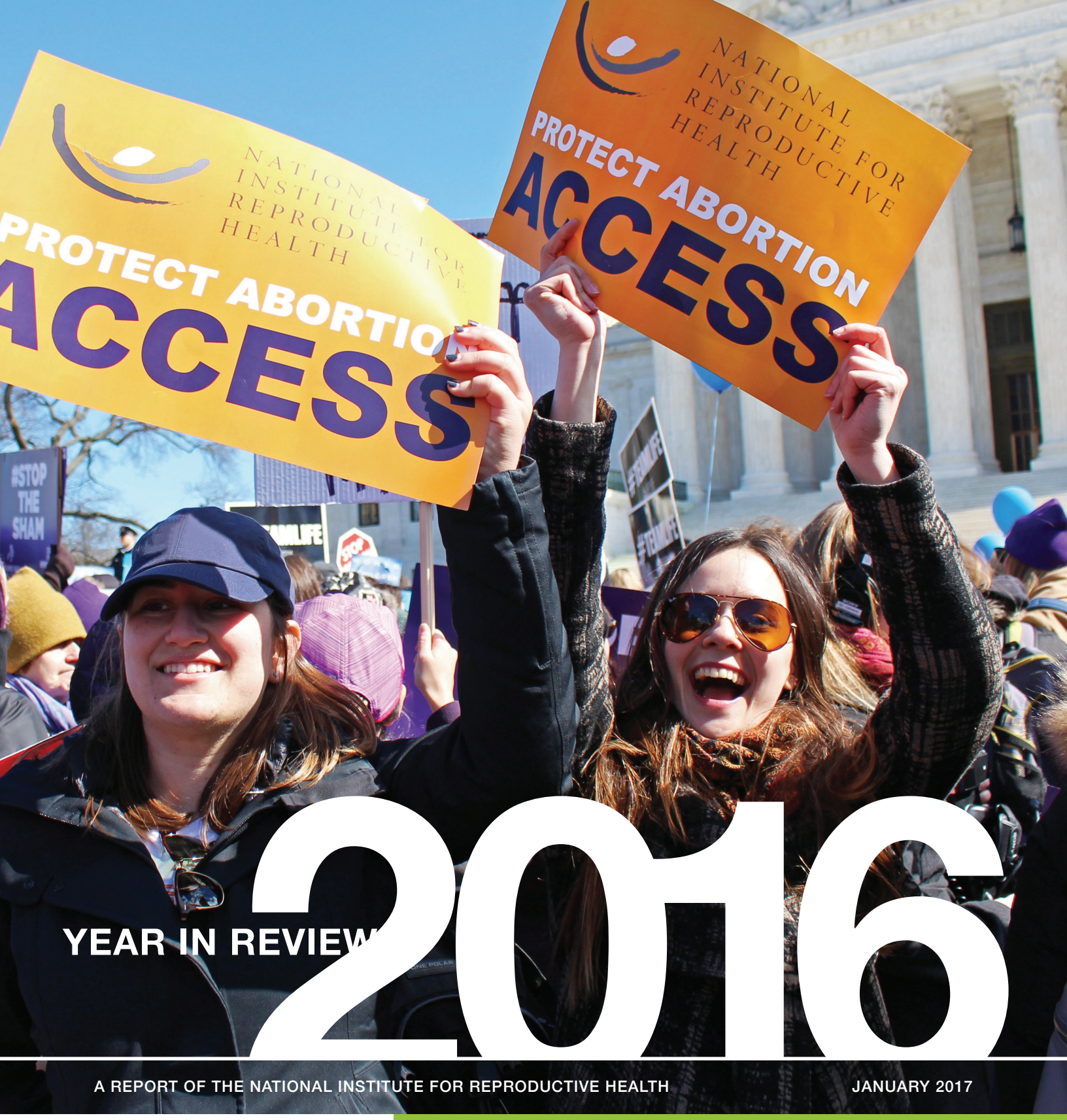


YEAR IN REVIEW 2016

A REPORT OF THE NATIONAL INSTITUTE FOR REPRODUCTIVE HEALTH

JANUARY 2017

NATIONAL INSTITUTE FOR REPRODUCTIVE HEALTH

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

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

National Institute for Reproductive Health

14 Wall Street
Suite 3B
New York, NY 10005

Tel. 212-343-0114
Fax 212-343-0119

info@nirhealth.org
www.nirhealth.org

Acknowledgements
This report was written by Jordan Goldberg, Senior Policy Advisor, and Rose MacKenzie, Policy Counsel, with bill tracking assistance from Lauren Boc, Program Associate; Winnie Ye, Policy and Program Associate; DeAnna Baumle, Legal Intern; Kelly Flannery, Legal Intern; and Tristan Sullivan-Wilson, Legal Intern. Staff of the National Institute, including Andrea Miller, President; Maria Elena Perez, Director of Policy and Strategic Partnerships; Tara Sweeney, Communications Director; and Christie Petrone, Associate Communications Director, contributed to and edited this report. Photo credits throughout this report go to Annie Zegers, Communications Assistant. 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 these 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

sectionone

INTRODUCTION: SETTING THE STAGE

The year 2016 might go down in history as a year in which attacks on women's health, rights, and dignity—including around reproductive health and rights—played an unprecedented role in the national dialogue, and a year in which the election outcomes presaged unparalleled rollbacks at both the federal and state levels. It was also a year rife with setbacks to achieving social justice in its myriad forms—mass tragedy, police shootings, racial tension, and a volatile election cycle dominated the headlines. But another critical part of the story of 2016 is that advocates and legislators worked together to advance state policies that would give women, young people, parents, and families support and respect for the decisions they make in their reproductive and sexual lives.

As in 2015, many new laws advancing reproductive health, rights, and justice were enacted in 2016, and it was a particularly banner year for proactive policy in the areas of contraception, healthy pregnancies, and the countering of discriminatory taxes on health care supplies related to menstruation. Moreover, while two-thirds of statehouses continued to be dominated by opponents of women's reproductive health and rights, advocates and legislators continued to push forward policies to expand access to abortion care. Working together, they greeted the U.S. Supreme Court's mid-year decision in *Whole Woman's Health v. Hellerstedt*[1] with a wave of excitement about the Court's recognition of importance of women's access to abortion and repudiation of non-scientific, ideological state abortion restrictions passed under the guise of protecting women's health.

With that complex backdrop in mind, this report seeks to highlight and celebrate the tenacity and hope embodied in the hundreds of pieces of legislation that were advanced in states across the country in an effort to improve people's lives, make reproductive health care easier to access, and help ease the experiences of pregnant women trying to do their jobs and parents balancing the demands of raising the next generation while supporting it. Legislators pushed back against attacks on women and health care providers, stripping away harmful anti-abortion laws and passing resolutions urging better access to abortion and other reproductive health care, and worked with coalitions in 16 states to try new approaches to increase access to contraception.

The National Institute for Reproductive Health once again had the great privilege of working with many of the state and local advocates across the United States who promoted affirmative reproductive health policies in 2016.* Throughout the year, we supported advocates' work to ensure direct access to the full range of reproductive and sexual health care without a referral, broadly expand insurance coverage for contraception, improve conditions for pregnant women who are incarcerated, and eliminate state laws restricting abortion care. In addition, the National Institute released groundbreaking public opinion research demonstrating that, for a woman who has decided to have an abortion, the public supports her ability to access that care safely, affordably, and in her community, without harassment, embarrassment, or shame.[2]

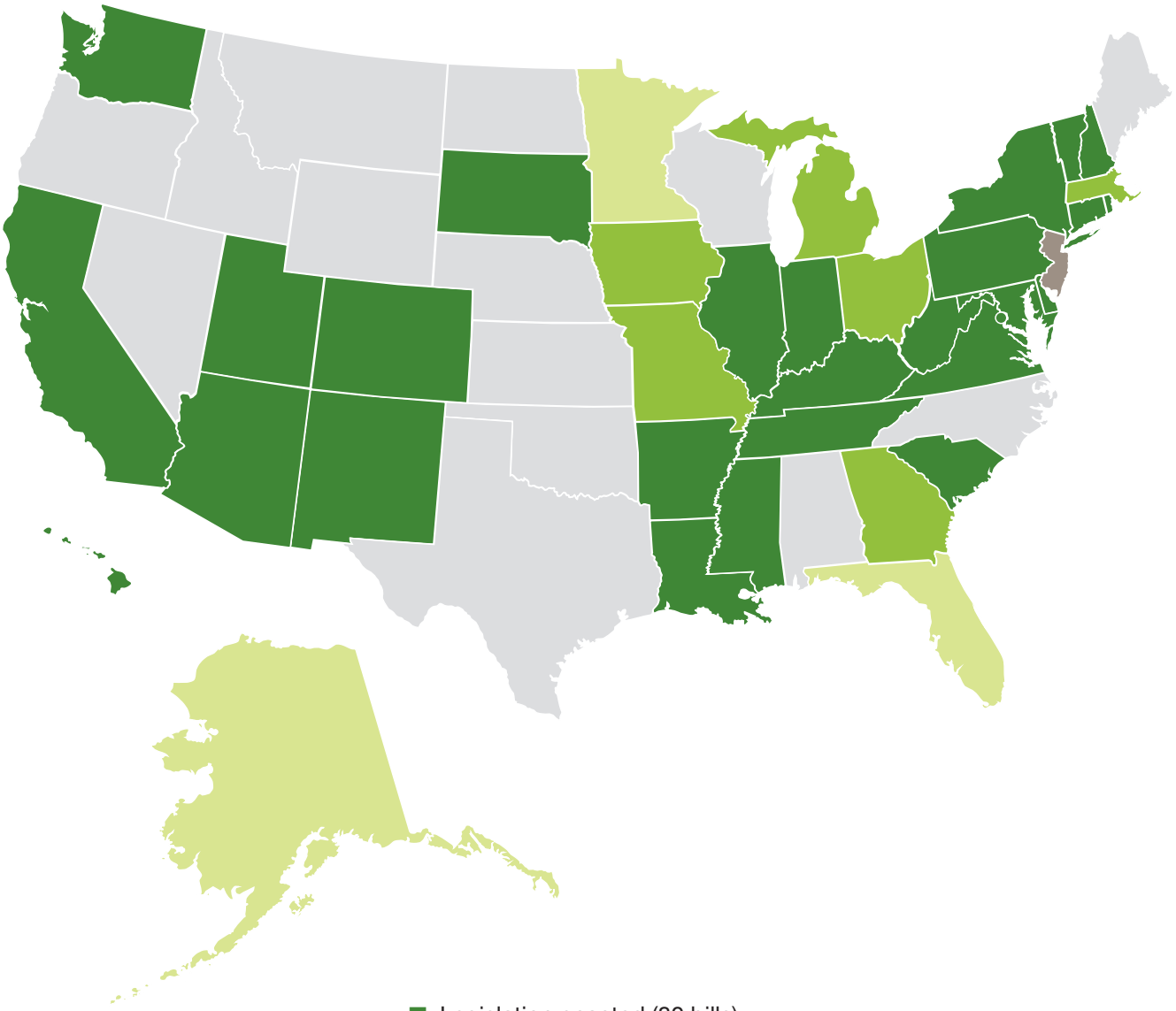
In our third annual report on proactive reproductive health policy, we have focused on legislation in several key priority areas:

1. Protecting and expanding access to abortion, contraception, and sexual health care;
2. Enhancing insurance coverage for reproductive and sexual health care;
3. Improving the reproductive and sexual health of youth; and
4. Promoting healthy pregnancies, parents, and infants.

This report includes legislation relating to these issues that passed at least one committee in at least one house of a state legislature, and it highlights one or two policies in each section that are particularly unique, innovative, or timely. It also includes an in-depth focus on key strategies for the reproductive health, rights, and justice movements to consider as we look at the year ahead, lifting up ideas that can help us combine new policy ideas with creative advocacy campaigns that rally support around a proactive approach to reproductive health, rights, and justice.

* Throughout our report, we have highlighted the names of organizations with whom the National Institute is currently working or has partnered in the past three years. We are pleased to have the opportunity to recognize so many new accomplishments by current and former partners.

Movement of Proactive Legislation in 2016



sectiontwo

PROTECTING AND EXPANDING ACCESS TO ABORTION, CONTRACEPTION, AND SEXUAL HEALTH CARE

In many states, access to reproductive and sexual health care is limited, especially access to abortion and reliable contraception. Barriers can include poverty that aggravates all entry points to access, such as transportation and co-pays for doctor visits; violence against providers and patients; and state laws that create unnecessary limitations, such as allowing any provider or entity to refuse to provide a basic health care service such as abortion.

Twenty-one states and the District of Columbia* considered legislation designed to expand access to reproductive and sexual health care in 2016, and 14 of them enacted new laws. Notably, advocates and legislators focused their attention on improving access to contraception in a variety of ways, by both expanding the ways people can access contraceptive supplies, such as through a pharmacy, and enhancing insurance coverage, described on page 17. The 2016 legislative sessions also saw a surge of legislator attention to the discriminatory nature of sales taxes on basic reproductive health supplies, such as tampons and maxipads.

Abortion Access

In 2016, seven states** considered 11 bills and resolutions, of which nine were enacted or adopted, that would protect and advance access to abortion care. These measures were fueled in large part by the response to the violent attack on the Planned Parenthood clinic in Colorado Springs in 2015 and the continuing fallout from the deceptive undercover videos of abortion providers.

Three states—**Arizona**, **California**, and **Illinois**—considered new laws designed to increase access to abortion and protect abortion providers and patients. After years of attacking access to abortion in myriad ways, **Arizona** rolled back just a few of its restrictions on access to medication abortion, prompted in part by new guidelines from the Food and Drug Administration (FDA) and several court cases brought on behalf of Arizona abortion providers by the American Civil Liberties Union, Center for Reproductive Rights, and Planned Parenthood Federation of America. In previous years, Arizona had enacted laws requiring physicians to lie to patients about the way medication abortion works and to provide medication abortion with an outdated protocol requiring both higher doses than medically necessary and unnecessary extra trips to a clinic. Arizona Senate Bill 1112 repealed both of those requirements, a move that was rightly hailed by advocates as a victory. Nonetheless, Arizona continues to maintain some of the most restrictive abortion laws in the United States.

California enacted Assembly Bill 2263, an amendment to the state's existing Safe at Home Act; this amendment prohibits any person or entity from posting online the home address of a reproductive health

---

* Throughout this report, states that enacted legislation will be listed in **bold font** in footnotes. **Arizona**, **Arkansas**, **California**, **Delaware**, District of Columbia, Florida, Georgia, **Hawaii**, **Illinois**, **Indiana**, Iowa, Mississippi, Missouri, **New Jersey**, **New Mexico**, **New York**, **Ohio**, **Pennsylvania**, **Tennessee**, **Utah**, **Washington**, and **West Virginia**

** **Arizona**, **California**, **Hawaii**, **Illinois**, **New Jersey**, New York, and **Washington**

policyhighlight

Ensuring Religious Refusals Don't Prevent Abortion Access

According to the Guttmacher Institute,[3] 45 states have some type of law on the books that allows health care providers and some health care institutions to refuse to provide abortion care. The ways these policies are written and implemented vary widely, and the variations can have a significant impact on patients seeking care.

In some states, even when a patient urgently needs abortion care to avoid a major medical complication, she may be denied both the procedure and the information that an abortion could preserve her health or prevent greater complications. **Illinois** is one state with a stringent, decades-old "refusal" law of this nature, which until 2016 allowed any health care provider or entity to refuse to provide treatment to a patient if the provider objected to the type of treatment, and even to deny the patient information about her condition and treatment options.

In 2016, after many years of lobbying and advocacy led by the **ACLU of Illinois**, Illinois enacted Senate Bill 1564, which mitigates the impact of this refusal law. Senate Bill 1564 changes the balance of considerations, starting with a significant statement from the legislature that it is "the public policy of the State of Illinois to ensure that patients receive timely access to information and medically appropriate care." The new law requires all health care providers and facilities to ensure that (1) conscience-based objections do not impair patients' health; (2) all patients are given medically appropriate information about their conditions; and (3) patients are either given the care by someone else at that facility or transferred, referred, or given information about how to access that care in a timely manner elsewhere. Upon the bill's passage, the ACLU of Illinois said, "The new law carefully balances the needs of patients to get complete information about their medical condition with the ability of health care providers to refuse health care services to which they have a religious or conscience objection. . . . When Illinois patients go into an exam room, they need no longer worry that they are being denied medical information based on their health care provider's religious beliefs."[4]

care services provider, employee, volunteer, or patient who has requested this protection.

Illinois enacted Senate Bill 1564, which mitigates the impact of the state's decades-old "refusal" law by requiring all health care providers and facilities to ensure that conscience-based objections do not impair patient health. The law will ensure that all patients are given medically appropriate information about their conditions, as well as ensure that if a provider refuses to provide a service, patients are given the necessary care by someone else at that facility, transferred or referred to a facility that will provide that care, or given information about how to access that care in a timely manner elsewhere. (See policy highlight above for more details.)

