The Status of Reproductive Rights in Wisconsin

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Executive Summary

This report focuses on the status of reproductive rights in Wisconsin and reviews several issues and topics of relevance to reproductive health in the state. This report is designed to closely examine the immediate reproductive health issues Wisconsin faces today and in the future.

First, the report reviews federal and Wisconsin state laws as they pertain to women’s access to reproductive services. This section examines several Supreme Court rulings and details changes to Wisconsin laws over several years. Next, an exploration of access to abortion in Wisconsin describes Wisconsin’s situation and compares this with states across the nation. A discussion of current research findings accompanies this issue.

Clinic violence is the next issue that will be discussed with an in-depth look at incidences of clinic violence in Wisconsin and the effects of this violence on the state. An examination of Wisconsin’s clinic protection laws follows this discussion. A discussion of contraceptive equity reveals Wisconsin’s current position and how the state measures up with neighboring states. A formal review of several statewide reports provides insight into the contraceptive equity debate. The next discussion topic, emergency contraception, details the current climate regarding EC and the implications associated with Wisconsin’s laws and attitude regarding EC.

A formal discussion of the Family Planning Waiver follows. The Family Planning Waiver section examines the political history and issues the Waiver entails and the economic implications for Wisconsin of the program including Medicaid reimbursement. The next section, entitled Reproductive Rights and Minorities, discusses the current constraints and information gaps experienced by minorities in Wisconsin when attempting to access reproductive health services or obtain information.

A comprehensive examination of current legislation including several Assembly and Senate bills continues to look at the exact implications and definitions of each bill recently introduced into the Wisconsin legislature.

Finally, a series of recommendations based on the findings throughout this report offers suggestions for improving reproductive rights in Wisconsin according to each respective issue and provides general insight into the steps necessary to change Wisconsin’s current climate surrounding reproductive rights.
STATUS OF REPRODUCTIVE RIGHTS IN WISCONSIN
FACT SHEET

- Wisconsin is one of 12 states that face particularly sustained levels of violence.¹
- In the last 10 years, the number of abortion clinics in Wisconsin has declined from 16 to five
- 96% of Wisconsin counties lack an abortion clinic
- A 2002 study conducted in Wisconsin found that 47% of sexually active girls under 18 would discontinue all sexual health care services if their parents were aware they were obtaining these services, however a majority of girls reported that they would continue having sex
- Wisconsin currently has no legislation regarding access to, dispensation, or disclosure of information about emergency contraception
- In Wisconsin, 21 counties do not have as single hospital that will prescribe emergency contraception
- There are 634,250 women in Wisconsin in need of contraceptive services and/or supplies
- Of these women 296,390, including 92,060 teenagers, are in need of publicly supported contraceptive services
- Estimated costs of adding contraceptive coverage to group insurance plans is a meager $1.43 per employee per month, in fact, not covering contraceptive in group health plans actually costs employers 15%-17% more than providing contraceptive coverage
- As of January 2004, 39,060 Wisconsin women are enrolled in the Family Planning Waiver Demonstration Project, a project that provides free reproductive health care services to women ages 18-44 who are at or below 185% of the poverty level
- The Department of Health and Family Services plans to serve 47,000 women through the Family Planning Waiver Demonstration Project throughout the program’s five-year life span
- In Wisconsin, 87.7% of white mothers, 69.8% of Hispanic mothers, and 69.5% of African American mothers receive beginning prenatal care in their first trimester.
- In Wisconsin, 10.2% of white mothers, 11.3% of Hispanic mothers, and 17.8% of African American mothers experience preterm births.
- Wisconsin has not made a practice of researching the reproductive health care needs of the minorities, who make up 12% of the state’s population.

¹ Clinic Violence and Intimidation. NARAL Pro-Choice America, http://www.naral.org
The following report focuses on women's reproductive rights in Wisconsin and attempts to demonstrate the necessity of involvement in and support of women's reproductive health issues. This report attempts to accurately address Wisconsin's need to examine laws, policies, and practices to provide women with the utmost care and respect regarding their reproductive health. By examining various reproductive laws and health topics in great depth, several recommendations are provided for readers that address each section to the fullest extent. Although this report is quite comprehensive, the authors recognize the omission of issues that may be of some relevance that are not included due to space and time constraints. This report is to be considered a work in progress to be periodically updated to ensure women's reproductive rights in Wisconsin remain at the forefront of legislative and public agenda. It is with great hope that this report encourages readers to advocate for greater reproductive freedom in Wisconsin and recognize the power each one of us possesses to make change.

**FEDERAL AND STATE LAWS**

**What Are Relevant Supreme Court Ruling?**

During the twentieth century, family planning and abortion were pushed to the forefront of American politics via the Supreme Court. In the 1940’s doctors and others who believed in the importance of family planning sought to change state laws that had originated during the 19\textsuperscript{th} century banning the dissemination of information about, and the use of instruments of contraception.\footnote{Craig, Barbara Hinkson and David O’Brien. (1993). Abortion and American Politics. Chatham, NJ: Chatham House Publishers. 6.} In most states these lobbyists were unsuccessful in persuading legislative majorities to revise state laws and, as a result, began to challenge the constitutionality of family planning laws in the courts. In 1965, the Supreme Court heard \textit{Griswold v. Connecticut} and struck down a law that banned doctors from giving advice about contraceptives and prohibited individuals from using them. The Court cited a constitutional “right to privacy”; a recognition that the enumerated guarantees in the Bill of Rights have penumbras, or shadows, that protect individuals’ privacy interests. In 1972, the Court extended the right to privacy to the reproductive decisions of unmarried people through its ruling in \textit{Eisenstadt v. Baird}.\footnote{Craig, Barbara Hinkson and David O’Brien. (1993). Abortion and American Politics. Chatham, NJ: Chatham House Publishers. 6.}
The constitutional right to privacy, the legal foundation established in cases dealing with contraception, was also the basis for the Court’s landmark decision on abortion. *Roe v. Wade* (1973) legalized abortion, which elevated the issue to the national political agenda and invited a larger political struggle in the country. One bold, momentous move the Court undid a century of legislative action and ultimately invalidated state abortion laws. In the *Roe* decision, the pregnancy was divided into thirds, or trimesters. The Court ruled that during the first trimester, states could not legally restrict abortion. During the second trimester, states could only impose regulations that were necessary to preserve a woman’s health. Only in the third trimester, when the fetus was considered viable could states impose regulations for the purpose of saving fetal life.

For a number of years after *Roe*, the Supreme Court consistently struck down attempts by state legislatures to restrict access to legal abortion. With the important exception of *Harris v. McRae*, a decision which upheld the Hyde amendment and allowed Congress to restrict Medicaid funding for abortion, for sixteen years the Court took the position that, with very few exceptions, governments could not seek to restrict access to abortion.³

In 1989, *Webster v. Reproductive Health Services* interrupted the rulings in support of legal abortion. The Court ruled, by a 5 to 4 margin, that some state-imposed restrictions on abortion are constitutionally permissible. The Court upheld the constitutionality of a Missouri law which: 1. Decreed that life begins at conception and that “unborn children have protectable interest in life, health, and well-being”; 2. Forced doctors to perform a series a viability tests before an abortion; 3. Prohibited public employees and facilities from being used to perform an abortion not necessary to save a woman’s life; and 4. Made it unlawful to use public funds, employees, and facilities for the purpose of “encouraging or counseling” a woman to have an abortion except when her life is endangered.⁴ The legal importance of the case went beyond the actual provisions of the Court’s decision. *Webster v. Reproductive Health Services* encouraged

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State legislatures to write restrictive abortion laws, which were then subject to judicial review. State legislatures had become the battlegrounds for the abortion issue. After Webster, the federal courts determined that the extent of their ability to intervene was limited to situations where state courts had placed an unwarranted or unjustified burden on the abortion decision. This determination was to be made weighing the state’s interest in the regulation against the woman’s choice, based on the length of her pregnancy. State laws enacted to restrict abortion usually fell into three categories: Medicalization Regulations, “Informed Consent” Regulations, and Substituted Consent Regulation.

Medical regulations include laws that restrict second trimester abortion to hospitals rather than doctors’ offices or clinics. “Informed Consent” regulations include laws which require a person who considers medical treatment be given information about the potential risks and benefits, possible side effects, and consequences of the treatment in order to make an informed choice. A number of states have passed laws requiring that the parents of a minor must give prior consent to a teen’s abortion, these laws fall under the substituted consent regulation. For young women who may face abuse or violence if her parents, family, partner, or others learn of her pregnancy, the Supreme Court has mandated that a judicial bypass act as a means of consent.

In 1992 with Planned Parenthood of Southeastern Pennsylvania v. Casey, the Court upheld Roe v. Wade but accepted the imposition of state restrictions which did not pose a “substantial” obstacle to a woman’s choice. The upheld statute required 1. physicians to provide patients with anti-abortion information, including pictures of fetuses at various stages of development, to discourage women from having abortions, 2. a mandatory 24-hour delay following these lectures, 3. the filing of reports, available for public inspection, including the name and location of any facility performing abortions that receives any state funds, and 4. a one-parent consent requirement for minors with a judicial bypass alternative.

More recently, in *Stenberg v. Carhart* (2000) the Court invalidated a Nebraska law that prohibited late term abortion because there was no exception to protect a woman’s health and the broad wording which would affect other forms of abortion, specifically the dilation and extraction procedure, most commonly used during second-trimester abortions. The late term abortion debate will continue in the months to come as President Bush signed an executive order banning the procedure this November. Less than an hour after the president signed the legislation, a federal judge in Nebraska issued a limited temporary restraining order against the new law. The judge questioned the law’s constitutionality and expressed concern that the ban contains no exception for the mother’s health.

The law states that any person who performs an abortion may be fined up to $5,000, imprisoned for three-15 years, or both.\(^7\) Nationally, Congress recently won a ban on late term abortion procedures. The “Partial-Birth Abortion Ban Act” prohibits late term abortion procedures from being performed. It is the first time an abortion procedure has been outlawed since the *Roe v. Wade* decision.\(^8\) In Wisconsin, “partial-birth” abortions are now illegal, and the previous injunction prohibiting its enforcement lifted.\(^9\) This Wisconsin law states that any person who intentionally performs a “partial-birth” abortion is guilty of a felony unless it was necessary to preserve the life of a woman.\(^10\) Almost half of the women obtaining abortions beyond 15 weeks of gestation say they were delayed in obtaining an abortion because of problems in affording, finding, or getting to abortion services.\(^11\)

### What are Wisconsin Laws?

Wisconsin is a microcosm of policy changes happening throughout the United States. In the 14 years following *Webster*, most states added restrictions or have moved to apply existing restrictions that had been unenforceable prior to the *Webster* ruling. Wisconsin has adopted several common state regulations that restrict a woman’s access to abortion. These statutes

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\(^7\) Ibid  
\(^10\) Ibid  
include “informed consent”; a woman may not have an abortion until at least 24 hours after a physician orally tells her the physiological characteristics of the ‘unborn child’, the details and medical risks of the proposed abortion procedure, that services are available to enable a pregnant woman to view the image or hear the heartbeat of her ‘unborn child’ and how she may obtain these services. Also, at least 24 hours prior to an abortion, the woman must receive a state mandated lecture on medical assistance benefits available for prenatal care and childbirth, on the father’s liability to pay child support, information about adoption and other abortion alternatives, counseling services in the case of rape or incest, and special programs and services for children born with disabilities. The state also discourages the abortion procedure through a counseling ban which states that no state, local, or federal funds passing through the state for pregnancy programs, projects or services including family planning may be used to make abortion referrals unless the procedure is necessary to preserve the woman’s life. Eleven other states enforce a mandatory delay for women seeking abortions: ID, KS, LA, MS, NE, ND, OH, PA, SC, SD, UT (CFRR, 1997). Many opponents to the waiting period include physicians who are forced to relay information that is provided by anti-choice organizations and causes patients to believe this information is the physician’s medical opinion, which it is not. Additionally, the waiting period causes women to make two trips to the clinic to obtain an abortion, which may be financially prohibitive or socially impossible because of abusive partners.

The state also requires that minors obtain parental consent before the abortion procedure. As of today, the consent of one adult relative; a parent, grandparent, an older sibling who is at least 25 years old, aunt, or uncle is acceptable. The minor may obtain an abortion without an adult’s consent by either securing a court order stating she is mature and well informed enough to make her own decision or by providing a sworn written statement to the physician that a parent has abused her or that the pregnancy is a result from sexual intercourse from a caregiver which will then be reported to authorities. Thirty-two states currently enforce parental consent laws for minors seeking an abortion: AL, AR, AZ, DE, GA, IA, ID, IN, KS, KY,

Perhaps the biggest restriction to a woman’s access to abortion is access to state and federal funding. Wisconsin does not allow women to use public funds to pay for an abortion unless the procedure is necessary to save a woman’s life, the procedure is medically necessary due to an existing medical condition or if the pregnancy is the result of sexual assault.

Almost every state has policies, often referred to as “refusal clauses,” explicitly allowing health care providers, on religious or moral grounds, to refuse to provide or participate in some types of reproductive health care, such as abortion, contraceptive, or sterilization services. Many of these policies specify that a person using this option is protected from legal liability or disciplinary action by an employer. Under current Wisconsin law hospitals, physicians, and all other hospital staff have the right exercise the refusal clause. Using the existing law as a foundation, Wisconsin Assembly Bill 63/ Senate Bill 21 would expand the list of health care services which pharmacists and health care providers may refuse to offer. The bill, termed the “Pharmacists’ Conscience Clause”, would allow a pharmacist to refuse to fill a patient’s prescriptions for contraceptives if they believe that birth control leads to abortions. The pharmacist is not required to inform a woman about all her health care treatment options nor is he or she required to give a woman referral information about where to obtain birth control. Pro-life supporters maintain that this bill falls within the anti-discriminatory language; they assert that no health care provider should be forced to act in a way that would challenge their moral beliefs. Pro-choice supporters feel as though the bill denies a woman vital health information, that it interferes with the patient/doctor relationship, and that it allows pregnant women to be subjected to substandard health care.

ACCESS TO ABORTION

Abortion is a prominent and important issue with regard to reproductive rights. Wisconsin has not been immune to current national and statewide debate. A closer examination of Wisconsin’s current position and climate regarding abortion reveals points of contention within legislation and between organizations.

What is the State of Abortion in Wisconsin?

Access to abortion is dismal throughout Wisconsin. Estimates indicate that 84 percent of U.S. counties have no identifiable abortion provider with non-metropolitan areas at 94 percent. These counties are home to 34 percent of all 15-44 year old women. The number of abortion providers in the U.S. declined by 11 percent between 1996 and 2000—from 2,042 to 1,819.

