



13 Ways States Can Protect and Advance Women's Health and Rights

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November 30, 2018

Since President Donald Trump ascended to the White House in January 2017, the federal landscape in women's health and rights has shifted dramatically as the administration has stalled and reversed years of progress. Attacks on family planning programs, rollbacks to the Affordable Care Act's (ACA) contraceptive coverage benefits, and reversals of patient nondiscrimination protections represent just some of the administration's actions that undermine reproductive rights.¹ Action at the state level has also been mixed, with many states pushing forward socially conservative and restrictive policies.²

However, with the results of November's midterm elections and with key changes in governors' mansions and state legislative chambers—in addition to changes at the federal level—states now have the opportunity to challenge these regressive policies and champion forward movement in women's health and rights. Even in states that remain under the control of conservative leaders, changing demographics and increasing support for key aspects of women's health and rights may encourage more legislators and governors to consider progressive proposals. Many of the women who won in this election—from Govs.-elect Gretchen Whitmer (D-MI) and Laura Kelly (D-KS) to Sen.-elect Kyrsten Sinema (D-AZ)—ran on pro-women platforms that explicitly embraced reproductive health access, including abortion care, as a fundamental right.³ Their wins are a testament to the power of women as a voting bloc and speak to the importance of incorporating women's health and rights into any legislative agenda.

This issue brief explores 13 ways that states across the country can capitalize on flipped state control and a changing country in order to protect and advance women's health and rights.

1. Preserving and expanding access to abortion care through proactive policy and legislation

Preserving access to abortion care

In 1973, the Supreme Court affirmed a woman's constitutional right to access abortion in its watershed *Roe v. Wade* decision.⁴ The law has given women the legal right to pursue abortion care—although these rights have not always translated into unhindered

access—and has generally conferred social and economic benefits that have allowed women to pursue their educational and professional goals.⁵ Today, abortion access is fundamental to women’s reproductive rights.

However, since 1973, states have introduced and passed a steady stream of administrative and legislative restrictions to abortion access in repudiation of *Roe*. These efforts have ramped up in recent years: Between January 2011 and July 2016, states enacted more than 300 restrictions to abortion access, and in some states, restrictions have made access to abortion care essentially impossible.⁶ For example, recently approved ballot measures in Alabama and West Virginia amend these states’ constitutions in ways that fundamentally undermine a woman’s right to an abortion.⁷ Such legislative maneuvers lay the groundwork for states to immediately ban abortion if *Roe* is overturned and only serve to underscore the necessity of strong state action to secure abortion rights.

Up to this point, much of the work to protect abortion access has been defensive. However, with the confirmation of Judge Brett Kavanaugh to the Supreme Court, the future of *Roe* is under threat and its protections are no longer a guarantee. If *Roe* were overturned today, 22 states would very likely ban abortion outright, while nine states’ unenforced and antiquated pre-*Roe* abortion bans could become de facto state law.⁸

For these reasons, it is critical to craft proactive policies that protect abortion care at the state level. Just this past July, Gov. Charlie Baker (R-MA) signed legislation that repealed a pre-*Roe* abortion ban criminalizing women for obtaining an abortion.⁹ The nine states with these unenforced bans on the books—including Michigan, New Mexico, and Wisconsin, with their newly elected governors—have the opportunity to pre-emptively take action against pre-*Roe* bans. Even in states that have expressed a strong intent to limit abortion access, recent governor pickups for Democrats, such as Gov.-elect Laura Kelly in Kansas, mean that traditionally conservative states now have the chance to enact protective measures around abortion access via executive orders or other legislative measures.

