National Institute for Reproductive Health

JANUARY 2020

2019 YEAR IN REVIEW

GAINING GROUND

PROACTIVE REPRODUCTIVE HEALTH AND RIGHTS LEGISLATION IN THE STATES

A report of the National Institute for Reproductive Health

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.

National Institute for Reproductive Health
14 Wall Street
Suite 3B
New York, NY 10005

Tel. 212-343-0114

info@nirhealth.org
www.nirhealth.org

All data and content is current as of December 15, 2019.

ACKNOWLEDGMENTS
This report was written by Rose MacKenzie, Senior Policy Counsel; Winnie Ye, Policy and Partnerships Manager; and Hanna Ali, Legal Fellow; with assistance from legal interns Rachel Baron, Sabrina Merold, and Kari Ross. Staff of NIRH — including Andrea Miller, President; Jordan Goldberg, Director of Policy; Tara Sweeney, Vice President for Communications; Kelly Novak, Deputy Director of Communications; and Annie Zegers, Senior Communications Coordinator — contributed to and edited this report. NIRH is grateful to the advocates and partners across the country whose advocacy is increasing access to reproductive health care and strengthening the reproductive health, rights, and justice movements every day, and whose work on these critical issues inspired this report. NIRH also gratefully acknowledges the foundations and individual donors who make our work possible.

INTRODUCTION

In 2019, we saw an unprecedented wave of state laws affecting abortion rights and access – both restrictive and affirmative – alongside a host of important advancements for reproductive health, rights, and justice. With a hostile federal government erecting an increasing number of barriers to abortion and contraception care and the balance of the Supreme Court veering dangerously toward dismantling reproductive freedom, it is clear that the onus is on states to do what they can to protect and expand access to reproductive health care, including abortion – and states are rising to the occasion.

PROACTIVE LEGISLATION PROTECTING REPRODUCTIVE HEALTH, RIGHTS, AND JUSTICE

944
BILLS INTRODUCED

49
STATES AND DC

147 BILLS	66 BILLS	135 BILLS
FULLY ENACTED	PASSED OUT OF AT LEAST 1 CHAMBER	PASSED OUT OF AT LEAST 1 COMMITTEE

4 BILLS VETOED

THE 2018 MIDTERM ELECTIONS, which swept a host of new progressive elected officials into office and led to new pro-choice majorities in several state legislatures along with a handful of new pro-choice governors, created both the conditions and the expectation for proactive policy change in the 2019 legislative session. The result was the enactment of some of the boldest and most progressive reproductive health, rights, and justice laws of our generation.

At the same time, conservative states doubled down on their goal of making abortion illegal or pushing this care entirely out of reach, passing some of the most extreme abortion bans since *Roe v. Wade*. Those bans in turn created an affirmative backlash, encouraging even more states to establish themselves as oases for abortion access.

By year's end, more laws to protect abortion rights and expand access passed in 2019 than in any previous year since *Roe*. Overall, the number of affirmative reproductive freedom bills introduced in 2019 was more than double that of the previous year, and 47 more laws were enacted in 2019 than in 2018.

The National Institute for Reproductive Health (NIRH)'s mission is to help build a society in which everyone has the freedom and ability to control their reproductive and sexual lives. To that end, NIRH employs a range of strategies to help move proactive reproductive health, rights, and justice policies, including by partnering with state advocates and lawmakers in many of the states and on the types of policies described in this report. The goal of this "Gaining Ground" report is to document the advances that have been made at the state level in 2019, and to support advocates' and legislators' work to advance affirmative policies in the years to come.

This report covers six policy areas that NIRH believes must be priorities for any state that wants to protect and support reproductive health, rights, and justice: access to abortion, access to contraception, access to pregnancy care, comprehensive sexuality education for all young people, supporting parents and families, and prohibiting interference with reproductive health care.

We reviewed the movement of proactive policy across the country in each of these six arenas, analyzing which of these policy changes move us closer to a world in which every woman* and person has the right to choose whether or when to become a parent, and to have a healthy family. Our analysis in these core areas continues to be greatly informed and influenced by the work of our colleagues in the reproductive justice movement, although this report does not reflect the full range of policies encompassed in the reproductive justice framework.

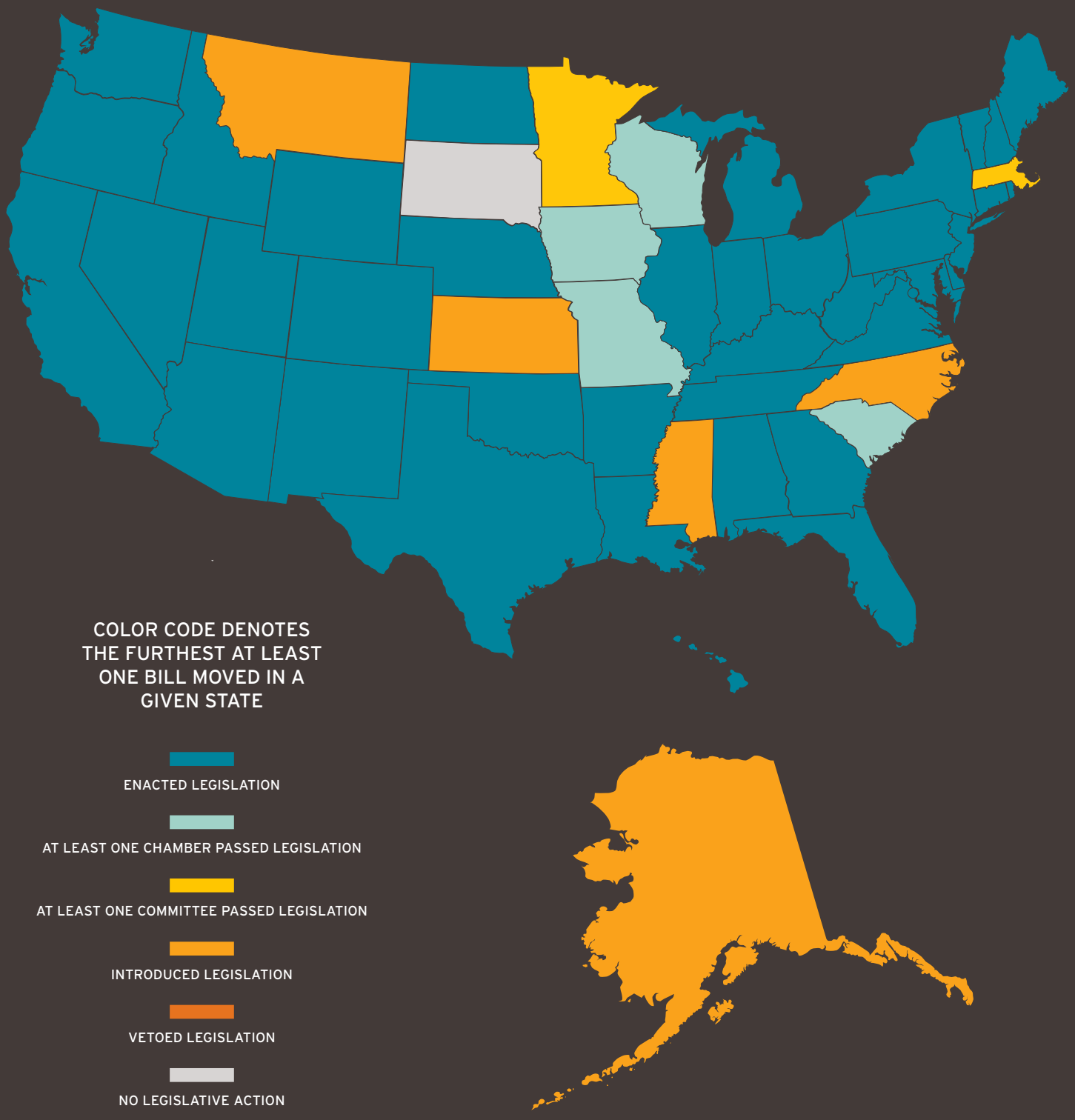
Because policy change is often a lengthy process, this report includes not only legislation that became law, but also bills that moved through committees, state houses, and sometimes onto governors' desks only to be vetoed. As experience shows, a bill that is introduced, considered, or even vetoed one year may become law the next. This report is intended to provide both 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 in their states.

This report covers six policy areas that NIRH believes must be priorities for any state that wants to protect and support reproductive health, rights, and justice.

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

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

AS OF DECEMBER 15, 2019



MOVING FORWARD: NINE POLICY IDEAS TO CONSIDER FOR 2020

As advocates and legislators determine their policy agendas for 2020 and look for ways to protect reproductive rights, improve access to reproductive health care, and change the public conversation about reproductive health, rights, and justice, NIRH suggests considering legislation to accomplish the following:

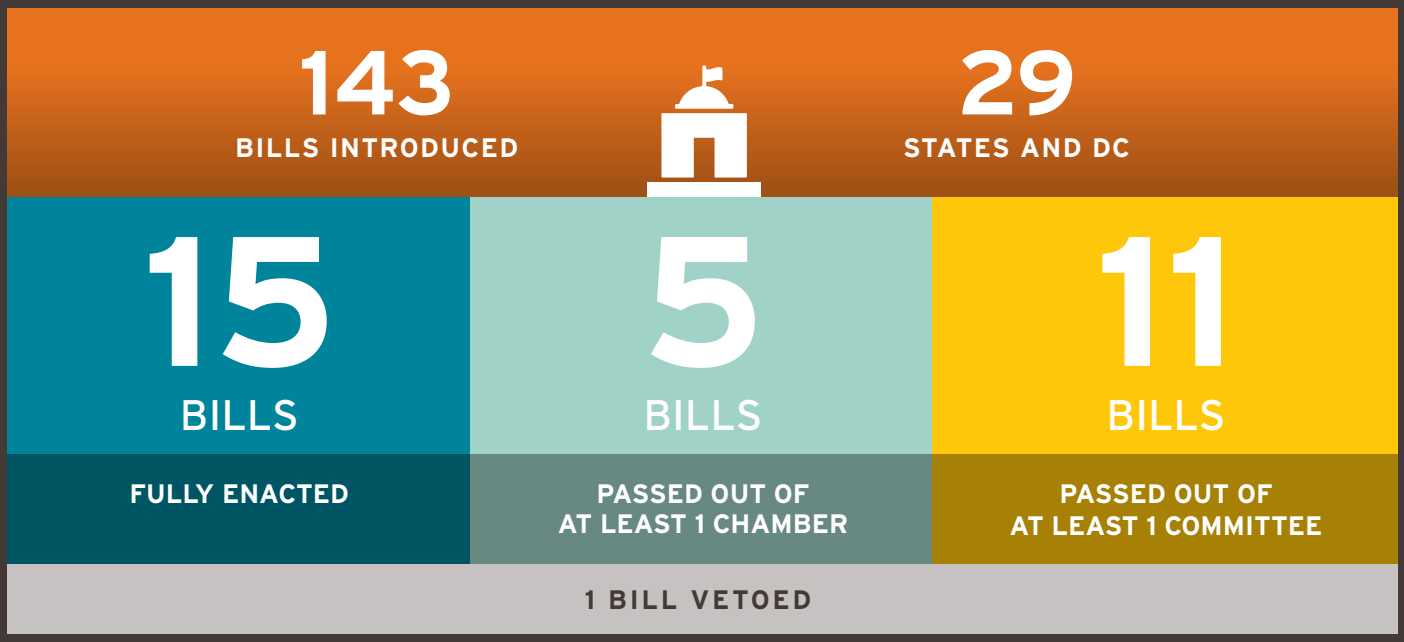
1. **Protect the right to decide when and whether to become a parent, including the right to decide to have an abortion**, by codifying that right in state law.
2. **Ensure that everyone who needs it can access abortion care**, by repealing state laws that restrict rights and access, such as waiting periods or bans on insurance coverage for abortion.
3. **Ensure that no one who becomes pregnant will be investigated, prosecuted, or imprisoned for managing their own abortion** by repealing laws that criminalize self-managed abortion and enacting legislation that makes it clear that no one can be prosecuted or jailed for ending their own pregnancy.
4. **Improve the health of women and families** by enacting legislation providing insurance coverage for the full range of reproductive health care, including contraception and abortion, prenatal care, postpartum care, and breastfeeding support and supplies.
5. **Expand access to the full range of contraceptive options** by mandating that insurance companies must cover all forms of contraception without additional barriers and by allowing patients to obtain a year's worth of birth control with one prescription.
6. **Keep abortion patients and providers safe** by ensuring that employees, volunteers, or patients of reproductive health providers can request that their private, personal information — including where they live and information about their children — is kept off the internet and away from those who seek to harass and harm them.
7. **Protect and promote the health of women, transgender men, and other people who can become pregnant who are incarcerated** by prohibiting shackling during pregnancy, requiring prisons and jails to meet prenatal and postnatal health and nutrition standards, creating lactation and breastfeeding support programs, requiring courts and prosecutors to strongly consider alternatives to incarceration for anyone who is pregnant or lactating, and following through on all of those guarantees.
8. **Support the ability of pregnant and parenting young people to stay in school** by ensuring that pregnant students can take time off to get pregnancy care or abortion care by requiring schools to help students catch up when they return and providing young parents with sick days specifically to take care of sick children without requiring a doctor's note.
9. **Ensure that no one's reproductive decisions are coerced by the government** by prohibiting any court or other state entity from making a benefit from the state — such as a reduced sentence — contingent on agreeing to use contraception, be sterilized, or make any other decision about one's reproductive life.

SECTION 1

EXPANDING ACCESS TO ABORTION CARE

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.[1] NIRH supports policies that enable any woman, transgender man, or other person who can become pregnant to have access to quality, affordable, supportive, and safe abortion care without shame or harassment. Anyone seeking abortion care should have access to complete and medically accurate information about their options and should not be misled by politicians, third parties, or other actors who oppose abortion. No one should face prosecution for attempting or performing their own abortion. This is particularly critical for those who are historically underserved by the medical system and/or have faced racial discrimination or coercion with regards to their reproductive decisions.

EXPANDING ACCESS TO ABORTION CARE



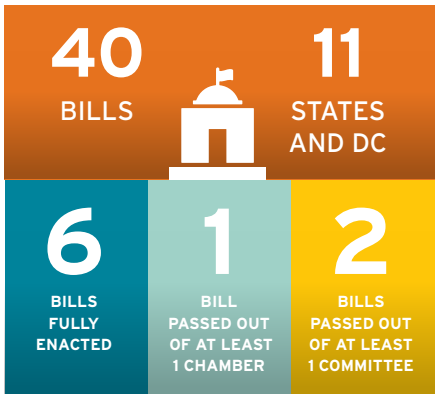
SINCE *ROE V. WADE* WAS DECIDED IN 1973, state legislators have imposed a patchwork of at least 1,276 restrictions on the provision of abortion care.[2] Just since 2011, more than 484 new laws restricting access to abortion have been enacted in state houses across the country.[3] And in 2019 there was an alarming rise in the number of partial or total abortion bans passed in parts of the country, pushed by anti-abortion activists and lawmakers who believe the Supreme Court may soon be willing to limit or eliminate federal constitutional protection for the right to make reproductive health decisions. In response, state advocates and policymakers fought hard to protect their communities by pushing through an unprecedented number of policies to establish the right to abortion in their states and make abortion care more accessible.

Establishing Rights and Decriminalizing Abortion

Before the Supreme Court decided *Roe v. Wade*, most states had laws that restricted access to abortion, including many that made it a crime to provide an abortion and, in some cases, a crime for a woman to perform her own abortion. Although generally unenforced since *Roe*, some of these unconstitutional laws remain on the books, causing uncertainty about what is legally permissible and sometimes limiting the type of care providers can offer their patients. These archaic abortion laws have also increasingly been used by prosecutors to investigate, arrest, or prosecute women, particularly low-income women and women of color, who are already subject to greater government surveillance and interference in their reproductive lives and health care decisions.

In the 46 years since *Roe v. Wade* was decided and abortion legalized throughout the United States, advocates and lawmakers at the state level have recognized these continued barriers to abortion rights and access, along with the potential that the Supreme Court could shift. Over those decades, a number of states have stepped forward to enshrine reproductive rights within their own state laws, ensuring that women and others who become pregnant can seek care in those states regardless of the Supreme Court's decisions. In the 1990s and early 2000s, California, Connecticut, Hawaii, Maryland, Maine, Nevada, and Washington State enacted abortion rights legislation, and in 2013 and 2014, Colorado and Vermont, respectively, repealed criminal abortion laws. Since the Trump-Pence administration took office, with the looming potential for a sea change on the Supreme Court, and the subsequent appointment of two new Justices whose presence calls into question the continued strength of federal constitutional protections for abortion, anti-abortion politicians have increased their efforts to outlaw abortion or push it entirely out of reach. State legislatures must respond to this threat by repealing outdated laws, establishing a firm right to abortion in their states, and ensuring that abortion is treated as health care and never as a crime. Indeed, in quick response, in 2017 and 2018, Delaware, Oregon, and Massachusetts joined the list of states that have repealed pre-*Roe* abortion laws or enshrined new rights in law.

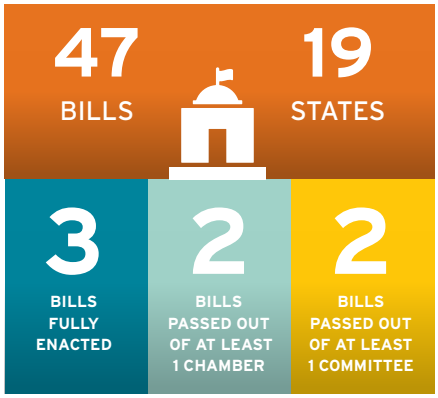
ESTABLISHING RIGHTS AND DECRIMINALIZING ABORTION



It is now clear that state legislatures must respond to this threat by repealing outdated laws, establishing a firm right to abortion in their states, and ensuring that abortion is treated as health care and never as a crime.

In 2019, a record number of states took up this issue, considering bills codifying a fundamental right to make reproductive health care decisions, including abortion, and/or repealing old laws that criminalize abortion. **Illinois** enacted the Reproductive Health Act, Senate Bill 25, which did both as well as mandate insurance coverage parity between pregnancy care and abortion services. This bill was supported by a diverse coalition of organizations including the American Civil Liberties Union (ACLU) of Illinois, the Chicago Abortion Fund, EverThrive Illinois, Hope Clinic for Women, the Illinois Caucus for Adolescent Health, the Midwest Access Project, Men4Choice, Planned Parenthood of Illinois, Planned Parenthood of the St. Louis Region and Southwest Missouri, the Religious Coalition for Reproductive Choice, and Whole Woman's Health. **Nevada** enacted Senate Bill 179, which repeals the state's pre-*Roe* law that made it a crime to provide an abortion or for a woman to manage her own abortion. **New York**, with the help of a broad coalition headed up by the National Institute for Reproductive Health, the New York Civil Liberties Union, Planned Parenthood Empire State Acts, and RHAvote, enacted the Reproductive Health Act, Senate Bill 240 / Assembly Bill 21 on January 22, the 46th anniversary of *Roe*. Senator Liz Krueger hailed the bill's significance, stating that "[b]y enacting the RHA, New York will once again lead the nation on women's reproductive healthcare, and help ensure that all New Yorkers have the freedom and opportunity to make their own decisions about their health and their families."[4] The law both decriminalizes abortion and recognizes a fundamental right to make reproductive decisions, and allows advanced practice clinicians to provide abortions within their scope of practice. Thanks to tireless advocacy by the Rhode Island Coalition for Reproductive Freedom, **Rhode Island** enacted House Bill 5125 or the Reproductive Privacy Act (and considered the similar Senate Bill 152), which codifies the right to abortion and repeals the state's pre-*Roe* criminal abortion law, spousal consent law, and other restrictions. **Vermont** enacted the most progressive abortion rights bill with House Bill 57, which recognizes that each person has a fundamental right to make decisions about reproductive health care, including abortion and ensures that those rights are not denied, restricted, or infringed by a governmental entity. **Vermont** also adopted Proposal 5, a proposed constitutional amendment that would enshrine those same protections in the state constitution if passed by the legislature once more and then approved by Vermont voters. **New Mexico** considered House Bill 51, which would have repealed New Mexico's criminal abortion law. Although the bill did not pass the Senate, it passed the House thanks to the work of a strong coalition including the ACLU of New Mexico, Planned Parenthood New Mexico, ProgressNow New Mexico, the Southwest Women's Law Center, Strong Families New Mexico, and Young Women United.

INCREASING ACCESS TO ABORTION CARE



Increasing Access to Abortion Care

The right to make decisions about abortion and other reproductive health care is an important first step, but must be coupled with measures to ensure that anyone who needs to can access an abortion in their own community.

Two states focused on easing barriers to abortion care by expanding health care providers' ability to offer it, ensuring that providers are not subject to

medically unnecessary restrictions on the way they provide care or the type of care they can provide. Thanks to strong organizing by a broad coalition of organizations including the ACLU of Maine, the Maine Nurse Practitioner Association, Mabel Wadsworth Center, Planned Parenthood of Northern New England, the Maine Council of Churches, and the Maine Women's Lobby and with strong support from Governor Janet T. Mills, **Maine** enacted House Bill 922, which allows physician assistants and advanced practice registered nurses to perform abortions within their scope of practice. **Hawaii** considered several similar bills that proposed different ways to make abortion care more accessible for the Hawaiian population. Senate Bill 415 / House Bill 357 passed the Senate and a House committee and would have created a task force to study allowing advanced practice registered nurses to provide abortions within their scope of practice, and House Bill 934 passed a committee and would have expanded the scope of practice of a physician assistant.

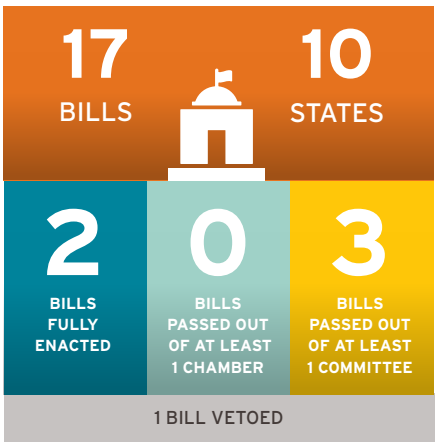
Two states considered legislation ensuring access to abortion care for young people. Building on the incredible organizing that took place in 2018 by a large coalition led by ACCESS Women's Health Justice, ACT for Women and Girls, California Latinas for Reproductive Justice, Students United for Reproductive Justice at Berkeley (SURJ), and the Women's Policy Institute, **California** enacted Senate Bill 24, which requires each student health center at a public university to offer medication abortion, making it possible for every public university student in California to access at least one form of abortion on their campus, and includes a mechanism to provide grants to university health centers for the cost of this program. As Senator Connie Leyva described, "Students should not have to travel off campus or miss class or work responsibilities in order to receive care that can easily be provided at a student health center."[5] **Illinois** considered Senate Bill 1594 / House Bill 2467, which would repeal the state's current parental notification requirement that a young person give notice to an adult family member or secure a court waiver before they can obtain an abortion.

Lastly, **Connecticut** responded to the current political moment by enacting Senate Bill 394, which establishes a Council on Protecting Women's Health that will monitor and report on federal legislation that could potentially affect women's health care in the state.

Expanding Coverage for Abortion Care

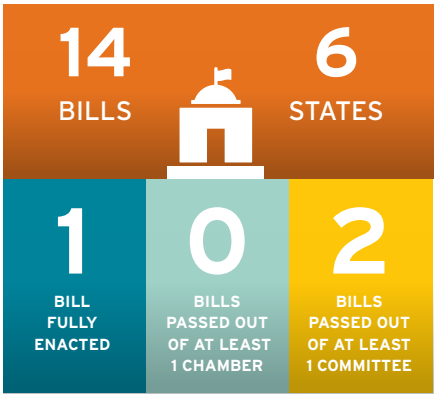
To ensure full access, everyone — regardless of their income level or immigration status — needs and deserves insurance coverage or access to other funding sources that adequately cover abortion services. **Maine** moved one step closer to that reality by enacting House Bill 594, because, as Senator Cathy Breen put it, "[i]t's time for reproductive health care to be on par with advances in other areas of medicine."[6] The bill requires abortion services to be covered under the state's insurance programs, including MaineCare and any other state program that covers maternity services, and private insurance plans governed by the state. This law makes Maine the 16th state that

EXPANDING COVERAGE FOR ABORTION CARE



will cover abortion through its Medicaid program, and the sixth state that requires private coverage of abortion – joining California, Illinois, New York, Oregon, and Washington.[7] **New York** enacted Senate Bill 1507 / Assembly Bill 2007, which prohibits discrimination by insurance companies based on an individual's sex or marital status, or based on pregnancy, false pregnancy, termination of pregnancy or recovery therefrom, childbirth, or other related medical conditions. **New Hampshire** enacted a budget bill (House Bill 2) that would have repealed the state's prohibition on using state funds to provide abortion services, but the full bill was ultimately vetoed by the governor due to unrelated budget concerns. **New Jersey** considered Assembly Bill 4455, which would give greater privacy protections to those receiving reproductive health care and other sensitive services by allowing them more control over what information is disclosed in their insurance policy's explanation of benefit forms. **Washington** considered House Bill 1902, which would require insurance plans on the State Exchange to cover abortion and collect payments using one invoice, mitigating a new and harmful federal regulation aimed at restricting access to abortion.

