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Reproductive Rights State Policy Snapshot: 2025

YENWEN / ISTOCK

More than three years after the U.S. Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization* (*Dobbs*),[1] reproductive health care remains a highly legislated issue. Over the course of 2025, access to abortion, fertility care, and maternal health care increased in many U.S. states. At the same time, anti-rights extremists have continued their attacks on all aspects of reproductive health care.

In 2025, the Center for Reproductive Rights tracked nearly 1,000 pieces of reproductive rights legislation introduced in states across the country. Over 300 of these bills were enacted, spanning a wide range of issue areas that impact reproductive rights and access to services.

This resource provides a countrywide snapshot of 2025 state legislative trends impacting access to abortion, assisted reproduction, and maternal health care. These trends are anticipated to continue in 2026 and are being closely monitored and analyzed by the Center for Reproductive Rights and our advocacy partners. For questions and technical assistance needs, legislators and advocates can email StatePolicy@reprorights.org.

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I. Laws Granting Legal Rights for Embryos/Fetuses

States hostile to reproductive health care continued to normalize legislation establishing fetal and embryo personhood granting personhood rights to fertilized eggs both in and out of utero. Fetal and embryo personhood laws are distinct but interconnected anti-abortion efforts that extend the rights of a person to a fetus or embryo, often defining legal personhood from the moment of conception. While some states had introduced and enacted various forms of fetal personhood bills in the past, the *Dobbs* decision has emboldened efforts to enforce them.

Even when personhood language falls outside of the reproductive health care context, like in tax credits or child support, fetal and embryo personhood laws lay the groundwork for further restricting or banning abortion and assisted reproduction care.[2]

II. Ensuring Private Insurance Coverage and Public Funding

Money can be one of the largest barriers to accessing all types of reproductive health care. Private insurance coverage and public funding for abortion care, fertility care, and maternal health care are necessary to ensure access.

Abortion

Public funding of abortion care can greatly impact access. To increase abortion access, states can appropriate money to programs that assist in abortion care, as well as expand coverage through Medicaid or other medical assistance programs.

In 2025, Colorado,[3] Maryland,[4] and California[5] expanded public funding by requiring funding for abortion care in their state Medicaid programs and creating grant programs to increase abortion access.

Meanwhile, hostile states continued to limit the accessibility of care through funding restrictions. In 2025, Texas went even further, enacting legislation prohibiting cities and counties from funding logistical support for people seeking abortion, including providing money for childcare, travel, lodging, food, and counseling regarding abortion care.[6] This law targets programs in cities like Austin and San Antonio and makes it harder for Texans to access abortion care in other states.[7]

Assisted Reproduction

One of the most significant obstacles to accessing fertility care in the United States is the lack of insurance coverage to mitigate the out-of-pocket cost. Policies that mandate inclusive private insurance and Medicaid coverage can expand access to care, especially for low-income, LGBTQ+, and BIPOC individuals and their families.

In 2025, six states enacted legislation requiring private insurance coverage of some fertility care: California,[8] Florida,[9] Georgia,[10] New York,[11] Utah,[12] and Virginia.[13] Although no states enacted new requirements for private insurance coverage of in vitro fertilization (IVF), Utah enacted legislation removing a $4,000 cap on fertility care coverage for state employees. Also noteworthy, Florida and Georgia enacted legislation requiring private insurance coverage for fertility preservation services for individuals experiencing iatrogenic infertility as a result of certain diagnoses or medical treatments. Finally, California and Virginia enacted legislation requiring the creation of a new benchmark plan that includes coverage of fertility treatment services and fertility preservation services.

In 2025, the **Georgia Fertility Justice Now Coalition**, co-founded and co-led by the Center for Reproductive Rights, SisterSong, and SPARK Reproductive Justice NOW!, introduced two fertility care insurance mandates. The bills, H.B. 588 and H.B. 589, are public and private insurance mandates aimed at ensuring Georgians have equitable and non-discriminatory access to fertility care.

Center for Reproductive Rights lawyers Jorie Dugan (second) and Israel Cook (fourth) alongside the other co-founders of the Fertility Justice Now Coalition Leah Jones, Director of Maternal Health and Birth Equity Initiatives, from SisterSong and Agbo Ikar, Policy and Advocacy Director of SPARK Reproductive Justice NOW!

