Abortion ‘Choice’: Fact or Fiction

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Introduction

For over the last century, many people have not had access to true, autonomous choices regarding abortion. Because abortion is not viewed as a necessary medical procedure to guarantee reproductive autonomy, and anti-abortion advocates occupy seats in our Supreme Court and government agencies, it has been, and continues to be, highly regulated through laws. Before *Roe v. Wade*, abortion was illegal in many states unless one was able to achieve the proper criteria for a therapeutic diagnosis, which meant women had to "associate themselves with psychosis" (Solinger, *Beggars and Choosers* 43). As there was no guarantee that they would receive this diagnosis, abortion access was restricted unless they were able to access an illegal abortion; however, illegal abortions were associated with the risk of death and could have an extreme cost as abortionists were able to charge hundreds or thousands of dollars (Reagan 197). Even when abortion was illegal, it is clear that those with resources were more likely to have "choices" around availability and access to the procedure. Scholar Rickie Solinger argues that during this "criminal era" of abortion, "the most profound and most certain source of danger to women" were the laws restricting access to safe and legal abortion (*Beggars and Choosers* 38). It wasn't until 1973, when the criminalization of abortion was ruled unconstitutional, that it seemed that implementing laws that were dangerous to women would end. However, this was, and is still, not the case.

By 2018, 1,193 abortion restrictions had been enacted since *Roe v. Wade*, and one-third of them were between 2011-2018 (Nash et al.). People's bodies are still being governed by laws that restrict abortion access, making it clear that attacks on abortion rights are ongoing. Since the beginning of 2021, eight abortion restrictions have been enacted: South Carolina with a six-week abortion ban, a Kentucky law that "grants additional authority to the state's attorney general to

penalize and close abortion clinics," Arkansas with a law requiring those seeking an abortion to call a state-sponsored hotline for information on pregnancy services, an Ohio law banning the use of telemedicine for medical abortions, Kentucky and South Dakota laws "that penalize physicians for not taking medically unnecessary actions for a fetus," and, lastly, a Kansas initiative began to amend the Kansas constitution to "explicitly exclude abortion rights" (Nash, "The Danger Ahead"). Once again, such laws create dangerous situations as they strip people of their autonomy and restrict access to safe, legal abortions. Scholar Robin West argues that *Roe v. Wade* does not need to be overturned in order to restrict abortion access as "…abortion will become less and less available, because of the impact of legislative and political decisions" (1403). It is clear that laws remain a dangerous threat to abortion access.

Furthermore, legislatures have framed these laws as protections for women's health in order to hide their anti-abortion agendas —although some legislatures are very open about banning abortion (*Whole Woman's Health v. Hellerstedt).* Abortion procedures have a safety record of over 99% and are safer than other medical procedures such as a colonoscopy, which has a "mortality rate 10 times higher than an abortion" (Melling and Richards; *Whole Woman's Health v. Hellerstedt*). It is clear that these regulations are not put into place to protect women, rather to restrict abortion access, and, ultimately, bodily autonomy.

Despite all of these regulations, reproductive rights advocates still tend to refer to reproductive health care services, such as abortion, as "choices." (Solinger; A. Smith; Roberts, "Reproductive Justice"). For example, they may argue that it is important to keep abortion "choices" legal. In response to this, I ask myself: what do we mean when we say "reproductive/abortion choice" rather than "reproductive/abortion rights?" Does this framework of "choice" allow everyone to have the same access to "choices" when there are laws that restrict

abortion access? These are the questions that motivated me to research laws that restrict abortion access, ultimately, restricting true, autonomous choices. As such, this paper will analyze how federal and state laws in the U.S restrict abortion access, thereby preventing individuals from exercising a truly, autonomous choice around abortion use. The following research questions will guide this paper: 1) why and how "choice" is a problematic construct to describe abortion access; 2) what federal laws restrict abortion access; 3) how state laws restrict abortion access. I will begin by outlining how the "choice" framework began to be utilized in reproductive rights, the criticisms that feminists have with "choice" rhetoric, and explain why it is a problematic construct to describe abortion access. Secondly, I will discuss federal laws, including the three major court cases surrounding abortion access (*Roe v. Wade, Planned Parenthood v. Casey,* and *Whole Woman's Health v. Hellerstedt*) explaining how they paved the way for future abortion restrictions, and end this section by describing the effects of the Hyde Amendment. Lastly, I will explain how state laws (gestational bans, targeted regulations of abortion providers, insurance policies, informed consent laws, and state-mandated waiting periods) restrict abortion access. To conclude, I will argue a reproductive justice framework is necessary to describe abortion access as the "choice" framework is inadequate.

Throughout my paper, I primarily use "woman/women" to describe the pregnancy population. While pregnant individuals do not necessarily identify as women, and nongender binary and trans individuals do experience pregnancy, the barriers to access abortion are gendered, as court cases and laws specifically use "women," so I will primarily use "women" to describe the pregnant population.

Why and how "choice" is a problematic construct to describe abortion access

Beginning of "Choice"

When discussing reproductive rights, it is common for activists to argue that people deserve "reproductive choices" (Solinger, "The Incompatibility of Neo-Liberal"). Although "choice" rhetoric is currently used to discuss reproductive rights, including abortion access, it hasn't always been the framework that activists used. During the late 1960s and early 1970s, before *Roe v. Wade*, "advocates of legal abortion mostly used the term 'rights,' not 'choice,' to refer to what they were after" (Solinger, *Beggars and Choosers* 4). Activists "claimed that 'the *right* to control whether you're pregnant or not [was] indivisible from the right to self-determination" (Solinger, *Beggars and Choosers* 5). Incidentally, it wasn't until *Roe v. Wade* that "choice" was used to describe abortion access.

In the opinion of *Roe v. Wade* (1973), one of the three major court cases for abortion access that will be discussed later, Justice Harry Blackmun described abortion as "this choice." For example, when comparing abortion access in the past to the 1970s, Justice Blackmun stated, "Phrasing it another way, a woman enjoyed substantially broader right to terminate a pregnancy than she does in most States today. At least with respect to the early stage of pregnancy, and very possibly without such a limitation, the opportunity to make this choice was present" (*Roe v. Wade)*. During this time, many abortion advocates wanted to create a "respectable, nonconfrontational movement" (Solinger, *Beggars and Choosers* 5). As "choice" would be an "easier sell," since it appeared less threatening than demanding "unadulterated rights," the movement adopted the term "choice," saying goodbye to "rights"; people were now demanding "choices" (Solinger, *Beggars and Choosers* 5). Thus, "choice" was now used to describe abortion access. However, many scholars have expressed criticisms with the "choice" construct.

"Choice" Criticisms

One of the main arguments against using a "choice" framework is that it is consumeristic as having "choices" is, ultimately, related to whether one has resources (Solinger; A. Smith; Roberts, "Reproductive Rights"). Solinger explains, "For one thing, the term 'reproductive choice' invites many people to distinguish, in consumer-culture fashion, between a woman who can—and a woman who can't—afford to make a choice" ("The Incompatibility of Neo-Liberal" 39). Through "choice" rhetoric, women become consumers of reproductive rights, and reproductive services become an object that certain women may be able to "purchase" (Solinger, *Beggars and Choosers).* Ultimately, in the United States capitalist society, only those who have resources are able to access the "reproductive choices" that are granted by laws and U.S Supreme Court cases. Additionally, "choice" is not an intersectional framework as it doesn't focus on the ways that oppressions intersect to create different access to "choices" (Crenshaw). Andrea Smith emphasizes this point when she argues that "individualist, consumerist notions of "free" choice…do not take into consideration all the social, economic, and political conditions that frame the so-called choices that women are forced to make" (A. Smith 127). A low-income woman of color is not going to be able to access the same "choices" that a wealthier white woman can, especially in terms of "reproductive choices." This is the main difference between fighting for "choices" and fighting for rights. Solinger argues that "rights" refer to "the privileges or benefits of being a human and specifically a woman in the United States, privileges or benefits that one can exercise *without access to any special resources* [sic], such as money", whereas "choice," as mentioned above, refers to what one is able to exercise if they have resources (Solinger, *Beggars and Choosers* 6). Fighting for rights includes everyone while fighting for "choices" includes only certain people (those with resources).

Furthermore, government officials have adopted "choice" rhetoric for their neoliberal actions. According to Solinger, "choice" is a neoliberal framework as it places the focus on the individual being able to obtain "choices" through consumerism, instead of focusing on government agencies that perpetuate systemic inequalities, which only allow certain groups to have "choices" (Solinger, "The Incompatibility of Neo-Liberal" 39). Solinger states,

> 'Reproductive Choice' makes individual, bad-choicemaking women into culprits and effaces impacts of low-wages, the housing crisis, the lack of medical care, racism, under-funded educational systems, racialized incarceration, war, and other factors that shape the context of reproduction differently for different groups of women. (Solinger, "The Incompatibility of Neo-Liberal" 39)

This perpetuates neoliberalism as the responsibility is shifted onto the individual woman to obtain access to different reproductive services, such as abortion, rather than holding the government responsible for ensuring that people have equal access. If women are solely responsible for their own "choices," then the government does not have to ensure access, which enables laws such as the Hyde Amendment and insurance policies that are discussed later in the paper. Dorothy Roberts extends this view when she writes,

> The language of choice has proved useless for claiming public resources that most women need in order to maintain control over their bodies and their lives. Indeed, giving women 'choices' has eroded the argument for state support, because women without sufficient resources are simply held responsible for making 'bad' choices. ("Reproductive Justice" 80)

This language of "bad choices" has been utilized by legislatures to shift responsibility onto individuals and is mentioned again in the Hyde Amendment section. For these reasons, "choice" is a problematic framework to describe abortion access.

"Choice" and Describing Abortion Access

Often, the term "choice" is used inaccurately when describing abortion access in the U.S. That is, the term "choice" can only be used accurately to describe abortion access in the U.S as an abstract concept. Rhetorically, "choice" around abortion does not account for the lack of true decisions available to pregnant individuals, or for the necessary resources that a pregnant individual must also rely on in order to exercise a truly autonomous choice. In this way, pregnant people are not able to exercise a true choice if their "choices" are dependent on whether they can afford abortion access, necessary travel to obtain access, and be able to bypass state mandates and legislation which further restrict access.

Additionally, using a "choice" framework to describe abortion access commodifies this access; pregnant individuals become consumers that have the "choice" to buy an abortion, but only if that individual has resources. "Choice" rhetoric has allowed governmental bodies to restrict abortion access through this commodification. West, in the piece "From Choice to Reproductive Justice," argues that "to be a meaningful support for women's equality or liberty, a right to abortion must mean more than a…right to purchase one. It must guarantee access to one" (1403). Using "choice" rhetoric to describe abortion rights does not grant this access.

