Family Planning Perspectives
Volume 27, Number 1, January/February 1997

State Actions on Reproductive Health Issues in 1996

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In 1996, state actions in such diverse areas as health care, welfare reform, education and the environment attracted national attention as they increased the states' involvement in setting the country's social agenda. Many of these initiatives were results of the federal government's giving more power and responsibilities back to the states, while in other instances, the states acted independently to assert authority over policy issues in which they had a particular interest. As has been the case in the recent past, reproductive health policy and the provision of services proved to be an area of concern to state legislators and officials in 1996. In particular, two key issues pertaining to reproductive health—abortion services and postpartum hospital stays—were the focus of a high level of legislative activity.

Although a majority of the hundreds of reproductive health-related legislative initiatives launched in 1996 were not implemented or even considered by the end of the year, significant trends emerged that heightened awareness of fertility-related matt ers and their impact on women's reproductive lives.[1] An examination of these issues and events shows the power of the states to shape reproductive health policy and to control the availability of services.

ABORTION

A majority of legislatures were confronted with the abortion issue—chiefly with attempts to limit access to services—in 1996. State lawmakers who oppose abortion were able to generate a substantial amount of debate on this subject, but they navigated an uphill road in their efforts to gain approval for restrictive measures. By the end of the year, most of the proposed antiabortion initiatives had not been voted on at the committee level. Even so, several states enacted antiabortion laws.

Mainstay antiabortion concerns—such as parental involvement in a minor's abortion decision, counseling and waiting period requirements, and funding prohibitions—continued to be emphasized; however, a new restriction, banning a specific late-term abortion procedure, was the focal point in numerous states. And for the first time in seven years, no measures were enacted to safeguard abortion clinics and providers from harassment and acts of violence. The drop in state-level activity in this area is likely attributable to a decease in the number of reported incidents against abortion providers and to the effect of the federal Freedom of Access to Clinic Entrances Act,

signed by President Clinton in 1994, in deterring violent protests outside clinics.

Late-Term Abortions

At the beginning of the year, antiabortion activists believed they had a winning strategy on the abortion issue, inundating legislative chambers with measures to ban dilatation and extraction (D&X) or place severe limits on abortion after 20 weeks' gestation. (D&X, one of the methods used to terminate late-term pregnancies, may be safer for the woman and more likely to preserve her future fertility than other abortion methods, according to some doctors who perform the procedure.[2]) Supporters of such restrictions considered them the centerpiece of the 1996 antiabortion agenda; however, by midyear, only two states had approved such bans (and no other states followed). Nevertheless, supporters were able to generate considerable debate about the procedure, which they dubbed "partial birth" abortion, and about late-term abortions in general.

The catalyst for this strategy came in 1995, when Ohio became the first state in the nation to criminalize D&X. Enforcement of that law, which also placed restrictions on abortions performed by any method after 22 weeks, was permanently enjoined by a federal court in January 1996. The judge ruled that the law was unconstitutional in that it imposed undue burdens on a woman's right to choose and was vague. The state has filed an appeal.

Taking their lead from Ohio legislators, congressional lawmakers passed similar legislation, the Partial Birth Abortion Ban Act, in March 1996. This measure prohibited D&X unless it was medically necessary to save the woman from certain death. President Clinton vetoed the legislation, saying it was not acceptable without a broader exception for medical circumstances that were not life-threatening. The House of Representatives voted to override Clinton's veto, but the Senate voted to sustain it. The measure is likely to be reintroduced in the new Congress.

Paying for Abortion

Several legislatures gave serious consideration to late-term abortion restrictions in 1996; only Michigan and Utah enacted laws. In Michigan, a measure was approved to ban abortions by D&X unless the procedure is necessary to save the life of the woma n, with no exceptions for less serious health problems or for fetal abnormalities. Opponents of the law have vowed to take it to court before its April 1997 implementation date.

