

# GAINING GROUND

2020 MIDYEAR REPORT • JULY 2020



National Institute for Reproductive Health

THE EVENTS OF 2020 HAVE THE POTENTIAL TO INFLUENCE abortion rights for years to come, with the Supreme Court's decision in *June Medical Services LLC v. Russo*, and upcoming elections for the presidency, Congress, and hundreds of state elected positions. Many state lawmakers and advocates entered 2020 ready to advance proactive reproductive health, rights, and justice policies, building on electoral and legislative momentum from 2018-19. States introduced, moved, and enacted bold legislation increasing access to reproductive health and rights in the first three months of the legislative session, as explained in the chart below and the map on p. 4. Then the global COVID-19 pandemic forced state legislatures to grind to a halt. In the absence of competent federal leadership, many state officials quickly shifted their agendas to protect their residents' health and safety – even while some state lawmakers exploited the pandemic to try to further restrict abortion access, ultimately losing those battles in courts. This report covers how states responded to COVID-19, along with two other important highlights from 2020: policy change following an electoral shift in Virginia, and addressing implicit bias in health care.

## PROACTIVE LEGISLATION ON REPRODUCTIVE HEALTH, RIGHTS, AND JUSTICE, 2020

ALL DATA AS OF JUNE 15, 2020

546 BILLS INTRODUCED IN 44 STATES AND DC

47 BILLS

FULLY ENACTED

44 BILLS

PASSED OUT OF AT LEAST 1 CHAMBER

77 BILLS

PASSED OUT OF AT LEAST 1 COMMITTEE

2 BILLS VETOED

### ABORTION

48 BILLS IN 18 STATES

4

BILLS



1

BILL



7

BILLS

### CONTRACEPTION

70 BILLS IN 22 STATES

7

BILLS



8

BILLS



9

BILLS

### PREGNANCY CARE

150 BILLS IN 36 STATES AND DC

14

BILLS



6

BILLS



19

BILLS

1 BILL VETOED

### SEXUALITY EDUCATION

13 BILLS IN 9 STATES

0

BILLS



1

BILL



1

BILL

### SUPPORTING PARENTS

111 BILLS IN 30 STATES AND DC

8

BILLS



5

BILLS



19

BILLS

### NONDISCRIMINATION

154 BILLS IN 38 STATES

14

BILLS



23

BILLS



22

BILLS

1 BILL VETOED

\*Montana, Nevada, North Dakota, and Texas did not have legislative sessions in 2020.

For more information about these bills, please contact the National Institute for Reproductive Health at [info@nirhealth.org](mailto:info@nirhealth.org).

# HIGHLIGHTS FROM 2020

**THE GLOBAL PUBLIC HEALTH CRISIS** crystallized what public health experts,<sup>1</sup> many state lawmakers, and the reproductive health, rights, and justice advocacy community have long known: reproductive health care, including abortion, is an essential component of comprehensive health care. It also amplified existing disparities, with Black, Latinx, Native, and other communities of color bearing the brunt of the pandemic, just as they – along with those with lower income, young people, immigrants, and those in rural settings – frequently face the greatest barriers to accessing health services and are most impacted by efforts to limit access to reproductive health care, including abortion.

In the first six months of 2020 and as the COVID-19 crisis emerged, we saw states act to protect access to reproductive health care, including abortion, by prohibiting political interference with the patient-doctor relationship; ensuring clinics could stay open; providing paid sick leave and insurance coverage; and calling for an expansion of telehealth during these unprecedented circumstances.

## STATE RESPONSES TO COVID-19

In most states across the country, governors, health officials, and mayors stepped up to protect public health, including access to reproductive health care. Although some anti-abortion governors and attorneys general tried to exploit the pandemic to ban or dramatically limit access to abortion and sow confusion, the majority of governors and departments of health recognized that reproductive health care, including abortion, is time sensitive, essential care. Some went further by explicitly naming abortion as a critical service in the relevant emergency orders. Abortion is one of the safest procedures or treatments available in the United States today, but a delay of several weeks, or in some cases days, may increase the risks or potentially make it inaccessible, depending on the state a patient lives in. Studies show that being unable to obtain an abortion has a serious impact on mental health,<sup>2</sup> socioeconomic status,<sup>3</sup> and a person's overall health and life.

