



STATE OF VERMONT
OFFICE OF LEGISLATIVE COUNCIL

MEMORANDUM

To: House Committee on Human Services
From: Brynn Hare
Date: January 27, 2019
Subject: H.57: summary of existing right to abortion and responses to questions

This memo is intended to 1) summarize the existing right to abortion in Vermont; 2) provide background information on some relevant U.S. Supreme Court decisions; and 3) respond to questions that have arisen during testimony on H.57.

Background on the Right to Abortion

In Vermont, there is an unrestricted legal right to get an abortion regardless of age or marital status. There is no requirement that a person notify or get permission from a parent, guardian, or spouse prior to getting an abortion. Vermont has no statute that creates an explicit right to abortion. Though there is a Vermont Supreme Court ruling that invalidated the State's now repealed criminal abortion statute¹, there is not currently Vermont court jurisprudence that examines whether there is an independent right to terminate a pregnancy within the Vermont Constitution.

In the event that Roe v. Wade is invalidated or otherwise undermined by the U.S. Supreme Court, the right to abortion would return to the several states. This would result in a patchwork of different regulations across the states, and an individual's ability to access abortion services would depend on the state in which the individual lives. Depending on the scope of such a ruling, states may be free to regulate abortion or prohibit it altogether.

¹ Beecham v. Leahy, 130 Vt. 164 (1972). In this case, the VT Supreme Court found the State's now repealed prohibition on abortion statute unenforceable. The statute (enacted in 1947 and repealed in 2014) criminalized the act of providing an abortion, imposing a sentence of not more than 20 years imprisonment for a provider. The statute provided that the person seeking the abortion was not liable for the penalty. The Court held that because the statute didn't deny the right to receive an abortion, it was an implicit recognition by the legislature of the plaintiff's personal right. By affirming that right, the legislature couldn't then prohibit its safe exercise by criminalizing the act of providing an abortion.

Roe v. Wade (1973) is the landmark abortion ruling that struck down a Texas statute that forbade all abortions not necessary for saving the life of the mother and imposed jail time on providers for performing one. The Court found that states may not categorically prohibit abortions by making their performance a crime, because the 14th Amendment right of personal privacy embraced a woman's decision whether to carry a pregnancy to term. The scope of the privacy right included only personal rights that can be deemed "fundamental" or "implicit in the concept of ordered liberty" and relates to activities in the realm of marriage, procreation, contraception, family relationships, and child rearing and education. Since the Court found that the right to privacy is a fundamental right, only a compelling state interest could justify its limitation by a state. The Court used a heightened scrutiny analysis, which means that 1) the state must have a compelling interest in regulating the behavior and 2) the regulation must be narrowly tailored to achieve that interest.

The right to privacy came from prior U.S. Supreme Court jurisprudence, including Griswold v. Connecticut (1965), the landmark case that was the first to articulate a Constitutional right to privacy. In that case, the Court found that States may not restrict a married couple's ability to access contraception. This case was followed up by Eisenstadt v. Baird (1972), which found the same for unmarried individuals, but the Court based the right on the Equal Protection Clause of the 14th Amendment.

The Court's decision in Roe established two major things. First, states could not regulate abortions during the first trimester, because it represented a private medical decision between a woman and her doctor. The other major holding was that states could regulate abortion later on in pregnancy. After the first trimester, they could regulate the procedure to protect the health of the mother, and in the viability stage, the state could regulate or prohibit abortion to preserve the potential life (with exceptions for the health of the mother). The decision noted that since during first trimester abortion is no more dangerous to maternal health than childbirth itself, the state's interest in protecting maternal health was insufficient to justify state regulation during that time. The "compelling" point with respect to the state's interest in the potential life of the fetus the Court found to begin at viability.

In other words, according to Roe, only after the first trimester does the state's interest in protecting maternal health provide a sufficient basis to justify state regulation of abortion, and then only to protect that interest. Following viability, the state's interest permits it to regulate and even proscribe abortion except when necessary for the preservation of the life or health of the person carrying the fetus.