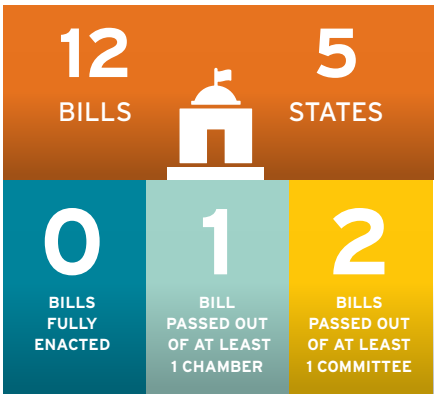
ENSURING THE SAFETY OF PATIENTS AND PROVIDERS



Ensuring the Safety of Patients and Providers

State legislatures have not been alone in their efforts to reduce access to abortion – some abortion opponents have also used violence and harassment to undermine the provision of abortion services, and some advocates and lawmakers have stepped up to respond to those threats. Building on last year's advocacy efforts and supported by the Thrive New Jersey coalition, **New Jersey** enacted Senate Bill 1761 (and considered similar versions in Assembly Bills 1651 and 1861), which creates an address confidentiality program for reproductive health service employees and patients, allowing patients and providers to request that their addresses be kept confidential and thus helping them stay safe in their homes.

CURTAILING THE DECEPTIVE PRACTICES OF ANTI-ABORTION PREGNANCY CENTERS



Curtailing the Deceptive Practices of Anti-Abortion Pregnancy Centers

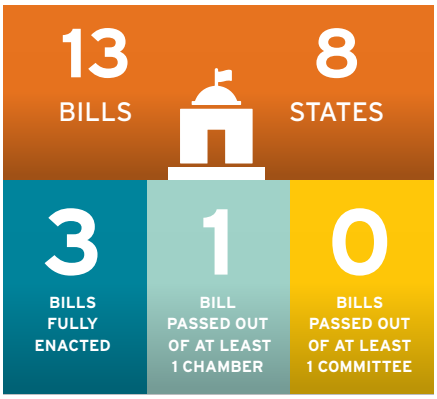
Women may not be able to make fully informed choices about their reproductive lives if they are subjected to manipulative, medically inaccurate, biased "counseling" from those who oppose their right to access abortion. Anti-abortion pregnancy centers – anti-choice organizations that often pose as women's 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 to curtail these fraudulent and deceptive practices, and in 2019, the **Connecticut** House passed House Bill 7070, supported by a coalition of advocates headed up by NARAL Pro-Choice Connecticut, that would prohibit facilities that appear to offer re-

productive health care services but are not actually medical facilities from engaging in deceptive advertising practices. **New York** considered Assembly Bill 8212 / Senate Bill 6311, which would direct the commissioner of health to conduct a study of centers that appear to offer reproductive health care services but may not do so and whether they provide accurate information and adequate services to women, as well as Senate Bill 2264 / Assembly Bill 2352, which would require anti-abortion pregnancy centers to disclose to clients and potential clients that they will not provide or refer for abortions or birth control services.

Publicly Supporting the Right to Abortion

Elected officials have a unique opportunity to use their positions of power to counter abortion stigma by vocally supporting abortion care and abortion providers. For instance, 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 policy measures can also help connect local, state, and federal advocacy, building a more powerful movement from the ground up. This is especially important in a time when the federal government has been threatening and undermining access to abortion and reproductive health more broadly. In 2019, **California** lawmakers proclaimed their support for the rights protected in *Roe v. Wade*, access to reproductive health care services, and clinics by adopting House Resolution 6 / Senate Resolution 7, and for the Title X program by adopting Senate Joint Resolution 4. **California** also considered Assembly Concurrent Resolution 110, which passed the Assembly and would have declared California to be a "Reproductive Freedom State for All."

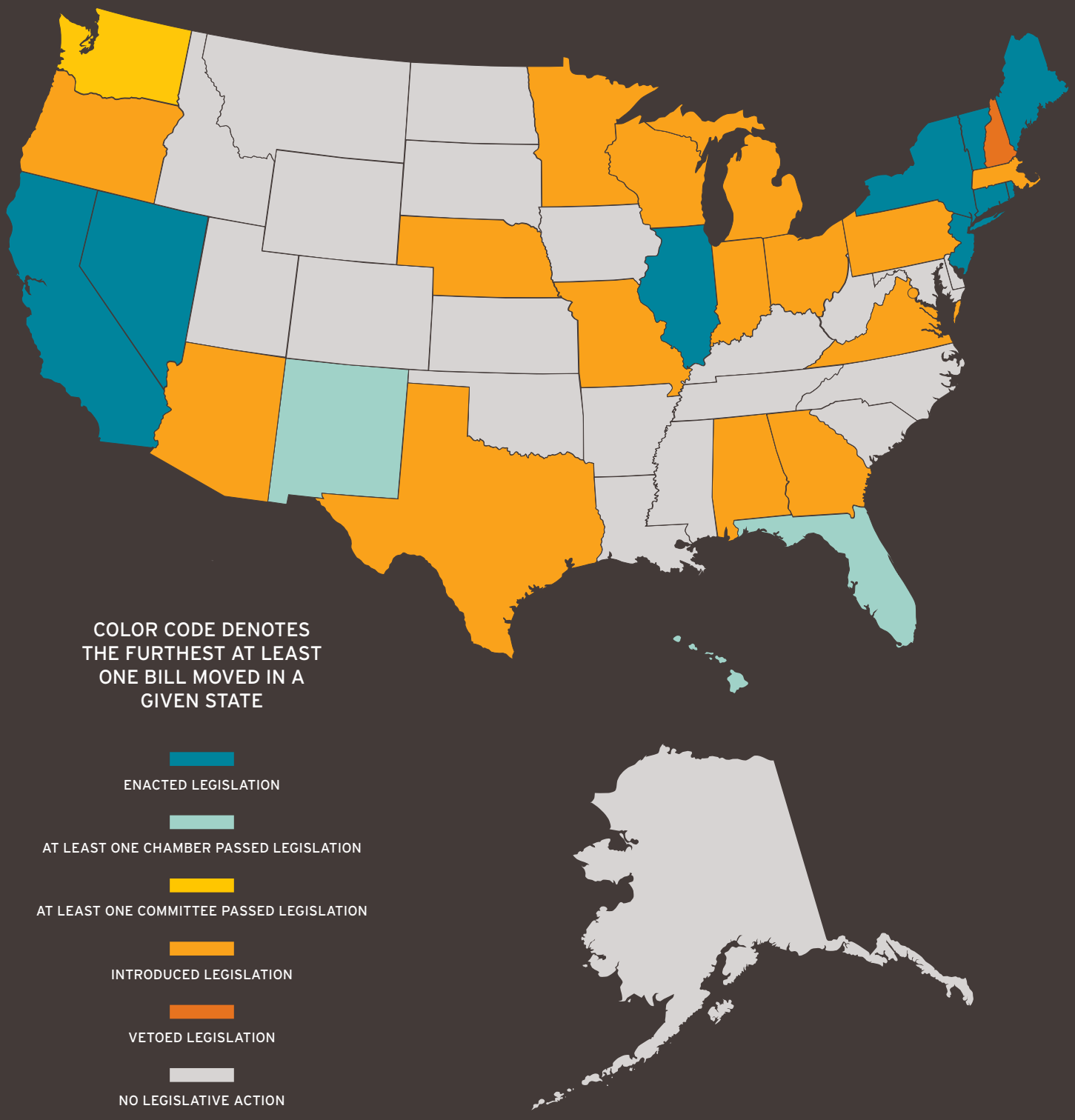
PUBLICLY SUPPORTING THE RIGHT TO ABORTION



Resolutions that call on federal lawmakers to protect women's rights or pass important new policy measures can also help connect local, state, and federal advocacy, building a more powerful movement from the ground up.

EXPANDING ACCESS TO ABORTION CARE

AS OF DECEMBER 15, 2019

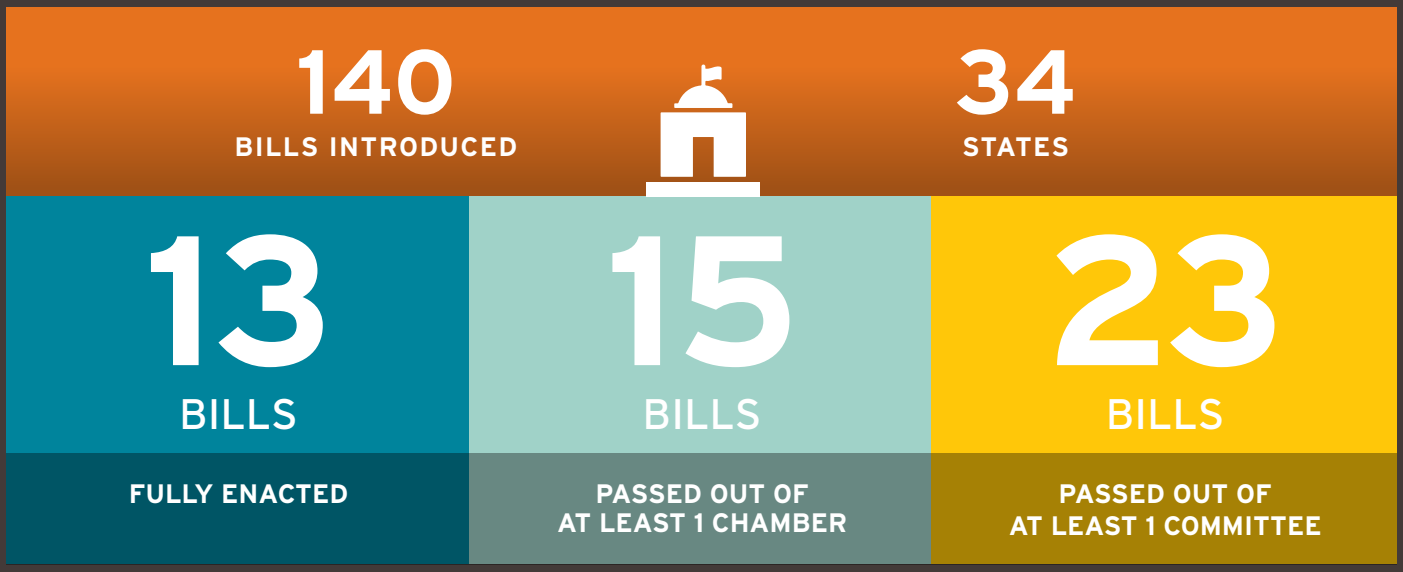


SECTION 2

IMPROVING ACCESS TO CONTRACEPTION

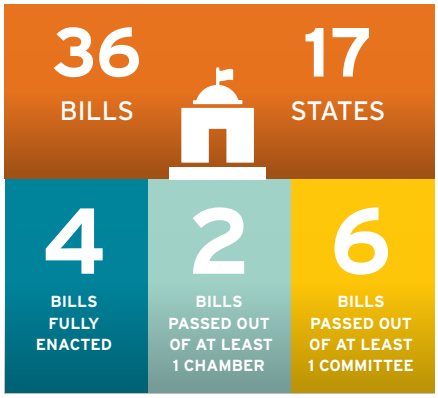
An individual's ability to control whether and when to have a child can determine the course of their lives. Having meaningful access to contraception is essential to individual self-determination as well as to overall gender equity. NIRH supports policies that ensure access to the full range of methods 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.

IMPROVING ACCESS TO CONTRACEPTION



DESPITE SCIENTIFIC AND MEDICAL ADVANCES in contraceptive methods, many barriers exist that prevent individuals from accessing or being able to afford the kind of contraception they want or need. These barriers can include everything from the unpredictability of insurance coverage for all forms of contraception from accessible providers to inadequate provider infrastructure, language barriers, and cost – which particularly impact low-income, rural, and immigrant populations. The Trump-Pence administration has put in place even more barriers to accessing contraception, particularly focusing on dismantling the protections of the Patient Protection and Affordable Care Act (ACA) in guaranteeing coverage for the full range of contraception and placing a gag rule on Title X providers, prohibiting recipients from providing or even referring for abortion care thereby forcing them to choose between getting federal funding and providing good medical care. In 2019, advocates and lawmakers continued to build upon the advances of the last several years to push forward both comprehensive policies to expand access to and coverage for contraceptives, as well as measures to address specific barriers that exist for specific communities within their states.

EXPANDING ACCESS TO CONTRACEPTIVE CARE



Expanding Access to Contraceptive Care

True access to contraceptive care exists when anyone seeking contraception can get the full range of services from a nearby provider who is appropriately trained to offer these services along with comprehensive and culturally competent counseling. This level of access requires support for all types of providers to be adequately trained and reimbursed, as well as appropriate availability of and reimbursement for all types of contraception. In many areas, long-acting reversible contraception (LARC) is often difficult to access for many reasons, including a lack of awareness, persistent myths among both patients and providers about the dangers of LARC devices, insufficient provider training in insertion and removal, and the high cost of the devices, as well as concerns in some communities about the history and ongoing reality of reproductive coercion.[8] Advocates and lawmakers continued to work this year to dismantle many of these barriers to LARC and other forms of contraception and to support providers in communities most in need of services.

Two states focused on making contraception more accessible to patients. **North Dakota** unanimously passed Senate Bill 2155, which allows registered nurses to prescribe and dispense many forms of contraception. **New Jersey** considered Senate Bill 3742, which would require retail pharmacies to stock and dispense emergency contraception.

Four states took steps to create new programs to ensure that family planning or women's health services would be provided in more areas. **New Jersey** enacted Assembly Bill 4938 / Senate Bill 3376, which establishes a "My Life, My Plan" program to promote and support family planning for all women of childbearing age and their families. **Florida** considered Senate Bill 410 / House Bill 579, which would have established a pilot program to improve the provision of LARC to women in some counties. **Illinois** considered House Bill 6, which would have required the Department of Public Health to establish

women's health clinics throughout the state to provide affordable health care for women. **Virginia** considered Senate Bill 1452, which would create a new type of license at a reduced fee to allow qualifying non-profit facilities to dispense contraception and treatment for sexually transmitted infections (STIs).

Three states strived to create or expand services for specific populations that may struggle with access to medical or reproductive health care. **Maine** enacted Senate Bill 159, which, among other things, protects young people's access to family planning services without parental consent and sets up a program to make contraception available to indigent individuals. In **Hawaii**, the Senate and a committee in the House passed Senate Bill 526 / House Bill 36, which would expand an existing mobile outreach clinic program that helps Hawaii's homeless population access medical care including family planning services. **Texas** considered House Bill 938, a bill supported by a wide array of organizations through the Trust. Respect. Access. coalition[9] which would allow a minor parent who is unmarried to consent to being examined and to receive contraception.

Lastly, the **Hawaii** Senate took a public stand on the importance of contraception by passing Senate Bill 698, which would codify the United Nations sustainable development goals in state law, including goals related to access to sexual and reproductive health care and family planning.

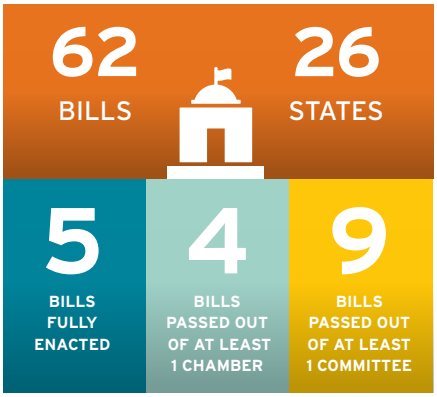
Ensuring Contraception Coverage

For all individuals — regardless of their income level or immigration status — to have meaningful access to contraception, they must have insurance coverage and other funding sources that sufficiently cover the full range of contraception services, including comprehensive and culturally competent counseling; provider care, including insertion and removal of LARC; and coverage for the actual method, including over-the-counter access to contraception that is approved for such sale. Unfortunately, insurance plans differ in the coverage they offer, refusing to cover some forms of contraception or erecting other barriers to accessing that care. However in 2019, states considered policies to ensure broader coverage for contraception.

While many states have required "contraceptive equity" since the 1990s, meaning that insurance plans that cover prescription drugs must also cover contraception, insurance companies often limit the types of contraception that are covered or charge high copays for some or all forms. While the ACA addressed some of these barriers by requiring coverage for all FDA-approved forms of female contraception with no copay,[10] many advocates and legislators have worked to enshrine this requirement in their state laws and to broaden the coverage guarantee even further by including over-the-counter and/or male forms of contraception. California became the first state to pass such a law in 2014, with Illinois, Maryland, and Vermont following suit in 2016. Since 2017, the Trump-Pence administration has attempted to repeal the ACA, and the federal administration has repeatedly and explicitly threatened contraceptive access. In response in 2017, Maine, Massachusetts, Nevada, and Oregon enacted contraceptive equity bills, and the District of Columbia and Hawaii enacted even broader protections by passing laws to enshrine cover-

True access to contraceptive care exists when anyone seeking contraception can get the full range of services from a nearby provider who is appropriately trained to offer these services along with comprehensive and culturally competent counseling.

ENSURING CONTRACEPTION COVERAGE



Advocates and lawmakers have stood up this year to protect the rights of the 1.4 million transgender people in the United States to access contraception and other health care.

age for the full range of the ACA's required women's preventive services. In 2018, Connecticut, Delaware, the District of Columbia, Maine, Rhode Island, and Washington all enacted similar laws.

In 2019, while the Trump-Pence administration continued its attack on the ACA and its protections for contraception, New Mexico and New York joined the 15 other states with contraceptive equity laws that codify and expand the ACA's requirement of coverage for the full range of FDA-approved contraception without cost sharing. **New Mexico's** House Bill 89 also requires coverage regardless of gender identity or expression, and includes coverage for vasectomies while **New York's** Senate Bill 659 / Assembly Bill 585 allows women to receive a full twelve-month supply of contraceptives at once. The **New York** legislature also considered Senate Bill 3543, which passed one chamber and would have clarified the coverage requirements to include vasectomies and over-the-counter contraceptive products. **Minnesota** considered (House Bill 963 / Senate Bill 1084) and **New Jersey's** Assembly passed (Assembly Bill 5508 / Senate Bill 3804) similar contraceptive equity laws. Two states also considered more limited bills focused on simply covering a full twelve-month supply of contraceptives at once: **New Jersey's** Assembly Bill 4503 and **Texas'** House Bill 937 / Senate Bill 795 each passed one committee.

Two states responded to the attacks on the ACA in a different way. After the federal government eliminated the ACA's individual mandate requiring every person to have minimum health insurance, **California** enacted Assembly Bill 414, which requires California residents to maintain monthly minimum essential coverage, including contraception and family planning. **New Jersey** considered Assembly Concurrent Resolution 209 / Senate Concurrent Resolution 154, which would have condemned the federal government's rules allowing employers to deny their employees health insurance coverage for contraception based on religious or moral objections.

Five states took steps to improve individual aspects of insurance coverage to make contraception more accessible and affordable for their residents. **Maine** enacted House Bill 64, which encourages providers to provide contraceptive care by requiring reimbursement for any family planning services for a person who is likely eligible for the state's Medicaid program, even if they are not yet enrolled. **California** considered Assembly Bill 1524, which would have streamlined some of the application process for new clinics and providers in the Medi-Cal and Family Planning, Access, Care, and Treatment (Family PACT) Programs. **Nevada's** Senate passed Senate Bill 344, which would have increased the reimbursement for family planning services, thereby easing the burden on family planning clinics that provide services to Medicaid patients. **New York** considered Senate Bill 3120 / Assembly Bill 6650, which would require employers or other policyholders who are exempt from the state's legal requirements to provide contraception coverage to notify current and prospective employees that such coverage is not provided. The **Texas** House passed House Bill 800, which would have required coverage for contraception within the state's Child Health Plan.

Advocates and lawmakers have stood up this year to protect the rights of the 1.4 million transgender people in the United States to access contraception and other health care. The Trump-Pence administration has consistently

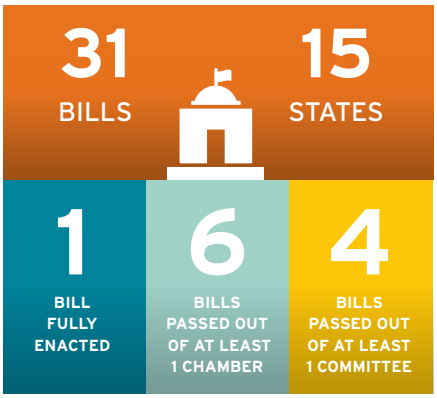
targeted the transgender community, most recently by proposing a rollback of Section 1557 of the ACA, or the Health Care Rights Law, which also targeted abortion coverage. **Washington** responded to this rollback by enacting Senate Bill 5602, which requires health plans to provide coverage for contraceptive drugs, devices, and other products, regardless of the covered person's gender or sexual orientation.

Easing Access to Contraception at the Pharmacy

Oral contraceptives are among the safest and best understood medications available, and recent medical evidence indicates that making them available without a prescription could safely increase access and reduce unintended pregnancy.[11] Nonetheless, under federal law, patients are still required to get a prescription to access them. While states cannot change the federal prescription requirement, states have continued to consider policies that would adjust pharmacists' scope of practice to help mitigate this barrier.

In 2019, **West Virginia** enacted House Bill 2583, permitting a pharmacist to dispense a self-administered hormonal contraceptive under a standing prescription drug order, thereby allowing consumers to access many types of contraception directly from the pharmacy. This bill unfortunately allows two limitations to access: a pharmacist may only dispense 12 months of contraception after receiving evidence that the consumer has visited a primary care provider, and participation by pharmacists is voluntary, which has the potential to undermine the purpose of the bill by allowing pharmacists to refuse to provide contraception and creating confusion about where these services are available. **Wisconsin's** Assembly passed Assembly Bill 304 / Senate Bill 286 which would allow pharmacists to prescribe and dispense self-administered hormonal contraception to people 18 years old or older after they complete a self-assessment questionnaire and undergo a blood pressure screening. Other states considered bills that allow a pharmacist to dispense contraception under a standing order: **Arkansas** House Bill, 1290 which passed the House, **Illinois** House Bill 1442, which passed a committee and went further by also requiring insurance plans to cover the contraception dispensed by a pharmacist, **Iowa's** two nearly identical bills, Senate Bill 513 and Senate Bill 348, which passed the Senate, **Missouri** House Bill 487, which passed the House, **Nevada** Senate Bill 361, which passed the Senate, **New Jersey** Senate Bill 845 which passed a committee, and **Rhode Island** House Bill 5549, which passed the House.