**CLINIC-BASED CARE:** In early March, many governors and state departments of health issued orders requiring residents to stay at home and suspending nonessential, elective invasive procedures. The goal was to focus personnel resources on responding to the outbreak,

conserve the critical shortage of personal protective equipment, and ultimately slow the spread of the virus. The majority of these executive orders allowed abortion and other pregnancy-related services to continue with COVID-19 appropriate protocols. However, in mid- to late March and early April, as events and conditions changed daily, there was great public confusion about what would be considered an “essential” service. In **California, Illinois, Michigan, Minnesota, Montana, New Mexico, Virginia,** and **Washington**, governors or executive agencies explicitly categorized reproductive health care, family planning services, or pregnancy-related care as essential services in their executive orders. Governors or state officials in three states – **Massachusetts, New Jersey,** and **New York** – went further and explicitly included abortion care on the list of essential and time-sensitive health care procedures that would continue to be available. In **Hawaii** and **Oregon**, the attorneys general publicly clarified that their state's order intended to classify abortion as “essential.”

**TELEMEDICINE:** State officials also took steps to increase access to reproductive health care by waiving existing regulations or enacting new laws to expand telemedicine, which allows patients to consult with their doctors on the phone or on video instead of in person and, where relevant, to be mailed any medication or sent a prescription to pick up at the pharmacy. As the nation was adjusting to stay-at-home orders, an increasing number of health care providers offered care using telemedicine whenever possible. Unfortunately, while studies have shown that medication abortion care can be offered safely and effectively through telemedicine, with medication sent directly to the patient, federal and state overregulation precludes providing the medication through the mail or at a pharmacy. In a few states, patients can access medication abortion through telemedicine as a result of a study run by Gynuity Health Project, but still more states ban telemedicine for abortion care outright. In late March, 21 attorneys general sent a letter to the U.S. Department of Health and Human Services and its U.S. Food and Drug Administration urging them to waive existing restrictions, called the Risk Evaluation and Mitigation Strategy (REMS), so that certified prescribers can use telemedicine and mail or pharmacy prescription for Mifepristone, the medication abortion prescription drug.

**HOSPITAL CARE:** During the pandemic, some hospitals originally made a decision to prohibit birthing patients from having a support person or partner present during labor and delivery due to COVID-19 concerns. However, recognizing the need to balance the public health and safety associated with COVID-19 with overwhelming research that shows that continuous support during pregnancy results in better outcomes for both mother and newborn, **New York**, through an agency order, and **New Jersey**, with Assembly Bill 3942, stepped in to mandate

1 *Joint Statement on Abortion Access During the COVID-19 Outbreak*, Am. Coll. Of Obstetricians and Gynecologists (Mar. 18, 2020), <https://www.acog.org/news/news-releases/2020/03/joint-statement-on-abortion-access-during-the-covid-19-outbreak>.

2 *The mental health impacts of receiving vs. being denied a wanted abortion*, Advancing New Standards in Reprod. Health (July 2018), available at [https://www.ansirh.org/sites/default/files/publications/files/mental\\_health\\_issue\\_brief\\_7-24-2018.pdf](https://www.ansirh.org/sites/default/files/publications/files/mental_health_issue_brief_7-24-2018.pdf).

3 *Socioeconomic outcomes of women who receive and women who are denied wanted abortions*, Advancing New Standards in Reprod. Health (Aug. 2018), available at [https://www.ansirh.org/sites/default/files/publications/files/turnaway\\_socioeconomic\\_outcomes\\_issue\\_brief\\_8-20-2018.pdf](https://www.ansirh.org/sites/default/files/publications/files/turnaway_socioeconomic_outcomes_issue_brief_8-20-2018.pdf).

that hospitals allow at least one support person during a birth, while **Michigan's** governor issued an updated executive order clarifying visitation restrictions.<sup>4</sup>

**INSURANCE COVERAGE AND PAID LEAVE:** A number of state lawmakers, some who had offered similar policies in the past and others who were influenced by the moment, understood that insurance coverage and paid sick leave were needed now more than ever before. **New Jersey** (Senate Bill 2374 / Assembly Bill 3913) and **New York** (Senate Bill 8091 / Assembly Bill 10153) enacted laws to extend existing paid family leave benefits to those affected by COVID-19, to ensure that residents did not have to choose between taking care of themselves or a sick family member and working during the pandemic. **Alabama** considered extending Medicaid coverage for pregnant women for a full year after giving birth, citing the renewed importance of health care coverage during the pandemic (House Bill 448). **California's** legislature considered a bill (Senate Bill 943) that would also allow workers to time take off specifically because of school closures.

