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Legislative Oversight Committee

South Carolina House of Representatives

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Raye Felder
Phyllis J. Henderson
Mia S. McLeod
Ralph W. Norman
Robert L. Ridgeway III
James E. Smith, Jr.
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Ad Hoc Committee - Other Study No. 1
Thursday, February 25, 2016
1:30 p.m.
Room 110 - Blatt Building

ARCHIVED VIDEO

I. You may access archived video of this meeting by visiting the South Carolina General Assembly's website (http://www.scstatehouse.gov) and click on "*Committee Postings and Reports*," then under House Standing Committees click on "*Legislative Oversight*". Lastly, click on *"Video Archives"* for a listing of archived videos for the Legislative Oversight Committee.

MINUTES

I. House Rule 4.5 requires the standing committees of the House to prepare and make available for public inspection, in compliance with Section 30-4-90, the minutes of full committee meetings. House Rule 4.5 further provides that such minutes need not be verbatim accounts of such meetings.

II. On August 26, 2015, a motion was adopted for the House Oversight Committee to commence an investigation into state agencies, including, but not limited to the Department of Social Services, the Department of Health and Environmental Control, and the Department of Health and Human Services, relationship with, funding of, and other activities relating to Planned Parenthood facilities and other abortion providers in South Carolina.

III. Pursuant to Committee Rule 6.1, an ad hoc committee was appointed to undertake the study as stated in the motion.

IV. Pursuant to Committee Rule 6.3, on September 3, 2015, the Legislative Oversight Committee Chair appointed the members and chair of the ad hoc committee. The members include the Honorable Nathan Ballentine, the Honorable Raye Felder, the Honorable Mia S. McLeod, the Honorable Walton J. McLeod, the Honorable Robert Ridgeway, III, the Honorable James E. Smith, Jr., the Honorable

Tommy M. Stringer, and the Honorable Bill Taylor. The chair of the ad hoc committee is the Honorable Gary E. Clary.

V. The **sixth** meeting of the ad hoc committee (Committee) was called to order at 1:30 p.m. by Chairman Gary E. Clary on Thursday, February 25, 2016, in Room 110 of the Blatt Building, Columbia, South Carolina. Unless otherwise noted, all members were in attendance for all or part of the meeting. Representative Nathan Ballentine and Representative James Smith were not in attendance, as both notified the ad hoc committee of prior commitments.

The following from the Department of Health and Environmental Control were present and placed under oath: Ms. Catherine Heigel, Director of the Department of Health and Environmental Control, and Mr. Marshall Taylor Jr., General Counsel of the Department of Health and Environmental Control. Testimony given to this Committee, which is an investigating committee, is under oath.

VI. There was an invocation by Representative Raye Felder.

VII. Representative Raye Felder made a motion to approve the minutes from the Committee meeting held Thursday, January 21, 2016. A roll call vote was held, and the motion was approved.

Rep. Raye Felder's motion:	**Yea**	**Nay**	**Not Voting**
Rep. Nathan Ballentine			Not Present
Rep. Raye Felder	X		
Rep. Mia S. McLeod	X		
Rep. Walton J. McLeod	X		
Rep. Robert L. Ridgeway, III	X		
Rep. James E. Smith, Jr.			Not Present
Rep. Tommy M. Stringer	X		
Rep. Bill Taylor	X		
Chair Gary E. Clary	X		

VIII. Chairman Clary provided a brief overview of the Committee's process for this study, which is also provided in the Committee's Standard Practices posted online. Highlights include the following:

- The Committee has obtained information from: the Department of Social Services, Department of Health and Human Services, Department of Health and Environmental Control, and Department of Correction. Additionally, the ad hoc committee obtained information from the Legislative Audit Council. Information obtained from agencies and the Legislative Audit Council as well as archived videos of meetings are available online.

- Committee staff summarized information obtained as of the end of 2015, and the summarization was provided by email to agencies on December 31, 2015. No agency under study filed a response to the staff summary. This summary is available online.

- At the January 21, 2016, meeting the ad hoc committee voted on several recommendations. Also, the ad hoc committee deferred a vote on one recommendation[1], until the committee could obtain an Attorney General opinion. The Attorney General's Office provided that opinion and ad hoc committee members have had an opportunity to review it. Additionally, the Attorney General Opinion has been posted online. A copy of this opinion is incorporated as a part of these minutes in an appendix. On February 24, 2016, the agency revised its recommendation. A copy of the February 24, 2016, letter to the ad hoc committee is included as an appendix to these minutes, and it has been posted online. Representative Walt McLeod made brief remarks about the Attorney General Opinion, and emphasized its conclusion.

The stated purpose for the meeting was to continue to discuss any recommendations ad hoc committee members would like to include for submittal to the full Legislative Oversight Committee. Notably, Standard Practice 12.4 allows individual members of the ad hoc committee the opportunity to provide a written statement for inclusion with the ad hoc committee's study.

IX. Director Catherine Heigel made brief remarks about the agency's recommendations to the ad hoc committee in which she emphasized these were conceptual recommendations, and she answered questions from ad hoc committee members.

Director Heigel stated that the agency stood behinds its recommendations and that it was not the agency's intention to suggest anything that results in a policy change for this state. Director Heigel stated it was not the agency's goal to set policy or to introduce new policy. Director Heigel further stated that it was an agency goal to be responsive to the Legislative Audit Council's recommendations and to provide greater clarity around different things which may assist the agency in being more effective.

Director Heigel provided a brief overview of the letter to the ad hoc committee dated, February 24, 2016, which is incorporated as a part of these minutes in an appendix and posted online. She answered questions relating to the manner in which the time of conception and the gestational age of a fetus is determined. She commented while the terms were utilized somewhat interchangeably in statutes, the medical community views the terms differently. Also, Director Heigel mentioned the term gestation is not defined in statute. She stated that the original recommendation, that was the subject of the Attorney General Opinion[2], utilized the terms conception and gestational age somewhat interchangeably, as the statutes do, and that the agency's amended recommendation[3] reflects the distinction between the terms, which make it clear the agency is not recommending a change in statute to what is currently expressed in regulation. There was not an intent to revise policy from the current law of today in regulation[4] but rather recommend that the ad hoc committee consider adding the law as expressed in the agency's

[1] The ad hoc committee deferred a vote on the following January 11, 2016, recommendation from the agency: "Limiting the abortions that can be performed in an abortion clinic to those within the first 18 weeks of pregnancy, beginning with conception rather than calculated on the basis of the menstrual cycle."

[2] The January 11, 2016, recommendation at issue from the agency: "Limiting the abortions that can be performed in an abortion clinic to those within the first 18 weeks of pregnancy, beginning with conception rather than calculated on the basis of the menstrual cycle."

[3] The February 24, 2016, recommendation from the agency: "Limiting abortions that can be performed in an abortion clinic to those within 18 weeks from gestational age. Abortion clinics that are also licensed as ambulatory surgical facilities may perform abortion procedures on patients within 26 weeks from gestational age." The agency further notes that "As used in this recommendation, gestational age correlates with LMP (last menstrual period), and can best be confirmed with the use of an ultrasound."

