individuals in their advance planning documents or by their surrogates when they are incapacitated. For example, food and water supplied through a feeding tube has been redefined by some as “medical treatment,” with the term “artificial nutrition” coined to analogize the process to “medical treatment” rather than “humane care.”¹
- (2) In some circumstances, life-sustaining care may be withheld or withdrawn at the discretion of healthcare providers or healthcare institutions.
- (3) The American Medical Association (AMA), which defines “life-sustaining treatment” as including but not limited to “mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration”² has stated that “[e]ven if the patient is not terminally ill or permanently unconscious, it is not unethical to discontinue all means of life-sustaining medical treatment in accordance with a proper substituted judgment or best interests analysis.”³
- (4) “Futile care theory” is rapidly penetrating hospital care protocols. This theory provides that a healthcare provider or healthcare institution may unilaterally withhold medical treatment because a healthcare provider or healthcare institution believes that a patient’s quality of life is not worth continuing or it is simply not cost effective to do so, despite the wishes of the patient or patient’s family.
- (5) “Futile care theory” contradicts “choice” and “patient autonomy;” instead, it is akin to euthanasia in that it replaces the ethic that all humans are equal and worthy of protection with one where doctors decide which lives are worth saving and sustaining.
- (6) Patients or their [Insert appropriate term(s), e.g. “healthcare agent,” “surrogate,” or “proxy”] whose desire that life-sustaining care be continued or provided is refused by a healthcare provider or institution benefit from state laws requiring the provision of life-sustaining care pending transfer to a willing provider or institution.
- (7) The law in the State of [Insert name of State] does not explicitly require healthcare providers or healthcare institutions to provide or continue to provide life-sustaining care pending transfer to a willing provider or institution.

(b) Based on the findings in subsection (a), the purpose of this Act is to require healthcare providers or healthcare

¹ Wesley J. Smith, Forced Exit: The Slippery Slope From Assisted Suicide To Legalized Murder 51 (2003).

² American Medical Association, H-140.966 Decisions Near the End of Life (2010), available at <https://ssl3.ama-assn.org/apps/ecommm/PolicyFinderForm.pl?site=www.ama-assn.org&uri=%2fresources%2fdoc%2fPolicyFinder%2fpolicyfiles%2fhN%2fh-140.966.HTM> (last visited Aug. 14, 2014).

³ American Medical Association, E-2.20 Withholding or Withdrawing Life-Sustaining Medical Treatment (2010), available at <https://ssl3.ama-assn.org/apps/ecommm/PolicyFinderForm.pl?site=www.ama-assn.org&uri=%2fresources%2fdoc%2fPolicyFinder%2fpolicyfiles%2fhN%2fE-2.20.HTM> (last visited Aug. 14, 2014).

institutions that decline to honor a patient or patient's [*Insert appropriate term(s), e.g. "healthcare agent," "surrogate," or "proxy"*]'s request for the provision or continuation of life-sustaining care to provide continuing life-sustaining care to the patient until a transfer can be effected and to make reasonable efforts to assist in the transfer of the patient to a willing healthcare provider or healthcare institution.

Section 3. Definitions.

As used in this Act only:

- (a) **"Healthcare provider"** means any individual who may be asked to participate in any way in a healthcare service, including, but not limited to: a physician, physician assistant, nurse, nurse aide, medical assistant, hospital employee, clinic employee, nursing home employee, or any other person who furnishes or assists in the furnishing of healthcare services.
- (b) **"Healthcare institution"** means any public or private organization, corporation, partnership, sole proprietorship, association, agency, network, joint venture, or other entity that is involved in providing healthcare services, including but not limited to: hospitals, clinics, medical centers, ambulatory surgical centers, private physician's offices, nursing homes, or other institutions or locations wherein healthcare services are provided to any person.
- (c) **"Life-sustaining care"** means health care including, but not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and nutrition and hydration that, in reasonable medical judgment, has a significant possibility of sustaining the life of a patient.

Section 4. Duty to Provide Life-Sustaining Care.

- (a) If a patient, a patient's [*Insert appropriate term(s), e.g. "healthcare agent," "surrogate," or "proxy"*], or a patient's advance directive directs the provision or opposes the withdrawal of life-sustaining care that, in reasonable medical judgment, has a significant possibility of sustaining the life of a patient, a healthcare provider or healthcare institution shall ensure the provision [*or continuation*] of the directed life-sustaining care.
- (b) A healthcare provider or healthcare institution that is unwilling to provide directed life-sustaining care under paragraph (a) may transfer the patient to another healthcare provider or healthcare institution capable of and willing to provide the directed life-sustaining care, but the unwilling provider or institution shall ensure the provision of the directed life-sustaining care until the patient is transferred. Any transfer of a patient under this subsection must be done promptly upon agreement by the receiving provider or institution to admit the patient.

Section 5. Right of Intervention.

The [*Legislature*], by joint resolution, may appoint one or more of its members, who sponsored or cosponsored this Act in his or her official capacity, to intervene as a matter of right in any case in which the constitutionality of this Act or any portion thereof is challenged.

Section 6. Severability.

If any provision, word, phrase, or clause of this Act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect the provisions, words, phrases, clauses, or applications of this Act which can be given effect without the invalid provision, word, phrase, clause, or application and to this end, the provisions, words, phrases, and clauses of this Act are declared severable.

Section 7. Effective Date.

This Act takes effect on [*Insert date*].



FREEDOM OF CONSCIENCE

Healthcare Freedom of Conscience Act

HOUSE/SENATE BILL NO. _____

By Representatives/Senators _____

Section 1. Title.

This Act may be known and cited as the “Healthcare Freedom of Conscience Act.”¹

Section 2. Legislative Findings and Purposes.

- (a) The [Legislature] of the State of [Insert name of State] finds that:
- (1) It is the public policy of [Insert name of State] to respect and protect the fundamental right of conscience of all individuals who provide healthcare services.
 - (2) Without comprehensive protection, healthcare rights of conscience may be violated in various ways, such as harassment, demotion, salary reduction, transfer, termination, loss of staffing privileges, denial of aid or benefits, and refusal to license or refusal to certify.
- (b) Based on the findings in subsection (a), it is the purpose of this Act to:
- (1) Protect as a basic civil right the right of all healthcare providers, institutions, and payers to decline to counsel, advise, [pay for,] provide, perform, assist, or participate in providing or performing healthcare services that violate their consciences. Such healthcare services may include, but are not limited to, abortion, artificial birth control, artificial insemination, assisted reproduction, human embryonic stem-cell research, fetal experimentation, [human cloning, physician-assisted suicide, euthanasia]² and sterilization.
 - (2) Prohibit all forms of discrimination, disqualification, coercion, disability, or liability upon such healthcare providers, institutions, and payers that decline to perform or provide any healthcare service that violates their consciences.

Section 3. Definitions.

- (a) **“Healthcare service”** means any phase of patient medical care, treatment, or procedure, including, but not limited to, the following: patient referral; counseling; therapy; testing, diagnosis, or prognosis; research; instruction; prescribing, dispensing or administering any device, drug, or medication; surgery; or any other care or treatment rendered by healthcare providers or healthcare institutions.
- (b) **“Healthcare provider”** means any individual who may be asked to participate in any way in a healthcare service, including, but not limited to, the following: a physician; physician’s assistant; nurse; nurses’ aide; medical assistant; hospital employee; clinic employee; nursing home employee; pharmacist; pharmacy employee; researcher; medical or nursing school faculty, student, or employee; counselor; social worker; or any professional, paraprofessional, or any other person who furnishes or assists in the furnishing of healthcare services.
- (c) **“Healthcare institution”** means any public or private organization, corporation, partnership, sole proprietorship, association, agency, network, joint venture, or other entity that is involved in providing healthcare services, including, but not limited to: hospitals, clinics, medical centers, ambulatory surgical centers, private

¹ Provisions in this model legislation may implicate the Patient Protection and Affordable Care Act (the federal healthcare law enacted in 2010) including, specifically, the “HHS Mandate” which requires most insurance plans to cover certain life-ending drugs and devices. Please contact AUL for drafting assistance.

² Where these activities are currently illegal, states should still consider specifically including them in this list. In the event that these activities are later legalized, whether through a future legislature or by a court decision, it will be clear – and not open to subsequent interpretation – that the state’s conscience law already protect healthcare providers, institutions, and payers from participating in these activities.

physician's offices, pharmacies, nursing homes, university medical schools, nursing schools, medical training facilities, or other institutions or locations wherein healthcare services are provided to any person.

(d) **“Healthcare payer”** means any entity or employer that contracts for, pays for, or arranges for the payment of, in whole or in part, any healthcare service or product, including, but not limited to: health maintenance organizations, health plans, insurance companies, or management services organizations.

(e) **“Employer”** means any individual or entity that pays for or provides health benefits or health insurance coverage as a benefit to its employees, whether through a third-party, a health maintenance organization, a program of self-insurance, or some other means.

