

Beyond Roe

The State of Sexual and Reproductive Healthcare in New York State

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Abortion is one of the most pressing issues in today's political arena, especially in light of the election of President Donald Trump and the shifting ideological balance on the United States Supreme Court. During the final 2016 presidential debate, then-candidate Trump was asked if he wanted to see *Roe v. Wade* overturned. He responded, "If we put another two or perhaps three justices on [the Supreme Court], that's really what's going to be — that will happen.... I am putting pro-life justices on the court."¹

As a presidential candidate, Donald Trump made it clear he wanted to appoint justices who would overturn *Roe v. Wade*. In an interview with Bill O'Reilly, he went so far as to say that the "biggest way you can protect [life] is by electing me president." Trump's emphasis on pro-life justices proved to be especially important to win over conservative voters who were cautious of the untraditional candidate. Notably, a poll conducted by *The Washington Post* revealed that 26 percent of all Trump voters expressed the basis of their decision was the Supreme Court.²

Once President Trump was officially elected, widespread concern over the fate of *Roe v. Wade* proliferated. In New York, various elected officials raised alarms. New York Senator Kirsten Gillibrand stated that "We are on the brink of not having reproductive freedom in the country," and framed the nomination of Brett Kavanaugh to the Supreme Court as the biggest threat to women's rights in her lifetime.³ New York Governor Andrew Cuomo said that "rights are under attack in Washington," referencing *Roe v. Wade*, and even proposing a state constitutional amendment to protect legal abortion, which garnered support from the New York Civil Liberties Union.⁴

Ultimately, if the Supreme Court overturns *Roe v. Wade*, the decision to legalize abortion would return to the states. In Republican-led states, lawmakers stand poised to implement sweeping bans on abortion, as in Ohio where lawmakers just approved a bill banning abortion after a fetal heartbeat is detected.⁵ However, it is unlikely that New York and other more progressive states will follow suit. The notion that *Roe*'s reversal will end abortion as we know it is therefore inaccurate, though there are problems policymakers must address.

At the same time, although a federal right to an abortion was established by the Supreme Court, it has not been evenly or uniformly applied among the states — many states have been chipping away at *Roe* for decades, placing restrictions on when, where, and how abortions are provided, while others have opted to maintain broad access. To better understand what's at stake in the current controversy over abortion rights, a more careful analysis of *Roe*'s legacy is needed.

In this report, we analyze changes in the law since *Roe v. Wade* was decided, discuss their implications for women's access to abortion, and draw attention to a wider set of issues surrounding women's reproductive health. To gain a better understanding of New York's reproductive landscape, we conducted interviews with local abortion providers, crisis pregnancy centers, political organizers, and government officials (see the [Appendix](#)). Ensuring women have the freedom to make their own reproductive health decisions, preventing unwanted pregnancies in the first place, and developing practical tools to improve parenting skills can decrease the need for abortion in New York State and help support healthy families.

Abortion in a Post-*Roe* World

The Supreme Court affirmed a woman's right to choose as a constitutional right in 1973 with the decision of *Roe v. Wade*. The 7-2 decision was the first to grant women the right to an abortion based on a trimester framework. During the first trimester, or first three months of pregnancy, the state could not enact any laws regulating abortion. At this time, abortion was considered a safe and simple procedure, therefore, a woman had the right to terminate the pregnancy with no involvement from the state. The second trimester began at week fourteen and ended at week twenty-seven, before the fetus is considered "viable," or able to live outside the womb. During the second trimester, states could enact laws regulating access to abortion, but only to the extent necessary for protecting the life and health of the mother. Finally, the third trimester began at the twenty-eighth week of pregnancy when the fetus becomes "viable." At this stage, the state has a "compelling" interest in protecting the life of the fetus and, therefore, could restrict or even prohibit abortions, except when the health of the woman is at risk.

Roe constitutes the basis of a woman's right to choose, but subsequent decisions have eroded access to safe and legal abortion in the United States.

Although *Roe v. Wade* afforded woman a degree of reproductive autonomy during the first trimester, Ruth Bader Ginsburg has observed that the decision "ventured too far in the change that it ordered," stimulating the mobilization of a right-to-life movement

and procuring a legislative backlash at the state and federal level.⁶ Enacted in 1976, just three years after *Roe*, the Hyde Amendment blocked federal Medicaid funding for abortion services. In upholding the statute, the Supreme Court ruled, in *Harris v. McRae* (1980), that *Roe* did not require the government to provide funds for abortion. “The financial constraints that restrict an indigent woman’s ability to enjoy the full range of constitutionally protected freedom of choice are the product not of governmental restrictions on access to abortions, but rather of her indigence.”⁷

As a result of *Harris*, access to abortion was severely restricted for poor women. Currently, thirty-four states and the District of Columbia do not provide Medicaid funding for abortions, except in cases involving life endangerment, rape, and incest.⁸ Studies show that the prohibition on funds forces 18 to 37 percent of women on Medicaid to carry a pregnancy to term, a disproportionate number of whom are African American.⁹

The Court initiated a further rollback of *Roe*’s protections in 1992. In *Planned Parenthood of Southeastern Pennsylvania v. Casey*, the Court reaffirmed *Roe*’s “essential holding” that a women’s right to abortion was secure before fetal viability. However, it upheld most of the restrictions in Pennsylvania’s 1989 Abortion Control Act, including parental notification for minors and a twenty-four-hour waiting period. In reaching its decision, the Court threw out *Roe*’s trimester framework and replaced it with the “undue burden” standard. Under this new standard, states could impose regulations on abortions any time prior to the viability of the fetus, so long as such measures did not place a “substantial obstacle in the path of a woman seeking an abortion.”

