National Institute for Reproductive Health

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A REPORT OF
THE NATIONAL INSTITUTE FOR
REPRODUCTIVE HEALTH

2017 YEAR IN REVIEW

GAINING GROUND

PROACTIVE REPRODUCTIVE HEALTH AND RIGHTS LEGISLATION IN THE STATES

THE NATIONAL INSTITUTE FOR REPRODUCTIVE HEALTH (NIRH) builds power at the state and local levels to change public policy, galvanize public support, and normalize women's decisions about abortion and contraception. Through our partnership model, we provide state and local advocates with strategic guidance, hands-on support, and funding to create national change from the ground up. We build connections within and across states, arming our partners with the latest knowledge and best tools to advance reproductive freedom for the people in their communities.

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INTRODUCTION

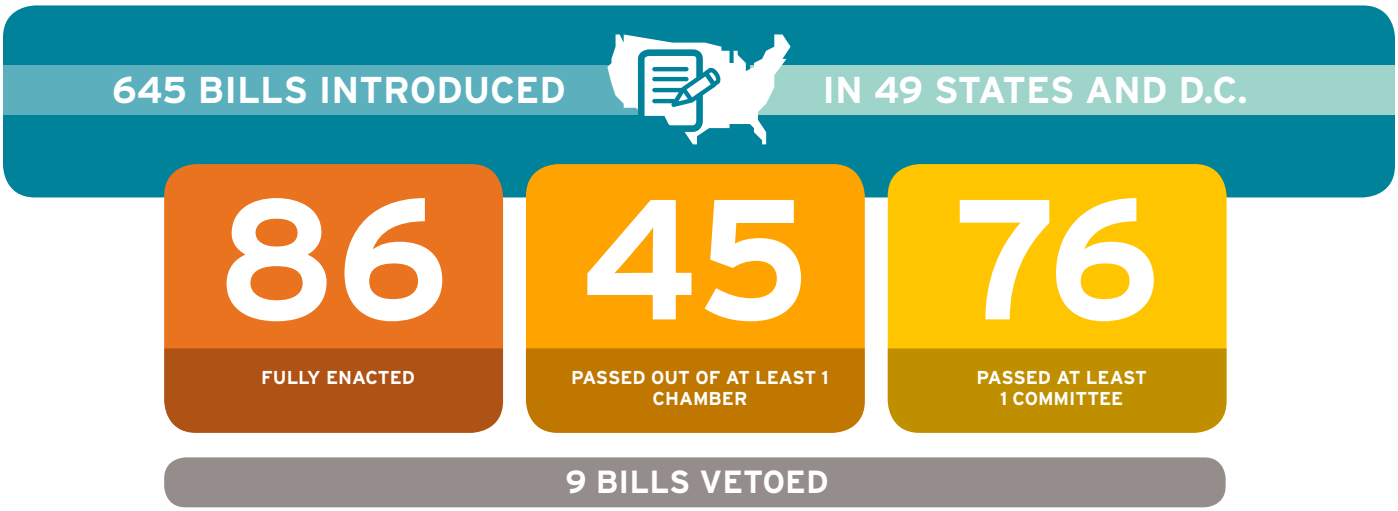
The National Institute for Reproductive Health's (NIRH) mission is to help build a society in which everyone has the freedom and ability to control their reproductive and sexual lives. In the current political climate, proactive policy change that advances that mission might seem out of reach—but in reality, state advocates, legislators, and governors are moving forward every day with innovative policies that will improve the daily lives of the residents of their states. The goal of this report is to encourage greater advocacy for such affirmative policies and to help demonstrate that real change is possible, ongoing, and being driven by advocates and lawmakers at the state and local levels.

2017 was a challenging year, with policy debates and politics shaped to an unprecedented degree by alarming and hateful rhetoric, while federal policymakers appear driven to make the lives of women, people of color, and marginalized communities of all types more difficult, dangerous, and less free. The response, however, has been inspiring and uplifting, as communities have come together to speak up for their values and to protect everyone's rights. The resulting groundswell of advocacy has led to gains for reproductive health, rights, and justice despite the challenges we all now face.

NIRH found that in 2017, every state except West Virginia introduced at least one piece of proactive legislation. In particular, more proactive abortion rights bills were introduced in the states, moved through a legislature, and passed than in each of the previous three years. The bills considered in 2017 exemplify unique and creative approaches to addressing the significant problems many historically overlooked communities already face, from pregnant and parenting youth to women who are incarcerated. And recognizing a new threat from the federal government, lawmakers in many states sent a clear message that, regardless of what Congress and the president choose to do, they want their residents to retain the important protections of the Affordable Care Act (ACA).

In order to be clear about the policies our nation needs to protect and support reproductive health, rights, and justice, the 2017 "Gaining Ground" report hones in on seven areas NIRH believes must be priorities for any state that wants to advance reproductive health

2017 NEW LAWS PROTECTING REPRODUCTIVE HEALTH AND RIGHTS

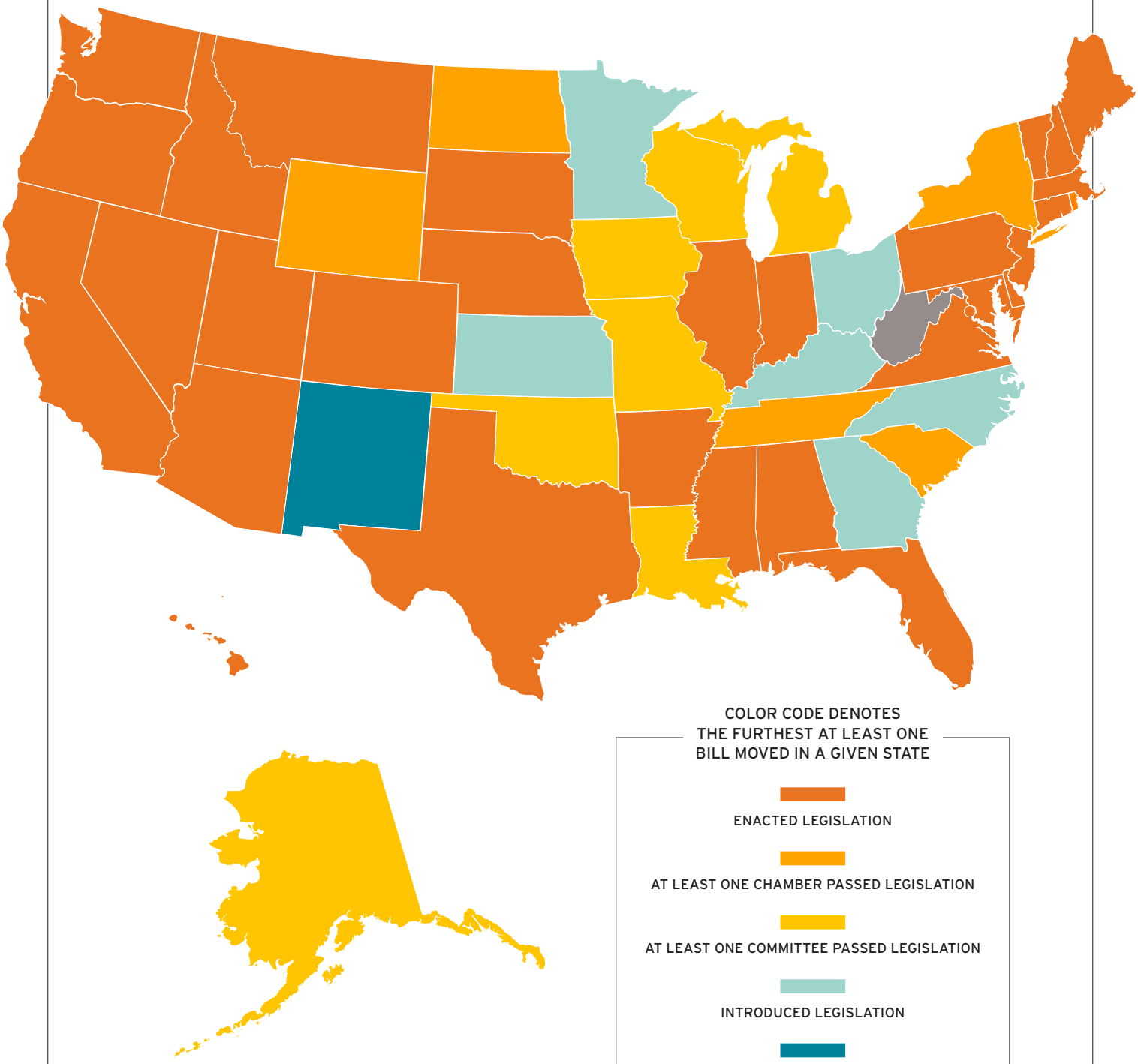


and rights: **access to abortion**, **contraception**, and **pregnancy care**; **comprehensive sexuality education for all young people**; **comprehensive reproductive health care coverage for all**; **supporting parents and families**; and **prohibiting discrimination based on reproductive decisions or health status**. We reviewed the movement of proactive policy in the states in each of these seven areas, analyzing which of these policy changes move us closer to a world in which every person has the ability to choose whether and when to become a parent, and to have a healthy family if they do become parents. Our analysis in these core areas has been greatly informed and influenced by the work of our colleagues in the reproductive justice movement, although this report remains focused on those policies specifically intended to advance reproductive freedom rather than reflecting the full range of policies that make up the reproductive justice framework.

Because policy change takes time, this report includes not only legislation that became law, but also bills that moved through committees, state houses, and sometimes on to governors' desks only to be vetoed—after all, the bill that is introduced and considered today may become law next month or next year. This report is intended both to provide an analysis of the current policy landscape in the states and to serve as a source of inspiration for advocates and policymakers around the country as they consider how best to advance reproductive freedom for women and families in their states.

THE 2017 "GAINING GROUND" REPORT HONES IN ON SEVEN AREAS NIRH BELIEVES MUST BE PRIORITIES FOR ANY STATE THAT WANTS TO ADVANCE REPRODUCTIVE HEALTH AND RIGHTS: ACCESS TO ABORTION, CONTRACEPTION, AND PREGNANCY CARE; COMPREHENSIVE SEXUALITY EDUCATION FOR ALL YOUNG PEOPLE; COMPREHENSIVE REPRODUCTIVE HEALTH CARE COVERAGE FOR ALL; SUPPORTING PARENTS AND FAMILIES; AND PROHIBITING DISCRIMINATION BASED ON REPRODUCTIVE DECISIONS OR HEALTH STATUS.

MOVEMENT OF PROACTIVE LEGISLATION FOR REPRODUCTIVE HEALTH, RIGHTS, AND JUSTICE IN 2017



7 POLICY IDEAS FOR 2018

2017 gave rise to some new and inspiring ideas with enormous promise to improve and expand access to reproductive health care.

As advocates and legislators come together to determine their policy agendas for 2018 and look for ideas that have the potential to advance reproductive health and change the public conversation about reproductive health, rights, and justice, NIRH suggests considering the following policy ideas:

Provide insurance coverage for the full range of reproductive health services, including contraception and abortion, prenatal care, postpartum care, and breastfeeding support and supplies. (See discussion on page 20 and Oregon House Bill 3391 for a legislative model.)

Repeal laws that restrict access to abortion, including waiting periods, laws that ban insurance coverage for abortion, bans that criminalize women's behavior during pregnancy, or bans on telemedicine for medication abortion. (See discussion on page 6 and Texas Senate Bill 1632 or Delaware Senate Bill 5 for legislative models.)

Keep abortion patients and providers safe by working with law enforcement to provide training, information, resources, and accountability to ensure safety for all those who work in or access clinics. (See Wisconsin Senate Bill 568 for a legislative model.)

Ensure that patients can choose their reproductive health care provider by prohibiting insurance plans from restricting access to providers, whether in or out of network. (See discussion on page 10 and California Senate Bill 743 for a legislative model.)

Ensure that all patients can get the contraceptive option of their choice by allowing access to a 12-month supply of birth control and guaranteeing that insurance companies cover all forms of contraceptives without additional barriers. (See discussion on page 21 and Nevada Assembly Bill 249 for a legislative model.)

Promote the health of incarcerated pregnant women by prohibiting shackling, requiring prisons and jails to meet health and nutrition standards for pregnant inmates, creating lactation and breastfeeding support programs for postpartum women, requiring courts and prosecutors to strongly consider alternatives to incarceration for any woman who is pregnant or lactating, and following through on all of those guarantees. (See discussion on page 36 and 2014's Massachusetts Senate Bill 2063 for one possible legislative model.)

Protect the rights of pregnant and parenting students by allowing students to take sick leave without endangering their academic career, providing breastfeeding support and accommodations, and providing childcare for students with young children. (See discussion on page 32 and Maryland House Bill 616 for a legislative model.)

EXPANDING ACCESS TO ABORTION CARE

Most U.S. voters agree that when a woman has decided to have an abortion, she should be able to access that care safely, affordably, without shame, and in her own community.[2] **NIRH supports policies that enable any woman or person who can become pregnant to have access to quality, affordable, supportive, and safe abortion care without encountering harassment or experiencing shame.** This is particularly true for those who are historically underserved by the medical system or have faced racial discrimination or coercion with regards to their reproductive decisions. Anyone seeking abortion care should have access to complete and medically accurate information about their options, and they should not be misled by politicians, third parties, or other actors who oppose abortion. And no one should face criminalization for attempting or performing their own abortion.

Unfortunately, we have a long way to go until we reach a time when abortion is truly accessible to anyone who needs it. As we approach the 45th anniversary of *Roe v. Wade*, state legislators have imposed a patchwork of onerous restrictions on the provision of abortion care. In just the last seven years, hundreds of new laws against abortion have been enacted in state houses across the country. However, state advocates and policymakers have also pushed back hard against this onslaught of restrictions, moving to repeal harmful laws and enact new proactive policies to make abortion more accessible for all.

Expanding Access to Abortion Care

As a result of the relentless pressure from anti-abortion activists and their allies in state legislatures, laws that restrict access to abortion and make it harder for health care providers to offer this care are now the norm in many states. In fact, more than half of all states are classified as "hostile" or "extremely hostile" to abortion by the Guttmacher Institute, and 39 percent of U.S. women of reproductive age live in a county with no abortion provider.[3] In order to ensure abortion access for all who need it, these policies must be repealed and replaced with laws that support the provision of abortion care, especially for underserved communities.

The 2016 Supreme Court decision in *Whole Woman's Health v. Hellerstedt*[4] struck down several Texas abortion restrictions and reaffirmed that state laws limiting abortion care must benefit women's health rather than burden access. Many advocates and lawmakers then determined that many of their state laws did not meet that standard and thus began introducing legislation to repeal some or all of the burdensome restrictions on the books in their states. Eight of these bills were modeled on the Whole Woman's Health Act, a piece of legislation codifying in state law that the benefit of an abortion restriction to women's health must outweigh the burden it imposes, and directing the repeal of any harmful, burdensome, and non-medically based laws that have recently been enacted. In **Utah**, legislators moved a different version of this type of bill: House Bill 384 would have repealed some of the state's Targeted Regulation of Abortion Providers (TRAP) laws to bring its regulations into compliance with the current constitutional standard.

In addition, **Idaho** was forced to repeal a previously enacted restriction on access to medication abortion through telemedicine (a promising way to deliver medical care to rural residents who may not live close to a health care provider). Under a court order finding its previous law unconstitutional, Idaho passed House Bill 250, which repeals these restrictions on telemedicine and allows for telehealth prescription of medication abortion. **New Mexico** considered Senate Bill 282, which would ensure that health care providers at hospitals could give all patients medically accurate, comprehensive information about their health status and refer them for reproductive health care, or provide it if the patient's health was at risk, even if the hospital itself objected to the care.

In **California**, a state with few abortion restrictions that is classified as "supportive" by the Guttmacher Institute, advocates including ACCESS Women's Health Justice, ACT for Women and Girls, the UC Berkeley Students United for Reproductive Justice (SURJ), and the Women's Foundation of California advocated for an innovative way to increase access to abortion for college students, who often face barriers in accessing this care. Senate Bill 320, a first-of-its-kind proposal that passed one committee, would have required medication abortion and a qualified provider to be available at any California state university campus. SURJ co-founder Adiba Khan noted how "it made no sense to us that something as simple as medication abortion wouldn't be provided on campus when other reproductive and sexual health services are available."[5]

Repealing Arcane Laws and Decriminalizing Abortion

Before the Supreme Court decided *Roe v. Wade*, most states had laws that restricted access to abortion, including some that made it a crime to provide an abortion or for a woman to perform her own abortion. Although generally unenforced, some of these clearly unconstitutional laws remain on the books, causing providers uncertainty about what is legally permissible and sometimes limiting the type of care they can offer to their patients. Other archaic, likely unconstitutional abortion laws have also occasionally been used by prosecutors to investigate, arrest, or prosecute women, particularly women of color and low-income women who are already subject to greater government surveillance and interference in their reproductive lives and health care decisions. Women and providers who feel threatened by outdated and unconstitutional laws cannot truly seek and provide abortion care freely, safely, and in a supportive environment.

