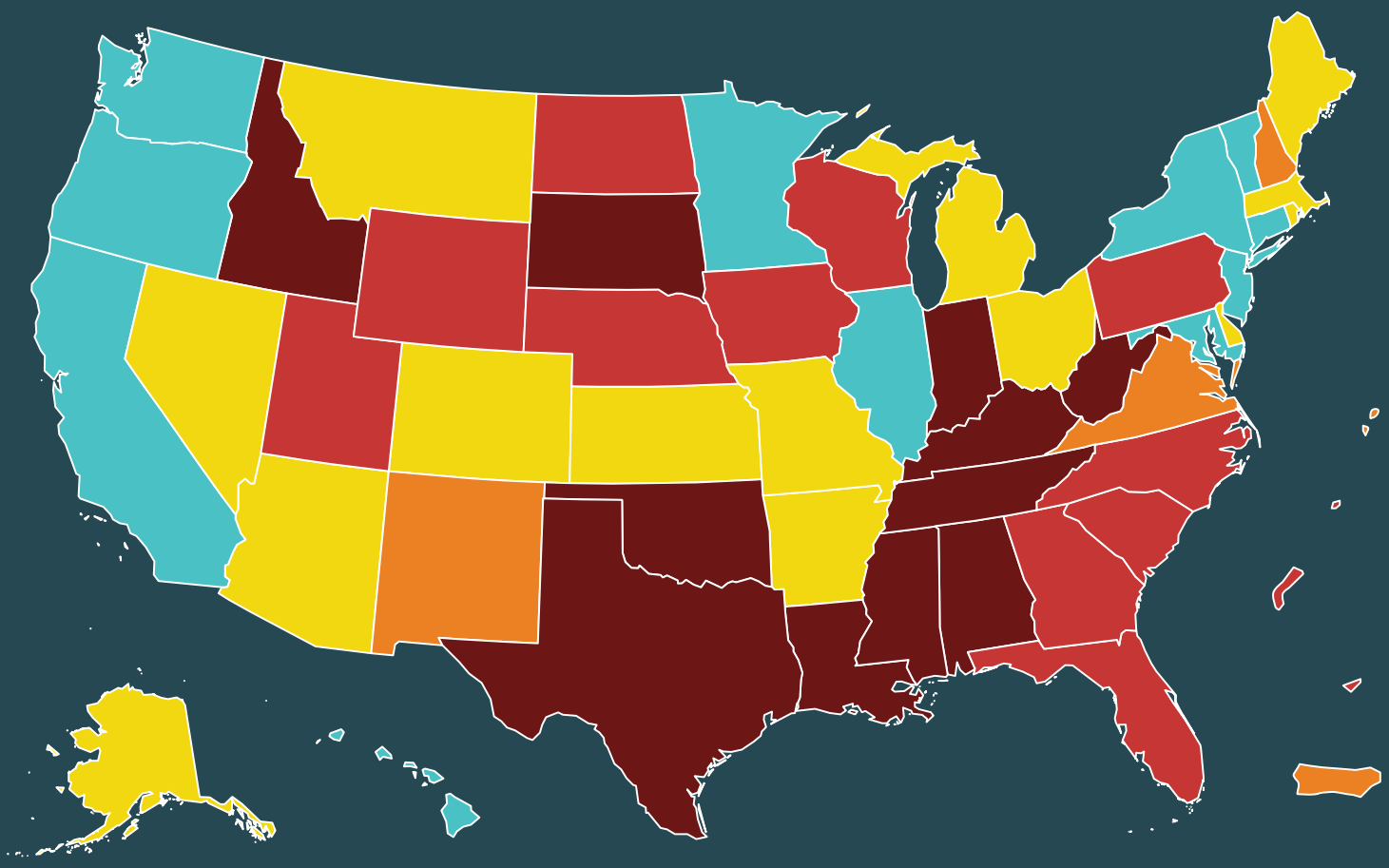


2024 State Legislative Wrap-up

CENTER *for* REPRODUCTIVE RIGHTS

State Policy Report:
An overview of the state landscape

Contents

The cover photo is reproduced from the Center's After Roe Fell interactive resource. Each state is placed into one of 6 categories based on laws, court cases, and state supreme court decisions. Each state is placed into one of 5 categories. The tool is updated in real time.

Introduction

More than two years after the U.S. Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization (Dobbs)*, reproductive health care access remains a contentious, frequently legislated issue even while supported by a majority of Americans. Across the U.S., regardless of the political climate, the Center for Reproductive Rights works to ensure more equitable access to abortion, assisted reproduction, and quality maternal health care. In 2024, many U.S. states expanded access to reproductive health care, including abortion care, while others further criminalized it. Tireless work by reproductive rights advocates has prevented further restrictions, and even expanded access to essential health care. Access to abortion, fertility care, and maternal health care increased in 25 states and the District of Columbia. At the same time, anti-reproductive rights advocates have continued attacks on reproductive health care, with a focus on creating barriers to fertility care, maternal health care and abortion access. We know that when access to reproductive health care is restricted, people will die. The deaths of Nevaeh Crain, Josseli Barnica, Amber Thurman, Candi Miller, and countless other people with the capacity for pregnancy made this abundantly clear. These people should still be with us. Two and a half years after *Dobbs* upended almost 50 years of legal precedent, we continue to see far reaching consequences for not only abortion access but reproductive health care more broadly.

The anti-rights movement will not stop at banning abortion in individual states. The election of Donald Trump will embolden anti-abortion legislators in Congress and could lead to the enactment of a national abortion ban. Since a federal abortion ban could supersede state law, banning abortion even in states that have protected the right to abortion in their state constitutions, the threat to everyone's rights, in every state, is serious. Restrictions on abortion care can be the pretext for restrictions on other reproductive health services. In February of 2024 for example, the state Supreme Court of Alabama relied in part on a fetal personhood provision in their state Constitution to hold in vitro fertilization (IVF) providers liable for wrongful death following any action that led to the destruction of embryos. This decision had the practical effect of temporarily stopping IVF care provision at the state's three major fer-

Report includes laws enacted before 11/1/24 and legislation introduced as of 12/3/24.

tility clinics. That constitutional provision, intended to prohibit abortion, was used to limit access to fertility care. Furthermore, legislators in many states are so focused on banning abortion and restricting fertility care that they continually fail to address the maternal morbidity and mortality crisis in the United States. Compared to other high-income countries, the United States has a high maternal mortality rate,[1] with 22.3 deaths per 100,000 live births.[2] Maternal mortality rates are highest for Black women, with 49.5 deaths per 100,000 live births.[3] And yet, instead of improving access to maternal health care, addressing providers' implicit bias, or devoting resources to better understanding maternal mortality, many state legislatures are curtailing bodily autonomy. In Hawai'i, for example, Native Hawaiian cultural practitioners and skilled midwives were forced to stop providing and teaching maternal care due to a change in licensing laws. Just as excessive regulation of abortion providers has restricted access to abortion care, regulating midwives and other birth workers without regard for cultural, historical, and geographic context can restrict an individual's bodily autonomy and access to care during pregnancy and birth.

Abortion is currently criminalized in 13 states, and in 2024, many of those states went a step further, enacting laws that criminalize abortion support, further restrict access to medication abortion, and increase criminal penalties for abortion care. Abortion bans and a lack of investment in maternal health care have life-threatening consequences for pregnant people, with a disproportionate impact on marginalized people who already face barriers to health care, specifically Black, Indigenous, and other people of color, people with disabilities, people in rural areas, young people, undocumented people, and people living on low incomes. Now more than ever, a person's ability to become pregnant, access the maternal health care they need, or end their pregnancy, is dependent on where they live.

States that protect the right to abortion are enacting new laws to create access bridges for people living in states that have banned or severely restricted abortion. Two additional states enacted comprehensive interstate shield laws to protect providers, patient medical records, and helpers who provide reproductive health care and gender-affirming care. Both laws protect providers who offer medication abortion care across state lines. Telemedicine abortion care now accounts for 21% of all abortions in the U.S., and there are

1 Munira Z. Gunja, Evan D. Gumas, Relebohile Masitha, Laurie C. Zephyrin, *Insights into the U.S. Maternal Mortality Crisis: An International Comparison*, The Commonwealth Fund (Jun. 4, 2024) https://www.commonwealthfund.org/publications/issue-briefs/2024/jun/insights-us-maternal-mortality-crisis-international-comparison.

2 Donna L. Hoyert, *Maternal Mortality Rates in the United States, 2022* Center for Disease Control (last reviewed May 2, 2024) https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2022/maternal-mortality-rates-2022.htm.

3 Donna L. Hoyert, *Maternal Mortality Rates in the United States, 2022* Center for Disease Control (last reviewed May 2, 2024) https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2022/maternal-mortality-rates-2022.htm.

an average of nearly 10,000 telehealth abortions provided under shield laws each month to people in states with total abortion bans, six-week bans, or telehealth bans.[4] This year also saw a rise in data privacy legislation to protect people providing and seeking abortion care, and more state public funding for abortion care.

Several states also expanded access to fertility care, by modifying existing fertility care insurance coverage mandates. This year saw the repeal of the last existing broad criminal ban on surrogacy, and several states updated parentage laws, to make it easier for people who form families through assisted reproduction to secure their parentage rights. Medicaid and insurance coverage of maternal health care, specifically care provided by doulas and midwives was established in several states as well.

Ten states had a reproductive freedom or abortion constitutional amendment on the November 2024 general election ballot. Voters in states across the country had the opportunity to create new constitutional protections for reproductive freedom or abortion rights, provide for state public funding for abortion care, and protect access to contraception. The response from voters was overwhelming, as seven of these initiatives passed, proving once again that the majority supports abortion care, including people in states with legislatures that are hostile to abortion care. This is true even in Florida, where a state constitutional amendment failed to be approved. While the amendment did not meet the 60% threshold required by the state constitution, 57% of voters supported it, demonstrating that a pro-abortion majority exists in the state. However, Florida raised the threshold of support needed to amend the state constitution to limit the success of constitutional amendments.[5] Raising the threshold is just one of many ways legislatures can intervene to prevent pro-abortion majorities from enacting change. The success of constitutional amendments across the country show that legislators who insist on enacting additional restrictions on abortion are out of step with their constituents.

Despite the U.S. Supreme Court majority's insistence in *Dobbs* that their decision to overturn *Roe v. Wade* would "return the issue of abortion to the people's elected representatives,"[6] two different abortion rights cases were before the Court in the October 2023 term. The plaintiffs in *FDA v. Alliance for Hippocratic Medicine ("FDA v. AHM")* sought to restrict access to mifepristone. In *Moyle v. United States*, Idaho aimed to lift an injunction preventing the state's abortion ban from taking effect to the extent the ban conflicted with the federal Emergency Medical Treatment and Active Labor Act (EMTALA).

4 *#WeCount Report*, Society of Family Planning (Oct. 22, 2024) https://societyfp.org/wp-content/uploads/2024/10/WeCount-Report-8-June-2024-data.pdf.
5 H.J.R. 1723, 107th Leg., Reg. Sess. (Fla. 2005).
6 Dobbs v. Jackson Women's Health Organization, 597 U.S. 215, 232 (2022).

The Supreme Court ruled in the *FDA v. AHM* case that the anti-abortion group Alliance for Hippocratic Medicine and its members had no standing to challenge Food and Drug Administration (FDA) medication abortion regulations. This ruling preserved access to mifepristone and ensured that providers could continue to provide abortion care through telemedicine. In *Moyle*, the Supreme Court reinstated the Idaho injunction, which requires hospitals to perform abortions if an abortion is needed to prevent serious health harms to the pregnant person. Unfortunately, the Court declined to hold that EMTALA would require emergency abortion care in all states where abortion is illegal. The Supreme Court will continue to decide cases related to bodily autonomy in the October 2024 term when they hear *United States v. Skrmetti*, a case challenging Tennessee's gender-affirming care ban.

At the federal level, the election of Donald Trump and J.D. Vance is expected to have a profound and negative impact on reproductive rights and access. Unfortunately, we are still feeling the effects of Donald Trump's first term A majority of the Supreme Court is still hostile to abortion, in part because of Senate Republican obstruction that allowed Donald Trump to appoint three Supreme Court justices, each of whom voted to overturn *Roe*. Recent Supreme Court decisions have also stripped power from the administrative state and agencies,[7] just as anti-abortion groups have begun to target medication abortion medication approved by the FDA. The absence of federal protection for abortion care has allowed states to enact criminal bans and other burdensome restrictions across the country. And Donald Trump's election-year promise to veto a national abortion ban cannot be trusted, given his past hostility to abortion, including his past support of abortion bans and his statement that "there has to be some form of punishment" for people who have abortions.[8]

With the U.S. Congress under the control of anti-abortion legislators starting in January 2025, we may see action on a federal ban on abortion care. A federal ban or other restriction on abortion would impact access to care even in states that have created constitutional protections for abortion care. Anti-abortion politicians are attempting to rebrand a potential federal abortion ban as "minimum national standards," a term being used to mislead and confuse voters. It is unlikely these anti-rights majorities would improve access to maternal health care or fertility care, and indeed, legislators who support fetal personhood could try to enact laws that threaten access to IVF.

7 *Loper Bright Enterprises v. Raimondo*, No. 22-451 (2023) (overruling *Chevron v. National Resources Defense Counsel*, 467 U.S. 837 (1984), a case that required courts to defer to agency interpretations of statutes. As a result, judges are now able to weigh in on agency decisions, despite potentially lacking the scientific background necessary to understand these decisions. The decision stripped power from administrative agencies, and put that power in the hands of judges).

8 Tom Kertscher, *In Context: Transcript of Donald Trump on punishing women for abortion*, POLITIFACT (Mar. 31, 2016) https://www.politifact.com/article/2016/mar/31/context-transcript-donald-trump-punishing-women-ab/.

The Center's State Policy and Advocacy team (pictured above) along with the US Human Rights team works to advance proactive laws and policies that expand access to reproductive rights and care.

In every state, the Center for Reproductive Rights works to ensure and increase access to abortion, assisted reproduction, and quality maternal health care. We do this by working with state partners to advance proactive legislation, including legislation that enhances protection for abortion across state lines and expands equitable access to reproductive health care services. We support our state partners in enforcing existing statutory and constitutional protections for reproductive rights and creating rights to reproductive health, including abortion care, through state constitutional amendments. We assist legislators and advocates who are working to mitigate the harm caused by restrictive laws and state court decisions and empower and assist partners bringing cases in state court to challenge restrictive state laws.

During 2024, the Center for Reproductive Rights tracked almost 2,000 pieces of reproductive rights related legislation across the 50 states, and Washington, D.C. This report highlights 2024 legislative trends impacting access to abortion care, assisted reproduction, and maternal health care. To begin, we examine state efforts to protect abortion and IVF in state law through constitutional and statutory protections. We discuss interstate shield laws, and the recent rise in legislation that criminalizes abortion support and restricts young people's access to care, as well as other unconstitutional cross-border restrictions. The report then turns to a discussion of the intersection between criminal law and reproductive health, abortion bans, and fetal and embryo personhood. Both public funding and private insurance coverage of reproductive health care demonstrates how funding and coverage can be used to expand access to care. The report addresses medication abortion, regulation of reproductive health care providers, substance use and mental health treatment for pregnant people, and recent developments in surrogacy legalization and regulation. Finally, we discuss barriers to care, parental leave, embryo and gamete regulation, data about maternal health outcomes, and recent local ordinances that aim to restrict abortion access and people traveling for care. The report concludes with an overview of the current state of reproductive rights in the United States.

Protecting Abortion and Assisted Reproduction in State Law

Since *Dobbs*, voters in eleven states amended their state constitutions to protect access to abortion. Voters in three more states defeated anti-abortion ballot initiatives. In 2022 and 2023, the right to abortion won every time that it was on the ballot. Abortion bans and restrictions are unpopular with voters, even voters in states where legislators easily enact those same bans thanks, in large part, to gerrymandering and systemic voter suppression. This year saw a record number of states voting on abortion rights constitutional amendments, as well as the first legislatively referred ballot initiative about access to fertility care. States supportive to reproductive rights also enacted state laws to protect access to care. Particularly in the wake of state and federal Supreme Court decisions about embryo personhood and emergency abortion care, states worked to pass laws to safeguard IVF and abortion care.

In the wake of these successes, legislatures hostile to abortion are trying to amend state constitutions through legislatively referred constitutional amendments that would prevent future litigation against abortion bans and restrictions. Hostile legislatures are also trying to make the process of amending state constitutions more difficult for voters, and anti-abortion groups continue to stymie efforts to enact constitutional abortion protections. Despite these hurdles, reproductive rights continue to be on the ballot, and they continue to win.

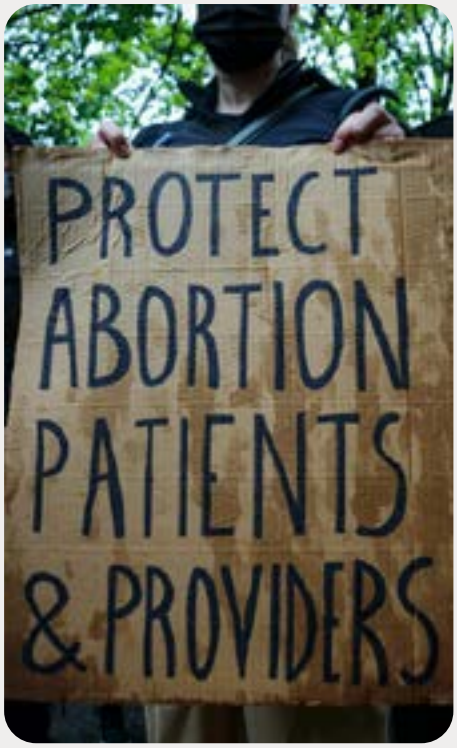
This section touches on the link between reproductive rights and voting rights, including efforts by states to curtail voter-initiated ballot initiatives. It examines legislation that would create affirmative and restrictive proposals to enshrine abortion rights in state constitutions or prohibit them. Finally, the section discuses statutory protections for abortion and fertility care.

Voter-Initiated State Constitutional Amendments and Efforts to Curtail the Democratic Process

Eighteen state constitutions allow voters to initiate state constitutional amendments. This mechanism is critical because abortion bans are the prod-

uct of anti-democratic gerrymandering and systemic power hoarding, which allows an anti-abortion minority to enact laws that conflict with the opinions of the majority of voters who support abortion rights. As such, the link between reproductive rights and voting rights is a consequential one. Anti-abortion advocates know that abortion rights are a winning ballot issue, so they do whatever they can to obstruct access to the ballot box.

Anti-abortion state executives in the Montana Secretary of State's Office tried to retroactively change the rules governing whose signatures could count on petitions, including on a petition to protect abortion rights.[9] Officials tried to eliminate the signatures of inactive voters, but a state district judge ruled these signatures must be included in the tally.[10] In Arkansas, advocates sued the state for a similar reason, after the state refused to verify over 100,000 signatures.[11] And in Nebraska, anti-abortion groups submitted a proposed constitutional amendment that mirrored the title and used similar language to the proactive ballot measure; voters approved the language, which will ban abortion in the second and third trimesters.[12]



In 2024, millions of people voted to enshrine the right to abortion in their state constitutions. The success of Amendment 3 in Missouri marked the first time voters in a state with a total abortion ban successfully amended their constitution to protect abortion rights. Photo: Emma Guliani/Pexels

Despite this opposition, eight voter-initiated proactive state constitutional amendments were on the ballot in eight states (Arizona, Colorado, Florida, Missouri, Montana, Nebraska, Nevada, and South Dakota) in addition to the two amendments referred by state legislators (Maryland and New York). These initiatives were approved by voters in 5 states (Arizona, Colorado, Missouri, Montana, and Nevada). The amendments to the state constitutions in Arizona and Missouri will likely lead to litigation against abortion bans in those states. In Arizona, advocates now have a constitutional protection for abortion that could lead to challenges against the state's existing fifteen-week ban, as well as support for the legislature to repeal the numerous unnecessary restrictions on abortion. Similarly, in Missouri—which had banned abortion--the state constitution was amended to protect the right to reproductive freedom, including abortion. In a state with a total ban on abortion, and a hostile legislature, the constitutional amendment could open new pathways for litigation to challenge the existing ban. The win in Missouri was notable, since this marks the first time a state with a total abortion ban has successfully amended its constitution to include a right to reproductive freedom.

9 Amy Beth Hanson, *Montana judge: Signatures of inactive voters count for initiatives, including 1 to protect abortion,* Associated Press (Jul. 16, 2024, 5:50 PM) https://apnews.com/article/montana-ballot-petition-signature-rules-bc9d861830203b0439e89afaa14bb6a3.

10 Amy Beth Hanson, *Montana judge: Signatures of inactive voters count for initiatives, including 1 to protect abortion,* Associated Press (Jul. 16, 2024, 5:50 PM) https://apnews.com/article/montana-ballot-petition-signature-rules-bc9d861830203b0439e89afaa14bb6a3.

11 Andrew Demillo, *Arkansas is sued for rejecting petitions on an abortion-rights ballot measure,* Associated Press (Jul. 16, 2024, 4:59 PM) https://apnews.com/article/arkansas-abortion-ban-lawsuit-ballot-measure-f5b8125263212437e9b5b2afd80906bc.

12 Lindsey Pipia and Bridget Bowman, *Dueling abortion amendments will appear on Nebraska's ballot,* NBC News (Aug. 23, 2024,1:09 PM) https://www.nbcnews.com/politics/2024-election/dueling-abortion-amendments-nebraska-ballot-rcna167980.

