2015 YEAR IN REVIEW

A REPORT OF THE NATIONAL INSTITUTE FOR REPRODUCTIVE HEALTH

JANUARY 2016

NATIONAL INSTITUTE FOR REPRODUCTIVE HEALTH

Gaining Ground: Proactive Reproductive Health and Rights Legislation in the States

The National Institute for Reproductive Health (National Institute) works in states and localities across the country to promote reproductive rights and expand access to reproductive health care, including abortion; reduce unintended pregnancies; and empower youth to make healthy sexual and reproductive decisions.

The National Institute develops and implements innovative and proactive strategies to galvanize public support, change policy, and remove barriers to care. Believing that a bottom-up strategy is necessary to create lasting change, we work through a partnership model, building connections between and among partner organizations at the local, state, and national levels and providing support in the form of funding, capacity building, strategic guidance, and technical assistance.

January 2016

National Institute for Reproductive Health
470 Park Avenue South
7th Floor South
New York, NY 10016
Tel. 212-343-2031
Fax 212-343-0119
info@nirhealth.org
www.nirhealth.org

Acknowledgements

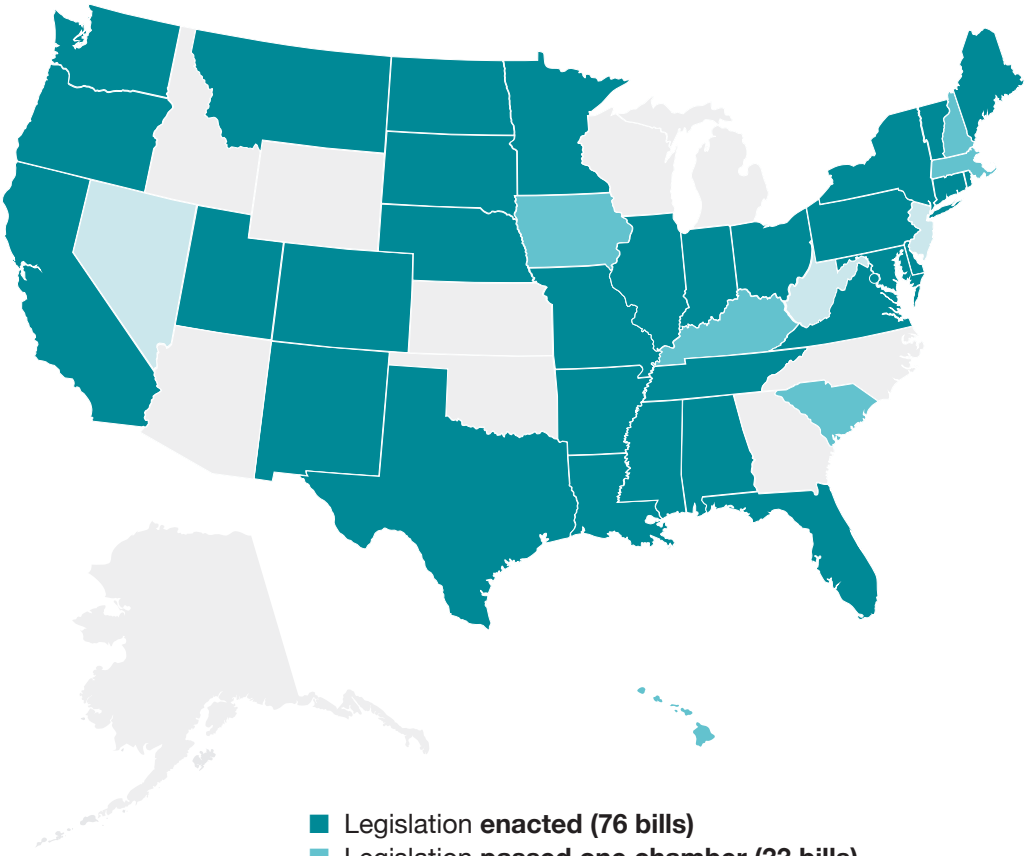
This report was written by Jordan Goldberg, Senior Policy Counsel, and Rose MacKenzie, Policy Counsel, with bill tracking assistance from Lauren Boc, Program Associate. Staff of the National Institute, including Andrea Miller, President; Maria Elena Perez, Director of Policy and Strategic Partnerships; Tara Sweeney, Communications Director; Christie Petrone, Associate Communications Director; and Ami Cholia, Senior Digital Communications Manager, contributed to and edited this report. The case studies contained in this report were highly informed by the advocates quoted within them. The National Institute is grateful to the advocates and partners across the country whose advocacy is increasing access to reproductive health care and strengthening the reproductive health, rights, and justice movements every day, and whose work on those critical issues inspired this report. The National Institute also gratefully acknowledges the foundations and individual donors who make our work possible.

NATIONAL
INSTITUTE FOR
REPRODUCTIVE
HEALTH

1 Introduction: Gaining Ground

IN 2015, EFFORTS TO UNDERMINE THE RIGHTS AND ABILITY OF WOMEN in the majority of states to access the full range of reproductive health services, particularly abortion, were at an all-time high. Even in the midst of this regressive atmosphere, advocates and legislators stepped forward in record numbers to promote legislation that affirmatively supports women's reproductive and sexual health, rights, dignity, and autonomy. They made significant gains in advancing policies associated with the full spectrum of women's reproductive lives—and demonstrated how reproductive decisions are integral to broader societal concerns, such as women's equality and financial stability. These efforts underscore that abortion—alongside using contraception, carrying a pregnancy to term, and parenting—figures prominently among the reproductive options that women routinely choose during their lifetimes.[1]

MOVEMENT OF PROACTIVE LEGISLATION IN 2015



SECTION **1**

In 40 states and the District of Columbia, advocates and legislators campaigned for proactive policies designed to expand women's access to sexual and reproductive health care, help level the playing field for pregnant and parenting workers, improve the sexual and reproductive health of young people, and make reproductive health care more accessible and affordable. Many new laws were passed, and even when affirmative legislation did not become law, introduction of and advocacy around such creative new policies frequently raised the profile of issues central to women's overall well-being, laying the groundwork for future policy advances.

This progress should be viewed in the context of the nationwide trend of state legislatures undermining women's health, rights, and access to a range of reproductive health services. Since 2010, 318 anti-abortion proposals have become law, severely limiting women's access to safe, legal abortion care.[2] Legislators in states across the country have also targeted access to contraception, funding for reproductive health care, and the medical professionals who provide comprehensive care.

Advocates and legislators are refusing to allow those who oppose women's health and rights to continue to monopolize the public discourse and dictate the policy trajectory in their states. Over the last two years, there has been a new surge of proactive policy work in statehouses in every region of the United States.

The National Institute for Reproductive Health (National Institute) has the great privilege of working with many of the state and local advocates across the United States who championed affirmative reproductive health policies in 2015. This second annual policy report focuses on legislation that passed at least one committee in at least one house of a state legislature within four proactive policy areas: (1) protecting and expanding access to abortion, contraception, and sexual health care; (2) enhancing insurance coverage for sexual and reproductive health care; (3) improving the sexual and reproductive health of youth; and (4) promoting healthy pregnancies, parents, and babies. In addition to reporting on the affirmative legislation that advanced in these topic areas, each section highlights one or two policies that are particularly unique, innovative, or timely. Finally, we have culled through many of the success stories from 2015 to create case studies that showcase some of the distinctive and inspiring situations in which advocates and policymakers have worked together to combine new policy ideas with creative advocacy campaigns that rally support around a proactive approach to reproductive health, rights, and justice.

2 Protecting and Expanding Access to Abortion, Contraception, and Sexual Health Care

SECTION **2**

In 2015, 16 states considered ways to protect and expand access to sexual and reproductive health care. Advocates and legislators championed a range of proactive policies on topics as varied as access to the full range of contraceptives without a prescription and expedited partner therapy for people diagnosed with STIs. **By the end of the year, 13 new state laws were enacted that will improve access to reproductive and sexual health care.**

ABORTION

Five states considered legislation designed to improve women's access to abortion, either by protecting patients seeking abortion care from misinformation or by removing barriers to care that currently exist. Two of these pieces of legislation were enacted, along with one resolution, in three states.

California enacted the Reproductive FACT Act, Assembly Bill 775, which requires licensed medical facilities to disseminate information to patients about California's free and low-cost family planning programs and requires unlicensed facilities that offer pregnancy-related services (often called "crisis pregnancy centers") to clearly inform their clients that the facility is "not licensed as a medical facility" and "has no licensed medical provider" available to provide medical services.

Under **Florida** law, a young woman under the age of 18 seeking an abortion must either obtain her parent or guardian's permission or seek permission from a state court to bypass that requirement. The state law protecting a young woman's confidentiality should she seek a court order was scheduled to be repealed in 2015. Florida Senate Bill 7016 was enacted to ensure that those petitions will continue to remain confidential.

In 2014, **Vermont** adopted Senate Bill 317 to ensure access to abortion in that state even if *Roe v. Wade* (1973) were overturned. In 2015, Vermont passed House Joint Resolution 2, urging Congress and other state legislatures to place similar protections in their statutes. The **New York** State Assembly passed such a bill, the Reproductive Services Act, Assembly Bill 6221, which would have placed into state law the protections for a woman's right to abortion prior to 24 weeks or thereafter if her life or health is at risk, thereby ensuring access to abortion care regardless of the status of *Roe v. Wade*. This marks the third time the Assembly passed legislation to accomplish this goal, and the first time it did so as a stand-alone bill rather than as part of a legislative package. This provision was included in the Women's Equality Act, which passed in the Assembly in 2013 and 2014. For more information about the Women's Equality Act, see "Case Study: Putting Abortion in the Context of Women's Lives" on page 21.

Illinois also took steps to protect women's access to abortion care. Existing Illinois law allows health care providers and institutions to use their purported religious beliefs to justify denying patients both health care services and information about the range of treatment options. Illinois Senate Bill 1564, which passed the Illinois Senate and the Human Services and Rules Committees in the House, would ensure that, even when a provider or institution has a religious objection, the patient can still get the information she needs or a referral to another provider; it is being championed by a number of advocates, including the ACLU of Illinois. A similar bill in Washington state, Senate Bill 5770, was introduced but has not yet moved; it would guarantee that health care providers could provide the health care their patients need—and that their medical ethics require them to provide—without fear of retaliation from their institution. Lead advocates for this include Legal Voice and the ACLU of Washington.

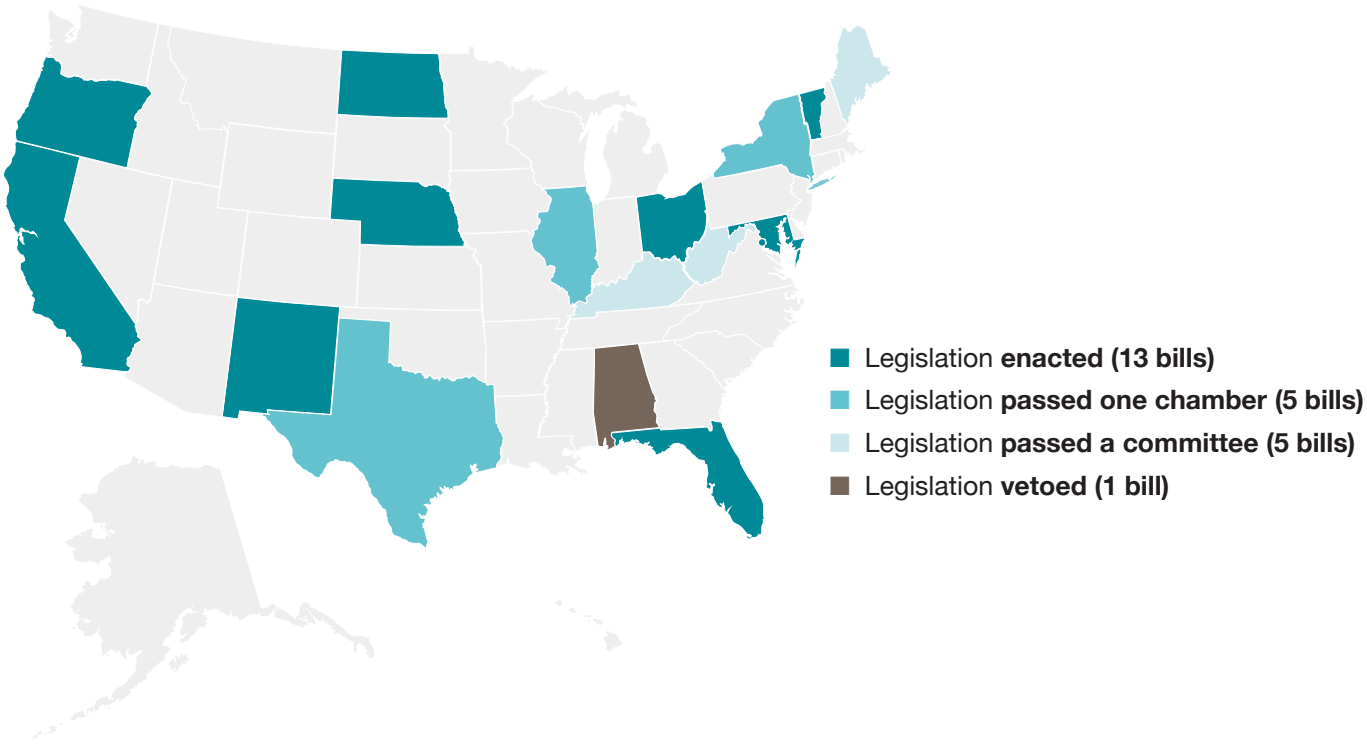
CONTRACEPTION

Five states considered legislation designed to protect and expand access to contraception, and three states enacted these proposed laws.