Access to abortion throughout the nation is dismal, as well. In the United States 49 percent of pregnancies are unintended with almost one-half of these ending in abortion. Approximately 1.31 million abortions occurred in 2000 and more than 39 million legal abortions have occurred since 1973. Women under 25 constitute 52 percent of women obtaining abortions. Black women are more than three times likely as white women to have an abortion and Hispanic women are more than two times likely to do so. Additionally, approximately 13,000 women have abortions each year following rape or incest. The risk of abortion complications is minimal with less than one percent of all abortion patients experiencing a major complication. There is no evidence of childbearing problems among women who have had abortions in the first 12 weeks of pregnancy. Additionally, the risk of death associated with childbirth is about 11 times as high as that associated with abortion.

These national numbers are reflected in Wisconsin. In the last 10 years, the number of clinics in Wisconsin has declined from 16 to five with the provider at one clinic traveling from a neighboring town each week to ensure that the only clinic outside Madison and Milwaukee can continue providing abortions. In fact, 96 percent of counties in Wisconsin lack a clinic.

One comprehensive study looked at hospital-based abortion in Wisconsin, which is the only access most women in Wisconsin have to abortion. The study conducted by the Wisconsin

16 Ibid.
17 Ibid.
18 Ibid.
19 Ibid.
20 Ibid.
21 Ibid.
22 Ibid.
Reproductive Access Project (WRAP) found that not a single hospital respondent reported a hospital policy permitting elective abortions. When a caller posing as a young woman wanting to obtain a first trimester abortion spoke with hospital staff in Milwaukee County, home to three of Wisconsin’s clinics, not one hospital referred her to one of those clinics. Most staff refused to provide a referral and a few referred the caller to Planned Parenthood, but provided no contact information. Four hospital staff people referred the caller to crisis pregnancy centers, which are non-medical facilities that typically provide misinformation about legal abortion such as: “You’ll never forgive yourself for having an abortion” “Don’t you know? Abortion will give you breast cancer?” “You don’t want to kill your baby.”

In a follow-up survey only one-third of Milwaukee County hospitals provided an appropriate referral to the caller seeking an abortion. The caller in this survey also reported being berated because of her inquiry into abortion with staff using harsh, humiliating and degrading language.

Women’s right to obtain an abortion is further being curtailed nationally and in Wisconsin. Wisconsin has not repealed its pre- Roe abortion law, which has been deemed unconstitutional. Wisconsin has also instituted an “informed” consent or waiting period for women wishing to obtain an abortion. Congress has stopped Medicaid from paying for abortions for low-income women except when the woman’s life is endangered or in cases of rape or incest. It is estimated that without publicly funded family planning services, an estimated 1.3 million additional unplanned pregnancies would occur annually, with about 632,300 ending in abortion. In Wisconsin, the state has placed severe

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24 Ibid
25 Ibid
26 Ibid
28 Ibid
29 Ibid
32 Ibid
limits on coverage for low-income women’s abortions under Medicaid. The state refuses to cover abortion services except in the case of life endangerment, rape, incest, or long-term health damage.\(^{33}\)

Wisconsin also has instituted a parental consent policy for women under 18 wishing to obtain an abortion. Please see the Supreme Court section for more information. A recent national survey revealed that 45 percent of minors who have abortions tell their parents, and 61 percent obtain abortions with at least one parent’s knowledge, with a large majority of parents supporting their daughter’s decision.\(^{34}\) In a survey conducted by Wisconsin Planned Parenthood released in 2002, 47 percent of sexually active girls under 18 would discontinue all sexual health care services at Planned Parenthood if their parents were aware they were obtaining these services. An additional 12 percent would delay or discontinue certain services, like HIV/STD treatment and testing, and pregnancy testing. However, a majority of girls surveyed reported that they would continue having sexual intercourse.\(^{35}\)

Clinic violence and harassment has also blocked access to abortion for women nationally and in Wisconsin. In March 1999 clinics in New Mexico, South Dakota, and Wisconsin were the targets of arson. In April and May 1999 two arson attacks on reproductive health clinics occurred in Wisconsin.\(^{36}\) In Wisconsin any person who intentionally enters a medical facility without the consent of a person on the premises and intending to provoke a “breach of the peace” is only guilty of a misdemeanor.\(^{37}\) Please see the Clinic Violence section for more information.

Additionally, two Senate bills (SB 27 and SB 28) make abortion services less accessible to women in Wisconsin. SB 27 would allow physicians to intentionally withhold important information about prenatal care and tests for women if the physician believed the woman might

\(^{34}\) Ibid
\(^{35}\) Ibid
have an abortion if told of her options.\textsuperscript{38} (Many opponents agree that this is unethical for physicians and would allow pregnant women to be treated as an inferior class of patients who are not entitled to patient rights.\textsuperscript{39}) SB 28 would require physicians to include information on newborn abandonment and “safe haven” laws in their pre-abortion counseling with women.\textsuperscript{40} A woman may legally abandon her unharmed newborn in Wisconsin up to three days old without prosecution, however, including this in pre-abortion counseling many encourage women to conceal a pregnancy and choose this path, opponents contend.\textsuperscript{41} Please see the Current Legislation section for more information.

**How Does Wisconsin Measures Up to Other States?**

Wisconsin recently received an “F” in a state-by-state report card on access to abortion and a rank of 35 out of 50 (NARAL, 2003). This grade is based on Wisconsin’s laws regarding clinic violence, parental consent, waiting periods, and more. New York, Vermont, Connecticut, Washington DC, California, Oregon, and Washington received top grades in protecting a woman’s right to choose.\textsuperscript{42} These states all have laws protecting clinics from violence by implementing either stricter penalties for offenders or creating new legislation that specifically adheres to clinics. Additionally, these states provide information prior to abortion, but do not require a litany of anti-choice speeches and respect a woman’s right to choose. Most of these states have no legislation restricting minors from obtaining an abortion and many do not require a waiting period.\textsuperscript{43} (Please see Table 1).

\textsuperscript{39} Ibid
\textsuperscript{40} Ibid
\textsuperscript{41} Ibid
\textsuperscript{43} Ibid
Table 1: State-by-State Report Card on Access to Abortion

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</table>

Source: NARAL, 2003 (Please See Appendix I for All States and key)

CLINIC VIOLENCE

What Incidences of Clinic Violence Have Occurred in the Nation?

Since 1993, seven reproductive health clinic workers, including three doctors, two clinic employees, a clinic escort, and a security guard have all been murdered in the United States.44 The most recent murder was on Oct. 23, 1998. Dr. Barnet Slepian was shot and killed by a single bullet fired through his kitchen window in Amherst, New York.45 Also during that year clinic security guard Robert Sanderson was murdered when a bomb exploded in front of the New Woman All Women Health Care Clinic in Birmingham, Alabama. This explosion also severely injured Nurse Emily Lyons, leaving her nearly blind and with almost $750,000 in medical bills.46 During 1994 four murders occurred. In December 1994 a man open fired on two clinics in Brookline, Massachusetts killing clinic receptionists Shannon Downey and Lee Ann Nicols, five

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44 Clinic Violence and Intimidation, NARAL Pro-Choice America, http://www.naral.org
45 Ibid.
46 Ibid
others were injured\textsuperscript{\textit{47}}. Earlier that year Dr. John Britton and clinic escort James Barrett were shot and killed at a clinic in Pensacola, FL. A second escort was wounded.\textsuperscript{\textit{48}} In 1993, Dr. David Gunn was killed at the clinic where he worked during an anti-abortion protest.\textsuperscript{\textit{49}}

Committing murder isn’t the only type of violence anti-abortion activists use. In addition to murders there has also been 17 attempted murders\textsuperscript{\textit{50}} and over 80,000 reported incidents of violence and disruption against abortion providers in the US and Canada since 1977. (See Table 2 for more detailed information) Incidences range from severe violence such as blockades, bombings, arson, chemical attacks, stalking, and gun fire to more disruptions such as hate mail, harassing phone calls, internet/e-mail harassment, bomb threats, and suspicious packages.\textsuperscript{\textit{51}} Since 1991, abortion clinics have been subject to at least 100 incidences of noxious chemical vandalism with an estimate of total damages of over $1 million.\textsuperscript{\textit{52}} Also after the anthrax threats to government officials in the wake of 9-11, the number of anthrax threats to abortion clinics increased. Between Oct. 15 and 23, 2001 over 250 abortion and family planning clinics in

\textsuperscript{\textit{47}} Ibid
\textsuperscript{\textit{48}} Ibid
\textsuperscript{\textit{49}} Ibid
\textsuperscript{\textit{50}} NAF Violence and Disruption Statistics, National Abortion Federation, http://www.prochoice.org
\textsuperscript{\textit{51}} Ibid.
\textsuperscript{\textit{52}} Clinic Violence and Intimidation, NARAL Pro-Choice America, http://www.naral.org
Incidents of Violence and Disruption Against Abortion Providers in the US and Canada

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<thead>
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<th>Source: National Abortion Federation</th>
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**Violence**

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<td>1999</td>
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</tr>
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<td>1998</td>
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**Disruption**

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17 states and the District of Columbia received letters claiming to contain anthrax and a letter stating, “You have been exposed to anthrax. We are going to kill you.” An additional 270 letters were sent to clinics during the first week of November 2001. A relatively new trend in
anti-choice intimidation is internet intimidation. \(^55\) Some groups have posted "wanted" posters of clinic doctors on their websites along with the doctor's phone number, work schedule, and home address.

Another type of internet intimidation is focusing on individual women as they visit reproductive health clinics. \(^56\) The anti-choice groups use "abortion-cams" to photograph the women and then post pictures of the women and clinic staff on websites. \(^57\)

These types of violent incidences are not exclusive to southern states or "other" states. There have been a number of incidences in neighboring states and Wisconsin.

**What are the Incidences of Clinic Violence in Neighboring States?**

At about 1:00 in the morning July 4, 2002 at least five bullets were fired into a Planned Parenthood clinic in Brainerd, Minnesota. The same clinic was destroyed by fire bombs in 1994. Less than three weeks after the Brainerd incident another Planned Parenthood clinic in Grand Rapids, Minnesota was struck by at least seven bullets from a shotgun and a handgun. \(^58\)

In September of 2000, a Catholic priest smashed his car into the only abortion clinic in Rockford, Illinois and then proceeded to attack the clinic with an ax. \(^59\) Also in Illinois, an anti-choice group posted a women’s picture and her medical records on the Internet. A court later issued an injunction ordering that they be removed from the website. \(^60\)

**Is There Clinic Violence in Wisconsin?**

Wisconsin is one of twelve states that face particularly sustained levels of violence. \(^61\) On November 3, 1998 Planned Parenthood in Milwaukee received a brown envelope in the mail. Inside a hoax bomb was constructed out of two AA batteries with wire wrapped in modeling clay. A message was included stating "Boom. The next one might be real. Stop killing babies." The

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\(^{57}\) Ibid.

\(^{58}\) Clinic Violence and Intimidation, NARAL Pro-Choice America, http://www.naral.org

\(^{59}\) Ibid


\(^{61}\) Reproductive Rights: The right to an abortion is a constitutional right. Milwaukee NOW, http://www.milwaukee NOW.org/issues/repro.html
next day Affiliated Medical Services in Milwaukee received a similar package.\textsuperscript{62} In 1999 there were also 3 cases of arson, two in March and one in April. Peter Quinn, age 17 was charged for the March fires. One clinic sustained $1,000 worth of damage. The other clinic sustained only minimal damages. The April arson case remains open and the clinic had only minimal damage.\textsuperscript{63}

**Are There Federal Laws to Protect Against Clinic Violence?**

There have been attempts at the state and federal level to create laws to minimize clinic violence. The Freedom of Access to Clinic Entrance Act (FACE) provides federal protection against the clinic violence. FACE or Section 248 makes it unlawful for a person to use force, the threat of force, or physical obstruction to intentionally injure or intimidate a person because he/she is or has been obtaining or providing reproductive health services. This section also makes it unlawful for a person to intentionally damage or destroy the property of a facility because it provides reproductive health services. FACE also prohibits any one from attempting to commit any of the above actions.\textsuperscript{64} An offense under this statute is punishable by a range of imprisonment up to a life term depending upon the nature of the offense and whether or not it is a repeat conviction.\textsuperscript{65}

One challenge associated with a majority of civil FACE cases is that financial penalties have not been collected because the violators shifted their assets before engaging in the criminal activities or they declare bankruptcy to avoid paying their legal judgment.\textsuperscript{66}

Another federal law can be used against violent protesters. In 1994, the U.S. Supreme Court in *NOW v. Scheidler* ruled that clinics could use the Rocketeer Influenced Corrupt Organizations Act (RICO), a law originally created to target the Mafia, to sue violent protesters.\textsuperscript{67}

The U.S. Supreme Court ruled in 2000 on a Colorado law that prohibits protesters from coming within 8 feet of a person who is within 100 feet of the clinic’s entrance door. The Court upheld the law in part because the law required that the protester intentionally step into the

\textsuperscript{62} Clinic Violence and Intimidation, NARAL Pro-Choice America, http://www.naral.org

\textsuperscript{63} Violence Statistics, National Abortion Federation, http://www.prochoice.org


\textsuperscript{65} Ibid


\textsuperscript{67}
floating zone to be considered breaking the law and because 8 feet is a “normal conversational distance” and therefore does not violate demonstrators’ free speech rights.\textsuperscript{68} This ruling has national importance because “bubble zone” laws in other states have been ruled unconstitutional therefore causing this ruling to set precedent for laws in other states.

**What are Wisconsin's Clinic Protection Laws?**

In 1985, Wisconsin was the first state to adopt an anti-clinic violence law. Currently 14 states and the District of Columbia have clinic protection laws on the books.\textsuperscript{69} The Wisconsin law prohibits threatening and intimidating but does not protect against obstruction access and property damage.\textsuperscript{70} The Wisconsin statute reads “Whoever intentionally enters a medical facility without the consent of some person lawfully upon the premises, under circumstances tending to create or provoke a breach of the peace, is guilty of a class B misdemeanor.”\textsuperscript{71}

**What are the Effects of Clinic Violence?**

Due to these incidences of violence and disturbances access to abortion and family planning services has been reduced. As a clinic manager in Sioux Fall, South Dakota said, “It’s not the amount of damage that is of importance here. . . It’s the intimidation, the threats, the attempt to provoke fear among the clinic staff, and among patients.”\textsuperscript{72}

Clinic directors have a difficult time hiring and retaining office staff because of the daily threats and harassment from anti-choice activists.\textsuperscript{73} In 2002, 7 percent of clinics reported that a physician or other staff member quit their job because of anti-abortion violence, harassment or intimidation.\textsuperscript{74} If a clinic cannot hire a doctor or clinic staff then the abortion services cannot be

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\textsuperscript{68} Ibid

\textsuperscript{69} Ibid

\textsuperscript{70} Ibid

\textsuperscript{71} Wisconsin State Statute 943.145(2)

\textsuperscript{72} Clinic Violence and Intimidation, NARAL Pro-Choice America, http://www.naral.org

\textsuperscript{73} Ibid

offered. In 1997, a 60-year old doctor flew to Minnesota, North Dakota, Wisconsin, and Indiana to perform abortions at clinics in need of an abortion provider.\textsuperscript{75}

CONTRACEPTIVE EQUITY

Contraceptive equity is the belief that contraception is integral to women’s health, autonomy, and equality and should be treated as a basic health care matter included in public policy. Wisconsin is currently exploring access to contraceptives and contraceptive insurance coverage options and legality at the time of this report; the overriding determinants of contraceptive equity.

