NATIONAL ABORTION FEDERATION

The TRAP:

Targeted Regulation of Abortion Providers

What is a TRAP law?

Targeted Regulation of Abortion Providers (TRAP) laws single out abortion providers for medically-unnecessary, politically-motivated requirements. Types of TRAP laws include:

- measures that single out abortion providers for medically unnecessary regulations, standards, or personnel qualifications, such as admitting privileges or transfer agreements;
- provisions that needlessly address the licensing of abortion clinics and/or charge an exorbitant fee to register a clinic in the state; or
- measures that unnecessarily regulate the facilities where abortion care may be provided or designate abortion clinics as ambulatory surgical centers, outpatient care centers, or hospitals — which impose numerous burdensome building and/or structural requirements without medical justification.

What is the purpose of a TRAP law?

TRAP laws stigmatize and burden abortion providers and are calculated to chip away at abortion access under the guise of legitimate regulation.

These measures are often introduced by abortion opponents who claim that abortion is an unsafe and unregulated procedure.

By implying that abortion facilities are uniquely dangerous and in need of special regulation, such bills recklessly promote an unfounded fear that abortion is unsafe. Abortion is in fact one of the safest medical procedures provided in the United States.[1]

Many TRAP laws grant broad authority to state departments of health to develop structural and staffing requirements for abortion care facilities. Often, the resulting regulations are based on existing hospital or ambulatory surgical center guidelines including specific dimensions for procedure rooms and hallways, doorway widths, and complex ventilation systems. Some regulations mandate what types of medical professionals must be on staff, assign certain duties to various staff members or require patient evaluations that are not medically necessary. These types of regulations are not medically justified, and no evidence-based, medically sound reasons exist for such standards. Instead, these regulations create an often insurmountable burden for small outpatient clinics. TRAP requirements often result in the closure of quality abortion providers that cannot afford an unnecessary extensive remodel, or find or afford to pay new staff, resulting in women having to travel great distances to obtain abortion care.

The NAF Hotline talked to Cara*, who lives in Killeen, Texas, with her three children, shortly after the partial implementation of H.B. 2, a Texas TRAP law that subsequently caused the closure of numerous facilities providing abortion care. She had lost her job and was struggling to make ends meet when she found out she was pregnant. Cara decided an abortion was the right decision for her family but, unfortunately, even after asking friends and family for help, she was not able to raise enough money for her procedure. On top of that, at the time, due to H.B. 2, the closest clinic to her was nearly 130 miles away, which meant she also had to find enough money to pay for gas, and ultimately had to rely on a last-minute loan from a friend. Cara could not find anyone to drive her to and from her procedure—a six-hour roundtrip drive—so she had to go alone. While she was finally able to obtain abortion care, the added obstacles imposed by the H.B. 2 TRAP restrictions constituted a severe hardship for Cara and her family.

**Name changed for patient privacy*

What are the real facts?

Abortion is very safe.

Abortion is one of the safest and most commonly provided medical procedures in the United States. Less than 0.05% of first-trimester abortion patients—which comprise 89% of all abortion patients—experience a complication requiring hospitalization.[2] Research conducted in 2012 found that pregnancy-related complications were far more common with childbirth than with abortion care; the risk of death is 14 times greater with childbirth than with abortion care.[3]

In the U.S., more than 90% of all abortions are provided in outpatient facilities such as doctors' offices and clinics.[4] Credit for the outstanding safety record of abortion care is attributed to the specialized quality care given and received in these facilities. Since the legalization of abortion in 1973, the provision of abortion in the U.S. has become a public health model for the rest of the world. There is no evidence that abortion care would be safer in

another setting, or that abortion care is inadequate in outpatient facilities.

Abortion care is already regulated.

All health care facilities, including abortion providers, are required to comply with a variety of federal and state regulations. These include the federal Clinical Laboratory Improvement Amendments (CLIA),[5] Health Insurance Portability and Accountability Act (HIPAA),[6] and Occupational Safety and Health Administration (OSHA)[7] requirements, as well as state and local regulations including building and fire codes. All medical professionals, including physicians and clinicians who work in abortion care, are required to maintain professional standards and licenses and complete continuing medical education courses.

