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“TRAP”ing *Roe* in Indiana and a Common-Ground Alternative

ABSTRACT. Public discourse over abortion overwhelmingly focuses on whether the Supreme Court will overrule *Roe v. Wade* and states will again ban abortion. But at least since 1992, when the Court in *Planned Parenthood v. Casey* reaffirmed *Roe*'s “central holding,” certain moderate-sounding abortion restrictions – sometimes framed as reasonable compromise regulations – have posed a greater threat to women’s reproductive health and liberty. This Essay examines one increasingly popular form of restriction: laws that regulate providers of abortion services in the name of advancing women’s health, without actual health justification. Little-noted efforts to enact such restrictions in Indiana, during the same period South Dakota made headlines enacting criminal abortion bans in 2006 and 2008, illustrate the potential impact of what opponents have called “TRAP laws,” for targeted regulation of abortion providers. The burdens that result from regulatory interference with the availability of services fall disproportionately on the most vulnerable women: those unable to bear increased costs, travel longer distances, or otherwise overcome government-created barriers to legal health services. The Indiana experience also points to the importance and effectiveness of “common-ground” alternative approaches to reducing the number of abortions. Through programs that prevent unintended pregnancy and promote healthy childbearing, the government can more effectively reduce abortions while respecting our nation’s fundamental liberties and values.

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INTRODUCTION: DUAL STRATEGIES FOR REVERSING ROE

The voters of South Dakota twice defeated ballot measures that sought to criminalize the performance of abortions, first in 2006 and again in 2008.¹ If enacted, either version of the ban clearly would have violated the constitutional right that the U.S. Supreme Court first recognized by a strong seven-Justice majority in *Roe v. Wade*² and that the Court continues to recognize more than three decades later, albeit by a diminished margin.³ Those who crafted the ballot measures hoped that by the time the inevitable constitutional challenge worked its way up to the Supreme Court, the Court's composition would have changed sufficiently to uphold the law. Instead, the South Dakota electorate defeated the bans and the nation elected a president, Barack Obama, whose judicial appointees are likely to continue to support *Roe*. The 2008 election thus reinforced the prevalent view that women's right to decide whether to continue a pregnancy is essentially secure: the political system will defend the right from serious infringement, and the Court will not overrule *Roe*.

A measure of complacency has prevailed among *Roe*'s supporters since the Court's 1992 decision in *Planned Parenthood of Southeastern Pennsylvania v. Casey*.⁴ By contrast, during the decade prior to *Casey*, abortion ranked high among the issues that occupied law and politics. Two successive presidents, Ronald Reagan and George H.W. Bush, were elected on platforms that called for the appointment of Justices who would overrule *Roe*. By the time the Court announced it would hear *Casey*, those two presidents had appointed five Justices and elevated a sixth to Chief Justice, and the Court appeared to have the votes to overrule *Roe*.

1. H.R. 1215, 2006 Leg., 81st Sess. (S.D. 2006) (repealed 2006 by voter referendum) (exempting only abortions intended to "prevent the death of a pregnant mother"); Initiative Petition: An Act To Protect the Lives of Unborn Children, and the Interests and Health of Pregnant Mothers, by Prohibiting Abortions Except in Cases Where the Mother's Life or Health Is at Risk, and in Cases of Rape and Incest (Dec. 14, 2007), <http://www.sdsos.gov/electionsvoteregistration/electvoterpdfs/2008/2008regulateperformanceofabortions.pdf> (exempting only abortions when necessary to prevent the death of a pregnant woman; when a pregnancy poses "a serious risk of a substantial and irreversible impairment of the functioning of a major bodily organ or system of the pregnant woman"; and, for rape and incest victims who reported the crime to the authorities, before the completion of the twentieth week of pregnancy).
2. 410 U.S. 113 (1973).
3. See *Gonzales v. Carhart*, 550 U.S. 124 (2007); *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992).
4. 505 U.S. 833.

The *Casey* Court defied expectations. To the great relief of some and the bitter disappointment of others, the Court reaffirmed what it described as *Roe*'s central holding. In the process, the Justices offered their most fully developed articulations to date of the nature of the right at stake and its centrality to women's liberty and equality—the most striking of which came in a plurality opinion jointly written by three Justices appointed by Presidents Reagan and Bush. The unexpected nature of the ruling and the Court's eloquence contributed to a sense of relief and victory among *Roe* supporters and distracted attention from the fact that the Court, in some respects, had also diminished *Roe*'s protections.

In the post-*Casey* world, a reversal of *Roe* is not the only threat to reproductive health and liberty. To be sure, public discourse over abortion has continued to focus on *Roe*'s formal status, but it has inadequately appreciated the ways in which abortion restrictions already in place, or on the near horizon, threaten to make abortion services unavailable to growing numbers of the most vulnerable women. While South Dakota's high-profile, anti-*Roe* strategy has floundered, an under-the-radar, ground-level strategy to restrict access to abortion services has flourished.

Advocates of *Roe*'s reversal have differed on how to accomplish their goal. Some have supported the South Dakota approach of enacting outright criminal bans, arguing that the Court (and most important, Justice Kennedy) might be persuaded to change its position if the public case against *Roe* were reoriented away from fetal protection and toward arguments that keeping abortion legal harms women who have abortions.⁵ The second and dominant anti-*Roe* strategy recognizes that the success of criminal bans would seem to require

5. See, e.g., Memorandum from Samuel B. Casey, Senior Counsel, Law of Life Project, Christian Legal Soc'y & Harold J. Cassidy, Litig. Counsel on Law of Life Initiative, to Members of the S.D. Pro-Life Leadership Coalition & Others 10, 12 (Oct. 10, 2007), [http://operationrescue.org/pdfs/Legal%20Memo%20&%20Proposed%20South%20Dakota%20Abortion%20Bill%20\(10-10-2007\).pdf](http://operationrescue.org/pdfs/Legal%20Memo%20&%20Proposed%20South%20Dakota%20Abortion%20Bill%20(10-10-2007).pdf) (noting that Justice Kennedy's majority opinion in *Gonzales v. Carhart* indicates that he—along with Justice Roberts—“would be most receptive to [a] women's interest analysis”); see also *Carhart*, 550 U.S. at 159 (upholding the Partial-Birth Abortion Ban Act of 2003, in part because although “no reliable data” exists, the experience of an amicus curiae indicated that “some women come to regret their choice”); Reva B. Siegel, *Dignity and the Politics of Protection: Abortion Restrictions Under Casey/Carhart*, 117 YALE L.J. 1694, 1788-90 (2008) (discussing strategy memos in which leaders of the anti-choice movement debated the kinds of abortion restrictions that would promote or diminish the movement's influence on Justice Kennedy); *id.* at 1773 (concluding that women's dignity is violated by abortion restrictions that purport to protect women but in reality “reviv[e] forms of gender paternalism that the Court and the nation repudiated in the 1970s”).

changing the Court's composition,⁶ which is unlikely in the short run. It therefore favors instead an incremental approach: the cumulative effect of legal restrictions short of bans and extralegal pressures to restrict the provision of legal abortion services and create "abortion free" states without criminalization.⁷

Even prior to President Obama's election, the incremental approach was prevalent. In a 2007 memorandum assessing "how best to advance the pro-life cause at present,"⁸ long-time general counsel to the National Right to Life Committee James Bopp commended "[a]stute pro-life leaders" for "rallying pro-lifers around passing what restrictions were permissible": "clinic regulations (which often shut down clinics), parental involvement, waiting periods, and informed consent."⁹ He advised that "now is not the time to pass . . . bills banning abortion" because "such an effort is presently doomed to expensive failure" before the Court—a failure that would make a future overruling of *Roe* even more difficult.¹⁰ Since the 2008 election, the consensus behind the incremental strategy has understandably strengthened among leading anti-*Roe* advocates, who have sought to convince their constituents, for example, that incrementalism is both "ethical" and "effective,"¹¹ and that "regulations which emphasize the risks to women and the need to protect women (such as informed consent, abortion clinic regulations, *etc.*) will be more effective means to curtail or overturn *Roe* than abortion prohibitions."¹²

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6. See, e.g., Memorandum from James Bopp, Jr., Member, Bopp, Coleson & Bostrom, & Richard E. Coleson, Senior Assoc., Bopp, Coleson & Bostrom, on Pro-Life Strategy Issues 3 (Aug. 7, 2007), <http://www.personhood.net/docs/BoppMemorandum1.pdf> [hereinafter Bopp Memorandum].
 7. See, e.g., Mark Hansen, *Following the Beat of the Ban: After a Loss in South Dakota, Many in the Anti-Abortion Movement Reassess Their Legal Strategy*, A.B.A. J. Feb. 2007, at 32 (discussing two competing approaches); *Frontline: The Last Abortion Clinic* (PBS television broadcast Nov. 8, 2005), available at <http://www.pbs.org/wgbh/pages/frontline/clinic/> (quoting the president of Pro-Life Mississippi, which lobbies for abortion regulations and organizes demonstrations at abortion clinics, as describing the organization's goal "to make Mississippi the first abortion free state in the nation").
 8. Bopp Memorandum, *supra* note 6, at 1.
 9. *Id.* at 5-6; see also *Frontline: The Last Abortion Clinic*, *supra* note 7.
 10. Bopp Memorandum, *supra* note 6, at 3.
 11. Clarke D. Forsythe, *Prudence in Policymaking: Is Incrementalism Ethical and Effective?*, in *DEFENDING LIFE 2009: PROVEN STRATEGIES FOR A PRO-LIFE AMERICA* 75, 75 (Denise M. Burke et al., eds.) (2009) [hereinafter *DEFENDING LIFE 2009*], available at <http://dl.aul.org/wp-content/uploads/pdfs/DLo9--ALL.pdf>.
 12. Clarke D. Forsythe, *The Road Map to Reversing Roe v. Wade*, in *DEFENDING LIFE 2009*, *supra* note 11, at 63, 65. Forsythe further instructs that "[i]nterim and incremental reductions of

To help explore some of the ramifications and lessons of abortion restrictions short of direct bans, this Essay takes as its principal example efforts to restrict access to abortion services in Indiana. In 2006, the year South Dakotans first rejected an abortion ban, an Indiana legislator also introduced a bill to outlaw abortion in most circumstances.¹³ That bill did not even progress to the point of a hearing, but two moderate-sounding bills that would have restricted the provision of abortion services came close to enactment.¹⁴ One of these bills is particularly worthy of study because, under the guise of health-related building standards, it would have ended the provision of abortion services at every clinic operating in the state. The phrase “TRAP laws,” which is short for targeted regulation of abortion providers, is sometimes used to describe such regulations by those who oppose them.¹⁵ Indiana abortion providers, like those throughout the country, continue to confront these and other restrictions in the state legislature and—beginning in 2008—in county commissions as well, in what the president of Indiana Right to Life described as “a new strategy” to work at the county level.¹⁶

Abortion, of course, has proven to be an issue of enduring public controversy and difficulty. Most Americans would welcome a workable compromise that maintains *Roe*’s core protections while reducing the number of abortions,¹⁷ and the 2008 election may bring some progress on that front.¹⁸

Roe (and the abortion license) are necessary to pave the way to a complete overruling.” *Id.* at 64.

13. H.R. 1096, 114th Gen. Assem., 2d Reg. Sess. (Ind. 2006), available at <http://www.in.gov/legislative/bills/2006/IN/IN1096.1.html>.
14. H.R. 1172, 114th Gen. Assem., 2d Reg. Sess. (Ind. 2006) (as passed by Indiana House, Feb. 1, 2006), available at <http://www.in.gov/legislative/bills/2006/HB/HB1172.3.html>; H.R. 1080, 114th Gen. Assem., 2d Reg. Sess. (Ind. 2006) (as passed by Indiana House, Feb. 1, 2006), available at <http://www.in.gov/legislative/bills/2006/HB/HB1080.1.html>.
15. See, e.g., NAT’L ABORTION FED’N, THE TRAP: TARGETED REGULATION OF ABORTION PROVIDERS (2007), available at http://www.prochoice.org/pubs_research/publications/downloads/about_abortion/trap_laws.pdf; cf. Gillian E. Metzger, *Abortion, Equality, and Administrative Regulation*, 56 EMORY L.J. 865, 870-75 (2007) (discussing the increase in the number of TRAP laws after *Casey* and the courts’ treatment of these regulations); Amalia W. Jorns, Note, *Challenging Warrantless Inspections of Abortion Providers: A New Constitutional Strategy*, 105 COLUM. L. REV. 1563, 1563-71 (2005) (discussing the development of TRAP laws—specifically, those that permit state health departments to conduct unannounced warrantless inspections).
16. Judy Keen, *County Abortion Regulations Scrutinized in Indiana: Rules Present New Obstacle for Providers*, USA TODAY, Sept. 26, 2008, at A1.
17. See, e.g., Gallup, Gallup’s Pulse of Democracy: Abortion, <http://www.gallup.com/poll/1576/Abortion.aspx> (last visited May 6, 2009).