As this paper will show, "choices" surrounding abortion access are dependent on federal and state laws. Because state laws around abortion vary per state, one's "choices" may change depending on the state one lives in. Through federal court cases and laws, abortion access is

severely restricted and dependent on resources, meaning those who are wealthier have more "choices" in terms of abortion. Solinger states, "Then and now, many Americans have glossed over this: poor and/or culturally oppressed women in the United States and abroad may lack the money to 'choose' abortion. They may live where abortion is inaccessible, illegal, or life-threatening" (Solinger, *Beggars and Choosers* 21). By using "choice" to describe abortion access, we are "glossing over" those who aren't able to "choose" abortion. We do not focus on the fact that certain people may have more access to abortion than others because everyone's actions are masked as a "choice." We need to distinguish that not everyone's actions regarding abortion access are true, autonomous choices. If we use "choice" to describe abortion access, then we ignore the systemic inequalities that shape abortion access and allow it to be based on individualistic resources, rather than on fundamental rights that are accessible to everyone.

In this paper, I argue that if a pregnant person does not have the resources necessary to make a true choice, then the concept "choice" is a misrepresentation of the availability of abortion access in the US. As such, the use of "choice" as a concept to describe abortion care in the US is solely a rhetorical strategy to shift responsibility for abortion access onto individuals. To distinguish between choice as a truly autonomous decision and 'choice' as a rhetorical ploy, I signify the latter with quotation marks around the term: "choice" versus true choice. To illustrate how individuals are not able to exercise a true choice around abortion, emphasizing how problematic it is to use "choice" to describe abortion access, the next two sections are going to focus on federal and state laws that restrict abortion.

What federal laws restrict abortion access

Overview

Since the 1970s, beginning with *Roe v. Wade*, there have been many Supreme Court cases that have restricted access to abortion. These cases have given immense power to state governments and have allowed the Federal Government to take an anti-abortion stance. The three main court cases that will be discussed in this section are *Roe v. Wade*, *Planned Parenthood v. Casey*, and *Whole Woman's Health v. Hellerstedt*. These court cases have shaped abortion laws by either upholding or striking down restrictive abortion laws. Similar to court cases, the Federal Government has implemented a law that severely restricts abortion access: the Hyde Amendment. It is important to understand how these court cases have allowed states to implement abortion restrictions despite *Roe v. Wade*. Considering this, it is important to begin with the court case that legalized abortion and set the precedent for future abortion restrictions: *Roe v. Wade.*

Roe v. Wade (1973)

It can be argued that *Jane ROE, et al., Appellants, v. Henry Wade* (referred to as *Roe v. Wade* throughout this paper) is one of the most well-known court cases in American history. In 1969, Norma McCorvey, referred to as Jane Roe in the case, sought an abortion in Texas; however, abortion was only legal in cases where the woman's life was in danger ("Roe v. Wade"). She was referred to Linda Coffe and Sarah Weddington, and they filed a lawsuit against Henry Wade, the district attorney of Dallas County, Texas, arguing that the current abortion statute violated the right to privacy guaranteed under the 14th amendment ("Roe v. Wade"). The case was eventually appealed to the United States Supreme Court (commonly referred to as the

Court throughout this paper), and their ruling on January 22nd, 1973 would impact abortion access for decades to come.

Due to *Roe's* notoriety regarding abortion, many believe that *Roe v. Wade* guarantees women the legal right to abortion, which, unfortunately, is not correct (Ratelle 196). In regard to whether criminalizing abortion was constitutional, the Court argued that it was not, but *only* during the first trimester. The Court explains, "This right of privacy, whether it be founded in the Fourteenth Amendment's concept of personal liberty…is broad enough to encompass a woman's decision whether or not to terminate her pregnancy" (*Roe v. Wade).* Therefore, abortion was protected under the 14th amendment's right to privacy, but under certain conditions. The Court further argued,

> The Court's decision recognizing a right to privacy also acknowledge that some state regulation in areas protected by that right is appropriate. As noted above, a State may properly assert important interests in safeguarding health, in maintaining medical standards, and in protecting potential life…The privacy right involved, therefore, cannot be said to be absolute…
>
> We, therefore, conclude that the right of personal privacy includes the abortion decision, but that this right is not unqualified and must be considered against important state interests in regulation. (*Roe v. Wade*)

It is clear that women do not have complete control over their decisions as *Roe v. Wade* granted states power to interfere with women's access to abortion; therefore, women's decisions are, ultimately, dependent on the state's interest. This is one of the many reasons why *Roe v. Wade* did not guarantee women the complete right, and therefore access, to abortion.

In addition to ruling that states have an interest in regulating abortion, the U.S Supreme Court ruled that a three-trimester system would be used to determine when states are able to regulate abortion. The Court explained,

> For the state prior to approximately the end of the first trimester, the abortion decisions and its effectuation must be left to the medical judgment of the pregnant woman's attending physician.
>
> For the stage subsequent to approximately the end of the first trimester, the State…may, if it chooses, regulate the abortion procedure in ways that are reasonably related to maternal health.
>
> For the stage subsequent to viability…may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother. (*Roe v. Wade)*

In summary, states are able to implement regulations after the first trimester and are able to ban abortion completely in the third trimester. However, even in the first trimester, women do not have full control. The decision is made by the "woman's attending physician." Additionally, the Court ruled that "the State may define the term 'physician…and may proscribe any abortion by a person who is not a physician as so defined" (*Roe v. Wade)* This restricts access as "physician" may be defined so narrowly that only a small group of people qualify to perform an abortion, which may restrict access due to waiting periods, or clinics not being able to staff someone that meets these criteria. Ultimately, *Roe v. Wade* granted everyone power except for those seeking an abortion. Although *Roe v. Wade* may have legalized abortion in the first trimester, it does not grant access to abortion.

Concerning *Roe v. Wade* and access, Nicole Ratelle wrote a journal article discussing the implications of *Roe v. Wade* creating a negative right. Ratelle argues, "The *Roe* Court located the right to abortion within the right to personal liberty, holding that the 'right to privacy is broad enough to encompass a woman's decision whether or not to terminate her pregnancy'" (Ratelle 196). Negative rights, sometimes called liberties, "restrains other persons or governments by limiting their actions toward or against the right holder" ("Negative Rights"; "Understanding the Difference"). Positive rights, sometimes referred to as entitlements, require others (including the government) to provide the right holder with a good or service ("Negative Rights"). An example of a positive right is the right to an attorney, where the government must provide an attorney to someone who cannot afford one because they are entitled to it through the sixth amendment ("Negative Rights"). It is important to note that negative rights limit the actions of the government, meaning that interference is still allowed. Under *Planned Parenthood v. Casey*, which is discussed next, the state's limit is declared. Ratelle argues that in order to grant full access to abortion, "a true right to abortion must be construed as a positive right to access the procedure, as opposed to a negative right against certain levels of state intervention in pregnant person's private rights" (211). Instead of negative rights, there is a need for positive civil rights, "which are necessary for full civic participation…necessary to promote individual flourishing and achieve some level of human welfare and are owed to everyone on the basis of their humanity" (Ratelle 210). Ratelle explains how the right to abortion is essential for "persons who can become pregnant to participate fully in society" (210-211). People need access to abortion in order to participate in society. If *Roe* was a positive right, the state would have to "facilitate access…this could require public financing for the procedure and the development of other institutional supports for abortion" (Ratelle 212). This would mean that the Hyde Amendment,

which will be discussed later in the paper, would not be implemented, and access to abortion would be made available to more people through public funding. Through establishing a negative right, *Roe v. Wade* has restricted abortion access as states are not required to provide access and are only limited in creating laws that restrict access, not completely prevented. *Roe v. Wade* is known as the court ruling that legalized abortion; however, it is clear that it did not grant women access to abortion.

By *Roe* establishing a negative right, governments are not required to provide funding, restricting access for women who are not able to afford an abortion. By claiming that states have an interest in life and are able to restrict, and even ban, abortion access after the second trimester, state governments are granted extreme control over women's reproductive decisions, further restricting access to abortion. Rickie Solinger states, "It became impossible to claim that *Roe* could grant all women equal protection," and that is the unfortunate truth (*Beggars and Choosers* 10). The only women that *Roe* gave true choices to are those with resources who are able to fund their own abortions, or travel to another state that does not have strict abortion laws. *Roe v. Wade* has, ultimately, created the pathway for future court cases and states to further restrict abortion access. Notably, *Planned Parenthood v. Casey* was able to further restrict abortion access due to the ruling of *Roe v. Wade*.

Planned Parenthood v. Casey (1992)

In 1992, the United States Supreme Court announced their decision regarding *Planned Parenthood of Southeastern Pennsylvania et al. v. Robert P. Casey et al.* (referred to as *Planned Parenthood v. Casey* throughout this paper), a court case determining whether The Pennsylvania Abortion Act of 1982 violated a "right to abortion as guaranteed in *Roe v. Wade"* ("Planned Parenthood"). The law required that informed consent must be obtained, that a woman must wait

24 hours before receiving an abortion, must notify their husbands if they were married, obtain parental consent if they were minors, and, lastly, required clinics to keep records of the procedure ("Planned Parenthood"). Planned Parenthood of Southeastern Pennsylvania, and other physicians and clinics, sued Robert P. Casey, the governor of Pennsylvania, arguing that the law was unconstitutional due to the right that was established in *Roe* ("Planned Parenthood"). The case was eventually appealed to the United States Supreme Court, and their ruling would, ultimately, give states more power over abortion laws and further restrict abortion access.

From the beginning of their ruling, the Court's opinion of abortion was established:

> Abortion is a unique act. It is an act fraught with consequences for others: for the woman who must live with the implications of her decision; for the person who must perform and assist in the procedure for the spouse, family, and society that must confront the knowledge that these procedures exist, procedures some need nothing short of an act of violence against innocent human life; and, depending on one's beliefs, for the life or potential life that is aborted. (*Planned Parenthood v. Casey)*

Words such as "consequences" and "life" emphasize that the Court was anti-abortion. Through reading this section alone, one can assume that this court case was (most likely) not going to strengthen access to an "act fraught with consequences." Consequently, they ruled that all of the provisions of the act were constitutional except for the partner notification requirement.