In Planned Parenthood of Southeastern Pennsylvania v. Casey (1992), the Court introduced a new standard of determining the validity of abortion laws by asking if the restriction on the right places any "undue burden" on the person attempting to get an abortion. The Court defined undue burden as "a substantial obstacle in the path of a

woman seeking an abortion of a nonviable fetus.” The PA statute at issue contained several restrictions. The Court upheld a 24-hour waiting period, informed consent, parental consent for minor’s abortions with a judicial bypass, and certain reporting requirements. The spousal notification provision, which required a married woman to tell her spouse if she intended to have an abortion, did not survive the undue burden test and was struck down as unconstitutional. The undue burden standard moved away from the strict scrutiny analysis of the fundamental right to privacy used by the Roe Court and allowed greater regulation during the first trimester of pregnancy.

Whole Woman’s Health v. Hellerstedt (2015) dealt with a Texas law requiring physicians who perform abortions to have admitting privileges at a hospital within 30 miles of the abortion clinic, and held abortion clinics to the same facilities standard as ambulatory surgical centers. The Court found that the regulations imposed an undue burden as defined by Casey, and were thus unconstitutional. The Court focused on the fact that there was no evidence to support that abortion was made safer under the regulations, and instead the statistics showed a significant increase in the difficulty of getting an abortion. Since there were more obstacles added than there was a health benefit, the court found the law to be an undue burden. In her concurrence, Justice Ginsburg emphasized that the research showed that other procedures with more inherent risks than abortion received less regulation than the statute required for abortion.

Two U.S. Supreme Court decisions, issued seven years apart, had opposite holdings regarding statutes banning “partial birth abortions.” First was Stenberg v. Carhart (2000), in which the Court determined that a Nebraska statute prohibiting these abortions was unconstitutional because it failed to include an exception to protect the health of the mother and because the language defining the prohibited procedure was too vague, and could be interpreted to apply to dilation and evacuation procedures, which are the most common procedures during the second trimester of pregnancy. Congress then passed the Partial-Birth Abortion Ban Act in 2003. Within two days of its signing, federal courts in NE, CA, and NY blocked its enforcement. In 2007, the Court upheld the Act as not unconstitutionally vague and not imposing an undue burden on a woman’s right to abortion.²

Three related U.S. Supreme Court decisions ruled that the states have neither a statutory nor a constitutional obligation to fund elective abortions or provide access to public facilities for such abortions.³ However, Title 19 of the Social Security Act left a state free to include coverage for nontherapeutic abortions should it choose to do so.

² Gonzales v. Carhart, 550 U.S. 124 (2007). In her dissent, Justice Ginsberg noted that in materially identical circumstances the Court found that a statute lacking a health exception for the mother was unconstitutional on its face, and that this about-face was likely due more to the makeup of the Court than a shift in public opinion.

³ Beal v. Doe, 432 U.S. 438 (1977); Maher v. Roe, 432 U.S. 464 (1977); and Poelker v. Doe, 432 U.S. 519 (1977). Later Supreme Court rulings indicate that there is no statutory or constitutional obligation of the

In Doe v. Celani (1986), the Chittenden Superior Court struck down under the State Constitution a State rule limiting State medical assistance for abortion to those procedures covered by the federal Medicaid program. At the time, the Hyde amendment limited federal reimbursement for abortions to situations where the life of the pregnant person would be endangered if the fetus were carried to term.⁴ The result of the State rule was to exclude reimbursement for medically necessary abortion services and only allow for reimbursement for abortion care in cases of life endangerment. As a result of this court order, in Vermont if a person is eligible to receive Medicaid, that person is entitled to have the cost of a medically necessary abortion covered through the General Assistance appropriation.