The particulars, however, matter tremendously. As recent Indiana events help to demonstrate, abortion restrictions crafted to sound reasonable and to appeal to moderate legislators who would not support outlawing abortion can operate, in practice, to make abortion unavailable, even while the Court continues to reaffirm *Roe* and protect the right from direct attacks. Abortion restrictions can impose burdens not apparent on their face, especially on the most vulnerable women—those who, because of their life circumstances, are most unable to bear increased costs, travel additional distances, or otherwise overcome government-imposed barriers to abortion.

Part I of this Essay describes the legal restrictions in effect in Indiana and throughout the nation as a backdrop for Part II's examination of the initiatives proposed during the 2006 legislative session. The surprising role that abortion opponents played in stopping this legislation is the subject of Part III. Part IV examines one lesson that can be taken from the Indiana experience: though their effects may be difficult to predict or measure, politically appealing "compromise" restrictions can harm women's health and undermine our nation's commitment to liberty and equality. This Essay concludes by suggesting a second lesson: the superiority of "common-ground" approaches that promise greater success in reducing the number of abortions while affirming our nation's fundamental values.

I. ABORTION RESTRICTIONS IN INDIANA

Ever since *Roe* prevented states from imposing criminal prohibitions on the performance of abortions prior to the point of fetal viability, states have enacted a wide range of statutes that have restricted the provision of abortion services in other ways. During the two decades between *Roe* and *Casey* (1973 to 1992), federal courts invalidated, under a "strict scrutiny" standard, several kinds of state restrictions.¹⁹ The Court's decision in *Casey* is best known for its reaffirmation of *Roe*'s "central holding,"²⁰ but it also substituted a less

18. See, e.g., Jacqueline L. Salmon, *Some Abortion Foes Shifting Focus from Ban to Reduction*, WASH. POST, Nov. 18, 2008, at A1 (reporting on a coalition of abortion opponents who seek to reduce the number of abortions through social service programs and other assistance to support women and children, rather than through abortion restrictions); *id.* (noting that "during the campaign, [now-President Barack Obama] spoke of wanting to reduce abortions and of finding 'common ground' in the debate").

19. See, e.g., *Thornburgh v. Am. Coll. of Obstetricians & Gynecologists*, 476 U.S. 747 (1986); *City of Akron v. Akron Ctr. for Reprod. Health, Inc.*, 462 U.S. 416 (1983); *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52 (1976).

20. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 853 (1992).

protective “undue burden” review standard for *Roe*’s traditional and more predictable “strict scrutiny” of abortion restrictions.²¹ The Court’s articulation and application of the undue burden standard in *Casey* promised more protection than has since been provided in some later applications. *Casey* itself, however, signaled that the new standard would be less protective than *Roe*’s by upholding restrictions that the Court had invalidated in two earlier decisions under strict scrutiny.²²

Indiana has adopted almost all of the abortion restrictions the courts have upheld. Prior to *Casey*, Indiana enacted the two significant types of restrictions the Court had found survived *Roe*. First, Indiana prohibited women enrolled in Medicaid from receiving abortion services through that program with only minor exceptions;²³ currently, thirty-three states and the District of Columbia

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21. See *id.* at 876-88 (joint opinion of O’Connor, Kennedy, Souter, JJ.). An abortion restriction is an “undue burden” and unconstitutional if its “purpose or effect is to place a substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability.” *Id.* at 878. The *Casey* Court also declared, “[T]he State has legitimate interests from the outset of the pregnancy in protecting the health of the woman and the life of the fetus that may become a child.” *Id.* at 846 (majority opinion). Three Justices opined that “[r]egulations designed to foster the health of a woman seeking an abortion are valid if they do not constitute an undue burden.” *Id.* at 878 (joint opinion of O’Connor, Kennedy, Souter, JJ.); see also Forsythe, *supra* note 12, at 73 n.33 (stating that “[b]y its inherent elasticity and subjectivity, the ‘undue burden’ standard is susceptible to ‘evolution’ and it could evolve in a new way that would be deferential toward state regulation or prohibition”). This Essay considers the policy implications of certain abortion restrictions and not their constitutionality, which courts would assess by applying *Casey*’s undue burden standard.
 22. *Casey*, 505 U.S. at 882-83 (joint opinion of O’Connor, Kennedy, Souter, JJ.) (overruling in part *Akron*, 462 U.S. 416, and *Thornburgh*, 476 U.S. 747).
 23. Like most states, the Indiana legislature elected to fund only those circumstances covered by the Federal Medicaid program. IND. CODE § 16-10-3-3 (1992), *repealed and reenacted by* Act of Apr. 30, 1993, § 17, 1993 Ind. Acts 2, 568 (codified at IND. CODE § 16-34-1-2 (2004)) (exempting from the funding ban abortions “necessary to preserve the life of the pregnant woman”), *invalidated by* *Humphreys v. Clinic for Women, Inc.*, 796 N.E.2d 247 (Ind. 2003); 405 IND. ADMIN. CODE 5-28-7 (2008) (exempting “other circumstances if the abortion is required to be covered by Medicaid under federal law”); see also *Harris v. McRae*, 448 U.S. 297, 315 (1980) (upholding the Hyde Amendment, which restricted Medicaid funding to only abortions necessary to save the life of the pregnant women or those resulting from rape or incest, finding that it “places no governmental obstacle in the path of a woman who chooses to terminate her pregnancy, but rather, by means of unequal subsidization of abortion and other medical services, encourages alternative activity deemed in the public interest”). In 2003, the Indiana Supreme Court found the state funding scheme, which covered abortion services only in cases of life endangerment, rape, and incest, violated the Indiana Constitution’s Equal Privileges and Immunities Clauses when applied to women in some cases of extreme medical need:

[S]o long as the Indiana Medicaid program pays for abortions to preserve the lives of pregnant women and where pregnancies are caused by rape or incest, it

(as well as the federal government) impose similar funding limitations.²⁴ Indiana also required girls under eighteen to obtain the consent of a parent before having an abortion;²⁵ thirty-four states currently require some form of parental involvement (typically the consent of a parent).²⁶

After *Casey*, the Indiana legislature added new abortion restrictions, consistent with the national trend. In 1995, Indiana enacted a mandatory waiting-period statute. Under the statute, abortion providers must relate, in person, certain mandatory information to a woman seeking to terminate a pregnancy, including that state funds are available for prenatal care, that adoption services are available, that an ultrasound is available, and that the man responsible for the pregnancy is liable for child support. The woman must then wait at least eighteen hours after receiving this information before she can

must also pay for abortions for Medicaid-eligible women whose pregnancies create serious risk of substantial and irreversible impairment of a major bodily function.

Humphreys, 796 N.E.2d at 260.

24. See GUTTMACHER INST., STATE POLICIES IN BRIEF: AN OVERVIEW OF ABORTION LAWS 2 (2009), available at http://www.guttmacher.org/statecenter/spibs/spib_OAL.pdf; Mailee R. Smith, *Abortion: A Survey of Federal and State Law*, in DEFENDING LIFE 2009, *supra* note 11, at 113, 115.
25. IND. CODE § 35-1-58.5-2.5 (1992), *repealed and reenacted by* Act of Apr. 30, 1993, § 17, 1993 Ind. Acts at 571-72 (codified at IND. CODE § 16-34-2-4 (2004)). If the minor objects or is unable to obtain consent from a parent or legal guardian, then the minor may petition the juvenile court for a waiver of the consent requirement. IND. CODE § 16-34-2-4(b) (2004). The judge may grant the petition if the judge finds the minor to “be mature enough to make the decision” or that the “abortion would be in the minor’s best interests.” *Id.* § 16-34-2-4(d); see also *Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320 (2006) (vacating a district court’s injunction of New Hampshire’s parental consent law and remanding for a determination of whether a narrower remedy was possible); *Hodgson v. Minnesota*, 497 U.S. 417 (1990) (finding Minnesota’s statute that required that both parents be notified of a minor’s abortion to be unconstitutional, but the judicial bypass for parental consent constitutional); *Planned Parenthood Ass’n of Kan. City, Mo. v. Ashcroft*, 462 U.S. 476 (1983) (upholding a Missouri statute that required one parent’s consent before a minor could obtain an abortion and that contained a judicial bypass); *City of Akron v. Akron Ctr. for Reprod. Health, Inc.*, 462 U.S. 416 (1983) (finding an Ohio parental consent statute unconstitutional in part because it did not provide a judicial bypass); *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52 (1976) (finding Missouri’s blanket parental consent requirement to be unconstitutional); *Ind. Planned Parenthood Affiliates Ass’n v. Pearson*, 716 F.2d 1127 (7th Cir. 1983) (finding an earlier Indiana parental notification law unconstitutional on various grounds later rectified by the legislature).
26. See GUTTMACHER INST., *supra* note 24, at 3 (reporting that thirty-four states require some form of parental consent or notification and Oklahoma and Utah require both); Smith, *supra* note 24, at 114 (reporting that thirty-six state parental involvement laws are in effect). The discrepancy between these two figures is because the Guttmacher Institute reported the number of states and Smith reported the number of statutes.

obtain an abortion.²⁷ Twenty-four states enforce mandatory information and waiting periods (most often twenty-four hours),²⁸ which typically prove most burdensome for women who live long distances from the nearest provider and have difficulty affording or otherwise arranging the second trip that the waiting period may necessitate. In 1997, Indiana enacted a ban on the performance of abortions using procedures described as “partial birth”;²⁹ fifteen states and the federal government currently have some version of this ban.³⁰ Additionally, a 1999 Indiana statute prohibited the director and all employees of the Indiana Office of Women’s Health from “advocat[ing], promot[ing], refer[ring] to, or otherwise advanc[ing] abortion or abortifacients”³¹—a variation on the “gag rule” on abortion counseling the Court upheld by a five-four vote in *Rust v. Sullivan*.³²

The impact of Indiana’s legal restrictions can best be understood against the backdrop of nonstatutory impediments to abortion services. Like many states, Indiana suffers from a shortage of providers, and those providers face picketing, hostility, and sometimes even violence.³³ The state’s nine clinics are located in just five of the state’s ninety-two counties; 95% of Indiana counties,

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27. IND. CODE § 16-34-2-1.1(a)(1); see *A Woman’s Choice-E. Side Women’s Clinic v. Newman*, 132 F. Supp. 2d 1150, 1151 (S.D. Ind. 2001) (enjoining the enforcement of the “‘in the presence’ requirement” because it constituted an undue burden), *rev’d*, 305 F.3d 684, 693 (7th Cir. 2002) (finding that the district court judge abused his discretion by “issu[ing] a pre-enforcement injunction while the effects of the law (and reasons for those effects) are open to debate”).
 28. GUTTMACHER INST., *supra* note 24, at 3; Smith, *supra* note 24, at 114.
 29. IND. CODE § 16-34-2-1(b).
 30. GUTTMACHER INST., STATE POLICIES IN BRIEF: BANS ON “PARTIAL BIRTH” ABORTION 1 (2009), available at http://www.guttmacher.com/statecenter/spibs/spib_BPBA.pdf; Smith, *supra* note 24, at 115.
 31. IND. CODE § 16-19-13-3.
 32. 500 U.S. 173 (1991) (upholding the federal government’s policy against abortion counseling despite claims that the policy was an impermissible construction of Title X, that it violated the Fifth Amendment due process rights of the woman seeking to terminate her pregnancy, and that it violated the First Amendment free speech rights of patients, physicians, and staff).
 33. See, e.g., Cathy Kightlinger, *Fires Set in Abortion Clinic, Police Say*, INDIANAPOLIS STAR, Sept. 7, 2003, at B2 (reporting arson that caused damage to an abortion facility); see also NAT’L ABORTION FED’N, NAF VIOLENCE AND DISRUPTION STATISTICS: INCIDENTS OF VIOLENCE & DISRUPTION AGAINST ABORTION PROVIDERS IN THE U.S. & CANADA (2008), available at http://www.prochoice.org/pubs_research/publications/downloads/about_abortion/violence_statistics.pdf (reporting violence in the United States and Canada, which since 1993 has included hundreds of violent acts, including seven murders and thousands of disruptive acts such as bomb threats and clinic blockades).

including nine metropolitan areas, lack any abortion provider.³⁴ The shortage is particularly acute in the southern half of Indiana, where only one clinic provides abortion services.³⁵ This shortage mirrors a national trend, underway since the early 1980s, of steadily decreasing numbers of abortion providers.³⁶

II. INDIANA'S 2006 LEGISLATIVE SESSION

From 2006 to 2008, while the nation watched South Dakota consider and reject two abortion bans, the Indiana legislature attracted a small measure of its own national attention for seriously contemplating new forms of abortion restrictions. In 2006, for the first time in years, an Indiana legislator introduced a bill to outlaw abortion. House Bill 1096, introduced by Indiana Representative Troy Woodruff, sought to impose criminal penalties of up to eight years on anyone who performed an abortion, with exceptions only for the performance of abortions necessary to save a woman's life or to prevent the permanent impairment of her health.³⁷