Finally, for the fourth year in a row, the **New York** Assembly passed a bill (Assembly Bill 6221) that would safeguard women's right to access abortion care under New York state law, as well as ensure that women's health is protected throughout pregnancy. The **National Institute**, along with Family Planning Advocates and the New York Civil Liberties Union, has led a broad coalition lobbying for this critical change to New York law, which currently fails to meet the U.S. Constitution's

standards and does not adequately protect women's access to abortion.[5]

The legislatures in **California**, **Hawaii**, **New Jersey**, and **Washington** also passed resolutions supporting access to reproductive health care, including abortion, and opposing efforts to defund Planned Parenthood (**California** Senate Joint Resolution 19 / House Resolution 32, **Hawaii** Senate Concurrent Resolution 85 and Senate Resolution 56, **New Jersey** Senate Concurrent Resolution 78/Assembly Concurrent Resolution 119, and **Washington** Senate Resolution 8699). In both Hawaii and Washington, the resolutions also condemned violence against abortion providers and patients seeking abortion care.

Access to Contraception

Fifteen states* considered and seven of them adopted legislation designed to expand access to contraception in different ways, such as funding state projects to expand access to long-acting reversible contraception (LARC), which includes intrauterine devices (IUDs), and giving patients direct access to contraception at the pharmacy. The renewed focus on LARCs reflects the relatively low uptake of this highly effective method of contraception in the United States compared to other Western countries; reasons for this include patients' and providers' lack of awareness, high costs, insufficient provider training in insertion and removal, operational challenges associated with offering this method, and persistent myths about safety.

LARCs have become more accessible in recent years, thanks to a range of interventions including the types of policy changes proposed in the bills described below. As states consider different approaches to improve access to LARCs, it is critical that any new policy initiative ensure that all women are able to access the method of contraception that is right for them, with non-coercive, culturally competent services and counseling, and, if they choose a LARC, that they are able to have it removed at any time.

Delaware enacted House Bill 316, making it unlawful for employers to discriminate against any employee or prospective employee because of their reproductive health decisions. Notably, Delaware House Bill 316 was included in a package of three bills enacted together in one agenda aimed at reducing discrimination against women, including House Bill 317, prohibiting employment discrimination on the basis of family responsibility, and House Bill 314, requiring pay transparency (for more information, see page 39). This agenda was promoted and supported by a coalition of national and state advocacy organizations, including A Better Balance; ACLU of Delaware; Congregation Beth Emeth; Delaware American Association of University Women; Delaware Americans for Democratic Action; Delaware Commission for Women; Henrietta Johnson Medical Center; National Coalition of 100 Black Women, Delaware Chapter; and the National Women's Law Center. **New York** considered similar legislation (Assembly Bill 1142 / Senate Bill 2709), which was promoted by the **National Institute** and other legislative allies and passed the Assembly but did not move in the Senate.

In **Arkansas**, **Florida**, and **New Mexico**, legislators focused on addressing different barriers to LARCs. A common one is the expense, as an IUD can cost more than $800 and may not be covered by insurance despite the requirements of the Affordable Care Act (ACA) (see page 17 for more information about coverage of contraceptives under the ACA). **Arkansas** enacted House Bill 1025, which gives the state Department of Health discretion to use up to $3.7 million to provide LARC devices to local Department of Health service providers, lowering

* **Arkansas**, **California**, **Delaware**, Florida, Hawaii, **Indiana**, Iowa, Missouri, New Jersey, **New Mexico**, New York, Ohio, **Tennessee**, Utah, and **Washington**

some of the costs for both patients and providers. Other barriers to LARC uptake can include lack of training for providers, device unavailability, and lack of information for patients. In **Florida**, two Senate committees passed Senate Bill 1116, which would have established a pilot program to expand access to LARCs with family planning providers in three counties, who could have worked on ways to address a number of those barriers. The **New Mexico** Senate adopted a resolution, SM 58, which requires two state agencies to convene a working group to study barriers to LARCs for adolescents in particular and to make specific recommendations to state agencies and the legislature to address those barriers. The working group must be made up of health care experts, providers, and advocates, including representatives from the **American Civil Liberties Union of New Mexico**, American College of Obstetricians and Gynecologists (ACOG), New Mexico Hospital Association, **Planned Parenthood of New Mexico**, **Southwest Women's Law Center, Strong Families New Mexico**, University of New Mexico Division of Adolescent Medicine, and **Young Women United**.

California and **Utah** considered legislation to expand access to contraception for those who are incarcerated. **California** enacted Senate Bill 1433, which requires all FDA-approved birth control methods to be made available to any incarcerated person who can become pregnant, and also requires all detention facilities to provide the contraceptive and related services, as well as counseling by a trained, licensed health care provider in a non-directive, unbiased, and non-coercive manner. The bill was supported by a wide coalition of reproductive health and criminal justice advocates, including the ACLU of California, California Attorneys for Criminal Justice, and a number of California Planned Parenthood affiliates.

In **Utah**, a House committee passed House Bill 449, which would have created an Incarcerated Women's Health Program to provide information about reproductive health care and contraception for all women who are incarcerated for more than 30 consecutive days.

Eight states explored options to increase access to contraception by expanding the powers of pharmacists. **California** built on their 2014 success allowing pharmacists to dispense contraceptives without a prescription by enacting Assembly Bill 1114 which permits Medicaid to cover those contraceptives. **Tennessee** enacted Senate Bill 1677, which will now allow pharmacists to prescribe and dispense hormonal contraception to people 18 and older, or emancipated minors under 18, provided the patients complete a questionnaire that assesses their health and helps determine the most appropriate contraceptive for them.

policyhighlight

Repealing the "Tampon Tax"

Across the country, advocates and legislators have started drawing attention to the fact that sanitary supplies, such as tampons and maxipads, are typically taxed as "luxury items" instead of treated like non-taxable necessities, such as food and health care. Among others commenting on this type of legislation in 2016, President Barack Obama said in an interview that he "has no idea why states would tax these as luxury items . . . I suspect it's because men were making the laws when those taxes were passed."[6] In 2016, five states and the **District of Columbia** (**California, Illinois, Mississippi, New York**, and **Utah**) moved forward legislation to repeal sales taxes for health care supplies related to menstruation. In New York, the Tampon Tax was part of the **National Institute's** 2016 legislative agenda (see page 12 for more information).

This pharmacy access bill was a major success in a state that has not taken many steps toward improving women's health, and it was supported by both professional pharmacy groups and a number of advocates, including the **Healthy and Free Tennessee** coalition. Allison Glass, State Director of Healthy and Free Tennessee, said upon its passage that "[o]ver-the-counter access [to contraception] helps to reduce disparities in reproductive health care access and outcomes, and increases opportunities for women to obtain a safe, effective method of contraception, free of medically unnecessary obstacles."[7] In a more limited move, **Washington** enacted House Bill 2681, which requires pharmacies that provide contraception without a prescription (for example, through an existing arrangement with a physician) to post a sticker on their door to inform customers of that possibility. (See section three for related bills that improve access to contraception by expanding insurance coverage for many of the delivery methods described here.)

Hawaii's Senate passed Senate Bill 2320, which would have allowed pharmacists to prescribe and dispense FDA-approved hormonal contraceptive supplies to people 18 and older based on a self-assessment test taken by the person indicating that a certain contraceptive was the right fit, and it would have also required insurers to cover those contraceptives. Both the **Iowa** Senate (Senate Bill 2222) and **Missouri** House (House Bill 1679) passed similar legislation that would have permitted pharmacists to prescribe contraception after the person took a self-assessment, and that also would have gone further by allowing the pharmacist to prescribe an initial three-month supply and then, with the refill, a 12-month supply of contraception at one time. Two **New Jersey** Senate committees passed related bills (Senate Bills 1073 and 2060) that would have allowed pharmacists to provide contraception, through a standing prescription order from a physician, to patients who took a self-assessment. The **Ohio** House and Senate passed a more limited bill (House Bill 285) that would allow pharmacists to provide a 90-day refill for many prescription drugs, including contraceptives, even with a 30-day prescription. In **Washington**, Senate Bill 6467, which passed a Senate committee, would have allowed pharmacists to prescribe and dispense FDA-approved hormonal contraceptive supplies to adults and minors under 18 as long as they had evidence of a previous prescription for contraception.

Finally, **Indiana** enacted House Bill 1263, which allows many health care providers to issue prescriptions through telemedicine for a variety of medications, including contraception. Using telemedicine to expand access to health care, including contraception, is a critical step forward, particularly for women in rural areas who may otherwise have to travel great distances to see a health care provider. However, Indiana explicitly excluded abortion medication from this bill, preventing the expansion of abortion care to that same population, which needs to be able to access the full range of reproductive health care.

Sexual Health Care

Ten states and the District of Columbia* considered, and six of those states enacted, legislation to expand access to and efficacy of various forms of sexual health care in 2016, ranging from expanding expedited partner therapy (EPT) to new funding for outreach to marginalized groups to ensure that they can and do access the reproductive and sexual health care available to them.

When someone is diagnosed by a physician with a sexually transmitted infection (STI), often

---

* **California**, District of Columbia, Georgia, Hawaii, **Illinois**, Mississippi, **New Jersey**, **New York**, **Pennsylvania**, Utah, and **West Virginia**

the most efficient and effective course is to treat both the person and their sexual partner simultaneously.[8] EPT is a clinical practice in which doctors provide treatment for some kinds of STIs for both the patient and the patient's sexual partner without also examining the partner; this helps address situations where the partner may not be that doctor's patient or might not have access to medical care. EPT helps make treatment more accessible to those who need it and cuts down on STI reinfection rates.[9]

West Virginia enacted Senate Bill 123, and **New York's** Assembly passed Assembly Bill 2170, both broad EPT laws that would allow health care providers to treat a patient's sexual partner for any diagnosed STI in many circumstances. **Georgia** and **New Jersey** considered similar but more limited legislation: The Georgia House passed House Bill 813, which would have allowed EPT specifically for chlamydia or gonorrhea, and a New Jersey Senate committee passed Senate Bill 2134, which did not limit the treatment to a particular disease but did state that insurance coverage would be mandated only if the partner was a designated beneficiary of the patient's insurance plan.

As noted earlier (see page 10), five states and the District of Columbia moved forward legislation to repeal sales taxes for health care supplies related to menstruation: **District of Columbia** Bill 415 (passed and on the Mayor's desk), **Illinois** Senate Bill 2746 (enacted), **New York** Assembly Bill 7555 (enacted), **California** Assembly Bill 1561 (passed both houses but was vetoed by the governor, along with several other tax-related bills), **Mississippi** Senate Bill 2053 (failed after both houses passed a version but could not agree on components), and **Utah** House Bill 202 (passed one committee).

California also considered two pieces of legislation designed to improve patient access and the patient experience. California Assembly Bill 1671 was enacted to make it a crime to eavesdrop on someone's confidential communication with their health care provider and then share that confidential information with anyone else. California's legislature also passed Senate Bill 1090, which would have required the state Department of Public Health to allocate specific funding for STI outreach and screening for certain counties and to develop new and innovative outreach and screening services. However, the governor vetoed that bill, citing budgetary concerns.

In spring 2016, the first transmission of the Zika virus within the United States was documented. Although not yet fully understood, the Zika virus causes minor symptoms in adults and children but can have a devastating effect on a growing fetus, including increased potential for miscarriage or the development of microcephaly.[10] The Zika virus is both carried by some types of mosquitos and sexually transmitted, and once found in a locality it may spread quickly without careful, expansive preventative action.[11] Although the medical community, policymakers, and scientists are still working to determine the best mix of approaches to fully combat Zika, it is clear that the ideal combination of policies will include mosquito eradication, sexuality education, broad access to the full range of available contraceptive options, testing for women who are or may become pregnant, and abortion care for women who need it. Advocates at the state and federal levels are urging both Congress and state governments to act quickly to address this disease, and in several states, legislators have added their voices to that chorus.[12]

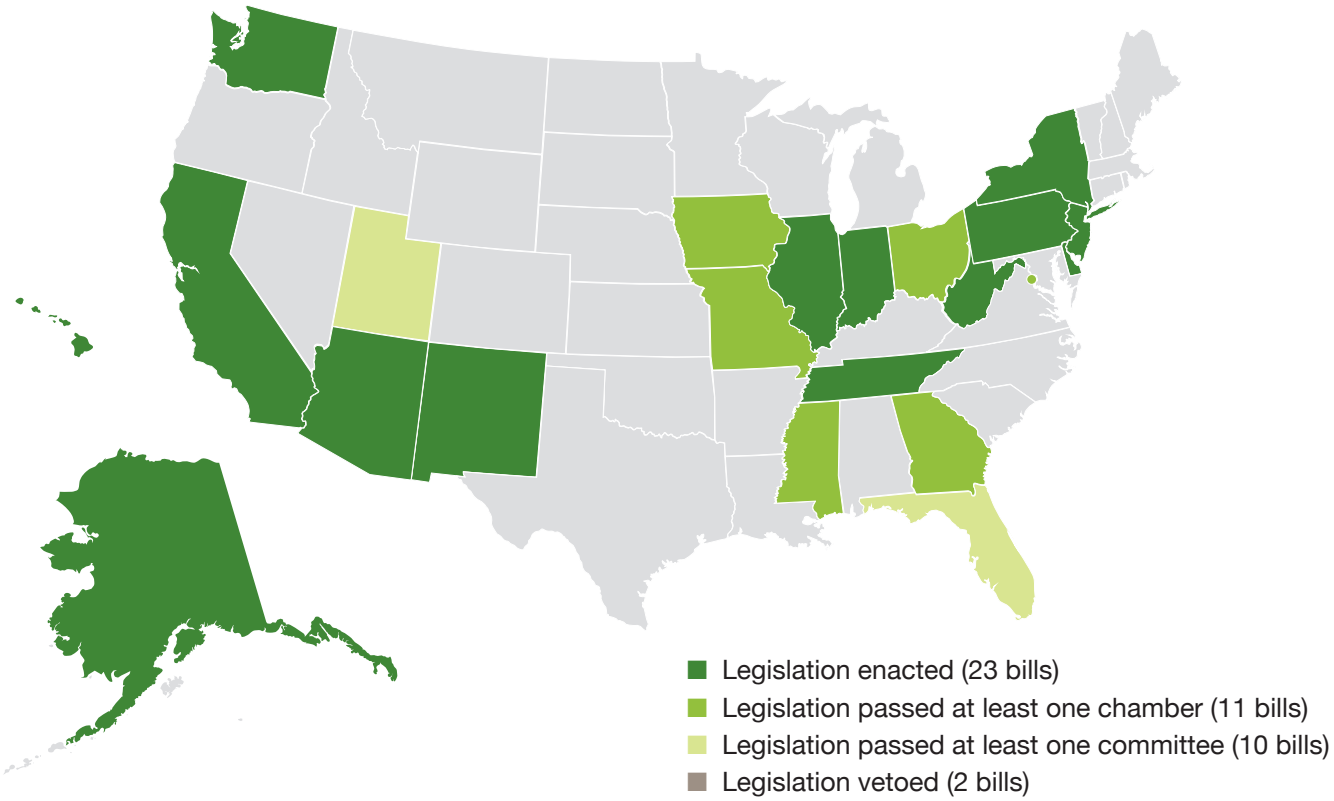
Four states have put forward legislation or resolutions addressing Zika as a sexual health issue. The **New Jersey** legislature adopted Senate Resolution 67, which calls on the president and other state and federal officials to work proactively to prevent Zika transmission and to search for a cure or vaccine. In **Hawaii**, a similar resolution, House

Concurrent Resolution 164, passed the House. Two similar resolutions were introduced but did not move in **Michigan**. In **Pennsylvania**, the legislature adopted House Resolution 694, calling February 2016 "Zika Virus Awareness Month" and supporting international, federal, and state efforts to raise awareness about and find ways to prevent Zika.

New Jersey is also considering Senate Bill 2476, which has passed one committee and will direct the state Division of Medical Assistance and Health Services to allow Medicaid coverage for treatment and prevention of the Zika virus and related health outcomes, including mosquito repellant, family planning services, diagnostic testing during pregnancy, and case management services for children born with disabilities related to Zika.

In other states, such as **Florida**, where Zika has spread the most quickly in the United States, executive officials have taken some steps to address the problem and advocates in the reproductive health community, including **Planned Parenthood Advocates of Florida** and **Equality Florida**, have come forward to urge further action.[13] In 2017, the medical community, advocates, and legislators will continue to learn more about Zika and how it can be controlled or prevented. We anticipate that new policy ideas and options will be moved forward in 2017 and encourage advocates to explore both administrative and legislative options to address this health threat, such as policies that would remove barriers to access to the full range of reproductive health care options, including abortion and contraception.

Movement of Proactive Legislation Protecting and Expanding Access to Abortion, Contraception, and Sexual Health Care in 2016



proactivefocus

PROACTIVE STRATEGIES FOR LONG-TERM SUCCESS

The 2016 election left anyone who cares about access to safe, legal, and affordable reproductive health care—particularly abortion—bracing for an onslaught of restrictions. This even more challenging environment may create a temptation to hunker down and strategize about how we defend the access that currently exists. But in the coming years, it will be more important than ever to continue to forge ahead with bold, proactive strategies that advance access, undermine our opposition, and build pathways to our vision of a world in which every individual is able to make and be supported in their own decisions about their reproductive and sexual lives.

When policy change is the primary goal, success is most easily measured by passage of a new law or adoption of a new regulation. However, advocating for policy change requires long-term strategies with multiple steps along the way to ultimate success—and each step in those strategies can be a measure of success in its own right. This is especially true with proactive policy change.