States must also recognize that for many women, access to abortion care is still out of reach because of insurance restrictions that prohibit coverage.¹⁰ The U.S. Department of Health and Human Services recently proposed rules that would force insurance companies to bill consumers separately for the portion of their premium that goes toward abortion services for plans on state-based and federal ACA marketplaces. This would single out abortion coverage by making the billing and payment process confusing and burdensome for insurance companies and consumers alike.¹¹ Such a move would be particularly harmful to women in the four states—California, New York, Oregon, and Washington—that require state-regulated private insurance plans to cover abortion services, as these state policies may soon be in conflict with new federal precedent.¹² Also, while 15 states have policies that direct state-based Medicaid funding to cover medically necessary abortion services, 34 states

and the District of Columbia employ restrictions similar to those in the federal Hyde Amendment, only using state Medicaid funds for abortion care in cases of life endangerment, rape, or incest.¹³ Fifty-four percent of women of reproductive age who are enrolled in Medicaid or the Child Health Insurance Program live in one of these 34 states or the District of Columbia.¹⁴ One state, South Dakota, goes a step further, only providing state funding for abortion in cases of life endangerment—a clear violation of federal standards. Insurance restrictions on private health plans and public insurance programs must be overturned to ensure all women have equitable access to abortion care.

Expanding access to abortion care

In addition to pre-emptive defensive action, states can also forge ahead with progressive policies and laws that expand access to abortion. Members of Maryland's state legislature are planning to introduce legislation for a ballot measure that would enshrine abortion rights in the state constitution, despite Gov. Larry Hogan's (R) personal opposition to abortion rights.¹⁵ And last year, Oregon Gov. Kate Brown (D) signed into law the Reproductive Health Equity Act, which ensures that all Oregonians have access to abortion care regardless of insurance status or income level.¹⁶ A slew of other states may follow suit.

Another way to increase access to abortion care is for states to expand the availability of medication abortion. Medication to induce an abortion is generally taken within the first 10 weeks of pregnancy and is considered very safe and less expensive than surgical abortion.¹⁷ To improve access, Gov.-elect Janet Mills (D-ME) pushed forward a bill while she was state attorney general that would allow providers other than physicians—advanced nurse practitioners and physician assistants—to administer the medication, a move that was particularly important for women in rural and underserved regions.¹⁸ And there are a number of other ways states can improve access to medication abortion. For example, they can lower administrative and financial barriers, such as a requirement for physicians to keep stocks of mifepristone—one of two drugs used for medication abortion—on hand, and they can also permit pharmacists to dispense the medication with a prescription.

Self-managed medication abortion is another important tool that states can use to expand access to abortion care and ensure equitable access for all women. Self-managed medication abortion, which numerous studies have found to be safe and effective, allows women to obtain important medical care outside of a clinic or hospital setting if the services offered in these venues are inaccessible or do not meet a woman's needs.¹⁹ Providing women with more options is key, especially for women of color, many of whom face numerous financial and logistical hurdles to accessing abortion care and who, for reasons related to a history of reproductive coercion and exploitation, have a distrust of the health care system.²⁰ Unfortunately, dozens of states—including New York, Arizona, and Michigan—have erected legislative barriers to medication abortion. Currently, seven states criminalize self-managed medication abortion generally, 10 criminalize women for harming a pregnancy, and 15 have laws that could be misapplied to women who self-manage medication abortion.²¹

And while some state legislatures, such as those in Rhode Island and West Virginia, have introduced bills to decriminalize self-managed medication abortion, much work remains to be done.²² States now have the opportunity to overturn these punitive laws and offer women access to the services they need.

2. Improving access to contraceptives by expanding coverage and delivery models and offering additional types of contraceptives

The United States has one of the highest unplanned pregnancy rates among developed countries; in 2011, nearly half of all pregnancies were unintended.²³ Access to reliable contraceptives is therefore a vital tool to reduce unintended pregnancies and to plan for safe, healthy pregnancies. The ACA requires that insurance plans make contraceptives available to women at no out-of-pocket cost. However, under the Trump administration, access to contraception has been curtailed through, among other things, rollbacks to this contraceptive coverage requirement and attacks on the Title X family planning program.²⁴ Just as states should look for innovative and progressive ways to protect abortion access, so too should they consider ways to protect and expand access to contraceptives.