This proposed ban revealed the same strategy split among abortion opponents at the state level as existed among national anti-choice advocates. Representative Woodruff defended his bill on the ground that the newly constituted Supreme Court might decide the issue differently than the *Roe*

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34. GUTTMACHER INST., STATE FACTS ABOUT ABORTION: INDIANA 2 (2008), available at <http://www.guttmacher.org/pubs/sfaa/pdf/indiana.pdf>; Abortion Clinic Licensing Program, Indiana State Department of Health, Directory of Licensed Abortion Clinics, http://www.in.gov/isdh/files/Abortion_Directory.pdf (last visited May 6, 2009) (listing nine licensed abortion clinics in five counties).
 35. Abortion Clinic Licensing Program, *supra* note 34; Ken Kusmer, *Abortion Foes Shift Restriction Push to Counties*, J. GAZETTE (Fort Wayne, Ind.), Aug. 15, 2008, at C4 ("Indiana has nine [clinics] in all, but none south of Bloomington.").
 36. See STANLEY K. HENSHAW & KATHRYN KOST, GUTTMACHER INST., TRENDS IN THE CHARACTERISTICS OF WOMEN OBTAINING ABORTIONS, 1974 TO 2004, at 26-27 (2008), available at <http://www.guttmacher.org/pubs/2008/09/23/TrendsWomenAbortions-wTables.pdf> (reporting numbers of abortion providers by year from 1973 to 2005); Lawrence B. Finer & Stanley K. Henshaw, *Abortion Incidence and Services in the United States in 2000*, 35 PERSP. ON SEXUAL & REPROD. HEALTH 6, 10-11 (2003) (reporting that, in 2000, 87% of U.S. counties did not have an abortion provider and more than 90% of counties in the Midwest did not have an abortion provider); Rachel K. Jones et al., *Abortion in the United States: Incidence and Access to Services, 2005*, 40 PERSP. ON SEXUAL & REPROD. HEALTH 6, 12, 14 (2008) (reporting statistics on the number of abortion providers and how far women must travel to the nearest provider).
 37. H.R. 1096, 114th Gen. Assem., 2d Reg. Sess. (Ind. 2006), available at <http://www.in.gov/legislative/bills/2006/IN/IN1096.1.html>.

Court did in 1973.³⁸ Indiana Governor Mitch Daniels, on the other hand, questioned the wisdom of devoting time and money to the bill given its “very limited prospect of ultimate success”: “Ultimately for this to change, first the heart of the country – and maybe ultimately the view the courts take of states’ rights to place some limits on abortion – would have to evolve.”³⁹ Indiana Senate President Pro Tempore Robert Garton also objected, “Why would someone want to deliberately run up court costs?”⁴⁰ This bill did not progress in the legislature.

Abortion opponents were more unified (though, in the end, not entirely so) in their support of two other bills that, instead of criminalizing abortion, sought to impose new restrictions.⁴¹ House Bill 1172 would have added more specifics to the mandatory information that Indiana already required physicians to give patients at least eighteen hours before performing an abortion, including a new requirement that physicians notify women in writing that “human life begins when a human ovum is fertilized by a human sperm.”⁴² South Dakota was the only state that required a similar statement to be made to all women seeking an abortion, and there it was clearly part of the state legislature’s broader effort to restrict abortion.⁴³ House Bill 1172 also would

38. Mary Beth Schneider & Michele McNeil, *Lawmaker’s Long Shot: Overturn Roe v. Wade*, INDIANAPOLIS STAR, Jan. 6, 2006, at A1.

39. *Id.*

40. *Id.*

41. In its reaction to the defeat of House Bill 1096, Planned Parenthood of Indiana shifted its focus to two other anti-choice bills, as House Bill 1096’s “spirit and intent were amended into” House Bills 1080 and 1172. Planned Parenthood Advocates of Indiana, 2006 Indiana Legislation, http://advocates.ppin.org/2006_legislation.aspx#hb1096 (last visited May 6, 2009).

42. H.R. 1172, 114th Gen. Assem., 2d Reg. Sess. (Ind. 2006) (as passed by Indiana House, Feb. 1, 2006), available at <http://www.in.gov/legislative/bills/2006/HB/HB1172.3.html>.

43. See S.D. CODIFIED LAWS § 34-23A-10.1(1)(b) (Supp. 2008) (requiring physicians to give women seeking an abortion a document stating “[t]hat the abortion will terminate the life of a whole, separate, unique, living human being”). The *Casey* joint opinion instructed that states may require physicians to pass on to women state-dictated information, including information that “expresses a preference for childbirth over abortion,” but the information must have the purpose of “ensuring a decision that is mature and informed.” Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 883 (1992) (joint opinion of O’Connor, Kennedy, Souter, JJ.). Accordingly, the Court upheld the Pennsylvania statute’s requirement that a woman seeking to terminate her pregnancy be provided information about “fetal development and the assistance available should she decide to carry the pregnancy to full term.” *Id.* A federal district court issued a preliminary injunction enjoining the South Dakota statute: “Unlike the truthful, non-misleading medical and legal information doctors were required to disclose in *Casey*, the South Dakota statute requires abortion doctors to enunciate the State’s viewpoint on an unsettled medical, philosophical,

have required physicians to tell women that the fetus might experience pain but that it was not medically possible to administer an anesthetic to the fetus before twenty weeks of pregnancy.⁴⁴ Three other states required a similar statement, but only for women past twenty weeks in their pregnancy.⁴⁵ Because the Indiana bill did not limit the requirement to a specified gestational period later in pregnancy, it received national press coverage for being “one of the furthest-reaching abortion consent laws in the country.”⁴⁶ As the legal director of Americans United for Life stated, the enactment of House Bill 1172 “would put Indiana on the cutting edge of an emerging issue.”⁴⁷

Proponents of the bill offered a few different public justifications. A National Right to Life Committee spokesperson said it would provide women with valuable information about the consequences of abortion.⁴⁸ An Indiana Right to Life lobbyist similarly said that it was important that women know that the procedure might cause the fetus pain.⁴⁹ An Indiana Representative who supported the bill said the purpose was to discourage abortion: “Given we can’t affect *Roe versus Wade*, this is an effort to try to reduce the number of abortions, which we can do.”⁵⁰ The substance of the message the bill sought to mandate is, of course, highly debated and disputed. Its opponents argued that it was not based in medical fact and would not give women true risk and

theological, and scientific issue, that is, whether a fetus is a human being.” *Planned Parenthood Minn., N.D., S.D. v. Rounds*, 375 F. Supp. 2d 881, 887 (D.S.D. 2005), *vacated*, 530 F.3d 724 (8th Cir. 2008). The Eighth Circuit, however, vacated the preliminary injunction, holding that Planned Parenthood could not establish that it would likely prevail on the merits of its claim that the statute constituted an undue burden. *Rounds*, 530 F.3d at 736. Robert Post has cautioned that the Eighth Circuit’s reasoning may be extended to allow states to require physicians to provide information on other subjects that is contrary to the majority or dominant beliefs of the medical profession. See Robert Post, *Informed Consent to Abortion: A First Amendment Analysis of Compelled Physician Speech*, 2007 U. ILL. L. REV. 939, 976-77, 988.

44. Ind. H.R. 1172.

45. See ARK. CODE ANN. § 20-16-1105 (West 2005); GA. CODE ANN. § 31-9A-4(a)(3) (2006); MINN. STAT. § 145.4242(a)(1)(iv) (Supp. 2008).

46. *Expansion Sought on Abortion Consent Laws*, L.A. TIMES, Feb. 12, 2006, at A31; see Deanna Martin, *Abortion Consent Law Before Ind. Legislature: Doctor Would Say Conception Begins Life*, WASH. POST, Feb. 12, 2006, at A10.

47. Greg Hafkin, *State Abortion Bill Has Few Models: Informed-Consent Measure Is Stricter than Most*, INDIANAPOLIS STAR, Jan. 29, 2006, at B1.

48. See Martin, *supra* note 46.

49. See Michele McNeil, *Senate Panel Overhauls Abortion Legislation: Effort To Limit Procedure Is Severely Weakened*, INDIANAPOLIS STAR, Feb. 23, 2006, at A1.

50. Greg Hafkin, *Abortion Bill Defines Start of Life: Conception Is It, Doctors Would Have To Tell Women*, INDIANAPOLIS STAR, Jan. 27, 2006, at A1.

benefit information; rather, the bill was a politically motivated attempt to use misinformation to dissuade women from having abortions.⁵¹

House Bill 1080, the second and by far more significant abortion-related bill that the Indiana legislature seriously considered in 2006, falls squarely within any definition of a TRAP bill: as passed by the House, it targeted abortion providers with onerous regulations that were not supported by health or safety needs.⁵² House Bill 1080 had its genesis in an Indiana bill enacted the previous year, Senate Bill 568, which directed the Indiana State Department of Health to promulgate rules regarding the licensing and inspection of abortion clinics and birthing centers.⁵³ Senate Bill 568 itself was unusual and controversial because it, too, targeted providers of abortion services for regulations that were not imposed on comparable health care providers.⁵⁴ Abortion providers unsuccessfully opposed the law, emphasizing their high safety rates and the lack of evidence of a problem that would warrant singling out abortion clinics for special regulation.⁵⁵ Governor Mitch Daniels signed the bill into law⁵⁶ after it passed both the Senate and the House overwhelmingly.⁵⁷

Pursuant to that law, the Indiana Department of Health promulgated over thirty pages of regulatory standards for clinics that provide abortion services.⁵⁸ Of critical importance to the clinics, the regulations included a grandfather clause that exempted clinics already in operation as of July 1, 2006 from the

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51. See Martin, *supra* note 46; *State Abortion Proposal Defines Life as Beginning at Conception*, HERALD-TIMES (Bloomington, Ind.), Feb. 12, 2006, at A12 (quoting Representative John Ulmer, a Republican who voted against House Bill 1172, as saying, “[t]o put our religious . . . beliefs into a statute that’s going to be law, without being able to back it up scientifically, I have real hard questions about doing that”).
 52. See H.R. 1080, 114th Gen. Assem., 2d Reg. Sess. (Ind. 2006) (as passed by Indiana House, Feb. 1, 2006), available at <http://www.in.gov/legislative/bills/2006/HB/HB1080.1.html>.
 53. S. 568, 114th Gen. Assem., 1st Reg. Sess. (Ind. 2005) (to be codified at IND. CODE 16-21-2-2.5).
 54. See, e.g., Greg Hafkin, *Abortion Clinics May Have To Close: Providers Say State Bill Regulating Facilities, With No ‘Grandfather’ Clause, Leaves No Time To Comply*, INDIANAPOLIS STAR, Feb. 3, 2006, at B1 (discussing how for over thirty years abortion facilities had not been subjected to individualized regulation by the state and the controversial nature of the new regulatory efforts).
 55. See *id.* (discussing opponents’ criticism that comparable legislation does not exist for podiatrists and plastic surgeons, for example, and that there is no evidence that the new requirements will improve abortion safety).
 56. J. SENATE, 114th Gen. Assem., 1st Reg. Sess. 1914 (Ind. 2005).
 57. J. SENATE, 114th Gen. Assem., 1st Reg. Sess. 1014 (Ind. 2005) (unanimous); J. HOUSE, 114th Gen. Assem., 1st Reg. Sess. 1037-38 (Ind. 2005) (passing by a vote of seventy-five to eighteen).
 58. See 410 IND. ADMIN. CODE 26-17-2(f) (2008).

“specifications of physical plant” section⁵⁹: only clinics opened after the effective date would be required to comply with the very detailed physical structure and design requirements, which, for example, dictated sizes, types, and numbers of rooms, hallways, and furnishings.⁶⁰ Grandfather clauses are often included when new physical structure requirements are imposed on health care providers, who otherwise might find it extremely burdensome to comply with the new regulations after their facilities were already constructed and their operations up and running.⁶¹ Indiana Right to Life had lobbied the Department of Health to make the new physical structure provisions applicable to existing clinics,⁶² but its efforts proved unsuccessful and the Department of Health included the grandfather clause.

A few months later, House Bill 1080 reignited the controversy.⁶³ As introduced by Representative Marlin Stutzman in the 2006 session, it sought to amend Indiana’s existing abortion consent law to mandate additional descriptions of the physical risks of abortion and the availability of adoption as an alternative.⁶⁴ The bill underwent extensive changes in the House

59. *Id.*

60. For example, the regulations required procedure rooms with a minimum of 120 square feet if “local analgesia or nitrous oxide” were required, 410 IND. ADMIN. CODE 26-17-2(d)(1)(A), “[a] separate recovery room or area . . . [with] [a] minimum clear area of two (2) feet, six (6) inches around three (3) sides of each recovery cart or lounge chair,” 410 IND. ADMIN. CODE 26-17-2(d)(4)(A), and a “minimum corridor width [of] forty-four (44) inches,” 410 IND. ADMIN. CODE 26-17-2(e)(5).