Casey had two effects. First, the progressive approach wherein women bear the right to privacy and freedom to make personal decisions without an undue burden was rescinded. At no point under the undue burden test is a woman autonomous from the state regarding her right to choose. Second, scholars have criticized the decision because although it reaffirmed *Roe*’s central holding, it seemed to invite states to test whether restrictive abortion laws constituted an undue burden.¹⁰ As then-Chief Justice William Rehnquist observed, *Casey* actually cut “back the protections afforded by *Roe*.”

Since 1992, antiabortion forces have sought to challenge the definition of an undue burden in court. In *Gonzalez v. Carhart*, for example, the Supreme Court upheld the Partial-Birth Abortion Act of 2003, a federal statute prohibiting intact dilation and extraction. Despite the act missing an exception for maternal health, the Court upheld the statute based on evidence provided by Congress that a partial-birth abortion “is never medically necessary.”¹¹ Although many medical professionals disagreed, the Court declared that “medical uncertainty” over the health risks imposed by the law



Supreme Court Justice Ruth Bader Ginsburg

was “a sufficient basis to conclude ... that the Act does not impose an undue burden.”¹² As Justice Ginsburg noted in her dissenting opinion, *Gonzalez* was the first time since *Roe v. Wade* that the Court did not require an exception for the health of the woman.

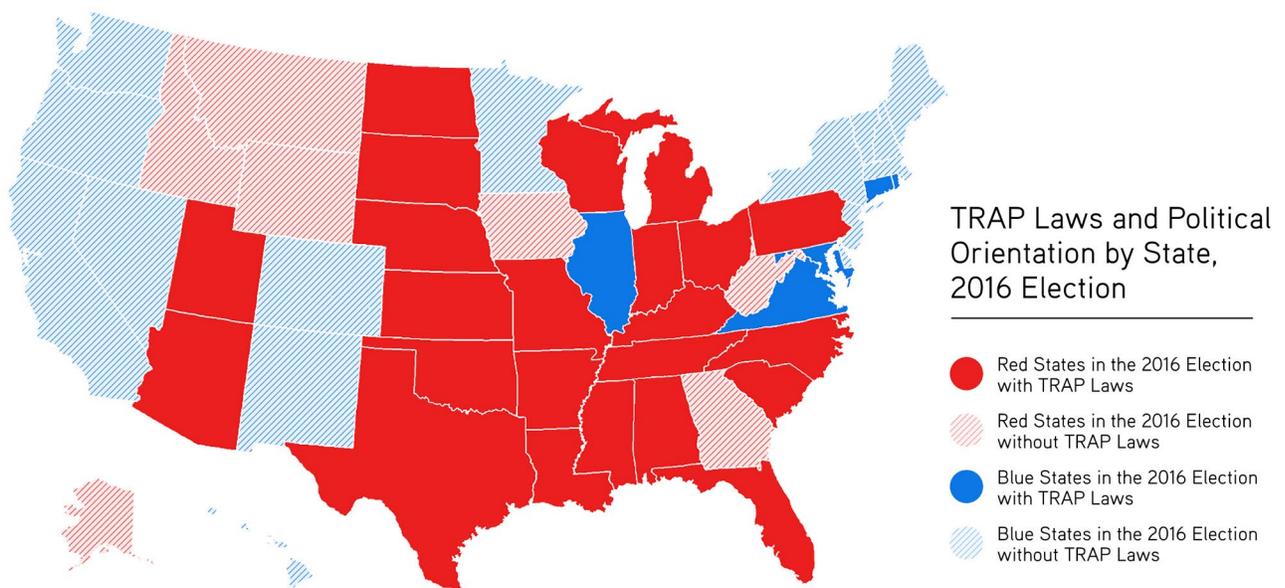
Scaling Back *Roe*: Targeted Regulations of Abortion Providers

The legal standard of undue burden remains vague and therefore open to case-by-case interpretation. Because of its subjectivity, nearly half the states have imposed access-barriers, also known as Targeted Regulations of Abortion Providers (TRAP), which aim to restrict abortion despite it being legal. In the words of one provider we spoke to — “Whether *Roe* gets overturned is irrelevant if my state has already restricted access.”¹³

TRAP laws are typically passed in red/conservative and swing states, with the exception of states like Maryland, Connecticut, and Rhode Island (see [Figure 1](#)).¹⁴ New York, by comparison, is a safe haven from TRAP laws. In essence, although abortion is considered a constitutional right, [Figure 1](#) illustrates that access to abortion has been severely limited in many parts of the country.

Three types of TRAP laws exist: those that apply to facilities, those that operate as requirements on clinicians, and those that apply directly to women.¹⁵

FIGURE 1. Targeted Regulations of TRAP Laws



Source: Authors' analysis of data from the Guttmacher Institute.

Facility Requirements

With respect to facilities, multiple states “have specific requirements for procedure rooms and corridors, as well as requiring facilities be near and have relationships with local hospitals.” For example, nine states “specify the size of the procedure rooms,” eight states “specify corridor width,” and nine states “require abortion facilities to be within a set distance from the hospital.” Six states go beyond the set distance standard, “requiring each abortion facility to have an agreement with a local hospital in order to transfer patients in the event complications arise.”¹⁶ In Texas, the requirement that abortion providers have admitting privileges at a hospital within thirty miles caused the number of abortion clinics to decline from forty-two to nineteen.¹⁷

The same dilemma presents itself when abortions must be performed in facilities that meet the states’ standards for ambulatory surgical centers (ASC) and other sophisticated healthcare facilities. ACS regulations typically encompass standards for infrastructure, staffing, administration, and quality improvement that are far more onerous than the ones imposed on outpatient clinics or physicians’ offices. Yet there is no evidence that they improve health outcomes in cases of abortion. To the contrary, “the corresponding effect of the laws and physicians’ response to them has been to hinder (and possibly preclude) timely access to safe and legal abortion services” because it is simply too costly for providers to comply.¹⁸

