CENTER *for*
REPRODUCTIVE
RIGHTS

2022 State Legislative Wrap-up

State Policy Report:
An overview of the state landscape

Introduction

The Center for Reproductive Rights works to ensure that people worldwide can make decisions about their reproductive health and lives and have access to the full range of reproductive health services, including abortion, maternal health care, and assisted reproduction, and related information. Our work to advance and defend reproductive rights centers those who are most likely to experience rights violations, including people who experience intersecting structural inequities due to gender, race/ethnicity, class, sexual orientation, religion, disability, poverty, and humanitarian situations.

This 2022 Legislative Wrap up provides an overview of the year's state legislative efforts to restrict and enhance reproductive rights and access to reproductive care, specifically abortion, assisted reproduction, and maternal health care.

Landscape

In the United States, reproductive rights were of utmost importance in 2022. The year will go down in history as the year that the U.S. Supreme Court overruled *Roe v. Wade* and eliminated the federal constitutional right to abortion—clearing the way for states to criminalize abortion. In anticipation of, and as a result of, the Court's ruling, state lawmakers rushed to both restrict and protect abortion rights and access.

But reproductive rights extend well beyond abortion. While public health restrictions pertaining to the COVID-19 pandemic have loosened, the pandemic continues, as does its impact on access to reproductive health care. For example, access to contraception continues to be hindered, especially for those who experience unemployment and financial instability. Anti-abortion activists continue to co-opt civil and human

All data within this report is valid as of December 1, 2022.

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rights language, such as the banners of choice and freedom, in their actions to restrict access to reproductive health care. Newly released data from the Centers for Disease Control and Prevention indicates an increase in the national maternal mortality rate, disproportionately impacting Black women and birthing people.[1] Despite the need to address the many ways that the U.S. is failing pregnant people, multiple states instead enacted abortion restrictions that only worsen reproductive health outcomes.

In May, Politico released a leaked draft of the majority opinion in *Dobbs v. Jackson Women's Health Organization (Dobbs)*. The draft was authored by Justice Samuel Alito and called the *Roe v. Wade (Roe)* decision "egregiously wrong from the start," maintaining that abortion is not a constitutionally protected right and should be entirely left to the states to legislate. While the leaked draft did not surprise advocates who foresaw an attack on abortion, many hoped the eventual decision would not deal the same blow. In June, however, the Supreme Court released the official opinion and overruled *Roe*, effectively allowing states to ban abortion entirely and allowing Mississippi's 15-week ban, which was ruled unconstitutional by lower courts, to go into effect.

Devastation and chaos followed as states moved to enforce trigger bans, pre-*Roe* bans, as well as total and early gestational bans. Abortion clinics closed and care that was always inaccessible to some populations—namely Black, Indigenous, and other people of color, the LGBTQI+ community, people with disabilities, people in rural areas, young people, undocumented people, and those having difficulty making ends meet—became illegal in many states. Make no mistake: we are experiencing a public health and human rights crisis. Now more than ever, supporters of reproductive rights need to center reproductive justice and the leadership of communities of color.

While the attacks on reproductive rights have intensified, the reproductive rights movement has also had several wins. In response to *Dobbs* and the enactment of new state abortion bans, states where abortion is legal

1 Donna L. Hoyert, Ph.D, *Maternal Mortality Rates in the United States, 2020* Center for Disease Control (Feb. 2022) https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2020/E-stat-Maternal-Mortality-Rates-2022.pdf.

enacted legislation to protect their abortion infrastructure by shielding providers and helpers from criminal, civil, and professional penalties that hostile states are likely to utilize to chill the provision of, or assistance with, abortion care. Additionally, some of this legislation allows people to sue bounty hunters and others who have sued them in states where abortion is illegal. We also witnessed wins in the fields of assisted reproduction and maternal health. Maine passed a progressive and inclusive fertility insurance mandate and Massachusetts' interstate shield law included fertility and gender-affirming services in the list of protected reproductive health care services. A wave of states extended Medicaid coverage to 12 months postpartum and provided Medicaid coverage of doula services.

While the U.S. Supreme Court dealt a severe blow to reproductive rights, President Joe Biden nominated Judge Ketanji Brown Jackson, formerly on the D.C. Circuit Court of Appeals, to serve as Justice Stephen Breyer's replacement as an Associate Justice of the Supreme Court. Judge Jackson's confirmation is historic; she is the first Black woman Justice of the Supreme Court, and the first public defender to serve on the Court since Justice Thurgood Marshall. Although Judge Jackson joined the Supreme Court bench after the *Dobbs* decision was released, she will play an important role interpreting and analyzing the decision in future cases.

Supreme Court Justice Ketanji Brown Jackson will play an important role in interpreting and analyzing the *Dobbs* decision in future cases.

Courtesy White House

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In August, Kansas voters resoundingly rejected an effort to remove protections for abortion rights from the state constitution. The ballot measure, rejected by approximately 60 percent of the voters, was the first test of voter sentiment since *Dobbs*. The result continues to prevent the Kansas legislature from passing severe abortion restrictions, which has become a key access point in the Midwest and South. Kansas illustrates that public opinion is on the side of abortion rights and no state is ceded ground.

Also in August, a historic delegation of Black and Indigenous reproductive rights, health, and justice leaders brought U.S. reproductive rights violations to the attention of human rights experts and the international community during a review of the U.S. by the United Nations (UN) Committee on the Elimination of Racial Discrimination (CERD) in Geneva, Switzerland. After the delegation submitted a written report (available on the Center's website) and provided testimony at the UN, the CERD issued groundbreaking recommendations on abortion and maternal health. The Committee called on the U.S. to "adopt all necessary measures, at the Federal and state level, to address the profound disparate impact of

From left to right: Erin Grant (Abortion Care Network), Nicolle Gonzales (Changing Woman Initiative), Chanel Porchia-Albert (Ancient Song Doula Services), Dr. Joia Crear-Perry and Jade Below (National Birth Equity Collaborative), and Breana Lipscomb (Center for Reproductive Rights) celebrate groundbreaking human rights statements supporting sexual and reproductive health and rights at the United Nations in Geneva, Switzerland.

In August 2022, these advocates provided testimony to the UN Committee on the Elimination of Racial Discrimination about state laws inhibiting access to abortion and maternal health care, leading the Committee to question the U.S. about these inequities. After completion of its review, the Committee recommended the U.S. "adopt all necessary measures, at the Federal and state level" to address the disparate impact of *Dobbs v. JWHO* and provide access to abortion. It also recommended the U.S. reduce maternal mortality through culturally respectful approaches, including midwifery care.

Courtesy Center for Reproductive Rights

The Center's State Policy & Advocacy Team members, Nimra Chowdhry and Elisabeth Smith, canvassed in support of Proposition 3 in Michigan. This winning proposal affirmed that every person has the fundamental right to reproductive freedom, which involves the right to make and carry out decisions without political interference about all matters relating to pregnancy, including birth control, abortion, prenatal care, and childbirth.

Courtesy Center for Reproductive Rights

Dobbs v JWHO," "provide safe, legal, and effective access to abortion" in line with the U.S.' human rights obligations," and "take all necessary measures to mitigate the risks faced by women seeking an abortion and by health providers assisting them, and to ensure that they are not subjected to criminal penalties." The Committee also recommended the U.S. take an "intersectional and culturally respectful approach" to reducing maternal mortality and morbidity, including "through midwifery care."

President Biden promised to codify *Roe* during a speech to motivate people to vote in the midterm elections, saying he would send a bill to Congress to codify abortion protections into law in January if the Senate can overcome the filibuster and pass the legislation. While urging people to vote, Biden said, "I'm asking the American people to remember how you felt that day the extreme *Dobbs* decision came down and *Roe* overturned after 50 years…The anger, the worry, the disbelief."

In the mid-term elections, we saw Americans across the political spectrum vote to preserve or expand reproductive rights. In states where abortion was directly on the ballot in November 2022, abortion rights supporters won every contest: voters approved measures to protect reproductive freedom in California, Michigan, and Vermont and rejected measures to restrict abortion in Kentucky and Montana.

The following sections provide an overview of the most recent state legislative efforts restricting reproductive rights and the proactive approaches state legislators are employing to strengthen access to reproductive health care. The three reproductive rights issue areas covered—abortion, maternal health, and assisted reproduction—have always been interrelated, with advances, setbacks, and general changes in one impacting the others. The reproductive rights movement has siloed these issues for far too long. Today's rapidly evolving reproductive rights landscape necessitates that we think about and emphasize this interconnectedness of these issues.

Abortion Rights

During 2022, the Center for Reproductive Rights tracked almost 700 abortion bills. States introduced more than 430 restrictive bills and more than 230 proactive abortion bills expanding protection for abortion.

Legislation tracked in 2022 was reactive to the impending Supreme Court decision in *Dobbs* as well as the Supreme Court decision allowing Texas to enforce a vigilante-style law* at six-weeks LMP. In response, many states introduced slates of proactive bills aiming to protect abortion access and state governors executed orders to protect access in their states.

* a vigilante-style bounty hunter law that allows anyone to sue someone suspected of violating the law and collect a monetary bounty, usually a minimum of $10,000

In June 2022, the Supreme Court overturned *Roe* in *Dobbs*, altering the abortion landscape. States moved to pass extreme restrictions, enforced trigger bans and formerly enjoined bans, and called special sessions to enact more restrictions.

This section will cover major trends in 1) abortion restrictions; 2) proactive abortion measures; and 3) state constitutional amendments tracked across the country during the 2022 state legislative cycle. While this report details major trends, during 2022, we tracked bills covering other restrictions on abortion, for example young people's access, state public funding restrictions, biased counseling and informed consent requirements, reporting requirements, and more. Many of these bills can be found on the Center's interactive map, *After Roe Fell: Abortion Laws by State*, previously known as *What if Roe Fell?*, which provides analysis of abortion rights and access in the U.S. The map is updated in real-time.

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Restrictive Legislation

This year the Center tracked more than 430 bills restricting access to abortion. In anticipation of the overruling of *Roe* in *Dobbs* and upcoming midterm elections in the fall, many states moved to enact total and early gestational bans and trigger bans. In previous legislative sessions, restrictions such as "born-alive" bills, method bans, reason bans, and fetal tissue restrictions were more prevalent. However, in 2022 we saw legislators focusing on pre-viability abortion bans, crisis pregnancy center funding, and medication abortion restrictions.