In Utah, legislation was signed to prohibit physicians from performing abortions after fetal viability using either D&X or saline amnio-infusion, unless all other methods would pose a greater risk to the woman's life or health. During debate, opponents of the bill argued that D&X is used in cases where severe fetal defects or conditions threatening the woman's health are discovered too late in pregnancy for most other techniques to be used. Once the bill was amended to include the health exception, it passed with ease. This new law, which became operational in April 1996, is the only D&X ban that is currently being enforced.

Since the late 1970s, state and congressional lawmakers opposed to abortion have targeted the use of public funds to pay for abortions sought by medically indigent

women. Additionally, opponents have attacked abortion coverage for public employees and in private-sector health insurance plans.

As has been the case since 1994, 17 states use their own funds, either voluntarily or under state court order, to pay for all or most abortions for low-income women.* All other states have restrictive funding policies. During the 1995-1996 legislative term, supporters of public financing for abortion were able to fend off efforts to cut back on full funding in four of those states (California, Illinois, New York and West Virginia). However, they were not able to move additional states to this funding category.

One development in 1996 related to Medicaid funding of abortions. Since FY 1994, Medicaid law has included coverage for abortion if a pregnancy resulted from rape or incest or if continuation of a pregnancy would endanger the woman's life, and federal courts have ordered 13 states† that had policies allowing Medicaid funding of abortion only to save a woman's life to comply with the law. In August 1996, officials from one state, Arkansas, announced that they had struck a deal with the federal government whereby a privately funded, third-party payment structure will be established to pay the state's share of the cost of abortions provided to Medicaid recipients who become pregnant as a result of rape or in

cest. Arkansas stands alone with this deal to circumvent direct payment; most states have changed their laws in order to stay in the Medicaid program and avoid a lawsuit. Alabama, Mississippi and South Dakota still are not complying, but so far remain in the program. In January 1996, the Supreme Court refused to hear appeals from Nebraska and Pennsylvania of lower court rulings that they were not in compliance and were therefore ineligible for federal reimbursement.

In two states, changes were made in 1996 regarding the coverage of abortion services for public employees who are insured via a joint state-employee premium payment structure. Massachusetts had a 17-year-old ban on using state funds to pay for abortions for employees or their spouses, but new legislation was signed to allow health insurance that is partially paid for by the state government to cover abortions for state and city employees.

Restrictions on Clinics

Moving in the opposite direction, Gov. George Allen of Virginia issued an executive order eliminating health insurance coverage for most abortions for state employees and their dependents. The state's health plan now covers abortion only when the procedure is necessary to save the life of the woman, when a pregnancy occurred as the result of rape or incest, or when a physician certifies that a fetus may have an incapacitating physical deformity or mental deficiency. Similarly, Colorado, Illinois, Nebraska and Pennsylvania have long-standing laws on the books that prohibit insurance coverage for abortion in some circumstances where state funds are used or state employees are insured.

Two-thirds of private health insurance plans routinely cover abortion services;[3] nonetheless, antiabortion lawmakers have targeted the private sector to force it, by statute, to exclude coverage. In 1996, bills that would prohibit private insurance coverage for abortion unless insurees pay an extra premium advanced in New Hampshire and Washington, although neither was approved by the full legislature

before adjournment. Idaho, Kentucky, Missouri and North Dakota enforce such laws.

In 1996, three states attempted to impose clinic requirements designed to make abortions more difficult to obtain. Abortion providers have long been regulated by state and local governments, as have other outpatient facilities; increasingly, however, providers charge that they are being subjected to excessive scrutiny and micromanagement by legislators and officials.

In Mississippi, where only two abortion clinics are licensed to operate and many women therefore seek abortion services from their own doctor, stringent new regulations targeted services offered at private physicians' offices. A measure requiring that doctors who perform 100 or more abortions a year license their practices as abortion clinics and that registered nurses be hired to work in the clinics was challenged in a federal court, which let those provisions stand. However, the court invalidated a dozen other provisions. Among these, one would have barred abortion clinics from locating within 1,500 feet of churches and schools, another would have mandated the installation of emergency power systems and separate locker rooms for nurses and doctors, and the most troublesome one would have allowed the state to seize clinic medical records for license investigations without deleting information identifying patients.