California adopted Senate Bill 464, which lets patients use technological applications—such as a website or an app on a mobile device—to "self-screen" for whether hormonal contraceptive is right for them, and then allows health care providers to prescribe or dispense the contraceptive based on that self-screening process. This law is designed particularly to improve access to health care for rural populations. In **Nebraska**, health care providers at public health clinics were already permitted to dispense oral contraceptives without the assistance of a pharmacist, and newly enacted Legislative Bill 37 enables them to dispense all types of contraception on site. **Oregon's** House Bill 2879 allows pharmacists to dispense both oral contraceptives and hormonal patch contraception from "behind the counter" (meaning without a prescription from a physician) to adult women and to women under 18 if they have already been prescribed that type of contraception in the past. See "Policy Highlight: Birth Control Prescribed by Pharmacists" on page 8.

Both the **Maine** and **New York** legislatures considered versions of the "Not My Boss's Business Act," initially proposed in Congress after the U.S. Supreme Court's decision in *Burwell v. Hobby Lobby Stores Inc.*, 134

MOVEMENT OF PROACTIVE LEGISLATION PROTECTING AND EXPANDING ACCESS TO ABORTION, CONTRACEPTION, AND SEXUAL HEALTH CARE IN 2015



POLICY HIGHLIGHT: BIRTH CONTROL PRESCRIBED BY PHARMACISTS

As a result of the federal Affordable Care Act (ACA), which passed in 2010,[3] many more women in the United States gained access to low- or no-cost birth control, particularly through the ACA's mandate that contraceptives be covered by insurance with no co-pay. However, implementation of this birth control benefit has been uneven: Some insurers have refused to cover the full range of contraceptive options, and some employers have asserted their "religious beliefs" to justify non-compliance with the benefit.

At the same time, advocates and legislators have sought out ways to expand access to contraception beyond the limitations of the ACA. In 2015, Oregon enacted House Bill 2879, which creates "behind the counter" access to contraception for adult women in the state and for minors who have been prescribed contraception in the past. This law is similar to Senate Bill 493, which passed in California in 2013. Under the new law, a woman in Oregon can get both oral contraceptives and hormonal patch contraception from a pharmacist without needing to get a prescription from her primary care physician. By permitting pharmacists to provide the prescriptions and dispense these contraceptives directly, Oregon House Bill 2879 not only eliminates a woman's need to visit a physician's office, it also allows her to use her insurance prescription benefit when purchasing her contraception.

S. Ct. 2751 (2014), which held that federal law allows for-profit corporations to deny their employees insurance coverage for contraception based on the corporation's religious beliefs. Both New York Assembly Bill 1142, which passed the Assembly, and Maine House Bill 698, which passed one committee, would have prohibited employers from discriminating against any employee because of any reproductive health decision that the employee or their dependent made. A similar bill was included in the Virginia Women's Equality Agenda, but did not move this session. See "Case Study: Putting Abortion in the Context of Women's Lives" on page 21.

SEXUAL HEALTH CARE

Nine states considered legislation intended to expand access to sexual health care, including services and drugs related to HIV and other STIs, three states enacted a combined total of six new laws, and a fourth approved one resolution.

Maryland adopted four new laws in 2015 that expanded access to sexual health care, including two related to expedited partner therapy (EPT), a clinical practice where doctors provide treatment for some kinds of STIs for both the patient and the patient's sexual partner without also examining the partner. EPT helps make treatment more accessible to those who need it and cuts down on STI transmission rates. Maryland Senate Bill 626 / House Bill 945 adds registered nurses to the list of health care providers eligible to provide EPT. Then, building off of the success of a Baltimore pilot program, Maryland Senate Bill 599 will now allow physicians, advanced practice registered nurses, and physician assistants at public and private health facilities across the state to prescribe and dispense EPT to any partner of a patient diagnosed with chlamydia or gonorrhea. **Ohio** enacted House Bill 124, which permits EPT across the state for chlamydia, gonorrhea, or trichomoniasis.

Several other states considered EPT legislation but did not enact it. In **New York**, Assembly Bill 2170, which passed the Assembly, would have expanded New York's existing EPT program beyond chlamydia to allow practitioners to provide EPT for any STI for which the Centers for Disease Control and Prevention (CDC) recommends the practice. Not only would this have expanded access to care, it would have also allowed

New York providers to keep pace with changes as the CDC brings new STIs onto its existing list. **Kentucky** House Bill 230 and **West Virginia** House Bill 2046, which each passed one committee in their respective legislatures, would have allowed for EPT statewide.

Maryland, New Mexico, and Alabama all considered legislation related to HIV/AIDS treatment. **Maryland** enacted two new laws designed to improve health care for HIV/AIDS patients. Maryland House Bill 978 brings Maryland law into compliance with CDC HIV testing guidelines, which are intended to reduce stigma and encourage early testing, and Senate Bill 796 authorizes the state to use certain drug-related rebates for patients in the Ryan White HIV/AIDS Program. **New Mexico** enacted Senate Memorial 132, which urges the legislature to create a department of corrections task force to study ways to improve health care in correctional facilities in the state, including improving access to prescription drugs for HIV/AIDS and other STIs. The **Alabama** Legislature passed House Bill 247, which would have allowed HIV clinics to redistribute unused HIV drugs to patients, but Governor Robert Bentley vetoed the bill.

In **New York**, an Assembly committee passed Assembly Bill 806, which would have allowed state employees to take up to four paid hours annually to get a cervical cancer screening. Another Assembly committee passed Assembly Bill 4463, which would have prevented prosecutors from submitting condoms as evidence in prostitution-related criminal cases—an important step to ensuring that sex workers in New York can protect their health without fear of criminal repercussions. The **Texas** House passed House Bill 1282, which would have required the Department of State Health Services to develop a plan to reduce morbidity and mortality from cancer associated with human papillomavirus (HPV).

North Dakota enacted Senate Bill 2284, which provides victims of sexual assault more autonomy over whether to undergo a forensic examination or report their assault to law enforcement; it also creates mechanisms for hospitals to offer appropriate care to victims of sexual assault who want an examination or STI treatment.

The Alabama Legislature passed House Bill 247, which would have allowed HIV clinics to redistribute unused HIV drugs to patients, but Governor Robert Bentley vetoed the bill.

CASE STUDY

FIGHTING FOR ABORTION COVERAGE IN OREGON

The Pro-Choice Coalition of Oregon—composed of the ACLU of Oregon, Asian Pacific American Network of Oregon (APANO), NARAL Pro-Choice Oregon, Oregon Latino Health Coalition (ORLHC), Planned Parenthood Advocates of Oregon (PPAO), Western States Center, the All* Above All Campaign, and the National Institute—launched a new policy campaign in 2015 to create and promote the Comprehensive Women's Health Bill. Michele Stranger Hunter, Executive Director of NARAL Pro-Choice Oregon, explained that the legislation was developed to "capitalize on ACA reform and to codify in statute access to the full range of reproductive health care services,"[4] including abortion, contraception, prenatal care, breastfeeding support, and a host of other types of care.

"The timing was strategic, in large part due to our strong political backing," said Hunter. "In the spring of 2014, we not only had a pro-choice governor, but a pro-choice House and Senate. At the same time, anti-choice organizations were actively working to collect signatures for IP6, a ballot measure that would prohibit public funding of abortion. For these reasons, it felt timely to introduce a proactive policy."[5]

The coalition laid the groundwork for this bill for more than a year. A number of the organizations involved used the prospect of advancing such legislation to increase public support for the goals of the bill and increase public engagement to build their own institutional strength and impact. For instance, Western States Center created the "We Are BRAVE" campaign, an innovative new collaboration and leadership development program that aims to raise the voices of people of color and people of color-led organizations in the movement for full abortion access, as well as to broaden the work done by organizations that have focused exclusively on reproductive health care in the past. Bringing new allies to the table to create broad-based proactive legislation that addresses their communities' needs in this way could serve as a model for other state advocates seeking to adopt a more proactive frame on abortion while at the same time engaging a broader base of supporters.

Research and messaging by All* Above All, a national campaign to restore public insurance coverage of abortion care for all women, combined with intense grassroots organizing by Western States Center, has helped to center abortion access as a primary and non-negotiable goal within the coalition. The National Institute is proud to have partnered with this coalition, which led to its adoption of the National Institute signature strategy of working to secure a local resolution (in Multnomah County) urging the passage of the bill to demonstrate to state legislators that there is community support for such policies.[6]

Although the coalition secured the political support necessary to introduce the bill, it did not pass in 2015. Going forward, Amy Casso, Western States Center Program Manager, says the organization plans to "reframe and broaden the narrative with legislators" about the importance of abortion access and to continue to educate lawmakers to understand "the broader challenges—economic, racial, cultural, and structural—to obtaining an abortion in Oregon.…In 2016, we need to change hearts and minds and remove the shame and stigma surrounding abortion. We need to elevate the voices of those most impacted and boldly share our stories and vision."[7]

3 Enhancing Insurance Coverage for Sexual and Reproductive Health Care

SECTION **3**

In 2015, 15 states and the District of Columbia moved legislation aimed at expanding insurance coverage for reproductive and sexual health care services. From bills that would help women get the coverage they need for abortion services, to those that recognized the importance of confidential health services, to those that require insurance companies to provide contraception, fertility treatment, and pregnancy care at the level women deserve, **states all over the country took creative approaches to ensuring their residents have access to sexual and reproductive health care.**

Many of these proposals were the result of the expertise and advocacy of women's health advocates—such as the broad coalition of organizations that have pushed the Reproductive Parity Act in Washington state over the past four years or the organizations in Illinois harnessing the power of youth advocacy to speak on behalf of their own reproductive health needs. Over the course of the year, 12 new laws were enacted in eight states and the District of Columbia that improve insurance coverage.

ABORTION

Two states took up bills in 2015 that would have expanded insurance coverage for abortion.

In **Illinois**, one House committee passed House Bill 4013, which would have repealed the state's existing prohibition on coverage for abortion in state employees' insurance and Medicaid as well as made it easier for health care providers to be reimbursed for the care they provide. See "Policy Highlight: An Attempt to Repeal Restrictions on Insurance Coverage for Abortion" on page 15. In **Washington**, the House passed House Bill 1647, also called the Reproductive Health Act, a comprehensive package of proposals to improve reproductive health. The bill would have required all insurance plans that cover maternity care or services to also cover abortion; ensured coverage for a 12-month supply of all forms of contraception, including voluntary sterilization and over-the-counter forms of contraception; and ensured coverage for counseling and medical services necessary for that contraception without cost sharing. This legislation is an updated version of the Reproductive Parity Act, which women's health advocates in Washington, including Legal Voice,

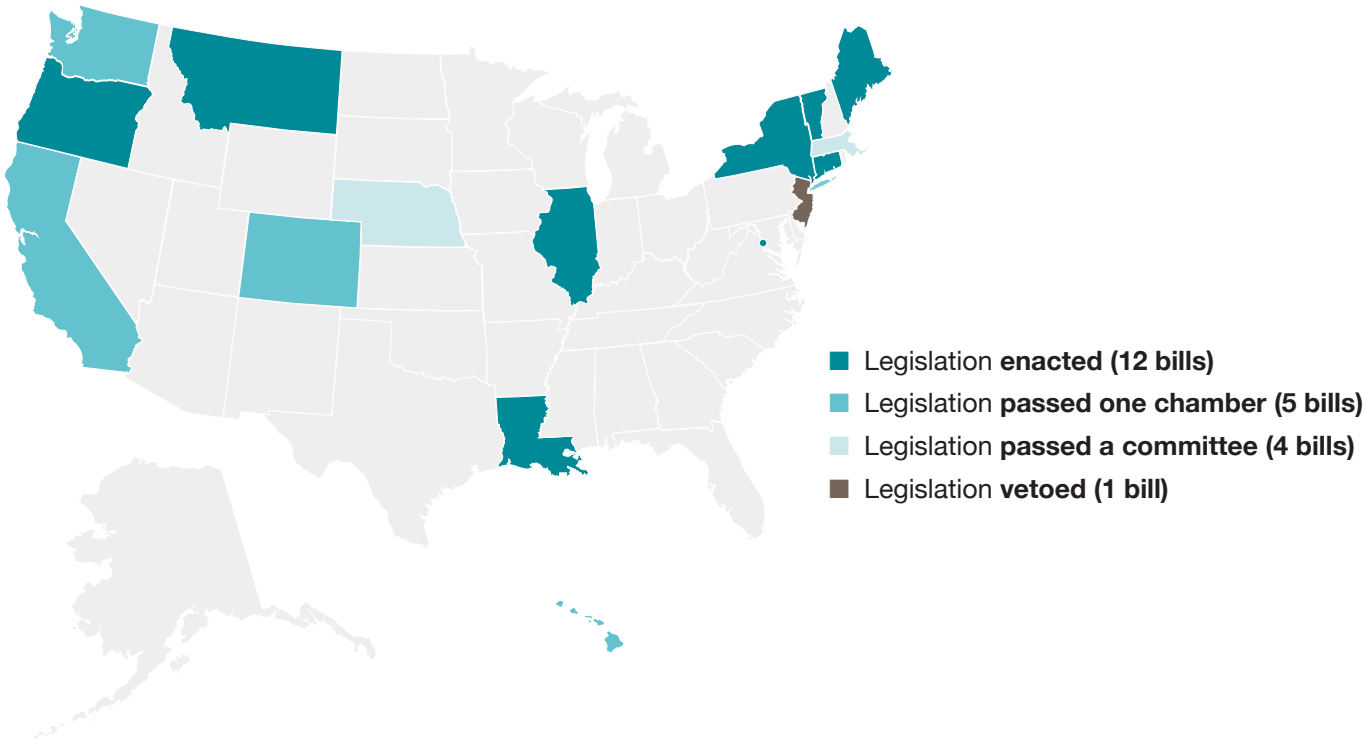
NARAL Pro-Choice Washington, Planned Parenthood of the Great Northwest, and Surge Northwest, have worked diligently to promote since 2012. If passed, the Reproductive Health Act would greatly improve access and affordability for all reproductive health services for Washington residents.

