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Abortion: Judicial History and Legislative Response

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Summary

In 1973, the U.S. Supreme Court concluded in *Roe v. Wade* that the U.S. Constitution protects a woman's decision to terminate her pregnancy. In *Doe v. Bolton*, a companion decision, the Court found that a state may not unduly burden the exercise of that fundamental right with regulations that prohibit or substantially limit access to the means of effectuating the decision to have an abortion. Rather than settle the issue, the Court's rulings since *Roe* and *Doe* have continued to generate debate and have precipitated a variety of governmental actions at the national, state, and local levels designed either to nullify the rulings or limit their effect. These governmental regulations have, in turn, spawned further litigation in which resulting judicial refinements in the law have been no more successful in dampening the controversy.

In recent years, the rights enumerated in *Roe* have been redefined by decisions such as *Webster v. Reproductive Health Services*, which gave greater leeway to the states to restrict abortion, and *Rust v. Sullivan*, which narrowed the scope of permissible abortion-related activities that are linked to federal funding. The Court's decision in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, which established the "undue burden" standard for determining whether abortion restrictions are permissible, gave Congress additional impetus to move on statutory responses to the abortion issue, such as the Freedom of Choice Act.

Legislation to prohibit a specific abortion procedure, the so-called "partial-birth" abortion procedure, was passed in the 108th Congress. The Partial-Birth Abortion Ban Act appears to be one of the only examples of Congress restricting the performance of a medical procedure. Legislation that would prohibit the knowing transport of a minor across state lines for the purpose of obtaining an abortion has been introduced in numerous Congresses.

Since *Roe*, Congress has attached abortion funding restrictions to various appropriations measures. The greatest focus has arguably been on restricting Medicaid abortions under the annual appropriations for the Department of Health and Human Services. This restriction is commonly referred to as the "Hyde Amendment" because of its original sponsor. Similar restrictions affect the appropriations for other federal entities, including the Department of Justice, where federal funds may not be used to perform abortions in the federal prison system, except in cases of rape or if the life of the mother would be endangered. Hyde-type amendments also have an impact in the District of Columbia, where federal funds may not be used to perform abortions except in cases of rape, incest, or where the life of the mother would be endangered, and affect international organizations like the United Nations Population Fund, which receives funds through the annual Foreign Operations appropriations measure.

The debate over abortion continued in the context of health reform. The Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, includes provisions that address the coverage of abortion services by qualified health plans that are available through health benefit exchanges. The ACA's abortion provisions have been controversial, particularly with regard to the use of premium tax credits or cost-sharing subsidies to obtain health coverage that includes coverage for elective or nontherapeutic abortion services. Under the ACA, individuals who receive a premium tax credit or cost-sharing subsidy are permitted to select a qualified health plan that includes coverage for elective abortions, subject to funding segregation requirements that are imposed on both the plan issuer and the enrollees in such a plan.

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In 1973, the U.S. Supreme Court concluded in *Roe v. Wade*, 410 U.S. 113 (1973), that the U.S. Constitution protects a woman's decision to terminate her pregnancy. In *Doe v. Bolton*, 410 U.S. 179 (1973), a companion decision, the Court found that a state may not unduly burden the exercise of that fundamental right with regulations that prohibit or substantially limit access to the means of effectuating the decision to have an abortion. Rather than settle the issue, the Court's rulings since *Roe* and *Doe* have continued to generate debate and have precipitated a variety of governmental actions at the national, state, and local levels designed either to nullify the rulings or limit their effect. These governmental regulations have, in turn, spawned further litigation in which resulting judicial refinements in the law have been no more successful in dampening the controversy.

Although the primary focus of this report is legislative action with respect to abortion, discussion of the various legislative proposals necessarily involves an examination of the leading Supreme Court decisions concerning a woman's right to choose.[1]

Judicial History

Roe v. Wade and *Doe v. Bolton*

In 1973, the Supreme Court issued its landmark abortion rulings in *Roe v. Wade* and *Doe v. Bolton*. In those cases, the Court found that Texas and Georgia statutes regulating abortion interfered to an unconstitutional extent with a woman's right to decide whether to terminate her pregnancy. The Texas statute forbade all abortions not necessary "for the purpose of saving the life of the mother." The Georgia enactment permitted abortions when continued pregnancy seriously threatened the woman's life or health, when the fetus was very likely to have severe birth defects, or when the pregnancy resulted from rape. The Georgia statute required, however, that abortions be performed only at accredited hospitals and only after approval by a hospital committee and two consulting physicians.

The Court's decisions were delivered by Justice Blackmun for himself and six other Justices. Justices White and Rehnquist dissented. The Court ruled that states may not categorically proscribe abortions by making their performance a crime, and that states may not make abortions unnecessarily difficult to obtain by prescribing elaborate procedural guidelines. The constitutional basis for the decisions rested upon the conclusion that the Fourteenth Amendment right of personal privacy embraced a woman's decision whether to carry a pregnancy to term. With regard to the scope of that privacy right, the Court stated that it included "only personal rights that can be deemed 'fundamental' or 'implicit in the concept of ordered liberty'" and "bears some extension to activities related to marriage, procreation, contraception, family relationship, and child rearing and education." *Roe*, 410 U.S. at 152-53. Such a right, the Court concluded, "is broad enough to encompass a woman's decision whether or not to terminate her pregnancy." *Id*. at 153.

With respect to protection of the right against state interference, the Court held that since the right of personal privacy is a fundamental right, only a "compelling State interest" could justify its limitation by a state. Thus, while it recognized the legitimacy of the state interest in protecting maternal health and the preservation of the fetus's potential life (*id*. at 148-150), as well as the

[1] For a more detailed discussion of the relevant case law, see CRS Report 95-724, *Abortion Law Development: A Brief Overview*, by Jon O. Shimabukuro.

existence of a rational connection between these two interests and the state's anti-abortion law, the Court held these interests insufficient to justify an absolute ban on abortions.

Instead, the Court emphasized the durational nature of pregnancy and found the state's interests to be sufficiently compelling to permit curtailment or prohibition of abortion only during specified stages of pregnancy. The High Court concluded that until the end of the first trimester, an abortion is no more dangerous to maternal health than childbirth itself, and found that "[With] respect to the State's important and legitimate interest in the health of the mother, the 'compelling' point, in light of present medical knowledge, is at approximately the end of the first trimester." *Id*. at 163. Only after the first trimester does the state's interest in protecting maternal health provide a sufficient basis to justify state regulation of abortion, and then only to protect this interest. *Id*. at 163-64.

The "compelling" point with respect to the state's interest in the potential life of the fetus "is at viability." Following viability, the state's interest permits it to regulate and even proscribe an abortion except when necessary, in appropriate medical judgment, for the preservation of the life or health of the woman. *Id*. at 160. In summary, the Court's holding was grounded in this trimester framework analysis and the concept of fetal viability which was defined in postnatal terms. *Id*. at 164-65.

In *Doe v. Bolton*, 410 U.S. 179 (1973), the Court extended *Roe* by warning that just as states may not prevent abortion by making the performance a crime, states may not make abortions unreasonably difficult to obtain by prescribing elaborate procedural barriers. In *Doe*, the Court struck down state requirements that abortions be performed in licensed hospitals; that abortions be approved beforehand by a hospital committee; and that two physicians concur in the abortion decision. *Id*. at 196-99. The Court appeared to note, however, that this would not apply to a statute that protected the religious or moral beliefs of denominational hospitals and their employees. *Id*. at 197-98.