Abortion Bans

In 2022, states moved to ban abortion outright, introducing various restrictions to limit access to abortion. Abortion ban trends include: 1) trigger bans and 2) gestational bans.

TRIGGER BANS

A trigger ban is a total abortion ban meant to prohibit abortion if *Roe* were to be overturned or the U.S. Constitution were to be amended to allow states to regulate abortion care. With the U.S. Supreme Court hearing oral arguments in *Dobbs* in late 2021 and with the leaked draft opinion in May, some states moved to introduce and enact trigger bans anticipating the overturning of *Roe*, bringing the total number of states with trigger bans to 13. Since the ruling in *Dobbs* overturned *Roe*, the 13 states with trigger bans have moved to enforce those bans.

In 2022, eight states (Iowa, Louisiana, Missouri, Ohio, Oklahoma, Nebraska, South Carolina, and Wyoming) introduced 12 trigger bans. Three states enacted or amended existing trigger bans including Louisiana, Oklahoma, and Wyoming.

Louisiana amended an existing trigger ban, prohibiting abortion except when performed by a Louisiana-licensed physician to prevent the death or substantial risk of death to the pregnant person due to a physical condition, prevent permanent impairment of a life-sustaining organ, or when the pregnancy is "medically futile." The bill imposed criminal penalties and took effect immediately upon the Supreme Court's decision to allow states to prohibit abortion.

Oklahoma added further restrictions to its existing trigger ban by allowing the state to revive its pre-*Roe* ban and prohibiting abortion entirely, while leaving in place all other abortion restrictions previously enacted. This ban took effect once the state Attorney General certified that *Roe* was overturned in whole or in part, which took place on June 24, 2022.

The Indiana legislature was one of the many state legislatures that took action to ban abortion in 2022.

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Wyoming, on the other hand, enacted a trigger ban that bans abortion and prohibits public funding except when necessary to prevent death or serious bodily impairment. The bill required the Attorney General to authorize enforcement of the ban 30 days after the date of a final decision of the Supreme Court. The ban is not in effect and is currently subject to a preliminary injunction.

GESTATIONAL BANS

In 2022, state legislators introduced 100 gestational bans in 33 states. These gestational bans included: 1) total bans; 2) six-week bans; 3) 15-week bans; and 4) vigilante bounty-hunter bans.

Since 2019, state legislators have launched direct challenges to *Roe* by introducing and enacting pre-viability gestational bans, particularly six-week bans, in reaction to the new composition of the U.S. Supreme Court. With oral arguments heard in *Dobbs* in late 2021, many states advanced pre-viability bans in anticipation of *Roe* being overruled in the summer of 2022. At the end of the summer, after *Roe* was overturned, states moved to introduce bans at the end of their sessions or call special sessions, as was the case in Indiana, to introduce bans.

> TOTAL BANS

In 2022, 20 states (Alaska, Arkansas, Colorado, Idaho, Illinois, Indiana, Kansas, Louisiana, Maryland, Michigan, Minnesota, Missouri, Mississippi, New Hampshire, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, and West Virginia) introduced 42 complete bans in the form of granting fetal personhood or just outright banning all abortions. Three states (West Virginia, Oklahoma, and Indiana) enacted complete bans. Many states also sought to completely ban medication abortion as well, which will be discussed further in the Medication Abortion section.

In April, Oklahoma enacted its total ban with limited exceptions and criminal penalties for violations. Their bill prohibited abortions and created criminal penalties for violations with some exceptions. This bill has been enacted and is in effect.

In anticipation of the overturning of *Roe* in *Dobbs*, Indiana's legislators and Governor indicated they would call a special session after the Supreme Court decision. In the summer of 2022, during the promised special session, Indiana enacted two restrictive bills, one banning abortion and one funding "crisis pregnancy centers."

In September, the Governor of West Virginia signed a bill that would prohibit all abortions with an immediate effective date. The ban went into effect on September 16th.

> SIX-WEEK BANS

In 2022, 16 states (Alabama, Arizona, Florida, Idaho, Louisiana, Maryland, Michigan, Minnesota, Missouri, Nebraska, New Hampshire, Oklahoma, Tennessee, Washington, West Virginia, and Wisconsin) introduced 28 six-week bans. While no states enacted six-week bans with criminal penalties or state enforcement, two states enacted six-week bans enforced through vigilante-style bounty hunter laws.

> FIFTEEN-WEEK BANS

Five states (Arizona, Florida, Kentucky, Washington, and West Virginia) introduced seven 15-week bans. Three states enacted 15-week bans in 2022.

In April, Florida enacted H.B. 5, a 15-week ban with limited exceptions that went into effect July 1, 2022. The law has an exception for abortions due to fatal fetal anomaly that requires written certification by two physicians. Kentucky and Arizona followed suit, enacting their 15-week bans as well.

> "VIGILANTE" BANS

Last year, Texas enacted the first of its kind vigilante bounty-hunter or private right of action law, S.B. 8, which banned abortion at six weeks and has been in effect since September 1, 2021. This law allows anyone to bring a civil suit against a provider who provides an abortion after six weeks or someone who aids or abets a pregnant person in accessing an abortion after six weeks. Texas state courts and the Supreme Court refused to block the law and allowed it to remain in effect.

In 2022, many states followed Texas in introducing vigilante bounty-hunter bills. Thirteen states (Alabama, Arizona, Arkansas, Florida, Idaho, Louisiana, Maryland, Minnesota, Missouri, Ohio, Oklahoma, Tennessee, and Wisconsin) introduced 15 vigilante bounty-hunter bills. Two states enacted new laws with Oklahoma enacting both a total ban and six-week vigilante bounty-hunter ban. Idaho enacted a vigilante bounty-hunter law that bans abortion at six weeks.

Medication Abortion

Medication abortion is safe and effective regardless of where people take it and regardless of who is involved in the process. In 2021, there was a rise in legislation restricting medication abortion that continued into 2022. The response during the pandemic coupled with the FDA's recent decision to remove the in-person dispensing requirement resulted in hostile states restricting medication abortion access. These restrictions work in tandem with other abortion restrictions to eliminate access to abortion in states.

In 2022, 28 states introduced 50 restrictive medication abortion bills, five of which were enacted. The bills included total medication abortion bans, medication abortion "reversal" requirements, medication abortion regulation schemes, telemedicine bans, and other medication abortion bans.

TOTAL MEDICATION ABORTION BANS

A total ban on medication abortion prohibits the use of medication abortion in all instances. This trend could be a result of the rise of telemedicine providing medication abortion or the perceived next frontier of abortion bans. During the 2022 legislative sessions, legislators introduced 10 total medication abortion bans in Alabama, Alaska, Arizona, Illinois, Indiana, Michigan, Mississippi, South Dakota, and Wyoming. Indiana enacted a total medication abortion ban in its special session in July.

MEDICATION ABORTION "REVERSAL"

Medication abortion "reversal" restrictions aim to misinform patients about the possibility of "reversing" a medication abortion once the patient has taken the first round of medication. Medication abortion "reversal" restrictions are usually introduced in amendments to bills requiring biased counseling for abortion care.

During 2022, states continued the onslaught of medication abortion restrictions and introduced 17 medication abortion "reversal" bills in 11 states (Georgian, Iowa, Kentucky, Michigan, Minnesota, Mississippi, Oregon, South Carolina, and Wisconsin). The only one that was enacted was Kentucky's omnibus bill containing a multitude of abortion restrictions. Kentucky's law requires providers to deliver medication abortion "reversal" information to patients when they receive the medication abortion, with civil and criminal professional penalties for violations.

States continued the onslaught of restrictions on medication abortion, including bans on telemedicine, regulation schemes, and total bans.

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MEDICATION ABORTION REGULATIONS SCHEMES

In 2021, Oklahoma enacted a medication abortion law that creates regulatory authority, separate from the FDA, to regulate medication abortion production, manufacturing, and distribution. This scheme grants medical and pharmaceutical licensure bodies the power to create and enforce regulations controlling the distribution and licensing of abortion providers to provide medication abortion. The licensing bodies could revoke a provider's ability to administer medication abortion or impose fines or criminal penalties for providers in violation of the law.

During the 2022 legislative sessions, seven states (Georgia, Kentucky, Maryland, Massachusetts, Mississippi, and Ohio) followed Oklahoma's lead and introduced similar legislation. Kentucky's aforementioned omnibus bill created a certification program to oversee and regulate medication abortion, similar to the program in Oklahoma. Kentucky's law created a private right of action for anyone to seek restitution for damages suffered from violations of the certification requirements.

TELEMEDICINE BANS

In 2022, telemedicine bans followed 2021 trends and limited access to medication abortion in response to the overturning of *Roe*.

In 2022, 17 states (Georgia, Indiana, Iowa, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Mississippi, Nebraska, North Carolina, South Dakota, Tennessee, and West Virginia) introduced 25 telemedicine bans. Of those, seven were enacted in Indiana, Kentucky, Louisiana, South Dakota, Tennessee and West Virginia. These bans built upon existing telemedicine bans in these states.

Indiana's law requires a physician to distribute medication abortion in person and perform a physical exam.

Louisiana's law prohibits the delivery of medication abortion to a person in Louisiana by mail, courier, or as a result of a sale made on the internet. This law creates criminal penalties for the sale of medication abortion without a prescription making each separate distribution a violation. The bill criminalizes the marketing, advertising, labeling, distributing, or importing of medication abortion and provides that the department of health may promulgate rules exempting the provision of mifepristone or misoprostol when distributed for purposes other than abortion.

After the *Dobbs* decision, supporters of abortion rights made their voices heard at their state houses.

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Crisis Pregnancy Center Funding

Crisis pregnancy centers are organizations that advertise as centers to assist with pregnancy. In truth, these centers use deceptive practices to divert people away from receiving abortions. Most of these centers do not have medically trained or licensed staff.

Alongside severely limiting access to abortion and instead of funding much-needed safety nets and family resources, states funded these fake clinics. Thirteen states (Arkansas, Illinois, Indiana, Iowa, Kansas, Louisiana, Michigan, Minnesota, Mississippi, North Carolina, Oklahoma, Rhode Island, and West Virginia) introduced 17 bills to fund crisis pregnancy centers. Eight funding bills were enacted in Arkansas, Indiana, Louisiana, Michigan, Mississippi, and North Carolina.

