EVALUATING PRIORITIES

Measuring Women’s and Children’s Health and Well-being against Abortion Restrictions in the States
Evaluating Priorities: Measuring Women’s and Children’s Health and Well-being Against Abortion Restrictions in the States

Anti-choice state legislators are passing and enacting restrictions on abortion under the pretext of protecting women’s health and safety. In many instances, their true political motives are made crystal clear by the underhanded legislative maneuvering and outlandish statements by state legislators and the lack of medical support for their claims. We know that legislators who seek to close down clinics, make women feel guilty or stigmatized for their reproductive choices, and force doctors to practice medicine in ways that conflict with their own evidence-based experience and medical judgment, cannot honestly claim to own the mantle of women’s health and safety. And we know that there are real challenges that women are facing today that impact their health, well-being, and lives that state legislators can and should be seeking to address.

To support an evidence-based effort to fight back against the onslaught of abortion restrictions, the Center for Reproductive Rights and Ibis Reproductive Health collaborated to evaluate some of the claims of anti-choice activists and policymakers. We aimed to determine if the concern that anti-choice advocates and legislators say they have for women and children translates into the passage of state policies known to improve the health and well-being of women and children, or into improved state-level health outcomes for women and children. We also aimed to look at the inverse and see how states with relatively few abortion restrictions fare in terms of women’s and children’s health policies and outcomes.

As the report from Ibis Reproductive Health details, there is an inverse relationship between a state’s number of abortion restrictions and a state’s number of evidence-based policies that support women’s and children’s well-being. States with more abortion restrictions tend to have fewer supportive policies in place. Such policies are crucial to ensuring women and families are able to live healthy and safe lives. These policies include efforts to address maternal mortality; improve general health care affordability and access; support pregnant women’s rights and health; address issues related to children’s education; support the financial health of families, and promote a healthy environment. Women’s health – and the health of their families – is impacted by a diverse host of factors, many of which can and should be addressed by state legislators.

Ibis Reproductive Health also found a consistently negative relationship between a state’s number of abortion restrictions and its performance on indicators of women’s health, children’s health, and social determinants of health. These data...
clearly show that states need to focus on improving outcomes for women’s and children’s health. Restricting abortion access and rights is not the way to address the real concerns and difficulties women are facing in their everyday lives.

The Center for Reproductive Rights will partner with state advocates throughout 2015 to utilize this research from Ibis Reproductive Health to support state policy and advocacy work that protects and advances women’s health. State legislators interested in taking concrete steps to actually improve the lives of their constituents should take heed: passing abortion restrictions is not the way to do it.

Our message is loud and clear. Anti-choice state legislators claim to care about women’s and children’s health, but they spend their time restricting and reducing access to abortion care. It’s time for them to check their priorities.

Health and Safety Claims in Context

➤ Texas State Representative Jodie Laubenberg and author of HB2 celebrated the passage of the bill saying that she was “proud of the step we've taken to protect both babies and women.” As of this publication, since its introduction, HB2 has closed more than half the number of health clinics that provide abortion care in Texas. Meanwhile, Texas performs poorly across indicators of women’s health, children’s health, social determinants of health, and policies supportive of women’s and children’s well-being.

➤ U.S. Senator David Vitter (R-LA) called for an unwarranted investigation of abortion clinics in his state “to protect the health and safety of children in Louisiana.” Meanwhile, the state has one of the highest maternal and infant mortality rates in the country. Yet despite this, legislators in 2014 advanced a medically unnecessary admitting privileges requirement claiming that it was “about the safety of women.”
Acknowledgements:

This report is the result of collaboration between Ibis Reproductive Health (Ibis) and the Center for Reproductive Rights (the Center). We are grateful to Kelly Blanchard at Ibis for her oversight on the project. We also acknowledge Sophie Higgins, Katie Johnston, Jessica Nichols, Annie Norman, Mackenzie Sumwalt, and Samantha Xia of Ibis who provided editorial assistance in preparing this report. Angela Hooton, Kelly Baden, and Fran Linkin of the Center provided critical feedback on our project approach. The Center sponsored this project. Views and opinions expressed in this paper are those of the authors and do not necessarily represent the views of the Center.

Suggested citation:

BACKGROUND

Since abortion was legalized in the United States (US) in 1973, states have created hundreds of laws limiting whether, when, and under what circumstances a woman may obtain an abortion.\(^1\) In recent years, abortion restrictions have begun passing at an alarming rate; from 2011 to 2013 states enacted 205 new restrictions on abortion, more than were enacted in the entire previous decade.\(^2\) These restrictions take many forms, but include prohibiting insurance coverage of abortion, mandating involvement of parents in minors’ abortion decisions, and requiring women to undergo counseling or ultrasound procedures prior to an abortion.