The attorneys suing the state charged that while state and local governments routinely establish policies and guidelines for medical facilities, in this instance, the state was striving to make the provision of services so cumbersome and expensive as to discourage physicians from even offering abortions to their patients. As a consequence, they said, women living in rural areas or small towns far from the urban centers where the abortion clinics are located could be forced to forgo or delay having an abortion. In its ruling invalidating these provisions, the court characterized them as unconstitutional burdens on people seeking and providing abortions.

Counseling and Waiting Periods

Also in 1996, a federal court blocked enforcement of a new regulation issued by the South Carolina Department of Health that would have imposed extensive requirements on the practices of physicians who perform five or more abortions a month. (The regulation was promulgated in response to a 1995 legislative measure that singled out private-practice physicians who perform abortions in their offices.) The court held that the staffing, structural renovations, and disclosure of patient records and medical agreements the regulation mandated would cause substantial changes in terms of privacy and expense and could constitute an undue burden on women seeking abortions.

In Missouri, Gov. Mel Carnahan vetoed legislation that would have required all facilities where abortions are performed to be licensed and undergo yearly state inspections. The measure also would have required doctors to carry $500,000 in medical malpractice insurance and to have privileges in obstetrics and gynecology at a hospital near where they practice. In his veto message, the governor expressed his belief that the legislature's intent was to make abortions more difficult to obtain.

As of the end of 1996, 11 states were enforcing state-scripted, compulsory counseling, coupled with a mandatory waiting period, before a woman could obtain an abortion.[‡]

Two of these states (Mississippi and Utah) amended their laws on counseling and waiting periods in 1996, making them more stringent. In addition, one new law was approved, in Wisconsin, that would mandate face-to-face counseling with a physician, followed by a 24-hour waiting period, before any woman could obtain an abortion. The provisions are particularly strict in that they would require the woman to consult with the doctor performing the procedure, rather than with a counselor, and would preclude counseling over the phone. A federal court enjoined enforcement of the law, pending a full hearing to determine whether it is constitutional.

Parental Involvement

Although the amended laws in Mississippi and Utah also mandate in-person counseling, most other laws allow counseling to be conducted over the phone so the woman does not have to make a separate visit to receive the information. Antiabortion legislators now contend that telephone consultation is a "loophole" that allows abortion providers to make short shrift of the prescribed counseling sessions.

A majority of the proposed bills on counseling and waiting periods introduced in the states in 1996 died without being considered before legislatures adjourned for the year. California lawmakers, however, defeated a measure partly because it prescribed that counseling include information on the potential association between breast cancer and abortion.

As of the end of 1996, 26 states were enforcing parental involvement laws for minors seeking abortion services.§ Traditionally, parental consent or notification laws usually have permitted a minor to bypass parental involvement only by obtaining a judicial waiver. A recent trend associated with consent or notification requirements has been to make them less onerous by allowing a minor to seek the involvement of a grandparent or other adult family member. A new one-parent notification law approved in Iowa in 1996 reflects this trend by also authorizing notice to a grandparent, an adult aunt or uncle, or an adult sibling instead of a parent. By contrast, an Arizona law approved last year did not make such an allowance; in fact, legislators defeated attempts to broaden the category of family members who could provide consent. A federal court invalidated the Arizona statute on constitutional grounds, since it did not provide a specific time limit for granting the judicial waiver to ensure a speedy review of the minor's petition.

As was the case with measures requiring counseling and waiting periods, most of the proposed parental involvement bills died without being considered before legislative sessions ended for the year. Legislators who support minors' ability to obtain confidential abortion services were successful in rejecting notice and consent bills in Alaska, New Hampshire and Virginia.

Several legal actions in this area in 1996 had a range of consequences. A federal district court blocked enforcement of Tennessee's two-year-old law requiring minors to obtain either the consent of one parent or a judicial waiver of the consent requirement. The court ruled that the process of applying for a judicial waiver created too much of a delay. In another case, a federal appeals court affirmed a lower court ruling that invalidated a 1995 Montana statute requiring a minor to notify one parent at least 48 hours before the procedure. As with the Tennessee lawsuit, the appeals court opinion

focused on a technicality concerning the law's judicial bypass procedure. The court found that the grounds on which a minor could seek a waiver were narrower in the statute than in the broader standard established by the U.S. Supreme Court, rendering Montana's law unconstitutional.