What is Wisconsin’s Current Position Regarding Contraceptive Equity?

There are approximately 634,250 women in Wisconsin in need of contraceptive services and/or supplies.\textsuperscript{76} (See Tables 3 and 4)\textsuperscript{48} these women 296,390, including 92,060 teenagers, are in need of publicly supported contraceptive services.\textsuperscript{77} Wisconsin family planning programs serve approximately 150,000 individuals, preventing 24,200 unintended pregnancies and 12,100 abortions each year in the state of Wisconsin.\textsuperscript{78} Wisconsin law does not currently mandate coverage of contraceptives or contraceptive services.\textsuperscript{79} However, a recent legal opinion offered by Attorney General Peg Lautenschlager concluded that current Wisconsin law requires employers to provide equitable insurance coverage for their employees. Specifically, the exclusion of prescription contraceptives from a group insurance program that provides prescription drugs violates the Wisconsin Fair Employment Act and anti-discrimination laws.\textsuperscript{80}

\textsuperscript{75} Reproductive Rights: The right to an abortion is a constitutional right. Milwaukee NOW, http://www.milwuakeenow.org/issues/repro.html
\textsuperscript{77} Allan Guttmacher Institute (2003) \textit{Induced Abortion}. The Allan Guttmacher Institute Facts in Brief.
\textsuperscript{78} Ibid
### Table 3

Total Number of Women aged 13-44 and Number of Women in need of contraceptive services and supplies, by age, poverty status, and race/ethnicity, 2000-Wisconsin

**Source:** The Alan Guttmacher Institute

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<th>Race/Ethnicity</th>
<th>Women needing contraceptive services and supplies</th>
<th>Women in need of contraceptive services and supplies</th>
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<td><strong>16-19</strong></td>
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<td>All women</td>
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<td>Other</td>
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<td>At or Above</td>
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<td>Black</td>
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<td>Other</td>
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</table>

**Source:** The Alan Guttmacher Institute
TABLE 4
Number of Women in Need of publicly supported contraceptives and supplies, by race/ethnicity and need status (under age 20 or age 20-44 and under 250% poverty), 2000- Wisconsin
Source: The Alan Guttmacher Institute

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<th>STATE AND COUNTY</th>
<th>Total</th>
<th>Non-Hispanic White</th>
<th>Non-Hispanic Black</th>
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<td>&lt;20</td>
<td>20-24 (&lt;250%)</td>
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<td>Hispanic</td>
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Recent federal court and EEOC decisions have determined that employers must cover prescription contraceptives in their health insurance policy under Title VII of the Civil Rights Act.
as amended by the Pregnancy Discrimination Act. The recently released legal opinion compares the Wisconsin Fair Employment Act and Title VII as “almost identical.”

In a 2001 survey conducted by the Wisconsin Office of the Commissioner of Insurance, 22 percent of Wisconsin insurance plans surveyed cover all FDA-approved contraceptive methods, and less than one-half of the plans cover birth control pills. Almost 28 percent of plans examined did not include any contraceptive coverage. Additionally, as a percentage of insurer costs, comprehensive contraceptive coverage would cost between .5 and 1 percent of insurer cost and would increase costs only .08 percent. The Department of Employee Trust Funds (ETF) estimates that their increased costs of covering contraceptives would be a meager $0.14 per member per month.

The Wisconsin Senate and Assembly are also attempting to amend Wisconsin statute regarding access to contraceptives. Assembly Bill 63 and Senate Bill 21 contain a pharmacist refusal clause that would allow a pharmacist to refuse to dispense any medical drug or device if he/she morally disagreed with its intended use. Additionally Assembly Bill 383 and Senate Bill 186, otherwise known as the amendment to the Family Planning Waiver, threatens to exclude 15-17 year olds from the Medical Assistance Program which provides family planning services to women whose family income does not exceed 185 percent of the federal poverty line. Please see the Current Legislation section for more information.

The Family Planning Waiver demonstrates saving Wisconsin $17 million by preventing teenage pregnancy. The Wisconsin Department of Health and Family Services released data confirming 7,081 births to teens in Wisconsin in 2000 of which Medicaid paid for 85 percent. The Family Planning Waiver prevents teenage pregnancy by providing funding for contraceptives and

81 Ibid
83 Ibid
84 Ibid

The Family Planning Waiver also allows teenagers privacy in obtaining contraceptive services. A study published in 2002 in the Journal of the American Medical Association found that nearly 47 percent of sexually active girls under the age of 18 would stop seeking all reproductive health services if their parents knew they were trying to obtain contraceptives. Another 12 percent would delay or stop HIV/STD treatment and/or testing and pregnancy testing if their parents were aware of their visits to a clinic. Yet the majority of the girls surveyed said they would continue to be sexually active.\footnote{Allan Guttmacher Institute (2003) Induced Abortion. The Allan Guttmacher Institute Facts in Brief.}


**How Does Contraceptive Equity Affect Wisconsin?**

One of the most important barriers to access to contraceptives is inadequate insurance coverage of contraceptives.\footnote{NARAL (2003) Insurance Coverage for contraception Improves the Health of Women and Families. NARAL Pro-Choice America pp. 1-5.} Sexually active women between the ages of 20 and 45 spend almost five years of life trying to become pregnant, or being pregnant or postpartum, and more than four times that long trying to avoid pregnancy.\footnote{Gold, Rachel Benson (1998) The Need for and Cost of Mandating Private Insurance Coverage of Contraception. The Guttmacher Report on Public Policy. Vol. 1, No. 4.} It is estimated that more than two-thirds of all adult women receive health insurance through their employers or as a dependent.\footnote{NARAL (2003) Insurance Coverage for contraception Improves the Health of Women and Families. NARAL Pro-Choice America pp. 1-5.} Women of childbearing age spend approximately 68 percent more in out-of-pocket health care costs than men of the same age, mostly due to reproductive health care such as contraceptives.\footnote{Gold, Rachel Benson (1998) The Need for and Cost of Mandating Private Insurance Coverage of Contraception. The Guttmacher Report on Public Policy. Vol. 1, No. 4.} American women overwhelmingly use contraception to avoid unintended pregnancy with 85
percent of women aged 20-44 using oral contraceptives at some point in their lives. Only seven percent of women with private health insurance coverage use no method of contraception.\footnote{Ibid}

Historically, private insurance companies have failed to provide contraceptive insurance coverage. A Guttmacher study in 1993 revealed that half of all indemnity plans did not cover any reversible prescription contraception methods and only 15 percent covered all of the five leading methods (oral contraceptives, diaphragm, Depo-Provera, Norplant, and IUD).\footnote{Dailard, Cynthia (2003) The Cost of Contraceptive Insurance Coverage. The Alan Guttmacher Institute Issues in Brief 2003 Series, No. 4.} However, a recent look at contraceptive coverage by the Kaiser Family Foundation in 2001 revealed that coverage remained insufficient. Findings revealed that only 41 percent of insured employees had coverage of all reversible contraceptives while 98 percent had coverage of prescriptions drugs in general.\footnote{Ibid}

While there continues to be arguments over possible increased costs of adding contraceptives to insurance plans, evidence of these rising costs does not appear to exist. A recent report by the Alan Guttmacher Institute reveals that adding contraceptive coverage to a group plan is a meager $1.43 per employee per month, a premium increase of 0.6 percent.\footnote{Gold, Rachel Benson (1998) The Need for and Cost of Mandating Private Insurance Coverage of Contraception. The Guttmacher Report on Public Policy. Vol. 1, No. 4.} In fact, not covering contraceptives in group health plans actually costs employers 15-17 percent more than providing contraceptive coverage.\footnote{Dailard, Cynthia (2003) The Cost of Contraceptive Insurance Coverage. The Alan Guttmacher Institute Issues in Brief 2003 Series, No. 4.} These costs are associated with unintended pregnancies. Insurers generally pay the costs of unintended pregnancies by covering: full-term pregnancy ($8,619-$10,000), ectopic pregnancy ($4,994), miscarriage ($1,038), and, less often, abortion ($416).\footnote{NARAL (2003) Insurance Coverage for contraception Improves the Health of Women and Families. NARAL Pro-Choice America pp. 1-5.} These figures pale in comparison to the $300-$350 it costs per year for oral contraceptives. The Office of Personnel Management, which is responsible for the new legislation regarding contraceptive equity (EPICC, please see below), notified health plans that premiums would be adjusted, if needed, based on the new requirements. However, OPM reported in January 2001 that “there was no need to do so since there was no cost increase due
to contraceptive coverage."Additionally, women who experience unintended pregnancies are less likely to receive timely or adequate prenatal care which increases the risk to the fetus, leads to low birth weight, and higher rates of infant mortality all of which increase insurer costs.

According to a Kaiser Family Foundation report three in four adult women say that cost is an important factor when choosing a contraceptive method that is covered or not. Without comprehensive coverage women may "choose" a method that is inappropriate for their lifestyle or needs. Additionally, without insurance coverage some women may not use contraceptives at all thereby relying on less effective methods over-the-counter methods or none at all. In any year, 85 of 100 sexually active women not using a contraceptive method will become pregnant in contrast to less than one-tenth that many of every 100 oral contraceptive users.

There has been overwhelming support for contraceptive equity as well. In a nationwide 2001 NARAL Foundation poll, 77 percent of respondents supported legislation requiring health insurance companies to cover the costs of contraception. A 1998 survey conducted by the Kaiser Family Foundation found that three-quarters of Americans agreed with policies requiring insurance plans to cover contraception, even if premiums were to increase as a result. In fact, eight in 10 privately insured adults or 78 percent support contraceptive coverage even if their premiums rose be as much as $5 a month—almost 14 times the actual cost to individuals. Additionally, seven in 10 privately insured Americans (71 percent) and eight in 10 insured women (79 percent) believe that legislation should require insurance providers to cover all FDA-approved contraceptive methods.

104 Ibid
105 Ibid
106 Ibid
Most recently, the U.S. Equal Employment Opportunity Commission determined that failure to include contraceptives in an employer’s prescription drug plan constitutes gender discrimination under Title VII of the Civil Rights Act. Additionally, Congress enacted legislation that requires contraceptive coverage for federal employees insured through the Federal Employees Health Benefits Program (FEHBP). In 1997 the Equity in Prescription Insurance and Contraceptive Coverage Act (EPICC) was introduced to Congress. This bill requires equitable coverage of prescription contraceptives and devices and contraceptive services under all health plans. Currently 20 individual states have enacted such laws regarding contraceptive equity.

How Does Wisconsin Measure Up with Other States?

Wisconsin recently received a grade of “F” in a state-by-state report card on access to contraception published by NARAL. Wisconsin ranked as number 43 in the nation with a score of 3 out of 37. This poor ranking is due to the lack of mandated contraceptive insurance coverage, a less than perfect score for coverage for state employees, and a loss of points for allowing refusal of health care information and/or services. The top scoring states are Vermont, New Hampshire, North Carolina, Georgia, Iowa, Washington, California, and Hawaii. These states all mandate contraceptive coverage by private insurers as well as mandate coverage for state employees without denial clauses.

EMERGENCY CONTRACEPTION

Emergency contraception (EC), or the morning-after pill, is a contraceptive method intended for use after unprotected intercourse or contraceptive failure. This method consists of low-dose birth control pills that, if taken correctly, can reduce the chance of unintended pregnancy by 89 percent and is most effective if taken within 72 hours of unprotected intercourse.

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112 Ibid
or contraceptive failure.\textsuperscript{114} A comprehensive study of Wisconsin's current position and climate regarding EC and a national overview examines the effects of making EC available to all women, including victims of sexual assault.

**What is the Current Climate of Emerging Contraception in Wisconsin?**

Almost half of the 6.3 million pregnancies in the United States every year are unintended, with more than half of these pregnancies ending in abortion.\textsuperscript{115} Of these pregnancies, approximately 32,000 women become pregnant each year due to rape or incest.\textsuperscript{116} Estimates from the American College of Obstetricians and Gynecologists (ACOG) conclude that if EC were available to all women in the U.S., 1.2 million unintended pregnancies could be avoided and the annual number of abortions would be reduced by 800,000.\textsuperscript{117,118} In 2000, an estimated 51,000 abortions were avoided and approximately 43 percent of the decrease in total abortions between 1994 and 2000 were due to the availability of EC.\textsuperscript{119}

Wisconsin currently has no legislation regarding access to, dispensation, or disclosure of information pertaining to EC. EC is currently available only via prescription. Physicians, hospitals, and clinics can choose to prescribe EC to any patient who requests a prescription, but they are not required to do so under current Wisconsin statute. The legislature has recently addressed the issue of access of EC through two bills: Assembly Bill 170 and Senate Bill 99.\textsuperscript{120} These bills would require a hospital to provide medically and factually accurate and unbiased written and oral information about EC to sexual assault victims and provide EC to her if she requests it. These bills also contain penalties for failing to comply with the law including a fine of $2,500 to $5,000 for each violation and after two violations a suspension or revocation of the

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\textsuperscript{114} Ibid
hospital’s certificate of approval.\(^{121}\) Please see the Current Legislation section for more information.