Louisiana, for example, created and funded a program in the Department of Children and Family Services to provide a statewide telecare network to "support childbirth as an alternative to abortion." However, the network cannot hold itself out as an entity that performs, refers, or assists in abortions and cannot refer a person to an organization that performs or refers to abortion services. Louisiana also enacted a law to amend requirements for organizational recipients of "Choose Life" license plate funds. This law requires fund applicants to offer supportive services to pregnant people considering parenting or adoption, but not abortion, and requires 50% of funds received be used for the material support of pregnant people considering parenting or adoption.

Other Restrictions

In addition to the restrictive laws outlined above, states enacted a number of other abortion restrictions.

> ABORTION PROVIDER RESTRICTIONS:

Thirty-seven states introduced 109 bills with restrictions on abortion providers. States enacted 13 laws with those restrictions. For example, Tennessee enacted legislation that (1) requires medication abortion to be performed by a "qualified physician," (2) creates onerous reporting requirements for medication abortion providers, and (3) requires admitting privileges for medication abortion providers.

> CRIMINAL PENALTIES:

Sixteen states introduced 28 bills to create new crimes in the criminal code or add additional criminal penalties to existing restrictions. These bills aimed to criminalize research on fetal tissue, self-managed abortions and feticide, medication abortion restrictions, and more. Two such bills were enacted.

For example, Indiana enacted an omnibus bill that criminalizes coerced abortions. It requires providers to question pregnant patients and inform them of their right to not be coerced.

Providers must postpone an abortion for 24 hours if they believe the pregnant person has been coerced.

> MINORS:

Sixteen states introduced 33 bills related to restricting young people's ability to access abortions. Two alarming trends include efforts to limit what can be taught about abortion in schools and amendments to child abuse statutes. Three bills were enacted related to restricting access to abortion for young people.

> TRAP:

Twenty-nine states introduced 51 bills with Targeted Regulations of Abortion Providers (TRAP). These types of restrictions include licensing requirements for clinics, reporting requirements for clinics, posting requirements for clinics, admitting privileges and transfer agreements, and clinic equipment requirements. Two such bills were enacted.

For example, Louisiana's law requires outpatient abortion facilities to allow patients to make unimpeded, private, and uncensored telephone communications. The bill prohibits requirements that patients forego possession of their cell phones and creates license penalties for violations.

> REASON BANS:

Sixteen reason bans were introduced in 10 states. Reason bans prohibit abortions that are sought for a particular reason including race, sex, or disability of a fetus. One bill was enacted.

For example, West Virginia created a disability reason ban with exceptions for medical emergencies and nonmedically viable fetuses. The bill creates abortion reporting and education requirements and civil and criminal penalties for violations.

> STATE PUBLIC FUNDING:

Twenty-two states introduced 47 public funding restrictions. These bills increase restrictions on Medicaid funding and the use of government property for providing abortions, prohibit doctors working at public university hospitals from performing abortions, and cut state funding for other abortion services.

For example, Louisiana enacted a bill that creates the office on Women's Health within the Louisiana Department of Health to improve women's health across the state. It prohibits the office from engaging in activities or expending funds related to assisting or promoting abortion except when necessary to save the pregnant person's life, or if the abortion is sought due to rape.

States introduced other restrictions such as "born alive" bills that were not enacted in 2022.

Proactive Legislation

In 2022, the Center tracked over 230 proactive abortion bills to expand or protect access to abortion care. Of these, 42 were enacted, including interstate shield protections, insurance coverage, and expanded provider scope of practice. Additional proactive bills included those that repeal restrictive laws, expand minors' access to abortion, expand medication abortion care, protect self-managed abortions, include crisis pregnancy center consumer protections, and expand clinic access protections and statutory protections for abortions. Whereas 2021 brought bills that repealed abortion restrictions, expanded scope of practice, and expanded insurance coverage for abortion care were popular, this year, legislators focused on protecting abortion providers and individuals seeking access outside their home state in anticipation of a negative *Dobbs* decision.

Proactive trends discussed include: 1) interstate shield bills, 2) scope of practice expansion, 3) statutory fundamental right to abortion, 4) expanded insurance coverage, and 5) other proactive measures.

Interstate Shield Laws

With the rise of extreme abortion bans and restrictions, states began to draft legislation to protect providers, helpers, and patient medical records from the reach of states that have banned abortion. Interstate shield legislation shields "access state" providers, patients, and people assisting in abortion provision by protecting against investigations, extradition, health care professional penalties, and judgments in out-of-state lawsuits.

In 2022, 10 states (California, Connecticut, Delaware, Illinois, Maryland, Massachusetts, Michigan, New Jersey, New York, and Pennsylvania) and the District of Columbia introduced interstate shield bills. California,

Connecticut, Delaware, Massachusetts, New Jersey, and New York enacted their bills.

California's law declares out-of-state civil actions stemming from the provision or attempted provision of abortion care to be against state public policy. It prohibits state courts from applying such laws and prohibits the enforcement or satisfaction of a civil judgment received under that law.

Connecticut's law creates interstate protections against civil and criminal actions arising in other states that are related to performing or assisting in abortion care. This law allows a Connecticut resident to recover damages from any party who brings an action in another state leading to a judgment against the Connecticut resident for performing or assisting in reproductive health care services that are permitted in Connecticut. It prohibits: (1) entities that provide reproductive health care services from disclosing information about a patient who is subject to a civil action or proceeding unless written consent is provided by the patient; (2) state judges from issuing summons or subpoenas in relation to actions arising in other states because of the provision of, or assistance with, reproductive health care services that are legal in Connecticut; and (3) state agencies and employees from expending time or providing information that furthers interstate investigations or proceedings relating to reproductive health care services.

Delaware's law prohibits courts from issuing summons or subpoenas in an out-of-state action arising from the lawful provision of abortion care. The law allows anyone who has a judgment entered against them in an out-of-state action stemming from the lawful provision of abortion care to recover actual damages, costs, and attorney's fees against anyone who brought the action or seeks to enforce the judgment. It amends the state's nonfugitive extradition law, allowing for the nonfugitive extradition of someone only when the alleged acts, if committed in Delaware, would have violated state law. The law shields abortion providers who lawfully provide abortion care in Delaware to residents of a state where abortion is illegal from professional licensure consequences and medical malpractice insurance

consequences in Delaware. Finally, it protects reproductive health care medical records from being disclosed in a civil action, unless the patient consents to disclosure.

Massachusetts' law makes any action by a foreign jurisdiction against a person related to reproductive health care services or gender affirming health care services a violation of the right to access these services. It prohibits interference with legally protected health care activity, including abortion, contraception, assisted reproduction, and gender-affirming care provided by a Massachusetts licensed provider either in-person or by telemedicine, regardless of where the patient is located. It also prohibits abusive litigation that interferes with a legally protected health care activity and creates a private cause of action for granting relief to the defendant targets of such litigation. The law protects providers from professional licensure penalties from a licensing board in connection with a reproductive health care service that was legal and occurred entirely in the state and prohibits law enforcement cooperation with requests for information about reproductive health care services legal and occurring in the state. It prohibits medical malpractice insurers from discriminating against a provider of reproductive health care services, prohibits a judgment creditor from filing a copy of a judgment from a foreign jurisdiction in connection with litigation concerning legally protected health care activity, prohibits courts from ordering a person to give testimony or statement or issuing a summons for use in a proceeding in a tribunal outside the state regarding legally protected health care activity, and prohibits the governor from extraditing someone for criminal proceedings related to legally protected health care activity.

New York enacted many interstate shield protections, one of which prohibits the governor from demanding extradition of a person charged with providing an abortion unless the executive authority of the demanding state alleges in writing that the accused was present in the demanding state at the time of the commission of the alleged offense and the person fled that state. The law prohibits a police officer from arresting any person

for performing or aiding in the performance of an abortion within New York or in procuring an abortion in the state, prohibits state or local law enforcement agencies from cooperating with or providing information to any individual or out-of-state agency or department regarding the provision of a lawful abortion performed in New York, and prohibits a court or county clerk from issuing a subpoena in connection with an out-of-state proceeding related to an abortion service legally performed in the state.

In addition to legislation, governors in Colorado, Massachusetts, Michigan, Minnesota, Nevada, New Mexico, North Carolina, Pennsylvania, Rhode Island, and Washington executed orders to create interstate shield protections for their states. Common components of these orders include: 1) prohibiting state agencies from expending resources on out-of-state investigations (civil or criminal) related to assisting, seeking, or obtaining reproductive health care that is legal in the state; 2) requiring professional licensing boards to protect providers and prohibiting disciplinary action related to civil or criminal penalties from another state for providing services legal in the state; 3) creating discretion for the governor to refuse to extradite or surrender a person who is not a fugitive to another state due to violation of laws related to reproductive health care services that were legal in the state; and 4) requiring state departments and agencies to assess work related to reproductive health care services and implement protections to ensure access, and requiring that information about care be made accessible to the public.

Scope of Practice

Legislators worked to expand the types of clinicians allowed to provide abortion care by repealing physician-only laws or expressly authorizing physician assistants, certified nurse midwives, nurse practitioners, and other qualified medical professionals to provide abortion care.

In 2022, 11 states (Arizona, California, Connecticut, Delaware, Illinois, Maryland, Nebraska, New Jersey, North Carolina, Pennsylvania, and Washington,) and the District of Columbia introduced 19 bills expanding scope of practice. Seven bills were enacted in Connecticut, Delaware, Maryland, Massachusetts, New Jersey, and Washington.

Maryland's law allows for the provision of care from nurse practitioners, nurse midwives, certified midwives, physician assistants, and any other individual licensed or certified in the state whose scope of license includes abortion care.

Fundamental Right

In 2022, 13 states (California, Colorado, Missouri, Minnesota, Wisconsin, Michigan, Ohio, Kentucky, Florida, Maryland, North Carolina, New Jersey, and Vermont) introduced 19 bills to make abortion a fundamental right through statute. Two of these types of bills were enacted in Colorado and New Jersey.