Clinician Requirements

A second type of TRAP law regulates abortion providers themselves, oftentimes “beyond what is necessary to ensure patient safety.”¹⁹ These include onerous licensing standards and reporting requirements, often upheld by the courts. In *Mazurek v. Armstrong* (1997), for example, the Supreme Court upheld a statute restricting abortions to licensed physicians in Montana, even though the state’s most active provider was a physician’s assistant. In other states, providers must have admitting privileges at local hospitals or be board-certified obstetrician-gynecologists. In Mississippi (one of the only states with an OB/GYN certification requirement), “99% of counties had no clinics that provided abortions, and 91% of women lived in those counties.”²⁰

Women-Protective Restrictions

Some TRAP laws operate directly on women under the pretense of protecting them. For example, twenty-nine states implemented informed consent statutes.²¹ In extreme cases, such as South Dakota, physicians must warn women of risks such as psychological distress and suicide, and provide a written statement that the abortion “will terminate the life of a whole, separate, unique living human being.”²² Consistent with the logic in *Carhart* that the government “has an interest in ensuring so grave a choice is well informed,” proponents have argued that such laws facilitate informed decision-making. However, presenting biased information can ultimately dissuade women from having an abortion. According to one study, 31 percent of the statements made on informed consent materials regarding fetal development were medically inaccurate.²³

Beyond informed consent laws, over half of the states (twenty-six) require women to either receive information on accessing ultrasound services, or be provided the opportunity to have one. Louisiana, Texas, and Wisconsin are among the three states whose laws include provisions requiring providers to display and describe the image to the pregnant woman prior to an abortion. As the Guttmacher Institute has observed, such “requirements appear to be a veiled attempt to personify the fetus and dissuade a woman from obtaining an abortion” because ultrasounds are not considered medically necessary during the first trimester.²⁴

Religious Exemptions

Religious exemptions pose yet another access barrier, particularly regarding contraception. In *Burwell v. Hobby Lobby* (2014), the United States Supreme Court held that the contraceptive mandate issued by the Department of Health and Human Services did not apply to religious-based employers. As a result, for-profit corporations can refuse to provide contraception coverage to their employees, forcing women to pay out of pocket for birth control. Justice Ginsberg dissented in the case, reasoning that the exemption prevented women from accessing contraceptive care and jeopardizing their overall health and well-being. Between January 2014 and March 2016, the Center for American Progress found that forty-five employers requested a religious exemption under *Hobby Lobby*, including from industries not traditionally thought of as faith-based; e.g., apparel, construction, real estate, and tax services.²⁵

In light of President Trump’s recent appointments to the United States Supreme Court, concern over abortion rights continues to proliferate and states continue to pass additional restrictions. However, primarily focusing on *Roe* obscures a constant attack on a woman’s right to choose after the decision was handed down. Our analysis illustrates how legal precedents since the 1970s have paved the way for the implementation of TRAP laws and other access barriers, putting the lives, health, and autonomy of women at stake. As one provider put it: “[W]hen the barriers become so much, and the health centers can’t afford to stay open, and the patients can’t afford to get the care, it doesn’t really make any difference whether they have *Roe*. They can’t get an abortion anyway.”²⁶

Our analysis also suggests that some states have more to lose than others if *Roe* is overturned. For example, Mississippi, Louisiana, North Dakota, and South Dakota have enacted trigger laws, which will automatically ban abortion in the case of a reversal.²⁷ Yet access to the procedure is relatively safe in New York State. As one constitutional scholar observed recently, “the New York Constitution and statutes already protect abortion rights in many of the same ways as the current federal constitutional precedents.”²⁸ If President Trump fulfills his campaign promise, and the Supreme Court overturns *Roe*, what, then, will that look like in New York?

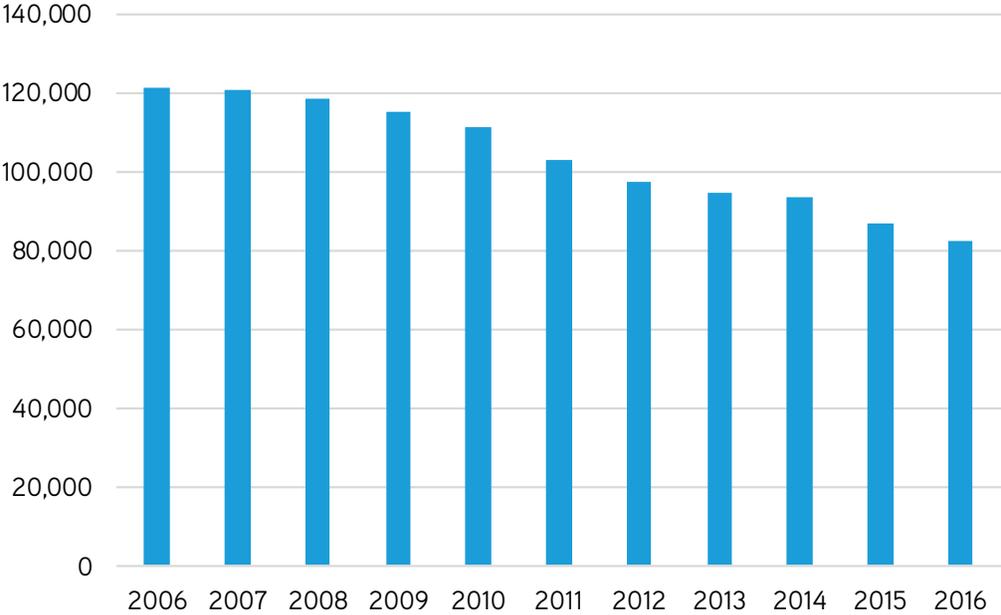
The Local Conversation: Sexual and Reproductive Healthcare in New York State

