SPECIAL REPORT

State Actions on Reproductive Health Issues in 1994

By Terry Sollom

In 1994, several significant, encouraging trends concerning reproductive health issues unfolded at the state level, as policymakers considered hundreds of legislative and administrative proposals. State legislators across the country were inundated with more than 436 bills related to abortion, family planning, teenage pregnancy and infertility.* By the end of the year, 19 of these bills had been approved, with five later vetoed. In addition, state officials weighed administrative policy changes, initiated at both the federal and state level, on fertility-related matters. While many of these changes were implemented, others are awaiting final action in 1995. A comprehensive examination of the various activities reveals the import state involvement has in the development of reproductive health policy and the provision of services.

Abortion Services

During the last legislative term, 304 bills on abortion-related issues were introduced in 38 states, with one-half meant to limit access to abortion services (by means of funding prohibitions, parental consent or notice for minors, and waiting period requirements) and one-third intended to protect abortion rights (by safeguarding clinics from harassment and violence and guaranteeing abortion legality). The high proportion of bills designed to preserve the provision of services is partly attributable to a backlash against efforts to outlaw abortion and against acts of violence targeted at clinic staff and property. By the end of 1994, two restrictive measures and two clinic access bills had been enacted. The most significant news, though, was that as a consequence of administrative and court rulings, an increased number of states could both fund most abortions for low-income women and expand income eligibility for subsidized abortions.

Abortion Legality

Attempts by state legislatures to ban abortion outright or severely restrict its legality appear to have ended. In 1994, no bills to outlaw abortion were even introduced. Such legislation had slowed to a trickle by 1993, mostly because the U.S. Supreme Court had reaffirmed the central holding of *Roe* v. *Wade*—that a woman has a constitutional right to choose abortion—in its 1992 decision in *Planned Parenthood* v. *Casey*. On the other hand, measures to guarantee abortion rights by statute continued to be introduced, although none was enacted. Prior to 1994, five states (Connecticut, Maine, Maryland, Nevada and Washington) had validated the right to choose abortion, either through voter referenda or through legislation.

Public Funding

Several affirmative developments with respect to public funding of abortion services transpired not in legislative chambers but as a result of administrative directives and court orders. In 1994 alone, four states (Idaho, Illinois, Minnesota and New Mexico) began subsidizing abortions for medically indigent women under most circumstances, bringing to 17 the number of states† that use their own funds, either voluntarily or under court order, to pay for abortions not covered by the federal government. (The federal-state medical assistance program, Medicaid, pays for abortions only when the woman's life is endangered by the pregnancy or if the pregnancy is the result of rape or incest.)

In Idaho, Illinois and Minnesota, courts ruled on state constitutional grounds that state funds must be made available to poor women for all "medically necessary" abortions, not just those needed in cases of rape, incest and life endangerment. In New Mexico, new regulations written by the state Department of Human Services and approved by the outgoing governor greatly expanded state-funded coverage; however, one provision of the regulations requires an indigent minor to obtain a parent's consent or convince her physician that she is mature enough to make the decision on her own. New Mexico does not have a parental consent or notice law for nonindigent minors seeking abortion.

Moreover, 16 of these states (all but New York) allowed their income eligibility criteria for Medicaid abortions to be set beyond their regular Medicaid ceiling so that they matched the expanded criteria set for low-income pregnant women seeking Medicaid coverage of pregnancy-related care. (In the mid-1980s, Congress greatly raised the income level at which pregnant women become eligible for Medicaid coverage, and gave states leeway to extend Medicaid eligibility above the level mandated nationwide. The federal government mandates Medicaid coverage for pregnancy-related services for women with incomes up to 133% of the federal poverty level; states have the option of including women with incomes up to 185% of poverty level. The rate at which the federal government matches state expenditures for services not related to pregnancy varies, with the average income eligibility level set at 55% of poverty level.) In practice, this allows some women with incomes above the federal poverty level ($7,360 for a single person) to obtain Medicaid-funded abortions. By making abortion services more widely available

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†Alaska, California, Connecticut, Hawaii, Idaho, Illinois, Maryland, Massachusetts, Minnesota, New Jersey, New Mexico, New York, North Carolina, Oregon, Vermont, Washington and West Virginia.

to low-income women, policymakers from these states intended to help women avoid unwanted births and reduce the prospect of welfare dependency.