Colorado's law creates a fundamental right to abortion and prohibits public interference with the right. It states that fetuses do not have independent or derivative rights under state law.

Expanded Insurance Coverage

In 2022, states expanded access to and coverage for abortion care in two ways. First, states required private insurance providers to cover abortion care. Second, states funded abortion services by requiring Medicaid or medical assistance programs to cover abortion, providing funding to public institutions for trainings on abortion services or to expand access to abortion services, and providing funding to abortion funds.

Private Insurance Coverage

Bills that expand private insurance coverage for abortion do so in two main ways. First, bills could repeal provisions prohibiting abortion from being covered by private insurance. Second, bills could create coverage requirements for the provision of abortion care by private insurance providers.

In 2022, 11 states (California, Delaware, Maryland, Massachusetts, Nebraska, New Jersey, New York, Oklahoma, Oregon, Pennsylvania, Rhode Island, Wisconsin) and the District of Columbia introduced 28 bills to either require private insurance providers to cover abortion care or to expand already existing coverage of abortion care by private insurance providers. Five states (California, Maryland, Massachusetts, New Jersey, and New York) enacted such bills.

In addition to provider education and training, Maryland's law requires insurance plans that cover labor and delivery to also cover abortion. Massachusetts' law requires coverage of abortion-related care by state insurance plans, private insurance plans, and Medicaid without cost-sharing requirements.

State Public Funding

State public funding bills are bills that require the state to grant funds to programs to assist in abortion care or to expand access to abortion care through Medicaid or other medical assistance programs.

In 2022, 14 states (Arizona, California, Florida, Illinois, Maryland, Massachusetts, Michigan, Nebraska, New Jersey, New York, Oregon, Pennsylvania, Rhode Island, and Wisconsin) introduced 65 bills to expand state public funding for abortion including Medicaid or medical assistance coverage for abortion services, state funding for abortion training and programs, and grants to abortion funds and facilities. Fourteen bills to

expand state public funding for abortion were enacted in California, Maryland, Massachusetts, New Jersey, and Oregon.

California created an abortion practical support fund housed in the Department of Health Care Access and Information. The fund will grant money to organizations who provide practical support services. Another California law added a section to the health and safety code and the insurance code to prohibit cost sharing for abortion-related services.

Oregon appropriated $15 million to the reproductive health equity fund for abortion to provide immediate support, including travel expenses and lodging, for people seeking abortions in Oregon.

State Constitutional Amendments

In 2022, state legislators sought to amend their state constitutions to expand or limit access to abortion by referring initiatives to the ballot. In many states, voters can initiate state constitutional amendments as well (for example, Michigan's Proposition 3, which was approved in November 2022). The section details legislatively referred proactive and restrictive initiatives.

Proactive

This year, the Center monitored five bills in four states (California, Maryland, Ohio, and Vermont) seeking to amend state constitutions to protect or expand access to abortion.

Ohio and Maryland proposed amendments to their state constitutions to enshrine the right to abortion. The Maryland proposal failed while the Ohio proposals are still in the first chambers. Two such bills were enacted in California and Vermont.

California introduced a resolution to propose a constitutional amendment to prohibit the state from interfering with an individual's reproductive freedom and to choose to get an abortion before viability or when necessary to protect the life or health of the pregnant person. The resolution was enacted and was approved by voters on the November 2022 ballot.

In February 2022, the Vermont legislature also approved a constitutional amendment to enshrine reproductive rights in the state constitution. The measure was approved in a landslide vote during the November 2022 election.

Voters in Nevada approved an Equal Rights Amendment in November 2022, but it is unclear what protection that amendment would offer to abortion rights.

Restrictive

This year, the Center monitored 12 bills in four states (Oklahoma, Missouri, Pennsylvania, and New Jersey) seeking to amend state constitutions to limit access to abortion. Pennsylvania's measure was the only one that passed.

Pennsylvania passed a proposed amendment to the state constitution stating there is no right to abortion and prohibiting taxpayer funding of abortion. It must pass in a subsequent legislative session before being submitted as a separate ballot question at the first primary, general, or municipal election at least three months after it passed.

In 2021, Kansas and Kentucky legislatures passed bills to place restrictive constitutional amendments on the ballot in 2022. Voters defeated both measures.

Maternal Health

Despite declines in maternal mortality globally, people in the U.S. continue to experience high rates of maternal mortality and severe maternal morbidity. Structural inequities and intersecting forms of discrimination, ill-treatment, and abuse in maternal health care settings contribute to these rising rates. Black, Indigenous, and low-income communities consistently face the greatest risks during pregnancy, childbirth, and postpartum due to discrimination and inadequate access to health services. Now more than ever, it is critical to protect, improve, and expand maternal health care. The Center works to increase access to respectful, quality, non-discriminatory maternal health care through advocacy, litigation, and human rights research and fact-finding.

Ensuring that patients with Medicaid don't lose insurance coverage and access to care when their pregnancy ends can help reduce maternal mortality and morbidity.

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This section discusses enacted state legislation in all 50 states and D.C on the subject of maternal health. During 2022, states introduced over 800 bills related to maternal health and enacted over 145. Major trends in 2022

include: 1) funding for maternal health care services (including Medicaid extension, doula care, and maternal mental health services); 2) provider licensing and training requirements (including regulation of midwives and doulas, and implicit bias training for health care professionals); 3) parental and bereavement leave for workers; 4) substance use disorder screening and treatment; 5) treatment of people incarcerated during pregnancy, birth, or postpartum; and 6) maternal mortality review committees.

Funding for Maternal Health Care Services

Forty-two percent of births in the United States are covered by Medicaid.[2] In some states, Medicaid covers the majority of births. Although CDC data indicates that maternal deaths occur throughout the first postpartum year, states are only required to provide Medicaid coverage for 60 days after delivery for eligible individuals. Additionally, states are not required to cover community-based care models proven to improve maternal health outcomes, such as doula care. This section describes bills that expanded public funding of maternal health care including: 1) postpartum Medicaid extension, 2) Medicaid coverage of doula services, and 3) private funding for maternal mental health care.

Postpartum Medicaid Extension

Half of pregnancy-related deaths occur between one week and one year after pregnancy.[3] Continued access to health care can help to diagnose and treat certain postpartum conditions and prevent them from becoming fatal. However, adequate postpartum care is difficult for many people to access, particularly without health insurance. Extending Medicaid coverage to a full year postpartum minimizes disruptions in care and can thus alleviate maternal mortality and morbidity.

2 *Births Financed by Medicaid*, Kaiser Family Foundation https://www.kff.org/medicaid/state-indicator/births-financed-by-medicaid/ (last accessed Nov. 21, 2022).

3 Susanna Trost, Jennifer Beauregard, Fanny Nije, et al., *Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 36 U.S. States, 2017-2019*, Center for Disease Control https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/data-mmrc.html (last reviewed Sep. 19, 2022).

In states that opted out of Medicaid expansion, Medicaid eligibility can be set as low as the federal poverty level, which for a single adult is $12,880 a year. Pregnancy-related Medicaid coverage, however, is mandatory for people earning up to 138% of the federal poverty level, regardless of general Medicaid eligibility in the state. In addition, 48 states go beyond this minimum threshold, with some covering pregnancy-related care for people making up to 380% of the federal poverty level. These increased income limits mean that Medicaid covers four in 10 births in the United States. This Medicaid coverage must last at least 60 days postpartum.

The American Rescue Plan of 2021 provided states with a new option to extend Medicaid eligibility for pregnant people up to 12 months postpartum through a state plan amendment. In 2022, eight states enacted postpartum Medicaid extension (PPME) through legislation. Of those, two states increased their existing PPMEs from six months to 12 months.

Georgia now allows people to access Medicaid coverage for up to 12 months, beginning on the last day of pregnancy, without reference to specific pregnancy outcomes. Maine also increased its existing PPME from six months to 12 months. Maine provides Medicaid coverage for up to 12 months "following delivery." Five states enacted PPMEs that provided for 12 months of coverage. Arizona's bill allows "a woman who is less than one year postpartum" to be eligible for Medicaid.

Indiana enacted a bill that gives certain government officials authority and discretion to extend Medicaid coverage in the postpartum period. This law is a PPME outlier; instead of defining the exact duration of the benefit, it extends Medicaid for "a period of time determined by the office of the secretary" of the state's Family and Social Services. This period must be at least 60 days and not more than 12 months.

PPME bills were introduced but did not pass in 11 states. A bill introduced in Iowa combined PPME with funding for crisis pregnancy centers (CPCs), which creates an association between the legitimate health

care covered by PPME and the often deceptive, anti-abortion activism performed by CPCs. Packaging policies in this way puts maternal health advocates in the difficult position of having to choose between opposing a much-needed Medicaid extension and supporting government funding of CPCs. It is possible that similar bills will be introduced in subsequent legislative sessions, particularly in states that already restrict access to abortion. Nevertheless, more than half of states and D.C. have extended postpartum Medicaid coverage to 12 months, and the general trend of PPMEs will likely continue in next year's legislative session.

Medicaid Coverage of Doula Services

Access to doula care can improve maternal health outcomes, but because few states provide Medicaid reimbursement for doula services, this care is often out of reach for low-income people. States across the country are working to amend their state Medicaid plan to allow for Medicaid coverage of doula services. Occasionally, these states will also require that doulas meet additional certification or licensing requirements, which could prevent some highly qualified, community-focused doulas from being eligible for Medicaid reimbursement. This year, two states (Delaware and Maryland) enacted laws to allow for Medicaid coverage of doula services, one of which included additional requirements for doulas.

Maryland enacted a bill that codifies earlier regulations that allowed for Medicaid reimbursement of doula services and requires permanent coverage of doula care for Medicaid enrollees. The law also licenses and regulates doulas, requiring doulas seeking reimbursement to be certified by an organization approved by the Department of Health and to present proof of a completed certification prior to providing doula services. Doulas must also hold adequate liability insurance. The law requires state Medicaid to cover doula services that are medically indicated.

Private Funding for Maternal Mental Health Care

Postpartum Medicaid extensions address some of the health conditions that contribute to maternal morbidity and mortality. But other conditions are not adequately addressed through extended Medicaid coverage. In some states, a significant proportion of maternal deaths result from suicide or drug overdose. Access to mental health care is an essential component of comprehensive maternal health care and remains an unmet need in many states.