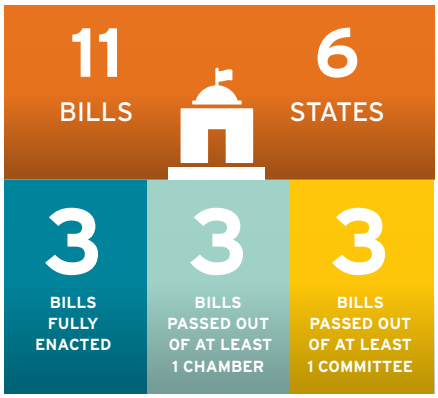
EASING ACCESS TO CONTRACEPTION AT THE PHARMACY



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.[12] They can also connect patients to coverage and other care, and are at times the only health care provider that a woman will

PROTECTING ACCESS TO FAMILY PLANNING CLINICS



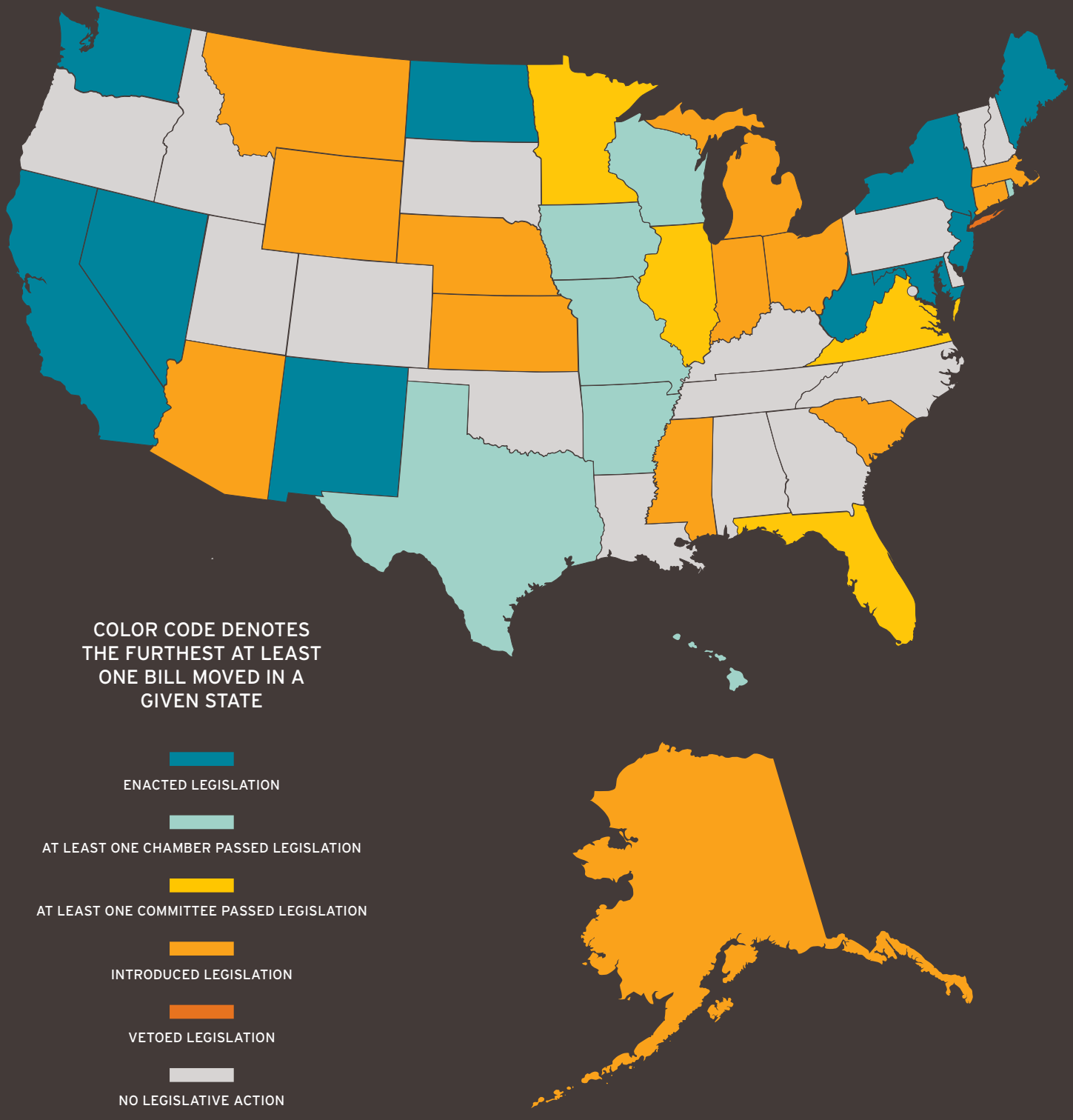
ever see.[13] In fact, publicly supported family planning clinics are the gateway provider for the more than six million women who receive contraceptive services at such a clinic.[14] For example, research has shown that without these clinics, the unintended pregnancy rate in the United States in 2015 would have been 31 percent higher.[15] Given the important role that family planning providers play, states have a significant opportunity to support reproductive health, especially for low-income residents, by passing policies that enable family planning clinics to thrive in their states.

Title X has been the sole federal grant program dedicated to advancing people's access to comprehensive contraceptive and related reproductive health services in the United States for almost 50 years.[16] Clinics funded by Title X provide care to approximately four million people each year,[17] many of whom encounter barriers to care, including low-income individuals, people of color, and LGBTQ individuals. In 2019, the Trump-Pence administration jeopardized funding to Planned Parenthood and other family planning clinics by promulgating a rule that will deny patients information about and referrals for abortion, and reduce access to high-quality contraceptive care.[18] Four states subsequently took steps to protect or bolster their family planning clinics in response to this risk. **Maryland** enacted House Bill 1272 / Senate Bill 904 which prohibits the Department of Health (DOH) from accepting any Title X funding if the Title X program excludes funding for family planning providers and does not require family planning providers to provide comprehensive family planning care. The **California** Senate and an Assembly committee passed Senate Bill 301, which would require the Department of Health Care Services to ensure the Family PACT program's sustainability and identify possible funds that could support it. The **New Jersey** Assembly and a Senate committee passed Assembly Bill 5802 / Bill 4103 which would provide supplemental funding to family planning providers who are excluded from Title X because of federal attacks. The **New York** Senate passed Senate Bill 2593, which would have established a family planning program to ensure the continuity of family planning services in the state regardless of the status of Title X.

Three states considered laws that would support family planning clinics unrelated to the attacks on Title X. **Maine** enacted Senate Bill 212, which ensures that women experiencing substance use, homelessness, or involvement with corrections receive access to family planning services. The bill emphasizes the right to self-determination regarding family planning and childbearing, which is an important addition because language around which specific groups should have access to contraception can reinforce the historical reproductive coercion of vulnerable populations. For more information on the history of reproductive coercion, see "Prohibiting or Remediating Coercion in Reproductive Decision-Making" on page 44. **Nevada** unanimously passed Senate Bill 94, allowing for state-issued family planning grants to be used for a broader set of contraceptive services, and clarifying that a community health nurse is an eligible provider for these services. Governor Steve Sisolak explained that "[the bill will] make a difference in the lives of countless Nevada women and men, but also send a message to the rest of the country that Nevada will NOT go backwards when it comes to reproductive rights and health."[19] **Texas** considered two bills that would gather more information about the needs for women's health and family planning services: House Bill 3337 would survey the needs of women enrolled in the Healthy Texas Women program, and House Bill 992 would create a women's health advisory committee.

IMPROVING ACCESS TO CONTRACEPTION

AS OF DECEMBER 15, 2019

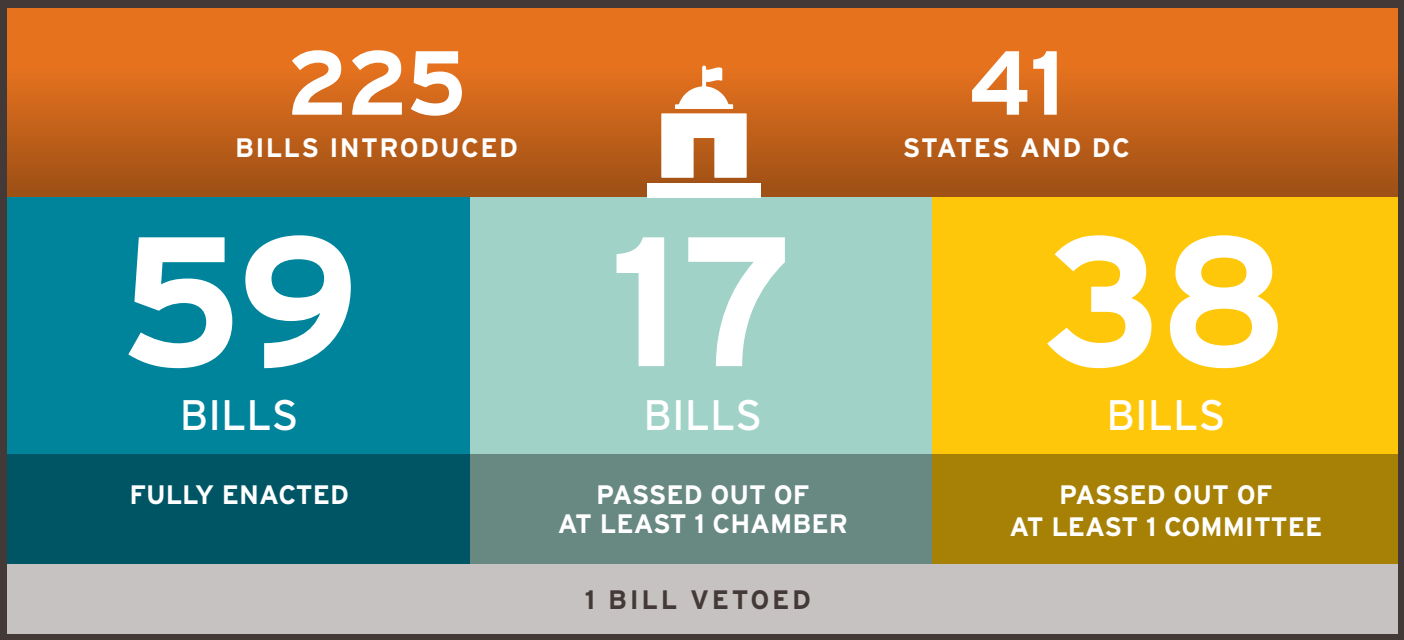


SECTION 3

INCREASING ACCESS TO PREGNANCY CARE

Pregnancy and childbirth are matters of bodily autonomy, dignity, and privacy, and implicate critical aspects of public health, such as equitable access to quality health care and health outcomes. NIRH supports policies that ensure that all women, transgender men, and other people who can become pregnant, regardless of income level or immigration status, have affordable, convenient access to prenatal, labor and delivery, and postnatal care from the provider of their choice in the delivery setting of their choice. Effective public health policy should include collaboration between communities, governments, and health care providers to prevent maternal morbidity and mortality, and to address and eliminate the racial disparities in maternal health indicators that currently plague the United States.

EXPANDING ACCESS TO PREGNANCY CARE



Improving Maternal Health Outcomes

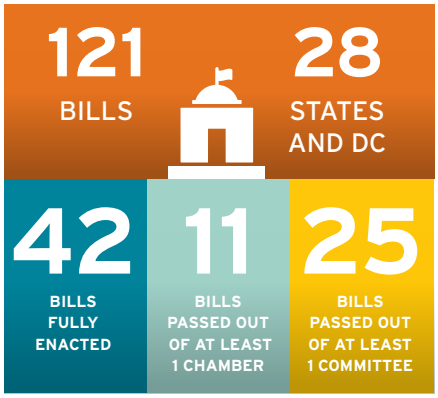
DESPITE OTHERWISE ADVANCED MEDICAL CARE in the United States, maternal health lags well behind, with the United States having the highest maternal mortality in the developed world.[20] This disparity is due in part to the reprehensible levels of maternal mortality and morbidity that exist among Black women and other women of color.[21] Advocates, reproductive health care professionals, and lawmakers have been considering policy options to address these issues for many years and are continually refining the possible solutions. In particular, Black Mamas Matter Alliance[22] – a Black women-led cross-sector alliance that advocates on behalf of Black maternal health, rights, and justice – has led the charge to bring public attention to this issue and to seek change at the state level. In April 2019, it helped community groups organize events on the local, state, federal, and global levels to amplify the voices of Black mamas, women, and families and increase attention for the issues around Black maternal health during their annual Black Maternal Health Week.

An important first step toward addressing this public health crisis is to study maternal health and collect accurate data on racial disparities in outcomes; identify failures in each state's health care delivery system; and take steps to ensure access to basic prenatal and postpartum care, including mental health care, especially for vulnerable or disparately impacted groups. From there, states can go further to address known gaps in health care access and begin to build out a more comprehensive approach to support pregnant and postpartum women. Many states that started by establishing commissions to study this issue are beginning to introduce and pass policies that tackle the problems and offer solutions.

In 2019, 12 states created or strengthened maternal mortality review commissions, triple the number of commissions created in 2018: **Arkansas** (House Bill 1440 and House Bill 1441), **Colorado** (House Bill 1122), **Idaho** (House Bill 109), **Maryland** (House Bill 583 / Senate Bill 356), **Nevada** (Assembly Bill 169), **New Jersey** (Assembly Bill 1862 / Senate Bill 495), **New Mexico** (Senate Bill 215), **New York** (Assembly Bill 3276 / Senate Bill 1819), **Oklahoma** (House Bill 2334), **Rhode Island** (House Bill 5543 / Senate Bill 574), **Virginia** (House Bill 2546), and **Washington** (Senate Bill 5425 / House Bill 1369) – while one state, **Missouri**, considered but did not pass similar legislation, House Bill 664 / Senate Bill 480.

Six states pushed forward legislation to create similar studies on maternal mortality that are not housed in the structure of a maternal mortality review commission: **Arizona** enacted Senate Bill 1040, which creates an advisory committee on maternal mortality and morbidity; **Georgia** enacted House Resolution 589, which establishes a maternal mortality House Study Committee; **Maryland** enacted House Bill 796 / Senate Bill 602, which convenes county-level teams to study maternal mortality alongside state officials; **New York** enacted Senate Bill 6529 / Assembly Bill 8338, which ensures a diverse maternal mortality review board comprised of mothers

IMPROVING MATERNAL HEALTH OUTCOMES



Women should be empowered during pregnancy, labor and delivery, childbirth, and the postpartum period to make healthy decisions for themselves and their babies.

and women from the community; **New Jersey's** Assembly and a Senate committee passed Assembly Bill 5029 / Senate Bill 3522, which would study racial and ethnic disparities in sexual and reproductive health, including in childbirth, among African American women; and **Texas** considered House Bill 2703, which would create a work group to study and make recommendations on creating a secure maternal mortality data registry.

Over the years, maternal mortality review commissions, along with other types of task forces and reproductive health care professionals and advocates, have been refining solutions to improve maternal health outcomes, understanding that women should be empowered during pregnancy, labor and delivery, childbirth, and the postpartum period to make healthy decisions for themselves and their babies. Five states took these kinds of steps to improve health care systems and support health care providers and patients. **California** enacted Senate Bill 464, which would require hospitals to implement evidence-based implicit bias training programs for all health care providers and inform their patients of their right to be free from discrimination on the basis of race, color, sex, gender, gender identity and expression, sexual orientation, and other protected classes. The **District of Columbia** adopted Resolution 484, enacted Bill 468, and the City Council passed Bill 469 declaring the existence of an emergency in maternal mortality rates and requiring the Chief Medical Officer to investigate all maternal deaths. **Illinois** enacted House Bill 2895, which would create a birth equity initiative to reduce racial disparities among women of color through implicit bias training and cultural competency education for health care providers and staff. The **New York** state legislature passed six bills: Assembly Bill 568 / Senate Bill 3158 would make health care providers who complete additional patient safety training in obstetrics or midwifery eligible for a premium reduction; Assembly Bill 6962 / Senate Bill 4498 would require hospitals to establish protocols to treat obstetric hemorrhaging; and Assembly Bill 2957 / Senate Bill 4637 would require the DOH to distribute information to pregnant women about possible complications during birth. **New Jersey's** Assembly Bill 4967 passed one chamber and would require DOH to survey all prenatal and antenatal clinics to evaluate availability, effectiveness, and inform policy changes to improve care. **New Jersey** also considered Senate Bill 3404 / Assembly Bill 4991, which would require DOH to create a manual of best practices for prenatal and postpartum care that hospitals would need to adopt and comply with as part of their licensing. **Minnesota** considered House Bill 909, which would direct funding toward programs aimed at eliminating racial and ethnic disparities in access and utilization of high quality prenatal services.

Two states took these kinds of policy solutions to a new level, identifying and then moving bold packages of bills to address the maternal mortality crisis in their communities. **Illinois** enacted four bills focused on this — House Bill 1, which creates a task force to examine infant and maternal mortality among African Americans and the impact of racism and toxic stress on pregnancy and childbirth; House Bill 2, which establishes the right of women to receive respectful and culturally competent health care before, during, and after pregnancy and childbirth, in the birth setting and with the provider of their choice, and require licensed health care providers, day care centers, and community centers to publicly post information so patients are aware of their

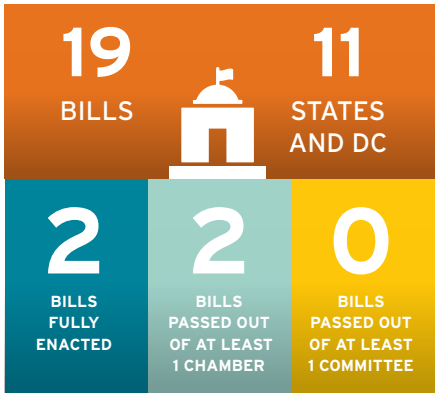
rights; House Bill 3, which updates existing law to require the Department of Public Health to provide quarterly Hospital Report Cards; and House Bill 5, which requires the Department of Human Services to ensure pregnant and postpartum women, especially incarcerated individuals, have access to gender-responsive, trauma-informed substance use and mental health services. In New Jersey, lawmakers moved forward a broad package of bills to improve maternal health outcomes and expand coverage of pregnancy care (read more under "Broadening Coverage for Pregnancy Care" on page 24). **New Jersey** enacted Senate Bill 3375 / Assembly Bill 4936 which establishes a pilot program to improve patient-centered maternal health care delivery; and Assembly Resolution 219 / Senate Resolution 121, which calls on DOH to adopt standards for respectful care at birth modeled after those established by New York City. The Assembly also passed three bills: Assembly Bill 4930 / Senate Bill 3373 would require DOH to establish maternity care standards throughout prenatal, childbirth, and postpartum periods to reduce complications and adverse outcomes; Assembly Bill 4937 / Senate Bill 3364 would direct DOH to secure federal funding to support maternal mental health initiatives; and Assembly 4941 / Senate Bill 3370 would create a maternity care public awareness campaign. Finally, New Jersey considered multiple bills: Assembly Bill 4931 / Senate Bill 3363 would require hospitals to collect maternity care-related data to improve outcomes; Assembly Bill 4933 / Senate Bill 3377 would survey patients' experiences with prenatal, maternal, and postpartum care; Assembly Bill 4939 / Senate Bill 3372 would give health care providers resources on providing postpartum care; and Assembly Bill 4940 / Senate Bill 3371 would develop a perinatal health curriculum to train community health workers about maternal and infant health and childbirth and breastfeeding. Illinois and New Jersey can serve as a model for other states that want to consider legislation that not only respects women's rights to autonomy and dignity in the health care setting, but also aims to improve birth experiences and overall maternal health outcomes, especially for Black women.

Four states considered policies that would raise awareness of and increase support and treatment specifically for maternal mental health. **Illinois** enacted two bills: House Bill 2897 which requires the Department of Public Health to apply for federal funding to support its maternal mental health program, and House Bill 3511, which requires the Department of Human Services to provide patients and health care providers with information on maternal mental health conditions. **Texas** enacted House Bill 253 which requires the Health and Human Services Commission to create a five-year strategic plan to treat and support women with postpartum depression. **California's** Assembly passed and the Senate considered Assembly Bill 798 to create a pilot program to increase the capacity of health care providers to effectively prevent, identify, and manage postpartum depression and other mental health conditions. **New Jersey's** Senate considered a very similar policy with Senate Bill 1759. **Texas** considered House Bill 2618 / Senate Bill 2301, which would create perinatal mood disorder peer support programs.

Lawmakers in six states adopted resolutions that promote maternal health awareness, urge their state government to improve maternal health outcomes, or call on the Centers for Disease Control and Prevention to study maternal mortality: **Delaware** adopted House Concurrent Resolution 29, **Illinois**

adopted Senate Resolution 63, **Louisiana** adopted House Resolution 294 / Senate Resolution 240, **Michigan** adopted Senate Resolution 33, **New Jersey** adopted Assembly Resolution 226 / Senate Resolution 126, and **Pennsylvania** adopted House Resolution 27 / Senate Resolution 7. **Ohio's** Senate passed a similar resolution, Senate Bill 151. The resolutions passed in Delaware and Michigan specifically recognize Black Maternal Health Week and was the result of the work of the Black Mamas Matter Alliance.

EXPAND ACCESS TO MIDWIFERY AND DOULAS



Expand Access to Midwifery and Doulas

Throughout history, women and others who can become pregnant have given birth in many different circumstances, sometimes with highly skilled medical professionals and compassionate assistance, but often without being able to control or influence the methods used to deliver their children or the medical treatment they receive. Today, many policymakers and reproductive health care professionals understand that the birth process should be driven by the birthing woman herself, rather than others making decisions for her. Enabling women to give birth attended by their chosen provider – whether a physician or midwife – and with a doula if they desire, in the delivery setting they choose not only respects women's autonomy and dignity, but also leads to better health outcomes and fewer interventions.[23] In order to expand access to the types of providers women can choose and the birth setting they prefer, some states have moved to remove legal barriers to home births, expand access to birthing centers outside of hospitals, and broaden the licensing categories for those permitted to deliver babies or provide women with physical and emotional support during pregnancy and birth.

In 2019, five states considered legislation to increase access to midwives and doulas for pregnant women. **Illinois** adopted Senate Joint Resolution 14, which creates a study committee to research and propose consumer-focused and evidence-based solutions to increase the number of providers who can attend home births. **Kentucky** enacted Senate Bill 84 which creates a licensing structure for midwives. **Connecticut's** Senate passed Senate Bill 1078, which would create new doula certification schemes and scope of practice, and allow state certified doulas to be reimbursed by Medicaid for services, and **Rhode Island's** Senate passed similar legislation, Senate Bill 678. **Florida's** House passed House Bill 821, which would add to the list of advanced practice clinicians allowed to perform pregnancy related services like ultrasounds and post-procedure follow ups.

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 the resources for a healthy pregnancy and delivery, and receive the

support she needs as a new mother. Legislation moved in 16 states in 2019 that would expand insurance coverage for many forms of pregnancy-related care.

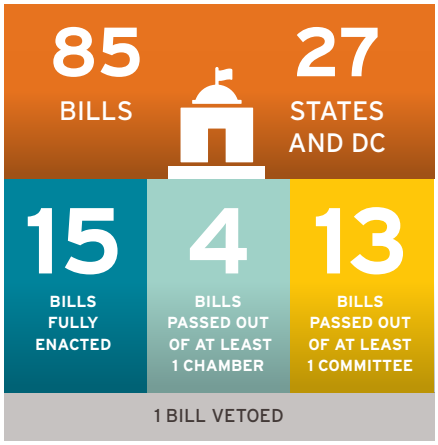
Seven states focused on improving eligibility for insurance plans for pregnant women. **California** enacted Senate Bill 104 / Assembly Bill 103 and Assembly Bill 577, which extends Medicaid eligibility for postpartum women diagnosed with a mental health condition for one year following the last day of their pregnancy. **Maryland** became the third state in the nation to ensure pregnant women can gain health care coverage outside of the six-week open enrollment period when it enacted House Bill 127 (the governor vetoed an identical bill, Senate Bill 36, saying it was duplicative). **North Dakota** (House Bill 1515) and **West Virginia** (Senate Bill 564) enacted legislation expanding Medicaid eligibility for low-income pregnant women. **Iowa** considered Senate Bill 251 which would provide Medicaid coverage to all pregnant women in the state by removing the prohibitions on coverage for certain populations of immigrants. **New Jersey** considered Assembly Bill 4934 / Senate Bill 3374, which would extend Medicaid coverage for pregnant women for a full year after giving birth. **Texas'** House passed similar legislation, House Bill 744 / Senate Bill 147, and considered House Bill 1110. **Texas** also considered House Bill 1879, which would seamlessly and automatically enroll eligible women who are covered under the Healthy Texas Women program and who become pregnant into the more expansive Medicaid plan that their pregnancy now makes them eligible for, to ensure continuity of access to health care services.

Eight states sought ways to improve the services pregnant women have access to when they are enrolled in the state's public health plans or covered by private insurance plans. Recognizing how essential dental care is to maternal and prenatal health,[24] **Colorado** enacted House Bill 1038, which provides dental coverage for pregnant women through the Children's Health Insurance Program. **Illinois** enacted House Bill 2438, which requires insurers to cover treatment for postpartum depression or other mental health conditions during pregnancy or the postpartum period. **New Hampshire** enacted Senate Bill 274, which makes its home visiting program available to all pregnant women and families enrolled in Medicaid. **New Jersey** enacted Assembly Bill 5021 / Senate Bill 3405, which requires Medicaid to cover group prenatal care visits based on a specific model shown to improve birth outcomes for mothers and babies and reduce health disparities related to race and socio-economic status.[25] **New Mexico** enacted Senate Bill 309, which requires insurance plans to cover gynecological and obstetrical ultrasounds without prior authorization.

California considered Assembly Bill 1676, which would require insurers to create a telehealth consultation program to more quickly treat pregnant and postpartum women with mental health conditions. **Massachusetts** considered House Bill 1879 which would require the state's public health programs to cover postpartum screenings for depression.

New York considered Assembly Bill 6381, which would require all insurance plans to cover hospital stays of at least 48 hours after birth for maternity patients and their newborns. In **Texas**, the House passed House Bill 1111, which would require the Health and Human Services Commission to study the costs and benefits of providing Medicaid coverage of telemedicine for prenatal and postpartum care.