Firstly, the Court ruled against the three-trimester system that *Roe* had established, which declared that states would only be able to implement laws after the first trimester regarding abortion (*Roe v. Wade)*. The Court explained,

> The trimester framework no doubt was erected to ensure that the woman's right to choose not become so subordinate to the State's interest in promoting fetal life that her choice exists in theory but not in fact. We do not agree, however, that the trimester approach is necessary…
>
> Though the woman has a right to choose to terminate or continue her pregnancy before viability, it does not at all follow that the State is prohibited from taking steps to ensure that this choice is thoughtful and informed…It follows that States are free to enact laws to provide a reasonable framework for a woman to make a decision that has such profound and lasting meaning. (*Planned Parenthood v. Casey)*

Thus, informed consent laws and state-mandated waiting periods were ruled constitutional throughout the entire pregnancy. It is important to note that the Court is using "choice" rhetoric to justify its rulings. The Court argues that eliminating the trimester framework would not "subordinate" a woman's "right to choose" to the "State's interest," but as this paper will show, that is exactly what happened. As states are able to implement laws, including informed consent and state-mandated waiting periods, regarding abortion throughout any stage of pregnancy, women's "choices" are "subordinated" as they aren't able to access abortion. In terms of informed consent, the Court states that the information must be "truthful and not misleading" in order to be "permissible" (*Planned Parenthood v. Casey).* However, as this paper will show, most of the information that providers are required to tell their patients is medically inaccurate, which stems from the Court allowing "scientific uncertainty." Scholar Mary Ziegler argues that anti-abortion advocates utilized "scientific uncertainty," the claim that there isn't enough scientific data to declare one-hundred percent certainty, to help pass restrictive abortion laws

(Ziegler 95). Ziegler explains that "scientific uncertainty" is apparent in *Planned Parenthood v. Casey* when the Court rules on these informed consent laws (97). The Court stated,

> It cannot be questioned that psychological well-being is a facet of health. Nor can it be doubted that most women considering an abortion would deem the impact on the fetus relevant…In attempting to ensure that a woman apprehend the full consequences of her decision, the State furthers the legitimate purpose of reducing the risk that a woman may elect an abortion, only to discover later, with devastating psychological consequences, that her decision was not fully informed. (*Planned Parenthood v. Casey*)

Ziegler explains, "The Court reacted to perceived uncertainty about postabortion regret. By raising the possibility that women suffered trauma after an abortion, abortion opponents provided a sufficient justification for informed-consent restrictions" (97). Informed consent laws will be discussed in greater length later on in this paper, but it is important to note that science, or in this case lack of scientific data, is used to justify abortion restrictions. This phenomenon will reprise itself in *Whole Woman's Health v. Hellerstedt,* which is discussed after this case.

In addition, the Court ruled that laws promoting states' interests are constitutional as long as they are not an "undue burden." The Court stated,

> A finding of an undue burden is a shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus…
>
> Unless it has that effect on her right of choice, a state measure designed to persuade her to choose childbirth over abortion will be upheld if reasonably related to that goal. Regulations designed to foster the health of a woman seeking

> an abortion are valid if they do not constitute an undue burden. (*Planned Parenthood v. Casey)*

The Court did not indicate what a "substantial obstacle" is, therefore, it is left up to the Supreme Court to decide, which has (potentially) dire consequences for abortion access if Supreme Court Justices are anti-abortion, and, therefore, restrictive abortion laws are not considered an "undue burden" (such as in *Planned Parenthood v. Casey).* As this paper will show, many of the abortion regulations in the U.S are undue burdens as they create "substantial obstacles" for many pregnant people because they restrict access. What is considered a "substantial obstacle" is unique to every person depending on their social categories, which is why an intersectional framework is so crucial when discussing abortion access (Crenshaw). Whether these regulations restrict access due to traveling, cost, waiting times, being given false medical information, or other laws, women do not have a "choice." The Court even acknowledged this when they stated,

> All abortion regulations interfere to some degree with a woman's ability to decide whether to terminate her pregnancy…
>
> [T]he District Court found that for those women who have the fewest financial resources, those who must travel long distances, and those who have difficulty explaining their whereabouts to husbands, employers, or others, the 24-hour waiting period will be 'particularly burdensome.'
>
> These findings are troubling in some respects, but they do not demonstrate that the waiting period constitutes an undue burden. (*Planned Parenthood v. Casey)*

If a woman's "ability to decide" is impeded, then that is a substantial obstacle that she must overcome, no matter what the cause is. Any burden is a substantial obstacle; the two should not

be differentiated. This is also an example as to why the "choice" framework is a problematic one to discuss abortion access in. The Court acknowledged that abortion laws may "fall on a particular group", meaning abortion access is limited for specific people, yet that isn't an undue burden because certain women (who are privileged) are still able to access that "choice." If abortion was framed as a right rather than an individual "choice," then abortion laws would not cater to a select group of people; they would be accessible to everyone.

Lastly, the court ruled on both partner notification and parental consent. Once again, their ruling for partner notification was based on scientific research. The Court ruled, "The spousal notification requirement is thus likely to prevent a significant number of women from obtaining an abortion. It does not merely make abortions a little more difficult or expensive to obtain; for many women, it will impose a substantial obstacle" (*Planned Parenthood v. Casey).* Although this was a "reproductive win," it must be noted how the Court justified their rulings. They claimed that it was unconstitutional because it did not make "abortions a little more difficult or expensive to obtain," which was constitutional. However, abortions that are "a little more difficult or expensive to obtain" should also be ruled unconstitutional because it creates burdens, and substantial obstacles, to many women. This emphasized how the Court is able to pick which laws are burdens for women. This had serious consequences for abortion access, as shown through *Planned Parenthood v. Casey*, as laws that are clearly an undue burden have been ruled constitutional. In terms of parental consent, the Court stated, "Our cases establish, and we affirm today, that a State may require a minor seeking an abortion to obtain the consent of a parent or guardian, provided that there is an adequate judicial bypass procedure" (*Planned Parenthood v. Casey).* Thus, parental and guardian consent for an abortion was ruled constitutional and is currently implemented in twenty-seven states ("Parental Involvement").

Lastly, the Court ruled on whether states could require clinics to file a report for every abortion performed with the following information:

> The physician (and the second physician where required); the facility; the referring physician or agency; the woman's age; the number of pregnancies and prior abortions she has had; gestational age' the type of abortion procedure; the date of the abortion; whether there were any pre-existing medical conditions which would complicate pregnancy; medical complications with the abortion; where applicable, the basis for the determination that the abortion was medically necessary; the weight of the aborted fetus; and whether the woman was married, and if so, whether notice was provided or the basis for the failure to give notice…In all events, the identity of each woman who has had an abortion remains confidential. (*Planned Parenthood v. Casey)*

The Court ruled that this record-keeping was constitutional, and reporting requirements are currently in effect in forty-six states ("Abortion Reporting Requirements"). This requirement may restrict access as it may intimidate physicians who live in abortion hostile states, preventing them from performing abortions, and women may be afraid to have an abortion if all of this information is being recorded as it could potentially be used against them (Henderson).

Overall, *Planned Parenthood v. Casey* was an extreme loss for abortion advocates as it severely restricted access. Out of the five provisions of the abortion law that were brought before the Court, only one, partner notification, was ruled unconstitutional. *Planned Parenthood v. Casey* severely restricted access to abortion as they ruled that states were able to implement informed consent laws throughout any period of pregnancy. The consequences of these laws and how they restrict abortion access are discussed later in this paper. The Court also emphasized the

"undue burden" standard which does not have a clear and specific definition, meaning that courts are able to freely decide which laws are an undue burden and which aren't. This is problematic as laws that clearly create burdens for women, such as informed consent laws, were ruled constitutional. The last court case that will be discussed in this paper is *Whole Woman's Health v. Hellerstedt,* which appeared to (finally) be a reproductive rights win.

Whole Woman's Health v. Hellerstedt (2016)

In 2013, Texas enacted House Bill 2 (referred to as HB2 throughout this paper), a TRAP law which required physicians to have admitting privileges at a hospital within 30 miles from the clinic, that clinics offering abortion care must meet the standards of ambulatory surgical centers (ASCs), banned abortion after 20 weeks, and prohibited the use of medical abortions except "as permitted by the Food and Drug Administration" (Goodwin 343). After HB2 was implemented, the number of abortion clinics decreased by 56%, and wait times for abortions increased by three weeks (Goodwin 343). On behalf of five Texas clinics, including Whole Woman's Health, and three physicians, the Center for Reproductive Rights challenged the bill arguing that these regulations constituted undue burdens for accessing abortion, which was unconstitutional under *Planned Parenthood v. Casey* ("Whole Woman's Health v. Hellerstedt"). After many appeals, the case was brought to the U.S Supreme Court, and the Court announced their ruling on June 27th, 2016 ("Whole Woman's Health v. Hellerstedt").

To begin with, the Court ruled that two provisions of HB2 were undue burdens, and, therefore, were unconstitutional: requiring the standards of ambulatory surgical centers and requiring physicians to have admitting privileges (Goodwin 345). The Court stated, "We conclude that neither of these provisions offers medical benefits sufficient to justify the burdens

upon access that each imposes. Each places a substantial obstacle in the path of women seeking a previability abortion" (*Whole Woman's Health v. Hellerstedt)*. The Court further elaborated on the need for medical benefits to "justify burdens" explaining, "The rule announced in Casey, however, requires that the courts consider the burdens a law imposes on abortion access together with the benefits" (*Whole Woman's Health v. Hellerstedt).* In order to test whether a law was more of a burden than it was beneficial, the Court relied on evidence, "including expert evidence, presented in stipulations, depositions, and testimony" (*Whole Woman's Health v. Hellerstedt)*. In regard to admitting privileges, the Court stated,

> But the District Court found that it brought about no such health-related benefits. The court found '[t]he great weight of evidence demonstrated that, before the act's passage, abortion in Texas was extremely safe with particularly low rates of serious complications and virtually no deaths on account of the procedure'…Thus, there was no significant health-related problem that the new law helped to cure…
>
> But here, those increases are but one additional burden, which, when taken together with others that the closings brought about, and when viewed in light of the virtual absence of any health benefits, lead us to conclude that the record adequately supports the District Court's "undue burden" conclusion. (*Whole Woman's Health v. Hellerstedt)*

The Court relied on evidence, again, for their decision on HB2 requiring ambulatory surgical centers:

> At the same time, the record provides adequate evidentiary support for the District Court's conclusion that the surgical-center requirement places a substantial

> obstacle in the path of women seeking an abortion. The parties stipulated that the requirement would further reduce the number of abortion facilities available to seven or eight facilities. (*Whole Woman's Health v. Hellerstedt)*

Whole Woman's Health v. Hellerstedt, is not the first court case to discuss scientific evidence, as *Planned Parenthood v. Casey* was a success for anti-reproductive rights proponents through "scientific-uncertainty" (Ziegler 97). However, *Whole Woman's Health* depended on scientific certainty through "peer-reviewed studies, arguments made in amicus briefs, and other record evidence" (Ziegler 107). Because of this emphasis on scientific evidence, Mary Ziegler argues that *"Whole Woman's Health* may promise less than it seems" (79). Ziegler explains, "Allowing abortion restrictions whenever there is a chance that new evidence could change the scientific status quo could permit far more regulation than those who have celebrated *Whole Woman's Health* might expect…the decision still seems likely to reignite a war about the facts" (79). This is problematic as "new evidence" could be the result of biased science, as anti-abortion advocates in the past have created new research organizations "that could collect proof that abortion hurt women" and "allow abortion opponents to more confidently make claims about the facts" (Ziegler 90). Ultimately, this means that biased science may potentially be used to restrict abortion access if it appears that benefits outweigh the burdens they impose (as ruled in *Whole Woman's Health v. Hellerstedt).* Using science to justify reproductive rights, or justify denying them, is an issue that many feminists are currently tackling. Activist Abby Minor argues that "when it comes to reproductive rights, we need more than science on our side" as science has been "wielded by privileged men and in the name of their interests" (Minor). Additionally, journalist Emma Green explains that although science has been a staple in the reproductive rights movement, anti-reproductive rights movements "rallied the power of scientific evidence to

promote their cause" (Green). *Whole Woman's Health v. Hellerstedt* introduces and allows the opportunity for restrictions for abortion access through biased science.