Advocating for a proactive bill presents an opportunity to contrast our positive vision with the often harmful, hypocritical proposals and messages presented by our opposition. Moreover, advocating for proactive legislation is an important way to engage the strong grassroots base—those who care about reproductive health, rights, and justice and want to improve conditions in their communities but may not have obvious opportunities to be "for" something, rather than simply opposed to bad policies.

In 2016, advocates across the country employed these strategies to build a stronger movement: For example, in **Ohio**—a state that has enacted more than 30 abortion restrictions since *Roe v. Wade* in 1973—advocates and legislators introduced the Access Without Apology legislative agenda, a broad package of proactive abortion bills, including insurance coverage and legislation to protect clinics from violence and harassment. Although advocates and bill sponsors knew that these bills were unlikely to pass in 2016, several advocacy organizations, including **NARAL Pro-Choice Ohio** and **Planned Parenthood of Greater Ohio**, used the bill introductions to draw attention to their vision of an Ohio where women could access abortion and other reproductive health care with dignity and respect. Actions on the ground included hosting a press conference with legislative sponsors to call for an end to the wave of restrictions passed in the last five years, educating their constituents about the bills and the harms they would address, and building a strong case when one of the bills came up for a hearing during the session. Although the proactive bills did not pass, this state-level proactive agenda inspired champions in the Columbus City Council who similarly wanted to take a stand and, ultimately, led to the passage of a municipal clinic protection law, Ordinance 1458, based on a bill in the Access Without Apology agenda.

Similarly, working toward passage of a resolution (typically a legislative body's statement that urges other public officials to make policy change, like a city council calling on a state legislature and/or Congress to allow Medicaid to pay for abortion care) can be used as a way to educate the public, galvanize grassroots support, and allow advocates and elected officials to take a public stand in favor of expanded access to reproductive health care.

In 2016, and for several years running, a resolution strategy spearheaded by the National Institute in partnership with All* Above All—a coalition committed to lifting the bans that deny women coverage for abortion—has been instrumental in shaping a new public conversation around abortion funding, engaging many new activists on this issue and emboldening legislative champions at the federal, state, and local levels. Over the past three years, the National Institute and All* Above All have partnered with local and state-based organizations to support a multi-layered strategy: At the local level, the two organizations are working with advocates to organize in their communities to introduce and move forward local resolutions that call on both the state and the federal government to support insurance coverage for abortion care by repealing the Hyde Amendment and any state laws banning coverage.

At the same time, a mutually reinforcing message is carried out on the state level in support of state legislation that would expand abortion coverage. Finally, on the federal level, a broad coalition works in support of the federal EACH Woman Act, which would reinstate insurance coverage for abortion under Medicaid and ensure coverage in all other federal health programs. This multi-layered strategy has already yielded clear results: Congressional co-sponsors of the EACH Woman Act have pointed to resolutions that have passed in their districts as part of their impetus to sign on to the federal bill, demonstrating how these three interlocking pieces are critical parts of the broad and growing movement to restore public insurance coverage for abortion. As of publication of this report, 12 cities had passed resolutions in support of abortion funding, including Boston; Los Angeles; Ithaca, New York; and Philadelphia in 2016.

In each new legislative session, introducing a proactive bill or resolution presents an opportunity to demonstrate an inspiring vision for reproductive health, rights, and justice; establish a positive contrast with those who oppose access to reproductive health care; motivate our supporters to stay engaged; and embolden our legislative champions who may agree with our policy positions but lack opportunities to step forward for something positive.

These introductions help us build power and support, engage in a different public conversation in our communities, and get us ever closer to our ultimate goal of expanding access to reproductive health care for all. Indeed, this is the groundwork that we must continue to lay, especially in the coming years.

sectionthree

ENHANCING INSURANCE COVERAGE FOR REPRODUCTIVE AND SEXUAL HEALTH CARE

Frequently, access to health care is determined, at least in part, by whether a person has insurance coverage and the scope of that coverage. In 2016, many states focused on removing barriers to contraceptive coverage and expanding coverage requirements to help people more easily and affordably access the kind of contraception they need. Overall, 17 states* considered, and seven of those enacted, legislation expanding and improving insurance coverage and other programs that pay for reproductive and sexual health care.

Contraception

Eleven states** took up legislation that would expand insurance coverage for contraception, and six enacted new laws. The ACA, which passed in 2010, requires that insurance cover contraception with no extra cost-sharing burden on consumers (meaning no co-pays or other out-of-pocket costs). Although this was a significant victory for women's health, implementation has been uneven and, at times, inadequate. Research by advocacy organizations in several states, including **Illinois** and **New York**, has demonstrated that many FDA-approved contraceptives are still not being covered and that women face significant barriers to accessing the coverage that exists.

Six states considered or enacted omnibus bills that would address these barriers. These bills codify the ACA's requirement into state law, making clear that insurance within the state must cover, with no cost sharing, all forms of FDA-approved contraceptive drugs and devices (as well as voluntary sterilization) and all related counseling. They also go further than the ACA's requirements in several ways: by ensuring gender equity in contraceptive services by covering male forms of birth control, by strictly limiting the ability of insurers to impose restrictions or delays on accessing contraception, and sometimes by requiring coverage of over-the-counter methods without a prescription. Some of these bills added in other pieces to improve access to care, such as making emergency contraception (EC) easier for consumers to access and afford or requiring insurance coverage of six or 12 months of contraception at one time, an advance discussed in more depth in "Filling Gaps, Ensuring Coverage for Birth Control" on page 21.

Illinois' House Bill 5576 and **Maryland's** House Bill 1005 / Senate Bill 848 were both enacted, and now require coverage with no co-pay of all FDA-approved contraceptive drugs and devices, sterilization, and related counseling and follow-up (and, in the case of Maryland, over-the-counter and male contraception). Both laws also limit the ability of insurance companies to impose restrictions and delays. Illinois House Bill 5576 was backed by a number of advocacy organizations, including the **ACLU of Illinois**, whose legislative director, Mary Dixon, said: "The vote … is a victory for thousands of women across the State of Illinois who, even with insurance, are forced to pay hundreds of dollars out of

*Alaska, **California**, Colorado, Connecticut, Florida, **Hawaii**, **Illinois**, **Maryland,** Massachusetts, Minnesota, Missouri, New Jersey, **New York**, Ohio, **Vermont,** Washington, and **West Virginia**
** Alaska, **California**, Colorado, **Hawaii**, **Illinois**, **Mayland**, New Jersey, New York, **Vermont**, Washington, and **West Virginia**

pocket in order to access the best contraceptive for them. House Bill 5576 will make a tangible difference for these women—both for their pocketbooks and for their health."[14]

Vermont enacted a similar bill, House Bill 620, which included almost all of the expansions and protections found in the **Illinois** and **Maryland** laws; it also included a provision that makes pregnancy a "qualifying event," allowing newly pregnant women to purchase insurance on the state health exchange outside of the normal enrollment period, and another provision directing the Department of Vermont Health Access to establish a program for adequate payments of insertion and removal of LARCs. (For other bills that increased access to LARCs, see page 9.) This legislation was supported by Planned Parenthood of Northern New England, whose CEO, Meagan Gallagher, stated that passage of this legislation "means that instead of thinking about what birth control a patient can afford, a woman can now think about what birth control method is right for her."[15]

The **New York** Assembly passed Assembly Bill 8135 / Senate Bill 6013, called the Comprehensive Contraception Coverage Act, which, in addition to requiring similar expansions and protections found in the Illinois, Maryland, and Vermont bills, also included a provision making EC more accessible and affordable. Similar omnibus legislation requiring broad coverage of contraception, counseling, and follow-up was considered in both **Alaska** (House Bill 345 as well as Senate Bill 156, which each passed one committee) and **Colorado** (House Bill 1294, which passed the House).

There were also efforts across the country to allow pharmacists to dispense, and require insurers to cover, more medication under one prescription than is currently permitted, as discussed in "Filling Gaps, Ensuring Coverage for Birth Control" on page 21. Five of the six omnibus bills above included requirements for either six- or 12-month dispersal coverage—those in Alaska, Illinois, Maryland, New York, and Vermont. Five additional states considered stand-alone laws that would require an insurance company to cover dispensing up to 12 months of contraception at a single time: **California** enacted Senate Bill 999; **Hawaii** enacted Senate Bill 2319, backed by a large advocacy push by Planned Parenthood Votes Northwest and Hawaii, which helped legislators understand that "[d]ispensing a one-year supply of birth control is associated with a 30 percent reduction in the odds of experiencing an unplanned pregnancy compared with dispensing for 30 or 90 days"[16]; **Colorado's** House passed House Bill 1322; **New Jersey's** Assembly Bill 2297 passed the Assembly and Senate Bill 659 passed one committee; and **Washington's** House Bill 2465 passed the House.

Four states considered legislation to expand access or reduce barriers to insurance coverage for contraception in other ways. **West Virginia** enacted Senate Bill 384 to address a gap in contraceptive coverage for low-income women who have just given birth. In that state, many low-income women are eligible for Medicaid only while they are pregnant and lose coverage soon after giving birth. Ideally, these patients would have access to contraceptive counseling and services while they are insured, but since many of these patients face barriers to receiving adequate prenatal care, sometimes their hospital stay for labor and delivery is the first time that they receive counseling for contraceptive options. Many are interested in tubal ligations, but patients are required to get approval from their insurance company 30 days before having a tubal ligation—at which point they will no longer be insured. Moreover, tubal ligations are effectively provided right after a cesarean birth, which is not

policyhighlight

Protecting Private Medical Information in Insurance

One of the most common barriers facing individuals seeking reproductive and sexual health care is the need or desire to keep these services confidential; this, in turn, can impact where they go for care and how they pay for it. For most health plans, when either the primary insurance policyholder or a dependent uses the insurance to pay for a service, an explanation of benefits (EOB) is sent to the primary policyholder.

This process was created in response to consumers' understandable need to comprehend their health care spending, which prompted insurers to move toward greater transparency in health care billing through documents like EOBs to explain what care patients (and their insurers) are being billed for. Unfortunately, then, EOBs can also pose threats to dependents' confidentiality, as the EOBs disclose to the primary policyholders services received by dependents such as spouses and children of any age. Spouses may need or want to keep their information confidential for a variety of reasons, including in situations where there is domestic violence.

Teens and adult children, a particularly large group now that the ACA allows parents to keep children on their insurance until the age of 26, may also need or want to keep their health information confidential. Advocates and legislators have recognized this confidentiality problem, and several states have adopted or proposed policies to create privacy protections for information sent to policyholders through EOB statements and other insurance-related paperwork.

Massachusetts' Senate Bill 2138, which passed the Senate, is an attempt to address these barriers while finding a balance with the need for transparency. This bill was backed by the PATCH Alliance—a diverse group of provider, advocacy, and community-based organizations concerned with maintaining confidentiality in health insurer communications with their members—headed up by **Health Care for All**. Gabrielle Ross, Executive Director of Health Quarters, described why the legislation was so needed, saying that "Protecting confidentiality is particularly acute at a reproductive and sexual health care agency, like Health Quarters, where many of our patients choose us to guarantee confidential care […] Without these proposed protections, many patients would otherwise forgo necessary testing, treatment, and prevention services."[17]

Senate Bill 2138 would require insurance companies to send EOBs directly to each insured dependent, rather than to the primary policyholder, using the method of delivery that the insured dependent has specified. This means that each individual accessing health care would receive information about their own services, instead of having all of that information go to the primary insurance policyholder. The EOBs would contain only generic information such as "office visit" rather than explicit descriptions that would identify a confidential service, helping to keep services like STI testing or contraceptive counseling private from those who may see an EOB.

Finally, the bill would allow each insured person to opt out of receiving an EOB at all if there is either no balance due on the service or if a disclosure of confidential information could compromise their safety or access to health services. This system could help, for example, domestic violence victims whose safety could be compromised by an EOB that describes, even in generic terms, a doctor's visit that their abusive partner did not know about.

possible if the woman learns about and decides to have one right after the birth but has to wait 30 days before receiving approval. The new law requires the Department of Health and Human Resources to seek a waiver from the federal government to eliminate this waiting period, thereby allowing low-income women to receive tubal ligations while they are still covered under Medicaid for pregnancy-related care.

In **California**, the Senate and one House committee passed Senate Bill 447, which would have simplified Medicaid processing and reimbursement for contraception, making it easier for women to access contraception directly at a health clinic. California's Senate Committee on Health passed Senate Bill 960, which would have allowed coverage under California's Medicaid program for reproductive health care provided via telemedicine. Although **New Jersey's** legislature passed Senate Bill 1017, which would have expanded Medicaid coverage of family planning services for individuals under 200 percent of the federal poverty line, Governor Chris Christie vetoed the legislation, as he has done for this and other family planning funding bills every year since 2010.[18] In **New York**, the **National Institute**, along with a coalition of other reproductive health organizations, supported Assembly Bill 5143 / Senate Bill 3151, which passed one committee and would have required employers to notify their employees in writing of any changes to contraceptive coverage on their employer-based health insurance plan.

Sexual Health Care

Eight states* considered and five of those states enacted legislation to improve coverage for sexual health services, from breast cancer screenings to STI testing and treatment. **California** enacted the Direct Access to Reproductive Health Care Act, which will ensure that patients are not required to get a referral for any reproductive or sexual health care but instead can go directly to their chosen provider. This legislation was supported by a large coalition of reproductive health, rights, and justice organizations, led by **California Family Health Council (CFHC) (now Essential Health Access)** and **California Latinas for Reproductive Justice (CLRJ)**, which explained that "[v]ariances in health plan networks and referral policies have created a patchwork of coverage and access to time-sensitive women's health services. This bill would level the playing field and create greater, more equitable and timely access to reproductive and sexual health care."[19] The National Institute is proud to have supported Essential Health Access and CLRJ in their work to pass Assembly Bill 1954.

Six states took steps to improve coverage for breast and cervical cancer screenings. **California** enacted Assembly Bill 1795, which establishes a breast and cervical cancer screening program for low-income, uninsured individuals. Other states considered increasing insurance coverage for cancer screenings, such as **Illinois'** House Bill 3673 (enacted), **Colorado's** House Bill 1381 (passed the House), and **New York's** Senate Bill 3510 (passed one committee), or ensuring that there would not be consumer cost sharing for them, such as New York's Assembly Bill 10679/ Senate Bill 8093 (enacted) and **Connecticut's** Senate Bill 158 (passed one committee).

States also addressed gaps in coverage for HIV/ AIDS care. One **California** Assembly committee passed Assembly Bill 2372, which would have allowed for patients to identify HIV specialists as their primary care provider, ensuring coverage for the type of care they need. **New York's**

* California, Colorado, Connecticut, Florida, **Hawaii**, **Illinois**, **Maryland**, and **New York**

policyhighlight

Filling Gaps, Ensuring Coverage for Birth Control

The ACA requires insurance coverage for female contraception, with no extra cost sharing (co-pays) for consumers. As a result, contraception should be easier than ever for insured women to access. Unfortunately, the challenges with oversight of this requirement have allowed insurers to retain uneven and inadequate coverage of the full range of FDA-approved methods. In many cases, insurance companies require co-pays for certain types of contraception, in conflict with the ACA; others have erected additional barriers, such as "step therapy," which requires women to try certain forms of contraception before allowing coverage for other forms, or prior authorization, which requires women to get approval from their insurance company before accessing their preferred form of contraception and is often a lengthy process.

Further, although the ACA was a huge step forward for access to contraception, there are still more ways to make contraception easier for women to access, regardless of their economic circumstances, as well as to make contraception without extra cost sharing available to men. Since the ACA's passage in 2010, states have begun to take steps to ensure implementation of the ACA requirements as well as to consider new ways to improve access to contraception.

In **New York**, the legislature took up Assembly Bill 8135 / Senate Bill 6013, also called the Comprehensive Contraception Coverage Act, which passed the Assembly. The **National Institute** made this a priority in 2016, along with a broad coalition of reproductive health and rights organizations, including Family Planning Advocates of New York State and the New York Civil Liberties Union. The bill would have closed the gaps that were found in New York by guaranteeing insurance coverage without a co-pay for a comprehensive range of contraceptive options for women and men, including vasectomies, and ending medical practices such as step therapy and prior authorization that delay access to the most appropriate contraception. It would have also allowed an individual to obtain up to 12 months of contraception at one time, reducing the barriers to consistent use that women, particularly those in rural areas, face.