CONFIDENTIAL EXPLANATION OF BENEFITS

Two states enacted and one state considered new laws to address the issues that arise for dependents on an insurance plan. Frequently, the spouses or teen and adult children of the primary policyholder need or would like to keep their health information confidential—something that is particularly important for survivors of domestic violence or young adults still on their parents' insurance plan. And, because the ACA now allows young adults to stay on their parents' insurance plans until the age of 26, the law has expanded the pool of dependents who may need help maintaining control over their private health care information. For most health plans, when either the insured or a dependent uses the insurance to pay for a service, an "explanation of benefits" is sent directly to the primary policyholder—regardless of which family member used the service. Advocates and legislators have recognized this can be a problem for maintaining patient confidentiality, and in several states, policies have been proposed or considered to create privacy protections for information sent to policyholders through explanation of benefits statements and other insurance-related paperwork.

Illinois enacted House Bill 2812 to address this issue for individuals who use Medicaid, thanks to a broad coalition of mental health care advocates, veterans, and reproductive and sexual health groups—including EverThrive Illinois, an organization committed to bringing the voices of youth into advocacy for their own issues. The new law prohibits Medicaid managed care entities from disclosing information regarding sensitive health services—such as those related to mental health, substance abuse treatment, reproductive health, family planning, STIs, and sexual assault or domestic abuse—through methods such as bills or explanations of benefits, unless the person who received the service affirmatively requests the information. This means that residents enrolled in a Medicaid managed

MOVEMENT OF PROACTIVE LEGISLATION ENHANCING INSURANCE COVERAGE FOR SEXUAL AND REPRODUCTIVE HEALTH CARE IN 2015



POLICY HIGHLIGHT: PREGNANCY AS A QUALIFYING LIFE EVENT FOR INSURANCE ENROLLMENT

The passage of the ACA in 2010 led to the creation of federally or state-run exchanges, where individuals can purchase health insurance. Enrollment in insurance plans is limited to a three-month "open enrollment period." However, the law also lays out exceptions for certain "qualifying life events" that allow enrollment outside of the normal enrollment period—including a change in job status, the loss of current health insurance, or a change in family status, such as getting married or the birth of a child. But being pregnant is not itself a qualifying life event, leaving many uninsured women who become pregnant without access to health care, including prenatal care as well as labor and delivery services, until after childbirth.

Under the ACA, individual states may add additional qualifying events to allow state residents to purchase insurance at times other than the open enrollment period. In 2015, New York became the first state to add pregnancy to the list of qualifying life events, allowing someone who becomes pregnant to purchase insurance on the exchange immediately. This legislation, which was signed into law in December, applies to all insurers that have open enrollment periods, both inside and outside of the exchange. A health care provider must certify the pregnancy, but even that visit would be covered retroactively. This will allow New York residents who find themselves pregnant without health insurance to get coverage and access to affordable care for the duration of their pregnancy.

care plan will have any sensitive service kept confidential automatically. Advocates also urged the legislature to address this issue for private insurance, but a proposed bill on that topic, Senate Bill 1318, died in committee.

Oregon enacted a similar law, House Bill 2758, which allows any health insurance enrollee to request that their medical information be communicated only directly to them through a mode of their choosing. Oregon residents who want to request this confidential treatment will need to submit a form to their insurance company asking that the information be sent to them in a particular way (for example, emailed instead of mailed to their home). **Massachusetts** considered a similar bill, House Bill 3920 / Senate Bill 2081, which passed favorably out of the Joint Committee on Health Care Financing.

CONTRACEPTIVE

Four states and the District of Columbia considered bills intended to expand insurance coverage for contraception. Two focused on state funding for family planning services. In **Montana**, House Bill 606 ensures that Title X grants will be used only for appropriate family planning and related sexual health services, rather than allowing federal funds to be put into larger state budget accounts that could be used for other purposes. In **Colorado**, the House passed House Bill 1194, which would have provided $5 million in additional funding for another year of the Colorado Family Planning Initiative, a successful program begun in 2009 to expand access to long-acting reversible contraception and other services to low-income women with the goal of reducing unintended pregnancies. Despite the program's success,[8] its funding through the Colorado Department of Public Health and Environment ended in 2015 because this bill did not become law.

Both **Oregon** and **Washington, D.C.,** enacted legislation expanding the amount of prescription birth control that may be covered at one time based on studies that have shown that having access to a full year's worth of birth control significantly increases a woman's ability to use it effectively to prevent unintended pregnancy. Oregon House Bill 3343 will now require insurance companies to cover an initial three-month prescription of contraception, followed by 12 months of contraception at one time for any

POLICY HIGHLIGHT:
AN ATTEMPT TO REPEAL RESTRICTIONS ON INSURANCE COVERAGE FOR ABORTION

At both the state and federal levels, anti-choice lawmakers have succeeded in making insurance coverage for abortion unavailable or out of reach for many women. In 1977, the federal government first enacted the Hyde Amendment, a budget condition that prohibits the use of federal funding for abortion coverage except in a very small number of extreme circumstances (such as it is, currently, cases of life endangerment, rape, or incest). The Hyde Amendment has been included in some form in every federal budget since then. As a result, even though Medicaid generally allows states to use federal funds to cover health care for low-income residents, states must use their own funds to cover abortion care in most circumstances. Thirty-three states have declined to expand Medicaid coverage with state funds and therefore restrict Medicaid's abortion coverage to the "Hyde exceptions."[9] Many states have further imposed their own restrictions or outright prohibitions on abortion coverage in other insurance plans—21 states restrict abortion coverage in their public employees' insurance plans, and 25 states prohibit private insurance companies from offering coverage for abortion care, either in the private market overall or on the state exchanges established by the ACA.[10] These policies limit a woman's use of her insurance coverage and thereby create significant financial barriers, particularly for low-income women, to receiving health care services.

In 2015, legislators in Illinois took steps to eliminate these barriers within their state, proposing a bill to repeal many of the harmful restrictions that had previously been enacted. House Bill 4013, which passed the House Committee on Human Services, would have repealed Illinois' prohibition on abortion coverage in Medicaid and the state employees' health plan. The bill also would have repealed a portion of section 4-100 of the Problem Pregnancy Health Services and Care Act that prohibits non-profit agencies that receive money from the Department of Human Services from using those grants to refer, counsel for, or perform abortions. This would have allowed non-profit agencies that provide services for women to help their clients reach the full range of health care they may require, including abortion care.

subsequent prescription—meaning that women can pick up a full year of a specific birth control method once they have found the type that works best for them. The Washington, D.C., City Council enacted a similar ordinance, Bill 20, which requires coverage of the dispersal of 12 months of contraception at a time.

In **New Jersey**, the legislature passed but Governor Chris Christie vetoed Assembly Bill 4604, which would have expanded Medicaid coverage for family planning services to individuals with incomes up to 200 percent of the federal poverty level.

SEXUAL HEALTH CARE

Three states moved toward increasing coverage of sexual health services, primarily attempting to expand the services that are offered in health insurance programs available for low-income residents. **Maine** enacted House Bill 213, which allows residents at or below 209 percent of the federal poverty rate to access pregnancy prevention services as well as testing and treatment for STIs and cancer. In **California**, the Assembly and one Senate committee passed Assembly Bill 94, which would have increased a range of services offered under

Medicaid, including raising the income limit for HIV/AIDS services to 500 percent of the federal poverty rate and instituting a program to increase the use of Pre-Exposure Prophylaxis (PrEP) treatment, a prevention option where patients can take a pill that will reduce the likelihood of contracting HIV if they are exposed. This would have given HIV/AIDS patients who need help affording care access to life-saving treatment. **Nebraska** Legislative Bill 77, which passed one committee, would have increased access for women at or below 185 percent of the federal poverty rate to services such as mammograms, breast exams, Pap smears, and other preventive and family planning health services.

FERTILITY TREATMENT

In 2015, three states considered enhancing coverage for fertility treatment. **Illinois** enacted Senate Bill 1764, which expands the definition of infertility in order to make it easier for individuals to get coverage for various forms of treatment.[11] **Connecticut's** Joint Committee on Insurance and Real Estate passed House Bill 5500, which would have required coverage for embryo, oocyte, and sperm cryopreservation procedures for people diagnosed with cancer, giving cancer patients the ability to access infertility treatment to help them have children in the future if they so choose. **Hawaii**, which already requires some coverage for infertility treatment, moved Senate Bill 768 / House Bill 864, which would have expanded access to in vitro fertilization (IVF) treatment, including by removing an existing requirement that a patient use only her partner's sperm to fertilize her eggs and that she have struggled with infertility for five years prior to treatment. The bill passed both houses, but in different forms, and is now in a conference committee where it could be considered in 2016.

PREGNANCY CARE

Two states advanced bills that will improve insurance coverage for health needs during pregnancy. **New York** passed Senate Bill 5972 / Assembly Bill 6780, which adds pregnancy to the list of qualifying events that allow an individual to purchase health insurance outside of regular open enrollment periods. See "Policy Highlight: Pregnancy as a Qualifying Life Event for Insurance Enrollment" on page 14. The **California** Assembly and two Senate committees passed an almost identical bill, Assembly Bill 1102. These bills would give those who become pregnant while uninsured the ability to purchase health insurance immediately, improving access to vital prenatal, labor, and delivery care, rather than forcing them to wait until after their child is born to purchase insurance.

SEXUAL ASSAULT SERVICES

Four states passed laws to expand coverage for sexual assault survivors, who are often forced to pay out of pocket for health services related to their sexual assault, such as rape examinations.[12] **Connecticut** enacted Senate Bill 966, which will allow sexual assault forensic examiners to provide care at a broad range of health care facilities rather than only at acute care hospitals. **Illinois** passed House Bill 3848, which will ensure that when a sexual assault survivor is given hospital emergency and forensic services, either their insurance company or a state fund will pay for them. **Louisiana** enacted House Bill 835, a broad law strengthening examination and investigation of sexually based crimes, including prohibiting health care providers from billing sexual assault providers and setting up a system for insurance or the state to pay for the costs. **Vermont** enacted Senate Bill 60, which expands coverage for sexual assault examinations through state funds and requires confidentiality for these services.

In New Jersey, the legislature passed but Governor Chris Christie vetoed Assembly Bill 4604, which would have expanded Medicaid coverage for family planning services to individuals with incomes up to 200 percent of the federal poverty level.

4 Improving the Sexual and Reproductive Health of Youth

SECTION 4

In 2015, 15 states considered proposals intended to improve the sexual and reproductive health of youth, and 13 new laws addressing the needs of youth were enacted by eight of them. Many strengthened their sexuality education programs, others provided more access to sexual health services, and several considered or implemented programs designed to address teen pregnancy and support pregnant and parenting youth.

SEXUALITY EDUCATION

Eight states took steps to expand or improve education around sexual health and sexuality. Six of them considered measures adding important information to their current sexual education curricula, while two others took a different approach. Five of these bills passed in four states, along with a resolution in another.

Alabama enacted House Bill 197, an "Erin's Law" that will now require schools to teach children how to recognize and report sexual abuse; these laws are named after Erin Merryn, a woman whose own sexual abuse experiences motivated her to campaign for such measures nationwide, and 10 states enacted such laws in 2014. **Arkansas** passed House Bill 1685, which incorporates dating violence awareness into the curriculum for health courses offered in grades 7-12. **California** adopted Assembly Bill 329, which now requires all students in grades 7-12 to receive comprehensive sexual health education including information on pregnancy, contraception, and STIs. See "Policy Highlight: Requiring Comprehensive Sexuality Education" on page 20. California also enacted Senate Bill 695, which requires the state agency charged with developing the state's sexuality education curriculum to consider adding a sexual harassment and violence education component to the next publication of the state's guidelines for health education. **Missouri's** House Bill 501 now requires course material regarding sexuality education to include information on sexual predators, online predators, and consequences of "inappropriate" text messaging. **Hawaii's** House and two Senate committees passed House Bill 459, which would have expanded existing sexual health information taught in schools and also changed the structure of enrollment in those classes so that parents or guardians of children below fifth grade must opt their children in, while parents or guardians of children in sixth grade or above must specifically opt their children out if they do not want them to participate. The **Massachusetts** Senate passed Senate Bill 2062, which would have required all sexual education that is provided to be age-appropriate, medically accurate, and include information about contraception and STIs.