In addition, by the end of 1994, all but eight states (Alabama, Kentucky, Mississippi, Missouri, Nebraska, North Dakota, South Dakota and Utah) were in compliance with federal policy mandating Medicaid coverage of abortions not only when pregnancy endangers the life of the woman, but also in cases of rape and incest. These changes came about as states implemented Congressional modifications of the federal Hyde Amendment that slightly expanded abortion coverage in 1993. Eight separate federal court decisions on this issue have universally ordered compliance.

Of 38 bills on funding-related issues introduced in the states last year, legislation to require a state to fully fund abortion services for low-income women (or at least write coverage of rape and incest into state law) was proposed in nine states, while legislation to roll back funding or restrict the use of public facilities and employees for abortion services was submitted in 10 states. This represented the first time in recent history when funding bills were evenly divided between those expanding and those restricting support for abortion services.

The only new funding law approved was in Louisiana, where the legislature, under extreme pressure, amended the state's life-only funding policy to allow for coverage of abortion in the case of rape and incest. The Louisiana legislature finally succumbed after the director of the federal Medicaid Bureau threatened to cut off $3 billion in reimbursements if the state's resistance to implementing the new Hyde language did not end and after a federal court ordered compliance.

Waiting Periods

Since the Supreme Court's *Casey* ruling in 1992, nine states have begun enforcing mandatory waiting periods and counseling sessions for women seeking abortion. Six became operational in 1994 alone as a result of court actions and one newly approved law. Ten years previous to *Casey*, state-ordered counseling designed to discourage women from having abortions and waiting periods that forced delays in obtaining abortion services were ruled unconstitutional. However, the Court revised that position in *Casey* to say these kinds of requirements are constitutional unless proven to be an "undue burden." Given this more lenient standard, antiabortion legislators have seized the opportunity to impose waiting periods and detailed counseling sessions. However, of the 49 measures introduced on this issue in 1994, just one was enacted; in fact, a majority of the bills died without being considered prior to adjournment. Most would have mandated extensive counseling about abortion and then required a 24-hour delay.

In South Carolina, a compromise measure was signed into law to require women to participate in a counseling session and then wait for one hour before having an abortion. In the case of a minor, the same counseling information is to be given to a parent, grandparent or guardian, who is to come to the facility to give consent to the minor's abortion. (State law requires the consent of one parent or grandparent.) These requirements are part of legislation that authorizes the state to develop and enforce regulations regarding the licensure and operation of abortion clinics.

Although waiting-period bills met with little legislative success last year, several legal actions resulted in the enforcement of requirements that had been approved previously in five states. Federal and state courts ruled that 24-hour waiting periods could take effect in North Dakota, Ohio, Pennsylvania, South Dakota and Utah. In the North Dakota case, the federal appellate court interpreted the statute as permitting counseling to be conducted over the telephone, thereby making the law less burdensome by allowing women to forgo an additional visit to the office. Only in Michigan did a 24-hour delay requirement fall; a state judge found it invalid on state constitutional grounds.

Parental Consent or Notification

In 1994, as in the last several years, more pieces of legislation were introduced on parental involvement than on any other abortion-related issue. The outcome of this continuous, high level of interest has been the enactment of such bills in 34 states since 1973. Court challenges have invalidated many of these laws, however; 26 currently are enforced. The growing acceptance of consent or notification requirements for minors seeking abortions lies in large part with legislators on both sides who have been willing to compromise. Recently, legislators have agreed to less onerous provisions—for instance, allowing a grandparent, an adult relative or a physician to be involved instead of a parent, or lowering the age requiring adult involvement. In any case, in accordance with U.S. Supreme Court rulings, most of the enforced laws include a mechanism to allow an alternative to mandatory involvement, generally an appearance before a judge to obtain a waiver.