In 2025, we also continued to see a legislative trend towards providing some fertility care coverage for those on public insurance, such as Medicaid. No state fertility insurance mandate currently provides Medicaid coverage of IVF. However, New York[14] enacted legislation requiring coverage of fertility preservation for Medicaid patients experiencing iatrogenic infertility, and Nevada[15] enacted legislation requiring fertility preservation coverage for individuals on Medicaid who are diagnosed with breast or ovarian cancer. These measures are an important step in ensuring everyone has access to the family-building care they need.

Maternal Health

Medicaid coverage for maternal health care often falls short of ensuring people have access to the services they need, despite Medicaid covering 41% of births in the United States.[16]

While the vast majority of states now provide Medicaid coverage for one year postpartum for eligible individuals, two states, Arkansas and Wisconsin, still provide only the federally mandated 60 days or just a slight extension of postpartum coverage, ending benefits at a time when people are still at risk of pregnancy-related health complications. Further, Medicaid programs in many states do not cover doula services, and coverage of midwifery services varies widely. Both doula and midwifery services are patient-centered and crucial for fostering better maternal health outcomes.

Ensuring complete and equitable Medicaid coverage of maternal health care and perinatal support is necessary to reduce health disparities for low-income populations.[17] This year, Louisiana,[18] Virginia,[19] and Vermont[20] enacted legislation requiring or expanding Medicaid coverage for doula services; Alabama,[21] Arkansas,[22] and Mississippi[23] amended current laws to provide presumptive Medicaid eligibility to pregnant people. Additionally, New Mexico enacted legislation establishing equitable facility fee reimbursement under Medicaid for free-standing birth centers, which is imperative for the sustainability and accessibility of such facilities.[24]

III. Emergency Care

Emergency Medical Treatment & Labor Act (EMTALA)

In 2025, states continued to grapple with the Supreme Court's rulings in *Moyle v. United States,* which considered a challenge to the Emergency Medical Treatment and Labor Act (EMTALA).[25] EMTALA requires hospitals to provide patients with life-saving care—including, when necessary, abortion care. The Supreme Court's opinion temporarily restores the ability of doctors in Idaho to provide emergency abortions under EMTALA, but dismissing the case without resolving the core issues continues to put pregnant patients' health at risk and leaves the door open for future litigation challenging EMTALA.[26]

In response to concerns surrounding federal EMTALA protections, New York,[27] Massachusetts,[28] Colorado,[29] and Washington[30] enacted legislation in 2025 to create explicit state statutory protections similar to EMTALA, requiring hospitals to stabilize patients experiencing emergency medical conditions, including when stabilizing care requires ending a pregnancy. Two restrictive states, Arkansas[31] and Idaho,[32] also enacted legislation clarifying that providers must provide emergency care pursuant to EMTALA, while also highlighting that the state bans abortion in almost all other cases. States may continue to amend or create similar laws to ensure that access to emergency abortion care is protected.

"Clarifying" Exceptions to Abortion Bans

Abortion exceptions are generally included within gestational bans, permitting abortion care for one or more of the following reasons: medical emergencies, sex crimes, and fetal abnormalities. Exceptions are inconsistent with the reality of medical practice. For example, in cases of medical emergencies, states commonly attempt to mitigate harm by enacting more legislative guidelines for providers to follow. However, many providers remain reticent to provide care in state contexts where abortion is otherwise illegal. The only real way to ensure that pregnant people can access necessary care when experiencing obstetric emergencies is to remove the gestational bans limiting care in the first place.

Despite the mounting evidence that exceptions do not ensure access to any type of abortion care, Texas,[33] Tennessee,[34] Kentucky,[35] and Arkansas[36] enacted legislation seeking to "clarify" their state abortion exceptions. These attempts fail to meaningfully change the exceptions to abortion bans and fall short at addressing the public health crisis these bans have caused.[37]