Three states moved legislation to update their unconstitutional abortion laws by bringing them in line with current constitutional standards and community values. **Delaware** enacted Senate Bill 5, which repeals unconstitutional parts of the state's pre-*Roe* abortion law and establishes clear protections for abortion access in the future—a victory for the coalition of state advocates and religious leaders led by the ACLU of Delaware and Planned Parenthood of Delaware. **New Mexico's** House Bill 473 and **New York's** Assembly Bill 1748, which similarly would bring the states in line with constitutional standards and decriminalize abortion, each advanced. The successful **Illinois** House Bill 40,

POLICY POSITION: ABORTION

FOR WOMEN TO MAKE FULLY INFORMED CHOICES ABOUT THEIR REPRODUCTIVE LIVES, THEY CANNOT BE SUBJECT TO MANIPULATIVE, MEDICALLY INACCURATE, BIASED "COUNSELING" FROM THOSE WHO OPPOSE THEIR RIGHT TO ACCESS ABORTION.

described at length in the "Ensuring Comprehensive Reproductive Health Care Coverage for All" section on page 20, also includes a similar repeal of an arcane criminal abortion law.

Ensuring the Safety of Patients and Providers

In order for reproductive health care, especially abortion care, to be truly within reach, it must be safe for patients and providers alike to enter clinics without fear of harassment or violence.

Illinois considered House Bill 3735, which would have imposed a stronger sentence for crimes such as violence, damage to property, and intimidation committed at a women's health clinic. "People should not have to fear receiving health care," said Illinois State Representative John D'Amico, the bill's sponsor, who proclaimed, "We need to continue to do everything we can at the state level to protect these health centers, fund them, and give patients and staff the peace of mind that they can operate safely."[6]

Curtailing the Deceptive Practices of Crisis Pregnancy Centers

For women to make fully informed choices about their reproductive lives, they cannot be subject to manipulative, medically inaccurate, biased "counseling" from those who oppose their right to access abortion. Crisis pregnancy centers (CPCs), anti-choice organizations that often pose as women's health clinics, frequently spread misinformation and use deceptive tactics to dissuade, shame, or trick pregnant women out of choosing abortion.

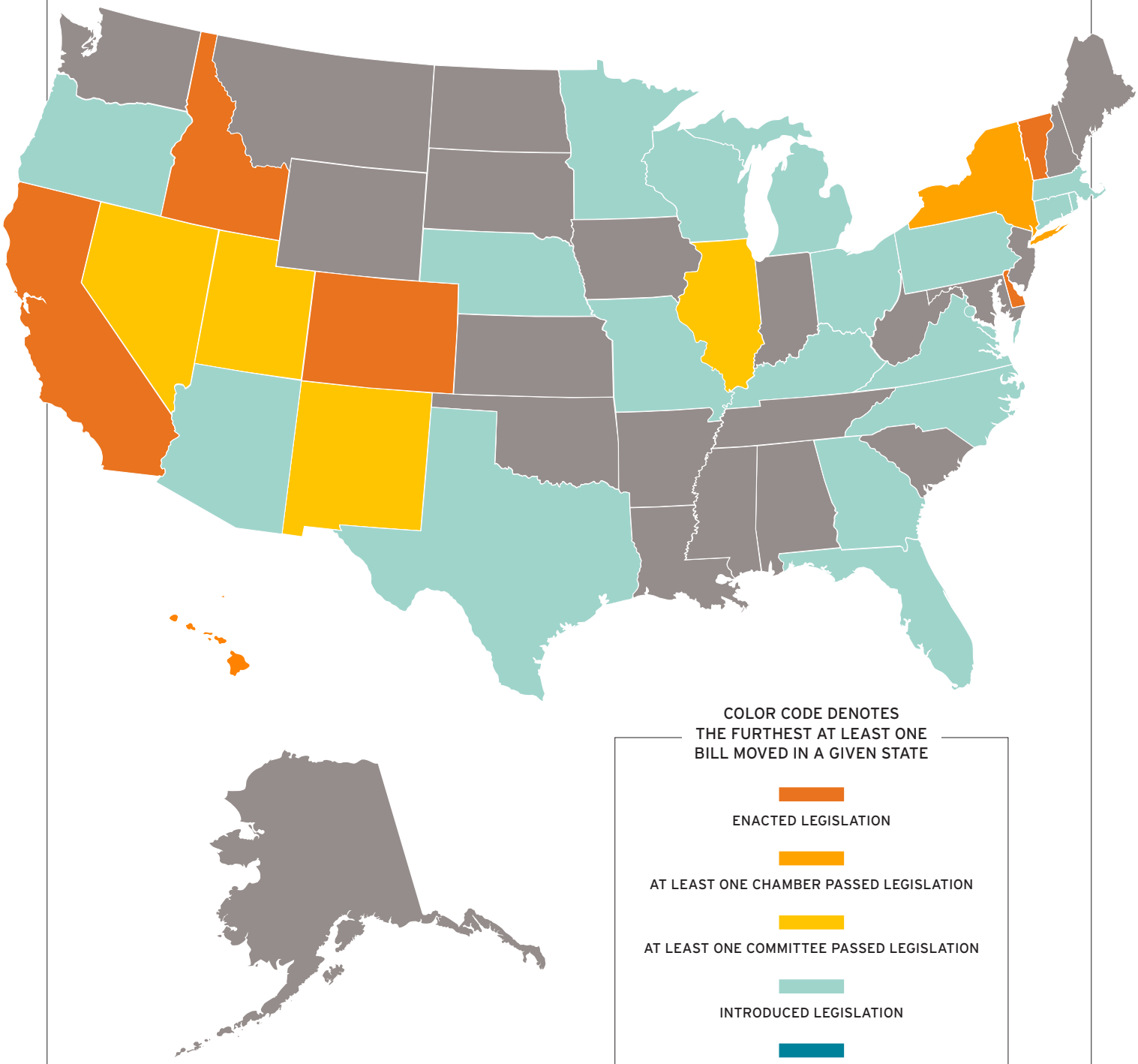
Both states and localities have considered policies that curtail CPCs' fraudulent and deceptive practices, and in 2017, **Hawaii** enacted Senate Bill 501 / House Bill 663, which requires any "limited service pregnancy center" to disclose to clients that Hawaii has public programs for insurance coverage for family planning services for low-income residents and to keep client information confidential.

Publicly Supporting the Right to Abortion

In the fight against abortion stigma, everyone has a part to play in standing up publicly on behalf of abortion and abortion providers. Adopting a resolution affirming support for abortion rights allows legislators to help normalize abortion care, communicate their support for women's reproductive decisions, and set the stage for future policy change. Resolutions that call on federal lawmakers to protect women's rights or pass important new policies can also help connect local, state, and federal advocacy, building a more powerful movement from the ground up.

In 2017, four states proclaimed their support for the rights protected in *Roe v. Wade* and reproductive health care services and clinics, and for opposing any federal actions that would endanger reproductive rights and health, including defunding Planned Parenthood: **California** adopted House Resolution 5 / Senate Resolution 9 and House Resolution 6 / Senate Resolution 12; **Colorado** adopted House Resolution 1005; **Vermont** adopted House Resolution 9 / Senate Resolution 4; and **Nevada** considered Assembly Joint Resolution 8.

EXPANDING ACCESS TO ABORTION CARE



SECTION 3

IMPROVING ACCESS TO CONTRACEPTION

An individual's ability to control whether and when to have a child can determine the course of their lives. Having meaningful access to both information about and the full range of contraceptive options is essential to individual self-determination as well as to overall gender equity. **NIRH supports policies that ensure access to the full range of methods of contraception and non-coercive, inclusive contraceptive counseling, and is committed to increasing knowledge of and access to underutilized contraceptive options in ways that center and honor patient autonomy and decision-making.**

Although contraception is widely available in most parts of the United States, there are still many barriers that keep individuals from accessing the contraceptive method that is best for them. Many forms of contraception, such as long-acting reversible contraception (LARCs), have been historically underutilized for reasons including lack of provider training, lack of public education, and high cost to providers and consumers. Moreover, although public health officials in some areas have encouraged LARC use, they have frequently targeted their efforts at marginalized communities and particularly women of color, who have historically experienced many forms of reproductive oppression, including forced sterilization, and may view such programs with warranted distrust. To ensure reproductive freedom, it is important that reproductive coercion in any form be eliminated, and every person must instead be provided with comprehensive, scientifically accurate information about the full range of contraceptive options in a medically ethical and culturally competent manner.

Contraception is also often hard to reach for underserved communities, including low-income, rural, or immigrant communities, because of issues such as inadequate provider infrastructure, language accessibility, and cost barriers. Young people who are still minors may lack access to contraception if they are unable to consent to their own health care and unable to discuss their need for contraception with their parents or guardians. Most of these barriers to contraceptive access can be addressed through policy change.

Expanding Access to Contraceptive Care

In order to have meaningful access to contraception, an individual must be able to get the contraceptive care they want from a nearby provider who is appropriately trained to offer the full range of services. Five states considered legislation to move in this direction. In 2017, **California** enacted Senate Bill 743, which prohibits Medicaid plans from restricting a patient's access to their chosen reproductive health care provider, whether in or out of network. This builds on existing law that gives people with private insurance plans the right to choose to access out-of-network reproductive health care providers.

Oregon enacted House Bill 2103, which permits nurse practitioners to perform vasectomies, thus increasing the number of providers patients can choose from and reducing the wait time for an appointment. The **Texas** legislature considered House Bill 1373, which would have allowed minors to consent independently to medical treatment or examination related to contraception.

Although LARCs are the most effective form of contraception, uptake in the United States is low relative to uptake in other Western countries due to lack of awareness, persistent myths about their dangers among both patients and providers, insufficient training in insertion and removal, and the high cost of the devices, as well as concerns in some communities about the history of reproductive coercion. Both **Florida** (Senate Bill 1400) and **Tennessee** (House Bill 1320 / Senate Bill 883) considered addressing some of these barriers, moving legislation that would have established programs to improve access to LARCs by training providers, supporting family planning centers, and educating the public.

Protecting Access to Family Planning Clinics

Family planning clinics are often the primary health care providers for the communities they serve, frequently acting as a patient's first point of contact into the health care system; for a patient, they can also serve as a connector to coverage and other care or even be the only health care provider that a woman will ever see.[7] In fact, publicly supported family planning clinics are the gateway provider for the more than six million women who receive contraceptive services at such a clinic.[8] Research has shown that without these clinics, the unintended pregnancy rate in the United States in 2015 would have been 31 percent higher.[9] Given the important role that family planning providers play, states have a significant opportunity to support reproductive health generally, especially for low-income residents, by passing policies that enable family planning clinics to thrive in their states.

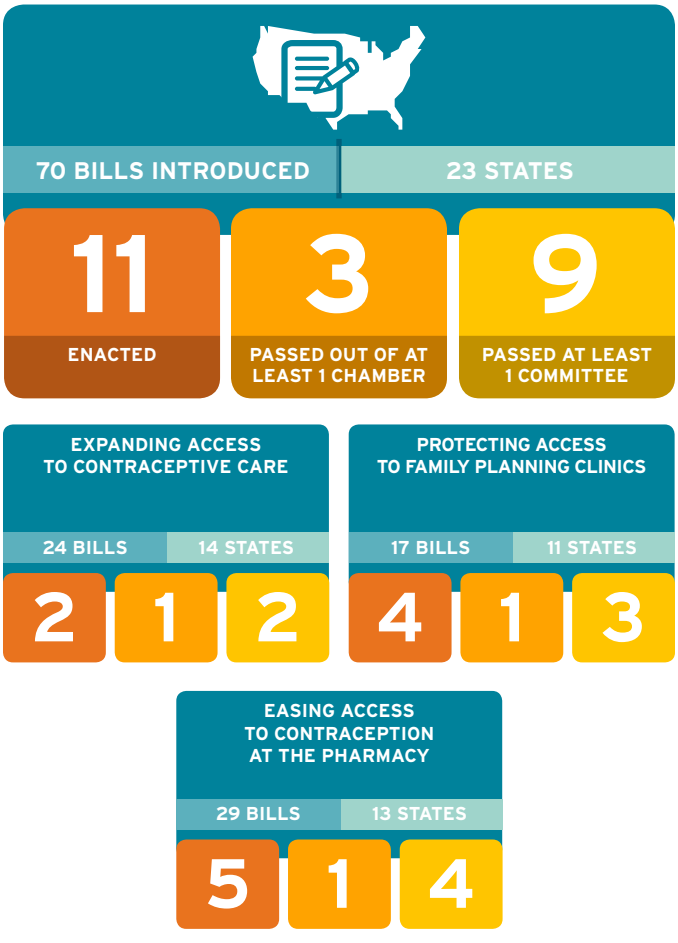
In 2017, seven states took steps to protect or bolster their family planning clinics. **Maryland** enacted House Bill 1083 / Senate Bill 1081 to ensure continued funding of family planning clinics such as Planned Parenthood should federal law restrict federal funding to those facilities, and **Connecticut's** legislature considered a similar bill (House Bill 7040). The **Illinois** legislature adopted House Resolution 78, which urges Congress to continue to fund Planned Parenthood. Four state legislatures considered legislation that would have created additional funding streams for family planning services: **Nevada** enacted Senate Bill 122, and legislation moved in **California** (Senate Bill 309), **New York** (Senate Bill 159), and **Utah** (House Bill 57).

Easing Access to Contraception at the Pharmacy

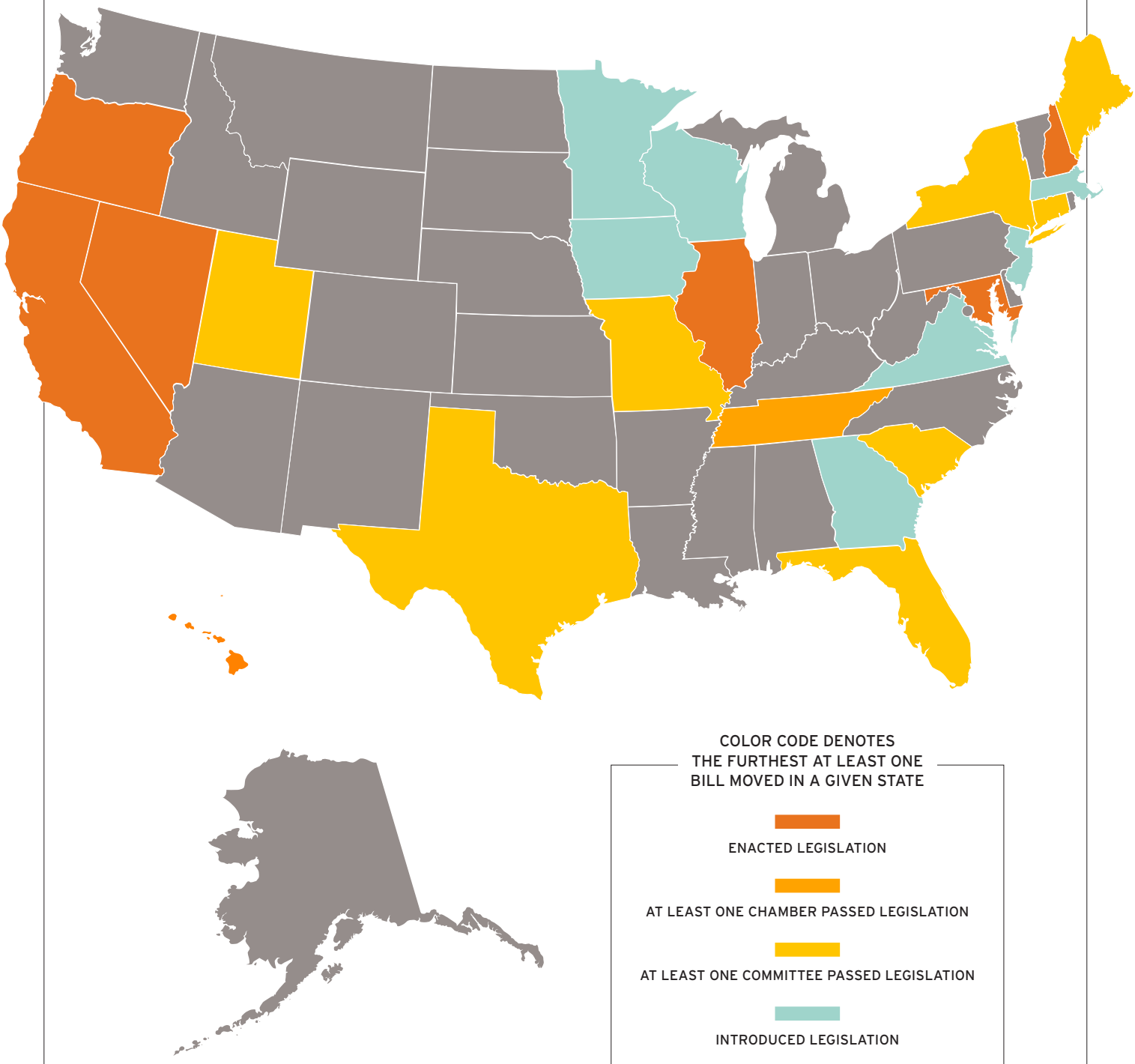
Oral contraceptives are among the safest and most well-understood medications available, and recent medical evidence suggests that making them available without a prescription could safely increase access and reduce unintended pregnancy.[10] Although states cannot change the federal requirement that a prescription is needed, seven states considered policies that adjust a pharmacist's scope of practice to help dismantle that barrier.

In **Hawaii** (Senate Bill 513), **Maryland** (House Bill 613 / Senate Bill 363), and **Oregon** (House Bill 2527), new laws were enacted that give pharmacists the ability to prescribe and dispense hormonal contraceptives, with some limitations, so that most women can skip the doctor's visit and simply see their local pharmacists for this method. Similar policies were considered in **Maine** (Senate Bill 309), **Missouri** (House Bill 233), and **South Carolina** (House Bill 3064), while **New Hampshire** considered a similar bill (Senate Bill 154) but ultimately enacted legislation to study the issue (House Bill 264). **Maryland** also considered Senate Bill 814, which would have allowed pharmacists to dispense up to six months of contraception at one time.