Five states enacted laws related to postpartum mental health care. Three states (Maine, New York, and Washington) enacted laws related to mental health treatment.

Maine enacted a law requiring all private health insurance plans issued in the state that provide maternity benefits to also provide coverage of postpartum services for up to 12 months after childbirth. These postpartum services must include a full assessment of the patient's psychological well-being, and any treatment required to address postpartum depression.

Two states (Louisiana and Nebraska) enacted laws related to mental health screening or education for pregnant and postpartum people. However, bills that mandate screening, without also covering treatment or even requiring providers to share resources, do little to support people with mental health conditions or reduce the stigma they face. Screening bills also raise concerns about discrimination and family separation, since people with disabilities are more likely to be viewed as unfit parents. To truly respond to the mental health needs of pregnant and postpartum people, legislation must ensure that when mental health conditions are identified, patients and their families are provided with treatment options and support.

Nebraska enacted a law that requires the state Board of Medicine to develop educational materials about perinatal (the period of time when you become

pregnant and up to a year after giving birth) mental health issues. Nebraska does not make screening mandatory but invites each patient to complete a questionnaire, which must be reviewed by health care providers who can then make referrals for treatment.

Provider Licensing

Many pregnant people lack meaningful options when it comes to where, how, and with whom they will give birth. The Center tracks provider licensing bills that determine who can be licensed as a midwife, as well as bills that impact the scope of practice for midwives, such as allowing midwives to practice independently or giving midwives prescriptive authority. Bills related to doulas include bills that license and regulate doulas. The Center also tracks bills that license and regulate lactation consultants, as well as bills that require birth workers and hospital providers to participate in anti-discrimination training.

Midwifery Care

Some states restrict the practice of midwifery to certified nurse midwives (CNMs), which prevents skilled midwives who completed a different training pathway from legally practicing. Some states further restrict CNMs by prohibiting them from practicing independently or limiting the services they can provide. This leaves pregnant people with limited options when choosing their maternity care provider and where they will give birth.

MIDWIFERY LICENSURE

Three states (Arizona, Utah, and Connecticut) enacted laws that would make it easier for midwives to become licensed or begin a process of expanding the categories of licensed midwives. Arizona's bill, for example, removes the requirement that midwives be of "good moral character" in order to be licensed.

Four states (Illinois, Iowa, Massachusetts, and Ohio) introduced bills that would license or otherwise regulate certified professional midwives (CPMs). Three states (Hawaii, Georgia, and New York) introduced bills that would license or regulate direct entry, community, or traditional midwives. Three states (Colorado, Florida, and Utah) enacted restrictive bills that, in one way or another, will make it harder for midwives to obtain a license and practice.

Florida already requires all midwives to graduate from an accredited and state-approved midwifery program. It enacted a law that changes the process by which midwifery training programs are approved by the state. The law adds certain clinical training requirements and a method of temporary licensure, as well as removes a requirement that midwives pass a state examination before they are licensed.

Although Utah enacted a law that removed the "good moral character" requirement for midwives, the state also enacted a law that requires nurse midwives to pass a criminal background check and complete a graduate degree from an accredited education program.

MIDWIFERY SCOPE OF PRACTICE

D.C. and two states (North Carolina and Washington) enacted laws that allow midwives to prescribe medication, thereby expanding the scope of practice for midwives.

Washington's law would allow all midwives licensed in Washington to apply for a limited prescriptive license extension that would allow them to prescribe antibiotics, antivirals, contraceptives, and certain medical devices. This law is unique in that it allows midwives who are not CNMs to obtain limited prescriptive authority.

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Doula Care

States frequently combine Medicaid coverage of doula services with doula licensing bills. In some states, however, laws that would license and regulate doulas would not provide Medicaid coverage for their services.

D.C., for example, enacted a law that establishes that doulas cannot perform clinical tasks, replace trained licensed medical professionals, or engage in the practice of medicine. The law requires doulas who are applying for a certificate to complete a training program from a nationally or internationally recognized certifying body, participate in a minimum of three births, and have a current CPR certification. Further rules related to the certification of doulas must be promulgated by the newly created Advisory Committee on Maternal Care Professionals.

Additional states (Connecticut and Tennessee) enacted laws initiating studies of how doulas should be licensed and regulated. Connecticut enacted a law that launches a study on expanding categories of licensed midwives in the state and creates a Doula Advisory Committee tasked with developing recommendations related to the certification of doulas. The Doula Advisory Committee must be composed primarily of practicing doulas, as well as a nurse-midwife, hospital representatives, and state commissioners. The committee will also create standards for doula training program curricula that satisfy the requirements for doula certification.

While access to doula care can improve maternal health outcomes, few states have taken steps to adequately fund doula care, leaving these services out of reach for many people.

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Implicit Bias Training

Racism manifests in myriad ways, including discrimination in health care delivery. Medical professionals may have implicit, discriminatory beliefs about different racial and ethnic groups. Research has shown that implicit bias is correlated with lower quality care for patients. Provider bias contributes to racial inequities in maternal health treatment and outcomes, including cesarean surgery rates, pain management, and preventable deaths. Implicit bias training can increase a provider's awareness of their own biases and emphasize the importance of making patient care decisions based on evidence and effective communication with the patient. Two states (Delaware and Minnesota) enacted laws that require or fund implicit bias training for maternal health care professionals.

Delaware enacted a law that requires all hospitals and freestanding birth centers to implement evidence-based explicit and implicit bias training programs. All health professionals, administrative, and clerical staff members who interact with patients must take this training. The training must include information about the effects of historical and contemporary exclusion and oppression of minorities, power dynamics and their effects on implicit bias, racial inequities in prenatal care, and reproductive justice.

Employee Leave

When reproductive health experiences interrupt an individual's ability to work, leave policies that protect their job and income can help. Giving people the time and economic security they need to recover after a birth or loss enables healing and fosters health-promoting conditions that may reduce the risk of maternal mortality and morbidity. Federal law allows certain employees to take up to 12 weeks of unpaid leave per year. However, this law only applies to companies that employ 50 or more employees and to employees who have worked for their employer for at least 12 months. Since there is no federal requirement that leave be paid, it is necessary for states to fill this gap.

Universal Paid Parental Leave

Three states (Colorado, Delaware, and Maryland) created universal paid parental leave programs which allow all employees in the state to access paid parental leave. Employers and employees make mandatory payroll contributions, ensuring that every employee, no matter where they work, can access paid parental leave.

Maryland's law gives employees 12 weeks of paid parental leave a year. Employees must have worked at least 680 hours in the preceding 12 months. Self-employed individuals can elect to participate in the program for a minimum of three years. Weekly benefits are calculated based on the employee's wages and the state average weekly wage. The program is funded through contributions from employees, and applies to employers with 15 or more employees.

State Employee Paid Parental Leave

Three other states (Louisiana, South Carolina, and Utah) enacted laws that created some form of paid leave for state employees only. These laws take a step in the right direction, but only cover a small group of workers. Employees working for private companies, non-profits, self-employed people, or anyone who does not work for the state do not benefit. Moreover, none of these laws provide 12 weeks of leave. For instance, Utah's law gives state employees up to three work weeks of paid leave following the birth of a child. People who give birth can access an additional three weeks of paid postpartum recovery leave to recover from childbirth.

Private Parental Leave Insurance

One state, Virginia, enacted a law that allows employers to purchase private insurance to fund a paid parental leave program. This insurance can be added as an amendment to a group disability income policy and

can allow employers to pay for a percentage or portion of the employee's income loss following the birth of a child. Employers are not required to purchase this insurance, nor are they required to provide any minimum amount of leave time or wage replacement to employees taking leave.

Bereavement Leave

States are increasingly enacting laws that require employers to extend paid bereavement leave to employees who experience a miscarriage or a stillbirth. Ideally, leave policies should give employees the time off that their mental and physical health requires, regardless of the outcome of pregnancy. However, this is not typically the case and most employees experiencing pregnancy loss cannot access bereavement or parental leave.

Bereavement leave is a category of leave for people who have lost a family member. This year, three states (Illinois, Utah, and Washington) enacted laws that allow workers to take bereavement leave following a pregnancy loss. Illinois' law allows all employees to use up to 10 workdays of bereavement leave following a miscarriage or stillbirth. Employers can require "reasonable documentation" from employees taking this leave. This "reasonable documentation" is a form filled out by a health care practitioner who treated the employee.

Substance Use Disorder Screening and Treatment

Pregnant people who use substances can face elevated risks to their health and rights, and often lack access to harm reduction services and treatment for substance use disorders.

Five states enacted laws that address treatment for people who are pregnant and use substances. Three states (Utah, Vermont, and Washington) enacted laws that would use revenue generated from opioid settlements or cannabis sales to fund treatment for substance use disorders.

Vermont's law creates an Opioid Settlement Special Fund. This fund would take all the funds gained from settlements against opioid companies, and any money distributed through national abatement account funds and other opioid abatement trusts. The money from this fund must then be used to address the needs of pregnant and parenting people with opioid use disorder. Specifically, these funds should be used for screening, brief intervention, and referrals for treatment for uninsured pregnant people who are not eligible for Medicaid. The funds must also be used to expand medication-assisted treatment for opioid use disorder for up to 12 months postpartum. Finally, money can be used to provide wraparound services to pregnant and postpartum people with opioid use disorder, including assistance with housing, transportation, job placement, and childcare.

Washington, which legalized cannabis in 2012, enacted a law that requires a percentage of state revenue from cannabis sales to be put towards programs aimed at preventing or reducing maladaptive substance use. Some of these programs must be aimed specifically at pregnant people, and the state must also use this money to assist community health centers that provide maternity health care services.

Two states (Louisiana and Virginia) enacted laws that either amend the types of treatment pregnant people who use substances can receive or make appropriations for treatment or other assistance from the state general fund.

Louisiana's law allows pregnant people receiving treatment for substance use disorders to access medication assisted treatment. This treatment must be provided onsite at the substance use disorder facility. Facilities do not, however, have to provide medication assisted treatment when a patient's insurance denies coverage of this treatment.