IV. Over-Regulation of Health Providers

Civil Penalties for Out-of-State Providers and Helpers

Efforts to restrict medication abortion have grown following *Dobbs,* and federal litigation seeking to limit or entirely invalidate FDA approval of mifepristone has emboldened state legislators' efforts to prohibit medication abortion from entering restrictive states. In 2025, Texas enacted HB 7,[38] creating civil liability for the manufacture, distribution, mailing, prescribing, or provision of abortion medication in Texas, enforceable through private "qui tam" lawsuits brought by almost anyone other than government officials. This law is particularly concerning in that it allows any person, regardless of relation to the pregnant person, to bring legal action against a provider or helper, regardless of their location. The law also includes provisions attempting to override external shield laws and allowing Texans to countersue against claw-back actions, which allow pregnant people, providers, and helpers to file civil actions in their own state in response to hostile civil litigation from people in states where abortion is banned. These claw-back lawsuits are designed to deter hostile states from pursuing legal action and to hold people who interfere with reproductive health services accountable. Louisiana enacted similar but narrower legislation, allowing a pregnant person to bring a cause of action against out-of-state abortion providers and distributors.[39]

Texas and Louisiana have historically served as testing grounds for highly restrictive abortion legislation. In 2024, Louisiana enacted legislation to reclassify medication abortion as Schedule IV controlled dangerous substances. Already in 2026, we are seeing many other states introduce versions of these bills. By mid-January, South Carolina advanced HB 4760,[40] a bill that would impose criminal penalties for providing medication abortion into the state and classify medication abortion as a controlled substance.

Targeted Regulation of Abortion Providers (TRAP) Bills

Many states subject abortion facilities to medically unnecessary and factually unsupported restrictions based on the politicization of the care they provide, referred to as TRAP (targeted regulation of abortion providers) laws. Wyoming enacted TRAP legislation requiring abortion clinics to be regulated as "ambulatory surgical centers," creating specific admitting privileges as well as licensing and data reporting requirements.[41] Wyoming also enacted a second piece of legislation requiring providers to conduct ultrasounds on patients 48 hours prior to a medication abortion.[42] In April of 2025, the Natrona County court temporarily blocked both laws, allowing abortion care to resume in the state.[43]

Targeted Regulation of IVF Providers (TRIP) and Restricted IVF

Legislators are mirroring the anti-abortion TRAP strategy and introducing legislation targeting IVF providers for regulation. In 2025, three such bills were introduced in Arkansas, Tennessee, and Texas[44] though none were enacted. Notably, the Tennessee bill incorporated provisions that would restrict the IVF care patients can receive. Restricted IVF (or what proponents call "ethical" IVF), can take multiple forms, but in the Tennessee bill would limit the number of eggs that can be fertilized per cycle and prohibit genetic screening and testing.[45] Bills like these would make it physically or financially more difficult for IVF providers to provide evidence-based, patient-centered care; undermine IVF's medical standard of care; and potentially force patients to undergo more cycles of IVF, unnecessarily putting their bodies through an already arduous regimen.

Midwifery Care

There are multiple training pathways that people in the United States can take to become a midwife. All states authorize certified nurse midwives (CNMs) to practice, while laws regulating the practice of certified midwives (CMs), certified professional midwives (CPMs), and other direct entry midwives, such as traditional midwives, vary across states. In some states, CPMs and/or CMs are not eligible for licensure. Such restrictions create unnecessary barriers to care for patients and impede development of the nation's midwifery workforce, which contradicts efforts to address the growing number of maternity care deserts across the United States. New York,[46] Georgia,[47] Mississippi,[48] and North Carolina[49] introduced legislation to expand pathways to licensure for midwives, primarily CPMs.

States must exercise caution when expanding or amending midwifery licensure laws. Some state midwifery laws criminalize the unlicensed practice of Indigenous and traditional midwives, thereby limiting access to culturally congruent care in underserved communities and threatening cultural birth traditions. For example, Hawaii enacted a law in 2019 that created licensing requirements and new restrictions for midwives which went into effect in 2023. This law essentially required anyone providing advice, information, or care during pregnancy, birth, and postpartum to have a state license. Nearly anyone without a state license—a group that included Native Hawaiian cultural practitioners, traditional midwives, some CPMs, doulas, childbirth and lactation educators, and even grandparents—was at risk of criminal sanctions and other penalties. Hawaii enacted legislation in 2025 to extend protections for Native Hawaiian traditional and customary practices, expand pathways for CPMs to be eligible for licensure, and make explicit that no criminal penalties exist under this law.[50] Similarly, Georgia introduced a bill that would decriminalize the unlicensed practice of direct entry midwifery with adherence to specific disclosure and informed consent requirements.[51]