POLICY POSITION: CONTRACEPTION



EXPANDING ACCESS TO CONTRACEPTION



SUPERSTAR STATES: MARYLAND AND NEVADA

A few states are noteworthy for the truly remarkable progress they made toward broad reproductive freedom by passing multiple new laws designed to improve conditions for their residents in many ways. In 2017, **Maryland** and **Nevada** in particular made enormous strides toward a more just, healthier, fairer world for women and families, passing seven reproductive health and rights bills each in a single legislative session.

Maryland enacted seven different new laws[11] in 2017 that will improve access to reproductive health care, address discrimination faced by women and their families, and increase young people's access to comprehensive sexuality education. These laws cover an impressive array of reproductive health issues, including dedicating funding to protect access to Planned Parenthood and other comprehensive reproductive health care providers that provide abortion care and other services in the face of federal attacks (House Bill 1083 / Senate Bill 1081), expanding access to contraception in pharmacies (House Bill 613 / Senate Bill 363), requiring accommodations that help keep pregnant and parenting students in school (House Bill 616 / Senate Bill 232), and providing free feminine hygiene products to homeless young women in shelters and schools (House Bill 1067 / Senate Bill 625).

Notably, these bills were not introduced as part of a package—rather, a variety of advocacy groups and legislative champions moved legislation prioritizing women and women's health successfully through the legislature as individual measures in their own right. Advocates across the spectrum took the lead on different bills, such as NARAL Pro-Choice Maryland, which was a major supporter of almost all of these new laws and led the charge on House Bill 616, while the Marylanders for the Right to Choose coalition championed House Bill 613 / Senate Bill 363. Other organizations supported these new laws, including the Maryland Hospital Association and the Women's Law Center of Maryland.

These are impressive victories that mean women and girls in Maryland will have better access to contraception; will not lose access to reproductive health care, including abortion, despite federal attacks; will be able to stay in school while pregnant and parenting; and will be able to access necessary health supplies with dignity.

THE HUFFINGTON POST RECENTLY WROTE THAT THIS LEGISLATIVE SESSION IN NEVADA INCLUDED A "STARTLING NUMBER OF PROGRESSIVE VICTORIES FOR WOMEN," NOTING THAT "WITH A STATE LEGISLATURE MADE UP 40 PERCENT OF WOMEN, NEVADA IS SECOND ONLY TO VERMONT IN TERMS OF FEMALE REPRESENTATION."

Nevada also enacted seven new laws[12] that will increase women's access to health care and protect their rights. This is notable not just because it is a significant number but also because in 2016, Nevada did not pass a single proactive reproductive health bill. In 2017, in addition to strong advocacy by various organizations, Nevada's legislative session was remarkable because many of these bills were sponsored and carried by female lawmakers. The Huffington Post recently wrote that this legislative session in Nevada included a "startling number of progressive victories for women," noting that "[w]ith a state legislature made up 40 percent of women, Nevada is second only to Vermont in terms of female representation. And that translated into a landmark session for women's rights and health in 2017, even under a male Republican governor."[13] Moreover, Nevada's broad-based approach revealed a willingness to analyze and address the problems facing women and families in the state from multiple angles, making it more likely that those whose lives are touched by the various new laws will see greater overall improvement in their health and day-to-day experiences.

The Nevada legislature stepped up to urge Congress not to repeal the ACA (Senate Joint Resolution 8) and then enacted three laws (Senate Bill 233, Assembly Bill 249, and Senate Bill 122) that will increase access to contraception and other reproductive health care by ensuring coverage for the full range of contraception, allowing an extended supply of hormonal contraception, and funding family planning services. These were significant victories for Immunize Nevada, NARAL Pro-Choice Nevada, Nevada Advocates for Planned Parenthood, the Nevada Primary Care Association, and the Nevada Public Health Association, who advocated on behalf of these bills. Nevada also took on discrimination against pregnant and nursing moms in the workplace, enacting Senate Bill 253, which is a broad Pregnant Workers Fairness Act, and Assembly Bill 113, which was supported by a broad coalition of child advocates, labor groups, and hospital organizations and will require many employers in the state to provide nursing moms with a break and a clean, private place to pump milk. Finally, if Senate Bill 415 / Assembly Bill 402 is approved by the voters in 2018, no one will be charged sales tax on any feminine hygiene products in Nevada in the future. With better access to feminine hygiene products for all, more affordable and reliable access to family planning and contraceptive services, and protection for working mothers when they decide to become parents, Nevada's government has taken important strides toward making the state a healthy place to be a woman and raise a family.

IN THIS POLITICAL CLIMATE, progressives are often told to limit their expectations, lower their sights, and aim for small changes. But this slate of victories in Maryland and Nevada proves that making change on a meaningful scale is possible.

INCREASING ACCESS TO PREGNANCY CARE

Between 80 and 85 percent of women in the United States become pregnant and deliver at least one child in the course of their lives.[14] Both pregnancy and childbirth implicate important reproductive rights, including autonomy, dignity, and privacy, as well as critical aspects of public health, such as equitable access to quality health care. **NIRH supports policies that ensure that everyone, regardless of income level or immigration status, has affordable, convenient access to prenatal, labor and delivery, and postnatal health care from the provider of their choice in the delivery setting of their choice**. Effective public health policy should include collaboration between and among communities, governments, and health care providers so that all are able to work together to prevent maternal morbidity and mortality and to address and eliminate the racial disparities in maternal health indicators that currently plague the United States.

Improving Maternal Health Outcomes

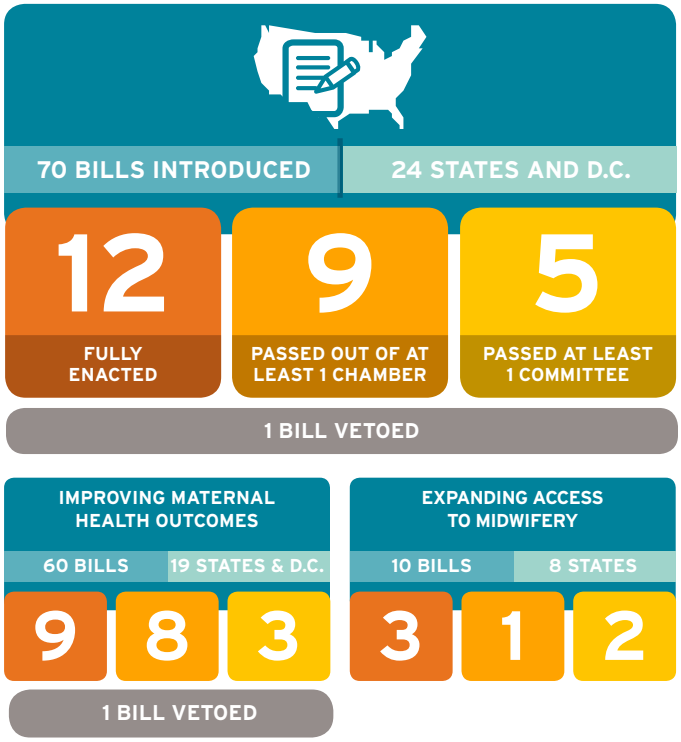
Despite otherwise advanced medical care in the United States, maternal health continues to be a significant problem throughout the country. Maternal health outcomes here lag behind those of many other nations[15] due in part to reprehensible rates of maternal mortality and morbidity that exist among black women and other women of color.[16] Advocates, reproductive health care professionals, and lawmakers have been considering policy options to address these issues for many years, although no perfect solution has yet to be identified.

A few key policy ideas seem to be the first important steps, including studying maternal health to identify the points of failure in each state's health care delivery system; ensuring access to basic prenatal and postpartum care, including mental health care; and creating programs that specifically target vulnerable or disparately impacted groups. From there, states can expand access in areas with gaps in care and begin to build out a more comprehensive approach that includes assessments of infant mortality and health or health of babies into their early childhood. In 2017, eleven states considered 21 proposals that would help address one or more of these serious health concerns.

Five states considered or expanded the powers of their maternal mortality and morbidity task forces, which generally draw upon the experience of members from different relevant professional stakeholder groups and make recommendations for necessary policy changes. **Maine** (Senate Bill 366) and **Mississippi** (House Bill 494) established new maternal mortality commissions, while **Texas** enacted Senate Bill 17a and moved forward seven other proposals to expand the tenure and scope of its existing task force. **New Mexico's** legislature voted overwhelmingly to approve a new Maternal Mortality and Morbidity Prevention Act, Senate Bill 137, supported by the American Congress of Obstetricians and Gynecologists (ACOG) and other experts, but Governor Susana Martinez vetoed the legislation, suggesting the women of New Mexico—who have a maternal mortality rate higher than most others in the United States—would be just as well served by experts voluntarily forming a group to analyze the issue without government support. **Pennsylvania** considered a similar bill, House Bill 1869.

Several additional states took other steps to try to address similar issues. **Colorado** expanded its Early Childhood Leadership Commission's mandate to more clearly encompass pregnant women and families (House Bill 1106). **New Jersey's** Senate Bill 1475 created a three-year Medicaid demonstration home visitation program to provide ongoing health and parenting information, parent and family support, and links to essential health and social services during pregnancy, infancy, and early childhood. **Utah** will now require its Department of

POLICY POSITION: PREGNANCY CARE



THROUGHOUT HISTORY, WOMEN HAVE GIVEN BIRTH IN MANY DIFFERENT CIRCUMSTANCES, SOMETIMES WITH COMPASSIONATE ASSISTANCE AND NECESSARY HIGHLY SKILLED MEDICAL CARE, BUT OFTEN WITHOUT BEING ABLE TO CONTROL OR INFLUENCE THE METHODS USED TO DELIVER THEIR CHILDREN OR THE MEDICAL TREATMENT THEY ARE SUBJECTED TO THEMSELVES.

Health to fund and study home-visiting nurse programs to improve maternal and child health (Senate Bill 135).

Other states considered or took policy actions intended to broaden access to prenatal and postpartum care. **Maryland** enacted a new law (House Bill 775) designed to expand awareness of maternal mental health needs, as well as access to information and services, and the **New York** (Assembly Bill 8308) and **Texas** (House Bill 2604) legislatures considered similar bills. **Alabama's** Senate passed Senate Bill 76, which would allow taxpayers to take a special deduction just for prenatal care expenses.

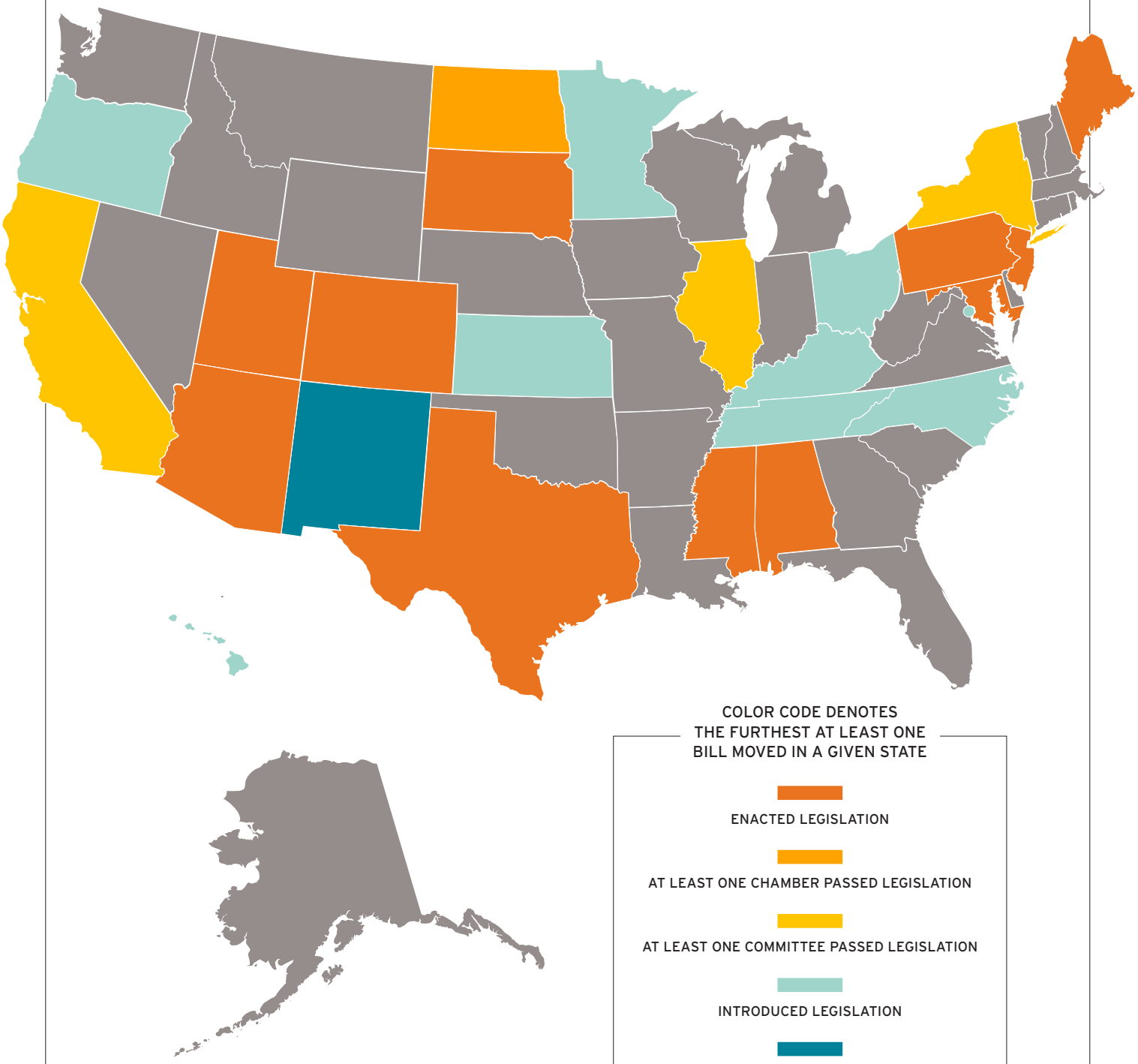
Finally, two states acknowledged the serious problems facing women who give birth—**New Jersey** recognized Maternal Health Awareness Day (Assembly Joint Resolution 130), and **Pennsylvania** recognized Postpartum Depression Awareness Month (House Resolution 183).

Expanding Access to Midwifery

Throughout history, women have given birth in many different circumstances, sometimes with compassionate assistance and necessary highly skilled medical care, but often without being able to control or influence the methods used to deliver their children or the medical treatment they are subjected to themselves. Today, many policymakers and reproductive health care professionals understand that the birth process should be driven by the woman herself, rather than others making decisions for her. Enabling women to give birth attended by their chosen provider—whether it is a physician or a midwife—in the delivery setting they choose not only respects women's autonomy and dignity, but also can lead to better health outcomes and fewer interventions. In order to expand access to the type of provider women may choose and the birth setting they prefer, some states have begun to remove legal barriers to home births, expand access to birthing centers, and broaden the licensing categories for those permitted to deliver babies.

In 2017, six states moved legislation to allow midwives broader ability to assist in births and the complications that can ensue—**Alabama** (House Bill 315), **Arizona** (Senate Bill 1133), and **South Dakota** (Senate Bill 136) all enacted new midwifery certification and licensure schemes, while legislative chambers in **California** (Assembly Bill 1612), **Illinois** (Senate Bill 1754), and **North Dakota** (Senate Bill 2256) moved forward related legislation. Alabama's law, which passed after 13 years of advocacy by grassroots organizations such as the Alabama Birth Coalition, allows midwives to attend home births in the state for the first time in more than 40 years.[17]

INCREASING ACCESS TO PREGNANCY CARE



ABORTION IN THE RESISTANCE: DELAWARE, ILLINOIS, AND OREGON

The reproductive health, rights, and justice movements have been building power in the states for years, and in 2017, those efforts came to fruition in three states amidst the rise of a strong and growing progressive resistance unlike anything this country has witnessed in decades.

2017 brought remarkable, hard-fought victories in **Delaware**, **Illinois**, and **Oregon** that will dramatically improve abortion access for their residents. This might seem counterintuitive given the increase in federal attacks on access to health care, abortion access, immigrants' rights, criminal justice, and more, alongside ongoing similar attacks at the state level. But in each instance, tireless, often multiyear community building and culture shift work enabled advocates for reproductive health, rights, and justice to achieve significant wins. At a time of unprecedented progressive organizing, these advancements provide critical proof that abortion need not be left behind in the fight for progressive values. Rather, to successfully resist a conservative tide, abortion rights must be affirmed and strengthened.

Delaware's advocates and lawmakers responded to heated federal rhetoric and attacks on the constitutional right to abortion by passing Senate Bill 5, which repeals unconstitutional portions of the state's pre-*Roe* abortion law and establishes clear protections for abortion access in the state. The ACLU of Delaware and Planned Parenthood of Delaware partnered to form the "She Decides Delaware" campaign to advocate for the bill.[18] Although the archaic pre-*Roe* abortion law had been a problem for many years, Kathleen MacRae, Executive Director of the ACLU of Delaware, said that "[t]here wasn't a sense of urgency until President Trump got elected."[19] With significant advocacy by a coalition that included state religious leaders—Episcopal, Jewish, Methodist, Presbyterian, and Unitarian clergy—who publicly declared acceptance of abortion in a show of support, the bill was passed 11 to seven in the Senate and 22 to 16 in the House, and it was signed by Governor John Carney. Similarly, in **New York**, the Assembly passed (but the Senate failed to vote on) the Reproductive Health Act (Assembly Bill 1748), which would have enshrined the protections of *Roe* in state law and decriminalized self-abortion. Advocates have been working for years to bring New York law into alignment with constitutional standards and protect New York women who act outside the medical system from arrest and prosecution.

