

The States at Midyear: Major Actions on Reproductive Health–Related Issues

By Adam Sonfield

By the end of July, 41 of the 50 state legislatures had adjourned, and almost all of them had devoted time to reproductive health and rights issues. With several of the most populous states, including California and New York, still in session, there is opportunity for additional drama—but the year’s rough contours have emerged.

Abortion

Following the U.S. Supreme Court’s ruling in *Stenberg v. Carhart* striking down Nebraska’s ban on so-called partial-birth abortion in June 2000, state antiabortion lawmakers and activists have found themselves—as have their federal counterparts—without a central focus for their efforts (see related story, page 10). Despite promises to the contrary, they have not regrouped with a new wave of “partial-birth” abortion legislation. Although such bills were introduced in 11 states, none has been approved even by a legislative committee. Similarly, state lawmakers made few attempts to restrict the distribution of mifepristone, which was approved by the Food and Drug Administration (FDA) in September 2000 for medical abortion. Only one

proposal to regulate the drug (in Arkansas) has so much as passed a legislative chamber. State policymakers, as well as members of Congress, appear to have been waiting for an expected Bush administration review of the FDA’s decision, which so far has failed to materialize.

Instead, state legislators have returned to several long-standing methods of restricting abortion but have made only modest gains thus far. Arkansas and Virginia enacted mandatory waiting periods, following state-directed counseling, before a woman may obtain an abortion; similar measures were vetoed in Iowa and Minnesota for the second straight year. Oklahoma enacted a mandatory parental involvement measure, but with a twist: It makes abortion providers who perform the procedure on a minor “without parental consent or knowledge” liable for the cost of any follow-up treatment. Idaho passed a law restricting Medicaid funding of abortions to cases of life endangerment, rape or incest, in an attempt to override a 1994 court decision requiring the state to pay for medically necessary abortions;

enforcement of the new law was immediately blocked by a court order. The Alaska Supreme Court, agreeing with lower courts, struck down a similar restriction in July, while the Florida Supreme Court that same month upheld such a restriction. One possible explanation for the enactment of so few laws in these areas this year is that these restrictions have previously been advanced, and many have been enacted, in the states over the years (see chart).

Family Planning Funding Limits

In what may be quietly becoming a national trend, antiabortion lawmakers in several states have been pushing for “gag rules” on their family planning programs, similar to the restriction on the federal program attempted by the Reagan and first Bush administrations—itsself patterned on the international gag rule (or “Mexico City” policy) the current President Bush reimposed on his first full day in office. In June, Ohio enacted a prohibition on the use of state family planning funds to perform abortion-related counseling or referral and a requirement that agencies receiving funds be physically and financially separate from affiliated groups that perform abortion services. These restrictions are similar to those renewed annually in Missouri, which were first upheld by a federal appellate court in 1999. Gag rules were stripped from budget bills in Minnesota and Wisconsin during conference committee negotiations; another version in Minnesota was vetoed with the abortion waiting period provision.

Contraceptive Coverage

For their part, reproductive health advocates have continued to make progress in requiring insurance coverage of contraceptives, with three states approving new mandates for a total of 16 (see chart). Missouri, New Mexico and Texas enacted laws requiring that insurers who cover prescription drugs cover all FDA-approved prescription contraceptive

MAJOR STATE ABORTION RESTRICTIONS

TYPE OF RESTRICTION	ENACTED IN 2001	NUMBER OF STATES WITH POLICIES
Requires a mandatory waiting period before an abortion	Arkansas (in effect) Virginia (effective October 2001)	16 in effect 1 effective later this year 4 enjoined or otherwise blocked
Requires parental involvement before a minors’ abortion	Oklahoma (in effect)	32 in effect 10 enjoined or otherwise blocked
Prohibits funding of medically necessary abortions for Medicaid recipients*	Idaho (enjoined)	31 (plus DC) in effect 15 enjoined or otherwise blocked

*Except in exceptional cases (typically in cases of life endangerment, rape or incest).