[4] Regulation 61-12 (Standards for Licensing Abortion Clinics), Section 302 (Limitations of Services Offered by Abortion Clinics).

regulation into statute. Representative Ridgway commented about the use of a common language in the medical community, and noted this recommendations' emphasis is on the location of the abortion.

Representative Mia McLeod asked questions about another recommendation from the agency[5] and expressed concerns about patient's privacy and potential revision of a vital statistics form. Director Heigel's comments emphasized the agency was not seeking to add any personally identifiable information, and she gave the example that a chart number would facilitate the agency's inspections. Director Heigel noted the Legislative Audit Council's recommendation to ensure that the number of procedures performed align with the number of procedures reported to the agency.[6] Director Heigel noted that addition of a chart number can provide for cross checks with field inspections. She again emphasized this is a conceptual recommendation.

Additionally, Representative Mia McLeod asked questions about another recommendation from the agency,[7] which related to post-operative complications reported to the agency. Director Heigel explained what is already supposed to be reported to the agency[8], and the reasoning for extending the reporting requirement to hospitals. Representative Bill Taylor made comments on the reasoning for extending the reporting to hospitals.

There was a motion by Representative Tommy Stringer that the ad hoc committee adopt the agency's amended recommendation as presented in its February 14, 2016, letter: "Limiting abortions that can be performed in an abortion clinic to those within 18 weeks from gestational age. Abortion clinics that are also licensed as ambulatory surgical facilities may perform abortion procedures on patients within 26 weeks from gestational age." The agency noted in it February 24, 2016, letter that "[a]s used in this recommendation, gestational age correlates with LMP [last menstrual period], and can best be confirmed with use of an ultrasound."[9] A roll call vote was held, and the motion was approved.

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[5] At the January 21, 2016, ad hoc committee meeting the following recommendation from the agency, among others, was adopted: "Adding a requirement for some identifying information to be included in the abortion reports, which would allow the agency to utilize these reports, ad necessary, to assist in investigating potential violations." Additionally, the agency recommended adding sanctions for failure to report this identifying information in a timely manner; the ad hoc committee adopted this recommendation as well at its January 21, 2016, meeting.

[6] See page 12 of the Legislative Audit Council's May 2015 "A Review of the S.C. Department of Health and Environmental Control's Regulation of Abortion Clinics" for additional information.

[7] At the January 21, 2016, ad hoc committee meeting the following recommendation, among others, was adopted: "The study to include a recommendation which requires: (1) abortion clinics and hospitals, including emergency rooms, to report to the agency post-operative complications arising as a result of an abortion procedure regardless of where the abortion was performed; (2) if the patient is willing to the provide the information, the name of the abortion clinic or hospital which performed the initial abortion, and (3) the agency use that reporting to collect and provide, by facility which performs the abortion, statistics on the number of post-operative complications reported."

[8] Director Heigel's testimony the agency does not have any such reports from clinics and further noted a concern that patients may not follow up with a clinic.

[9] Director Heigel's testimony at today's meeting noted this is the current law as expressed in the agency's regulation and the recommendation was have this expressed in statute as well.

Rep. Tommy Stringer's motion:	Yea	Nay	Not Voting
Rep. Nathan Ballentine			Not Present
Rep. Raye Felder	X		
Rep. Mia S. McLeod	X		
Rep. Walton J. McLeod	X		
Rep. Robert L. Ridgeway, III	X		
Rep. James E. Smith, Jr.			Not Present
Rep. Tommy M. Stringer	X		
Rep. Bill Taylor	X		
Chair Gary E. Clary	X		

Subsequently, there was a motion from Representative Robert Ridgeway to technically amend the language of this recommendation: "Limiting abortions that can be performed in an abortion clinic to those within 18 weeks ~~from~~ of gestational age. Abortion clinics that are also licensed as ambulatory surgical facilities may perform abortion procedures on patients within 26 weeks ~~from~~ of gestational age." The agency noted in it February 24, 2016, letter that "[a]s used in this recommendation, gestational age correlates with LMP [last menstrual period], and can best be confirmed with use of an ultrasound."[10] A roll call vote was held, and the motion was approved.

Rep. Robert Ridgeway's motion:	Yea	Nay	Not Voting
Rep. Nathan Ballentine			Not Present
Rep. Raye Felder	X		
Rep. Mia S. McLeod	X		
Rep. Walton J. McLeod	X		
Rep. Robert L. Ridgeway, III	X		
Rep. James E. Smith, Jr.			Not Present
Rep. Tommy M. Stringer	X		
Rep. Bill Taylor	X		
Chair Gary E. Clary	X		

Representative Tommy Stringer asked questions and made comments about another recommendation by the agency.[11] Director Heigel noted that her verbal recommendation clarified that the agency's recommendation was to add a provision in statute that makes it illegal to sell or donate products of conception for reimbursement. Director Heigel again noted the agency was not seeking to change existing law but to provide clarification about the reimbursement.

Representative Felder made a motion that staff incorporate today's actions in the ad hoc committee study. A roll call vote was held, and the motion was approved.

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[10] Director Heigel's testimony at today's meeting noted this is the current law as expressed in the agency's regulation and the recommendation was to have this expressed in statute as well.

[11] At the January 21, 2016, meeting the ad hoc committee adopted the following recommendation: "[t]o add a provision in statute which makes it illegal to sell products of conception but allow donation for medical research without compensation and with the mother's written consent."

Rep. Raye Felder's motion:	Yea	Nay	Not Voting
Rep. Nathan Ballentine			Not Present
Rep. Raye Felder	X		
Rep. Mia S. McLeod	X		
Rep. Walton J. McLeod	X		
Rep. Robert L. Ridgeway, III	X		
Rep. James E. Smith, Jr.			Not Present
Rep. Tommy M. Stringer	X		
Rep. Bill Taylor	X		
Chair Gary E. Clary	X		

Standard Practice 12.4 allows individual member of this subcommittee the opportunity to provide a written statement for inclusion with this ad hoc committee's study. Representative Tommy Stringer made a motion that any such written statements be provided to staff before close of business (5:00 p.m) on Wednesday, March 2, 2016. A roll call vote was held, and the motion was approved.

Rep. Tommy Stringer's motion:	Yea	Nay	Not Voting
Rep. Nathan Ballentine			Not Present
Rep. Raye Felder	X		
Rep. Mia S. McLeod	X		
Rep. Walton J. McLeod	X		
Rep. Robert L. Ridgeway, III	X		
Rep. James E. Smith, Jr.			Not Present
Rep. Tommy M. Stringer	X		
Rep. Bill Taylor	X		
Chair Gary E. Clary	X		

Representative Walt McLeod made a motion that this be the final meeting of this ad hoc committee, unless after review of the written study, an ad hoc committee member requests in writing to the Chair by close of business on Friday, March 4, another meeting to discuss any issues of concern with the written study. A roll call vote was held, and the motion was approved.