BROADENING COVERAGE FOR PREGNANCY CARE



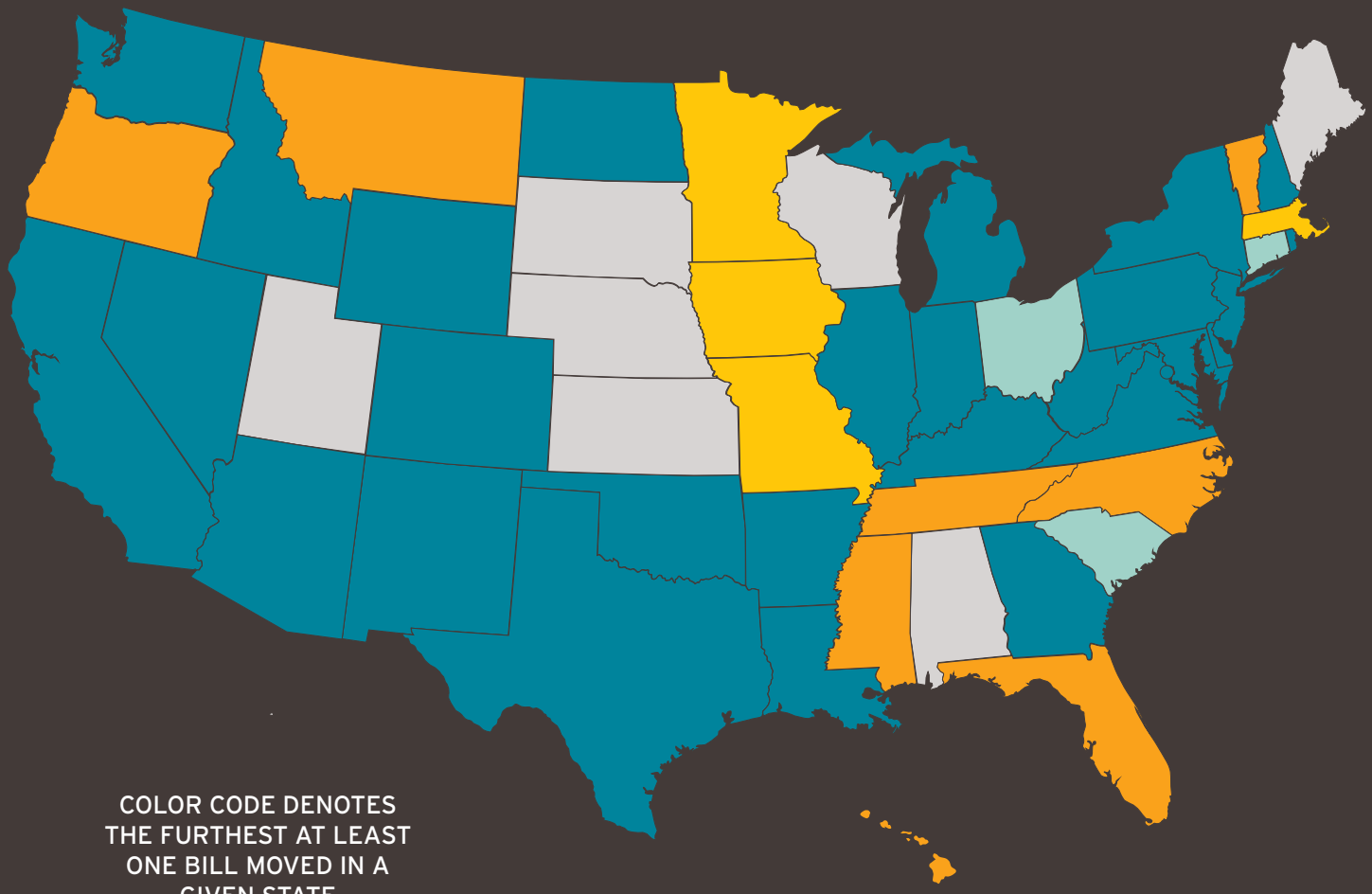
Five states focused on ensuring that pregnant women can have access to the provider of their choice, as well as support from doulas throughout pregnancy. **Indiana** and **New Jersey** enacted Senate Bill 416 and Senate Bill 1784 / Assembly Bill 1662, respectively, which requires their Medicaid programs to cover certified doula services, while **Wyoming** enacted House Bill 43, expanding Medicaid coverage for midwifery services. In **Connecticut**, lawmakers considered Senate Bill 837, which would increase access to nurse-midwives by prohibiting Medicaid from reimbursing nurse-midwives at a rate lower than obstetricians-gynecologists. **Minnesota** considered Senate Bill 855, which would set reimbursement rates for doula services and prohibit prior authorization requirements for initial prenatal or postpartum visits.

Finally, three states moved forward legislation to ensure that their residents have access to fertility services. **California** enacted Senate Bill 600, which requires health insurance plans that provide essential health benefits to also cover medically necessary fertility preservation services while the Assembly passed Assembly Bill 767, which would require the State Exchange program to develop options to provide coverage for in vitro fertilization. **New Hampshire** enacted Senate Bill 279, which requires insurers to cover certain fertility treatments. **Texas** considered a similar piece of legislation, House Bill 2682 / Senate Bill 959.

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 the resources for a healthy pregnancy and delivery, and receive the support she needs as a new mother. Legislation moved in 16 states in 2019 that would expand insurance coverage for many forms of pregnancy-related care.

INCREASING ACCESS TO PREGNANCY CARE

AS OF DECEMBER 15, 2019



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

PROTECTING AND EXPANDING ABORTION IN THE FACE OF RESTRICTIONS

In 2019, states were the key battlegrounds for efforts to restrict and advance access to abortion care.

Anti-abortion lawmakers saw the opportunity to mount a direct challenge to *Roe v. Wade*, and passed laws that not only diminish a woman's right to make decisions about her own body, life, and future, but also endorse the prosecution and punishment of women who obtain abortions and the medical professionals who provide compassionate abortion care.

Reproductive health champions, on the other hand, felt a clear urgency to move swiftly to protect women's health and rights from these and other threats. Having spent the last five years laying the groundwork by introducing and advancing proactive policy, in 2019 pro-choice state legislators passed some of the boldest and most progressive laws in the country, which enshrine the right to abortion in state law and guarantee affordable access to abortion care for everyone who needs it within their states.

New York was the first state to take up the mantle with the enactment of the landmark Reproductive Health Act (RHA), Senate Bill 240 / Assembly Bill 21. In one of the first legislative actions of the year, both chambers passed the bill and, in a rare move signaling the significance of this policy, Governor Andrew Cuomo signed it into law the same day, on the 46th anniversary of *Roe*. The RHA decriminalizes abortion, treating it as a health care matter rather than a criminal act, and recognizes a fundamental right to make reproductive decisions; it also safeguards abortion care by ensuring that qualified health care providers can provide care within their scope of practice without fear of punishment, including after the 24th week of pregnancy if a woman's health or life is in danger or if a fetus is not viable. This victory was a perfect marriage of years of state advocates organizing to build support for this law – through a broad coalition headed up by the National Institute for Reproductive Health, the New York Civil Liberties Union, Planned Parenthood Empire State Acts, and the notable addition of RHAvote whose patient advocacy helped bring to life the need for this policy – and a political moment ushered in by the midterm elections that allowed both longtime champions and newly elected lawmakers to make concrete change on the policies they believe in.

Many other states followed suit with momentous victories to protect abortion rights and expand access. In **Nevada**, where women comprised the majority of state legislators for the first time, reproductive rights soared to the top of the agenda with the enactment of the Trust Nevada Women Act (Senate Bill 179), which removes several restrictions on abortion and decriminalizes self-managed abortion. In a matter of weeks toward the end of their legislative sessions, Illinois, Maine, Rhode Island, and Vermont all enacted proactive policies on abortion.

Pushed by advocates in the state and faced with the sharp contrast of states as close as Missouri and as far as Alabama banning abortion outright, **Illinois** enacted its own RHA (Senate Bill 25), which recognizes that each person has a fundamental right to make decisions about reproductive health care, including abortion, and treats abortion like all other health care, not as a crime. The Illinois debate was marked by a unique cross-state organizing strategy where lawmakers from states that had recently banned abortion came to testify about the need for Illinois to take action. **Maine** then enacted two bills that will greatly expand access to abortion care in the state – House Bill 922 allows all qualified health care providers to offer abortion in accordance with their scope of practice, rather than limiting provision of abortion to physicians, and House Bill 594 requires Medicaid and private insurers to cover abortion services. **Rhode Island**, a state with many outdated anti-abortion laws on the books, faced an uphill battle in passing the Reproductive Privacy Act (House Bill

5125), which codifies abortion rights into state law. After passing the House, the bill was stalled in a Senate committee until advocates and lawmakers galvanized public support to secure its passage, again motivated in part by the draconian restrictions being passed in some states and by the rights-protecting laws being passed in others. Ultimately, the Senate and House passed an updated version of the bill and the governor signed it on the same day. **Vermont** passed the most progressive abortion bill in the country, House Bill 57, which officially recognizes a woman's fundamental right to an abortion and prohibits government from placing any restrictions on it.

Massachusetts, New Hampshire, and New Mexico also advanced similar legislation. After repealing **Massachusetts**' centuries-old criminal abortion ban in 2018, advocates and legislators moved forward the ROE Act (House Bill 3320 / Senate Bill 1209), which would reform the state's laws to ensure that each person who needs an abortion, regardless of age, income, or insurance, can access it. **New Hampshire** attempted to repeal the state's prohibition on using state funds to provide abortion services through a budget bill (House Bill 2) but unfortunately, after being passed by the legislature, the full bill was vetoed by the governor. In **New Mexico**, the House passed House Bill 51, which would have repealed a 50-year old statute that criminalizes abortion providers; while the bill ultimately failed in the Senate, the House's passage marked the first floor action on abortion rights or access in decades in the state. This progress was made possible by the election of new champions in the midterm elections and the momentum built across the state by a diverse and strong coalition of advocates supporting the bill.

These hard-won victories to protect and expand abortion came against a backdrop of outright bans on abortion, as well as continued efforts by state and federal lawmakers to reduce or eliminate access to contraception. The existing challenges, particularly for low-income women and women of color, to manage a pregnancy safely, end a pregnancy, and to raise a family with support are increasing as hostile politicians at the state and federal level target their policies at already marginalized communities. However, in 2019, many advocates and legislative champions used the power of states to push bold, proactive agendas for reproductive freedom. In today's political and legal landscape, when a person's access to abortion is more dependent on their zip code than ever before, progressive lawmakers must build on this momentum and continue to take action to protect rights and eliminate barriers to abortion.

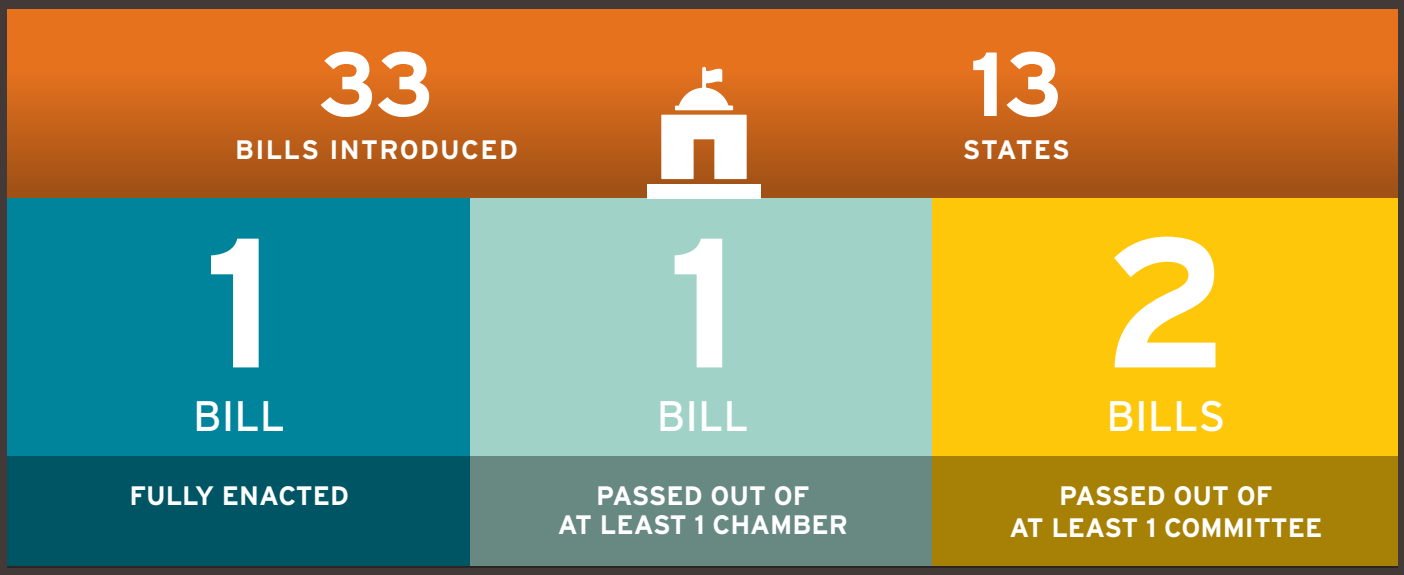
These hard-won victories to protect and expand abortion came against a backdrop of outright bans on abortion, as well as continued efforts by state and federal lawmakers to reduce or eliminate access to contraception.

SECTION 4

PROMOTING COMPREHENSIVE SEXUALITY EDUCATION FOR ALL YOUNG PEOPLE

Young people have a right to lead full and healthy lives, which means having the right information and resources to make informed and independent decisions about their reproductive and sexual health.

PROMOTING COMPREHENSIVE SEXUALITY EDUCATION FOR ALL YOUNG PEOPLE



COMPREHENSIVE SEXUALITY EDUCATION PROGRAMS in schools provide young people with the information and ability to make healthy decisions, and they have also been proven to delay the onset and frequency of sexual activity, increase condom and contraceptive use, and reduce the number of sexual partners.[26] NIRH supports policies that 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 make healthy decisions about relationships, sexuality, and sexual behavior.

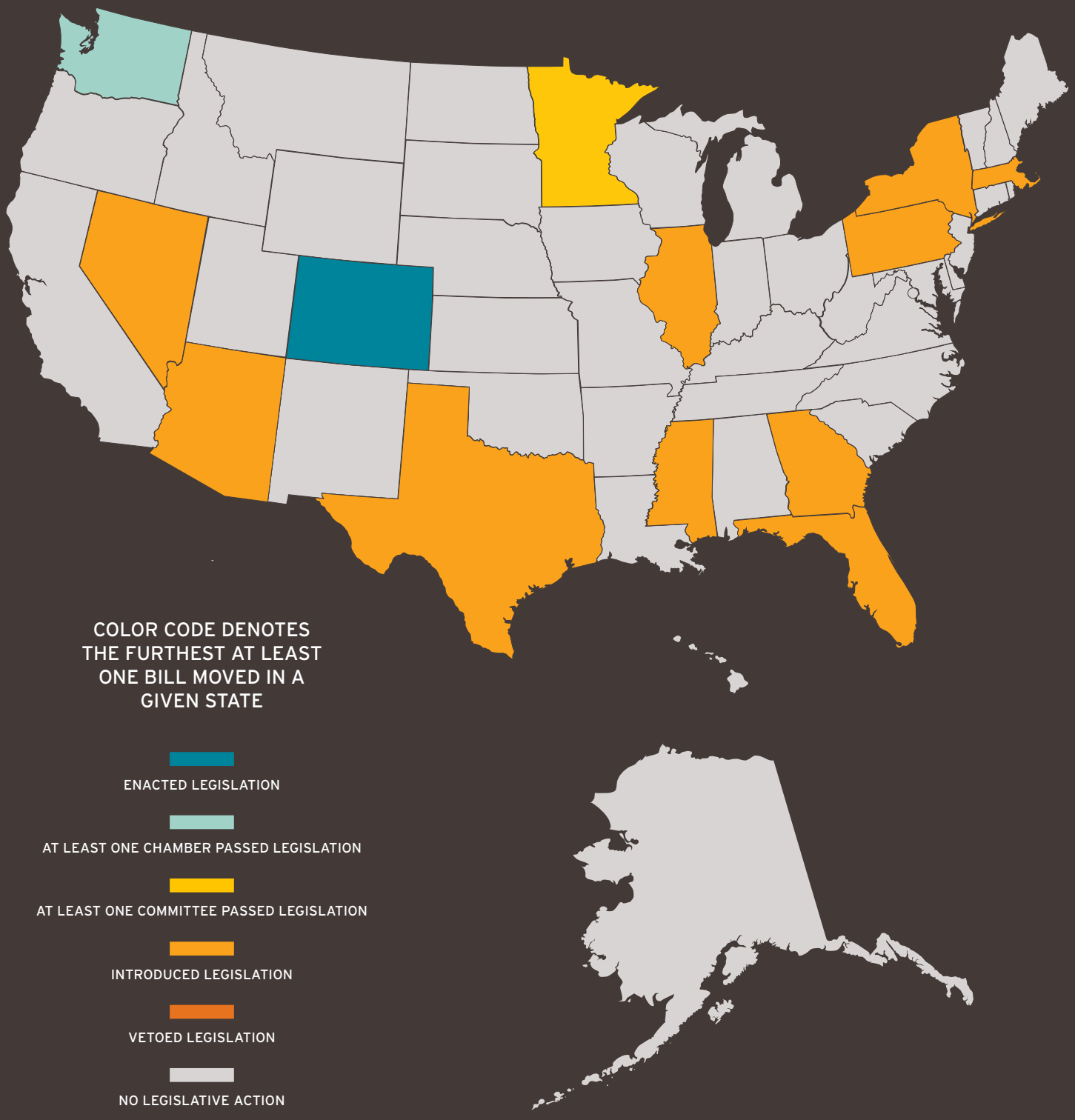
Sexuality education is both a state and local responsibility, providing two avenues to improve on the status quo. While state governments tend to be responsible for setting sexual health education standards, sexuality education curricula are often determined by a combination of state and local laws and school district policies, and implementation largely falls on school districts or even individual schools.

In 2019, three states moved legislation to increase access to comprehensive sexuality education for young people. The **Colorado** state legislature passed and the governor signed House Bill 1032, requiring school districts that choose to provide sexuality education to teach comprehensive sexuality education that includes discussion of all forms of contraception. Furthermore, if schools choose to teach about pregnancy options, they must cover all pregnancy outcome options, including abortion. Supported by a number of state organizations, including the ACLU of Colorado, the Colorado Coalition Against Sexual Assault, Colorado Organization for Latina Opportunity and Reproductive Rights (COLOR), the Interfaith Alliance of Colorado, NARAL Pro-Choice Colorado, Planned Parenthood of the Rocky Mountains, and Positive Women's Network of Colorado, the bill also prohibits public schools from using shame-based or stigmatizing language, employing gender norms or gender stereotypes that can be harmful, or excluding the health needs of intersex or LGBT individuals.

Minnesota considered House Bill 1711 and House Bill 1414 / Senate Bill 2065, which would require the state commissioner of education and other qualified experts to develop a model comprehensive sexuality education program — consisting of written materials, curriculum resources, and training for instructors — that school districts and charter schools can use. **Washington's** Senate passed Senate Bill 5395, which would mandate that age-appropriate, medically and scientifically accurate, and inclusive comprehensive sexuality education be taught in all public schools and at all grade levels by September 2021.

PROMOTING COMPREHENSIVE SEXUALITY EDUCATION FOR ALL YOUNG PEOPLE

AS OF DECEMBER 15, 2019

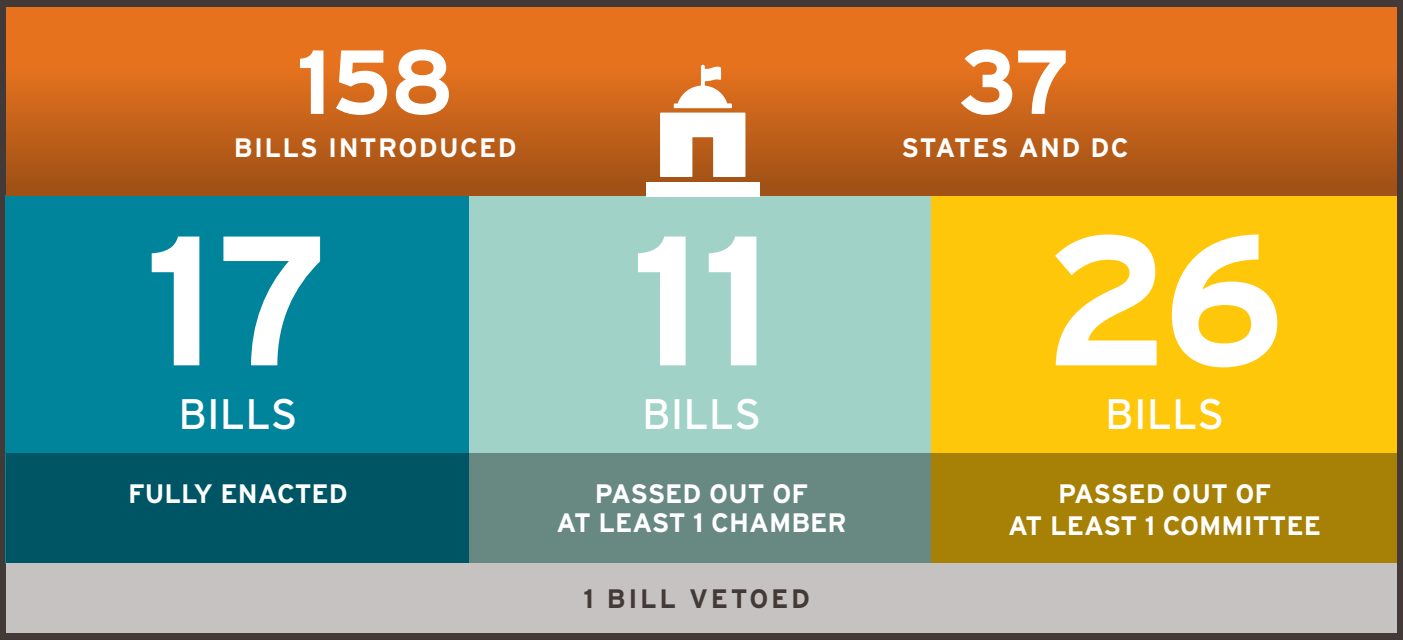


SECTION 5

SUPPORTING PARENTS AND FAMILIES

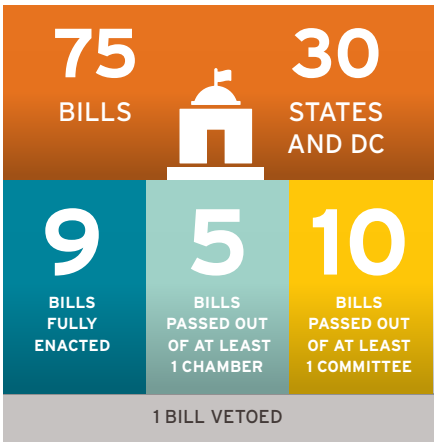
For more than two decades, the reproductive justice movement has pushed our nation to recognize the basic human rights we all share, including the right of all women, transgender men, and other people who can become pregnant to choose when and whether to become parents, and the right of every person to parent their children with dignity and in safety.[27] 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.

SUPPORTING PARENTS AND FAMILIES



AT ALL LEVELS OF GOVERNMENT, the United States continues to lack policies that guarantee important rights and freedoms for parents, including policies to ensure paid family and sick leave, support for mothers who want to return to work but also breastfeed, and pathways for young parents to continue school and enter the workforce as they choose without being subject to stigmatization. States play an important role in supporting healthy families and communities by enacting policies that allow parents the time and support they need to take care of their children.

EXPANDING ACCESS TO PAID FAMILY LEAVE



Expanding Access to Paid Family Leave

Paid family leave impacts the health and well-being of families and communities, helping to ensure that birth mothers have adequate time to heal after labor and delivery, giving new parents time to bond with their children, and promoting gender equality in the home.[28] However, with no federal paid family leave policy, it is up to the states to ensure that policies are in place to support families in having the paid time off they need. This year state lawmakers considered a range of different leave options to support families in their states.