61. When the Facility Guidelines Institute and American Institute of Architects promulgate new design and construction guidelines for health care facilities, the physical plant guidelines are to apply only to newly constructed or renovated facilities—not to existing facilities. See FACILITY GUIDELINES INST. & AM. INST. OF ARCHITECTS, GUIDELINES FOR DESIGN AND CONSTRUCTION OF HEALTH CARE FACILITIES § 5.2.1 (2006) (listing design requirements for outpatient facilities, including corridor width, ceiling height, and boiler room specifications); *id.* § 3 (applying the guidelines when “renovation or replacement work is done to an existing facility” and to “all new work or additions”); *id.* § 3.2 (applying new physical plant guidelines to “only that portion of the total facility affected by the [renovation] project”). These guidelines are used by over forty states to “regulate new health facility construction and health care renovation.” Press Release, Facility Guidelines Inst., Comment Period Open for Health Care Design and Construction Guidelines 2 (Aug. 25, 2008), available at http://www.fgiguilines.org/pdfs/2010Guidelines_comment_period.pdf. In addition, the federal government references the Guidelines when regulating several of its programs. *Id.*

62. See Planned Parenthood Advocates of Indiana, *supra* note 41.

63. See H.R. 1080, 114th Gen. Assem., 2d Reg. Sess. (Ind. 2006) (as introduced, Jan. 5, 2006), available at <http://www.in.gov/legislative/bills/2006/IN/IN1080.1.html>.

64. *Id.*

Committee on Public Policy and Veterans Affairs,⁶⁵ however, and passed the House, sixty to thirty-eight.⁶⁶ As amended and passed, House Bill 1080 would have codified the physical structure and design regulations originally promulgated by the Department of Health—but without the critical grandfather clause.⁶⁷ Thus, this version of the bill would have made the Department of Health regulations mandatory for all clinics—effectively shutting down all of Indiana’s existing abortion clinics without directly banning abortion.⁶⁸

Providers of abortion services and supportive legislators and advocates worked hard to explain to the legislature and the press the real expected impact of the relatively innocuous-sounding provisions of House Bill 1080. According to testimony presented at hearings and other reports of providers of abortion services, its enactment would have shut down all nine health care clinics in Indiana that provided abortion services.⁶⁹ Compliance with the requirements would have required multimillion dollar renovations that, even if affordable, would have taken more time than the legislation would have given clinics to comply.⁷⁰ The director of the Women’s Pavilion in South Bend, for example, expressed concern that the way her clinic housed its heating, air conditioning, hot water, mechanical, and electrical equipment did not comply with House Bill 1080’s requirement that all such equipment be housed in an “equipment

65. Compare *id.*, with H.R. 1080, 114th Gen. Assem., 2d Reg. Sess. (Ind. 2006) (as reported by the Ind. H. Comm. on Pub. Policy & Veterans Affairs, Jan. 26, 2006), available at <http://www.in.gov/legislative/bills/2006/PDF/HCRP/AM108002.001.pdf>.

66. See J. HOUSE, 114th Gen. Assem., 2d Reg. Sess. 489 (Ind. 2006).

67. Compare 410 IND. ADMIN. CODE 26-17-2 (2008), with H.R. 1080, 114th Gen. Assem., 2d Reg. Sess. (Ind. 2006) (as passed by Indiana House, Feb. 1, 2006), available at <http://www.in.gov/legislative/bills/2006/HB/HB1080.1.html>.

68. Planned Parenthood of Indiana compared the effect of House Bill 1080 to that of a criminal ban: “While Indiana may yet become the first state in the union to end access to abortion without making it illegal, the South Dakota and Mississippi laws have been passed to serve as direct challenges to *Roe v. Wade* (much like HB 1096 was introduced here).” Planned Parenthood Advocates of Indiana, Legislative Wrap-Up, http://advocates.ppin.org/other_news_2006.aspx (last visited May 6, 2009).

69. See Hafkin, *supra* note 54 (quoting Planned Parenthood of Indiana’s director of legislative affairs, who stated that “[n]o provider currently meets [House Bill 1080’s] standard[s], and the amount of time and resources it takes to renovate the facilities could take years and cost millions of dollars”); Betty Cockrum, President, Planned Parenthood of Ind., Statement to the Senate Health and Provider Services Committee (Feb. 22, 2006) (on file with author).

70. See Hafkin, *supra* note 54.

room.”⁷¹ The Fort Wayne Women’s Health Organization, the sole provider of abortion services in Fort Wayne, complained that it would have also failed the bill’s requirements, because it did not have a “housekeeping room.”⁷² The Planned Parenthood clinic located in Bloomington, the only clinic that provides abortion services in all of southern Indiana,⁷³ is a multifloor facility located near the center of town that could not have expanded to meet the bill’s square-footage requirements at its current location due to insufficient available land.⁷⁴ The clinics also highlighted the absence of any health, safety, or other rationale that justified the alterations the bill would have required.⁷⁵

The prospects for enactment of both House Bill 1080 and House Bill 1172 seemed strong at the outset. The Indiana House passed both bills by wide margins: House Bill 1172 by a vote of seventy to thirty⁷⁶ and House Bill 1080 by a vote of sixty to thirty-eight.⁷⁷ The Indiana Senate Health and Provider Services Committee, however, amended both bills in ways that substantially diminished their impact, and the Senate passed the amended versions.⁷⁸ In the end, both bills died when the 2006 legislative session ended *sine die* without

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71. *Id.* The director of the clinic also said of the bill, “I’ve fought so many battles for so many years. When you’ve had to worry about people shooting your windows out and harassing you and death threats, [House Bill 1080 is] just one more thing.” *Id.*
 72. *Id.* A “housekeeping room” must include “a service sink” and “adequate storage for housekeeping supplies and equipment.” Ind. H.R. 1080 (as passed by Indiana House, Feb. 1, 2006).
 73. See Kusmer, *supra* note 35 (“Indiana has nine [clinics] in all, but none south of Bloomington.”); Abortion Clinic Licensing Program, *supra* note 34.
 74. Cockrum, *supra* note 69.
 75. See *id.*; Hafkin, *supra* note 54 (quoting the medical director of the Fort Wayne clinic as saying, “If we had a bad track record, I’d be the first one to understand it. But we don’t”); Letter from Vicki Saporta, President & CEO, Nat’l Abortion Fed’n, to Senator Patricia Miller, Ind. Senate (Feb. 8, 2006) (on file with author); see also IND. STATE DEP’T OF HEALTH, INDIANA MEDICAL ERROR REPORTING SYSTEM: FINAL REPORT FOR 2006, at 23 (2007), available at <http://www.in.gov/isdh/files/FinalReport2006.pdf> (tabulating all medical errors reported, as required by Indiana state law, and reporting that no medical errors were reported in any of Indiana’s nine licensed abortion-services providers); Amanda Iacone, *Doctor Law Would Cover Only Abortion*, J. GAZETTE (Fort Wayne, Ind.), Sept. 6, 2008, at A1 (“[N]o one has died from abortion complications in Indiana since 1978, when a teenage girl had a back-alley abortion and didn’t want to tell her parents when she had problems . . .”); Planned Parenthood Advocates of Indiana, *supra* note 41 (reporting a complication rate of less than half of one percent for first trimester abortions across all Indiana clinics at the time House Bill 1080 was being considered).
 76. J. HOUSE, 114th Gen. Assem., 2d Reg. Sess. 491 (Ind. 2006).
 77. *Id.* at 489.
 78. J. SENATE, 114th Gen. Assem., 2d Reg. Sess. 671-72 (Ind. 2006) (passing House Bill 1080 as amended); *id.* at 711 (passing House Bill 1172 as amended).

resolution of the differences between the House and Senate versions of the bills.⁷⁹

III. OPPOSITION FROM UNUSUAL SOURCES

Among the most interesting factors behind the failure of the legislation that would have used clinic regulations to close all of Indiana’s existing clinics was the principled opposition of some who were known for their opposition to abortion and *Roe*.⁸⁰ Democratic Representative Peggy Welch provided a strong and persuasive voice in the House against House Bill 1080. Welch, a nurse at Bloomington Hospital,⁸¹ strongly opposed abortion.⁸² She had supported the 2005 legislation that directed the development of the new regulations for abortion clinics that would become the basis for House Bill 1080.⁸³ Welch explained that the purpose of the earlier legislation was not to close clinics, but to ensure the safety of women undergoing abortions.⁸⁴ In response to House Bill 1080, Welch confirmed that she would “like to see abortion clinics closed,” but said that it was wrong for anti-choice advocates to seek to do so by removing the grandfather clause in the clinic regulations.⁸⁵ Welch gave an impassioned plea against the bill, refuting Indiana Right to Life’s claim that the bill was meant to protect women and stating instead that “with this new bill, it

79. Michele McNeil & Bill Ruthhart, *Credit, Deduction Will Offset Property Taxes - Legislature Approves Reductions for 2006-07*, INDIANAPOLIS STAR, Mar. 15, 2006, at A11.

80. See Indiana Right to Life, *How Did They Vote?: H.R. 1080*, <http://www.indianalife.org/html/bills/billsleg.asp?billid=87> (last visited May 6, 2009) (describing votes on House Bill 1080); Indiana Right to Life, *How Did They Vote?: H.R. 1172*, <http://www.indianalife.org/html/bills/billsleg.asp?billid=85> (last visited May 6, 2009) (describing votes on House Bill 1172).

81. Peggy Welch’s Resume, <http://www.peggywelch.com/about.html> (last visited May 6, 2009).

82. See *Legislature in Brief*, INDIANAPOLIS STAR, Feb. 2, 2006, at B2; see also Indiana Right to Life, *How Did They Vote?: Peggy Welch*, <http://www.indianalife.org/html/bills/legbills.asp?legid=96&Submit=Search> (last visited May 6, 2009) (describing Welch as voting “pro-life” 85% of the time).

83. See *Legislature in Brief*, *supra* note 82.

84. Dann Denny, *Welch Joins Abortion-Rights Advocates in Decrying Legislation*, HERALD-TIMES (Bloomington, Ind.), Feb. 11, 2006, at A1; see also David Swindle, *State Legislation Could Close Abortion Clinics Throughout Indiana*, BALL ST. DAILY NEWS (Muncie, Ind.), Feb. 22, 2006, at 4 (“As much as I would like to see clinics close, it was not my goal to use a clinic-regulation bill to do that.”).

85. Denny, *supra* note 84.

appears the goal is to shut down the clinics.”⁸⁶ Given her prior assurances about the purpose behind the 2005 law and implementing regulations, Welch said of House Bill 1080, “I can’t support it. It’s a matter of personal integrity and honoring my word.”⁸⁷ She also cited the certainty of a lawsuit, which she said might derail any attempts to regulate clinics.⁸⁸

Even more central to the defeat of House Bill 1080 was the position taken in the Senate by the Republican chair of the Senate Health and Provider Services Committee, Patricia Miller. Miller made such substantial changes to both House Bill 1080 and House Bill 1172 that the *Indianapolis Star* reported that this “staunch opponent of abortion” had “gutted” the bills, giving “a boost to abortion rights supporters.”⁸⁹ The Senate version of House Bill 1080 substituted more generalized safety standards for the rigid physical building requirements that no existing Indiana abortion provider would have satisfied.⁹⁰ And instead of requiring physicians to tell women that life begins at conception and that fetuses might experience pain during abortion, the Senate version of House Bill 1172 would have required physicians only to tell women that there were families waiting and willing to adopt children and that the

86. *Id.*

87. *Id.*

88. Hafkin, *supra* note 54 (“Passing the bill and not grandfathering existing facilities would essentially derail any effort by the state to regulate abortion clinics because of the certainty of a lawsuit, Welch said.”).

89. McNeil, *supra* note 49.

90. In place of the House’s particularized physical and design requirements, see H.R. 1080, 114th Gen. Assem., 2d Reg. Sess. (Ind. 2006) (as passed by Indiana House, Feb. 1, 2006), available at <http://www.in.gov/legislative/bills/2006/HB/HB1080.1.html>, the Senate inserted the following more generic requirements:

(1) Be constructed, arranged, modified, or maintained to ensure the safety and well being of patients, employees, and visitors to the clinic.

(2) Provide a physical plant and equipment that meet state fire prevention and building safety codes or rules established by the fire prevention and building safety commission or the state department.

(3) Provide a safe and healthy environment that minimizes infection exposure and risk to patients, employees, and visitors to the clinic.