In short, this ruling appeared to be a reproductive rights win, as two major TRAP laws (requiring admitting privileges and ambulatory surgical centers) were ruled unconstitutional. However, it is important to note the consequences. After Texas HB2 was ruled unconstitutional, only three of the clinics that had been forced to close reopened (Lindo et al. 1142). The ruling did not relieve the burdens of those who live in a county without accessible abortion clinics. Despite this TRAP law being ruled unconstitutional in Texas, other states' laws that are identical are not automatically ruled constitutional; a U.S Supreme court "ruling that strikes down a state law only invalidates that particular state's law" (H. Smith). Other states may repeal their laws because of this ruling, or each state's laws will need to be challenged individually in order for them to be repealed, which is more likely (H. Smith). As there is now precedent, their laws will be struck down when they are brought to court, which is one positive of *Whole Woman's Health.* However, one cannot ignore that this ruling may, potentially, restrict abortion access in future court cases through its focus on scientific evidence. Despite two TRAP laws being ruled unconstitutional, there are still federal laws that restrict abortion access even further, including the Hyde Amendment.

The Hyde Amendment

In 1976, Congress passed the HEW Medicaid Bill, which is now referred to as the Hyde Amendment, which banned federal funding for abortion services and has been passed by Congress every year since 1976 (Cohen and Joffe 90; Solinger 14). Federal funding is not only prohibited from being used by Medicaid, but also the "Indian Health Services, the Children's Health Insurance Program, the military's TRICARE health insurance program, federal prisons,

the Peace Corps, and the Federal Employees Health Benefits Program" (Cohen and Joffe 90). This paper is going to focus solely on the Hyde Amendment's effect on Medicaid. Under Medicaid, federal funding will not cover an abortion unless it is the result of rape, incest, or life endangerment, which means that it will "not cover when a pregnancy is a threat to the patient's health or well-being but not to her life" (Cohen and Joffe 93). However, under Medicaid, "indigent women pay nothing for their health care related to their pregnancy" (Cohen and Joffe 90). This restricts "choice" as someone may carry out their pregnancy because that will be covered when an abortion would not be. Before the Hyde Amendment was passed, twenty-five percent of abortions were funded by Medicaid; currently, one in four women with Medicaid who wish to obtain an abortion is not able to because of this lack of coverage (Enstrom 451). These statistics illustrate how vital insurance coverage is in order to have access to abortion.

When discussing the Hyde Amendment in 1977, Henry Hyde, whom the Hyde Amendment is named after, stated, "I certainly would like to prevent, if I could legally, anybody having an abortion, a rich woman, a middle-class woman, or a poor woman. Unfortunately, the only vehicle available is the HEW Medicaid Bill" (qtd. in Solinger 13-14). It is clear that one of the main goals of the Hyde Amendment was to prevent those who are on Medicaid from having access to abortion, which predominantly includes low-income people ("Eligibility"). President Jimmy Carter, in 1977, also shared his thoughts after someone asked him about the Hyde Amendment and how it meant "that women who can afford to get an abortion can go ahead and have one, and women who cannot afford to are precluded" (Solinger 19). President Carter responded, "Well, as you know, there are many things in life that are not fair, that wealthy people can afford and poor people can't. But I don't believe that the Federal government should take action to try to make these opportunities exactly equal" (qtd. in Solinger 19). President

Carter linked abortion access to consumerism, emphasizing that abortion "choice" is ultimately dependent on the resources one has. Additionally, Senator Orrin Hatch of Utah stated, "[T]here is nothing to prevent [a poor woman]…from either exercising increased self-restraint, or from sacrificing on some item or other for a month or two to afford [her] own abortion" (qtd. in Solinger 17). Senator Hatch was arguing that if a poorer woman was not able to afford an abortion, it was because she had made "bad choices" with her money, similar to the Dorothy Roberts statement mentioned earlier. Senator Hatch placed the responsibility of being able to access abortion onto individual people, perpetuating neoliberalism, and relieved the government of any responsibility to help provide access, despite the government actively placing obstacles, including financial ones, in pregnant people's way.

In response to the Hyde Amendment, Cora McRae challenged the Hyde Amendment's ban on federal funding for abortions under Medicaid in 1976, and sued Patricia R. Harris, the Secretary of Health and Human Services, arguing that it violated the 14th amendment ("Harris v. McRae"). In *Harris v. McRae* (1980), the U.S Supreme Court ruled that the Federal Government was not required to provide funding for all medically necessary abortions (*Harris v. McRae)*. A medically necessary abortion, which is mentioned multiple times throughout this paper and was defined in *Doe v. Bolton* (1973), is when an abortion is considered necessary "for a patient's physical or mental health" (*Doe v. Bolton*). The decision is made by the physician who must take into account "all factors physical, emotional, psychological, familial, and the woman's age relevant to the well-being of the patient" risk (*Doe v. Bolton)*. Once again, the power is in the physician's hand. To explain why the Federal Government is not required to fund all medically necessary abortions, only those that are the result of rape or incest or life endangerment, the Court stated,

> But regardless of whether the freedom of woman to choose to terminate her pregnancy for health reasons lies at the core of the periphery of the due process liberty recognized in *Wade,* it simply does not follow that a woman's freedom of choice carries with it a constitutional entitlement to the financial resources to avail herself of the full range of protected choices…although government may not place obstacles in the path of a woman's exercise of her freedom of choice, it need not remove those of its own creation. Indigency falls in the latter category. The financial constraints that restrict an indigent woman's ability to enjoy the full range of constitutionally protected freedom of choice are the product not of governmental restrictions of access to abortions, but rather of her indigency. (*Harris v. McRae)*

Throughout the entire opinion, the Court uses "choice" rhetoric to argue that women do have "choices," and if a woman is not able to afford them, then it is because of her own wrongdoing. "Choice" rhetoric has allowed the Court to perpetuate neoliberalism by arguing that it is the individual woman's responsibility to afford "choices," and not be "indigent," rather than the governments'. The Court was able to argue that *Roe v. Wade* guaranteed women "choices" as abortions are legal, the women are just not able to afford them. Ultimately, "choice" rhetoric has enabled the Court to relieve the government of all responsibility, which is why abortion access needs to be framed as a right, which is not dependent on resources, rather than an individual "choice." Through this ruling, only women with resources have an autonomous choice.

Additionally, the Court emphasized that *Roe v. Wade* created a negative right, and not a positive right, so, therefore, the government does not need to provide any resources. The Court explained,

> Although the liberty protected by the Due Process Clause affords protection against unwarranted government interference with freedom of choice in the context of certain personal decisions, it does not confer an entitlement to such funds as may be necessary to realize all the advantages of that freedom. (*Harris v. McRae)*

If *Roe v. Wade* had been ruled as a positive right, as Ratelle argued previously, then "a positive right to abortion would be inconsistent with the Supreme Court's decision in *Harris v. McRae*" as "a positive right would require public funding of the procedure where an abortion is medically necessary and a person qualifies for a program like Medicaid" (Ratelle 212). The decision in *Roe v. Wade* greatly impacted abortion access in a negative way, as it did not require the government to assist with access. Those who cannot afford access are not "entitled" to a true choice. Furthermore, it is also important to note how the Hyde Amendment affects those who have intersecting identities.

Alexa Solazzo examined how abortion laws, specifically those regarding abortion timing, impacted race and poverty. In the study, 808 Black women were on Medicaid compared to 607 white women, and women on Medicaid were more likely to have later abortions than those not on Medicaid (Solazzo 535). In the United States, during 2019, 32.9% of those on Medicaid were Black, 30% were Hispanic, and 15.2% were white ("Medicaid Coverage Rates"). As women of color are more likely to be on Medicaid, the Hyde Amendment severely restricts access for women of color. The United States has a dark history of controlling women of color's reproduction, and this emphasized how this is still prevalent (Roberts, "Killing the Black Body"). Women of color on Medicaid, because of the Federal Government and Supreme Court, are not able to exercise true autonomous choice.

In sum, the Hyde Amendment severely restricts access for those who are not able to afford an abortion. By refusing to allow federal funding to pay for an abortion, those on Medicaid may not be able to afford an abortion. If they cannot afford an abortion, they do not have access. If they do not have access, then they do not have "choices." Despite what anti-abortion advocates and politicians believe, people should not have to "sacrifice" other necessities in order to obtain a medical procedure. Sacrificing other necessities does not grant "choices." The only way to have an autonomous choice is to have abortion be publicly funded and accessible, which is why a positive right to abortion is so crucial. Unfortunately, the Federal Government is not the only governmental body with the ability to restrict abortion access, as states have also implemented many abortion restrictions.

How state laws restrict abortion access

Overview

As discussed earlier, *Roe v. Wade*, and other supreme court cases that followed, established that states can have an interest in the "potentiality of human life" (*Roe v. Wade*). Since *Roe v. Wade* is also a negative right, state interference is limited, but not completely unconstitutional, and governments are not responsible for ensuring that women have access to abortion services (Ratelle). Due to this, states are given a lot of power when it comes to legislation and abortion access. A lot of states have used this power to implement laws that restrict abortion access, whether that is through banning abortion after a certain point in the pregnancy, restricting what is covered through insurance, mandated waiting delays, informed consent laws, or targeted regulations of abortion providers, commonly referred to as TRAP laws. Since *Roe v. Wade*, over 1000 laws have been passed that restrict abortion access (Shepherd and Turner). Ultimately, women are not the ones deciding whether they are able to get an abortion,

states are. These state laws restrict women in three ways: financially, emotionally, and physically. First of all, they restrict financially as women are not able to afford an abortion and states may not have it covered by government-funded healthcare. Secondly, they restrict emotionally as states require providers to tell inaccurate medical information to women about abortion which may cause confusion as to whom they can trust. Lastly, they restrict physically as abortion clinics are forced to shut down when they aren't able to abide by state-mandated regulations. The states that are mentioned throughout these sections are those that currently have these laws enacted. If a state had these laws at one point, but they were enjoined (meaning that the Court ordered the state to stop enforcing these laws), they were not included in the lists ("Enjoin"). Ultimately, state laws do not allow women to exercise a truly, autonomous choice, as their decisions are decided by the laws that state legislatures have put into place.