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Treatment of People Incarcerated During Pregnancy, Birth, or Postpartum

Federal and state authorities do not track the number of pregnant people they incarcerate. One study, which surveyed incarcerated people in 22 state prisons, found that 1,396 people were pregnant. And yet, there are no mandatory standards of care that prisons must provide for pregnant incarcerated people. This has led to people giving birth while shackled or in restraints, pregnant people placed in solitary confinement, inadequate access to nutritious food, and other instances of cruel and dangerous treatment.

The Center tracked bills that alter the treatment pregnant people receive in prisons, as well as bills that create early release or deferred sentencing programs for pregnant people.

Anti-Shackling Policies and Other Maternal Health Protections

Five states (Alabama, Connecticut, Delaware, Indiana, and Tennessee) enacted laws that prohibit detention facilities from subjecting pregnant and postpartum people to shackling or solitary confinement, or otherwise improved the prenatal care provided to incarcerated people.

Alabama's law prohibits the use of leg and waist restraints on pregnant people during pregnancy and for up to six weeks after birth. Wrist and leg restraints can be used if the pregnant person poses an immediate flight risk or a risk of harm to themselves or their pregnancy. The bill does not prohibit solitary confinement.

Indiana passed a law that requires correctional facilities to provide necessary prenatal and postnatal care, consistent with acceptable medical practices. The bill also requires that, when possible, arrangements be made for the birth to occur outside the correctional facility. The bill prohibits the use of restraints on people who are in labor, giving birth, or during the immediate postdelivery period. If restraints are deemed necessary at other times, whether because the pregnant person is a substantial flight risk or poses an immediate danger to themselves or others, the least restrictive restraints must be used.

Maternal Mortality Review Committees

Maternal Morality Review Committees (MMRC) are multi-disciplinary committees that comprehensively review the deaths of people who died during, or within a year of pregnancy. MMRCs seek to understand the circumstances surrounding each death and determine whether they were pregnancy related and preventable. Although the information MMRCs review is confidential, the recommendations they develop to prevent future deaths are intended to be made public. Two laws related to MMRCs were enacted, a bill amending an existing commission to also investigate maternal death, and a funding bill.

Delaware's law amends the Child Death Review Commission to include provisions to investigate maternal deaths. It also amends the composition of the committee to remove the Secretary of the Department of Health and Social Services, the Chair of the Child Protection Accountability Commission, and the Chief Judge of the Family Court, and instead adds the Director of the Division of Medicaid and Medical Assistance, the Direct of the Division of Substance Abuse and Mental Health, a licensed mental health professional, a maternal child advocate, and a certified midwife or certified professional midwife. The Governor must consider representation of Black, Indigenous, and other people of color on the commission.

The law requires the commission to publicly post its findings and host meetings that are open to the public.

New York's law appropriates $25,000 to cover the expenses of the statewide MMRC and related maternal mortality reduction protocols and $8,000,000 for services and expenses related to addressing maternal mortality.

Assisted Reproduction

Infertility impacts millions of people in the United States and is a nationally recognized public health concern. Yet numerous barriers—such as limited information, restrictive laws and policies, stigma, high costs, and more—put fertility care, including in vitro fertilization (IVF), out of reach for many. Those already facing difficulties accessing health care are particularly impacted, with people of color, low-income people, people with disabilities, and LGBTQI+ communities receiving treatment at disproportionately low rates.

Infertility and access to fertility care implicate core human rights—including the rights to health, including sexual and reproductive health, reproductive autonomy (such as if and when to have children), benefit from scientific progress, equality and non-discrimination, and informed consent. To realize these rights, laws and policies must ensure that all people impacted by infertility have access to information and fertility care services, including IVF, without discrimination. The Center's work on assisted reproduction seeks to destigmatize infertility and ensure equitable access to fertility care, protect the rights of all parties in surrogacy agreements, and influence embryo and gamete regulations.

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This section discusses enacted state legislation on assisted reproduction and attendant issues. During 2022, states considered over 160 bills related to assisted reproduction and enacted 18. Major assisted reproduction trends in state legislation included: 1) expanding access to IVF; 2) regulating embryos and gametes; and 3) legalizing and regulating surrogacy agreements.

Laws and policies must ensure that all people impacted by infertility have access to information and fertility services, including IVF, without discrimination.

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In Vitro Fertilization

The Centers for Disease Control and Prevention defines infertility as the inability to become pregnant after one year of regular, unprotected sexual intercourse. This clinical definition of infertility, however, is predicated on a heteronormative framing that fails to recognize the inability to reproduce due to social factors, including a person's lack of a partner or a person's sexual orientation. IVF offers individuals and couples who struggle to become pregnant via regular, unprotected sexual intercourse or other forms of assisted reproduction like intrauterine insemination, or who for other reasons turn to medical intervention to grow their family. A single cycle of IVF in the United States can cost over $20,000 in out-of-pocket costs, a prohibitively expensive cost for most Americans.

State insurance mandates, which require insurance plans to provide coverage of fertility benefits, often including IVF, are vital to ensure people can access the care they need to grow their families. As of the beginning of the 2022 session, only 13 states, however, required insurance companies to cover IVF and many of them exempt small, religiously affiliated, and self-insured employers. These state mandates also fail to apply to Medicaid, leaving its over 74 million beneficiaries without the coverage necessary to afford fertility care out-of-pocket.[4] Moreover, even when states have insurance mandates that cover IVF, they often require that an insured prove clinical infertility. Often, single women and women in same-sex couples, for example, are required to meet the clinical definition of infertility before they can avail themselves of fertility benefits coverage. That is, they must show that they've unsuccessfully tried to become pregnant after six to 12 months of regular, unprotected sexual intercourse. This requires them to pay out-of-pocket for multiple cycles of other forms of fertility care, like intrauterine insemination, which like IVF can be prohibitively expensive for many.

4 One exception is New York state, which in 2017 required state Medicaid to cover ovulation enhancing drugs and other tests and services for people experiencing infertility, N.Y. Soc. Serv. Law § 365-a(2)(ee). The state does not provide Medicaid coverage of IVF, IUI, or any other fertility care outside of ovulation enhancing drugs and certain tests.

This year the Center tracked 110 state bills related to expanding access to IVF. We noted several trends including the introduction of new fertility insurance mandates; bills amending existing insurance mandates to cover additional services or communities; bills that included fertility preservation care coverage; bills that would study access to fertility care; and religious refusal bills.

In 2022, two laws were enacted to expand access to IVF—a new fertility insurance mandate bill in Maine and an amendment to an existing fertility insurance mandate in Colorado.

New Fertility Insurance Mandates

In 2022, Maine became the fourteenth state to enact a fertility insurance mandate that includes IVF coverage.

The Maine fertility insurance mandate applies to all insurance carriers offering health plans in the state and requires them to provide coverage for fertility care, including but not limited to IVF and fertility preservation. It requires health plans to provide fertility care coverage to "an individual or couple with infertility, an individual or couple who is at increased risk of transmitting a serious heritable genetic or chromosomal abnormality to a child," and notably, "an individual unable to conceive as an individual or with a partner because the individual or couple does not have the necessary gametes for conception" thereby including single and LGBTQI+ individuals and couples who seek fertility care to build their families. The law prohibits insurance carriers from imposing any waiting period or from withholding coverage based on the insured's use of donor gametes. The mandate was signed into law by the Governor in May 2022 and will take effect January 1, 2024.

Though not enacted, fertility insurance mandates were introduced in D.C., Iowa, Minnesota, Oregon, Pennsylvania, Tennessee, Vermont, Virginia, Washington, and Wisconsin. Of these, seven bills would have included

coverage for people experiencing social infertility. Bills were introduced in D.C. and Oregon that would have allowed religious employers to opt out of providing IVF coverage, and in Tennessee that would have placed cost and age limits on IVF coverage.

Amendments to Existing Fertility Insurance Mandates

Several of the 13 states that already had fertility insurance mandates as of the beginning of the 2022 session introduced bills to amend them. One bill was enacted in Colorado, which allows portions of a mandate passed in 2020 that had been blocked to take effect.

Colorado enacted a fertility insurance mandate in 2020 requiring health benefit plans to cover fertility care, including IVF. The mandate was set to apply to health benefit plans issued or renewed on or after January 1, 2022, but has not taken effect. A last-minute amendment to the 2020 insurance mandate required the state to determine whether fertility care coverage would require a defrayal by the state. This determination had to be confirmed by the U.S. Department of Health and Human Services (HHS), and the bill could not take effect if it was determined there would be a defrayal. After the mandate was passed, HHS determined there was a possibility of defrayal for individual and small group markets and, because the law did not carve out large group employers, the mandate could not take effect at all. The 2022 law corrects this loophole. While individual and small group employers are still not required to provide coverage until there is a confirmation from HHS that such coverage does not require defrayal by the state, Colorado's fertility insurance mandate will take effect for large group employers on January 1, 2023.

Fertility Preservation Insurance Mandates

Mandates that include fertility preservation require insurance carriers to cover the medical costs associated with oocyte, sperm, and embryo procurement and cryopreservation. These procedures are frequently not covered by insurance and can be cost-prohibitive, particularly for people who are already undergoing necessary medical care, including cancer treatment. Like fertility insurance mandates, how fertility patients are defined in bills impacts who can have their fertility preservation care covered under state mandates. There are many medical treatments that can affect a person's fertility, but state laws risk limiting fertility preservation coverage only to people undergoing cancer treatment. Fertility preservation coverage mandates must be inclusive and provide this care to all people undergoing treatments that can impact a person's fertility, including gender-affirming treatment.

Maryland and Massachusetts introduced inclusive fertility preservation bills. Hawaii, Kentucky, Louisiana, and Vermont introduced fertility preservation coverage for a narrower set of patients, limiting this coverage to people diagnosed with cancer or to people experiencing iatrogenic infertility, which is commonly understood to be infertility associated with medical treatment for cancer or other diseases.[5] Only one state in 2022 enacted a fertility insurance mandate that included fertility preservation. Maine's Act to Provide Access to Fertility Care (discussed *infra* in New Fertility Insurance Mandates), requires health plans to cover the procurement, cryopreservation, and storage of gametes, embryos, and reproductive material for a minimum of five years.