While abortion was already protected in Colorado, Montana, and Nevada, the amendments to these state constitutions will strengthen abortion protections in those states. The Colorado amendment also removes the state's existing ban on coverage for abortion care, allowing the state legislature to repeal this ban, and allow for public funding for abortion. Explicit constitutional protections for abortion in Montana will ensure that abortion remains legal, a necessary protection and a potential basis for challenging the unnecessary abortion restrictions still in effect. The Nevada amendment must be approved by Nevada voters in the 2026 election in order to take effect, but voters approving that amendment could allow for similar litigation against that state's abortion restrictions.

The amendment to the Florida constitution failed to pass, despite 57% of voters voting for the amendment, due to a requirement that amendments to the constitution receive 60% of the vote. The constitutional amendment in Nebraska which would have protected the right to abortion through at least the first two trimesters failed to pass, whereas the constitutional amendment that was backed by anti-abortion groups and would ban abortions after the first trimester was approved by voters. Finally, the constitutional amendment in South Dakota that would have established a right to abortion failed to pass. A variety of factors, including well-funded opposition movements, high voting thresholds, anti-abortion groups creating dueling ballot initiatives, and a swell of support for Republican candidates, contributed to the failure of these amendments, but the support, particularly in Florida, is an encouraging sign for future abortion rights advocacy in those states.

Legislatively-Referred State Constitutional Amendments on Abortion

State constitutional protection for reproductive freedom ensures that abortion and reproductive health care remains legal and accessible. These protections also prohibit anti-abortion lawmakers from enacting barriers to or prohibitions on care. Legislatures in 49 states can refer constitutional amendments to the ballot. This year, the Center monitored 20 bills in 15 states (Alabama, Georgia, Hawai'i, Iowa, Louisiana, Nebraska, New Hampshire, New York, Mississippi, Missouri, North Carolina, South Carolina, Virginia, Washington, and West Virginia) seeking to amend state constitutions to protect or expand access to abortion. Many proposed state constitutional amendments this year included language that explicitly protected abortion providers and people who help others access abortion care.

Simultaneously, five states (Illinois, Mississippi, Missouri, New Jersey, and Oklahoma) introduced twelve state constitutional amendments that would have placed abortion restrictions on the ballot. These efforts included bills

that would have established constitutional fetal personhood rights and provisions that explicitly stated abortion is not protected under the state constitution. No state legislature referred a proactive or restrictive abortion amendment to the ballot in 2024.

Voters in two states voted on and approved legislatively referred proactive constitutional amendments.[13] New York's Equal Rights Amendment would prohibit government discrimination based on pregnancy and pregnancy outcomes.[14] Maryland's referendum would amend the state constitution to create a fundamental right to reproductive freedom, including the right to access abortion and birth control.[15] Voters in both of these states approved these constitutional amendments. While Maryland already has statutory protections for abortion, the constitutional amendment will solidify those protections against any future hostile legislatures. The New York constitutional amendment does not specifically protect the right to abortion, but the protections against pregnancy, pregnancy outcome, and gender discrimination among other identities are a vital part of protecting access to all forms of reproductive health care.

Building on the successes of abortion ballot initiatives, the Illinois legislature referred advisory questions to the ballot this year that would measure public support for a requirement that health insurance plans to provide coverage of "medically appropriate assisted reproduction treatments."[16] This ballot initiative would not require the state to provide this coverage, it is instead an "advisory question of public policy" and is non-binding.[17] This initiative could mark the beginning of ballot measures to expand access to and affordability of fertility care services. Illinois already provides insurance coverage for fertility care, but voters approving this initiative shows that there is strong support for access to fertility care, which could empower the legislature to further expand this access, including by establishing Medicaid coverage of fertility care.

State Statutory Protections for Abortion and Fertility Care

For the first time this year, states introduced legislation that would protect the right to IVF, in response to a state Supreme Court decision in Alabama. In February, the Alabama State Supreme Court held in *LePage v. Center for Reproductive Medicine ("LePage")* (discussed in-depth on page 27) that the state's Wrongful Death of a Minor Act applied to "all unborn children, without lim-

13 H.B. 705/S.B. 798, 445th Leg., Reg. Sess. (Md. 2023) (to be codified at MD. CONST. art. 48); A. 1283/S. 108, 245th Leg., Reg. Sess. (N.Y. 2023) (to be codified at N.Y. CONST. art. 1, § 11).
14 *Abortion on the Ballot*, CENTER FOR REPRODUCTIVE RIGHTS https://reproductiverights.org/abortion-on-ballot-2024/ (last updated Aug. 23, 2024).
15 *Abortion on the Ballot*, CENTER FOR REPRODUCTIVE RIGHTS https://reproductiverights.org/abortion-on-ballot-2024/ (last updated Aug. 23, 2024).
16 S.B. 2412, § 4-1, 103rd Gen. Assemb., Reg. Sess. (Ill. 2024).
17 S.B. 2412 § 4-5, 103rd Gen. Assemb., Reg. Sess. (Ill. 2024).

itation" including cryopreserved embryos.[18] This decision meant that fertility care providers would face significant civil wrongful death liability for any action that led to the destruction of an embryo. This included, but was not limited to, unsuccessfully thawing a cryopreserved embryo, transferring an embryo that did not implant and lead to a pregnancy, and discarding embryos at the direction of a patient. The ruling in *LePage* meant that by following the wishes of their patients, and providing high-quality IVF care, providers would be opening themselves up to civil liability. In the wake of the ruling, Alabama's three largest fertility clinics abruptly paused IVF care rather than risk wrongful death suits.[19]

Fearful that this kind of decision could lead to a similar disruption of IVF services, 7 states (Idaho, Kentucky, New Jersey, North Carolina, Missouri, Ohio, and Washington) introduced 10 bills that would have created a statutory right to IVF, established that an embryo is not a person under state law, or both. None of these bills passed. Other states, including Alabama (discussed below in Criminal and Civil Immunity for IVF Providers) introduced legislation to protect providers, but fell short of creating a right to IVF. Three states (California, Georgia, and New Jersey) introduced 6 resolutions that affirmed the state's support for IVF or condemned the Alabama ruling. Resolutions supporting IVF were enacted in Georgia and New Jersey. While state support for IVF and state statutory rights to IVF help to shore up support for IVF access, they do not materially ensure access to care. As threats to IVF and other fertility care continue to rise, states will need to look to insurance mandates to ensure meaningful access to fertility care.

States also continued to grapple with the maternal and pregnancy health crisis triggered by abortion bans. States can no longer rely on federal protections for abortion and must protect abortion in state law or state constitutions. Eighteen states currently have statutory protections for abortion,[20] but no additional states enacted legislation this year to codify a right to abortion in state law.

Protection of Emergency Abortion Care

This year, the U.S. Supreme Court heard arguments in *Moyle v. United States ("Moyle")* a case that invalidated aspects of Idaho's abortion ban to the extent the provisions conflicted with the Emergency Medical Treatment and Labor

18 LePage v. Center for Reproductive Medicine, SC-2022-0515 *7 (Ala. 2024).

19 Aria Bendix, *Three Alabama clinics pause IVF services after court rules that embryos are children,* NBC News (Feb. 21, 2024, 6:00PM) https://www.nbcnews.com/health/health-news/university-alabama-pauses-ivf-services-court-rules-embryos-are-childre-rcna139846.

20 California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Maine, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New York, Oregon, Rhode Island, Vermont, and Washington have statutory protections for abortion, *After Roe Fell: Abortion Laws by State*, Center for Reproductive Rights https://reproductiverights.org/maps/abortion-laws-by-state/ (last visited Oct. 22, 2024). Alaska, California, Illinois, Kansas, Massachusetts, Michigan, Minnesota, Montana, New Jersey, Ohio and Vermont have constitutional protections for abortion, *After Roe Fell: Abortion Laws by State*, Center for Reproductive Rights https://reproductiverights.org/maps/abortion-laws-by-state/ (last accessed Oct. 22, 2024).

Act (EMTALA), the federal law requiring all hospitals that receive Medicare payments to provide stabilizing care to all people, regardless of their ability to pay. The federal government argued that EMTALA preempts state abortion law and requires hospitals to provide abortion care when abortion is a necessary stabilizing treatment for an emergency medical condition. The Idaho abortion ban, on the other hand, only allows abortion if the abortion is necessary to prevent the death of the pregnant person or in very limited medical situations.

In June, the Court restored a lower court injunction that blocked the Idaho abortion law from taking effect to the extent the law prohibits hospitals from providing emergency abortions that are necessary to protect against serious harm to the health of the pregnant person. The Court stopped short of stating that EMTALA requires all hospitals in every state to provide stabilizing abortion care.

In anticipation of this ruling, Connecticut, Illinois, Maryland, and Pennsylvania introduced legislation that explicitly requires hospitals licensed in those states to provide abortion care when that care is necessary to resolve a medical condition that could lead to death, severe injury, or serious illness. The Illinois law, which subjects hospitals that violate the law to a $50,000 fine, was enacted.[21] While only the U.S. Congress can amend EMTALA, states can amend or create similar state laws to ensure that access to emergency abortion care is protected.

Criminal and Civil Immunity for IVF Providers

In the wake of *LePage,* four states (Alabama, Kentucky, Louisiana, and Ohio) introduced legislation that would give IVF providers immunity from civil and criminal suits related to the destruction of an embryo. Only Alabama, where IVF care had paused in response to the state Supreme Court decision, enacted this kind of legislation. The Alabama law provides civil and criminal immunity to providers and clinics, as well as any manufacturers of goods used in IVF care or the transportation of embryos.[22] While this law resulted in the practice of IVF to resume in Alabama, granting providers immunity for the destruction of embryos does not address the central tenet of the state Supreme Court's ruling or the consequences that flow from the enforcement of fetal and embryo personhood laws that currently exist across the country.

21 H.B. 581 § 1, 103rd Gen. Assemb., Reg. Sess. (Ill. 2024) (to be codified at 210 Ill. Comp. Stat. 80/1).
22 S.B. 159 § 1, 2022-2026 Leg., Reg. Sess. (Ala. 2024) (codified at Ala. Code § 6-5-810).

Interstate Shield Laws and Data Privacy

States supportive of abortion responded to *Roe* being overturned by enacting interstate shield laws. Interstate shield laws protect abortion providers, the medical records of people seeking abortion, reproductive or transgender health care, and people helping others access that care from criminal, civil, and administrative consequences that may arise in states where abortion or other health care is illegal. Since 2022, 18 states and D.C. have enacted interstate shield laws.

Shield laws enacted in anticipation of and directly after *Dobbs* primarily focused on protections against extradition and out-of-state criminal investigations. These laws also created protections against foreign civil judgements, professional licensure penalties, and medical malpractice insurance penalties. As more states enacted shield laws, they expanded to also include protections for gender-affirming care in addition to reproductive health care, including abortion and fertility care. Subsequent interstate shield laws have also included data privacy protections, and many shield laws protect telehealth providers who prescribe and mail abortion medication across state lines. This section examines the states that introduced comprehensive shield legislation, states that expanded shield protections, and states that enacted and introduced stand-alone data privacy legislation in 2024.

Comprehensive Interstate Shield Legislation

This year, 53 bills creating or expanding interstate shield laws were introduced in 15 states (California, Delaware, Hawai'i, Kentucky, Maine, Maryland, Michigan, Missouri, New Hampshire, New Jersey, New York, Rhode Island, Vermont, Virginia, and Washington). Only Maine[23] and Rhode Island[24] enacted comprehensive interstate shield legislation. In addition to protecting abortion care, these new shield laws also protect providers, patient medical records, and helpers engaged in the provision of fertility care, miscarriage care,

23 L.D. 227 (H.P. 148), 131st Leg., Reg. Sess (Me. 2024) (codified at ME. STAT. tit. 14 §§ 9001—9007, 9010; ME. STAT. tit. 10 § 8012; ME. STAT. tit. 24 § 2513; amending ME. STAT. tit. 14 §§ 402, 403; ME. STAT. tit. 15 § 203; ME. STAT. tit. 16 § 642; ME. STAT. tit. 5 § 90-B; ME. STAT. tit. 24-A §§ 2159-F, 4301-A, 4303; ME. STAT. tit. 22 § 1711-C).

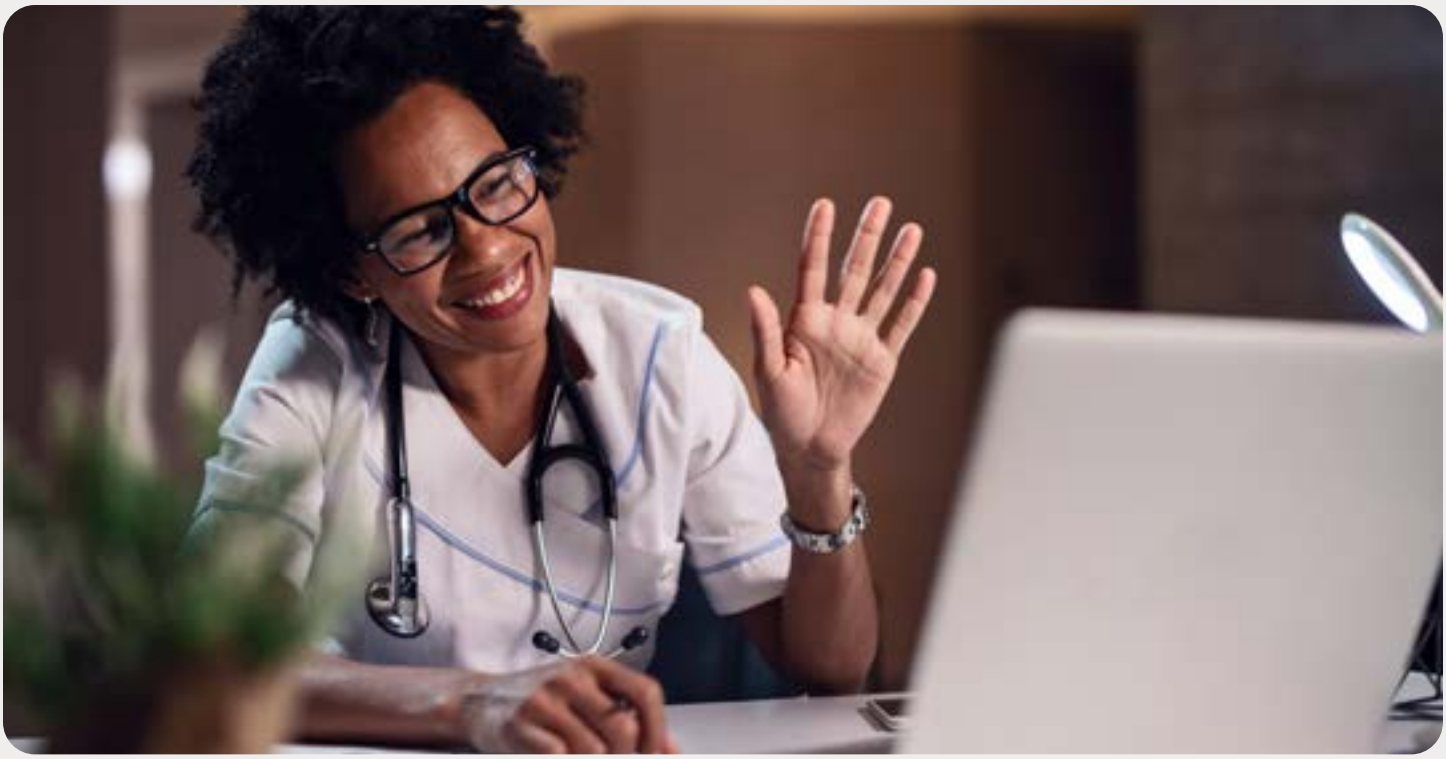
24 H.B. 7577/S.B. 2262, 2023-2024 Gen. Assemb., Reg. Sess. (RI. 2024) (to be codified at 23 R.I. GEN. LAWS §§ 23-100-1—23-100-9; 12 R.I. GEN. LAWS § 12-9-36; 5 R.I. GEN. LAWS § 5-37.8-1—5-37.8-3; 6 R.I. GEN. LAWS § 23-17-53; 5 R.I. GEN. LAWS § 5-37-9.2; 23 R.I. GEN. LAWS § 23-1-42.2).

and gender-affirming health care.[25] Both laws protect providers located within the state who provide telehealth abortion care across state lines.[26] They also protect providers, patients, and helpers from extradition,[27] prohibit state employees and agencies from assisting with out-of-state investigations into legally protected health care activity,[28] protect providers from adverse action from state licensing boards and medical malpractice carriers,[29] and allow people to file civil action in response to hostile civil litigation from people in states where abortion is banned.[30] Both laws also allow providers to participate in the state's address confidentiality program or otherwise keep their addresses private,[31] and prohibit the disclosure of patient health information.[32] Both Maine and Rhode Island's shield laws are currently in effect, protecting providers, and further expanding access to abortion care in those states.

"We knew passing a shield law was an essential way to guarantee access both for abortion seekers and gender affirming care for patients travelling from banned states. Despite serious, violent threats from our opposition, Mainers stood their ground and passed these protections to ensure this vital care remains safely accessible for all people, no matter where they come from. We were more than ably supported by the Center for Reproductive Rights, which provided us and our citizen advocates with fact-based legal advice." -Maine Family Planning, which provides affordable reproductive health care services for all Mainers, as well as primary care, help for new parents and families, and gender-affirming health services.

Although Virginia's legislature passed a sweeping package of interstate shield legislation, the legislation was vetoed by anti-abortion Governor Glenn Youngkin. The current makeup of the Virginia state legislature means there is no veto-proof majority, but this does signal potential future reproductive rights wins in that state. In some states where the right to access abortion care is protected, there are no interstate shield laws, so shield laws could be introduced in those states in the coming years.

25 Me. Stat. tit. 14 § 9002(8); 23 R.I. Gen. Laws §§ 23-101-2(4), (8)(i).
26 Me. Stat. 14 § 9002(8)(B); 23 R.I. Gen. Laws § 23-101-2(8)(ii).
27 Me. Stat. tit. 15 § 203(5); 12 R.I. Gen. Laws § 12-9-36.
28 Me. Stat. tit. 14 § 9006 (prohibition on assisting with out-of-state investigations); Me. Stat. tit. 14 § 9005 (prohibition on issuing summons); Me. Stat. tit. 14 § 403(1-A) (prohibition on issuing subpoenas); 3 R.I. Gen. Laws § 23-101-5 (prohibition on issuing summons and subpoenas in connection with prosecutions or civil suits in another state); 23 R.I. Gen. Laws § 23-101-6 (prohibition on assisting with out-of-state investigations); 23 R.I. Gen. Laws § 23-101-7 (prohibition on arrests).
29 Me. Stat tit. 10 § 8012; Me. Stat. tit. 24 § 2513 (licensure); Me. Stat. tit. 24-A, § 2159-F (malpractice insurance); 5 R.I. Gen. Laws § 5-37.8-1 (licensure); R.I. Gen. Laws §§ 5-37.8-1, 5-37.8-2.
30 Me. Stat. tit. 14 § 9003; 23 R.I. Gen. Laws § 23-101-3.
31 Me. Stat. tit. 5 § 90-B(2); 5 R.I. Gen. Laws § 5-37-9.2(c).
32 Me. Stat. tit. 22 § 1711-C(8)(A); 3 R.I. Gen. Laws § 23-100-5(e)(1).



Interstate shield laws have become critical tools in protecting abortion providers, helpers, and patient medical records when care is provided to out-of-state residents. Photo: Drazen Zigic/ Shutterstock.

Expanding Shield Protections

Eight states that already have interstate shield protections introduced and enacted legislation that expands existing interstate shield legislation.[33] This legislation to amend or expand shield laws takes many forms. Maryland, for example, enacted legislation that applies the interstate shield protections to gender-affirming care, including fertility preservation.[34] Of the 18 states and Washington D.C. that have shield laws, only fourteen and D.C. currently include protections for gender-affirming care.[35] Because attacks on reproductive and transgender rights originate from the same spaces and are motivated by the same ideological opposition to bodily autonomy, legislatures that have not already protected providers, helpers, and the medical records of individuals accessing gender-affirming care should amend their interstate shield laws to do so.

In response to a decision by the Arizona Supreme Court that allowed an 1848 abortion ban to take effect (before the state repealed the law in September 2024), California enacted legislation that authorizes physicians who are licensed in Arizona to provide abortion care in California.[36] The authorization

33 *See e.g.* Cal. Health & Safety Code §§ 103005, 123462, 123466; Del. Code Ann. tit. 18, § 2535; Haw. Rev. Stat. § 323J-4; Md. Code Ann., Cts. & Jud. Proc. § 9-302; N.J. Stat. Ann. § 2A:84A-22.19; N.Y. C.P.L.R. § 3119; Vt. Stat. Ann. tit. 12 § 7306; Wash. Rev. Code § 7.115.020.

34 H.B. 691/S.B. 119, 446th Gen. Assemb., Reg. Sess. (Md. 2024) (to be codified at Md. Code Ann. State Pers. & Pens. § 2-312).

35 *Transgender Healthcare "Shield" Laws*, Movement Advancement Project https://www.lgbtmap.org/equality-maps/healthcare/trans_shield_laws (last accessed Nov. 18, 2024).

36 S.B. 233, 2024 Leg., Reg. Sess. (Cal. 2024) (to be codified at Cal. Bus. & Prof. Code § 2076.6(a)(1)).

was limited to providers who were only providing abortion care to people traveling to California from Arizona, and will be repealed on January 1, 2025.[37]

There are states that have enacted interstate shield laws that do not contain certain critical protections, including prohibitions against adverse actions related to malpractice insurance, laws to more comprehensively shield medical records, or protections for telemedicine abortion care across state lines. States that have already enacted interstate shield laws should continue to amend these laws to make them even stronger and include protections they did not include in the first iteration of shield legislation.