STATES REQUIRING COMPREHENSIVE INSURANCE COVERAGE OF PRESCRIPTION CONTRACEPTIVES

	INCLUDES RELIGIOUS EXEMPTIONS FOR	
	EMPLOYERS	INSURERS
1998		
MARYLAND	X	
1999		
CALIFORNIA	X	
CONNECTICUT	X	*
GEORGIA		
HAWAII	X†	
MAINE	X	
NEVADA		X
NEW HAMPSHIRE		
NORTH CAROLINA	X	
VERMONT		
2000		
DELAWARE	X	
IOWA		
RHODE ISLAND	X	
2001		
MISSOURI‡	X†	X
NEW MEXICO	X	
TEXAS‡		X

**A religious insurer is not exempted from the mandate but may provide for the coverage of contraceptives through a subcontract with another insurer or a third-party entity. †An enrollee whose employer objects to coverage of contraceptives may purchase such coverage directly from the insurer. ‡Scheduled to go into effect in January 2002.*

drugs and devices. (Texas had a 1978 regulation mandating coverage of oral contraceptives but not the full range of prescription options.) Washington State issued regulations in January to the same effect, although the state’s new insurance commissioner is revising them before they become effective next year.

Both reproductive health advocates and lawmakers have been reinvigorated by two rulings—one in December 2000 by the Equal Employment Opportunity Commission, the other in June by a federal district court judge using the same reasoning—that employer exclusion of contraceptives from their employees’ health coverage while including other preventive care constituted sex discrimination in violation of Title VII of the federal Civil Rights Act. Although the rulings technically applied only to the specific

companies in question, proponents of contraceptive coverage have used them to bolster their arguments that failure to provide coverage is a form of illegal discrimination against women.

The most significant challenges to contraceptive coverage legislation this year have continued to come from battles over proposed exemptions for religious employers and insurers (“State Contraceptive Coverage Laws: Creative Responses to Questions of ‘Conscience,’” *TGR*, August 1999, page 1). This issue has been the primary obstacle to a mandate in New York, where both chambers have approved competing bills but with the Senate insisting on an exemption. All three new laws include some type of exemption: Missouri’s, a painstaking compromise, is the broadest, applying to employers, insurers and individual enrollees and allowing for moral and ethical objections, in addition to religious ones. However, it also allows enrollees to buy coverage directly from the insurer, and it protects enrollees from discrimination and guarantees their privacy in relation to their decisions about coverage. The New Mexico exemption applies only to employers, while the Texas exemption applies only to insurers; neither includes enrollee options or protections. Meanwhile, a state appeals court in July upheld a narrow religious exemption in California’s law.

Emergency Contraception

Advocates of reproductive health also continued to have some success in advancing a second major issue on their agenda: ensuring access to emergency contraception pills (ECPs). Lawmakers in several states have put forth legislation requiring hospitals to provide ECPs and information about them to women who have been raped, citing studies finding that hospital emergency rooms, both secular and religious, commonly do not provide such services. After a protracted debate, Illinois this year enacted a law requiring

hospitals’ state-approved protocols for treating sexual assault survivors to include the provision of medically accurate information on ECPs and information on how and when they may be dispensed; the law does not, however, actually require any hospitals to dispense the drugs. Similar legislation has been approved by the New York Assembly and is pending in the Senate.

Other states, meanwhile, are considering allowing pharmacists to dispense ECPs without an order from a physician. Such proposals follow the model of a successful Washington State program and parallel efforts to convince the FDA to make ECPs available over the counter (“Increased Awareness Needed to Reach Full Potential of Emergency Contraception,” *TGR*, June 2001, page 4). A Virginia bill passed both legislative chambers but was derailed by an attempt to require parental consent. A California proposal has passed the Senate and is pending in the Assembly.

Infant Abandonment

Finally, for the second straight year, legislation intended to offer a safe and confidential alternative to abandoning newborns (“The Drive to Enact ‘Infant Abandonment’ Laws—A Rush to Judgment?” *TGR*, August 2000, page 1) has had more traction than any other issue even tangentially related to reproductive health. Already this year, 18 states have enacted new infant abandonment laws, for a total of 34 states that have approved such laws, all since 1999; Illinois has also sent a bill to its governor. The laws allow a parent to relinquish a newborn without threat of prosecution for child abandonment. The laws are similar but vary, for instance, in their definition of “newborn” (from up to three days after birth to up to one year) and in the personnel or places authorized to accept a newborn (such as hospital emergency rooms, adoption agencies and police stations). ☉