Two key barriers to accessing contraceptives are restrictions on the types of contraceptives that insurance plans will cover and prescription quantity limits. In response, some states have stepped in to address the shortfall. In 2016, Maryland passed the Contraceptive Equity Act, which ensures coverage of all forms of contraceptives for women and men—including over-the-counter birth control—at little to no cost and in six-month batches.²⁵ And in anticipation of the ACA contraceptive coverage requirement being further eroded, Maine's and New York's state legislatures pushed forward bills that would require insurance companies to cover contraceptives for up to one year with no cost-sharing.²⁶

States can also improve access by making contraceptives available over the counter as well as by expanding pharmacists' scope of practice. Utah and the District of Columbia recently passed measures that allow pharmacists to dispense contraceptives without a doctor's prescription.²⁷ It is also key to educate pharmacists about how to appropriately dispense contraceptives over the counter and to provide educational materials to patients. And recently, Iowa Gov. Kim Reynolds (R) introduced a proposal to allow women to obtain contraceptives over the counter, modeling her plan after a similar proposal in Oregon.²⁸

States can also improve contraceptive utilization by making long-acting reversible contraceptives (LARCs) more accessible. LARCs have been shown to be incredibly effective at reducing rates of unintended pregnancies, particularly when administered postpartum and post-abortion.²⁹ In 2014, Delaware formed a private-public partnership with the nonprofit Upstream to launch Contraceptive Access Now, which, among other things, ensures that hospitals are reimbursed separately for providing LARCs postpartum and helps providers employ new device-stocking strategies to allow for same-day insertions.³⁰

Since the implementation of this initiative, Delaware has seen a substantial increase in LARC use and subsequent drops in unintended pregnancy rates.³¹ Colorado has undertaken a similar initiative in expanding access to LARCs, with equally impressive reductions in teen pregnancy and abortion rates.³²

Colleges have also made recent gains in access to contraceptives for their student populations. These gains include increasing the accessibility of health centers, through which most students receive their contraceptives; establishing relationships with nearby pharmacies that students can visit if health center services are not available; and ensuring students' health insurance plans cover contraceptives with no cost-sharing. Unfortunately, access to contraceptives in college is not universal or unfettered; many religious institutions have been involved in lengthy legal battles over the ACA's requirement that health insurance plans, including student plans, cover all Food and Drug Administration (FDA)-approved contraceptive methods with no cost-sharing.³³ Just recently, the Department of Health and Human Services finalized rules exempting entities—including higher education institutions—from being required to cover contraceptive services if they object on religious or moral grounds.³⁴ This means that thousands of students across the country could be left without viable means to obtain contraceptive care. States must step in to meet the shortfall by expanding insurance coverage at the state level for their student populations.

3. Protecting funding for family planning services

Family planning services—which allow for women to decide on birth spacing and family size through access to contraceptive services, pregnancy testing and counseling, and sexually transmitted infection services—have played a critical role in the United States.³⁵ In 2014, these services helped women avoid about 2 million unintended pregnancies, thereby preventing nearly 1 million unintended births and almost 700,000 abortions.³⁶ Without publicly funded family planning services, rates of unintended pregnancy, unplanned birth, and abortion could have been 68 percent higher.³⁷ The cost savings from family planning services have also been significant, saving federal and state governments \$13.6 billion in 2010.³⁸

Unfortunately, many of these services have been chipped away or eliminated as a result of funding restrictions to grant programs such as Medicaid, Title X, and federal block grants.³⁹ For example, in Arizona and Michigan, the allocation of these funds is barred to certain family planning providers that also offer abortion with private funds.⁴⁰ These types of restrictions must be undone if states are committed to allowing women and men to select the providers that best meet their needs.