Data Privacy Legislation

In the absence of a federal law prohibiting private data brokers from collecting, sharing, and selling sensitive health care information, states have stepped up to fill these gaps, enacting laws to protect data privacy.[38] Data privacy protections include laws to prohibit the collection, sharing, and selling of health care information, prohibitions on creating geofences[39] around abortion clinics, and expanding access to address confidentiality programs for abortion providers, helpers, and patients. While these protections are occasionally included in interstate shield laws, states are enacting standalone data privacy legislation.

Maryland was the only state to enact a comprehensive data privacy law this year, which prohibits all entities doing business in Maryland from selling or sharing health data without the consumer's consent.[40] The law also prohibits geofencing around health care facilities, and applies to all activities beginning April 1, 2026.[41] California amended a previously enacted data privacy law to establish that the law does not apply to health service plans or contractors.[42]

Finally, Vermont's legislature passed a comprehensive data privacy bill, but the bill was vetoed by Governor Phil Scott.[43] All states seeking to protect providers and patients should enact comprehensive, standalone data privacy laws that allow consumers to control how their sensitive health data is collected, retained, sold, and shared. Data privacy laws protect sensitive patient information for all kinds of health care, and need not be limited to reproductive health care.

37 S.B. 233, 2024 Leg., Reg. Sess. (Cal. 2024) (to be codified at Cal. Bus. & Prof. Code § 2076.6(l)).
38 The Health Insurance Portability and Accountability Act (HIPAA) only regulates covered entities like health care providers (C.F.R. tit. 45 § 160.103) and the Federal Trade Commission Act (FTCA) simply prohibits unfair or deceptive acts or practices (15 U.S.C. §45).
39 Geofencing is location-based targeted advertising that creates a virtual boundary, and triggers marketed advertising when a device, commonly a cellphone, enters the geographical boundary. Prohibiting geofencing of facilities aims to restrict the collection of data that could be used to identify individuals that go to an abortion facility and deters targeted advertisements by anti-abortion centers.
40 H.B. 567, 446th Gen. Assemb., Reg. Sess. (Md. 2024) (to be codified at Md. Code Ann. Com. Law §§ 14-4601—14-4613).
41 H.B. 567, 446th Gen. Assemb., Reg. Sess. (Md. 2024) (to be codified at Md. Code Ann. Com. Law §§ 14-4601—14-4613).
42 A.B. 3281, 2024 Leg., Reg. Sess. (Cal. 2024) (amending Cal. Civ. Code § 56.101).
43 S. 173, 2024 Leg., Reg. Sess. (Vt. 2024).

Young People's Access to Reproductive Health Care

Young people[44] are one of the most impacted groups in the country when it comes to abortion bans and restrictions. In the 13 states where abortion is banned, many people who need abortion care must travel out of state to receive it. In response, the anti-abortion movement is testing new types of legislation, aimed at curtailing the movement of young people and punishing those who support them. This legislation is similar to legislation that has been enacted across the country to prohibit young people from accessing gender-affirming care, legislation that will be considered by the U.S. Supreme Court this term when they hear a case brought by the Biden Administration challenging Tennessee's prohibition on youth access to gender-affirming care.[45] This anti-rights legislation is both a reflection of the broader "parental rights" movement that threatens young people's bodily autonomy, and a way for people hostile to abortion rights and transgender rights to restrict access to this care, first for young people and then for all people.

States also continue to require parental involvement for young people seeking abortion care, even in instances of medical emergencies in states that ban abortion care. Parental notification and consent requirements are particularly burdensome for young people in the foster care system, juvenile justice system, and other systems-involved young people. State requirements that mandate documentation proving a parental relationship between a young person and the person consenting to their abortion create additional barriers for undocumented people and young people whose parents or guardians are impacted by the carceral system. One way that states supportive of abortion can make this care easier to access is by repealing these parental involvement requirements. This section discusses abortion support bans, as well as amendments to abortion restrictions that target young people.

Abortion Support Bans

In 2023, Idaho became the first state to enact a law that prohibits people from providing support to pregnant young people who travel out of state for abortion care.[46] A federal district court in Idaho issued a preliminary injunction, and the law is not currently in effect.[47] A federal court decision stating that the Idaho

44 "Young people" refers to unemancipated people under 18 or the age of majority in their state.
45 United States v. Skrmetti, 144 S.Ct. 2679 (2024) (granting petition for writ of certiorari).
46 Idaho Code § 18-623.
47 Matsumoto v. Labrador, 701 F.Supp.3d 1032 (D. Idaho 2023).

law was likely unconstitutional under the federal constitution did not stop other states from introducing bills that would restrict young people from traveling for care. During the 2024 legislative session, four states (Alabama, Mississippi, Oklahoma, and Tennessee) introduced 7 bills that created the crime of "abortion trafficking." This term was invented by anti-abortion legislators and advocates in an effort to try to link abortion with human trafficking.

Providing logistical, financial, or emotional support to a person who is trying to access legal health care in another state is not human trafficking. Human trafficking is when a person uses "force, fraud, or coercion" to induce another person into performing labor, providing services, or engaging in commercial sex acts.[48] When young people are accessing support for abortions, they are not being exploited, but are instead seeking and receiving assistance from people or organizations that they trust. Not only does the use of human trafficking language stigmatize people seeking abortion care and those who help them access abortion care, but this language also makes it more difficult to address the very real issue of human trafficking. These bans on abortion support not only fail to address the problem of human trafficking, but the bills take focus away from human trafficking survivors, some of whom are also likely young people who need abortion care.

In 2024, Tennessee was the only state to enact an abortion support ban.[49] The law prohibits people from transporting an unemancipated minor within the state in order to conceal an abortion from the minor's parents or guardians.[50] The law prohibits people from concealing acts that would be considered an abortion, regardless of where the abortion occurs, and from providing a young person with a medication abortion.[51] While there are exceptions for parents, guardians, and people who have gone through the extremely burdensome requirements of obtaining written and notarized consent from a young person's parent or guardian--the young person's consent to abortion care is not a defense.[52] People who violate this law and provide abortion support to young people can be charged with a class A misdemeanor.[53] In September of 2024, the part of this law that prohibited the "recruitment" of young people for an out-of-state abortion was temporarily enjoined, as the federal district court found that the provision was an unconstitutional content-based regulation, and amounted to viewpoint discrimination.[54] The provisions about "harboring" or "transporting" a young person remain in effect.

48 22 U.S.C. § 7102(11).
49 S.B. 1971, 113th Gen. Assemb., 2nd Reg. Sess. (Tenn. 2024) (to be codified at Tenn. Code Ann. § 39-15-2).
50 S.B. 1971, 113th Gen. Assemb., 2nd Reg. Sess. (Tenn. 2024) (to be codified at Tenn. Code Ann. § 39-15-2).
51 S.B. 1971, 113th Gen. Assemb., 2nd Reg. Sess. (Tenn. 2024) (to be codified at Tenn. Code Ann. § 39-15-2).
52 S.B. 1971, 113th Gen. Assemb., 2nd Reg. Sess. (Tenn. 2024) (to be codified at Tenn. Code Ann. § 39-15-2).
53 S.B. 1971, 113th Gen. Assemb., 2nd Reg. Sess. (Tenn. 2024) (to be codified at Tenn. Code Ann. § 39-15-2).
54 *Welty v. Dunaway*, Case No. 3:24-cv-00768 (D. Tenn. 2024).

The enactment of this Tennessee law makes it even more difficult for young people to access the care they need, and puts abortion funds, practical support organizations, and the friends and family of young people at risk if they provide support to pregnant young people traveling for care. The law is intended to further isolate young people seeking abortion care, and does nothing to support young people who continue their pregnancies. In addition, this year the state of Missouri filed a lawsuit against Planned Parenthood, alleging that the clinic violated state law by offering to provide assistance to a young person who needed to travel out of state for an abortion.[55] While Missouri does not currently have a law that prohibits young people from traveling out of state, the state does prohibit people form providing assistance to a young person to obtain an abortion without parental consent.[56] Given the increase in legislation between 2023 and 2024, it is likely that this type of legislation will continue to be introduced in states that are hostile to abortion or where abortion is already illegal. There is also a possibility that these states will twist existing parental consent laws to further punish people who provide abortion support to young people.

Young People's Access to Abortion Care

Six states (Arizona, Illinois, Kansas, Maryland, New Jersey, and Tennessee) introduced 11 bills that would have otherwise restricted young people's access to abortion care. These bills included judicial bypass restrictions, abuse reporting requirements for providers, and parental involvement and notification requirements. The only state to enact this kind of legislation was Kansas, which enacted a law that created the crime of "coercion to obtain an abortion."[57] The law creates increased penalties if a person coerces a young person into an abortion.[58] People who violate the law could face between 30 days and up to a year in prison and a fine of $5,000.[59] If the pregnant person is under 18, and the person coercing them into an abortion is over 18 and the father of the fetus, the violator can face between 90 days and a year in prison, and a fine of up to $10,000.[60] While the bill was vetoed by the Kansas Governor Laura Kelly, a Democrat who supports abortion rights, the legislature has a veto-proof majority and overrode the veto. The law is currently in effect.

California was the only state to enact a law supporting access to abortion care for young people. The state enacted a law that would authorize social workers to inform people 10 and older of their right to consent to receive

55 State of Missouri v. Planned Parenthood Great Plains, 24BA-CV00090 (Cir. Ct. Boone Cnty., Feb. 29, 2024).
56 State of Missouri v. Planned Parenthood Great Plains, 24BA-CV00090 (Cir. Ct. Boone Cnty., Feb. 29, 2024).
57 H.B. 2436, 90th Leg., Reg. Sess. (Kan. 2024).
58 H.B. 2436, 90th Leg., Reg. Sess. (Kan. 2024).
59 H.B. 2436, 90th Leg., Reg. Sess. (Kan. 2024).
60 H.B. 2436, 90th Leg., Reg. Sess. (Kan. 2024).

abortion care.[61] Given the hostile climate for young people accessing abortion care, states that are supportive of abortion should work to eliminate restrictions for young people, including parental consent and notification laws. This will ensure that if a young person lives in or can travel to a state where abortion is legal, they will not encounter additional barriers to care.

61 A.B. 866, 2024 Leg., Reg. Sess. (Cal. 2024) (amending Cal. Welf. & Inst. Code § 369).

Cross-Border Restrictions on Abortion Care

Young people are not the only target of legislation that seeks to restrict travel for abortion care. And while the right to travel between states has long been recognized by the Supreme Court,[62] that has not stopped states hostile to abortion from trying to restrict people who are traveling between states for abortion care. States have also introduced bills that aim to regulate interstate commerce, despite Congress's power to do so, as outlined in Article I of the U.S. Constitution.[63]

In 2024, 12 states (Alabama, Florida, Idaho, Indiana, Iowa, Mississippi, Missouri, New York, Ohio, Oklahoma, Tennessee, and West Virginia) introduced 27 bills that in some way restricted interstate travel or the flow of goods across state lines. As discussed in Young People's Access to Reproductive Health Care, four of these states introduced legislation that would criminalize people who provided support to young people traveling for abortion care. Tennessee was the only state to enact such a law.[64]

States where abortion is illegal or severely restricted also introduced additional cross-border restrictions, including bills that would make it illegal to possess, mail, or provide abortion medication from access states. Seven states (Florida, Indiana, Iowa, Mississippi, Oklahoma, Tennessee, and West Virginia) introduced legislation that aims to in some way restrict the provision of medication abortion across state lines. None of these bills passed.

Finally, some states took these cross-border restrictions a step further, with legislation that likely would have violated the federal interstate commerce clause and the First Amendment if enacted. Four states (Idaho, Mississippi, Oklahoma, and West Virginia) introduced legislation that would have prohibited organizations from advertising or sharing information about abortion services, including medication abortion, through billboards, websites, and other advertisements. While none of these bills passed, they built on a trend noted last year and which is certain to continue in 2025.

62 See e.g. Ward v. State, 79 U.S. 418, 430 (1870) ("[T]he [Privileges and Immunities Clause] plainly and unmistakably secures and protects the right of a citizen of one State to pass into any other State of the Union"); U.S. v. Guest, 383 U.S. 745, 759 (1966) ("All have agreed that the right [to travel] exists.").

63 U.S. Const. Art. 1, § 8, cl. 3 (stating that Congress has the power "To regulate Commerce with foreign Nations, and among the several States").

64 Discussed *supra*, Section IV(a).

A dozen states introduced bills to restrict interstate travel for abortion care. Tennessee enacted a law that criminalizes people providing support to young people who travel out of state to obtain care.

The rise in cross-border anti-rights legislation demonstrates that just banning abortion is not enough for anti-abortion legislators. These legislators want to make it impossible for anyone to access abortion care, even in states where it is legal, and where they do not have jurisdiction. Anti-abortion legislators have shown they are willing to violate the U.S. Constitution and their state constitutions to stop people from accessing necessary health care, and they will continue to introduce these types of restrictions in the coming years.

Criminal Law and Reproductive Health Care Access

Criminal law touches all aspects of reproductive health care, from the criminal penalties used to enforce abortion bans and restrictions, to the rise in criminal consequences for fertility fraud in assisted reproduction procedures, to supports for pregnant incarcerated people. A rise in abortion bans means that there are multiple regions in the United States where the right to abortion exists on one side of a state line and is criminalized on the other. At the same time, some states are working to protect pregnant incarcerated people, including with programs that keep pregnant and postpartum people out of jail entirely, while other states still have laws that would criminalize pregnant people following a miscarriage or stillbirth. As with many other issues in reproductive rights, criminal penalties vary widely from state to state, and the rights people have often depended solely on where they live. This section discusses the repeal of certain abortion-related criminal penalties, the introduction of new crimes related to abortion, fertility fraud legislation, and protections for pregnant incarcerated people.

Repeal of Abortion-Related Criminal Penalties

Many states have criminal penalties related to abortion, including incarceration and fines, in their state law even if abortion is legal. This year provided another clear demonstration of why all abortion bans and restrictions, even those permanently enjoined or considered dead letter, need to be repealed: in April 2024 the Arizona state Supreme Court ruled that the state's 1836 pre-*Roe* total ban was enforceable.[65] The pre-*Roe* ban would have acted as a total ban and stopped the provision of abortion care in the state. In response, legislators passed a law to repeal the pre-*Roe* ban, which Governor Hobbs signed into law on May 2, 2024.[66] The repeal, however, took effect several months after the end of the legislative session. This meant there could have been a period where the pre-*Roe* ban would have been in effect, and abortion care would have ceased in the state. Instead, the court stayed enforcement of the ban, allowing access to abortion to continue until the repeal took effect. The shifting situation in Arizona, however, is a lesson to other states that retain criminal penalties. While eight other states (Alabama, Kentucky, New Jersey,

65 Planned Parenthood Arizona, Inc. v. Mayes, 545 P.3d 892 (Ariz. 2024).
66 H.B. 2677, 56th Leg., Reg. Sess. (Ariz. 2024) (repealing Ariz. Rev. Stat. § 13-3603).

North Carolina, Pennsylvania, Wisconsin and Wyoming) introduced legislation to repeal criminal penalties, none were enacted. The Arizona case is sure to be top of mind for legislators next session and should motivate legislators supportive of abortion to introduce bills to repeal criminal penalties.

New Abortion-Related Criminal Penalties

Anti-abortion legislators were emboldened this year to introduce bills imposing severe criminal penalties. Legislators introduced bills that would have allowed for criminal charges, including incarceration and fines, to be brought against pregnant people seeking abortion care and created new crimes related to abortion. Seventeen states (Alabama, Alaska, Colorado, Illinois, Indiana, Iowa, Kansas, Louisiana, Maryland, Massachusetts, Mississippi, Missouri, New York, Oklahoma, Tennessee, Washington, and West Virginia) introduced 33 bills that created new abortion-related crimes or expanded criminal penalties to existing restrictions. Tennessee enacted an abortion support ban with criminal penalties (discussed in Young People's Access to Reproductive Health Care).

Kansas and Louisiana enacted legislation criminalizing so-called "coerced" abortion. Kansas's law (discussed briefly in Young People's Access to Reproductive Health Care) prohibits people from threatening to harm people, physically restraining people, using the legal system to threaten, extorting, or otherwise coercing someone into obtaining an abortion.[67] Under the law, coercion to obtain an abortion can be punished with up to a year in prison and a fine of up to $5,000.[68] Louisiana's new law, like the law enacted in Kansas, creates a new crime related to so-called "coerced" abortion. The Louisiana law creates the crime of "coerced criminal abortion by means of fraud" and punishes a person using medication abortion pills without the pregnant person's knowledge or consent.[69] People who violate the law can face between five and ten years in prison if the fetus has a gestational age of less than three months, and between ten and twenty years in prison if the fetus has a gestational age of more than three months.[70] The Louisiana law created additional restrictions on medication abortion, discussed in more depth in Medication Abortion.

Criminalization of Fertility Fraud

Fertility fraud occurs when, in the course of providing fertility care, a provider uses their own gametes without the patient's knowledge or consent. Fertility fraud can also occur when a provider uses gametes to which a patient did not previously consent. Thirteen states have laws that either criminally punish

67 H.B. 2436, 90th Leg., Reg. Sess. (Kan. 2024).
68 H.B. 2436, 90th Leg., Reg. Sess. (Kan. 2024).
69 S.B. 276, 2024 Leg., Reg. Sess. (La. 2024) (to be codified at LA. REV. STAT. § 87.6.1).
70 S.B. 276, 2024 Leg., Reg. Sess. (La. 2024) (to be codified at LA. REV. STAT. § 87.6.1).

fertility fraud, or create a civil cause of action for people who have experienced fertility fraud.[71] This year, Washington became the fourteenth state to pass a law punishing fertility fraud.[72] The law punishes providers who use their own gametes in the course of fertility procedures with both felony charges and unprofessional conduct under state licensing law.[73] Two other states (Georgia and New Jersey) introduced, but did not enact, fertility fraud legislation.

Deferred Sentencing, Early Release, and Judicial Diversion Programs

Pregnant people in jails and prisons often experience pregnancy complications at a higher rate than the national average.[74] State level studies have revealed higher rates of miscarriage, stillbirth, and preterm birth for pregnant incarcerated people.[75] This is likely partly because there are no mandatory standards of care that prisons must provide for pregnant incarcerated people.[76] This absence allows poor treatment to flourish in jails and prisons, including placing pregnant people in solitary confinement, denying them adequate nutritious food, and forcing them to give birth while shackled or restrained. As awareness of the dangers faced by pregnant incarcerated people increases, states have responded with legislation to better protect the rights of pregnant incarcerated people, and to reduce the number of people incarcerated during the perinatal period through deferred sentencing and early release programs.

Deferred sentencing bills allow pregnant and recently postpartum people to delay commencement of their prison sentence until their pregnancy and a determined postpartum period has concluded. This delay enables the individual to access prenatal care and experience birth in circumstances that are more supportive of their health, bodily autonomy, and dignity. Early release bills allow pregnant and postpartum people, as well as caregivers for minor children, to move to a less restrictive environment and be with their children or otherwise change the remainder of their sentences. Judicial diversion and alternative court programs allow people arrested for certain crimes to enter drug or alcohol treatment programs instead of jail or receiving probation.

This year, two states enacted legislation about deferred sentencing, early release, or judicial diversion. Washington state enacted legislation that would

71 *Federal Legislation in Assisted Reproduction*, Right to Know, https://righttoknow.us/fertility-fraud-laws/ (last accessed Jul. 9 2024).
72 H.B. 1300, 68th Leg., Reg. Sess. (Wash. 2024) (to be codified at Wash. Rev. Code §§ 9A.36.031, 18.130.180).
73 H.B. 1300, 68th Leg., Reg. Sess. (Wash. 2024) (to be codified at Wash. Rev. Code §§ 9A.36.031, 18.130.180).
74 Leah Wang, *Unsupportive environments and limited policies: Pregnancy, postpartum, and birth during incarceration* Prison Policy Initiative (Aug. 19, 2021) https://www.prisonpolicy.org/blog/2021/08/19/pregnancy_studies/.
75 Leah Wang, *Unsupportive environments and limited policies: Pregnancy, postpartum, and birth during incarceration* Prison Policy Initiative (Aug. 19, 2021) https://www.prisonpolicy.org/blog/2021/08/19/pregnancy_studies/.
76 *First of its Kind Statistics on Pregnant Women in U.S. Prisons*, Johns Hopkins Medicine (Mar. 21, 2019) https://www.hopkinsmedicine.org/news/newsroom/news-releases/first-of-its-kind-statistics-on-pregnant-women-in-us-prisons.

allow incarcerated people participating in the residential parenting program, which allows people to keep their newborn children with them during confinement, to serve the final 18 months of their term in home detention.[77] Indiana enacted legislation that allows judges to refer pregnant people who have been charged with drug crimes to a forensic diversion program or a drug court, which provide people with access to treatment and supportive services instead of, or in addition to, incarceration.[78]

Utah enacted a law that requires the state Correctional Postnatal and Early Childhood Advisory Board to study best practices for placing infants and their mothers who are incarcerated in a diversion program located outside of a correctional facility.[79] The law prohibits the state from operating a nursery within a correctional facility,[80] which had previously been allowed as part of a law enacted last year.[81] This year's law could signal that Utah plans to create programs outside of correctional facilities for parents and children, much like the law enacted in Washington this year.

Protections for Pregnant Incarcerated People

If a state does not have an early release or deferred sentencing program, there are still laws that can be implemented to protect the rights of pregnant incarcerated people. States should prohibit the shackling of pregnant people, prevent them from being placed in solitary confinement, facilitate prenatal care, and ensure that they have a support person present while they are giving birth. This year, three states enacted legislation that would prohibit the use of restraints and establishes other protections for pregnant incarcerated people.