Other states looked at different ways to support sexuality education for their youth. **Louisiana** enacted

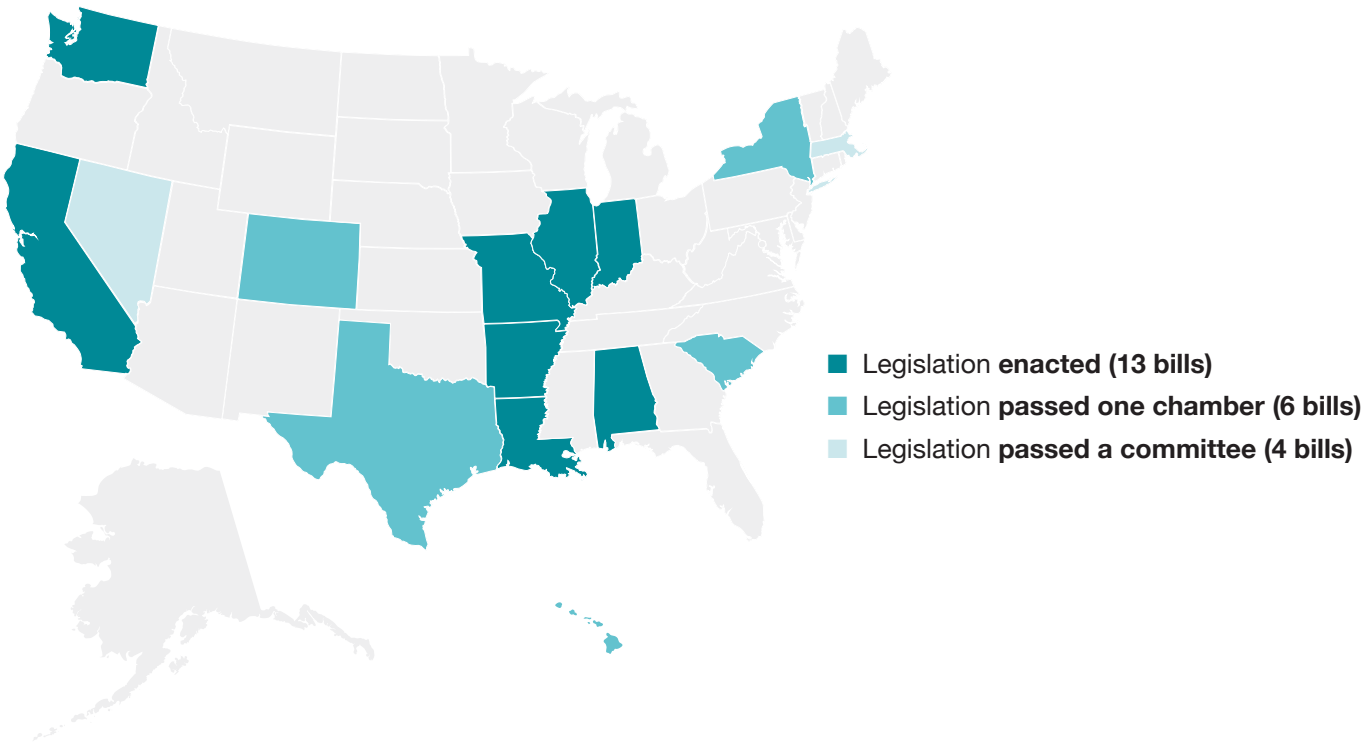
House Resolution 69, which directs the state's Board of Elementary and Secondary Education and the Department of Health and Hospitals to study and evaluate the effectiveness of the current state public school sexual education curriculum. Louisiana's House Committee on Education passed House Bill 326, which would have authorized a risk behavior survey of public school students in Orleans Parish in New Orleans. **New York's** Assembly and Senate Committees on Health passed Assembly Bill 1616 / Senate Bill 700, which would have established a grant program to support age-appropriate, medically accurate sexual health education in public schools.

SEXUAL HEALTH

Six states considered and three enacted legislation to improve the sexual health of youth. The **Illinois** Foster Children's Bill of Rights, House Bill 3684, is a comprehensive measure that, among many other provisions, requires that foster children at or over the age of 12 have access to age-appropriate, medically accurate information about reproductive health care, prevention of unplanned pregnancy, and prevention and treatment of STIs. Illinois also adopted Senate Resolution 90, which calls upon the Department of Children and Family Services and the Department of Public Health to develop solutions for HIV prevention and services for HIV-positive youth in the custody of the Department of Children and Family Services.

Five states moved legislation to expand access to HPV vaccinations for youth. Although the HPV vaccine is highly effective, vaccination rates remain low across the country, making legislation like this vital to combatting HPV. **Indiana** and **Washington** both adopted resolutions addressing the importance of HPV prevention: Indiana's House Resolution 63 calls upon the legislative council to develop a committee to look at improving the HPV vaccination rate in the state, and Washington's Senate Resolution 8635 recognizes the importance of HPV awareness. Indiana also enacted Senate Bill 461, which directs the state's Department of Health to create materials about HPV immunizations to be provided to parents and guardians of all sixth graders regardless of gender. This was a major step forward because in the past only parents or guardians of girls were required to receive information, even though the HPV vaccine is also recommended for boys. Currently,

MOVEMENT OF PROACTIVE LEGISLATION IMPROVING THE SEXUAL AND REPRODUCTIVE HEALTH OF YOUTH IN 2015



POLICY HIGHLIGHT: REQUIRING COMPREHENSIVE SEXUALITY EDUCATION

Under current California law, pupils in grades 7-12 must receive HIV/AIDS prevention education, but no mandate exists for the provision of other sexual health information. Local school districts can provide further sexuality education, as long as it is comprehensive, age-appropriate, and medically accurate information, but they may also forego it entirely.

In 2015, California enacted Assembly Bill 329, which expands existing law to require that all public school students in grades 7-12 receive comprehensive sexual health education from appropriately trained teachers, including information about STIs other than HIV/AIDS, all FDA-approved forms of contraception, parenting, abortion, and adoption. Although some local school districts already provide this information to their students, this bill will ensure that, for California youth, where one goes to school does not determine whether one receives adequate sexual health information and instruction.

Indiana has among the lowest HPV vaccination rates for boys, with only 13 percent of 13- to 17-year-old boys being fully vaccinated.[13] **Hawaii's** House Bill 458, which passed the House, and Senate Bill 394, which passed both the Education and Health Committees, would have required public schools to provide information about HPV and the available vaccines to the parents and guardians of all incoming sixth graders. Indiana's House Committee on Public Health passed House Bill 1359, which would have established a program to provide information about HPV to parents or guardians, health care providers, and other individuals approved to administer the HPV vaccine. **Nevada's** Senate Committee on Education passed Senate Bill 117, which would have added HPV to the list of diseases for which a student must be immunized before enrolling in public school. **South Carolina's** House Bill 3204, which passed the House, and Senate Bill 278, which passed one committee, would have allowed the Department of Health and Environmental Control to offer the HPV vaccine series for adolescent students enrolling in seventh grade.

PREGNANT AND PARENTING TEENS

Four states considered and two passed bills to address teen pregnancy in their states. **Arkansas'** House Bill 1534 was enacted, requiring the Arkansas Higher Education Board to develop a plan to address the prevention of unplanned pregnancy as well as to identify and address barriers for pregnant and parenting youth to accessing education. **California** adopted Assembly Bill 302, which requires that reasonable accommodations be made for any students who are breastfeeding in public schools, including access to a private room, permission to bring a breast pump on campus, a place to store breast milk, and adequate time to pump or breastfeed. The need to breastfeed or pump can be a significant barrier for parenting teens who want to continue their education; this law will make it easier for breastfeeding youth to continue attending school with their peers. **Colorado's** House passed House Bill 1079, which would have continued funding their current teen pregnancy prevention program until 2020. The **Texas** House passed House Bill 1143, which would have directed the Department of Family and Protective Services to collect information and publish a report on pregnant and parenting youth in their system and to develop resources and trainings for those parents and the caregivers who work with them.

PUTTING ABORTION IN THE CONTEXT OF WOMEN'S LIVES

OVER THE LAST SEVERAL YEARS, advocates for reproductive health, rights, and justice have piloted a new strategy that promotes proactive policies on reproductive health and rights as a core component of improving women's overall well-being. In three diverse states—New York, Pennsylvania, and Virginia—advocates and policymakers have come together to advance these new, more comprehensive agendas, a central tenet of which is that access to reproductive health care, including abortion, is one of the key policies necessary to promote women's equality and economic security.

The National Institute has had the unique opportunity to work with advocates in all of these states, supporting the development of their policy agendas, helping them link abortion and other reproductive health care with policies that promote healthy families and financial stability, and demonstrating public support for this kind of agenda. Over the course of 2015, public opinion research by the National Institute in all three states showed exceptionally strong support not only for these policies individually, but also for the agendas overall and elected officials who pursue a package of policies aimed at improving women's health and equality.[14] Voters in these states further concurred with advocates that access to reproductive health care, including abortion, is integral to women's equality and financial stability.

NEW YORK

In 2013, Governor Andrew Cuomo announced a 10-point Women's Equality Act to accomplish a slate of legislative ideas addressing women's equality, including policies relating to equal pay, sexual harassment, the treatment of pregnant women in the workplace, intimate partner violence, and abortion rights. The act was introduced as an omnibus bill in 2013 and championed by legislators and advocates for the next two years. A coalition encompassing nearly 1,000 organizations and scores of grassroots activists formed to demonstrate public support and build political pressure for the 10-point Women's Equality Act across the state. Reproductive rights groups, at the forefront of that coalition, were able to rally unprecedented support for the entire slate of issues, winning allies in large part by affirmatively emphasizing that, in addition to protecting access to abortion under state law, the Women's Equality Act constituted one of the few pieces of proactive abortion legislation in the country at that time.

Support for the Women's Equality Act was extremely high throughout the course of this campaign—and inclusion of the abortion-specific bill in the package meant that New York's vocal and passionate pro-choice base rallied on behalf of all 10 issues in the agenda, breathing new momentum into many bills that advocates and legislators had been trying to advance for years.

Public opinion research conducted by the National Institute further demonstrated both the need for and public affirmation of these proposals. A 2014 survey found that 84 percent of those polled supported the full legislative package, 73 percent preferred that the agenda include legislation to address access to abortion, and 68 percent were more likely to support an elected official who voted for the whole package.[15]

Advocates took advantage of this support by broadening the grassroots base for the Women's Equality Act to include supporters for the other issues it addressed, energizing long-standing and new activists alike. As National Institute President Andrea Miller summed it up, the Women's Equality Act recognizes that "You can't have women's equality without reproductive rights, but reproductive rights alone are not sufficient to guarantee that women are treated equally."[16]

This omnibus legislation was passed by the New York Assembly twice in two years but stalled each session in the anti-choice Senate. In 2015, legislators split the package into stand-alone bills (Assembly Bills 506, 4272, 5360, 6075, 6221, 6262, 6354B, 6547B, 7189, and 7317) on each of its components, all of which also passed the Assembly; all but the abortion rights measure were approved by the Senate (Senate Bills 1-8 and 5605) and became law.

PENNSYLVANIA

Inspired by the efforts in New York and energized by new reports showing the abysmal state of affairs for women's health and rights in Pennsylvania, in 2013 advocates and legislators in the state began to develop the Agenda for Women's Health, a comprehensive, explicitly pro-choice set of legislative proposals addressing issues such as medically accurate abortion care, employment opportunities and fair treatment on the job for women who are pregnant or nursing, safety and sexual assault, and a host of other related concerns. Introduced by the Bipartisan Women's Caucus of the Pennsylvania Legislature, this agenda has been a catalyst for legislative action and advocacy. According to Susan Frietsche, senior staff attorney at the Women's Law Project, "One of the purposes of the Pennsylvania Agenda for Women's Health is to show that there are many, many things a state legislature should be doing to protect women's health. Having a lot of bills in our agenda conveys this message and also spreads ownership of the agenda around to lots of supportive legislators, giving us a broader base of legislative support."[17]

In 2015, advocates launched the Campaign for Women's Health, a broader public education and advocacy campaign that promotes the agenda and related legislation to ensure that Pennsylvanians are aware of the many challenges facing women and motivated to take action to change those conditions. With a new website, http://pa4womenshealth.org/, a strong (and explicitly) pro-choice statement of principles, a broad coalition of more than 35 organizations, and a steering committee (composed of AccessMatters, the ACLU of Pennsylvania, Keystone Progress Education Fund, New Voices for Reproductive Justice, Planned Parenthood Pennsylvania Advocates, and the Women's Law Project), this campaign has the potential to achieve great policy change in Pennsylvania while engaging new audiences and activists in the fight for women's health, rights, and equality.

Since the beginning of the campaign, three bills have passed. Senate Resolution 62 calls for a study of the "cliff effect," an issue created when a working parent or guardian earns just enough to lose eligibility for the very programs that allow them to work, such as child care assistance. House Bill 1796 prevents landlords from using "nuisance" ordinances to evict domestic violence victims for calling 911 for help. House Bill 1901 criminalizes non-consensually posting sexually explicit or nude photos of a former partner on the Internet.

One of the main sponsors of the legislation, state Rep. Dan Frankel, has said, "These bills...really go to the roots of what concerns women in Pennsylvania."[18] State Sen. Judy Schwank, one of the Bipartisan Women's Caucus co-chairs, has said: "Women and families play a pivotal role in the overall health of our communities and the commonwealth. To know that there are still many things we can do to help deliver better policies, better laws, and better protections for all means we still have some work to do."[19] Both advocates and legislators plan to continue to add new legislation to the agenda; the Women's Law Project reports that already, the agenda is "becoming more bipartisan, which will help some of the bills to pass" and that many of the bills are already starting to look likely to pass within the next two years.

Public opinion research conducted by the National Institute further demonstrated both the need and public support for these proposals. A 2014 survey found that 80 percent of those polled supported the full legislative package, more than 70 percent preferred that the agenda include bills addressing access to abortion, and 68 percent were more likely to support an elected official who voted for the whole package. Moreover, 83 percent of those polled believed that a woman's ability to control when or whether she has children is an important part of women's equality, and 72 percent believed it is related to her financial stability, demonstrating the public's awareness of the link between policies to ensure access to contraception and abortion and women's advancement in the workplace and at home.[20]

VIRGINIA

Intrigued by the progress of their colleagues in New York and Pennsylvania and emboldened by a change in the political climate in their state, advocates and legislators in Virginia pursued a broad Women's Equality Agenda in 2015, believing that the time was ripe for elected officials to support a full agenda to "secure women's health and safety, advance our economic opportunity, and promote women's democratic participation."[21] Launched at the beginning of session, the Virginia Women's Equality Agenda was championed by legislators and the new Virginia Women's Equality Coalition, made up of nine major advocacy groups—AAUW of Virginia, League of Women Voters of Virginia, NARAL Pro-Choice Virginia, National Latina Institute for Reproductive Health Virginia LAN, New Virginia Majority, Planned Parenthood Advocates of Virginia, Progress Virginia, Virginia Chapter of the National Organization for Women, and Women Matter. According to Anna Scholl, Executive Director of ProgressVA, one of the primary advocacy partners supporting the agenda, "A key goal in launching the Women's Equality Coalition was to more closely tie together reproductive rights and economic security to make a comprehensive argument for the advances we need in order for women and families to succeed."[22]

More than 15 legislators signed on to support the agenda and introduced a number of pieces of legislation under its umbrella. These policies range from universal paid sick days and equal pay, to non-partisan redistricting, to providing unemployment benefits for victims of domestic violence who are forced to leave their job, and include three bills addressing reproductive health specifically: Senate Bill 733, which would have repealed the state's mandatory waiting period and ultrasound requirement, and two bills intended to protect and expand access to contraception (House Bill 2287 and Senate Bill 1277). In the first year, three bills relating to domestic and intimate partner violence (HB 1796 and HB 1901) and family support (SR 62) passed.