(f) **“Participate”** in a healthcare service means to counsel, advise, provide, perform, assist in, refer for, admit for purposes of providing, or participate in providing any healthcare service or any form of such service.

(g) **“Pay”** or **“payment”** means pay, contract for, or otherwise arrange for the payment of, in whole or in part.

(h) **“Conscience”** means the religious, moral, or ethical principles held by a healthcare provider, a healthcare institution, or a healthcare payer. For purposes of this Act, a healthcare institution or healthcare payer's conscience shall be determined by reference to its existing or proposed religious, moral, or ethical guidelines; mission statement; constitution; bylaws; articles of incorporation; regulations; or other relevant documents.

Section 4. Freedom of Conscience of Healthcare Providers.

(a) ***Freedom of Conscience.*** A healthcare provider has the right not to participate, and no healthcare provider shall be required to participate, in a healthcare service that violates his or her conscience.

(b) ***Immunity from Liability.*** No healthcare provider shall be civilly, criminally, or administratively liable for declining to participate in a healthcare service that violates his or her conscience.

(c) ***Discrimination.*** It shall be unlawful for any person, healthcare provider, healthcare institution, public or private institution, public official, or any board which certifies competency in medical specialties to discriminate against any healthcare provider in any manner based on his or her declining to participate in a healthcare service that violates his or her conscience. For purposes of this Act, discrimination includes, but is not limited to, the following: termination; transfer; refusal of staff privileges; refusal of board certification; adverse administrative action; demotion; loss of career specialty; reassignment to a different shift; reduction of wages or benefits; refusal to award any grant, contract, or other program; refusal to provide residency training opportunities; or any other penalty or disciplinary retaliatory action.

Section 5. Freedom of Conscience of Healthcare Institutions.

(a) ***Freedom of Conscience.*** A healthcare institution has the right not to participate, and no healthcare institution shall be required to participate, in a healthcare service that violates its conscience.

(b) ***Immunity from Liability.*** A healthcare institution that declines to provide or participate in a healthcare service that violates its conscience shall not be civilly, criminally, or administratively liable if the institution provides a consent form to be signed by a patient before admission to the institution stating that it reserves the right to decline to provide or participate in healthcare services that violate its conscience.

(c) ***Discrimination.*** It shall be unlawful for any person, public or private institution, or public official to discriminate against any healthcare institution or any person, association, corporation, or other entity attempting to establish a new healthcare institution or operating an existing healthcare institution, in any manner, including but not limited to the following: any denial, deprivation or disqualification with respect to licensure; any aid assistance, benefit, or privilege, including staff privileges; or any authorization, including authorization to create, expand, improve, acquire, or affiliate or merge with any healthcare institution because such healthcare institution or person,

association, or corporation planning, proposing, or operating a healthcare institution declines to participate in a healthcare service which violates the healthcare institution's conscience.

(d) **Denial of Aid or Benefit.** It shall be unlawful for any public official, agency, institution, or entity to deny any form of aid, assistance, grants, or benefits or in any other manner to coerce, disqualify, or discriminate against any person, association, corporation, or other entity attempting to establish a new healthcare institution or operating an existing healthcare institution because the existing or proposed healthcare institution declines to participate in a healthcare service which violates the healthcare institution's conscience.

Section 6. Freedom of Conscience of Healthcare Payers.

[**Drafter's Note:** *This provision specifically implicates the Patient Protection and Affordable Care Act, the federal healthcare law enacted in 2010. Please contact AUL for drafting assistance when seeking to protect any category of healthcare payer.*]

(a) **Freedom of Conscience.** A healthcare payer has the right to decline to pay, and no healthcare payer shall be required to pay for or arrange for the payment of any healthcare service or product that violates its conscience.

(b) **Immunity from Liability.** No healthcare payer and no person, association, corporation, or other entity that owns, operates, supervises, or manages a healthcare payer shall be civilly or criminally liable by reason of the healthcare payer's declining to pay for or arrange for the payment of any healthcare service that violates its conscience.

(c) **Discrimination.** It shall be unlawful for any person, public or private institution, or public official to discriminate against any healthcare payer or any person, association, corporation, or other entity attempting to establish a new healthcare payer or operating an existing healthcare payer, in any manner, including but not limited to the following: any denial, deprivation, or disqualification with respect to licensure, aid, assistance, benefit, privilege, or authorization including but not limited to any authorization to create, expand, improve, acquire, or affiliate or merge with any healthcare payer, because a healthcare payer or a person, association, corporation, or other entity planning, proposing, or operating a healthcare payer declines to pay for or arrange for the payment of any healthcare service that violates its conscience.

(d) **Denial of Aid or Benefits.** It shall be unlawful for any public official, agency, institution, or entity to deny any form of aid, assistance, grants, or benefits or in any other manner to coerce, disqualify, or discriminate against any healthcare payer or any person, association, corporation, or other entity attempting to establish a new healthcare payer or operating an existing healthcare payer because the existing or proposed healthcare payer declines to pay for or arrange for the payment of any healthcare service that violates its conscience.

Section 7. Civil Remedies.

(a) **Civil Action.** A civil action for damages or injunctive relief, or both, may be brought for the violation of any provision of this Act. It shall not be a defense to any claim arising out of the violation of this Act that such violation was necessary to prevent additional burden or expense on any other healthcare provider, healthcare institution, individual, or patient.

(b) **Damage Remedies.** Any individual, association, corporation, entity, or healthcare institution injured by any public or private individual, association, agency, entity, or corporation by reason of any conduct prohibited by this Act may commence a civil action. Upon finding a violation of this Act, the aggrieved party shall be entitled to recover threefold the actual damages including pain and suffering sustained by such individual, association, corporation, entity, or healthcare institution, the costs of the action, and reasonable attorney's fees; but in no case shall recovery be less than \$5,000 for each violation, in addition to costs of the action and reasonable attorney's fees. These damage remedies shall be cumulative and not exclusive of other remedies afforded under any other state or federal law.

(c) ***Injunctive Remedies.*** The court in such civil action may award injunctive relief including, but not limited to, ordering reinstatement of a healthcare provider to his or her prior job position.

Section 8. Severability.

Any provision of this Act held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as to give it the maximum effect permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event such provision shall be deemed severable herefrom and shall not affect the remainder hereof or the application of such provision to other persons not similarly situated or to other, dissimilar circumstances.

Section 9. Effective Date.

This Act takes effect on *[Insert date]*.

Pharmacist Freedom of Conscience Act

HOUSE/SENATE BILL NO. _____

By Representatives/Senators _____

Section 1. Title.

This Act may be known and cited as the “Pharmacist Freedom of Conscience Act.”¹

Section 2. Legislative Findings and Purposes.

- (a) The [Legislature] of the State of [Insert name of State] finds that:
- (1) It is the public policy of [Insert name of State] to respect and protect the fundamental rights of conscience of all individuals, organizations, and entities who prescribe, provide, administer, dispense, pay for, refer for, or participate or assist in providing or administering pharmaceuticals.
 - (2) Without comprehensive protection, the rights of conscience of pharmaceutical providers, institutions, and payers may be violated in various ways, such as hiring discrimination, harassment, demotion, salary reduction, transfer, termination, loss of staffing privileges, denial of aid or benefits, and refusal to license or refusal to certify.
- (b) Based on the findings in subsection (a), it is the purpose of this Act to:
- (1) Protect as a basic civil right the right of all pharmaceutical providers, institutions, and payers to decline to prescribe; provide; administer; dispense; [pay for;] counsel on behalf of the administration or provision of any pharmaceutical product, medication, drug, device, or service; refer for the administration or provision of any pharmaceutical product, medication, drug, device, or service; or participate or assist in providing or administering any pharmaceutical product, medication, drug, device, or service that violates their consciences. Such pharmaceuticals may include, but are not limited to, abortion-inducing drugs and medications used for artificial contraception, sterilization, artificial insemination, assisted reproduction, “aid in dying,” “mercy killing,” physician-assisted suicide, and euthanasia.
 - (2) Prohibit all forms of discrimination, disqualification, coercion, disability, or liability upon such pharmaceutical providers, institutions, and payers that decline to provide pharmaceutical products, medications, drugs, devices, or services that violate their consciences.

Section 3. Definitions.

- (a) **“Pharmaceutical”** means any product, medication, drug, or device that must be prescribed by a physician or obtained at a pharmaceutical institution.
- (b) **“Pharmaceutical provider”** means any individual who may be asked to participate in any way in a pharmaceutical service, including, but not limited to, the following: a pharmacist, pharmacy owner, agent, employee, extern, technician, researcher, or any other person responsible to dispense or administer pharmaceuticals. *[This includes physicians, physician’s assistants, nurses, nurses’ aides, medical assistants, hospital employees, clinic employees, nursing home employees, counselors, social workers, medical and pharmacy school faculty or students, and professionals, paraprofessionals, or any other person who furnishes or assists in the dispensing or administering of pharmaceuticals.]*
- (c) **“Pharmaceutical service”** means any phase of patient pharmaceutical care or treatment including, but not limited to, the following: prescribing, providing, dispensing, or administering a pharmaceutical or patient referral,

¹ Provisions in this model legislation may implicate the *Patient Protection and Affordable Care Act* (the federal healthcare law enacted in 2010) including, specifically, the “HHS Mandate” which requires most insurance plans to cover certain life-ending drugs and devices. Please contact AUL for drafting assistance.

counseling, therapy, testing, or any other care or treatment rendered by pharmaceutical providers or pharmaceutical institutions related to prescribing, providing, administering, or dispensing of any product, medication, drug, or device.