Rep. Tommy McLeod's motion:	Yea	Nay	Not Voting
Rep. Nathan Ballentine			Not Present
Rep. Raye Felder	X		
Rep. Mia S. McLeod	X		
Rep. Walton J. McLeod	X		
Rep. Robert L. Ridgeway, III	X		
Rep. James E. Smith, Jr.			Not Present
Rep. Tommy M. Stringer	X		
Rep. Bill Taylor	X		
Chair Gary E. Clary	X		

Representative Tommy Stringer made a motion to allow the minutes from this meeting to be posted online with approval of the chair. A roll call vote was held, and the motion was approved.

Rep. Tommy Stringer's motion:	Yea	Nay	Not Voting
Rep. Nathan Ballentine			Not Present
Rep. Raye Felder	X		
Rep. Mia S. McLeod	X		
Rep. Walton J. McLeod	X		
Rep. Robert L. Ridgeway, III	X		
Rep. James E. Smith, Jr.			Not Present
Rep. Tommy M. Stringer	X		
Rep. Bill Taylor	X		
Chair Gary E. Clary	X		

X. Chairman Clary stated unless an ad hoc committee member makes a request in writing by Friday, March 4, to discuss an issue of concern with the written study, the ad hoc committee stands adjourned to not meet again, unless further directed to do so by the full committee. However, if by 5:00 p.m. on Friday, March 4, no member has requested another meeting in writing, pursuant to Standard Practice 12.5 he will notify the committee chairman that a study is available for consideration by the full committee.

There being no further business, the meeting was adjourned.

XI. Appendix I is the February 10, 2016, Attorney General Opinion.

Appendix II is the February 24, 2015, letter from the Department of Health and Environmental Control to the ad hoc committee.

Legislative Oversight Committee

Ad Hoc Committee
February 25, 2016 Minutes
Appendix I

ALAN WILSON
ATTORNEY GENERAL

February 10, 2016

The Honorable Gary E. Clary
Ad Hoc Committee Chair
Legislative Oversight Committee
Post Office Box 11867
Columbia, SC 29211

Dear Representative Clary:

You have asked our opinion regarding the constitutionality of an abortion regulation. By way of background, you advise:

> [o]n August 26, 2015, a motion was adopted for the House Oversight Committee to commence an investigation into state agencies, including, but not limited to the Department of Social Services, the Department of Health and Environmental Control, and Department of Health and Human Services, relationship with, funding of, and other activities relating to Planned Parenthood facilities and other abortion providers in South Carolina. On September 3, 2015, an ad hoc committee was appointed to undertake the study as stated in the motion. The ad hoc committee's study will be submitted for consideration by the full committee. Any legislator may file legislation, which will go through the normal legislative process, to implement study recommendations.
>
> During the ad hoc committee's study of the Department of Health and Environmental Control, on January 11, 2016, the agency was asked if it had any recommendations for improvement of existing laws. One of the agency's recommendations was to consider limiting the abortions that can be performed in an abortion clinic to those within the first eighteen weeks of pregnancy, beginning with conception rather than calculated on the basis of the menstrual cycle. At its meeting on January 21, 2016, the ad hoc committee approved a motion to seek an opinion from your office as to whether this recommendation from the agency may conflict with any federal statute or case law.

REMBERT C. DENNIS BUILDING • POST OFFICE BOX 11549 • COLUMBIA, SC 29211-1549 • TELEPHONE 803-734-3970 • FACSIMILE 803-253-6283

Law/Analysis

At the outset, we emphasize that we address herein only the question of the facial validity of any such statute with which your question is concerned. The standard for facial attack is summarized by the Fourth Circuit in Greenville Women's Clinic v. Bryant, 222 F.3d 157, 164 (4th Cir. 2000) as follows:

> [b]ecause of the conceptual difficulties that attend the ruling on the constitutionality of a statute in the abstract, the Supreme Court has held that "[a] facial challenge to a legislative Act is, of course, the most difficult challenge to amount successfully, since the challenger must establish that no set of circumstances exist under which the Act would be valid." United States v. Salerno, 481 U.S. 739, 745, 107 S.Ct. 2095, 95 L. Ed.2d 695 (1987); see also Rust v. Sullivan, 500 U.S. 173, 183, 111 S.Ct. 1759, 114 L. Ed.2d 233 (1991) (a facial challenge will fail if an act "can be construed in such a manner that [it] can be applied to a set of individuals without infringing upon constitutionally protected rights").
>
> In Planned Parenthood v. Casey, 505 U.S. 833, 112 S.Ct. 2791, 120 L. Ed.2d 674 (1992), the Supreme Court ruled that a statute regulating abortion was invalid because "in a large fraction of cases in which [it] is relevant, it will operate as a substantial obstacle to a woman's choice to undergo an abortion. Id. at 895, 112 S.Ct. at 2791 (majority opinion) (emphasis added). Whether this holding displaced the Salerno standard to facial challenges in abortion cases has been the subject of considerable debate among the circuits [citing cases] . . . Previously, this Court had stated its agreement with the Fifth Circuit position in Barnes v. Moore [970 F.2d 12 (5th Cir. 1992)] observing that until the Supreme Court specifically overrules Salerno in the abortion-regulation context, "this Court is bound to apply the Salerno standard as it has been repeatedly applied in the context of other abortion regulations reviewed by the Supreme Court. . . and in the context of other abortion regulations reviewed by the Supreme Court . . . and in the context of challenges to legislative acts based on other constitutional grounds." Manning v. Hunt, 119 F.3d 254, 268, n. 4 (4th Cir. 1997) (emphasis added).

Despite this uncertainty, the Fourth Circuit nevertheless concluded that under either the Salerno or Casey standard, the DHEC Regulation at issue (61-12) was facially valid. The Court noted:

> [e]ven when we apply a less deferential standard than that articulated in Salerno, we nevertheless conclude in this case that the record provides no evidence from which to conclude that Regulation 61-12 would present a "substantial obstacle" to "a large fraction" of women in South Carolina who

> might seek an abortion at a clinic subject to Regulation 61-12. Casey, 505 U.S. at 895, 112 S.Ct. at 2791 (majority opinion).

Id.

Having set forth the standard for facial constitutionality, we now turn to your question regarding the constitutional validity of a statute such as you describe. The starting point, obviously, is the seminal decision of Roe v. Wade, 410 U.S. 113 (1973). There, the Supreme Court held that "the right of privacy, grounded in the concept of personal liberty guaranteed by the Constitution, encompasses a woman's right to decide whether to terminate her pregnancy." City of Akron v. Akron Center for Reproductive Health, Inc., 482 U.S. 416, 419 (1983). "Roe established a trimester framework to govern abortion regulation. Under the elaborate but rigid construct, almost no regulation at all is permitted during the first trimester of pregnancy, regulations designed to protect the woman's health, but not to further the State's interest in potential life, are permitted during the second trimester, and during the third trimester when the fetus is viable, prohibitions are permitted, provided the life or health of the mother is not at stake." Planned Parenthood v. Casey, 505 U.S. 833, 872 (1992).