In the face of expanded federal restrictions on abortion funding, the **Illinois** legislature passed House Bill 40, which restores public insurance coverage for abortion for Medicaid recipients and state employees. State Representative Sara Feigenholtz, the bill's sponsor, said that passing the bill was "a victory for every woman in our state because it protects every woman's right to choose....Today, we stated unequivocally that access to safe legal abortion

IN THE FACE OF GROWING FEDERAL AND STATE EFFORTS TO LIMIT REPRODUCTIVE RIGHTS AND ACCESS TO HEALTH CARE, IT IS MORE IMPORTANT THAN EVER TO UNAPOLOGETICALLY COMMUNICATE OUR VALUES, USE A PROACTIVE APPROACH TO PASS INNOVATIVE AND BOLD ABORTION POLICIES, AND GALVANIZE THE EVER-INCREASING BASE OF PEOPLE WHO DEMAND THOSE POLICIES FROM THEIR LAWMAKERS.

will remain protected in Illinois."[20] When Governor Bruce Rauner threatened to veto the legislation, activists led by organizations including the ACLU of Illinois, All* Above All, Illinois Caucus for Adolescent Health, the Indivisible Chicago chapter, and Planned Parenthood of Illinois converged on the Illinois capitol for the Women's March on Springfield.[21] The groups also rallied in Chicago dressed like handmaids from the dystopian novel and television show "The Haidmaid's Tale,"[22] which advocate Renee Wsol said "seemed like something that could never happen...now the themes feel so much like the direction we could be heading in."[23] Throughout the summer, activists flooded the governor's office with phone calls, letters, and social media messages urging him to sign HB 40. In September, Governor Rauner signed HB 40, thereby ensuring women "[a]re empowered to make their own health care and life choices without interference from politicians," as Lorie Chaiten, Director of the Women's and Reproductive Rights Project at the ACLU of Illinois, explained.[24]

In **Oregon**, the Reproductive Health Equity Act (House Bill 3391) was enacted, ensuring coverage for the full range of reproductive health services, including abortion, for all Oregonians regardless of their income or citizenship status. This was the latest version of a comprehensive coverage policy that has been supported by the Pro-Choice Coalition of Oregon since 2015. The coalition has adopted a reproductive justice framework and has been a model for advocates everywhere, successfully centering the voices and advocacy of people of color and the specific communities most affected by the policy. Amy Casso, the Gender Justice Program Director from Western States Center, a coalition member, explained, "For too long, marginalized communities have been left behind. No one should have to go bankrupt or deep into debt because they don't have affordable reproductive health care."[25] In service of that, the We are BRAVE project of Western States Center has built an ever-expanding group of core activists who were critical to this impressive policy success and who engage in this advocacy using a reproductive justice framework. "Oregon's success represents a formidable and proactive resistance to Trump's agenda to shame, bully, and punish women who decide to have an abortion, and to state lawmakers who've passed hundreds of new restrictions on abortion in recent years," Destiny Lopez, co-director of All* Above All, said in a statement.[26]

These hard-won successes signify that the power that state advocates and legislative champions have been building over the past decade is paying off. In the face of growing federal and state efforts to limit reproductive rights and access to health care, it is more important than ever to unapologetically communicate our values, use a proactive approach to pass innovative and bold abortion policies, and galvanize the ever-increasing base of people who demand those policies from their lawmakers. In today's newly energized and united progressive fight, abortion advocates are leading the way.

ENSURING COMPREHENSIVE REPRODUCTIVE HEALTH CARE COVERAGE FOR ALL

The availability of reproductive health care services is meaningless if people cannot afford their care. To have meaningful access, everyone—regardless of their income level or immigration status—must have insurance coverage and other funding sources that adequately cover the full range of services that individuals need in order to lead healthy reproductive lives. **NIRH supports policies that ensure that all insurance coverage, whether offered privately, by employers, or through the government, provides coverage for all forms of reproductive health care, including abortion, contraception and non-coercive contraceptive counseling, fertility treatment, prenatal care, labor and delivery, postpartum care, and breastfeeding support and services**. In addition, insurance policies should not impose barriers to receiving care, and coverage for contraception should include a year's supply of all methods with no cost sharing, as well as over-the-counter access to any contraceptive that is approved for over-the-counter sale.

Restoring and Expanding Coverage for Abortion

Restrictions on insurance coverage for abortion have been used to discriminate against low-income women for decades. Federal law, reenacted each year in the federal budget and known as the Hyde Amendment, withholds abortion coverage from anyone enrolled in the Medicaid program or other federal insurance programs. This ban on coverage can sometimes be an insurmountable obstacle to abortion for low-income women; it forces one in four poor women seeking an abortion to carry an unintended pregnancy to term, which can in turn push women deeper into poverty.[27] These types of restrictions on abortion care are echoed throughout many states' Medicaid plans, exchange marketplaces, and even state employees' health plans. These restrictions must be repealed and replaced with policies that ensure abortion coverage for every individual; in 2017, two states moved forward with these kinds of policies.

Illinois' House Bill 40 was enacted to restore public insurance coverage of abortion in the state's Medicaid coverage and the state employee insurance plan. The bill also repealed an old law that could have endangered the legality of abortion if *Roe v. Wade* were overturned, called a "trigger ban." (*See* "Abortion in the Resistance" on page 18.) **Oregon** enacted the Reproductive Health Equity Act (House Bill 3391), which is considered the most progressive reproductive health policy in the country and is a significant victory for all Oregonians and the Pro-Choice Coalition of Oregon, which led the effort. The new law requires all health plans to cover the full range of reproductive health services, including abortion, regardless of an individual's income, type of insurance, citizenship status, or gender identity and expression.[28]

Protecting and Expanding Coverage for Contraception

Some insurance plans lack comprehensive coverage for all forms of contraception, or they create barriers to accessing contraception at a convenient place in a manner that works for providers and patients. However, states can adopt policies to ensure broader coverage for contraception, and many legislatures considered such policies in 2017.

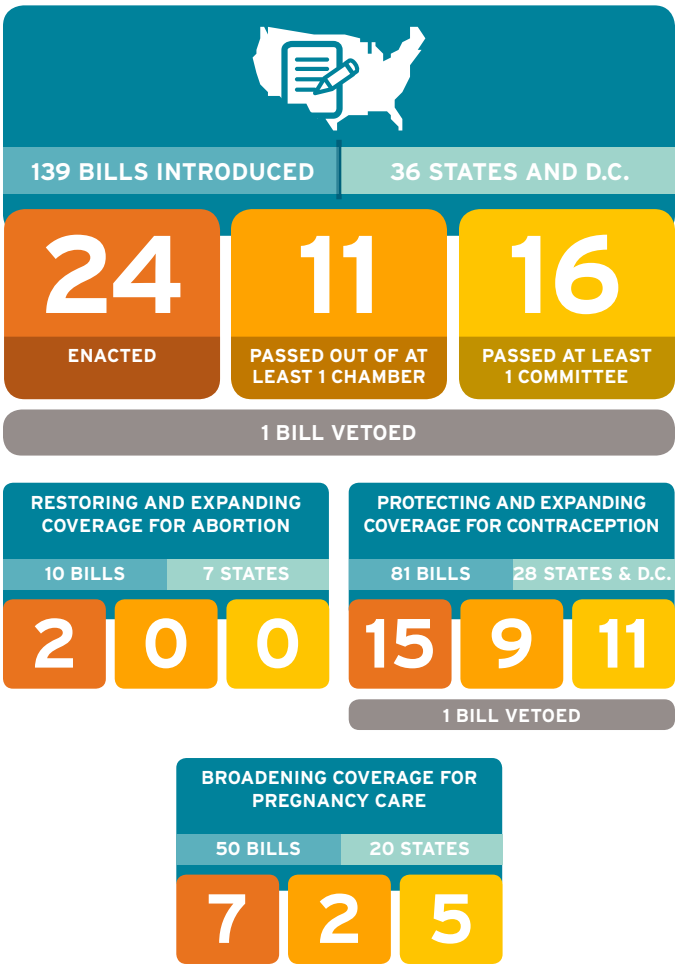
CONTRACEPTIVE EQUITY AND THE ACA'S PROMISE

Since the 1990s, many states have required insurers to provide "contraceptive equity," meaning that insurance plans that cover prescription drugs must also cover contraception. However, insurance companies often limited the types of contraception that were covered or charged high copays for some or all forms. The ACA addressed some of these barriers by requiring coverage for all FDA-approved forms of female contraception with no copay.[29] Many advocates and legislators worked to enshrine this requirement in their state law and to broaden the coverage guarantee even further, such as by including over-the-counter and/or male forms of contraception. In 2014, **California** became the first state to pass such a law, with **Illinois**, **Maryland**, and **Vermont** following suit in 2016.

As Congress and the president devoted much of 2017 to attempts to repeal the ACA, and the White House explicitly threatens contraceptive access, many states introduced bills that would ensure, at minimum, no-copay coverage for all FDA-approved contraceptives, regardless of federal law. **Maine**, **Massachusetts**, and **Nevada** enacted these types of laws (Maine House Bill 860, Massachusetts House Bill 4009, and Nevada Assembly Bill 249 / Senate Bill 233); Senator Julia Ratti, the Nevada bill sponsor, explained, "these services are so critical to the health care of women that all of us should have access."[30] Three other state legislatures considered these policies (**Alaska** House Bill 25, **New Mexico** House Bill 284 / Senate Bill 347, and **New York** Assembly Bill 1378). Each of these bills also included a requirement for coverage for 12 months of contraception at a time (discussed below).

Some state legislatures considered broader responses to the threats to the ACA, proposing legislation that included requirements of coverage for a range of reproductive health services. The **District of Columbia** enacted Bill 224 and Bill 225, and it considered Bill 106; **Hawaii** enacted House Bill 552 / Senate Bill 403, which would require coverage for the full range of women's preventive health services as laid out in the ACA and its regulations, including services such as pregnancy, maternity, and newborn care, and breastfeeding services. **Nevada's** legislature passed a similar bill (Assembly Bill 408), but Governor Brian Sandoval vetoed it; **Connecticut** (Senate Bill 586) and **Washington** (House Bill 1523) moved similar legislation. Relatedly, Connecticut's House Bill 6175 would have created a task force to study how to ensure continued access to the benefits of the ACA if it is repealed. Three

POLICY POSITION: COVERAGE



state legislatures also adopted resolutions supporting the ACA and urging Congress not to repeal or endanger current benefits (**Illinois** House Resolution 445, **Maryland** House Joint Resolution 9 / Senate Joint Resolution 7, and **Nevada** Senate Joint Resolution 8).

REQUIRING COVERAGE FOR AN EXTENDED SUPPLY OF CONTRACEPTION

Along with requiring robust coverage for all forms of contraception, some state lawmakers considered easing other barriers to access by mandating coverage for specific forms or amounts of contraception. Research has shown that having a year's supply of contraception on hand reduces a woman's odds of unintended pregnancy by 30 percent and is an identified best practice by the Centers for Disease Control and Prevention. Yet many insurance companies will cover only three months at a time.[31] **Colorado** (House Bill 1186), **Virginia** (House Bill 2267), and **Washington** (House Bill 1234 / Senate Bill 5554) enacted new laws to require insurance companies to cover dispersing 12 months of contraception at one time, although some require an initial three-month supply for all women or for those under 18 (similar measures were adopted in **Maine** and **Nevada** as part of broader contraceptive equity measures described above). The Colorado Organization for Latina Opportunity and Reproductive Rights (COLOR) praised the new law, explaining, "House Bill 1186 is an important bill for women and families in the Latinx community. Systemic barriers like poverty, language, lack of transportation, and immigration status make getting care more difficult resulting in ongoing health disparities. As a result, Latinas are twice as likely to experience unintended pregnancy."[32]

Similar legislation, but covering only six months at a time, was passed by the **New Jersey** legislature (Assembly Bill 2297 / Senate Bill 659). Similar twelve month bills moved in **Rhode Island** (House Bill 5486), **South Carolina** (House Bill 3809), and **Texas** (House Bill 1161), while such provisions were considered as part of broader contraceptive equity bills in **Alaska**, **New Mexico**, and **New York** (discussed above).

COVERAGE FOR UNDERUTILIZED CONTRACEPTION

LARCs should be accessible to any woman who determines that it is the best method for her circumstances. However, LARCs are underutilized in the United States for a variety of reasons, including the high cost of the devices that insurance companies pass on to consumers and delays in obtaining LARCs due to payment and reimbursement structures that make it cost-prohibitive for providers to have LARCs on hand or to provide them during certain visits. Legislators in **Connecticut** (House Bill 7008), **New Jersey** (Senate Bill 2918), **Oregon** (House Bill 3135), and **Wyoming** (Senate Bill 150) considered bills in 2017 that would have made changes to Medicaid payment structures to make it easier and more affordable for providers in the Medicaid system to offer LARCs, including offering them immediately postpartum—a time when many patients and providers would like to be able to have them inserted.

INCREASING COVERAGE FOR EMERGENCY CONTRACEPTION

Although emergency contraception (EC), a time-sensitive medication, is now widely available over the counter at pharmacies, insurance companies often provide coverage for EC only when it is prescribed by a health care provider. This means patients face a choice between accessing the medication as soon as possible or getting affordable medication but with an additional and possibly harmful delay. Two 2017 bills focused on increased coverage for EC: **California** enacted Assembly Bill 1312, which requires that EC be given to sexual assault victims at no cost to the patient, while **New York** moved Senate Bill 3790, which would have ensured that EC be covered by insurance when dispensed by a pharmacist rather than only with a physician's prescription.

Broadening Coverage for Pregnancy Care

In order to have the ability to truly decide whether, when, and how to start a family, a woman must be able to afford the care she needs to become pregnant, have a healthy pregnancy and delivery, and get the support she needs as a new mother. Legislation was proposed in many states in 2017 that would expand insurance coverage for many forms of pregnancy-related care.

Two states considered making it easier for pregnant women to obtain insurance coverage. The **Arkansas** legislature adopted a resolution, House Concurrent Resolution 1012, encouraging the governor to submit a plan to extend Medicaid coverage to pregnant women who have recently emigrated from the Compact of Free Association (COFA) countries and may experience higher rates of cancer, diabetes, and other ailments due to the lingering effects of radiation after decades of U.S. occupation and weapons testing following World War II.[33] **Connecticut** legislators considered Senate Bill 877 to address the fact that, in the private insurance market, individuals without health insurance can enroll in new

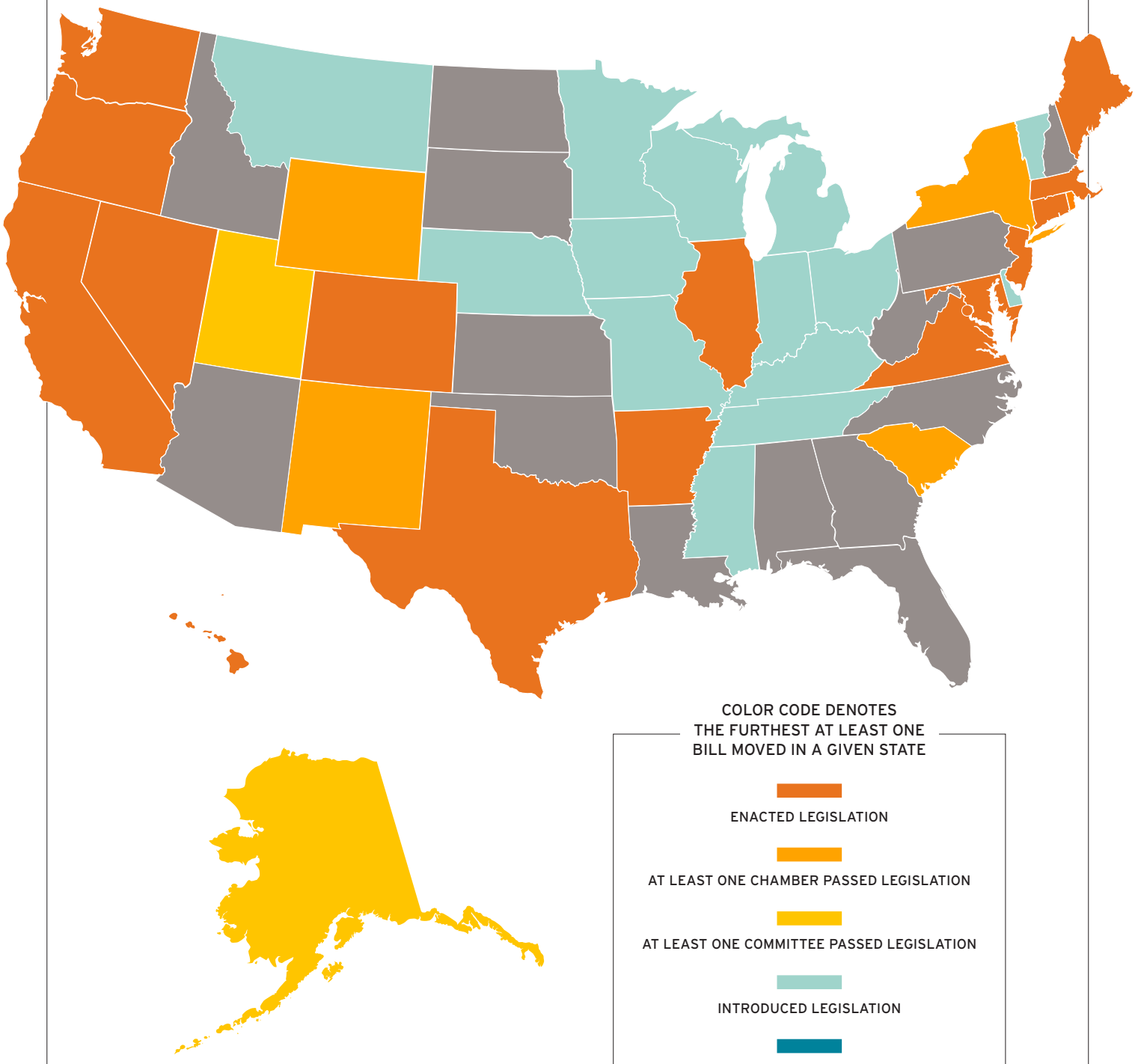
IN ORDER TO HAVE THE ABILITY TO TRULY DECIDE WHETHER, WHEN, AND HOW TO START A FAMILY, A WOMAN MUST BE ABLE TO AFFORD THE CARE SHE NEEDS TO BECOME PREGNANT, HAVE A HEALTHY PREGNANCY AND DELIVERY, AND GET THE SUPPORT SHE NEEDS AS A NEW MOTHER.

plans only at designated times, including after the birth of a child but not during the pregnancy itself. The bill would have permitted an individual who becomes pregnant to enroll in health insurance outside of a normal open enrollment period.