The National Institute conducted public opinion research, released in conjunction with NARAL Pro-Choice Virginia and ProgressVA, finding broad support for the goals of the agenda and the proposals within it. Seventy-five percent of voters believe that more work remains to be done to ensure equality for women in Virginia, and 79 percent support the full Women's Equality Agenda. Moreover, 64 percent see the connection between a woman's financial stability and her ability to control when and whether to have children, drawing the links between the need for policies to promote and protect women's access to contraception and abortion and women's ability to provide for themselves and their families.[23] Like voters polled in New York and Pennsylvania, those in Virginia said that they would be more likely to vote for an elected official who supported the full Women's Equality Agenda.

Although none of the bills passed in 2015, many of the proposals were considered in committee, which gave advocates and legislators an opportunity to educate their constituencies about the issues and draw attention to the need for these policies in the future. Moving forward, the Virginia Women's Equality Coalition will continue to press these and other important concerns for women and their families and bring new activists into the movement to advocate for women's equality, health, and economic security in the state. Scholl "would strongly encourage other states to consider a similar approach, [with] reproductive rights...a non-negotiable part of the agenda ....This has been a great platform to strengthen and grow our network, and we're excited for the future."[24]

5 Promoting Healthy Pregnancies, Parents, and Babies

In 2015, more than half of the state legislatures across the country considered legislation designed to promote healthy pregnancies, produce better birth outcomes, and support new parents. Among the 38 new laws and resolutions that states enacted, many expanded employment protections for breastfeeding mothers, pregnant women in the workplace, and new parents. **A number of these new laws were the result of many years of advocacy on the part of broad coalitions of women's health, rights, and justice advocates and are significant achievements for women and families.**

HEALTH CARE FOR PREGNANT WOMEN

Twelve states considered and nine enacted legislation designed to expand access to or improve the quality of health care for pregnant women, for a total of 12 new measures passed.

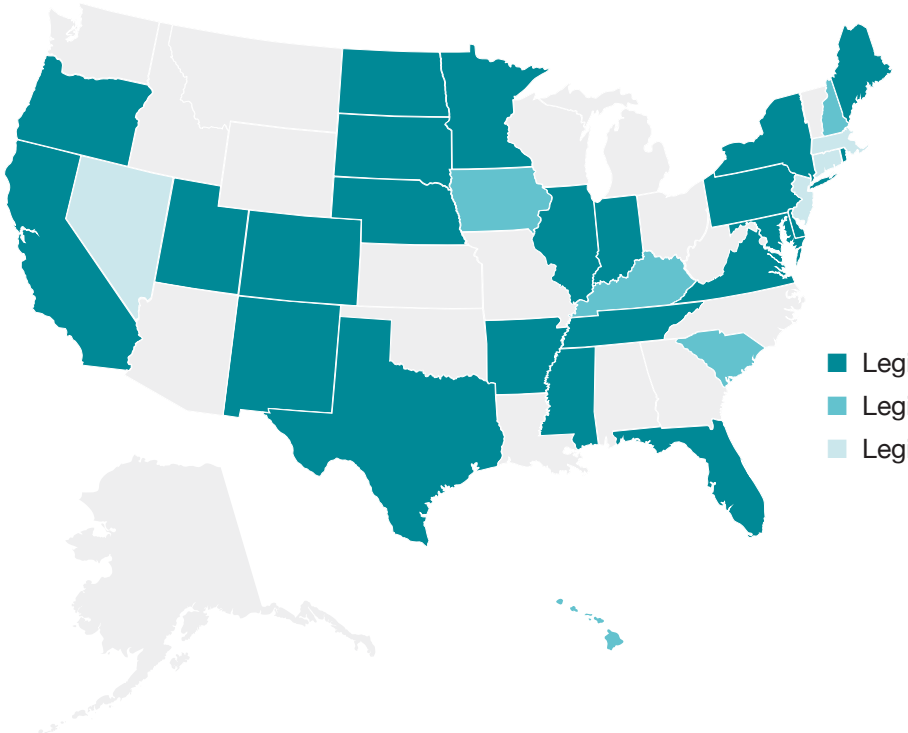
Six states focused on the health of incarcerated pregnant women and three of these measures passed. **Maine** joined the 21 other states that have prohibited the shackling of pregnant women[25] by passing Senate Bill 353, a law that addresses some of the weaknesses in such legislation in other states. Championed by the Maine Alliance for Reproductive Freedom, the Maine Prisoner Advocacy Coalition, and a number of medical professionals, public health advocates, faith groups, prisoner rights organizations, and women's rights groups, Senate Bill 353 was a major victory for pregnant women in the state. It prohibits the shackling of pregnant women at any point in pregnancy; although there is an exception allowing corrections officers to use restraints if they determine that there are extraordinary circumstances, a health care provider can override that determination and require a corrections officer to immediately remove the restraints. The law also prohibits shackling during labor and delivery for any reason. Moreover, the measure prohibits a corrections officer from being present in the room while a pregnant woman is in labor or delivery unless medical professionals specifically request the officer's presence.

Several of these states considered revisions to their existing anti-shackling laws. **New York** passed Senate Bill 983 / Assembly Bill 6430, which prohibits the shackling of incarcerated women for eight weeks postpartum; it also enacts some critical amendments to New York's existing anti-shackling law as a result

of strong advocacy by many groups, including the Correctional Association of New York, whose recent in-depth report on the treatment of incarcerated pregnant women spurred the passage of the legislation.[26] The new law limits even further the situations in which any restraints can be used and the types of restraints permitted, prohibits corrections officers from being present in the labor and delivery room unless specifically requested by a medical provider, and contains new provisions requiring notice about the law's protections for all incarcerated people as well as new requirements for careful documentation of the treatment of incarcerated pregnant women. **Texas** enacted House Bill 1140, an amendment to an existing law that requires adequate care for pregnant women in county jails. The new law adds an accountability requirement for enforcement agencies, in response to widespread reports of non-compliance, described in "Policy Highlight: Strengthening Anti-Shackling Laws for Incarcerated Pregnant Women" on page 28. **Minnesota's** Senate considered Senate Bill 1269, which passed one committee and would have improved the state's existing anti-shackling law by further limiting the types of restraints that can be used on incarcerated pregnant women and increasing the ability of advocacy organizations to provide educational materials and pregnancy and parenting resources to incarcerated pregnant women. The **New Mexico** Senate passed Senate Bill 363, which would have required courts to take into account and adopt a presumption that a woman who is pregnant or lactating should be eligible for release or bond; it would also have given courts further discretion to grant a woman due to give birth a temporary leave of absence from incarceration prior to her due date and after the birth of her child. The department of corrections would also have been required to develop policies to allow incarcerated women who are lactating to express milk to keep up their milk supply while incarcerated. Finally, **New York's** Assembly passed Assembly Bill 1347 / Senate Bill 5729, which would have prohibited solitary confinement for incarcerated pregnant and postpartum women as well as women living with infants in prison programs. **New Jersey's** Assembly considered Assembly Bill 4155, which passed through one committee and would have prohibited shackling of pregnant incarcerated women during labor and delivery.

Five states focused on expanding both the range of health care that advanced practice clinician midwives can provide and the settings in which health care can be provided in order to expand access to obstetrical

MOVEMENT OF PROACTIVE LEGISLATION PROMOTING HEALTHY PREGNANCIES, PARENTS, AND BABIES IN 2015



care, and three passed such measures, for a total of six new laws. **California** enacted Senate Bills 407 and 408, which together expand the scope of care that midwives and midwives' assistants can provide. **Maryland's** House Bill 9 will allow direct-entry midwives to become formally licensed in order to expand the care they offer to include home births. And Maryland Senate Bill 187 authorizes the state hospital association and other entities to form a working group to make recommendations for legislation to expand the availability of obstetrical care throughout the state. **New Mexico** enacted two new laws that will expand access to obstetrical care: Senate Bill 299 expands the scope of practice for advanced practice clinicians, including nurse midwives, and generally removes barriers to their ability to provide appropriate care for their patients, while House Bill 84 creates a new licensing procedure for freestanding birthing centers, expanding the options for birthing mothers and allowing midwives to provide care in the best setting for their patients, which could include a hospital, birthing center, or home. These bills were widely supported by medical groups and advocates, including by reproductive justice groups such as Young Women United. The **Indiana** House passed House Bill 1548, which would have removed a requirement in state law that midwives have a "collaborative" agreement with a physician, thus allowing midwives to more widely offer birthing options to their patients. The **New York** Assembly and one committee in the New York Senate passed Assembly Bill 446 / Senate Bill 4325, which would have licensed freestanding birthing centers and expanded birthing options for New York women.

Five states considered, and three states passed, legislation intended to more generally expand and promote care for pregnant women. **Illinois** enacted House Bill 421, which broadly expands the scope of practice for advanced practice nurses and also allows them to provide prenatal HIV testing without a physician's participation. The **Rhode Island** Legislature passed Senate Resolution 419, calling on the state's Department of Health director to study current medical screening practices for postpartum depression, create educational materials about postpartum depression, and make those resources available to relevant health care facilities. **Virginia** enacted House Bill 1657, giving additional autonomy to pregnant patients by allowing women to include special instructions in their advance directives pertaining to whether they want life-prolonging treatment if they are pregnant when diagnosed with a terminal condition. **California** Assembly Bill 50 passed the Assembly and Senate and would have required the Department of Health Care Services to create a nurse home visiting program for Medi-Cal eligible pregnant and parenting women. Governor Jerry Brown vetoed the bill, citing financial concerns. **Maine's** House considered House Bill 787, which passed one committee and would have required the Department of Health and Human Services to report on Maine's efforts to achieve the pregnancy and birth goals of Healthy Maine 2020, a slate of public health goals in 13 areas to improve the health of Maine residents.

MATERNAL AND INFANT HEALTH

Four states considered and one state enacted legislation intended to study and improve maternal health and reduce mortality and morbidity. **Maryland** enacted Senate Bill 74, which creates a task force to study maternal mental health and make recommendations for legislation, policy initiatives, funding requirements, and budgetary priorities based on needs found in the state and successful models in other states. **Colorado** House Bill 1111, which passed the House and one Senate committee; **Hawaii** Senate Bill 304, which passed both houses and is now in conference committee; and **South Carolina** House Bill 3251, which passed the House, all considered establishing maternal mortality and/or morbidity review committees.

In **New Mexico**, both the House and Senate considered legislation—House Bill 509 and Senate Bill 116, respectively—that would have created a statewide perinatal collaborative to improve health outcomes for pregnant women and newborns; each bill passed one committee.

Three states enacted legislation designed to prevent infant mortality. **Indiana** House Bill 1004 creates a new grant program, the Safety PIN (Protecting Indiana's Newborns), which will provide funding for programs aimed at reducing infant mortality rates in at-risk populations. **Minnesota** Senate Bill 1504 extended the mandate of an existing task force on maternal and child health to encourage it to study and research prevention

of stillbirths. **Mississippi** House Bill 910 creates the Infant Mortality Reduction Collaborative, which will engage in a number of activities, including applying for grants aimed at reducing infant mortality and making policy recommendations annually to the Legislature about best practices to prevent infant mortality.

PREGNANCY DISCRIMINATION

Ten states considered and five enacted bills that would improve the treatment of pregnant women on the job, following in the footsteps of the 12 states that adopted similar laws in 2014. In 2015, Nebraska, New York, North Dakota, and Rhode Island all enacted versions of a Pregnant Workers Fairness Act. In **Nebraska**, as described in "Policy Highlight: Broad Protections for Pregnant Workers" on page 31, Legislative Bill 627 is a broad law that will require employers to provide a range of reasonable accommodations to employees who are pregnant, postpartum, or have related medical conditions, and it will prohibit employers from discriminating on the basis of pregnancy, recent childbirth, or related medical conditions in hiring, advancement, promotion, or any of the terms, conditions, or privileges of employment. **Rhode Island** passed a similarly expansive Pregnant Workers Fairness Act, House Bill 5674 / Senate Bill 276, which also adds that employers cannot require an employee to take leave due to pregnancy, childbirth, or related

POLICY HIGHLIGHT:
STRENGTHENING ANTI-SHACKLING LAWS FOR INCARCERATED PREGNANT WOMEN

Texas is one of the growing number of states that prohibits the shackling of pregnant incarcerated women during labor and delivery. It is also one of a few states that specifically requires all county jails to have a plan to address the physical and mental health needs of pregnant women while incarcerated. Despite this, advocates in Texas had been growing increasingly concerned that, while these laws were helpful, they were not being enforced. This concern is not limited to Texas—advocates all over the country, including in California, Massachusetts, and Pennsylvania, have succeeded in passing anti-shackling laws only to witness a lack of enforcement.