The requirement for abortions to be performed in an acute care, general hospital was addressed by the Supreme Court in City of Akron, supra. There, the Court reaffirmed Roe in the context of an Akron Ordinance which required that all second trimester abortions must be performed in a hospital. The Court recounted its previous Roe opinion as follows:

> [i]n Roe v. Wade the Court held that after the end of the first trimester of pregnancy the State's interest becomes compelling, and it may "regulate the abortion procedure to the extent that the regulation reasonably relates to the preservation and protection of maternal health." 410 U.S. at 163, 93 S.Ct. at 731. We noted, for example, that States could establish requirements relating "to the facility in which the procedure is to be performed, that is, whether it must be in a hospital or may be a clinic or some other place of less-then-hospital status." Ibid. In the companion case of Doe v. Bolton the Court invalidated a Georgia requirement that all abortions be performed in a hospital licensed by the State Board of Health and accredited by the Joint Accreditation of Hospitals. See 410 U.S. at 201, 93 S.Ct. at 752. We recognized the State's legitimate health interest in establishing for second-trimester abortions, "standards for licensing all facilities where abortions may be performed." Id. at 195, 93 S.Ct. at 749. We found, however, that "the State must show more than [was shown in Doe] in order to prove that only the full resources of a licensed hospital, rather than some other appropriately licensed institution, satisfy those health interests. Ibid. . . .

In reaffirming Roe and Doe, the Akron Court noted that while "a State's interest in health regulation becomes compelling at approximately the end of the first trimester," the "State's regulation may be upheld only if it is reasonably designed to further that State's interest." 482

U.S. at 434. The Court stated that ". . . if it appears that during a substantial portion of the second trimester the State's regulation depart[s] from accepted medical practice," the regulation "may not be upheld simply because it may be reasonable for the remaining portion of the trimester." Id. Based upon this reasoning, the Court struck down the Akron Ordinance at issue, concluding as follows:

> [t]here can be no doubt that § 1870.03's second-trimester hospitalization requirement places a significant obstacle in the path of women seeking an abortion. A primary burden created by the requirement is additional cost to the woman. The Court of Appeals noted that there was testimony that a second-trimester abortion costs more than twice as much in a hospital as in a clinic. . . . Moreover, the Court indicated that second-trimester abortions were rarely performed in Akron hospitals. . . . Thus, a second-trimester hospitalization requirement may force women to travel to find available facilities, resulting in both financial expense and additional health risk. It therefore is apparent that a second-trimester hospitalization requirement may significantly limit a woman's ability to obtain an abortion.

Id. at 435. The Court in Akron found that medical practice had advanced considerably since Roe was decided. According to the Court, the American Congress of Obstetricians and Gynecologists (ACOG) no longer suggested that all second-trimester abortions be performed in a hospital. ACOG recommended instead that abortions performed in a physician's office or outpatient clinic be limited to 14 weeks of pregnancy, but indicated that abortions may be performed safely in "a hospital-based, or in a free-standing ambulatory surgical facility, or in an out-patient clinic meeting the criteria required for a free-standing surgical facility," until 18 weeks of pregnancy 462 U.S. at 437 (emphasis added).

Justices O'Connor, White and Rehnquist dissented from the Court's opinion in Akron. The three dissenters deemed Roe's trimester analysis to be unworkable, believing instead that the appropriate test for State regulation was not "the point at which these interests become compelling," but whether the regulation imposes an "'unduly burdensome interference with 'the [woman's] . . . freedom to decide whether to terminate her pregnancy.'" 482 U.S. at 461. In applying the "undue burden" test, the dissent noted that a court must be cognizant of the Legislature's resolution of the issue. According to the dissent, such a standard

> . . . does not mean that in determining whether a regulation imposes an "undue burden" on the Roe right that we defer to the judgment made by state legislatures. "The point is, rather, that when we face a complex problem with many hard questions and few easy answers we do well to pay careful attention to how the other branches of Government have addressed the same problem." Columbia Broadcasting System, Inc. v. Democratic National Committee, 412 U.S. 94, 103, 93 S.Ct. 2080, 2087, 36 L.Ed.2d 772 (1973). . . .

The Akron Ordinance's hospitalization requirement, in the view of the dissent, was thus valid when considered pursuant to this "undue burden" standard. The dissent explained its analysis as follows:

> [f]or the reasons stated above, I find no justification for the trimester approach used by the Court to analyze this restriction. I would apply the "unduly burdensome" test and find that the hospitalization requirement does not impose an undue burden on that decision. The Court's reliance on increased abortion costs and decreased availability is misplaced. As the City of Akron points out, there is no evidence in this case to show that the two Akron hospitals that performed second-trimester abortions denied an abortion to any woman, or that they would not permit abortion by the D&E procedure. See City of Akron Reply Br. In No. 81-748, at 3. In addition, there was no evidence presented that other hospitals in nearby areas did not provide second-trimester abortions. Further, almost <u>any</u> state regulation, including that the licensing requirements that the Court <u>would</u> allow . . . inevitably and necessarily increased costs for any abortion. In <u>Simopoulos v. Virginia</u>, 482 U.S. 506, 103 S.Ct. 2532, 75 L.Ed.2d ____, the Court upholds the State's stringent licensing requirements that will clearly involve greater cost because the State's licensing scheme "is not an unreasonable means of furthering the State's compelling interest in" preserving maternal health. <u>Id</u>. at 2540. Although the court acknowledges this indisputably correct notion in <u>Simopoulos</u>, it inexplicably refuses to apply it in this case. A health regulation, such as the hospitalization requirement, simply does not rise to the level of "official interference" with the abortion decision. See <u>Harris [v. McRae</u>, 448 U.S. 297] at 328, 100 S.Ct. at 2894 (White J., concurring).
>
> Health-related factors that may legitimately be considered by the State go well beyond what various medical organizations have to say about the <u>physical</u> safety of a particular procedure. Indeed, "all factors – physical, emotional, psychological, familial and the woman's age – [are] relevant to the well-being of the patient." <u>Doe v. Bolton</u>, 410 U.S. 179, 192, 93 S.Ct. 201 (1973). The ACOG standards, upon which the Court relies, state that "[r]egardless of advances in abortion technology, mid-trimester terminations will likely remain more hazardous, expensive, and emotionally disturbing for a woman then early abortions." American College of Obstetricians and Gynecologists, Technical Bulletin No. 56, Methods of Mid-Trimester Abortions (Dec. 1979).
>
> The hospitalization requirement does not impose an undue burden, and it is not necessary to apply an exacting standard of review. Further, the regulation has a "rational relation" to a valid state objective of ensuring the health and welfare of its citizens. See <u>Williamson v. Lee Optical Co.</u>, 348 U.S. 483, 491, 75 S.Ct. 481, 466, 99 L.E.2d 563 (1955). . . .