(d) **“Pharmaceutical institution”** means any public or private organization, corporation, partnership, sole proprietorship, association, agency, network, joint venture, or other entity that is involved in providing pharmaceutical services, including but not limited to: pharmacies, hospitals, clinics, medical centers, ambulatory surgical centers, private physicians’ offices, nursing homes, university medical or pharmacy schools, nursing schools, medical or pharmaceutical training facilities, or other institutions or locations wherein pharmaceutical services are provided to any person.

(e) **“Pharmaceutical payer”** or **“prescription payer”** means any entity or employer that contracts for, pays for, or arranges for the payment of, in whole or in part, any pharmaceutical product, medication, drug, device, or service.

(f) **“Healthcare payer”** means any entity or employer that contracts for, pays for, or arranges for the payment of, in whole or in part, any healthcare service or product, including, but not limited to health maintenance organizations, health plans, insurance companies, or management services organizations.

(g) **“Employer”** means any individual or entity that pays for or provides pharmaceutical coverage as a benefit to its employees, whether through a third party, a health maintenance organization, a program of self-insurance, or some other means.

(h) **“Participate in pharmaceutical services”** means to prescribe, provide, dispense, administer, counsel on behalf of, refer for, or participate or assist in providing any pharmaceutical product, medication, drug, device, or service.

(i) **“Pay”** or **“payment”** means to pay, contract for, or otherwise arrange for the payment of in whole or in part.

(j) **“Conscience”** means the religious, moral, or ethical principles held by a pharmaceutical provider, a pharmaceutical institution, or a pharmaceutical payer. For purposes of this Act, a pharmaceutical institution or pharmaceutical payer’s conscience shall be determined by reference to its existing or proposed religious, moral, or ethical guidelines; mission statement; constitution; bylaws; articles of incorporation; regulations; or other relevant documents.

Section 4. Freedom of Conscience of Pharmaceutical Providers.

(a) ***Freedom of Conscience.*** A pharmaceutical provider has the right not to participate in, and no pharmaceutical provider shall be required to provide or refer for any pharmaceutical services including, but not limited to: prescribing, providing, administering, dispensing, paying for, counseling on behalf of the administration or provision of any pharmaceutical product, medication, drug, device, or service; referring for the administration or provision of any pharmaceutical product, medication, drug, device, or service; or participating or assisting in providing or administering any pharmaceutical product, medication, drug, device, or service that violate his or her conscience.

(b) ***Immunity from Liability.*** No pharmaceutical provider shall be civilly, criminally, or administratively liable for declining to participate in a pharmaceutical service including, but not limited to: prescribing, providing, administering, dispensing, paying for, counseling on behalf of the administration or provision of any pharmaceutical product, medication, drug, device, or service; referring for the administration or provision of any pharmaceutical product, medication, drug, device, or service; or participating or assisting in providing or administering any pharmaceutical product, medication, drug, device, or service that violates his or her conscience.

(c) ***Discrimination.*** It shall be unlawful for any person, pharmaceutical provider, pharmaceutical institution, public or private institution, public official, or any board which certifies competency in pharmacy to discriminate

against any pharmaceutical provider in any manner based on his or her declining to participate in a pharmaceutical service including, but not limited to: prescribing, providing, administering, dispensing, paying for, counseling on behalf of the administration or provision of any pharmaceutical product, medication, drug, device, or service; referring for the administration or provision of any pharmaceutical product, medication, drug, device, or service; or, participating or assisting in providing or administering any pharmaceutical product, medication, drug, device, or service that violates his or her conscience. For purpose of this Act, discrimination includes, but is not limited to the following: termination; transfer; refusal of staff privileges; refusal of board certification; adverse administrative action; demotion; loss of career specialty; reassignment to a different shift; discrimination in hiring; reduction of wages or benefits; refusal to award any grant, contract, or other program; refusal to provide training opportunities; or any other penalty, disciplinary, or retaliatory action.

Section 5. Freedom of Conscience of Pharmaceutical Institutions.

(a) ***Freedom of Conscience.*** A pharmaceutical institution has the right not to participate, and no pharmaceutical institution shall be required to participate, in any pharmaceutical service including but not limited to: prescribing; providing; administering; dispensing; paying for; counseling on behalf of the administration or provision of any pharmaceutical product, medication, drug, device, or service; referring for the administration or provision of any pharmaceutical product, medication, drug, device, or service; or participating or assisting in providing or administering any pharmaceutical product, medication, drug, device, or service that violates its conscience.

(b) ***Immunity from Liability.*** A pharmaceutical institution that declines to provide or participate in a pharmaceutical service that violates its conscience shall not be civilly, criminally, or administratively liable if the institution provides notification posted in a clearly visible location where pharmaceuticals are provided, dispensed, or administered.

(c) ***Discrimination.*** It shall be unlawful for any person, public or private entity or institution, or public official to discriminate against any pharmaceutical institution, any person, association, corporation, or other entity attempting to establish a new pharmaceutical institution, or any person, association, corporation, or other entity operating an existing pharmaceutical institution, in any manner, including, but not limited to the following: any denial, deprivation, or disqualification with respect to licensure; any aid, assistance, benefit, or privilege including staff privileges; or any authorization including authorization to create, expand, improve, acquire, affiliate, or merge with any pharmaceutical institution because such pharmaceutical institution, person, association, or corporation planning, proposing, or operating a pharmaceutical institution declines to participate in a pharmaceutical service which violates the pharmaceutical institution's conscience.

(d) ***Denial of Aid or Benefit.*** It shall be unlawful for any public official, agency, institution, or entity to deny any form of aid, assistance, grants, or benefits, or in any other manner to coerce, disqualify, or discriminate against any person, association, corporation, or other entity attempting to establish a new pharmaceutical institution or operating an existing pharmaceutical institution because the existing or proposed pharmaceutical institution declines to participate in a pharmaceutical service contrary to the pharmaceutical institution's conscience.

Section 6. Freedom of Conscience of Healthcare and Pharmaceutical Payers.

[**Drafter's Note:** *This provision specifically implicates the Patient Protection and Affordable Care Act, the federal healthcare law enacted in 2010. Please contact AUL for drafting assistance when seeking to protect any category of pharmaceutical payer.*]

(a) ***Freedom of Conscience.*** A healthcare, pharmaceutical, or prescription payer has the right to decline to pay, and no healthcare, pharmaceutical, or prescription payer shall be required to pay for or arrange for the payment of any pharmaceutical product or service that violates its conscience.

(b) ***Immunity from Liability.*** No healthcare, pharmaceutical, or prescription payer and no person, association,

corporation, or other entity that owns, operates, supervises, or manages a healthcare, pharmaceutical, or prescription payer shall be civilly or criminally liable by reason of the healthcare, pharmaceutical, or prescription payer's declining to pay for or arrange for the payment of any pharmaceutical product or service that violates its conscience.

(c) **Discrimination.** It shall be unlawful for any person, public or private institution, or public official to discriminate against any healthcare, pharmaceutical, or prescription payer or any person, association, corporation, or other entity (i) attempting to establish a new healthcare or pharmaceutical payment plan, or (ii) operating an existing healthcare or pharmaceutical payment plan, in any manner, including, but not limited to the following: any denial, deprivation, or disqualification with respect to licensure; aid; assistance; benefit; privilege; or authorization including, but not limited to any authorization to create, expand, improve, acquire, affiliate, or merge with any healthcare, pharmaceutical, or prescription payment plan because a healthcare, pharmaceutical, or prescription payer or a person, association, corporation, or other entity planning, proposing, or operating a healthcare, pharmaceutical, or prescription payment plan declines to pay for or arrange for the payment of any pharmaceutical product or service that violates its conscience.

(d) **Denial of Aid or Benefits.** It shall be unlawful for any public official, agency, institution, or entity to deny any form of aid, assistance, grants, or benefits or in any other manner seek to coerce, disqualify, or discriminate against any healthcare, pharmaceutical, or prescription payer or any person, association, corporation, or other entity attempting to establish a new healthcare, pharmaceutical, or prescription payment plan or operating an existing healthcare, pharmaceutical, or prescription payment plan because the existing or proposed healthcare, pharmaceutical, or prescription payment plan declines to pay for or arrange for the payment of any pharmaceutical product or service that violates its conscience.