During its 2015 legislative session, Texas took an important step toward better care for pregnant incarcerated women by enacting House Bill 1140, which amended existing law to require not only that pregnant women not be shackled and that each county jail have a plan for their mental and physical health, but also that there be a documented level of accountability from each sheriff in the state. Under the new law, each sheriff must report to the Commission on Jail Standards about their implementation of policies and procedures to provide adequate care to pregnant incarcerated women and must include in that report a long list of detailed requirements, including the health care provided to each pregnant prisoner, nutritional standards, work assignments, housing conditions, and descriptions and reasons for any situation in which a pregnant prisoner has been restrained. Texas House Bill 1140 was supported by a wide coalition of advocates, including women's health and rights organizations, interfaith organizations, and those who work to improve the criminal justice system, all of whom agreed that reporting on and investigating actual practices in the prison system is an important first step to rectifying any violations.

medical conditions, and that employers must provide written notice to employees of these protections. This law was supported by a broad coalition of advocates and legislators. **New York** Senate Bill 8 / Assembly Bill 4272 adds pregnancy to the existing list of conditions for which an employer must offer reasonable accommodations. Finally, **North Dakota** House Bill 1463 is a much more limited reform that adds pregnancy to the list of conditions for which an employer must provide reasonable accommodations, as long as the accommodations do not "disrupt or interfere" with the normal course of business.

Several other states considered but have not yet enacted similar laws—the Houses of Representatives in **Kentucky** (House Bill 218) and **New Mexico** (House Bill 409) passed bills that mirror the broad Pregnant Workers Fairness Acts enacted in Nebraska and Rhode Island. **New Jersey** considered a related bill, Assembly Bill 4264, which passed one committee and would have required colleges and universities to provide their pregnant students with reasonable accommodations and prohibited them from requiring those students to take a leave of absence or limit their studies while pregnant.

Florida enacted Senate Bill 982, which adds pregnancy to the state's antidiscrimination in employment statute. **Connecticut**, which already has a law prohibiting discrimination against pregnant employees, considered House Bill 6252, which passed one committee and would have amended that law to prevent employers from forcing a pregnant employee to take an accommodation or leave of absence if she did not request it. The **Virginia** Senate passed Senate Bill 785, which would have added pregnancy, childbirth, and related medical conditions, as well as sexual orientation and gender identity, to the list of reasons for which employers may not discriminate against employees.

BREASTFEEDING

Twelve states considered legislation that would have expanded or enacted new protections for nursing mothers in the workplace, in public, and when called upon to serve jury duty—11 pieces of legislation became law. **Illinois** enacted Senate Bill 344, a unique law entitled the Lactation Accommodation in Airports Act, which will now require all major airports in the state to provide lactation accommodations other than a bathroom for nursing mothers. **Texas** and **Utah** enacted new laws requiring public employers to provide accommodations to public employees who are breastfeeding and prohibiting public employers from discriminating on the basis that an employee is nursing. Texas House Bill 786 requires public employers to give public employees reasonable breaks to express breast milk in a private place that is not a multiple-user bathroom. Utah House Bill 105 amends the state's

Illinois enacted Senate Bill 344, a unique law entitled the Lactation Accommodation in Airports Act, which will now require all major airports in the state to provide lactation accommodations other than a bathroom for nursing mothers.

existing employment protections to ensure that women who are breastfeeding or have medical conditions related to breastfeeding cannot be discriminated against on that basis. Utah House Bill 242 requires that public employees be given reasonable breaks to express milk, a private place that is not a bathroom for that purpose, and a refrigerator in which to store the expressed milk. A similar bill in **Nevada**, Assembly Bill 306, passed its first committee. The **New Hampshire** Senate and the House Committee on Commerce and Consumer Affairs passed Senate Bill 219, which would have required employers to provide breastfeeding mothers with break time and a private place, not a bathroom or toilet stall, in which to express milk. The bill would also have provided nursing mothers with an exemption from jury duty and created a state advisory committee on breastfeeding; the bill is still pending and will be considered in the 2016 legislative session.

Colorado (House Bill 1164), **Delaware** (Senate Bill 84), **Pennsylvania** (Senate Bill 210), and **Utah** (House Bill 154) enacted laws automatically exempting breastfeeding women from jury duty. The **Indiana** Senate passed the related but much more limited Senate Bill 99, permitting nursing women only the ability to request an accommodation rather than guaranteeing one.

Four states considered legislation designed to protect the rights of breastfeeding mothers. **New York**, which already requires nursing accommodations in the workplace and has a breastfeeding bill of rights, passed Senate Bill 5183 / Assembly Bill 7202, which requires that information about those rights be posted by all employers along with the other types of posted rights in employment settings. **South Dakota** (Senate Bill 77) and **Virginia** (House Bill 1499 / Senate Bill 1427) enacted breastfeeding bills of rights, allowing breastfeeding mothers to nurse wherever they are legally allowed to be and prohibiting discrimination against them on that basis. South Dakota's new law also prohibits municipalities from banning breastfeeding in public. The **Texas** House also considered a breastfeeding bill of rights, House Bill 232, which passed one committee.

EXPANDED FAMILY LEAVE

Sixteen states considered and five enacted legislation designed to expand family leave options for parents.

Several states adopted laws expanding leave options for their state employees. **Arkansas** House Bill 1468 adds parental leave for the birth or adoption of a child to the list of reasons that public employees can donate unused leave to another public employee, a practice often called "shared leave." The Arkansas House also passed House Bill 1426, which would have entitled female state employees to take six weeks of partially paid maternity leave upon the birth of a child. Although maternity

> North Dakota enacted two bills that, among other things, increase the amount of sick leave that an employee can use upon the birth of a child from six weeks to 12 weeks.

leave is critical, most other states have considered and experts recommend that leave programs extend to all new parents, not just mothers, in order to promote full equality for women and ensure that fathers' rights to parent are protected as well. **California** Assembly Bill 375 allows certified school employees to get additional wage replacement when on unpaid parental leave for up to five months. **North Dakota** enacted two bills that, among other things, increase the amount of sick leave that an employee can use upon the birth of a child from six weeks to 12 weeks (House Bill 1387) and also amend existing law so that this leave can be taken within the first six months—rather than six weeks—after the birth or adoption of a child (House Bill 1244). **Tennessee** also expanded its state employee family leave law. Senate Bill 950 now allows each state employee to take up to 30 days of sick leave, regardless of whether the other parent of the child is a state employee as well—under existing state law, if both parents were state employees, they could use only 30 days total between them.

POLICY HIGHLIGHT: BROAD PROTECTIONS FOR PREGNANT WORKERS

Across the country and in Congress, advocates are urging their elected representatives to do more to protect pregnant workers' rights. As was highlighted by *Young v. United Parcel Service*, 135 S. Ct. 1338 (2015), in which a UPS employee sued the company for refusing to allow her to lift lighter burdens while pregnant, employers are not necessarily obligated under state or federal law to provide the types of basic accommodations that would make it possible for a pregnant employee to stay on the job. This lack of accommodations is both harmful and misguided, given that roughly 65 percent of first-time pregnant women continue to work through their pregnancies and return to work within a year,[27] as well as the fact that pregnant women make up only about 2 percent of the working population, meaning that accommodations would impose little cost on businesses but have a significant impact on retention and continued employment.[28] For these reasons, advocates have been urging legislators—successfully, in a growing number of cases—to enact pregnant workers fairness acts. These bills vary by state and in Congress, but they generally provide a measure of protection to pregnant workers and ensure that a woman who is pregnant will not lose her job simply because, for example, she needs to bring a bottle of water with her as she stocks shelves or needs to sit on a stool rather than stand at her cash register.

By the end of 2015, 15 states, four cities, and Washington, D.C., had passed such laws.[29] Nebraska's Legislative Bill 627, enacted in 2015, was a standout example of this type of legislation, ensuring broad protections for pregnant workers in that state. Legislative Bill 627 requires employers to provide reasonable accommodations to employees who are pregnant, postpartum, or have related medical conditions, including by providing additional breaks, modified work schedules or light duty assignments, and appropriate facilities for expressing breast milk; allowing them to sit or take rests; and making other accommodations. The new law also prohibits employers from discriminating on the basis of pregnancy, recent childbirth, or related medical conditions in hiring, advancement, promotion, or any of the terms, conditions, or privileges of employment. This bill was supported by a broad coalition of advocates, including the ACLU of Nebraska, the National Women's Law Center, and Voices for Children in Nebraska, and passed the Legislature unanimously.

SECTION **5**

Four states considered creating or expanding paid family leave programs for broader groups of state employees. **Colorado** House Bill 1258 and **Connecticut** House Bill 6932 each passed several committees and would have created a paid family leave program with at least partial wage replacement for 12 weeks for both public and private employees. In Colorado, a number of women's health and rights groups, small business groups, and others supported the bill, and in Connecticut, a well-organized, strong coalition of more than 50 organizations have formed the Connecticut Campaign for Paid Family Leave, which will continue to promote this legislation in the future. **Illinois** House Bill 166, which passed two committees, and **Maine** House Bill 493, which passed one, would have created more limited programs, with partial wage replacement available for six weeks. Illinois also considered Senate Bill 1238, which passed one committee and would have allowed grandparents to take 12 weeks of unpaid leave to care for a new grandchild.

Finally, three states considered legislation to study paid and unpaid leave programs. **Hawaii** House Bill 496, which passed both houses of the state legislature in different forms and is now in conference committee, would require the state lieutenant governor and Department of Labor and Industrial Relations to do a study on the costs and feasibility of a paid family leave program. **Minnesota** Senate Bill 779, which passed one committee, and **Virginia** Senate Joint Resolution 285, which passed the Virginia Senate, would also have required state agency studies on state-based family leave programs.

Apart from paid or unpaid leave, five states considered and one enacted laws that would improve the conditions of employment for parents. **Oregon** House Bill 2600 requires employers to maintain full group health benefit coverage for parents who take family leave under state law. The **Iowa** Senate passed Senate Bill 375, which would have prohibited employers from terminating or discriminating against employees who take a leave of absence of up to eight weeks to adopt a child. A similar bill, House Bill 116, passed through one committee in the Iowa House of Representatives. In **Massachusetts**, a joint committee passed Senate Bill 92, which would have ensured that employees on maternity leave for the adoption of a child are entitled to the same benefits as those on leave for the birth of a child. In **New Jersey**, both Senate Bill 1519, which would have required employers to add to their already existing posted notices about the state family and medical leave law information on all the other types of temporary and disability-related leave that parents might be able to take upon the birth of a child, and Senate Bill 3129, which would have required the Department of Labor and Workforce Development to maintain a website with information about family leave, passed one Senate committee. Finally, the **New York** Assembly passed Assembly Bill 3870, which would have added family leave to the reasons for which an employee may use their disability benefits and expanded disability benefits for employees statewide.

RECLAIMING THE ABORTION DEBATE

EVEN IN STATES WITH SOME OF THE MOST RESTRICTIVE ANTI-ABORTION LAWS in the country, advocates and legislators are putting forward proactive policy ideas that forefront the need to advance access to abortion and connect it to other areas of women's lives. In these states especially, it is important to define what a successful campaign entails, as enacting legislation is not the sole marker of progress. The National Institute has worked with the advocates in this case study to develop strategies that allow them, in the context of their state, to bring forward the issue of abortion and begin to have a public dialogue about the role of reproductive health and abortion in women's lives. In Georgia and Texas, in particular, advocates and legislators have introduced legislation that goes on the offensive, begins to reclaim the debate on abortion, and has the power to build a broader base of supporters and rally them around building a future that we can all support.

GEORGIA

A group of advocates in Georgia promoted a broad reproductive justice resolution in 2015 that "advocates for public policy that will improve access to affordable, comprehensive health care, remove barriers to workforce participation, address issues of racial disparity, and acknowledge all kinds of Georgia families."[30] House Resolution 746 was announced in March 2015 by two champion legislators, Representatives Nikki Randall and Simone Bell, and the new Thriving Families Georgia Coalition, led by the Feminist Women's Health Center.

Crafted with assistance from the National Institute and Forward Together, the resolution lays out a vision for Georgia policy that addresses a host of barriers that women and families face to living full and healthy lives, putting access to abortion and other reproductive health care squarely in context. "Protecting the health of the entire woman from annual checkups to postnatal care is the goal of the resolution," said co-sponsor Rep. Bell. "By addressing the issues of working mothers and racial disparities in relation to access to health care, Georgia can work to strengthen families from within."[31] This approach allows both the public debate and public policy to reflect the lived experiences of women and families who need a broad and integrated approach to health and well-being—where access to abortion and reproductive health care is one vital piece of the puzzle for a healthy, supportive policy structure.

This broad vision has also proved to be a valuable tool to bring together new allies and supporters—both in the statehouse and beyond. The resolution helps explain to new allies who are hesitant to engage on abortion how the broad range of issues they care about are integrally connected to access to comprehensive reproductive health care and gives them a platform and tool to help connect those issues for others. The resolution is also a key part of growing a more diverse activist base: The coalition is reaching new activists across the state to get them excited about the resolution and engaging them in the political process by connecting around the issues they and their communities face.

The resolution is only a first step for Georgia advocates, who have big plans for their state. According to Kwajelyn Jackson, Community Education & Advocacy Manager at Feminist Women's Health Center, "We hope that this resolution can be a foundation from which a platform of proactive bills can be developed and ultimately passed. We hope to formalize and solidify a coalition of organizations that are interested in a continuing proactive agenda, as well as a defensive one, that is varied across mission and focus, but aligned in values and communities served. We hope that this is a step forward for access in Georgia that will make way for greater gains to follow."[32]

TEXAS

In 2015, a group of reproductive health advocates in Texas came together to create the Trust. Respect. Access. campaign—a "multi-year campaign to restore trust in Texans to make their own reproductive health care decisions, respect for health care professionals' judgment, and access to the full range of reproductive health care, from sex education and birth control to abortion."[33] The campaign, spearheaded by the ACLU of Texas, NARAL Pro-Choice Texas, National Latina Institute for Reproductive Health, Planned Parenthood Texas Votes, Texas Freedom Network, Texas Research Institute, and Whole Woman's Health, provides a vision for what Texas needs in order to fully support the reproductive and sexual health and well-being of all Texans.