The Court in *Roe* also dealt with the question of whether a fetus is a person under the Fourteenth Amendment and other provisions of the Constitution. The Court indicated that the Constitution never specifically defines "person," but added that in nearly all the sections where the word "person" appears, "the use of the word is such that it has application only post-natally. None indicates, with any assurance, that it has any possible pre-natal application." 410 U.S. at 157. The Court emphasized that, given the fact that in the major part of the 19th century prevailing legal abortion practices were far freer than today, the Court was persuaded "that the word 'person', as used in the Fourteenth Amendment, does not include the unborn." *Id*. at 158.

The Court did not, however, resolve the question of when life actually begins. While noting the divergence of thinking on this issue, it instead articulated the legal concept of "viability," defined as the point at which the fetus is potentially able to live outside the womb, although the fetus may require artificial aid. *Id*. at 160. Many other questions were also not addressed in *Roe* and *Doe*, but instead led to a wealth of post-*Roe* litigation.

Supreme Court Decisions Subsequent to *Roe* and *Doe*

The post-*Roe* litigation included challenges to state restrictions requiring informed consent/waiting periods (*Planned Parenthood v. Danforth*, 428 U.S. 52 (1976), *City of Akron v. Akron Center for Reproductive Health, Inc*., 462 U.S. 416 (1983)); spousal/parental consent (*Planned Parenthood v. Danforth*, *supra*, *Bellotti v. Baird*, 443 U.S. 622 (1979), *City of Akron*, *supra*, *Planned Parenthood Association of Kansas City, Missouri Inc. v. Ashcroft*, 462 U.S. 476 (1983)); parental notice (*Bellotti v. Baird*, *supra*, *H. L. v. Matheson*, 450 U.S. 398 (1981), *Hartigan v. Zbaraz*, 484 U.S. 171 (1987), *Hodgson v. Minnesota*, 497 U.S. 417 (1990), *Ohio v.*

Akron Center for Reproductive Health, 497 U.S. 502 (1990)); reporting requirements (*Planned Parenthood v. Danforth*, *supra*, *Planned Parenthood of Kansas City, Missouri, Inc. v. Ashcroft*, *supra*); advertisement of abortion services (*Bigelow v. Virginia*, 421 U.S. 809 (1975)); abortions by nonphysicians (*Connecticut v. Menillo*, 423 U.S. 9 (1975)); locus of abortions (*City of Akron*, *supra*, Ashcroft, *supra*, *Simopoulos v. Virginia*, 462 U.S. 506 (1983)); viability, fetal testing, and disposal of fetal remains (*Planned Parenthood of Central Missouri v. Danforth*, *supra*, *Colautti v. Franklin*, 439 U.S. 379 (1979), *Ashcroft*, *supra*, *City of Akron*, *supra*); and "partial-birth" abortions (*Stenberg v. Carhart*, 530 U.S. 914 (2000)).

The Court in *Rust v. Sullivan*, 500 U.S. 173 (1991), upheld on both statutory and constitutional grounds the Department of Health and Human Services' Title X regulations restricting recipients of federal family planning funding from using federal funds to counsel women about the option of abortion. While *Rust* is probably better understood as a case involving First Amendment free speech rights rather than as a challenge to the constitutionally guaranteed substantive right to abortion, the Court, following its earlier public funding cases (*Maher v. Roe* and *Harris v. McRae*), did conclude that a woman's right to an abortion was not burdened by the Title X regulations. The Court reasoned that there was no constitutional violation because the government has no duty to subsidize an activity simply because it is constitutionally protected and because a woman is "in no worse position than if Congress had never enacted Title X."

In addition to *Rust*, the Court decided several other noteworthy cases involving abortion following *Roe*. *Webster v. Reproductive Health Services*, 492 U.S. 490 (1989), and *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992), illustrate a shift in direction by the Court from the type of constitutional analysis it articulated in *Roe*. These cases and other more recent cases, such as *Stenberg v. Carhart*, 530 U.S. 914 (2000), and *Ayotte v. Planned Parenthood of Northern New England*, 126 S.Ct. 961 (2006), have implications for future legislative action and how enactments will be judged by the courts in the years to come. *Webster*, *Casey*, and *Ayotte* are discussed in the subsequent sections of this report. A discussion of *Stenberg* is included in the "Partial-Birth Abortion" section of the report.

Webster

The Supreme Court upheld the constitutionality of the state of Missouri's abortion statute in *Webster v. Reproductive Health Services*, 492 U.S. 49 (1989). In this 5-4 decision, while the majority did not overrule *Roe*, it indicated that it was willing to apply a less stringent standard of review to state restrictions on abortion. *Webster* made it clear that state legislatures have considerable discretion to pass restrictive legislation in the future, with the likelihood that such laws would probably pass constitutional muster.

The main provisions in the 1986 Missouri law upheld by the Court included (1) barring public employees from performing or assisting in abortions not necessary to save the life of the mother; (2) barring the use of public buildings for performing abortions, despite the fact that there were no public monies involved (e.g., a building situated on public land); and (3) requiring physicians believing a woman desiring an abortion to be at least 20 weeks pregnant to perform tests to determine whether the fetus is viable. The *Webster* ruling was narrow in that it did not affect private doctors' offices or clinics, where most abortions are performed. Its significance derives more from the rationales articulated by the five Justices regarding how abortion restrictions would be reviewed in the future. However, because the Missouri law did not limit abortion prior to viability, the plurality did not believe it was necessary to consider overruling *Roe*. *Webster* set the stage for the Court's 1992 decision in *Casey*, where a real shift in direction was pronounced.

Casey

Both *Webster* and *Rust* energized legislative activity, the former at both the federal and state levels and the latter at the federal level. Some of the state legislative proposals that became law were challenged in the courts (e.g., Pennsylvania, Guam, Louisiana, and Utah). The Pennsylvania case, *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992), was decided by the Supreme Court on June 29, 1992. In a highly fractionated 5-4 decision, the Court reaffirmed the basic constitutional right to an abortion while simultaneously allowing some new restrictions. Justices O'Connor, Kennedy, and Souter wrote the plurality opinion, and they were joined in part by Justices Stevens and Blackmun. Chief Justice Rehnquist and Justices White, Scalia, and Thomas dissented. The Court refused to overrule *Roe*, and the plurality explained at length why it was important to follow precedent. At the same time, the plurality indicated that state laws which contained an outright ban on abortion would be unconstitutional. Nevertheless, the Court abandoned the trimester framework articulated in *Roe* and the strict scrutiny standard of judicial review of abortion restrictions. Instead, it adopted a new analysis, "undue burden." Courts will now need to ask the question whether a state abortion restriction has the effect of imposing an "undue burden" on a woman's right to obtain an abortion. "Undue burden" was defined as a "substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus." 505 U.S. at 877.