Of the 60 measures concerning parental involvement that were introduced in 1994, bills to mandate notification or consent were proposed in 12 states, while bills to repeal laws, make existing laws less strict or guarantee minors' confidentiality rights were submitted in five states. Just one such law was enacted, however, and another was vetoed. In Kentucky, a new law requires an unmarried minor younger than 18 who seeks an abortion to obtain the consent of one parent or petition a court to have the consent provision waived. Although amendments to allow a grandparent to consent and to allow clergy or a psychologist to file for a waiver on behalf of the minor failed, the new law replaced a harsher law that mandated two-parent consent.

In Virginia, the governor, after intensive lobbying from antiabortion groups, vetoed a one-parent notification bill with a judicial bypass option. The legislature had approved the notification requirement for unmarried, unemancipated minors aged 16 or younger after more burdensome bills had been rejected and after the governor had indicated that he would sign the bill. In his veto message, the governor complained that the bill contained loopholes that would enable minors to sidestep "true" parental involvement.

Several legal actions in this area in 1994 had a range of consequences. A federal court struck down a one-parent notification law passed in 1993 in South Dakota because it did not have a judicial bypass option. In addition, a one-parent consent law passed in California in 1987 but never enforced was once again found unconstitutional. However, a one-parent consent requirement included in Pennsylvania's 1989 omnibus Abortion Control Act, which was the target of the *Casey* lawsuit, became operational in March 1994. Finally, a judge in Tennessee held that the state could enforce a one-parent notification requirement, but that physicians need not comply if they determined that notification would "harm the health of the minor."

Clinic Access

With the steady escalation of antiabortion harassment and violent incidents, including the murder of two doctors, two clinic staff members and a volunteer escort in the past two years, prochoice legislators in 1994 again introduced a record number of bills designed to safeguard women's access to abortion services and protect the lives and property of abortion providers. In fact, there were almost as many clinic access bills introduced as waiting period bills. By the end of the year, 11 states had

antiharassment laws on the books; prior to 1993, only four states had approved such legislation. The state laws accompany groundbreaking federal antiharassment legislation, the Freedom of Access to Clinic Entrances (FACE) Act, which President Bill Clinton signed in May 1994.

Of the 45 measures on clinic access introduced in 20 states, almost all specifically called for criminal penalties against protesters who threaten patients and staff, obstruct entrances or trespass at abortion facility sites. One-third of these bills also sought to establish civil liabilities, including the ability to obtain court orders barring further demonstrations. Several bills would have created "buffer zones" around a facility wherein particular types of antiabortion activity would be prohibited. In June, the Supreme Court ruled in a Florida case, *Madsen* v. *Women's Health Center,* that some court-ordered restrictions on clinic demonstrations are constitutional, including buffer zones designated to protect entrances and driveways and certain noise constraints on protesters outside the clinic.

In California, two new laws were enacted: one creating civil liability for individuals who block health care clinic entrances and one making the intimidation or harassment of the children of abortion providers and other health care workers a misdemeanor. (The state already had on the books a law prohibiting the obstruction of entrances to health care facilities.) New Hampshire's governor vetoed legislation that would have made it unlawful to interfere with access to medical facilities or with a licensed health care provider in the provision of legally permissible medical treatment. The bill would have made the first offense a misdemeanor and a second offense a felony punishable by 3–7 years in prison. The governor, who is not supportive of abortion rights, said that the bill was too broad and threatened constitutionally protected free speech. The legislature was unable to override his veto.

Family Planning Services

Significant nonlegislative actions taken in several states in 1994 helped augment the provision of family planning services to low-income women by tapping into the Medicaid expansions for pregnant women. In the legislative arena, 114 bills were introduced on matters relating to family planning, contraceptives and teenage pregnancy. By the end of the year, nine of these bills had been enacted and two others vetoed. None of the controversial measures that were intended to intimidate poor women into using the contraceptive implant or to deny welfare payments to pregnant or parenting minors passed. Nevertheless, they generated passionate debate and undoubtedly will be revisited in 1995, especially given the current nonpartisan drive to restructure the welfare system.