5 Of note, the American Medical Association voted in June 2022 to support the amendment of the definition of iatrogenic infertility to include "impaired fertility as a consequence of gender-affirming hormone therapy and gender-affirming surgery." Alison Sherwood, *AMA: Insurance Should Cover Treatment for Infertility Caused by Gender-Affirming Care,* Medscape, June 17, 2022, https://www.medscape.com/viewarticle/975803?reg=1.

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Interstate Shield Bills

As previously discussed, following the Supreme Court's overturning of *Roe*, several states supportive of abortion rights passed bills to protect abortion providers by prohibiting courts from summons or subpoenas in out-of-state actions, preventing the extradition of providers or patients, and otherwise expanding access to abortion care. One of these states, Massachusetts, included protections for assisted reproduction providers, becoming the first state to enact an interstate shield law that explicitly included such protections.

In Massachusetts, physicians, physician assistants, pharmacists, advance practice registered nurses, psychologists, and social workers who provide reproductive health care services—whether in person or via telemedicine—are now protected from discipline by the state medical board if the services they provide are lawful and consistent with good medical practice in the state. Notably, reproductive health care services are defined to include assisted reproduction. Law enforcement agencies are prohibited from providing information or assistance to investigations that arise from legally provided health care activity, judges cannot issue summons for these providers, and the governor is forbidden from extraditing these providers. The law creates civil penalties for people who engage in abusive litigation against providers of reproductive health care.

Massachusetts was the first state to include protections for assisted reproduction providers in an interstate shield law.

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Given potential threats to IVF by lawmakers who believe that life begins at fertilization, it is encouraging that Massachusetts included assisted reproduction in its interstate shield law and likely that other states will follow its lead in 2023.

Infertility Incidence and Access to Care Studies

Fertility insurance mandates are an important step to ensuring equitable fertility care access. Also critical is understanding the scale of infertility incidence and identifying disparities in access to care. One major gap already identified is Medicaid beneficiaries who by and large cannot access fertility care because they lack insurance coverage and the out-of-pocket cost of care is prohibitive. To better understand how many people are impacted by infertility and what barriers different communities face in accessing fertility care, California, Massachusetts, and Oregon introduced bills that would study barriers and inequities in access. Unfortunately, none of these bills passed this session.

Refusal of Care

For the first time, the Center tracked bills related to the right of providers to refuse to provide fertility care based on their religious objections to that care. Religious refusal bills are common in abortion legislation, but in 2022 several states introduced, but did not pass, bills that would allow providers to refuse to provide IVF or other forms of fertility care. Bills in Maryland and Vermont would allow providers and institutions to "decline to counsel, advise, provide, perform, assist or participate in" any health care services that violate their conscience, including assisted reproduction. While these bills represent an anomaly in the assisted reproduction legislation the Center tracks, they may signal a concerning trend for future legislative sessions.

Embryo and Gamete Regulation

This year the Center tracked 33 bills related to the regulation of embryos and gametes, four of which passed. Two of these laws, in Missouri, were appropriations bills that contained prohibitions on the funding of any research that would destroy a human embryo. Additionally, Arizona passed an embryo personhood bill and Colorado passed a bill that includes provisions regulating gamete use, both discussed in greater detail below.

Embryo "Personhood"

So-called embryo personhood bills frequently championed by anti-abortion legislators have damaging consequences for reproductive autonomy, including in the context of IVF where the goal of treatment is to create as many embryos as possible in the hope that one of them will result in a pregnancy and lead to a live birth. These bills, which often recognize life as beginning at fertilization or conception, undermine fertility patients' ability to access fertility care and to make decisions about their care, including by limiting their decision-making authority over their frozen embryos. The inability of patients to dispose of remaining cryopreserved embryos, and the cost involved in storing these, could lead many individuals and families to forgo IVF care in their state or to be unable to afford care in another state, preventing them from building their families via IVF. These bills would also have a chilling effect on fertility care providers who may be less willing to provide IVF for fear of civil or criminal liability. For example, fertility care providers may fear criminal liability for unsuccessfully thawing cryopreserved embryos, inadvertently compromising an embryo in pursuit of preimplantation genetic testing, or unsuccessfully transferring an embryo. Whether in isolation or in aggregate, the consequences of an embryo personhood bill would make IVF care more difficult to provide and access.

Three states (Kansas, Louisiana, and Oklahoma) introduced, but did not pass, embryo personhood bills. These bills all prohibited the intentional disposal of embryos and the bill in Kansas contained several scientific inaccuracies. Louisiana, which already prohibits the intentional disposal or destruction of embryos, introduced a bill to enhance the penalties for their destruction by amending the definition of homicide to include the killing of an "unborn child," defined to begin at fertilization.

Requirements for Gamete Banks

This year saw a rise in bills that would require gamete banks to collect information about gamete donors, disclose identifying information to donor-conceived people, and, in some cases, limit how many families can be formed using a single donor's gametes. Generally, these bills govern sperm donation. There is no federal law regulating gamete banks, leaving them to self-regulate their practices in accordance with guidance issued by relevant professional organizations. The intent behind these bills is multipronged and includes establishing minimum standards for gamete banks and bringing to bear the interests of children born using donated gametes, including the donor-conceived person's access to identifying information about gamete providers.

These bills raise privacy concerns for would-be gamete donors and may cause a decline in donors, especially Black, Indigenous, and other gamete donors of color. Proposed bills have included provisions requiring donors to disclose several generations' worth of medical history and seeking to establish a national registry that would, in part, store a donor's medical history. Both may act as a disincentive for Black, Indigenous, and other would-be gamete donors of color who don't have access to quality health care but do have a deep distrust of the American health care and government systems based on this country's history of reproductive oppression in their communities. Already, there is a documented shortage of racial/ethnic minority sperm donors in the United States' leading gamete banks. This shortage impacts individuals and families of color who struggle to find

sperm donors who share their race and may lead them to procure sperm outside the gamete bank system with possible attendant legal consequences for their legal parentage.

Numerous barriers—such as limited information, restrictive laws and policies, stigma, high costs, and more—put IVF and other fertility care out of reach for many.

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Four states introduced this type of bill and only Colorado enacted a new law. Colorado's Donor-Conceived Persons Protection Act requires all gamete agencies, gamete banks, and fertility clinics to collect and periodically update a sperm donor's identifying information and medical history, including but not limited to the donor's full name, present and past physical illnesses, and social, genetic, and family medical history. These requirements apply to any gametes that will be used by Colorado residents, meaning that out-of-state gamete agencies, gamete banks, and fertility clinics must comply with these requirements if they are providing gametes to Colorado residents. Upon their request, a sperm donor's identifying and medical information must be disclosed to a donor-conceived person if they reach 18 years of age or to the parent or guardian of a donor-conceived minor.

To facilitate the collection, storage, and disclosure of this information, gamete agencies, gamete banks, and fertility clinics must permanently maintain identifying information about the donor, the number of families established with each donor's gametes, and records of gamete screening and testing. The Act also requires the state to develop written materials for parents using donor gametes and gamete donors about: the importance of telling donor-conceived people that they are donor-conceived at a young age and in an age-appropriate manner; the available tools that donor-conceived people have to learn about the identity of their donors; the limitations of donor screening; and future implications for the donor-conceived person, given that there may be other people in other families conceived with the same donor's gametes.

The Act caps the number of families that can be established from a single donor's gametes at 25. This limit does not apply to children conceived by the donor as a parent or to children conceived using the donor's gametes when the donor is known to the recipient parent(s). The Act will take effect on and apply to gametes and embryos collected after January 1, 2025.

Surrogacy

Compensated gestational surrogacy is a practice wherein an intended parent or parents execute a contract with a person who agrees to attempt to become pregnant and deliver a child or children using embryos created via IVF. The person acting as surrogate receives a payment beyond reimbursement for medical expenses and neither contributes their own gametes nor intends to act as a parent to the child or children who are born via surrogacy. Laws that regulate compensated gestational surrogacy agreements must ensure that the rights of all parties are protected, with a particular focus on the power dynamics inherent between the intended parent or parents and the person acting as a gestational surrogate.

No laws legalizing compensated gestational surrogacy were enacted in 2022. However, two bills allowing intended parents to take bereavement

leave following a miscarriage by a person acting as a surrogate were enacted. Additionally, Virginia enacted a bill amending what could be included in surrogacy contracts and Colorado enacted a law to simplify the adoption process for parents who conceive a child through assisted reproduction, including surrogacy.

Surrogacy Contracts

Five states (Hawaii, Indiana, Massachusetts, Pennsylvania, and South Dakota) introduced, but did not pass, bills that would legalize and regulate compensated gestational surrogacy in their states. South Dakota introduced both a bill that would legalize compensated gestational surrogacy and, in contrast, a bill that would prohibit surrogacy in the state. Neither of these bills passed. Virginia was the only state to enact a law amending existing state law governing surrogacy contracts. Specifically, it prohibits surrogacy contracts from requiring or prohibiting a person acting as a surrogate from having an abortion.

Surrogacy legalization and regulation in the coming years will likely continue to closely mirror the Uniform Parentage Act of 2017. This is in part because it is the latest iteration of the Uniform Parentage Act and has been enacted – in whole or in part – in multiple states since it was adopted. Notably, the 2017 iteration is the first to use gender-neutral language and to directly address and protect the parentage rights of LGBTQ parents who use assisted reproduction to build their families.

Hawaii, Massachusetts, and Pennsylvania all introduced bills that included safeguards to protect the rights of surrogates, including requirements that the intended parents pay for the surrogate's legal representation, and specific clauses that allow the surrogate to make all their own health and welfare decisions throughout the duration of the surrogacy agreement. This contrasts to bills from Indiana and South Dakota that contained several alarming provisions that either infringed on the bodily autonomy of surrogates or unnecessarily limited who could become a surrogate.

Parentage Determination

How parentage is determined for children born via surrogacy agreements and other methods of assisted reproduction, like IUI and IVF, have profound legal consequences for families. Parentage bills establish frameworks for how legal parentage is determined, allowing parents who are not genetically related, or did not give birth to a child, to be recognized as legal parents without going through a lengthy adoption process. Different forms of parentage determination are especially important for LGBTQI+ couples where one individual is not biologically related to the child and may not automatically be recognized as a legal parent.