Colorado enacted a law that requires private prisons and county jails to comply with the state's existing "Protection of Individuals from Restraint and Seclusion" law when using restraints during labor, delivery, and postpartum recovery.[82] Private prisons, state facilities, and county jails must also develop policies for breast milk storage.[83] Illinois enacted legislation that prohibits restraints on any pregnant, laboring, or postpartum person.[84] The law requires the removal of any electronic monitoring devices during labor and delivery, and pregnant people who are pregnant, lactating, nursing, or pumping breast milk to receive at least 300 calories a day of supplemental nutrition.[85]

77 S.B. 5938, 68th Leg., Reg. Sess. (Wash. 2024) (to be codified at Wash. Rev. Code § 9.94A.6551).
78 H.B. 1418, 123rd Gen. Assemb., Reg. Sess. (Ind. 2024) (to be codified at Ind. Code § 35-33-7-5).
79 H.B. 358, 66th Leg., Reg. Sess. (Utah 2024) (to be codified at Utah Code § 64-13-46.1).
80 H.B. 358, 66th Leg., Reg. Sess. (Utah 2024) (to be codified at Utah Code § 64-13-46).
81 Utah Code § 64-14-46.5.
82 H.B. 24-1459, 74th Leg., Reg. Sess. (Colo. 2024) (to be codified at Colo. Rev. Stat. §§ 17-1-113.7, 17-1-114.5, 17-26-104.4, 17-26-104.7, 25-3-126, 26-1-136.8, 26-20-102).
83 H.B. 24-1459, 74th Leg., Reg. Sess. (Colo. 2024) (to be codified at Colo. Rev. Stat. §§ 17-1-113.7, 17-1-114.5, 17-26-104.4, 17-26-104.7, 25-3-126, 26-1-136.8, 26-20-102).
84 H.B. 5431/S.B. 3600, 103rd Gen. Assemb., Reg. Sess. (Ill. 2024) (to be codified at 55 Ill. Comp. Stat. 5/3-15003.6, 5/3-15003.8, 5/3-15003.9, 5/3-15003.11, 5/3-15003.12).
85 H.B. 5431/S.B. 3600, 103rd Gen. Assemb., Reg. Sess. (Ill. 2024) (to be codified at 55 Ill. Comp. Stat. 5/3-15003.6, 5/3-15003.8, 5/3-15003.9, 5/3-15003.11, 5/3-15003.12).

California enacted two laws to protect pregnant incarcerated people. The first law requires incarcerated pregnant people to receive referrals to a social worker, who will provide options for parenting classes and secure placement for the child, allows postpartum incarcerated people to receive additional meals and provide breast milk for their infants, and requires the state to expedite family visitation options for postpartum incarcerated people.[86] The state also enacted a law prohibiting pregnant incarcerated people from being placed in solitary confinement during their pregnancy and for up to 12 weeks postpartum, as well as requiring free and clean bottled water and high calorie meals for all pregnant incarcerated people.[87] Additionally, this law establishes that incarcerated people who have an abortion, miscarriage, or stillbirth are entitled to the same comprehensive medical care as pregnant and postpartum incarcerated people.[88]

Finally, Pennsylvania enacted a law that protects pregnant and postpartum young people in juvenile detention facilities by prohibiting the use of restraints on pregnant and postpartum young people and allowing newborns to remain with their parents for up to 72 hours after birth.[89] While these kinds of protections are important, there is more states can do to ensure that pregnant incarcerated people are able to access the health care and support they need during their pregnancy, birth, and postpartum recovery.

86 A.B. 2740, 2024 Leg., Reg. Sess. (Cal. 2024) (to be codified at Cal. Penal Code §§ 3408.4; 3408.5; 6404.5).
87 A.B. 2527, 2024 Leg., Reg. Sess. (Cal. 2024) (to be codified at Cal. Penal Code § 3408).
88 A.B. 2527, 2024 Leg., Reg. Sess. (Cal. 2024) (to be codified at Cal. Penal Code § 3408).
89 H.B. 1509, 208 Gen. Assemb., Reg. Sess. (Pa. 2024) (to be codified at 42 Pa. Cons. Stat. § 6381 et. seq.).

Abortion Bans and Fetal and Embryo Personhood

Dobbs allowed states to totally ban abortion, and in the two years since the Supreme Court decision, 13 states have made abortion illegal at any point in a pregnancy. Additional states ban abortion at early stages of pregnancy, including six weeks, and advance other types of abortion bans, including bans on medication abortion and telemedicine bans. The impact of these abortion bans falls hardest on people who already face systemic and discriminatory barriers to care, particularly Black, Indigenous, and other people of color, people with disabilities, young people, undocumented people, people in rural areas, and people living on low incomes.

States also continue to introduce legislation that establishes fetal or embryo personhood, distinct but interconnected anti-abortion efforts that seek to grant legal rights to fertilized eggs, with dire circumstances for pregnant people and people trying to become pregnant. Fetal personhood laws extend the legal rights of a person to a fetus, including laws that define a "person" to include a fetus from the moment of conception. Embryo personhood laws are a distinct type of law that gives legal rights to embryos that are created as part of fertility treatment. Embryo personhood deals with the storage, care, and disposal of embryos created outside the body via IVF, and fetal personhood deals with embryos once they have been created or implanted in the uterus. Both types of laws greatly undermine people's ability to make decisions about their own health and care. These laws put providers, pregnant people, and people trying to become pregnant at risk of criminal and civil penalties and violate people's bodily autonomy.

This section discusses fetal and embryo personhood laws in both criminal and civil law, gestational bans on abortion, and technical changes and exceptions to existing abortion bans.

Fetal and Embryo Personhood in Civil Law

Although unenforceable under *Roe v. Wade*, fetal and embryo personhood legislation has been introduced by states, and sometimes enacted, for many years. This year we saw one of many consequences of this kind of language when the Alabama Supreme Court decided *LePage* – a case concerning whether the accidental destruction of cryopreserved embryos was action-

able under the state's civil law allowing people to sue following the wrongful death of a minor. As early as 2011, the Alabama Supreme Court held that "an unborn child qualifies as a 'minor child'" for the purposes of the state's Wrongful Death of a Minor Act.[90] In 2022, the state added a "Sanctity of Unborn Life" amendment to its constitution, which "affirms that it is the public policy of this state to ensure the protection of the rights of the unborn child."[91] The court ruled in *LePage* that past decisions, along with the state's fetal personhood amendment, required the court to rule that "children" should be defined to include "unborn children."[92]

The fertility clinic facing the lawsuit argued that even if the state had a fetal personhood law, the court should not extend that law to cryopreserved embryos in a lab, because no past precedent ruled that cryopreserved embryos would be treated as people for the purposes of state criminal law.[93] The court, however, ruled that even if that were the case, civil liability can often encompass more conduct than criminal liability.[94] The court was unsympathetic to any arguments about the public policy consequences of treating embryos as "unborn children" with civil liability attached, arguing that was a concern for the state legislature.[95]

The result was a fertility clinic facing civil wrongful death liability following the destruction of embryos. This ruling led the state's three largest fertility clinics to immediately stop their provision of IVF for fear of having wrongful death claims brought against them.[96] Care did not resume until weeks later when the state legislature enacted a law exempting IVF providers from civil and criminal liability (discussed on page 11).

During a standard IVF cycle, providers and patients work together to fertilize as many eggs as are retrieved to create as many embryos as possible to give the patient the best chance of having one of those embryos lead to a pregnancy and live birth. Not every fertilized egg leads to an embryo. Often these embryos are cryopreserved to allow for preimplantation testing to determine which embryos have the best chance of implanting. Not every embryo will be deemed to have a high chance of leading to a pregnancy. Cryopreservation also allows patients the ability to decide if and when they will transfer the embryos and to consider discarding them or donating them to science or to another individual or couple. Too often embryo transfers do not lead to a pregnancy or result in an early miscarriage, underscoring why creating multiple embryos and cryopreserving serves the goals of patients undergoing IVF and why Alabama's

90 LePage v. Center for Reproductive Medicine, 2024 WL 656591, *4 (Ala. 2024).
91 LePage v. Center for Reproductive Medicine, 2024 WL 656591, *6 (Ala. 2024).
92 LePage v. Center for Reproductive Medicine, 2024 WL 656591, *6 (Ala. 2024).
93 LePage v. Center for Reproductive Medicine, 2024 WL 656591, *6-*7 (Ala. 2024).
94 LePage v. Center for Reproductive Medicine, 2024 WL 656591, *7 (Ala. 2024).
95 LePage v. Center for Reproductive Medicine, 2024 WL 656591, *8 (Ala. 2024).
96 Aria Bendix, *Three Alabama clinics pause IVF services after court rules that embryos are children,* NBC NEWS (Feb. 21, 2024, 6:00PM) https://www.nbcnews.com/health/health-news/university-alabama-pauses-ivf-services-court-rules-embryos-are-childre-rcna139846.

state Supreme Court ruling, and laws granting legal rights to embryos, threaten fertility care and the hopes of people seeking to grow their families via IVF.

In response to *LePage,* states began to introduce legislation that specifically stated that reproductive material, fertilized eggs, and embryos outside of the uterus were not "unborn children" or people under state law. This legislation was introduced in 11 states (Alabama, Georgia, Idaho, Kansas, Kentucky, New York, North Carolina, Ohio, Pennsylvania, South Carolina and Washington). None of these bills passed, and even if this type of legislation was enacted, it would do little to fix the underlying issue in fetal and embryo personhood laws. Legislation permitting some reproductive health care but not others does not meaningfully protect any reproductive health care. Instead, it creates a landscape where patients and providers are forced to rely on exceptions, rather than full statutory protection.

Other states did not learn from *LePage* and continued to introduce bills that would establish or strengthen fetal or embryo personhood laws. In 2024, 7 states (Florida, Illinois, Iowa, Kansas, Oklahoma, Pennsylvania, and Tennessee) introduced 13 bills establishing fetal personhood for the purposes of civil law. The most troubling are bills that allow people to bring wrongful death claims on behalf of a fetus. Wrongful death statutes allow people to bring civil lawsuits and recover damages following the death of a family member. Expanding these claims to fetuses would allow people to sue providers or helpers who assist people with accessing abortion care. None of these bills passed. The bill introduced in Florida was ultimately shelved following the backlash to Alabama's Supreme Court decision in *LePage*.

Iowa and Louisiana introduced legislation that defined an embryo as a person. Louisiana already has a law that treats embryos as "juridical persons," prohibits embryos from being intentionally destroyed and forces patients to keep their embryos indefinitely cryopreserved, put them up for "adoption," or move them out of the state to fully exercise their rights over them.[97] The legislation introduced this session would have gone a step further by prohibiting embryos from being moved out of state to be discarded.[98] Neither of these broad embryo personhood bills passed.

Worryingly, Utah enacted an embryo personhood law treating embryos as people for the purposes of crime victim restitution.[99] While the law does not directly impact IVF, it does contribute to the mainstreaming of radical anti-abortion theories that are used as a foundation for the expansion of fetal personhood efforts.

97 La. Rev. Stat. § 9:124.
98 H.B. 833, 73rd Leg., Reg. Sess. (La. 2024).
99 H.B. 218, 66th Leg., Reg. Sess. (Utah 2024) (to be codified at Utah Code § 77-38b-102(25)).

Fetal and Embryo Personhood in Criminal Law

Fetal and embryo personhood language in criminal laws can lead to life-altering criminal consequences for providers, pregnant people, and their families. Harsh penalties and the lack of clarity in fetal and embryo personhood laws lead to arbitrary and discriminatory enforcement, often targeting Black people, other people of color, and people living on low incomes. These personhood laws frequently lead to people being penalized for adverse fertility care or pregnancy outcomes and have a chilling effect on people who provide reproductive health care.

Despite these concerns, states continue to introduce fetal and embryo personhood legislation. This year, 9 states (Alaska, Colorado, Indiana, Iowa, Massachusetts, Missouri, Oklahoma, South Carolina, and West Virginia) introduced legislation that would have created fetal personhood with criminal consequences, but none were enacted. Three states (Colorado, Indiana, and Iowa) introduced legislation that would have amended the state criminal code to define a person to include an embryo from the moment of fertilization, with no exception for embryos created in the course of IVF. None of these laws were enacted, but the continued support for fetal and embryo personhood laws across the country, even in a year where the possible consequences of these laws have become obvious, is deeply concerning.

Gestational Abortion Bans

In 2024, 18 states (Florida, Idaho, Illinois, Kansas, Kentucky, Massachusetts, New Hampshire, New Jersey, New Mexico, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Virginia, Washington, West Virginia, and Wisconsin) introduced 28 gestational abortion bans, none of which were enacted. Florida previously enacted a six-week ban with an effective date tied to the Florida Supreme Court holding that the state's 15-week abortion ban was constitutional. In April 2024, the state Supreme Court reversed its earlier ruling that the Florida Constitution's right to privacy included abortion,[100] and held that the state Constitution does not include a right to abortion, allowing the six-week ban to take effect.[101] Florida joins Georgia, Iowa, and South Carolina as the latest state to enforce a six-week abortion ban.

Nebraska was the only state to have a voter-initiated abortion restriction on the ballot this year. The state Supreme Court allowed both a proactive con-

100 *See e.g.* Gainesville Woman Care v. State, 210 So. 3d 1243, 1254 (Fla. 2017) ("Florida's constitutional right of privacy encompasses a woman's right to choose to end her pregnancy."); N. Fla. Women's Health & Counseling Servs., Inc. v. State, 866 So. 2d 612, 634-36 (Fla. 2003) (rejecting application of "undue burden" test, as established in Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833, 874 (1992) in favor of strict scrutiny); In re T.W., 551 So. 2d 1186, 1193 (Fla. 1989) ("The Florida Constitution embodies the principle that [f]ew decisions are more personal and intimate, more properly private, or more basic to individual dignity and autonomy, than a woman's decision ... whether to end her pregnancy. A woman's right to make that choice freely is fundamental.") (internal quotations and citations omitted).

101 Planned Parenthood of S.W. and Central Fla. et al. v. Florida, No. 384 So.3d 67 (Fla. Apr. 1, 2024).

stitutional amendment, which would establish a right to abortion in the state constitution, and a constitutional amendment that would ban abortion after the first trimester, to be placed on the ballot in November.[102] The amendment to ban abortion after the first trimester was approved by voters, which enshrines the state's existing twelve-week ban into the state constitution.

Technical Changes and Exceptions

States that have already banned abortion continue to introduce legislation to create exceptions to abortion bans. Often, these bills are framed as a harm reduction effort, a way to make sure that abortion bans do not lead to deaths or serious health consequences for pregnant people, yet none of them were enacted. In practice, abortion bans continue to operate as total bans as few patients can access care under the exceptions. The language used in exceptions is vague and confusing, which makes it unclear to providers whether they can legally offer abortion care, even when a pregnancy threatens the life or health of a pregnant person. This was clearly demonstrated in a case brought by the Center in December 2023, when the Texas Supreme Court ruled against Kate Cox,[103] holding that she did not meet the qualifications for an abortion under the state's medical exception, despite testimony from her OB-GYN that the pregnancy would threaten her life, health, and future fertility, and that the fetus she was carrying had no chance of survival.[104]

Despite the mounting evidence that exceptions are not enough to ensure access to any type of abortion care, states where abortion is illegal continued to introduce these bills. Six states (Alabama, Idaho, Kentucky, Louisiana, Oklahoma, and Tennessee) introduced 19 bills that would have amended state abortion ban exceptions, though none passed, which demonstrates that a majority of legislators in those states support the bans and do not support access to care even in emergencies or for survivors of rape and incest.

Other states have become even more specific in their exceptions. South Dakota enacted a law that required the state to create material that explains the state's abortion law, common medical exceptions to the law, accepted standards of care, and the criteria practitioners might use to determine a course of treatment for those conditions.[105] This law, and others like it, are far from adequate when it comes to ensuring people can access medically necessary abortion care. The only way to ensure that all people can access the medical care without the threat of draconian criminal and civil penalties is to repeal abortion bans.

102 State ex rel. Brooks v. Evnen, 317 Neb. 581 (Neb. 2024); State ex rel. Constance v. Evnen, 317 Neb. 600 (Neb. 2024).
103 In re State of Texas et al., No. 23-0994 (Tex. 2023) (order dismissing emergency motion for temporary relief).
104 Cox et al. v. State of Texas et al., D-1-GN-23-008611 (D. Travis Cnty. 2023) (complaint).
105 H.B. 1224, 99th Leg., Reg. Sess. (S.D. 2024) (to be codified AT S.D. CODIFIED LAWS § 34-23A-94).

Public Funding for Reproductive Health Care

For people to fully enjoy the right to reproductive health care, they must be able to access this care. In addition to laws that ban reproductive care, cost is a major barrier. Over 73 million people in the U.S. were enrolled in state Medicaid programs as of May 2024,[106] but Medicaid frequently does not cover all necessary reproductive health services. Nineteen states and D.C. do not provide Medicaid coverage of abortion except in very specific circumstances.[107] No states require full Medicaid coverage of fertility care, few provide coverage for doula services, and the reimbursement rate for midwives is often lower than reimbursement rates for other maternity care providers. This section examines advances in state Medicaid coverage for abortion, maternal health, and fertility care, as well as public funding for abortion care, and restrictions on state funding for abortion care.

Medicaid Coverage of Reproductive Health Care

Medicaid finances a large proportion of births in the U.S. In some states, more than half of all births are funded by Medicaid.[108] This is partly because Medicaid eligibility increases when a person is pregnant to a minimum of 138% of the federal poverty level, regardless of other state Medicaid eligibility requirements.[109] This expanded Medicaid coverage must last for up to 60 days postpartum,[110] but the American Rescue Plan Act of 2021 allowed states the option to extend Medicaid eligibility to up to 12 months postpartum through a state plan amendment.[111] Since one in three pregnancy-related deaths occur between a week and a year postpartum, extending Medicaid coverage prevents disruptions in care and can alleviate maternal mortality and morbidity.[112]

106 *May 2024 Medicaid & CHIP Enrollment Data Highlights*, Centers for Medicare & Medicaid Services https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html (last updated Aug. 30, 2024).

107 Alina Salganicoff, Laurie Sobel, Ivette Gomez, and Amrutha Ramaswamy, *The Hyde Amendment and Coverage for Abortion Services Under Medicaid in the Post-Roe Era*, Kaiser Family Foundation (Mar. 14, 2024) https://www.kff.org/womens-health-policy/issue-brief/the-hyde-amendment-and-coverage-for-abortion-services-under-medicaid-in-the-post-roe-era/.

108 *Births Financed by Medicaid*, Kaiser Family Foundation https://www.kff.org/medicaid/state-indicator/births-financed-by-medicaid/ (last accessed Jul. 22, 2024).

109 Usha Ranji, Ivette Gomez, and Alina Salganicoff, *Expanding Postpartum Medicaid Coverage*, Kaiser Family Foundation (Mar. 9, 2022), https://www.kff.org/womens-health-policy/issue-brief/expanding-postpartum-medicaid-coverage/.

110 Usha Ranji, Ivette Gomez, and Alina Salganicoff, *Expanding Postpartum Medicaid Coverage*, Kaiser Family Foundation (Mar. 9, 2022), https://www.kff.org/womens-health-policy/issue-brief/expanding-postpartum-medicaid-coverage/.

111 Sarah Gordon et al., *Medicaid After Pregnancy: State-Level Implications of Extending Postpartum Coverage*, U.S. Dept. of Health and Hum. Serv. (Dec. 7, 2021), https://aspe.hhs.gov/reports/potential-state-level-effects-extending-postpartum-coverage.

112 Sarah Gordon et al., *Medicaid After Pregnancy: State-Level Implications of Extending Postpartum Coverage*, U.S. Dept. of Health and Hum. Serv. (Dec. 7, 2021), https://aspe.hhs.gov/sites/default/files/documents/cf9a715be16234b80054f14e9c9c0d13/medicaid-postpartum-coverage-ib%20.pdf.

This year, Idaho[113] and Iowa[114] became the latest states to enact postpartum Medicaid extensions (PPME). This leaves only two states that have not taken advantage of the PPME program to extend Medicaid to a year postpartum.[115] These most recent PPMEs, however, have some limitations. The Idaho PPME will be reevaluated if federal financial participation in the program is eliminated or reduced by 10%.[116] And while the Iowa law extends the postpartum coverage period, the same law also reduced Medicaid eligibility guidelines for pregnant and postpartum people from 300% of the federal poverty level to 215% of the federal poverty level.[117] While PPMEs are vital, they should not be paired with legislation that lowers Medicaid eligibility, nor should they be at risk of repeal based on federal participation.