Currently, most insurers will allow a pharmacy to dispense only between one and three months of contraception at one time. But recent studies have shown that dispensing 12 months at a time reduces unintended pregnancy, and both the Centers for Disease Control and Prevention (CDC) and the U.S. Department of Health & Human Services' Office of Population Affairs now recommend it.[20] Lastly, it would have increased access to EC: Currently, EC is available over the counter for approximately $50, which can be a significant cost barrier, or it can be obtained through a prescription with no co-pay. This bill would have allowed pharmacists to use a non-patient-specific prescription to allow women to use their insurance for over-the-counter EC, thereby allowing individuals to receive timely EC without a co-pay. If enacted, this bill would have decreased the barriers to accessing all kinds of contraception and actualized the full promise of the ACA.

legislature passed Senate Bill 8129, although the governor has yet to sign it, which will streamline information and consent requirements for routine testing of HIV/AIDS; authorize registered nurses to screen for chlamydia, gonorrhea, and syphilis; and expand access to pre-exposure prophylaxis (PrEP), a set of drugs that patients can take to lower their chances of contracting HIV. Housing Works led the advocacy efforts on this bill and stated that the legislation "provides us with the opportunity to increase HIV testing by streamlining the testing process and making it routine, bringing us closer to two key goals: 1) everyone knowing their HIV status and 2) reducing the stigma associated with having an HIV test. The legislation also allows HIV prevention medications to become more readily accessible after an exposure and builds a new linkage to care for individuals at risk."[21] Many states considered laws that will expand coverage of HIV- and AIDS-related drugs, with an emphasis on PrEP coverage, including **Illinois** House Bill 4554 (enacted), **Maryland** Senate Bill 91 (enacted), and **Florida** House Bill 583 / Senate Bill 780 (passed one committee).

Finally, **Hawaii** enacted House Bill 1897, which will now require insurance coverage for annual STI screenings.

Confidential Explanation of Benefits

Two states considered new laws to address confidentiality concerns that often arise for dependents on insurance plans, such as spouses, teens, or adult children of the primary insurance policyholder. (For more information, see "Protecting Private Medical Information in Insurance" on page 19). In **Illinois**, House Bill 887 passed one committee and would have required insurance companies to set up a system for each insured person to be able to request confidential communications for information pertaining to "sensitive health services." This would have allowed patients to ask that EOBs for certain services be sent to a different physical or electronic address, thereby helping the patient maintain their privacy. In **Massachusetts**, lawmakers took up Senate Bill 2138, which passed the Senate and would have allowed each insured person to choose an alternate method of receiving all EOB forms, regardless of the type of services, and have control over their own health information.

Pregnancy Care

Five states considered improving insurance coverage for pregnancy-related care. In its 2016 budget, **Massachusetts** appropriated new funding to provide remote mental health consultations for women who may be experiencing postpartum depression. Massachusetts House Bill 3701 / Senate Bill 2104 also passed a joint committee on health and would have provided coverage for low-income, uninsured women to receive postpartum depression screening from their children's pediatricians. **Minnesota's** House Bill 2703 / Senate Bill 2485 passed only one committee, but it would have allowed federally qualified health centers to determine presumptive Medicaid eligibility for pregnant women. (Presumptive eligibility is a process that is authorized by the ACA where states may allow certain health care providers to temporarily enroll women in Medicaid at the time that they show up for care, thereby allowing patients to receive the health services they are eligible for in a timely manner.) Another Minnesota bill, House Bill 3419, which passed one committee, would have created a grant program to develop new avenues for screening and treatment of pre- and postpartum depression and anxiety. **Missouri** Senate Bill 621/House Bill 1923, which would have expanded coverage for pregnancy-related telehealth services like maternal-

fetal ultrasounds and home telemonitoring, passed both the House and Senate with different language, but the two houses were unable to resolve their differences. **New York** took up three bills to improve pregnancy-related coverage: Senate Bill 6583 was vetoed by Governor Cuomo, but would have required insurance coverage for donor breastmilk for both home and in-patient use for certain infants; Assembly Bill 10066 passed the Assembly and would have ensured that pediatricians can screen for maternal depression under the child's insurance coverage; and Senate Bill 6715 passed the Senate and would have required the state to compile a searchable online list of health care providers treating maternal health depression. **Ohio's** House Bill 216 passed both chambers; it would expand the scope of practice of advanced practice registered nurses (APRNs) in a variety of ways, including by requiring insurance companies to cover follow-up maternity care when provided by an APRN.

Sexual Assault Care

Two states took steps to ensure coverage for health care related to sexual assault. **Minnesota's** Senate Bill 3102, supported by the Minnesota Coalition Against Sexual Assault, passed one committee and would have required the county where a sexual assault occurs to pay the costs incurred by a health care provider for treating sexual assault, including the cost of EC and prophylactic medication related to STIs. One committee in the **New York** Assembly moved Assembly Bill 10503, which would have ensured that every hospital provide treatment to sexual offense victims that would be paid for by the Office of Victim Services, including offering the full PrEP treatment, a set of drugs that patients can take to lower their chances of contracting HIV, to patients as CDC guidelines recommend.[22]

"Pregnant women and new mothers deserve high-quality, full-spectrum health care across the board. It is critical that pregnant and post-partum New Yorkers get coverage for the preventive mental health care they need."

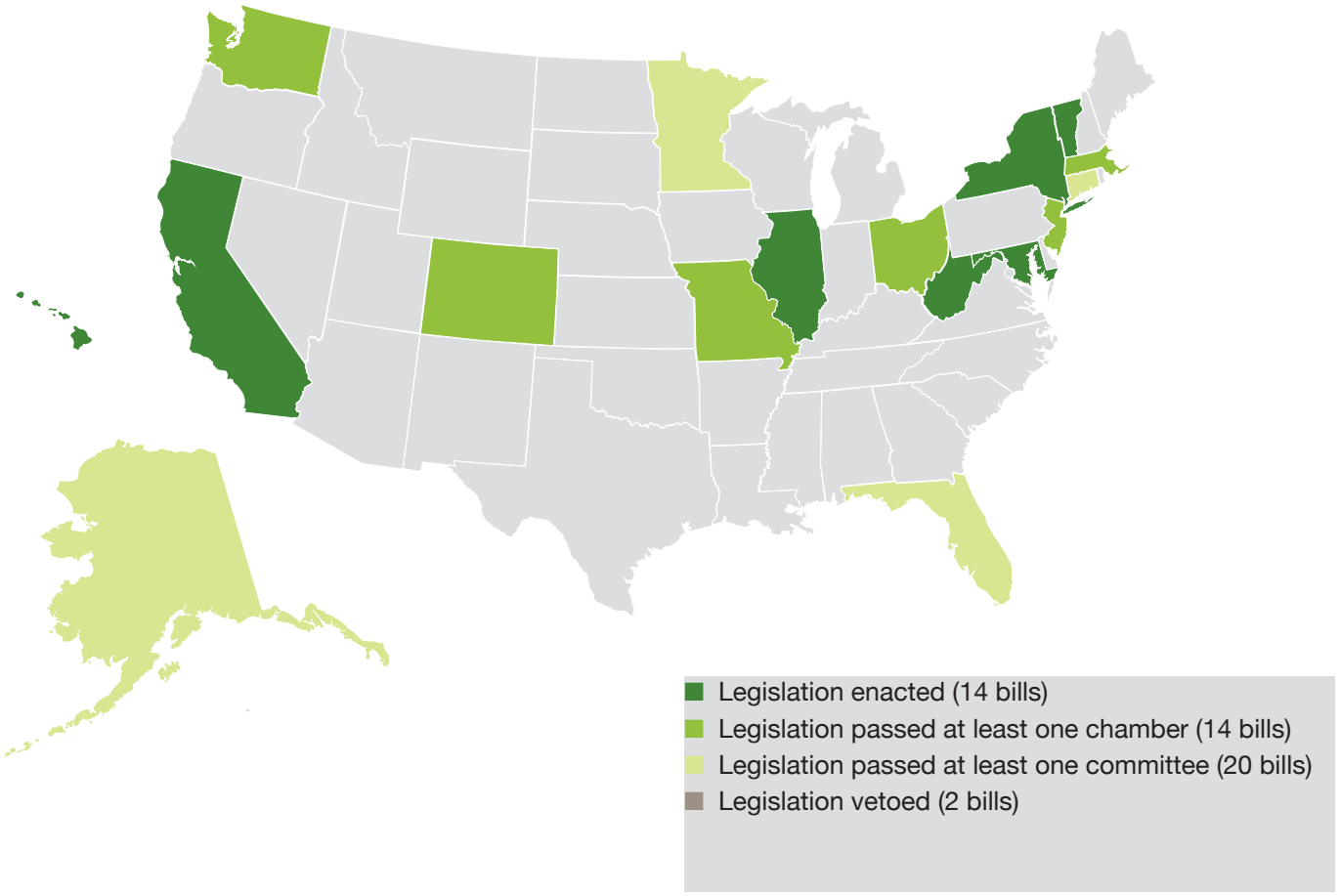
ANDREA MILLER

President of the National Institute, in response to the New York Assembly's passage of Assembly Bill 10066, which would have ensured that pediatricians can screen for maternal depression under the child's insurance coverage

Fertility Treatment

Two states expanded coverage of fertility treatments and assisted reproductive technology. **California** enacted Senate Bill 1408, repealing the state's ban on compensation for women who provide oocytes or embryos for research. In **New York**, legislators considered Assembly Bill 10137, which passed one committee and would have expanded coverage for fertility treatment. Current New York law requires coverage for some fertility treatments, such as diagnostic testing and medications, but does not require coverage for others, such as in-vitro fertilization. This bill would have required coverage for these treatments as well.

Movement of Proactive Legislation Enhancing Insurance Coverage for Reproductive and Sexual Health Care in 2016



proactivefocus

BUILDING ON THE VICTORY IN *WHOLE WOMAN'S HEALTH V. HELLERSTEDT*

In 2017, our movement must look for every opportunity to embrace and build on the victory in *Whole Woman's Health v. Hellerstedt*, in which the U.S. Supreme Court, in June 2016, struck down two of the nation's harshest abortion restrictions.

In *Whole Woman's Health*, the Supreme Court held that two medically unjustified Texas laws, one requiring physicians who provide abortion care to have hospital admitting privileges and another requiring all abortions to be performed in ambulatory surgical centers (often called TRAP laws), violated women's constitutional right to terminate a pregnancy.[23] The court also emphasized that in assessing abortion regulations, "courts [must] consider the burdens a law imposes on abortion access together with the benefits those laws confer."[24]

In light of the court's decision, many anti-abortion policies that have been enacted over the past two decades, including physician-only requirements, medication abortion restrictions, and, of course, TRAP laws, are arguably unconstitutional, and the court provided strong arguments to counter our opponents' specious claims that these laws promote women's health.

Advocates can continue to capitalize on the momentum from the *Whole Woman's Health* decision, along with the growing public concern over the fate of abortion rights and abortion access, to rally their own base, engage new grassroots supporters, and conduct further education in their communities and with the media about the need for abortion access and the harmful nature of abortion laws that currently impede it.

Advocates and lawmakers should consider using this important milestone to communicate our vision for abortion care, work together to eliminate these barriers, and boldly counter efforts to impose new ones. Making the case after *Whole Woman's Health* about what women need in order to have better access to care right now will improve women's health in the short term and lay the groundwork for legislative champions and grassroots activists to pursue broader proactive policies to expand access to comprehensive reproductive health care in the future.

sectionfour

IMPROVING THE REPRODUCTIVE AND SEXUAL HEALTH OF YOUTH

Fourteen states* considered, and seven of those states adopted, legislation aimed at improving the reproductive and sexual health of youth. Many focused on sexuality education, adding improvements to existing curricula—a needed stepping stone toward comprehensive, age-appropriate, and medically accurate sexuality education for all K-12 students. Comprehensive sexuality education has been linked to decline in teen pregnancy, delay in first intercourse, and increased usage of contraception.[25] Other states put in place programs that will help youth stay healthy or that will support pregnant and parenting youth.

Sexuality Education

Four states enacted laws aimed at improving sexuality education in schools. Three of these enacted legislation based on Erin's Law (**Delaware** Senate Bill 213, **Maryland** House Bill 72, and **New Hampshire** Senate Bill 460), which requires schools to teach children how to recognize and report sexual abuse; these laws, which passed in 26 other states since 2011, are named after Erin Merryn, a woman whose own sexual abuse experiences motivated her to campaign for such measures nationwide. Several other states tried to pass similar measures in 2016: **Hawaii's** House Bill 1782 passed one committee, the **New York** Senate passed Senate Bill 1947, and the **Ohio** House passed House Bill 85. Two states considered legislation that would have created an Erin's Law Task Force to make recommendations for a sexual abuse prevention curriculum: **Hawaii's** Senate Bill 2232 passed the Senate, while **Washington's** House Bill 2183 passed one committee.

Two states considered legislation that would add information about dating violence to sexuality education programs: **Virginia** enacted House Bill 659; **Iowa's** Senate Bill 2195 passed the Senate before the legislature adjourned.

Louisiana's House passed House Bill 402, which would have authorized the Department of Education and the Department of Health and Hospitals to anonymously survey high school students about risk behaviors associated with chronic health conditions, including sexual health. Marsha Broussard of the Louisiana Public Health Institute spoke at the Senate hearing, explaining the importance of this bill: "Only in the states of Louisiana and Georgia do we not include these additional questions on our YRBS [Youth Risk Behavior Survey], which is a standard survey done by the Centers for Disease Control every other year."[26]

Mississippi's Senate Committee on Education passed Senate Bill 2413, which would have replaced the state's abstinence-only requirement for sexuality education with a requirement that the curriculum be based on "personal responsibility" in middle and high school. Schools can choose their curriculum from a

* California, **Delaware**, **Hawaii**, Iowa, **Louisiana**, **Maryland**, Mississippi, **New Hampshire**, New York, Ohio, **South Carolina**, Utah, **Virginia**, and Washington

Department of Education list of approved curricula, or it must be approved by the department as evidence-based and medically accurate. **New York** considered Assembly Bill 1616 / Senate Bill 700, which passed several committees thanks to advocacy by a group of organizations led by the **National Institute** before the legislature adjourned; it would have established an age-appropriate sexuality education grant program within the Department of Health to be given to eligible school districts, boards of cooperative educational services, school-based health centers, and community-based organizations, particularly those in high-need areas. In **Utah**, House Bill 246, which would have replaced the state's abstinence-based curriculum with a comprehensive sexuality education curriculum, passed one committee. The bill would have also expanded Medicaid coverage for family planning services.

policyhighlight

Rights for Pregnant and Parenting Students

Although all students have the right to equal educational opportunities, pregnant and parenting youth often face major obstacles in receiving the education they deserve. Many students do not receive the support that they need to parent and stay in school, and some are actively pushed out of school by policies that do not take their circumstances into account.

California built upon its history of legislative initiatives to support educational equality by taking up Senate Bill 1014, which passed the Senate and one committee in the Assembly. The bill would have ensured that both pregnant students and parenting students, regardless of whether they gave birth themselves, could take sick leave from school without penalties, enhancing their ability to parent successfully and succeed academically.

Sexual Health Care

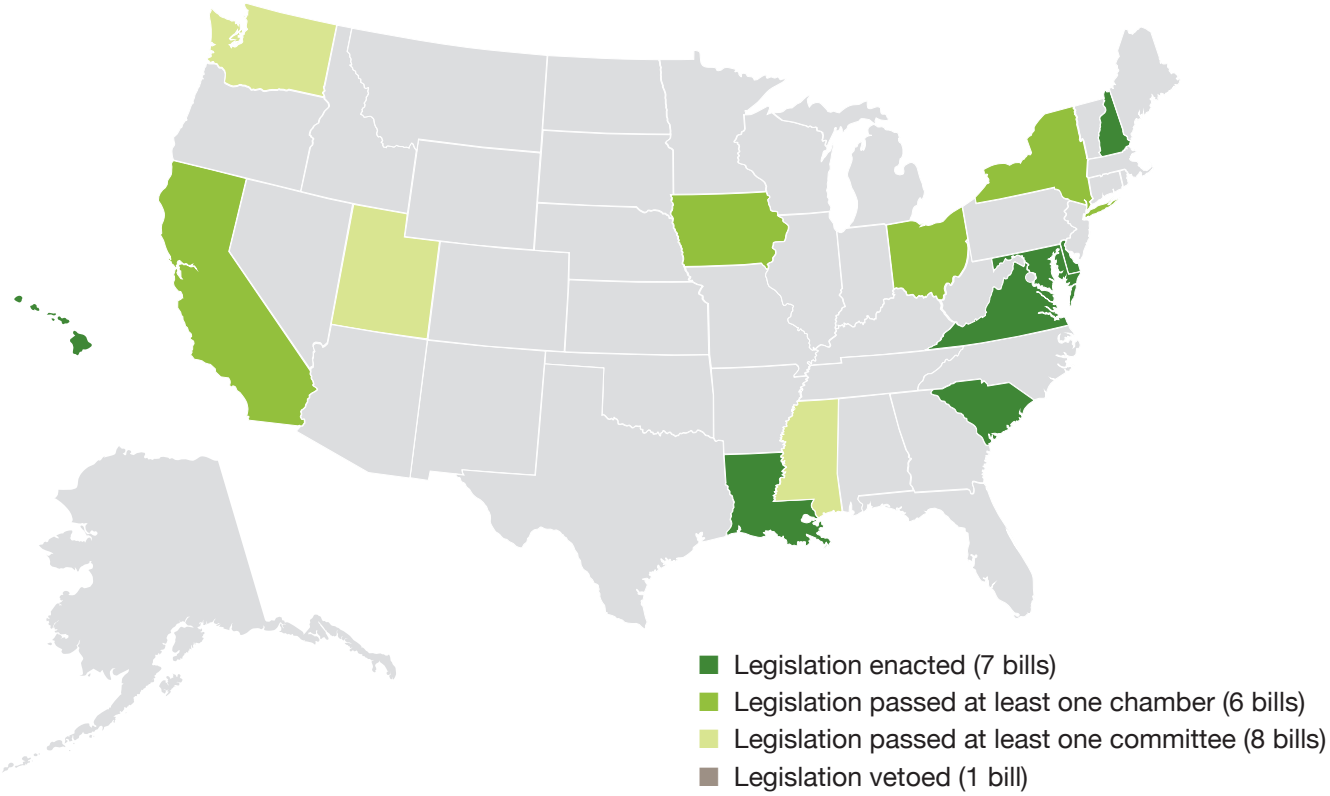
Three states took other steps to improve the sexual health of youth. For two, this involved measures to try to increase knowledge of and access to human papillomavirus (HPV) vaccines: **Hawaii** passed Senate Resolution 12, which calls upon the Department of Health and Education to provide educational information and materials about HPV to the parents of public school children based on recommendations by the CDC; **South Carolina's** House Bill 3204, which allows the Department of Health and Environmental Control to offer the HPV vaccine series to students enrolling in seventh grade, had been introduced in various forms since 2006 and was finally enacted into law in 2016 with the help of advocacy from reproductive health organizations such as Planned Parenthood South Atlantic, **South Carolina Coalition for Healthy Families**, and Tell Them. Unfortunately, this version of the bill includes a provision that bars the department from contracting for the provision of the vaccine with any health care provider that also provides abortion services, a provision that was not included in the nearly identical Senate Bill 278 that passed one committee.