Public Funding and Welfare Reform

Three states—Maryland, Rhode Island and South Carolina—received permission (known as a waiver) from the federal government to extend the postpartum eligibility period for family planning services under the Medicaid program. For example, under Medicaid expansions enacted during the 1980s, Maryland provides Medicaid coverage for prenatal and maternity care to women with an income of up to 185% of the poverty level (far above the state's regular income eligibility ceiling of 43% of poverty); this expansion occurs regardless of whether the woman meets other criteria for Medicaid eligibility, such as family composition. Without the waiver, coverage for an "expansion" client must end 60 days after delivery, unless the woman qualifies under standard Medicaid rules. Maryland's waiver allows it to cover family planning services for these expansion clients for a five-year postpartum period, the longest period covered under any of the approved waivers. Both Rhode Island and South Carolina extended family planning services for approximately two years postpartum. Five other waiver applications are pending from Delaware, Illinois, Missouri, New Mexico and Washington.

These kinds of administrative waivers not only increase the number of low-income women receiving family planning services and maximize the state's family planning resources, they also reinforce the focus on maternal and child health by offering mothers with infants the means to manage birthspacing. In terms of welfare reform, family planning waivers provide low-income women a greater opportunity to prevent unintended pregnancies on a voluntary basis.

A variety of welfare reform measures were introduced in state legislatures in 1994, with a majority aiming to establish a time limitation for the receipt of benefits or a job-training requirement. Many of these bills also sought to establish a policy of "disincentives" (or punitive measures) as the primary strategy for regulating poor women's reproductive behavior. Such disincentives, designed to discourage out-of-wedlock births, included a "family cap" or "child exclusion" provision. Under a family cap, women who give birth to another child while receiving welfare would be denied an increase in benefits for the child. (Paradoxically, several reform bills included prohibitions on the use of welfare or other public funds to provide abortion information and counseling, as well as abortion services.) States cannot implement a family cap policy affecting the federal-state Aid to Families with Dependent Children (AFDC) program without first obtaining a waiver from the federal government. By the end of 1994, six states (Arkansas, California, Georgia, Indiana, New Jersey and Wisconsin) had received such waivers, while six others (Arizona, Maryland, Massachusetts, Nebraska, South Carolina and Virginia) had waiver applications pending.

Four of the welfare reform bills approved in 1994 included language regarding family planning. In Arizona and Nebraska, two newly enacted laws imposed a family cap on AFDC recipients and, in a minimal nod to assisting in the prevention of other births, required appropriate state agencies to inform recipients that publicly funded family planning services are available. However, in Nebraska, "services" cannot include counseling, referral or funding for abortion. Similarly, in South Carolina, a welfare reform measure passed in 1994 mandated, among other provisions, that information on contraceptive methods and family planning (excluding information on abortion) be disseminated to individuals applying for AFDC assistance. In Washington, a new welfare-related law directs the state not only to offer family planning information to each AFDC recipient, but also to provide women with assistance in obtaining services.

It is not known at this time if any of the states concerned with welfare reform increased state funding for family planning services to existing public health programs. It is known that in FY 1992, state governments spent a total of $155 million of their own revenues for contraceptive services for low-income women—24% of combined state and federal funding in this area. However, when inflation is taken into account, total public expenditures for contraceptive services decreased by 27% between 1980 and 1992.[1]

Teenage Pregnancy

As lawmakers in many states have proffered welfare reform legislation, there has been a resurgence in debate concerning

adolescent sexual and reproductive behavior—specifically, pregnancy and childbearing among unmarried teenagers. Some of the proposals aim to reduce welfare dependence and avert out-of-wedlock births by denying AFDC payments to unwed pregnant or parenting teenagers under age 18. Others propose denying benefits to parenting minors who choose not to live with a parent or under adult supervision, as well as forbidding AFDC payments if an infant's paternity is not established. There have also been suggestions to apply future AFDC savings toward group homes for teenage mothers, adoption assistance programs and abstinence education programs. During debate, however, some legislators have labeled these disincentives to teenage pregnancy and out-of-wedock births as "misguided" and have questioned the underlying assumption of these approaches that the mere availability of welfare benefits is a catalyst to adolescent pregnancy.

Of 44 bills introduced in 1994 concerning teenage pregnancy overall, a very limited number offered family planning approaches that would have assured the wide availibility of voluntary services to low-income adolescents who want to delay having a baby. Most bills addressed teenagers who were already pregnant or were parents. Four of these bills were enacted. Welfare reform legislation specific to minors was introduced in six states (Alabama, California, Georgia, Maryland, Michigan and West Virginia), but only one of these bills passed, and it was later vetoed.