States must also ensure that funding is directed toward comprehensive family planning providers that offer medically accurate information and quality care. Unfortunately, many states have instead sought to permanently fund fake women's health centers—ideologically driven centers that use coercion and manipulation to prevent women from

considering abortion as part of their reproductive options. In 2018, 14 states funneled \$40.5 million in state taxpayer dollars—including funds meant for the Temporary Assistance for Needy Families block grant—to programs that finance these fake centers and even made some of this funding permanent.⁴¹ Over the past several years, the North Carolina state legislature also redirected some of its Maternal and Child Health block grant to a group that funds these centers.⁴² Regulation and oversight of these funder groups is lax at best, and misuse and abuse of funds by their grantees is rampant. In fact, state auditors in Pennsylvania and Texas have entered into repayment plans or canceled contracts with funder groups because of misused funds or lack of progress in reaching proposed health outcomes and cost savings goals.⁴³ States must prevent the flow of dollars intended for low-income families to fake centers and move away from allocating permanent funding for them in their state budgets. To combat the reach of fake women’s health centers, governors such as Andrew Cuomo (D-NY) have launched public awareness campaigns to help connect women to comprehensive and confidential reproductive health clinics.⁴⁴ Other states can pursue similar strategies to ensure that their residents are receiving complete, evidence-based medical care and are not being misdirected or denied care by ideologically driven organizations.

4. Safeguarding the patient-provider relationship

The relationship between patients and their doctors is centered on trust and confidentiality. In no other domain are these tenets more important than in reproductive health care, which often involves intimate, difficult conversations and decisions. However, over the past decade, attacks against providers and patient privacy have ramped up on the state level. State policymakers must develop proactive solutions to protect the relationship between patients and their providers from this onslaught of attacks.

Over the summer, the Trump administration issued a proposed rule—called the “domestic gag rule”—that would prohibit Title X grantees from providing the full range of pregnancy-related options, including abortion care, to their patients.⁴⁵ The rule would do this by, among other things, forcing providers to lie to their patients or withhold information that women need to make the best decision for themselves and their families.⁴⁶ The gag rule is part of the administration’s attempts to reshape the Title X grantee network and foist abstinence-only and fertility-based awareness methods on women, thus denying them access to a full suite of reproductive health options.

The domestic gag rule would also require parents or guardians to be involved in a young person’s decision to obtain family planning services. For example, under the rule, Title X providers would be required to document the particulars of their interactions with adolescent patients, such as actions the provider took to encourage family participation and sensitive information about patients—including the age of their sexual partners.⁴⁷ This could have a chilling effect on teen clients who would otherwise be interested in family planning services, as they may no longer feel they

can receive confidential and safe care.⁴⁸ Young people's failure to seek care can lead to a host of negative outcomes, as adolescents are at higher risk of having unintended pregnancies and contracting sexually transmitted infections than other age groups.⁴⁹ States that are interested in protecting young people's access to a vital source of care should secure the privacy rights of clients who utilize Title X clinics.

Three states have introduced legislation that attempts to prevent and even reverse the erosion of the patient-provider relationship. Pennsylvania introduced the Patient Trust Act, which seeks to preserve and protect the patient-provider relationship from political interference.⁵⁰ Meanwhile, in the Ohio House of Representatives, policymakers drafted the Doctor-Patient Relationship Protection Act, which would ensure that doctors who choose not to disseminate scientifically inaccurate information or choose not to perform medically unnecessary services do not face any criminal charges.⁵¹ And Massachusetts successfully passed the PATCH Act, which ensures that private health information is not conveyed to an insurance plan's primary policyholder, a fact that is vital for young women as well as women in abusive relationships.⁵² Each of these laws centers women's health care within the patient-provider relationship and explicitly prohibits outside political interference or the intrusion of non-evidence-based facts into medical decision-making.

5. Limiting religious exemptions in order to protect patient rights

The promise of religious liberty is being co-opted in order to justify health care discrimination and denial of care when it comes to sexual and reproductive health care. With new guidance issued by the Department of Justice last year broadly expanding the scope of so-called religious liberty and conscience protections, followed by rules allowing employers and health care workers to deny care based on their religious and moral objections, it is up to states to step up to the plate and create protections against this type of overreach.⁵³

Under the federal government's proposed rules, hospitals, health care workers, and pharmacists across the country can refuse to dispense medication or administer reproductive health care by claiming that such actions would conflict with their religious or moral beliefs.⁵⁴ In addition, an equally troubling provision requires health care institutions to accommodate personnel whose religious beliefs conflict with their duties, potentially exempting personnel—from schedulers to physicians—from having to fulfill their job duties related to reproductive health services and other health care.⁵⁵ The Trump administration also recently finalized rules that provide religious and moral exemptions to a wide swath of employers who, under the ACA, were required to provide their employees with contraceptive coverage.⁵⁶