The focus on hospitals in Wisconsin stems from the issue of access to EC for women in rural areas in which community hospitals are often the only places providing reproductive health care services.\(^{122}\) Additionally, given the time constraints involved in preventing pregnancy with EC, victims of sexual assault must have access to EC as soon as possible. Moreover, low-income women or women in rural areas may be unable to obtain EC that is only available many miles away which places an exceptional burden on victims of sexual assault.\(^{123}\)

Yet, EC is still not available in all hospitals to women who are victims of sexual assault nor is EC prescribed as often as necessary because these bills have not been passed. Moreover, all women in Wisconsin do not have access to EC via physicians, clinics, and hospitals because of Wisconsin’s lack of statutes regarding EC. This lack of availability may be caused by the fact that EC is often confused with medical abortion (mifepristone) which is a false assumption.\(^{124}\) EC does not terminate an established pregnancy but rather prevents pregnancy by preventing ovulation, fertilization, or implantation and has been found to be safe to a fetus if taken when accidentally pregnant.\(^{125}\) In fact, the Family Health International Organization released a statement that confirmed that EC is nontoxic and therefore there is no danger of overdose or addiction with the dosage being the same for all women.\(^{126}\) Additionally, there are no known risk factors associated with EC (for women or for a fetus if taken when accidentally pregnant) with only one in five women experiencing vomiting and only one-half experiencing some nausea.\(^{127}\) In 1997, the FDA issued a notice in the Federal Register announcing EC to be

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\(^{121}\) Ibid


safe and effective and encouraged manufacturers to apply for approval of EC specific
products.\textsuperscript{128} Two products are now available, Preven and Plan B. EC has proven safe and
effective since its introduction in the 1960s with over 80 countries worldwide having EC
products.\textsuperscript{129}

However, many women in the U.S., approximately 73 percent aged 18-44 have not heard
of EC pills.\textsuperscript{130} According to a 1997 survey by the Kaiser Family Foundation many women are
unaware of EC pills, most likely due to a failure of physicians, hospitals, and clinics to routinely
discuss EC with patients.\textsuperscript{131} In a 2000 follow-up survey, 51 percent of women were aware of
something that prevented pregnancy after intercourse, but did not know that a product was
available in the U.S., that it requires a prescription, or when it must be taken.\textsuperscript{132} The survey also
revealed that only one in five obstetrician-gynecologists discuss EC as part of their routine
counseling.\textsuperscript{133}

The only survey conducted about EC in Wisconsin, by the Wisconsin Reproductive
Access Project (WRAP), focused on hospitals and their prescription of EC to sexual assault
victims. In a survey of hospitals, only 50 percent reported that they prescribed EC in all cases,
only 43 percent reported dispensing EC at all, and 28 percent of respondents reported that they
do not prescribe EC to victims of sexual assault.\textsuperscript{134}

When hospitals responded to a call from a study participant who claimed to be the friend
of a sexual assault victim, only 51 percent told the caller that her friend could receive a
prescription for EC and only 28 percent said that their hospitals prescribed EC for sexual assault
victims (NARAL, 2002). This is quite a discrepancy between the formal survey and the phone
survey perhaps revealing problems with hospital staff understanding hospital policy. Additionally,

\begin{itemize}
  \item \textsuperscript{128} Ibid
  \item \textsuperscript{129} Ibid
  \item \textsuperscript{132} Ibid
\end{itemize}
among those hospitals that reported that no one at that hospital prescribed EC, only 47 percent were willing or able to provide a referral after being asked to do so. Of the hospitals willing to provide a referral, 42 percent referred the caller to a hospital that did not prescribe EC.\footnote{Ibid}

In the phone study several hospital staff told the caller that the sexual assault victim would have to file a police report and have a doctor determine if she were raped or not to receive EC, with some suggesting that the burden was on the sexual assault victim to prove she was a victim.\footnote{Ibid} In Wisconsin, 21 counties do not have a single hospital that will prescribe EC to sexual assault victims. Therefore, more than 350,000 women of reproductive age are unable to obtain EC where they live, even in cases of sexual assault.\footnote{Ibid}

In Congress, two representatives introduced a bill in April 2002 that would deny federal funds to a hospital that does not provide EC information and services to victims of sexual assault.\footnote{Boonstra Heather (2003) Emergency Contraception: Improving Access. The Allan Guttmacher Institute Issues in Brief 2003 Series, No.3.} In addition, another federal bill would allot $10 million a year for five years for an information and education campaign on the safety and availability of EC to all women.\footnote{Alan Guttmacher Institute (2003) Emergency Contraception: Increasing Public Awareness. The Alan Guttmacher Institute Issues in Brief 2003 Series, No. 2.} A survey conducted by Reproductive Health Technologies Project (RHTP) in July 2002 found that two-thirds of voters think that government involvement in reducing unintended pregnancies is a good issue to examine.\footnote{Ibid} Additionally, three-fourths favor legislation that would expand public health information about EC with over 70 percent citing that they consider the 72-hour window of EC effectiveness as a compelling reason for women to be aware of their options.\footnote{Ibid}

**How Does Wisconsin Measures Up to Other States?**

Several states have taken steps toward addressing the access and availability issue of EC to women. Planned Parenthood in North Carolina in conjunction with Family Health International introduced a toll-free number for women to call to receive counseling about EC and

\footnote{Ibid} \footnote{Ibid} \footnote{Ibid} \footnote{Ibid}
After the launch of the number in February 2001, more than 6,400 women from over 400 towns and cities throughout the state have received prescriptions. Washington State became the first state in the nation in 1997 to allow pharmacists to provide EC to patients through voluntary “collaborative drug therapy agreements.” The agreements allow physicians or nurse practitioners to give pharmacists authority to prescribe certain medications to patients. By June 2001, “pharmacists in Washington were providing EC at a rate of about 1,200 prescriptions per month... [with] more than 35,600 prescriptions [being] provided since the program began, prevent[ing] an estimated 2,000 unintended pregnancies.” Additionally, following the Washington program, California and Alaska recently changed state policy to allow pharmacists, through a collaborative system, to dispense EC.

Due to the safety of EC and success of programs such as those in Washington, many organizations have called for EC to become an over-the-counter medication. A study in the August 2002 issue of Obstetrics & Gynecology of over 660 women, including many young and minority women and low-literacy women, revealed that a prototype of an over-the-counter EC package was easy to understand. The key message were understood by 85 percent of the women including those about indications for use, contraindications, instructions, possible side effects, and management of serious complications. In fact, 97 percent of women understood that the first dose should be taken within 72 hours of as soon as possible after unprotected intercourse of contraceptive failure in order to prevent pregnancy.

Some opposition to EC has claimed that improved availability of EC will cause many women to abandon more reliable methods of contraception and use EC more frequently. However, in studies conducted in the U.S. and Scotland women who have EC at home do not

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143 Ibid
144 Ibid
145 Ibid, pg. 2
146 Ibid
147 Ibid
148 Ibid
149 Ibid
150 Ibid
forego their original choice of contraceptive. In fact, the Co-director of the Center for Reproductive Health Research & Policy at the University of California in San Francisco Felicia Stewart confirmed that there was no evidence of women taking greater risks when they had easy access to EC. Women explained their use of “plan-ahead” contraception because of its reliability against unintended pregnancy.

THE FAMILY PLANNING WAIVER

What is the Family Planning Waiver?

The Family Planning Waiver is a Medicaid Program for women 15 and 44 years of age who are at or below 185% of the federal poverty level. Administered by the Department of Health and Family Services (DHFS), the Waiver provides family planning services and supplies. Specifically, the Waiver covers basic family planning services, including:

- Contraceptives
- Testing and treatment for sexually transmitted diseases (STDs)
- Initial family planning office visits and exams
- Other primary care services of preventative nature

To be eligible for the Family Planning Waiver (FPW), a woman must:

- Be a Wisconsin resident
- Be a woman between 15 and 44 years of age (including women 15 and 44 years of age)
- Be a US citizen or a qualified immigrant
- Not be receiving Medicaid
- Have a family gross income that does not exceed 185% of the federal poverty level. (For minors, a parent’s income does not count)
- Cooperate with all requirements of the Medicaid program

The Family Planning Waiver is part of a larger effort to improve comprehensive health of Wisconsin women. The larger effort includes programs like Healthy Start, Badger Care, Medicaid’s Well Woman Program, and Wisconsin Adolescent Pregnancy Prevention Plan initiatives. Together, these programs attempt to improve Wisconsin women’s access to health care by offering more opportunities for low-cost or free health care.

151 Ibid
152 Medicaid is a joint federal and state program that provides health care services for low-income Americans. Federal law requires that Medicaid programs cover family planning services and supplies.
153 The Medicaid Family Planning Waiver Program, www.hcet.org (PowerPoint presentation)
How Does the Family Planning Waiver Measure Success?

As a way to measure the improvement of women’s access to health care, Wisconsin’s Department of Health and Family Services has published five key measures of success for the Family Planning Waiver, including:

1. Expanded coverage for 47,000 Wisconsin women,
2. Decrease in unintended pregnancies,
3. Reduction in uninsured,
4. Maximizing federal revenues, and
5. Healthier Wisconsin\textsuperscript{154}

Currently, the Department of Health and Family Services is focusing on the first measure, expanding coverage to 47,000 Wisconsin women, because the other four measures are not measurable in the short ten-month time span the Waiver has been in effect in Wisconsin.\textsuperscript{155}

What is the Political History of the Family Planning Waiver?

Politically, an unlikely leader and his administration have championed Wisconsin’s Family Planning Waiver. Wisconsin’s Department of Health and Family Services submitted an application to obtain a Section 1115 Waiver in 1999, under guidance of then Governor and current U.S. Department of Health and Human Services Secretary Tommy Thompson. In early 2001, Wisconsin obtained approval from the U.S. Department of Health and Human Services for a federal Section 1115 waiver to fund Wisconsin Family Planning Waiver.\textsuperscript{156}

What are the Issues Surrounding the Family Planning Waiver

The Alan Guttmacher Institute estimates that the number of people without any health insurance—public or private—has increased by 10 million over the last decade, to an estimated 44 million.\textsuperscript{157} Another study shows that many women are “falling through the cracks.”\textsuperscript{158}

\textsuperscript{154} The Medicaid Family Planning Waiver Program, www.hcet.org (PowerPoint presentation) 12/3/03
\textsuperscript{155} Interview: Joy Grotsky, WI Department of Health and Family Services, December 1st, 2003
\textsuperscript{156} Summary of Wisconsin’s Family Planning Medicaid Waiver, www.hcet.org 12/3/03
\textsuperscript{157} Alan Guttmacher Institute, Fulfilling the Promise: Public Policy and U.S. Family Planning Clinics (2000), www.agi-usa.org 10/20/03
words, women do not have private insurance and do not qualify for Medicaid. On a national level, the number of jobs that provide private health insurance is decreasing, while the number of Medicaid recipients is increasing.\textsuperscript{159}

The Alan Guttmacher Institute argues that 51\% of all women in Wisconsin need publicly supported contraceptive services who are served by publicly supported family planning clinics.\textsuperscript{160} Lack of health insurance is an even more prevalent issue for women of color, as generally people of color are less likely than whites to have employer-related health insurance.\textsuperscript{161} This lack of insurance occurs in African American and Latina populations both because of higher unemployment rates and because these women work in jobs and industries that fail to provide employees with health coverage, such as small businesses, service occupations, and part-time jobs.\textsuperscript{162}

- 69\% of whites have employer-sponsored health coverage,
- 52\% of African American workers have employer-sponsored health coverage, and
- 44\% of Latino workers have employer-sponsored health coverage\textsuperscript{163}

Even among workers in similar occupations, people of color are less likely than whites to be covered by employer-based insurance.\textsuperscript{164}

\textsuperscript{158} “Medicaid Family Planning Waivers,” State Policies In Brief (1/1/02), www.agi-usa.org 10/20/03

\textsuperscript{159} Alan Guttmacher Institute, www.agi-usa.org 10/20/03

\textsuperscript{160} “Medicaid Family Planning Waivers,” State Policies In Brief (1/1/02), www.agi-usa.org 10/20/03

\textsuperscript{161} Alan Guttmacher Institute, \textit{Fulfilling the Promise: Public Policy and U.S. Family Planning Clinics} (2000), www.agi-usa.org 10/20/03

\textsuperscript{162} www.agi-usa.org 10/20/03

\textsuperscript{163} www.agi-usa.org 10/20/03

\textsuperscript{164} Alan Guttmacher Institute, \textit{Fulfilling the Promise: Public Policy and U.S. Family Planning Clinics} (2000), www.agi-usa.org 10/20/03
What are the Economic implications of the Family Planning Waiver?

*Increased Access to Health Care Improves Overall Health.* On a national level, increasing access to health care has improved the overall health of women and children. Publicly funded family planning efforts prevent 1.3 million unintended pregnancies annually. In a six-year period, publicly funded contraceptive services prevented 20,000 likely low birth weight births, 6500 likely infant deaths, and 5500 likely neonatal deaths by helping women to plan and space births. Most states have similar success stories as a result of implementing a Medicaid Family Planning Waiver.

After the Family Planning Waiver’s time period has lapsed, Wisconsin will be able to report similar measures of success in the form of lower teen pregnancies and lower numbers of women without access to health care. The most effective measure of success for the short existence of Wisconsin’s Family Planning Waiver is the number of women who are receiving coverage. In 12 months, 37,152 women have successfully registered to receive coverage by the Family Planning Waiver. By this measure, the Family Planning Waiver has had overwhelming success, as the goal set forth by Wisconsin’s Department of Health and Family Services is to extend coverage to a total of 47,000 women over a period of five years.

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165 www.iwpr.org 10/20/03

166 www.iwpr.org 10/20/03

167 www.agi-usa.org, and press releases from sixteen states that have implemented Family Planning Waiver. This statement is my own generalization from reading about success in each state. 10/20/03

168 The Medicaid Family Planning Waiver Program, www.hcet.org (PowerPoint presentation) 12/3/03
**Increased Access to Health Care is Cost-Effective.** On a national level, family planning efforts have proven to be a cost-effective measure in reducing Medicaid costs. In addition to giving women more control over family planning, contraceptive services are financially beneficial. Every dollar spent for contraceptive services saves three dollars in public funds that would otherwise be needed for prenatal and newborn medicare alone."\(^{169}\)

On a state level, most states have reported financial success as a result of implementing a Family Planning Waiver. Maryland’s family planning waiver demonstration project prevented subsequent pregnancies and births, resulting in savings of approximately half a million dollars in Medicaid spending.\(^{170}\) Rhode Island’s program was cost-effective: expanding family planning services helped prevent 1443 provisions of services\(^{171}\) to Medicaid-eligible women from 1994 through 1997—saving the state over 2.5 times its original investment.\(^{172}\)

For Wisconsin, the estimated cost savings is similar to that of other states that have implemented a Family Planning Waiver. Planned Parenthood of Wisconsin estimates that the Family Planning Waiver will save Wisconsin taxpayers $17 million over its five-year lifespan.\(^{173}\) A large part of these savings include averting as many as 66,687\(^{174}\) unintended pregnancies resulting in live birth, which can cost the state up to $8,000\(^{175}\) each in health care expenses.\(^{176}\)

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\(^{169}\) Frederick, 1998

\(^{170}\) “Expanding Access to Family Planning Through Medicaid,” www.naral.org 10/20/03

\(^{171}\) Deliveries can be defined as provision of services.