Section 7. Civil Remedies.

(a) **Civil Action.** A civil action for damages or injunctive relief, or both, may be brought for the violation of any provision of this Act. It shall not be a defense to any claim arising out of the violation of this Act that such violation was necessary to prevent additional burden or expense on any other pharmaceutical provider, pharmaceutical institution, pharmaceutical payer, individual, or patient.

(b) **Damage Remedies.** Any individual, association, corporation, entity, pharmaceutical institution, or pharmaceutical payer injured by any public or private individual, association, agency, entity, or corporation by reason of any conduct prohibited by this Act may commence a civil action. Upon a finding of a violation of this Act, the aggrieved party shall be entitled to recover threefold the actual damages, including pain and suffering, sustained by such individual, association, corporation, entity, pharmaceutical institution, or pharmaceutical payer, the costs of the action, and reasonable attorney's fees; but in no case shall recovery be less than \$5,000 for each violation in addition to costs of the action and reasonable attorney's fees. These damage remedies shall be cumulative and not exclusive of other remedies afforded under any other state or federal law.

(c) **Injunctive Remedies.** The court in such civil action may award injunctive relief, including, but not limited to ordering reinstatement of a pharmaceutical provider to his or her prior job position.

Section 8. Severability.

Any provision of this Act held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as to give it the maximum effect permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event such provision shall be deemed severable herefrom and shall not affect the remainder hereof or the application of such provision to other persons not similarly situated or to other, dissimilar circumstances.

Section 9. Effective Date.

This Act takes effect on [Insert date].

Ensuring Compliance With Healthcare Freedom of Conscience Act

HOUSE/SENATE BILL NO. _____

By Representatives/Senators _____

Section 1. Title.

This Act may be known and cited as the “Ensuring Compliance with Healthcare Freedom of Conscience Act.”

Section 2. Legislative Findings and Purposes.

- (a) The [Legislature] of the State of [Insert name of State] finds that:
- (1) It is the public policy of [Insert name of State] to respect and to protect the fundamental right of conscience of all individuals who provide healthcare services.
 - (2) Without comprehensive protection, healthcare rights of conscience may be violated in various ways including harassment, demotion, salary reduction, transfer, termination, loss of staffing privileges, denial of aid or benefits, refusal to license, or refusal to certify.
- (b) Based on the findings in subsection (a), it is the purpose of this Act to:
- (1) Ensure compliance with the protection of the basic civil right of all healthcare providers to decline to counsel, advise, pay for, provide, perform, assist, or participate in providing or performing healthcare services that violate their consciences, as protected by state and federal laws. *[Such healthcare services may include, but are not limited to, abortion, artificial birth control, artificial insemination, assisted reproduction, human cloning, euthanasia, human embryonic stem-cell research, fetal experimentation, physician-assisted suicide, and sterilization.]*
 - (2) Ensure that state and federal funds are not used to promote discrimination and are not dispersed to institutions that, contrary to state and federal law, discriminate, disqualify, coerce, disable, or make liable healthcare providers that decline to perform *[any healthcare service]* that violates their consciences.

Section 3. Definitions.

For the purposes of this Act only:

- (a) **“Conscience”** means the religious, moral, or ethical principles held by a healthcare provider.
- (b) **“Department”** means the [Insert name of State] Department of [Insert name of appropriate state department or agency responsible for state healthcare contracts].
- (c) **“Healthcare service”** means any phase of patient medical care, treatment, or procedure including, but not limited to: patient referral; counseling; therapy; testing, diagnosis, or prognosis; research; instruction; prescribing, dispensing, or administering any device, drug, medication, surgery, or any other care or treatment rendered by healthcare providers or healthcare institutions.
- (d) **“Healthcare provider”** means any individual who may be asked to participate in any way in a healthcare service, including, but not limited to: a physician, physician’s assistant, nurse, nurses’ aide, medical assistant, hospital employee, clinic employee, nursing home employee, pharmacist, pharmacy employee, researcher, medical or nursing school faculty, student, employee, counselor, social worker, or any professional, paraprofessional, or any other person who furnishes or assists in the furnishing of healthcare services.

(e) “**Healthcare institution**” means any public or private organization, corporation, partnership, sole proprietorship, association, agency, network, joint venture, or other entity that is involved in providing healthcare services, including but not limited to: hospitals, clinics, medical centers, ambulatory surgical centers, private physician’s offices, pharmacies, nursing homes, university medical schools and nursing schools, medical training facilities, or other institutions or locations wherein healthcare services are provided to any person.

Section 4. Certification of Compliance.

Every healthcare institution that contracts with or receives a grant from the Department to provide healthcare services in this State shall certify annually and in writing on forms provided by the Department that it has complied with the requirements of [*List all applicable federal and state laws, regulations, and/or administrative rules protecting healthcare conscience*]¹ and submit a copy of this written certification to the Department, along with a written description of the policies the institution has adopted to ensure that it complies with the federal and state laws, regulations, and administrative rules protecting healthcare providers’ exercise of their individual consciences. Certifications shall be made by an officer or other individual authorized to bind the healthcare institution.

Section 5. Notification of Certification Requirement.

The Department shall notify funding recipients of the certification requirement at the time of the award through the [*Request for Proposal, Request for Agreement, Provider Agreement, or other appropriate terms*] contract, guidance, or other public announcement of the availability of funding. Recipients shall not construe anything in this Section to mean that a healthcare institution is in any way exempt from providing the required certification in the event the Department should fail to provide notification.

Section 6. Monitoring Program.

(a) The Department shall establish and maintain a monitoring program designed to reduce the possibility of noncompliance with federal and state laws, regulations, and administrative rules protecting healthcare providers’ exercise of their individual consciences and to institute sanctions and other remedial measures where a violation of these federal and state laws, regulations, and administrative rules is substantiated.

(b) The monitoring program shall establish an education campaign which shall include, but not be limited to maintaining a website for healthcare institutions and healthcare providers, explaining federal and state laws, regulations, and administrative rules protecting healthcare conscience and the processes available for addressing a violation of these federal and state laws, regulation, and administrative rules.

(c) The monitoring program shall be designated to receive complaints of discrimination based on the federal and state laws, regulations, or administrative rules protecting healthcare conscience. The Department will coordinate the handling of any complaints according to [*Insert reference(s) to appropriate administrative or other procedures for the handling of complaints.*]

(d) The monitoring program shall be established no later than [six months] from the effective date of this legislation.

Section 7. Sanctions.

(a) If a healthcare institution is found not to be in compliance with any federal or state law, regulation, or administrative rule protecting healthcare providers’ exercise of their individual consciences, the Department [*or Secretary, Commissioner, or other appropriate term*] may cancel existing or approved contracts and/or grants for healthcare services with or withhold monies already allocated to or approved for the healthcare institution under the existing or approved contracts and/or grant(s) for healthcare services.

¹ AUL may be contacted for assistance in compiling a comprehensive list of federal and state conscience protections.

(b) The monies withheld from the healthcare institution under this Section may be withheld until the healthcare institution is found to be in compliance with all federal and state laws, regulations, and administrative rules protecting healthcare providers' exercise of their individual conscience and which are applicable to the healthcare institution.

Section 8. Procedure for Remedial Action.

(a) When a healthcare institution is found not to be in compliance with any federal or state law, regulation, or administrative rule protecting healthcare providers' exercise of their individual consciences, the Department [*or Secretary, Commissioner, or other appropriate term*] shall comply with the procedures detailed in this Section when cancelling an existing or approved contract or grant for healthcare services or when withholding any portion of the monies already allocated or approved under existing or approved contracts or grants.

(b) The Department [*or Secretary, Commissioner, or other appropriate term*] shall notify the healthcare institution in writing and by certified mail of the federal or state law, regulation, or administrative rule with which the healthcare institution has not demonstrated compliance.

(c) The Department [*or Secretary, Commissioner, or other appropriate term*] shall give the healthcare institution thirty (30) days to demonstrate to the Department [*or Secretary, Commissioner, or other appropriate term*] that the healthcare institution is in compliance with the federal or state law, regulation, or administrative rule cited in the written notice or to develop a corrective action plan to address the noncompliance. Upon request from the healthcare institution, the Department [*or Secretary, Commissioner, or other appropriate term*] shall provide technical assistance to the healthcare institution in developing a corrective action plan. The healthcare institution shall have thirty (30) days from the date the technical assistance is provided to complete and submit the corrective action plan to the Department [*or Secretary, Commissioner, or other appropriate term*] for approval.

(d) The Department [*or Secretary, Commissioner, or other appropriate term*] shall take no further action if the healthcare institution demonstrates compliance with the federal or state law, regulation, or administrative rule cited in the written notice.

(e) The Department [*or Secretary, Commissioner, or other appropriate term*] shall review and approve or disapprove the corrective action plan within thirty (30) days after the Department [*or Secretary, Commissioner, or other appropriate term*] receives the corrective action plan.