New York has been one of the most progressive states in protecting reproductive rights, including abortion. New York was one of only four states to legalize abortion before *Roe*, “within 24 weeks of pregnancy and at any time if the woman’s life was at risk.” As a result, women from neighboring states, including Pennsylvania and New Jersey, flocked to New York for abortion services. Between 1970 and 1972, out-of-state residents obtained nearly 400,000 abortions in New York, or about two-thirds of all abortions performed in the state.²⁹

In addition, because of policies that allowed for increased contraceptive use, research suggests that abortion rates have fallen generally in the United States from a high of 29.3 per 1,000 women in 1980-81 to 14.6 per 1,000 women in 2014.³⁰ In New York, the number of abortions decreased more than 32 percent, from 121,278 abortions in 2006 to 82,189 abortions in 2016 (see [Figure 2](#)).

Because New York was one of the first states to make abortion legal prior to *Roe*, the state has taken steps to develop policy consistent with the constitutional ruling. Even though existing state law bans abortions after twenty-four weeks, the state attorney general released a formal legal opinion in 2016, stating that a woman’s reproductive decisions cannot be diminished by New York’s Penal Law.³¹ In other words, the state must make exceptions in cases involving the mother’s health or an unviable late-term fetus. “We’re fortunate here in New York State,” one provider told us, “even though it’s not perfect.”³²

FIGURE 2. Total Number of Induced Abortions in New York State, 2006-16

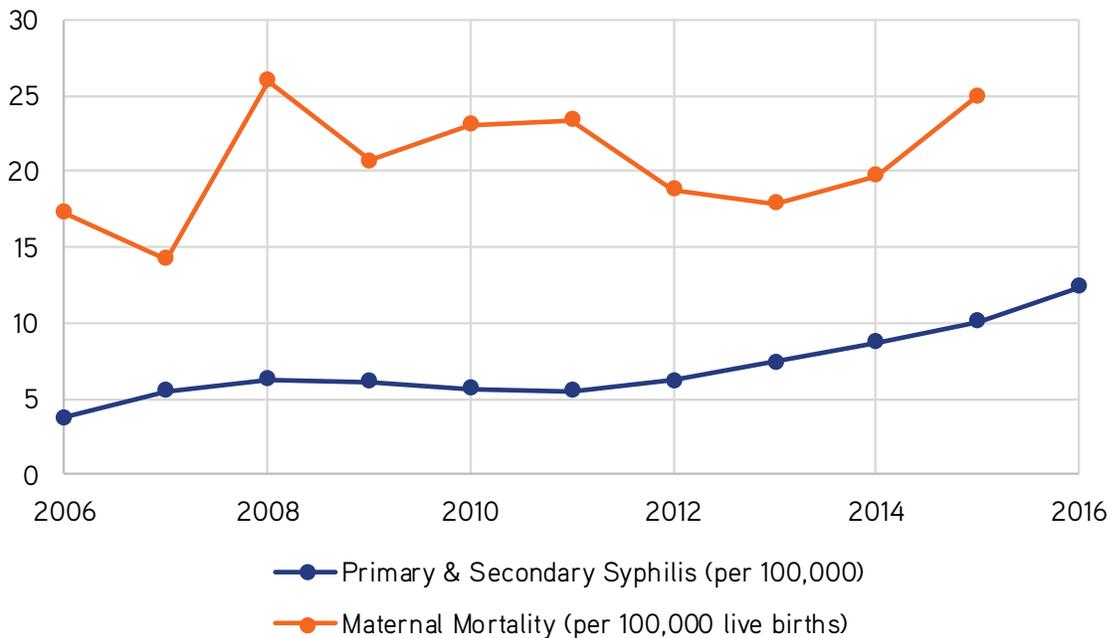


SOURCE: Authors’ analysis of NYS Department of Health Data in “Vital Statistics of New York State,” NYS Department of Health, revised September 2018, https://www.health.ny.gov/statistics/vital_statistics/.

Roe’s reversal will not have the same deleterious impact on New York State as on other states, but lawmakers must address myriad issues affecting women’s reproductive health. Indeed, the occurrence of maternal mortality and sexually transmitted infections such as syphilis are on the rise in New York State, which suggests there is still more work to be done (see [Figure 3](#)). “Rensselaer County has a horrible syphilis issue” one provider told us, “and the Department of Health really believes it’s related to the hit that Planned Parenthood has taken.”³³

Even though formal legal access to abortion remains secure, several structural barriers continue to restrict access to sexual and reproductive health services in New York State.

FIGURE 3. New York State Maternal Mortality and Syphilis Rate, 2006-16



Authors’ analysis of CDC’s AtlasPlus Data and NYS Department of Health Maternal Mortality Rates.