H.R. 1080, 114th Gen. Assem., 2d Reg. Sess. (Ind. 2006) (as passed by Indiana Senate, Feb. 28, 2006), available at <http://www.in.gov/legislative/bills/2006/EH/EH1080.1.html>. The Senate version retained the House version’s requirement of at least one annual inspection by the Indiana State Department of Health. *Id.* A conference committee was appointed to reconcile the two versions of the legislation. J. HOUSE, 114th Gen. Assem., 2d Reg. Sess. 774 (Ind. 2006); J. SENATE, 114th Gen. Assem., 2d Reg. Sess. 779 (Ind. 2006). The conference committee, however, did not issue a report prior to the end of the session. See J. HOUSE, 114th Gen. Assem., 2d Reg. Sess. (Ind. 2006).

abortion procedure does have physical risks.⁹¹ The Senate ultimately passed Miller’s substitute versions of both bills by the same overwhelming vote of forty-eight to one.⁹²

Miller, like Welch, was a longtime abortion opponent.⁹³ Miller explained that she was “still very pro-life” but that “she didn’t think the bills appropriately addressed the larger issue of reducing the number of abortions in Indiana.”⁹⁴ Miller particularly favored efforts to reduce the number of abortions by encouraging women to put their babies up for adoption.⁹⁵ The *Indianapolis Star* reported that Miller described her position in very personal terms and that her voice cracked as she tearfully explained: “I’d have two less grandchildren,” because two of her four grandchildren had been adopted.⁹⁶ Miller continued, “I think we ought to do more to honor women that make that courageous decision.”⁹⁷

Also striking was the opposition to both bills by the self-described antiabortion editorial board of the *Indianapolis Star*, which characterized the bills as “stray[ing] from good public policy into government meddling.”⁹⁸ The

91. Compare H.R. 1172, 114th Gen. Assem., 2d Reg. Sess. (Ind. 2006) (as passed by Indiana House, Jan. 31, 2006), available at <http://www.in.gov/legislative/bills/2006/HB/HB1172.3.html>, with H.R. 1172, 114th Gen. Assem., 2d Reg. Sess. (Ind. 2006) (as passed by Indiana Senate, Feb. 28, 2006), available at <http://www.in.gov/legislative/bills/2006/EH/EH1172.1.html>. After the Senate passed its version of House Bill 1172, a conference committee, composed of two members from each chamber, met and adopted a compromise version of House Bill 1172, which reinserted the House’s life-begins-at-conception and fetal-pain provisions into the Senate version, but omitted the House’s fetal-anesthesia provision. J. HOUSE, 114th Gen. Assem., 2d Reg. Sess. 1121-22 (Ind. 2006) (reporting the committee’s version of House Bill 1172). The House passed the conference committee’s version of House Bill 1172 on March 14, 2006, by a vote of seventy-five to twenty-three. J. HOUSE, 114th Gen. Assem., 2d Reg. Sess. 1233 (Ind. 2006). The conference committee report, however, was not voted on in the Senate by the end of the session. See J. SENATE, 114th Gen. Assem., 2d Reg. Sess. (Ind. 2006).

92. See J. SENATE, 114th Gen. Assem., 2d Reg. Sess. 671-72 (Ind. 2006) (passing House Bill 1080 as amended); *id.* at 711 (passing House Bill 1172 as amended).

93. See Indiana Right to Life, How Did They Vote?: Pat Miller, <http://www.indianalife.org/html/bills/legbills.asp?legid=223&Submit2=Search> (last visited May 6, 2009) (reporting Miller as voting “pro-life” 100% of the time).

94. McNeil, *supra* note 49.

95. *Id.* (“[Miller] said that besides not addressing the reduction of unwanted pregnancies, [House Bills 1172 and 1080] did not encourage more women to give their babies up for adoption.”).

96. *Id.*

97. *Id.*

98. Editorial, *Legislation Intrudes into Private Affairs*, INDIANAPOLIS STAR, Jan. 28, 2006, at A14.

editorial board noted that it “ha[d] consistently opposed abortion” and that it found the existing eighteen-hour mandatory waiting period “reasonable.”⁹⁹ But it found that House Bill 1172, by requiring physicians to tell women that life begins at conception, ignored the “uncertainty” over what is “as much a moral concept as it is a medical issue” and one on which “there isn’t a uniform answer among the medical, scientific, or religious communities.”¹⁰⁰ And with its fetal pain notification requirement, House Bill 1172 “would require physicians to give women information that might not be true.”¹⁰¹ With regard to House Bill 1080, the board opined that “[w]hile clinics should be held to the highest standards for safety and patient care, it’s not the legislature’s job to dictate the width of hallways in private businesses.”¹⁰²

The unusual role played here by prominent antiabortion voices invites examination for what it might portend for future TRAP bills. In opposing House Bill 1080, the editorial board of the *Indianapolis Star* invoked an ideal of limited government, harkening back to traditional libertarian arguments against restrictive abortion laws—though its concern was the property rights of private businesses rather than the reproductive rights of women. Beyond the possible appeal of libertarian arguments, two other potential lessons emerge; these are the subject of the remainder of this Essay. First, TRAP laws can sometimes be resisted by exposing their actual effect, as well as the true intent motivating some of their leading proponents.¹⁰³ Second, common-ground alternative approaches, which may in fact be more effective in reducing the number of abortions than TRAP laws, might play a key role in defeating them. Both lessons prove instructive for legislators and voters from across the ideological spectrum as they confront TRAP laws that are presented as health and safety regulations but threaten to diminish the availability of abortion services without evidence of countervailing health and safety benefits.

First, however, a caution: the opposition from antiabortion quarters to the House versions of House Bill 1080 and House Bill 1172 might not be easily replicated, as evidenced by both its deviation from the norm of antiabortion advocacy for such legislation and subsequent events in Indiana itself. In the following legislative sessions, legislators pursued the restrictions contained in

99. *Id.*

100. *Id.*

101. *Id.*

102. *Id.*

103. See, e.g., *supra* notes 7–12 and accompanying text. As discussed below, see *infra* note 122 and accompanying text, of course not all who support TRAP laws are motivated by a desire to shut down clinics.

House Bill 1080¹⁰⁴ and House Bill 1172,¹⁰⁵ as well as other restrictions, particularly as “poison pill” amendments¹⁰⁶ used to prevent the enactment of bills on subjects from inspections of day care centers for lead-based paint¹⁰⁷ to kidney dialysis.¹⁰⁸ An antiabortion “poison pill” helps explain why Indiana is one of only five states¹⁰⁹ in the nation without a criminal law banning hate crimes.¹¹⁰ One of these instances illustrates the special challenge created when

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104. See, e.g., S. 166, 115th Gen. Assem., 2d Reg. Sess. (Ind. 2008) (as amended by Representative Jeff Thompson, Feb. 26, 2008), *available at* <http://www.in.gov/legislative/bills/2008/PDF/HAMF/MO016602.002.pdf> (seeking to remove the grandfather clause exception in the Health Department’s licensing requirements for existing abortion clinics, with compliance by all abortion clinics mandated by January 1, 2012); S. 221, 115th Gen. Assem., 1st Reg. Sess. (Ind. 2007) (as introduced by Senator Dennis Kruse, Jan. 8, 2007), *available at* <http://www.in.gov/legislative/bills/2007/IN/IN0221.1.html> (requiring compliance by July 1, 2011).
 105. See, e.g., S. 90, 116th Gen. Assem., 1st Reg. Sess. (Ind. 2009) (as passed by Indiana Senate, Feb. 10, 2009), *available at* <http://www.in.gov/legislative/bills/2009/SB/SB0090.2.html>; S. 146, 115th Gen. Assem., 2d Reg. Sess. (Ind. 2008) (as passed by Indiana Senate, Jan. 29, 2008), *available at* <http://www.in.gov/legislative/bills/2008/SB/SB0146.1.html>; S. 135, 115th Gen. Assem., 1st Reg. Sess. (Ind. 2007) (as introduced, Jan. 11, 2007), *available at* <http://www.in.gov/legislative/bills/2007/IN/IN0135.1.html>; S. 172, 115th Gen. Assem., 1st Reg. Sess. (Ind. 2007) (as introduced, Jan. 8, 2007), *available at* <http://www.in.gov/legislative/bills/2007/IN/IN0172.1.html>.
 106. In 2008 alone, opponents of abortion introduced twenty-eight abortion-related amendments to nineteen bills, according to pro-choice advocates. JOAN LASKOWSKI, SESSION SUMMARY AND VOTING RECORDS: 2008 INDIANA GENERAL ASSEMBLY 2 (2008), *available at* <http://www.aclu-in.org/upload/newsletters/2008SummaryandVotingRecords.pdf>; Planned Parenthood Advocates of Indiana, 2008 Indiana “Poison Pill” List (Mar. 18, 2008), http://advocates.ppin.org/poison_pills.aspx.
 107. S. 143, 115th Gen. Assem., 2d Reg. Sess. (Ind. 2008) (as amended by Representative Jackie Walorski, Feb. 26, 2008), *available at* <http://www.in.gov/legislative/bills/2008/PDF/HAMP/MO014305.005.pdf>. This amendment, which also would have required abortion clinics to pass lead-based paint inspections, passed the House, J. HOUSE, 115th Gen. Assem., 2d Reg. Sess. 671 (Ind. 2008), but was removed from the bill during the House and Senate Conference Committee, *see* J. HOUSE, 115th Gen. Assem., 2d Reg. Sess. 886-89 (Ind. 2008). The governor ultimately signed bill S. 143 into law without the abortion restriction. J. SENATE, 115th Gen. Assem., 2d Reg. Sess. 1772 (Ind. 2008).
 108. S. 166, 115th Gen. Assem., 2d Reg. Sess. (Ind. 2008) (as amended by Representative Jeff Thompson, Feb. 26, 2008), *available at* <http://www.in.gov/legislative/bills/2008/PDF/HAMF/MO016602.002.pdf>.
 109. Those states are Arkansas, Georgia, Indiana, South Carolina, and Wyoming. See Anti-Defamation League, State Hate Crime Statutory Provisions, http://www.adl.org/99hatecrime/state_hate_crime_laws.pdf (last visited May 6, 2009).
 110. See H.R. 1076, 115th Gen. Assem., 2d Reg. Sess. (Ind. 2008) (as amended by Representative Jeff Thompson, Jan. 24, 2008), *available at* <http://www.in.gov/legislative/bills/2008/PDF/HAMP/MO107603.006.pdf>; Planned Parenthood Advocates of Indiana, *supra* note 106.

observers and even legislators have a difficult time discovering when an abortion restriction has been introduced. A 2008 amendment to a kidney dialysis bill would have removed the grandfather clause in the Department of Health's clinic-licensing requirements.¹¹¹ This amendment was very difficult to spot, however, for two reasons. First, it was added late in the process, after the bill had already passed the Senate¹¹² and the House Committee on Insurance.¹¹³ More significant, the amendment made no mention of abortion—it instead referred to the numerical citation for the relevant Indiana Code sections that granted the Department of Health the authority to create licensing requirements for abortion providers.¹¹⁴

Frustrated by their near-victories but ultimate failure to enact new legislation since 2005, anti-*Roe* advocates increased the political heat on Indiana legislators. Indiana Right to Life blamed, among others, President Pro Tempore of the Indiana Senate Bob Garton for failing to ensure a vote on the abortion restrictions before the 2006 legislature adjourned.¹¹⁵ Garton, an anti-choice Republican, had served in the Indiana Senate for thirty-six years and as President Pro Tempore for twenty-six years.¹¹⁶ Nonetheless, in 2006, for the first time since 1970,¹¹⁷ Garton faced a challenge in the Republican primary by a candidate who ran from the far ideological right.¹¹⁸ The challenger won, in a surprise upset that might strike fear in other Republican legislators.¹¹⁹ Additionally, in 2008, Indiana Right to Life sent a memo to Democratic members of the House notifying them that it would not support a single Democratic candidate, even those with strong anti-choice records whom the

After Representative Thompson's amendment, House Bill 1076 was not called for a second reading and was effectively defeated. See J. HOUSE, 115th Gen. Assem., 2d Reg. Sess. (Ind. 2008); Planned Parenthood Advocates of Indiana, 2008 Indiana Legislation (Mar. 18, 2008), http://advocates.ppin.org/2008_legislation.aspx#hb1076.

111. Ind. S. 166.

112. J. SENATE, 115th Gen. Assem., 2d Reg. Sess. 386 (Ind. 2008).

113. J. HOUSE, 115th Gen. Assem., 2d Reg. Sess. 624-28 (Ind. 2008).

114. Ind. S. 166.

115. See Michele McNeil, *Senate Leader Ousted: Greg Walker Stuns 36-Year Old Veteran Garton; Departure Creates Power Vacuum*, INDIANAPOLIS STAR, May 3, 2006, at A1; Bill Ruthhart, *Anti-Abortion Group Shuns Garton*, INDIANAPOLIS STAR, Apr. 6, 2006, at B2.