Gestational Bans

To begin with, states have implemented gestational bans, laws that ban abortion after a certain gestational age, to restrict abortion access. Unless stated otherwise, gestational age in this paper is referred to as being calculated from the last known menstrual period (LMP), as this is how most states estimate gestational age ("State Bans on Abortion"). Because these bans are implemented by the state, there are variations between dates. As ruled in *Roe v. Wade*, states are able to ban abortion after fetal viability (which can range from 24-28 weeks determined by LMP) as long as there are provisions for the life and health of the mother ("State Bans on Abortion"). Thus, viability is determined on an individual basis and is up to the discretion of the woman's physician ("State Bans on Abortion"). Once again, physicians have immense power over the "choices" women are able to make, which *Roe v. Wade* declared constitutional.

In fact, there are currently forty-three states that ban abortion after a certain gestational age ("State Bans on Abortion"). Mississippi has the earliest gestational ban in effect at 20 weeks, with an exception of physical health (throughout this section, physical health refers to "substantial and irreversible impairment, or imminent peril, or major bodily function"), life, and lethal fetal anomaly, based on their "assertion that a fetus can feel pain at 18 or 20 weeks postfertilization," with postfertilization calculated from the date of conception (20 weeks "postfertilization is equivalent to 22 weeks LMP") ("State Bans on Abortion"). There are seventeen states that ban abortion at 22 weeks, based on the idea that a fetus can feel pain (with exceptions in parenthesis): Alabama (life, physical health), Arkansas (life, physical health, rape, incest), Georgia (life, physical health, lethal fetal anomaly), Indiana (life, physical health), Iowa (life, physical health), Kansas (life, physical health), Kentucky (life, physical health), Louisiana (life, physical health, lethal fetal anomaly), Nebraska (life, physical health), North Dakota (life, physical health), Ohio (life, physical health), Oklahoma (life, physical health), South Carolina (life, physical health, lethal fetal anomaly), South Dakota (life, physical health), Texas (life, physical health, lethal fetal anomaly), West Virginia (life, physical health), and Wisconsin (life, physical health). Additionally, there are four states that ban abortion at 24 weeks: Florida (life, physical health), Nevada (life, general health), Massachusetts (life, general health, lethal fetal anomaly), and Pennsylvania (life, physical health) ("State Bans on Abortion"). Virginia has a third-trimester ban (25 weeks LMP on), with exceptions for life and general health ("State Bans on Abortion"). Lastly, there are states that ban abortion at viability.

There are currently twenty states with a gestational ban at viability (with exceptions in parenthesis): Arizona (life, general health), California (life, general health), Connecticut (life, general health), Delaware (life, general health, lethal fetal anomaly), Hawaii (life, general

health), Idaho (life), Illinois (life, general health), Maine (life, general health), Maryland (life, general health, fetal anomaly), Michigan (life), Minnesota (life, general health), Missouri (life, physical health), Montana (life, physical health), New York (life, general health), North Carolina (life, physical health), Rhode Island (life, general health), Tennessee (life, physical health), Utah (life, physical health, rape, incest, lethal fetal anomaly), Washington (life, general health), and Wyoming (life, physical health). As viability is determined by the physician, "in many instances, [the] physicians' views on the acceptability of a particular abortion often reflect their larger view on abortion" (Cohen and Joffe 205). Ultimately, in the case of gestational bans, a physician has a critical role in whether a woman is able to have an abortion.

Overall, gestational bans restrict abortion access as they prevent women from having an abortion after a certain gestational age. Certain states (Alabama, Louisiana, and Utah) have tried banning abortion at the moment of conception, and others (Georgia, Iowa, Kentucky, Mississippi, North Dakota, Ohio, South Carolina, and Tennessee) have tried banning abortion at six weeks ("State Bans on Abortion"). The goal of these abortion bans is to make abortion illegal at every point in pregnancy; therefore, they hope to restrict access to the point where an individual is unable to receive, legally, an abortion at any stage. By explaining that these bans are put into place because "fetuses feel pain," through either biased science or "scientific uncertainty" as mentioned above, anti-abortion advocates are able to advance their goal in preventing women from exercising an autonomous choice. As these laws vary by state, women with resources may be able to travel to another state for an abortion, emphasizing that having a "choice" around abortion is dependent on resources. In the section on state-mandated waiting periods, it highlights how gestational bans and state-mandated waiting periods intersect to prevent abortion access. If a woman has not passed the legal gestational age, the next obstacle

that many face when trying to obtain an abortion is finding an abortion clinic as many have closed due to targeted regulations of abortion providers laws, also referred to as TRAP laws.

Targeted Regulations of Abortion Providers (TRAP) Laws

TRAP is an umbrella term to encompass the different regulations that states have implemented. Although this is not the official term given by the states, they were granted this name because, as this paper will show, these laws specifically target abortion clinics to force them to shut down (Cohen and Joffe 60). It is estimated that over 160 clinics have been forced to shut down since 2010, the year states started implementing more TRAP laws (Cohen and Joffe 60-61). TRAP laws cover multiple types of regulations, including paint color, doorway and hallway widths, requiring admitting privileges, requiring ambulatory surgical centers (ASCs), location requirements, and more ("What are TRAP laws"). There are currently twenty-four states that have TRAP laws implemented: Alabama, Arizona, Arkansas, Connecticut, Florida, Indiana, Kentucky, Louisiana, Maryland, Michigan, Mississippi, Missouri, Nebraska, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Utah, and Wisconsin ("Targeted Regulation"). Regarding these TRAP laws, there two main groupings: facility and clinician regulations ("Targeted Regulation"). For clinician requirements, there are three different regulations that states may implement: requiring hospital privileges, requiring hospital admitting privileges or an alternative agreement, or that the clinician must be OB/GYN certified or is eligible for certification ("Targeted Regulation"). In regard to requiring that the provider is OB/GYN certified or is eligible for certification, Mississippi is the only state where this requirement is enforced, as Arkansas and Louisiana's laws were enjoined; however, South Carolina requires that only obstetricians/gynecologists are

able to perform an abortion after 14 weeks of pregnancy ("Targeted Regulations"). The next requirements are admitting privileges, which "allow providers to admit patients to a particular hospital and to personally provide specific medical services at the hospital" ("TRAP"). Missouri and North Dakota are the only two states that require admitting privileges ("Targeted Regulation"). As mentioned earlier, *Whole Woman's Health v. Hellerstedt* ruled Texas' admitting privileges as unconstitutional, yet that does not automatically mean that the same laws in other states are also ruled unconstitutional (H. Smith). Similar to admitting privileges, there are nine states that require a clinician to have admitting privileges or an alternative agreement "such as an agreement with another physician who has admitting privileges": Alabama, Arizona, Arkansas, Florida, Indiana, Mississippi, Oklahoma, South Carolina, and Texas ("Targeted Regulation"). These two regulations restrict access as hospitals in counties that are hostile to abortion can refuse to give a clinician admitting privileges, which means that providers would not be able to perform abortions ("What are TRAP Laws?"). This has a domino effect as a lack of providers may mean clinics are forced to shut down, which then impacts abortion access for women.

Additionally, there are four common TRAP laws that have precise requirements for the facility: requiring ambulatory surgical centers, specific procedure room size, specific corridor (hallway) widths, the facility must be within a certain distance from the hospital or needs a transfer agreement with the hospital ("Targeted Regulation"). Ambulatory surgical centers (ASCs) requirements state that the clinic must have a surgical center that is equal or similar to those that are used in "invasive and risky procedures and use higher levels of sedation" ("Targeted Regulation"). There are currently seventeen states that have ASC requirements: Alabama, Arizona, Arkansas, Indiana, Kentucky, Louisiana, Michigan, Mississippi, Missouri,

North Carolina, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, and Utah ("Targeted Regulation"). In *Whole Woman's Health v. Hellerstedt,* the ASC requirements in Texas under TRAP law House Bill 2 (HB2) were ruled unconstitutional as abortion is a safe procedure and the requirement offered no medical benefits to outweigh the burdens (*Whole Woman's Health v. Hellerstedt).* However, as this paper mentioned, the outcome in Texas does not automatically rule other states' laws as unconstitutional, which is why other states are still able to have these regulations implemented (H. Smith). Updating a building to have an ambulatory surgical center is extremely expensive and is not something that every clinic is able to afford and implement, meaning clinics may be forced to close ("What are TRAP Laws"). If clinics are forced to shut down, then women's access is impacted. As this paper has shown, women may not be able to afford to travel to a clinic that is further away, meaning that only those with resources are able to access abortion and have a "choice."

Similar to the requirement that clinicians must have admitting privileges with hospitals, six states (Florida, Michigan, North Carolina, Ohio, Pennsylvania, and Wisconsin) mandate that the clinic itself must have a transfer agreement with a hospital in case of severe complications ("Targeted Regulation"). Similar complications for clinicians arise as hospitals may refuse to allow for a transfer agreement. States may also require that clinics cannot be further than a specific maximum distance from the hospital. The eight states that have this requirement (with distance in parenthesis) are Arizona (30 miles only for clinics that provide surgical abortions), Arkansas (30 miles), Florida (nearby), Indiana (adjacent county), Michigan (30 minutes), Missouri (no distance specified), North Dakota (30 miles), and Ohio (30 miles) ("Targeted Regulation").

Lastly, states may also require specific hallway or procedure room sizes. Arkansas, Indiana, Louisiana, Michigan, Mississippi, Nebraska, Oklahoma, Pennsylvania, and Utah have TRAP laws that require the procedure room to be a specific size; Alabama, Indiana, Michigan, Mississippi, Missouri, Pennsylvania, South Carolina, and South Dakota have requirements regarding hallways ("Targeted Regulation"). It is clear that hallway or procedure room sizes have nothing to do with improving abortion care; they are specifically implemented to force clinics to shut down. If a clinic is not able to accommodate these changes for any reason, but most likely because of cost, then they will be shut down.