462 U.S. at 467 (O'Connor, White and Rehnquist, JJ. dissenting).

The same reasoning as that of the majority in Akron, finding the Akron ordinance invalid, has been used in other cases as well. See Planned Parenthood Assn. of Kansas City v. Ashcroft, 462 U.S. 476 (1983) [requirement that abortions after twelve weeks of pregnancy be performed in hospitals is unconstitutional]; Simopoulos, supra; Planned Parenthood v. Janklow, 216 F. Supp.2d 983 (D. South Dakota 2002), rev. on other grounds, sub. nom., Planned Parenthood of Minn./S.D. v Rounds, 372 F.3d 969 (8th Cir. 2004). [statute requiring that abortions performed following the 12th week of pregnancy be performed in a hospital is unconstitutional]; McCormack v. Herzog, 788 F.3d 1017 (9th Cir. 2015) [provision requires all second-trimester abortions occur in a hospital, unconstitutional on its face]; McCormack v. Hiedeman, 900 F.Supp.2d 1128 (D. Idaho) [statutes requiring hospitalization for second-trimester abortions impermissibly burdened abortion rights]. In Ashcroft, the Court stated that "at least during the early weeks of the second trimester, [,] D&E abortions may be performed as safely in an outpatient clinic as in a full scale hospital." 103 S.Ct. at 2520 (emphasis added). And, in Simopoulos, the Court was careful to distinguish Virginia's requirement from that in Akron, such distinction rested upon the fact that Virginia's requirement was not expressly limited to general hospitals. The Simopoulos Court thus upheld Virginia's requirement that all second-trimester abortions be performed in an "outpatient surgical hospital." 462 U.S. at 515. As the Supreme Court noted, "[u]nder Virginia's hospitalization requirement, the surgical hospitals may qualify for licensing as 'hospitals' in which second-trimester abortions lawfully may be performed." Id. at 516. Moreover, the Court further explained,

> [g]iven the plain language of the Virginia regulations and the history of their adoption . . ., we see no reason to doubt that an adequately equipped clinic could, upon proper application, obtain an outpatient hospital license permitting the performance of second-trimester abortions. We conclude that Virginia's requirement that second-trimester abortions be performed in licensed clinics is not an unreasonable means of furthering the State's interest in protecting the woman's original health and safety." Roe, 410 U.S. at 150, 93 S.Ct. at 725. . . .

482 U.S. at 518-519.

Planned Parenthood v. Casey, supra, represented a major change in direction by the Supreme Court in its analysis of abortion regulation. While the Court in Casey reaffirmed Roe v. Wade, at the same time, it abandoned its trimester analysis altogether. The plurality opinion, authored by Justice O'Connor, stated: "[w]e reject the trimester framework, which we do not consider to be part of the essential holding of Roe." 505 U.S. at 873. Instead, the Court concluded that, prior to viability of the fetus, the appropriate constitutional analysis was whether the State's regulation imposed an "undue burden" upon the woman's right to terminate the pregnancy. According to the Court, "[a] finding of an undue burden is a shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the

path of a woman seeking an abortion of a viable fetus." Id. at 874. If a law does not constitute such an "undue burden," it is constitutional, if reasonably related to a legitimate state interest. Id. at 877.

The Casey plurality emphasized that "the 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." 505 U.S. at 846. Moreover, "[a]s with any medical procedure, the State may enact regulations to further the health or safety of a woman seeking an abortion. Unnecessary health regulations that have the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion impose an undue burden on the right." Id. at 878. Casey's analysis is quite consistent with Justice O'Connor's earlier dissenting opinion in Akron. The Supreme Court has reaffirmed on several occasions since Casey that the "undue burden" analysis is the correct one. See Mazurek v. Armstrong, 520 U.S. 968 (1997) (per curiam) [reversing an injunction of Montana's requirement that only physicians may perform abortions, rejecting the argument that invalid purpose was proven by lack of medical evidence]; Stenberg v. Carhart, 530 U.S. 914 (2000) [striking down Nebraska's ban on partial birth abortion]; Gonzales v. Carhart, 550 U.S. 124 (2007) [upholding as facially constitutional the Partial Birth Abortion Ban Act of 2003]. In the latter case, the Court recognized that "[w]here it has a rational basis to act, and it does not impose an undue burden, the State may use its regulatory power to bar certain procedures and substitute others." 550 U.S. at 158.

Courts and legal commentators have recognized the significant impact of Casey upon abortion regulation, particularly with respect to a hospitalization requirement. For example, the Fourth Circuit, in Greenville Women's Clinic v. Bryant, 222 F.3d 157 (4th Cir. 2000), upheld as facially valid a DHEC regulation concerning abortion clinics in South Carolina. The Fourth Circuit, relying upon Casey, stated:

> . . . State regulations that do not "reach into the heart" of the protected liberty do not violate the abortion-decision right. Casey, 505 U.S. at 874, 112 S.Ct. 2791 (joint opinion of O'Connor, Kennedy, and Souter, JJ.). If a regulation serves a valid purpose – "one not designed to strike at the right itself" – the fact that it also has "the incidental effect of making it more difficult or more expensive to procure an abortion cannot be enough to invalidate it." Id. One such valid purpose is a State's effort to "further the health or safety of a woman seeking an abortion." Id. at 878, 112 S.Ct. at 2791. Of course, if such health regulations are unnecessary and have the "purpose or effect of presenting a substantial obstacle to a woman seeking an abortion," they will be found to "impose an undue burden on the right." Id.

The DHEC Regulation at issue, and which was upheld by the Fourth Circuit, requires in part that "[a]bortions beyond 18 weeks . . . must be performed in a hospital, although a licensed ambulatory, surgical center that is also licensed as an abortion clinic may perform abortions on patients up to 26 weeks. . . . See S.C. Code Regs. 61-12, Section 302." Greenville Women's

Clinic v. Bryant, 66 F. Supp.2d 691, 707-708 n. 8 (D.S.C. 1999). While this particular portion of the DHEC Regulation was not at issue in the Fourth Circuit decision, it is important to note that the Court upheld the entire Regulation as facially valid and that this particular part of the Regulation was not scrutinized by the Court as causing any particular constitutional concern.