The Court applied this new analysis to the Pennsylvania statute and concluded that four of the provisions did not impose an undue burden on the right to abortion and were constitutional. The provisions that were upheld involved the 24-hour waiting period; informed consent; parental consent for minors' abortions with a judicial bypass; and reporting requirements. The spousal notification provision, which required a married woman to tell her husband if she intended to have an abortion, did not survive the "undue burden" test and was struck down as unconstitutional.

The Court's decision in *Casey* was significant because the new standard of review appeared to allow more state restrictions to pass constitutional muster. In addition, the *Casey* Court found that the state's interest in protecting the potentiality of human life extended throughout the course of the pregnancy. Thus, the state could regulate, even to the point of favoring childbirth over abortion, from the outset. Under *Roe*, which utilized the trimester framework, a woman's decision to terminate her pregnancy was reached in consultation with her doctor with virtually no state involvement during the first trimester of pregnancy.

Moreover, under *Roe*, abortion was a "fundamental right" that could not be restricted by the state except to serve a "compelling" state interest. *Roe*'s strict scrutiny form of review resulted in most state regulations being invalidated during the first two trimesters of pregnancy. The "undue burden" standard allowed greater regulation during that period. This is evident from the fact that the *Casey* Court overruled, in part, two of its earlier decisions which had followed *Roe*: *City of Akron v. Akron Center of Reproductive Health*, 462 U.S. 416 (1983), and *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747 (1986). In these cases, the Court, applying strict scrutiny, struck down 24-hour waiting periods and informed consent provisions; whereas in *Casey*, applying the undue burden standard, the Court upheld similar provisions.

Casey had its greatest immediate effect on women in the state of Pennsylvania; however, its reasoning prompted other states to pass similar restrictions that could withstand challenge under the "undue burden" standard.

Partial-Birth Abortion

On June 28, 2000, the Court decided *Stenberg v. Carhart*, 530 U.S. 914 (2000), its first substantive abortion case since *Casey*. In *Stenberg*, the Court determined that a Nebraska statute that prohibited the performance of so-called "partial-birth" abortions was unconstitutional because it failed to include an exception to protect the health of the mother and because the language defining the prohibited procedure was too vague.[2] In affirming the decision of the U.S. Court of Appeals for the Eighth Circuit, the Court agreed that the language of the Nebraska statute could be interpreted to prohibit not just the dilation and extraction (D&X) procedure that prolife advocates oppose, but the standard dilation and evacuation (D&E) procedure that is the most common abortion procedure during the second trimester of pregnancy. The Court believed that the statute was likely to prompt those who perform the D&E procedure to stop because of fear of prosecution and conviction. The result would be the imposition of an "undue burden" on a woman's ability to have an abortion.

After several attempts to pass federal legislation that would prohibit the performance of partial-birth abortions, Congress passed the Partial-Birth Abortion Ban Act of 2003 (P.L. 108-105) during the 108th Congress. The measure was signed by President George W. Bush on November 5, 2003. In general, the act prohibits physicians from performing a partial-birth abortion except when it is necessary to save the life of a mother 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. Physicians who violate the act are subject to a fine, imprisonment for not more than two years, or both.

Despite the Court's holding in *Stenberg* and past decisions that found that restrictions on abortion must allow for the performance of an abortion when it is necessary to protect the health of the mother, the Partial-Birth Abortion Ban Act of 2003 does not include such an exception. In his introductory statement for the act, Senator Rick Santorum discussed the measure's lack of a health exception.[3] He maintained that an exception is not necessary because of the risks associated with partial-birth abortions. Senator Santorum insisted that congressional hearings and expert testimony demonstrate "that a partial birth abortion is never necessary to preserve the health of the mother, poses significant health risks to the woman, and is outside the standard of medical care."[4]

Within two days of the act's signing, federal courts in Nebraska, California, and New York blocked its enforcement. On April 18, 2007, the Court upheld the Partial-Birth Abortion Ban Act of 2003, finding that, as a facial matter, it is not unconstitutionally vague and does not impose an undue burden on a woman's right to terminate her pregnancy.[5] In *Gonzales v. Carhart*, 550 U.S. 124 (2007), the Court distinguished the federal statute from the Nebraska law at issue in *Stenberg*. According to the Court, the federal statute is not unconstitutionally vague because it provides doctors with a reasonable opportunity to know what conduct is prohibited. *Id*. at 149. Unlike the Nebraska law, which prohibited the delivery of a "substantial portion" of the fetus, the federal statute includes "anatomical landmarks" that identify when an abortion procedure will be subject to the act's prohibitions. The Court noted: "[I]f an abortion procedure does not involve the delivery of a living fetus to one of these 'anatomical landmarks'—where, depending on the

[2] *See also* CRS Report RL30415, *Partial-Birth Abortion: Recent Developments in the Law*, by Jon O. Shimabukuro (available to congressional clients upon request).

[3] 149 *Cong. Rec.* S2523 (daily ed. February 14, 2003) (statement of Senator Santorum).

[4] *Id*.

[5] Unlike "as-applied" challenges, which consider the validity of a statute as applied to a particular plaintiff, facial challenges seek to invalidate a statute in all of its applications.

presentation, either the fetal head or the fetal trunk past the navel is outside the body of the mother—the prohibitions of the Act do not apply." *Id*. at 148.

The Court also maintained that the inclusion of a scienter or knowledge requirement in the federal statute alleviates any vagueness concerns. Because the act applies only when a doctor "deliberately and intentionally" delivers the fetus to an anatomical landmark, the Court concluded that a doctor performing the D&E procedure would not face criminal liability if a fetus is delivered beyond the prohibited points by mistake. *Id*. at 148. The Court observed: "The scienter requirements narrow the scope of the Act's prohibition and limit prosecutorial discretion." *Id*. at 150.

In reaching its conclusion that the Partial-Birth Abortion Ban Act of 2003 does not impose an undue burden on a woman's right to terminate her pregnancy, the Court considered whether the federal statute is overbroad, prohibiting both the D&X and D&E procedures. The Court also considered the statute's lack of a health exception.

Relying on the plain language of the act, the Court determined that the federal statute could not be interpreted to encompass the D&E procedure. The Court maintained that the D&E procedure involves the removal of the fetus in pieces. In contrast, the federal statute uses the phrase "delivers a living fetus." The Court stated: "D&E does not involve the delivery of a fetus because it requires the removal of fetal parts that are ripped from the fetus as they are pulled through the cervix." *Id*. at 152. The Court also identified the act's specific requirement of an "overt act" that kills the fetus as evidence of its inapplicability to the D&E procedure. The Court indicated: "This distinction matters because, unlike [D&X], standard D&E does not involve a delivery followed by a fatal act." *Id*. at 153. Because the act was found not to prohibit the D&E procedure, the Court concluded that it is not overbroad and does not impose an undue burden a woman's ability to terminate her pregnancy.

According to the Court, the absence of a health exception also did not result in an undue burden. Citing its decision in *Ayotte*, the Court noted that a health exception would be required if the act subjected women to significant health risks. *Id*. at 161. However, acknowledging medical disagreement about the act's requirements ever imposing significant health risks on women, the Court maintained that "the question becomes whether the Act can stand when this medical uncertainty persists." *Id*. at 163. Reviewing its past decisions, the Court indicated that it has given state and federal legislatures wide discretion to pass legislation in areas where there is medical and scientific uncertainty. *Id*. The Court concluded that this medical uncertainty provides a sufficient basis to conclude in a facial challenge of the statute that it does not impose an undue burden. *Id*. at 164.