V. Blame and Shame Fertility and Religious Refusals

There is a growing number of states introducing and enacting legislation that would limit or undermine IVF access and care.[52] Arkansas enacted legislation requiring private insurance providers to cover and Title-X facilities and public health programs to include "restorative reproductive medicine" (RRM) as part of their reproductive care.[53] Blame and Shame Fertility, or RRM, purports to "fix" women's infertility, rejecting assisted reproductive technologies like IVF and casting them as "inherently suppressive, circumventive, or destructive to natural human functions."[54] Blame and Shame Fertility bills like this one place the burden of infertility solely on women's shoulders and further stigmatize them for struggling to become pregnant or to carry a pregnancy to term. They also delays people's access to IVF and siphon funding

from public health programs. Additionally, this Arkansas law allows providers at publicly funded entities to refuse to train in, provide, or in any way facilitate assisted reproductive technologies like IVF based on their "sincerely held religious beliefs or moral convictions" without guaranteeing a patient's access to care.[55]

VI. Privacy and Access

Data Privacy

Data privacy legislation includes policies that prevent the sharing of and increase protection for, sensitive patient information. There is currently no federal privacy law prohibiting entities such as data brokers from collecting, sharing, and selling certain health-related data such as a person's geolocation data and web browsing data. This lack of regulation leaves individuals' data related to abortion and gender-affirming care at risk of being acquired by law enforcement in a state where care is criminalized. To address this gap, states have enacted legislation to regulate data brokers by prohibiting the collection, sharing, and sale of data related to what is often framed as "sensitive health care information," or requiring the entity to obtain separate and informed consent before sharing or selling sensitive data. In 2025, Nevada,[56] Virginia,[57] California,[58] and New Mexico[59] enacted legislation strengthening their state data privacy protections.

The Center for Reproductive Rights, along with our partners at If/When/How and the National Partnership for Women & Families, published a resource for legislators and advocates who want to better understand the legal landscape surrounding key health data issues and potential policy opportunities to address reproductive privacy concerns.

Shield Expansions

Since the overturning of *Roe*, 18 states and Washington, D.C. have enacted interstate shield legislation to protect providers, helpers, and patients from out-of-state civil and criminal investigations concerning the provision of abortion care and, in some states, gender-affirming care. As attacks on abortion and gender-affirming care advance, so do shield laws. In 2025, seven states enacted expansions to their existing shield protections: California,[60] Colorado,[61] Delaware,[62] Maryland,[63] Massachusetts,[64] Vermont,[65] and Washington.[66]

The Center for Reproductive Rights was an early adopter and strong advocate of shield legislation. We have and will continue to provide drafting and technical assistance support on many aspects of these laws across the country, including licensure, malpractice insurance, final judgement responses, telemedicine, prohibition of collaboration and extradition, medical records and data privacy, and other protections. While threats to shield providers continue, these laws continue to evolve to meet the needs of providers and fill the gaps in access to care experienced by people in states that have banned abortion.

IVF Protections

Numerous states sought to establish IVF protections, including an individual's right to receive fertility care. Georgia,[67] Nevada,[68] Virginia,[69] and Tennessee[70] were successful in enacting such statutory protections. Notably, Tennessee protects the right of a health care provider to perform and the right of an individual to receive or use not only fertility treatment but also contraceptives in the state. While these so-called "Right to IVF" laws do not alone ensure an individual has meaningful access to fertility care, they can be an important tool to better ensure individuals and providers have the right to receive and provide this critical health care, particularly in the face of increasing attacks on reproductive rights, including fertility care, across the US.

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Conclusion

So far in 2026, it is clear that reproductive health care will remain a heavily legislated issue. Access to abortion, assisted reproduction, and maternal health care are deeply interconnected, and 2025 continued to prove this. Throughout their lives, people may need access to one or more of these forms of care, and attacks on certain reproductive health services can impact access to others. As legal advocacy experts with extensive knowledge in these integrated policy issues, the Center for Reproductive Rights is committed to working alongside advocates, organizers, legislators, providers, and the public. Together, we fight for a future where all forms of reproductive health care are accessible, regardless of a person's age, identity, income, or geographic location.

For policy strategy and other technical assistance needs, legislators and advocates can email StatePolicy@reprorights.org.

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Endnotes

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