\(^{172}\) “Expanding Access to Family Planning Through Medicaid,” www.naral.org 10/20/03

\(^{173}\) Planned Parenthood Advocates of Wisconsin, www.wwpi.org 10/20/03

\(^{174}\) www.agi-usa.org (AGI’s number for unintended pregnancies in Wisconsin for the year 2002) 10/20/03

\(^{175}\) “Group Joins Contraceptive Fight”, Wausau Daily Herald (11/12/03)

\(^{176}\) I did not estimate state Medicaid savings for unintended pregnancies, because no percentage goal is universally touted as the statewide goal for reducing unintended pregnancies. If all 66,687 unintended pregnancies resulting in live births cost the state $8,000, and the Family Planning Waiver prevented all unintended pregnancies, then it would save Wisconsin an estimated $533,496,000. This number is a bit too high to be considered realistic. So, without a realistic projection, I did not include a savings amount in the paper.
Another part of the savings include preventing up to 12,100 abortions each year, resulting in state Medicaid savings of up to $2.75 million annually.

**WI FAMILY PLANNING WAIVER ENROLLMENT 2003**

![Graph showing enrollment by month.]

Source: Wisconsin DHFS Family Planning Waiver enrollees by month (www.dhfs.state.wi.us)

**What are the Implications of Medicaid Reimbursement?**

Family planning clinics that receive Title X or Title V funding administer the Family Planning Waiver to women who are eligible for the program. Clinics do not receive payment from the women in the program. Instead, clinics receive Medicaid reimbursement for each service provided. Medicaid provides the reimbursement four to six weeks after the clinic provides the service. A Registered Nurse at a clinic estimates that the amount Medicaid provides per

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177 www.agi-usa.org (AGI’s number for abortions in Wisconsin for the year 2002) 10/20/03

178 My estimation based on AGI’s number of abortions for the year 2002 multiplied by the Medicaid reimbursement cost for an abortion procedure, “Dilation and Curettage, Diagnostic and/or Therapeutic,” which equals $227.56.

service covers about 58.5% of the actual cost the clinic incurs by providing the service.\textsuperscript{180} A clinic office manager noted, “This program is great for women in Wisconsin. It is not great for family planning clinics.”\textsuperscript{181}

Family planning clinics in Wisconsin may not have difficulty serving 47,000 Family Planning Waiver participants, assuming that two-thirds are new clients and the other third are existing clients. If clinics aim to serve three patients per hour\textsuperscript{182}, and if Wisconsin has 71 family planning clinics\textsuperscript{183}, then each clinic must absorb 147 hours of work per year added to its current patient load, or a little more than 11 hours of work per month. These calculations assume one visit per year. It is possible that these family planning clinics could absorb these extra hours of work each year without a stretch of resources.

While they may not have difficulty serving 47,000 Family Planning Waiver participants, clinics face serious financial troubles when asked to incorporate the low proportion of Medicaid reimbursement into their annual budgets. In order to realize the actual amount of money clinics stand to lose annually as a result of the Family Planning Waiver, I created a bundle of goods and services a client might receive in one annual visit to a family planning clinic, and calculated the corresponding Medicaid reimbursement.\textsuperscript{184}

Next, I compared the amount of reimbursement with the actual cost of providing the services.\textsuperscript{185} The amount of Medicaid reimbursement ($237.68) represents 58.5% of the actual cost.

\textsuperscript{180} Interview: Planned Parenthood RN, December 8, 2003.
\textsuperscript{181} Interview: Joy Grotsky, WI Department of Health and Family Services, December 1\textsuperscript{st}, 2003. Grotsky noted that, in a recent meeting with clinic representatives, one clinic manager made this statement.
\textsuperscript{182} Interview: Amber Zeddies, Planned Parenthood of Wisconsin, December 4\textsuperscript{th}, 2003
\textsuperscript{183} www.dhfs.state.wi.us 11/31/03
\textsuperscript{184} The average bundle of goods and services I created includes:

<table>
<thead>
<tr>
<th>GOODS AND SERVICES</th>
<th>MEDIC AID $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual check up exam (named “General Health Panel”)</td>
<td>50.93</td>
</tr>
<tr>
<td>Battery of tests, including STD tests and an HIV test</td>
<td>36.75</td>
</tr>
<tr>
<td>Contraception (average of the cost of the three most prominent types of birth control for this entry.)</td>
<td>150.00</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>237.68</strong></td>
</tr>
</tbody>
</table>

“Medicaid $” represents amount of Medicaid reimbursement for each good or service.

\textsuperscript{185} Interview: Planned Parenthood RN, December 8, 2003.
cost ($407.00) of providing the bundle of goods and services, or roughly $169.00 per Waiver enrollee.

While an estimated one-third of 47,000 projected Family Planning Waiver enrollees who are current clients of family planning clinics will pay $407.00 less in family planning health care costs, Wisconsin’s family planning clinics will lose an estimated $2.64 million annually.\(^{186}\) For the estimated two-thirds of 47,000 projected Family Planning Waiver enrollees who were not clients previous to enrollment, Wisconsin family planning clinics will see an estimated additional $7.45 million in annual income.\(^{187}\)

In a real model, the amount of work family planning clinics are asked to absorb is much higher in the beginning, and not distributed in a linear way. In 10 months, 34,000 women signed up for the Family Planning Waiver. If half of two-thirds of these women are new clients, the new client load equals 31,334 new women. If family planning clinics aim to serve three patients per hour, the Family Planning Waiver has generated 10,445 hours of work in the short period of 10 months. Distributed evenly over Wisconsin’s 71 family planning clinics, the family planning waiver has created 147 hours of work per clinic annually in just under one year, conservatively assuming one visit per year from each of these 34,000 Family Planning Waiver enrollees. In tandem with the number of hours of work family planning clinics absorb, they also absorb a large fiscal shock. While clinics are losing $2.64 million in revenue from Family Planning Waiver enrollees who were previously paying for services, they are gaining $7.45 million in income that represents 60% of the actual cost of providing the goods and services. The additional time and revenue loss clinics are absorbing is probably more than they can financially bear.

| Annual check up exam (named “General Health Panel”) and battery of tests, including STD tests and an HIV test | 131.00 |
| Contraception (average of the cost of the three most prominent types of birth control for this entry.) | 276.00 |
| **TOTAL** | **407.00** |

“Cost”: Actual cost to Planned Parenthood of Wisconsin clinic.

\(^{186}\) 15,667 Family Planning Waiver enrollees who previously paid an average of $407.00 for services each year now each generate $237.68 annually for family planning clinics.

\(^{187}\) 31,334 new Family Planning Waiver enrollees who generate $237.68 each for family planning clinics.
By implementing the Family Planning Waiver, Wisconsin is on its way to improving women’s health, reducing the amount of money it spends on Medicaid, and improving the state’s labor market and workforce.

REPRODUCTIVE RIGHTS AND MINORITIES

Of Wisconsin’s population of 5,322,470, African Americans make up 5% (290,060), Hispanics make up 4% (212,280), and other minority groups make up 3% (146,060). Of this population, 15% of African Americans, 23% of Hispanics, 17% of other minority groups are uninsured.  

Of the 74,224 births in Wisconsin in 2001, 59,383 babies were white, 6,567 babies were African American, 5,152 babies were Hispanic, 2,133 were Asian American, and 989 were Native American. Of the 6,823 babies born to teenage mothers, 55% were white, 24% were African American, 14% were Hispanic, and 7% were part of another minority group. Regarding access to prenatal care, 87.7% of white mothers, 69.5% of African American mothers, and 69.8% of Hispanic mothers received beginning prenatal care in the first trimester.

Other than these statistics, we do not have research that addresses main concerns and health care issues for minority women in Wisconsin. We also do not know about cultural barriers that hinder access to reproductive health care. Further, we do not know about the difference between reproductive health care experiences and barriers specific to minority women in rural areas or specific to minority women in urban areas. Clearly, we are a long way from knowing how to appropriately meet the reproductive health care needs of 12% of Wisconsin’s population.

CURRENT LEGISLATION

Assembly Bill 63/ Senate Bill 21

This bill amends the Wisconsin Fair Employment Act (WFEA) to state that employment discrimination based on creed includes discriminating against any licensed pharmacist in a manner prohibited by the WFEA on the basis of the pharmacist's refusal to dispense a prescribed drug or devices because the pharmacist believes that the drug or device would be used for, (1) Causing an abortion, or (2) Causing the death of any person, if the pharmacist consults with the practitioner who prescribed the drug or device before the pharmacist makes the refusal.

The bill also amends the law so that no pharmacist is required to dispense or prescribe a drug or device if the pharmacist has reason to believe that the drug or device will be used to cause an abortion or death of a person. Such a refusal may not be the basis for a claim for damages against the pharmacist or their pharmacy, or disciplinary action by the Pharmacy Examining Board or the Department of Regulation and Licensing.\footnote{Wisconsin Legislative Council Amendment Memo. 2003 Assembly Bill 63, Assembly Amendment 2 May 19, 2003}

Assembly Amendment 2

Representative Owens introduced Assembly Amendment 2 and it was recommended for adoption by the Assembly Committee on Labor on May 14, 2003 by a vote of Ayes 7; Noes, 1. Assembly Amendment 2 deletes the term “believes” and replaces it with “has reason to believe.” Therefore, with the adoption of Assembly Amendment 2 the bill protects the refusal of a pharmacist who “has reason to believe” that a drug or device with be used to cause an abortion or cause a death of a person.\footnote{Wisconsin Legislative Council Amendment Memo. 2003 Assembly Bill 63, Assembly Amendment 2 May 19, 2003}

ASSEMBLY BILL 67-THE “CONSCIENCE CLAUSE”

Assembly Bill 67 was introduced on February 18, 2003. This bill makes three major changes to current Wisconsin law. It changes the law regarding 1) employment discrimination based on creed, 2) refusal of certain health care providers and hospital employees to participate in certain procedures on moral or religious grounds, and 3) duties of physician regarding power of
attorney for health care instruments and patient declarations.\textsuperscript{193} For the purpose of this paper we will focus on the first two changes.

\textit{Employment discrimination based on creed.} The current definition of “creed” is a system of religious beliefs, including moral or ethical beliefs about right and wrong. Under current law, an employer can not discriminate against an employee based on creed. The current definition of employment discrimination based on creed is refusing to reasonably accommodate an employee’s or prospective employee’s religious observances or practices unless the employer can demonstrate undue hardship on the employer. This bill expands the definition to include his or her refusal, based on creed, to participate in any of the following activities\textsuperscript{194}:

1) sterilization procedures
2) abortions
3) experiments or medical procedures that involve the destruction of a human embryo or that involve a human embryo or unborn child but do not relate to the beneficial treatment of the human embryo or unborn child
4) procedures using fetal tissue or organs other than fetal tissue or organs from a stillbirth, spontaneous abortion, or miscarriage
5) withholding or withdrawing nutrition or hydration under certain circumstances
6) actions intentionally causing or assisting in the death of an individual, including assisted suicide, euthanasia, or mercy killing.

There is no exception for an employer to show that this refusal poses an undue hardship.

\textit{Refusal to participate in procedures on moral or religious grounds.} Under current law certain health care workers and hospital employees are not required to participate in procedures involving sterilization or removal of a human embryo or fetus. Also, physicians or other hospital staff that refuse, in writing, to participate in such procedures may not be disciplined for their refusal. Finally, a hospital or the person\textsuperscript{195} refusing to participate is exempt from liability for damages that may result because of the refusal if the refusal is based or religious or moral grounds.\textsuperscript{196}

This bill expands the procedures a person can object to based on religious or moral grounds to the six procedures listed above. This bill also adds pharmacists licensed by the

\textsuperscript{193} AB 67, analysis by the Legislative Reference Bureau, http://www.legis.state.wi.us
\textsuperscript{194} Ibid.
\textsuperscript{195} Those persons exempt include persons employed by or associated with the staff of a hospital, physicians, and other health care professionals licensed or certified by the Medical Examining Board in the DRL and registered nurses licensed by the Board of Nursing in DRL.
Pharmacy Examining Board in the Department of Regulation and Licensing (DRL) to the list of those that are exempt from liability for damages that result from a refusal to participate in any of the six activities, if the refusal is based on religious or moral grounds.\textsuperscript{197} Not only does this bill exempt physicians, registered nurses, and pharmacists from liability for damages that may result from their refusal, this bill allows those that are adversely affected by conduct that violates object to bring a civil action for injunctive relief, damages, and attorney fees.\textsuperscript{198}

Finally, this bill states that the Medical Examining Board may not take disciplinary action against a physician even if a physician refuses to transfer a patient who has executed a declaration authorizing the withholding or withdrawal of life-sustaining procedures, to a physician who will comply with this declaration.\textsuperscript{199} In short, a physician can refuse to comply with a patient's legal wishes based on moral or religious grounds and not be disciplined.

**Assembly Substitute Amendment to Assembly Bill 67**

On April 21, 2003 Representative Jean Hundtermark introduced the Assembly Substitute Amendment 1 (ASA 1) to Assembly Bill 67. ASA 1 makes a number of changes to the bill. First off ASA 1 allows a person seeking equitable relief to obtain reinstatement and/or damages but does not included non-economic damages\textsuperscript{200}. This amendment also modifies the definition of “participate in” to mean “to perform; practice; engage in; assist in; recommend; counsel in favor of; make referrals for; prescribe, dispense, or administer drugs or devices, other than contraceptive articles, as defined in s. 450.155(1)(a), for or otherwise promote or encourage, or aid.”\textsuperscript{201} Under ASA 1, protections are expanded to cover a person licensed as a practical nurse.

Finally, ASA 1 deletes two of the six activities specified in AB 67, 1) the destruction of a human embryo, and 2) a human embryo or unborn child, at any state of development, in which

\begin{footnotes}
\footnote{AB 67, analysis by the Legislative Reference Bureau, http://www.legis.state.wi.us}
\footnote{Ibid.}
\footnote{AB 67, analysis by the Legislative Reference Bureau, http://www.legis.state.wi.us}
\footnote{Ibid.}
\footnote{Wisconsin Legislative Council Memo, April 21, 2003, 2003 Assembly Bill 77 and Assembly Substitute Amendment 1, Relating to a "Conscience Clause" for Health Care Providers.}
\footnote{Ibid. The definition of “contraceptive article” means any drug, medicine, mixture, preparation, instrument, article, or device of any nature used or intended or represented to be used to prevent a pregnancy. (s. 450.155(1)(a)
the experiment or procedure is not related to the beneficial treatment of the human embryo or
unborn child, and substitutes the following three procedures:

1) An experiment or medical procedure that destroys an in vitro human embryo or uses
cells or tissue derived from the destruction of an in vitro human embryo.
2) An experiment or medical procedure on an in vitro human embryo that is not related
to the beneficial treatment of the in vitro human embryo.
3) An experiment or medical procedure on a developing child in a natural or artificial
womb, at the any stage of development, that is not related to the beneficial treatment
of the developing child.  