116. See Mary Beth Schneider, *Garton Wielded Power for 26 Years*, INDIANAPOLIS STAR, May 7, 2006, at B3.

117. McNeil, *supra* note 115.

118. See Russ Pulliam, *Pro-Life David Runs Against Goliath*, INDIANAPOLIS STAR, Apr. 16, 2006, at E2 (describing Garton's opponent in the primary as "a more conservative alternative").

119. See McNeil, *supra* note 115.

organization had previously supported, because it blamed the Democratic House leadership for the House’s recent failure to enact any new abortion restrictions.¹²⁰

Both Senator Miller and Representative Welch were among the Indiana legislators who supported new restrictions on the provision of abortion services during the legislative sessions that followed the 2006 defeat of House Bill 1080. Most significant, they cosponsored legislation, which the legislature nearly enacted in 2009, that would have prohibited physicians from performing abortions unless they possessed admitting or transfer privileges at a hospital located near the clinic—again, a burdensome requirement that appears reasonable on its face. Although this subsequent action suggests that their opposition to the extreme version of House Bill 1080 may have reflected factors unique to that bill, statements at the time by both Senator Miller and Representative Welch do suggest potentially effective responses to TRAP legislation: establish the intent behind the legislation and its actual effect, and highlight common-ground alternative approaches to reducing abortion

IV. DISCERNING TRAP LAWS’ EFFECTS

The expected impact of House Bill 1080 as passed by the Indiana House—closing all then-existing clinics—would have been extreme, which helps account for its defeat and the opposition to it even from some abortion opponents. Often, however, making a convincing case against a TRAP bill—demonstrating its harm to services and the lack of any countervailing benefit—is exceedingly difficult. As discussed above, leading anti-choice organizations have made the enactment of clinic regulation laws “which often shut down clinics” a priority.¹²¹ Their aim is to craft bills that diminish the availability of services while appearing moderate and health-related, thereby appealing to legislators and voters who would not support a direct prohibition on abortion services.¹²² Indeed, many legislators who vote for such bills may not share the

120. See Memorandum from Mike Fichter, Chairman, Ind. Right to Life Political Action Comm., to Ind. Legislative Candidates (Aug. 28, 2008), <http://www.candidatesurveys.com/documents/irtlpolicy2008.pdf>.

121. Bopp Memorandum, *supra* note 6, at 6.

122. Americans United for Life, for example, in its *Road Map to Reversing Roe v. Wade*, placed the priority on “regulations which emphasize the risks to women and the need to protect women,” Forsythe, *supra* note 12, at 65, and specifically listed regulations that “[r]aise the requirements for clinic regulations” along with restrictions on “[i]nformed consent,” minors, and “abortifacients, including RU-486,” *id.* at 70. The *Road Map* describes the target audience for the focus on health and women as “the 60% of people in the ‘middle’

motivations of those who crafted the legislation and may even consider themselves supporters of *Roe v. Wade*.

More generally, in the many years since *Casey* reaffirmed *Roe*'s "central holding,"¹²³ the appeal of "compromise" restrictions has grown among *Roe*'s supporters. Complacency about *Roe*'s security has been fortified by what can be described as abortion fear and fatigue: fear about the impact of the issue on other legal and political objectives, and a fatigue manifested in a desire for the issue to be resolved in order to allow focus and energy to be allocated to other goals. Abortion has always been viewed, in the main, as a difficult and risky issue that is best avoided at political, professional, and personal levels alike. In recent years, efforts by anti-choice advocates to increase the stigma associated with abortion appear to have contributed, if not to a weakening of support for the legality of abortion—most polls indicate support has remained relatively steady¹²⁴—then to discomfort with the issue, including a reluctance even to name it.¹²⁵

Abortion fear and fatigue underlie certain refrains among some who support keeping abortion legal and who are otherwise politically progressive: that abortion plays too great a role in electoral politics, constitutional law, and Supreme Court confirmations; that battles over abortion have cost elections and distracted from other social ills; that the progressive constitutional vision might not accommodate *Roe*; that the current state of affairs is not particularly harmful to women; and that *Casey* will hold and the Court will never overrule *Roe*. This account deserves respect and careful response, for it reflects important realities. Ultimately, however, it is dangerously incomplete and misguided. Among its shortcomings, it encourages a tolerance—even a welcoming—of political "compromises" that actually betray core commitments to conceptions of equality, liberty, and justice. These putative compromises take the form of abortion restrictions, such as TRAP laws, that are finely crafted to sound reasonable and to appeal to moderates, but that in practice impose disproportionate burdens on the most vulnerable women and exacerbate existing inequalities—much as the pre-*Roe* regime of state

who are conflicted or ambivalent about abortion." *Id.* at 71; see *supra* notes 7-12 and accompanying text.

123. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 853 (1992).

124. See, e.g., Gallup, *supra* note 17.

125. Cf. Linda Greenhouse, *How the Supreme Court Talks About Abortion: The Implications of a Shifting Discourse*, 42 SUFFOLK U. L. REV. 41 (2008) (describing changes in the Supreme Court's discourse about abortion from its decision in *Roe v. Wade*, 410 U.S. 113 (1973), to its decision in *Gonzalez v. Carhart*, 550 U.S. 124 (2007)).

regulation resulted in grossly disparate harms that tracked economic and political power.

House Bill 1080 demonstrates just how devastating TRAP laws can be, but rarely is the impact of such laws so obvious. The particulars vary substantially, making it difficult sometimes to know whether the term “TRAP law” is even appropriate.¹²⁶ For example, notwithstanding the defeat of House Bill 1080, Indiana is among the states typically cited as already having a TRAP law in effect¹²⁷—namely, Indiana’s 2005 law that led to the Department of Health’s thirty-plus pages of physical structure requirements for clinics. The regulations, however, included a grandfather clause protecting existing providers from the most burdensome of the regulations, which new clinics—not yet in existence—would have to satisfy.¹²⁸ This underscores that the actual impact of TRAP laws is notoriously difficult to assess, because it occurs over time¹²⁹ and because abortion providers do what they can to minimize the harm, especially by seeking statutory exemptions¹³⁰ and working with state regulators post-enactment to win waivers, exemptions, and extensions. Grandfather clauses, such as the one in the Indiana regulations, constitute one common

126. See Forsythe, *supra* note 12, at 66 (reporting that “[l]egislative fences have been erected that significantly reduce abortions” and citing the twenty-seven states with “abortion clinic regulations”). It may not always be clear whether a particular piece of legislation should be considered a TRAP law in the sense that phrase typically is used—that is, to connote a medically unnecessary restriction that would diminish the availability of abortion services under the guise of protecting health. It is possible that a particular regulation aimed only at abortion providers might be motivated by a desire to protect women’s health—and in fact do so—but that certainly was not the case with House Bill 1080. See generally NARAL: Pro-Choice America, State Profiles, http://www.prochoiceamerica.org/choice-action-center/in_your_state/who-decides/state-profiles/ (last visited May 6, 2009) (providing a database with all abortion restrictions and regulations in each state).

127. See NAT’L ABORTION FED’N, *supra* note 15; Hafkin, *supra* note 54; Center for Reproductive Rights, Targeted Regulation of Abortion Providers (TRAP): Avoiding the TRAP, <http://reproductiverights.org/document/targeted-regulation-of-abortion-providers-trap-avoiding-the-trap>.

128. See 410 IND. ADMIN. CODE 26-17-2(f) (2008).

129. See, e.g., *Planned Parenthood of Greater Iowa v. Atchison*, 126 F.3d 1042, 1046 (8th Cir. 1997) (affirming that an Iowa statute that required a new abortion clinic to be subject to a “certificate of need” review constituted an undue burden on the abortion right, in part because this statute was passed ten years prior to its enforcement in this case and because in the interim Iowa did not enforce it against any similarly situated health care facility).

130. See, e.g., MISS. CODE ANN. § 41-75-1(f) (2008) (exempting facilities that perform ten or fewer abortions in any month, one hundred or fewer a year, and do not hold themselves out to the public as an abortion provider through advertising).

approach to mitigating harm.¹³¹ Thus, opposition to a bill usually must depend upon conjecture about highly uncertain future effects.¹³² What is entirely clear, however, is that the resulting harm falls disproportionately on the most vulnerable women because the principal effect of such laws is to decrease the availability and raise the costs of already-diminishing abortion services.¹³³ One result, especially for women who lack resources, might be that larger numbers of women will have later-term, more morally problematic, and more physically dangerous abortions.

A relatively new form of TRAP law, promoted by anti-choice organizations and legislators around the country, is illustrative of both the harms TRAP laws threaten and the difficulty of successful opposition. This form of restriction would require that physicians who perform abortions obtain admitting or “transfer” privileges at local hospitals. Senator Patricia Miller, who in 2006 was instrumental in amending House Bill 1080 to remove its most harmful effects, has in each of the three years since introduced¹³⁴ legislation that would have prohibited physicians from performing abortions unless they have “privileges at a hospital located: (1) in the county; or (2) in a county adjacent to the county; in which the abortion is performed.”¹³⁵ The Indiana Senate passed the bill each year.¹³⁶ Representative Peggy Welch, another opponent of the extreme

131. See also *Women’s Med. Prof’l Corp. v. Baird*, 438 F.3d 595, 608 (6th Cir. 2006) (describing how the Director of the Ohio Department of Health “has granted waivers and variances to . . . abortion clinics in the past”); *Planned Parenthood of Kan. v. Drummond*, No. 07-4164, 2007 WL 2811407, at *8 (W.D. Mo. Sept. 24, 2007) (emphasizing Missouri’s willingness to grant a waiver of its clinic design requirements for an existing facility and the factors Missouri would consider).

132. See, e.g., *Drummond*, 2007 WL 2811407, at *8 (enjoining Missouri’s clinic design requirements because whether the state would require full compliance, as opposed to granting a waiver, was unknown).

133. See, e.g., *Greenville Women’s Clinic v. Bryant*, 222 F.3d 157, 162 (4th Cir. 2000) (acknowledging that South Carolina’s abortion clinic regulations would increase the cost of each abortion by \$22 to \$368, depending on the clinic).

134. J. SENATE, 116th Gen. Assem., 1st Reg. Sess. 31 (Ind. 2009) (listing Senator Patricia Miller as the author); J. SENATE, 115th Gen. Assem., 2d Reg. Sess. 17 (Ind. 2008) (listing Senator Patricia Miller as a coauthor with Senator Jeff Drozda); J. SENATE, 115th Gen. Assem., 1st Reg. Sess. 32 (Ind. 2007) (listing Senator Patricia Miller as the author).

135. S. 89, 116th Gen. Assem., 1st Reg. Sess. (Ind. 2009) (as passed by Indiana Senate, Feb. 10, 2009), available at <http://www.in.gov/legislative/bills/2009/SB/SB0089.1.html>; S. 146, 115th Gen. Assem., 2d Reg. Sess. (Ind. 2008) (as passed by Indiana Senate, Jan. 29, 2008), available at <http://www.in.gov/legislative/bills/2008/SB/SB0146.1.html>; S. 194, 115th Gen. Assem., 1st Reg. Sess. (Ind. 2007) (as passed by Indiana Senate, Feb. 27, 2007), available at <http://www.in.gov/legislative/bills/2007/SB/SB0194.1.html>.

136. J. SENATE, 116th Gen. Assem., 1st Reg. Sess. 292 (Ind. 2009) (passing the Indiana Senate on Feb. 10, 2009, by a vote of forty-four to six); J. SENATE, 115th Gen. Assem., 2d Reg. Sess. 376

version of House Bill 1080, cosponsored the hospital-privileges legislation in the House,¹³⁷ and in April of 2009, the House passed an amended version of the bill.¹³⁸ Among several significant changes, the House bill extended the reach of the privileges requirement beyond providers of abortions to cover other health care providers who perform surgical procedures.¹³⁹

Eleven states currently impose some form of hospital-admitting privileges or patient-transfer requirement, though their precise requirements vary dramatically.¹⁴⁰ In 2008, legislation was introduced in Congress to impose a

(Ind. 2008) (passing the Indiana Senate on Jan. 29, 2008, by a vote of thirty-nine to nine); J. SENATE, 115th Gen. Assem., 1st Reg. Sess. 528 (Ind. 2007) (passing the Indiana Senate on Feb. 27, 2007, by a vote of thirty-seven to ten).