Finally, recognizing that women, girls, femme-identified and nonbinary people, especially Native Hawaiian, Pacific Islander, and immigrant women have been the groups hit hardest by the COVID-19 crisis, **Hawaii's** Commission on the Status of Women released a response and recovery plan that takes a feminist approach and provides policy recommendations that will advance gender equality and help rebuild the economy. The plan calls for a number of policies to improve women's health and lives including expanding access to midwives to improve maternal health outcomes, providing paid sick days and family leave, and expanding state Medicaid to Compact of Free Association (COFA) migrants.

## ELECTIONS LEAD TO POLICY CHANGE IN VIRGINIA

Virginia is an ideal case study in how elections can change the policy landscape. The Commonwealth's 2019 election and 2020 legislative session saw not only abortion access and reproductive freedom advanced, but other important social justice policies moved forward after years of being stymied.

In November 2019, following a year in which Virginia was ground zero for a campaign of anti-abortion misinformation, Virginia voters elected a pro-choice majority in the General Assembly for the first time in more than twenty years. Rounding out a governing trifecta, newly elected lawmakers who campaigned on bold platforms of standing up for reproductive freedom quickly unraveled decades of politically motivated abortion restrictions. On the first day of session in January 2020, **Virginia** legislators introduced the Reproductive Health Protection Act (House Bill 980 / Senate

Bill 733) (RHPA), ground-breaking legislation for a state that had recently been a hotbed of abortion restrictions. The 2020 RHPA repealed three of the most harmful barriers: a 2011 law that forced abortion providers to meet medically unnecessary building and facility requirements, making it difficult or impossible for some providers to continue to offer care; a 2012 law that required every abortion patient to receive state-created, biased information before being allowed to have an abortion, as well as requiring patients to receive an ultrasound whether medically necessary or not; and an archaic restriction that prevented qualified, trained advance practice clinicians like nurse practitioners and certified nurse midwives from providing abortion care within their scope of practice. The Virginia House of Delegates and Senate swiftly passed the RHPA and the governor signed it into law on April 9, taking a key step toward making Virginia a true access point for abortion care across the South.

In addition to improving abortion access at a time when it is under attack across the country, Virginia lawmakers enacted laws to provide menstrual products in schools (House Bill 405 / Senate Bill 232), expand access to doulas (House Bill 687), prohibit employment discrimination on the basis of pregnancy or childbirth (House Bill 827 / Senate Bill 712), and prohibit the shacking of incarcerated women during pregnancy, labor and delivery, and postpartum recovery (House Bill 1648).

## ADDRESSING IMPLICIT BIAS IN MATERNAL HEALTH CARE

The United States is notorious for having the highest rate of maternal mortality in the developed world, largely due to high levels of maternal mortality and morbidity among Black women and other women of color.<sup>5</sup> In recent years, maternal mortality review commissions, along with other types of task forces and many reproductive health care professionals and advocates, have been refining solutions to improve maternal health outcomes and eliminate racial and ethnic disparities in care. This work has included extensive academic research into the significant effects of racism, racial bias, and implicit bias on health outcomes.<sup>6</sup> In 2020, state lawmakers were influenced by that research: Legislatures in **Kentucky** (House Bill 138), **Minnesota** (House Bill 3093 / Senate Bill 3173) and **Oklahoma** (House Bill 3088) all considered legislation to require health care facilities or hospitals to implement programs for health care providers regarding implicit bias.