Issues Surrounding AB 67 and ASA 1

There has been a strong opposition to the “conscience clause” from a variety of
organizations. Twenty-five organizations have registered to be lobbying on this issue. Fourteen
organizations are against, eight have undisclosed positions, two are in favor, and one is
undecided but has reservations. There is concern amongst the opposition that this bill
threatens women’s health. This bill allows hospitals and its employees to deny women any
referral or information about pregnancy termination, even when the woman’s life and/or health are
in danger. Also because of the language “do not relate to the beneficial treatment of the
human embryo,” women could be denied necessary medical treatment because it is not beneficial
to the embryo. For example doctors and nurses could refuse to administer anti-seizure
medication to a pregnant woman with epilepsy, or a pregnant cancer patient could be denied
chemotherapy. This elevates the health of a fetus or embryo above the health needs of a
woman.

202 Wisconsin Legislative Council Memo, April 21, 2003, 2003 Assembly Bill 77 and Assembly Substitute
Amendment 1, Relating to a “Conscience Clause” for Health Care Providers.

Those organizations lobbying against AB 67 are AARP, American Civil Liberties Union of Wisconsin Inc.,
American College of Nurse-Midwives (WI Chapter), HOPE, League of Women Voters of Wisconsin Inc.,
Milwaukee Jewish Council for community Relations, NARAL Wisconsin, Planned Parenthood Advocates
of Wisconsin, Planned Parenthood of Wisconsin Inc., Pro-Life Wisconsin, VITAS Health Corporation,
Wisconsin Academy of Family Physicians, Wisconsin Association of School Nurses, and Wisconsin
Nurses Association. Those lobbying for AB 67 are Wisconsin Right to Life Inc. and Wisconsin Catholic
Conference.

204 Planned Parenthood Advocates of Wisconsin, Inc. Press Release, Oppose Assembly Bill 67 Health Care
Denial Bill.

205 Interview with Chris Taylor, Legislative Director for Planned Parenthood, October 16, 2003.

206 Planned Parenthood Advocates of Wisconsin, Inc. Press Release, Oppose Assembly Bill 67 Health Care
Denial Bill.
There is also concern because this bill also harms patients in general, not just women. It allows health care professionals to deny patients health care services even if the denial harms the patient. It then eliminates the patient’s right to sue the hospital, physician, or health care worker if that denial results in a permanent, life-threatening injury. Finally, it prohibits disciplinary actions against all health care professionals if a worker presently or fatally injures a patient because of the professional’s moral or religious beliefs. This threatens patient’s rights and allows health care workers to refuse necessary treatment. Another concern is that AB 67 may not provide protection because of the federal Emergency Medical Treatment and Active Labor Act (EMTALA). EMTALA requires that any hospital with an emergency room must provide a medical screening examination to any patient who appears complaining of an emergency medical condition. It further provides that such patients cannot be transferred to another facility in an unstable condition, and requires that such a transfer be “appropriate.” It appears that the federal law will take precedence.

Assembly Bill 170/ Senate Bill 99

This bill requires that if a hospital provides emergency services to a alleged victim of sexual assault, the hospital must do the following things: 1) provide her with medically and factually accurate and unbiased written and oral information about emergency contraception, 2) orally inform her of her option to receive emergency contraception, and 3) provide emergency contraception immediately to her if she requests it.

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207 Ibid.
209 Ibid.
222 Wisconsin Department of Administration, Division of Executive Budget and Finance, Fiscal Estimate.
DHFS must respond to complaints about violations of not having or providing factually information on emergency contraception. After providing notice, DHFS may suspend or revoke the hospitals certificate of approval and deny application for anew certificate of approval if the hospital has violated the requirements twice.

Fiscal Impact

The State Fiscal Impact would be related to the enforcement of this legislation. DHFS currently does not have enough staff to monitor compliance so they would have to hire one FTE nurse consultant to monitor compliance and respond to complaints. The cost of producing information and training staff would be borne by the hospitals.\textsuperscript{222}

Assembly Bill 186

This bill prohibits a person from intentionally obstructing, detaining, hindering, impeding, or blocking another person’s entry to or exit from a health care facility. The bill also prohibits a person from intentionally approaching within eight feet of another person without the other’s consent on a public walk way or sidewalk within a radius of 100 feet from an entrance door to a health care facility for the purpose of (1) passing a leaflet or handbill to the other person, (2) displaying a sign to the other person; or 3) engaging in oral protest, education, or counseling with the other person.

The bill also creates a civil cause of action for individuals who suffer physical injury or emotion distress against the person who causes the injury or distress by performing the action prohibited above. A prevailing plaintiff may recover special and general damages, punitive damages, and costs, including reasonable attorney fees and investigation and litigation costs.\textsuperscript{223}

Assembly Bill 383/ Senate Bill 186

Under current law the Department of Health and Family Services must request a wavier from the federal Department of Health and Human Services in order to conduct a demonstration project under the Medical Assistance Program. This demonstration project is to provide family planning services to women aged 15 to 44 whose family incomes do not exceed 185% of the

\textsuperscript{222} Assembly Bill 186, Analysis by the Legislative Reference Bureau

\textsuperscript{223} Wisconsin Department of Administration. Division of Executive Budget and Finance, Fiscal Estimate 2003.
poverty line. DHFS must implement the wavier, if granted (the wavier was implement January 2003\textsuperscript{225}) by July, 1998, or the waiver’s effective date, whichever is later.

This bill changes the minimum age requirement from 15 to 18 years for eligibility for the demonstration project.

This bill was introduced as required by s. 227.26(2)(f), stats., in support of the Joint Committee for Review of Administrative Rules in suspending a revision to chs. HFS 101 to 107 on April 31, 2003, relating to the Medicaid Family Planning Demonstration Project.\textsuperscript{226}

Fiscal Impact

This project is to demonstrate that there will be no cost to Medical Assistance as a result in increase funding for family planning services because there will be a net savings over the five year period of the wavier because of reduced Medical Assistance births.

The Department of Health and Family Services has projected that Medicaid savings for the 15 to 17 year old age group would be $12,689,500 ($11,520,900 GPR and $1,168,600 FED) over the five years of the wavier. Therefore if the minimum age was increased to 18, the state would loose the annual savings of $2,537,900 ($2,304,200 GPR and $233,700 FED).\textsuperscript{227}

In addition, in FY 04 the state received enhanced federal matching funds under Medical Assistance. The provisions began in April 2003 and is in effect until June 2004. Under this provision the federal government pays 61.38\% of Medicaid costs compared to 58.41\%. The federal government has stated that states eligible for this enhancement are only eligible if the state plan is no more restrictive than the eligibility in effect on September 2, 2003. Under this provision the state cannot reduce eligibility for the Medical Assistance wavier until July 1004 without loosing federal funding.

\textsuperscript{225} Assembly Bill 383, Analysis by the Legislative Reference Bureau
\textsuperscript{226} Wisconsin Department of Administration. Division of Executive Budget and Finance, Fiscal Estimate 2003.
The enhanced funding provides approximately $10 million per month more in federal matching funds. Wisconsin could lose this funding for every month the revised eligibility criteria were in effect and may have to replace the funding with GPR.  

**ASSEMBLY BILL 634**

**The Issue**

Assembly Bill 634 aims to change the minimum age eligibility in the statute relating to the Medical Assistance family planning demonstration project. Specifically, the bill changes the age requirement from 15 to 18 years of age. Grothman introduced AB634 in order to delay the date of implementation to July 1, 2004 in order to take advantage of the increased federal Medicaid matching rates for states included in the federal Jobs and Growth Tax Relief Reconciliation Act of 2003.

**Background**

The Wisconsin Department of Health and Family Services (DHFS) estimates that the State of Wisconsin will save $12,689,500 in Medicaid costs for the 15 to 17 year old age group. DHFS attributes these savings to the subsequent decline in delivery costs and Medicaid-related health care costs. When the Family Planning Waiver applies to the 15 to 17 year old age group, the number of Medicaid-eligible children born to this age group declines.

**Findings**

On January 8, 2004, the Assembly Family Law Committee, approved AB 634 with a 5/1 vote (Berceau dissenting). The Committee Chairperson, Carol Owens, announced at the beginning of the hearing that the Committee would only hear testimony on the change of date of the bill’s implementation.

**Assembly Bill 635/Senate Bill 304**

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228 Wisconsin Department of Administration. Division of Executive Budget and Finance, Fiscal Estimate 2003.

229 www.legis.state.wi.us 1/10/04


231 Author’s report from attending the hearing.
Under current law before an unemancipated minor may have an abortion, she must have written consent from, (1) one of her parents, (2) her guardian or legal custodian, (3) an adult family member who is at least 25 years of age, (4) one of her foster parents or treatment foster parents. She also may obtain a waiver of these requirements from the circuit court.

This bill eliminated the authority of an adult family member, a foster parent, a treatment foster parent, or a parent that does not have legal custody, to consent to an abortion for a minor. The bill also requires the parent to declare before a notary public their consent.

The minor may also petition the circuit court for a waiver of the consent requirement. The minor must file the petition on her own behalf and be present at the initial appearance. This bill eliminates the option of permitting a member of the clergy to file a petition and affidavit on a minors behalf.

Fiscal Impact

It is unlikely that this bill will have any fiscal impact on the circuit courts.

However, it is likely that the number of abortions provided to minors will decrease under this bill. Therefore the number of births to minors will increase. About 86% of births to minors are funded by Medicaid. The delivery costs are approximately $7,500 per birth, health care costs for the first year of life are about $1,400. The mother would also be added to the Medicare case loads, at a cost of $2,100 per person per year. It is unknown to what extent the number of births to minors will increase but if abortions decrease and medicare births increase, Medicaid costs will increase. Currently, 60% of abortions annually are performed on minors. If for example 5% are not performed, and 86% of the subsequent births are funded by Medicaid, than there would be an increased cost of $286,000 to Medicaid annually.\(^{232}\)

Senate Bill 27

Under current law, if a child is born with a disability that a person could have informed the parents about while there was still time for the fetus to be aborted, that person may be liable for the costs of caring for that child and for the child’s medical expenses. The person could be liable

\(^{232}\) Wisconsin Department of Administration. Division of Executive Budget and Finance, Fiscal Estimate 2003.
if he or she negligently failed to inform the parents of the disability or if he or she negligently
incorrectly diagnosed the fetus's condition while an abortion was still an available option.

This bill prohibits recovery of damages from a person in a wrongful birth or wrongful life
action if the damages resulted from a condition that existed at the time of the child's birth and the
defendant's negligence contributed to the mother's decision not to undergo an abortion. 233

RECOMMENDATIONS

Current Wisconsin law

Laws that are unconstitutional should be removed from Wisconsin’s books. Over 30 years
after the Roe v. Wade decision, Wisconsin continues to retain its pre-Roe law banning abortions.
The outdated law is unconstitutional, unnecessary, and it creates an environment in which
abortion is not supported as a legal procedure.

Laws that impose a burden on women choosing abortion should be overturned. Parental
consent laws, mandatory ‘Informed’ consent, and 24-hour waiting periods excessively impose
upon a woman’s very personal decision.

Abortion

Wisconsin Must Increase the Number of Abortion Providers in the State, Particularly in
Rural, Northern Wisconsin. This can be accomplished by number of factors which include the
following. Permitting Physicians Assistants and Nurse Practitioners to perform abortions will
increase access to those who can perform abortion services. Reproductive Health and Women's
organizations need to coordinate with other organizations and across state lines to provide
access to abortion clinics, such as placing a clinic on a state border to allow access to women
from both states. Hospitals should provide space for a traveling abortion doctor to perform
abortion services, and an incentive system for medical students who train in abortion services
such as tuition repayment for working in a rural or family planning clinic should be implemented.

Wisconsin Must Mandate Medicaid Coverage of Abortion for All Women and mandate public
hospitals provide abortions to all women. Wisconsin must mandate private hospitals inform
patient of options including phone numbers and addresses of abortion providers. Mandated
scripts must be used to ensure accuracy of information and oversight and enforcement measures
must be put in place to ensure hospital and/or clinic staff do not offer personal opinions. Referrals
to non-medical facilities should be prohibited

A Network of Supportive Services Must Be Established. A central state contact, such as a 1-
800 number where women can call and find services or people that will help them in their time of
need such as driving them to an abortion clinic, providing housing during while waiting for the
abortion, or moral support. This support network will help women in secluded rural setting
connect to abortion services.

Women’s Health Agencies and Organizations Need to Increase Education and Awareness
Campaigns. Non-Profit, Government, and Professional Organizations need to increase

233 Senate Bill 27, Analysis by the Legislative Reference Bureau
education on the abortion needs of women in their communities in an effort to decrease the stigma associated with abortions and increase the access to abortion services.

Contraceptive Equity

Wisconsin Must Mandate Insurer Coverage of All FDA Approved Contraceptive Methods and make contraceptives more accessible for uninsured individuals through increased Medicaid funding such as the Family Planning Waiver.

Wisconsin Must Conduct a Statewide Cost-Benefit Analysis of Contraceptive Coverage versus unintended pregnancy to realize the financial benefits of providing this coverage.

Wisconsin Must Mandate Pharmacists Dispense Any and All Prescribed Contraceptive Methods and deny any legislation that seeks to implement a denial clause

Emergency Contraception

Wisconsin Must Make EC Available to All Women, not just victims of incest and sexual assault, and must mandate that all hospitals and clinics inform women of their option to receive EC, prescribing EC if a patient requests it. With greater hospital and clinic oversight, EC would be more accessible to all women in all areas of the state.

Wisconsin Must Regulate Access to, Dispensation of, and Disclosure of Information about EC. Wisconsin must conduct an information campaign to raise awareness of EC, to advocate the safety of EC, and introduce EC as a viable birth control measure, not an “abortion” pill. A toll-free number where women can receive information about EC and a prescription for EC over the phone must be included.

Wisconsin Must Pass Laws such as SB 99 and ensure similar legislation is enacted while working toward over the counter status for EC

Family Planning

Continue to fund the Family Planning Waiver Demonstration Project. With shortage of funding, government agencies must look for effective efforts that aim to solve multiple budget shortfalls. Pregnancy prevention programs help alleviate the high Medicaid costs associated with births to Wisconsin’s low-income and teen mothers.

Fund capacity building efforts for Wisconsin’s family planning clinics. The family planning clinics cannot bear the financial burden of serving 47,000 additional Family Planning Waiver enrollees on Medicaid reimbursements alone. Designate funding for clinics to add staff and accommodate capital and equipment needs.