This year, Colorado enacted a law to create a confirmatory adoption process for people who become parents via a gestational surrogacy agreement or through another form of assisted reproduction. While intended parents must still petition for an adoption, the process does not require elements like an in-person hearing or home study. Instead, intended parents must provide a court with a copy of their marriage or civil union certificate, a declaration explaining the circumstances of the birth and that the birth parent consented to the conception of a child through assisted reproduction, a copy of the child's birth certificate, and a sworn statement by the petitioner acknowledging their parentage. The court must grant the confirmatory adoption within 30 days after finding the parent in question has filed a complete petition and any other presumed parent(s) has been notified. The law establishes that a petition cannot be denied solely because the petitioner's parentage is already presumed or legally recognized.

Legal parentage uncertainty is especially prevalent among LGBTQI+ parents and amendments to state parentage determination laws can mitigate this concern. Given the nationwide attacks on LGBTQI+ communities, progress made to facilitate legal parentage determinations for families formed through assisted reproduction is encouraging and likely to continue next year.

Parental and Bereavement Leave

States across the country are expanding both parental and bereavement leave for intended parents who use assisted reproduction, including surrogacy, to build their families. Parental leave is a category of leave for new parents, both ones who give birth and those who adopt. As a result, there is a risk that intended parents who become parents through gestational surrogacy agreements can only access parental leave if their state law requires them to adopt their child born through a gestational surrogacy agreement. As policies for determining the parentage of children born via surrogacy agreements change, parental leave policies are being amended to ensure that intended parents can access parental leave. Utah, for example, enacted a law that allows state employees who are the intended parents of a child born under a valid gestational surrogacy agreement to take up to three work weeks of parental leave.

Two other states (Kentucky and New Jersey) introduced parental leave bills that specifically included provisions for people who become parents via a gestational surrogacy agreement. As surrogacy agreements become more common, and as more people become legal parents through pre-birth parentage orders and means other than adoption, we will see more parental leave bills specifically including intended parents of children born to gestational surrogates.

As discussed in the maternal health section, bereavement leave is a category of leave for people who have lost a family member. This leave does not explicitly include parents who have lost a child to a miscarriage or stillbirth. As states introduce bereavement leave bills for pregnancy loss, many have included intended parents who use assisted reproduction, including surrogacy, to become pregnant and who experience a miscarriage or stillbirth in the category of parents eligible for bereavement leave. Two states (Illinois and Utah) passed bereavement leave bills that include intended parents participating in gestational surrogacy agreements. Illinois' bill, for example, allows all employees

to use up to 10 workdays of bereavement leave following a miscarriage or stillbirth. This leave can also be taken following a failed surrogacy agreement or an unsuccessful round of IUI or assisted reproductive technology procedure.

Four other states (New Jersey, New York, Massachusetts, and Oklahoma) introduced bereavement leave bills for intended parents experiencing a miscarriage or stillbirth of a child conceived via a gestational surrogacy agreement, or for parents who had experienced other events that negatively impacted their fertility. The main difference in these bills was the amount of time given for leave. New Jersey and New York introduced bills that would have allowed intended parents to take the full amount of parental leave following a miscarriage or stillbirth by a gestational surrogate, while Massachusetts and Oklahoma provided only 10 and three days of bereavement leave, respectively.

Conclusion

In 2022, state legislatures doubled down on their efforts to undermine reproductive autonomy by attacking legal protections for abortion, failing to pass laws to safeguard maternal health, and declining to expand access to fertility care. These attacks are interconnected, and a threat to any one of these issues is a threat to them all.

Legislators amplified challenges to *Roe* through various pre-viability bans and vigilante bounty-hunter laws to skirt judicial review. The Supreme Court ultimately delivered a wrecking ball to the constitutional right to abortion, destroying the protections of *Roe*, and utterly disregarding the fact that one in four pregnant people in America make the decision to end a pregnancy.

In preparation for and in response to this retrogression, states where abortion remains legal moved to introduce novel legislation to protect access to abortion in the form of interstate shield bills. Other states pursued tried and true safeguarding methods like creating a fundamental right to abortion, expanding funding for care, and broadening the category of individuals who can legally provide care.

The trends of 2022 are likely to continue in 2023; some states will introduce creative bills to restrict abortion, including via novel criminal penalties, and others will seek to protect access to abortion. Likewise, the chaos of 2022 will continue, as some states race to the bottom with criminal abortion bans, forcing pregnant people to travel across multiple state lines and, for those without means to travel, to continue a pregnancy against their will—dictating pregnant peoples' health, lives, and futures.

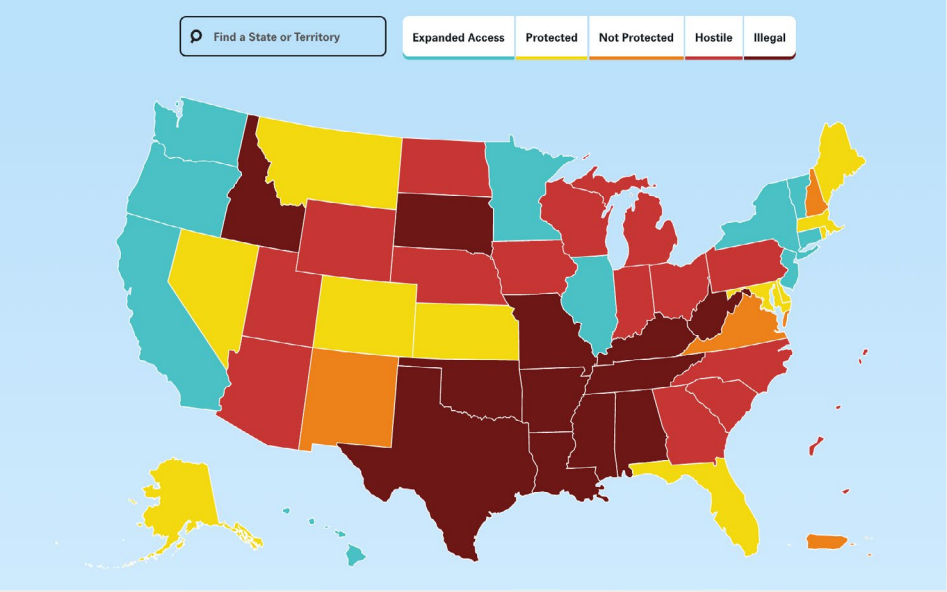
Although there was political interest in maternal health, the 2022 legislative accomplishments were modest and the need to better protect pregnant people's rights remains great. Lawmakers were particularly interested in addressing maternal mortality and morbidity by expanding benefits for people

after pregnancy. Though several PPME and paid leave bills were enacted, policies that define eligibility for pregnancy-related benefits raise questions about the purpose of the benefit and the outcome of the pregnancy. Conflict over the intended purpose of the benefits (such as physical recovery, infant bonding, grieving, etc.) and the intended beneficiaries will likely intensify as some politicians try to prevent people who have abortions from receiving support. The question of who is considered deserving of benefits continues to be salient.

Maternal health efforts also failed to meaningfully advance accountability and equity. This was especially evident in funding allocations for problematic non-health care service providers, such as CPCs. Despite evidence that doula care improves health outcomes, states continue to grapple with how to regulate doulas and whether or not to financially support them through Medicaid. Further, despite devastating shortages of maternity care providers across the country, midwifery regulations remain largely restrictive. The trends in provider licensing bills signals hesitation from states to meaningfully expand and diversify the maternity care workforce to include knowledgeable, community-based providers. This reluctance disproportionately impacts and marginalizes Black and Indigenous midwives and doulas. Moreover, incarcerated people continue to face enormous barriers to dignified maternal health care, as demonstrated by bills aimed at incrementally reducing cruel treatment such as regulating circumstances under which people can be shackled or isolated.

In *Dobbs*, the Supreme Court allowed states to ban or restrict abortion as long as the laws passed were rationally related to "legitimate state interests." One such interest the court identified as rational was the promotion of maternal health. As the Center has previously shown, however, the states that most aggressively ban or restrict abortion are unlikely to pass any laws that promote or safeguard maternal health. The divide between states with strong maternal health policies and states where maternal health is neglected will only continue to grow without understanding and consequential action from lawmakers.

2022 legislative sessions also saw the introduction of many inclusive fertility insurance mandates and the expansion of existing mandates. Positively, these mandates are moving towards the inclusion of social infertility and away from coverage limits and employer exemptions. 2022 saw a dramatic rise in bills regulating how gametes are used and how donor gamete information is collected, stored, and disclosed to donor-conceived persons, a trend that is likely to continue. Likewise, we are likely to see continued efforts to include surrogates and intended parents in parental and bereavement leave bills and to update and streamline parentage determination laws governing children born via assisted reproduction, including IVF and surrogacy.



The Center's *"After Roe Fell: Abortion Laws by State"* tool tracks state abortion laws and policies in real time.

Courtesy Center for Reproductive Rights

In light of the increased state efforts to ban abortion, it is likely that threats to assisted reproduction will follow. Already there has been legislation linking religious refusals to the provision of fertility care and we anticipate an increase in embryo "personhood" bills that limit IVF provision and access next year. With threats to LGBTQI+ rights on the rise, states may target the legal mechanisms that LGBTQI+ couples use to ensure that both parents are recognized as their children's legal parents, regardless of a genetic connection or who birthed the child.

At the same time, progressive states will continue to expand access to IVF by passing fertility insurance mandates and parentage bills to protect LGBTQI+ parents' rights. Additionally, we may see more states introduce interstate shield bills that protect fertility care providers and access to assisted reproduction. Without proactive legislation, access to assisted reproduction including IVF could become as state specific as abortion care access has become.

We must seize every opportunity to comprehensively strengthen protections for people seeking to become parents, pregnant people, and people who do not want to have children. Abortion rights must be understood alongside maternal health and assisted reproduction and addressed in the wider context of reproductive justice, the human right to reproductive autonomy, to have children, not have children, and parent the children we have in safe and sustainable communities.

In the face of continuing uncertainty, we at the Center, along with our partners, will work determinedly until everyone's reproductive autonomy and agency are upheld in the law and in practice. We will use every legal lever to ensure that every person's right to make decisions about their body, family, and life is realized, and that they have access to the full range of reproductive health care.

For more information or technical assistance please contact the Center's State Policy & Advocacy team at **statepolicy@reprorights.org**.

For all press inquiries, please contact **center.press@reprorights.org**.