Why are these abortion restrictions in place? Anti-choice policymakers claim they are necessary to protect the health and well-being of women, their pregnancies, and their children. Such claims of concern for health and well-being have become the bedrock of numerous newly passed abortion restrictions.\(^3\)-\(^5\) Anti-choice groups such as The National Right to Life Committee and Americans United for Life craft model legislative proposals with a specific goal of framing such laws to increase their chances of passing.\(^6\)-\(^7\) Some scholars attribute the passage of these proposals to the successful framing of abortion restrictions as necessary for the health and well-being of women, their pregnancies, and their children.\(^8\)

Given how foundational claims of concern for health and well-being appear to be to the success of anti-choice policy efforts, Ibis Reproductive Health and the Center for Reproductive Rights collaborated to evaluate these claims. We aimed to determine if the concern that anti-choice policymakers say they have for women, their pregnancies, and their children translates into the passage of state policies known to improve the health and well-being of women (throughout their life course, including during pregnancy) and children, or into improved state-level health outcomes for women and children. We also aimed to look at the inverse and see how states with relatively few abortion restrictions fare in terms of women’s and children’s health policies and outcomes.
METHODS

To meet our aims, we examined state-level policies and outcomes related to the well-being of women and children; our definition of well-being is broad, encompassing health, social, and economic status. We then determined what, if any, relationship exists between those policies and outcomes and state-level restrictions on abortion. This involved: (1) selecting indicators of abortion restrictions, policies supportive of women’s and children’s well-being, and women’s and children’s health outcomes, (2) scoring the selected state restrictions, policies, and outcomes, and (3) graphically exploring the relationship between abortion restrictions and women’s and children’s health policies and outcomes.

Indicator selection

We collected indicators in five topic areas: abortion restrictions, women’s health outcomes, children’s health outcomes, social determinants of health, and policies supportive of women’s and children’s well-being. We selected indicators of abortion restrictions and policies relevant to the health of women and children because the claims of policymakers are the focal point of our analysis. Indicators of health outcomes for women and children are also included as they provide context for health status in the state. Finally, in keeping with our broad perspective on women’s and children’s well-being, we included indicators of social determinants of health – i.e., social, economic, and environmental factors that have been documented to affect well-being. In selecting indicators for these categories, we selected those that were: (1) representative of a broad range of issues relating to women’s and children’s health and well-being, (2) available at the state-level, (3) publicly available, (4) regularly updated, (5) easy to understand, (6) important for the well-being of women and children, (7) evidence-based, and (8) available by gender (for women’s health indicators). We also aimed to include parallel indicators for both women’s and children’s health whenever possible (e.g., we included asthma prevalence among women and among children).

To determine which indicators were most meaningful, we consulted experts, academic literature, public health guidance, and prior policy analyses. This resulted in a large pool of potential indicators. We narrowed down our list of potential indicators to ensure our grading system was consumable, easy to update, and balanced in its representation of women’s and maternal and child health. We also eliminated indicators with an aim to avoid duplication of subject matter.

**“Indicator” refers to the presence or absence of a policy (either an abortion restriction or a policy to support women and children) or a health outcome statistic (e.g., infant mortality rate, prevalence of asthma, etc.).**
The final indicator list included 76 indicators in the five topic areas: abortion restrictions (14), women’s health outcomes (15), children’s health outcomes (15), social determinants of health (10), and policies supportive of women’s and children’s health (22).

**Data collection and analysis**

The data for this analysis were collected from a variety of government and nonprofit organizations with expertise in women’s and children’s health, such as the Guttmacher Institute, the Kaiser Family Foundation, the Centers for Disease Control and Prevention, the National Women’s Law Center, and the Annie E. Casey Foundation. A full list of indicators, the evidence of their impact, and data sources is presented in the Appendix.

For each state, we calculated two primary scores: one score for abortion restrictions and one score for overall women’s and children’s well-being.

- For abortion restrictions, each state was scored 0-14 to reflect the total number of 14 possible abortion restrictions. Any legislation signed into law was counted, including those unenforced due to court challenges. Higher scores indicate more abortion restrictions.
- For overall women’s and children’s well-being, we calculated scores for each of the four topic areas within women’s and children’s well-being (women’s health, children’s health, social determinants of health, and policies supportive of women’s and children’s well-being), then summed the four sub-scores to calculate an overall well-being score. Each state was scored 0 or 1 for each of the selected indicators, for a total possible score of 0-62 (see below for details on how we determined 0 or 1 for indicators in each sub-topic). Higher scores indicate better performance on women’s and children’s well-being.
- For each indicator in the three health outcome sub-topics (women’s health, children’s health, and social determinants of health), a benchmark was set equal to one half of a standard deviation better than the national average. This benchmark was set to be moderately but meaningfully better than the national average. Because the national average for selected indicators is often poor relative to other developed countries, the pre-determined benchmarks do not necessarily reflect an “ideal,” but rather are meant to be attainable goals for states. A state received a score of 1 if it met or exceeded the benchmark and a 0 if it did not. Total possible scores were 0-15 for women’s health, 0-15 for children’s health, and 0-10 for social determinants of health. Higher scores indicate better performance in that sub-topic.
For indicators of policies to support women’s and children’s well-being, each state was scored 0-22 to reflect the total number of 22 possible supportive policies. Higher scores indicate more policies supporting women’s and children’s well-being.