In the campaign's first year, advocates worked with champion legislators to introduce a series of bills that would address the needs they had identified and highlight the problems with existing state law. "After our legislature passed one of the most restrictive abortion laws in the country, we realized it was time to go on the offensive and begin changing the public conversation emerging from the Capitol," said Terri Burke, Executive Director of the ACLU of Texas. "We joined forces with a broad and united coalition to introduce, for the first time, a multi-pronged slate of abortion-out-loud legislation. We used it as a platform to engage activists, to recruit new champions to talk about abortion, and to set the terms of the debate for the inevitable pivot to defense with the ultimate goal of building a newly ignited offense to deploy in all areas of the state, at all times of the year."[34]

Senate Bills 88 and 468 and House Bill 78 improve access to contraception and comprehensive sexual education. To ensure respect for health care professionals' medical and ethical judgment about patient care, legislators introduced House Bill 708, which would protect the judgment of doctors and patients against the mandates of politicians. To guarantee access to safe, timely abortion care for all Texans, legislators introduced House Bill 709, which would repeal harmful and unnecessary waiting periods for women accessing abortion care.

Advocates launched a public education website, http://trustrespectaccess.org, detailing the Trust. Respect. Access. campaign, each policy plank, and what Texas needs in order to be truly supportive of reproductive health. They also hosted several events in support of the legislative package and organized social media campaigns asking legislators and the public to #TrustTX. As Kathy Miller, President of the Texas Freedom Network, put it, "Texas isn't an easy place to advocate for reproductive health, rights, and justice! But having a proactive, comprehensive set of bills to promote allowed us to disseminate a positive message through the press and with supporters: Trust. Respect. Access. This positive message was very effective in base-building efforts and kept the 'Stand with Wendy' activists engaged through a difficult legislative session."[35]

6 Conclusion: A Proactive Year

SECTION **6**

OVER THE COURSE OF 2015, 40 states and the District of Columbia moved or passed a total of 143 proactive policies aimed at improving reproductive and sexual health for their residents. Advocates and elected officials worked together to pass 76 pieces of legislation ranging from allowing pharmacists to prescribe birth control to expanding family leave to protecting women seeking abortion services from misinformation and breaches of their confidentiality. Many of these successes resulted from years of collaboration between advocates and legislators, who built long-term support and tirelessly advocated on behalf of these important proposals and the people they are intended to help.

At the same time, advocates and legislative champions advanced creative ideas, such as the expansion of insurance coverage for abortion, assistance for pregnant and parenting teens, and protection from discrimination for women's reproductive health choices—forward-looking proposals that respect women's health, rights, dignity, and autonomy and form the basis of what will become the policy successes of years to come.

THE NATIONAL INSTITUTE FOR REPRODUCTIVE HEALTH applauds not only the many legislative victories of 2015, but also the burgeoning work of state advocates to identify and promote new, proactive policy proposals and build the grassroots and political support needed to get them passed. We are proud of the role that we have played in supporting this emerging trend, and we encourage advocates who are interested in pursuing these types of policy initiatives to contact us or to connect directly with the many local and state advocates who were instrumental in moving these proposals forward. We look forward to continuing to support and partner with reproductive health, rights, and justice advocates across the country and to celebrating new successes in 2016.

Appendix

ST	BILL	TITLE AS FILED	SECTION	PAGE(S)
AL	AL H 197	Sexual Abuse of Children Curriculum	4. Improving the Health of Youth	18
AL	AL H 247	Prescription Drugs Redispensing	2. Protecting and Expanding Access	9
AR	AR H 1426	Paid Maternity Leave for State Employees	5. Promoting Healthy Pregnancies, Parents, and Babies	30
AR	AR H 1468	Use of Shared Leave Under the Attendance and Leave Act	5. Promoting Healthy Pregnancies, Parents, and Babies	30
AR	AR H 1534	Education Coordinating for Unplanned Pregnancy	4. Improving the Health of Youth	20
AR	AR H 1685	Dating Violence Awareness	4. Improving the Health of Youth	18
CA	CA A 1102	Health Coverage: Medi-Cal Access: Disclosures	3. Enhancing Insurance Coverage	16
CA	CA A 302	Pupil Services: Lactation Accommodations	4. Improving the Health of Youth	20
CA	CA A 329	Pupil Instruction: Sexual Health Education	4. Improving the Health of Youth	18, 20
CA	CA A 375	School Employees: Sick Leave: Paternity/Maternity Leave	5. Promoting Healthy Pregnancies, Parents, and Babies	31
CA	CA A 50	Medi-Cal: Evidence-Based Home Visiting Programs	5. Promoting Healthy Pregnancies, Parents, and Babies	27
CA	CA A 775	Reproductive FACT Act	2. Protecting and Expanding Access	6
CA	CA A 94	Health	3. Enhancing Insurance Coverage	15
CA	CA S 407	Comprehensive Perinatal Services Program: Midwives	5. Promoting Healthy Pregnancies, Parents, and Babies	27
CA	CA S 408	Midwife Assistants	5. Promoting Healthy Pregnancies, Parents, and Babies	27
CA	CA S 464	Healing Arts: Self-Reporting Tools	2. Protecting and Expanding Access	7
CA	CA S 695	School Health Education: Harassment Training	4. Improving the Health of Youth	18
CO	CO H 1079	Teen Pregnancy Dropout Prevention Program Funding	4. Improving the Health of Youth	20
CO	CO H 1111	Maternal Mortality Prevention Act	5. Promoting Healthy Pregnancies, Parents, and Babies	27
CO	CO H 1164	Jury Service Postponement for Breast-feeding	5. Promoting Healthy Pregnancies, Parents, and Babies	30
CO	CO H 1194	Long-Acting Reversible Contraception	3. Enhancing Insurance Coverage	14
CO	CO H 1258	Insurance Program Wage Replacement	5. Promoting Healthy Pregnancies, Parents, and Babies	32
CT	CT H 5500	Health Insurance Coverage for Fertility Preservation	3. Enhancing Insurance Coverage	16
CT	CT H 6252	Pregnancy and the Workplace	5. Promoting Healthy Pregnancies, Parents, and Babies	29
CT	CT H 6932	Paid Family Medical Leave	5. Promoting Healthy Pregnancies, Parents, and Babies	32
CT	CT S 966	Sexual Assault Forensic Examiners	3. Enhancing Insurance Coverage	16
DC	DC B 20	Contraceptive Insurance Coverage	3. Enhancing Insurance Coverage	15
DE	DE S 84	Jury Service Exemption for Breastfeeding Women	5. Promoting Healthy Pregnancies, Parents, and Babies	30
FL	FL S 7016	Minor Identifying Information	2. Protecting and Expanding Access	6
FL	FL S 982	Civil Rights Act	5. Promoting Healthy Pregnancies, Parents, and Babies	29
HI	HI H 458 / S 394	Human Papillomavirus	4. Improving the Health of Youth	20
HI	HI H 459	Women's Legislative Caucus Package	4. Improving the Health of Youth	18
HI	HI H 496	Family Leave Insurance Benefits	5. Promoting Healthy Pregnancies, Parents, and Babies	32
HI	HI S 304	Maternal Mortality Review Panel	5. Promoting Healthy Pregnancies, Parents, and Babies	27
HI	HI S 768 / H 864	Infertility Services Insurance Coverage	3. Enhancing Insurance Coverage	16
IA	IA H 116	Employment Protections	5. Promoting Healthy Pregnancies, Parents, and Babies	32

APPENDIX

ST	BILL	TITLE AS FILED	SECTION	PAGE(S)
IA	IA S 375	Pregnant Employment Protection	5. Promoting Healthy Pregnancies, Parents, and Babies	32
IL	IL H 166	Family Leave Insurance Program Act	5. Promoting Healthy Pregnancies, Parents, and Babies	32
IL	IL H 2812	Medicaid Managed Care Entities	3. Enhancing Insurance Coverage	13
IL	IL H 3684	Foster Children's Bill of Rights Act	4. Improving the Health of Youth	19
IL	IL H 3848	Sexual Assault Survivors Emergency Treatment Act	3. Enhancing Insurance Coverage	16
IL	IL H 4013	State Employees Group Insurance Act	3. Enhancing Insurance Coverage	12, 15
IL	IL H 421	Nurse Practice Act	5. Promoting Healthy Pregnancies, Parents, and Babies	27
IL	IL S 1238	Family Care Provider Act	5. Promoting Healthy Pregnancies, Parents, and Babies	32
IL	IL S 1564	Conscience Act	2. Protecting and Expanding Access	7
IL	IL S 1764	Insurance Code	3. Enhancing Insurance Coverage	16
IL	IL S 344	Lactation Accommodation in Airports	5. Promoting Healthy Pregnancies, Parents, and Babies	29
IL	IL SR 90	Department of Children and Family Services	4. Improving the Health of Youth	19
IN	IN H 1004	Safety PIN Grant Program	5. Promoting Healthy Pregnancies, Parents, and Babies	27
IN	IN H 1359	Human Papillomavirus Vaccine Information	4. Improving the Health of Youth	20
IN	IN H 1548	Midwife Requirements	5. Promoting Healthy Pregnancies, Parents, and Babies	27
IN	IN HR 63	Human Papillomavirus Vaccination Study	4. Improving the Health of Youth	19
IN	IN S 461	Health Matters	4. Improving the Health of Youth	19
IN	IN S 99	Nursing Mothers and Jury Duty	5. Promoting Healthy Pregnancies, Parents, and Babies	30
KY	KY H 218	Pregnancy and Childbirth Rights	5. Promoting Healthy Pregnancies, Parents, and Babies	29
KY	KY H 230	Expedited Partner Therapy	2. Protecting and Expanding Access	9
LA	LA H 326	Students	4. Improving the Health of Youth	19
LA	LA H 835	Victims of Sexually Oriented Criminal Offenses	3. Enhancing Insurance Coverage	16
LA	LA HR 69	Sex Education	4. Improving the Health of Youth	19
MA	MA S 2062	Healthy Youth	4. Improving the Health of Youth	18
MA	MA S 92	Equal Benefits for All New Mothers	5. Promoting Healthy Pregnancies, Parents, and Babies	32
MA	MA H 3920	Summary of Payments Forms for Health Care Services	3. Enhancing Insurance Coverage	14
MA	MA S 2081	Confidential Healthcare Access Protection	3. Enhancing Insurance Coverage	14
MD	MD H 9	Licensure of Direct Entry Midwives Act	5. Promoting Healthy Pregnancies, Parents, and Babies	27
MD	MD H 978	HIV Testing	2. Protecting and Expanding Access	9
MD	MD S 187	Governor's Workforce Investment Board	5. Promoting Healthy Pregnancies, Parents, and Babies	27
MD	MD S 599	Expedited Partner Therapy Pilot Program	2. Protecting and Expanding Access	8
MD	MD S 74	Maternal Mental Health	5. Promoting Healthy Pregnancies, Parents, and Babies	27
MD	MD S 796	AIDS Drug Assistance Program Rebates	2. Protecting and Expanding Access	9
MD	MD S 626	Registered Nurses and Local Health Departments	2. Protecting and Expanding Access	8
ME	ME H 213	Medicaid Coverage for Reproductive Health Care	3. Enhancing Insurance Coverage	15
ME	ME H 493	Maine Paid Family Leave Insurance Program	5. Promoting Healthy Pregnancies, Parents, and Babies	32
ME	ME H 698	Discrimination by Employers	2. Protecting and Expanding Access	8
ME	ME H 787	Maine Center for Disease Control and Prevention To Report on Progress toward Meeting Healthy Maine 2020 Goals Pertaining to Reproductive Health	5. Promoting Healthy Pregnancies, Parents, and Babies	27
ME	ME S 353	Use of Restraints on Pregnant Prisoners	5. Promoting Healthy Pregnancies, Parents, and Babies	25