Pregnant women should be able to choose the kinds of providers they want for their prenatal care and delivery and have access to the full range of services they need. In 2017, three states considered bills to give low-income women coverage for a broad range of services and providers. **Oregon** enacted House Bill 2015, which will allow women on Medicaid to access insurance coverage for doula care during their pregnancies—a service that is otherwise often cost-prohibitive for many low-income communities. Legislators in **Texas** enacted House Bill 2466 and considered House Bill 2135, and **Utah** considered House Bill 122, all of which would have expanded coverage for mental health services for mothers on Medicaid, ensuring coverage for postpartum depression, among other conditions.

For many people, choosing when and how to start a family can be out of reach if they do not have access to insurance coverage for fertility services. In 2017, **Connecticut** (House Bill 7124) and **New Jersey** (Assembly Bill 1447 / Senate Bill 1398) enacted bills that will require insurance to cover the diagnosis and treatment of infertility in many cases, and legislators in **Maryland** (Senate Bill 96) and **Rhode Island** (Senate Bill 490) considered similar legislation. Many of these enacted and proposed bills allowed for certain limitations such as lifetime caps, age limits, and/or religious exemptions to the coverage. Legislation was enacted in **Rhode Island** (House Bill 6170 / Senate Bill 821) and considered in **California** (Senate Bill 172) that requires coverage for infertility that did or could result from medical treatment, such as cancer treatments.

ENSURING COMPREHENSIVE REPRODUCTIVE HEALTH CARE COVERAGE FOR ALL



COLOR CODE DENOTES THE FURTHEST AT LEAST ONE BILL MOVED IN A GIVEN STATE

- ENACTED LEGISLATION
- AT LEAST ONE CHAMBER PASSED LEGISLATION
- AT LEAST ONE COMMITTEE PASSED LEGISLATION
- INTRODUCED LEGISLATION
- VETOED LEGISLATION
- NO LEGISLATIVE ACTION

PROMOTING COMPREHENSIVE SEXUALITY EDUCATION FOR ALL YOUNG PEOPLE

Young people have the right to lead full and healthy lives, which means having knowledge and feeling empowered to make informed decisions about their reproductive and sexual health. Comprehensive sexuality education programs provide young people with the information and ability to make those choices, and they have been proven to delay the onset and frequency of sexual activity, increase condom and contraceptive use, and reduce the number of sexual partners.[34]

NIRH supports policies to support or mandate age- and developmentally appropriate, medically accurate, comprehensive sexuality education in schools and communities so that all young people—regardless of where they live or what school they attend—have the opportunity to lead healthy sexual and reproductive lives.

Requiring K-12 Comprehensive Sexuality Education

Comprehensive sexuality education empowers young people to make healthy decisions about relationships, sexuality, and sexual behavior. Unfortunately, sexuality education curricula are often determined by a patchwork of state and local laws and school district policies, so each student's access to information about their reproductive and sexual health is dependent on where they live. On the other hand, local and state control of this issue means that states have many ways to improve upon the status quo.

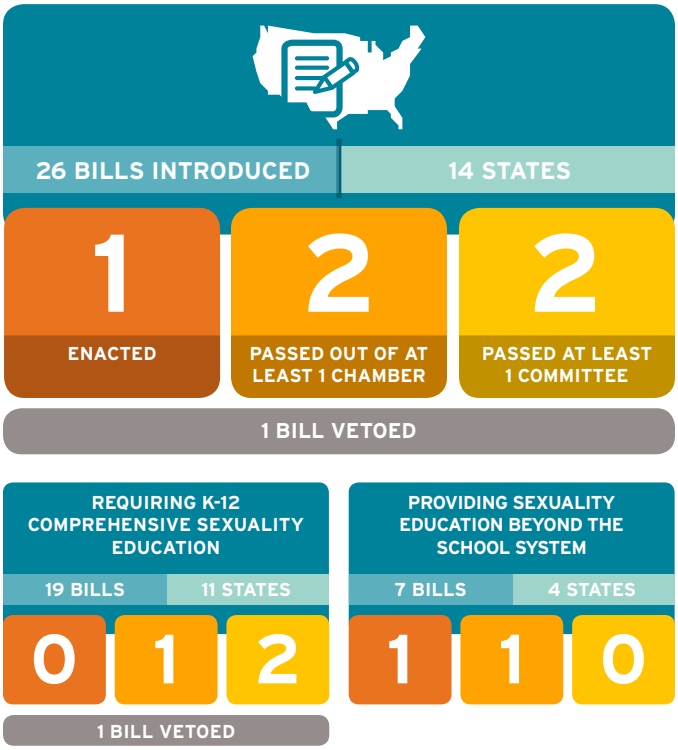
In 2017, three states considered five bills that would mandate comprehensive sexuality education or improve existing curricula in their schools. For the second time, and after multiple bill revisions, the **Massachusetts** legislature moved forward Senate Bill 2128 to mandate that age-appropriate, medically accurate, comprehensive sexuality education curriculum be taught in all schools. **Nevada's** legislature passed similar legislation (Assembly Bill 348), which was vetoed by Governor Brian Sandoval. **New York's** Assembly Bill 2705 / Senate Bill 1070, which would establish a grant program to fund age-appropriate sexuality education in public schools around the state, passed one committee.

Providing Sexuality Education Beyond the School System

Sexuality education is a lifelong process that does not end once a school bell rings or a diploma is issued. Community programs and other unique opportunities that provide ongoing education are a vital way to ensure that young people, especially youth of color and those from low-income backgrounds, can access sexual and reproductive health information despite inconsistent education in schools in the traditional K-12 setting.

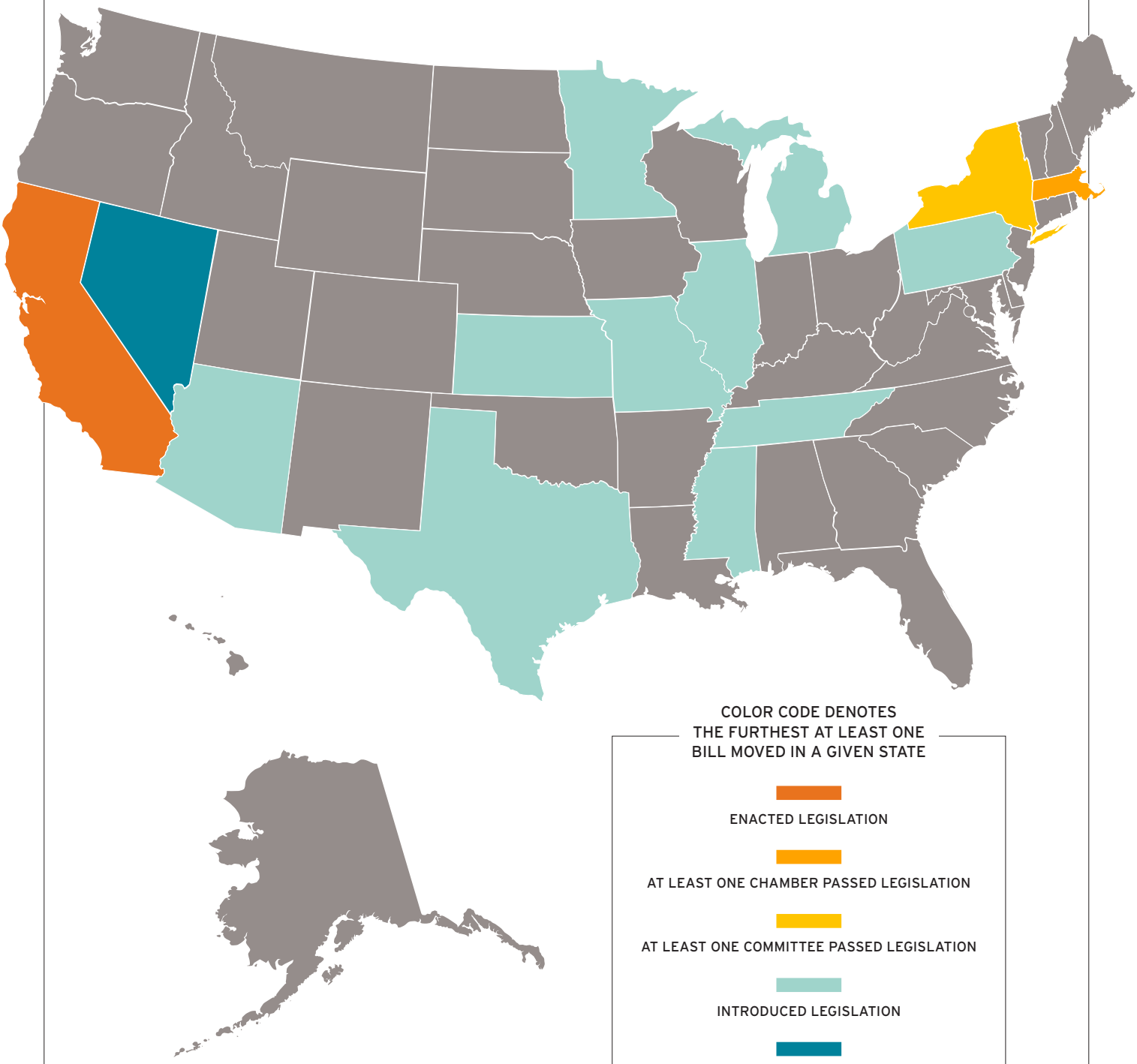
California enacted Senate Bill 89 and considered Senate Bill 245 to address the serious gaps for youth in foster care by requiring the state to provide young people in the foster care system with comprehensive sexuality education. Young people in foster care are at a higher risk for teen pregnancy—in California, it's estimated that half of the young women in care were pregnant at least once by age 19[35]—and often face disrupted educational experiences, which can result in limited or inconsistent access to sexuality education as they move through the child welfare system. Moreover, as youth are also placed in different households, each foster family has its own attitudes and may prohibit conversations about sex or access to birth control.

POLICY POSITION: SEXUALITY EDUCATION



SEXUALITY EDUCATION IS A LIFELONG PROCESS THAT DOES NOT END ONCE A SCHOOL BELL RINGS OR A DIPLOMA IS ISSUED. COMMUNITY PROGRAMS AND OTHER UNIQUE OPPORTUNITIES THAT PROVIDE ONGOING EDUCATION ARE A VITAL WAY TO ENSURE THAT YOUNG PEOPLE, ESPECIALLY YOUTH OF COLOR AND THOSE FROM LOW-INCOME BACKGROUNDS, CAN ACCESS SEXUAL AND REPRODUCTIVE HEALTH INFORMATION DESPITE INCONSISTENT EDUCATION IN SCHOOLS IN THE TRADITIONAL K-12 SCHOOL SETTING.

PROMOTING COMPREHENSIVE SEXUALITY EDUCATION FOR ALL YOUNG PEOPLE



PROACTIVE POLICY AND THE POWER OF GOVERNORS: NEW YORK, OREGON, AND ILLINOIS

In the process of developing and moving proactive policy, the state legislature often takes center stage. But governors can make or break access to reproductive health care in a state.

Governors hold outsized power to both create and ensure the effective implementation of proactive policy: Governors can support proactive policy publicly, lobby legislators, and sign laws once they are passed. Once a bill becomes law, agencies overseen by the governor are often charged with ensuring the law is faithfully executed, which can mean promulgating the right regulations, producing public education materials to inform groups about new rights or services, or changing internal policies to conform with newly enacted standards. Further, governors and their agencies can use the administrative process to improve policy at many different levels without new legislation by creating new regulations or less formal policy based on the existing authority already found in state law.

On the other hand, governors can use their significant power to harm their citizens, even when the legislatures in their states are committed to advancing proactive policy. Governors can veto proactive legislation, create harmful new regulations that rescind or narrow benefits or the way rights are protected, or issue harmful executive orders.

In 2017, a few governors stand out for their actions, both good and bad, on reproductive health, rights, and justice. In **New York**, Governor Andrew Cuomo and his agencies clearly demonstrated their commitment to women's reproductive health and rights by issuing four different regulations that affirm access to insurance coverage for abortion and contraception in New York State, protect access to insurance coverage for all New Yorkers if the federal government repeals or restricts the ACA, and improve conditions for women who are incarcerated. The abortion and contraception regulations are wide-ranging and, when implemented, will ensure that women have full access to those services in the state without having to pay coinsurance or copayments or meet a deductible. With regard to abortion care, this groundbreaking policy is found in only one other state, **Oregon**, which enacted its Reproductive Health Equity Act earlier in 2017. "With an anti-choice president, a health care bill that takes aim at reproductive health care, and the threat of *Roe v. Wade* being overturned, it is more important than ever to safeguard access to reproductive health at the state level. Through these regulations, Governor Cuomo has set an example," said Andrea Miller, President of NIRH, which took the lead in advocacy for these regulations. "States around the country should take note of this action and help lead the movement to protect health care for women."[36]

A third set of regulations, released in September, ensures that all residents of New York will continue to have access to insurance coverage that covers the full range of essential health benefits guaranteed under the ACA, regardless of congressional action. Finally, Governor Cuomo's administration promulgated a regulation requiring county correctional facilities to provide all women at their facilities with free menstrual supplies in sufficient quantities, addressing the clear harms that had been brought to the attention of the legislature, administration, and public earlier in the year. Gail Smith, director of the Women in Prison Project, announced that the organization was "pleased to see that the State Commission of Correction has addressed the basic need for adequate sanitary supplies for women in county facilities," adding that "no woman should be put in the humiliating position of not having sanitary supplies when they need them and having to ask corrections officers for extras or face humiliating requirements in order to receive necessary supplies."[37]

In **Oregon**, Governor Kate Brown not only signed the most expansive reproductive health coverage bill in the nation's history (see page 20 for more), but she also enthusiastically supported it as it moved through the legislature, motivating legislators to continue pushing it forward. The Oregon bill requires comprehensive coverage for reproductive health care, including, as in the **New York** regulations, access to many services without copays, coinsurance, or having to meet a deductible. Governor Brown's support both during the process and when it arrived on her desk is a strong indication that she and her agencies will implement the new law in a way that maximizes its positive impact on the lives of Oregon women.

In **Illinois**, after months of deliberation and in response to strong advocacy on the ground, and in opposition to his own party's traditional stance, Republican Governor Rauner signed a bill that restores public insurance coverage for abortion in the state and repeals a harmful "trigger" law that might have endangered abortion access if the Supreme Court decides to reverse *Roe v. Wade*.

On the other hand, governors in New Mexico and New Jersey used their power to stymie the efforts of advocates and legislators to advance reproductive health, rights, and justice in their states. In **New Mexico**, the legislature passed several important progressive pieces of legislation, with large majorities or unanimously, that would have ensured that pregnant workers could stay on the job, allowed courts the ability to provide alternatives to incarceration for pregnant or recently postpartum women, given new mothers who are incarcerated the ability to breastfeed their babies, and created a new task force to investigate and address the sources of maternal mortality and morbidity in the state. New Mexico Governor Susana Martinez vetoed each and every one of these pieces of legislation, some with no explanation at all, others with a dismissive wave that discounted both the harm experienced by women in her state and the consensus that exists among the advocates, legislators, and community to address them. Indeed, Governor Martinez even used her "pocket veto" to avoid an override on several of these bills, simply failing to take action and thus dooming the legislation to ultimate failure.

Governor Chris Christie also used the power of his veto pen to harm women in his state of **New Jersey**, for the seventh year in a row vetoing a bill that would have expanded access to family planning to women making 200 percent or less of the federal poverty level. He also vetoed a bill that would have expanded the state's paid family leave to other family members and issued a conditional veto of legislation that would have allowed women to obtain 12 months of birth control with one prescription, reducing it to six months, with no rationale or analysis accompanying his decision.

In the current political climate, protecting reproductive rights and advancing reproductive health and justice are critical, and the challenges in this arena require creative advocacy. Understanding the range of policy tools available can help advocates and lawmakers make positive change, even in the face of legislative obstacles. Governors hold the power to make new laws, grant new benefits, protect rights, and improve conditions for the residents of their states, as well as the power to stand in the way of such advancements. Governors and their executive branch agencies can change the course of people's reproductive lives—for better or worse—and it is up to advocates and voters to hold governors accountable for the life-altering decisions they make.