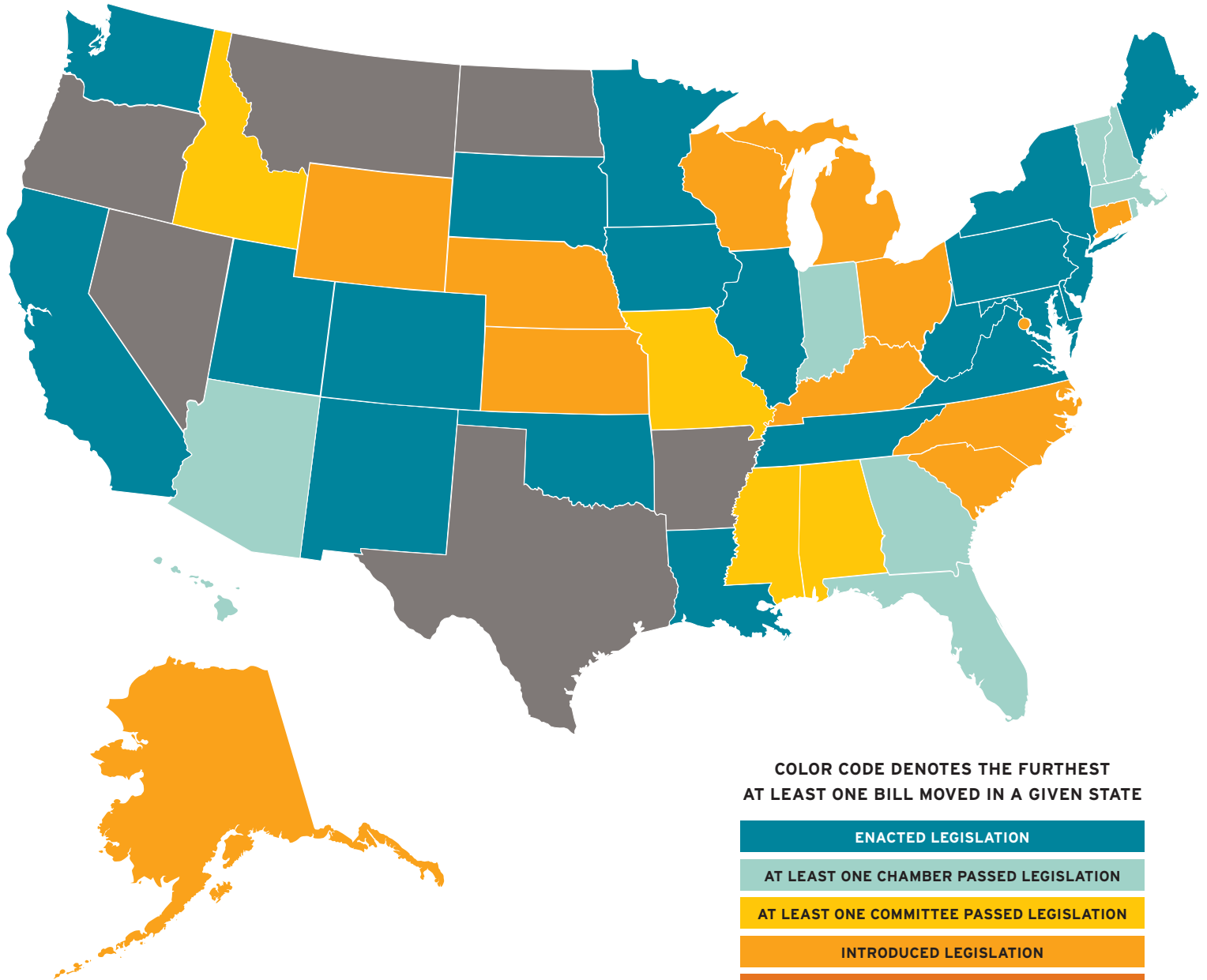
4 Meghan A. Bohren, G. Justus Hofmeyr, Carol Sakala, Rieko K. Fukuzawa & Anna Cuthbert, Continuous support for women during childbirth, COCHRANE LIBR. (July 6, 2017), available at <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003766.pub6/abstract>; Health Advisory: COVID-19 Guidance for Hospital Operators Regarding Visitation Updated Guidance regarding Obstetrical and Pediatric Settings, New York Department of Health (Mar. 27, 2020), available at [https://coronavirus.health.ny.gov/system/files/documents/2020/03/doh\\_covid19\\_obpedsvisitation\\_032720.pdf](https://coronavirus.health.ny.gov/system/files/documents/2020/03/doh_covid19_obpedsvisitation_032720.pdf).

5 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>.

6 William J. Hall et al., *Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review*, 105 AM. J. PUB. HEALTH e60, e76 (2015) available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4638275/>. See also Kelly M. Hoffman, Sophie Trawalter, Jordan R. Axt & M. Norman Oliver, *Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites*, 113 Proc. of the Nat'l Acad. of Sci. of the U.S.A. 4296, 4296 (2016) available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4843483/>.

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

AS OF JUNE 15, 2020



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