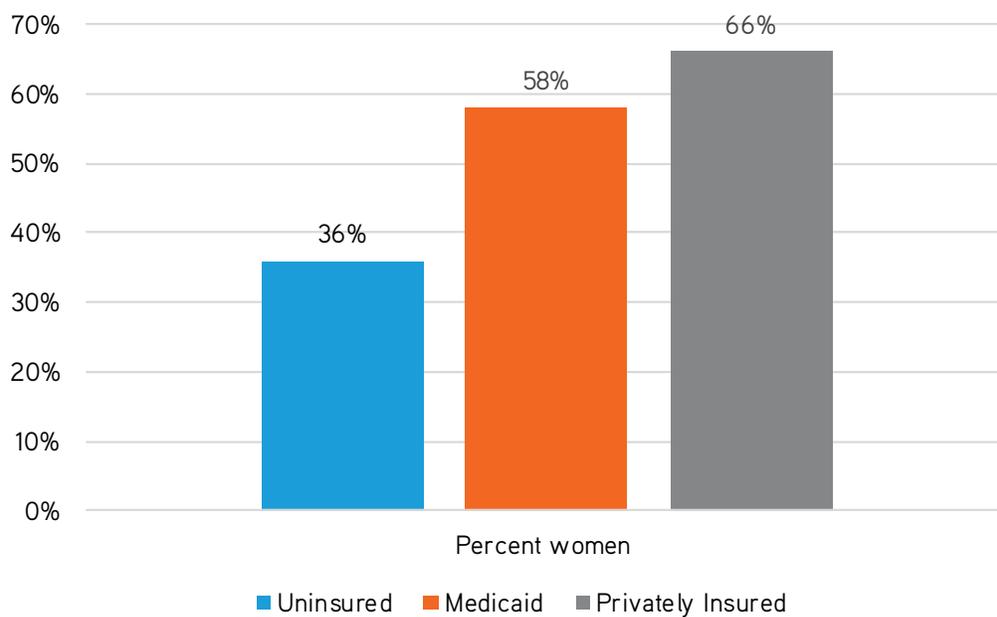
Insurance Coverage

The question of healthcare coverage for women is especially important in understanding access to reproductive services because it is a decisive factor in determining if a woman can afford care.

In 2018, 8 percent of women in New York aged eighteen to forty-four were uninsured, not covered by either private or public insurance.³⁴ Although this is lower than the national average of 12.2 percent, it still means that thousands of women are paying out of pocket not only for abortion but for all reproductive services.

Lack of insurance can lead women to delay or skip reproductive care. For example, uninsured women are more likely to avoid gynecological and obstetric visits. According to the Kaiser Family Foundation, 36 percent of uninsured women made gynecologic or obstetric visits in 2017, compared to 66 percent of privately insured women and 58 percent of women on Medicaid (see [Figure 4](#)).³⁵ Part of the reason is because uninsured women do not anticipate being treated. “It must be a little unnerving,” one family support worker explained. “A lot of times when you go to the doctor’s office, even if it’s like a clinic setting, the first thing they ask you for is your insurance card. And I think that scares the living bejesus out of a lot of people.”³⁶

FIGURE 4. Gynecologic or Obstetric Visits among Women Age Eighteen to Forty-Four, 2017



SOURCE: Authors’ analysis of data from the Kaiser Family Foundation.

Medicaid provides a variety of reproductive health services to the poorest Americans, including Sexually Transmitted Infections (STI) testing, prenatal and postnatal services, and birth care. Unlike many other states, in New York, Medicaid covers abortions that are “medically necessary.” However, financial requirements shut out a large chunk of New Yorkers who are still struggling with incomes just barely above the threshold for eligibility. For example, to be Medicaid eligible, a single, nonpregnant woman seeking reproductive care such as birth control or STI testing must earn \$16,754 annually, which is a mere \$4,500 above the poverty threshold.³⁷ Since the income limit is extremely low, Medicaid serves only a small sector of New York’s poor.



Connecting to Services

One of New York’s distinguishing features is the amount of services that exist to inform and support women during their pregnancies, as well as foster healthy families. In particular, the New York State Department of Health (NYSDOH) funds over forty-eight agencies in more than 177 sites to provide free or reduced-cost services to women, men, and adolescents.³⁸ Under the Comprehensive Family Planning Program, individuals have access to a variety of services including contraceptive education; counseling and testing for HIV and other sexually transmitted infections; and routine screenings for breast and cervical cancer.

Unfortunately, the array of services that sets New York apart from other states is the very same thing that can create challenges for women seeking assistance. Fragmentation across agencies, combined with inadequate knowledge of what services are available, can prevent women from receiving adequate care. As one provider observed: “when you sit, and you talk, and you put all the services, and you say ‘ok how can we work all together,’ there’s no connection. There’s a hole in between them and that is where the families fall ... in that hole.”³⁹

Part of the problem is that reproductive health is not fully integrated into the primary healthcare system. As one provider observed, “it’s kind of funny how certain components of healthcare have been separated out of the umbrella of primary healthcare, women’s health being one of them.”⁴⁰ Although it is common for women — many of whom are pregnant or already have children — to depend on multiple providers throughout the course of their pregnancies and during the span of their child’s life, reproductive health services, including contraception, abortion, STI screening, and maternity care, are typically not offered in primary care settings.

NYSDOH relies heavily on providers to inform women about the services they are eligible for.⁴¹ However, providers face their own set of problems, including competition for scarce resources and staffing challenges. One provider aptly described rural communities around the Capital Region, from parts of Fulton-Montgomery counties to the southern Adirondacks, as “care deserts.” “It’s not uncommon for somebody living in that area to drive forty-five minutes to get to a health center,” she proclaimed.⁴² In Essex, Hamilton, Herkimer, Orleans, Putnam, and Washington counties, not a single family planning program site exists.⁴³

Competition for scarce resources also results in turf wars among providers, making it difficult for them to obtain referrals. “Departments within our own agencies ... don’t refer families to us or pick and choose who they want to refer to us,” one family support worker explained. “I think sometimes [it’s] because they feel like we’re stepping on their toes.” Staffing challenges further constrain the provision of services. “Our staff are paid really low salaries,” a program manager told us, making it difficult to recruit and retain healthcare workers to meet their clients’ needs.⁴⁴

Challenges among Young People

When it comes to reproductive care, different populations face distinct challenges in regards to accessing care. Teens and adolescents are at the forefront of these challenges. According to a 2017 Centers for Disease Control survey of high school students, 30 percent were sexually active in the previous three months, 46 percent did not use a condom the last time they had sex, and 14 percent did not use any method to prevent pregnancy.⁴⁵ Yet adults are the ones doing most of the talking when it comes to issues of sexual and reproductive healthcare for young people.