Medicaid reimbursement rates for midwives are often lower than those paid to physicians for the same maternity care. Photo: ©KAMPUS / Adobe Stock

While all states provide for Medicaid reimbursement of midwifery care, some states reimburse midwives at a lower rate than physicians, even if midwives are providing the same care.[118] Other states only provide Medicaid reimbursement to certified nurse midwives (CNMs), rather than all state-licensed midwives,[119] or do not provide Medicaid coverage for home births.[120] This year, Illinois enacted legislation to provide Medicaid coverage of services provided by certified professional midwives.[121]

113 H. 633, 67th Leg., Reg. Sess. (Idaho 2024) (to be codified at IDAHO CODE § 56-270).
114 S.F. 2251, 90th Gen. Assemb., (Iowa 2024) (to be codified at IOWA CODE § 249A.3).
115 *Medicaid Postpartum Coverage Extension Tracker*, Kaiser Family Foundation (Aug. 1, 2024) https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/ (Arkansas does not yet have a PPME and Wisconsin's PPME ends after 90 days).
116 H. 633, 67th Leg., Reg. Sess. (Idaho 2024) (to be codified at IDAHO CODE § 56-270).
117 S.F. 2251, 90th Gen. Assemb., (Iowa 2024) (to be codified at IOWA CODE § 249A.3).
118 *Midwife Medicaid Reimbursement Policies by State*, NATIONAL ACADEMY FOR STATE HEALTH POLICY (Apr. 23, 2023) https://nashp.org/midwife-medicaid-reimbursement-policies-by-state/.
119 *Midwife Medicaid Reimbursement Policies by State*, NATIONAL ACADEMY FOR STATE HEALTH POLICY (Apr. 23, 2023) https://nashp.org/midwife-medicaid-reimbursement-policies-by-state/.
120 Usha Ranji, Ivette Gomez, and Alina Salganicoff, *Medicaid Coverage of Pregnancy-Related Services: Findings from a 2023 State Survey*, KAISER FAMILY FOUNDATION (May 19, 2022), https://www.kff.org/report-section/medicaid-coverage-of-pregnancy-related-services-findings-from-a-2021-state-survey-report/.
121 H.B. 5142, 103rd Gen. Assemb., 2nd Reg. Sess. (Ill. 2024) (to be codified at 305 ILL. COMP. STAT. 5/5-18.5).

Only twelve states currently provide Medicaid coverage of doula care.[122] This year, Pennsylvania enacted a law to provide for Medicaid coverage of doula care, and establishes an advisory board to provide guidance on best practices for doulas and racial and geographic disparities in maternal health.[123] Delaware and New York, which established Medicaid coverage for doula services last year, amended their coverage requirements. Delaware provided for coverage for additional postpartum doula visits, if those visits were recommended by another clinician.[124] New York enacted a law that required the state to establish and maintain a community doula directory with information about doulas who accept Medicaid.[125] These modifications will make doula care easier to access for people living in those states who receive Medicaid.

No state provides Medicaid coverage of IVF. New York and D.C. mandate Medicaid coverage for the diagnosis of infertility, as well as for ovulation-enhancing drugs and monitoring.[126] States, though, are beginning to introduce fertility care coverage mandates that include Medicaid coverage for IVF (Connecticut, Massachusetts, New Jersey, and New York), but none were enacted.

Two states enacted laws this year to provide or amend Medicaid coverage for abortion. Delaware enacted a law requiring Medicaid coverage of abortion care, but limited this coverage to $750 per covered individual per year.[127] California enacted a law that would require the state to seek federal approval for reimbursement rate increases for abortion services.[128] Unlike other Medicaid laws enacted this year (namely the PPME enacted in Idaho), the California law requires reimbursement rate increases to apply, even in the absence of federal financial participation.[129]

These laws, which require Medicaid coverage of critical reproductive health care services, even in the absence of federal financial participation, should serve as models for other states' health care. Statutory caps on coverage, on the other hand, should be avoided, as they require regular legislative approval to increase the caps as inflation increases. Failure to increase these caps means Medicaid rates will eventually be too low for providers to participate in state Medicaid programs.

Other states supportive of abortion rights took steps to ensure that people could access Medicaid coverage of abortion. A ballot initiative in Colorado, approved by voters in November 2024, will enshrine the right to abortion in

122 Amy Chen, *Doula Medicaid Project: February 2024 State Roundup*, National Health Law Program (Feb. 21, 2024) https://healthlaw.org/doula-medicaid-project-february-2024-state-roundup/.
123 H.B. 1608, 208 Gen. Assemb., Reg. Sess. (Pa. 2024) (to be codified at 62 Pa. Cons. Stat. § 443.15).
124 H.B. 345, 152nd Gen. Assemb., 2nd Reg. Sess. (Del. 2024) (to be codified at Del. Code Ann. tit. 31 § 530).
125 A. 8529/S. 8080, 246th Leg., Reg. Sess. (N.Y. 2024) (to be codified at N.Y. Soc. Serv. Law § 365-p).
126 N.Y. Soc. Serv. Law § 365-a(2)(ee), see also N.Y. Comp. Codes R. & Regs. tit. 18 § 505.1(a)(iii) (provides for Medicaid coverage of ovulation enhancing drugs, office visits, hysterosalpingogram services, pelvic ultrasounds and blood tests, only for women between 21 and 44); D.C. B. 25-0034 (2023).
127 H.B. 110-2, 152nd Gen. Assemb., 1st Spec. Sess. (Del. 2024) (to be codified at Del. Code Ann. tit. 31 § 533).
128 S.B. 159, 2024 Leg., Reg. Sess. (Cal. 2024) (to be codified at Cal. Welf. & Inst. Code §§ 14124.162, 14124.165).
129 S.B. 159, 2024 Leg., Reg. Sess. (Cal. 2024) (to be codified at Cal. Welf. & Inst. Code §§ 14124.162, 14124.165).

the state constitution and also repeal a constitutional prohibition on public coverage of abortion care, allowing enrollees in Medicaid and other government insurance programs to receive coverage for abortion care.[130] In addition, following the passage of Prop 3 last year in Michigan, which established a right to reproductive freedom in the state constitution, a lawsuit was brought to challenge the state's existing ban on Medicaid coverage for abortion.[131] These are just a few of the ways that state constitutional and statutory protections for abortion can be used to expand access to care.

Public Funding for Abortion Care

States can increase abortion access by appropriating money to programs that assist with abortion care. This support can come in the form of direct appropriations to clinics and other organizations that provide abortion, or appropriating funds to nonprofits that facilitate access to abortion care. This year, California,[132] Maryland,[133] and Massachusetts[134] all enacted laws that provided funding to abortion facilities for security or other improvements. California,[135] Connecticut,[136] and New York[137] enacted laws that appropriated funds to clinics and nonprofits to facilitate access to abortion care. Finally, Michigan appropriated $5,000,000 to expand access to reproductive health care services, in response to recent changes in state law removing barriers to abortion access.[138] Altogether, 23 states (California, Colorado, Connecticut, Delaware, Florida, Illinois, Indiana, Iowa, Kansas, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, South Carolina, Washington, and Wyoming) introduced 96 bills that would have expanded state public funding for abortion. This legislation was introduced in states both supportive of and hostile to abortion, and the trend of appropriations bills being used to fund abortion care and access will likely continue in the coming years.

Restrictions on State Public Funding for Abortion

While advances have been made in providing state public funding for abortion, restrictions on the use of state funding for abortion continue to be introduced. This year, 23 states (Alaska, Arizona, Florida, Illinois, Indiana, Iowa, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Nebraska, New Hampshire, New York, Ohio, South Carolina, South Dakota, Tennes-

130 *Colorado Ballot Initiative #89 Final Text*, Colorado Secretary of State https://www.sos.state.co.us/pubs/elections/Initiatives/titleBoard/filings/2023-2024/89Final.pdf (last visited Sep. 19, 2024).
131 Ed White, *Michigan ban on taxpayer-funded abortions targeted by lawsuit*, Associated Press (Jun. 27, 2024, 4:38 PM) https://apnews.com/article/michigan-medicaid-abortion-lawsuit-a7489bf8c5c685e78ec5311fe7f1d3a3.
132 A.B. 106, 2024 Leg., Reg. Sess. (Cal. 2024); A.B. 158, 2024 Leg., Reg. Sess. (Cal. 2024).
133 S.B. 975, 446th Gen. Assemb., Reg. Sess. (Md. 2024).
134 H. 4800, 193rd Gen. Ct., Reg. Sess. (Mass. 2024).
135 A.B. 107, 2024 Leg., Reg. Sess. (Cal. 2024); A.B. 157, 2024 Leg., Reg. Sess. (Cal. 2024).
136 H.B. 5523, 2024 Gen. Assemb., Reg. Sess. (Conn. 2024).
137 A. 8806/S. 8306, 246th Leg., Reg. Sess. (N.Y. 2024); R. 1952, 246th Leg., Reg. Sess. (N.Y. 2024).
138 S.B. 747, 102nd Leg., Reg. Sess. (Mich. 2024).

see, Virginia, West Virginia, and Wisconsin) introduced 65 bills that would have restricted the use of state funds for abortion care. These bills included increased restrictions on Medicaid funding, including provider reimbursement; prohibitions on the use of government property for the provision of abortion care; and limits on state funding for other abortion services. States also introduced legislation to prohibit the use of public funds, including expenditures by municipalities, to assist residents accessing out-of-state abortion care. Missouri was the only state to enact such a law, which prohibits any public funds from being expended to any abortion clinic or facility, and prohibits abortion providers from participating in the state Medicaid program.[139]

This year also saw the continuation of a trend in legislation prohibiting corporations that contract with the state from engaging in economic boycotts to oppose the state's restrictions on abortion access. Efforts to prohibit economic boycotts are likely motivated by anti-abortion politicians' recognition of the business community's power in furthering access to abortion for their employees, and are part of a growing effort to restrict residents of banned states from seeking out-of-state care. In 2024, 8 states (Arizona, Georgia, Idaho, Indiana, Iowa, Kentucky, Mississippi, and Tennessee) introduced legislation that would prohibit the use of "social criteria" in lending by financial institutions, but no state enacted such a law.

139 H.B. 2634, 102nd Gen. Assemb., 2nd Reg. Sess. (Mo. 2024) (to be codified at Mo. Rev. Stat. §§ 188.015, 208.152, 208.164, 208.659).

Private Insurance Coverage of Reproductive Health Care

People with private insurance coverage are often also subject to restrictions on reproductive health care. States across the country prohibit private insurance policies from providing coverage for abortion.[140] Other states do not explicitly prohibit insurance coverage of abortion, but do not require private insurance to cover abortion.[141] Few states require private insurance plans to provide coverage of fertility care, including IVF. Certain types of maternal health care are also not covered by insurance. This section reviews developments in private insurance coverage requirements for people seeking reproductive health care.

Insurance Coverage of Maternal Health Care and Abortion

Legislation can expand private insurance coverage for abortion by repealing coverage prohibitions, enacting new coverage mandates, or expanding existing coverage requirements. Similarly, expanding private coverage of midwifery and doula services can expand access to this care, to ensure that cost is not a barrier. Three states this year enacted laws to require insurance coverage of doula services, and Illinois specifically enacted a law to require insurance coverage of abortion doulas.

Illinois enacted a law (discussed briefly in Public Funding for Reproductive Health Care) to provide for Medicaid coverage of midwifery services as well as private insurance coverage for doula services, requiring coverage of up to 16 prenatal and 16 postpartum visits.[142] This insurance coverage applies to doulas and midwives providing support during a pregnancy, or during and following a miscarriage or abortion.[143]

Three other states enacted laws that require private insurance coverage of doula care. Colorado enacted a law requiring insurance plans offered on the large group market to include coverage for doula care provided by doulas who meet state requirements for qualifications and training.[144] Individual and

140 *Interactive: How State Policies Shape Access to Abortion Coverage*, Kaiser Family Foundation (Jul. 22, 2024) https://www.kff.org/womens-health-policy/issue-brief/interactive-how-state-policies-shape-access-to-abortion-coverage/.
141 *Interactive: How State Policies Shape Access to Abortion Coverage*, Kaiser Family Foundation (Jul. 22, 2024) https://www.kff.org/womens-health-policy/issue-brief/interactive-how-state-policies-shape-access-to-abortion-coverage/.
142 H.B. 5142, 103rd Gen. Assemb., 2nd Reg. Sess. (Ill. 2024) (to be codified at 215 Ill. Comp. Stat. 5/352z.40).
143 H.B. 5142, 103rd Gen. Assemb., 2nd Reg. Sess. (Ill. 2024) (to be codified at 215 Ill. Comp. Stat. 5/352z.40).
144 S.B. 24-175, 74th Gen. Assemb., Reg. Sess. (Colo. 2024) (to be codified at Colo. Rev. Stat. § 10-16-104).

small group markets must provide coverage for doula care upon confirmation from the federal Department of Health and Human Services that the coverage does not require defrayal by the state.[145] Delaware enacted a law requiring all individual and group health insurance policies to provide coverage for doula services provided by a trained doula, including attendance through labor and birth, three prenatal visits, and three postpartum visits.[146] Virginia enacted a law that requires private insurance policies to provide coverage for doula care services, provided by a state-certified doula, and coverage must include at least eight visits during the prenatal and postpartum periods, as well as support during labor and delivery.[147]

Finally, an additional ten states (California, Delaware, Hawai'i, Illinois, Kansas, Minnesota, New Jersey, Pennsylvania, Tennessee, and Washington) and D.C. introduced bills to either require private insurance plans to cover abortion care or to expand existing coverage requirements for private insurance providers. Delaware was the only state to enact a law requiring insurance coverage of abortion care, with an exception for "religious employers".[148] The Delaware law also allows private insurance plans to limit abortion coverage to $750 per individual per year.[149] The amount at which providers are reimbursed, by both insurance and Medicaid, should be carefully considered by legislators when enacting these laws, because if reimbursement rates are too low, or if there is no easy way to adjust them as inflation increases, it can make it impossible for clinics to stay open. Locking in reimbursement rates can create additional problems for clinics, as the cost of abortion care can vary based on numerous factors and one rate will not cover the cost of all procedures a clinic may perform.

Insurance Coverage of Fertility Care

One of the most significant barriers to accessing fertility care in the United States is the cost of care. A single cycle of in vitro fertilization (IVF) can cost up to $30,000,[150] and most states do not require insurance plans to cover IVF care.[151] This puts family building out of reach for many people experiencing infertility, as well as single people and LGBTQ+ couples who need fertility

145 S.B. 24-175, 74th Gen. Assemb., Reg. Sess. (Colo. 2024) (to be codified at Colo. Rev. Stat. § 10-16-104) (if a year passes since the state submitted a request for confirmation that these services do not require a defrayal, and have received no response from the federal Department of Health and Human Services, the coverage requirement for small group and individual markets will take effect, and the state will consider the "federal department's unreasonable delay as a preclusion from requiring defrayal by the state.").

146 H.B. 362, 152nd Gen. Assemb., 1st Spec. Sess. (Del. 2024) (to be codified at Del. Code Ann. tit. 18 §§ 3370G, 3553A).

147 H.B. 935/S.B. 118, 2024 Leg., Reg. Sess. (Va. 2024) (to be codified at Va. Code Ann. §§ 38.2-3414.2, 38.2-4319).

148 H.B. 110-2, 152nd Gen. Assemb., 1st Spec. Sess. (Del. 2024) (to be codified at Del. Code Ann. tit. 33 § 3370G, tit. 35 § 3571AA, tit. 52 § 5217) (religious employers must cover abortion when an abortion is necessary to preserve the life and health of a covered individual).

149 H.B. 110-2, 152nd Gen. Assemb., 1st Spec. Sess. (Del. 2024) (to be codified at Del. Code Ann. tit. 33 § 3370G, tit. 35 § 3571AA, tit. 52 § 5217).

150 *Fact Sheet: In Vitro Fertilization (IVF) Use Across the United States*, Department of Health and Human Services (Mar. 13, 2024) https://www.hhs.gov/about/news/2024/03/13/fact-sheet-in-vitro-fertilization-ivf-use-across-united-states.html.

151 *Insurance Coverage by State*, Resolve https://resolve.org/learn/financial-resources-for-family-building/insurance-coverage/insurance-coverage-by-state/ (last accessed on Sep. 20, 2024).

Family building is often out of reach for many people due to the high cost of fertility treatment and weak or non-existent insurance mandates.

care to grow their family.

When states mandate that insurance plans cover fertility care, the mandates frequently fall short of inclusivity. Mandates will exempt certain insurers, exclude people from coverage based on their age, or require people to prove infertility before they can access coverage.

No new fertility care insurance mandates were enacted in 2024, but 9 states introduced mandates (Michigan Missouri, Minnesota, Nebraska, Oklahoma, Virginia, Washington, West Virginia, and Wisconsin). Unfortunately, only five of these states (Oklahoma, Virginia, Washington, and Wisconsin) introduced mandates that would have been inclusive of single individuals and same-sex couples.

Three states, however, amended their existing mandates to further expand access to fertility care. Illinois already has a fertility care coverage mandate, and this year the legislature expanded the mandate to include coverage for preimplantation genetic testing.[152] The law also extended fertility care coverage for the State Employees Group Insurance Program through July 1, 2026.[153] Similarly, California had an existing mandate that insurance providers had to "offer" fertility care coverage. This year, the state enacted a law to require large group insurance plans to *provide* coverage for the diagnosis and treat-

152 S.B. 773, 103rd Gen. Assemb., Reg. Sess. (Ill. 2024) (to be codified at 5 ILL. COMP. STAT. 375/6.11B; 215 ILL. COMP. STAT. 5/356m).

153 S.B. 773, 103rd Gen. Assemb., Reg. Sess. (Ill. 2024) (to be codified at 5 ILL. COMP. STAT. 375/6.11B; 215 ILL. COMP. STAT. 5/356m).

ment of infertility, three completed oocyte retrievals, and unlimited embryo transfers.[154] This coverage applies both to people experiencing infertility and to single individuals and LGBTQ+ couples.[155] Small group insurance plans in California still have the mandate to offer care, rather than a mandate to provide care.[156]

Finally, Utah had previously created a pilot program that provided $4,000 towards the cost of each qualified assisted reproductive technology cycle, and this year enacted a law to make that program permanent.[157] The benefit is limited to people experiencing infertility who have been unable to become pregnant through "less-costly, potentially effective infertility treatments" that are already covered by insurance.[158]

Similar issues of prohibitive out-of-pocket costs and discriminatory eligibility restrictions arise with fertility preservation coverage, which is frequently excluded from insurance coverage and even when included is often limited to people with certain health conditions, such as cancer. This means that where these mandates exist, they often exclude people undergoing other treatments that may impact their fertility, such as gender-affirming health care. Fertility preservation involves cryopreserving oocytes, sperm, embryos, or other reproductive tissue and is critical to people undergoing medical treatments that could impact their fertility who wish to delay having biological children as well as people who need to pursue fertility care due to genetic or other medical conditions.

Like fertility insurance mandates, fertility preservation mandates can sometimes fall short of full inclusivity. There are many medical treatments that impact a person's fertility, but legislation frequently limits coverage to only those undergoing cancer treatment. While fertility preservation coverage is becoming more common, a majority of states do not require this coverage.[159] This year, Massachusetts enacted a law expanding access to fertility preservation services, requiring private insurance and state employee health plans to provide coverage of fertility preservation services to people with a "diagnosed medical or genetic condition that may directly or indirectly cause impairment of fertility."[160] Oklahoma enacted a similar law, requiring all health insurance plans in the state, including health plans issued to state employees, to provide coverage of fertility preservation services, but restricted this coverage to people who are diagnosed with cancer and "within reproductive

154 S.B. 729, 2024 Leg., Reg. Sess. (Cal. 2024) (to be codified at Cal. Health & Safety § 1374.55; Cal. Ins. Code § 10119.6).
155 S.B. 729, 2024 Leg., Reg. Sess. (Cal. 2024) (to be codified at Cal. Health & Safety § 1374.55; Cal. Ins. Code § 10119.6).
156 S.B. 729, 2024 Leg., Reg. Sess. (Cal. 2024) (to be codified at Cal. Health & Safety § 1374.55; Cal. Ins. Code § 10119.6).
157 S.B. 35, 66th Leg., Reg. Sess. (Utah 2024) (to be codified at Utah Code §§ 49-20-418; 63I-1-249).
158 S.B. 35, 66th Leg., Reg. Sess. (Utah 2024) (to be codified at Utah Code §§ 49-20-418; 63I-1-249).
159 *State Laws & Legislation*, Alliance for Fertility Preservation (Aug. 1, 2024) https://www.allianceforfertilitypreservation.org/state-legislation/.
160 H. 4800, 193rd Gen. Ct., Reg. Sess. (Mass. 2024) (to be codified at Mass. Gen. Laws ch. 32A § 17T; ch. 175 § 47VV).

age."[161] Under Oklahoma's law, moreover, religious employers can receive an exemption and can refuse to provide coverage if providing it conflicts with their bona fide religious beliefs and practices.[162]

Fourteen additional states (Connecticut, Georgia, Hawai'i, Illinois, Maryland, New Jersey, Oklahoma, Rhode Island, Tennessee, Virginia, Washington, West Virginia, and Wisconsin) introduced fertility preservation legislation that was not enacted. Notably, the Massachusetts and Virginia bills would have required Medicaid coverage of fertility preservation. The number of bills introduced this session to establish broad coverage for fertility preservation, including in public health programs, is encouraging and signals a trend toward more equitable access to fertility care. The Oklahoma law, however, could represent a concerning trend, where fertility preservation is only covered for people with specific medical diagnoses. Instead of restricting fertility preservation to people with medical and genetic conditions, or even more narrowly, to just those who have been diagnosed with cancer, states should enact fertility care coverage mandates that cover the full scope of fertility care, including IVF and fertility preservation, and ensure that every individual and couple who needs this care can access it, including single people, LGBTQ+ couples, and people insured through Medicaid.

161 S.B. 1334, 59th Leg., Reg. Sess. (Okla. 2024) (to be codified at Okla. Stat. tit. 36 § 6060.8b).
162 S.B. 1334, 59th Leg., Reg. Sess. (Okla. 2024) (to be codified at Okla. Stat. tit. 36 § 6060.8b).