Potential Scope of H.57

The bill prohibits public entities from depriving a consenting individual of the choice to carry out or terminate the individual's pregnancy. It also prohibits public entities from interfering with or restricting, in the regulation or provision of benefits, facilities, services, or information, the choice of a consenting individual to terminate the individual's pregnancy.

The definition of public entity includes the three branches of State government. The General Assembly is granted the supreme legislative authority in Chapter II section 2 of the Vermont Constitution. That power includes the power to prepare bills and enact them into laws.⁵ There is nothing to prevent a future legislature from "notwithstanding" the provisions of law in H.57 and passing legislation that restricts the right of an individual to terminate the individual's pregnancy. The nature of legislative action is that subsequent governments are free to revisit the policy choices of the past. However, if H.57 passes and some administrative action were taken that restricts or interferes with the right to abortion, the injured party in that scenario may have a private right of action under the statute.

H.57 does not impose any duty on a private practitioner to participate in any abortion. Nor does it interfere with the operation of crisis pregnancy centers, which are organizations established to counsel pregnant individuals against having an abortion. In fact, Vermont is a state that does not impose any regulations on crisis pregnancy centers. Many states regulate these organizations because generally they strive to give the impression that they are clinical centers, offering legitimate medical services and advice, but in fact they are exempt from the regulatory, licensure, and credentialing oversight that apply to health care facilities. Crisis pregnancy centers generally do not provide comprehensive, accurate, or evidence-based clinical information about all available options regarding pregnancy and abortion since their mission is typically based on religious ideology, rather than the health and well-being of the individual seeking care.

states or federal government to fund medically necessary abortions either. Harris v. McRae, 448 U.S. 297 (1980) and U.S. v. Zbaraz, 448 U.S. 358 (1980).

⁴ Currently, the Hyde amendments limit federal reimbursement for abortion care to situations where 1) the life of the pregnant person is endangered, or 2) the pregnancy was the result of incest or rape.

⁵ See Constitution of the State of Vermont § 6 [Legislative Powers].

Interaction with Federal Law

The Federal Partial-Birth Abortion Ban Act was passed by Congress in 2003 and prohibits providers from performing a procedure that the Act defines as “partial-birth abortion.” In the event that a provider in Vermont knowingly performed a “partial-birth abortion” as it is defined by the Act in violation of that federal statute, the provider could be prosecuted as provided for in the Act, and regardless of the provisions in H.57.

Age of Consent to Medical Treatment

Individuals under 18 years of age are minors under Vermont law. 1 V.S.A. § 173. Generally, a parent or guardian or representative appointed by a judge to make health care decisions for the minor may give informed consent to health care for a minor. 14 V.S.A. § 3069, § 3075. Minors emancipated by a court order, minors who are married or have ever been married, and minors on active U.S. military duty may give informed consent to their own health care. 12 V.S.A. § 7151.

Minors 12 years of age or older may give informed consent to treatment for sexually transmitted infections, drug dependence, and alcoholism. 18 V.S.A. § 4226. Minors 14 years of age or older may also voluntarily admit themselves to a hospital for mental health related treatment, and minors under 14 may admit themselves to a hospital for mental health related treatment with a written application from a parent or guardian. 18 V.S.A. § 7503.

For minors in the custody of the Department for Children and Families, DCF has the authority to provide informed consent for a minor’s health care as a parent or guardian would by law. According to DCF policy, caseworkers ensure that contraceptive services are available to teens in custody, and DCF staff may or may not inform parents of teens in custody about their pregnancy-related care, depending upon the Department’s determination of what is in the best interests of the minor.

The legal doctrine of the “mature minor” is recognized by statute or caselaw in some other states, including Massachusetts. This doctrine gives providers guidance on circumstances in which unemancipated minors can make decisions; specifically, if a provider believes the minor is mature enough and able to give informed consent to the medical care, and it is in the best interest of the minor not to notify the parents, the physician may accept the minor's consent alone.