Certain states have taken measures to ensure that the expansion of religious exemptions does not continue to come at the cost of reproductive health care. For example, legislation in Illinois would require health care facilities to ensure that religious objections do not prevent patients from accessing timely care and that patients have

alternative options to care that are available on-site or by referral.⁵⁷ A 2009 Louisiana law requires providers to present current and potential patients with written notice of their objections, so that these patients can seek care elsewhere.⁵⁸ And eight states prohibit pharmacists from refusing to fill contraceptive prescriptions or provide emergency contraceptives when requested.⁵⁹

6. Expanding access to reproductive health services through telemedicine

Despite impressive advances in medicine, according to the Health Resources and Services Administration, the United States will face a shortage of about 20,400 physicians by 2020.⁶⁰ Even today, about 20 percent of Americans have limited or no access to primary health care because of physician shortages.⁶¹

These statistics highlight the important role of telemedicine for increasing access to reproductive health services, among other things. Telemedicine is a tool used to deliver health care services and other information to patients using telecommunications technology, allowing providers to administer care from another city or even another state. By allowing patients to access care remotely via broadband connection, irrespective of geography and with fewer logistical barriers, telemedicine can improve health outcomes and the quality of care while helping to address the nation's physician shortage.⁶²

Dozens of states have set up reimbursement schemes for telemedicine; for example, 46 states and the District of Columbia provide Medicaid reimbursement for services rendered via live videoconference.⁶³ However, there are restrictions on the types of care allowed. Telemedicine medication abortion is one of the most restricted forms of telemedicine care, despite studies finding it to be as safe as abortion care administered in-person and highly acceptable to patients.⁶⁴ Nineteen states currently ban the service outright.⁶⁵ Fortunately, there are some states—including Minnesota and, recently, Maine—that do allow for medication abortion by telemedicine.⁶⁶ As state legislatures move to make abortion access more difficult, access to telemedicine can help those women who still want to pursue abortion care to more easily obtain such care across state lines.

Similarly, there are digital apps that make access to contraceptives easier. Today, 20 states and the District of Columbia allow women to order contraception online without a prescription and receive it in the mail. Patients receive contraceptive counseling by chatting with a provider via text or video link and filling out a form to ensure they understand side effects and risks.⁶⁷

Telemedicine has also been used to improve maternal health outcomes. Providers are increasingly using new telemedicine case management strategies for medically high-risk pregnancies, which can help prevent the progression of obstetrical complications and improve the chances that women have safe deliveries at local hospitals.⁶⁸

This technology is being expanded to medically low-risk pregnancies through the use of virtual at-home visits, during which a prenatal provider can instruct women on how to use home monitoring supplies to track maternal blood pressure and fetal heart rates.⁶⁹ These interventions have been found to produce similar outcomes to traditional prenatal care and offer women significant cost and time savings—an important boon to low-income women and women who live in rural settings.⁷⁰

7. Encouraging states to protect and expand their Medicaid programs

The ACA allows states to expand federally funded Medicaid coverage to nonelderly adults with incomes up to 138 percent of the federal poverty level. Medicaid expansion opened the doors to coverage for many populations with some of the highest uninsured rates, including low-income women; and among nonelderly women, the uninsured rate fell from 17 percent in 2013 to 11 percent in 2016.⁷¹ Medicaid has had a significant positive impact on women and their reproductive health, allowing millions more women to gain coverage for critical reproductive health services such as contraceptives, cancer screenings, and maternity care, which are essential health benefits under the ACA. As of November 2018, 36 states and the District of Columbia have implemented or plan to implement Medicaid expansion.⁷² A CAP analysis found that expanding Medicaid in nonexpansion states, as well as in states that only recently implemented Medicaid expansions, could save 14,000 lives per year.⁷³