Medication Abortion

Medication abortion is the most common method of abortion in the United States, currently accounting for more than 60% of all abortions.[163] The most common medication abortion regime in the U.S. includes the use of both mifepristone and misoprostol. Since its approval in 2000, mifepristone has been used by more than five million people. It has also been the subject of hundreds of studies that have found it to be safe and effective, regardless of where people take it and regardless of who is involved in the process.[164] This data does not stop anti-abortion legislators and politicians, however, from trying to restrict access to mifepristone. While the U. S. Supreme Court held that the Alliance for Hippocratic Medicine did not have standing to challenge the FDA regulation of mifepristone, states across the country introduced novel legislation to restrict medication abortion. This section discusses the Supreme Court case, as well as efforts by states to limit access to medication abortion.

FDA v. Alliance for Hippocratic Medicine

In June 2024, the U. S. Supreme Court ruled that the individual providers and anti-abortion association that sued to challenge the FDA's 2000 approval of mifepristone, as well as subsequent FDA changes to prescribing and dispensing requirements, did not have standing to bring the case.[165] The Court ruled that since the providers who brought the case do not actually prescribe mifepristone, they had not suffered any actual injury that could be redressed by the courts.[166]

The Court's decision to deny standing for the individual doctors and organizations meant that the existing regulations of mifepristone were unchanged, and mifepristone can still be dispensed through pharmacies and the mail. In addition, while the case brought by the Alliance for Hippocratic Medicine will not be allowed to proceed, the trial court that originally suspended access to mifepristone allowed three states, Kansas, Missouri, and Idaho, to intervene in the case. In October, those states moved to amend their original complaint, in the hopes of continuing to challenge FDA regulation of mifepristone. As made clear by this year's rise in new types of restrictions on medication abortion,

163 *The Availability and Use of Medication Abortion,* Kaiser Family Foundation (Mar. 20, 2024) https://www.kff.org/womens-health-policy/fact-sheet/the-availability-and-use-of-medication-abortion/.
164 *Review of proposed Major REMS Modification Summary Review for Mifepristone*, Center for Drug Evaluation and Research, (Dec. 2022) https://www.accessdata.fda.gov/drugsatfda_docs/summary_review/2023/ 020687Orig1s025SumR.pdf.
165 Food and Drug Administration v. Alliance for Hippocratic Medicine, 620 U.S. ___, 3-4 (2024).
166 Food and Drug Administration v. Alliance for Hippocratic Medicine, 620 U.S. ___, 13 (2024).

attacks on medication abortion will not stop with the Supreme Court's ruling denying standing for the Alliance for Hippocratic Medicine.

Medication Abortion Restrictions

Anti-abortion lawmakers continue to try novel ways to restrict access to medication abortion—which is now the most commonly used abortion method in the country. Photo: Robin Marty/Flickr

Louisiana enacted a first of its kind law this year (discussed briefly in Criminal Law and Reproductive Health Care Access) that garnered national attention for categorizing mifepristone and misoprostol, the medications used in a medication abortion, as Schedule IV drugs, a category that also includes drugs like Valium.[167] Dispensing or possessing these medications without a valid prescription is now a criminal offense, and violators could face between one and ten years in prison and a $5,000 fine.[168] The law has an exception for pregnant people who possess the medication for their own use.[169] Finally, the law takes the unique step of allowing for the prosecution of "criminal abortion by means of an abortion inducing drug" as racketeering activity, posing a threat to organizations that manufacture or assist with the provision of medication abortion.[170] This is the first time a state has ever treated medication abortion as a scheduled drug, a categorization usually reserved for medications that have some potential for abuse and dependency.

Treating mifepristone and misoprostol as Schedule IV controlled substances harms access to these critical medications. Louisiana's controlled substances law requires that prescriptions be written or submitted electronically, meaning providers will no longer be able to call these prescriptions into the pharmacy. This complication will hamper access in rural areas, where providers may not have electronic prescription capabilities. Hospitals also often have additional rules about accessing controlled substances, which will make it more difficult for providers to obtain this medication in emergency situations, such as to control postpartum hemorrhages.

While the law has an exception for pregnant people who possess the medication for their own use, there is no other exception in the section of the law that makes it illegal to possess mifepristone or misoprostol without a prescription. People not using the drug for their own use may be prevented from picking up the medication for someone else, like a child or a spouse, or could risk criminal prosecution. Pharmacists may elect not to dispense controlled substances to people not listed on the prescription. These restrictions will make care more difficult to access for people who are receiving abortions pursuant to one of the state's abortion exceptions, people who need the medications for miscarriage care, or people who need misoprostol for other conditions, specifically ulcer management.

167 S.B. 276, 2024 Leg., Reg. Sess. (La. 2024) (to be codified at La. Stat. Ann. § 40.964). *See also* La. Stat. Ann. § 40.964.
168 S.B. 276, 2024 Leg., Reg. Sess. (La. 2024) (to be codified at La. Stat. Ann. § 40.969(C)(1)(b)).
169 S.B. 276, 2024 Leg., Reg. Sess. (La. 2024) (to be codified at La. Stat. Ann. § 40.969(C)(2)).
170 S.B. 276, 2024 Leg., Reg. Sess. (La. 2024) (to be codified at La. Stat. Ann. § 15.1352(A)(71)).

In addition, treating the possession of abortion-inducing drug as racketeering activity could open a new avenue for the state to bring criminal charges against organizations that provide medication abortion in Louisiana, including those that provide this care through telemedicine. This year, Louisiana became the first to allow for racketeering charges to be brought against people providing medication abortions. Other states hostile to abortion will likely introduce similar bills in the coming year.

In addition to the restriction enacted in Louisiana, 14 states (Colorado, Florida, Illinois, Indiana, Iowa, Kansas, Kentucky, Massachusetts, Mississippi, New Hampshire, Oklahoma, Tennessee, West Virginia, and Wyoming) introduced 43 bills that would restrict medication abortion. Many of these bills would prohibit mailing medication abortion into the state, prohibit advertising medication abortion, or otherwise restrict access to medication abortion. None of these bills passed. One notable trend was the increase in bills that would require the provision of "medication abortion catch kits" to patients to prevent medication abortion from entering public wastewater and hold medication abortion manufacturers liable if water treatment facilities detect certain levels of residue. Three states (Oklahoma, West Virginia, and Wyoming) introduced legislation that related to medication abortion disposal and wastewater. This continues the trend of anti-abortion lawmakers coopting other issues, in this case environmental concerns, to facilitate the passage of abortion restrictions. None of these wastewater bills passed.

Medication Abortion Protections

This year, two states enacted laws to increase access to medication abortion, recognizing that medication abortion is safe and effective regardless of where people take it and who is involved in the process. Delaware enacted a law requiring all universities that receive state funds and have campuses physically located in Delaware to offer medication abortion at the university health center.[171] Washington state enacted a law that allows medication abortion labels to include the name of the health care facility rather than the prescriber's name.[172] As medication abortion faces additional legislative threats from states hostile to abortion, legislators in other states can increase protections for medication abortion and continue to expand access to care.

171 S.B. 301-1, 152nd Gen. Assemb., Reg. Sess. (Del. 2024) (to be codified at Del. Code Ann. tit. 14, § 9001F).
172 H.B. 2115, 68th Leg., Reg. Sess. (Wash. 2024) (amending Wash. Rev. Code. § 69.41.050)

Regulation of Reproductive Health Care Providers

Over-regulation of reproductive health care providers can impede access to care. Anti-abortion legislators frequently try to limit the provision of abortion care to physicians, even though other health care professionals have the training and experience necessary to provide this care.[173] Licensing requirements prevent traditional and certified professional midwives from practicing in multiple states, and even certified nurse midwives (CNMs) face burdensome restrictions. As legislators consider expanding access to reproductive health care, they should make sure that licensing and regulation does not serve as an unnecessary barrier to care. This section discusses legislation that expands access to care through laws that allow additional providers to perform abortions, and the creation or amendment of midwifery licensing laws.

Expanding Access to Care

Legislation broadening scope of practice can increase abortion access by allowing health care providers other than physicians to provide abortion care. When enacted, this type of legislation repeals physician-only laws or expressly authorizes physician assistants, certified nurse midwives, nurse practitioners, and other qualified medical professionals to provide abortion care. In 2024, four states (Arizona, Massachusetts, New York, and Wyoming) introduced legislation expanding who could perform abortions, but none were enacted. California, however, enacted a proactive facility licensing law, requiring local agencies reviewing applications for reproductive health care clinics to use objective standards to review the clinic's application.[174]

Similarly, there are multiple training pathways that people in the United States can take to become a midwife. Various states allow CNMs, certified midwives (CMs), certified professional midwives (CPMs), and traditional or community midwives to practice. In some states, however, CPMs or CMs are not eligible for licensure. Such restrictions create unnecessary barriers

173 Advance Practice Clinicians (APCs) including physician's assistants, certified nurse midwives, and advance practice registered nurses are all qualified to provide abortion care and can expand access to abortion care, particularly in places where there are a shortage of physicians, *Advance Practice Clinicians and Abortion Care Provision*, American College of Obstetricians and Gynecologists https://www.acog.org/advocacy/abortion-is-essential/trending-issues/issue-brief-advanced-practice-clinicians-and-abortion-care-provision (last accessed Oct. 29, 2024).

174 A.B. 2085, 2024 Leg., Reg. Sess. (Cal. 2024) (amending Cal. Gov. Code § 65914.900).

As legislators expand access to reproductive health care, they should make sure that licensing and regulation do not serve as unnecessary barriers to care. >

to care for patients in many states and impedes development of the nation's midwifery workforce. Additionally, state midwifery laws may criminalize the practices of Indigenous and traditional midwives, thereby limiting access to care in underserved communities and threatening cultural birth traditions. One way that states can combat this is by introducing legislation that removes criminal consequences for Indigenous and traditional midwives. States can also create pathways for more midwives to become licensed. This year, states including Georgia, Massachusetts, Mississippi, New York, and West Virginia, introduced, but did not enact, legislation to expand access to legal practice for midwives.

Amending Midwifery Licensure

In addition to expanding eligibility for midwifery licensure or exemption, states also enacted legislation that amends existing licensure frameworks. Such legislation may alter language, scope of practice, and oversight mechanisms associated with midwifery regulation. This year, Washington state enacted a law that allows people to be licensed as midwives or doulas regardless of their immigration or citizenship status, taking a step to expand access to care.[175]

D.C. enacted a law that clarifies the type of care CNMs can provide.[176] The law also prohibits people from using the title of certified professional midwife, unless they are licensed to practice midwifery in D.C.[177] Finally, the law requires that the D.C. Board of Medicine regulate the practices of certified professional midwifery and doulas with the advice of the Advisory Committee on Maternal Care Professionals.[178]

175 H.B. 1889, 68th Leg., Reg. Sess. (Wash. 2024) (to be codified at Wash. Rev. Code § 18.130.040).
176 B. 25-0545, 26th Council, Reg. Sess. (D.C. 2024) (to be codified at D.C. Code § 3-1206.09).
177 B. 25-0545, 26th Council, Reg. Sess. (D.C. 2024) (to be codified at D.C. Code § 3-1210.03).
178 B. 25-0545, 26th Council, Reg. Sess. (D.C. 2024) (to be codified at D.C. Code § 3-1206.13).

Driven by financial concerns, Idaho enacted a law to regulate licensed midwives (who must be certified professional midwives) under the state Board of Nursing, rather than the state Board of Midwifery, and amends the composition of the state Board of Nursing to include CPMs or licensed midwives.[179] When doulas and Certified Professional Midwives are regulated by health care professionals in different roles (such as physicians or nurses) tensions can arise. Representation of, and respect for, all affected professions on the governing committee is essential.

States must exercise caution when expanding or amending midwifery licensure laws. For example, Hawai'i enacted a law in 2019 that created licensing requirements and new restrictions for midwives.[180] This law essentially requires anyone providing advice, information, or care during pregnancy, birth, and postpartum to have a state license. Nearly anyone without a proper license—a group that includes Native Hawaiian cultural practitioners, traditional midwives, some CPMs, doulas, childbirth and lactation educators, and even grandparents—is at risk of criminal sanctions and other penalties.[181] Hawai'i has an ongoing shortage of maternal health care providers, especially in rural areas, and Native Hawaiian and other Pacific Islander people have some of the highest rates of maternal mortality.[182] Restricting access to midwifery care and other forms of perinatal support puts pregnant people at even greater risk, and violates their right to make informed, autonomous decisions about where, how, and with whom they experience pregnancy and birth.[183] The Center for Reproductive Rights, the Native Hawaiian Legal Corporation, and Perkins Coie challenged this law on behalf of nine plaintiffs, including midwives, student midwives, and pregnant people.[184] In July of 2024, the state Circuit Court granted a preliminary injunction in the case, *Kahoʻohanohano v. Hawaiʻi*, blocking the state from enforcing the law against Native Hawaiian individuals who perform, teach, and learn traditional maternal health practices.[185]. While Native Hawaiian cultural practitioners can resume serving their communities without fear of criminal sanctions for now, legislation is still necessary to fully and permanently protect the rights of pregnant people and traditional midwives in Hawai'i.

179 H. 437, 67th Gen. Assemb., Reg. Sess. (Idaho 2024) (to be codified at Idaho Code § 54-1403).
180 Danielle Campoamor, *Hawaii's new law could jail traditional midwives. They are fighting back*, INDEPENDENT (Jun. 15, 2024, 6:30 PM) https://www.independent.co.uk/news/world/americas/hawaii-midwife-sue-court-case-b2563285.html.
181 Kaho'ohanohano v. State, 1CCV-24-0000269, *32 (Feb. 27, 2024) (complaint) https://reproductiverights.org/wp-content/uploads/2024/02/Kahoohanohano-v.-State-of-Hawaii-Complaint-and-Summons-2-27-24.pdf.
182 Kaho'ohanohano v. State, 1CCV-24-0000269, *4 (Feb. 27, 2024) (complaint) https://reproductiverights.org/wp-content/uploads/2024/02/Kahoohanohano-v.-State-of-Hawaii-Complaint-and-Summons-2-27-24.pdf.
183 Kaho'ohanohano v. State, 1CCV-24-0000269 (Feb. 27, 2024) (complaint) https://reproductiverights.org/wp-content/uploads/2024/02/Kahoohanohano-v.-State-of-Hawaii-Complaint-and-Summons-2-27-24.pdf.
184 Kaho'ohanohano v. State, 1CCV-24-0000269, *3-4 (Feb. 27, 2024) (complaint) https://reproductiverights.org/wp-content/uploads/2024/02/Kahoohanohano-v.-State-of-Hawaii-Complaint-and-Summons-2-27-24.pdf.
185 Kaho'ohanohano v. State, 1CCV-24-0000269 (Jul. 23, 2024) (preliminary injunction) https://reproductiverights.org/wp-content/uploads/2024/07/PI-Order-July-24-2024-Hawaii.pdf.

Substance Use and Mental Health

Pregnant people who use substances can face elevated risks to both their health and their rights. Overdoses contribute to maternal deaths across the country, and individuals with substance use disorders may encounter discrimination in the health care system, or struggle to access the care they need. Pregnant people also often lack access to basic harm reduction services. Pregnant people who use substances face additional challenges when they come into contact with the criminal justice and family policing systems.[186] To address substance use disorders during pregnancy, states must repeal punitive laws that deter access to care, ensure that patients are not tested for drugs without their informed consent, prevent unnecessary family separations, and develop substance use treatment options that work for all pregnant and parenting people who need that care. This section discusses state laws that fund substance use treatment, as well as amendments to testing and reporting requirements.

Funding and Treatment

States can fund and create non-punitive programs that provide treatment to pregnant people with substance use disorder. Only one state enacted legislation this year to support pregnant people with substance use disorder. Washington created a program to provide integrated care for pregnant and postpartum people, including access to behavioral and mental health care, extended hospitalization, social work support, addiction medication and parent-infant bonding.[187] States must continue to enact legislation that makes comprehensive health care and other necessary resources more accessible to pregnant people and families affected by substance use disorders.

Testing and Reporting

Across the country, individuals are often tested for drugs without their consent while accessing prenatal care or giving birth. Providers will also frequently drug test newborns directly after birth. These testing practices

186 *AMA Report on Overdose Crisis in Pregnant and Postpartum People*, American Medical Association (Feb. 29, 2024) https://end-overdose-epidemic.org/wp-content/uploads/2024/02/AMA-Manatt-2024-Improving-Access-to-Care-Pregnant-Parenting-People-with-SUD.pdf.

187 S.B. 5580, 68th Leg., Reg. Sess. (Wash. 2024)) (to be codified at Wash. Rev. Code § 74.09.835).

are often motivated by race and class-based stereotypes and can lead to the separation of families by the family policing system. These kinds of drug testing practices also deter pregnant and postpartum people from seeking health care. States can combat this by enacting legislation to require informed consent prior to drug testing or by amending mandatory reporting laws. Illinois was the only state this year to enact a law amending state reporting requirements around drug testing.[188] The law creates a Family Recovery Plan Implementation Task Force to help develop a public health focused approach to prenatal substance exposure. It repealed a portion of state law that required the Department of Children and Family Services to report newborns who tested positive for controlled substances to the State's Attorney, and repealed a law that established a rebuttable presumption that a parent was unfit following a positive toxicology screen of the newborn.[189]

This law is a step in the right direction. Parental drug use, on its own, does not automatically render a parent unfit. States should follow Illinois' example and amend their mandatory reporting laws and laws around child removal based on parental drug use.

188 S.B. 3136, 103rd Gen. Assemb., Reg. Sess. (Ill. 2024) (repealing 325 Ill. Comp. Stat. 5/4.4; 750 Ill. Comp. Stat. 50/1(D)(k)).

189 S.B. 3136, 103rd Gen. Assemb., Reg. Sess. (Ill. 2024) (repealing 325 Ill. Comp. Stat. 5/4.4; 750 Ill. Comp. Stat. 50/1(D)(k)).

Surrogacy

Surrogacy is a critical method of family building for individuals and families who want to become parents but cannot become pregnant or cannot carry a pregnancy to term. Compensated gestational surrogacy is a practice where an intended parent or parents execute a contract with a person who agrees to become pregnant and deliver a child or children using embryos created through IVF and who receives payment beyond reimbursement for medical care. The person acting as surrogate does not contribute their own gametes, nor do they intend to act as a parent to the child or children who are born.

While the legal status of children born via surrogacy is unclear or subject to legal hurdles in some states,[190] this year marks the first time that no state has a broad criminal ban on surrogacy contracts. The passage of the Michigan Family Protection Act (MFPA) was the culmination of a years-long effort by fertility care advocates in Michigan to modernize the state's surrogacy and parentage law. Following its success, advocates across the country are focusing their work on replicating its success in more states, as in Massachusetts, with the Massachusetts Parentage Act (MPA), to enact legislation that both updates outdated parentage laws and recognizes surrogacy as a critical method of family formation. They are also pushing to amend existing and newly enacted laws to protect the rights of all parties, in particular the bodily autonomy of persons who act as surrogates. This section discusses laws enacted this year that legalize surrogacy, amend existing surrogacy laws to change regulations, and update parentage laws for children born via a surrogacy agreement.

Legalizing and Regulating Surrogacy

This year, Massachusetts[191] and Michigan[192] enacted laws to legalize and regulate surrogacy within their states. Both laws reflect the Uniform Parentage Act of 2017,[193] and require people acting as surrogates to be at least 21 years old, have previously given birth to at least one child, and complete a physical evaluation and mental health consultation before entering into a contract.[194] Intended parents must be at least 21 and complete a mental health consulta-

190 *The US Surrogacy Law Map*, Creative Family Connections https://www.creativefamilyconnections.com/us-surrogacy-law-map/ (last accessed Sep. 23, 2024).
191 H. 4970, 193rd Gen. Ct., Reg. Sess. (Mass. 2024) (to be codified at Mass. Gen. Laws ch. 209C §§ 28A—28P).
192 H.B. 5207, 102nd Leg., Reg. Sess. (Mich. 2024) (to be codified at Mich. Comp. Laws §§ 722.1901—722.1909).
193 *Uniform Parentage Act (2017)*, National Conference of Commissioners on Uniform State Laws (Jan. 25, 2024) https://www.uniformlaws.org/viewdocument/final-act-96?CommunityKey=c4f37d2d-4d20-4be0-8256-22dd73af068f.
194 H. 4970, 193rd Gen. Ct., Reg. Sess. (Mass. 2024) (to be codified at Mass. Gen. Laws ch. 209C §§ 28A—28P).; H.B. 5207, 102nd Leg., Reg. Sess. (Mich. 2024) (to be codified at Mich. Comp. Laws §§ 722.1901—722.1909).

The Center worked with partners on legislation to ensure equitable and non-discriminatory access to fertility care. Shown above is Polly Crozier, GLAD Law at the signing of the Massachusetts Parentage Act in August 2024. Photo: GLAD Law

GLAD Law

"This work presents a vision of a country where children and families are respected and protected, no matter what. Work to secure the legal relationships between parents and children is essential to realizing this vision, and we'll move forward as a movement by working collaboratively and leveraging our collective expertise."
-- Polly Crozier, Director of Family Advocacy at GLBTQ Legal Advocates & Defenders (GLAD Law)

The Center worked closely with GLAD Law and other Michigan and national partners to create a coalition, develop bill language and a legislative strategy, and to support the legislation with messaging, letters of support, and public testimony. In MA we publicly supported the legislation and provided technical assistance to policymakers to secure its passage.