Moreover, based upon Casey, the Supreme Court of Oklahoma has upheld a statutory requirement that abortions performed "[f]rom the end of the first trimester until the fetus becomes viable" must be performed in general hospitals. In Davis, the Court recounted the various Supreme Court decisions dealing with a requirement of hospitalization including Doe v. Bolton, supra, City of Akron, supra, Planned Parenthood Assn. of Kansas City v. Ashcroft, supra and Simopoulos, supra. See Davis v. Fieker, 952 P.2d 505 (Okl. 1997). The Oklahoma Supreme Court rejected any argument that Akron still controlled. That Court instead followed Casey, explaining as follows:

> [W]e must then look to the record before us as the source of information to determine whether the evidence shows that restricting abortions performed during the first trimester to hospitals, including clinics and offices, and restricting abortions performed during the second trimester before viability to general hospitals places an undue burden on a woman's right to seek an abortion during these periods of her pregnancy. . . . An increase in cost, the risk of delay, a limit on the physician's discretion, and particularly burdensome effects do not necessarily place an undue burden on the right to have an abortion. . . . These effects must amount to substantial obstacles before the restrictions will be invalidated. . . .
>
> The evidence in this case is insufficient to show that the restrictions place an undue burden on a woman's right to an abortion. In striking down a spousal notification requirement in Casey, the Court relied on evidence that the requirement would allow "the husband to wield an effective veto over his wife's decision." . . . There is no evidence in the present case that Oklahoma's location restriction on an abortion place a substantial obstacle on the right to have an abortion. . . .
>
> In Casey, the United States Supreme Court upheld an informed consent requirement based on the lack of evidence in the record that "the requirement would amount in practical terms to a substantial obstacle to a woman seeking an abortion." . . . The Court also noted: "While at some point increased cost could become a substantial obstacle, there is no showing on the present record before us. . . . The defendants in the present case have not presented any evidence that Oklahoma's restrictions will amount to a substantial obstacle to a women seeking an abortion. While at some point the negative impact of Sections 1-731 and 1-737 may become a substantial obstacle, there is no evidence of such on the record before the Court.

> The defendants urge that the decision in Akron controls the present case. The Casey decision addressed some of the issues raised in Akron and explicitly overruled parts of the Akron decision although it did not address the requirement that second-trimester abortions be performed in hospitals. The United States Supreme Court in Casey rejected the rigid standard of review endorsed in Roe and on which the Akron decision was based. After a review of the Casey decision and subsequent decisions, we disagree that Akron retains its validity. For these reasons, the Casey decision, not the decision in Akron, controls the present case.

952 P.2d at 515-516.

A Tennessee case, Planned Parenthood v. Sundquist, 38 S.W.3d (Tenn. 2000), reached a conclusion opposite from that of Davis. In Sundquist, the Supreme Court of Tennessee concluded that Tennessee's hospitalization requirement made applicable to all second semester abortions was unconstitutional. The Sundquist Court reasoned as follows:

> [a]lthough the State has a compelling interest in maternal health from the beginning of pregnancy, . . . the second trimester hospitalization requirement is not narrowly tailored to further the State interest. Substantial evidence was introduced at trial to indicate that abortions can be performed safely outside the hospital setting through at least the first eighteen weeks of pregnancy. American College of Obstetricians and Gynecologists, Standards for Obstetrics-Gynecologist Services (7th ed. 1989). As observed by the Court of Appeals, a general agreement exists within the medical community that abortions can be performed safely in physicians' offices and outpatient clinics through the fourteenth week of pregnancy and, further, that physicians agree that abortions through the eighteenth week of pregnancy may be performed safely in free-standing surgical facilities. As noted by the trial court, the evidence is clear that second-trimester abortions are performed in the Nashville community in "'ambulatory surgical centers'" which have resulted from advanced medical technology and care, and are also the product of an attempt to lower costs to patients."
>
> The State may, of course, adopt standards for licensing facilities where second trimester abortions may be performed such as requiring facilities to be properly equipped and staffed. See e.g. American College of Obstetricians and Gynecologists, Standards for Obstetric-Gynecologic Services (setting forth suggested qualification standards). However, the State may not simply prohibit all second trimester abortions that are not performed in a hospital. Such a regulation is not narrowly tailored to promote maternal health. Moreover, in light of the complete absence of a medical emergency exception to the hospitalization requirement, the provision is constitutionally infirm even

> under the federal undue burden standard. Casey, 505 U.S. at 879, 112 S.Ct. at 2821 ("[T]he State . . . may, if it chooses, proscribe abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother." (quoting Roe, 410 U.S. at 164-65, 93 S.Ct. at 732) (emphasis added). Accordingly, we conclude that the second trimester hospitalization requirement "place[s] a substantial obstacle on in the path of a woman seeking an abortion." Id. at 878, 112 S.Ct. at 2821.

38 S.W.2d at 18-19.

The relevant DHEC Regulation, which is R 61-12, Section 302, remains the same as that when the Fourth Circuit decided Greenville Women's Clinic. Such Regulation states in pertinent part, as follows:

> A. Abortions performed in abortion clinics shall be performed only on patients who are within 18 weeks from the first day of their last menstrual period. Those beyond eighteen weeks shall be performed in a hospital. A licensed ambulatory surgical facility that is also licensed as an abortion clinic may perform abortions on patients who are up to 26 weeks after the first day of their last menstrual period.

The Court, in Greenville Women's Clinic, further noted that:

> [p]regnancy is measured either from the date of a woman's lmp (last menstrual period) or from conception, which is generally considered to occur two weeks after a woman's lmp. Accordingly, eight weeks after the lmp is equivalent to six weeks from the date of conception. Under Regulation 61-12, the first trimester of pregnancy ends at fourteen weeks after the lmp. See S.C. Code Ann. Regs 61-12, § 103(5).

Based upon Simopoulos, Casey, and Greenville Women's Clinic, the foregoing portion of DHEC Regulation 61-12 is unquestionably constitutional.

Moreover, Casey and other decisions, discussed above, make it likely that a court would conclude that a statute which requires all abortions performed more than eighteen weeks from the date of conception is facially constitutional. We believe that application of the "undue burden" standard, recognized by Casey, would lead to the conclusion that such a statute does not impose an undue burden and is, moreover, rationally related to a legitimate state purpose – the protection of the woman's health. Such a conclusion is consistent also with the Akron decision which held that abortions could be performed "'in a hospital-based or in a free-standing ambulatory surgical facility, or in an out-patient clinic meeting the criteria required for a free-standing surgical facility' until eighteen weeks of pregnancy," 462 U.S. at 437.

Use of the benchmark of eighteen weeks from the date of conception (or 20 weeks from lmp) has a strong basis with respect to protecting the health of the mother. As the Court recognized in Planned Parenthood of Wisconsin v. Doyle, 162 F.3d 463, 466 (7th Cir. 1999), an abortion at 20 weeks and beyond defines a "late-term abortion." It is well recognized that "[a]pproximately 99 percent of the abortions terminate pregnancies that are no later than 20 weeks LMP (no later than 18 weeks from fertilization." Comprehensive Health of Planned Parenthood of Kansas and Mid-Missouri, Inc. v. Templeton, 954 F. Supp.2d 1205, 1213 (D. Kan. 2013). Moreover, in the District Court decision in Planned Parenthood v. Casey, 744 F.Supp. 1323, 1352 (E.D. Pa. 1990), the Court stated: "[a] substantial increase in the risk of death from an abortion procedure occurs when the pregnancy moves from the earlier stages of the second trimester to the middle portion of the second trimester (16 to 20 weeks of gestation)." More specifically, it has been estimated that:

> . . . the risk of death form abortion increases about thirty percent (30%) with each week of gestation from eight weeks lmp to twenty weeks lmp. Dr. Westhoff adds that the risk of major medical complications increases about twenty percent (20%) with each week of gestation from seven weeks to full term.