To examine the relationship between abortion restrictions and women’s and children’s health and well-being, we created a series of scatter plots, comparing states’ abortion restriction scores against their total scores on overall women’s and children’s well-being, as well as against their scores on each of the sub-topics (women’s health, children’s health, social determinants of health, and supportive policies).

**RESULTS**

We obtained data on all 76 indicators for all 50 states and the District of Columbia.

**Abortion restrictions**

The 14 abortion restrictions included in this analysis are listed in Table 1; more information on these restrictions, including the impact of these restrictions and data sources, can be found in the Appendix.

**Table 1. Abortion restrictions**

<table>
<thead>
<tr>
<th>Description</th>
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<tbody>
<tr>
<td>Parental involvement before a minor obtains an abortion</td>
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<tr>
<td>Mandatory waiting periods between time of first appointment and abortion</td>
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<tr>
<td>Mandatory counseling prior to abortion</td>
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<tr>
<td>Requirement to have or be offered an ultrasound</td>
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<td>Restrictions on abortion coverage in private health insurance plans</td>
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<td>Restrictions on abortion coverage in public employee health insurance plans</td>
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<td>Restrictions on abortion coverage in Medicaid</td>
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<tr>
<td>Only licensed physicians may perform abortions</td>
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<tr>
<td>Ambulatory surgical center standards imposed on facilities providing abortion</td>
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<tr>
<td>Hospital privileges or alternative arrangement required for abortion providers</td>
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<tr>
<td>Refusal to provide abortion services allowed</td>
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<tr>
<td>Gestational age limit for abortion set by law</td>
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<tr>
<td>Restrictions on provision of medication abortion</td>
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<tr>
<td>Below average number of providers (per 100,000 women aged 15-44)</td>
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</table>

The median number of state abortion restrictions was ten. Only one state, Vermont, had zero restrictions while three states, Kansas, Mississippi, and Oklahoma, had the maximum of 14 restrictions (see Table 2). Eight states had 13 abortion restrictions.
Table 2. Number of abortion restrictions by state

<table>
<thead>
<tr>
<th>Number of abortion restrictions</th>
<th>State(s)</th>
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<tbody>
<tr>
<td>0</td>
<td>Vermont</td>
</tr>
<tr>
<td>1</td>
<td>District of Columbia, Oregon, Washington</td>
</tr>
<tr>
<td>2</td>
<td>Hawaii, New Hampshire, New York</td>
</tr>
<tr>
<td>3</td>
<td>California, Connecticut, Montana, New Jersey, New Mexico</td>
</tr>
<tr>
<td>4</td>
<td>Maine, Maryland, Wyoming</td>
</tr>
<tr>
<td>5</td>
<td>Alaska, Colorado, West Virginia</td>
</tr>
<tr>
<td>6</td>
<td>Delaware, Illinois, Iowa, Massachusetts, Minnesota</td>
</tr>
<tr>
<td>7</td>
<td>Nevada</td>
</tr>
<tr>
<td>8</td>
<td>N/A</td>
</tr>
<tr>
<td>9</td>
<td>Rhode Island</td>
</tr>
<tr>
<td>10</td>
<td>Kentucky</td>
</tr>
<tr>
<td>11</td>
<td>Arkansas, Florida, Georgia, Idaho, Michigan, Pennsylvania, Tennessee, Wisconsin</td>
</tr>
<tr>
<td>12</td>
<td>Alabama, Ohio, South Dakota, Texas, Utah, Virginia</td>
</tr>
<tr>
<td>13</td>
<td>Arizona, Indiana, Louisiana, Missouri, Nebraska, North Carolina, North Dakota, South Carolina</td>
</tr>
<tr>
<td>14</td>
<td>Kansas, Mississippi, Oklahoma</td>
</tr>
</tbody>
</table>
Overall women’s and children’s well-being

We found that the more abortion restrictions present, the worse a state performed overall on indicators of women’s and children’s well-being (see Figure 1). Among the 23 states with 0-6 abortion restrictions, 18 (78%) were above the median overall score for well-being. In contrast, only eight of the 28 states with 7-14 abortion restrictions (29%) were above the median.