In New York, teens can consent to family planning services — including abortion, pregnancy and sexually transmitted infections testing, and contraception — without asking their parents’ permission.⁴⁶ However, young people’s access to reproductive healthcare is still dependent on whether they have health insurance, as well as their ability to pay for services directly. “A lot of folks are still on their parents insurance so they’re concerned of their parents finding out what they need,” one provider explained.⁴⁷ Thus, for teens who cannot or do not want to discuss their sexual and reproductive health needs with their parents, confidentiality is a major concern.

Exacerbating the problems young people face are inconsistencies among different schools when it comes to sexual health education. Although sex education is important for teaching young people about consent and sexual misconduct, it also teaches them basic anatomy and disease prevention. As one provider observed: “It’s really important that students have comprehensive sex education, not only for the consent aspect of it, but also so they understand their bodies and what’s happening to their bodies, and have bodily autonomy.”⁴⁸

State law requires that students receive one semester of comprehensive health education by a certified health instructor at both the middle- and high-school levels. However, schools have the discretion on whether to implement programs based on community need and preference. A recent report issued by New York City’s Comptroller Office, for example, found that 88 percent of middle and high schools in New York City do not have a licensed health teacher and that only 57 percent of eighth graders completed the state-mandated requirement of one semester of health during middle school.⁴⁹ Inconsistent information among teens is problematic because it can lead to negative outcomes, including increased rates of sexually transmitted infections and teen pregnancy.

At the federal level, the Trump administration has cut grants for teen-pregnancy education programs⁵⁰ and put in place new funding rules that support an abstinence-only approach.⁵¹ In particular, the Department of Health and Human Services



announced that it would shift Title X family planning dollars toward programs that advocate abstinence outside marriage and the so-called rhythm method, a notoriously unreliable form of birth control. Because abstinence-only curricula have proven ineffective in reducing teen pregnancy and sexually transmitted infections,⁵² these funding decisions at the federal level only put younger New Yorkers at risk.

Meeting the Needs of Immigrant Communities

Like young people, immigrants — especially the undocumented — face unique challenges in regards to their sexual and reproductive healthcare, including language barriers. From our interviews, we learned how a lack of bilingual providers impairs communication between doctors and their patients, leading to poor health outcomes for immigrant women. For example, one home visitor recounted the story of a woman who was unable to read the label on a pill bottle because it was in English, causing her to take the medication improperly.⁵³ Yet another was afraid to make an appointment at Whitney Young because, even though the center offers low-cost healthcare options, she said they do not have a Spanish-speaking doctor. Such phenomenon are not restricted to New York, where an estimated 2.5 million people have limited English proficiency.⁵⁴ In 2016, 97 percent of physicians reported treating patients with limited English, yet only 56 percent of the 5,000 hospitals surveyed offered translation services.⁵⁵

Fear of deportation can have a chilling effect, causing undocumented people to forgo reproductive care. We heard stories about immigration officials waiting for women outside the emergency room, and about immigrant parents who stopped sending their children to school. The story of a ten-year-old girl, Maria Rosa Hernandez, gained national attention when she was taken to a detention center after a gallbladder surgery.⁵⁶ These many instances of medical visits leading to detainment have proliferated into widespread fear, even in more progressive states like New York. A 2018 report by the Kaiser Family Foundation attributes increased fear among immigrant families to decreases in well-child visits, follow-ups on referrals, and mothers seeking prenatal care, as well as decreased participation in Medicaid and the Children's Health Insurance Program.⁵⁷ In sum, high levels of fear prevent immigrant families from accessing care, with long-term consequences for children.

Crisis Pregnancy Centers and Misinformation

Despite how incredibly common abortion is, misinformation and deception threaten to delay or interfere with women's reproductive health decisions. A Google search for "abortion clinics Albany NY" reveals the first result is Alpha Pregnancy Center, a faith-based organization that does not actually offer abortions. Crisis pregnancy centers, including Alpha, provide free pregnancy tests and ultrasounds, but they do not offer abortion services or referrals to practitioners who do.⁵⁸ These facilities are usually Christian-based, pro-life organizations, aiming to "persuade teenagers and women with unplanned pregnancies to choose motherhood or adoption."⁵⁹

We interviewed executive staff from one of the ten crisis pregnancy centers in the Capitol Region. Like many other crisis pregnancy centers, they rely heavily on volunteers to offer classes in prenatal care, parenting, and Bible study.⁶⁰ However, they are not a medically licensed facility. Instead, they offer options counseling, referring to options women may have when pregnant.⁶¹ When prompted during our interview, staff were forthcoming about the lack of licensed medically trained personnel on site. However, the receptionist did not offer this information over the phone when we called unidentified, nor is there a disclaimer of their nonmedically licensed status on their website.

Although crisis pregnancy centers claim to provide "factual information" on abortions,⁶² information provided over the phone, in-person, and via official websites is often incomplete or inaccurate. For example, crisis pregnancy centers tend to overstate the risks associated with abortion and provide false or misleading information linking abortion to breast cancer, infertility, miscarriages, and ectopic pregnancies.⁶³ Even though abortion is considered safer than carrying a pregnancy to term, one counselor stressed in a phone call the possibility of death.