ST	BILL	TITLE AS FILED	SECTION	PAGE(S)
MN	MN S 1269	Public Safety	5. Promoting Healthy Pregnancies, Parents, and Babies	26
MN	MN S 1504	Health	5. Promoting Healthy Pregnancies, Parents, and Babies	27
MN	MN S 779	Employment	5. Promoting Healthy Pregnancies, Parents, and Babies	32
MO	MO H 501	Course Materials Related to Sexual Education	4. Improving the Health of Youth	18
MS	MS H 910	Infant Mortality Reduction Collaborative	5. Promoting Healthy Pregnancies, Parents, and Babies	28
MT	MT H 606	Statutory Appropriation for Title X Funding	3. Enhancing Insurance Coverage	14
ND	ND H 1244	Use of State Employee Sick Leave	5. Promoting Healthy Pregnancies, Parents, and Babies	31
ND	ND H 1387	Parking on the Capitol Grounds for Employees	5. Promoting Healthy Pregnancies, Parents, and Babies	31
ND	ND H 1463	Accommodations in the Workplace for Pregnancy	5. Promoting Healthy Pregnancies, Parents, and Babies	29
ND	ND S 2284	Hospital Treatment of Victims of Sexual Assault	2. Protecting and Expanding Access	9
NE	NE L 37	Prescription Drug Safety Act	2. Protecting and Expanding Access	7
NE	NE L 627	Nebraska Fair Employment Practice Act	5. Promoting Healthy Pregnancies, Parents, and Babies	28, 31
NE	NE L 77	Every Woman Matters Program	3. Enhancing Insurance Coverage	16
NH	NH S 219	Breastfeeding	5. Promoting Healthy Pregnancies, Parents, and Babies	30
NJ	NJ A 4155	Restraint of Prisoners	5. Promoting Healthy Pregnancies, Parents, and Babies	26
NJ	NJ A 4264	Equal Rights and Opportunities	5. Promoting Healthy Pregnancies, Parents, and Babies	29
NJ	NJ S 1519	Employer and Health Care Information Dissemination	5. Promoting Healthy Pregnancies, Parents, and Babies	32
NJ	NJ A 4604	Medicaid Coverage	3. Enhancing Insurance Coverage	15
NM	NM H 409	Pregnant Worker Accommodation Act	5. Promoting Healthy Pregnancies, Parents, and Babies	29
NM	NM H 509	Public Health	5. Promoting Healthy Pregnancies, Parents, and Babies	27
NM	NM H 84	Freestanding Birth Center Licensure	5. Promoting Healthy Pregnancies, Parents, and Babies	27
NM	NM S 116	Statewide Perinatal Collaborative	5. Promoting Healthy Pregnancies, Parents, and Babies	27
NM	NM S 299	Nurse Practitioner Scope of Practice	5. Promoting Healthy Pregnancies, Parents, and Babies	27
NM	NM S 363	Expectant and Postpartum Prisoners Act	5. Promoting Healthy Pregnancies, Parents, and Babies	26
NM	NM SM 132	Corrections Health Care Task Force	2. Protecting and Expanding Access	9
NV	NV A 306	Employer Accommodations for Nursing Mothers	5. Promoting Healthy Pregnancies, Parents, and Babies	30
NV	NV S 117	Provisions Relating to Immunizations	4. Improving the Health of Youth	20
NY	NY A 1142 / S 2709	Discrimination Based on a Reproductive Health Decision	2. Protecting and Expanding Access	8
NY	NY A 1347 / S 5729	Segregated Confinement of Pregnant Inmates	5. Promoting Healthy Pregnancies, Parents, and Babies	26
NY	NY A 1616 / S 700	Age-Appropriate Sex Education Grant Program	4. Improving the Health of Youth	19
NY	NY A 2170 / S 4860	Expedited Partner Therapy for Certain Infections	2. Protecting and Expanding Access	8
NY	NY A 3870	Workers' Compensation Benefits	5. Promoting Healthy Pregnancies, Parents, and Babies	32
NY	NY A 4272 / S 8	Reasonable Accommodations for Pregnant Women	5. Promoting Healthy Pregnancies, Parents, and Babies	21, 29
NY	NY A 4463	Possession of a Condom as Evidence	2. Protecting and Expanding Access	9
NY	NY A 6221	Access to Reproductive Services	2. Protecting and Expanding Access	6, 21
NY	NY A 6430 / S 983	Restraint of Female Prisoners During Childbirth	5. Promoting Healthy Pregnancies, Parents, and Babies	25
NY	NY A 7202 / S 5183	Breastfeeding Mothers' Bill of Rights	5. Promoting Healthy Pregnancies, Parents, and Babies	30
NY	NY A 806	Excused Leave for Cervical Cancer Screening	2. Protecting and Expanding Access	9
NY	NY S 4325 / A 446	Midwifery Birth Centers	5. Promoting Healthy Pregnancies, Parents, and Babies	27
NY	NY S 5972 / A 6780	Enrollment in State Health Insurance Exchange	3. Enhancing Insurance Coverage	16

APPENDIX

ST	BILL	TITLE AS FILED	SECTION	PAGE(S)
OH	OH H 124	Sexual Partner Drug Prescriptions	2. Protecting and Expanding Access	8
OR	OR H 2600	Group Health Insurance Coverage	5. Promoting Healthy Pregnancies, Parents, and Babies	32
OR	OR H 2758	Prohibits Disclosure of Sensitive Information	3. Enhancing Insurance Coverage	14
OR	OR H 2879	Pharmacist to Prescribe Hormonal Contraceptives	2. Protecting and Expanding Access	7, 8
OR	OR H 3343	Prescription Contraceptives Insurance Coverage	3. Enhancing Insurance Coverage	14
PA	PA S 210	Exemptions from Jury Duty	5. Promoting Healthy Pregnancies, Parents, and Babies	30
RI	RI H 5674 / S 276	Labor and Labor Relations	5. Promoting Healthy Pregnancies, Parents, and Babies	28
RI	RI S 419	Care of Postpartum Depression	5. Promoting Healthy Pregnancies, Parents, and Babies	27
SC	SC H 3204 / S 278	Cervical Cancer Prevention Act	4. Improving the Health of Youth	20
SC	SC H 3251	Department of Health and Environmental Control	5. Promoting Healthy Pregnancies, Parents, and Babies	27
SD	SD S 77	Breastfeeding	5. Promoting Healthy Pregnancies, Parents, and Babies	30
TN	TN S 950	State Employee Paternity and Maternity Leave	5. Promoting Healthy Pregnancies, Parents, and Babies	31
TX	TX H 1140	County Jails Pregnant Prisoners Confinement Reports	5. Promoting Healthy Pregnancies, Parents, and Babies	26, 28
TX	TX H 1143	Foster Children Who are Pregnant or Minor Parents	4. Improving the Health of Youth	20
TX	TX H 1282	Human Papillomavirus-Associated Cancer Strategic Plan	2. Protecting and Expanding Access	9
TX	TX H 232	Breast-feeding Right	5. Promoting Healthy Pregnancies, Parents, and Babies	30
TX	TX H 786	Right to Express Breast Milk in Workplace	5. Promoting Healthy Pregnancies, Parents, and Babies	29
UT	UT H 105	Antidiscrimination Modifications	5. Promoting Healthy Pregnancies, Parents, and Babies	29
UT	UT H 154	Jury Duty Exemption Amendments	5. Promoting Healthy Pregnancies, Parents, and Babies	30
UT	UT H 242	State and Local Government Employee Policies	5. Promoting Healthy Pregnancies, Parents, and Babies	30
VA	VA H 1499 / S 1427	Right to Breastfeed in Public Places	5. Promoting Healthy Pregnancies, Parents, and Babies	30
VA	VA H 1657	Life-Prolonging Procedures During Pregnancy	5. Promoting Healthy Pregnancies, Parents, and Babies	27
VA	VA S 785	Nondiscrimination in Public Employment	5. Promoting Healthy Pregnancies, Parents, and Babies	29
VA	VA SJR 285	Expanding Family and Medical Leave	5. Promoting Healthy Pregnancies, Parents, and Babies	32
VT	VT HJR 2	Commemorative Joint Resolution	2. Protecting and Expanding Access	6
VT	VT S 60	Medical Examinations for Victims of Sexual Assault	3. Enhancing Insurance Coverage	16
WA	WA H 1647	Health Plan Coverage for Reproductive Health Care	3. Enhancing Insurance Coverage	12
WA	WA S 5770	Health Care Facilities	2. Protecting and Expanding Access	7
WA	WA SR 8635	HPV Awareness	4. Improving the Health of Youth	19
WV	WV H 2046	Treatment for Sexually Transmitted Diseases	2. Protecting and Expanding Access	9

Endnotes

1 Changes in Abortion Rates Between 2000 and 2008 and Lifetime Incidence of Abortion." *Obstetrics and Gynecology* 117:6 (2011).

2 Guttmacher Institute, "Laws Affecting Reproductive Health and Rights: State Trends at Midyear, 2015," July 1, 2015, *available at* http://www.guttmacher.org/media/inthenews/2015/07/01/ (last visited Aug. 13, 2015). Email communication with Elizabeth Nash, Senior State Issues Associate, Guttmacher Institute, Nov. 30, 2015.

3 The Affordable Care Act, 42 U.S.C. § 18001 (2010), created a new health care insurance system that operates across the country and ensures that virtually every resident of the United States can get access to affordable or subsidized health insurance through a series of "health care exchanges." 42 U.S.C. § 18001 (2010). For more detailed information about what the Affordable Care Act requires, visit https://www.healthcare.gov/.

4 Email communication with Marina Barcelo, Director of Equity & Community Engagement, NARAL Pro-Choice Oregon, Sept. 18, 2015.

5 Ibid.

6 Local resolutions have passed in Cambridge, Massachusetts; Cook County, Illinois; Madison, Wisconsin; New York, New York; Philadelphia, Pennsylvania; Seattle, Washington; and Travis County, Texas. See Reinstating Coverage for Abortion at http://www.nirhealth.org/what-we-do/issue-advocacy/abortion/reinstating-coverage-for-abortion-2/.

7 Email communication with Amy Casso, Gender Justice Program Manager, Western States Center, Sept. 18, 2015.

8 Sabrina Tavernise, "Colorado's Effort Against Teenage Pregnancies Is a Startling Success," The New York Times, July 5, 2015, *available at* http://www.nytimes.com/2015/07/06/science/colorados-push-against-teenage-pregnancies-is-a-startling-success.html?_r=0 (last visited Nov. 30, 2015).

9 Guttmacher Institute, "State Policies in Brief: State Funding of Abortion Under Medicaid," Nov. 1, 2015, *available at* http://www.guttmacher.org/statecenter/spibs/spib_SFAM.pdf (last visited Nov. 30, 2015).

10 Guttmacher Institute, "State Policies in Brief: Restricting Insurance Coverage of Abortion," Nov. 1, 2015, *available at* http://www.guttmacher.org/statecenter/spibs/spib_RICA.pdf (last visited Nov. 30, 2015).

11 National Women's Law Center, "Pregnancy Accommodations in the States," Aug. 2015, *available at* http://www.nwlc.org/sites/default/files/pdfs/pregnancy_accommodations_in_the_states_8.27.15.pdf (last visited Nov. 30, 2015).

12 Although many states considered important laws that help survivors of sexual assault in many ways, the scope of this report is limited to reproductive and sexual health care and thus includes only those bills that focus on the health care and coverage of health services for sexual assault survivors.

13 Centers for Disease Control and Prevention, "National, Regional, State, and Selected Local Area Vaccination Coverage Among Adolescents Aged 13-17 Years—United States, 2014," July 31, 2015, Morbidity and Mortality Weekly Report (MMWR), *available at* http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6429a3.htm.

14 National Institute for Reproductive Health, *Analysis of Voters' Opinions on Abortion in Women's Lives: Exploring Links to Equal Opportunity and Financial Stability*, Oct. 14, 2014, *available at* http://www.nirhealth.org/analysis-of-voters-opinions-on-abortion-in-womens-lives-exploring-links-to-equal-opportunity-and-financial-stability/.

15 Ibid.

16 Eleanor J. Bader, "Reproductive Justice and Women's Equality: There is Some Good News!" Truthout, May 10, 2014, *available at* http://www.truth-out.org/news/item/23588-reproductive-justice-and-womens-equality-there-is-some-good-news (last visited Nov. 30, 2015).

Endnotes

17 Email communication with Susan Frietsche, Senior Staff Attorney, Women's Law Project, Aug. 26, 2015.

18 Mary Wilson, "Women's health remains a focus for bipartisan group in Pa.," Newsworks, May 11, 2015, *available at* http://www.newsworks.org/index.php/politics/item/81776-womens-health-remains-a-focus-for-bipartisan-group-in-pa (last visited Nov. 30, 2015).

19 Angela Couloumbis, "Bills for women," Philly.com, May 11, 2015, *available at* http://www.philly.com/philly/blogs/harrisburg_politics/Bills-for-women.html#Y97lc3I6OBaWXzxA.99 (last visited Nov. 30, 2015).

20 National Institute for Reproductive Health, *Analysis of Voters' Opinions on Abortion in Women's Lives: Exploring Links to Equal Opportunity and Financial Stability*, Oct. 14, 2014, *available at* http://www.nirhealth.org/analysis-of-voters-opinions-on-abortion-in-womens-lives-exploring-links-to-equal-opportunity-and-financial-stability/.

21 Virginia Women's Equality Coalition, http://vawomensequalitycoalition.org/ (last visited Aug. 13, 2015).

22 Email communication with Anna Scholl, Executive Director, ProgressVA, Aug. 10, 2015.

23 National Institute for Reproductive Health, *Exploring Virginia Voters' Views toward Women's Equality and Economic Security*, July 7, 2015, *available at* http://www.nirhealth.org/wp-content/uploads/2015/07/Memo_VA_FINAL.pdf.

24 Email communication with Anna Scholl, Executive Director, ProgressVA, Aug. 10, 2015.

25 Audrey Quinn, "In Labor, in Chains," The New York Times, http://www.nytimes.com/2014/07/27/opinion/sunday/the-outrageous-shackling-of-pregnant-inmates.html?_r=1 (last visited Nov. 30, 2015).

26 Correctional Association of New York, Women in Prison Project, *Reproductive Injustice*: *The State of Reproductive Health Care for Women in New York State Prisons*, Feb. 2015, *available at* http://www.correctionalassociation.org/wp-content/uploads/2015/03/Reproductive-Injustice-FULL-REPORT-FINAL-2-11-15.pdf (last visited Nov. 30, 2015).

27 U.S. Department of Labor, First-Time Mothers At Work, *available at* http://www.dol.gov/wb/First-Time_Mothers_final_508.pdf (last visited Nov. 30, 2015).

28 National Women's Law Center, "The Business Case for Accommodating Pregnant Workers," May 22, 2015, *available at* http://www.nwlc.org/resource/business-case-accommodating-pregnant-workers (last visited Aug. 13, 2015).

29 Ibid.

30 Thriving Families Georgia, http://www.thrivingfamsga.org/about/ (last visited Nov. 30, 2015).

31 Thriving Families Georgia, "Strong Families Resolution Makes a Splash at the State Capitol," March 25, 2015, *available at* http://www.thrivingfamsga.org/m%C2%AD%C2%ADedia-release-strong-families-resolution-makes-a-splash-at-the-state-capitol/ (last visited Nov. 30, 2015).

32 Email communication with Kwajelyn Jackson, Community Education & Advocacy Manager, Feminist Women's Health Center, Aug. 10, 2015.

33 Trust. Respect. Access., http://trustrespectaccess.org/#About (last visited Nov. 30, 2015).

34 Email communication with Terri Burke, Executive Director, ACLU of Texas, Sept. 9, 2015.

35 Email communication with Kathy Miller, Executive Director, Texas Freedom Network, Sept. 18, 2015.

National Institute for Reproductive Health

470 Park Avenue South
7th Floor South
New York, NY 10016

Tel. 212-343-2031
Fax 212-343-0119

info@nirhealth.org
www.nirhealth.org

NATIONAL
INSTITUTE FOR
REPRODUCTIVE
HEALTH