Research the reproductive health care needs of Wisconsin’s minority women. Clearly, we do not know enough about minority women’s needs in Wisconsin. When we research experiences and barriers, we will be able to serve this important 12% of our state’s population.

Legislation

Enhance Clinic Access Protection Laws. Current Wisconsin Law only protects against intimidation and threats. There needs to be protection against property damage and obstructing access. Legislation such as Assembly Bill 186 is a good way to protect against obstructing access; efforts should be made to see that Assembly Bill 186 is passed. Efforts should also be made to introduce and pass legislation against property damage. Enhanced Clinic Protection Laws will assist in increasing the number of abortion providers in this state by making the clinics less dangerous to operate.
Legislation that is harmful to women’s health or reproductive rights should be defeated. Bill such as SB 27, AB 63, AB 67, AB 383, AB 634 are harmful to women’s reproductive health. These bill need to be defeated and never become Wisconsin State law.

Increase Women’s Participation in Wisconsin Politics. Wisconsin Women need to place those in office that will state up for their health and their rights.

FINAL THOUGHT

Wisconsin has historically and continues to be a progressive leader throughout the nation in policies that address the needs of citizens. The continuance of this tradition rests on the ability of Wisconsin to pursue fair and just women’s reproductive rights and health issues to the fullest extent possible. Women’s reproductive health must remain at the forefront of legislative and public agenda in order to ensure a healthy state and a healthy future for its residents. Although barriers exist, Wisconsin must draw on its strength as a progressive and responsive state and enact change. It is only with the support of legislators, elected officials, community leaders, and citizens that Wisconsin’s reproductive laws will reflect the needs of the community today and for years to come.
### APPENDIX I

#### STATE-BY-STATE REPORT CARD ON ACCESS TO ABORTION

![Map of the United States with states labeled and a key indicating ratings.]

**KEY**
- **WHITE** = states that most fully protect the right to choose

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See following page for key.
NARAL Pro-Choice America scored each state and the District of Columbia ("state") in 14 categories. For each category, a state received either points, from zero to the maximum, or a dash indicating that the state had no applicable law in that category. The points earned in the individual categories, which were based on the factors listed below, were summed to give each state its overall grade.

1. **Abortion Ban (Post-Roe)** (5 points) - Demerits were based on the point in pregnancy when the ban would begin if the law were in effect and the exceptions.

2. **Bans on Abortion Procedures** (20 points) - Demerits were based on: the point in pregnancy when the ban begins; the exceptions; and the extent to which the law is in effect.

3. **Clinic Violence** (10 points) - Points were subtracted based on whether the law prohibits: interference with entry or exit to a facility; physical invasion of the facility including trespass, property damage, arson, and bombing; excessive noise, odors, or telephone calls; threats, including weapon possession at demonstrations. Points were also subtracted if the law permits injunctive relief and if the law is in effect.

4. **Conscience-Based Exemption** (10 points) - Demerits were based on whether the law applies to insurers, private facilities, and/or public facilities; whether the law permits individuals or organizations to withhold information or refuse to refer for abortion; the exceptions; and the extent to which the law is in effect.

5. **Counseling Ban** (10 points) - Demerits were based on: whether the ban applies to counseling and/or referring; whether the ban applies to all or some public funds or employees; and the exceptions.

6. **Husband Notice/Consent** (5 points) - Demerits were based on: whether husband notice or consent is required; and whether the law has been challenged.

7. **"Informed" Consent/Waiting Period** (20 points) - Demerits were based on: the length of the waiting period; whether multiple trips are required; whether a physician is required personally to provide specified information; whether the woman must receive state-prepared materials; whether the woman must receive other information, oral or written, that contains information beyond risks, benefits, and alternatives; and the extent to which the law is in effect.

8. **Insurance** (10 points) - Demerits were based on: whether the law prohibits insurance coverage for abortion for all or some public funds or employees; whether the law prohibits abortion coverage unless an extra premium is paid; whether the law requires insurers to provide a policy alternative excluding abortion; and the exceptions.

9. **Minors’ Access** (20 points) - Demerits were based on: whose consent or notice is required before a minor can obtain an abortion; whether the bypass procedure is adequate; and the extent to which the law is in effect.

10. **Physician-Only Requirement** (5 points) - Demerits were based on who is prohibited from performing an abortion and the extent to which the law is in effect.

11. **Post-Viability Ban** (10 points) - Demerits were based on: the inadequacy of the definition of post-viability; the exceptions; and the current enforcement status of the law.

12. **Public Employees** (5 points) - Demerits were based on whether all or some public employees are prohibited from performing abortions and the exceptions.

13. **Public Facilities** (10 points) - Demerits were based on whether abortions are prohibited in all or some public facilities and the exceptions.

14. **Public Funding** (20 points) - Demerits were based on the circumstances under which the state medical assistance program funds abortions: only to preserve the woman’s life; only in cases of rape, incest, or life endangerment; in cases of rape, incest, life endangerment, and some health circumstances; in most circumstances; or in all circumstances.

APPENDIX II

Major U.S. Supreme Court Rulings on Reproductive Health and Rights (1965–2002)

Since the 1973 decision in Roe v. Wade, the U.S. Supreme Court has handed down more than 20 major opinions regarding a woman’s access to safe, legal abortion. Prior to 1973, the Supreme Court decided two contraceptive cases, Griswold v. Connecticut and Eisenstadt v. Baird, which helped to establish the basic principle in Roe: that the constitutional right to privacy extends to decisions regarding whether or not to have children.

Contraceptive Cases

1965
Griswold v. Connecticut
381 U.S. 479
Nature of Case: Challenge to a Connecticut law prohibiting use of contraceptives.
Holding: The law is unconstitutional. The Constitution contains a "right to privacy" that protects the decision of married couples to use contraceptives.

1972
Eisenstadt v. Baird
405 U.S. 438
Nature of Case: Challenge to a Massachusetts law allowing the sale or distribution of contraceptives only to married persons.
Holding: The law is unconstitutional. The right to privacy extends to individuals and protects the right of unmarried persons to obtain contraceptives.

1977
Carey v. Population Services International
431 U.S. 678
Nature of Case: Challenge to a New York law banning sale of even nonprescription contraceptives by persons other than licensed pharmacists; sale or distribution to minors under sixteen; and contraceptive display and advertising.
Holding: Statute is unconstitutional because it violates the right to privacy of adults and minors and to the right of free speech of vendors of contraceptives.

1983
Bolger v. Youngs Drug Products Corporation
463 U.S. 60
Nature of Case: Challenge to a federal law that made it a crime to send through the U.S. mail unsolicited advertisements for contraceptives.
Holding: The law is unconstitutional because it violates the First Amendment's protection of "commercial speech." Possible offensiveness to sensitive addressees is not valid rationale for prohibiting communication of truthful, non obscene information. The law also interferes with parents' access to information that might help them to discuss birth control with their children.

Abortion Cases

1973
Roe v. Wade
410 U.S. 113
Nature of Case: Challenge to a Texas law prohibiting abortions except to save the woman's life.
Holding: The law is unconstitutional. The right to privacy extends to the decision of a woman, in consultation with her physician, to terminate her pregnancy. During the first trimester of pregnancy, this decision may be effectuated free of state interference. After the first trimester, the state has a compelling interest in protecting the woman's health and may reasonably regulate abortion to promote that interest. At the point of fetal
viability (capacity for sustained survival outside the uterus), the state has a compelling interest in protecting potential life and may ban abortion, except when necessary to preserve the woman's life or health.

1973

*Doe v. Bolton*

410 U.S. 179

Nature of Case: Challenge to a Georgia law, based on the model proposed by the American Law Institute, prohibiting abortions except in cases of medical necessity, rape, incest, and fetal abnormality. The Georgia law also required that all abortions be performed in accredited hospitals and that two doctors and a committee concur in the woman's abortion decision; and that only Georgia residents may obtain abortions in that State.

Holding: The law is unconstitutional. It violates a woman’s right to choose abortion as recognized in *Roe v. Wade* (see above). The residency requirement violates the Privileges and Immunities Clause of the Constitution.

1975

*Connecticut v. Menillo*

423 U.S. 9

Nature of Case: Appeal from conviction of non-physician for performing abortion.

Holding: States may require that only physicians provide abortions. Such a regulation provides the minimum standard of safety upon which the constitutional right recognized in *Roe* was predicated.

1976

*Planned Parenthood of Central Missouri v. Danforth*

428 U.S. 52

Nature of Case: Challenge to a Missouri law requiring (a) parental consent to a minor's abortion; (b) husband's consent to a married woman's abortion; (c) the woman's written informed consent; (d) that no second-trimester abortion be done by saline amniocentesis; and (e) that abortion providers do certain record keeping and reporting.

Holding: Parental and spousal consent requirements held unconstitutional because they delegate to third parties an absolute veto power over a woman's abortion decision which the state does not itself possess. The requirement that the woman certify that her consent is informed and freely given is constitutional, as are the record-keeping and reporting requirements. The ban on saline amniocentesis is struck down because saline amniocentesis is the most commonly used abortion method after the first 12 weeks of pregnancy and was shown to be less dangerous to the woman's health than other available methods; the choice of method must be left to the physician. (Currently, dilatation and evacuation — D&E — is the most common method of mid trimester abortion.)

1976

*Bellotti v. Baird (Bellotti I)*

428 U.S. 132

Nature of Case: Challenge to a Massachusetts law that required consent of both parents to a minor's abortion, but allowed the requirement to be waived by a judge for "good cause shown."

Holding: The statute may be constitutional, depending on the meaning of "good cause" and exact procedure that will be utilized. Case remanded for definitive interpretation by Massachusetts state courts of meaning of the statute (see discussion of Bellotti II, 1979.)

1977

*Maher v. Roe*

432 U.S. 464

Nature of Case: Challenge to Connecticut's limitation of state Medicaid funding to medically necessary abortions and refusal to fund "elective" abortions.

Holding: The law is constitutional. The state need not fund a woman's exercise of her right to choose abortion even though it pays the costs of childbirth.

1977

*Poelker v. Doe*

432 U.S. 519

Nature of Case: Challenge to a St. Louis, Missouri, municipal policy of refusal of all publicly financed hospital services for "elective" abortions.

Holding: The law is constitutional for the reasons stated in *Maher v. Roe* (see above).
1979
*Colautti v. Franklin*
439 U.S. 379
Nature of Case: Challenge to provisions of Pennsylvania law requiring physician intending to perform an abortion to determine that fetus is not viable. If physician finds that fetus "is or may be viable," he or she is required to exercise the degree of care in performing abortion that would have been exercised if a live birth were intended.
Holding: Provisions are "void for vagueness" because meanings of "viable" and "may be viable" are unclear. Decision on viability must be left to the good-faith judgment of the physician. Provisions are also unconstitutional because they impose criminal liability on physicians regardless of their intent to violate the law.

1979
*Bellotti v. Baird (Bellotti II)*
443 U.S. 622
Nature of Case: The Massachusetts law challenged in Bellotti I (1976) arrived at the court definitively interpreted by the Massachusetts Supreme Judicial Court. The law would require, the Massachusetts court said, (a) that a minor first attempt to obtain her parents' consent and be refused before approaching a court for permission for her abortion and that parents be notified when a minor files a petition for judicial waiver; and (b) that the judge hearing the minor's petition may deny the petition if the judge finds that an abortion would be against the minor's best interests.
Holding: The law is unconstitutional. All minors must have an opportunity to approach a judge without first consulting their parents, and the proceedings must be confidential and expeditious. A mature minor must be given permission for an abortion, regardless of the judge's view as to her best interests. Even an immature minor must be permitted to have a confidential abortion, if the abortion is in her best interests.

1980
*Harris v. McRae*
448 U.S. 297
Nature of Case: Challenge to the Hyde Amendment's ban on the use of federal Medicaid funds for medically necessary abortions except those necessary to save the woman's life.
Holding: The Hyde Amendment is constitutional. The government has no obligation to provide funds for medically necessary abortions.

1980
*Williams v. Zbaraz*
448 U.S. 358
Nature of Case: Challenge to an Illinois version of the Hyde Amendment.
Holding: The statute is constitutional for the same reasons the Hyde Amendment is upheld in Harris v. McRae (see above).

1981
*H.L. v. Matheson*
450 U.S. 398
Nature of Case: Challenge to a Utah law requiring the physician to notify a parent of an unemancipated minor prior to abortion.
Holding: The law is constitutional. The plaintiff is a dependent minor, living at home, who has made no claim that she is mature enough to give informed consent to abortion or that she has any problems with her parents that make notice inappropriate. As to this minor, the law is valid. Justices Stewart and Powell wrote a concurring opinion to emphasize that mature minors and those whose best interests mandate that parents not be involved have a right to a confidential abortion.

1983
*City of Akron v. Akron Center for Reproductive Health*
462 U.S. 416
Nature of Case: Challenge to an Akron, Ohio, ordinance requiring that (a) a woman wait 24 hours between consenting to and receiving an abortion; (b) all abortions after the first trimester of pregnancy be performed in full service hospitals; (c) minors under fifteen have parental or judicial consent for an abortion; (d) the attending physician personally give the woman information relevant to informed consent; (e) specific information be given to a woman prior to an abortion, including details of fetal anatomy, a list of risks and consequences of the procedure, some of which were false or hypothetical, and a statement that "the unborn child is a human life from the moment of conception"; and (f) fetal remains be "humanely" disposed of.
Holding: All challenged portions of the ordinance are unconstitutional: (a) the 24-hour waiting period serves neither the state's interest in protecting the woman's health nor in ensuring her informed consent; (b) the post first-trimester hospitalization requirement interferes with a woman's access to abortion services without protecting her health because the dilatation and evacuation (D&E) method of mid trimester abortion may be performed as safely in outpatient facilities as in full-service hospitals; (c) the minors' consent requirement fails to guarantee an adequate judicial alternative to parental involvement (see Bellotti II, 1979); (d) the physician counseling requirement makes abortions more expensive and is not necessary to ensure informed consent since the physician can delegate the counseling task to another qualified individual; (e) the informed consent "script" intrudes on the physician's judgment as to what is best for the individual woman and contains information designed to dissuade the woman from having an abortion; and (f) the requirement for "humane" disposal of fetal remains is too vague to give fair warning of what the law requires.

In 1992, the Supreme Court overruled parts of this case (see Planned Parenthood v. Casey).