(f) If the Department [*or Secretary, Commissioner, or other appropriate term*] approves the corrective action plan submitted by the healthcare institution, the institution has ninety (90) days after the date of approval to implement the corrective action plan.

(g) If the healthcare institution fails to demonstrate compliance or fails to implement the corrective action plan as approved, the Department [*or Secretary, Commissioner, or other appropriate term*] may cancel existing or approved contracts and/or grants for healthcare services with or withhold monies already allocated to or approved for the healthcare institution under the existing or approved contracts and/or grant(s) for healthcare services.

Section 9. Civil Remedies.

A healthcare institution's certification of compliance shall not preclude any party that seeks to enforce its rights under any federal and state laws, regulations, and administrative rules protecting healthcare providers' exercise of their individual consciences from bringing a civil action for injunctive relief and/or damages against the entity that allegedly commits a violation of any federal or state law, regulation, or administrative rule protecting healthcare providers' exercise of their individual consciences.

Section 10. Severability.

Any provision of this Act held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as to give it the maximum effect permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event such provision shall be deemed severable herefrom and shall not affect the remainder hereof or the application of such provision to other persons not similarly situated or to other, dissimilar circumstances.

Section 11. Effective Date.

This Act takes effect on *[Insert date]*.

Joint Resolution Calling for Rescission of the Coercive HHS Mandate & Affirming Freedom of Conscience

HOUSE/SENATE BILL NO. _____

By Representatives/Senators _____

WHEREAS, contrary to the stated intent of the Affordable Care Act’s “preventive services” provision to prevent *diseases*, the United States Department of Health and Human Services (HHS) mandate includes drugs and devices with known life-ending mechanisms of action, including the abortion-inducing drug *ella*;

WHEREAS, mandated coverage for *ella* opens the door to off-label, intended-abortion usage of the drug being funded by all health insurance plans;

[WHEREAS, the established policy of [Insert name of State] provides [Insert appropriate description of and reference(s) to any state laws and/or policies against public funding for abortion and/or abortion-inducing drugs]];

WHEREAS, the Institute of Medicine (IOM), which advised HHS on what should be included in the preventive services mandate [or the HHS mandate], had an abortion-advocacy bias in its panel membership, as well as its invited presenters;

WHEREAS, several members of the IOM panel had direct ties to Planned Parenthood as well as other openly pro-abortion organizations. In addition, at the IOM’s first meeting, groups invited to speak on “women’s issues” included Planned Parenthood, the nation’s largest abortion provider, which as a distributor of “contraceptives” stands to gain tremendously if health insurance plans are required to cover contraceptives without co-pay. Notably, Planned Parenthood’s financial stake was never disclosed as a conflict of interest;

WHEREAS, dissenting from the IOM recommendation, committee member Dr. Anthony Lo Sasso specifically criticized the committee’s lack of transparency and creation of an advocacy-based recommendation, “The committee process for evaluation of the evidence lacked transparency and was largely subject to the preferences of the committee’s composition. Troublingly, the process tended to result in a mix of objective and subjective determinations filtered through a lens of advocacy;”

WHEREAS, the Founders of the United States believed protecting the freedom of conscience was of utmost importance. For example, Thomas Jefferson wrote, “No provision in our Constitution ought to be dearer to man than that which protects the rights of conscience against the enterprises of civil authority;”

WHEREAS, the Affordable Care Act states explicitly that “Nothing in this Act shall be construed to have any effect on Federal laws regarding – (i) conscience protection...;”

WHEREAS, in contrast to the principles of long-standing federal laws which recognize an individual’s right not to be coerced into participating in abortion, sterilization, and other services “contrary to his [or her] religious or moral convictions,” the HHS mandate leaves most Americans no option but to purchase and maintain insurance plans that cover the abortion-inducing drug *ella*, sterilization, and other “contraceptive” items, devices, and services to which he or she may have a sincerely held ethical, moral, or religious objection;

WHEREAS, the HHS mandate disrupts the conscience protections provided for in the laws of several states, supplanting the reasoned judgment of the states with an ideologically-driven, coercive measure;

[WHEREAS, the constitution of [Insert name of State] provides [Insert appropriate description of and reference(s) to

provisions protecting freedom of conscience, freedom of religion, or religious expression]];

[WHEREAS, the laws of [Insert name of State] provide [Insert appropriate description of and reference(s) to statute(s) and other law(s) protecting freedom of conscience, freedom of religion, or religious expression]]; and

[WHEREAS, the established policy of [Insert name of State] provides [Insert appropriate description of and reference(s) to any state policies protecting the freedom of conscience, freedom of religion, or religious expression]].

NOW, THEREFORE, BE IT RESOLVED BY THE LEGISLATURE OF THE STATE OF [INSERT NAME OF STATE]:

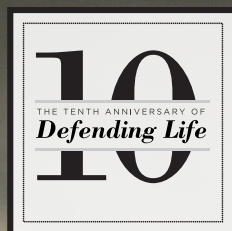
Section 1. That the [Legislature] calls on Congress to enact legislation ensuring that no provision of the Affordable Care Act may be used to mandate coverage for drugs, devices, procedures, or services with life-ending mechanisms of action.

Section 2. That the [Legislature] calls on the United States Department of Health and Human Services (HHS) to rescind its mandated coverage for “all FDA approved contraceptives and sterilization.”

Section 3. That the [Legislature] strongly supports the federal Health Care Conscience Rights Act *[and/or other similar and already introduced federal legislation protecting the freedom of conscience]* to ensure consistency with longstanding federal law and policy *[and the laws and policies of this State]* protecting the freedom of conscience.

Section 4. That the Secretary of State of [Insert name of State] transmit a copy of this resolution to the Governor; to the President of the United States; to the President of the Senate and the Speaker of the House of Representatives of the United States Congress; and to each individual member of [Insert name of State]’s Congressional delegation.

APPENDIX



EVALUATION CRITERIA

for State Rankings in *Defending Life* 2015

States receive credit for an enforceable law only, not for laws enacted but later enjoined by a court or otherwise deemed unenforceable. The 2015 state ranking reflects all legislative and litigation activity through August 15, 2014.

» WOMEN'S PROTECTION PROJECT

35 pt.

A. Five Month (20 Week) Abortion Limitation

7 pt.

1. Based, at least in part, on maternal health concerns 5 pt.
2. Based only on concerns for fetal pain 3 pt.
3. Penalties 2 pt.
 - a. Criminal penalties 1 pt.
 - b. Civil remedies/professional sanctions 1 pt.

B. Abortion Provider Requirements

8 pt.

1. Abortion facility regulations 5 pt.
 - a. Regulates facilities like ambulatory surgical centers/facilities 5 pt.
 - b. Regulates facilities performing first-trimester abortions 3 pt.
 - c. Regulates only facilities performing post-first trimester abortions 1 pt.
2. Requires abortion providers to maintain hospital admitting privileges or transfer agreement 3 pt.
 - a. Requires admitting privileges 3 pt.
 - b. Only requires transfer agreement 1 pt.

C. Laws Ensuring Fully Informed Consent

6 pt.

1. Basic informed consent requirements (e.g., mandatory counseling as to risks of procedure and gestational age of unborn child) 3 pt.
2. Reflection period (of any length) 1 pt.
3. Penalties 2 pt.

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| a. Criminal penalties | 1 pt. |
| b. Civil remedies/professional sanctions | 1 pt. |
| D. Regulation of Abortion-Inducing Drugs/Chemical Abortions | 5 pt. |
| 1. Law or regulation on abortion-inducing drugs | 3 pt. |
| a. Requires compliance with FDA-approved protocols and/or bans “telemed” abortions | 3 pt. |
| b. Imposes administrative requirements on provision of abortion-inducing drugs | 1 pt. |
| 2. Penalties | 2 pt. |
| a. Criminal penalties | 1 pt. |
| b. Civil remedies/professional sanctions | 1 pt. |
| E. Parental Involvement for Minors | 6 pt. |
| 1. Maintains enforceable parental involvement law | 3 pt. |
| a. Parental consent law | 3 pt. |
| b. Parental notice law | 2 pt. |
| 2. Any enhancements of parental involvement requirements | 1 pt. |
| 3. Penalties | 2 pt. |
| a. Criminal penalties | 1 pt. |
| b. Civil remedies/professional sanctions | 1 pt. |
| F. Child Protection Act | 3 pt. |
| 1. Abortion clinic personnel are mandatory reporters of abuse | 1 pt. |
| 2. Requirement to retain physical evidence from minor’s abortion | 1 pt. |
| 3. Penalizes efforts to circumvent parental involvement laws | 1 pt. |

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| » OTHER ABORTION-RELATED LAWS | 25 pt. |
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| A. State Funding Limitations | 8 pt. |
| 1. Public/taxpayer funding of abortion | 2 pt. |
| a. Consistent with federal Hyde Amendment | 2 pt. |
| b. In cases of rape, incest, fetal abnormalities, and/or threats to woman’s life or health | 1 pt. |
| c. Public funding in most cases (e.g., “medical necessity”) | -2 pt. |
| 2. Has defunded abortion providers (including Planned Parenthood) | 1 pt. |
| 3. Law opting out of federal abortion mandate (in healthcare law) | 1 pt. |