New York considered legislation that would improve minors' access to HIV/AIDS testing. Assembly Bill 10184, which passed one committee, would have authorized health care providers to provide consenting minors with testing, diagnosis, referrals, and treatment for HIV/AIDS, including preventative treatment, without the consent or knowledge of a parent or guardian, and would have ensured the confidentiality of HIV/AIDS-related information.

Pregnant and Parenting Youth

Two states considered legislation that would support pregnant and parenting youth. **Louisiana** enacted Senate Bill 353 which directs public schools to develop policies to support pregnant students. In **California**, Assembly Bill 1838 passed both houses but was vetoed by Governor Jerry Brown. The bill would have increased the support that foster families receive when a foster child is a parent, made that support available before the birth of the infant, and created a curriculum for foster care providers on the reproductive rights of youth in foster care. California's Senate Bill 1014 passed the Senate thanks to advocacy from the Reproductive Justice Team, a coalition of the Woman's Foundation of California that includes organizations such as **ACT for Women and Girls**, **California Latinas for Reproductive Justice**, Girls Incorporated of Alameda County, **National Center for Youth Law**, and Planned Parenthood of the Pacific Southwest. The legislation would have allowed "care for a sick child" to be a form of excused absence from school and would have authorized a school's governing board to allow parenting leave for students for up to six weeks. As Lizzie Laferriere of the **National Center for Youth Law** stated, "All students have the right to equal educational opportunities regardless of sex. [This legislation] would take an important step forward to ensure students in grades 6-12 can continue their education while navigating parenthood."[27]

Movement of Proactive Legislation Improving the Reproductive and Sexual Health of Youth in 2016



proactivefocus

TEN REPRODUCTIVE HEALTH POLICY IDEAS TO CONSIDER FOR 2017

In 2016, advocates and legislators collaborated on new policy ideas, built on past successes, and pushed for long-overdue changes to existing policies that harm women and families. With the new challenges facing the reproductive health, rights, and justice movements in 2017, it is more important than ever to lay out a clear and compelling vision for the future that reflects the views and values of the majority in this country and improves people's lives and health.

FIVE PROACTIVE POLICIES THAT MOVED IN 2016

THE NATIONAL INSTITUTE SURVEYED PROACTIVE POLICY PROPOSALS INTRODUCED AROUND THE COUNTRY AND IDENTIFIED THE MOST INSPIRING POLICIES THAT MOVED IN 2016. TOGETHER WITH THE FIVE POLICY IDEAS ON THE FOLLOWING PAGE, THEY HAVE THE POTENTIAL TO CHANGE THE PUBLIC CONVERSATION ABOUT REPRODUCTIVE HEALTH, RIGHTS, AND JUSTICE AND ULTIMATELY IMPROVE AND EXPAND ACCESS TO REPRODUCTIVE HEALTH CARE.

Ensuring that patients receive timely access to abortion and other reproductive health care and information by amending a state's law to require that even when a medical provider has an objection to providing some types of medical care, including abortion, the patient can still access it. (See page 8.)

Protecting privacy in abortion and other reproductive health care by ensuring that confidential information about an individual's health care, including abortion care, is sent directly to that person, not to the person who holds the insurance policy. (See page 19.)

Protecting and expanding access to contraception by requiring contraceptive coverage with no cost sharing and without delays or barriers and providing coverage for 12 months of contraception with one prescription and for over-the-counter contraception. (See page 21.)

Protecting and promoting the health of incarcerated pregnant women by prohibiting shackling, requiring prisons and jails to meet health and nutrition standards for pregnant prisoners, and following through on all of those guarantees after they are enacted into law. (See page 35.)

Protecting the rights of pregnant and parenting students by allowing students to take sick leave without endangering their academic career. (See page 28.)

FIVE BOLD IDEAS TO CONSIDER FOR 2017

THE FOLLOWING FIVE POLICY IDEAS ARE SOME OF THE BOLDEST IN THE STATES AND, ALTHOUGH THEY WERE NOT ACTED UPON IN 2016, THEY SHOW ENORMOUS PROMISE FOR FUTURE YEARS.

Promote healthy women and families by enacting legislation that provides comprehensive insurance coverage for the full range of reproductive health care, including contraception and abortion, prenatal care, postpartum care, and breastfeeding support and supplies for all women, regardless of where their insurance comes from or their immigration status.

Ensure that abortion patients receive medically accurate and appropriate care by allowing doctors to provide only scientifically supported information and care and enabling patients to refuse biased, misleading, or unnecessary information, testing, and protocols.

Protect abortion patients and providers by keeping their personal information confidential, allowing them to sue those who harass them to prevent further harassment and violence, and working with law enforcement to ensure that those who are tasked with protecting clinics are equipped with the training and information they need to do so.

Ensure access to abortion care by prohibiting restrictions on abortion that burden abortion access and do not provide legitimate health benefits, and by removing existing laws that impose those burdens.

Expand access to reproductive health care for women in rural areas by allowing for the provision of health services, including medication abortion, through telemedicine.

For more information about these and other policy ideas for 2017, contact Jordan Goldberg at jgoldberg@nirhealth.org or 646-520-3521.

sectionfive

PROMOTING HEALTHY PREGNANCIES, PARENTS, AND INFANTS

Twenty-eight states and the District of Columbia* considered, and 20 states and the District of Columbia enacted, legislation to promote healthy pregnancies, parents, and infants, ranging from prohibiting employment discrimination against pregnant women to ensuring that the full range of qualified health care professionals can provide reproductive and sexual health care.

Health Care for Pregnant Women

Ten states** considered and seven of those enacted legislation to improve health care for pregnant women, with policies ranging from protecting the rights of pregnant women and girls who are incarcerated to ensuring access to prenatal care.

Three states considered measures that would prohibit the mistreatment of incarcerated pregnant women and girls, as well as minors in general, as is described further on page 35. **Maryland**, which enacted anti-shackling legislation in 2014, enacted two bills in 2016 focused on better understanding the standards in the detention system: Senate Bill 946 will require the state Department of Public Safety and Correctional Services to submit an annual report with information about all prisoners placed in solitary confinement, including prisoners known to be pregnant, and House Bill 1634 will create a task force to study the shackling of youth in the juvenile justice system.

Massachusetts considered House Bill 3679, which has passed several committees, to further protect the health of incarcerated pregnant women. The bill would add new requirements to ensure that the intent of an initial law passed in 2014—that pregnant and postpartum women are not shackled and that they receive adequate health care and nutrition—is truly fulfilled. **New York's** Assembly passed Assembly Bill 1347, which would have gone further, prohibiting solitary confinement for women who are pregnant, postpartum, or living with their infants while in prison.

Three states enacted laws to increase access to substance abuse treatment for pregnant and parenting women. As public health organizations like ACOG, advocates like the Drug Policy Alliance, and even the Obama Administration agree, criminal penalties are not effective for reducing substance abuse and make it more difficult for doctors to establish the relationships with patients necessary to provide high-quality prenatal care.[28] As a Committee Opinion from ACOG states, "[d]rug enforcement policies that deter women from seeking prenatal care are contrary to the welfare of the mother and fetus."[29]

Colorado enacted Senate Bill 202, which now requires managed care organizations to assess existing availability of services for substance abuse programs for pregnant, postpartum, and parenting women, and to come up with a community action plan to increase access to effective substance abuse services.

---

* **California**, **Colorado**, **Connecticut**, **Delaware**, **District of Columbia**, **Hawaii**, **Illinois**, **Indiana**, Iowa, **Kentucky**, **Maryland**, Massachusetts, Michigan, Minnesota, **Mississippi**, Missouri, **New Hampshire**, New Mexico, **New York**, Ohio, **Rhode Island**, **South Carolina**, **South Dakota**, **Tennessee**, **Utah**, Virginia, **Vermont**, **Washington**, and **West Virginia**

** **Colorado**, **Indiana**, **Maryland**, Massachusetts, New Mexico, **New York**, **South Dakota**, **Utah**, Washington, and **West Virginia**

Organizations will receive funding appropriated from the state's marijuana tax cash fund for programs to implement their community action plans. **Indiana** enacted Senate Bill 186, which now prohibits any health care provider from releasing the results of drug or alcohol screenings of pregnant women to law enforcement without either consent from the woman or a court order. **West Virginia** enacted House Bill 4347, which requires health care providers who accept Medicaid and treat substance abuse to give priority to pregnant patients and prohibits providers from refusing access to services because of pregnancy.

Two states would have expanded access to prenatal care. **South Dakota** enacted House Bill 1110, which had been considered for several years and will expand access to prenatal care for women who are not eligible for Medicaid because of their immigration status. While this expansion of care will have a major positive impact on South Dakota women, it raises some understandable concerns by purporting to give the coverage directly to the fetus rather than the woman. Concerns about this approach include that it makes a woman's access to health care contingent on her connection to her fetus, which means both that the woman's health is viewed as subordinate and also that the coverage for the woman ends when the pregnancy ends, leaving her potentially without coverage for important postpartum care. For these reasons, this would not be a recommended approach for other states seeking to expand access to prenatal care for groups that are not currently able to get coverage. Following the recommendations of the U.S. Preventative Services Task Force, **Washington's** Senate Bill 6270, which passed one committee, would have required all state Medicaid programs offered by the state's Health Care Authority to provide prenatal vitamins to all women who could become pregnant.

Four states considered legislation to increase access to freestanding birthing centers. **Maryland** enacted House Bill 1303, mandating new regulations to allow the use of ultrasound machines, which had previously been prohibited at freestanding birthing centers. **New York** enacted Assembly Bill 446, a bill that includes midwifery birth centers as part of the statutory definition of a hospital, thereby making it easier for such centers to open and operate. **Utah** enacted Senate Bill 108, a bill limiting the types of restrictions that the state Department of Health can impose on birthing centers to ensure that women can continue to freely access care at those facilities. Among other things, the bill prohibits the Department of Health from requiring providers at birthing centers to maintain admitting privileges at a hospital, and while it allows the department to require birthing centers to each develop a written transfer plan for emergencies, it prohibits the department from requiring each facility to have an agreement with the hospital. Utah appears to have recognized, in the context of labor and delivery, that these types of restrictions lack medical justification, should not be arbitrarily imposed, and that they prevent women from accessing the reproductive health care they need. Such unjustified requirements have often been applied to abortion providers, a trend that will hopefully be truncated by the U.S. Supreme Court ruling in *Whole Woman's Health* (see page 25).

Finally, **New Mexico** considered Senate Bill 291, which passed a Senate committee and would have given Medicaid recipients the option of giving birth outside of a hospital and receiving care from a certified nurse midwife.

Maternal and Infant Health

Nine states* considered and six of them enacted legislation to improve maternal and infant health and reduce mortality and morbidity. Maternal mortality and morbidity continue to be major

policyhighlight

Human Rights and Health Care Services for Pregnant Women Who Are Incarcerated

In 2014, with unanimous support from the legislature and governor, **Massachusetts** enacted a groundbreaking law to promote the health of pregnant women who are incarcerated.

Although 22 states have banned shackling of incarcerated pregnant women,[30] the 2014 **Massachusetts** law went further to protect women's health: It prohibited most restraints from being used on pregnant prisoners beginning in the second trimester and any restraints at all while in labor and during the postpartum period, mandated access to a range of physical and mental health services for pregnant and postpartum prisoners, and required the state to create basic standards for health care and nutrition for incarcerated women.

The bill was supported by a broad coalition of medical groups, criminal justice organizations, and women's rights groups, including **Prison Birth Project** and **Prisoners' Legal Services**. After the law was enacted, Prison Birth Project and Prisoners' Legal Services engaged in an implementation project, supported by the National Institute, to ensure that the law was properly enforced. Over the course of their extensive research, resulting in the Breaking Promises: Violations of the Massachusetts Pregnancy Standards & Anti-Shackling Law report,[31] it became clear that, in fact, the law was not adequately understood or enforced. This lack of enforcement is not unique to either **Massachusetts** or anti-shackling legislation—in fact, many proactive victories may not result in the intended outcome without additional advocacy with the enforcement agencies.

After documenting the continuing problems, the **Massachusetts** advocates once again worked with lawmakers to try to address the significant harms to maternal and infant health and human rights violations that occur when pregnant women who are incarcerated are shackled and given inadequate health care and lack access to nutrition and other basic needs. House Bill 3679, which passed several committees, was proposed to fill some of the gaps left by the 2014 law, and would add new requirements to ensure that the intent of the initial law is truly fulfilled. This bill has been championed by a large coalition of advocacy organizations, medical groups, and clergy, led once again by the Prison Birth Project and Prisoners' Legal Services.

problems in the United States, particularly among certain communities, despite our advanced health care system. For instance, African-American women are "more than three times as likely to die as a result of pregnancy and childbirth than white women [are] in the United States."[32] Efforts to reduce maternal mortality and morbidity and to address these disparities are critical for ensuring that every woman in the United States who becomes pregnant—regardless of her race, income, or where she lives—stays healthy and has a healthy pregnancy outcome.

Five states considered further studying maternal mortality and morbidity, with the goal of improving care and outcomes. Of those, three states enacted

* California, **Connecticut**, **Hawaii**, Michigan, Ohio, **Rhode Island**, **South Carolina**, **Tennessee**, and **Washington**

new legislation to create maternal mortality review programs that include the creation of a team of experts that will study all incidents of maternal mortality and make recommendations to their respective departments of health and legislatures: **South Carolina** House Bill 3251, **Tennessee** Senate Bill 2303, and **Washington** Senate Bill 6534. **California's** Assembly passed a similar bill, Assembly Bill 508. **Hawaii** enacted Senate Bill 2317, which requires annual reporting and study, but allows for, rather than requires, a multidisciplinary, multi-agency approach. Hawaii Senate Bill 1033 would have created a stronger review program, but only passed one committee. A related bill, **Michigan** House Bill 4235, which would require all physicians and health care facilities to report information about maternal deaths to the state, has passed both houses and is on the governor's desk.

Two other states enacted laws intended to improve infant health and overall child development. **Connecticut** enacted Senate Bill 218, which will now require health care providers who test newborns for HIV at birth to inform the infant's mother of the results before she leaves the hospital and to provide her with resources if the infant tests positive. **Rhode Island** enacted House Bill 7220, which created a statewide visiting nurse service program that aims to use evidence-based models to improve child and family outcomes, including improved prenatal, maternal, infant, and child health; child safety; and early childhood education, among other indicators. The **Ohio** Senate and House have passed Senate Bill 332, which, if signed by the governor, would have required both the Department of Health and the Department of Medicaid to create an infant mortality scorecard to monitor and report infant health indicators.

Preventing Pregnancy Discrimination

Pregnant women often face discrimination in the workplace— for example, employers can refuse to consider a candidate who is pregnant or refuse to accommodate some basic need of a pregnant employee. Since 2014, a dozen states have enacted legislation designed to address these problems, and in 2016, 12 states and the **District of Columbia*** considered legislation and six states and the District of Columbia enacted laws to reduce discrimination against pregnant and breastfeeding women in the workplace.

Colorado enacted House Bill 1438, a Pregnant Workers Fairness Act that requires employers to provide pregnant or postpartum employees or applicants with reasonable accommodations, including longer breaks and the ability to sit or bring water to a work station. The law also prohibits employers from requiring pregnant or postpartum employees to take accommodations that the employee did not ask for, and it requires employers to provide information about these rights in writing and by posting them in the workplace. **Utah** enacted Senate Bill 59, which ensures that public employers who are not based in office buildings can provide non-electric insulated containers for breastmilk; these employers were already required to provide accommodations for nursing mothers in the workplace, including refrigeration for breastmilk. The **Iowa** Senate passed a similar bill, Senate Bill 2252, and the Washington House (HB 2307) and Senate (6149) passed similar legislation but could not reconcile the differences in order to pass the law. One committee in the **Kentucky** House also passed a similar bill, House Bill 18, but an anti-abortion amendment was attached to it on the House floor, and supporters of women's health and rights refused

* California, **Colorado**, **District of Columbia**, **Hawaii**, Iowa, **Kentucky**, Massachusetts, Minnesota, **Mississippi**, **New Hampshire**, New York, **Utah**, and Washington

to enact it as amended.[33] Finally, the **District of Columbia** enacted Bills 604 and 605, amending its existing Protecting Pregnant Workers Fairness Act to ensure that employers accommodate pre-birth complications as well.