Planned Parenthood v. Vernicro, 41 F. Supp.2d 478, 483, n. 1 (D.N.J. 1998). As the Court in Vernicro summarized, "[t]he risk of death form abortion . . . increase[s] as the pregnancy progresses." Id. at 483. While a fetus is generally not viable at 18 weeks from conception, (or 20 weeks from lmp or gestation), the Supreme Court upheld as consistent with Roe v. Wade, supra, the testing for viability at a gestational age of 20 weeks. See Webster v. Reproductive Health Services, 49 U.S. 490 (1989). Thus, it is quite logical and reasonable to use this 18 weeks from conception or 20 weeks from lmp as a benchmark to require hospitalization.

Conclusion

Your question relates to the constitutionality of the requirement that all abortions performed after eighteen weeks from the date of conception must be performed in a hospital. As noted above, dating any such restrictions from the date of conception rather than the last menstrual period (lmp) would add an extra two weeks, thereby meaning that the restrictions contemplated would be twenty weeks from the lmp. In either event, we believe such a regulation is facially constitutional under Casey, supra, as reasonably related to the preservation of the woman's health.

More specifically, we believe a court would likely find, as the Oklahoma Supreme Court did in Davis, supra, that Casey's "undue burden" analysis would now lead to the conclusion that all second-trimester abortions may be constitutionally required to be performed in a hospital. Justice O'Connor, who wrote a powerful dissent in Akron, would have concluded that such a restriction was constitutional under the "undue burden" standard. Importantly, Justice O'Connor also authored the plurality opinion in Casey, which adopted that same standard. As one legal

commentator has observed, "[a]lthough City of Akron made clear that any state law mandating second-trimester abortions occur in hospitals would not be upheld under Roe, it is not clear whether the same would be true under Casey." Ettinger, "Seeking Common Ground in the Abortion Regulation Debate," 90 Notre Dame L. Rev. 875, 886 (2014). As the Supreme Court of Oklahoma, in upholding a provision requiring all second-trimester abortions be performed in a general hospital, concluded:

> [t]he United States Supreme Court in Casey, rejected the rigid standard of review endorsed in Roe and on which the Akron decision was based. After a review of the Casey decision and subsequent decisions, we disagree that Akron retains its validity. For these reasons, the Casey decision, not the decision in Akron, controls the present case.

We agree with the Oklahoma Supreme Court's reasoning in Davis. While we discuss other decisions, which have reached a different conclusion from the Court in Davis, we believe a court is likely, based upon Casey, to uphold facially any requirement that all second-trimester abortions must be performed in a hospital.

However, based upon your specific question, we need not go so far in our conclusions here. Your Committee seeks only to require hospitalization for abortions performed after eighteen weeks from conception (or about 20 weeks from lmp). It is our opinion that a court would likely conclude that such a requirement is valid under Casey.

First of all, as discussed above, medical data strongly supports a 20 week restriction (18 weeks after lmp). As one authority has written,

> [a]bortions performed in the second or third trimester are rare; only one half of 1% take place past 20 weeks, and 0.01% take place after 24 weeks. Such abortions require more difficult procedures involving an increased risk of complications, and so are more often performed in hospitals. Dilation (also called *dilatation*) and Evacuation (D & E) is the method most commonly used in second-trimester abortions.

Miller, "Medical and Psychological Consequences of Legal Abortion in the United States," in Evaluating Women's Health Messages: A Resource Book, at 20.

Thus, based upon this data, pursuant to the Casey "undue burden" standard, such a hospitalization requirement late in the second trimester of pregnancy (18 weeks from conception or 20 weeks from lmp) is reasonably related to the preservation of the woman's health.

Further, even Akron acknowledged that abortions "may be performed safely in 'a hospital-based or in a free-standing ambulatory surgical facility, or in an out-patient clinic meeting the criteria required for a free-standing surgical facility,' until 18 weeks of pregnancy."

462 U.S. at 437. (emphasis added). This eighteen week point (from lmp) appears, according to the Supreme Court, to be the medically safe outer limit for second-trimester abortions outside the hospital setting. As the Court stated in Planned Parenthood of Middle Tennessee v. Sundquist, 38 S.W. 3d 1, 18 (Tenn. 2000), ". . . Planned Parenthood points to evidence that second trimester abortions are safe outside the hospital setting up to eighteen weeks of pregnancy,. . ." (emphasis added). Beyond 18 weeks, however, the Legislature could constitutionally conclude that the health of the mother becomes jeopardized except in a hospital.

Moreover, the analysis in Justice O'Connor's dissenting opinion in Akron should be dispositive here. There, Justice O'Connor wrote:

> [t]he ACOG standards, upon which the Court rules, state that "[r]egardless of advances in abortion technology, midtrimester terminations will likely remain more hazardous, expensive, and emotionally disturbing for a woman than early abortions." American College of Obstetricians and Gynecologists, Technical Bulletin No. 56: Methods of Midtrimester Abortion (Dec. 1979). The hospitalization requirement does not impose an undue burden, and it is not necessary to apply an exacting standard of review. Further, the regulation has a "rational relation" to a valid state objective of ensuring the health and welfare of its citizens. See Williamson v. Lee Optical Co., 348 U.S. 483, 491, 75 S.Ct. 461, 466, 99 L. Ed. 563 (1955). . . .

462 U.S. at 467. Justice O'Connor's views were essentially the basis of the Court's opinion in Casey.

Based upon the foregoing, it is our opinion that a court would likely conclude that a statutory provision which requires all abortions performed after eighteen weeks from conception (or 20 weeks lmp) would not impose an undue burden upon the woman's right to terminate her pregnancy. Casey and other decisions make clear that "[a]n increase in cost, the risk of delay, a limit on the physician's discretion, and particularly burdensome effects do not necessarily place an undue burden on the right to have an abortion." Davis, 952 P.2d at 515. Medical data concerning the risks to the woman at this stage of the pregnancy support this conclusion. Thus, such a statute would be facially valid, as reasonably related to a legitimate state purpose – that of preserving the woman's health.

Sincerely,

Robert D. Cook
Solicitor General

Legislative Oversight Committee

Ad Hoc Committee
February 25, 2016 Minutes
Appendix II

Catherine E. Heigel, Director
Promoting and protecting the health of the public and the environment

February 24, 2016

The Honorable Gary E. Clary
Ad Hoc Committee Chair
Legislative Oversight Committee
Post Office Box 11867
Columbia, SC 29211

Dear Representative Clary:

In our presentation to the Legislative Oversight Committee (LOC) on January 11, 2016, the Department recommended six conceptual changes to South Carolina's abortion statute.[1] We are writing to provide additional information concerning Recommendation 3 related to performance of an ultrasound and Recommendation 4 related to the time at which an abortion may be performed in a clinic.

