What is HB2?

HB2 is a law that was passed by the 83rd Texas state legislature in 2013. The law includes four new restrictions on abortion care:

1. A requirement that **physicians have admitting privileges** at a hospital within 30 miles of the facility.

2. A **ban on abortions at 20 weeks of pregnancy post-fertilization or later**, with an exception in the case of life endangerment to the pregnant woman or severe fetal abnormality (but not for rape).

3. Additional **restrictions on the use of medical abortion (the abortion pill).**

4. A requirement that all abortion facilities **meet the standards of ambulatory surgical centers (ASCs),** including facilities that only provide medical abortion.

ADMITTING PRIVILEGES: Requires that physicians have admitting privileges at a hospital within 30 miles of the facility.

Context: Hospitals extend admitting privileges to physicians who admit patients, and providers who primarily perform abortion care do not admit patients to hospitals because abortion is so safe. The risk of transferring a patient from an outpatient abortion clinic to a hospital is less than 1 out of 1,000. When such a transfer occurs, it is important that the physician most qualified to care for that patient treat her; in many cases, that may not be the abortion provider. In addition, hospitals are obligated to provide emergency care to any patient experiencing a medical emergency under the federal Emergency Medical Treatment and Labor Act of 1986 (EMTALA). Therefore, requiring doctors to have admitting privileges is not medically relevant and does not increase the safety of the patients undergoing procedures in clinics.[1]

What it means for Texas clinics and women: Many clinics rely on visiting providers who cannot obtain privileges at local hospitals for reasons not associated with the quality of the doctor's care. Some clinics are surrounded by religiously affiliated hospitals that may deny abortion providers admitting privileges. Clinics that cannot secure privileges for their providers will be forced to close, thus limiting access to safe, legal abortions.

Timeline: Went into effect November 2013.

20-WEEK BAN: Bans abortions at 20 weeks of pregnancy post-fertilization or later, with an exception in the case of life endangerment to the pregnant woman or severe fetal anomaly (but not for rape).

Context: Abortions that occur at 20 weeks of pregnancy post-fertilization or more are rare (only about 0.8% of abortions), but are sought by a particularly vulnerable population of women.[2] Research indicates that a variety of circumstances can lead to second-trimester abortion, including delays in suspecting and testing for pregnancy, delay in obtaining insurance or other funding, delay in obtaining referrals from other physicians, and difficulties in locating and traveling to a provider. Poverty and having multiple disruptive life events have been associated with higher rates of seeking second-trimester abortion.

What it means for Texas clinics and women: The 20-week post-fertilization ban disproportionately impacts women with difficulty accessing reproductive healthcare, including young women, women with chronic illness, poor women, and women who became pregnant because of a rape. Women with chronic illness may recognize pregnancy later because their menstrual cycle and weight were already affected by their treatment. It is also concerning that HB2 does not have an exception for victims of sexual assault. Women who experience rape may be more likely to hide the pregnancy or be in denial about the pregnancy due to the traumatic circumstances, and only a minority of women seek medical care after a rape.[3] This may lead to late recognition of the pregnancy and need for abortion after 20 weeks of pregnancy post-fertilization.

Timeline: Went into effect November 2013.

RESTRICTIONS ON MEDICAL ABORTION: Restricts physicians to using specified protocols for medical abortion that are neither commonly used nor based on the most up-to-date evidence.

Context: A medical abortion is one that is brought about by taking medications that will end a pregnancy. The legislation restricts physicians to medical abortion protocols described in the drug label approved by the Food and Drug Administration (FDA) or the medication dosages described in the American College of Obstetricians and Gynecologists (ACOG) Practice Bulletin that existed on January 1, 2013 (and was written in 2005). Since mifepristone (also known as Mifeprex or RU-486) was approved in 2000 and since the Practice Bulletin was written in 2005, medical practice has evolved, and more effective protocols that allow medical abortion later in pregnancy have been developed. The restrictions reduced the gestational age eligibility from 63 days to 49 days from the last menstrual period, taking away this option from many women could safely and effectively use it and who may prefer it.

What it means for Texas clinics and women: The restrictions on medical abortion limit access to this method by forcing providers to use regimens that are inferior to the current, evidence-based protocols. The restrictions, in combination with Texas's 24 hour waiting period, can require a woman to make up to four separate trips to the clinic: one primary consultation visit, two appointments to take the consecutive doses of medication, and one follow up visit. For women who do not have the time, money, transportation, or other resources needed to make these four separate trips, medical abortion is no longer a viable

option. Furthermore, few clinics are able to bring in the same doctor for these four separate appointments; as a result, many clinics in Texas are no longer able to offer medical abortion as an option.

Timeline: Went into effect November 2013.

ASC REQUIREMENT: This provision mandates that all abortion facilities meet the standards of ambulatory surgical centers (ASCs), including facilities that only provide medical (or nonsurgical) abortion.

Context: Standards of ambulatory surgical centers often include requirements for the physical plant, such as room size and corridor width, beyond what is necessary to ensure patient safety in the event of an emergency. This means many clinics and facilities would have to undergo very expensive, excessive physical modifications in order to meet the standards of an ASC. Clinics that are not able to bear this expense will be forced to close. Expanding the ASC requirement to include all abortions, rather than just those beyond 16 weeks, is not medically necessary, and it would decrease access without improving patient safety.[4]

What it means for Texas clinics and women: The ASC requirement will reduce the number of abortion providers in the state to six. This will have a serious impact on abortion access; in 2012 just 21% of abortions in Texas were performed in ASCs. Many women will have to travel farther, and therefore take more time off from work or school and spend more money to access abortion care. Clinics that do become ASCs may have to charge more for abortion services, again limiting access for women, particularly a woman who is already struggling to make ends meet.

Timeline: Goes into effect September 2014.

Additional Resources:

The Difference Between Medical Abortion and Emergency Contraceptive Pills

Dallas Hospital Revokes Privileges, Tells Abortion Providers They Damage Its 'Reputation'

TRAP Laws Gain Political Traction While Abortion Clinics—and the Women They Serve—Pay the Price

State Policies in Brief

How Abortion Restrictions Would Impact Five Areas of Texas

Bill Could Reduce Number of Texas Abortion Facilities

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[1] Starling J 3rd, Thosani MK, Coldiron BM. Determining the safety of office-based surgery: what 10 years of Florida data and 6 years of Alabama data reveal. Dermatol Surg. 2012 Feb;38(2):171-7.

[2] Drey EA, Foster DG, Jackson RA, Lee SJ, Cardenas LH, Darney PD. Risk factors associated with presenting for abortion in the second trimester. Obstet Gynecol. 2006 Jan;107(1):128-35.

[3] Jones RK, Finer LB. Who has second-trimester abortions in the United States? Contraception. 2012 Jun;85(6):544-51.

[4] Grimes DA, Cates W and Selik RM, Abortion facilities and the risk of death, *Family Planning Perspectives*, 1981, 13(1):30–32.