137. J. HOUSE, 115th Gen. Assem., 2d Reg. Sess. 470 (Ind. 2008) (adding Representative Peggy Welch as a cosponsor of the bill in the House); J. HOUSE, 115th Gen. Assem., 1st Reg. Sess. 713 (Ind. 2007) (listing Representative Peggy Welch as a co-sponsor of the bill in the House).
138. See J. SENATE, 116th Gen. Assem., 1st Reg. Sess. 1369 (Ind. 2009).
139. S. 89 (as passed by the Indiana House, Apr. 15, 2009), available at <http://www.in.gov/legislative/bills/2009/ES/ES0089.2.html>. The House bill exempted, however, “surgical procedures performed by dentists licensed under IC 25-14.” *Id.* It also included two other substantial changes: a requirement that physicians notify women contemplating having an abortion that “the fetus might feel pain” and the establishment of a program for breast and cervical cancer screening. *Id.* The Senate dissented from all of the House’s amendments, J. SENATE, 116th Gen. Assem., 1st Reg. Sess. 1373 (Ind. 2009), and the bill died when the Senate and House failed to reconcile these differences before the end of the 2009 legislative session, *Deadlock Kills Abortion Doctor Bill*, INDIANAPOLIS STAR, Apr. 29, 2009, <http://www.indystar.com/apps/pbcs.dll/article?AID=2009904290411>. Differences over the addition of the costly cancer screening program were cited as the main cause of the bill’s ultimate failure. *Id.*; Bill Ruthhart, *Fate of Abortion Bill Is Up in the Air*, INDIANAPOLIS STAR, Apr. 28, 2009, <http://www.indystar.com/article/20090428/NEWS0501/904280375>.
140. See Smith, *supra* note 24, at 116 (reporting that eleven states currently require that abortion providers maintain hospital admitting privileges); Steven Ertelt, *Indiana Senate Backs Bill Requiring Abortion Providers To Have Hospital Privs*, LIFE NEWS.COM, Feb. 4, 2009, <http://www.lifenews.com/state3810.html> (listing the eleven states with admitting privileges statutes: Alabama, Arkansas, Kentucky, Louisiana, Mississippi, Missouri, Ohio, Pennsylvania, South Carolina, Texas, and Utah); see, e.g., ARIZ. REV. STAT. ANN. § 36-449.03(F)(4) (2008) (requiring that abortion recovery rooms must have “[a] physician with admitting privileges at an accredited hospital in this state [who] remains on the premises of the abortion clinic”); FLA. STAT. ANN. § 390.012(3)(c)(1) (West 2008) (requiring “a medical director who is licensed to practice medicine in this state and who has admitting privileges at a licensed hospital in this state or has a transfer agreement with a licensed hospital within reasonable proximity of the clinic”); MO. ANN. STAT. § 188.080 (West 2009) (“Any physician performing or inducing an abortion who does not have clinical privileges at a hospital which offers obstetrical or gynecological care located within thirty miles of the location at which the abortion is performed or induced shall be guilty of a class A misdemeanor”); OHIO ADMIN. CODE 3701:83-19 (2006) (requiring “a written transfer

nationwide requirement that “[a] physician who performs an abortion shall . . . have admitting privileges at a hospital to which the physician can travel in one hour or less.”¹⁴¹ That same year, Indiana Right to Life instituted the “bold new strategy” of seeking enactment of a hospital privileges requirement at the county level, through local county ordinances.¹⁴² It was successful in enacting the requirement in Vanderburgh County and Dubois County,¹⁴³ and tried and failed in Allen County.¹⁴⁴ Now Indiana’s abortion providers and other concerned observers must not only monitor the state legislature, ever alert for the possibility of abortion restrictions hidden in eleventh-hour amendments to unrelated legislation, but they must also track the activity of Indiana’s ninety-two counties. *USA Today* covered this development and reported that national organizations on both sides of the issue were closely following this effort to impose restrictions at a new level of government.¹⁴⁵ The President of Indiana Right to Life told *USA Today* that the ordinances would both protect women’s health and, he hoped, would make abortion services more difficult for women to obtain.¹⁴⁶

Like other TRAP laws, provisions requiring admitting or transfer privileges at a nearby hospital seem, on their face, to be aimed at promoting patients’ health, and the costs they would impose are not immediately apparent. Providers of abortion services and some supporters of *Roe* contend that such requirements serve no medical need and would impose a great burden—quite simply, because hospitals are not required and in fact are unlikely to grant physicians the privileges the legislation requires. Again, the precise effect of these regulations is difficult—perhaps impossible—to establish prior to their implementation and the passage of time.

agreement with a hospital for transfer of patients in the event of medical complications, emergency situations, and for other needs as they arise”).

141. Pregnant Women Health and Safety Act, S. 2788, 110th Cong. § 2(b) (2008).

142. See Thomas B. Langhorne, *E-mails Show Planning Behind Abortion Ordinance*, EVANSVILLE COURIER & PRESS (Ind.), Oct. 10, 2008, <http://www.courierpress.com/news/2008/oct/10/e-mails-show-planningbehind-abortion-ordinance>.

143. See Amanda Iacone, *Long Touts State’s Abortion Legislation: Favors Single Law To Assure Patients’ Follow-Up Care*, J. GAZETTE (Fort Wayne, Ind.), Oct. 14, 2008, at C1.

144. See Amanda Iacone, *County Seeks Wider Doctor-Privilege Law*, J. GAZETTE (Fort Wayne, Ind.), Feb. 5, 2009, at C8 (noting that county “commissioners debated the proposed ordinance and received feedback from residents but never introduced the ordinance for a vote”).

145. See Keen, *supra* note 16 (noting that this “new strategy” was one that “abortion-rights groups say might be the leading edge of a nationwide effort to limit access to the procedure”).

146. *Id.*

A 2006 federal court of appeals decision helps demonstrate the practical challenges created by government mandates of admitting privileges or transfer agreements and the limited judicial protection against the resulting burdens. In *Women’s Medical Professional Corp. v. Baird*,¹⁴⁷ the Sixth Circuit reversed a district court’s finding that Ohio had acted unconstitutionally in denying a request for a license renewal filed by an abortion clinic operating in Dayton, Ohio.¹⁴⁸ State law required that the clinic obtain a written transfer agreement with a local hospital, but hospitals were free to refuse such requests. The local hospital refused to enter into a transfer agreement, and the Director of the Ohio Department of Health, in the exercise of his statutory discretion, refused to grant a waiver from the licensing requirement.¹⁴⁹

The court found that the license denial, if upheld, would shut down a clinic that performed approximately three thousand abortions a year and was the only clinic in southern Ohio that performed abortions after eighteen or nineteen weeks of pregnancy.¹⁵⁰ The court nonetheless held that requiring women to travel longer distances did not constitute an unconstitutional undue burden.¹⁵¹ The court reached this conclusion without first requiring any demonstration that the transfer agreement actually promoted any medical purpose. The court also held that there was no unconstitutional delegation of authority to the private hospital effectively to close the clinic through denial of the transfer agreement, because the state health director had the ultimate authority to grant the license without it (which the director refused to do).¹⁵² The district court had found that the Ohio Health Director and the Ohio Department of Health “were affected by political pressure from constituents and politicians to find a way to ‘shut down’ the clinic” in denying the waiver application and license application, but the Sixth Circuit held that that did not

147. 438 F.3d 595 (6th Cir. 2006).

148. *Id.* at 616. The Sixth Circuit did, however, affirm the district court’s conclusion that the clinic’s procedural due process rights were violated when it was not afforded a hearing before Ohio issued a cease-and-desist order closing the clinic, thereby depriving the clinic of its “property interest in its ongoing business.” *Id.* at 613. Accordingly, the Sixth Circuit vacated the district court’s preliminary injunction because the sole remaining violation, “the procedural due process violation[,] can be remedied” by a hearing. *Id.* at 616. The Sixth Circuit then remanded the case because “it would be inappropriate for [the Court] to presume what decision might be reached during the hearing.” *Id.*

149. *Id.* at 599-601.

150. *Id.*

151. *Id.* at 605.

152. *Id.* at 610.

amount to, and that the facts did not support, a finding that the denial reflected an unconstitutional purpose.¹⁵³

The Sixth Circuit's opinion in *Baird* provides insight into how such requirements work in practice. It showcases the lack of evidence of medical need for the requirement; the extensive lobbying from anti-choice organizations, elected officials, and others of both the local hospital and the state agency to deny the transfer agreement and the license in order to close the clinic (the hospital first agreed, then withdrew its agreement);¹⁵⁴ the deviation from typical internal decision-making processes, including the exclusion of the state official who ordinarily would have reviewed the request;¹⁵⁵ and the state director's refusal to accept an alternative that depended on keeping confidential the names of physicians who agreed to provide equivalent support but, because of security concerns, only if their identities would be kept confidential.¹⁵⁶

At times, analyzing the contours of a right requires delving deeply into the practicalities of the exercise and oversight of that right. That certainly was true, for example, of the voting rights of African Americans, who for decades were guaranteed the right to vote in theory, but in practice faced literacy tests, poll

153. *Id.* at 608 (quoting *Women's Medical Professional Corp. v. Baird*, 277 F. Supp. 2d 862, 879 (S.D. Ohio 2003)).

154. *Id.* at 599-600.

155. *Id.* at 601-02.

156. *See id.* at 616. The court noted the limited authority on "whether requiring women to travel further for an abortion constitutes an undue burden." *Id.* at 604. The court first cited the Fourth Circuit's *Greenville Women's Clinic v. Bryant* decision, which upheld a South Carolina licensing requirement that closed an abortion clinic and found no evidence that the additional seventy miles women would have to travel to obtain an abortion created an undue burden. *Id.* at 604 (citing *Greenville Women's Clinic v. Bryant*, 222 F.3d 157, 170-71 (4th Cir. 2000)). The court then cited the Eighth Circuit's *Fargo's Women's Health Organization v. Schafer* decision, which found that "a single trip, whatever the distance to the medical facility, [would not] create an undue burden." *Id.* (citing *Fargo's Women's Health Org. v. Schafer*, 18 F.3d 526, 533 (8th Cir. 1994)). Finally, the court cited the Supreme Court's *Mazurek v. Armstrong* decision, which upheld a Montana statute requiring abortions to be performed by licensed physicians as not imposing an undue burden, in part because the statute would not require women "to travel to a different facility than was previously available." *Id.* at 605 (citing *Mazurek v. Armstrong*, 520 U.S. 968, 974 (1997)). The court found that the *Mazurek* decision "intimated that the distance a woman must travel to obtain an abortion factors into the" undue burden analysis, but concluded that "binding and persuasive authority of other courts does not firmly establish when distance becomes an undue burden on a woman's right to chose to have an abortion." *Id.* at 605. The court, however, neglected to mention the Ninth Circuit's *Tucson Woman's Clinic v. Eden* decision, which stated that "[a] significant increase in the cost of abortion or the supply of abortion providers and clinics can, at some point, constitute a substantial obstacle to a significant number of women choosing an abortion." 379 F.3d 531, 541 (9th Cir. 2004).

taxes, and violence. And it is increasingly true with regard to the constitutional right of reproductive liberty. As is now appreciated in the context of the long battle against racial segregation and discrimination in voting, employment, and public accommodations, real and substantial interference with rights can result from a complex interplay between direct governmental regulations, government-endorsed messages, the empowerment of private interference with rights, and private actions of various kinds.

Nationwide, the number of abortion providers has declined steadily since the early 1980s.¹⁵⁷ A combination of legal and extralegal pressures has left three states—Mississippi, North Dakota, and South Dakota—just one clinic away from being “abortion free.”¹⁵⁸ Governments at various levels have contributed to this diminishing availability of abortion services, as well as to the growing social stigma around abortion and the demeaning of women who choose to have abortions. These developments are at odds with our constitutional commitments to liberty and equality. Legislators contemplating the enactment of additional abortion restrictions should carefully consider their potential impact on the women and healthcare providers most likely to be affected by them.

Although the Supreme Court in *Casey* lessened the degree of judicial protection by adopting a new “undue burden” standard of review, the Court’s application of that standard in *Casey* retained from *Roe*’s strict scrutiny approach the insight that the right at issue is that of every woman; it is not a group right that can be satisfied by respecting the rights of most women. For example, the *Casey* Court took care to assess the burden that a husband-notification provision would have on those it would truly affect: the small minority of women who, absent government compulsion, would not choose to involve their husbands in the decision.¹⁵⁹ The fact that the vast majority of married couples make this decision jointly, the Court held, did not negate the unconstitutional burden the government imposed on a minority of women by attempting to compel such communications.¹⁶⁰ Even some supporters of *Roe* have lost sight of the fact that at stake is the constitutional right of each individual woman to make her own decision whether to continue or terminate a pregnancy. At issue is the right of each woman actually affected—not some

157. HENSHAW & KOST, *supra* note 36, at 26-27.

158. See Evelyn Nieves, *S.D. Abortion Bill Takes Aim at ‘Roe,’* WASH. POST, Feb. 23, 2006, at A4; *Frontline: The Last Abortion Clinic*, *supra* note 7.

159. See *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 887-95 (1992).

160. *Id.* at 894 (rejecting respondents’ argument that because 20% of women who obtain an abortion are married and 95% of married women notify their husbands of their abortion, the husband-notification provision “imposes almost no burden at all”).

evenly distributed, incremental burden on all women. The harmful effects of TRAP laws fall disproportionately on women who already suffer challenges of economic status, educational status, domestic violence, and distance from providers.