Important to this discussion is the manner in which the time of conception and the gestational age of a fetus is determined. The abortion statute defines the three trimesters of a pregnancy as follows:

> "First trimester of pregnancy" means the first twelve weeks of pregnancy **commencing with conception rather than computed on the basis of the menstrual cycle**.
>
> "Second trimester of pregnancy" means that portion of a pregnancy following the twelfth week and extending through the twenty-fourth week **of gestation**.
>
> "Third trimester of pregnancy" means that portion of a pregnancy beginning with the twenty-fifth week **of gestation**.[2]

"Conception" is defined in statute as "the fecundation of the ovum by the spermatozoa."[3] "Gestation" is not defined in statute.[4]

We understand the medical community views these two concepts distinctly. According to the American College of Obstetricians and Gynecologists (ACOG), "Gestational age (GA) refers to the length of pregnancy after the first day of the last menstrual period (LMP) and is usually expressed in weeks and days. This is also known as menstrual age. Conceptional age (CA) is the true fetal age and refers to the length of pregnancy from the time of conception."[5] Our medical advisors indicate that it is not possible, with current technology, to determine the exact time of

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[1] Attachment 1.
[2] S.C. Code §§ 44-41-10(i), (j), and (k), respectively. (Emphasis added).
[3] S.C. Code § 44-41-10(g).
[4] While "gestation" is not defined in statute, the use of the phrase "of gestation" in the definitions of second and third trimesters correlates gestation with conception. This is inconsistent with the view of the medical community, which links gestational age to the length of pregnancy after the first day of the last menstrual period (LMP).
[5] ACOG Guidelines for Perinatal Care, Seventh Edition, Published 2012.

conception; however, as discussed below, an ultrasound provides for a more accurate estimation of GA. A better estimation of GA, in turn, provides for a better estimation of CA.

The Department's regulation defines the "Probable Gestational Age of the Embryo or Fetus" as follows:

> What, in the judgment of the attending physician, based upon the attending physician's examination and the woman's medical history, is within reasonable probability, the gestational age of the embryo or fetus at the time the abortion is planned to be performed. This estimate must be guided by recommendations found in The American College of Obstetricians and Gynecologists Standards for Obstetric-Gynecologic Services, i.e., calculated from the first day of the last menstrual period.[6]

The regulation also provides the following chart to clarify gestational age as referenced throughout the regulation[7]:

Calculation	Weeks of Gestational Age								
Conception	8	10	12	14	16	18	20	22	24
LMP	10	12	14	16	18	20	22	24	26

As noted in the chart, the regulation recognizes a two-week differential between the first day of a woman's LMP and the date of conception. ACOG states, however, the practice of determining an estimated due date based solely on the first day of the LMP "assumes a regular menstrual cycle of 28 days, with ovulation occurring on the 14th day after the beginning of the menstrual cycle," and "does not account for inaccurate recall of the LMP, irregularities in cycle length, or variability in the timing of ovulation."[8]

ACOG concludes that "[u]ltrasound measurement of the embryo or fetus in the first trimester (up to and including 13 6/7 weeks of gestation) is the most accurate method to establish or confirm gestational age."[9] As noted by ACOG, "[a]ccurate dating of pregnancy is important to improve outcomes and is a research and public health imperative."[10]

ACOG's conclusion is reflected in the 2015 report prepared by Legislative Audit Council (LAC) wherein LAC recommended, "The General Assembly should amend state law to require a pre-abortion ultrasound to determine the gestational age of the fetus for all abortions."[11] An ultrasound is the current gold standard for determining the gestational age of a fetus, and the Department recommended that the performance of an ultrasound be required prior to the performance of an abortion for the purpose of making that determination. [12]

The Department also recommended limiting abortions that can be performed in an abortion clinic to those within the first 18 weeks of pregnancy, beginning with conception rather than calculated on the basis of the menstrual cycle.[13] The LOC requested an Attorney General Opinion regarding

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[6] S.C. Code Regs. 61-12, § 101.Q.
[7] S.C. Code Regs. 61-12, § 101.S.4.
[8] ACOG Committee Opinion No. 611, Method of Estimating Due Date.
[9] *Id.*
[10] *Id.*
[11] LAC Report, A Review of the S.C. Department of Health and Environmental Control's Regulation of Abortion Clinics (Report), May 2015, p. 29.
[12] *See* Recommendation 3.
[13] *See* Recommendation 4.

this recommendation. The Attorney General opined, and the Department agrees, the recommendation is constitutional.

It was the Department's intent in making this recommendation to place a statutory limitation, consistent with the existing regulation, on when abortions may be performed in an abortion clinic. However, the recommendation does not accurately reflect the existing regulatory limitation.

As noted above, the Department's regulation recognizes a two-week time differential between LMP and conception. The recommendation, if implemented as currently stated, would limit the performance of abortions in abortion clinics to 20 weeks from LMP, which is greater than the current regulatory limitation of 18 weeks from LMP. *See* S.C. Code Regs. 61-12, § 101.S.4 and § 302.A. The recommendation as written also did not incorporate the language in the regulation permitting abortion clinics dually licensed as ambulatory surgical facilities to perform abortion procedures up to 26 weeks from LMP. It was not the intent to change the current law related to this issue. Therefore, the Department amends the recommendation as follows:

> Limiting abortions that can be performed in an abortion clinic to those within 18 weeks from gestational age. Abortion clinics that are also licensed as ambulatory surgical facilities may perform abortion procedures on patients within 26 weeks from gestational age.[14]

I hope this letter is helpful in clarifying our recommendations and appreciate any guidance the Committee has going forward.

Sincerely,

Catherine E. Heigel

Attachment 1: January 11, 2016, Recommendations

[14] As used in this recommendation, gestational age correlates with LMP, and can best be confirmed with use of an ultrasound.

Attachment 1

January 11, 2016, Recommendations

1. Adding a provision to make it illegal to sell or donate products of conception.
2. Adding a provision to require abortion clinics and hospitals to report to DHEC post-operative complications arising as a result of an abortion procedure.
3. Adding a provision to require that an ultrasound be performed prior to an abortion procedure to determine the gestational age of the fetus.
4. Limiting the abortions that can be performed in an abortion clinic to those within the first 18 weeks of pregnancy, beginning with conception rather than calculated on the basis of the menstrual cycle.
5. Requiring physicians performing any abortion to comply with requirements of the "Woman's Right to Know" article. Currently, the law applies only to facilities in which any second trimester or five or more first trimester abortions are performed in a month.
6. Adding a requirement for some identifying information to be included in the abortion reports, which would allow DHEC to utilize these reports, as necessary, to assist in investigating potential violations. Also, we would add sanctions for failure to report this information to us in a timely manner.