SUPPORTING PARENTS AND FAMILIES

As the leaders of the reproductive justice movement have made clear, true reproductive freedom means that all people have the right and the ability to choose whether and when to become a parent, as well as the right and ability to parent their children with dignity.[38] However, the United States lacks policies at any level to ensure those freedoms exist for all parents, including paid family and sick leave, support for mothers who want to breastfeed but also return to work, and support for young parents to continue school and enter the workforce as they choose without being subject to stigmatization. Moreover, some federal and state policies penalize low-income parents and young children directly through policies known as "TANF caps," which essentially cap the number of children low-income parents can have before they lose the ability to receive financial assistance to feed, clothe, and house those children. **NIRH supports policies that enable parents to raise their children safely, in a healthy environment, and with dignity and support, and it opposes policies that coerce decision-making about parenting by withholding assistance or conditioning benefits based on a person's decision not to become a parent or to have additional children.**

Expanding Access to Paid Family Leave

The benefits of paid family leave are both well documented and numerous, from ensuring that mothers have adequate time to heal after labor and delivery, to giving new parents of birth or adopted children time to bond, to promoting gender equality in the home when all types of parents have time to learn and adjust to the tasks of child-rearing, among other benefits.[39] However, for many, time at home after the birth or adoption of a child simply is not possible because the family needs the parent's income to survive. With no federal paid family leave policy, advocates and lawmakers at the state level have considered a range of different options to support families in their state, with 32 states and the District of Columbia considering proposals in 2017 alone to try to address this serious gap.

Only a handful of states have enacted and begun administering paid family leave programs (**California**, **New Jersey**, and **Rhode Island**, with **New York's** scheduled to go into effect in 2018). While **Washington** State was actually one of the first to act, passing a paid family leave program in 2007, the state never determined the funding source for the program and thus, for the last decade, has failed to implement the legislation. However, in 2017, Washington's legislature, advocates, and business community worked together to come up with a bipartisan solution and enacted Senate Bill 5975c, which will go into effect in 2020 and provide 12 weeks of paid leave for many employees. Washington also considered House Bill 1116 / Senate Bill 5032 and Senate Bill 5829, which would have expanded family leave. Four states considered changes to the eligibility, benefits, and time available for leave. **Hawaii** enacted House Bill 213 and **New Jersey's** legislature approved Assembly Bill 4927, but Governor Chris Christie vetoed the legislation; **Connecticut** (Senate Bill 1) and **New York** (Assembly Bill 1834) each passed their bill through one committee.

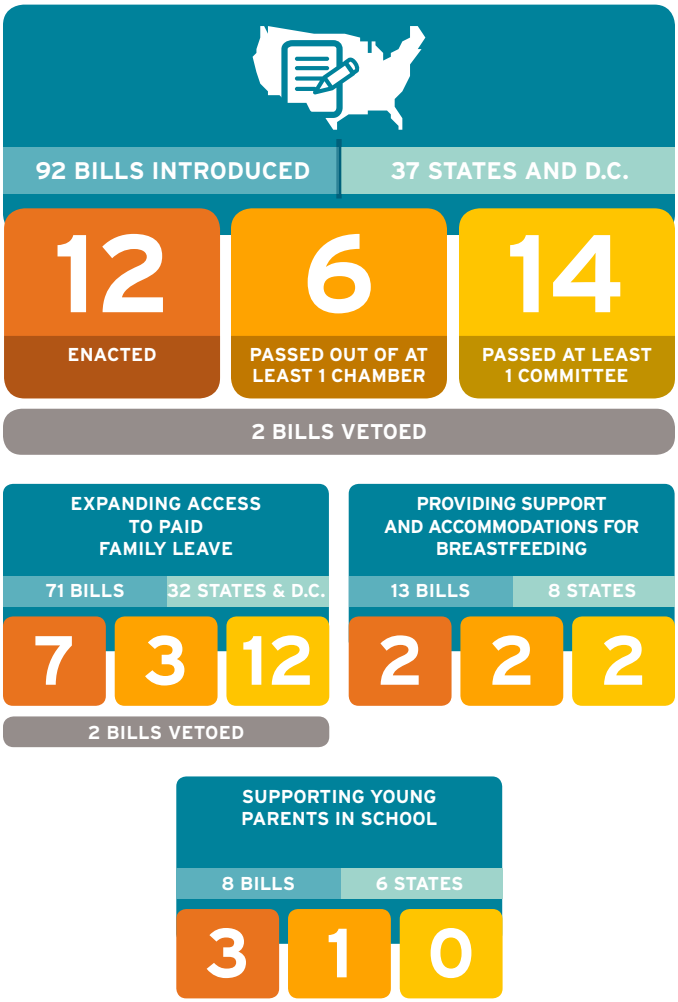
In seven other states and the District of Columbia, legislatures moved forward legislation that would have created statewide paid family leave programs: **Colorado** (House Bill 1307), **Connecticut** (House Bill 6212), **Illinois**

(House Bill 2376), **Maine** (House Bill 492), **Oregon** (House Bill 3087), **Utah** (House Bill 242), and **Vermont** (House Bill 196). The **District of Columbia** also joined the list of governments providing paid leave at the municipal level, enacting Bill 415.

Although creating and implementing a widely available and well-funded paid family leave program for all employees is a critical part of ensuring that all parents can raise a healthy family, there are ways for states to take smaller steps toward that larger goal. Federal law requires certain employers to give some employees 12 weeks of unpaid family leave, and some states have built upon that program. In 2017, **California** passed but Governor Jerry Brown vetoed Assembly Bill 568, which would have required six weeks of paid leave for employees of a school district or community college. **Delaware** passed House Bill 64, which adds six weeks of additional unpaid leave for mothers who experienced complications requiring hospitalization before birth or for mothers of multiples, both of whom often exhaust their family leave benefits before birth. **Indiana** enacted Senate Bill 253, which creates a commission to develop guidelines for a paid family and medical leave program. **Montana** enacted legislation (House Bill 175) allowing individuals to increase their contributions to their medical savings accounts and to use the funds in those accounts to reimburse themselves for lost wages during unpaid family leave time.

Nevada's Assembly considered a bill (Assembly Bill 266) that would have given tax credits to employers who provide paid family leave for their employees. A bill in **Oklahoma** (Senate Bill 736) that would have mandated paid family leave for state employees passed through one committee. A bill in **Utah** (House Bill 438) also passed one committee and would have required paid family leave for employees of executive agencies and state higher education institutions. In addition to enacting its widely available paid family leave program, **Washington's** legislature is also currently negotiating a new benefit for state employees (House Bill 1434) to allow them to share parental leave and pregnancy-related disability leave with other state employees. **Arkansas** enacted a similar piece of legislation, Senate Bill 125.

POLICY POSITION: SUPPORTING PARENTS



THE LACK OF SUPPORT FOR BREASTFEEDING IN INSURANCE COVERAGE, PUBLIC ACCOMMODATION LAWS, AND EDUCATION POLICIES HAS CONTRIBUTED TO THE DROP IN WOMEN WHO ARE ABLE TO BREASTFEED AS LONG AS THEY WOULD LIKE TO, AND HAS ALSO RESULTED IN RACIAL DISPARITIES AMONG WOMEN WHO ARE ABLE TO START AND CONTINUE BREASTFEEDING THEIR CHILDREN.

Expanding Support and Accommodations for Breastfeeding

After giving birth, many mothers choose to breastfeed for a variety of reasons. Across the globe, health organizations like the American Academy of Pediatrics,[40] ACOG,[41] and the World Health Organization[42] have linked breastfeeding to many positive health outcomes for both women and their babies. Those organizations and others recommend that women breastfeed exclusively for six months and up to a year or more, if possible.[43] However, many policies in the United States create barriers for women who want to breastfeed, including by limiting access to lactation consultants who can help get breastfeeding off to the right start or assist mothers who encounter challenges, and by failing to create spaces where women can breastfeed or pump while in public places, in school, or on the job. The lack of support for breastfeeding in insurance coverage, public accommodation laws, and education policies has contributed to the drop in women who are able to breastfeed as long as they would like to, and has also resulted in racial disparities among women who are able to start and continue breastfeeding their children. In order to ensure that every woman who wants to breastfeed has the opportunity to do so and to continue as long as she would like to, states need to enact policies that support the beginning of breastfeeding and make it possible to nurse and pump in public and private spaces. In 2017, 13 bills were introduced in eight states to accomplish some of those necessary goals.

Both **New Mexico** (House Bill 138) and **Oregon** (House Bill 2503) enacted new laws to extend licenses to qualified lactation consultants, thus making it easier for women to access a trained provider and for health insurance to provide coverage for their services.

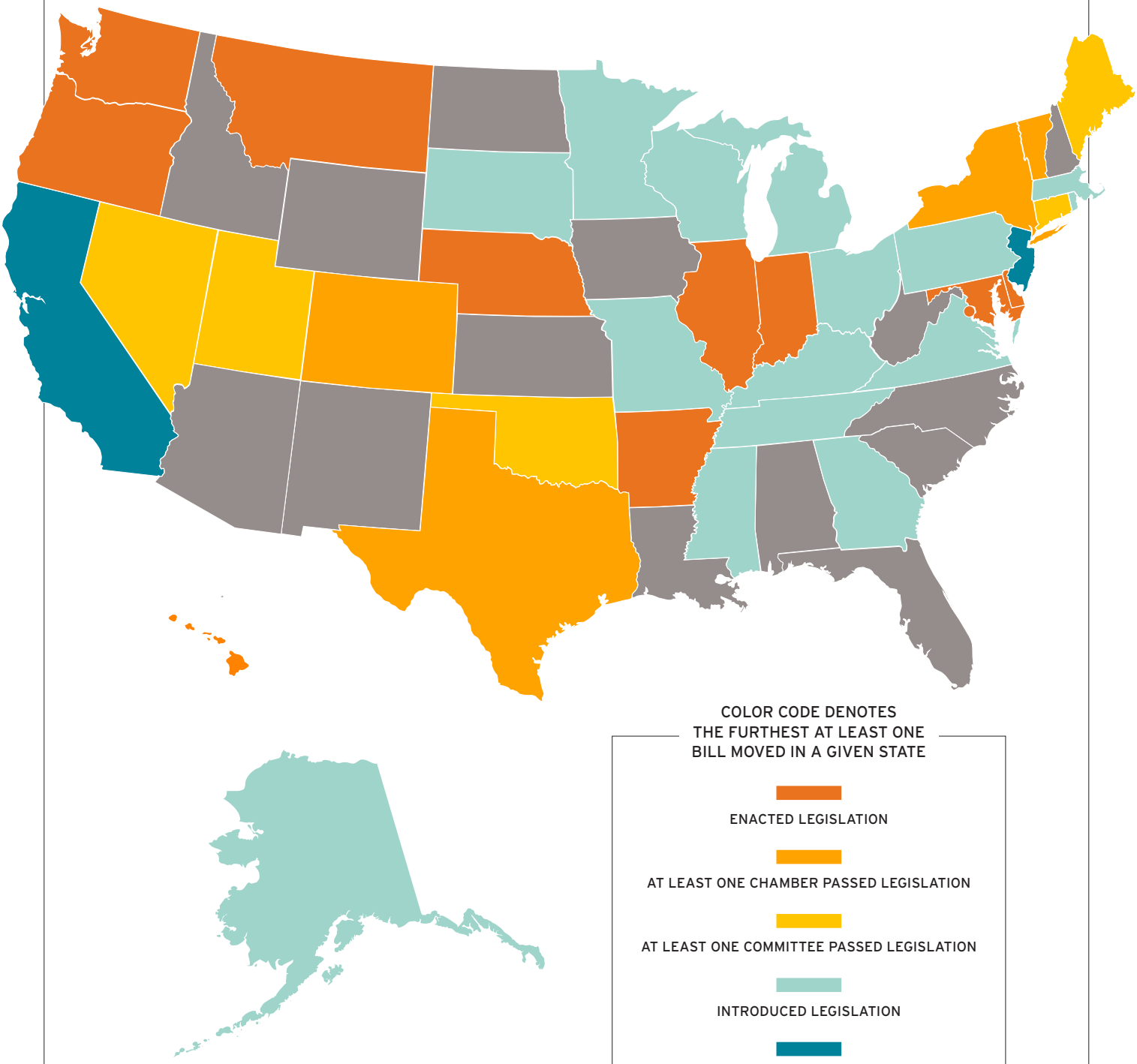
New Jersey considered Assembly Bill 5150, which would have mandated new lactation rooms in airports. In **New York**, the Assembly passed a similar bill (Assembly Bill 7032), as well as one that would mandate lactation rooms in other public buildings (Assembly Bill 6675). Another New York bill (Senate Bill 4442) would have exempted breastfeeding women from jury duty.

Supporting Young Parents in Schools

When young people become parents before they have finished their education, lack of supportive programs can make both pregnancy and parenting barriers to graduation and economic success. State and local policies should ensure that young parents are able to stay in school, complete their educations, and find meaningful employment.

In 2017, **Illinois** (House Bill 2369) and **Nebraska** (Legislative Bill 427) enacted laws mandating strong protections and accommodations for breastfeeding students. Nebraska's new law also allows the state Department of Education to develop a broad, progressive model policy for all school districts to address the needs and "encourage the educational success of pregnant and parenting students." **Maryland** enacted House Bill 616, which specifies that absences due to pregnancy or parenting must be considered a lawful absence, and Nebraska considered a similar law. **Texas'** House passed a unique bill (House Bill 223) that would have allowed school districts to use a public funding stream to pay for childcare for student parents otherwise at risk of leaving school or for other services for pregnant or parenting students.

SUPPORTING PARENTS AND FAMILIES



PROHIBITING DISCRIMINATION BASED ON REPRODUCTIVE DECISIONS OR HEALTH

The ability to make reproductive decisions and access health care without coercion from discriminatory policies or practices is central to reproductive freedom. No one should face discrimination by an employer, a school, or a government institution on the basis of their reproductive health needs or decisions, family status, pregnancy, or parenting. **NIRH supports policies that move our society away from all institutionalized, accepted, and de facto forms of discrimination based on reproductive health choices.**

Over the last few years, advocates and policymakers have considered and advanced proposals that would address some of the forms of discrimination that still exist widely in our society, particularly for pregnant and parenting women who continue to face disparate treatment in the terms and conditions of their employment and in their access to and use of public accommodations. Moreover, as a result of great and growing pressure from advocates across the country, policymakers in many states now realize that when pregnant women are incarcerated, their reproductive decisions, freedom, and health are at risk. Incarceration, by its very nature, involves temporarily surrendering a number of freedoms, but the freedom to be healthy, to decide whether and when to bear a child, and to have a healthy pregnancy should not be among them. All incarcerated women should have access to the same reproductive health care as anyone else, including contraception and counseling, abortion, menstrual supplies, STI testing, prenatal care, adequate nutrition and other basic care during pregnancy, labor and delivery services, and breastfeeding services. Furthermore, no incarcerated woman should be shackled during her pregnancy at any point, including during transportation to health care or court, labor and delivery, or postpartum recovery.

Prohibiting Employment Discrimination

In order for everyone to exercise reproductive freedom and control their reproductive lives, they must live free from discrimination on the basis of their reproductive health needs and decisions where they live and work.

Partly in response to an outrageous overreach by those opposed to contraception, abortion, fertility treatments, and other reproductive and sexual health needs and decisions, **California's** legislature passed but Governor Jerry Brown vetoed Assembly Bill 569, and **New York** considered Assembly Bill 566 / Senate Bill 3791, legislation to ensure that no employer can discriminate against an employee based on their reproductive decision-making. Amy Everitt, State Director of NARAL Pro-Choice California, stated, "While Trump and his cronies seek to grant broad licenses to discriminate, California is showing that we stand for reproductive freedom and economic justice for all."[44] **California** enacted Assembly Bill 1556 and **Virginia** considered Senate Bill 783, policies to update their laws so that all those who experience pregnancy are protected from discrimination on that basis from their employers, regardless of their gender identification. Women's rights and LGBTQ groups in both California and Virginia strongly supported these bills, including Equality California and Planned Parenthood Affiliates of California, as well as the ACLU of Virginia and Equality Virginia.