In 2019, California strengthened its existing policy while Connecticut and Oregon joined four states and the District of Columbia in offering paid family leave to employees to bond with a new child and care for themselves or a family member with a serious health condition.[29] **California** enacted Senate Bill 83 which extends its Paid Family Leave benefits from six weeks to eight weeks. **Connecticut** enacted Senate Bill 1 and considered House Bill 5003 and Senate Bill 881 while **Oregon** enacted House Bill 2005, which also allows leave for employees or their dependents experiencing domestic violence, harassment, sexual assault, or stalking, and considered House Bill 3031. **Louisiana** (Senate Bill 186) and **Minnesota** (House Bill 5) considered programs similar to Connecticut's, while **Vermont's** legislature passed House Bill 107, which would provide up to 12 weeks paid leave for pregnancy, birth, or adoption, and up to eight weeks for medical leave.

Three states also considered policies that would give paid leave to some employees. **Virginia** enacted House Bill 2234 / Senate Bill 1581, which provides eight weeks of fully paid parental leave for state employees after the birth, adoption, or foster placement of a child. The **California** legislature passed, but the governor vetoed, Assembly Bill 500, which would allow female employees of school districts, charter schools, and community college districts to take a leave of absence because of pregnancy, miscarriage, or childbirth. The **New York** Senate passed a similar bill, Senate Bill 3821 / Assembly Bill 5875, which would extend paid family leave benefits to lay teachers at religious institutions.

Four states also considered policies to strengthen the benefits that employees are already eligible for under current practices. **New Jersey** enacted Assembly Bill 3975 (and considered the very similar Senate Bill 2528), which increases the number of eligible employees under the existing state paid family leave law and expands the benefits available including increasing the

amount of time an individual can take for leave and increasing the wages they are eligible for. **Washington** enacted House Bill 1399 / Senate Bill 5449, expanding options for how employers can offer paid family leave programs voluntarily to their employees. **California** considered Senate Bill 135, which would increase the number of employees eligible for the state's existing unpaid family and medical leave program, and expand the types of family members that an employee may take time off to care for. **California's** Assembly also passed Assembly Bill 196, which would have increased the wages received through the family temporary disability insurance program. **Hawaii's** state legislature passed but the bill stalled in conference committee, House Bill 1343, which would allow an employee to take a week of family leave each year to care for a seriously ill grandchild as part of the four weeks of family leave currently provided.

Two states focused on disseminating information about existing paid family leave programs. **California** enacted Assembly Bill 406, which requires the application form for paid family leave to be distributed in non-English languages spoken by at least five percent of the population served by the state or local agency. **New Jersey** considered Senate Bill 3210 / Assembly Bill 4836, which would require the DOH and the Department of Labor to create and distribute informational materials on the state's Family Leave Act, to be distributed to health care professionals and facilities providing maternity care.

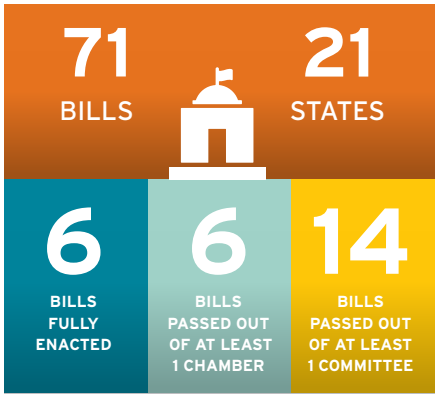
Lastly, **Colorado** enacted Senate Bill 188, creating a task force to develop a paid family and medical leave insurance and benefits program by 2020. **North Dakota** considered Senate Concurrent Resolution 4018 and **West Virginia's** Senate passed Senate Concurrent Resolution 41, similar bills that would commission a study on creating a paid family and medical leave program.

Paid family leave impacts the health and well-being of families and communities, helping to ensure that birth mothers have adequate time to heal after labor.

Providing 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,[30] the American Congress of Obstetricians and Gynecologists,[31] and the World Health Organization[32] have linked breastfeeding with many positive health outcomes for both women and their babies.[33] However, many policies in the United States create barriers for women who want to breastfeed their babies, including limiting access to lactation consultants and 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.[34] In order to ensure that every woman who wants to breastfeed has the opportunity to do so and resources to continue as long as she would like to, states need to enact policies that support breastfeeding and make it possible to nurse and pump in public and

PROVIDING SUPPORT AND ACCOMMODATIONS FOR BREASTFEEDING



In order to ensure that every woman who wants to breastfeed has the opportunity to do so and resources to continue as long as she would like to, states need to enact policies that support breastfeeding and make it possible to nurse and pump in public and private spaces.

private spaces. For more information about protections for nursing mothers against discrimination in the workplace, see "Protecting Against Employment Discrimination" on page 40.

Six states considered legislation focused on improving affordability of and coverage for breastfeeding-related services. **Connecticut** (House Bill 7165) and **Illinois** (House Bill 3509) enacted, **New Jersey's** (Senate Bill 3159 / Assembly Bill 4747) Senate and an Assembly committee passed and **Nevada** (Senate Bill 115) considered, bills that would provide Medicaid coverage for donated breast milk for an eligible child. The **New Jersey** Senate and an Assembly committee also passed Assembly Bill 5509 / Senate Bill 3805, which would require insurance plans to fully cover the costs of lactation support and counseling, as well as breastfeeding equipment. **New York's** state legislature passed a similar bill, Senate Bill 3387 / Assembly Bill 2345, which would provide Medicaid coverage for lactation counseling services without requiring a referral, and the Senate passed Senate Bill 3352 / Assembly Bill 715, which would exempt breast pump equipment from sales and use taxes. **Nebraska's** Legislative Bill 13 passed a committee and would also have exempted breastfeeding equipment from sales tax as well as clarified that breastfeeding does not constitute public indecency.

Seven states considered policies to facilitate breastfeeding in public spaces. **California** enacted Assembly Bill 752, which requires lactation rooms in newly built transit stations. **New Jersey** enacted Senate Bill 1735 / Assembly Bill 1663 to ensure the presence of lactation rooms in public facilities such as health care centers and public assistance agencies, and considered Assembly Resolution 244 and Assembly Resolution 245 to urge the federal government to prohibit airlines from restricting passengers from carrying breast milk on flights. **New York** enacted Senate Bill 748 / Assembly Bill 5424, which allows mothers to be exempt from jury duty while breastfeeding and to postpone their jury duty for two years after the date they were originally called. **Texas** enacted House Bill 541, explicitly extending the right to breastfeed anywhere a woman would otherwise be allowed to be. **Texas** also considered broader legislation, House Bill 243, which would have prohibited interfering with the right to breastfeed and created a private right of action against those who violate this right. Other states focused specifically on the availability of lactation rooms in public areas. **Georgia** (Senate Bill 4 / House Bill 627), **Hawaii** (Senate Concurrent Resolution 170), and **New Hampshire** (House Bill 385) considered policies ensuring lactation rooms in the Capitol Building or Legislative Office Building; and the **New York** Senate passed Senate Bill 1544 / Assembly Bill 8372, which would require lactation rooms in area airports to the extent New Jersey does the same, as the two states regulate their airports through one shared agency.

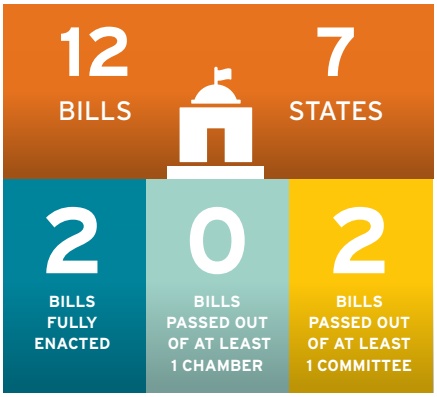
Two states considered committing resources toward studying the racial disparities in breastfeeding rates and identifying solutions. **Minnesota** considered House Bill 1167, which would commission a study of disparities in breastfeeding among different populations and make recommendations based on those results. The **New York** Assembly passed Assembly Bill 6986, a similar bill that would require the DOH to conduct a study on the effects of racial and ethnic disparities on breastfeeding rates with the intention of proposing ways to reduce these disparities.

Supporting Young Parents

Young people who are parenting need support to continue their education, which is critical to their health, well-being, and future success, and to that of their children. In 2019, three states moved legislation intended to make education more accessible for young parents.

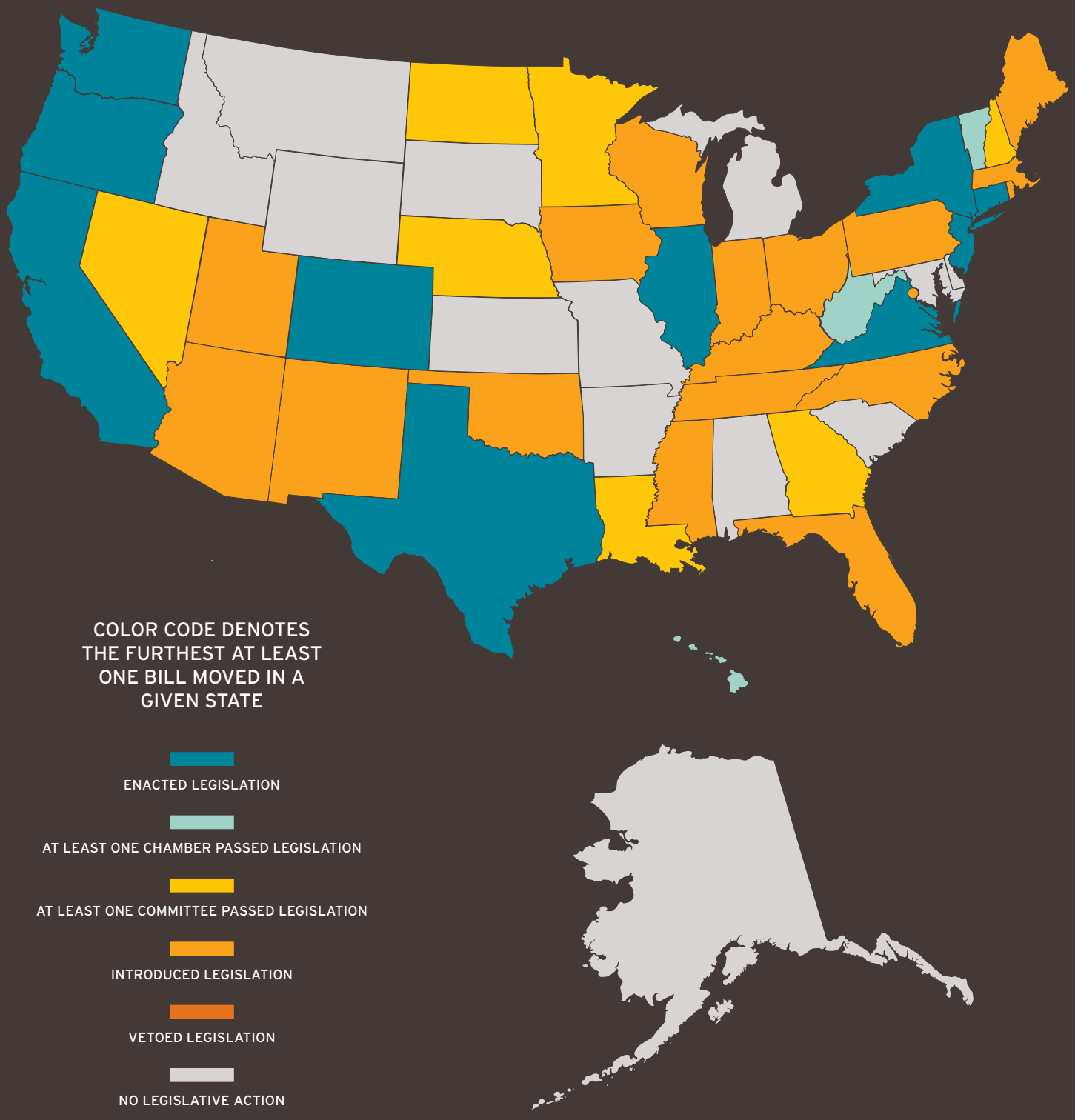
California enacted Assembly Bill 809, which requires public colleges and universities in the state to clarify Title IX protections for students who are pregnant or are parents by including this information on their websites and through their medical centers. **Texas** enacted House Bill 475 / Senate Bill 1290, requiring the Department of Family and Protective Services to offer information and support to youth in foster care who are pregnant or are parents to help them provide safe environments for their children. **Minnesota** considered House Bill 681 / Senate Bill 340, which would allow school districts to be reimbursed for the costs of providing transportation to pregnant or parent students for particular programs established prior to 2018. **Texas** considered House Bill 3003, which would have required public colleges and universities to appoint one employee to be a liaison officer to parenting students under 18 and provide resources to assist them, including information about medical and behavioral health care, parenting and child care resources, and academic success strategies.

SUPPORTING YOUNG PARENTS



SUPPORTING PARENTS AND FAMILIES

AS OF DECEMBER 15, 2019

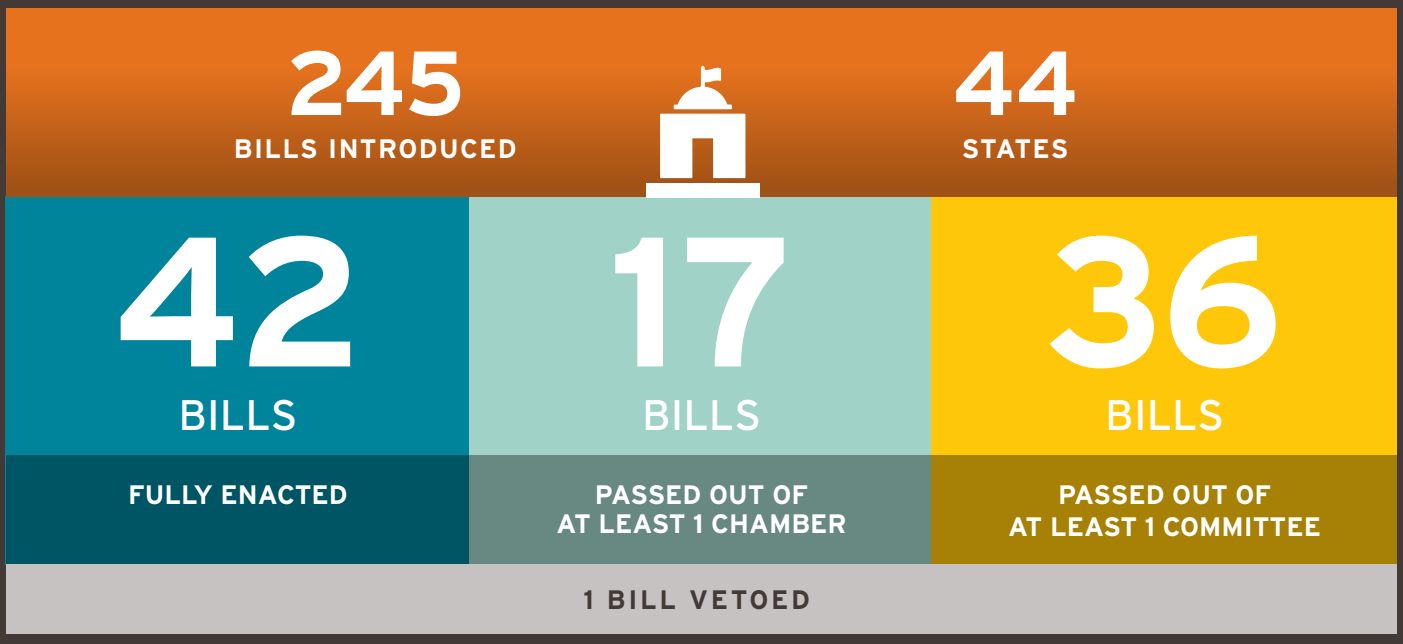


SECTION 6

PROHIBITING INTERFERENCE WITH REPRODUCTIVE HEALTH CARE

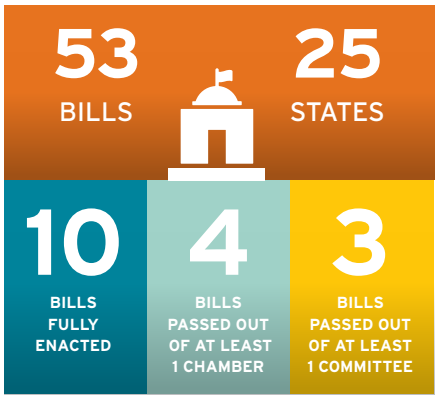
The ability to make reproductive decisions and access health care without coercion is central to reproductive freedom. No one should face discrimination by or coercion from an employer, a school, or a government institution on the basis of their reproductive health needs or decisions, family status, pregnancy, or parenting. NIRH supports policies that move our society away from all institutionalized, accepted, or de facto forms of discrimination based on reproductive health choices. Given the significant role of the state in controlling the healthcare available to incarcerated people, it is even more critical that policies must ensure that all incarcerated women have full access to reproductive health care, including contraception and counseling, abortion, menstrual supplies, STI testing and treatment, prenatal care, adequate nutrition and other basic care during pregnancy, labor and delivery services, and breastfeeding services. Furthermore, no incarcerated person should be shackled during their pregnancy at any point, including during transportation to health care or court, labor and delivery, or postpartum recovery.

PROHIBITING INTERFERENCE WITH REPRODUCTIVE HEALTH CARE



UNFORTUNATELY, SOME FORMS OF DISCRIMINATION on the basis of reproductive decisions or health are still pervasive, particularly for pregnant and parenting people, who continue to face disparate treatment in the terms and conditions of their employment and in their access to and use of public accommodations. Incarcerated pregnant people also need protections from discrimination that they may be subjected to by being denied access to appropriate health care or other needed support by virtue of being incarcerated. Furthermore, thanks in large part to the work of reproductive justice advocates, there is greater recognition that when pregnant women are incarcerated, their reproductive decisions, freedom, and health are at risk. Incarceration, by its very nature, involves a temporary loss of 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. Over the last few years, advocates and policymakers have had increased success in advancing proposals to address some of these forms of discrimination.

PROTECTING AGAINST EMPLOYMENT DISCRIMINATION



Protecting Against Employment Discrimination

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

Some employees face discrimination based on their decisions about whether and when to become parents. Two states moved forward long-awaited legislation to prohibit discrimination based on the reproductive decisions of an employee: **Hawaii** enacted House Bill 710, first introduced in 2018, and **New York** enacted Senate Bill 660 / Assembly Bill 584, after more than five years of work by advocates and lawmakers. **Virginia's** Senate passed a similar policy, Senate Bill 998, which would codify protections against discrimination in employment on the basis of pregnancy, childbirth or related medical conditions, and other protected classifications for state and local government employees.

Many pregnant workers are denied reasonable accommodations that would enable them to continue working and supporting their families, which often means being forced out of their jobs altogether. Eleven states advanced policies that enable women to keep their jobs, experience healthy pregnancies, and breastfeed their babies if they choose to do so. In 2019, **Kentucky** (Senate Bill 18), **Maine** (House Bill 487), and **Oregon** (House Bill 2341) enacted while **New Mexico's** House and a Senate committee passed the Pregnant Workers Fairness Act, which require employers to make reasonable accommodations for workers during their pregnancies — such as allowing an employee to carry a water bottle, sit on a stool while doing her job, or lift less weight — and when they return to work, such as providing time and a private place to pump. Oregon's law goes further, prohibiting employer discrimination or retaliation against pregnant workers who request reasonable accommodations.

Pregnant and nursing mothers also often face high levels of discrimination at work. Eight states considered legislation to address the challenges nursing employees face when they return to work (for more information about broader accommodations outside of the workplace, see "Providing Support

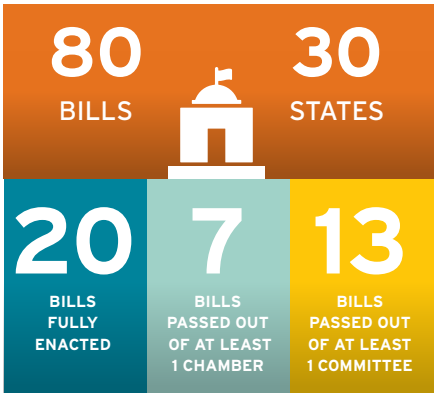
and Accommodations for Breastfeeding" on page 35). **California** enacted Senate Bill 142, which would strengthen employees' rights to breastfeed or pump by updating requirements for lactation spaces, requiring employers to provide workers with reasonable break periods, and protecting employees from discrimination or retaliation for exercising their rights. **New York's** state legislature passed and the governor signed Assembly Bill 5975 / Senate Bill 4211, which updates the definition of "pregnancy-related condition" to explicitly include lactation in order to strengthen protections for workers who are breastfeeding. **Oregon** enacted House Bill 2593, which updates existing law to require more businesses to provide nursing employees with reasonable rest periods during which to pump. **Virginia** enacted House Bill 1916, requiring the Department of Human Resource Management to develop state personnel policies that provide nursing mothers with break times to pump. **Washington** enacted House Bill 1930 / Senate Bill 5911, requiring employers to provide nursing employees with a reasonable amount of break time to pump or nurse, as well as a private place to pump or nurse that is not a bathroom. **Connecticut's** House passed House Bill 7043, a similar policy noting that the space that lactating employees may access to pump must be near an outlet and a refrigerator or storage device in which they can store breast milk. In **South Carolina**, the House passed House Bill 3200 / Senate Bill 406, which would mandate accommodations for nursing mothers including break time, but does not require those breaks to be paid. **Texas** considered House Bill 1041, which amends an existing law that allows public employers to satisfy lactation space requirements by providing employees only with a bathroom to express milk, now requiring those employers to provide a separate dedicated space.

Improving Reproductive Health in the Criminal Justice System

As the rate of women's incarceration rapidly grew to a historic high in the last few decades, reproductive justice organizations began to document the unconscionable treatment that women are subjected to, especially while pregnant, and used these findings to push for policy change along with their coalition allies. The initial wave of these laws proposed by state legislators, more than a decade ago, generally prohibited shackling of incarcerated pregnant women during labor and delivery, and now, 31 states and the District of Columbia had such laws on the books.[35] More recently, advocates have pushed state legislators to consider new, more expansive legislation aimed at prohibiting shackling during pregnancy more broadly as well as meeting the overall needs of incarcerated women, especially access to the full range of reproductive health care, including abortion and prenatal care, health care supplies such as menstrual hygiene products, proper nutrition, support during labor and delivery, and breastfeeding and parenting support after birth.

Five states considered legislation to address the practice of shackling women during pregnancy. **Nebraska** enacted the Healthy Pregnancies for Incarcerated Women Act (Legislative Bill 690), prohibiting shackling of incarcerated individuals throughout pregnancy and during labor and delivery, postpartum recovery or transportation. **Utah** enacted similar legislation, House Bill 318, which prohibits correctional staff from shackling or restraining women during labor,

IMPROVING REPRODUCTIVE HEALTH IN THE CRIMINAL JUSTICE SYSTEM



More recently, advocates have pushed state legislators to consider new, more expansive legislation aimed at prohibiting shackling during pregnancy more broadly as well as meeting the overall needs of incarcerated women, especially access to the full range of reproductive health care.

childbirth, or postpartum recovery while in medical facilities but unfortunately still allows them to use restraints on pregnant and postpartum women during transportation and at other times. **Virginia** enacted Senate Bill 1772, which requires the Board of Corrections to review its policies on shackling pregnant individuals.[36] **Alabama** considered Senate Bill 386 / House Bill 585, which would prohibit shackling during the postpartum period. **Ohio's** Senate passed Senate Bill 18 which would prohibit the use of restraints during pregnancy, labor and delivery, or postpartum recovery. **South Carolina's** House passed a similar policy, House Bill 3967, though unfortunately it allows wrist restraints to be used during transportation.

Five states took a more comprehensive approach, considering legislation that bans shackling and goes further to ensure that women have access to the health care and nutrition they need to stay healthy. **Arkansas** enacted House Bill 1523, which prohibits the use of shackles or restraints on a woman who is pregnant, in labor, or in postpartum recovery, and requires correctional or detention facilities to provide women with prenatal nutrition, hygiene products, and access to prenatal and parenting classes. **Texas** enacted House Bill 1651, which prohibits county jails from shackling pregnant and postpartum women and provides women with obstetrical and gynecological care. **Texas** also enacted House Bill 650, a comprehensive bill that requires the State Department of Criminal Justice to train correctional officers on the health care needs of pregnant women and provide pregnant women with information on prenatal care and parenting, ensure that pregnant women receive proper nutrition and menstrual supplies, and review and study visitation policies that strengthen the relationship between a mother and her child, as well as limiting the use of solitary confinement. **California** considered Assembly Bill 732, which would ensure that incarcerated pregnant women have access to prenatal and postpartum care and menstrual products, and are not shackled or placed in solitary confinement throughout pregnancy, during labor, and in recovery. **Missouri** considered House Bill 920, which would ban shackling during the third trimester, labor, delivery, and recovery; make women who are in their third trimester or have high-risk pregnancies eligible for furloughs; require local jails to establish procedures for the intake and care of pregnant individuals; and require correctional facilities to ensure that an appropriate number of menstrual products are made available for free. **New Jersey's** Assembly and a Senate committee passed Assembly Bill 3979 / Senate Bill 2540, which would require correctional facilities to ban shackling of pregnant and postpartum individuals, provide free health care and hygiene products, offer drug abuse and mental health programs, and adopt policies and a visitation program that support parents.