Although the Court upheld the Partial-Birth Abortion Ban Act of 2003 without a health exception, it acknowledged that there may be "discrete and well-defined instances" where the prohibited procedure "must be used." *Id*. at 167. However, the Court indicated that exceptions to the act should be considered in as-applied challenges brought by individual plaintiffs: "In an as-applied challenge the nature of the medical risk can be better quantified and balanced than in a facial attack." *Id*.

Justice Ginsburg authored the dissent in *Gonzales*. She was joined by Justices Stevens, Souter, and Breyer. Describing the Court's decision as "alarming," Justice Ginsburg questioned upholding the federal statute when the relevant procedure has been found to be appropriate in certain cases. *Id*. at 170. Citing expert testimony that had been introduced, Justice Ginsburg maintained that the prohibited procedure has safety advantages for women with certain medical conditions, including bleeding disorders and heart disease. *Id*. at 177.

Justice Ginsburg also criticized the Court's decision to uphold the statute without a health exception. Justice Ginsburg declared: "Not only does it defy the Court's longstanding precedent affirming the necessity of a health exception, with no carve-out for circumstances of medical uncertainty ... it gives short shrift to the records before us, carefully canvassed by the District Courts." *Id*. at 179. Moreover, according to Justice Ginsburg, the refusal to invalidate the Partial-Birth Abortion Ban Act of 2003 on facial grounds was "perplexing" in light of the Court's decision in *Stenberg*. *Id*. at 187. Justice Ginsburg noted: "[I]n materially identical circumstances we held that a statute lacking a health exception was unconstitutional on its face." *Id*.

Finally, Justice Ginsburg contended that the Court's decision "cannot be understood as anything more than an effort to chip away at a right declared again and again by [the] Court—and with increasing comprehension of its centrality to women's lives." *Id*. at 191. Citing the language used by the Court, including the phrase "abortion doctor" to describe obstetrician-gynecologists and surgeons who perform abortions, Justice Ginsburg maintained that "[t]he Court's hostility to the right *Roe* and *Casey* secured is not concealed." *Id*. at 186. She argued that when a statute burdens constitutional rights and the measure is simply a vehicle for expressing hostility to those rights, the burden should be viewed as "undue." *Id*. at 191.

Ayotte

In *Ayotte v. Planned Parenthood of Northern New England*, 546 U.S. 320 (2006), the Court concluded that a wholesale invalidation of New Hampshire's Parental Notification Prior to Abortion Act was inappropriate. Finding that only a few applications of the act raised constitutional concerns, the Court remanded the case to the lower courts to render narrower declaratory and injunctive relief.

The New Hampshire law at issue in *Ayotte* prohibited physicians from performing an abortion on a pregnant minor or a woman for whom a guardian or conservator was appointed until 48 hours after written notice was delivered to at least one parent or guardian. The notification requirement could be waived under certain specified circumstances. For example, notification was not required if the attending abortion provider certified that an abortion was necessary to prevent the woman's death and there was insufficient time to provide the required notice.

Planned Parenthood of Northern New England and several other abortion providers challenged the New Hampshire statute on the grounds that it did not include an explicit waiver that would allow an abortion to be performed to protect the health of the woman. The U.S. Court of Appeals for the First Circuit invalidated the statute in its entirety on that basis. The First Circuit also maintained that the act's life exception was impermissibly vague and forced physicians to gamble with their patients' lives by preventing them from performing an abortion without notification until they were certain that death was imminent.

Declining to revisit its prior abortion decisions, the Court insisted that *Ayotte* presented a question of remedy. Maintaining that the act would be unconstitutional only in medical emergencies, the Court determined that a more narrow remedy, rather than the wholesale invalidation of the act, was appropriate: "Generally speaking, when confronting a constitutional flaw in a statute, we try to limit the solution to the problem. We prefer, for example, to enjoin only the unconstitutional applications of a statute while leaving other applications in force ... or to sever its problematic portions while leaving the remainder intact." *Id*. at 328-29.

The Court identified three interrelated principles that inform its approach to remedies. First, the Court tries not to nullify more of a legislature's work than is necessary because a ruling of unconstitutionality frustrates the intent of the elected representatives of the people.

Second, the Court restrains itself from rewriting a state law to conform to constitutional requirements, even as it attempts to salvage the law. The Court explained that its constitutional mandate and institutional competence are limited, noting that "making distinctions in a murky constitutional context" may involve a far more serious invasion of the legislative domain than the Court ought to take. *Id*. at 330.

Third, the touchstone for any decision about remedy is legislative intent; that is, a court cannot use its remedial powers to circumvent the intent of the legislature. The Court observed that "[a]fter finding an application or portion of a statute unconstitutional, we must next ask: Would the legislature have preferred what is left of its statute to no statute at all?" *Id*.

On remand, the lower courts were expected to determine the intent of the New Hampshire legislature when it enacted the parental notification statute. Although the state argued that the measure's severability clause illustrated the legislature's understanding that the act should continue in force even if certain provisions were invalidated, the respondents insisted that New Hampshire legislators actually preferred no statute rather than one that would be enjoined in the manner described by the Court. On February 1, 2007, a federal district court in New Hampshire entered a procedural order that stayed consideration of the case while a bill to repeal the Parental Notification Prior to Abortion Act was pending in the state legislature.[6] The act was subsequently repealed by the legislature, effective June 29, 2007.

Some criticized the Court's willingness to invalidate the New Hampshire statute only as it applied during medical emergencies. While it is not uncommon for federal courts to save a statute from invalidation by severing unconstitutional provisions, these courts have generally limited this practice to federal statutes. Critics maintained that the Court's opinion represented an impermissible expansion of federal judicial power over the states. They also argued that the opinion could encourage states to enact legislation with provisions that are possibly or clearly unconstitutional, knowing that a reviewing court will sever the impermissible provisions and allow the remaining statute to continue in force.

Hellerstedt

In *Whole Woman's Health v. Hellerstedt*, 136 S.Ct. 2292 (2016), the Court invalidated two Texas requirements that applied to abortion providers and physicians who perform abortions. Under a Texas law enacted in 2013, a physician who performs or induces an abortion was required to have admitting privileges at a hospital within 30 miles from the location where the abortion was performed or induced. In general, admitting privileges allow a physician to transfer a patient to a hospital if complications arise in the course of providing treatment. The Texas law also required an abortion facility to satisfy the same standards as an ambulatory surgical center (ASC). These standards address architectural and other structural matters, as well as operational concerns, such as staffing and medical records systems. Supporters of the Texas law maintained that the requirements would guarantee a higher level of care for women seeking abortions. Opponents, however, characterized the requirements as unnecessary and costly, and argued that they would make it more difficult for abortion facilities to operate.