A principled approach to reproductive rights should genuinely honor our nation's constitutional commitment to equal justice. Critical to that endeavor is an appreciation of the real-world impact of abortion restrictions short of bans. State criminal bans on abortion pre-*Roe* disparately affected women largely along lines of wealth and other means, making abortions completely unavailable for some, but more difficult and dangerous for many. In some places today, a multitude of restrictions on the availability of abortion services—some already in place and many more under consideration—threaten a similarly discriminatory effect: making abortion more difficult and dangerous for many, and completely unobtainable for some. Even in contexts in which judges should not or will not uphold constitutional values of equality and liberty by constraining government (for example, out of deference to elected officials), these values should nonetheless guide the actions of state legislatures and other law and policy makers.¹⁶¹

CONCLUSION: SEEKING COMMON GROUND

Beyond illustrating the potential impact of TRAP laws, the Indiana experience supports an alternative approach more in keeping with our nation's fundamental commitments to liberty and equality. One question raised in the debate over House Bill 1080 and House Bill 1172 was the proposed legislation's likely effectiveness in reducing the number of abortions. Senator Patricia Miller, for example, expressed concern that the legislation did not adequately address the larger issue of reducing abortions; she particularly favored a greater focus on encouraging adoption.¹⁶² Planned Parenthood of Indiana President Betty Cockrum similarly urged lawmakers to support family planning efforts to prevent unintended pregnancy, which would reduce the need for abortion.¹⁶³ Senator Miller, Betty Cockrum, and others promoted

161. Again, this Essay does not consider how courts are likely to adjudicate the constitutionality of TRAP laws, which would be governed by the undue burden analysis of *Casey*. See *supra* note 21 and accompanying text.

162. See *supra* notes 93-97 and accompanying text.

163. See Schneider & McNeil, *supra* note 38 (“Planed [sic] Parenthood President and CEO Betty Cockrum said that if lawmakers want to reduce the need for abortions, they should be supporting family planning groups. ‘That’s how they need to spend their time and energy, and not on passing unconstitutional laws,’ Cockrum said.”).

alternatives to the proposed abortion restrictions. Similar themes emerged in South Dakota during the efforts to criminalize abortion. The leader of South Dakota’s task force on abortion, who was herself opposed to *Roe*, criticized the task force’s strongly anti-*Roe* report, expressing concerns about the report’s scientific accuracy and objectivity and explaining that she believed the state ought to support policies that would reduce unwanted pregnancy.¹⁶⁴

“Common ground” instead of “compromise” is a useful way of conceptualizing the organizing principle that should guide constructive efforts to bridge the abortion divide. A common-ground approach should situate abortion where it logically belongs as a matter of public policy and constitutional values: within a broader agenda that empowers individuals both to prevent unintended pregnancy and to choose wanted childbearing through a range of government-supported programs for women and families. Common ground is not a new concept in the reproductive rights arena, but it may be one whose time has come.¹⁶⁵

Several facts provide an important foundation to a common-ground approach. Of the six million pregnancies that occur among American women each year, half are unintended.¹⁶⁶ By age forty-five, more than half of women will have experienced an unintended pregnancy, and about one-third will have had an abortion.¹⁶⁷ The typical woman, who bears two children, spends about three decades of her life trying to avoid an unintended pregnancy, compared with about five years trying to become pregnant, being pregnant, or postpartum.¹⁶⁸ Among the three million unintended pregnancies each year, about half occur among couples who did not use contraception in the month the woman became pregnant; the other half of couples used some

164. See Reva B. Siegel, *The Right’s Reasons: Constitutional Conflict and the Spread of Woman-Protective Antiabortion Argument*, 57 DUKE L.J. 1641, 1681-84 (2008).

165. See, e.g., Salmon, *supra* note 18 (noting that “during the campaign, [Barack Obama] spoke of wanting to reduce abortions and of finding ‘common ground’ in the debate” and reporting on recent “common-ground” efforts by some abortion opponents).

166. Centers for Disease Control and Prevention, Unintended Pregnancy Prevention: Home, <http://www.cdc.gov/reproductivehealth/UnintendedPregnancy/index.htm> (last visited May 6, 2009) (citing Lawrence B. Finer & Stanley K. Henshaw, *Disparities in Rates of Unintended Pregnancy in the United States, 1994 and 2001*, 38 PERSP. ON SEXUAL & REPROD. HEALTH 90, 92 (2006)).

167. RACHEL BENSON GOLD ET AL., GUTTMACHER INST., NEXT STEPS FOR AMERICA’S FAMILY PLANNING PROGRAM: LEVERAGING THE POTENTIAL OF MEDICAID AND TITLE X IN AN EVOLVING HEALTH CARE SYSTEM 6-7 (2009), available at <http://www.guttmacher.org/pubs/NextSteps.pdf>.

168. *Id.* at 6.

contraceptive method, but typically inconsistently or improperly.¹⁶⁹ Contraceptive use matters greatly: the two-thirds of sexually active women who properly use contraception all year account for only 5% of unintended pregnancies.¹⁷⁰ Low-income women are more likely to have inadequate access to contraceptives than wealthy women. While the national rate of unintended pregnancies “stagnated” between 1994 and 2001, the rate of unintended pregnancies rose among low-income women and decreased among wealthy women.¹⁷¹ Public policy must address these realities.

In Indiana as elsewhere, many people on all sides of the abortion issue support the goal of reducing the number of abortions. Differences certainly arise over how best to achieve that goal. In contrast with compromise abortion restrictions that diminish services, increase costs, and constrain choices, common-ground efforts to prevent unintended pregnancy and support post-conception options, including healthy childbearing and adoption, work to reduce the number of abortions by enhancing responsible reproductive decisionmaking and by empowering especially those most in need of support. Common-ground alternatives are thus in keeping with our fundamental commitments to liberty and equality.

Another striking possibility about TRAP laws is that their approach to reducing abortion—making services more expensive and less available—may also prove ineffective, and certainly not as effective as some alternatives. Although, as discussed, their actual effect is difficult to predict or measure, TRAP laws that target clinics with medically unnecessary regulations, not imposed on comparable health care providers, might in some instances have the indirect and perverse effect of increasing the number of abortions or delaying abortion. The same clinics that provide abortion services often are principal providers of pregnancy prevention services and other reproductive and sexual health care. Indeed, six out of ten clients of family planning clinics cite the clinic as their “usual” source of health care.¹⁷² Nationally, the Guttmacher Institute estimates that publicly funded contraceptive services help women prevent nearly two million unintended pregnancies each year and that without these services, the number of abortions would be nearly two-thirds higher.¹⁷³ By increasing the costs of providing abortion services (including expensive building renovations), TRAP laws could increase the costs of, or

169. See *Finer & Henshaw, supra* note 166, at 92.

170. *GOLD ET AL., supra* note 167, at 7.

171. *Id.* at 10.

172. *Id.* at 16.

173. *Id.* at 4.

divert resources from, the provider’s other health services, including those aimed at preventing pregnancy. In any event, a direct focus of those resources on prevention and healthy childbearing promises to be more effective in reducing unintended pregnancy, and therefore abortions.

In Indiana, for example, among the abortion providers targeted by House Bill 1080 were clinics run by Planned Parenthood of Indiana. Betty Cockrum testified on behalf of Planned Parenthood against the legislation, stating that the clinics could not renovate or relocate by the effective dates of House Bill 1080 and that coming into compliance at some later date would require extremely costly renovations or relocations.¹⁷⁴ Only 5% of Planned Parenthood of Indiana’s patients obtain abortion services,¹⁷⁵ which are available at only three of its thirty-five locations.¹⁷⁶ Ninety-five percent of its patients come for other services, including contraceptives, cancer screenings, and tests and treatment for sexually transmitted diseases.¹⁷⁷ In 2006, Planned Parenthood began offering onsite adoption services¹⁷⁸ and currently offers onsite adoption services at all three of its clinics that perform abortions.¹⁷⁹ Planned Parenthood also launched a “Prevention First” initiative,¹⁸⁰ which in 2009 included the

174. Cockrum, *supra* note 69.

175. Betty Cockrum, President, Planned Parenthood of Ind., Equality Day Speech (Aug. 24, 2007) (on file with author).

176. Compare Planned Parenthood of Indiana, Abortion Services, <http://www.ppin.org/abservices.aspx> (last visited May 6, 2009) (listing three locations providing abortion services), with Planned Parenthood of Indiana, A Planned Parenthood Health Center Is Near You and a Caregiver Is Waiting for Your Call, <http://www.ppin.org/locations.aspx> (last visited May 6, 2009) (listing thirty-five locations).

177. See Cockrum, *supra* note 175. Nationally, Planned Parenthood reported that 3% of all services provided by its affiliates in 2007 were abortions. Planned Parenthood Federation of America, Inc., Planned Parenthood Services, <http://www.plannedparenthood.org/issues-action/birth-control/teen-pregnancy/reports/pp-services-17317.htm> (last visited May 6, 2009). In comparison, of the services rendered in 2007, 36% were contraceptive related, 31% dealt with sexually transmitted disease testing, and 17% pertained to cancer screening and prevention. *Id.*

178. See Ruth Holladay, *Planned Parenthood Partnership a Good Match*, INDIANAPOLIS STAR, June 20, 2006, at B1 (reporting that “Independent Adoption Centers will have a presence at a Planned Parenthood of Indiana clinic two or three times a week”).

179. Compare Planned Parenthood of Indiana, Am I Pregnant?, <http://www.ppin.org/pregnant.aspx> (last visited May 6, 2009) (listing three locations that provide adoption services: Indianapolis, Bloomington, and Merrillville), with Planned Parenthood of Indiana, Abortion Services, <http://www.ppin.org/abservices.aspx> (last visited May 6, 2009) (listing the same three locations as the locations that provide abortion services).

180. Betty Cockrum, *Women’s Health Is Focus of Agency*, J. GAZETTE (Fort Wayne, Ind.), Nov. 5, 2007, at A11.

introduction of a legislative package to protect access to contraception and medically accurate sexuality education.¹⁸¹ The need in Indiana is particularly stark: in one study, Indiana ranked forty-ninth among the states in meeting the need for contraceptive services.¹⁸²

Certainly, disagreements over precisely how best to reduce the number of abortions will remain, even beyond the most controversial issues of abortion restrictions themselves. Perhaps the greatest challenge for a common-ground agenda will be how to handle the issue of sexuality education and, more generally, the promotion of safe and responsible sexual practices that help prevent unintended pregnancies, all while respecting differences of perspective all along the ideological spectrum.¹⁸³ One important consideration is the overwhelming public support for medically accurate, age-appropriate, and comprehensive sexuality education that includes (but is not limited to) promoting abstinence.¹⁸⁴ Another challenge will be to incorporate across the political spectrum a genuine commitment to empowering women to bear chosen and healthy babies through a range of social programs, from health care to childcare to domestic violence protections. Notwithstanding inevitable differences, shifting coalitions will have a far greater ability to find common ground if all strive to be sensitive to the moral dimensions of the issues and to take care not to demean sincerely held, principled religious and moral views.

If common-ground approaches require honest debate about real differences, then that is to be welcomed. TRAP laws that make abortion services more expensive and difficult to obtain without countervailing health benefits, in contrast, are at best a misguided and harmful response to legitimate moral concerns about abortion, and at worst a tactical effort to close down clinics under the guise of protecting women's health. The burdens of this

181. See Planned Parenthood of Indiana, *Prevention First Legislation*, http://advocates.ppin.org/prev_first_legislation.aspx (last visited May 6, 2009).

182. GUTTMACHER INST., *CONTRACEPTION COUNTS: INDIANA 1* (2006), available at http://www.guttmacher.org/pubs/state_data/states/indiana.pdf.

183. See Salmon, *supra* note 18 (reporting that the recent coalition of abortion proponents and opponents who are advocating for legislation to “provide pregnant women with health care, child care, and money for education” have purposefully avoided “more sensitive aspects of the issue, such as laws that restrict abortion, contraception, sex education and abstinence-only programs” in order to “preserve the coalition”).

184. See, e.g., Amy Bleakley, Michael Hennessy & Martin Fishbein, *Public Opinion on Sex Education in U.S. Schools*, 160 ARCHIVES PEDIATRICS & ADOLESCENT MED. 1151, 1154 (2006) (reporting that 82% of its nationally representative sample supported the teaching of “abstinence plus” sexuality education, which teaches abstinence in addition to information on contraception and how to prevent sexually transmitted diseases, while 36% supported “abstinence only” education).

flawed strategy fall disproportionately on women with the fewest economic and other means to navigate them. Common-ground approaches would seek to build practical, responsible policies on a shared goal of reducing abortions while protecting the liberty and equality interests of women and their families.