NAF, the professional association of abortion providers, has established evidence-based *Clinical Policy Guidelines* (CPGs)[8] which set the standards for quality abortion care. NAF's CPGs are developed by consensus of medical professionals and based on rigorous review of the relevant medical literature and known patient outcomes. Other medical organizations, such as Planned Parenthood Federation of America and the American College of Obstetricians and Gynecologists, have also established professional guidelines for abortion facilities.[9]

What is the impact of TRAP laws?

Enactment of this type of legislation discourages health care providers from offering abortion care and can make provision very burdensome and/or expensive, which exacerbates the provider shortage that already exists in the United States. As of 2014, 90% of counties in the U.S. did not have a single abortion provider.[10] In addition, mandated staffing requirements and qualifications that often appear in TRAP bills restrict clinicians' autonomy by tying them to a particular hospital within a certain distance of the facility, which unnecessarily limits providers' ability to travel to provide care to underserved populations.

Take for example Texas House Bill 2 (H.B. 2), passed in 2013. This law specifically required abortion providers to obtain admitting privileges and required abortion facilities to meet ambulatory surgical center requirements. Following the partial implementation of H.B. 2, nearly half of the more than 40 abortion providers in the state were forced to close their doors due to the law's onerous facility restrictions. If permitted to take full effect, H.B. 2 would have had a devastating result, further reducing the number of providers in the state to ten or fewer.[11]

Whole Woman's Health v. Hellerstedt

Abortion providers challenged the legality of H.B. 2. The law was upheld by the Fifth Circuit Court of Appeals,[12] only to be partially restrained by the Supreme Court pending review. The Supreme Court later heard oral arguments during March of 2016, in *Whole Woman's Health v. Hellerstedt.* In a historic ruling on June 27, 2016, the court struck down the onerous requirements of H.B. 2, finding that the TRAP requirements constituted an undue burden on abortion access.[13] The Court found that the TRAP provisions of H.B. 2 placed a substantial obstacle in the path of women seeking pre-viability abortions without providing a clear benefit to women's health, and as such were unconstitutional.[14]

This decision set up a framework for lower courts to evaluate TRAP laws by weighing the alleged medical benefits of any abortion regulations against the burdens imposed on women's access to care. Since the Court found that, contrary to Texas' claims, the H.B. 2 TRAP laws did not protect or provide any benefit to women's health and were merely a guise for making abortion access more difficult, it is likely that other state TRAP laws passed with the stated justification of protecting women's health, without providing any clear health benefit to patients seeking abortion care, will also be found unconstitutional when challenged. Since the *Whole Woman's Health v. Hellerstedt* decision, courts have blocked or overturned TRAP laws in states including Alabama, Mississippi, Wisconsin, Louisiana, and Missouri.[15]

How prevalent are TRAP laws?

Currently, at least 28 states have some type of TRAP law on their books.[16] Although fewer states have passed new H.B. 2-style TRAP restrictions since the *Whole Woman's Health v. Hellerstedt* decision, state legislatures across the country continue to introduce new TRAP provisions or modify their existing regulations each year. More recent legislation has targeted abortion providers for onerous regulation relating to waste management practices, extensive reporting requirements, and unnecessary inspections of abortion facilities. In 2016, seven states adopted new TRAP laws.[17]

As additional restrictions accumulate, targeting abortion providers with burdensome regulations, it becomes more and more difficult for abortion providers to remain open and for women to safely access their full range of reproductive health care services. We must be vigilant to ensure that these targeted regulations do not force facilities to close and deny women access to safe and legal abortion care.