In a blow to minors' access to abortion, the California supreme court upheld the state's one-parent consent law, the enforcement of which had been enjoined for eight years. Previous lower court rulings held that under the state constitution, minors have the same privacy rights as adult women seeking abortion, thereby granting women younger than 18 the right to make the abortion decision. The state supreme court has agreed to reconsider its ruling; in the meantime, implementation of the law remains on hold.

By contrast, the U.S. Supreme Court refused to review a decision that invalidated South Dakota's 1994 one-parent notification law, which does not have a judicial bypass procedure. In allowing the decision to stand, the Supreme Court may have effectively put to rest a major question in abortion notification litigation. Although the Court had never before ruled on whether a one-parent notice law must provide a bypass mechanism, it has said that parental consent and two-parent notice laws must have a judicial bypass; lower courts have consistently assumed that the Supreme Court's reasoning in those cases would apply to one-parent notice laws as well.

FAMILY PLANNING

To make family planning services available and affordable to the largest number of women in need of them, officials and legislators in several states approached the issue from two directions last year: They sought to expand eligibility for publicly funded family planning services under the Medicaid program and to mandate private-sector insurance coverage of contraceptive services and supplies. The former approach was successfully implemented in five states, while the latter was rejected at nearly every turn. In addition, California created a fully state-funded entitlement to family planning services for low-income women.

Medicaid Expansions

Since 1993, 12 states have sought federal permission to establish family planning expansion programs under Medicaid. All of these demonstration programs are designed to be funded with a combination of federal and state dollars. Because of federal involvement, states must file waiver applications and obtain consent from the federal Health Care Financing Administration, the agency that administers the Medicaid program, before implementing a demonstration program. Programs in two states (Delaware and Illinois) received approval in 1996, and three others (Maryland, Rhode Island and South Carolina) had been approved in previous years. Approval is pending for programs in seven states (Arkansas, Michigan, Missouri, New Mexico, New York, Texas and Washington), and South Carolina has a second application pending to expand its demonstration program.

Of the five approved programs, all but Delaware's have linked their family planning provisions to the Medicaid expansions enacted in the 1980s to establish eligibility for pregnant and postpartum women with incomes up to 133% of the federal poverty level. These four states have received permission to extend eligibility for family planning

services to as long as five years postpartum (well past the normal 60-day postpartum termination date), and to further expand their income criteria (in one case, to 250% of the poverty standard).

Insurance Coverage

The program in Delaware utilized a different approach. The state received permission to extend Medicaid coverage for family planning services for two years following the termination of regular Medicaid benefits for any reason. This demonstration program is a breakthrough, as it is the first not to tie its family planning expansion to the Medicaid expansions for pregnant and postpartum women, although these women will be covered along with all other Medicaid enrollees who lose their coverage.

Choosing a very different route to expand services, California committed its own revenues to establish an entitlement to a broad package of family planning services for all women with incomes between the regular Medicaid ceiling (86% of the federal poverty level) and 200% of the poverty level. The state legislature approved, and Gov. Pete Wilson signed into law, this dramatic expansion of eligibility for family planning services through Medi-Cal (the state's Medicaid program). The initiative builds on a long-established state tradition of providing Medi-Cal coverage to individuals with incomes well above levels permitted in the joint federal-state program. (Since only state dollars are used to provide care, federal approval was not needed.)

No state mandates coverage for prescription contraceptives, and several long-standing gaps exist in coverage: Almost half of typical large-group plans do not routinely cover any contraceptive method, and only 15% cover all five major reversible prescription methods (IUD, diaphragm, implant, injectable and pill). The most commonly used reversible prescription method, the pill, is routinely covered by only 33% of large-group plans.[4] During the 1995-1996 legislative term, measures to require coverage were proposed, but not enacted, in seven states (California, Hawaii, Illinois, New York, Oregon, Virginia and Wisconsin). Advocates for mandatory contraceptive coverage charge that many legislators who have expressed reluctance in general to impose government mandates on health insurers are partisan in applying this philosophy, since they have endorsed mandates to extend postpartum hospital stays.