In a 5-3 decision, the Court rejected the procedural and constitutional grounds that were articulated by the U.S. Court of Appeals for the Fifth Circuit (Fifth Circuit) to uphold the requirements. Writing for the majority in *Hellerstedt*, Justice Breyer concluded that *res judicata* did not bar facial challenges to either the admitting privileges requirement or the ASC requirement. *Id*. at 2309. In applying the undue burden standard, Justice Breyer maintained that

[6] *See* Planned Parenthood of Northern New England v. Ayotte, 571 F.Supp. 2d 265 (D. N.H. 2008).

courts should place considerable weight on the evidence and arguments presented in judicial proceedings when they consider the constitutionality of abortion regulations. *Id*. at 2310. Justice Breyer also noted that the undue burden standard requires courts to consider "the burdens a law imposes on abortion access together with the benefits those laws confer." *Id*. at 2309.

The *Hellerstedt* Court referred heavily to the evidence collected by the district court in its examination of the admitting privileges and ASC requirements. With regard to the admitting privileges requirement, the Court cited the low complication rates for first- and second-trimester abortions, and expert testimony that complications during the abortion procedure rarely require hospital admission. *Id*. at 2311. Based on this and similar evidence, the Court disputed the state's assertion that the purpose of the admitting privileges requirement was to ensure easy access to a hospital should complications arise. The Court emphasized that "there was no significant health-related problem that the new law helped to cure." *Id*. Citing other evidence concerning the closure of abortion facilities as a result of the admitting privileges requirement and the increased driving distances experienced by women of reproductive age because of the closures, the Court maintained, "[T]he record evidence indicates that the admitting-privileges requirement places a 'substantial obstacle in the path of a woman's choice.'" *Id*. at 2312 (quoting *Casey*, 505 U.S. at 877).

The Court again referred to the record evidence to conclude that the ASC requirement imposed an undue burden on the availability of abortion. Noting that the record supports the conclusion that the ASC requirement "does not benefit patients and is not necessary," the Court also cited the closure of facilities and the cost to comply with the requirement as evidence that the requirement poses a substantial obstacle for women seeking abortions. *Id*. at 2315. While Texas argued that the clinics remaining after implementation of the ASC requirement could expand to accommodate all of the women seeking an abortion, the Court indicated that "requiring seven or eight clinics to serve five times their usual number of patients does indeed represent an undue burden on abortion access." *Id*. at 2318.

The majority's focus on the record evidence, and a court's consideration of that evidence in balancing the burdens imposed by an abortion regulation against its benefits, is noteworthy for providing clarification of the undue burden standard. Although the *Casey* Court did examine the evidence collected by the district court with respect to Pennsylvania's spousal notification requirement, and was persuaded by it, the Fifth Circuit discounted similar evidence collected by the district court in its consideration of the two requirements.[7] In *Hellerstedt*, the Court maintained that the Fifth Circuit's approach did "not match the standard that this Court laid out in *Casey* ..." *Id*. at 2310.

Public Funding of Abortions

After the Supreme Court's decisions in *Roe* and *Doe*, some of the first federal legislative responses involved restrictions on the use of federal money to pay for abortions. In 1976, Representative Henry J. Hyde offered an amendment to the Departments of Labor and Health, Education, and Welfare, Appropriation Act, 1977, that restricted the use of appropriated funds to

[7] *See* Planned Parenthood of Greater Texas Surgical Health Services v. Abbott, 748 F.3d 583, 598 (2014) (stating that the district court's finding that "there will be abortion clinics that will close" was too vague); Whole Woman's Health v. Cole, 790 F.3d 563, 590 (5th Cir. 2015) (finding the district court's determination that the ASCs that perform abortions could not accommodate patients affected by the closure of non-ASC facilities was "unsupported by evidence" and "clearly erroneous").

pay for abortions provided through the Medicaid program.[8] Almost immediately, the so-called Hyde Amendment and similar restrictions were challenged in the courts. Two categories of public funding cases have been heard and decided by the Supreme Court: those involving (1) funding restrictions for nontherapeutic (elective) abortions; and (2) funding limitations for therapeutic (medically necessary) abortions.

The 1977 Trilogy—Restrictions on Public Funding of Nontherapeutic or Elective Abortions

The Supreme Court, in three related decisions, ruled that the states have neither a statutory nor a constitutional obligation to fund elective abortions or provide access to public facilities for such abortions (*Beal v. Doe*, 432 U.S. 438 (1977); *Maher v. Roe*, 432 U.S. 464 (1977); and *Poelker v. Doe*, 432 U.S. 519 (1977) (per curiam)).

In *Beal v. Doe*, the Court held that nothing in the language or legislative history of Title XIX of the Social Security Act (Medicaid) requires a participating state to fund every medical procedure falling within the delineated categories of medical care. The Court ruled that it was not inconsistent with the act's goals to refuse to fund unnecessary medical services. However, the Court did indicate that Title XIX left a state free to include coverage for nontherapeutic abortions should it choose to do so. Similarly, in *Maher v. Roe*, the Court held that the Equal Protection Clause does not require a state participating in the Medicaid program to pay expenses incident to nontherapeutic abortions simply because the state has made a policy choice to pay expenses incident to childbirth. More particularly, Connecticut's policy of favoring childbirth over abortion was held not to impinge upon the fundamental right of privacy recognized in *Roe*, which protects a woman from undue interference in her decision to terminate a pregnancy. Finally, in *Poelker v. Doe*, the Court upheld a municipal regulation that denied indigent pregnant women nontherapeutic abortions at public hospitals. It also held that staffing those hospitals with personnel opposed to the performance of abortions did not violate the Equal Protection Clause of the Constitution. *Poelker*, however, did not deal with the question of private hospitals and their authority to prohibit abortion services.

Public Funding of Therapeutic or Medically Necessary Abortions

The 1977 Supreme Court decisions left open the question of whether the Hyde Amendment and similar state laws could validly prohibit the governmental funding of therapeutic abortions. In *Harris v. McRae*, 448 U.S. 297 (1980), the Court ruled 5-4 that the Hyde Amendment's abortion funding restrictions were constitutional. The majority found that the Hyde Amendment violated neither the due process or equal protection guarantees of the Fifth Amendment nor the Establishment Clause of the First Amendment. The Court also upheld the right of a state participating in the Medicaid program to fund only those medically necessary abortions for which it received federal reimbursement. In companion cases raising similar issues, the Court held that an Illinois statutory funding restriction that was comparable to the Hyde Amendment also did not contravene the constitutional restrictions of the Equal Protection Clause of the Fourteenth Amendment (*Williams v. Zbaraz*; *Miller v. Zbaraz*; *U.S. v. Zbaraz*, 448 U.S. 358 (1980)). The Court's rulings in *McRae* and *Zbaraz* indicate that there is no statutory or constitutional obligation of the states or the federal government to fund medically necessary abortions.

[8] *See* P.L. 94-439, §209, 90 Stat. 1418, 1434 (1976) ("None of the funds contained in this Act shall be used to perform abortions except where the life of the mother would be endangered if the fetus were carried to term.").

Legislative History

Rather than settle the issue, the Court's decisions in *Roe* and *Doe* have prompted debate and a variety of governmental actions at the national, state, and local levels to limit their effect. Congress continues to be a forum for proposed legislation and constitutional amendments aimed at limiting or prohibiting the practice of abortion. This section examines the history of the federal legislative response to the abortion issue.