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| 4. Prohibition on use of state funds for abortion counseling and/or referrals | 1 pt. |
| 5. Prohibition on use of state facilities for abortions | 1 pt. |
| 6. Prohibition on abortion (insurance) coverage for state employees | 1 pt. |
| 7. Prohibition on private insurance coverage for abortion | 1 pt. |
| B. State Constitutional Right to Abortion or Freedom of Choice Act | 3 pt. |
| 1. Has no state FOCA and does not recognize state constitutional right to abortion | 3 pt. |
| 2. Has state FOCA and/or recognizes state constitutional right to abortion | -3 pt. |
| C. Abortion Bans/Limitations | 4 pt. |
| 1. Enforceable pre-Roe ban or a “delayed enforcement” ban | 1 pt. |
| 2. State ban on partial-birth abortion | 1 pt. |
| 3. Ban on post-viability abortions | 1 pt. |
| 4. Ban on sex-selective abortions and/or abortions for genetic abnormalities | 1 pt. |
| D. Enhanced Informed Consent Requirements | 4 pt. |
| 1. Ultrasound requirement | 2 pt. |
| 2. Counseling on fetal pain | 1 pt. |
| 3. Coercion prohibition/information requirement | 1 pt. |
| E. Other Abortion Provider Requirements | 4 pt. |
| 1. Physician-only law | 1 pt. |
| 2. Abortion reporting requirements | 3 pt. |
| a. General Reporting | 2 pt. |
| 1. Information on all abortions | 2 pt. |
| 2. Information on surgical abortions only | 1 pt. |
| b. Any required reporting on complications | 1 pt. |
| F. Support for Pregnancy Resource Centers (PRCs) | 2 pt. |
| 1. Provides direct funding to PRCs and/or offers “Choose Life” license plates (with proceeds going to PRCs) | 1 pt. |
| 2. Enacted pro-PRC resolution in 2014 | 1 pt. |
| 3. State legislature has enacted anti-PRC statute, regulation, or resolution | -2 pt. |

» **LEGAL RECOGNITION OF UNBORN AND NEWLY BORN**

10 pt.

A. Unborn Victims of Violence/Fetal Homicide

3 pt.

1. Recognizes unborn child at any stage of gestation as potential homicide victim 3 pt.
2. Recognizes unborn child later in gestation (but before viability) as potential homicide victim 2 pt.
3. Recognizes unborn child after viability as potential homicide victim 1 pt.

B. Protection for Unborn Children from Nonfatal Assaults

1 pt.

C. Prohibits Wrongful Life & Wrongful Birth Lawsuits

2 pt.

1. Wrongful life lawsuits 1 pt.
 - a. Prohibits or limits wrongful life lawsuits 1 pt.
 - b. Allows wrongful life lawsuits -1 pt.
2. Wrongful birth lawsuits 1 pt.
 - a. Prohibits or limits wrongful birth lawsuits 1 pt.
 - b. Allows wrongful birth lawsuits -1 pt.

D. Recognizes Wrongful Death (Civil) Action for Death of Unborn Child

2 pt.

1. Allows suits before viability 2 pt.
2. Allows suits only after viability 1 pt.

E. Born-Alive Infant Protection (BAIPA)

2 pt.

1. Provides protection at any stage of development 2 pt.
2. Provides protection after viability and/or only protects child from “deliberate acts” by physician 1 pt.

» **BIOETHICS**

10 pt.

A. Human Cloning

2 pt.

1. Bans all forms of human cloning 2 pt.
2. Affirmatively permits any type of human cloning -2 pt.

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| B. Stem Cell Research | 3 pt. |
| 1. Destructive embryo research (DER) | 2 pt. |
| a. Bans at least some forms/methods of DER | 2 pt. |
| b. Bans “fetal experimentation” only | 1 pt. |
| c. Expressly allows any form of DER | -2 pt. |
| 2. Encourages, promotes, or funds any ethical alternative to DER (e.g., adult stem cells, iPS, or cord blood) | 1 pt. |
| C. State Funding of Destructive Embryo Research and/or Cloning | 2 pt. |
| 1. Prohibits or restricts state funding of DER and/or cloning | 2 pt. |
| 2. Funds DER and/or cloning | -2 pt. |
| D. Assisted Reproductive Technologies & IVF | 3 pt. |
| 1. Limits number of embryos that may be implanted during each treatment cycle | 1 pt. |
| 2. Requires informed consent for IVF procedure and/or for storage/disposition of unused embryos | 1 pt. |
| 3. Imposes some regulation on human egg harvesting | 1 pt. |

» **END OF LIFE** **5 pt.**

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| Assisted Suicide | 5 pt. |
| 1. Statutory prohibition on assisted suicide | 5 pt. |
| 2. Common law prohibition of assisted suicide | 3 pt. |
| 3. Requires physicians to counsel patients on how to commit suicide and to provide prescriptions for patients who decide to commit suicide | -1 pt. |
| 4. No law prohibiting assisted suicide | -3 pt. |
| 5. Law or judicial decision permitting assisted suicide | -5 pt. |

» **HEALTHCARE FREEDOM OF CONSCIENCE** **15 pt.**

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| A. Protects Individual Healthcare Freedom of Conscience | 8 pt. |
| 1. Provides protection for healthcare providers for all procedures/services | 8 pt. |
| 2. Provides protection for healthcare providers for abortion and specified procedures (e.g., sterilization and contraception) | 5 pt. |

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| 3. Provides protection for healthcare providers for abortion only | 3 pt. |
| 4. Compels any healthcare provider (including pharmacists) to provide any procedure/service | -8 pt. |

B. Protects Institutional Healthcare Freedom of Conscience

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| 1. Provides protection for public, private, and religious healthcare institutions for all procedures/services | 7 pt. |
| 2. Provides protection for public, private, and religious institutions for abortion and other specified procedures/services (e.g., sterilization and contraception) | 7 pt. |
| 3. Provides protection for private and religious institutions for abortion and other specified procedures/services (e.g., sterilization and contraception) | 5 pt. |
| 4. Provides protection for public, private, and religious institutions for abortion only | 3 pt. |
| 5. Provides protection for private or religious institutions for abortion only | 2 pt. |
| 6. Compels any healthcare institution (including pharmacies) to provide any service in violation of its conscience | 1 pt. |
| | -7 pt. |

ABOUT AMERICANS UNITED FOR LIFE

Americans United for Life, is the legal architect of the pro-life movement. We are accumulating victories, building momentum, and advancing a culture of life in America. As the nation's premier pro-life legal team, we work through the law and legislative process to one end: achieving comprehensive legal protection for human life from conception to natural death. We hold the unique distinction of being the first national pro-life organization in America, incorporated in 1971, before the infamous *Roe v. Wade* decision.

AUL's legal team has been involved in every abortion-related case before the U.S. Supreme Court since *Roe v. Wade*, including AUL's successful defense of the Hyde Amendment before the high court. AUL's legal expertise and acumen set the bar in the pro-life community for the creation of effective and defensible pro-life laws. At the state, federal, and international levels, AUL works to advance life issues through the law and does so through measures that can withstand judicial obstacles and ultimately be enforced. AUL knows that reversing *Roe v. Wade* can be accomplished through deliberate, legal strategies that accumulate victories, build momentum, and restore a culture of life.

A Leader in the States

AUL's distinction extends beyond federal measures. AUL works at the state level to craft tailored strategies and legislative tools that will assist state and local officials as they defend and protect life. In all 50 states, AUL's team has worked with governors, legislators, and pro-life leaders to ensure that everyone is welcomed in life and protected in law. AUL's representatives in the states are on the frontlines of the policy debates, while AUL attorneys craft model legislation and legal analysis, as well as provide expert testimony on critical life issues being debated in the states.

An example of success: since 1985 AUL has spearheaded efforts both to educate about and to pass fetal homicide laws, protecting unborn victims of violence. As a result, 38 states – and counting – now have fetal homicide laws.

A Leader in Print

Comprehensive analysis and state-by-state insight are extraordinary resources that AUL makes available to pro-life leaders, attorneys, and officeholders nationwide. The source: *Defending Life*, an annual guide which details the life initiatives underway in all 50 states, analyzes important issues, provides model legislation, and compares the 50 states in the well-publicized "Life List," which ranks the states based their progress on the full spectrum of life issues.

Defending Life has been unparalleled in pointing the way to protecting women now, to limiting the abortion license created by the Supreme Court, and to preparing the ground to overturn *Roe*.