Despite repeated attempts at the federal level to repeal the ACA and roll back its Medicaid expansion, these efforts have fallen flat and have even been rebuked, as it is clear to voters and policymakers alike that health care coverage leads to better health outcomes.⁷⁴ Voters in Idaho, Nebraska, and Utah just approved ballot measures that would expand Medicaid in their states, allowing an additional 325,000 low-income adults to gain Medicaid coverage; meanwhile, recent flips in governors' mansions in Kansas and Maine may allow previous legislative attempts to pursue expansion move forward without the threat of veto.⁷⁵ Gov.-elect Janet Mills may also choose to advance a ballot measure to expand Medicaid that was approved by Maine voters last year but was repeatedly blocked and ignored by then-Gov. Paul LePage (R).⁷⁶

In the past couple of years, the Trump administration has attempted to transform federal policy around Section 1115 Medicaid demonstration waivers. Historically, these waivers have been used to promote flexibility in how federal funds, including Medicaid funds, are used by states in order to test new coverage approaches and health care delivery models. Now, the administration is pushing states to instead apply these waivers more narrowly by issuing strict work and community engagement requirements for Medicaid enrollees.⁷⁷ States should resist federal initiatives to impose these burdensome requirements on Medicaid enrollees and eliminate existing work requirements that have been approved for the first time under this administration. More than a dozen states have already sought waivers to impose work requirements on Medicaid

enrollees. As of November 2018, four states—Arkansas, Indiana, New Hampshire, and Wisconsin—have had their Section 1115 waivers approved, and 11 states’ waivers are pending approval.⁷⁸ These work requirements would harm women, who are more likely to be caregivers for children or family members, thus making it difficult for them to work the minimum number of hours per month. Many women are also employed in industries with irregular working hours that, on an annual basis, reach the hourly threshold but, on a monthly basis, may fall short and lead to termination of coverage.⁷⁹ In Arkansas, 12,000 residents have already lost coverage due to supposed noncompliance with these strict requirements.⁸⁰

8. Ensuring women and girls with pre-existing conditions are protected on the insurance marketplace

The midterm elections revealed the potency and importance of pre-existing conditions coverage, especially for women. Before the ACA, insurance companies in the individual market could charge higher premiums to people with health conditions or even deny them coverage altogether. Women faced discrimination in the insurance market due to pregnancy and childbirth-related procedures such as cesarean sections, as well as due to reproductive cancers such as breast and ovarian cancer.⁸¹ The transgender community also faced significant and harmful coverage exclusions; being transgender prior to the passage of the ACA was considered a pre-existing condition and often resulted in denial of coverage for medically necessary treatments for gender transition, routine preventive services, and even basic medical needs.⁸² With more than 67 million women and girls experiencing a pre-existing condition and almost 20 percent of transgender patients being refused treatment by a provider because of their gender identity, the ACA offered a powerful way to balance the scales and ensure that women and transgender people could not be denied coverage in the individual market.⁸³

Recently, however, this hard-won progress has been undermined by congressional efforts to repeal the ACA, coupled with the Trump administration’s move to widen the availability of short-term junk plans—which can exclude coverage for pre-existing conditions. One of the latest attacks on the ACA began this past February when 20 state attorneys general issued a questionable lawsuit challenging the constitutionality of the ACA; former Attorney General Jeff Sessions then decided not to defend important parts of the law that were under challenge—namely, community ratings and guaranteed issue provisions.⁸⁴ These two parts of the law, which ensure that people cannot be charged more based on health status or denied coverage, are crucial to protecting comprehensive coverage for people with pre-existing conditions. Of the 20 states that joined this lawsuit, nine have among the highest rates of pre-existing conditions in the country for adults less than 65 years old.⁸⁵

Other state attorneys general and governors have stepped in to answer these threats. Eighteen states, led by California state Attorney General Xavier Becerra (D), are currently defending the ACA in court against this lawsuit.⁸⁶ And Gov. Kate Brown of Oregon led eight other states in a call for the federal government to protect the ACA, while also raising concerns about the former attorney general's actions.⁸⁷ It is incumbent on states such as California and Oregon, as well as others who joined suit—such as Illinois and Minnesota—to engage in any necessary legislative or administrative action to protect the health of their constituents. These states must also continue their work to prohibit discrimination in the insurance marketplace on the basis of sex, sexual orientation, and gender identity and to bar coverage exclusions for procedures such as cesarean sections and transition-related care.