Leading medical organizations, including the ACOG[34] and the American Academy of Pediatrics,[35] encourage new mothers to breastfeed their newborns exclusively for at least six months and then along with food for a year, and they urge physicians to "support each woman's informed decision about whether to initiate or continue breastfeeding."[36] However, while 79 percent of new mothers start out nursing, only 49 percent of them are still nursing by six months, and only 27 percent are nursing at a year.[37] Some of the most common barriers to breastfeeding include having to return to work soon after giving birth, having no place to pump or store breastmilk when back at work, initial problems with breastfeeding, and no access to lactation help.[38] Another barrier that states have been eager to address over the last few years is mandatory jury service while breastfeeding.[39]

Eight states considered legislation specifically to ensure the health and rights of nursing mothers in the workplace and elsewhere. **Hawaii** enacted Senate Bill 2315 / House Bill 2585, which provides a jury exemption for breastfeeding women for two years after birth. **Kentucky** adopted Senate Concurrent Resolution 9, recognizing the importance of removing barriers to breastfeeding in the workplace and through health programs. **Mississippi** enacted Senate Bill 2070, which acknowledges the benefits of breastfeeding, notes that Mississippi has one of the lowest breastfeeding rates in the country, and creates a program through which the Department of Health will both develop materials for state agencies and others about the benefits of breastfeeding and encourage hospitals to support mothers' infant feeding decisions.

Six states and the District of Columbia enacted laws to reduce discrimination against pregnant and breastfeeding women in the workplace.

New Hampshire enacted Senate Bill 488, which establishes an advisory council on lactation to examine best practices in the state and make recommendations for additional legislation to support breastfeeding.

California's Assembly and one committee in the Senate passed Assembly Bill 2589, which would have expanded access to the Women, Infants and Children's (WIC) program and required it to study breastfeeding rates and barriers among participants in its programs. In **Massachusetts**, the Joint Committee on Health passed Senate Bill 1148, which would have required the existing state maternity bill of patient rights to include that all hospitals must support mothers' infant feeding decisions. In **Minnesota**, Senate Bill 2154 and House Bill 2322 each passed a committee and would have created a licensing and certification structure for certified lactation consultants, which would have increased access to those providers for nursing mothers.

New Hampshire's Senate passed Senate Bill 219, which would have required employers to provide accommodations for nursing mothers on the job and provided a jury exemption. The **New York** Assembly passed Assembly Bill 9767, which would require many public buildings to provide nursing mothers with a private space to nurse or pump. One committee of the New York Senate passed a narrower bill, Senate Bill 6026, which would require airports to provide appropriate private spaces for nursing or pumping mothers.

Expanded Family Leave

Across the country, states and localities are taking a hard look at the fact that the United States is the only industrialized country without paid family leave.[40] Although the benefits of paid leave are clear, from better health outcomes for mothers and children to more equitable division of childcare between working parents,[41] paid family leave legislation has not yet moved in a meaningful way on the federal level.[42] According to the U.S. Department of Labor, only 12 percent of employees have access to any type of paid family leave, while the vast majority of workers are faced with family caregiving responsibilities and cannot afford to take or do not have access to unpaid leave.[43] Several states and localities have addressed this issue, including **California**, **New Jersey**, **Rhode Island**, and **Washington**. Many other states recognize the problem and are actively debating how to address it.

In 2016, 13 states and the District of Columbia* took up the issue of paid and unpaid family leave, and eight states enacted legislation that made some progress toward supporting working parents, adult children, and others with family members who need care.

California, which already gives many workers six weeks of paid family leave but with a minimal amount of wage replacement, enacted Assembly Bill 908, which increases the amount of money available to employees during both family and disability leave and also removes an existing seven-day waiting period before individuals are eligible for the paid leave.

Connecticut already has an unpaid family and medical leave program entitling employees to take 16 weeks away from work. In 2016, Connecticut enacted Senate Bill 262, which added a new reason for permissible leave: that a son or daughter has been called for active service in the military. In addition, a committee in the Connecticut Senate passed Senate Bill 221, which would have established a new paid family and medical leave program with 12 weeks of paid leave funded through a payroll tax.

---

* **California**, **Connecticut**, **Delaware**, District of Columbia, **Hawaii**, **Illinois**, Iowa, **Maryland**, Massachusetts, Minnesota, Missouri, **New York**, Utah, and **Vermont**

Delaware considered a number of options to help families and enacted House Bill 317, prohibiting employers from discriminating against an employee based on current or possible family responsibilities, as part of its agenda for women's economic equality in 2016 (see description on page 9). A committee in the Delaware House passed House Bill 301, which would have provided six weeks of unpaid leave specifically for mothers of twins or multiple babies, even if the mother had already used her federal medical and family leave time for complications prior to birth. Another committee passed House Bill 165, which would have given all state employees the right to 12 weeks of paid leave for the birth or adoption of a child.

Hawaii, which already has an unpaid family leave program, adopted Senate Resolution 57, which calls for the creation of a task force to determine costs and benefits of creating a paid family leave program. Two other pieces of legislation that would create similar study committees passed only the Senate—Senate Bill 2961 and Senate Concurrent Resolution 86. Hawaii also considered House Bill 1683, which passed both chambers in different forms before going to a conference committee and would have provided four weeks of family leave to care for siblings.

Illinois enacted Senate Bill 2817, which eliminates the requirement that a physician provide proof of disability before a woman can take eight weeks of disability leave after a pregnancy. Illinois House Bill 166 passed one house committee and would have required state agencies to provide partial wage replacement for six weeks for eligible state employees for the birth or adoption of a child.

Maryland passed House Bill 740, which created a task force to study family and medical leave programs in other states and make a recommendation about whether to adopt a program in the state.

Across the country, states and localities are taking a hard look at the fact that the United States is the only industrialized country without paid family leave. Although the benefits of paid leave are clear, from better health outcomes for mothers and children to more equitable division of childcare between working parents, paid family leave legislation has not yet meaningfully moved on the federal level.

New York enacted a new paid family leave program in the state budget, Senate Bill 6406 (along with associated appropriations in Assembly Bill 9005), which will provide employees with 12 weeks of paid leave to care for a child or family member. The program, one of the most expansive in the country, will provide wage replacement of up to 67 percent of weekly salary for many workers and will be paid for through a small employee payroll tax. The program also includes construction workers who work for multiple employers and would otherwise therefore be ineligible. New York's bill was championed by the New York Paid Leave Coalition, composed of a wide range of advocacy organizations from labor, women's health, and other social justice movements, including the **National Institute**. The **District of Columbia** City Council pushed a similar bill, DC Bill 696, but it is likely to be vetoed by the mayor.

New York also considered three other bills that would have expanded family leave. The Assembly passed both Assembly Bill 3870, which would have expanded paid workers' compensation benefits to include disability leave due to pregnancy and 12 weeks of family care leave after the birth or adoption of a child, and Assembly Bill 10680, which would have expanded the group of employees eligible for family leave benefits to those in contracting and construction positions who work for multiple employers. The Senate passed Senate Bill 7599, which ensures that employers' unemployment rates are not affected by the termination of an employee who was brought on to cover another employee's family leave time.

Vermont included funding in its enacted budget, House Bill 611, for a study of the feasibility of a paid family leave program for the state, building on a study conducted by a study committee established by the Vermont General Assembly in 2013.

In **Massachusetts**, the Senate passed and the House is now considering Senate Bill 2477, which would entitle employees to take up to 16 weeks of parental leave or 26 weeks of paid temporary disability and would provide up to 50 percent wage replacement for many workers.

Iowa's Senate considered Senate Bill 2097, which passed one committee and would have required many employers to provide specific paid leave for prenatal appointments. Several committees in the **Minnesota** Senate passed Senate Bill 2558, which would similarly have created a paid family and medical leave program with 12 weeks of paid leave. One committee in the **Massachusetts** Senate passed House Bill 4351, which would establish a paid family leave program with 12 weeks of paid leave for the birth, adoption, or fostering of a child, and 26 weeks of temporary disability leave for the employee's own health conditions, including pregnancy. One committee in the **Missouri** House passed House Bill 2228, which would have provided 10 days of paid parental leave for state employees. One committee in the **Utah** House passed House Bill 188, which would have required state agencies to provide six weeks of paid parental leave to eligible state employees for the birth or adoption of a child.

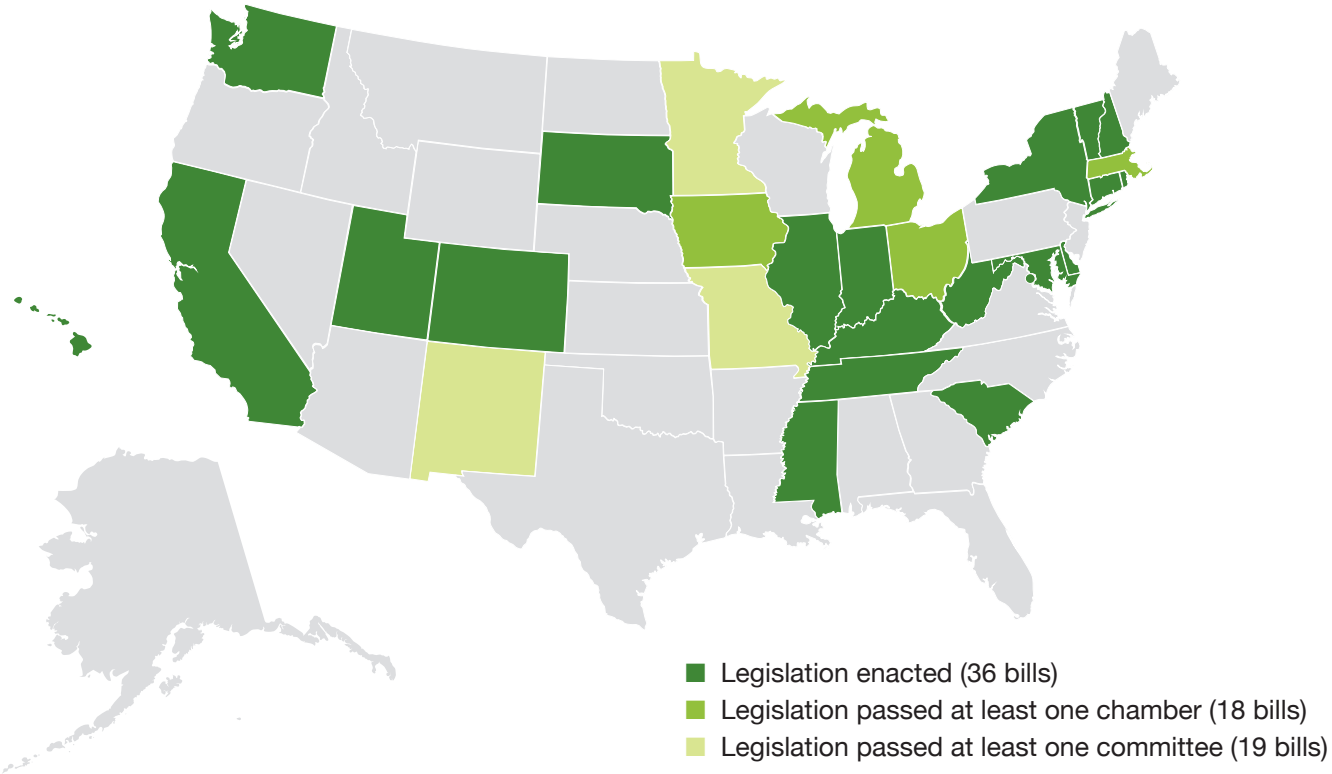
Scope of Practice

Many Americans face significant barriers to accessing both reproductive and general health care, simply because their community lacks a sufficient number of physicians.[44] These types of barriers disproportionately affect women who live in rural communities, low-income women, and women of color.[45] One of the primary ways to address the physician shortage is to empower other qualified health care professionals to provide basic primary and reproductive health care.[46] However, in many states, existing state law prevents PAs and APRNs from providing that care, even though it fits squarely within their

scopes of practice.[47] Over the past few years, a number of states have enacted laws loosening restrictions on advanced practice clinicians such as PAs and APRNs in order to expand access to primary and reproductive health care in those states. In 2016, four states considered or enacted legislation to expand the scope of practice of advanced practice clinicians in ways that will increase access to reproductive health care for women in those states.

Colorado enacted Senate Bill 158, which expands PAs' scope of practice and specifically requires that insurance companies provide direct access to reproductive health care provided by a PA without a referral. **Illinois** enacted a similar bill, Senate Bill 2900, which expands the definition of health care provider to include both PAs and APRNs, thus allowing both types of health care professionals to deliver a range of general and reproductive health care. Other states enacted legislation that gives advanced practice clinicians the ability to provide one or more specific types of care to expand access: **Connecticut** enacted Senate Bill 67, which will now, among many other things, allow APRNs to certify illness or disability in order for employees to be eligible to take family and medical leave. **Hawaii** enacted a broader bill, Senate Bill 2672, which will now allow APRNs to deliver a range of reproductive health services, including certifying illness or disability for family and medical leave and authorizing pharmacists to provide EC "behind the counter."

Movement of Proactive Legislation Promoting Healthy Pregnancies, Parents, and Infants in 2016



sectionsix

CONCLUSION: LOOKING FORWARD

During 2016, 36 states and the District of Columbia* passed or moved 191 pieces of legislation aimed at advancing the reproductive and sexual health of their residents. These 2016 numbers continue the proactive trend established over the last few years, showing that a broad and organized movement is building to defeat efforts to restrict access to reproductive health care and promote a new landscape that respects and supports people in their sexual and reproductive lives.

Grassroots activists, advocacy organizations, and elected officials all worked together to pass 80 pieces of legislation, from protecting access to abortion even when some health care providers have religious objections, to requiring insurance companies to cover 12 months of contraception with one prescription, to the creation of a new paid family leave programs, many of which resulted from years of strategic collaborations and long-term support from advocates and legislators dedicated to improving the lives, health, and well-being of their constituents and communities. Progress happened in states across the country, in traditionally progressive political environments and consistently conservative states alike. Indeed, over the last two years, advocates for reproductive health, rights, and justice have made progress despite facing challenging and, at times, outright hostile legislatures and governors in more than half the states.

That forward momentum does not have to end in 2017.

Policy change is possible—each section of this report shows the many new proactive policies that are now law across the country. But change takes time, energy, and long-term commitment: For example, in 2016, **Illinois** House Bill 1564, a bill removing harmful barriers to abortion care, and **New York** Senate Bill 6406, enacting 12 weeks of paid leave, became law after many years of strong, focused support from the advocacy community over a number of sessions. Even in states traditionally opposed to reproductive health, rights, and justice, the many-year resolve of advocates and their allies in government paid off in 2016: For example, **Arizona** repealed some of its harmful restrictions on medication abortion in Senate Bill 1112, despite the fact that anti-choice legislators control all three branches of the Arizona state government. And **West Virginia** enacted Senate Bill 123, one of 2016's most expansive sexual health laws, which allows treatment for a patient's sexual partner for any diagnosed STI in many circumstances. Now more than ever, with an increased hostile landscape facing our movement in 2017, we must keep that perspective and these inspiring examples in mind.