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For More Information:
For referrals to abortion providers who offer quality care, call NAF's toll-free hotline: 1-800-772-9100 or visit www.prochoice.org

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[1] Tracy A. Weitz et al., *Safety of aspiration abortion performed by nurse practitioners, certified nurse midwives, and physician assistants under a California legal waiver*, AMERICAN JOURNAL OF PUBLIC HEALTH, Mar. 2013, 103(3):454–461.
[2] *See Induced Abortion in the United States*, THE GUTTMACHER INSTITUTE (Jan. 2017), https://www.guttmacher.org/fact-sheet/induced-abortion-united-states.
[3] Raymond, Elizabeth G.; Grimes, David A. The Comparative Safety of Legal Induced Abortion and Childbirth in the United States. Obstetrics & Gynecology. 119(2, Part 1):215-219, February 2012. PMID: 22270271
[4] *See* Rosanne L. Botha, et. al, *Complications of Medical and Surgical Abortion*, *in* HANDBOOK OF OBSTETRIC AND GYNECOLOGIC EMERGENCIES 255, 255 (Guy I. Benrubi MD ed., 2012).
[5] *Clinical Laboratory Improvement Amendments (CLIA*), US FOOD & DRUG ADMINISTRATION (Apr. 2014), http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/IVDRegulatoryAssistance/ucm124105.htm.
[6] Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, https://aspe.hhs.gov/report/health-insurance-portability-and-accountability-act-1996.
[7] Occupational Safety and Health Act of 1970, Public Law 91-596, https://www.osha.gov/law-regs.html.
[8] *Clinical Policy Guidelines*, National Abortion Federation (2017), https://prochoice.org/education-and-advocacy/cpg/.
[9] *Abortion: Resource Overview,* THE AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS (last updated Nov. 2014), http://www.acog.org/Womens-Health/Abortion.
[10] *See* THE GUTTMACHER INSTITUTE, *supra* note 2.
[11] Brief for National Abortion Federation and Abortion Providers as Amici Curiae in Support of Petitioners, Whole Woman's Health v. Hellerstedt, et al., 790 F.3d 563 (5th Cir. 2015), *cert. granted* (U.S. Nov. 13, 2005) (No. 15-274).
[12] Whole Woman's Health v. Hellerstedt, et al., 790 F.3d 563 (5th Cir. 2015), *cert. granted* (U.S. Nov. 13, 2005) (No. 15-274).
[13] Whole Woman's Health v. Hellerstedt, 136 S.Ct. 2292 (2016).
[14] *Id.*
[15] *See* W. Alabama Women's Ctr. v. Miller, 217 F. Supp. 3d 1313 (M.D. Ala. 2016); Jackson Women's Health Org. v. Currier, 760 F.3d 448 (5th Cir. 2014); Planned Parenthood of Wisconsin, Inc. v. Schimel, 2016 WI App 19, 367 Wis. 2d 712, 877 N.W.2d 604; June Med. Servs. LLC v. Kliebert, No. 14-CV-00525-JWD-RLB, 2017 WL 1505596 (M.D. La. Apr. 26, 2017); Comprehensive Health of Planned Parenthood Great Plains v. Williams, No. 2:16-CV-04313-HFS, 2017 WL 1407656 (W.D. Mo. Apr. 19, 2017) (Mem. at 1.), https://bloximages.newyork1.vip.townnews.com/stltoday.com/content/tncms/assets/v3/editorial/a/91/a915419b-1e06-5e72-a041-0a6552a39a0f/58e549f8bea15.pdf.pdf.
[16] *See Targeted Regulations of Abortion Providers,* THE GUTTMACHER INSTITUTE (Sept. 2017), https://www.guttmacher.org/state-policy/explore/targeted-regulation-abortion-providers.
[17] *See* Ala. Code § 22-21-35 (West 2017); Fla. Stat. Ann. § 390.0111 (West 2017); H.B. 337, 119th Gen. Assemb., Reg. Sess. (Ind. 2016); La. Stat. Ann. § 40:1061.10 (West 2017); S.B. 127, 131st Gen. Assemb., Reg. Sess. (Oh. 2017); H.B. 1065, 2017 Leg., 92nd Sess. (S.D. 2017); S.B. 2568, 109th Gen. Assemb., Reg. Sess. (Tenn. 2016).