All of the bills proposed last year would have required that private insurance policies cover contraceptive services and supplies, generally with the same cost-sharing requirements as for other covered services. In four of the states, benefits for contraceptive services would have been extended not only to employees insured under group plans but also to their dependents.

Most of the measures saw no action during the last legislative term. However, the California legislature approved its bill in late 1995, only to have it vetoed by the governor; similar legislation was reintroduced in 1996, but did not advance before adjournment. A measure pending before the Virginia legislature would require private health insurance policies that offer coverage for prescription drugs to include prescription contraceptives. Sponsors and backers of the bill acknowledge that it has little chance of passage during the 1997 session. Instead, their long-range strategy to win approval is twofold: They seek to create awareness of the cost-effectiveness and social benefit of preventing unplanned pregnancies, and to show that inequitable

prescription drug policies drive contraceptive costs beyond the reach of many women. Health insurers in Virginia, as in other states, have said they are opposed to any mandates because they believe the market should determine the type and extent of coverage.

Maternal and Child Health

State and federal lawmakers alternated taking the lead on two key issues concerning maternal and child health in 1996: postpartum hospital stays for mothers and newborns, and the testing of infants for the human immunodeficiency virus (HIV). Legislative and regulatory efforts to require insurance coverage of extended postpartum hospital stays for mothers and newborns easily won approval in state after state in 1996. On the coattails of this movement, federal legislation was enacted late in the year with language crafted so as not to preempt the majority of state laws in this area.

In contrast, there was limited state activity in 1996 on the issue of HIV testing of mothers and infants. However, the number of actions increased from the previous year, apparently in response to new federal directives—HIV counseling and testing guidelines issued in 1995 by the Centers for Disease Control and Prevention (CDC), and a newborn testing provision enacted by Congress as part of the Ryan White CARE Act.**

Postpartum Hospital Stays

Few issues have seen the flurry of legislative activity that the topic of "drive-through deliveries" has generated since 1995. Under managed care, which is increasingly viewed by both the private and the public sectors as an antidote to rising health care costs, the standard discharge time for an uncomplicated birth is 24 hours. Advocates for maternal and child health have argued, however, that more time is needed for the mother's recuperation and to ensure that the baby is well enough to go home. The new laws generally require that health insurance plans and health maintenance organizations cover minimum hospital stays of 48 hours for uncomplicated vaginal births and 96 hours for cesarean sections.

HIV Testing of Mothers and Infants

The legislative brushfire began in mid-1995, when in rapid succession, five states passed measures to extend postpartum hospital stays for mothers and newborns. In 1996, another 24 states followed suit, with maternal and child health advocates meeting very little resistance from legislators or the insurance industry. In three other states, lawmakers, health insurance commissioners, insurance companies and health maintenance organizations brokered voluntary agreements whereby insurers consented to adopt a recommended length of stay in lieu of a legislative mandate. By the end of the year, 32 states had minimum postpartum hospital stay requirements.*† Legislation was acted on, but not given final approval, in five states (California, Hawaii, Utah, West Virginia and Wisconsin).

On the federal level, in the face of protests from those who were opposed to a federal insurance mandate, Congress enacted the Newborns' and Mothers' Health Protection Act. Following the same formula adopted at the state level, this law requires all insurers

to cover hospital stays of at least 48 hours for a normal delivery and 96 hours for a cesarean delivery. State laws meeting one of three criteria set forth in the federal law will not be preempted;*‡ virtually all of the state statutes should remain in effect. Also affected by this action are the Federal Employees Health Benefits plans and the federal portion of Medicaid. While the new law does not amend these programs, its postpartum requirements apply to health plans providing services through contracts with them. The effective date of the law is January 1998, giving an advisory panel of the U.S. Department of Health and Human Services (DHHS) time to study a number of the statute's provisions.