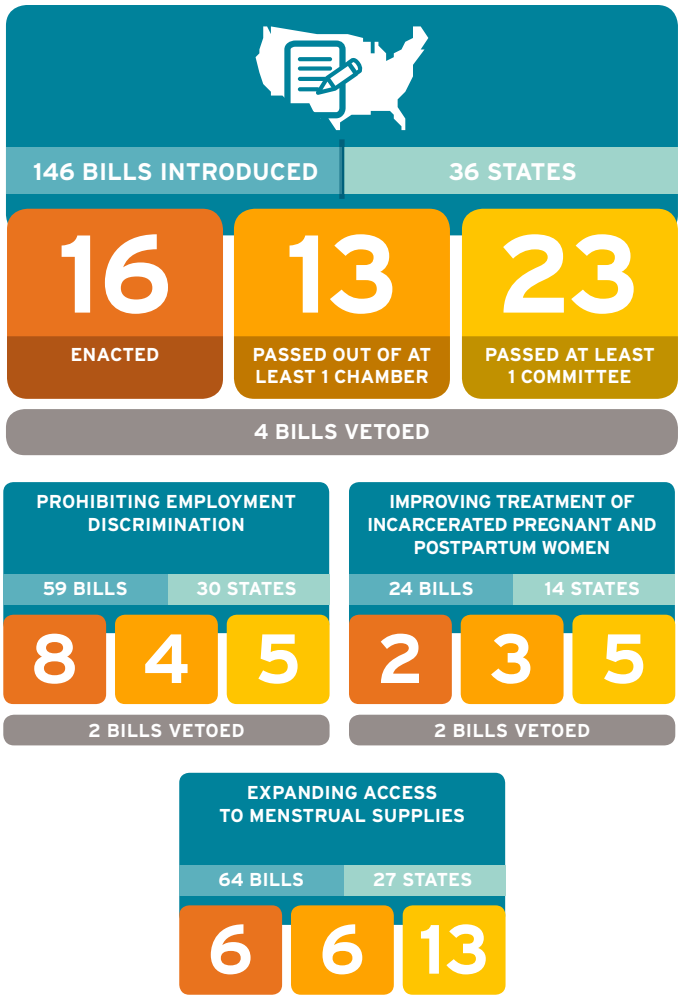
A woman's full equality is dependent upon her ability not only to choose whether and when to become a parent, but also to be able to participate fully in society when she is a parent—and our economy also depends on women's ability to work while pregnant and parenting.[45] Eighty-two percent of pregnant women stay on the job until a month before giving birth,[46] more than 70 percent of women with children under 18 are in the workforce,[47] and pregnant women and new mothers continue to face discrimination while at work, despite some protections under federal and state law.

Advocates from both women's rights and economic justice backgrounds have long recognized the intersection of these issues, and lawmakers in many states have begun to address some of the serious overt discrimination that still exists. In the last decade, 19 states and 5 cities have enacted laws to ensure that pregnant women can stay on the job, often called Pregnant Workers Fairness Acts.[48] These laws typically require employers to offer pregnant workers reasonable accommodations—such as allowing a worker to carry a water bottle, sit on a stool while doing her job, or lift less weight during her pregnancy—and they generally require accommodations for nursing mothers once they return to work, such as a private place to pump and time to do so. Although these accommodations typically do not impact employers significantly, they can make the difference between women being able to keep their jobs, experience healthy pregnancies, and breastfeed their babies or not.

In 2017, **Massachusetts** (House Bill 3680), **Nevada** (Senate Bill 253), and **Vermont** (House Bill 136) joined the list of states with Pregnant Workers Fairness Acts, and **Connecticut** broadened its previously narrow protections for pregnant women at work by enacting one as well (House Bill 6668). **Washington** also joined the list with an omnibus bill (Senate Bill 5835) aimed at improving health outcomes for pregnant women and babies across the state as well as preventing discrimination. **New Mexico's** legislature also passed a Pregnant Workers Fairness Act (House Bill 179) with support from advocates and coalitions including ACLU of New Mexico, New Mexico Religious Coalition for Reproductive Choice, and Respect New Mexico Women, but Governor Susana Martinez once again vetoed the legislation. Pregnant Workers Fairness Acts were also considered and moved in **Iowa** (House Bill 376) and **South Carolina** (House Bill 3865).

Some legislatures have focused specifically on the challenges facing mothers who return to work but continue to breastfeed. **Nevada** enacted legislation to mandate accommodations for breastfeeding mothers at work, requiring reasonable break time and a private place to pump (Assembly Bill 113). The sponsor, Majority Whip Ellen Spiegel, raised constituent stories in committee hearings, including a story about a teacher who shared how the principal "told her she needed to pump her milk in the janitor's closet."[49] **New Jersey** considered a similar bill, Assembly Bill 2294 / Senate Bill 2709. The **Texas** House adopted a resolution (House Resolution 497) recognizing the importance of breastfeeding and the discrimination

POLICY POSITION: NONDISCRIMINATION



that breastfeeding mothers continue to face at work and in public, and several committees in the Texas House moved legislation that would have created a nursing mother's bill of rights, including ensuring that women can breastfeed anywhere they have a right to be and requiring employers to develop "mother friendly" worksites (House Bill 742), as well as requiring public employers to give employees reasonable accommodations for pumping (House Bill 443). These Texas bills were supported by a broad coalition including medical groups, such as the Texas Medical Association and the Texas Pediatric Society, and advocacy organizations, such as NARAL Pro-Choice Texas and the Texas Breastfeeding Coalition.

Improving Treatment of Incarcerated Pregnant and Postpartum Women

Over the past decade, a number of states have enacted laws to improve the treatment and conditions of pregnant women while incarcerated. The initial wave of legislation related to incarcerated pregnant women simply prohibited shackling during delivery, but in recent years states have expanded on those laws to prohibit such actions as shackling at any time during pregnancy or putting pregnant women in solitary confinement. In 2017, **Missouri** considered legislation to limit shackling during pregnancy and postpartum (Senate Bill 180), and **Rhode Island** considered expanding its existing prohibition on shackling during labor and recovery (Senate Bill 282).

Advocates and lawmakers have also worked together to move beyond prohibition of shackling to identify and address the wider range of existing problems, especially access to prenatal care, proper nutrition, and breastfeeding support after birth. In 2017, **Texas** enacted a law (House Bill 239) requiring regular reporting on the implementation of all policies and procedures related to the situation of pregnant inmates, including nutrition, restraints, and health outcomes.

New Mexico's legislature passed two different bills that would have supported and improved conditions for incarcerated pregnant women: Senate Bill 277, which passed with wide support and would have directed judges to have a presumption in favor of release for a woman who is pregnant or lactating and given courts leeway to consider an incarcerated woman's pregnancy and lactation status when deciding whether to release her on bond, to a home-based custody, or entirely; and House Bill 277, which passed unanimously and would have required every jail, prison, or detention facility to provide medically appropriate support and care for breastfeeding and pumping mothers. Both bills drew wide support from medical groups such as ACOG and the New Mexico Pediatric Society, and advocates including New Mexico Voices for Children and Southwest Women's Law Center. Nonetheless, Governor Susana Martinez pocket vetoed both bills without explanation. **Virginia** unanimously enacted a law (House Bill 2183) that will make it easier for eligible incarcerated people to enroll in Medicaid, which provides important coverage for pregnant women.

Legislatures in **Illinois** (House Bill 1464), **New York** (Assembly Bill 8213), **Utah** (House Bill 412), and **Wisconsin** (Senate 393) moved forward related legislation. **New York** also moved forward Senate Bill 4795, which would have prohibited placing pregnant and postpartum women in solitary confinement, and **Washington's** House passed House Bill 2016, which would have allowed for incarcerated women to access midwifery and doula services.

Expanding Access to Menstrual Supplies

Women make up roughly 51 percent of the United States' population, and most women menstruate for

ADVOCATES AND LAWMAKERS HAVE ALSO WORKED TOGETHER TO MOVE BEYOND PROHIBITION OF SHACKLING TO IDENTIFY AND ADDRESS THE WIDER RANGE OF EXISTING PROBLEMS, ESPECIALLY ACCESS TO PRENATAL CARE, PROPER NUTRITION, AND BREASTFEEDING SUPPORT AFTER BIRTH.

A REPORT BY THE CORRECTIONAL ASSOCIATION OF NEW YORK FOUND THAT THE VAST MAJORITY OF FEMALE INMATES BOTH DID NOT HAVE SUFFICIENT ACCESS TO SANITARY PADS AND WERE SUBJECTED TO HUMILIATING POLICIES TO RECEIVE EVEN THE INADEQUATE SUPPLIES THEY WERE GIVEN.

about four decades of their lives—meaning that for 40 years, many women must buy feminine hygiene products or menstrual supplies each month. While menstruation is a shared experience among half of the world's population, it has historically been stigmatized or ignored. In the last few years, advocates and lawmakers have drawn attention to the fact that silence around menstruation has resulted in discrimination against women, who pay taxes on menstrual supplies as if they are "luxury items" instead of untaxed necessities like food and medical supplies. The tax burden on any one package of maxi pads or tampons may be small, but when added up over the course of a year, or even a month or two for women and girls living in poverty, the cost can be overwhelming. Indeed, one lawmaker in **California** estimated that the state takes in more than $20 million a year from taxes on menstrual supplies.[50] Moreover, some women, such as the 15 percent of women and 20 percent of children in families living in poverty,[51] may face an impossible choice of choosing between groceries and a box of tampons, especially since menstrual supplies are not covered by food stamps or WIC. Finally, women who are in homeless shelters or are incarcerated face serious barriers to accessing necessary supplies.

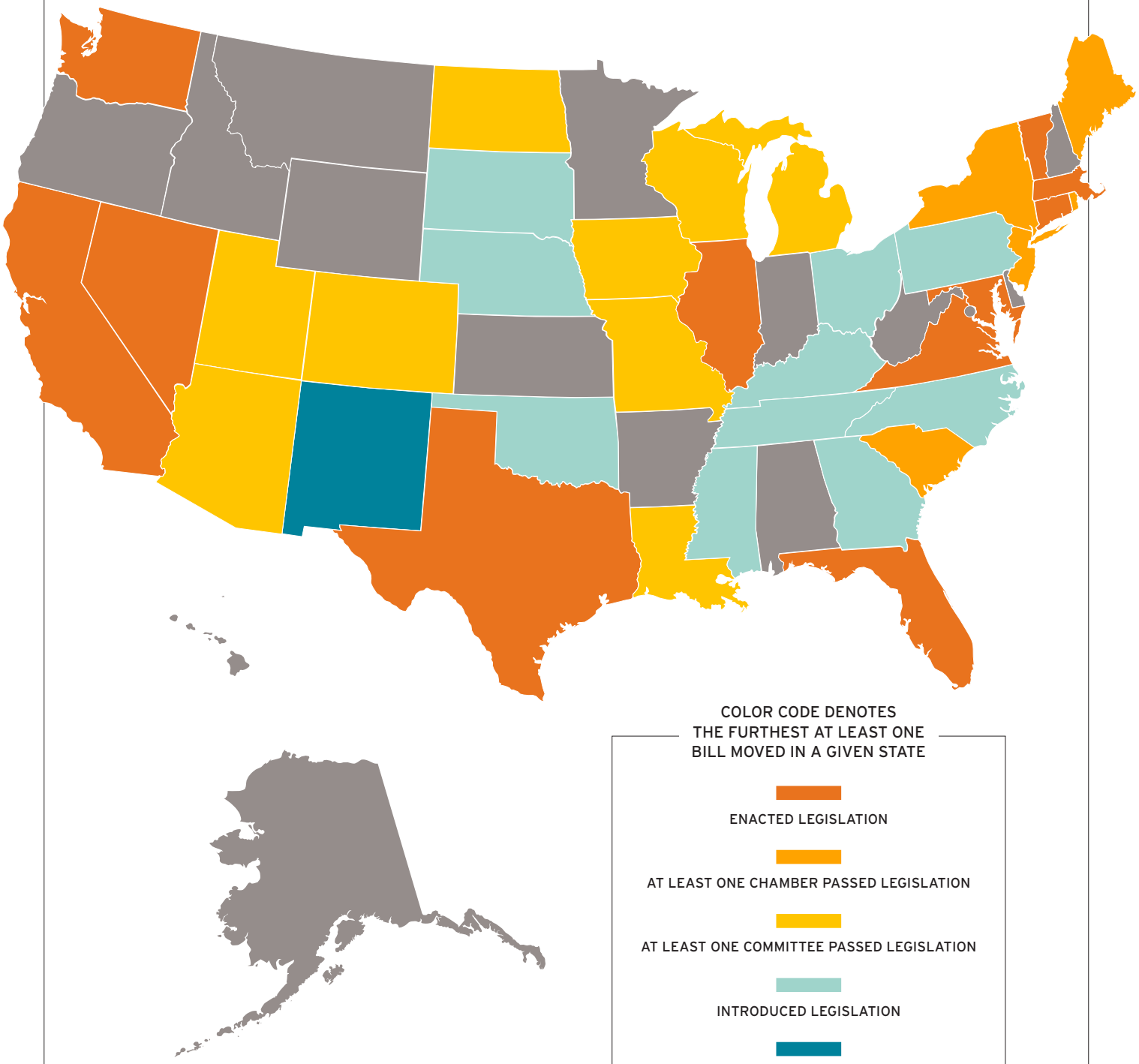
A report by the Correctional Association of New York found that the vast majority of female inmates did not have sufficient access to sanitary pads and were subjected to humiliating policies to receive even the inadequate supplies they were given.[52] In 2017, policymakers considered some of these challenges, with some states moving legislation that would make menstrual supplies available for free to some of the lowest-income women and girls in their states, as well as to incarcerated women.

In 2017, 26 states considered 61 bills to remove the "Tampon Tax," as it is widely known, and expand access to feminine hygiene products for women and girls. **Florida** passed House Bill 7109 to remove taxes on "products that absorb or contain menstrual flow," and **California**, **Colorado**, **Maine**, **Maryland**, **Michigan**, and **North Dakota** considered similar bills. **Nevada** enacted a similar bill, Senate Bill 415, which will remove the tax if voters approve the decision on the 2018 ballot.

In addition, four states moved seven bills to provide menstrual products to some women and girls for free. **California** passed Assembly Bill 10, which will provide free menstrual products to women in homeless shelters as well as homeless students, and **Maryland** enacted a similar bill (House Bill 1067 / Senate Bill 625). **Illinois** enacted House Bill 3215, which will provide free menstrual products in schools. **New York** also considered three bills that would have provided menstrual products at no cost in schools (Assembly Bill 347), homeless shelters (Assembly Bill 585), and correctional facilities (Assembly Bill 588 / Senate Bill 6176). Assemblymember Linda Rosenthal, who sponsored all three pieces of legislation, noted, "It is unfathomable to believe that a low-income girl or woman is not worthy of something as basic as pads or tampons once a month."[53] In regards to Assembly Bill 588, Kelsey De Avila, a social worker with Brooklyn Defender Services who works with inmates on Rikers Island, noted that while "some women have reported no issues…others have to beg for [menstrual products]."[54]

Advocates, activists, and policymakers also considered lifting taxes on diapers and breast pumps, recognizing the discriminatory nature of taxing these necessary supplies for families to live and thrive. **Arizona's** House Bill 2418, **Louisiana** Senate Bills 24 and 27, and **Utah's** House Bill 71 would have removed taxes on both feminine hygiene products and diapers, and **Nevada's** Assembly Bill 402 would have done the same if approved by the voters. **New Jersey** considered Assembly Bill 4670 / Senate Bill 3112 to make breast pumps exempt from sales and use taxes.

PROHIBITING DISCRIMINATION BASED ON REPRODUCTIVE DECISIONS OR HEALTH



COLOR CODE DENOTES THE FURTHEST AT LEAST ONE BILL MOVED IN A GIVEN STATE

- ENACTED LEGISLATION
- AT LEAST ONE CHAMBER PASSED LEGISLATION
- AT LEAST ONE COMMITTEE PASSED LEGISLATION
- INTRODUCED LEGISLATION
- VETOED LEGISLATION
- NO LEGISLATIVE ACTION

CONCLUSION

In 2017, in the face of truly reprehensible actions by elected leaders at the federal level and in many states, advocates and lawmakers brought a renewed energy and determination to move forward protective reproductive health policy that would make change for the people of their states.

Across the country, advocates and lawmakers have pushed forward important policies that will protect and advance reproductive freedom in their states. As a result, in 2018, states will begin enforcing laws in all seven of the areas covered in this report.

Even so, there is much work left to do, and the pressure and hostility coming from Washington, D.C., has emboldened some of the most regressive, racist, and sexist elements in our society, making the work for proactive policy change more challenging than ever before. We are confident and grateful that the reproductive rights, health, and justice movements will continue to push for change—in fact, it has never been more important to fight to make our country a place where everyone can lead safe and healthy lives.

NIRH applauds the incredible work and successes of advocates and policymakers who have led these efforts, and looks forward to supporting similar work in the year to come.