The Center's work with GLAD Law on legislative efforts like those in Michigan and Massachusetts is critical because in addition to advocating for equitable and non-discriminatory access to fertility care, we also want all families built via assisted reproduction to be legally protected under their state's parentage laws.

tion.[195] All parties to the agreement must have independent legal representation paid for by the intended parents.[196] Critically, under the MPA, persons acting as surrogates must have health insurance and retain their right to make all health and welfare decisions regarding themselves, including their medical decision-making authority during attempts to become pregnant, pregnancy, labor and delivery, and post-partum.[197] Any contract that would limit these rights are void as against public policy.[198] Similarly, under the MFPA, surrogacy agreements must permit the person acting as a surrogate to make all health and welfare decisions themselves and the pregnancy and any provision to the contrary in such a contract is void and unenforceable.[199] Both the MPA and MFPA allow surrogates to receive payment for acting as a surrogate and for reasonable expenses.[200]. Both also allow intended parents to obtain pre-birth parentage orders, which establish that parental rights and responsibilities vest immediately on the intended parents following the birth of the child.[201] Finally, the MPA and MFPA allow for gestational and genetic surrogacy, and are inclusive of single individuals and same-sex couples.[202] Michigan also enacted a law that repealed existing criminal penalties for entering into a surrogacy contract.[203] The Center worked closely with Michigan Fertility Alliance (MFA), a state-based volunteer-run advocacy organization, to support the development and advocacy of the MFPA. The successful passage of the MFPA was in large part due to a cross-movement effort, brought together by the Center and MFA and involving reproductive rights and justice organizations, LGBTQ+ organizations, and family law and surrogacy attorneys and academics.

One other state enacted legislation to update its surrogacy laws. Utah enacted a law that removes references to a gestational surrogate's "husband" and updates them to instead refer a gestational surrogate's "spouse."[204]

The elimination of the last remaining broad criminal ban on surrogacy, and

195 H. 4970, 193rd Gen. Ct., Reg. Sess. (Mass. 2024) (to be codified at Mass. Gen. Laws ch. 209C §§ 28A—28P).; H.B. 5207, 102nd Leg., Reg. Sess. (Mich. 2024) (to be codified at Mich. Comp. Laws §§ 722.1901—722.1909).

196 H. 4970, 193rd Gen. Ct., Reg. Sess. (Mass. 2024) (to be codified at Mass. Gen. Laws ch. 209C §§ 28A—28P).; H.B. 5207, 102nd Leg., Reg. Sess. (Mich. 2024) (to be codified at Mich. Comp. Laws §§ 722.1901—722.1909).

197 H. 4970, 193rd Gen. Ct., Reg. Sess. (Mass. 2024) (to be codified at Mass. Gen. Laws ch. 209C §§ 28A—28P).; H.B. 5207, 102nd Leg., Reg. Sess. (Mich. 2024) (to be codified at Mich. Comp. Laws §§ 722.1901—722.1909).

198 H. 4970, 193rd Gen. Ct., Reg. Sess. (Mass. 2024) (to be codified at Mass. Gen. Laws ch. 209C §§ 28A—28P); H.B. 5207, 102nd Leg., Reg. Sess. (Mich. 2024) (to be codified at Mich. Comp. Laws §§ 722.1901—722.1909).

199 H.B. 5207, 102nd Leg., Reg. Sess. (Mich. 2024) (to be codified at Mich. Comp. Laws §§ 722.1901—722.1909).

200 H. 4970, 193rd Gen. Ct., Reg. Sess. (Mass. 2024) (to be codified at Mass. Gen. Laws ch. 209C §§ 28A—28P); H.B. 5207, 102nd Leg., Reg. Sess. (Mich. 2024) (to be codified at Mich. Comp. Laws §§ 722.1901—722.1909).

201 H. 4970, 193rd Gen. Ct., Reg. Sess. (Mass. 2024) (to be codified at Mass. Gen. Laws ch. 209C §§ 28A—28P); H.B. 5207, 102nd Leg., Reg. Sess. (Mich. 2024) (to be codified at Mich. Comp. Laws §§ 722.1901—722.1909).

202 H. 4970, 193rd Gen. Ct., Reg. Sess. (Mass. 2024) (to be codified at Mass. Gen. Laws ch. 209C §§ 28A—28P); H.B. 5207, 102nd Leg., Reg. Sess. (Mich. 2024) (to be codified at Mich. Comp. Laws §§ 722.1901—722.1909).

203 H.B. 5209, 102nd Leg., Reg. Sess. (Mich. 2024) (repealing Mich. Comp. Laws §§ 722.857, 722.859(3)) (the law repealed criminal penalties for entering into a surrogacy contract with a minor or a person who had intellectual disabilities. The surrogacy law enacted by Michigan this year prohibits anyone under 21 from entering into a surrogacy contract and requires mental health consultations and independent legal representation for all parties).

204 S.B. 126, 66th Leg., Reg. Sess. (Utah 2024) (amending Utah Code §§ 78B-15-801, 78B-15-802, 78B-15-803, 78B-15-806, 78B-15-808).

two different states adopting surrogacy legislation that mirrors the Uniform Parentage Act is a positive trend that will hopefully continue and that will reflect the work done by advocates in Massachusetts and Michigan. This is in part because many states still do not have laws providing strong protections for all parties to a surrogacy agreement and instead rely on a patchwork of legislation and case law. Many of these same states unfortunately also lack clear and equitable legal protections for all families, including LGBTQ+ families.

Parentage Determinations

Several states that allow surrogacy, or even facilitate access to other assisted reproduction technology, often lack updated parentage laws to ensure families formed through assisted reproduction are legally recognized and protected. These out-of-date parentage laws are particularly dangerous for same-sex parents, especially where one or both parents are not biologically related to their children. Many states have laws that create presumptions of parentage but restrict these presumptions based on the sex of the intended parent or parents, often discriminating against LGBTQ+ couples. Other states require intended parents to go through a lengthy adoption process to secure parentage rights for their own children, whom they have raised from birth.

In tandem with updating its surrogacy law, Michigan enacted a package of legislation to update its parentage law. The state enacted laws to update the law around issuing birth certificates,[205] intestate succession,[206] the existing state paternity act used to determine parentage,[207] the state revocation of parentage act,[208] the state summary support and paternity act,[209] the state acknowledgement of parentage act,[210] and the state genetic parentage act[211] to ensure existing laws comply with parentage determinations made pursuant to surrogacy agreements. The enactment of these news laws and repeal of existing, outdated, laws will help ensure that all families in Michigan, including LGBTQ+ families, have legal protections that guarantee their legal security.

Similarly, the MPA enacted in Massachusetts provides for a clearer, more equitable pathway to parentage for families born in the state, including for LGBTQ+ families formed via assisted reproduction. The MPA added a non-discrimination provision to ensure equality in legal parentage for all children and allows for a "voluntary acknowledgement of parentage," an administrative route through which parents can establish their legal parentage,

205 H.B. 5208, 102nd Leg., Reg. Sess. (Mich. 2024) (amending MICH. COMP. LAWS §§ 333.2831; 333.2832).
206 H.B. 5210, 102nd Leg., Reg. Sess. (Mich. 2024) (amending MICH. COMP. LAWS § 700.2114).
207 H.B. 5211, 102nd Leg., Reg. Sess. (Mich. 2024) (amending MICH. COMP. LAWS § 722.714c).
208 H.B. 5212, 102nd Leg., Reg. Sess. (Mich. 2024) (amending MICH. COMP. LAWS § 722.1439).
209 H.B. 5213, 102nd Leg., Reg. Sess. (Mich. 2024) (amending MICH. COMP. LAWS § 722.1439).
210 H.B. 5214, 102nd Leg., Reg. Sess. (Mich. 2024) (amending MICH. COMP. LAWS §§ 722.1003, 722.1004).
211 H.B. 5215, 102nd Leg., Reg. Sess. (Mich. 2024) (amending MICH. COMP. LAWS § 722.1465).

including intended parents.[212]

Minnesota also enacted a law to update its parentage law this year, including by allowing people to file pre-birth parentage orders.[213] The law further establishes that gamete donors are not the parents of children born via assisted reproduction, and that intended parents who consent to assisted reproduction are to be the parents of a child born via assisted reproduction.[214] Additionally, Vermont enacted a law to update its law on parentage determinations, including amending how intended parents can consent to assisted reproduction procedures and how courts can make determinations about presumed parents.[215]

As threats to assisted reproduction and LGBTQ+ people continue to increase, states must update their parentage laws to ensure that intended parents who have consented to and taken part in parenting a child cannot have their parental rights stripped away due to a lack of genetic connection to the child. Given the variety of different parentage laws in states, many of which have not been updated to reflect modern families, states supportive of LGBTQ+ rights should make parentage law updates a priority in the coming years.

212 H. 4970, 193rd Gen. Ct., Reg. Sess. (Mass. 2024) (to be codified at Mass. Gen. Laws ch. 209C §§ 28A—28P).
213 H.F. 3204, 93rd Gen. Assemb., Reg. Sess. (Minn. 2024) (to be codified at Minn. Stat. § 257E.15).
214 H.F. 3204, 93rd Gen. Assemb., Reg. Sess. (Minn. 2024) (to be codified at Minn. Stat. § 257E.21).
215 H. 745, 2023-2024 Gen. Assemb., Reg. Sess. (Vt. 2024) (amending Vt. Stat. Ann. tit. 15C §§ 402, 402a, 704, 708).

Barriers to Care

Barriers to reproductive health care take a variety of forms and are regularly a focus of state legislation. Anti-abortion lawmakers continue to support barriers to care, through the funding of anti-abortion centers, biased counseling laws, religious refusals, and other targeted regulations of abortion providers. Similar barriers are appearing in maternal health care, with states creating additional regulation requirements for birth centers. Meanwhile, legislators supportive of abortion continue to work to repeal unnecessary restrictions on abortion facilities, while working to increase regulations on anti-abortion centers. This section discusses restrictions on abortion providers, facility licensing requirements of abortion clinics and birthing centers, funding for anti-abortion centers, expanded programming for anti-abortion centers, and finally, efforts by states to restrict activities by anti-abortion centers.

Restrictions on Abortion Providers

There is a wide variety of laws that aim to regulate how abortion providers provide care. For example, so-called "born alive" bills are regularly introduced by state legislatures. These bills, which proport to create a duty of care for providers when a fetus is "born alive" are deceptive, stigmatizing, and create no operative change in the law. This year, 24 bills included a provision that required care for an infant "born alive," but none passed. This result could be in recognition of the fact that other laws and ethical codes require providers to provide medical care in emergency situations. Similarly, states continue to introduce legislation that would allow providers, institutions, and insurance companies or other payers to refuse to participate in abortion care based on religious objections. These religious refusal bills would also protect providers who refuse to provide care from retaliation by the state and their employers. Seven states (Idaho, Indiana, Iowa, Nebraska, Oklahoma, Rhode Island, and West Virginia) introduced legislation to allow religious refusals for abortion care, but none passed.

Misinformation through biased counseling is another barrier to care, requiring providers to share medically inaccurate and stigmatizing information with patients prior to providing abortions. These anti-rights requirements have worsened since the overturning of *Roe*, particularly in states where abortion is legal but restricted. Kansas, for example, enacted a law this year that required providers to ask patients why they are seeking an abortion, and report those answers to the state.[216] Reasons must be chosen from a predeter-

216 H.B. 2749, 90th Leg., Reg. Sess. (Kan. 2024) (to be codified at KAN. STAT. ANN. § 65-445).

mined list, and providers must also report the patient's age, marital status, level of education, race, and whether the patient received services from an anti-abortion center, among other information.[217] This law was vetoed by Kansas Governor Laura Kelly, but the legislature overrode the veto, and the law is currently being challenged by the Center, along with Planned Parenthood, the Woody Law Firm, and Arnold & Porter Kaye Scholer LLP.[218] The law will not be enforced until a final judgment is issued by the District Court.[219] Seven states (Colorado, Illinois, Iowa, Kansas, Massachusetts, New York, and West Virginia) introduced additional biased counseling bills, including bills that required providers to share information about "medication abortion reversal," none of which passed.

Beyond laws that require health care practitioners to share medically inaccurate information about abortion care, states are now introducing legislation that would require providers to alert patients to the existence of "palliative care" services following a fatal fetal diagnosis. Several states, including Iowa and West Virginia, introduced legislation that would require state agencies to create publicly available websites or lists of information about perinatal hospice, palliative care organizations, support programs, and hotlines providing information about fetal diagnoses. While perinatal hospice is a legitimate service that can be provided to patients as part of a set of options following a fetal diagnosis, the information provided by states hostile to abortion will likely come from biased anti-abortion groups, rather than from providers skilled in perinatal palliative care.[220] None of these bills passed, but this is a worrying trend. The last thing people need when they are facing a serious fetal diagnosis is state mandated, medically inaccurate material that does not provide them with information about the full range of options, including an option for abortion care.

Facility Licensing Requirements

Abortion clinics continue to be subject to medically unnecessary and factually unsupported restrictions that abortion providers are required to meet based on the politicization of the care they provide. These targeted regulations of abortion providers, or TRAP laws, create burdensome licensing, reporting, equipment, and admitting privileges requirements for clinics. In the absence of state and federal protection for abortion, states can pile on oppressive regulations, making it difficult for clinics to operate. In 2024, nine states (Illinois, Missouri, New Mexico, Oregon, Rhode Island, South Dako-

217 H.B. 2749, 90th Leg., Reg. Sess. (Kan. 2024) (to be codified at KAN. STAT. ANN. § 65-445).
218 Hodes & Nauser v. Kobach, 23-CV-03140 (Dist. Ct. Kan. Jul. 22, 2024) (granting motion for leave to supplement second amended petition).
219 Hodes & Nauser v. Kobach, 23-CV-03140 (Dist. Ct. Kan. Jul. 29, 2024) (stipulation of non-enforcement).
220 *See e.g.* Jessica Valenti, *Calculated Cruelty*, ABORTION EVERY DAY (Oct. 19, 2023) https://jessica.substack.com/p/calculated-cruelty.

Increased support for birth centers that provide culturally competent midwifery care is also urgently needed. Photo: Duda Oliveira/Pexels

ta, Utah, West Virginia, and Wyoming) introduced TRAP legislation. Utah enacted two laws, one that would allow the state Department of Health and Human Services to deny or revoke the license of abortion clinics that perform abortions in violation of state law.[221] Utah also repealed an existing state law that prevents abortion clinics from being licensed or from operating in the state.[222] This law does not, however, aim to increase abortion access. Rather, it was enacted to simplify the state's abortion law in the eyes of the state supreme court, which is currently considering litigation about Utah's trigger ban on abortion.[223]

Facility licensing and regulatory requirements can also impact the birth settings available in a community. This year the Center tracked legislation related to the regulation of freestanding birth centers. While most birth centers provide midwifery care to people with low risk pregnancies (who are transferred to a hospital if a cesarean section becomes necessary), Florida enacted a law that creates a new "advanced birth center" designation.[224] These newly licensed "advanced birth centers" are permitted to perform "planned low-risk cesarean deliveries," vaginal deliveries for patients between the 37th and 41st week of gestation, and select vaginal births after cesareans for qualified patients.[225] The law also lays out requirements for these advanced birth

221 S.B. 229, 65th Leg., Reg. Sess. (Utah 2024) (to be codified at Utah Code Ann. § 26B-2-703).
222 H.B. 560, 65th Leg., Reg. Sess. (Utah 2024) (repealing Utah Code Ann. §§ 26B-2-204(1), (2), (3)).
223 Hannah Seariac, *Utah Supreme Court is weighing state's abortion law. A new bill aims to simplify the legal issues*, Deseret News (Feb. 15, 2024, 9:25 PM) https://www.deseret.com/utah/2024/2/15/24074344/utah-abortion-clinic-licensing-law/.
224 S.B. 7016, 126th Leg., Reg. Sess. (Fla. 2024) (to be codified at Fla. Stat. §§ 383.302, 383.3081, 383.309, 383.313, 383.3131, 383.315, 383.316, 383.318).
225 S.B. 7016, 126th Leg., Reg. Sess. (Fla. 2024) (to be codified at Fla. Stat. §§ 383.302, 383.3081, 383.309, 383.313, 383.3131, 383.315, 383.316, 383.318).

centers, including the employment of medical doctors and anesthesiologists, a surgical suite, transfer agreements, and that the centers meet the minimum standards for ambulatory surgical centers.[226]

Two other states, Oklahoma and Washington, enacted laws that created additional requirements for birth centers. Oklahoma made minor changes to how birth centers are regulated by the state,[227] and Washington enacted a law that allowed the state to take action against birth centers that operate without a license.[228] Finally, Colorado enacted a law that requires health facilities that provide labor and delivery related services to establish processes to transfer and receive pregnant and birthing patients from other locations, which can include birth centers and home births.[229] State legislatures must carefully consider safety, access, and equity issues as they regulate free-standing birth centers and should ensure that pregnant people have options when it comes to where they birth. Increased support for birth centers that provide culturally competent midwifery care in communities of color is also urgently needed.

Funding for Anti-Abortion Centers

Anti-abortion centers, also referred to as crisis pregnancy centers or fake clinics, are organizations that advertise their ability to assist with pregnancy. In truth, these centers use deceptive practices to discourage people from accessing abortion care, while providing no meaningful information about pregnancy, or any real financial, logistical, or emotional support. Most of these centers do not have medically trained or licensed staff, and frequently engage in deceptive practices in advertising and the services they provide.[230]

To make matters worse, states provide millions of dollars in funding to anti-abortion centers, providing these fake clinics millions of dollars a year while severely limiting access to abortion and refusing to fund much-needed safety nets and family resources. Legislation funding anti-abortion centers is enacted every year, but the volume of legislation, and the amount of money, is steadily increasing. Since *Dobbs*, states have appropriated more than $489 million dollars to anti-abortion centers.[231] This year alone, fifteen states (Alabama, Arkansas, Florida, Louisiana, Iowa, Kansas, Kentucky, Minnesota, Mississippi, Missouri, Oklahoma, South Carolina, Tennessee, Utah, and

226 S.B. 7016, 126th Leg., Reg. Sess. (Fla. 2024) (to be codified at FLA. STAT. §§ 383.302, 383.3081, 383.309, 383.313, 383.3131, 383.315, 383.316, 383.318).
227 S.B. 1739, 59th Leg., Reg. Sess. (Okla. 2024) (to be codified at OKLA. STAT. tit. 36 § 6060.3).
228 S.B. 5271, 68th Leg., Reg. Sess. (Wash. 2024) (to be codified at WASH. REV. STAT. §§ 18.46.010, 18.46.050, 18.46.130).
229 H.B. 24-1459, 74th Leg., Reg. Sess. (Colo. 2024) (to be codified at COLO. REV. STAT. § 25-3-216(1)(f)).
230 *Crisis Pregnancy Centers*, AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS https://www.acog.org/advocacy/abortion-is-essential/trending-issues/issue-brief-crisis-pregnancy-centers (last accessed Sep. 24, 2024).
231 *New Research: More Than One Billion Dollars of Public Funding Has Gone to Anti-Abortion Centers*, EQUITY FORWARD (Jul. 2024) https://equityfwd.org/sites/default/files/anti_abortion_centers_public_funding_by_states_2024_equity_forward_research_final_updates_august_1_20240801_3.pdf.

West Virginia) introduced 42 bills to fund anti-abortion centers. Of these, Arkansas,[232] Florida,[233] Iowa,[234] Kansas,[235] South Carolina,[236] Tennessee,[237] and West Virginia[238] enacted laws to fund anti-abortion centers. This funding furthers the work of anti-abortion centers that do not provide meaningful support or accurate information to pregnant people and, in fact, routinely gather and misuse sensitive health care data.

Extending Programming for Anti-Abortion Centers

In addition to appropriating millions for anti-abortion centers, states hostile to abortion moved to increase programming at anti-abortion centers. Legislation passed this year gave anti-abortion centers greater autonomy and created partnerships between anti-abortion centers and the state. This increase in power and state-sanctioned work makes it harder to combat inaccurate and stigmatizing information provided by anti-abortion centers. This year, Iowa,[239] Louisiana,[240] Oklahoma,[241] and Utah[242] enacted legislation increasing the power and programming in anti-abortion centers.

Efforts to Regulate Anti-Abortion Centers

At the same time, some states continued their long-standing efforts to better regulate anti-abortion centers. Eleven states (California, Kentucky, Massachusetts, Minnesota, Missouri, New Jersey, New York, North Carolina, Ohio, Pennsylvania, and Wisconsin) introduced 23 bills that would regulate or defund anti-abortion centers. Pennsylvania was the only state to enact a law this year that repealed funding allocations to the state's Alternatives to Abortion program.[243] This law comes after the state's decision in 2023 to terminate its contract with anti-abortion centers, which had been in place for nearly 30 years.[244] This change is a positive step forward, since Pennsylvania was the first state to enact such a program. Just as many states followed Pennsylvania's lead and established "alternatives to abortion" programs, states should again follow Pennsylvania's lead now, and end their subsidies and funding of this deceptive work.

232 S.B. 64, 94th Gen. Assemb., Reg. Sess. (Ark. 2024).
233 H.B. 415, 126th Leg., Reg. Sess. (Fla. 2024); H.B. 5001, 126th Leg., Reg. Sess. (Fla. 2024).
234 H.F. 2698, 90th Gen. Assemb., Reg. Sess. (Iowa 2024).
235 S.B. 28, 90th Leg., Reg. Sess. (Kan. 2024).
236 H. 5100, 125th Gen. Assemb., Reg. Sess. (S.C. 2024).
237 H.B. 2973, 113th Gen. Assemb., 2nd Reg. Sess. (Tenn. 2024).
238 S.B. 200, 86th Leg., Reg. Sess. (W. Va. 2024).
239 S.F. 2252, 90th Gen. Assemb., Reg. Sess. (Iowa 2024) (to be codified at IOWA CODE § 217.41C).
240 S.B. 278, 73rd Leg., Reg. Sess. (La. 2024) (to be codified at LA. REV. STAT. § 46:972.1); S.B. 312, 73rd Leg., Reg. Sess. (La. 2024) (to be codified at LA. REV. STAT. §§ 46:1445.1—46:1445.14).
241 S.B. 538, 59th Leg., Reg. Sess. (Okla. 2024) (to be codified at OKLA. STAT. tit. 63 §§ 1-740.16—1-740.18).
242 S.B. 147, 65th Leg., Reg. Sess. (Utah 2024) (to be codified at UTAH CODE § 26B-4-326).
243 S.B. 1001, 208th Gen Assemb., Reg. Sess. (Pa. 2024).
244 Brooke Schultz and Kimberlee Kruesi, *After nearly 30 years, Pennsylvania will end state funding for anti-abortion counseling centers*, ASSOCIATED PRESS (Sep. 1, 2023, 8:23 AM) https://apnews.com/article/abortion-pennsylvania-92c940a80f675f5b6cc6fd1642ea9ba3.