Regarding these TRAP laws, Jones and colleagues conducted a study to compare the implementation of TRAP laws in states with state laws governing other office interventions (referred to as OBS in the article). The authors explained how advancements in technologies have resulted in health care adapting and having "moved some surgeries, procedures, and sedation and anesthesia use from ACS to offices and clinics." Office interventions included cosmetic surgery, "removal of a mole…liposuction, hernia repairs or knee arthroscopies" (Jones et al. 486). Jones et al. were curious as to whether "states' regulation of abortion-providing facilities differed from the states' regulations of facilities providing other office interventions" (Jones et al. 487). They concluded that the answer was yes, there are differences. They found that as of August 2016 (with their study being published in 2018), states had implemented 55 TRAP laws in 34 states, yet only 25 OBS laws in 25 states (Jones et al. 488). When comparing the exact laws, they found that: 21% of TRAP laws and 16% of OBS laws required a procedure room, TRAP laws (51%) were more likely than OBS laws (16%), to require a separate recovery room TRAP laws (36%) were more likely than OBS laws (8%) to require specific hallway or doorway widths, 54% of TRAP laws required a hospital transfer agreement while only 36% of OBS laws

had that requirement, and 18% of TRAP laws required one or more physicians to have admitting privileges to local hospitals while only 4% of OBS laws had that requirement (Jones et al. 489-491). It is clear that states are not implementing equal laws regarding healthcare; they are specifically targeting abortion providers and abortion clinics. It is hard for a politician to argue that TRAP laws are meant to protect women when it is clear that other types of health offices do not receive the same number of regulations. If it was truly about protecting the health of women, these laws would be equal. These laws are meant to restrict abortion access. Similar to other laws regarding abortion, TRAP laws impact groups of women differently in terms of socio-economic status and race.

As discussed earlier, after Texas HB2 (a TRAP law) was implemented, 56% of clinics were forced to shut down (Goodwin 343). Traveling distance to clinics also increased significantly as "[the distance] the average Texas woman had to travel…increased from 21 miles in the quarter prior to HB2 to 44 miles in the quarter immediately after" (Lindo et al. 1143). Although this study targeted the TRAP law in Texas, it can be assumed that traveling in other states increased as clinics were forced to shut down. For example, due to clinics having been shut down because of TRAP laws, 20% of women lived 43 or more miles from an abortion provider, with travel distances being even longer for those living in certain areas in 2017 (Brown et al. 227). This severely restricts abortion access because a lack of clinics equates to a lack of access, especially for those who aren't able to travel to a further clinic due to transportation, costs, or any other reason. For example, in the study conducted by Solazzo, it was concluded that "traveling even 25 miles to have the procedure is associated with later abortions, particularly among minority women," and that "traveling further distances significantly increases predicted weeks pregnant at time of abortion for Hispanic and black women" (539). Due to gestational

bans and state-mandated waiting periods, women of color may not be able to have an abortion at all, severely restricting their "choices." The lack of clinics, and traveling, also impacts women who are low-income. Louis Shepherd and Hilary D. Turner argue,

> But as the court [in *Whole Woman's Health v. Hellerstedt*] also pointed out, for some women, 50 miles can matter as much as 200…The distance that women have to travel to obtain abortion services adds to the time off from work and perhaps time away from other travel…as well as to the expense for travel and hotel. In order to find the money for these additional expenses and time, abortion can be further delayed. (674)

If an abortion is delayed, then the woman may fall into a later gestational age, which may restrict access if they are unable to afford the more expensive abortion, or if they fall outside of the legal gestational limit. Looking at these laws intersectionally is extremely important to see how certain women do not have access to "choices" because of intersecting oppressions, such as class and race (Crenshaw).

Overall, TRAP laws restrict abortion access because they force clinics to shut down. Regarding clinician requirements, local hospitals may refuse to grant admitting privileges to physicians who perform abortion. If a physician is not able to have privileges and is therefore not able to perform abortions, a clinic may not have a physician allowed, by law, to perform any abortions; therefore, they may be forced to shut down. Facility requirements may also force clinics to shut down, as these "upgrades can cost over a million dollars" (Cohen and Joffe 61). As mentioned above, "over 160 abortion facilities have closed since 2010" at the same time these TRAP laws were introduced (Cohen and Joffe 61). This cannot be a coincidence. The closing of clinics has resulted in "abortion deserts," which are counties without a clinic (Cohen and Joffe

74). Those seeking an abortion may not be able to travel to another county, or potentially farther, for a multitude of reasons, including, but not limited to, childcare, transportation, and/or finances. TRAP laws restrict access by forcing clinics to shut down, therefore, preventing abortion access for those who do not have the resources to travel far distances to receive an abortion. If someone does not have access to a clinic, then they do not have a true choice. If someone is able to find a clinic that is accessible to them in terms of distance, they may face another barrier regarding insurance and finances.

Insurance Coverage

The average cost for a first-trimester abortion, without insurance, is $508 with the cost increasing to almost $1,200 in the second trimester ("Abortion Costs"). These prices are not absolute, and they can vary depending on the insurance coverage one has, as well as whether it is a medical abortion (the abortion pill) or a surgical abortion (Attia). For many, these prices are extremely high and are costly to their living situations. In a 2016 survey, more than 40% of participants said they would not be able to afford an unexpected cost of $400, while others said they might if they sacrificed other essentials (qtd. in "Medicaid Coverage of Abortion"). It is clear that insurance coverage is necessary to ensure access to abortion; without it, women, specifically low-income women, do not have a true choice. However, many states do not allow insurance coverage for abortion.

As mentioned above, the Federal Government reimplements the Hyde Amendment every year restricting federal funding, specifically Medicaid, from being used to pay for an abortion (Cohen and Joffe 90). Medicaid is a "federal-state partnership", meaning that some funding comes from the federal government and the rest from the state governments (Cohen and Joffe

94). The Hyde Amendment forbids federal funds from being used for an abortion except in cases of rape, incest, or a life-threatening situation, in which cases state Medicaid programs must also allow state funding to be used for ("Medicaid Coverage of Abortion"). However, states are able to decide whether they will allow state funding to be used to cover other cases of abortion (Cohen and Joffe 94). In *Harris v. McRae*, the Court ruled, "Thus, if Congress chooses to withdraw federal funding for a particular service, a State is not obliged to continue to pay for that service…Title XIX does not obligate a participating State to pay for those medically necessary abortions for which Congress has withheld federal funding" (*Harris v.* McRae). As a result, many states do not cover medically necessary abortions that are not covered by the federal government.

Currently, there are only sixteen states that allow for state Medicaid funds to be used for all or most medically necessary abortion procedures ("State Funding of Abortion"). These states include Alaska, California, Connecticut, Hawaii, Illinois, Maine, Maryland, Massachusetts, Minnesota, Montana, New Jersey, New Mexico, New York, Oregon, Vermont, and Washington ("State Funding of Abortion"). Seven of these states (Hawaii, Illinois, Maine, Maryland, New York, Oregon, and Washington) have passed laws allowing for use of funds voluntarily ("State Funding of Abortion"). In the other nine, state courts have mandated state funds to be used to cover abortion (Cohen and Joffe 94). Despite having government funding, some providers argue that this means little as other barriers ultimately prevent women from using Medicaid to cover their abortions. Gabrielle Goodrick, a doctor who performs abortions, explains that "Medicaid has never paid for an abortion outside a small number of hospitals" (Cohen and Joffe 94). Shelly Jones, a doctor in the south, experiences a similar situation and she explains that there are three barriers in her state regarding the use of Medicaid:

> First, the state covers abortions only under a limited number of conditions that some providers interpret strictly. Second, if a woman enrolls in…program *after* [sic] learning she is pregnant, she is not eligible for an abortion under Medicaid, only pregnancy care. Third, less than half of the abortion providers in the state accept Medicaid because…the program reimburses at a low rate and takes a long time to do so. (Cohen and Joffe 95)

Ultimately, those with Medicaid coverage may not have their abortions covered, emphasizing that not all women have "choices." This is not the case with every state, but it illustrates that even a law that is designed to ensure abortion access does not necessarily help all women. It is important to note that states may cover those abortions that are deemed "medically necessary." As mentioned earlier when discussing *Roe v. Wade* and *Doe v. Bolton,* physicians are ultimately given the power over women's decisions as they are the ones who decide whether an abortion is deemed "medically necessary;" therefore, they also decide whether Medicaid will fund an abortion if the state allows for medically necessary abortions to be covered. Since these programs only cover "medically necessary" abortions, if a woman doesn't fall under these characteristics, her abortion will not be covered by insurance—a serious barrier for many women. As only sixteen states cover all or most medically necessary abortions, thirty-four states do not receive any public funding. This restricts access as the cost may be a significant barrier for people seeking an abortion. Those on Medicaid do not have the privilege to be able to exercise a true choice, as their actions are dependent on whether the state allows for funding, and whether physicians will grant them the necessary "diagnoses" to allow their abortions to be covered by Medicaid. Additionally, certain states have passed legislation prohibiting private insurance coverage of abortion in order to further restrict abortion access.

Eleven states currently ban all private health insurance plans from covering abortion (Cohen and Joffe 95). These states do have exceptions dependent on life endangerment, rape, incest, severe health problems, or fetal impairment ("Regulating Insurance Coverage"). The eleven states (with the exceptions in parenthesis for each state) are Idaho (life), Indiana (life, rape, incest, severe health), Kansas (life), Kentucky (life), Michigan (life), Missouri (life), Nebraska (life), North Dakota (life), Oklahoma (life), Texas (life, severe health), and Utah (life, rape, incest, incest, severe health, fetal impairment) ("Regulating Insurance Coverage"). People do have the "choice" to purchase additional coverage of abortion, at an extra cost, in almost all of the states mentioned except for Utah and Texas ("Regulating Insurance Coverage"). "Choice" is once again not exactly a true choice as people may not be able to afford this additional coverage, and state governments know this. In this neoliberal society, those who have resources, are the ones who have more choices when it comes to abortion access.

In addition to banning coverage in private health insurance, states also ban coverage in plans "offered through health insurance exchanges" ("Regulating Insurance Coverage"). A health insurance exchange is "when private insurance companies list their health plans with the exchange, and people comparison shop on the exchange from among the available health plan listings" (Davis). The 26 states that ban abortion coverage specific to health insurance exchanges (with the exceptions in parenthesis next to each state) are Alabama (life, rape, incest), Arizona (life, severe health), Arkansas (life, rape, incest), Florida (life, rape, incest), Georgia (life, severe health), Idaho (life, rape, incest), Indiana (life, rape, incest, severe health), Kansas (life), Kentucky (life), Louisiana (no coverage), Michigan (life), Mississippi (life, rape, incest), Missouri (life), Nebraska (life), North Carolina (life, rape, incest), North Dakota (life), Ohio (life, rape, incest), Oklahoma (life), Pennsylvania (life, rape, incest), South Carolina (life, rape,

incest), South Dakota (life, severe health), Tennessee (no coverage), Texas (life, severe health), Utah (life, rape, incest, severe health, fetal impairment), Virginia (life, rape, incest), and Wisconsin (life, rape, incest, severe health) ("Regulating Insurance Coverage"). Similar to private plans, people are able to buy coverage for abortion beyond these exceptions in Arkansas, Florida, Kentucky, Michigan, North Dakota, Oklahoma, and Pennsylvania ("Regulating Insurance Coverage"). Once again, people run into the same issues with "choice." Does someone actually have a true choice to add on additional coverage at a higher cost if they cannot afford it? No. State legislators have found a way to not only forbid government funding to cover abortion, but also private insurance companies.