APPENDIX: BILL INDEX BY STATE

ST	BILL	TITLE AS FILED	SECTION	PAGE(S)
AK	AK H 25	Insurance Coverage for Contraceptives	Ensuring Comprehensive Reproductive Health Care Coverage for All	21, 22
AL	AL H 315	Midwifery Certification	Increasing Access to Pregnancy Care	16
AL	AL S 76	Income Tax	Increasing Access to Pregnancy Care	16
AR	AR HCR 1012	Coverage for Migrant Children and Pregnant Women	Ensuring Comprehensive Reproductive Health Care Coverage for All	22
AR	AR S 125	Uniform Attendance and Leave Policy Act	Supporting Parents and Families	31
AZ	AZ H 2418	Transaction Privilege Tax and Diapers and Formula	Prohibiting Discrimination Based on Reproductive Decisions or Health	37
AZ	AZ S 1133	Certified Nurse Midwives and Nurse Practitioners	Increasing Access to Pregnancy Care	16
CA	CA A 9	Sales and Use Taxes: Exemption: Sanitary Napkins	Prohibiting Discrimination Based on Reproductive Decisions or Health	37
CA	CA A 10	Feminine Hygiene Products: School and College Bathrooms	Prohibiting Discrimination Based on Reproductive Decisions or Health	37
CA	CA A 568	School and Community College Employees: Maternity Leave	Supporting Parents and Families	31
CA	CA A 569	Discrimination: Reproductive Health	Prohibiting Discrimination Based on Reproductive Decision or Health	34
CA	CA A 1312	Sexual Assault Victims: Rights	Ensuring Comprehensive Reproductive Health Care Coverage for All	22
CA	CA A 1556	Employment Discrimination: Unlawful Employment Practice	Prohibiting Discrimination Based on Reproductive Decisions or Health	34
CA	CA A 1612	Nursing: Nurse-Midwives	Increasing Access to Pregnancy Care	16
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CA	CA HR 6	Women's Reproductive Health	Expanding Access to Abortion Care	8
CA	CA S 89	Human Services	Promoting Comprehensive Sexuality Education for All Young People	25
CA	CA S 172	Health Care Coverage: Fertility Preservation	Ensuring Comprehensive Reproductive Health Care Coverage for All	23
CA	CA S 245	Foster Youth: Sexual Health Education	Promoting Comprehensive Sexuality Education for All Young People	25
CA	CA S 309	License Plates: Reproductive Freedom Fund	Improving Access to Contraception	11
CA	CA S 320	Public Health: Public Postsecondary Education	Expanding Access to Abortion Care	7
CA	CA S 743	Medi Cal: Family Planning Providers	Improving Access to Contraception	5, 10
CA	CA SR 9	Planned Parenthood	Expanding Access to Abortion Care	8
CA	CA SR 12	Women's Reproductive Health	Expanding Access to Abortion Care	8
CO	CO H 1106	Extend Early Childhood Leadership Commission	Increasing Access to Pregnancy Care	15
CO	CO H 1127	Exempt Feminine Hygiene Products From Sales Tax	Prohibiting Discrimination Based on Reproductive Decisions or Health	37
CO	CO H 1186	Health Coverage Prescription Contraceptives Supply	Ensuring Comprehensive Reproductive Health Care Coverage for All	22
CO	CO H 1307	Family and Medical Leave Insurance Program	Supporting Parents and Families	30
CO	CO HR 1005	Reproductive Health Care Access	Expanding Access to Abortion Care	8
CT	CT H 6175	Affordable and Comprehensive Health Care Coverage	Ensuring Comprehensive Reproductive Health Care Coverage for All	21
CT	CT H 6212	Family and Medical Leave Compensation Program	Supporting Parents and Families	30
CT	CT H 6668	Pregnant Women in the Workplace	Prohibiting Discrimination Based on Reproductive Decisions or Health	35
CT	CT H 7008	Long-Acting Reversible Contraceptives Reimbursement	Ensuring Comprehensive Reproductive Health Care Coverage for All	22
CT	CT H 7040	Human Services Programs Budget Recommendations	Improving Access to Contraception	11
CT	CT H 7124	Fertility Preservation	Ensuring Comprehensive Reproductive Health Care Coverage for All	23
CT	CT S 1	Paid Family and Medical Leave System	Supporting Parents and Families	30
CT	CT S 586	Health Insurance Coverage for Preventive Care	Ensuring Comprehensive Reproductive Health Care Coverage for All	21
CT	CT S 877	Pregnancy as a Qualifying Event for Special Enrollment	Ensuring Comprehensive Reproductive Health Care Coverage for All	23
DC	DC B 106	Womens Health Care Services	Ensuring Comprehensive Reproductive Health Care Coverage for All	21
DC	DC B 224	Defending Access to Women's Health Care Services	Ensuring Comprehensive Reproductive Health Care Coverage for All	21

APPENDIX (CONTINUED)

ST	BILL	TITLE AS FILED	SECTION	PAGE(S)
DC	DC B 225	Defending Access to Women's Health Care Services	Ensuring Comprehensive Reproductive Health Care Coverage for All	21
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DE	DE H 64	Family Leave	Supporting Parents and Families	31
DE	DE S 5	Supreme Court Decisions	Expanding Access to Abortion Care	5, 7, 18
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FL	FL S 176	Sales and Use Tax Exemption for Feminine Products	Prohibiting Discrimination Based on Reproductive Decisions or Health	37
FL	FL S 1400	Child Welfare	Improving Access to Contraception	10
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HI	HI H 552	Health Insurance Benefits	Ensuring Comprehensive Reproductive Health Care Coverage for All	21
HI	HI H 663	Limited Service Pregnancy Centers	Expanding Access to Abortion Care	8
HI	HI S 403	Health Insurance	Ensuring Comprehensive Reproductive Health Care Coverage for All	21
HI	HI S 501	Limited Service Pregnancy Centers	Expanding Access to Abortion Care	8
HI	HI S 513	Pharmacists and Contraceptives	Improving Access to Contraception	11
IA	IA H 376	Reasonable Accommodations to Employees	Prohibiting Discrimination Based on Reproductive Decisions or Health	35
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IL	IL H 40	State Employees Group Insurance	Ensuring Comprehensive Reproductive Health Care Coverage for All	7, 18-19, 20
IL	IL H 1464	Criminal Code	Prohibiting Discrimination Based on Reproductive Decisions or Health	36
IL	IL H 2369	School Code	Supporting Parents and Families	32
IL	IL H 2376	Family Leave Insurance Program	Supporting Parents and Families	30-31
IL	IL H 3215	Schools Feminine Hygiene Products Availability	Prohibiting Discrimination Based on Reproductive Decisions or Health	37
IL	IL H 3735	Health Clinic and Crime of Violence	Expanding Access to Abortion Care	8
IL	IL HR 78	Planned Parenthood	Improving Access to Contraception	11
IL	IL HR 445	American Health Care Act Opposition	Ensuring Comprehensive Reproductive Health Care Coverage for All	22
IL	IL S 1754	Home Birth Safety	Increasing Access to Pregnancy Care	16
IN	IN S 253	Voluntary Paid Family and Medical Leave	Supporting Parents and Families	31
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LA	LA S 27	Tax Exemptions	Prohibiting Discrimination Based on Reproductive Decisions or Health	37
MA	MA H 3680	Pregnant Worker Fairness Act	Prohibiting Discrimination Based on Reproductive Decisions or Health	35
MA	MA H 4009	Contraceptive Insurance Coverage	Ensuring Comprehensive Reproductive Health Care Coverage for All	21
MA	MA S 2128	Healthy Youth	Promoting Comprehensive Sexuality Education for All Young People	25
MD	MD H 95	Use Tax	Prohibiting Discrimination Based on Reproductive Decisions or Health	37
MD	MD H 613	Pharmacist Contraceptives	Improving Access to Contraception	11, 13
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MD	MD H 775	Maternal Mental Health	Increasing Access to Pregnancy Care	16
MD	MD H 1067	Homeless Shelter Services	Prohibiting Discrimination Based on Reproductive Decisions or Health	13, 37
MD	MD H 1083	Health Family Planning Services	Improving Access to Contraception	11, 13
MD	MD HJR 9	Federal Affordable Care Act Resolution	Ensuring Comprehensive Reproductive Health Care Coverage for All	22
MD	MD S 96	Health Insurance Coverage	Ensuring Comprehensive Reproductive Health Care Coverage for All	23
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MD	MD S 625	Homeless Girls	Prohibiting Discrimination Based on Reproductive Decisions or Health	13, 37

APPENDIX (CONTINUED)

ST	BILL	TITLE AS FILED	SECTION	PAGE(S)
MD	MD S 814	Prescription Drugs	Improving Access to Contraception	11
MD	MD S 1081	Family Planning Services	Improving Access to Contraception	11, 13
MD	MD SJR 7	Federal Affordable Care Act Resolution	Ensuring Comprehensive Reproductive Health Care Coverage for All	22
ME	ME H 162	Feminine Hygiene Products Sales Tax	Prohibiting Discrimination Based on Reproductive Decisions or Health	37
ME	ME H 492	Maine Paid Family Leave Insurance Program	Supporting Parents and Families	31
ME	ME H 860	Contraceptive Supplies Insurance Coverage	Ensuring Comprehensive Reproductive Health Care Coverage for All	21
ME	ME S 309	Contraception Available Over the Counter	Improving Access to Contraception	11
ME	ME S 366	Maternal and Infant Death Review Panel	Increasing Access to Pregnancy Care	15
MI	MI S 91	Feminine Hygiene Products	Prohibiting Discrimination Based on Reproductive Decisions or Health	37
MI	MI S 92	Feminine Hygiene Products	Prohibiting Discrimination Based on Reproductive Decisions or Health	37
MO	MO H 233	Dispensing of Contraceptives	Improving Access to Contraception	11
MO	MO S 180	Restraint of Pregnant or Postpartum Offenders	Prohibiting Discrimination Based on Reproductive Decisions or Health	36
MS	MS H 494	Maternal Mortality Review Committee	Increasing Access to Pregnancy Care	15
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ND	ND S 2254	Sales and Use Tax Exemption	Prohibiting Discrimination Based on Reproductive Decisions or Health	37
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NE	NE L 427	Breastfeeding Student Parent Accommodations	Supporting Parents and Families	32
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NJ	NJ A 1447	Infertility Health Insurance Coverage	Ensuring Comprehensive Reproductive Health Care Coverage for All	23
NJ	NJ A 2294	Breastfeeding Civil Rights Protections	Prohibiting Discrimination Based on Reproductive Decisions or Health	35
NJ	NJ A 2297	Contraceptive Health Insurance Coverage	Ensuring Comprehensive Reproductive Health Care Coverage for All	22
NJ	NJ A 4670	Breast Pumps Tax Exemption	Prohibiting Discrimination Based on Reproductive Decisions or Health	37
NJ	NJ A 4927	Family and Domestic Violence Safety Leave	Supporting Parents and Families	30
NJ	NJ A 5150	Lactation Rooms in Airports	Supporting Parents and Families	32
NJ	NJ AJR 130	Maternal Health Awareness Day	Increasing Access to Pregnancy Care	16
NJ	NJ S 659	Health Insurance Coverage for Contraceptives	Ensuring Comprehensive Reproductive Health Care Coverage for All	22
NJ	NJ S 1398	Infertility Coverage Health Insurance Plans	Ensuring Comprehensive Reproductive Health Care Coverage for All	23
NJ	NJ S 1475	Medicaid Home Visitation Demonstration Project	Increasing Access to Pregnancy Care	15
NJ	NJ S 2709	Civil Rights Protections Expansion	Prohibiting Discrimination Based on Reproductive Decisions or Health	35
NJ	NJ S 2918	Long Acting Reversible Contraceptives	Ensuring Comprehensive Reproductive Health Care Coverage for All	22
NJ	NJ S 3112	Breast Pumps Sales and Use Tax Exemption	Prohibiting Discrimination Based on Reproductive Decisions or Health	37
NM	NM H 138	Lactation Consultant Practice Act	Supporting Parents and Families	32
NM	NM H 179	Pregnant Worker Accommodation Act	Prohibiting Discrimination Based on Reproductive Decision or Health	35
NM	NM H 277	Lactation Policies For Female Inmates	Prohibiting Discrimination Based on Reproductive Decision or Health	36
NM	NM H 284	Health Coverage For Contraception	Ensuring Comprehensive Reproductive Health Care Coverage for All	21
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NM	NM H 473	Abortion Decriminalization	Expanding Access to Abortion Care	7
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NM	NM S 277	Release of Incarcerated Pregnant Women	Prohibiting Discrimination Based on Reproductive Decision or Health	36
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NV	NV A 266	Tax Credit for Employers Who Provide Paid Family Leave	Supporting Parents and Families	31
NV	NV A 348	Courses of Instruction in Sex Education	Promoting Comprehensive Sexuality Education for All Young People	25
NV	NV A 402	Tax Exemption for Sales of Feminine Hygiene Products	Prohibiting Discrimination Based on Reproductive Decisions or Health	37
NV	NV A 408	Medicaid and Health Insurance	Ensuring Comprehensive Reproductive Health Care Coverage for All	21
NV	NV AJR 8	Woman's Reproductive Rights	Expanding Access to Abortion Care	8
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NY	NY A 585	Feminine Hygiene Products in Homeless Shelters	Prohibiting Discrimination Based on Reproductive Decisions or Health	37
NY	NY A 588	Feminine Hygiene Products in Correctional Facilities	Prohibiting Discrimination Based on Reproductive Decisions or Health	37
NY	NY A 1378	Comprehensive Contraception Coverage Act	Ensuring Comprehensive Reproductive Health Care Coverage for All	21
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NY	NY A 1834	Paid Family Leave Benefits	Supporting Parents and Families	30
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NY	NY A 6775	Establishment of Lactation Rooms in Public Buildings	Supporting Parents and Families	32
NY	NY A 7032	Provision of Lactation Accommodations in Airports	Supporting Parents and Families	32
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NY	NY A 8308	Maternal Depression Treatment	Increasing Access to Pregnancy Care	16
NY	NY S 159	Freestanding Diagnostic and Treatment Centers	Improving Access to Contraception	11
NY	NY S 1070	Age-Appropriate Sex Education Grant Program	Promoting Comprehensive Sexuality Education for All Young People	25
NY	NY S 3790	Dispensing of Emergency Contraception	Ensuring Comprehensive Reproductive Health Care Coverage for All	22
NY	NY S 3791	Discrimination Based on Reproductive Health Decisions	Prohibiting Discrimination Based on Reproductive Decisions or Health	34
NY	NY S 4442	Exemption From Jury Duty for Breastfeeding Women	Supporting Parents and Families	32
NY	NY S 4795	Segregated Confinement of Pregnant Inmates	Prohibiting Discrimination Based on Reproductive Decisions or Health	36
NY	NY S 6176	Feminine Hygiene Products in Correctional Facilities	Prohibiting Discrimination Based on Reproductive Decisions or Health	37
OK	OK S 736	State Employee Benefits	Supporting Parents and Families	31
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OR	OR H 2503	Lactation Consultants	Supporting Parents and Families	32
OR	OR H 2527	Hormonal Contraceptives	Improving Access to Contraception	11
OR	OR H 3087	Family and Medical Leave Insurance Program	Supporting Parents and Families	31
OR	OR H 3135	Reversible Contraceptive Devices Medical Coverage	Ensuring Comprehensive Reproductive Health Care Coverage for All	22
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RI	RI H 6170	Fertility Preservation Services Insurance Coverage	Ensuring Comprehensive Reproductive Health Care Coverage for All	23
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TX	TX H 10 a	Maternal Morbidity and Pregnancy Related Deaths	Increasing Access to Pregnancy Care	15
TX	TX H 11 a	Pregnancy Related Deaths and Maternal Morbidity	Increasing Access to Pregnancy Care	15
TX	TX H 28 a	Membership of the Maternal Mortality Task Force	Increasing Access to Pregnancy Care	15
TX	TX H 223	Compensatory Education Allotment Funding	Supporting Parents and Families	32
TX	TX H 239	Pregnant Inmates Confinement Report	Prohibiting Discrimination Based on Reproductive Decisions or Health	36
TX	TX H 443	Public Employer	Prohibiting Discrimination Based on Reproductive Decisions or Health	36
TX	TX H 742	Promotion of Breast Feeding and Right to Breast Feed	Prohibiting Discrimination Based on Reproductive Decisions or Health	36
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TX	TX H 1373	Examination or Treatment Related to Contraception	Improving Access to Contraception	10
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TX	TX H 2403	Study Concerning Maternal Mortality and Morbidity	Increasing Access to Pregnancy Care	15
TX	TX H 2466	Coverage for Services Related To Maternal Depression	Ensuring Comprehensive Reproductive Health Care Coverage for All	23
TX	TX H 2604	Strategic Plan To Address Postpartum Depression	Increasing Access to Pregnancy Care	16
TX	TX HR 497	Recognition Resolution	Prohibiting Discrimination Based on Reproductive Decisions or Health	35
TX	TX S 17 a	Maternal Health and Safety	Increasing Access to Pregnancy Care	15
TX	TX S 1929	Report on Maternal Mortality	Increasing Access to Pregnancy Care	15
UT	UT H 57	Reproductive Health and Medicaid Amendments	Improving Access to Contraception	11
UT	UT H 71	Hygiene Tax Act	Prohibiting Discrimination Based on Reproductive Decisions or Health	37
UT	UT H 122	Medicaid Waiver for Postpartum Mental Health Coverage	Ensuring Comprehensive Reproductive Health Care Coverage for All	23
UT	UT S 135	Maternal and Child Health	Increasing Access to Pregnancy Care	16
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VA	VA S 783	Nondiscrimination in Public Employment	Prohibiting Discrimination Based on Reproductive Decisions or Health	34

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VT	VT HR 9	Supporting Women's Right to Decide	Expanding Access to Abortion Care	8
VT	VT SR 4	Senate Resolution Supporting a Woman's Right To Decide	Expanding Access to Abortion Care	8
WA	WA H 1116	Family and Medical Leave Insurance	Supporting Parents and Families	30
WA	WA H 1234	Private Health Plan Coverage of Contraceptives	Ensuring Comprehensive Reproductive Health Care Coverage for All	22
WA	WA H 1434	Shared Leave for Employees	Supporting Parents and Families	31
WA	WA H 1523	Preventive Services	Ensuring Comprehensive Reproductive Health Care Coverage for All	21
WA	WA H 2016	Midwifery and Doula Services for Incarcerated Women	Prohibiting Discrimination Based on Reproductive Decisions or Health	36
WA	WA S 5554	Private Health Plan Coverage	Ensuring Comprehensive Reproductive Health Care Coverage for All	22
WA	WA S 5829	Paid Family Leave	Supporting Parents and Families	30
WA	WA S 5835	Pregnant Women and Infants	Prohibiting Discrimination Based on Reproductive Decisions or Health	35
WA	WA S 5975 c	Paid Family and Medical Leave	Supporting Parents and Families	30
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WY	WY S 150	Family Planning	Ensuring Comprehensive Reproductive Health Care Coverage for All	22

ENDNOTES

1. In portions of this document, we use the term "women," but we recognize that other people, such as transgender and gender non-conforming people, can become pregnant and need reproductive health care. We intend for them to be included in this analysis as well.
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