Prior to the Court's decision in *Roe*, relatively few bills involving abortion were introduced in either the House or the Senate. Since 1973, however, more than 1,000 separate legislative proposals have been introduced. The wide disparity in these statistics illustrates the impetus that the Court's 1973 decisions gave to congressional action. By far, most of these proposals have sought to restrict the availability of abortions. A few measures have been introduced to better secure the right to terminate a pregnancy. The Freedom of Choice Act (FOCA), for example, was introduced and debated in both the 102nd and 103rd Congresses, but was never enacted. FOCA attempts to codify *Roe* legislatively, and was reintroduced in the 110th Congress. The Freedom of Access to Clinic Entrances Act of 1994, P.L. 103-259 (18 U.S.C. 248), made it a federal crime to use force, or the threat of force, to intimidate abortion clinic workers or women seeking abortions.

Proponents of more restrictive abortion legislation have employed a variety of legislative initiatives to achieve this end, with varying degrees of success. Initially, legislators focused their efforts on the passage of a constitutional amendment which would overrule the Supreme Court's decision in *Roe*. This course, however, proved to be problematic.

Constitutional Amendments

Since 1973, a series of constitutional amendments have been introduced in each Congress in an attempt to overrule the Court's decision in *Roe*. To date, no constitutional amendment has been passed in either the House or the Senate. Indeed, for several years, proponents had difficulty getting the measures reported out of committee. Interest in the constitutional approach peaked in the 94th Congress, when nearly 80 amendments were introduced. By the 98th Congress, the number had significantly declined. It was during this time that the Senate brought to the floor the only constitutional amendment on abortion that has ever been debated and voted on in either house.

During the 98th Congress, S.J.Res. 3 was introduced. Subcommittee hearings were held, and the full Judiciary Committee voted (9-9) to send the amendment to the Senate floor without recommendation. As reported, S.J.Res. 3 included a subcommittee amendment eliminating the enforcement language and declared simply, "A right to abortion is not secured by this Constitution." By adopting this proposal, the subcommittee established its intent to remove federal institutions from the policymaking process with respect to abortion and reinstate state authorities as the ultimate decisionmakers.

S.J.Res. 3 was considered in the Senate on June 27 and 28, 1983. The amendment required a two-thirds vote to pass the Senate since super-majorities of both houses of Congress must approve a constitutional amendment before it can be submitted to the states. On June 28, 1983, S.J.Res. 3 was defeated (50-49), not having obtained the two-thirds vote necessary for a constitutional amendment.[9]

[9] For a review of the full debate on S.J.Res. 3, see 129 Cong. Rec. S9076 *et seq*. (daily ed. June 27, 1983); 129 Cong. Rec. S9265 *et seq*. (daily ed. June 28, 1983).

Statutory Provisions

Bills that Seek to Prohibit the Right to Abortion by Statute

As an alternative to a constitutional amendment to prohibit or limit the practice of abortion, opponents of abortion have introduced a variety of bills designed to accomplish the same objective without resorting to the complex process of amending the Constitution. Authority for such action is said to emanate from Section 5 of the Fourteenth Amendment, which empowers Congress to enforce the due process and equal protection guarantees of the amendment "by appropriate legislation." One such bill, S. 158, introduced during the 97th Congress, would have declared as a congressional finding of fact that human life begins at conception, and would, it was contended by its sponsors, allow states to enact laws protecting human life, including fetuses. Hearings on the bill were marked by controversy over the constitutionality of the declaration that human life begins at conception, which contradicted the Supreme Court's specific holding in *Roe*, and over the withdrawal of lower federal court jurisdiction over suits challenging state laws enacted pursuant to federal legislation. A modified version of S. 158 was approved in subcommittee, but that bill, S. 1741, had no further action in the 97th Congress.

Hyde-Type Amendments to Appropriations Measures

As an alternative to the unsuccessful attempts to prohibit abortion outright, opponents of abortion sought to ban the use of federal funds to pay for the performance of abortions. Because most federally funded abortions were reimbursed under Medicaid, they focused their efforts primarily on that program.

The Medicaid program was established in 1965 to fund medical care for indigent persons through a federal-state cost-sharing arrangement. Abortions were not initially covered under the program. During the Nixon Administration, the Department of Health, Education and Welfare decided to reimburse states for the funds used to provide abortions to poor women. This policy decision was influenced by the Supreme Court's decision in *Roe*, which, in addition to decriminalizing abortion, was seen as legitimizing the status of abortion as a medical procedure for the purposes of the Medicaid program.

Since *Roe*, Congress has attached abortion funding restrictions to numerous appropriations bills. Although the Foreign Assistance Act of 1973, P.L. 93-189, included the first of such restrictions, the greatest focus has arguably been on the Hyde Amendment, which generally restricts Medicaid abortions under the annual appropriations for the Department of Health and Human Services (HHS).

Since its initial introduction in 1976, the Hyde Amendment has sometimes been reworded to include exceptions for pregnancies that are the result of rape or incest, or abortions that are sought to prevent long-lasting physical health damage to the mother. Until the early 1990s, however, the language was generally identical to the original enactment, allowing only an exception to preserve the life of the mother. In 1993, during the first year of the Clinton Administration, coverage under the Hyde Amendment was expanded to again include cases of rape and incest. Efforts to restore the original language (providing only for the life of the woman exception) failed in the 104th Congress.

The Hyde Amendment process has not been limited to appropriations for HHS. Beginning with P.L. 95-457, the Department of Defense appropriations measures have contained Hyde-type abortion limitations. This recurring prohibition was eventually codified and made permanent by P.L. 98-525, the Department of Defense Authorization Act of 1984.

In 1983, the Hyde Amendment process was extended to the Department of the Treasury and Postal Service Appropriations Act, prohibiting the use of funds for the Federal Employees Health Benefits Program (FEHBP) to pay for abortions, except when the life of the woman was in danger. Prior to this restriction, federal government health insurance plans reportedly paid an estimated $9 million for both therapeutic and nontherapeutic abortions.

The restriction on FEHBP funds followed an administrative attempt by the Office of Personnel Management (OPM) to eliminate non-life-saving abortion coverage. OPM's actions were challenged by federal employee unions, and a federal district court later concluded that the agency acted outside the scope of its authority. In *American Federation of Government Employees v. AFL-CIO*, 525 F.Supp. 250 (1981), the court found that absent a specific congressional statutory directive, there was no basis for OPM's actions.

The restriction on FEHBP funds was removed briefly in 1993, before being reinstated by the 104th Congress. That Congress passed language prohibiting the use of FEHBP funds for abortions, except in cases where the life of the mother would be endangered or in cases of rape or incest.

Under Department of Justice appropriations, funding of abortions in prisons is prohibited, except where the life of the mother is endangered, or in cases of rape. First enacted as part of the FY1987 Continuing Resolution, P.L. 99-591, this provision has been reenacted as part of the annual spending bill in each subsequent fiscal year.

Finally, since 1979, restrictive abortion provisions have been included in appropriations measures for the District of Columbia (DC). The passage of P.L. 100-462, the FY1989 DC Appropriations Act, marked the first successful attempt to extend such restrictions to the use of DC funds, as well as federal funds. Under the so-called Dornan Amendment, DC was prohibited from using both appropriated funds and local funds to pay for abortions. In 2009, Congress lifted the restriction on the use of DC funds to pay for abortions. Under the Consolidated Appropriations Act, 2010 (P.L. 111-117), only federal funds were restricted. The Dornan Amendment has since been reimposed.