Legislation enacted in Oklahoma established a joint legislative committee to review state efforts targeted at the prevention of adolescent pregnancy and sexually transmitted disease and to evaluate programs throughout the nation that have successfully reduced teenage pregnancy (including abstinence-only programs). In California, a new law created a task force to develop a comprehensive statewide strategic plan regarding the "epidemic" of adolescent pregnancy and parenting. Other legislation approved in California called for the organization of community-based parenting education programs for school-age students. In Washington, the state superintendent of public school instruction was authorized to provide school districts with grants to develop abstinence-based media campaigns.

The governor of California vetoed a compromise bill that would have required case-by-case determinations of whether an unmarried minor with a dependent child (or an unmarried pregnant minor) who does not reside with her parent or other legal guardian could receive AFDC benefits. Similar legislation that would have instituted a uniform statewide prohibition of such benefits was introduced but not considered in Georgia and Maryland. In Michigan, although both houses of the legislature approved such a measure, the bill was never finalized for the governor's signature.

The Contraceptive Implant

As it has been in previous years, the long-acting contraceptive implant continued to be a contentious subject in 1994, as legislators in several states promoted implant-related measures that were inconsistent with voluntary contraceptive use. Punitive or coercive practices, such as mandatory birth control requirements and incentives for contraceptive use, have been proposed since the implant received federal approval in December 1990, especially as support for welfare reform heightened. Even so, no bill offering public assistance recipients cash bonuses or other financial incentives for the insertion and continued use of the implant has as yet been enacted. In addition, no legislation requiring (or permitting courts to order) certain women—such as welfare recipients, pregnant women who abuse drugs or alcohol, or those who abuse or neglect their children—to use the implant has passed. On the other hand, six bills have been enacted since 1990 to facilitate women's voluntary, informed decision-making and expand implant access to lower income women who voluntarily choose the method but cannot afford its high price.

In 1994, 21 bills pertaining to the implant were introduced in 12 states; none was adopted. A breakdown of the legislation shows that nine bills would have provided incentives to women receiving public assistance or to female inmates, five would have mandated implant use for certain women or would have denied nonusers increases in their AFDC payments, two would have required that women receiving welfare be informed about the implant's availability, two would have permitted public school health programs to counsel students about the implant, one would have prohibited forced implant use as a condition of receiving AFDC benefits, one would have offered the implant free to women with an income at or below 185% of the federal poverty level, and one would have allowed a tax credit to health practitioners who provided the implant to AFDC recipients.

Insurance Coverage

For many higher income women, access to family planning services depends largely on the kind of private-sector health insurance that they carry. A recent study showed that 49% of typical private insurance plans do not routinely cover reversible contraceptive methods.[2] Oral contraceptives, for example, are routinely covered by only 33% of plans, even though 97% of plans cover prescription drugs. Despite this lack of coverage, state legislators in general made short shrift of reproductive health care services last year (particularly coverage of family planning services and supplies) when considering efforts to rework their state's health care system.

In 1994, legislation regarding private insurance coverage for contraceptive services was introduced in three states, but was not adopted. In Hawaii, a bill was submitted that would have mandated private-sector insurance coverage for contraceptive procedures and supplies. (In 1993, the legislature had approved a measure requiring insurers to determine the cost of providing coverage for contraceptive services and supplies and employers to consider including this coverage in the plans that they offer to employees. This law was seen as a stepping stone to mandating coverage in the near future.) In California, a bill was offered that would have directed all private-sector health plans to provide coverage for all prescription contraceptive devices and for "contraceptive management, including, but not limited to, counseling and advice." Requiring coverage of prescription contraceptives was also proposed in a measure from New York. Currently, no state specifically mandates coverage for contraceptive services.

Infertility Services

In 1994, 18 measures on insurance-related matters pertaining to infertility were introduced in 11 states. Most dealt with whether (and to what extent) private and public medical coverage should be available for the diagnosis and treatment of infertility. By the end of the year, one such bill had been enacted and one had been vetoed.