9. Reducing health disparities through targeted policy and legislation

Health disparities are often rooted in racial discrimination and systemic disenfranchisement, causing African American, Hispanic, and Native American populations as well other communities of color to experience greater rates of disease, disability, and premature death.⁸⁸ According to the National Conference of State Legislatures, excess costs for racial and ethnic groups are responsible for about 30 percent of direct medical expenditures, and if health disparities were completely eliminated, indirect costs would fall by more than \$1 trillion.⁸⁹

Two states in particular have taken strides in identifying key areas where disparities exist and passing legislation to address them. This year, the New York State Senate passed a bill aimed at reducing New York's maternal mortality rates and creating more equitable maternal health outcomes by establishing a state maternal mortality review board.⁹⁰ This is an acknowledgement of the significant disparities in maternal health outcomes for African American mothers, who are 12 times more likely to die due to pregnancy-related complications than white women.⁹¹ In regards to mental health, racial disparities do not necessarily exist in incidence of mental health issues, but rather in access to services to diagnose and treat conditions. That is why Kansas' move to increase diversity among mental health nurses was important, as a lack of cultural competency and diversity among health care providers can disincentive people of color from pursuing services.⁹² In the same way that dozens of states have created maternal mortality review boards in an effort to reduce disparities in maternal health outcomes, states could create general review boards on disparities. These could be run by state health departments that would report on outcomes to the state legislature.

10. Promoting gender equity by eliminating the “pink tax”

It has been well-documented that women face additional costs related to their general purchases, compared with men. In fact, the New York City Department of Consumer Affairs found that products marketed toward women cost about 7 percent more than products marketed toward men.⁹³ This gender-based price discrimination—known as a “pink tax”—can have an outsized impact on women who are already low-income and financially insecure.

Taxes on feminine hygiene products are especially problematic; 36 states currently classify these products as luxury items, which carry commensurate taxes.⁹⁴ However, these products are a medical necessity for many women. Just recently, Nevada joined nine other states in eliminating their tax on feminine hygiene products, through which the state had previously made \$900,000 to \$1.3 million each year.⁹⁵ Other states, such as Texas and Wisconsin, have provided a tax-exempt status for cowboy boots and gun club memberships, respectively, yet have not provided women with similar supports on products that are necessary for their reproductive health.⁹⁶ States should re-examine their policies around taxing feminine hygiene products and take steps to ensure women are not paying more simply because of their gender.

11. Strengthening comprehensive sexual education

Ensuring that adolescents and young adults have the resources and knowledge to lead sexually healthy lives is a vital component of their educational and social development. Comprehensive sexuality education—an approach to sex education that addresses the physical, mental, emotional, and social aspects of human sexuality and that is inclusive of nonheterosexual identities and relationships—ensures that students have access to this information.⁹⁷ Comprehensive sexuality education leads to a host of positive benefits for young people, including a reduction in teen and unplanned pregnancies, fewer sexually transmitted infections, reduced rates of dating violence, and improved educational and professional outcomes.⁹⁸

There is no one sex education standard across the country, and policies vary widely by state. While in recent years many states have moved toward more restrictive policies—such as abstinence-only-until-marriage programs, parental notification, and opt-in policies—it is important to note that in the 2017 and current 2018 legislative sessions, there was significant positive movement in advancing sexuality education.⁹⁹ Common legislative provisions included child sexual abuse, assault, and dating violence prevention instruction, as well as requirements that education be medically accurate and age-appropriate.¹⁰⁰

Out of the 139 bills introduced so far in 2018, 108 sought to advance sex education and six were signed into law.¹⁰¹ For example, a 2018 Georgia law requires sexual abuse and assault awareness and prevention education for students in grades K-9. In 2017, California signed into law amendments to its California Healthy Youth Act, which stipulated additional instruction on sexual abuse, human trafficking, and intimate partner violence. And in 2014 and 2015, Mississippi and Arkansas, respectively, passed legislation requiring community colleges and public universities to develop plans to tackle unplanned pregnancy in their student populations.