A Leader on Campus

AUL is taking its pro-life message to law schools through Advocates for Life, building networks of future lawyers and helping develop and train the next generation of pro-life leaders. To equip them, AUL experts created the “Constitutional Law and Abortion Primer” as a resource for students who are learning how to turn their pro-life convictions into pro-life legal expertise. Through Advocates for Life, law students contribute their enthusiasm and ideas to the work of AUL at the state and local levels.

A Leader Around the Nation

Lawyers for Life, the nationwide network of pro-life attorneys, is also building a presence in the legal community to enable pro-life lawyers to network, to learn from one another and to provide protections for all in every state.

A Leader Around the World

AUL is also defending life around the world. Though human rights belong to all human beings, anti-life forces seek to develop a body of international law that provides for a “right to abortion” that agenda-driven U.S. judges will, in turn, impose upon America. AUL, joining with pro-life lawyers around the world, fights this at the United Nations, in international courts, and in other countries. Our groundbreaking Latin American counterpart to *Defending Life*, *Defending the Human Right to Life in Latin America*, was published in Spanish and in English in 2011. An interactive web page with the latest updates and additional country reports was launched in 2014: www.defendiendovidas.org. AUL attorneys regularly consult with pro-life allies in other countries to assist them in passing pro-life laws.

A Leader Among Leaders

AUL’s expertise leads to many opportunities to make a case for life and the legal foundation that supports this gift we share. AUL experts speak and write for news outlets and at events nationwide. AUL’s name appears thousands of times each month in the media as the complicated legal issues surrounding life are debated. You can find AUL on television, in print, and on informative websites every day, from the *New York Times* to Fox News. AUL has been innovative in getting its message out through on-line events, innovative media strategies, and award-winning advertising.

An Award Winning Viewpoint

The national vantage point of AUL’s operation makes it uniquely qualified to recognize and honor pro-life leadership for accomplishments at state, federal, and international levels, often achieved in partnerships with AUL’s team. Among the leaders who have accepted AUL’s honors for their consistent and effective efforts to protect life are the legendary Rep. Henry Hyde, Rep. Chris Smith, Gov. Haley Barbour, and U.S. Speaker of the House John Boehner.

AUL’s work promotes a culture of life through the law. For assistance on legislation, questions about litigation, or to have AUL host a briefing for legislators and policy makers in your state, please contact:

AMERICANS UNITED FOR LIFE
655 15th Street NW, Suite 410 | Washington, DC 20005
(202) 289-1478 | Info@AUL.org | www.AUL.org

AUL'S PROVEN TRACK RECORD OF SUCCESS

With more than 40 years of pro-life legal leadership, AUL has a distinguished record of accomplishments. But a few key victories stand out as representative of AUL's unique contributions to pro-life success.

1. Winning the Hyde Amendment Case Before the U.S. Supreme Court.

In 1980, AUL won an historic victory for the Hyde Amendment in the celebrated U.S. Supreme Court case, *Harris v. McRae*. AUL's Victor Rosenblum argued the case before the Court, resulting in a life-affirming decision and ending a four-year court battle. This monumental court decision upheld federal and state prohibitions on public funding of abortion except in cases where the life of the mother is implicated.

2. Establishing Fetal Homicide Laws in 38 states.

A fetal homicide law recognizes an unborn child as a potential victim of criminal violence. AUL's legal experts laid the intellectual groundwork to implement these laws nationwide. At the time of the *Roe* decision in 1973, only three states enforced these protective laws. Today, 38 states have fetal homicide laws in place, and 29 of these states protect the child beginning at conception.

3. Defending Life, Reducing Abortions State by State.

According to scholar Dr. Michael J. New, AUL's crucial work in helping pass and enact parental involvement laws, informed consent laws, and limits on taxpayer funding of abortion has reduced abortions across the country by an estimated 25 percent since 1992 (when the Supreme Court's decision in *Planned Parenthood v. Casey* opened the door to more significant regulations of abortion). In 2006, AUL decided to make its legal knowledge accessible to pro-life legislators and activists across the country and published the first edition of *Defending Life*, which instantly became known as the "legal bible of the pro-life community."

4. A Leading Role in the Fight Against Assisted Suicide.

In 1980, AUL published an important book on "Death, Dying and Euthanasia" and has continued to be involved in every significant case, at the state and federal level, concerning assisted suicide, including the extensive role AUL played in *Baxter v. Montana* in 2009.

5. Successfully Protecting Life Overseas.

In 1979, AUL played a pivotal role in amending the Irish Constitution to protect life by precluding abortion. At a pro-life conference in Ireland, AUL was consulted about abortion and the role *Roe v. Wade* played in the U.S. AUL also engaged in an extensive educational and media campaign to educate the Irish people who eventually amended their constitution. As a result, Ireland remains one of the strongest pro-life nations in Europe and a target of the international pro-abortion Left. Its pro-life constitution was challenged before the European Court of Human Rights in a case in which AUL served as a consultant. The Court held that Ireland was required to amend its laws to provide for abortion when the mother threatened suicide (to conform its laws to a decision of the Irish Supreme Court that had so interpreted the constitution). Pro-abortion forces began an effort to pass such a law. AUL's Senior Vice President of Legal Affairs William Saunders consulted several times with Irish politicians opposed to such a law during their visits to the United States and worked with Irish pro-life groups and attorneys on the matter.

If you are interested in supporting AUL's life-saving work financially we will accept your donations by mail, on our website www.AUL.org, or over the telephone. For more information about making a donation, email Info@AUL.org.

[*DEFENDING LIFE* ONLINE]

AUL's annual publication, *Defending Life*, is the definitive legal guide to abortion, legal protection of the unborn child in contexts other than abortion, bioethics, healthcare freedom of conscience, and the end-of-life. Cutting through the murky cloud of media chatter and controversy, *Defending Life* provides comprehensive, timely, and thought-provoking information to anyone who wants to understand key pro-life issues—including the inherent risks to women's health from abortion – and utilize proven strategies to address them.

For information about obtaining copies of *Defending Life 2015* or for convenient online access, visit **www.AUL.org/defendinglife**

DEFENDING THE HUMAN RIGHT TO LIFE IN LATIN AMERICA

AUL collaborated with legal experts in Latin America to produce *Defending the Human Right to Life in Latin America*.

The book, written in Spanish and translated into English, reports on pro-life laws in seven countries and contains articles by leading jurists and legal scholars. It has been distributed to Latin American legislators, pro-life activists, and others interested in human rights and life issues. It demonstrates Latin America's unequivocal commitment to life and contains recommendations for legislators to respond to new anti-life challenges and to protect the first and most fundamental of all human rights: the right to life. For information about obtaining copies of *Defending the Human Right to Life in Latin America* or for convenient online access, visit **www.aul.org/contents-defending-the-human-right-to-life-in-latin-america**.

AUL, in collaboration with its Latin American allies, has also launched an interactive web page devoted solely to protecting the human right to life in Latin America. The page provides all the reports from the original print publication, as well as updates on recent developments, reports on additional countries, an analysis of the Inter-American legal system of human rights, endorsements of the project from Latin American leaders, Frequently Asked Questions, and an introductory video. To visit the interactive web page on the human right to life in Latin America, visit **www.defendiendovidas.org**.

AUL SPECIAL REPORT:

The Case For Investigating Planned Parenthood

Following years of AUL legal team research, including pouring over more than 20 years of Planned Parenthood records, law enforcement reports, and other materials, Americans United for Life released a groundbreaking analysis of the nation's largest abortion business. The report, "The Case for Investigating Planned Parenthood: AUL looks behind the closed doors of the nation's largest abortion provider," details evidence of systemic financial irregularities and other legal abuses within the abortion giant.

The weight of the evidence shows Planned Parenthood to be a scandal-ridden, heavily-subsidized, and abortion-centric organization despite its efforts to claim otherwise. The Report substantiated, synthesized, and gave clear direction for the growing case against Planned Parenthood.

Representative Chris Smith called AUL's special report a "blueprint of action" to investigate Planned Parenthood, which is heavily funded by the American taxpayer.

Following the release of AUL's report, the U.S. House of Representatives' Energy and Commerce Committee launched the first Congressional investigation of Planned Parenthood on September 15, 2011.

The Case for Investigating Planned Parenthood is available online at
www.AUL.org/aul-special-report-the-case-for-investigating-planned-parenthood

THE PLANNED PARENTHOOD EXHIBITS:

*The Continuing Case For Investigating
the Nation's Largest Abortion Provider*

In October 2012, AUL commemorated Planned Parenthood's 96th anniversary by launching a new project, "The Planned Parenthood Exhibits: The Continuing Case for Investigating the Nation's Largest Abortion Provider." AUL released new background papers delineating additional grounds for investigation including continued financial scandals, the often dangerous and substandard care that women receive from Planned Parenthood, tragic and preventable deaths at its clinics, consistent misuse of abortion-inducing drugs, and the improper use of "telemedicine" to increase the reach and profitability of its abortion business. These short background papers serve as "Exhibits" in the Continuing Case Against Planned Parenthood.