Publicly Funded Coverage

Infertility services for Medicaid recipients came under fire as state lawmakers worked on health care and welfare reform measures. In keeping with efforts both to prune back subsidized health services deemed not "medically indicated or necessary" and to thwart Medicaid-eligible women from having additional children, eight states (Alabama, Connecticut,

Maine, Massachusetts, Montana, Pennsylvania, West Virginia and Wisconsin) acted—either through administrative ruling or through legislation—to prohibit Medicaid coverage for fertility drugs and therapies. The federal government allows states the option of whether to cover infertility services under Medicaid; consequently, it is also within a state's discretion to discontinue such services.

Of the three legislative proposals to ban such publicly funded coverage, one was enacted. A new law in Pennsylvania prohibited Medicaid reimbursement for any medical service, procedure or drug related to infertility therapy. A similar bill introduced in New York was not adopted; that bill also would have excluded reimbursement for the reversal of tubal ligation. In New Jersey, an antifunding measure submitted in 1994 was carried over for consideration in 1995.

Private-Sector Coverage

For the third consecutive year, no state enacted a law mandating infertility coverage in private-sector insurance plans. From 1985 to 1991, seven states (Arkansas, Hawaii, Illinois, Maryland, Massachusetts, New York and Rhode Island) had approved mandatory coverage of infertility diagnosis and treatment, and three states (California, Connecticut and Texas) had enacted laws requiring insurance companies to offer such coverage. The trend toward mandatory inclusion ended at around the time that legislatures began to tackle health care reform measures. Despite this development, all attempts in 1994 to roll back mandated infertility-related benefits were unsuccessful.

Fifteen measures that would have required private insurance coverage (or would have expanded existing mandates) for the diagnosis and treatment of infertility were introduced in 1994, with most specifying that coverage would be available only if pregnancy-related conditions were already covered in health insurance policies; none of these was enacted. The governor of California vetoed a measure that would have mandated private insurers to provide coverage for infertility services on the same terms and conditions as other policy benefits and would have prohibited such services from being subject to copayments, lifetime benefit limits or other restrictions that differ from other policy benefits.

In Maryland, legislation intended to amend the state's 10-year-old law mandating private-sector infertility insurance coverage died: The bill would have expanded services by eliminating a five-year waiting period for certain assisted reproductive technology services, ordering health maintenance organizations to offer in vitro fertilization procedures, requiring private health plans to cover at least four in vitro fertilization attempts, requiring the state employee health plan to include the same benefits offered by private-sector insurers, and stipulating that male and female infertility be given equal consideration in determining who qualifies for services.

Conclusions

Although several actions taken in the states in 1994 demonstrate promising movement toward expanding abortion services for low-income women, expanding publicly funded family planning services, rejecting coercive contraceptive use proposals and protecting access to abortion clinics, there are many potential problems ahead for reproductive health policies and services. Support is mounting for welfare reform measures with punitive provisions, waiting periods for abortion services and overall cutbacks in subsidized health programs.

Just as a markedly more conservative Congress took office in January 1995, so a similar conservative swing occurred in the states. Indeed, a majority of state and federal legislators are espousing the same themes of eliminating or consolidating social welfare programs, lowering taxes, restructuring welfare and shrinking government. During the upcoming debates on these issues, state lawmakers are expected not only to seek to make their mark at home, but assuredly will be major players in influencing the national domestic policy agenda as well. The implications of these actions on reproductive health services could prove dramatic.

Legislators' hesitance last year to acknowledge the relevance of family planning services and, as a backup measure, abortion services as an integral part of the welfare solution is striking. The need to educate policymakers about the importance of ensuring low-income women's access to services that can enable them to prevent unintended pregnancies and unwanted births on a voluntary basis is imperative, not only to protect women's well-being and promote their self-sufficiency, but also as a cost-effective way of dealing with the myriad problems of unplanned pregnancy, unwed motherhood, teenage pregnancy and welfare dependency.

Last year was a good start in many ways; it is now the legislators' task to continue their work on bolstering public policies that enhance the ability of disadvantaged women to control their childbearing voluntarily. Women's ability to determine the number and spacing of their children, regardless of income, is critically important, and the means to manage their reproductive lives depends on the provision of equal and safe access to the full range of reproductive health care services.

References

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