Aside from the physical risks of abortion, crisis pregnancy centers also provide misleading information regarding its effects on mental health. One center's website listed the "emotional and psychological consequences of having an abortion" including "eating disorders, relationship problems, guilt, depression, flashbacks of abortion, suicidal thoughts, sexual dysfunction, alcohol and drug abuse."⁶⁴ Even during our interview, staff said they opposed abortion because they knew what a woman would go through. Hence, they provide "post-abortive" counseling in a "no judgement zone." This type of misinformation leads to unreasonable and unfounded fears among women considering abortions and deters people from making properly informed decisions.

Enhancing Reproductive Rights in New York State

Given the changes in the state legislature, there is a possibility that long-stalled legislation to protect reproductive rights could be adopted. As one provider said, "It's a whole different world in New York State," in light of recent changes in the composition of the Senate.⁶⁵ In the following section, we outline our proposals for confronting barriers to reproductive care in New York State, with the hope that on-the-ground knowledge from our research will help inform decision making at the State Capitol.



1 | Enact Pending Legislation to Enhance Access to Reproductive Services

Decriminalize Abortion in New York State

In the New York State legislature, an effort to pass the Reproductive Health Act is underway, which removes abortion from the criminal code and places abortion regulations under the public health code. “We’re regulating a medical procedure,” one provider pointed out. “It really shouldn’t be in the penal code at all.”⁶⁶

According to the New York Civil Liberties Union, “unless it’s immediately life-saving, getting an abortion after 24 weeks is a criminal act under New York law—even when it’s necessary for a woman’s health or when a fetus is not viable.”⁶⁷ The result is women therefore often travel outside of New York in order to obtain an abortion after twenty-four weeks.

Although passed by the New York State Assembly from 2016 to 2018, the Reproductive Health Act was defeated in the Senate Health Committee in May 2018. The bill guarantees a woman’s right to make private decisions about their reproductive healthcare and must be enacted to improve the outdated legal reproductive apparatus in New York.

Pass the Comprehensive Contraceptive Care Act

We also recommend the state enact the Comprehensive Contraceptive Care Act, which proclaims, “that all health insurers provide cost-free contraceptive coverage as a part of their insurance policies.”⁶⁸ Although passed by the New York State Assembly in 2017 and 2018, it has stalled in the Senate.

The benefits to providing free birth control are immense. Beyond saving the state money via prenatal care, birth expenses, and social safety net programs, research suggests that implementing a free birth control policy can reduce abortions by a range of 62 to 78 percent.⁶⁹

However, the Comprehensive Contraceptive Care Act lacks some key features. Primarily, it does not encompass all aspects of reproductive healthcare (such as abortion and prenatal care), nor does it focus on improving conditions at reproductive

healthcare facilities. A more expansive program, modeled on Colorado's Family Planning Initiative, might also provide training to healthcare providers and support family planning clinics across the state.⁷⁰

Enhance Access to Reproductive Health Services by Expanding Our Public Healthcare System

One way to expand reproductive healthcare access would be to expand our public healthcare system. One example is the New York Health Act, which would provide a publicly funded healthcare apparatus in which "every New York resident would be eligible to enroll, regardless of age, income, wealth, or employment."⁷¹ Versions of the act passed the New York State Assembly four years in a row, from 2015 to 2018. Benefits would "include comprehensive outpatient and inpatient medical care, primary and preventative care, prescription drugs, laboratory tests, rehabilitative, dental, vision, hearing and all benefits required by current state insurance law, by publicly funded medical programs or provided by the state public employee package."⁷²

A key element of this legislation is that it goes beyond the goals prescribed by the Comprehensive Contraceptive Coverage Act (discussed above). The bill's philosophy, as described by Assembly Speaker Carl Heastie, is simple: "decisions regarding medical care should not be based on cost.... Despite Washington's efforts to undermine access to affordable care, we recognize that New Yorkers, and all Americans, deserve a healthcare system that guarantees coverage for all."⁷³ To implement the program, the state would have to explore additional funding mechanisms, including expanding Medicare and Medicaid.

2 | Help People Connect to Services

In order to prevent people from slipping between the cracks, New York must integrate reproductive health services into primary care settings. The following principles should guide reform efforts:

- **Enhance access to services:** All women should have access to the full range of reproductive services including abortion, contraception, STI screening and treatment, as well as screenings for breast and cervical cancer. In order to reach the greatest number of people, providers must tailor existing services to meet women where they're at. At a minimum, this means offering same day/next day appointments and sliding fee scales; enrolling people in insurance; subsidizing transportation via bus passes and other financial mechanisms; expanding or rescheduling hours of operation; and even relocating clinics to underserved, high-need areas.

Enhancing access to care also requires coordinating reproductive care with the rest of a woman's primary health needs. In the paraphrased words of one provider, we don't just treat one part of a woman. We treat her as a whole human being.⁷⁴

- **Improve communication among providers:** Part of care coordination is improving communication among service providers through regularly scheduled

meetings. As we heard in our interviews, communication can strengthen referral relationships and help providers assess patient needs.⁷⁵ The most effective model would include interdisciplinary partnerships between reproductive and behavioral health organizations, as well as social service providers in the areas of housing, nutrition, and employment. Even though providers are generally supportive of the integration of reproductive health and primary care, obtaining their input is critical to the development of successful partnerships.⁷⁶

- **Inform patients of their rights:** Doctors, nurses, and receptionists should familiarize themselves with patients' rights and inform them of the best treatment options available, even if they do not have insurance. "There's a lot of education that has to be done within the communities we all serve ... to help people understand what their options are and how to access affordable healthcare."⁷⁷
- **Address the challenges of providing care in underserved communities, including but not limited to rural areas:** When addressing issues regarding rural communities and their struggle to access healthcare, it is important to note telehealth as a tangible solution. Telehealth refers to both remote clinical and nonclinical services, and can provide an alternative for rural commuters who must travel long distances to obtain care. Providing a compact office for reproductive healthcare services, combined with remote computer communication, can vastly cut down or eliminate commute times for rural residents. Incentives, from higher wages to student loan forgiveness, can also be used to persuade physicians and other providers to practice in rural communities.