Lastly, certain states have implemented legislation that bans coverage regarding insurance policies for public employees ("Regulating Insurance Coverage"). A public employee is counted as someone who is "employed by a government agency and includes the employees of a municipal, county, state, or federal agency or state college or university" ("Public Employee Law"). There are currently 22 states that have this ban. They (with the exception in parenthesis next to them) are Arizona (life, severe health), Colorado (no coverage), Georgia (life), Idaho (life), Indiana (life, rape, incest, severe health), Kansas (life), Kentucky (no coverage), Michigan (life), Mississippi (life, rape, incest, fetal impairment), Missouri (life), Massachusetts (specifically bans coverage of so-called "post-viability 'partial-birth' abortions"), Nebraska (life), North Carolina (life, rape, incest), North Dakota (life), Ohio (life, rape, incest), Oklahoma (life), Pennsylvania (life, rape, incest), Rhode Island (life, rape, incest), South Carolina (life, rape, incest, severe health), Texas (life, severe health), Utah (life, rape, incest, severe health, fetal impairment), and Wisconsin (life, rape, incest, severe health) ("Regulating Insurance Coverage"). Only Idaho, Indiana, Michigan, Nebraska, and Oklahoma allow for the purchase of

additional coverage ("Regulating Insurance Coverage"). Similar to the other bans involving health insurance exchanges and private insurance plans, adding the option of the additional coverage does not equivocate to more "choice" or freedom.

Given these points, it is clear that many states have found ways to further restrict insurance coverage of abortion. They restrict access by denying abortion coverage through Medicaid, private insurance plans, health-exchange plans, or policies for public employees. There is extreme overlap with these policies as dozens of states have restrictions in all four of the categories mentioned. Those seeking an abortion have sacrificed other goods or finances that "they would otherwise spend on rent, car payments, utilities, child care, and Christmas presents" in order to pay for an abortion (Cohen and Joffe 106). Having insurance coverage is extremely important in accessing abortion; if there is a lack of coverage, there is a lack of access as women are not able to afford it or are forced to sacrifice other things. Due to these laws, women are not able to exercise true choice around abortion. Their "choices" are dependent on their location and what laws state governments have implemented. After finding the funds to receive an abortion, and seeing if they fall within the legal gestational timeframe, women must tackle another obstacle: informed consent laws, also known as Women's Right to Know Acts.

Informed Consent Laws

Similar to other medical procedures, counseling occurs before an abortion to obtain informed consent (Cohen and Joffe 147). The National Abortion Federation explains the basic principle of this counseling process:

> The decision whether or not to have an abortion must rest with the patient. The provider must ascertain before providing an abortion that the patient…is prepared

> to do so and has not been coerced in any way…The process must include a description of the abortion procedure; any medically accepted alternatives that might be appropriate for the patient; and medically accurate risks and benefits of the abortion to be provided and alternatives. (qtd. in Cohen and Joffe 147)

The National Abortion Federation makes it clear that the purpose of counseling is to guarantee that women receive medically accurate facts about abortion to help ensure true choice. To prevent women from exercising this "choice," states have enacted Women's Right to Know Acts, which require providers to tell women "facts" during their counseling session about abortion (Daniels et al.). I put the word "facts" in quotation marks because as this paper will show, these are not facts, they are medically inaccurate pieces of information. As of March 1st, 2021, thirty-three states require women to receive counseling before their abortion ("Counseling and Waiting Periods"). However, the requirements for counseling varies between states. For example, some states implement certain provisions regarding who can perform the counseling, or whether it has to be in-person or over the phone.

Depending on the state, women can either receive counseling over the phone, or they have to physically go into the clinic. There are currently twelve states that require in-person counseling: Arizona, Arkansas, Indiana, Kentucky, Louisiana, Mississippi, Missouri, Ohio, South Dakota, Texas, Utah, and Wisconsin ("Counseling and Waiting Periods"). Texas has the provision that if a patient lives over 100 miles from the clinic, they can do their counseling over the phone, Utah allows a patient to receive in-person counseling at any medical office in the state, and in Kentucky, a patient may be eligible to use telemedicine for their counseling ("Counseling and Waiting Periods"). Requiring in-person counseling also requires women to make two trips to the clinic, which is not always feasible. This, ultimately, restricts women's

ability to exercise a true choice if they aren't able to make multiple trips because of lack of resources, transportation, childcare, or the long distance that many individuals must travel to access a clinic to begin with (due to the clinics close to them being shut down). They may be forced to carry out the pregnancy because of this one requirement. Another provision that many states have implemented is to only allow certain people to perform counseling. "Some states allow anyone working at the clinic to do so, others require a physician to do it, and the strictest require that the same physician performing the abortion be the one who delivers the initial counseling" (Cohen and Joffe 177). This has tremendous consequences, especially regarding mandated waiting times, which will be discussed later on in the paper. By requiring certain provisions for counseling, states have formulated multiple ways to restrict women's access to abortion.

Furthermore, as these acts are not federally mandated, each state is able to implement which "facts" they force providers to present. It is important to note that these "facts" are selected by the state, not doctors or medical professionals, and states may have different "facts" presented (Beusman). Ultimately, this means that women are receiving different information depending upon the state in which they request an abortion. Information can be presented in verbal counseling, through written materials (referred to as pamphlets in this paper), or both ("Counseling and Waiting Periods"). Currently, twenty-eight states mandate that pamphlets are either offered or given to patients: Alabama (given), Alaska (offered), Arizona (offered), Arkansas (offered), Florida (offered), Georgia (offered), Idaho (given), Indiana (given), Iowa (offered), Kansas (given), Kentucky (offered), Louisiana (given), Michigan (given), Minnesota (offered), Mississippi (offered), Missouri (given), Nebraska (offered), North Carolina (offered), North Dakota (offered), Ohio (given), Oklahoma (offered), Pennsylvania (offered), South

Carolina (offered), South Dakota (given), Texas (offered), Utah (given), West Virginia (offered), and Wisconsin (given) ("Counseling and Waiting Periods"). The information presented in these pamphlets varies by state. For example, twenty-seven states include information on fetal development throughout pregnancy in their pamphlets: Alabama, Alaska, Arizona, Arkansas, Florida, Georgia, Idaho, Indiana, Kansas, Kentucky, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nebraska, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Texas, Utah, West Virginia, and Wisconsin ("Counseling and Waiting Periods"). Eight states (Arkansas, Georgia, Kansas, Louisiana, Minnesota, Missouri (only given if woman is over 20 gestational weeks), Oklahoma, and Utah) include information on fetuses being able to feel pain, three states (Kansas, Missouri, and Oklahoma) say that "personhood" begins at conception, three states (Kansas, Louisiana, and Texas) explain that abortion increases the risk of breast cancer, seven states (Kansas, Louisiana, Michigan, Nebraska, North Carolina, South Dakota, and West Virginia) specify that abortion is linked to negative emotional responses, and Texas states that abortion decreases fertility ("Counseling and Waiting Periods"). Other states' pamphlets may contain similar information, but if it was not mandated by the state, they were excluded from this list. There is overlap as multiple states have pamphlets with information from all five categories mentioned. It is important to note that the Supreme Court ruled in *Planned Parenthood v. Casey* that informed consent materials are constitutional as long as they are medically and scientifically accurate (*Planned Parenthood v. Casey*). With this in mind, Cynthia Daniels and her colleagues conducted a study to see how medically accurate counseling pamphlets are.

They collected pamphlets from the states that require providers to either offer or give them to patients and analyzed the 954 statements that were included (Daniels et al. 187). They

concluded that 31 percent of all the statements were medically inaccurate, which translates to around 300 of the statements. Some of these statements included that "from week 2, 'the head was formed'…from week 4, 'brain activity can be recorded,'" and "from week 9, 'hiccups begin'" (Daniels et al. 187). When comparing states, inaccuracies ranged from 14 to 46 percent with "higher levels of inaccuracy" in the South and Midwest (Daniels et al. 187). North Carolina had the most inaccuracies with 36 out of its 78 statements being inaccurate, and Alaska had the lowest with 15 out of 107 being inaccurate (Daniels et al. 187). Clearly, these statements do not constitute the requirement of medically and scientifically accurate information that was established in *Planned Parenthood v. Casey.* Women are not able to make a "choice" around abortion if they are being fed lies. It is clear that Women's Right to Know Acts do not help ensure informed consent as most states require providers to explain false information. Similar to pamphlets with inaccurate information, providers are forced to comply with mandated scripts during counseling.

Mandated scripts, or verbal counseling, are another way that states force providers to give inaccurate information to patients during in-person counseling. States may require providers to say that patients are "terminating the life of a whole, separate, unique living being" (Cohen and Joffe 152). This language is purposeful as states are trying to persuade women from proceeding with an abortion; states are equivocating abortion with murder. As mentioned above, other mandates include informing patients that fetuses may feel pain (Arkansas, Indiana, Louisiana, Minnesota, and Oklahoma), or that abortion causes breast cancer, infertility, or depression (which have been proven scientifically false) (Cohen and Joffe 152). In Arkansas, Minnesota, Oklahoma, and Utah, women are told that the fetus may feel pain only after 20 weeks, and in Missouri, after 16 weeks. In Utah, the physician may waive the counseling requirement if the

abortion is because of "rape, incest, life endangerment, a severe health problem or if the fetus has a lethal condition" ("Counseling and Waiting Periods"). Therefore, providers are forced to tell their patients inaccurate facts about abortion, and in Utah, the physician holds the power over deciding whether they will give the counseling regardless of the woman falling into one of those categories.

In response to these mandated acts, many providers try to make certain that women do not mistake these statements as actual facts. Providers will say something similar to, "The state requires me to read…" or will explicitly say that these statements are inaccurate (Cohen and Joffe 155). One provider explained, "I think we do a good job of explaining that we really don't think this is true and that patients shouldn't count on this information" (Cohen and Joffe). Unsurprisingly, state governments have retaliated against providers who are trying to not lie to their patients. In 2018, South Dakota implemented a law that forbids providers from saying a disclaimer before the counseling (Cohen and Joffe 157). As there is now precedent for this law, other states may follow South Dakota's lead and implement their own restrictions.