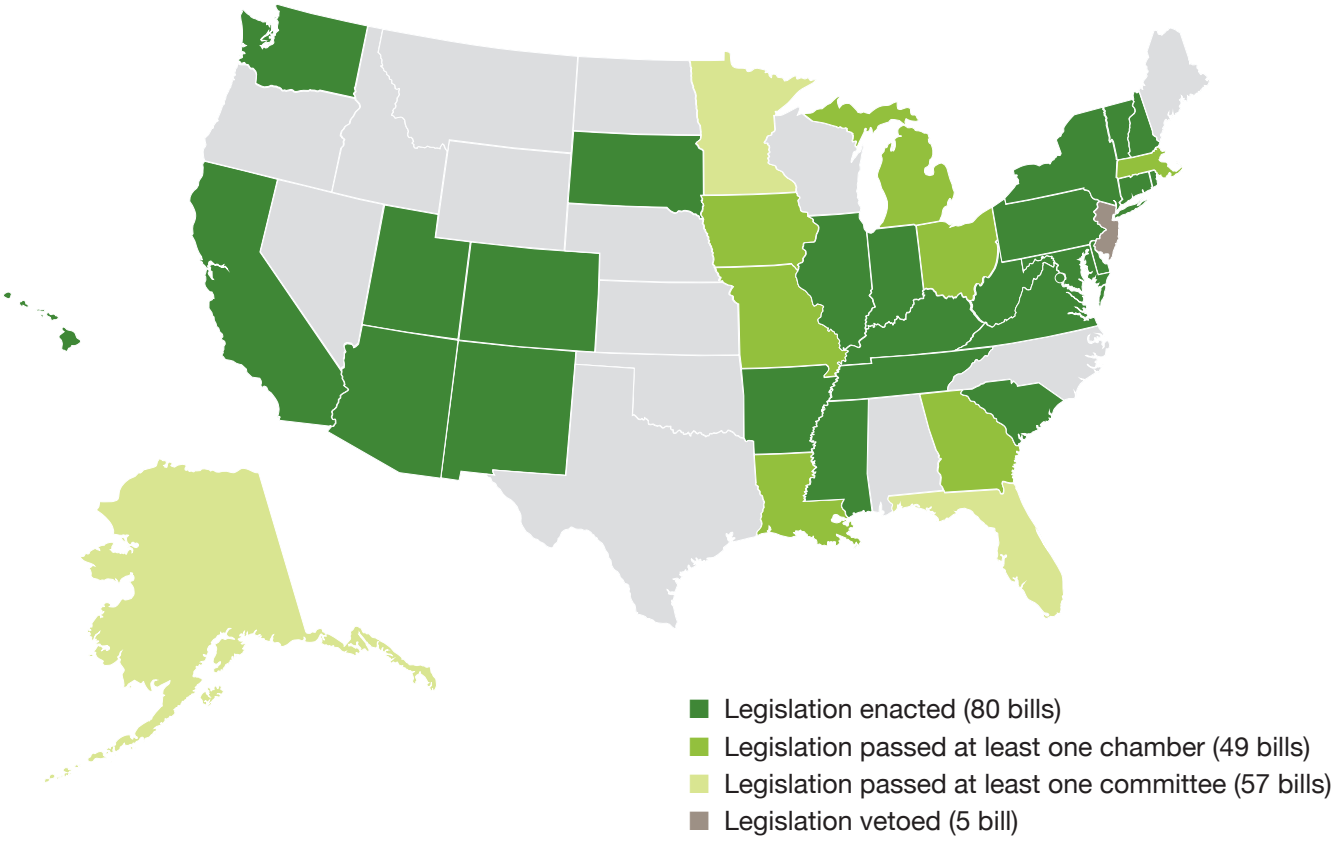
The National Institute for Reproductive Health celebrates not only the many legislative victories of 2016, but also the tireless work of state and local advocates to create and promote new, proactive policy

---

* Alaska, **Arizona**, **Arkansas**, **California**, **Colorado**, **Connecticut**, **Delaware**, **District of Columbia**, Florida, Georgia, **Hawaii**, **Illinois**, **Indiana**, Iowa, **Kentucky**, **Louisiana**, **Maryland**, Massachusetts, Michigan, Minnesota, **Mississippi**, Missouri, **New Hampshire**, **New Jersey**, **New Mexico**, **New York**, Ohio, **Pennsylvania**, **Rhode Island**, **South Carolina**, **South Dakota**, **Tennessee**, **Utah**, **Vermont**, **Virginia**, **Washington**, and **West Virginia**

proposals and build grassroots and political support for them. We are proud of the role that we have played in supporting these advocates, and we encourage those who are interested in pursuing these types of policy initiatives to contact us or connect directly with the many local and state advocates featured in this report, who were essential 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 2017. With the renewed challenges before us, it has never been more important for our movement to come together, rededicate ourselves to building allies and community, and unapologetically promote our vision for a more just and equitable country that respects and protects the ability of each of us to make important, life-affirming, and often life-changing decisions about our reproductive and sexual health and lives.

Movement of Proactive Legislation in 2016



APPENDIX

STATE	BILL NUMBER	TITLE AS FILED	SECTION	PAGE NUMBER(S)
AK	AK H 345	Insurance Coverage	3. Enhancing Insurance Coverage	18
AK	AK S 156	Insurance Coverage for Contraceptives	3. Enhancing Insurance Coverage	18
AR	AR H 1025	Department of Health Appropriation	2. Protection and Expanding Access	9
AZ	AZ S 1112	State Board of Pharmacy	2. Protection and Expanding Access	7, 43
CA	CA A 508	Public Health: Maternal Health	5. Promoting Healthy Pregnancies	36
CA	CA A 908	Disability Compensation: Disability Insurance	5. Promoting Healthy Pregnancies	38
CA	CA A 1114	Medi-Cal: Pharmacist Services	3. Enhancing Insurance Coverage	10
CA	CA A 1561	Sales and Use Taxes: Exemption: Sanitary Napkins	2. Protection and Expanding Access	12
CA	CA A 1671	Confidential Communications: Disclosure	2. Protection and Expanding Access	12
CA	CA A 1795	Health Care Programs: Cancer	3. Enhancing Insurance Coverage	20
CA	CA A 1838	Foster Care: Infant Supplement	4. Improving the Health of Youth	29
CA	CA A 1954	Health Care Coverage: Reproductive Health Care Services	3. Enhancing Insurance Coverage	20
CA	CA A 2263	Protect Victims and Reproductive Health Care Providers	2. Protection and Expanding Access	7
CA	CA A 2372	Health Care Coverage: HIV Specialists	3. Enhancing Insurance Coverage	20
CA	CA A 2589	Public Health: Lactation Services and Equipment	5. Promoting Healthy Pregnancies	38
CA	CA S 447	“Medi-Cal: Clinics: Drugs, Devices and Supplies”	3. Enhancing Insurance Coverage	20
CA	CA S 960	Medi-Cal: Telehealth: Reproductive Health Care	3. Enhancing Insurance Coverage	20
CA	CA S 999	Health Insurance: Contraceptives: Annual Supply	3. Enhancing Insurance Coverage	18
CA	CA S 1014	Pupil Rights: Pregnant and Parenting Pupils	4. Improving the Health of Youth	28, 29
CA	CA S 1090	Sexually Transmitted Diseases: Outreach and Screening	2. Protection and Expanding Access	12
CA	CA S 1408	Tissue Donation	3. Enhancing Insurance Coverage	24
CA	CA S 1433	Incarcerated Persons: Contraceptive Counseling	2. Protection and Expanding Access	10
CA	CA SJR 19 / HR 32	Women’s Reproductive Health	2. Protection and Expanding Access	9
CO	CO H 1294	Contraception Coverage and Private Insurance	3. Enhancing Insurance Coverage	18
CO	CO H 1322	Health Coverage Prescription Contraceptives Supply	3. Enhancing Insurance Coverage	18
CO	CO H 1381	Health Care Coverage for Cancer Screening	3. Enhancing Insurance Coverage	20
CO	CO H 1438	Employer Accommodations Related to Pregnancy	5. Promoting Healthy Pregnancies	36
CO	CO S 158	Physician Duties Delegated to Physician Assistant	5. Promoting Healthy Pregnancies	41
CO	CO S 202	Access to Effective Substance Use Services	5. Promoting Healthy Pregnancies	33
CT	CT S 67	Responsibilities of Advanced Practice Registered Nurses	5. Promoting Healthy Pregnancies	41
CT	CT S 158	Cost Sharing for Mammograms and Breast Ultrasounds	3. Enhancing Insurance Coverage	20
CT	CT S 218	Human Immunodeficiency Virus	5. Promoting Healthy Pregnancies	36
CT	CT S 221	Paid Family and Medical Leave	5. Promoting Healthy Pregnancies	38
CT	CT S 262	State Family and Medical Leave Act	5. Promoting Healthy Pregnancies	38
DC	DC B 415	Universal Paid Leave	5. Promoting Healthy Pregnancies	12
DC	DC B 604	Protecting Pregnant Workers	5. Promoting Healthy Pregnancies	36
DC	DC B 605	Protecting Pregnant Workers	5. Promoting Healthy Pregnancies	36

STATE	BILL NUMBER	TITLE AS FILED	SECTION	PAGE NUMBER(S)
DC	DC B 696	Feminine Hygiene and Diapers Sales Tax Exemption	2. Protection and Expanding Access	40
DE	DE H 165	Full-Time State Employees	5. Promoting Healthy Pregnancies	39
DE	DE H 301	Monoamniotic Twins	5. Promoting Healthy Pregnancies	39
DE	DE H 316	Employment Discrimination	2. Protection and Expanding Access	9
DE	DE H 317	Employment Discrimination	5. Promoting Healthy Pregnancies	9, 38-39
DE	DE S 213	Personal Body Safety and Child Sexual Abuse Awareness	4. Improving the Health of Youth	27
FL	FL H 583 / S 780	Pharmaceutical Services	3. Enhancing Insurance Coverage	22
FL	FL S 1116	Long-Acting Reversible Contraception Pilot Program	2. Protection and Expanding Access	10
GA	GA H 813	Control of Venereal Disease	2. Protection and Expanding Access	12
HI	HI H 1683	Family Leave	5. Promoting Healthy Pregnancies	39
HI	HI H 1782	Sexual Abuse Prevention Instructional Program	4. Improving the Health of Youth	27
HI	HI H 1897	Insurance Coverage of Health Screenings	3. Enhancing Insurance Coverage	22
HI	HI HCR 164	Zika Virus	2. Protection and Expanding Access	12
HI	HI S 1033	Maternal Mortality Review Panel	5. Promoting Healthy Pregnancies	36
HI	HI S 2232	Sexual Abuse Prevention Program Task Force	4. Improving the Health of Youth	27
HI	HI S 2315 / H 2585	Breastfeeding Mothers Exempt from Jury Duty	5. Promoting Healthy Pregnancies	37
HI	HI S 2317	Child and Maternal Death Reviews	5. Promoting Healthy Pregnancies	36
HI	HI S 2319	Insurance for Prescription Contraceptive Supplies	3. Enhancing Insurance Coverage	18
HI	HI S 2320	Pharmacists to Prescribe and Dispense Contraceptives	2. Protection and Expanding Access	11
HI	HI S 2672	Advanced Practice Registered Nurses	5. Promoting Healthy Pregnancies	41
HI	HI S 2961	Family Leave	5. Promoting Healthy Pregnancies	39
HI	HI SCR 85	Planned Parenthood	2. Protection and Expanding Access	9
HI	HI SCR 86	Paid Family Leave	5. Promoting Healthy Pregnancies	39
HI	HI SR 12	Human Papillomavirus Vaccine	4. Improving the Health of Youth	28
HI	HI SR 56	Planned Parenthood	2. Protection and Expanding Access	9
HI	HI SR 57	Paid Family Leave	5. Promoting Healthy Pregnancies	39
IA	IA S 2097	Prenatal Appointments	5. Promoting Healthy Pregnancies	40
IA	IA S 2195	Human Growth and Development Instruction	4. Improving the Health of Youth	27
IA	IA S 2222	Self-Administered Oral Contraceptives	2. Protection and Expanding Access	11
IA	IA S 2252	Reasonable Accommodations to Employees	5. Promoting Healthy Pregnancies	36
IL	IL H 166	Family Leave Insurance Program Act	5. Promoting Healthy Pregnancies	39
IL	IL H 887	Insurance Code	3. Enhancing Insurance Coverage	22
IL	IL H 3673	Cancer Screening Coverage and Payment	3. Enhancing Insurance Coverage	20
IL	IL H 4554	Insurance Code	3. Enhancing Insurance Coverage	22
IL	IL H 5576	Insurance Code	3. Enhancing Insurance Coverage	17-18
IL	IL S 1564	Conscience Act	2. Protection and Expanding Access	8, 43
IL	IL S 2746	Use Tax Exemptions	2. Protection and Expanding Access	12
IL	IL S 2817	Pension Code	5. Promoting Healthy Pregnancies	39
IL	IL S 2900	Physicians Assistants	5. Promoting Healthy Pregnancies	41
IN	IN H 1263	Health Information and Telemedicine	2. Protection and Expanding Access	11

STATE	BILL NUMBER	TITLE AS FILED	SECTION	PAGE NUMBER(S)
IN	IN S 186	Release of Medical Tests of Pregnant Women	5. Promoting Healthy Pregnancies	34
KY	KY H 18	Employee Accommodations for Certain Medical Conditions	5. Promoting Healthy Pregnancies	36
KY	KY SCR 9	Removing Breastfeeding Barriers	5. Promoting Healthy Pregnancies	37
LA	LA H 402	Student Survey Regarding Risk Behavior	4. Improving the Health of Youth	27
LA	LA S 353	Schools	4. Improving the Health of Youth	29
MA	MA H 3679	Incarcerated Pregnant Women Anti-Shackling Statute	5. Promoting Healthy Pregnancies	33, 35
MA	MA H 3701 / S 2104	Postpartum Depression Screening	3. Enhancing Insurance Coverage	22
MA	MA H 4351	Family and Medical Leave and Temporary Disability	5. Promoting Healthy Pregnancies	40
MA	MA S 1148	Maternity Patient Rights	5. Promoting Healthy Pregnancies	38
MA	MA S 2138	Confidential Healthcare Access Protection	3. Enhancing Insurance Coverage	19, 22
MA	MA S 2477	Family and Medical Leave and Temporary Disability	5. Promoting Healthy Pregnancies	40
MD	MD H 72	Sexual Abuse Awareness and Prevention Program	4. Improving the Health of Youth	27
MD	MD H 740	Family and Medical Leave Task Force	5. Promoting Healthy Pregnancies	39
MD	MD H 1005 / S 848	Health Insurance Contraceptive Equity Act	3. Enhancing Insurance Coverage	17
MD	MD H 1303	Freestanding Birth Centers	5. Promoting Healthy Pregnancies	34
MD	MD H 1634	Children in the Juvenile System	5. Promoting Healthy Pregnancies	33
MD	MD S 91	AIDS Drug Assistance Program	3. Enhancing Insurance Coverage	22
MD	MD S 946	Prison Restrictive Housing Data	5. Promoting Healthy Pregnancies	33
MI	MI H 4235	Maternal Deaths	5. Promoting Healthy Pregnancies	36
MN	MN H 2322	Clinical Lactation Services	5. Promoting Healthy Pregnancies	38
MN	MN H 2703 / S 2485	Human Services	3. Enhancing Insurance Coverage	22
MN	MN H 3419	Grant Program for Screening and Treatment	3. Enhancing Insurance Coverage	22
MN	MN S 2154	Clinical Lactation Services	5. Promoting Healthy Pregnancies	38
MN	MN S 2558	Paid Family Medical Leave Benefits	5. Promoting Healthy Pregnancies	40
MN	MN S 3102	Criminal Justice	3. Enhancing Insurance Coverage	23
MO	MO H 1679	Dispensing of Contraceptives	2. Protection and Expanding Access	11
MO	MO H 1923	Provision of Telehealth Services	3. Enhancing Insurance Coverage	22
MO	MO H 2228	Paid Paternity Leave	5. Promoting Healthy Pregnancies	40
MO	MO S 621	Telehealth	3. Enhancing Insurance Coverage	22-23
MS	MS S 2053	Sales Tax Exemption for Home Medical Supplies	2. Protection and Expanding Access	12
MS	MS S 2070	Breast Feeding Guidelines	5. Promoting Healthy Pregnancies	37
MS	MS S 2413	Personal Responsibility Education	4. Improving the Health of Youth	27-28
NH	NH S 219	Breastfeeding	5. Promoting Healthy Pregnancies	38
NH	NH S 460	Child Sexual Abuse and Healthy Relationship Rules	4. Improving the Health of Youth	27
NH	NH S 488	Reasonable Accommodations for Pregnant Workers	5. Promoting Healthy Pregnancies	37-38
NJ	NJ A 2297	Contraceptive Health Insurance Coverage	3. Enhancing Insurance Coverage	18
NJ	NJ ACR 119 / SCR 78	Women's Reproductive Health Care Access	2. Protection and Expanding Access	9
NJ	NJ S 659	Health Insurance Coverage for Contraceptives	3. Enhancing Insurance Coverage	18
NJ	NJ S 1017	Medicaid Coverage for Family Planning Services	3. Enhancing Insurance Coverage	20
NJ	NJ S 1073	Self-Administered Hormonal Contraceptives	2. Protection and Expanding Access	11