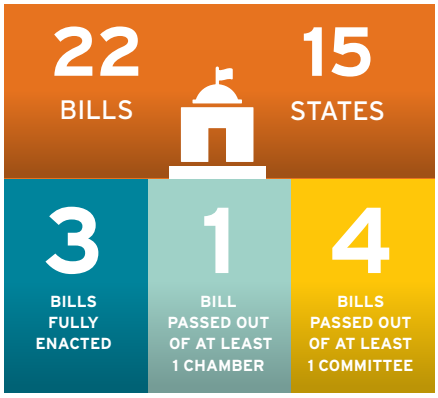
Three states took bold action to improve the health and lives of incarcerated women by considering bills that address the practice of solitary confinement. **Georgia** enacted House Bill 345, which prohibits immediate postpartum women from being held in solitary confinement as well as the use of shackles throughout pregnancy. **Maryland**, a state with some of the strongest protections for incarcerated women, enacted Senate Bill 809 / House Bill 745, prohibiting the solitary confinement of pregnant women — a move inspired by a formerly incarcerated woman sharing her story of being held in solitary confinement in the Maryland Correctional Institution for 24 hours a day while she was eight months pregnant.[37] The bill was championed by

Reproductive Justice Inside, a statewide coalition formed in 2017 to increase access to quality sexual and reproductive health care in Maryland's correctional and detention facilities. The bill's author, State Senator Susan Lee, said, "By ending the practice of placing pregnant and post-pregnant women in solitary confinement, Maryland is again a national leader in restoring and ensuring the dignity for incarcerated women. This archaic practice flies in the face of public health, decency, and global rules about incarceration."[38] While Maryland was the first state in the nation to pass this kind of legislation, New Jersey quickly followed. Originally vetoed in 2016, **New Jersey** passed and the governor signed Assembly Bill 314 / Senate Bill 3261, which prohibits the placement of women who are pregnant, postpartum, breastfeeding, or recently had an abortion or miscarriage in solitary confinement.

Eight states worked on standalone legislation to ensure that incarcerated women have the hygiene products they need. **Alabama**, **Colorado**, **Maine** and **Oregon** enacted House Bill 308, House Bill 1224, House Bill 457, and House Bill 2515, respectively, all requiring their respective state Departments of Corrections to provide incarcerated women with feminine hygiene products at no cost, while **Missouri's** House passed House Bill 303 and considered House Committee Bill 2. **Florida** (House Bill 49 / Senate Bill 332) and **Tennessee** (House Bill 129 / Senate Bill 75) enacted legislation that goes further and requires correctional facilities to provide individuals with a wide array of personal hygiene products for free, including menstrual products, moisturizing soap, and toothbrushes and toothpaste. **Texas** enacted House Bill 2169, which requires the county jails to make quality menstrual products available for sale.

Six states moved forward legislation that would address other specific issues impacting incarcerated women. **California** enacted Senate Bill 394, which allows a judge to set up a program for defendants who are primary caregivers that allows them to continue to parent their children. **New Mexico** enacted two bills: Senate Bill 124 requires correctional facilities to develop a breastfeeding and lactation policy, and Senate Bill 192, first introduced in 2018, requires courts to consider an individual's pregnancy and lactation status when determining eligibility for release, bond, or time served. **Utah** enacted House Bill 398, which establishes a committee to review existing policies and procedures surrounding reproductive health care for incarcerated individuals and make recommendations to improve access. **New Jersey** considered six bills – Senate Bill 3278 / Assembly Bill 4926 which would require the Department of Corrections to provide prenatal and postpartum education and services, as well as birth control, abortion care, and child placement services; Senate Bill 3279 / Assembly Bill 4925 which would provide emergency contraception; and Senate Bill 3281 / Assembly Bill 4923 which would provide family planning services to women prior to their release. **New York** considered Assembly Bill 118 / Senate Bill 3126, which would ensure that incarcerated women have access to the full range of reproductive and sexual health care including pregnancy counseling, prenatal care, abortion care, and the right to have access to a chosen support person during birth. **Texas'** House passed House Bill 2701, which would require county correctional officers to undergo training on how to treat incarcerated pregnant women, and House Bill 3303, which would require judges to consider an individual's status as the sole caretaker of a child when modifying their community supervision requirements.

PROHIBITING OR REMEDIATING COERCION IN REPRODUCTIVE DECISION-MAKING



Prohibiting or Remediating Coercion in Reproductive Decision-Making

In the United States and in many places around the world, governments have had a long and ugly history of reproductive violence and coercion, including forced sterilizations, abortions, pregnancies, and births. Forced sterilization has occurred for a variety of discriminatory reasons based on racism, sexism, ableism, and other types of harmful social engineering goals pursued at various times by different leaders of nations and states.[39] In this century, the United States and other countries have begun a slow reckoning with that history, often led by reproductive justice advocates, and states have begun to examine policies to address reproductive coercion and abuse by state actors.

At the height of the United States' eugenics movement, disabled people, in particular, were considered unfit to be parents and more than 70,000 people were forcibly sterilized during the 20th century alone.[40] While many states no longer permit forcible sterilization, some states still have laws on the books that allow people with disabilities to be sterilized without their consent. In 2019, pushed by advocates in the state, **Illinois** policymakers enacted legislation to empower disabled people to make decisions about their reproductive and sexual lives – House Bill 3299 provides individuals in developmental disability facilities with comprehensive sexuality education and resources that support their right to sexual health and healthy sexual practices, and to be free from sexual exploitation or abuse. This bill was supported by the Illinois Coalition Against Sexual Assault and The Arc, an advocacy organization for people with intellectual and developmental disabilities. In Nevada, the Nevada Disability Advocacy and Law Center raised concerns that a state law dating back to 1933 gave guardians and judges broad authority to seek and permit the sterilization of disabled people without considering their wishes.[41] **Nevada** enacted Assembly Bill 91, strengthening protections for disabled people by providing them with a guardian ad litem to represent their best interests and make recommendations on their behalf.

California was one of the states that led the country in the number of forced sterilizations upon people in state institutions, specifically targeting Latinas.[42] Beginning in 1909 and continuing into present times, California has performed sterilization procedures on 20,000 people who lived in state homes or hospitals, were disabled, or were incarcerated – nearly one-third of the national total – often without their full knowledge and consent.[43] Although the state repealed the law permitting such sterilizations in 1979 and recognized and apologized for those practices in 2003, a state audit report found that California continued to forcibly sterilize other people within its control, including women in prison, as recently as 2013.[44] Building on legislation that moved forward for the first time in 2018, in 2019, **California** considered Assembly Bill 1764, which would establish the Forced or Involuntary Sterilization Compensation Program to compensate individuals who were sterilized under the state's eugenic laws from 1909 to 1979 and expand eligibility to also include individuals sterilized under coercive policies in correc-

tional facilities after 1979. While this bill cannot fix the legacy and continued practice of sterilization or government-backed reproductive coercion, Laura Jimenez, executive director of California Latinas for Reproductive Justice, who supported the bill, said, "this bill is a step in the right direction in remedying the violence inflicted on these survivors."[45]

As the #MeToo movement has gained momentum since 2017, our nation continues to grapple with consent and the ways that institutions have allowed or even condoned the harassment and sexual assault of their students, patients, or employees. In 2018, patients and doctors raised awareness about a common but little known practice wherein teaching hospitals allow medical students to perform pelvic exams on patients who are under anesthesia, without the patient's knowledge or consent.[46] While the American College of Obstetricians and Gynecologists[47], the American Medical Association[48], and the Association of American Medical Colleges[49] have condemned this practice, few states have taken steps to prohibit this clearly harmful practice. In 2019, three states considered legislation to prohibit physicians from performing, instructing, or supervising unauthorized pelvic examinations on sedated or unconscious patients without consent: **New York's** Senate Bill 1092 / Assembly Bill 6325 was enacted, **Michigan's** House Bill 4958 passed one chamber, and **Texas** House Bill 3017 and **Washington's** Senate Bill 5282 were considered.

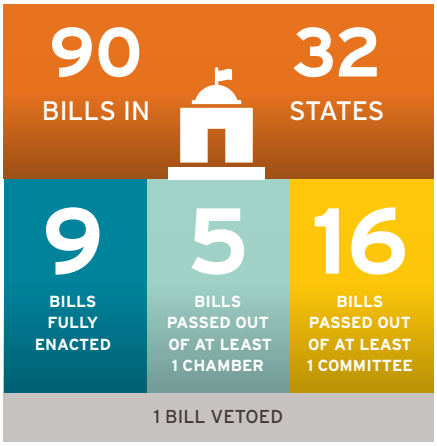
Achieving Menstrual Equity

In order for women and others who menstruate to participate fully and equally in society, menstrual hygiene products must be safe, accessible, and available to all who need them. Having access to menstrual products is vital to participating in public life, school, and work, and women who are unable to afford sanitary pads or tampons risk isolation and infection. Nonetheless, despite the fact that half of the world's population menstruates, women, girls, transgender men, and other people who menstruate still face financial and logistical challenges when it comes to managing their periods.[50] An average woman menstruates for roughly four decades of her life – meaning that each month for 40 years, she must purchase menstrual supplies.

The cost of menstrual supplies, including the tax on those supplies, can be a meaningful burden for women and girls living in poverty, who are often forced to choose between purchasing menstrual supplies or their next meal. Many states tax menstrual supplies as "luxury items" instead of treating them as necessities like food and medicine (notably, many states tax diapers in the same way). Over the past few years, a number of states have enacted laws to end the so-called "Tampon Tax" by removing the tax on menstrual supplies. Recently, some states have expanded on these laws to provide free menstrual products in schools, homeless shelters, and jails (read more under "Improving Reproductive Health in the Criminal Justice System" on page 41), and to ensure that menstrual products are safe and free of harmful chemicals.

In 2019, 10 states considered legislation to lower or remove these sex-specific taxes from the books. **Ohio** (Senate Bill 26), **Rhode Island** (House Bill 5151), and **Utah** (Senate Bill 2001 b) enacted laws to exempt menstrual products

ACHIEVING MENSTRUAL EQUITY



Having access to menstrual products is vital to participating in public life, school, and work, and women who are unable to afford sanitary pads or tampons risk isolation and infection.

from their state's sales tax and four states moved forward similar legislation: **California** (Assembly Bill 31); **Louisiana** (Senate Bill 5); **Maine** (House Bill 210); and **Washington** (House Bill 1053 / Senate Bill 5147 and Senate Bill 5206). **Louisiana** considered Senate Bill 4, which would propose a constitutional amendment to make menstrual products and diapers exempt from state sales tax. **New Mexico** considered House Bill 119, which would allow residents to claim a tax deduction for menstrual products. Meanwhile in Virginia and Missouri, where nearly all goods are taxed, **Virginia** enacted House Bill 2540 / Senate Bill 1715, which reduces the tax on menstrual products to the same rate as food, and **Missouri** considered House Bill 747, which would lower the tax on menstrual products, diapers, and incontinence products to one percent.

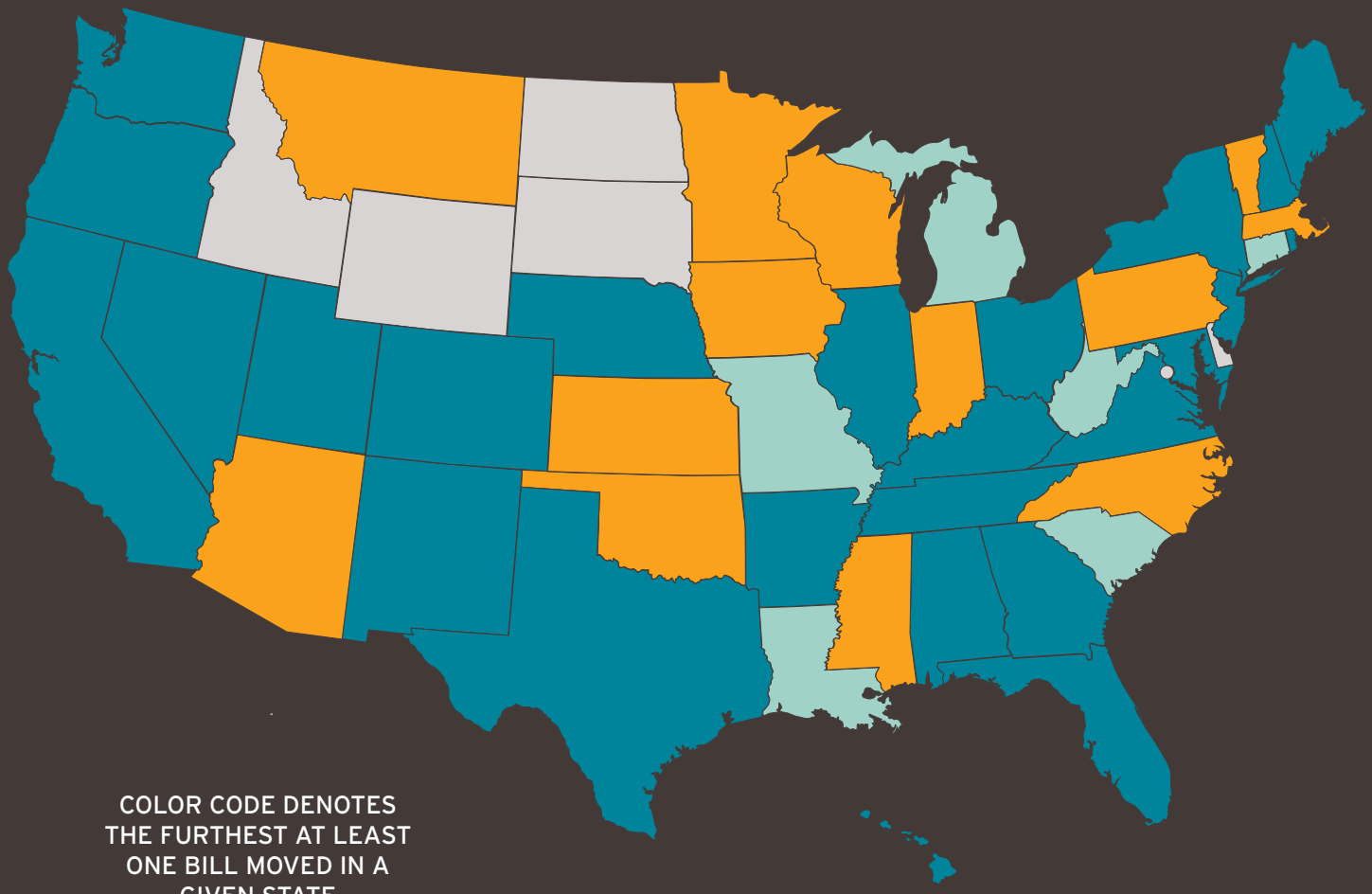
Seven states moved bills to provide free menstrual products in schools. **New Hampshire** enacted Senate Bill 142, which requires school boards to provide menstrual products at no cost in all female and gender-neutral restrooms in public middle and high schools. **Tennessee** enacted House Bill 1483 / Senate Bill 1046, which authorizes local education boards to provide free menstrual products in public schools. **Illinois** considered House Bill 922 and **West Virginia's** Senate passed Senate Bill 86 / House Bill 2464, both of which would require public secondary schools to make menstrual products available for free to students, while **New Mexico** considered House Bill 21, which would offer free products in all public schools. **New Jersey** considered Senate Bill 3645, which would require public secondary schools in districts where nearly half of the students live in poverty to provide free menstrual products. In **New York**, where public school students can access menstrual products for free under a law passed in 2018, the state legislature passed Assembly Bill 290 / Senate Bill 3125 to include charter schools, but the governor vetoed the bill.

California, Illinois, and New York moved forward legislation to provide specific populations with menstrual products. **California** enacted Assembly Bill 175, which gives youth in foster care the right to receive clothing, grooming, and hygiene products that respect their gender identity and expression, culture, and ethnicity, as well as the right to receive reproductive and sexual health care. **New York** enacted Assembly Bill 484 / Senate Bill 6368 / Senate Bill 1016 which would have educated students about menstrual disorders and symptoms. **Illinois'** House and a Senate committee passed House Bill 2656, and **New York** considered Assembly Bill 686, which would each have provided free menstrual products at homeless shelters.

In 2013, a report by Women's Voices for the Earth examined the potential health hazards associated with the chemicals used in menstrual products such as tampons and sanitary pads, which are used by 70 percent to 85 percent of women.[51] In 2019, after years of advocacy, **New York** enacted Assembly Bill 164 / Senate Bill 2387, which requires menstrual products sold in the state to have a list of ingredients printed on the box.

PROHIBITING INTERFERENCE WITH REPRODUCTIVE HEALTH CARE

AS OF DECEMBER 15, 2019



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

2019 was a year packed with legislative action on reproductive health, rights, and justice — particularly in the battle for abortion rights and access. We saw the hard work of advocates and lawmakers come to fruition with the passage of legislation that had been in the works for decades, as well as huge leaps forward in states that recognized the threats to abortion and contraception at the federal level and acted quickly to protect it in their states. We also saw more states begin to tackle the pressing issue of maternal health and to find policy responses to the reprehensible levels of maternal mortality and morbidity among Black women and other women of color.

Yet the anti-abortion movement also doubled down, and 2019 was marked by the rapid passing of draconian bans on abortion access in a number of states across the country, as lawmakers there increasingly invite the federal government and the Supreme Court to weaken or overturn existing constitutional protections. This creates an even more urgent call for state advocates and lawmakers to continue the fight for reproductive freedom. States certainly rose to the challenge in 2019 and will undoubtedly continue to push forward with policies that protect reproductive freedom and expand access to services and supports that everyone needs to live full and healthy reproductive lives. In 2020, this will unfold against the backdrop of the 2020 elections, in which issues of women's rights, health, and autonomy — including reproductive rights and access to abortion care — will likely be front and center.

There are opportunities at every level of government to help secure reproductive freedom for all. NIRH is extremely grateful to the reproductive health, rights, and justice movements in the states, including our partners this year from 25 states, who worked tirelessly to push for change — often against seemingly insurmountable odds. We applaud the extraordinary efforts and exciting successes of advocates and policymakers who have led these efforts, and we look forward to supporting similar initiatives in 2020. Together, we can continue the forward progress toward making our country a place where everyone has the freedom and ability to control their reproductive and sexual lives.

APPENDIX: BILL INDEX BY STATE

ST	BILL	TITLE AS FILED	SECTION	PAGE(S)
AL	AL H 308	County Jails and State Penitentiaries	Prohibiting Interference with Reproductive Health Care	43
AL	AL H 585	Prisons and Prisoners	Prohibiting Interference with Reproductive Health Care	42
AL	AL S 386	Prisons and Prisoners	Prohibiting Interference with Reproductive Health Care	42
AR	AR H 1290	Practice of Pharmacy	Improving Access to Contraception	17
AR	AR H 1440	Maternal Mortality Review Committee	Increasing Access to Pregnancy Care	21
AR	AR H 1441	Maternal and Perinatal Outcomes Quality Committee	Increasing Access to Pregnancy Care	21
AR	AR H 1523	Treatment of Female Inmates	Prohibiting Interference with Reproductive Health Care	42
AZ	AZ S 1040	Maternal Fatalities and Morbidity	Increasing Access to Pregnancy Care	21
CA	CA A 31	Sales and Use Taxes: Sanitary Napkins: Tampons	Prohibiting Interference with Reproductive Health Care	46
CA	CA A 83	Employment	Supporting Parents and Families	34
CA	CA A 103	Health	Increasing Access to Pregnancy Care	25
CA	CA A 175	Foster Care: Rights	Prohibiting Interference with Reproductive Health Care	46
CA	CA A 196	Paid Family Leave	Supporting Parents and Families	35
CA	CA A 406	Disability Compensation: Paid Family Leave: Application	Supporting Parents and Families	35
CA	CA A 414	Healthcare Coverage: Minimum Essential Coverage	Improving Access to Contraception	16
CA	CA A 500	School and Community College Employees: Maternity Leave	Supporting Parents and Families	34
CA	CA A 577	MediCal: Maternal Mental Health	Increasing Access to Pregnancy Care	25
CA	CA A 732	County Jails: Prisons: Incarcerated Pregnant Persons	Prohibiting Interference with Reproductive Health Care	42
CA	CA A 752	Public Transit: Transit Stations: Lactation Rooms	Supporting Parents and Families	36
CA	CA A 767	Health Care Coverage: Infertility	Increasing Access to Pregnancy Care	26
CA	CA A 798	Maternal Mental Health	Increasing Access to Pregnancy Care	23
CA	CA A 809	Public Postsecondary Education: Child Development	Supporting Parents and Families	37
CA	CA A 1524	Medi-Cal: Provider Enrollment	Improving Access to Contraception	16
CA	CA A 1676	Health Care: Mental Health	Increasing Access to Pregnancy Care	25
CA	CA A 1764	Forced Or Involuntary Sterilization Compensation	Prohibiting Interference with Reproductive Health Care	44
CA	CA ACR 110	Access to Reproductive Care and Expanding Access to Abortion Care Services	Expanding Access to Abortion Care	11
CA	CA HR 6	Women's Reproductive Health	Expanding Access to Abortion Care	11
CA	CA S 24	Student Health Centers: Expanding Access to Abortion Care by Medication	Expanding Access to Abortion Care	9
CA	CA S 104	MediCal Eligibility	Increasing Access to Pregnancy Care	25
CA	CA S 135	Paid Family Leave	Supporting Parents and Families	35
CA	CA S 142	Employees: Lactation Accommodation	Prohibiting Interference with Reproductive Health Care	41
CA	CA S 301	Medi-Cal: Family Planning Services	Improving Access to Contraception	18
CA	CA S 394	Criminal Procedure: Diversion for Primary Caregivers	Prohibiting Interference with Reproductive Health Care	43
CA	CA S 464	California Dignity in Increasing Access to Pregnancy Care and Childbirth Act	Increasing Access to Pregnancy Care	22
CA	CA S 600	Health Care Coverage: Fertility Preservation	Increasing Access to Pregnancy Care	26
CA	CA SJR 4	Title X	Expanding Access to Abortion Care	11
CA	CA SR 7	Women's Reproductive Health	Expanding Access to Abortion Care	11

APPENDIX (CONTINUED)

ST	BILL	TITLE AS FILED	SECTION	PAGE(S)
CO	CO H 1032	Comprehensive Human Sexuality Education	Promoting Comprehensive Sexuality Education for All Young People	31
CO	CO H 1038	Dental Services for Pregnant Women	Increasing Access to Pregnancy Care	25
CO	CO H 1122	Maternal Mortality Review Committee	Increasing Access to Pregnancy Care	21
CO	CO H 1224	Hygiene Products for Women In Custody	Prohibiting Interference with Reproductive Health Care	43
CO	CO S 188	Family Medical Leave Insurance Program	Supporting Parents and Families	35
CT	CT H 5003	Family and Medical Leave Insurance Program	Supporting Parents and Families	34
CT	CT H 7043	Breastfeeding in the Workplace	Prohibiting Interference with Reproductive Health Care	41
CT	CT H 7070	Deceptive Advertising Practices	Expanding Access to Abortion Care	10
CT	CT H 7165	Medicaid Coverage for Donor Breast Milk	Supporting Parents and Families	36
CT	CT S 1	Family and Medical Leave Insurance Program	Supporting Parents and Families	34
CT	CT S 394	Quality Health Care for Women	Expanding Access to Abortion Care	9
CT	CT S 837	Medicaid Payment Rates for Nurse Midwives	Increasing Access to Pregnancy Care	26
CT	CT S 881	Paid Family and Medical Leave Program	Supporting Parents and Families	34
CT	CT S 1078	Doula Certification and Medicaid Reimbursement	Increasing Access to Pregnancy Care	24
DC	DC B 468	Investigating Maternal Mortalities	Increasing Access to Pregnancy Care	22
DC	DC B 469	Investigating Maternal Mortalities	Increasing Access to Pregnancy Care	22
DC	DC R 484	Emergency Declaration Resolution	Increasing Access to Pregnancy Care	22
DE	DE HCR 29	Black Maternal Health Awareness Week Resolution	Increasing Access to Pregnancy Care	23
FL	FL H 49	Incarcerated Women	Prohibiting Interference with Reproductive Health Care	43
FL	FL H 579	Long Acting Reversible Contraception Pilot Program	Improving Access to Contraception	15
FL	FL H 821	Advanced Practice Registered Nurses	Expanding Access to Abortion Care	24
FL	FL S 332	Incarcerated Women	Prohibiting Interference with Reproductive Health Care	43
FL	FL S 410	Long Acting Reversible Improving Access to Contraception Pilot Program	Improving Access to Contraception	15
GA	GA H 345	Pregnant Inmates	Prohibiting Interference with Reproductive Health Care	42
GA	GA H 627	Private Lactation Room Provisions	Supporting Parents and Families	36
GA	GA HR 589	House Study Committee on Maternal Mortality	Increasing Access to Pregnancy Care	21
GA	GA S 4	Private Lactation Room at the Capitol Building	Supporting Parents and Families	36
HI	HI H 36	Department of Human Services	Improving Access to Contraception	15
HI	HI H 357	Termination of Pregnancy	Expanding Access to Abortion Care	9
HI	HI H 710	Employment Practices	Prohibiting Interference with Reproductive Health Care	40
HI	HI H 935	Scope and Practice of Physician Assistants	Expanding Access to Abortion Care	9
HI	HI H 1343	Family Leave	Supporting Parents and Families	35
HI	HI S 415	Termination of Increasing Access to Pregnancy Care	Expanding Access to Abortion Care	9
HI	HI S 526	Homeless Person Mobile Clinics	Improving Access to Contraception	15
HI	HI S 698	Sustainable Development Goals	Improving Access to Contraception	15
HI	HI SCR 170	Breastfeeding Room	Supporting Parents and Families	36
IA	IA S 251	Pregnant Women Medicaid Coverage	Increasing Access to Pregnancy Care	25
IA	IA S 348	Self Administered Hormonal Contraceptives	Improving Access to Contraception	17
IA	IA S 513	Self Administered Hormonal Contraceptives	Improving Access to Contraception	17