3 | Reinvent Services to Engage Young People, Including Comprehensive Sex Education

When it comes to accessing services, teens can find the process intimidating and many are reluctant to seek care. Reinventing services to be more youth friendly can break down barriers to sexual and reproductive health services for young people. Initiatives such as teen clinics and after-school hours can accommodate the needs of young people who are often in school during regularly scheduled office hours. Offering confidential counseling and education can also help. One local provider, for instance, sets aside a special waiting room for young people to meet with intake providers and fill out paperwork. Such services create a more inclusive environment, making teens feel comfortable and educating them about important services.

Comprehensive sex education also plays an integral role in promoting the well-being of adolescents. Thus, policymakers should treat it as a basic educational right. The institutionalization of comprehensive sexual health programs at a statewide level would help ensure that every student, in every school, receives accurate information about their sexual and reproductive health needs, regardless of where they live.

Comprehensive sexual health education programs offer a range of evidence-based learning for students, integrating developments in anatomy and physiology and education about sexually transmitted infections.⁷⁸ They are more effective in preventing teen pregnancies, STIs, and misuse of contraceptives. Evidence also



suggests that comprehensive sex education causes adolescents to delay engaging in sex.⁷⁹ State-funded abstinence-only programs, commonly rebranded as sexual risk-aversion programs, do not contribute to promoting effective practices, yet receive millions in funding from Congress. In schools that provide sexual health programs, parents can opt out. However, 90 percent of parents support sexual health being taught in middle and high schools.⁸⁰

Planned Parenthood operates a sexual health program in several school districts throughout the Capital Region called “Get Real” that can serve as a statewide model. Over the course of twenty-seven classroom lessons and take-home activities, the curriculum provides accurate, age-appropriate information on sex and sexuality. A three-year evaluation performed by the Wellesley Centers for Women found that the Get Real program resulted in 16 percent fewer boys and 15 percent fewer girls having sex. If we are serious in our commitment to reduce unwanted pregnancies, New York State must provide medically accurate and age-appropriate sexual education to meet the sexual and reproductive needs of adolescents.

4 | Tailor Service Delivery to the Needs of Immigrant Populations

In order to improve health outcomes for immigrant communities, New York must provide increased access to high-quality medical translators. While it is ideal for healthcare providers to have trained interpreters on site, video remote interpreting uses technology such as iPhones to provide interpreting services through an off-site interpreter. For instance, hospitals in California have partnered to create the Health Care Interpreter Network of Northern California, which includes a shared database of remote interpreters that can be reached within minutes.⁸¹ Following implementation, hospitals reported a 59 percent decrease in misunderstanding due to language barriers.⁸² Furthermore, additional studies found that utilizing interpreters over telephones significantly decreased readmission rates, saving hospitals an estimated \$161,404 in monthly expenditures.⁸³ Thus, an ethical, medical, and financial incentive exists to provide these kinds of services.

Additionally, New York State should consider a statewide initiative for students to act as translators. Project Totem recruits bilingual undergraduate students to provide translation and interpretation services for the Albany Law School Immigration Law Clinic. A similar model of matching up bilingual students with immigrant communities

can expand into the medical field. Such an initiative would have the dual effect of decreasing the language barrier and providing students with an experiential educational opportunity, at little to no cost for the state.

5 | Implement Statewide Pregnancy Center Disclosure Requirements

Every person deserves honest and truthful information regarding their health and reproductive health should be no exception. One's right to what type of information they receive does not stop where another's freedom of expression begins. The implementation of a state-level law requiring crisis pregnancy centers to disclose their medical status would concurrently serve the public's right to truthful information and protect organizations' right to freedom of expression.

In 2016, New York City adopted pregnancy service center disclosure requirements, known as Local Law 17. The law requires all pregnancy centers to clarify their services to consumers with signage at the facility, online, and in advertisements, as well as verbally with a disclosure reading, "This facility does not have a licensed medical provider on site to provide or supervise all services."⁸⁴ We recommend New York State pass legislation similar to the provisions of Local Law 17, including a clear path to enforcement. Within the Division of Consumer Protection, an enforcement entity should be responsible for investigating claims against crisis pregnancy centers, as well as independently monitoring facilities, advertisements, and websites to ensure compliance with state laws.

Conclusion

If *Roe v. Wade* is overturned, the issue of abortion will return to the states. Given its already progressive stance on this issue, New York is likely to retain the underlying tenets of *Roe*. Yet, even with progressive abortion policies, legal access to abortion does not guarantee access to a robust reproductive healthcare system. As represented by our research, there is still more work to be done, from ensuring comprehensive healthcare coverage for all to rooting out dangerous misinformation. If action on our initiatives is taken, New York will continue to serve as a national leader on reproductive rights.

Appendix: List of Interviews

Title	Organization	Interview #
Program Manager	Family Planning	01_11202018
Chief Experience Officer	Abortion Provider	02_11212018
Public Affairs & Volunteer Organizer	Abortion Provider	03_11212018
Senior Family Support Worker	Family Planning	04_11262018
Home Visitor	Family Planning	05_11262018
Vice President of Marketing & Communications	Abortion Provider	06_11282018
Director	NYS Department of Health	07_11282018
Associate Bureau Director	NYS Department of Health	08_11282018
Director	Crisis Pregnancy Center	09_11282018
Assistant Director	Crisis Pregnancy Center	10_11282018
Communications Director	Advocacy Organization	11_12052018
Vice President of Public Policy and Regulatory Affairs	Advocacy Organization	12_12052018



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