12. Ensuring students can attend college free from sexual violence

Students should be able to attend school free from any form of sexual violence. Unfortunately, the statistics do not bear this out: 1 in 5 women and 1 in 20 men on college campuses experience rape or sexual assault during their college tenure.¹⁰² In order to tackle these staggering numbers, there are a number of steps states can take to protect students: namely, strengthening the Clery Act; mandating comprehensive prevention and awareness education; issuing school guidance to address new and dangerous changes proposed to Title IX at the federal level; and improving anonymous reporting systems, including online reporting. While states must remain cognizant of potential changes to Title IX law that may complicate their legislative proposals, they should not wait to embark on important and necessary protections to ensure that survivors of sexual assault are provided the support they need.

Some states have already made important strides in the past few years to address sexual violence. For example, in 2015, Gov. Andrew Cuomo passed “Enough is Enough,” a law that requires all New York State colleges to adopt a standard definition of consent and implement policies that protect students who report sexual assault and give students the right to know they can report sexual assault to outside law enforcement.¹⁰³ Minnesota requires colleges to submit reports to the state about campus sexual assaults and related disciplinary proceedings and has also created an anonymous online reporting system.¹⁰⁴ And Texas recently passed legislation that would allow individuals to anonymously report sexual assaults to their universities online and grant protections to students who report incidents of sexual assault.¹⁰⁵

13. Strengthening climate change mitigation and adaptation approaches

About one-third of U.S. counties are in danger of experiencing water shortages by the middle of this century, and the Natural Resources Defense Council and other environmental advocacy groups project that many states will face larger flood plains, severe droughts, and other extreme weather events.¹⁰⁶ As climate change exacerbates these conditions and threatens human health, the U.N. Educational, Scientific and

Cultural Organization has warned that climate change will be “a threat multiplier for women and girls.”¹⁰⁷ In fact, women and girls in regions affected by natural disasters often experience increases in sexual and domestic violence; difficulty accessing medical assistance and other important resources; and poor economic recovery.¹⁰⁸ For example, recent reports from Puerto Rico—which was hit by devastating hurricanes last year—indicate a surge in gender-based violence.¹⁰⁹ So far this year, 22 women have been killed by an intimate partner—a number that is most likely an underestimate given unreliable data collection—and dozens of advocacy groups and shelters are experiencing large increases in requests for survivor-related services.¹¹⁰

These threats have compelled several states to take independent action. Last year, governors from California, New York, and Washington formed the U.S. Climate Alliance. This coalition is a way for states to counter what they see as President Trump’s reckless and short-sighted actions and to create a roadmap for other states committed to addressing climate change.¹¹¹ Since its formation, the coalition’s list of governors has grown to 17 and includes states such as Colorado, Maryland, and Minnesota. These governors have pledged to invest significant capital in building sustainable infrastructure, scaling up renewable energy, and protecting land and coastal systems.¹¹²

But more needs to be done to specifically address the challenges that climate change creates for women. This can be done through the development of targeted mitigation and resiliency programs, which, for example, can establish emergency funds to address women’s relocation and safety needs after disasters and can develop tools such as telemedicine to ensure that women can access health care when transportation services are limited.

Conclusion

States represent the next proving ground to test and advance progressive policies related to women’s health and rights. With an anticipated gridlock between the House and Senate for the next two years, and a staunchly conservative executive branch, women’s health and rights advocates must look to the states to take bold action and use innovative policy and legislative approaches. There is clearly broad-based public support and a wealth of research and evidence around women’s health and rights—from abortion care to contraceptive services to advances in telemedicine. It is now up to state legislators and governors to pre-empt failures at the federal level and enact the changes their citizens need.

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The author would like to extend a special thanks to Shilpa Phadke, Jamila K. Taylor, Maggie Jo Buchanan, Emily Gee, and Madeleine Twomey.

Endnotes

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