Other Legislation

In addition to the temporary funding limitations contained in appropriation bills, abortion restrictions of a more permanent nature have been enacted in a variety of contexts since 1970. For example, the Family Planning Services and Population Research Act of 1970, P.L. 91-572 (42 U.S.C. 300a-6), bars the use of funds for programs in which abortion is a method of family planning.

The Legal Services Corporation Act of 1974, P.L. 93-355 (42 U.S.C. 2996f(b)(8)), prohibits lawyers in federally funded legal aid programs from providing legal assistance for procuring nontherapeutic abortions and prohibits legal aid in proceedings to compel an individual or an institution to perform an abortion, assist in an abortion, or provide facilities for an abortion.

The Pregnancy Discrimination Act, P.L. 95-555 (42 U.S.C. 2000e(k)), provides that employers are not required to pay health insurance benefits for abortion except to save the life of the mother, but does not preclude employers from providing abortion benefits if they choose to do so.

The Civil Rights Restoration Act of 1988, P.L. 100-259 (20 U.S.C. 1688), states that nothing in the measure either prohibits or requires any person or entity from providing or paying for services related to abortion.

The Civil Rights Commission Amendments Act of 1994, P.L. 103-419 (42 U.S.C. 1975a(f)), prohibits the commission from studying or collecting information about U.S. laws and policies concerning abortion.

Health Reform

The Patient Protection and Affordable Care Act (ACA; P.L. 111-148) was enacted on March 23, 2010, to reduce the number of uninsured individuals and restructure the private health insurance market. The ACA includes provisions that address the coverage of abortion services by qualified health plans that are available through health benefit exchanges (exchanges). The ACA's abortion provisions have been controversial, particularly with regard to the use of premium tax credits or cost-sharing subsidies to obtain health coverage that includes coverage for elective or nontherapeutic abortion services.[10]

In addressing the coverage of abortion services by qualified health plans offered through an exchange, the ACA refers to the Hyde Amendment to distinguish between two types of abortions: abortions for which federal funds appropriated for HHS may be used, and abortions for which such funds may not be used (elective abortions). Under the ACA, individuals who receive a premium tax credit or cost-sharing subsidy are permitted to select a qualified health plan that includes coverage for elective abortions. However, to ensure that funds attributable to such a credit or subsidy are not used to pay for elective abortion services, the ACA prescribes payment and accounting requirements for plan issuers and enrollees.

Under the ACA, the issuer of a qualified health plan must determine whether to provide coverage for either elective abortions or abortions for which federal funds appropriated for HHS are permitted. It appears that a plan issuer could also decide not to cover either type of abortion. The ACA also permits a state to prohibit abortion coverage in exchange plans by enacting a law with such a prohibition.

The ACA indicates that an issuer of a qualified health plan that provides coverage for elective abortions cannot use any funds attributable to a premium tax credit or cost-sharing subsidy to pay for such services. The issuer of a qualified health plan that provides coverage for elective abortions is required to collect two separate payments from each enrollee in the plan: one payment that reflects an amount equal to the portion of the premium for coverage of health services other than elective abortions; and another payment that reflects an amount equal to the actuarial value of the coverage for elective abortions. The plan issuer is required to deposit the separate payments into separate allocation accounts that consist solely of each type of payment and that are used exclusively to pay for the specified services. State health insurance commissioners will ensure compliance with the segregation requirements in accordance with applicable provisions of generally accepted accounting requirements, Office of Management and Budget circulars on funds management, and Government Accountability Office guidance on accounting.

To determine the actuarial value of the coverage for elective abortions, the plan issuer will estimate the basic per enrollee, per month cost, determined on an average actuarial basis, for including such coverage. The estimate may take into account the impact on overall costs of including coverage for elective abortions, but cannot take into account any cost reduction estimated to result from such services, such as prenatal care, delivery, or postnatal care. The per

[10] For additional information on abortion and the Patient Protection and Affordable Care Act, see CRS Report R41013, *Abortion and the Patient Protection and Affordable Care Act*, by Jon O. Shimabukuro.

month cost will have to be estimated as if coverage were included for the entire population covered, but cannot be less than $1 per enrollee, per month.

Under the ACA, a qualified health plan that provides coverage for elective abortions is also required to provide notice of such coverage to enrollees as part of a summary of benefits and coverage explanation at the time of enrollment. The notice, any plan advertising used by the issuer, any information provided by the exchange, and any other information specified by the Secretary will provide information only with respect to the total amount of the combined payments for elective abortion services and other services covered by the plan.

The ACA also provides for conscience protection and the preservation of certain state and federal abortion-related laws. The ACA prohibits exchange plans from discriminating against any individual health care provider or health care facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortions. State laws concerning the prohibition or requirement of coverage or funding for abortions, and state laws involving abortion-related procedural requirements are not preempted. Federal conscience protection and abortion-related antidiscrimination laws, as well as Title VII of the Civil Rights Act of 1964, are also not affected.

Legislation in the 114th Congress

FY2016 Appropriations

On December 18, 2015, the President signed H.R. 2029, the Consolidated Appropriations Act, 2016 (P.L. 114-113). The measure provided FY2016 funds for foreign operations, the District of Columbia, HHS, and other federal agencies. Long-standing funding restrictions on abortion and abortion-related services, including restrictions on the use of federal and local DC funds to pay for abortions, were retained.

With regard to foreign operations, none of the appropriated funds could be made available to an organization or program that supported or participated in the management of a program of coercive abortion or involuntary sterilization. In addition, appropriated funds were not available for the performance of abortions as a method of family planning, or to motivate or coerce any person to practice abortions. Appropriated funds were also not available to lobby for or against abortion. To reduce reliance on abortion in developing nations, funds were available only for voluntary family planning projects that offered a broad range of family planning methods and services. Such voluntary family planning projects were required to meet specified requirements.

Contributions to the United Nations Population Fund (UNFPA) were conditioned on the entity not funding abortions. In addition, amounts appropriated to the UNFPA were required to be kept in an account that was separate from the UNFPA's other accounts. The UNFPA could not commingle funds provided under H.R. 2029 with the entity's other sums.

The omnibus measure prohibited the use of appropriated funds to pay for abortions or for any administrative expenses related to a health plan in the Federal Employees Health Benefits Program that provided benefits or coverage for abortions. This prohibition would not apply where the life of the mother would be endangered if the fetus were carried to term, or in the case of rape or incest. Funds provided to the Department of Justice could also not be used to pay for an abortion, except where the life of the mother would be endangered if the fetus were carried to term, or in the case of rape or incest.

Finally, funds appropriated for HHS, as well as funds derived from any trust fund that received appropriations, could not be used to pay for abortions except in cases of rape or incest, or where a

woman who suffered from a physical disorder, injury, or illness would have her life jeopardized if an abortion was not performed.

Additional Legislation

H.R. 3762, a reconciliation measure that would have eliminated the cost-sharing subsidy provided by the ACA, was passed by both the House and Senate before being vetoed by President Barack Obama on January 8, 2016. Introduced by Representative Tom Price on October 16, 2015, H.R. 3762 would have also restricted the availability of federal funds for certain nonprofit organizations that provide elective abortions.