Although the issue of testing mothers and infants for HIV saw legislative action in only a handful of states in 1996, the debate promises to reach many more state capitals in 1997 as policymakers race to safeguard their share of federal AIDS dollars. Under the latest federal reauthorization of the Ryan White program, a total of $10 million will be given to the states to help them comply with CDC recommendations regarding voluntary counseling and testing of pregnant women, as well as to help them collect and report to the CDC data related to perinatal transmission. In four years, after DHHS has assessed the extent to which HIV testing of infants has become standard medical practice, each state must be able to demonstrate either that it has reduced the incidence of perinatal transmission by at least 50% since 1993 or that at least 95% of women who received prenatal care were tested for HIV. States failing to meet either criterion will have to institute mandatory HIV testing of newborns, or else forfeit federal AIDS funds.

Critics of the testing provisions say that given such a strong federal directive, states will be hard-pressed not to require the routine HIV testing of all infants, thus diverting resources from financially strained prevention and treatment services. Moreover, mandatory testing of a newborn infant amounts to mandatory testing of the mother, they say, violating her right to informed consent and possibly jeopardizing her right to confidentiality. Women's groups, health professionals and civil rights groups maintain that the emphasis should be on voluntary counseling and testing of women during pregnancy, when perinatal transmission of the disease can be prevented.

SEX EDUCATION

Delaware and New York tackled this issue last year by enacting new requirements. The Delaware law directs health professionals providing prenatal care to counsel their pregnant patients about HIV and AIDS, and offer to perform the test at that time. Women have the right to refuse testing, but they must sign a written waiver that will become part of their permanent medical record. (California, New Jersey and Virginia had instituted similar statutes in previous years.)

In New York, Gov. George Pataki signed legislation in 1996 giving the state health commissioner unprecedented authority to implement a comprehensive program for the testing of newborns for the presence of HIV. Opponents decried the measure's focus on mandatory testing, its lack of regard for a woman's right to give informed consent and its failure to mention the need for additional funds for prenatal care or for services for families in which a woman or her newborn tests positive for HIV.

While many state lawmakers remain torn over the precise role schools should play in

combating high rates of teenage pregnancy and sexually transmitted diseases, including HIV, most support some form of school-based sex education. Contributing to their uncertainty about schools' involvement is division among public officials, school boards and parents over whether schools should provide comprehensive programs that encourage abstinence but also include instruction on contraception and disease prevention, or should focus narrowly on abstinence education. Over the years, the comprehensive approach has been instituted in most schools with sex education programs, but not without controversy. In the last 2-3 years, this approach has come under renewed attack by conservatives, who by and large support "abstinence-only" sex education.

CONCLUSIONS

Some 22 bills addressing school-based education on sexuality and sexually transmitted diseases advanced in 1996. Half of these would have increased parental involvement or would have anchored programs to an approach emphasizing abstinence until marriage; the other half would have created or expanded such programs. By the end of the year, bills had been enacted in Florida, Massachusetts and Rhode Island.

In Florida, lawmakers authorized the award of incentive grants to public schools wishing to implement AIDS education activities. The law details the criteria that will be used to award the competitive grants, but does not specify what type of programs—classroom-based or otherwise—will be supported. The new Massachusetts law requires that public school students obtain parental consent to participate in sex education classes. In Rhode Island, a new law amends the state's AIDS education statute to allow parental review of educational curricula and materials, and to permit parents to remove their children from such courses.

Public debate on matters pertaining to reproductive health issues is a difficult and complex process; over the years, it has resulted in an ever-changing, scattered mix of policies. In 1996, there was minimal movement overall toward ensuring access to the full range of reproductive health care services to all those who want and need them. There was no significant backtracking in this area either, despite the predominance of conservative strongholds in a majority of state legislatures. Two new bright spots emerged, though: California's breakthrough initiative guaranteeing low-income women access to family planning services and the broad show of support across the country to protect women's health after childbirth.