Lastly, ultrasound requirements may fall under informed consent laws. Despite ultrasounds not being considered medically necessary in the first trimester of pregnancy, states may still require ultrasounds to be part of the counseling experience ("Requirements for Ultrasound"). These ultrasounds typically cost around $100, which may be an extra burden for many women ("Abortion Cost"). There are twenty-six states that have ultrasound requirements: Alabama, Arizona, Arkansas, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Louisiana, Michigan, Mississippi, Missouri, Nebraska, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, West Virginia, Wisconsin, and Wyoming. Although these ultrasounds are required in all of these states, states have different

requirements for what must happen during the ultrasound. Nine states require that if an abortion is to be performed, the provider must offer to show the ultrasound to the woman (Arkansas, Georgia, Idaho, Michigan, Nebraska, Ohio, South Carolina, Utah, and West Virginia), and in eight states, the provider must offer to show the ultrasound to "each woman seeking an abortion" (Alabama, Arizona, Florida, Indiana, Iowa, Kansas, Mississippi, and Ohio) ("Requirements for Ultrasound"). Louisiana, Tennessee, Texas, and Wisconsin take their requirements even further as they demand that the provider must display and describe the image on the ultrasound for each woman considering an abortion ("Requirements for Ultrasound"). According to these states, patients are "legally permitted to turn their heads away and 'avert their eyes,' as these laws put it" (Cohen and Joffe 159). Being able to turn their heads away means absolutely nothing as women are still forced to listen to their providers. Van May, a provider in one of these four states, explains, "Whenever they're played the fetal heart sounds and are forced to view the images of the ultrasound, it's just when some women start crying, they start questioning themselves…" (Cohen and Joffe 161). Other women get angry and frustrated (Cohen and Joffe 161). Before rescinding his support (due to protests) of an ultrasound bill in Virginia in 2012, Governor Bob McDonnel explained, "I think it gives full information…To be able to have that information before making what most people would say is a very important, serious, life-changing decision, I think is appropriate" (Lithwick). Politicians argue that ultrasound requirements, despite not being medically necessary, are a way to help women make informed "choices." McDonnel's argument implies that women have not fully thought through their decisions, perpetuating paternalism and the idea that women do not know what is in their own best interests. However, I would argue, as well as others, that they are just another way to restrict abortion. The Guttmacher Institute explains, "the requirements appear to be a veiled attempt to

personify the fetus and dissuade a woman from obtaining an abortion. Moreover, an ultrasound can add significantly to the cost of the procedure" ("Requirements for Ultrasound"). States implementing ultrasound requirements hope to restrict access by trying to make women feel guilty for their actions through personifying the fetus. As mentioned above, receiving an ultrasound may restrict access financially as well, as women are required to pay an extra cost. If a woman is made to feel guilty about having an abortion and then proceeds to not receive one, or if she cannot afford the required ultrasound so she is not eligible to receive one, then she did not make a "choice." Her access to abortion was restricted, and that, ultimately, made the "choice" for her.

Informed consent laws restrict access because, in many states, providers are forced to tell their patients medically inaccurate facts about abortion, only certain providers are allowed to perform the counseling, and ultrasounds may be required. Women are not able to make a true choice if they are not receiving accurate information, are forced to make multiple trips to the clinic, or are made to feel guilty for their actions; state governments are the ones who are deciding the actions for women. As mentioned above, these acts were ruled constitutional due to *Planned Parenthood v. Casey*. The Supreme Court specifically stated, "Requiring that the woman be informed of the availability of information relating to the fetal development to full term… is a reasonable measure to ensure an informed choice" (*Planned Parenthood v. Casey*). It is important to note that "choice" rhetoric is used to justify this ruling. Through the title of these laws (Women's Right to Know), and the opinion of the Supreme Court, it is clear that these acts have been worded to manipulate people into believing that these laws are meant to protect women; they give the illusion that women are able to have a "choice" because they are informed (as if women what was in their own best interests before counseling). This section illustrates that

this is not the case. Women are unable to exercise a true choice because of these laws. As discussed earlier, despite being inaccurate, these laws were ruled constitutional because anti-abortion advocates have used "scientific-uncertainty" or biased science to support their medically inaccurate information, and the Supreme Court allowed it (Minor; Ziegler). This is why science is a problematic way to fight for reproductive rights, which Abby Minor has argued; science may restrict the "choices" that people are fighting for. In addition to this counseling, women may have to wait a specific number of hours in certain states before they can have an abortion, which may further restrict abortion access.

State-Mandated Delays

Time is an important factor when it comes to abortion. As the weeks pass, abortion becomes more expensive or may be banned in certain states depending on how far along a woman is (due to gestational bans). Many states have implemented mandated delays, which require a woman to wait a specific amount of time between receiving counseling and the abortion procedure itself. As mentioned earlier in the paper, the Supreme Court stated, "The idea that important decisions will be informed and deliberate if they follow some period of reflection does not strike us as unreasonable…" (*Planned Parenthood v. Casey).* Thus, state-mandated waiting periods were ruled constitutional, and states have taken full advantage. Similar to the other state laws, waiting times vary between states.

There are currently twenty-five states with waiting periods (with the length of waiting hours in parenthesis): Alabama (48), Arizona (24), Arkansas (72), Georgia (24), Idaho (24), Indiana (18), Kansas (24), Kentucky (24), Louisiana (24), Michigan (24), Minnesota (24), Mississippi (24), Missouri (72), Nebraska (24), North Carolina (72), North Dakota (24), Ohio

(24), Oklahoma (72), Pennsylvania (24), South Carolina (24), South Dakota (72), Texas (24), Utah (72), West Virginia (24), and Wisconsin (24) ("Counseling and Waiting Periods"). South Dakota enforces even more restrictive waiting periods by prohibiting weekends and holidays from being included in the waiting period ("Counseling and Waiting Periods"). Ultimately, this means that if a woman receives counseling on a Friday, the earliest her abortion could be scheduled is the following Wednesday. Even then, that date is not guaranteed for a multitude of reasons. As mentioned above, states may require the same doctor to perform counseling and the abortion (Cohen and Joffe 177). If that specific doctor is not available on that specific Wednesday, or is not available for that entire week, a woman is forced to wait even longer for her procedure, which may also affect the cost, or whether she will still be within the legal gestational age. Another barrier could be if the appointments for that day are already filled. After Texas HB2 went into effect, 56% of Texas clinics closed, and wait times increased three weeks due to congestion of patients (Goodwin 343). This may mean that waiting times increase to longer than a day, which initially could have been avoided if the woman was able to have an abortion the same day she received her counseling. As these wait times may require multiple trips to a clinic, they affect groups of women differently in terms of privilege.

Due to these mandated wait periods and whether in-person counseling is required, women may be forced to make multiple trips to the clinic: one for counseling and another for the actual procedure. This affects those who have less financial resources, have to travel to another state to receive an abortion, have to work, go to school, or have children; it results in people losing wages from missing work, having to find childcare, and a possible increase in transportation costs (Cohen and Joffe 185). As abortion is not covered by Medicaid and other insurance companies, as discussed earlier, many may not be able to find the funds to cover their

abortion as well as these extra costs. It is clear that for those who are not financially stable, these costs may mean that they, ultimately, aren't able to have an abortion. Because of these mandated delays and financial barriers, they cannot exercise true choice because their access to abortion is severely restricted.

Additionally, state-mandated delays may result in the procedure being scheduled much later than originally intended, which may result in dire consequences both financially and legally. Due to state-mandated delays, women may have to wait multiple days until they can have an abortion, ranging from 18 hours to potentially more than three days depending on whether a patient receives counseling on a Friday or before a holiday (such as in South Dakota). This may result in women increasing in gestational weeks. Erica Valverde, a doctor in a western state that has a 72-hour delay, explains:

> [Patients] May cross a gestational age where the price increases, sometimes even double…If someone first comes to see me at twelve weeks and six days, the next day they are thirteen weeks. Because of fetal development, that's a completely different procedure with a different price, which can be very burdensome as well. (Cohen and Joffe 184)

Women may not be able to afford this new price, therefore, their "choice" is limited. Women are also restricted if their gestational week does not fall within a timeframe where abortions are considered legal. If a woman was not able to schedule her counseling appointment (for various reasons) until she was 19 weeks and 6 days and lives in Mississippi with a 24-hour waiting period, she would not be able to receive an abortion the next day because abortions after 20 weeks are banned in Mississippi. These state-mandated delays present a clear burden to those who are seeking an abortion.

State-mandated delays restrict abortion access for those who do not have the resources to make multiple trips to a clinic, or who are close to the gestational ban. Different state laws, in this case requiring in-person counseling, gestational bans, and state-mandated delays, are intersecting to create immense restrictions for women. If women are not able to access abortion due to these laws, then they are not able to exercise a true choice.

Conclusion

In current day America, accessing abortion is extremely difficult for those who do not have resources. To answer my second research question, as to what federal laws restrict abortion access, I gave details as to how federal laws and court cases (*Roe v. Wade*, *Planned Parenthood v. Casey, Whole Woman's Health*, and the Hyde Amendment) restrict abortion access through granting states immense power to regulate abortion and prohibiting federal funds from being used to cover an abortion. To answer the third research question, I detailed the ways in which state laws (gestational bans, TRAP laws, insurance policies, informed consent laws, and state-mandated delays) further restrict abortion access by creating significant barriers financially, emotionally, and physically. It is clear that federal and state laws intersect to create immense restrictions that may prevent an individual from accessing abortion, especially someone who does not have resources. If someone is not able to access abortion, then they are not able to exercise a true, autonomous choice; thus, answering my thesis as to how federal and state laws restrict abortion, thereby preventing an individual from exercising true choice around abortion use. For these reasons, "choice" is a problematic construct to describe abortion access, answering my first research question.

It is clear that women's decisions regarding abortion access are not "choices;" they are the direct result of restrictions created by laws and a lack of resources. If we continue calling them "choices," we ignore the systemic inequalities that are created by these laws and place the responsibility onto the woman wishing to receive an abortion. We turn abortion access into a commodity that is only accessible to those with certain resources and allow government bodies to adopt this rhetoric to justify their restrictive laws. Instead of using "choice," we need to adopt a reproductive justice framework.

Reproductive justice is an intersectional framework that is dedicated to fighting for the right, not the choice, to parent, not to parent, and parent in safe communities (Ross). The right to safe, accessible abortion falls under this right not to parent, but reproductive justice goes further by arguing that although legal abortion is extremely important to fight for, we need to also fight for access to these reproductive services and abolish the systemic inequalities (such as racism and classism) that lead to barriers to access ("Reproductive Justice"). Without access, people simply cannot make true autonomous choices ("Reproductive Justice"). As mentioned earlier in the paper, Rickie Solinger distinguishes between "rights" and "choices," explaining that rights are not dependent on resources (*Beggars and Choosers* 6). We, as feminists and reproductive justice activists, need to right for rights, not empty promises through rhetorical "choices."

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