"The Planned Parenthood Exhibits" adds to the mounting and incontrovertible evidence that the track record of the nation's largest abortion provider demands a thorough investigation by both federal and state authorities and that Big Abortion does not deserve the nearly \$1.5 million it receives from American taxpayers each and every day.

"The Planned Parenthood Exhibits: The Continuing Case for Investigating the Nation's Largest Abortion Provider," are available on-line at www.aul.org/plannedparenthoodexhibits.

PLANNED PARENTHOOD'S MEGA-CENTERS:

*Convincing Proof of the Abortion Giant's
Increasingly Abortion-Centric Nature and Plans*

To be released in 2015, the third installment in Americans United for Life's ongoing work to expose the true nature and objectives of the nation's largest abortion provider will spotlight the increase in Planned Parenthood "mega-centers" and discuss what these centers mean for Planned Parenthood's indisputable status as America's largest abortion provider, as well as for the women targeted by the abortion chain and for American taxpayers who are forced to underwrite its increasingly abortion-centric agenda.

Over the last 10 years, while consolidating or closing many of its smaller facilities, Planned Parenthood has opened or announced that it is opening more than a dozen "mega-centers;" stand-alone clinics in larger urban centers that encompass more than 10,000 square-feet and, without exception, perform abortions including, at some facilities, very financially lucrative, late-term abortions.

The rise of Planned Parenthood's mega-centers coincides with tremendous growth in Planned Parenthood's abortion business and taxpayer funding, even while the organization's overall client base stagnates. Planned Parenthood's mega-center business model undermines Planned Parenthood's public assertions that, in order to ensure maternal health, women need expansive access to abortion in their own communities.

Notably, over the last decade, as Planned Parenthood announced, built, and opened its mega-centers, Planned Parenthood's share of the U.S. abortion market increased from 15 percent to over 30 percent. The increase in Planned Parenthood's abortion numbers runs sharply counter to the decades-long national decline in abortion.

[LAWYERS FOR LIFE]

Lawyers for Life is a national network of pro-life attorneys in affiliation with AUL.

AUL created Lawyers for Life to provide an opportunity for pro-life attorneys to come together, exchange insights and recommendations on pro-life legal issues, and collaborate to advance the pro-life cause.

Lawyers for Life is forming local chapters across the country. Chapters can be an effective way to build support for life-affirming legislation, pursue *pro bono* research and litigation opportunities, and encourage lawyers, whatever their areas of practice, to share their talents and expertise in support of the pro-life cause.

If you are interested in learning more or wish to join Lawyers for Life, please visit www.AUL.org/lawyers-for-life or email Lawyersforlife@AUL.org.



[ADVOCATES FOR LIFE]

Founded in 2009, Advocates for Life (AFL) is a national, non-partisan association of pro-life law students. AFL is dedicated to fostering a balanced and open discussion about fundamental right to life principles within the legal community. By building a culture of courage and support among pro-life law students and lawyers, Advocates for Life will turn the legal environment into one that values and upholds the dignity of human life.

Statement of Principles:

Advocates for Life is founded on the principles that all human beings have an unalienable right to life, existing from the moment of conception until natural death; that an essential end of government is the protection of human life; and that every law and policy decision must uphold, affirm, and safeguard this fundamental right. AFL opposes all unjust attacks on innocent human life, including abortion, euthanasia, and destructive embryo research.

Mission Statement:

Advocates for Life seeks to promote awareness of the above principles and to further their application through education, advocacy, and networking. AFL establishes and sustains pro-life groups at law schools, promotes networking and mentoring between pro-life law students and lawyers, helps enlist pro-life attorneys to speak at law schools, and organizes regular receptions and conferences. AFL is uniquely positioned to support pro-life law students in engaging a largely hostile legal environment within law schools. Through these pro-life groups on law school campuses, AFL is training America's future lawyers, legislators, and judges to shape laws and legal norms that protect life.

For more information about Advocates for Life, to find an Advocates chapter near you, or to start an Advocates for Life chapter at your law school, please visit AUL's website at

www.aul.org/initiative/advocates-for-life, or email us at Advocates@AUL.org.



[LAW STUDENT OPPORTUNITIES]

AUL Fellowship Program

Every summer, law students from across the country apply for a limited number of openings in the Americans United for Life Fellowship Program. Law students with an interest in pro-life law come to Washington D.C. for a summer internship that is unparalleled.

AUL accepts first and second-year students for up to eight weeks each summer at the AUL headquarters in Washington D.C. Mentored by an AUL attorney, each fellow is tasked with a special legal project. During their summer, they meet regularly with AUL staff in conjunction with their work.

Qualifications for becoming an AUL Fellow include a firm commitment to life issues and demonstrated excellence both inside and outside the classroom. Additionally, we look for individuals who stand out to the faculty of their school.

For more information, contact Americans United for Life at (202) 289-1478, by email at **Fellows@AUL.org**, or by visiting **www.AUL.org/about-aul/career-opportunities/#fellowship**.

AUL Externship Program

AUL accepts highly-qualified and motivated law students to serve as legal externs during the fall and spring academic semesters.

Externs work closely with AUL attorneys in researching, drafting, and editing scholarly articles. These articles are published in a variety of resources and venues, including AUL's *Defending Life*, law reviews, national magazines, and websites. Externs also provide legal research and drafting assistance for *amicus* briefs, model legislation, and public policy educational material on life issues including abortion, legal protection for the unborn in contexts other than abortion, bioethics, healthcare freedom of conscience, and the end of life.

Candidates are not required to be in the Washington D.C. area, but must be available by telephone and email. The externships are unpaid and may be undertaken for credit (as approved by the extern's law school) or to fulfill other graduation requirements.

Qualifications include excellent legal research and writing skills, demonstrated initiative and attention to detail, and an ability to work with minimal direct supervision.

For more information, contact Americans United for Life at (202) 289-1478, by email at **Resumes@AUL.org**, or by visiting **www.aul.org/about-aul/career-opportunities/#externship**.

PRESIDENT'S COUNCIL

A Chance to Advance the Pro-Life Mission

Since our founding in 1971, Americans United for Life has had the privilege of partnering with thousands of faithful advocates for life who have generously donated to advance our shared mission. We are deeply honored and grateful for this partnership, which continues to inspire us to excellent stewardship and productivity for the cause of life.

AUL's President's Council consists of financial supporters of \$1,000 and above per year who wish to have greater involvement in AUL's work to defend life by serving as honorary advisory members. This gives AUL an opportunity to benefit from the vision of supporters who represent the true passion and power of the pro-life movement.

The President's Council is designed to foster a personal dialogue with our supporters to learn about their hopes and goals for the life movement. In turn, members receive personal insight on life issues from AUL President and CEO, Dr. Charmaine Yoest, as well as some of the top pro-life legal and legislative leaders.

With your help, we can advance our shared mission of seeing all welcomed in life and protected in law.

President's Council Member Benefits

- **Regional Events:** Members have the opportunity to meet with Dr. Charmaine Yoest and other prominent leaders in the pro-life movement at AUL's exclusive regional events.
- **Insider's Briefings:** Members receive a personal phone call with Dr. Charmaine Yoest or other senior AUL staff members to discuss ongoing events within the life movement.
- **President's Report:** Members receive this special publication with in-depth, confidential reports on developments within the pro-life arena.
- **Exclusive Events in Washington, D.C.:** Members are invited to attend private events hosted by Dr. Charmaine Yoest and other pro-life leaders in Washington, D.C.

For more information, contact Americans United for Life at (202) 289-1478, by email at Info@AUL.org, or by visiting www.AUL.org.

PRAISE FOR *Defending Life* 2015

“Defending Life has played a key role in providing tools enabling states to enact constitutionally sound pro-life legislation to protect women and their unborn children and to motivate the states to do so through AUL’s state rankings in *Defending Life*’s “Life List.” I am proud that the State of Louisiana has ranked number one on the “Life List” for several years, and I hope our work inspires leaders in other states to follow suit.”

Bobby Jindal, Governor of Louisiana

“Americans United for Life has a long and successful history of fighting to protect our most vulnerable— the unborn. I share that passion for protecting life and have seen the benefits of AUL’s efforts both during my time as a Congressman and now as the Governor of the State of Indiana. I have long believed that a society will be judged by the way it treats its most vulnerable, and I am proud that Indiana is one of the top ten most pro-life states in the country. Congratulations on the 10th anniversary of *Defending Life*, and let it inspire us to renew our efforts to protect the sanctity of every human life.”

Michael R. Pence, Governor of Indiana

Defending Life 2015 is a nonpartisan guide to aid state legislators and policy makers in passing effective pro-life laws in their state. Covering abortion, bioethics, end of life, and protecting healthcare providers’ rights of conscience, this book provides all the tools necessary to pass laws which defend human life and withstand judicial scrutiny.

Defending Life is an annual publication of
AMERICANS UNITED FOR LIFE.



655 15TH STREET NW, SUITE 410
WASHINGTON, D.C. 20005

WWW.AUL.ORG