APPENDIX (CONTINUED)

ST	BILL	TITLE AS FILED	SECTION	PAGE(S)
ID	ID H 109	Maternal Mortality Review Committee	Increasing Access to Pregnancy Care	21
IL	IL H 1	Task Force on Infant and Maternal Mortality	Increasing Access to Pregnancy Care	22
IL	IL H 2	Pregnant and Childbirth Medical Patient Rights	Increasing Access to Pregnancy Care	22
IL	IL H 3	Infant and Maternal Mortality Reports	Increasing Access to Pregnancy Care	23
IL	IL H 5	Substance Use and Mental Health Services Access	Increasing Access to Pregnancy Care	23
IL	IL H 6	Women Health Clinic Requirements	Improving Access to Contraception	14
IL	IL H 922	Schools Feminine Hygiene Products Availability	Prohibiting Interference with Reproductive Health Care	46
IL	IL H 1442	Public Health Powers and Duties Law	Improving Access to Contraception	17
IL	IL H 2438	Insurance Code	Increasing Access to Pregnancy Care	25
IL	IL H 2467	Abortion Parental Notice	Expanding Access to Abortion Care	9
IL	IL H 2656	Feminine Hygiene Products for the Homeless	Prohibiting Interference with Reproductive Health Care	46
IL	IL H 2895	Maternal Condition Hospital Educational Training	Increasing Access to Pregnancy Care	22
IL	IL H 2897	Maternal Mental Health Federal Grant	Increasing Access to Pregnancy Care	23
IL	IL H 3299	Mental Health and Developmental Disabilities	Prohibiting Interference with Reproductive Health Care	44
IL	IL H 3509	Donated Breast Milk	Supporting Parents and Families	36
IL	IL H 3511	Maternal Mental Health Conditions Education	Increasing Access to Pregnancy Care	23
IL	IL S 25	Reproductive Health Act	Expanding Access to Abortion Care	8, 28
IL	IL S 1594	Parental Notice of Expanding Access to Abortion Care Act	Expanding Access to Abortion Care	9
IL	IL SJR 14	Home Birth Maternity Care Crisis Study Committee	Increasing Access to Pregnancy Care	24
IL	IL SR 63	Maternal Mortality Prevention Improvement	Increasing Access to Pregnancy Care	23
IN	IN S 416	Medicaid Coverage for Services	Increasing Access to Pregnancy Care	26
KY	KY S 18	Increasing Access to Pregnancy Care Related Discrimination	Prohibiting Interference with Reproductive Health Care	40
KY	KY S 84	Licensed Certified Professional Midwives	Increasing Access to Pregnancy Care	24
LA	LA HR 294	Health Care	Increasing Access to Pregnancy Care	24
LA	LA S 4	Tax and Sales	Prohibiting Interference with Reproductive Health Care	46
LA	LA S 5	Tax and Sales	Prohibiting Interference with Reproductive Health Care	46
LA	LA S 186	Employment	Supporting Parents and Families	34
LA	LA SR 240	Health Care	Increasing Access to Pregnancy Care	24
MA	MA H 1879	Postpartum Depression Screenings	Increasing Access to Pregnancy Care	25
MA	MA H 3320	Women's Reproductive Health	Expanding Access to Abortion Care	29
MA	MA S 1209	Abortion Access Expansion	Expanding Access to Abortion Care	29
MD	MD H 127	Health Benefit Plans	Increasing Access to Pregnancy Care	25
MD	MD H 583	Maternal Mortality Review Program	Increasing Access to Pregnancy Care	21
MD	MD H 745	Correctional Facility Pregnant Inmate Policy	Prohibiting Interference with Reproductive Health Care	42
MD	MD H 796	Maternal Mortality Review Program	Increasing Access to Pregnancy Care	21
MD	MD H 1272	Family Planning Program	Improving Access to Contraception	18
MD	MD S 36	Health Insurance Health Benefit Plans	Increasing Access to Pregnancy Care	25
MD	MD S 356	Maternal Mortality Review Program	Increasing Access to Pregnancy Care	21
MD	MD S 602	Maternal Mortality Review Program	Increasing Access to Pregnancy Care	21
MD	MD S 809	Correctional Facilities	Prohibiting Interference with Reproductive Health Care	42

APPENDIX (CONTINUED)

ST	BILL	TITLE AS FILED	SECTION	PAGE(S)
MD	MD S 904	Family Planning Program	Improving Access to Contraception	18
ME	ME H 64	MaineCare Family Planning Benefit	Improving Access to Contraception	16
ME	ME H 210	Sales Tax Exemption for Feminine Hygiene Products	Prohibiting Interference with Reproductive Health Care	46
ME	ME H 457	Correctional Facilities	Prohibiting Interference with Reproductive Health Care	43
ME	ME H 487	Pregnant Workers	Prohibiting Interference with Reproductive Health Care	40
ME	ME H 594	Discrimination in Public and Private Insurance Coverage	Expanding Access to Abortion Care	9, 28
ME	ME H 922	Health Care Professionals	Expanding Access to Abortion Care	9, 28
ME	ME S 159	Family Planning Statutes	Improving Access to Contraception	15
ME	ME S 212	Outreach Programs	Improving Access to Contraception	18
MI	MI H 4958	Nonconsensual Pelvic Examinations	Prohibiting Interference with Reproductive Health Care	45
MI	MI SR 33	Black Maternal Health Resolution	Increasing Access to Pregnancy Care	24
MN	MN H 5	Family and Medical Benefit Leave	Supporting Parents and Families	34
MN	MN H 681	Pregnant and Supporting Parents and Families Pupils Transportation	Supporting Parents and Families	37
MN	MN H 909	Prenatal Care Service Programs and Funding	Increasing Access to Pregnancy Care	22
MN	MN H 963	Supply Requirements for Prescription Contraceptives	Improving Access to Contraception	16
MN	MN S 1084	Prescription Contraceptives Supply Requirements	Improving Access to Contraception	16
MN	MN H 1167	Breastfeeding Disparity Study	Supporting Parents and Families	36
MN	MN H 1414	Sexual Health Education Curriculum	Promoting Comprehensive Sexuality Education for All Young People	31
MN	MN H 1711	Education	Promoting Comprehensive Sexuality Education for All Young People	31
MN	MN S 340	Pregnant and Parenting Pupils Transportation	Supporting Parents and Families	37
MN	MN S 855	Early Childhood	Increasing Access to Pregnancy Care	26
MN	MN S 2065	Sexual Health School Curriculum	Promoting Comprehensive Sexuality Education for All Young People	31
MO	MO H 303	Prison Canteen Funds	Prohibiting Interference with Reproductive Health Care	43
MO	MO H 487	Dispensing of Contraceptives	Improving Access to Contraception	17
MO	MO H 664	Healthy Mothers Initiative	Increasing Access to Pregnancy Care	21
MO	MO H 747	Taxation of Feminine Hygiene Products	Prohibiting Interference with Reproductive Health Care	46
MO	MO H 920	Healthcare Products For Prisoners	Prohibiting Interference with Reproductive Health Care	42
MO	MO HCB 2	Criminal Justice	Prohibiting Interference with Reproductive Health Care	43
MO	MO S 480	Pregnancy Associated Mortality Review Board	Increasing Access to Pregnancy Care	21
ND	ND H 1515	Medical Assistance Coverage	Increasing Access to Pregnancy Care	25
ND	ND S 2155	Pharmacy Practice	Improving Access to Contraception	14
ND	ND SCR 4018	Paid Family Leave Program Feasibility Study	Supporting Parents and Families	35
NE	NE L 13	Breast Pumps and Feeding	Supporting Parents and Families	36
NE	NE L 690	Incarcerated Women Healthy Pregnancies	Prohibiting Interference with Reproductive Health Care	41
NH	NH H 2	State Fees	Expanding Access to Abortion Care	10, 29
NH	NH H 385	Maternity Care Room	Supporting Parents and Families	36
NH	NH S 142	School Restrooms and Feminine Hygiene Products	Prohibiting Interference with Reproductive Health Care	46
NH	NH S 274	Newborn Home Visiting Program	Increasing Access to Pregnancy Care	25
NH	NH S 279	Fertility Care Access	Increasing Access to Pregnancy Care	26

APPENDIX (CONTINUED)

ST	BILL	TITLE AS FILED	SECTION	PAGE(S)
NJ	NJ A 314	Use of Isolated Confinement in Correctional Facilities	Prohibiting Interference with Reproductive Health Care	43
NJ	NJ A 1651	Address Confidentiality Program Expansion	Expanding Access to Abortion Care	10
NJ	NJ A 1662	Doula Care Medicaid Coverage	Increasing Access to Pregnancy Care	26
NJ	NJ A 1663	On-Site Lactation Room Requirements	Supporting Parents and Families	36
NJ	NJ A 1861	Address Confidentiality Program for Certain Employees	Expanding Access to Abortion Care	10
NJ	NJ A 1862	Maternal Mortality Review Commission	Increasing Access to Pregnancy Care	21
NJ	NJ A 3975	Family and Disability Leave	Supporting Parents and Families	34
NJ	NJ A 3979	Dignity for Incarcerated Primary Caretaker Parents	Prohibiting Interference with Reproductive Health Care	42
NJ	NJ A 4455	Health Insurance Carriers Requirement	Expanding Access to Abortion Care	10
NJ	NJ A 4503	Contraceptive Prescription Coverage	Improving Access to Contraception	16
NJ	NJ A 4747	Pasteurized Donated Human Breast Milk Coverage	Supporting Parents and Families	36
NJ	NJ A 4836	Family Leave Informational Materials	Supporting Parents and Families	35
NJ	NJ A 4925	Correctional Facility Inmate Pregnancy Prevention	Prohibiting Interference with Reproductive Health Care	43
NJ	NJ A 4926	Prenatal and Post Partum Inmate Education	Prohibiting Interference with Reproductive Health Care	43
NJ	NJ A 4930	Maternity Training Protocols and Treatment Guidelines	Increasing Access to Pregnancy Care	23
NJ	NJ A 4931	Maternity Care Evaluation Protocols	Increasing Access to Pregnancy Care	23
NJ	NJ A 4933	Mothers Survey	Increasing Access to Pregnancy Care	23
NJ	NJ A 4934	Pregnant Women Medicaid Coverage	Increasing Access to Pregnancy Care	25
NJ	NJ A 4936	Maternal Health Care Pilot Program	Increasing Access to Pregnancy Care	23
NJ	NJ A 4937	Maternal Mental Health Federal Funding	Increasing Access to Pregnancy Care	23
NJ	NJ A 4938	My Life My Plan Program	Improving Access to Contraception	14
NJ	NJ A 4939	Interconception Care Resources	Increasing Access to Pregnancy Care	23
NJ	NJ A 4940	Community Health Workers Perinatal Curriculum	Increasing Access to Pregnancy Care	23
NJ	NJ A 4941	Maternity Care Public Health Campaign	Increasing Access to Pregnancy Care	23
NJ	NJ A 4967	Antenatal and Prenatal Care Clinic Survey	Increasing Access to Pregnancy Care	22
NJ	NJ A 4991	Best Practices Manual for Maternity Care	Increasing Access to Pregnancy Care	22
NJ	NJ A 5021	Prenatal Care Services	Increasing Access to Pregnancy Care	25
NJ	NJ A 5029	Racial and Ethnic Disparities Study	Increasing Access to Pregnancy Care	22
NJ	NJ A 5508	Law Requiring Health Benefits Contraceptives Coverage	Improving Access to Contraception	16
NJ	NJ A 5509	Breastfeeding Support Health Benefits Coverage	Supporting Parents and Families	36
NJ	NJ A 5802	Family Planning Services Supplemental Appropriation	Improving Access to Contraception	18
NJ	NJ ACR 209	Improving Access to Contraception Employees Health Insurance Coverage	Improving Access to Contraception	16
NJ	NJ AR 219	Respectful Birth Care and Public Outreach Initiative	Increasing Access to Pregnancy Care	23
NJ	NJ AR 226	Maternal Mortality Uniform Data System	Increasing Access to Pregnancy Care	24
NJ	NJ AR 244	Presidential and Congressional Resolution	Supporting Parents and Families	36
NJ	NJ AR 245	Breast Pumps and Breast Milk onto Aircraft Allowance	Supporting Parents and Families	36
NJ	NJ S 495	Maternal Mortality Review Commission	Increasing Access to Pregnancy Care	21
NJ	NJ S 845	Hormonal Contraceptive Insurance Coverage	Improving Access to Contraception	17
NJ	NJ S 1735	Providing On Site Lactation Rooms	Supporting Parents and Families	36

APPENDIX (CONTINUED)

ST	BILL	TITLE AS FILED	SECTION	PAGE(S)
NJ	NJ S 1759	Treatment of Perinatal Anxiety	Increasing Access to Pregnancy Care	23
NJ	NJ S 1761	Address Confidentiality Program	Expanding Access to Abortion Care	10
NJ	NJ S 1784	Medicaid Coverage for Doula Care	Increasing Access to Pregnancy Care	26
NJ	NJ S 2528	Family and Disability Leave	Supporting Parents and Families	34
NJ	NJ S 2540	Dignity for Incarcerated Primary Caretaker Parents	Prohibiting Interference with Reproductive Health Care	42
NJ	NJ S 3159	Pasteurized Donated Human Breast Milk Coverage	Supporting Parents and Families	36
NJ	NJ S 3210	Family Leave Informational Materials	Supporting Parents and Families	35
NJ	NJ S 3261	Isolated Confinement in Correctional Facilities	Prohibiting Interference with Reproductive Health Care	43
NJ	NJ S 3278	Prenatal and Post-Partum Education and Services	Prohibiting Interference with Reproductive Health Care	43
NJ	NJ S 3279	Female Inmates	Prohibiting Interference with Reproductive Health Care	43
NJ	NJ S 3281	Female Inmates	Prohibiting Interference with Reproductive Health Care	43
NJ	NJ S 3363	Maternity Care Evaluation Database	Increasing Access to Pregnancy Care	23
NJ	NJ S 3364	Maternal Mental Health	Increasing Access to Pregnancy Care	23
NJ	NJ S 3370	Maternity Care Public Health Campaign	Increasing Access to Pregnancy Care	23
NJ	NJ S 3371	Community Health Worker Perinatal Health Curriculum	Increasing Access to Pregnancy Care	23
NJ	NJ S 3372	Interconception Care Resources Postpartum	Increasing Access to Pregnancy Care	23
NJ	NJ S 3373	Maternity Training Protocols and Treatment Guidelines	Increasing Access to Pregnancy Care	23
NJ	NJ S 3374	Pregnant Women Medicaid Coverage	Increasing Access to Pregnancy Care	25
NJ	NJ S 3375	Maternal Health Care Pilot Program	Increasing Access to Pregnancy Care	23
NJ	NJ S 3376	My Life My Plan Program	Improving Access to Contraception	14
NJ	NJ S 3377	Mothers Survey	Increasing Access to Pregnancy Care	23
NJ	NJ S 3404	Maternity Care Manual	Increasing Access to Pregnancy Care	22
NJ	NJ S 3405	Group Prenatal Care Services	Increasing Access to Pregnancy Care	25
NJ	NJ S 3522	Sexual and Reproductive Health Racial Disparity	Increasing Access to Pregnancy Care	22
NJ	NJ S 3645	Feminine Hygiene Products in Public Schools	Prohibiting Interference with Reproductive Health Care	46
NJ	NJ S 3742	Pharmacies Stock and Dispense Emergency Improving Access to Contraception	Improving Access to Contraception	14
NJ	NJ S 3804	Health Benefits Coverage of Contraceptives	Improving Access to Contraception	16
NJ	NJ S 3805	Health Benefits Coverage for Breastfeeding Support	Supporting Parents and Families	36
NJ	NJ S 4103	Supplemental Appropriations	Improving Access to Contraception	18
NJ	NJ S 4923	Female Inmates Family Planning Service	Prohibiting Interference with Reproductive Health Care	43
NJ	NJ SCR 154	Contraception Employees Health Insurance Coverage	Improving Access to Contraception	16
NJ	NJ SR 121	Respectful Care at Birth and Public Outreach	Increasing Access to Pregnancy Care	23
NJ	NJ SR 126	Center for Disease Control Uniform Data System	Increasing Access to Pregnancy Care	24
NM	NM H 21	Free Female Sanitary Products In Schools	Prohibiting Interference with Reproductive Health Care	46
NM	NM H 51	Decriminalize Expanding Access to Abortion Care	Expanding Access to Abortion Care	8, 29
NM	NM H 89	Health Coverage for Improving Access to Contraception	Improving Access to Contraception	16
NM	NM H 119	Feminine Hygiene Product Gross Receipts	Prohibiting Interference with Reproductive Health Care	46
NM	NM H 196	Pregnant Worker Accommodation Act	Prohibiting Interference with Reproductive Health Care	40
NM	NM S 124	Correctional Facility Lactation Policies	Prohibiting Interference with Reproductive Health Care	43

APPENDIX (CONTINUED)

ST	BILL	TITLE AS FILED	SECTION	PAGE(S)
NM	NM S 192	Judicial Discretion for Pregnant Inmates	Prohibiting Interference with Reproductive Health Care	43
NM	NM S 215	Maternal Mortality and Morbidity Prevention Act	Increasing Access to Pregnancy Care	21
NM	NM S 309	Insurance Ultrasound Authorizations	Increasing Access to Pregnancy Care	25
NV	NV A 91	Protected Persons Sterilization	Prohibiting Interference with Reproductive Health Care	44
NV	NV A 169	Maternal Mortality Review Committee	Increasing Access to Pregnancy Care	21
NV	NV S 94	Account for Family Planning Provisions	Improving Access to Contraception	18
NV	NV S 115	Donor Breast Milk Medicaid Coverage	Supporting Parents and Families	36
NV	NV S 179	Expanding Access to Abortion Care Provisions	Expanding Access to Abortion Care	8, 28
NV	NV S 344	Family Planning Services	Improving Access to Contraception	16
NV	NV S 361	Contraceptive Supplies	Improving Access to Contraception	17
NY	NY A 21	Reproductive Health Act	Expanding Access to Abortion Care	8, 28
NY	NY A 118	Women's Health in Correctional Facilities	Prohibiting Interference with Reproductive Health Care	43
NY	NY A 164	Menstrual Product Labeling	Prohibiting Interference with Reproductive Health Care	46
NY	NY A 290	Feminine Hygiene Products Free in Charter Schools	Prohibiting Interference with Reproductive Health Care	46
NY	NY A 484	Commissioner of Health	Prohibiting Interference with Reproductive Health Care	46
NY	NY A 568	Premium Reduction for Physicians and Licensed Midwives	Increasing Access to Pregnancy Care	22
NY	NY A 584	Discrimination Based on Reproductive Health	Prohibiting Interference with Reproductive Health Care	40
NY	NY A 585	Comprehensive Improving Access to Contraception Coverage	Improving Access to Contraception	16
NY	NY A 686	Free Menstrual Hygiene Products at Homeless Shelters	Prohibiting Interference with Reproductive Health Care	46
NY	NY A 715	Breast Pump Replacement Parts Tax Law	Supporting Parents and Families	36
NY	NY A 2007	Health and Mental Hygiene Budget	Expanding Access to Abortion Care	10
NY	NY A 2345	Lactation Counseling Services	Supporting Parents and Families	36
NY	NY A 2352	Disclosure by Crisis Pregnancy Centers to Clients	Expanding Access to Abortion Care	11
NY	NY A 2957	Complications from Increasing Access to Pregnancy Care	Increasing Access to Pregnancy Care	22
NY	NY A 3276	Maternal Mortality Review Boards	Increasing Access to Pregnancy Care	21
NY	NY A 5424	Jury Duty Exemptions	Supporting Parents and Families	36
NY	NY A 5875	Paid Family Leave Benefit Eligibility	Supporting Parents and Families	34
NY	NY A 5975	Definition of Increasing Access to Pregnancy Care Related Condition	Prohibiting Interference with Reproductive Health Care	41
NY	NY A 6325	Professional Misconduct	Prohibiting Interference with Reproductive Health Care	45
NY	NY A 6381	Insurance Coverage for Maternity Patients and Newborns	Increasing Access to Pregnancy Care	25
NY	NY A 6650	Employee Notification of Contraceptive Coverage	Improving Access to Contraception	16
NY	NY A 6962	Hospital Obstetric Hemorrhaging Protocols	Increasing Access to Pregnancy Care	22
NY	NY A 6986	Study on Racial Disparities on Breastfeeding Rates	Supporting Parents and Families	36
NY	NY A 8212	Report on Unmet Health Needs of Pregnant Women	Expanding Access to Abortion Care	11
NY	NY A 8338	Makeup and Structure of Maternal Mortality Review Board	Increasing Access to Pregnancy Care	21
NY	NY A 8372	Provision of Lactation Accommodations in Airports	Supporting Parents and Families	36
NY	NY S 240	Reproductive Health Act	Expanding Access to Abortion Care	8, 28
NY	NY S 659	Comprehensive Improving Access to Contraception Coverage	Improving Access to Contraception	16
NY	NY S 660	Discrimination Based on Reproductive Health	Prohibiting Interference with Reproductive Health Care	40

APPENDIX (CONTINUED)