Representative Christopher H. Smith introduced H.R. 7, the No Taxpayer Funding for Abortion and Abortion Insurance Full Disclosure Act of 2015, on January 21, 2015. H.R. 7 would have amended Title 1 of the U.S. Code to add new sections that would have permanently prohibited the use of federal funds for abortion. Unlike the Hyde Amendment and the other Hyde-type restrictions that have been included annually in various appropriations measures, the proposed sections would not have to be renewed each year. Moreover, these funding limitations would have applied to all federal funds and not just those specifically appropriated for HHS and other federal agencies.

H.R. 7 would have imposed additional restrictions on the availability of abortion. The measure would have amended the Internal Revenue Code to indicate that a health plan that includes coverage for elective abortions is not a "qualified health plan" for purposes of the availability of a premium tax credit. Under the ACA, recipients of a premium tax credit are permitted to select a qualified health plan that includes elective abortion coverage, so long as the plan enrollee and plan issuer comply with specified payment and accounting requirements.[11] Thus, if enacted, H.R. 7 would have likely affected a recipient's decision to select a health plan that covers elective abortions.

Finally, H.R. 7 would have made permanent the Dornan Amendment, which restricts the use of local DC funds to pay for abortions, and would have amended the ACA to require plans to disclose coverage of abortion services in marketing or advertising materials, comparison tools, and benefit summaries. H.R. 7 was passed by the House on January 22, 2015, by a vote of 242-179. The measure was not considered by the Senate.

Representative Trent Franks introduced H.R. 36, the Pain-Capable Unborn Child Protection Act, on January 6, 2015. H.R. 36 would have prohibited the performance or attempted performance of an abortion if the probable postfertilization age of the "unborn child" was 20 weeks or greater. The prohibition would not have applied to abortions that are necessary to save the life of a pregnant woman whose life was endangered by a physical disorder, physical illness, or physical injury. The bill's prohibition would also not apply when a pregnancy was the result of rape and certain specified conditions were satisfied. Individuals who violated H.R. 36 would have been subject to a fine under Title 18, U.S. Code, imprisonment for not more than five years, or both. H.R. 36 was passed by the House on May 13, 2015, by a vote of 242-184. The measure was not considered by the Senate.

On September 15, 2015, Representative Franks also introduced H.R. 3504, the Born-Alive Abortion Survivors Protection Act. The bill would have required care to be provided to a fetus "born alive" following an abortion or attempted abortion. Under the measure, any health care practitioner who was present at the time the fetus was "born alive" would have been required to

[11] For additional information on abortion and the Patient Protection and Affordable Care Act, see CRS Report R41013, *Abortion and the Patient Protection and Affordable Care Act*, by Jon O. Shimabukuro.

exercise the same degree of skill, care, and diligence necessary to preserve the life and health of the fetus as a "reasonably diligent and conscientious health care practitioner would render to any other child born alive at the same gestational age." A health care practitioner who failed to exercise the specified level of care would have been subject to a fine, imprisonment for not more than five years, or both. H.R. 3504 was passed by the House on September 18, 2015, by a vote of 248-177. The Born-Alive Abortion Survivors Protection Act was also passed by the House as an amendment to S. 1603 on September 18, 2015. The House-passed text of S. 1603 was identical to H.R. 3504. Neither H.R. 3504 nor S. 1603 was considered by the Senate.

H.R. 3134, the Defund Planned Parenthood Act of 2015, was passed by the House on September 18, 2015, by a vote of 241-187. Introduced by Representative Diane Black, H.R. 3134 would have restricted the availability of federal funds for Planned Parenthood Federation of America and any of its affiliates or clinics for one year, unless these entities certified that they would not perform abortions or provide any funds to another entity that performs abortions during that period. The restriction would not have applied to an abortion involving a pregnancy that was the result of an act of rape or incest, or if a woman's life would have been endangered if an abortion were not performed. H.R. 3134 was not considered by the Senate.

H.R. 3495, the Women's Public Health and Safety Act, was passed by the House on September 29, 2015, by a vote of 236-193. Introduced by Representative Sean P. Duffy, H.R. 3495 would have allowed a state to establish criteria for entities and individuals who perform abortions or participate in the performance of abortions for purposes of providing services in the Medicaid program. H.R. 3495 was not considered by the Senate.

On July 13, 2016, the House passed the Conscience Protection Act of 2016 as an amendment to S. 304, which originated in the Senate as the Motor Vehicle Safety Whistleblower Act. The new text, adopted by a vote of 245-182, would have established a private right of action for health care providers who suffer retaliation or discrimination for not performing or otherwise participating in an abortion. Under the measure, a prevailing plaintiff could receive all necessary equitable and legal relief, including compensatory damages, as well as reasonable attorneys' fees. S. 304, as amended by the House, was not considered by the Senate.

Legislation in the 115th Congress

FY2017 Appropriations

On May 5, 2017, President Donald J. Trump signed H.R. 244, the Consolidated Appropriations Act, 2017 (P.L. 115-31). The measure retains the same long-standing funding restrictions on abortion and abortion-related services that appear in the Consolidated Appropriations Act, 2016.

Additional Legislation

On January 13, 2017, Representative Christopher H. Smith reintroduced the No Taxpayer Funding for Abortion and Abortion Insurance Full Disclosure Act of 2017. The bill, again numbered H.R. 7, is identical to the measure that was passed in the 114th Congress. H.R. 7 was passed by the House on January 24, 2017, by a vote of 238-183.

Representative Diane Black introduced H.R. 1628, the American Health Care Act of 2017, on March 20, 2017. The reconciliation bill would make two notable changes related to the ACA. First, it would amend Section 36B(c)(3)(A) of the Internal Revenue Code to provide that a health plan that includes coverage for elective abortions would not be considered a "qualified health

plan." Because the tax credit provided under Section 36B is available only to enrollees in a qualified health plan, the change could affect an individual's choice of health coverage. Second, the bill would define the term "qualified health plan" to exclude any plan that includes coverage of elective abortions for purposes of Section 45R of the Internal Revenue Code, which provides a small employer health insurance credit based on employee enrollment in a qualified health plan. The bill would also restrict the availability of federal funds for certain nonprofit organizations that provide elective abortions.

H.R. 1628 was passed by the House on May 4, 2017, by a vote of 217-213. The Better Care Reconciliation Act, a Senate amendment in the nature of a substitute to H.R. 1628, included similar provisions with regard to abortion. The measure was rejected by the Senate in late July.

On January 3, 2017, Representative Trent Franks reintroduced the Pain-Capable Unborn Child Protection Act. The measure is once again numbered H.R. 36, and its provisions are identical to the version of the bill that was passed by the House during the 114th Congress. The current version of H.R. 36 was passed by the House on October 3, 2017, by a vote of 237-189. Many expect S. 2311, the Senate version of the Pain-Capable Unborn Child Protection Act, to be considered by the Senate in the near future. S. 2311 includes the same provisions that appear in H.R. 36.

Representative Marsha Blackburn reintroduced the Born-Alive Abortion Survivors Protection Act on December 21, 2017. The measure, numbered H.R. 4712 in the 115th Congress, includes the same provisions that appeared in the version passed by the House during the 114th Congress. H.R. 4712 was passed by the House on January 19, 2018, by a vote of 241-183.

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