STATE	BILL NUMBER	TITLE AS FILED	SECTION	PAGE NUMBER(S)
NJ	NJ S 2060	Self-Administered Hormonal Contraceptives	2. Protection and Expanding Access	11
NJ	NJ S 2134	Partner Therapy for Sexually Transmitted Disease	2. Protection and Expanding Access	12
NJ	NJ S 2476	Zika Treatment and Prevention	2. Protection and Expanding Access	13
NJ	NJ SR 67	Zika Virus Legislation Funding	2. Protection and Expanding Access	12
NM	NM S 291	Medicaid Birthing Options Program	5. Promoting Healthy Pregnancies	34
NM	NM SM 58	Study Long-Acting Reversible Contraceptives	2. Protection and Expanding Access	10
NY	NY A 446	Midwifery Birth Centers	5. Promoting Healthy Pregnancies	34
NY	NY A 1142 / S 2709	Discrimination Based on Reproductive Decision Making	2. Protection and Expanding Access	9
NY	NY A 1347	Segregated Confinement of Pregnant Inmates	5. Promoting Healthy Pregnancies	33
NY	NY A 1616 / S 700	The Healthy Teens Act	4. Improving the Health of Youth	28
NY	NY A 2170	Partner Therapy for Sexually Transmitted Infections	2. Protection and Expanding Access	12
NY	NY A 3870	Workers Compensation Benefits	5. Promoting Healthy Pregnancies	40
NY	NY A 5143 / S 3151	Employee Notification of Contraceptive Coverage	3. Enhancing Insurance Coverage	20
NY	NY A 6221	Access to Reproductive Services	2. Protection and Expanding Access	8-9
NY	NY A 7555	Exemption from Sales and Use Taxes	2. Protection and Expanding Access	12
NY	NY A 8135 / S 6013	Comprehensive Contraception Coverage Act	3. Enhancing Insurance Coverage	18, 21
NY	NY A 9005	Public Protection and General Government Budget	5. Promoting Healthy Pregnancies	40
NY	NY A 9767	Establishment of Lactation Rooms in Public Buildings	5. Promoting Healthy Pregnancies	38
NY	NY A 10066	Coverage for Maternal Depression Screenings	3. Enhancing Insurance Coverage	23
NY	NY A 10137	Insurance Coverage of In Vitro Fertilization	3. Enhancing Insurance Coverage	24
NY	NY A 10184	HIV and AIDS Testing for Minors	4. Improving the Health of Youth	28
NY	NY A 10503	Health Care Services for Sexual Assault Victims	3. Enhancing Insurance Coverage	23
NY	NY A 10679 / S 8093	Coverage for the Detection of Breast Cancer	3. Enhancing Insurance Coverage	20
NY	NY A 10680	Workers' Compensation	5. Promoting Healthy Pregnancies	40
NY	NY S 1947	Erin Merryn's Law	4. Improving the Health of Youth	27
NY	NY S 3510	Health Insurance Coverage for a Follow Up Ultrasound	3. Enhancing Insurance Coverage	20
NY	NY S 6026	Provision of Lactation Accommodations in Airports	5. Promoting Healthy Pregnancies	38
NY	NY S 6406	Education and Family Assistance Budget	5. Promoting Healthy Pregnancies	40, 43
NY	NY S 6583	Medical Assistance Coverage for Donor Breast Milk	3. Enhancing Insurance Coverage	23
NY	NY S 6715	Maternal Depression Treatment	3. Enhancing Insurance Coverage	23
NY	NY S 7599	Employers Unemployment Experience Rating Account	5. Promoting Healthy Pregnancies	40
NY	NY S 8129	HIV-Related Testing and Screening for Certain Diseases	3. Enhancing Insurance Coverage	22
OH	OH H 85	Child Sexual Abuse Prevention	4. Improving the Health of Youth	27
OH	OH H 216	Advanced Practice Registered Nurses	3. Enhancing Insurance Coverage	23
OH	OH H 285	Multiple Prescription Refills	2. Protection and Expanding Access	11
OH	OH S 332	Commission on Infant Mortality	5. Promoting Healthy Pregnancies	36
PA	PA HR 694	Zika Virus Awareness Month	2. Protection and Expanding Access	13
RI	RI H 7220	Family Home Visiting Act	5. Promoting Healthy Pregnancies	36
SC	SC H 3204	Cervical Cancer Prevention Act	4. Improving the Health of Youth	28
SC	SC H 3251	Department of Health and Environmental Control	5. Promoting Healthy Pregnancies	36

STATE	BILL NUMBER	TITLE AS FILED	SECTION	PAGE NUMBER(S)
SC	SC S 278	Cervical Cancer Prevention Act	4. Improving the Health of Youth	28
SD	SD H 1110	Prenatal Care and Citizenship Status	5. Promoting Healthy Pregnancies	34
TN	TN S 1677	Birth Control	2. Protection and Expanding Access	10-11
TN	TN S 2303	Maternal Mortality	5. Promoting Healthy Pregnancies	36
UT	UT H 188	Paid Family Leave	5. Promoting Healthy Pregnancies	40
UT	UT H 202	Sales and Use Tax Exemptions	2. Protection and Expanding Access	12
UT	UT H 246	Reproductive Health	4. Improving the Health of Youth	28
UT	UT H 449	Women's Health Education	2. Protection and Expanding Access	10
UT	UT S 59	Antidiscrimination and Workplace Accommodations	5. Promoting Healthy Pregnancies	36
UT	UT S 108	Birthing Centers	5. Promoting Healthy Pregnancies	34
VA	VA H 659	High School Health Education Programs	4. Improving the Health of Youth	27
VT	VT H 611	Fiscal Year 2016 Budget Adjustments	5. Promoting Healthy Pregnancies	40
VT	VT H 620	Contraceptives Health Insurance and Medicaid Coverage	3. Enhancing Insurance Coverage	18
WA	WA H 2183	Curriculum for Prevention of Sexual Abuse	4. Improving the Health of Youth	27
WA	WA H 2307 / S 6149	Accommodations in the Workplace for Pregnant Women	5. Promoting Healthy Pregnancies	36
WA	WA H 2465	Contraceptive Drug Reimbursement	3. Enhancing Insurance Coverage	18
WA	WA H 2681	Contraceptives in Pharmacies	2. Protection and Expanding Access	11
WA	WA S 6149	Accommodations in the Workplace for Pregnant Women	5. Promoting Healthy Pregnancies	36
WA	WA S 6270	Prenatal Vitamin Coverage	5. Promoting Healthy Pregnancies	34
WA	WA S 6467	Contraceptive Patches and Oral Contraception	2. Protection and Expanding Access	11
WA	WA S 6534	Maternal Mortality Review Panel	5. Promoting Healthy Pregnancies	36
WA	WA SR 8699	Violence Against Women's Health Care Clinics	2. Protection and Expanding Access	9
WV	WV H 4347	Pregnant Women and Substance Abuse Treatment	5. Promoting Healthy Pregnancies	34
WV	WV S 123	Treatment for Sexually Transmitted Diseases	2. Protection and Expanding Access	12, 43
WV	WV S 384	Medical Services Seek Federal Waiver for 30-Day Waiting	3. Enhancing Insurance Coverage	18

ENDNOTES

1 *Whole Woman's Health v. Hellerstedt*, 579 U.S. __, 136 S. Ct. 2292 (2016).

2 National Institute for Reproductive Health, 2016 Proactive Poll, http://www.nirhealth.org/2016-poll/.

3 Guttmacher Institute, State Policies In Brief, Refusing to Provide Reproductive Health Care (March 2016), *available at* https://www.guttmacher.org/state-policy/explore/refusing-provide-health-services.

4 ACLU of Illinois, Press Release, ACLU hails signing of measure to protect patients, July 29, 2016, *available at* http://www.aclu-il.org/aclu-hails-signing-of-measure-to-protect-patients/.

5 The New York State Attorney General recently issued a formal opinion that confirms that New York state law is inconsistent with the U.S. Constitution. The opinion assures providers and patients that their rights under the Constitution are paramount and that the Constitution already overrides several components of New York's outdated, harmful law. Specifically, the attorney general opinion emphasizes that under the Constitution, women in New York may seek abortion care up until viability and medical providers may provide abortion care at any point in pregnancy if it is necessary to preserve a woman's health. Abortion Opinion, F1 Op. Att'y Gen 2016, *available at* https://ag.ny.gov/sites/default/files/abortion_opinion_2016-f1.pdf.

6 Bryce Covert, New York Will Stop Taxing Tampons Like Luxury Items, Think Progress, Apr. 12, 2016, *available at* http://thinkprogress.org/economy/2016/04/12/3768690/new-york-end-tampon-tax.

7 Healthy and Free Tennessee, Press Release, Over-the-Counter Contraception Access Good for Reproductive Health, Mar. 29, 2016.

8 Centers for Disease Control and Prevention. Expedited partner therapy in the management of sexually transmitted diseases. Atlanta, GA: US Department of Health and Human Services, 2006. https://www.cdc.gov/std/treatment/eptfinalreport2006.pdf.

9 Expedited partner therapy in the management of gonorrhea and chlamydial infection. Committee Opinion No. 632. American College of Obstetricians and Gynecologists. Obstet Gynecol 2015;125:1526–8. http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Gynecologic-Practice/Expedited-Partner-Therapy-in-the-Management-of-Gonorrhea-and-Chlamydial-Infection.

10 Centers for Disease Control and Prevention, Zika Virus, http://www.cdc.gov/zika/index.html.

11 Alexandra Zavis, Florida finds Zika in trapped mosquitoes, confirming the virus is being spread by the insects, L.A. Times, Sept. 1, 2016, http://www.latimes.com/nation/nationnow/la-na-zika-mosquito-trapped-20160901-snap-story.html.

12 Id.

13 Planned Parenthood asks to weigh in on Florida Zika, birth control discussions, WJHG.com, Oct. 13, 2016, *available at* http://www.wjhg.com/content/news/Zika-concerns-396946361.html.

14 ACLU of Illinois, Press Release, Statement on Passage of Contraceptive Coverage Bill in Illinois House, Apr. 21, 2016, *available at* http://www.aclu-il.org/statement-on-passage-of-contraceptive-coverage-bill-in-illinois-house/.

15 Pat Bradley, Vermont Governor Signs Bill Broadening Birth Control Access, WAMC Northeast Public Radio, May 25, 2016, *available at* http://wamc.org/post/vermont-governor-signs-bill-broadening-birth-control-access#stream/0.

16 Testimony of Planned Parenthood of Hawaii in strong support of S.B. 2319, S.D.1, H.D.1, Relating to Insurance, Mar. 21, 2016, *available at* http://www.capitol.hawaii.gov/session2016/testimony/SB2319_HD1_TESTIMONY_CPC_03-21-16_.PDF.

17 Health Care for All New York, Family Planning And Reproductive Health Services Organizations And Providers, An Act to Protect Access To Confidential Healthcare (S.557, H.871), https://www.hcfama.org/family-planning-and-reproductive-health-services-organizations-and-providers.

18 Planned Parenthood Action Fund of New Jersey, Press Release, Governor's Sixth Veto of Family Planning Funding Puts New Jersey Women's Health at Risk, June 30, 2016, *available at* http://ppactionnj.org/governors-sixth-veto-of-family-planning-funding/.

19 Essential Access, Fact Sheet, Direct Access to Reproductive Health Act AB 1954 (Burke), Sept. 28, 2016, *available at* http://www.essentialaccess.org/sites/default/files/AB1954_Direct_Access_to_Reproductive_Health_Act_Fact_Sheet.pdf.

20 Centers for Disease Control and Prevention, Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs, Apr. 25, 2014, *available at* https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6304a1.htm?s_cid=rr6304a1_w. Diana Foster, Number of Oral Contraceptive Pill Packages Dispensed and Subsequent Unintended Pregnancies, Obstetrics & Gynecology: Mar. 2011, http://journals.lww.com/greenjournal/Abstract/2011/03000/Number_of_Oral_Contraceptive_Pill_Packages.8.asp.

21 Mikola De Roo, Legislative Leaders Pass Bill Aimed at Ending the AIDS Epidemic But Much Work Remains, Housing Works AIDS Issues Updates Blog, June 17, 2016, *available at* http://www.housingworks.org/advocate/detail/legislative-leaders-pass-bill-aimed-at-ending-the-aids-epidemic-but-much-wo/.

22 Centers for Disease Control and Prevention. Expedited partner therapy in the management of sexually transmitted diseases. Atlanta, GA: US Department of Health and Human Services, 2006.

https://www.cdc.gov/std/treatment/eptfinalreport2006.pdf.

23 *Whole Woman's Health v. Hellerstedt*, 579 U.S. __, 136 S. Ct. 2292 (2016).

24 Id. at 2309.

25 Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases," The National Campaign to Prevent Teen and Unplanned Pregnancy, *available at* https://thenationalcampaign.org/resource/emerging-answers-2007%E2%80%94full-report.

26 Louisiana State Senate Broadcast Archives, Debate on House Bill 402, http://senate.la.gov/video/videoarchive.asp?v=senate/2016/03/032916EDUC_0 (last visited Nov. 29, 2016).

27 National Center for Youth Law, Highlights of Our Work, February 2016, *available at* http://youthlaw.org/publication/highlights-of-our-work-february-2016/.

28 Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist. Committee Opinion No. 473. American College of Obstetricians and Gynecologists. Obstet Gynecol 2011;117:200–1, *available at* http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Substance-Abuse-Reporting-and-Pregnancy-The-Role-of-the-Obstetrician-Gynecologist; Tamar Todd, The War on Drugs Aims its Sights on Pregnant Women, Drug Policy Alliance, Apr. 25, 2014, *available at* http://www.drugpolicy.org/blog/war-drugs-aims-its-sights-pregnant-women; Katie Zezima, The Obama administration does not approve of a law making it a crime to use drugs while pregnant, The Washington Post, July 1, 2016, *available at* https://www.washingtonpost.com/news/post-politics/wp/2014/07/01/the-obama-administration-does-not-approve-of-a-law-making-it-a-crime-to-use-drugs-while-pregnant/.

29 Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist. Committee Opinion No. 473. American College of Obstetricians and Gynecologists. Obstet Gynecol 2011;117:200–1, *available at* http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Substance-Abuse-Reporting-and-Pregnancy-The-Role-of-the-Obstetrician-Gynecologist.

30 New York City Bar Committees on Corrections and Community Reentry & Sex and Law, Letter to Governor Cuomo in Support of Assembly Bill 6430 and Senate Bill 983, Oct. 9, 2015, *available at* http://www2.nycbar.org/pdf/report/uploads/20072965Anti-shacklingPregnantPrisonersCorrectionsSexLawReportFINAL10915.pdf.

31 Prison Birth Project & Prisoners' Legal Services, Report, Breaking Promises: Violations of the Massachusetts Pregnancy Standards & Anti-Shackling Law, May 2016, *available at* http://theprisonbirthproject.org/wp-content/uploads/2016/05/Breaking-Promises_May2016.pdf.

32 Centers for Disease Control and Prevention, Pregnancy Mortality Surveillance System, December 2016 ("Considerable racial disparities in pregnancy-related mortality exist. During 2011–2013, the pregnancy-related mortality ratios were– 12.1 deaths per 100,000 live births for white women [and] 40.4 deaths per 100,000 live births for black women."), https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html, last visited Jan. 3, 2017. Kelly Wallace, Why is the maternal mortality rate going up in the United States?, CNN, Dec. 1, 2015, http://www.cnn.com/2015/12/01/health/maternal-mortality-rate-u-s-increasing-why/.

33 Editorial, Is Punishing Kentucky Women Pro-Life?, Lexington Herald Leader, Mar. 3, 2016, http://www.kentucky.com/opinion/editorials/article63911407.html ("The booby prize for petty partisanship in this legislative session goes to Rep. Kim King, R-Harrodsburg, whose anti-abortion poison-pill is bottling up a Democratic-sponsored protection for pregnant women that many pro-life groups support.").

34 American College of Obstetricians and Gynecologists, Breastfeeding, http://www.acog.org/About-ACOG/ACOG-Departments/Breastfeeding.

35 American Academy of Pediatrics, Policy Statement, Breastfeeding and the Use of Human Milk, http://pediatrics.aappublications.org/content/129/3/e827.full.

36 Optimizing support for breastfeeding as part of obstetric practice. Committee Opinion No. 658. American College of Obstetricians and Gynecologists. Obstet Gynecol 2016;127:e86–92, *available at* http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Optimizing-Support-for-Breastfeeding-as-Part-of-Obstetric-Practice.

37 Centers for Disease Control and Prevention, Breastfeeding Report Card United States 2014, *available at* https://www.cdc.gov/breastfeeding/pdf/2014breastfeedingreportcard.pdf.

38 Office of the Surgeon General et al., Barriers to Breastfeeding in the United States, Office of the Surgeon General (2011), *available at* http://www.ncbi.nlm.nih.gov/books/NBK52688/.

39 See e.g., Corrina Knoll, For lactating mothers, jury duty poses logistical challenges, Los Angeles Times, May 18, 2014, http://www.latimes.com/local/la-me-breastfeeding-jurors-20140518-story.html.

40 A Better Balance, The Need for Paid Leave, http://www.abetterbalance.org/web/ourissues/familyleave; National Partnership for Women and Families, Paid Leave, http://www.nationalpartnership.org/issues/work-family/paid-leave.html.

41 Kelly Wallace and Jen Christensen, The benefits of paid leave for children are real, majority of research says, CNN, Oct. 29, 2015, http://www.cnn.com/2015/10/29/health/paid-leave-benefits-to-children-research/.

42 Letter from Family Act Coalition to Congress, June 29, 2016, *available at* http://www.nationalpartnership.org/research-library/work-family/coalition/family-act-coalition-letter.pdf.

43 United States Department of Labor, Factsheet: Paid Family and Medical Leave, https://www.dol.gov/wb/PaidLeave/PaidLeave.htm.

44 Lenny Bernstein, U.S. faces 90,000 doctor shortage by 2025, medical association warns, Washington Post, Mar. 3, 2015, https://www.washingtonpost.com/news/to-your-health/wp/2015/03/03/u-s-faces-90000-doctor-shortage-by-2025-medical-school-association-warns/.

45 Amelia Thomson-DeVeaux, Changing Primary Care's Colors, American Prospect, Nov. 14, 2013, http://prospect.org/article/changing-primary-cares-colors; Brian Koenig, U.S. Physician Shortage to Impact Rural, Urban Areas, the New American, June 18, 2013, http://www.thenewamerican.com/usnews/health-care/item/15744-u-s-physician-shortage-to-impact-rural-poor-urban-areas.

46 Id.

47 Id.

National Institute for Reproductive Health

14 Wall Street
Suite 3B
New York, NY 10005

Tel. 212-343-0114
Fax 212-343-0119

info@nirhealth.org
www.nirhealth.org

NATIONAL
INSTITUTE FOR
REPRODUCTIVE
HEALTH