ST	BILL	TITLE AS FILED	SECTION	PAGE(S)
NY	NY S 748	Exemption from Jury Duty for Breastfeeding Women	Supporting Parents and Families	36
NY	NY S 1016	Informational Materials for Menstrual Disorders	Prohibiting Interference with Reproductive Health Care	46
NY	NY S 1092	Consent to Perform a Pelvic Examination	Prohibiting Interference with Reproductive Health Care	45
NY	NY S 1507	State Budgets	Expanding Access to Abortion Care	10
NY	NY S 1544	Provision of Lactation Accommodations in Airports	Supporting Parents and Families	36
NY	NY S 1819	State and New York City Maternal Mortality Review Board	Increasing Access to Pregnancy Care	21
NY	NY S 2264	Crisis Increasing Access to Pregnancy Care Centers Disclosures	Expanding Access to Abortion Care	11
NY	NY S 2387	Menstrual Product Labeling	Prohibiting Interference with Reproductive Health Care	46
NY	NY S 2593	Continuity of Family Planning Services in the State	Improving Access to Contraception	18
NY	NY S 3120	Contraceptive Coverage Employee Notification	Improving Access to Contraception	16
NY	NY S 3125	Charter School Free Feminine Hygiene Products	Prohibiting Interference with Reproductive Health Care	46
NY	NY S 3126	Correctional Facility Women's Health Education	Prohibiting Interference with Reproductive Health Care	44
NY	NY S 3158	Physicians and Licensed Midwives	Increasing Access to Pregnancy Care	22
NY	NY S 3352	Breast Pump Parts and Supplies Tax Exemption	Supporting Parents and Families	36
NY	NY S 3387	Lactation Counseling Services	Supporting Parents and Families	36
NY	NY S 3543	Over the Counter Contraceptive Products	Improving Access to Contraception	16
NY	NY S 3821	Eligibility for State Paid Family Leave Benefits	Supporting Parents and Families	34
NY	NY S 4211	Definition of Increasing Access to Pregnancy Care Related Condition	Prohibiting Interference with Reproductive Health Care	41
NY	NY S 4498	Establishment of Obstetric Hemorrhage Protocols	Increasing Access to Pregnancy Care	22
NY	NY S 4637	Information on Possible Complications From Increasing Access to Pregnancy Care	Increasing Access to Pregnancy Care	22
NY	NY S 6311	Study on Unmet Health Needs Facing Pregnant Women	Expanding Access to Abortion Care	11
NY	NY S 6368	Informational Materials on Menstrual Disorders	Prohibiting Interference with Reproductive Health Care	46
NY	NY S 6529	Makeup of the Maternal Mortality Review Board	Increasing Access to Pregnancy Care	21
OH	OH S 18	Pregnant Female Offenders	Prohibiting Interference with Reproductive Health Care	42
OH	OH S 26	Income Tax Reductions	Prohibiting Interference with Reproductive Health Care	45
OH	OH S 151	Maternal Mortality Awareness Month	Increasing Access to Pregnancy Care	24
OK	OK H 2334	Public Health and Safety	Increasing Access to Pregnancy Care	21
OR	OR H 2005	Family and Medical Leave Insurance Program	Supporting Parents and Families	34
OR	OR H 2341	Employer Accommodation for Increasing Access to Pregnancy Care	Prohibiting Interference with Reproductive Health Care	40
OR	OR H 2515	Correctional Facilities Tampon Costs	Prohibiting Interference with Reproductive Health Care	43
OR	OR H 2593	Workplace Accommodations	Prohibiting Interference with Reproductive Health Care	41
OR	OR H 3031	Family and Medical Leave Insurance Program	Supporting Parents and Families	34
PA	PA HR 27	Designation Resolution	Increasing Access to Pregnancy Care	24
PA	PA SR 7	Designation Resolution	Increasing Access to Pregnancy Care	24
RI	RI H 5125	Privacy Rights	Expanding Access to Abortion Care	8, 28
RI	RI H 5151	Appropriations Provision	Prohibiting Interference with Reproductive Health Care	45
RI	RI H 5543	Office of State Medical Examiners	Increasing Access to Pregnancy Care	21

APPENDIX (CONTINUED)

ST	BILL	TITLE AS FILED	SECTION	PAGE(S)
RI	RI H 5549	Hormonal Contraceptives	Improving Access to Contraception	17
RI	RI S 152	Reproductive Health Care Protections	Expanding Access to Abortion Care	8
RI	RI S 574	Office of State Medical Examiners	Increasing Access to Pregnancy Care	21
RI	RI S 678	Medical Assistance	Increasing Access to Pregnancy Care	24
SC	SC H 3200	Employee Lactation Support Break	Prohibiting Interference with Reproductive Health Care	41
SC	SC H 3967	Inmates with a Clinical Diagnosis of Increasing Access to Pregnancy Care	Prohibiting Interference with Reproductive Health Care	42
SC	SC S 406	Lactation Support Act	Prohibiting Interference with Reproductive Health Care	41
TN	TN H 129	State Inmates	Prohibiting Interference with Reproductive Health Care	43
TN	TN H 1483	Public High School Free Feminine Hygiene Products	Prohibiting Interference with Reproductive Health Care	46
TN	TN S 75	Women Prisoner Hygiene Products	Prohibiting Interference with Reproductive Health Care	43
TN	TN S 1046	Free Feminine Hygiene Products in High Schools	Prohibiting Interference with Reproductive Health Care	46
TX	TX H 243	Promotion of Breast Feeding	Supporting Parents and Families	36
TX	TX H 253	Postpartum Depression	Increasing Access to Pregnancy Care	23
TX	TX H 475	Pregnant Foster Children Information	Supporting Parents and Families	37
TX	TX H 541	Right To Express Breast Milk	Supporting Parents and Families	36
TX	TX H 650	Female Inmates	Prohibiting Interference with Reproductive Health Care	42
TX	TX H 744	Medicaid Eligibility of Certain Women After a Increasing Access to Pregnancy Care	Increasing Access to Pregnancy Care	25
TX	TX H 800	Covered Benefits Under the Child Health Plan	Improving Access to Contraception	16
TX	TX H 937	Prescription Contraceptive Drug Health Plan Coverage	Improving Access to Contraception	16
TX	TX H 938	Maternal Health Care Minors Consent	Improving Access to Contraception	15
TX	TX H 992	Women's Health Advisory Committee	Improving Access to Contraception	18
TX	TX H 1041	Place for Public Employee to Express Breast Milk	Prohibiting Interference with Reproductive Health Care	41
TX	TX H 1110	Increasing Access to Pregnancy Care Medicaid Eligibility	Increasing Access to Pregnancy Care	25
TX	TX H 1111	Maternal and Newborn Health Care	Increasing Access to Pregnancy Care	25
TX	TX H 1651	Pregnant Women Confined Care	Prohibiting Interference with Reproductive Health Care	42
TX	TX H 1879	Women in Medicaid Automatic Enrollment	Increasing Access to Pregnancy Care	25
TX	TX H 2169	Female Prisoners	Prohibiting Interference with Reproductive Health Care	43
TX	TX H 2618	Maternal Peer Support Pilot Program	Increasing Access to Pregnancy Care	23
TX	TX H 2682	Health Benefit Coverage	Increasing Access to Pregnancy Care	26
TX	TX H 2701	County Jailer Training and Continuing Education	Prohibiting Interference with Reproductive Health Care	43
TX	TX H 2703	Maternal Mortality Establishment	Increasing Access to Pregnancy Care	22
TX	TX H 3003	Designation of Liaison Officers At Public Institutions	Supporting Parents and Families	37
TX	TX H 3017	Nonconsensual Pelvic Examinations	Prohibiting Interference with Reproductive Health Care	45
TX	TX H 3303	Revocation of Community Supervision	Prohibiting Interference with Reproductive Health Care	43
TX	TX H 3337	Healthy State Women Program Survey	Improving Access to Contraception	18
TX	TX S 147	Medicaid Eligibility of Certain Women After a Pregnancy	Increasing Access to Pregnancy Care	25
TX	TX S 795	Health Benefit Plan Coverage	Improving Access to Contraception	16
TX	TX S 959	Family Preservation Services Coverage	Increasing Access to Pregnancy Care	26

APPENDIX (CONTINUED)

ST	BILL	TITLE AS FILED	SECTION	PAGE(S)
TX	TX S 1290	Foster Children who are Pregnant	Supporting Parents and Families	37
TX	TX S 2301	Maternal Peer Support Pilot Program	Increasing Access to Pregnancy Care	23
UT	UT H 318	Inmate Restrictions Standards	Prohibiting Interference with Reproductive Health Care	41
UT	UT H 398	Substance Use and Health Care	Prohibiting Interference with Reproductive Health Care	43
UT	UT S 2001 b	State and Local Taxes and Revenue	Prohibiting Interference with Reproductive Health Care	45
VA	VA H 1916	Breast Feeding Mothers Break Requirements	Prohibiting Interference with Reproductive Health Care	41
VA	VA H 2234	Paid Parental Leave	Supporting Parents and Families	34
VA	VA H 2540	Sales and Use Tax Exemptions	Prohibiting Interference with Reproductive Health Care	46
VA	VA H 2546	Maternal Mortality Review Team	Increasing Access to Pregnancy Care	21
VA	VA S 998	Prohibiting Interference with Reproductive Health Care in Public Employment	Prohibiting Interference with Reproductive Health Care	40
VA	VA S 1452	Dispensing of Controlled Substances and Devices	Improving Access to Contraception	15
VA	VA S 1581	State Employee Parental Leave	Supporting Parents and Families	34
VA	VA S 1715	Sales and Use Tax Exemptions	Prohibiting Interference with Reproductive Health Care	46
VA	VA S 1772	Restraint of Pregnant Offenders	Prohibiting Interference with Reproductive Health Care	42
VT	VT H 57	Right to Expanding Access to Abortion Care	Expanding Access to Abortion Care	8, 29
VT	VT H 107	Paid Family Leave	Supporting Parents and Families	34
VT	VT P 5	Declaration of Rights	Expanding Access to Abortion Care	8
WA	WA H 1053	Feminine Hygiene Products	Prohibiting Interference with Reproductive Health Care	46
WA	WA H 1369	Relating to Maternal Mortality Reviews	Increasing Access to Pregnancy Care	21
WA	WA H 1399	Paid Family and Medical Leave	Supporting Parents and Families	35
WA	WA H 1902	Single Bill for Health Services	Expanding Access to Abortion Care	10
WA	WA H 1930	Workplace Reasonable Accommodations	Prohibiting Interference with Reproductive Health Care	41
WA	WA S 5147	Feminine Hygiene Product Tax Relief	Prohibiting Interference with Reproductive Health Care	46
WA	WA S 5206	Feminine Hygiene Product Tax Exemption	Prohibiting Interference with Reproductive Health Care	46
WA	WA S 5282	Pelvic Exams Informed Consent	Prohibiting Interference with Reproductive Health Care	45
WA	WA S 5395	Comprehensive Sexual Health Education	Promoting Comprehensive Sexuality Education for All Young People	31
WA	WA S 5425	Maternal Mortality Reviews	Increasing Access to Pregnancy Care	21
WA	WA S 5449	Paid Family and Medical Leave	Supporting Parents and Families	35
WA	WA S 5602	Reproductive Health Care Barriers	Improving Access to Contraception	17
WA	WA S 5911	Breast Milk Expression Workplace Accommodation	Prohibiting Interference with Reproductive Health Care	41
WI	WI A 304	Contraceptive Prescription	Improving Access to Contraception	17
WI	WI S 286	Contraceptives Prescribe Permit	Improving Access to Contraception	17
WV	WV H 2464	Free Feminine Hygiene Products for Youth	Prohibiting Interference with Reproductive Health Care	46
WV	WV H 2583	Family Planning Access Act	Improving Access to Contraception	17
WV	WV S 86	Free Feminine Hygiene Products	Prohibiting Interference with Reproductive Health Care	46
WV	WV S 564	Pregnant Woman Medicaid Comprehensive Coverage	Increasing Access to Pregnancy Care	25
WV	WV SCR 41	Paid Family and Medical Leave Study	Supporting Parents and Families	35
WY	WY H 43	Midwife Services Medicaid	Increasing Access to Pregnancy Care	26

ENDNOTES

1. NAT'L INST. FOR REPRODUCTIVE HEALTH, ANALYSIS OF VOTERS' OPINIONS ON ABORTION RESTRICTIONS AND AFFIRMATIVE POLICIES (Jan. 20, 2016), available at https://www.nirhealth.org/wp-content/uploads/2016/01/Memo-NIRH-Poll_Final_3.pdf.
2. Elizabeth Nash, *Unprecedented Wave of Abortion Bans is an Urgent Call to Action*, GUTTMACHER INST. (May 22, 2019), https://www.guttmacher.org/article/2019/05/unprecedented-wave-abortion-bans-urgent-call-action; E-mail from Elizabeth Nash, Senior State Issues Manager, Guttmacher Inst., to Winnie Ye, Policy and Program Coordinator, Nat'l Inst. for Reproductive Health (Dec. 4, 2019, 04:06 EST) (on file with author).
3. *Id*.
4. *Governor Cuomo Signs Legislation Protecting Women's Reproductive Rights*, NEW YORK STATE, https://www.governor.ny.gov/news/governor-cuomo-signs-legislation-protecting-womens-reproductive-rights (last visited May 22, 2019).
5. Jenni Fink, *California Abortion Bill Would Make It The First State to Require University Health Clinics to Offer Pregnancy Termination on Campus*, NEWSWEEK (Apr. 5, 2019, 12:55 PM), https://www.newsweek.com/california-bill-would-make-it-first-state-require-university-health-clinics-1387430.
6. *Sen. Breen Testifies in Favor of Bill to Allow Advance Practice Clinicians to Perform Abortions*, MAINE SENATE DEMOCRATS, http://www.mainesenate.org/sen-breen-testifies-in-favor-of-bill-to-allow-advance-practice-clinicians-to-perform-abortions/ (last visited May 22, 2019).
7. Elizabeth Nash & Adam Sonfield, *States Lead the way in Promoting Coverage of Abortion in Medicaid and Private Insurance*, GUTTMACHER INST. (June 24, 2019), https://www.guttmacher.org/article/2019/06/states-lead-way-promoting-coverage-abortion-medicaid-and-private-insurance.
8. Donna Shoupe, *LARC Methods: Entering a New Age of Contraception and Reproductive Health*, 1 CONTRACEPTION AND REPRODUCTIVE MEDICINE 4 (2016), https://contraceptionmedicine.biomedcentral.com/articles/10.1186/s40834-016-0011-8.
9. Good Bills, TRUST RESPECT ACCESS COAL., available at https://trustrespectaccess.org/TRA_Good_Bills.pdf.
10. Patient Protection and Affordable Care Act § 1001 (2010), codified at 42 U.S.C. 300gg-13.
11. Daniel Grossman, *Over-the-counter Access to Oral Contraceptives*, 6 EXPERT REVIEW OF OBSTETRICS & GYNECOLOGY 5 (2011).
12. Rachel Benson Gold, Adam Sonfield, Cory L. Richards & Jennifer J. Frost, *Next Steps for America's Family Planning Program: Leveraging the Potential of Medicaid and Title X in an Evolving Health Care System*, GUTTMACHER INSTIT. (Feb. 2009), https://www.guttmacher.org/sites/default/files/report_pdf/nextsteps.pdf; Rachel Benson Gold, *The Role of Family Planning Centers as Gateways to Health Coverage and Care*, 14 GUTTMACHER INSTIT. (June 1, 2011), https://www.guttmacher.org/gpr/2011/06/role-family-planning-centers-gateways-health-coverage-and-care.
13. Rachel Benson Gold, *The Role of Family Planning Centers as Gateways to Health Coverage and Care*, GUTTMACHER INST. (June 1, 2011), https://www.guttmacher.org/gpr/2011/06/role-family-planning-centers-gateways-health-coverage-and-care.
14. Jennifer J. Frost et al., *Publicly Funded Contraceptive Services at U.S. Clinics*, 2015, GUTTMACHER INST. (Apr. 2017), https://www.guttmacher.org/report/publicly-funded-contraceptive-services-us-clinics-2015.
15. *Id*.
16. Kinsey Hasstedt, *Dangerous and Coercive Title X Gag Rule Released*, GUTTMACHER INST. (Feb. 27, 2019), https://www.guttmacher.org/article/2019/02/dangerous-and-coercive-title-x-gag-rule-released.
17. *Id*.
18. *Id*.
19. *Governor Signs Abortion and Family Planning Bills*, ABC KOLO NEWSNOW (May 31, 2019, 4:44 PM), https://www.kolotv.com/content/news/Governor-signs-abortion-and-womens-health-bills-510691061.html.
20. Munira Z. Gunia, Roosa Tikkanen, Shanoor Seervai & Sara R. Collins, *What Is the Status of Women's Health and Health Care in the U.S. Compared to Ten Other Countries?*, The Commonwealth Fund (Dec. 19, 2018), https://www.commonwealthfund.org/publications/issue-briefs/2018/dec/womens-health-us-compared-ten-other-countries.
21. *Black Mamas Matter: A Toolkit for Advancing the Human Right to Safe and Respectful Maternal Health Care, Research Overview of Maternal Mortality and Morbidity in the United States*, CTR. FOR REPRODUCTIVE RIGHTS (July 16, 2016), available at https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/USPA_MH_TO_ResearchBrief_Final_5.16.pdf.
22. Black Mamas Matter Alliance, https://blackmamasmatter.org/ (last visited July 31, 2019).
23. Lena Nilsson, et al., *Factors Influencing Positive Birth Experiences of First-Time Mothers*, 6 NURSING RESEARCH AND PRACTICE (2013), http://dx.doi.org/10.1155/2013/349124. *See also* Donna J. Sauls, *Effects of Labor Support on Mothers, Babies, and Birth Outcomes*, 31 J. OF OBSTETRIC, GYNECOLOGICAL, AND NEONATAL NURSING 6 (2002), https://www.jognn.org/article/S0884-2175(15)34027-2/fulltext.
24. DENTAL COVERAGE FOR LOW-INCOME PREGNANT WOMEN, NAT'L HEALTH LAW PROGRAM (July 23, 2013), available at https://healthlaw.org/resource/dental-coverage-for-low-income-pregnant-women/.
25. Damali Campbell, Nataki Douglas & Lisa Gittens-Williams, *NJ Needs Innovative Solutions to Address Black Maternal Health Disparities*, RUTGERS MED. SCH., http://njms.rutgers.edu/archives/spotlight/articles/4_15_19.cfm (last visited May 22, 2019).
26. Comprehensive sexuality education programs are those that contain age-appropriate, medically accurate lessons that cover topics such as human development; sexual health, including HIV and other sexually transmitted infections; unintended pregnancy prevention; sexual behaviors, including abstinence, healthy relationships, personal skills, and communications; and sexuality within society and culture. Building a Foundation for Sexual Health is a K-12 Endeavor: Evidence Underpinning the National Sexuality Education Standards, ADVOCATES FOR YOUTH (2019), https://advocatesforyouth.org/wp-content/uploads/2019/09/Building-a-foundation-for-Sexual-Health.pdf.

ENDNOTES (CONTINUED)

27. SisterSong Women of Color Reproductive Justice Collective, *What is Reproductive Justice?,* http://sistersong.net/reproductive-justice/ (last visited Aug. 7, 2019).
28. Betsey Stevenson, *Why America needs a paid family leave policy*, AEIDEAS (Apr. 3, 2017), http://www.aei.org/publication/ why-america-needs-a-paid-family-leave-policy/. *See also* Harry J. Holzer, *Paid family leave: Balancing benefits and costs*, BROOKINGS INST. (Jan. 30, 2017), https://www.brookings.edu/blog/social-mobility-memos/2017/01/30/paid-family-leavebalancing-benefits-and-costs/.
29. Nat'l P'ship for Women and Families, *State Paid Family and Medical Leave Insurance Laws*, http://www.nationalpartnership.org/our-work/resources/economic-justice/paid-leave/state-paid-family-leave-laws.pdf (last visited Sep. 27, 2019).
30. Am. Acad. of Ped., Policy Statement, *Breastfeeding and the Use of Human Milk*, 129 PEDIATRICS 3 (2012), http://pediatrics.aappublications.org/content/129/3/e827.full.
31. Am. College of Obstetricians and Gynecologists, *Breastfeeding*, http://www.acog.org/About-ACOG/ACOG-Departments/Breastfeeding (last visited Aug. 8, 2019).
32. Statement, World Health Org., *Exclusive Breastfeeding for Six Months Best for Babies Everywhere*, (Jan. 15, 2011), available at http://www.who.int/mediacentre/news/statements/2011/breastfeeding_20110115/en/.
33. Committee Opinion No. 570, Am. Coll. of Obstetricians and Gynecologists, *Breastfeeding in Underserved Women: Increasing Initiation and Continuation of Breastfeeding* (Aug. 2013), https://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Breastfeeding-in-Underserved-Women-Increasing-Initiation-and-Continuation-of-Breastfeeding. *See also* U.S. Dep't of Health and Human Servs., *The Surgeon General's Call to Action in Support Breastfeeding* (2014), available at https://www.surgeongeneral.gov/library/calls/breastfeeding/index.html.
34. Julia H. Kim, et al., *Breastfeeding is Natural but Not the Cultural Norm: A Mixed-Methods Study of First-Time Breastfeeding*, African American Mothers Participating in WIC, 49 J. OF NUTRITION EDUC. AND BEHAV. 7 (2017), https://www.jneb.org/article/S1499-4046(17)30221-X/abstract.
35. *Incarcerated Women and Shackling: State Policies*, AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS (last visited June 20, 2019), https://www.acog.org/-/media/Departments/State-Legislative-Activities/2018ShacklingTally.pdf?dmc=1&ts=20191217T1646355446.
36. *Coalition Calls on General Assembly to Pass Restrictions on the Shackling of Pregnant Prisoners*, ACLU Va. (Feb. 7, 2012), https://acluva.org/en/press-releases/coalition-calls-general-assembly-pass-restrictions-shackling-pregnant-prisoners.
37. Victoria Law, *You Go Through It Alone: New Bill Would Keep Incarcerated Pregnant Women from Being Put in Medical Isolation*, REWIRE (Mar. 22, 2019), https://rewire.news/article/2019/03/22/you-go-through-it-alone-new-bill-would-keep-incarcerated-pregnant-women-from-being-put-in-medical-isolation/.
38. Press Statement on Signing First-in-Nation Bill to Protect Pregnant Women From Forced Solitary Confinement, NARAL Pro-Choice MD. (Apr. 29, 2019), https://prochoicemd.org/2019/04/29/press-statements-signing-first-nation-bill-protect-pregnant-women-forced-solitary-confinement/.
39. Sneha Barot, *Governmental Coercion in Reproductive Decision Making: See It Both Ways*, GUTTMACHER INST. (Oct. 17, 2012), https://www.guttmacher.org/gpr/2012/10/governmental-coercion-reproductive-decision-making-see-it-both-ways.
40. Fresh Air, *The Supreme Court Ruling that Led to 70,000 Forced Sterilizations*, NPR (Mar. 7, 2016, 1:22 PM), https://www.npr.org/sections/health-shots/2016/03/07/469478098/the-supreme-court-ruling-that-led-to-70-000-forced-sterilizations.
41. April Corbin Girnus, *Advocates Seek to Strengthen Laws Regarding Sterilization of Disabled People*, NEV. CURRENT (Aug. 1, 2018), https://www.nevadacurrent.com/2018/08/01/advocates-seek-to-strengthen-laws-regarding-sterilization-of-disabled-people/.
42. Kimberly Lawson, *California's Dark History of Forcibly Sterilizing Latinas*, BROADLY (Aug. 16, 2018), https://broadly.vice.com/en_us/article/gy339b/california-forced-sterilizations-latina-women-history.
43. Nicole L. Novak & Natalie Lira, *Analysis: California's Forced Sterilization Programs Once Harmed Thousands, Especially Latinas*, PBS (Mar. 23, 2018, 3:50 PM), https://www.pbs.org/newshour/health/analysis-californias-forced-sterilization-programs-once-harmed-thousands-especially-latinas.
44. *Sterilization of Female Inmates: Some Inmates Were Sterilized Unlawfully, and Safeguards Designed to Limit Occurrences of the Procedure Failed*, CA. STATE AUDITOR (2014), https://www.auditor.ca.gov/pdfs/reports/2013-120.pdf.
45. *CA Must Provide Compensation to Victims of Forced Sterilization*, Assemblymember Wendy Carrillo District 51 (May 14, 2019) available at https://a51.asmdc.org/press-releases/20190514-ca-must-provide-compensation-victims-forced-sterilization.
46. Zoë Naseef, *Doctors Regularly Give Anesthetized Patients Non-Consensual Pelvic Exams – and This Needs to Stop*, BUST (Sep. 12, 2018), https://bust.com/feminism/195099-public-exams-anesthesia.html.
47. Professional responsibilities in obstetric-gynecologic medical education and training. Committee Opinion No. 500, AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS, 2011;118:400-4 available at https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Ethics/Professional-Responsibilities-in-Obstetric-Gynecologic-Medical-Education-and-Training.
48. AMA Council on Ethical and Judicial Affairs, *Medical Student Involvement in Patient Care: Report of the Council on Ethical and Judicial Affairs*, AMA J. OF ETHICS (2001), https://journalofethics.ama-assn.org/article/medical-student-involvement-patient-care-report-council-ethical-and-judicial-affairs/2001-03.
49. Press Release, Jordan J. Cohen, President, Ass'n of Am. Med. Coll., AAMC Statement on Patient Rights and Medical Training (June 12, 2003), https://web.archive.org/web/20040213040614/http:/www.aamc.org/newsroom/pressrel/2003/030612.htm.
50. Karen Zraick, *22 States Considered Eliminating the 'Tampon Tax' This Year. Here's What Happened*., N.Y. TIMES (July 12, 2019), https://www.nytimes.com/2019/07/12/us/tampon-tax.html.
51. Alexandra Scranton, *Chem Fatale: Potential Health Effects of Toxic Chemicals in Feminine Care Products*, WOMEN'S VOICES FOR THE EARTH (2013), available at https://womensvoices.org/wp-content/up%1floads/2013/11/Chem-Fatale-Report.pdf.

National Institute for
Reproductive Health

National Institute for Reproductive Health
14 Wall Street
Suite 3B
New York, NY 10005

Tel. 212-343-0114

info@nirhealth.org
www.nirhealth.org