Parental Leave

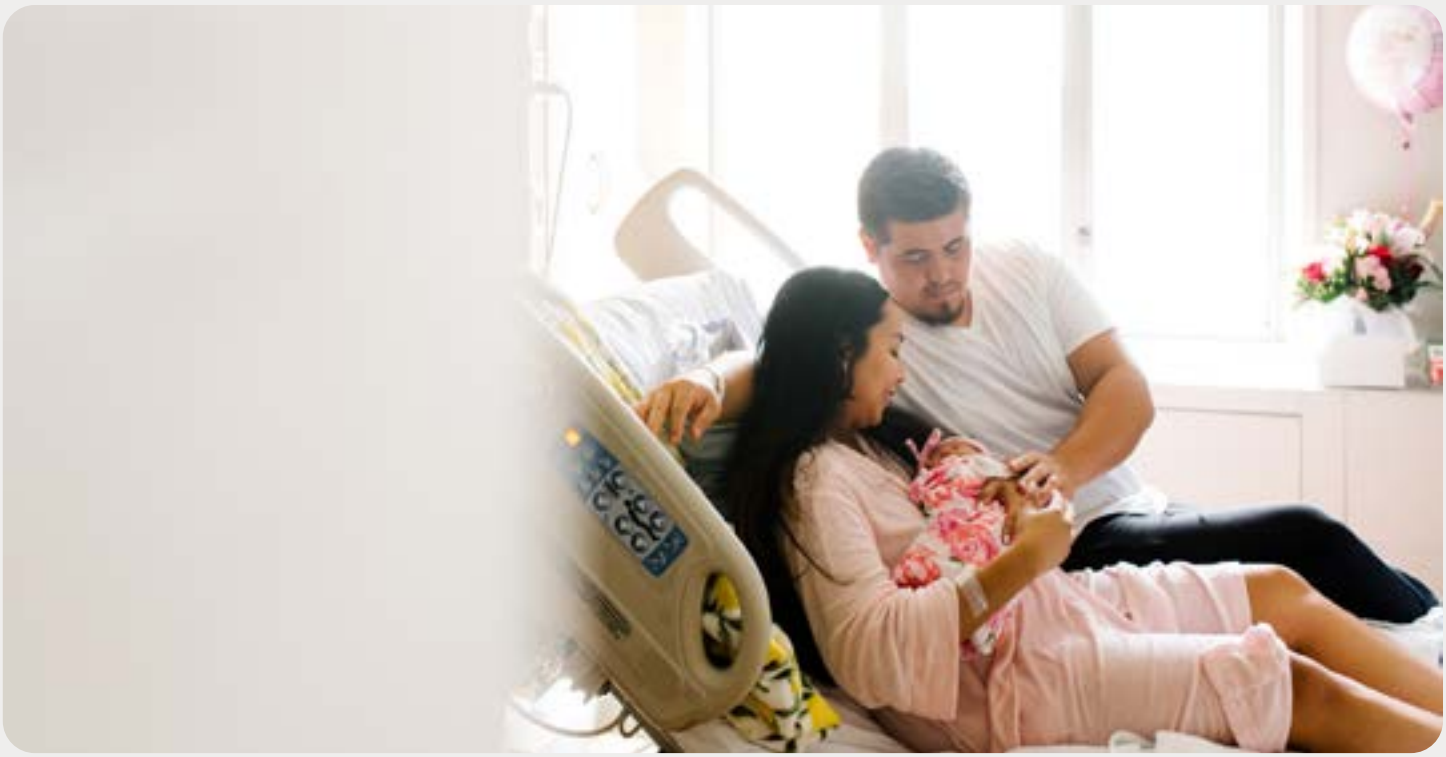
Paid parental leave is critical for the health of pregnant, postpartum, and parenting people. There is no federal requirement that employers provide any paid leave following the birth of a child. Federal law does allow people to access up to 12 weeks of unpaid, job-protected leave.[245] It thus falls to states to fill this gap and establish laws requiring, and creating funding mechanism for, paid parental leave. Giving individuals and families the time to recover after birth can reduce maternal mortality and result in maternal health benefits.[246] Universal paid parental leave programs allow all employees in the state to access paid parental leave, but none of these programs were enacted this year. This section discusses the leave programs that were enacted, namely parental leave for state employees, paid leave insurance programs, and bereavement leave.

Parental Leave for State Employees

Laws that only provide paid leave to state employees are far from ideal. While state governments are often large employers, these types of bills leave out all individuals not employed by the state. Tennessee this year enacted a law to provide employees of public charter schools six work weeks of paid leave following the birth of their child.[247] Utah enacted several laws related to paid leave for state employees. The state now requires local education agencies to develop paid parental and postpartum recovery leave programs.[248] Utah's leave programs must provide the same amount of leave other state employees get, which is three weeks of parental leave following the birth of a child, and an additional three weeks of postpartum recovery leave for people who gave birth.[249] This legislation is also inclusive of people who become parents pursuant to a valid gestational surrogacy agreement.[250] Utah also enacted a law to allow people to take postpartum leave following any "childbirth that occurs at 20 weeks or greater gestation."[251]

Not only do parental leave bills for state employees leave wide swaths of working individuals unprotected and unable to take leave, but the bills

245 *Family and Medical Leave Act*, U.S. Department of Labor, https://www.dol.gov/agencies/whd/fmla (last accessed Sep. 9, 2024).
246 Sarah Coombs, *Paid Leave is Essential for Healthy Moms and Babies*, National Partnership for Women and Families (2021) https://nationalpartnership.org/wp-content/uploads/2023/02/paid-leave-is-essential-for-healthy-moms-and-babies.pdf.
247 S.B. 2655, 113th Gen. Assemb., 2nd Reg. Sess. (Tenn. 2024) (to be codified at Tenn. Code Ann. § 8-50-814).
248 H.B. 192, 65th Leg., Reg. Sess. (Utah 2024) (to be codified at Utah Code § 53G-11-208); H.B. 431, 65th Leg., Reg. Sess. (Utah 2024) (to be codified at Utah Code § 53F-5-222).
249 H.B. 431, 65th Leg., Reg. Sess. (Utah 2024) (to be codified at Utah Code § 53F-5-222).
250 H.B. 192, 65th Leg., Reg. Sess. (Utah 2024) (to be codified at Utah Code § 53G-11-208); H.B. 431, 65th Leg., Reg. Sess. (Utah 2024) (to be codified at Utah Code § 53F-5-222).
251 H.B. 75, 65th Leg., Reg. Sess. (Utah 2024) (to be codified at Utah Code § 63A-17-511).



With no federal requirement for paid family leave, developing paid parental leave programs and funding mechanisms is left up to the states.

frequently do not provide for twelve weeks of leave. Indeed, none of the laws enacted this year provided state employees with twelve weeks of paid leave. Much more work must be done to ensure that all employees have the ability to take the leave they need following the birth of their child.

Paid Family Leave Insurance

Unlike universal paid parental leave programs, paid family leave insurance programs allow insurance companies to offer policies that, if purchased by private companies, would provide paid family leave. These bills are similar to disability insurance programs, in that they are insurance policies that can, but do not have to, be purchased by employers and which can cover employees' salaries while employees are out of work. These bills leave the provision of paid family leave up to individual employers, which is essentially the status quo of paid family leave currently. As a result, these bills do little to expand access to family leave. This year, South Carolina enacted a law creating a paid family leave insurance program and requires employers who use the insurance to provide at least two weeks of paid leave.[252] This leave, however, is only available to employees at companies that have purchased the leave insurance and decide to provide it. Even with the passage of this law, many people in the state still lack access to paid leave.

252 H. 4832, 125th Gen. Assemb., Reg. Sess. (S.C. 2024) (to be codified at S.C. Code Ann. §§ 38-103-10—38-103-80).

Bereavement Leave

Bereavement leave is a category of leave for people who have lost a family member. In many states, this leave is not explicitly available to individuals who have experienced a miscarriage or a stillbirth. However, there is a growing number of states providing bereavement leave following pregnancy loss. Ideally, employees would be able to take the full amount of parental leave following a miscarriage, fetal loss, or stillbirth since the physical, mental, and emotional toll of those pregnancy outcomes can be significant. Complications arise when bereavement leave laws provide only a few days to employees experiencing a pregnancy loss.

The laws providing paid leave to school employees in Tennessee allows people to take the full amount of leave following a birth or stillbirth.[253] Maryland enacted a law allowing state employes to take up to sixty days of bereavement leave after experiencing a stillbirth or death of an infant.[254] Utah enacted a law that allows employees to take three days of leave following a miscarriage or stillbirth.[255] The Utah law is the only law that extends bereavement leave to intended parents, and allowed intended parents to take bereavement leave following a stillbirth by a gestational surrogate.[256]

States should provide the same amount of leave to individuals and families who have experienced a miscarriage or stillbirth as they provide to individuals and families following a live birth. Unfortunately, no states enacted laws this year to provide for twelve weeks of paid parental leave, so many workers are left without necessary protections.

253 S.B. 2655, 113th Gen. Assemb., 2nd Reg. Sess. (Tenn. 2024) (to be codified at Tenn. Code Ann. § 8-50-814).
254 H.B. 52/S.B. 109, 446th Gen. Assemb., Reg. Sess. (Md. 2024) (to be codified at Md. Code Ann. State Pers. & Pens. § 9-1109).
255 S.B. 192, 65th Leg., Reg. Sess. (Utah 2024) (to be codified at Utah Code § 53G-11-208).
256 S.B. 192, 65th Leg., Reg. Sess. (Utah 2024) (to be codified at Utah Code § 53G-11-208).

Embryo and Gamete Regulations

There are many ways states can regulate or restrict embryos or gametes beyond embryo personhood. States can enact laws that limit what people can do with their own gametes, restrict or regulate gamete provision and donation, and hamper vital research. While not as restrictive as embryo personhood, these laws can still affect the provision of fertility care in a number of ways. This section discusses recent state laws aiming to regulate the provision and handling of embryos and gametes.

Regulation of Gamete Provision

This year, Colorado modified its 2022 law regulating gamete provision to prohibit gamete agencies, gamete banks, and fertility clinics from matching intended parents with donors who do not agree to disclose their identifying information.[257] The law also modifies licensing requirements and allows the Colorado Department of Public Health and Environment to conduct on-site inspections of gamete agencies, gamete banks, and fertility clinics located outside of Colorado.[258]

While we did not see more states introduce legislation regulating gamete provision, these regulations raise privacy concerns for donors, and strict regulations may lead to a decline in donors. This in turn could cause gametes to become more expensive, putting fertility care further out of reach.

Restrictions on Use or Handling Embryos and Gametes

This year, states hostile to abortion enacted laws restricting how gametes and embryos could be used, indicating that states are comfortable limiting access to fertility care and research. Louisiana amended existing state law that restricts the use of gametes and punishes fertility fraud to add an exception for people who use their spouse's gametes to conceive a child.[259] Mississippi enacted three appropriations bills, each of which prohibits the use of funds for any research that results in the destruction of a human embryo.[260] Requirements like Mississippi's limit vital scientific research and could lead to additional restrictions on embryos and fertility care. Since this is not an area that has seen an increase in legislation in recent years it is possible that these restrictions will not spread to other states.

257 S.B. 24-223, 74th Leg., Reg. Sess. (Colo. 2024) (to be codified at Colo. Rev. Stat. §§ 25-57-103, 25-57-105, 25-57-108, 25-57-110, 25-57-111, 25-57-112).
258 S.B. 24-223, 74th Leg., Reg. Sess. (Colo. 2024) (to be codified at Colo. Rev. Stat. §§ 25-57-103, 25-57-105, 25-57-108, 25-57-110, 25-57-111, 25-57-112).
259 H.B. 60, 2024 Leg., Reg. Sess. (La. 2024) (to be codified at La. Rev. Stat. § 14:101.2).
260 S.B. 3006, 139th Leg., Reg. Sess. (Miss. 2024); S.B. 3007, 139th Leg., Reg. Sess. (Miss. 2024); S.B. 3014, 139th Leg., Reg. Sess. (Miss. 2024).

Maternal Health Data

Maternal Mortality Review Committees (MMRCs) are multi-disciplinary committees that comprehensively review all deaths of people who died during or within a year of their pregnancy. MMRCs seek to fully understand the circumstances surrounding each death, determine if the death was related to the pregnancy, and develop recommendations and policies for hospitals, providers, and state governments to prevent similar deaths in the future.

It is not enough that states establish MMRCs. These MMRCs must also be adequately staffed and produce timely reports. Governments, hospitals, and state agencies must seriously consider and follow the evidence-based recommendations announced by MMRCs. This section discusses recent legislation to establish and amend requirements for MMRCs.

Maternal Mortality Review Committees

This year, Kentucky enacted a law to create a state maternal fatality review team to examine maternal fatalities and recommend changes in state programs and legislation. The law also gives the Department of Public Health the ability to select representatives they deem appropriate, allowing law enforcement officers to serve on the maternal fatality review team, in addition to public health experts and health care providers.[261] Reports must be submitted by the team every year, but can be combined with reports submitted by the state child fatality review team.[262]

Three other states enacted laws that modified the policies or makeup of MMRCs. Arizona enacted a law that allowed the maternal mortality review programs to conduct interviews or obtain information from close contacts or family of people who die during or following a pregnancy.[263] Oklahoma enacted a law reducing the number of people on the state MMRC from 25 to 11.[264]

West Virginia enacted a law to change the mandate and composition of the state Fatality and Mortality review team, so the team focuses on people who die during and up to a year after pregnancy, as well as all people who die as

261 S.B. 74, 2024 Gen. Assemb., Reg. Sess. (Ky. 2024) (to be codified at Ky. Rev. Stat. § 211.684).
262 S.B. 74, 2024 Gen. Assemb., Reg. Sess. (Ky. 2024) (to be codified at Ky. Rev. Stat. § 211.684).
263 H.B. 2116/S.B. 1048, 56th Leg., Reg. Sess. (Ariz. 2024) (to be codified at Ariz. Rev. Stat. § 36-3503).
264 H.B. 2152, 59th Leg., Reg. Sess. (Okla. 2024) (to be codified at Okla. Rev. Stat. tit. 63 § 1-242.4).

a result of suspected domestic violence.[265] The law also added a state health officer, a member selected by the Chair of the Minority Health Institute at Marshall University, licensed physicians, and licensed nurses, as well as designees of other organizations.[266] Finally, the law repeals an existing section of West Virginia law that laid out what variables should be analyzed when pregnancy-associated deaths are studied and requires that reports be distributed to the Commission on Legislative Oversight.[267] Given the United States' high rates of maternal morbidity and mortality, it is vital that states continue to strengthen their MMRCs to give states more tools and recommendations to respond to the maternal health crisis.

265 H.B. 4874, 86th Leg., Reg. Sess. (W. Va. 2024) (to be codified at W. Va. Code §§ 61-12A-1—61-12A-4).
266 H.B. 4874, 86th Leg., Reg. Sess. (W. Va. 2024) (to be codified at W. Va. Code §§ 61-12A-1—61-12A-4).
267 H.B. 4874, 86th Leg., Reg. Sess. (W. Va. 2024) (repealing W. Va. Code §§ 61-12A-5).

Local Ordinances

As reproductive rights advocates work to ensure bodily autonomy for people across the country, anti-abortion activists are utilizing local and municipal law to limit these freedoms by introducing "Sanctuary Cities for the Unborn" ordinances. These ordinances seek to use local enforcement mechanisms to punish someone for providing or helping someone access reproductive health care in local communities in an attempt to ban abortion, restrict access to medication abortion, block abortion clinics from operating, and establish fetal personhood at the local level, among other things. This year, two cities in Texas enacted these ordinances,[268] while city councils in Amarillo, Texas, and Clarendon, Texas, rejected these ordinances.[269] The Amarillo ordinance would have made it illegal for Amarillo residents to receive abortion care, even in states where abortion is legal. After it failed in the City Council, anti-abortion groups succeeded in placing the ordinance on the Amarillo ballot, where it was voted on and defeated in November.[270]

Given the unpopularity of strict abortion bans, it is no surprise the ballot initiative in Amarillo failed. However, this failure will not stop the national group that introduced this ballot initiative, which has already begun to introduce this ballot initiative in cities and counties across the country. But just as the anti-abortion movement has developed a playbook to enact these ordinances, reproductive rights and justice advocates have started to create a set of tactics that can be replicated across the country by people who oppose these abortion bans.

268 *Trafficking Ordinances*, Sanctuary Cities for the Unborn https://sanctuarycitiesfortheunborn.org/trafficking-ordinances (last accessed Sep. 25, 2024).

269 Michael Cuviello, *Amarillo council rejects anti-abortion ordinances, could go to voters* Amarillo Globe News (Jun. 12, 2024, 9:17 AM) https://www.amarillo.com/story/news/politics/government/2024/06/12/amarillo-council-rejects-anti-abortion-ordinance-could-go-to-voters/74067247007/.

270 Noah Dawson, *Abortion Ordinance Ballot Language Approved, 'Criminal Offense' Language Removed*, The Amarillo Pioneer (Aug. 13, 2024) https://www.amarillopioneer.com/blog/2024/8/13/abortion-ordinance-ballot-language-approved-strikes-criminal-offense-language.

Conclusion

Every branch of government, at every level, local, state and federal, continues to grapple with the chaos directly caused by the U.S. Supreme Court's decision to remove a fundamental right upon which generations of Americans depended. Far from putting the issue of abortion to rest, the *Dobbs* decision has intensified litigation and legislation. The Supreme Court had two abortion cases in front of them in the October 2023 term because anti-abortion groups, the minority in the U.S., will not stop until abortion care is illegal across the country, and because abortion bans are putting people's lives at risk, often in ways that conflict with existing federal laws. The election of Donald Trump will further embolden anti-abortion groups and lawmakers and result in additional threats to reproductive rights. These threats could include the enactment of a federal abortion ban that would supersede state laws, including state constitutional amendments protecting the right to abortion.

Access to reproductive health care is polarized, with a vocal minority expressing disagreement, and the law in many states reflects either greater abortion and reproductive health care access or the criminalization of essential health care. The November 2024 election demonstrated that many state elected officials are wildly out of step with their constituents who are committed to reproductive freedom and see access to abortion as a matter of personal liberty. In 2025, we are likely to see litigation and legislation implementing the new state constitutional amendments protecting abortion and reproductive freedom approved by voters in 7 states to further expand abortion rights and access to care. While fewer states enacted shield laws this year, many states continued to expand and build upon existing shield protections for reproductive and transgender health care. Notably, advocates and providers have worked to develop the next iteration of interstate shield protections, including data privacy efforts, protections for gender-affirming care, and additional protections for providers mailing medication abortion into banned states.

In 2024, we witnessed real progress in some states and an outpouring of support for reproductive health care. Michigan repealed its broad criminal ban on surrogacy, and additional states regulated surrogacy and parentage determinations, securing legal pathways for all families formed via assisted reproduction. People from across the political spectrum made their support for IVF access known through demonstrations and calls to their legislators. But the threats to fertility care are still very real and, in 2025, legislators will

likely continue to work to protect the right to IVF. While ensuring that people can access fertility care, legislators must also enact legislation that provides for coverage for fertility care, so that people can enjoy this right.

At the end of this legislative session, a total of 48 states have now established postpartum Medicaid extensions, and other states expanded access to maternal health care by providing for Medicaid and insurance coverage of doulas and midwives. States are working to strengthen their Maternal Mortality Review Committees and provide parental and bereavement leave. Protecting the right to access reproductive health care and creating more equitable access to services has had benefits across all communities. In 2025, legislators must make maternal health a priority, and enact evidence-based policies that have been shown to improve maternal health.

At the same time, in states hostile to reproductive health care, anti-abortion legislators found new ways to restrict access to care. Tennessee became the second state to criminalize the provision of abortion support to young people, following Idaho's lead. While both laws have been blocked by federal courts, we are likely to see other states introduce similar bans to prevent young people from accessing abortion care. Louisiana became the first state to designate abortion medication as a controlled substance, making this vital medication more difficult to access. And Alabama's state Supreme Court demonstrated how far anti-rights factions will go when they held that embryos could be treated as people for the purposes of civil law.

The right to abortion, assisted reproduction, and high-quality and accessible maternal health care are interconnected, and this year made it clear that a threat to one of these rights is a threat to all of them. Only full statutory or constitutional protections for bodily autonomy and more equitable access to care will ensure that these rights are protected. The Center for Reproductive Rights is committed to securing those protections in state and federal law and we will continue to work alongside advocates, organizers, legislators, and the general public until the right to access all forms of reproductive health care is not dependent upon a person's income, identity, or where in the country they live.

In 2025, we look forward to working with you. Please reach out to **statepolicy@reproductiverights.org** with all questions and ideas.

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