1983
Planned Parenthood of Kansas City, Missouri, v. Ashcroft
462 U.S. 476
Nature of Case: Challenge to a Missouri law requiring that (a) all post first-trimester abortions be performed in hospitals; (b) minors under 18 have parental consent or judicial authorization for their abortions; (c) two doctors be present at the abortion of a viable fetus; and (d) a pathologist's report be obtained for every abortion.
Holdings: (a) The hospitalization requirement is unconstitutional for the reasons stated in City of Akron v. Akron Center for Reproductive Health (1983); (b) the parental consent requirement is constitutional because the judicial bypass alternative contained in the statute conforms to the standards set out in Bellotti II (1979); (c) the presence of two doctors at late abortions serves the state's compelling interest in protecting potential life after viability and is, therefore, constitutional; and (d) the requirement of a pathology report is constitutional because it poses only a small financial burden to the woman and protects her health.

1983
Simopoulos v. Virginia
462 U.S. 506
Nature of Case: Criminal conviction of a physician for violating a Virginia law that requires all post first-trimester abortions to be performed in hospitals.
Holding: The physician's conviction is upheld. Virginia law provides for licensing of freestanding ambulatory surgical facilities as "hospitals." Consequently, the Virginia law is not as restrictive as the laws struck down in City of Akron v. Akron Center for Reproductive Health (1983) and Planned Parenthood of Kansas City, Missouri v. Ashcroft (1983), and is therefore constitutional. Dr. Simopoulos could have avoided criminal prosecution by having his clinic licensed.

1986
Babbitt v. Planned Parenthood of Central and Northern Arizona
789 F. 2nd 1348 (9th Cir. 1986)
Affirmed 479 U.S. 925 (1986)
Nature of Case: Federal Court of Appeals for the Ninth Circuit ruled unconstitutional an Arizona law prohibiting grants of state money for family planning to organizations that provide abortion or abortion counseling and referral. The law would be valid, the appeals court said, only if the state could prove it was the only way to stop its money from being used to pay for abortions and abortion related activities. Since the state could not prove this, the law was struck down.

1986
Thornburgh v. American College of Obstetricians and Gynecologists, Pennsylvania Section
476 U.S. 747
Nature of Case: Challenge to Pennsylvania's 1982 Abortion Control Act requiring (a) that a woman be given specific information before she has an abortion, including state-produced printed materials describing the fetus; (b) that physicians performing post-viability abortions use the method most likely to result in fetal survival unless it would cause "significantly" greater risk to a woman's life or health; (c) the presence of a second physician at post viability abortions; (d) detailed reporting to the state by providers on each abortion, with reports open for public inspection; and (e) one parent's consent or a court order for a minor's abortion.
Holding: (a) the informed consent provision is invalid because it interferes with the physician's discretion and requires a woman to be given information designed to dissuade her from having an abortion; (b) the provision restricting post-viability abortion methods is invalid because it requires the woman to bear an
increased risk to her health in order to maximize the chances of fetal survival; (c) the second-physician requirement is invalid because it does not make an exception for emergencies; (d) the reporting requirement is unconstitutional because it could lead to disclosure of the woman's identity; and (e) the parental consent issue is remanded to the lower court for consideration in light of newly enacted state court rules.

In 1992, the Supreme Court overruled portions of this case in Planned Parenthood v. Casey.

1989
Webster v. Reproductive Health Services
492 U.S. 490
Nature of Case: Challenge to Missouri's 1986 Act: (a) declaring that life begins at conception; (b) forbidding the use of public funds for the purpose of counseling a woman to have an abortion not necessary to save her life; (c) forbidding the use of public facilities for abortions not necessary to save a woman's life; and (d) requiring physicians to perform tests to determine viability of fetuses after 20 weeks gestational age.

Holding: (a) the court allowed the declaration of when life begins to go into effect because five justices agreed that there was insufficient evidence that it would be used to restrict protected activities such as choices of contraception or abortion. Should the declaration be used to justify such restrictions in the future, the affected parties could challenge the restrictions at that time; (b) the court unanimously declined to address the constitutionality of the public funds provision. The court accepted Missouri's representation that this provision was not directed at the conduct of any physician or health care provider, private or public, but solely at those persons responsible for expending public funds, and that the provision would not restrict publicly employed health care professionals from providing full information about abortion to their clients; (c) the court upheld the provision that barred the use of public facilities. It ruled that the state may implement a policy favoring childbirth over abortion by allocations of public resources such as hospitals and medical staff; and (d) the court upheld the provision requiring viability tests by interpreting it not to require tests that would be "imprudent" or "careless" to perform.

1990
Ohio v. Akron Center for Reproductive Health
497 U.S. 502
Nature of Case: Challenge to a 1985 Ohio statute requiring a physician performing an abortion on a minor to give notice to her parent or guardian 24 hours prior to the procedure. Although the law provided a judicial bypass mechanism, the Sixth Circuit Court of Appeals found several aspects of it unduly burdensome to minors and constitutionally deficient.

Holding: Without deciding whether a law that requires notice to only one parent requires a judicial bypass, the court held the bypass provided by the Ohio law met constitutional standards. The court rejected the argument that the judicial bypass was flawed because it required the minor to sign her name on court papers, prove her entitlement to avoid parental involvement by clear and convincing evidence, and wait as long as three weeks to obtain a court ruling. It also upheld a requirement that the physician personally notify the parent.

1990
Hodgson v. Minnesota
497 U.S. 417
Nature of Case: Challenge to a 1981 Minnesota statute that required notification of both biological parents, followed by a wait of at least 48 hours, prior to a minor's abortion. No exception to the notification requirement was provided for divorced parents or couples who were not married. A second section of the statute provided for a judicial bypass if the two-parent notification provision without a waiver procedure were enjoined. The plaintiffs challenged the second section based on evidence gathered during the five years that the parental consent requirement and judicial bypass were in effect.

Holding: The court held that two-parent notification with no judicial bypass alternative poses an unconstitutional burden on a minor's right to abortion. A different majority of the court allowed the second section of the Minnesota law to stand, however, because of the addition of a judicial alternative. In addition, the court upheld the validity of the 48-hour waiting period following notification before the abortion can be performed.

1991
500 U.S. 173
Nature of Case: Challenge to 1988 federal regulations that forbade counseling and referral for abortion or advocacy of abortion rights in programs that receive funds under Title X of the federal Public Health Service Act (1970). Additionally, the regulations require clinics to "financially and physically" separate Title X-funded
activities from privately funded "abortion-related activities."

Holding: The court held that the regulations do not violate the Title X statute because they are a reasonable interpretation of the statutory prohibitions against the use of Title X funds in programs "where abortion is a method of family planning." The court further held that the regulations do not violate the First Amendment or the right to choose abortion, ruling that the government has no obligation to pay for the exercise of constitutional rights. The court held that the government's decision not to fund the provision of information does not directly interfere with the rights of doctors, clinics, or patients, since providers are free to offer abortions and abortion-related information in separate programs, and women who wish unbiased medical information and services are free to seek them elsewhere.

1992

Planned Parenthood of Southeastern Pennsylvania v. Casey
505 U.S. 833

Nature of Case: Challenge to Pennsylvania’s 1989 Abortion Control Act. The 1989 statute required that, except in medical emergencies: (a) a woman wait 24 hours between consenting to and receiving an abortion; (b) the woman be given state-mandated information about abortion and offered state-authored materials on fetal development; (c) a married woman inform her husband of her intent to have an abortion; and (d) minors' abortions be conditioned upon the consent, provided in person at the clinic, of one parent or guardian, or upon a judicial waiver. In addition, physicians and clinics that perform abortions were required to provide to the state annual statistical reports on abortions performed during the year, including the names of referring physicians.

Holding: The court reaffirmed the validity of a woman’s right to choose abortion under Roe v. Wade, but announced a new standard of review that allows restrictions on abortion prior to fetal viability so long as they do not constitute an "undue burden" to the woman. A restriction is an "undue burden" when it has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion. Under this standard, only the husband notification provision was considered an undue burden and therefore unconstitutional. All the other provisions were upheld as not unduly burdensome.

In upholding the Pennsylvania abortion restrictions, the court overturned portions of two of its previous rulings, City of Akron v. Akron Center for Reproductive Health (1983) and Thornburgh v. American College of Obstetricians and Gynecologists (1986).

1993

Bray v. Alexandria Women's Health Clinic
506 U.S. 753

Nature of Case: Anti-abortion demonstrators (including the leadership of Operation Rescue) challenged an injunction against their activities that included blocking access to health care facilities in the Washington, D.C. area. The injunction was based on a 1871 civil rights statute that forbids private conspiracy to violate constitutional rights. The demonstrators claimed their activities did not violate the statute.

Holding: The court held that the demonstrators' activities did not violate the civil rights statute because their actions were not motivated by "class-based discriminatory animus against women," as the statute requires, but rather by opposition to abortion. The court held further that the demonstrators incidental impact on the right of women to travel interstate (for the purpose of securing an abortion) was not the kind of violation of a right for which the 1871 statute was enacted.

1994

National Organization for Women v. Scheidler
510 U.S. 249

Nature of Case: National Organization for Women (NOW) sought to use the federal Racketeer Influenced and Corrupt Organizations (RICO) Act to sue anti-abortion organizations that engage in unlawful blockades and other harassment against reproductive health clinics. The RICO Act, established in 1970 as a tool against organized crime, punishes "enterprises" that engage in a "pattern of racketeering." NOW argued that RICO is applicable because the unlawful actions constituted a nationwide conspiracy to eliminate access to abortion by using extortion and intimidation to drive the clinics out of business. The U.S. Court of Appeals for the Seventh Circuit had ruled that the case could not go forward because RICO applies only to activities that are motivated by economic gain, which could not be demonstrated in this case.

Holding: The court overturned the appeals court decision, allowing the lawsuit to proceed using RICO as its basis. The court held that RICO can be used in the absence of an economic motive, and that the term "enterprise" can include any individual or group of individuals, partnership, corporation, association, or other legal entity.

1994

Madsen v. Women's Health Center
512 U.S. 5753
Nature of Case: Anti-abortion protesters sought to overturn on First Amendment grounds an injunction against their activities at a Melbourne, Florida, clinic. The injunction prohibited demonstrations within 36 feet of the clinic property line; noise and visual displays that could be heard and seen inside the clinic; approaching any person seeking services within 300 feet of the clinic, unless the person indicated a desire to communicate; and established a 300-foot buffer zone around the residences of clinic physicians and staff. Holding: The court held that the 36-foot buffer zone protecting clinic entrances and driveways is a content-neutral measure that does not infringe on the First Amendment rights of abortion opponents, and that the ban on disruptive noise was also constitutional. The majority indicated that Florida's interests include "protecting a woman's freedom to seek lawful medical or counseling services in connection with her pregnancy." But the court limited the scope of its ruling by striking portions of the injunction as broader than necessary to protect the state's interests, including application of the buffer zone to certain private property adjoining the clinic, the 300-foot no approach zone and residential buffer zone, and the prohibition against "images observable to" patients inside the clinic.

1997
Schenck v. Pro-Choice Network of Western New York
519 U.S. 357
Nature of Case: Challenge on First Amendment grounds to injunction aimed at protecting access to reproductive health care clinics. Three elements of the injunction were challenged: (1) a "fixed" buffer zone prohibiting all demonstration activity within 15 feet of the clinics' doorways, driveways, and parking lot entrances; (2) a "floating" zone prohibiting all demonstration activity within 15 feet of any person or vehicle entering or leaving the clinics; (3) "cease and desist" provisions, which allowed no more than two "sidewalk counselors" to approach patients within the buffer zones, but required them to stop "counseling" and withdraw outside the zones upon request. Holding: The government interests in ensuring public safety and protecting a woman's freedom to seek pregnancy-related services justify properly tailored injunctions to secure unimpeded physical access to clinics. The court upheld the "fixed" buffer zone as necessary to ensure safe access to the clinics in light of the demonstrators' previous behavior. The court, however, struck down as unconstitutional the "floating buffer zone," because it burdened more speech than was necessary to achieve the government interest. The court upheld the "cease and desist" provision because it allowed demonstrators to espouse their message outside of the zone and was necessary to address their previous harassing and intimidating behavior. As the court struck down the "floating" zone, it did not rule on the "cease and desist" provisions as applied to that zone.

1997
Mazurek v. Armstrong
520 U.S. 968
Nature of the Case: Challenge to a Montana law that requires only physicians, i.e., not physician assistants, may provide abortion. Holding: The law has neither the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion. It therefore does not create an undue burden on a woman's right to abortion and is constitutional. The court reiterated its position that "the performance of abortions may be restricted to physicians." Note: this statute was later ruled unconstitutional by the Montana Supreme Court under the Montana Constitution. Armstrong v. Montana, 989 P.2d 364.

2000
Hill v. Colorado
530 U.S. 703
Nature of Case: Challenge on First Amendment grounds to a Colorado statute that established an eight-foot "bubble zone" around anyone within 100 feet of a healthcare facility. This statute forbade individuals from knowingly approaching closer than eight feet another person who is within 100 feet of the entrance of a healthcare facility, without that person's consent, in order to leaflet, display a sign, or engage in protest, education, or counseling. Holding: The statute does not violate the First Amendment because it does not regulate speech on the basis of content or viewpoint. The court concluded that it was a reasonable time, place, and manner restriction that left open ample alternative means of communication. The court reasoned that; (1) the eight-foot distance of separation required by the statute would not adversely affect the regulated speech because this is a normal conversational distance; (2) because the statute only bans "approaches," protestors are not liable if they stand still and others come within eight feet of them; and (3) the protester must "knowingly" approach, and the "knowingly" requirement protects against accidentally or unavoidably coming within eight feet of someone who is in motion. The court also addressed the question of the legitimacy of the state's
interest in enacting this type of restriction and found the state’s interest in protecting the unwilling listener from persistent and dogged intrusions, particularly in situations that the listener cannot choose to avoid, to be legitimate.

2000

Stenberg v. Carhart
530 U.S. 914
Nature of Case: Challenge to Nebraska’s so-called “partial-birth” abortion ban.
Holding: The statute is unconstitutional because it lacks an exception for situations when the procedure is necessary to protect the woman’s health. The exception must allow the banned procedure both because the woman’s medical condition requires it and because the banned procedure is less risky than others. In addition, the statute creates an undue burden on a woman’s right to abortion because it has the effect of outlawing the dilation and evacuation (D&E) procedure, the most commonly used method for performing second-trimester abortions.

Intrusions on Privacy of Pregnant Women

2001

Ferguson v. City of Charleston
532 U.S. 67
Nature of Case: A state hospital had a policy of testing the urine of pregnant women for cocaine and turning the results over to law enforcement. Ten women who were arrested as a result of the policy sued the hospital claiming that their Fourth Amendment right to be free of unreasonable searches and seizures had been violated.
Holding: A state hospital must obtain the informed consent of its patients (or a warrant) in order to collect urine samples for the purpose of creating evidence of a crime. Otherwise, the patients’ Fourth Amendment rights are violated.

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