In 1997, as the new legislative session gets under way and as new administrations take over in a majority of the states, the controversy over late-term abortions will be the focal point of the attack on abortion rights. As a consequence of recent debate at the state and federal levels over banning the D&X procedure, lawmakers on both sides of the abortion issue are once again struggling with years-old controversies regarding the legal and ethical ramifications of abortions performed around or after the point of fetal viability.

Antiabortion activists have vowed to pursue legislative bans on D&X abortions with even greater intensity in 1997, which undoubtedly will lead to wide-ranging discussions and actions on late-term abortions, opening floodgates that may prove very difficult to close. This could be the case particularly if moderate lawmakers continue to express

misgivings about the availability of abortion late in pregnancy.

In addition, most, if not all, of the states will be confronted with policy debates concerning the implementation of welfare reform. Some of these discussions may lead to initiatives that could have a profound impact on women's reproductive health. Although states have been overhauling their welfare programs for several years—instituting special demonstration programs with the federal government's approval—the new federal welfare law, signed in August 1996 by President Clinton, has set in motion a revolution for the states. This historic reform law eliminated Aid to Families with Dependent Children, the 60-year-old entitlement to public assistance, and replaced it with a block-grant cash assistance program to the states, called Temporary Aid to Needy Families. States have until July 1, 1997, to submit their plans to the federal government on how they intend to use their block-grant money to help needy families. While the states now have much more authority to establish standards and policies, it is not known if the national trend will be to institute drastic changes immediately, continue existing programs or expand demonstration programs.

This complex and sometimes ambiguous law has among its stated purposes a reduction in the incidence of out-of-wedlock childbearing and the promotion of two-parent families. The federal law provides a financial incentive for states to reduce their number of out-of-wedlock births (to all women, not just to teenagers or to women on welfare) from that of the previous two years. A $20 million bonus will be provided to states that do so and can demonstrate that the number of abortions has not increased since FY 1995.

The states have many options in terms of what kinds of programs they can establish to try to lower nonmarital childbearing. However, the new law no longer requires states to make family planning services available to welfare recipients, and block-grant funds may not be used to pay for medical care except "prepregnancy family planning services." Two options that conservative lawmakers support are to cut off increased cash payments to families that have additional children while receiving welfare and to emphasize abstinence outside marriage. While neither of these provisions has been shown to reduce out-of-wedlock fertility, the federal law sanctions both and allocates $50 million to abstinence education.

During the upcoming debates on abortion, family planning and welfare reform, state legislators and officials need to be made aware of the importance of supporting public policies that promote the teaching of sex education and that enhance the ability of women to manage their childbearing goals. Ensuring women's access to services that can enable them to prevent unintended pregnancies and unwanted births on a voluntary basis is imperative, not only to protect their well-being and promote self-sufficiency, but also as a cost-effective way of dealing with the myriad problems associated with unplanned pregnancy, unwed motherhood, teenage pregnancy and welfare dependency.

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3. The Alan Guttmacher Institute, *Uneven and Unequal: Insurance Coverage and Reproductive Health Services,* New York, 1994.

4. Ibid.

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

†Arkansas, Colorado, Illinois, Kentucky, Louisiana, Michigan, Missouri, Montana, Nebraska, North Dakota, Oklahoma, Pennsylvania and Utah.

‡Idaho, Kansas, Louisiana, Mississippi, Nebraska, North Dakota, Ohio, Pennsylvania, South Carolina, South Dakota and Utah.

§Alabama, Arkansas, Delaware, Georgia, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, North Carolina, North Dakota, Ohio, Pennsylvania, Rhode Island, South Carolina, Utah, West Virginia, Wisconsin and Wyoming.

**The Ryan White program provides funds to cities and states for health care and support services for HIV-infected individuals and persons with AIDS.

*†Alabama, Alaska, Arizona, Colorado, Connecticut, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Virginia and Washington.

*‡Generally, state laws will not be preempted if they require coverage for at least 48 hours after uncomplicated vaginal deliveries and 96 hours after cesarean deliveries, coverage of all services the attending physician deems medically necessary, or coverage that is consistent with guidelines established by the American College of Obstetricians and Gynecologists.