Figure 1. State abortion restrictions and overall score on indicators of well-being

Note: $R^2$ is a statistical measure of how close the data are to the trend line. A higher $R^2$ value indicates a stronger relationship between the two variables.
The 11 states with the best overall well-being scores were New Hampshire (2 restrictions; ranked 1st in well-being), Iowa (6 restrictions; ranked 2nd in well-being), Vermont (0 restrictions; ranked 2nd in well-being), New Jersey (3 restrictions; ranked 4th in well-being), Connecticut (3 restrictions; ranked 5th in well-being), Minnesota (6 restrictions; ranked 5th in well-being), Maine (4 restrictions; ranked 7th in well-being), Massachusetts (6 restrictions; ranked 8th in well-being), Rhode Island (9 restrictions; ranked 9th in well-being), Washington (1 restriction; ranked 9th in well-being), and Wisconsin (11 restrictions; ranked 9th in well-being). While most of these states have few abortion restrictions, Wisconsin stands out as an outlier that has a high number of abortion restrictions and also performs relatively well on overall well-being. Wisconsin’s high overall score is primarily driven by good scores on women’s health (ranked 4th) and social determinants of health (ranked 11th); its scores for child health (ranked 14th) and supportive policies (ranked 20th) were not as high.

The 11 states with the worst overall well-being scores were Oklahoma (14 restrictions; ranked 48th in well-being), Arkansas (11 restrictions; ranked 48th in well-being), Florida (11 restrictions; ranked 48th in well-being), Indiana (13 restrictions; ranked 40th in well-being), Texas (12 restrictions; ranked 40th in well-being), Kentucky (10 restrictions; ranked 40th in well-being), Alabama (12 restrictions; ranked 40th in well-being), Mississippi (14 restrictions; ranked 33rd in well-being), Arizona (13 restrictions; ranked 33rd in well-being), Missouri (13 restrictions; ranked 33rd in well-being), and Georgia (11 restrictions; ranked 33rd in well-being). All of these states uniformly have high numbers of abortion restrictions.

In plotting states’ numbers of abortion restrictions against their scores on each of the sub-topics, the overall trend remained the same, though the strength of the relationship varied (see Figures 2-5). For all sub-topics, as abortion restrictions increased scores on other indicators decreased. This relationship was particularly strong in the policy sub-topic; states with restrictive abortion policies have fewer policies that support women and children.
Women's health outcomes

While there was significant variation between states, the overall trend was that states with more abortion restrictions generally performed worse on women's health outcomes (see Figure 2). Iowa, Minnesota, and New Hampshire tied for the highest score, meeting the benchmark for ten of the 15 indicators of women’s health; New Hampshire had two abortion restrictions and the other two states had six. The states with the lowest women’s health score were Arkansas, Florida, New Mexico, and Oklahoma, which met the benchmark for none of the 15 women’s health indicators. Arkansas, Florida, and Oklahoma had 11-14 abortion restrictions; New Mexico is an outlier that had only three abortion restrictions while being one of the lowest-scoring states for women’s health.

Figure 2. State abortion restrictions and women’s health
**Children’s health outcomes**

The relationship between abortion restrictions and children’s health was stronger than that between abortion restrictions and women’s health (See Figure 3). States with many abortion restrictions met fewer benchmarks on children’s health outcomes than states with few abortion restrictions. New Hampshire had the highest children’s health score and met the benchmark for 12 of the 15 indicators analyzed. Vermont and Washington tied for second with a score of 11. All of the top three states for children’s health had between 0-2 abortion restrictions. Texas and Oklahoma had the lowest children’s health score and met the benchmark for none of the 15 indicators. Louisiana, Nevada, and South Carolina tied for the second-lowest score, meeting one of 15 benchmarks. With the exception of Nevada, all of the lowest-scoring states for children’s health had 12-14 abortion restrictions. Nevada is an outlier that is among the worst states for child health while being only moderately restrictive of abortion.

**Figure 3. State abortion restrictions and children’s health**
Social determinants of health

Similar to the pattern observed with the women’s health indicators, while there is significant variation, the general trend suggests that states with more abortion restrictions meet fewer social determinants of health benchmarks than states with fewer abortion restrictions (see Figure 4). The top four states were New Hampshire (met the benchmark for 9 out of 10 indicators), Iowa, North Dakota, and Vermont (all 8 of 10). Vermont and New Hampshire are among the least restrictive states for abortion, Iowa is moderately restrictive, and North Dakota is highly restrictive. Arkansas, Arizona, and Tennessee had the lowest score, meeting the benchmark for none of the ten indicators; all three states are highly restrictive of abortion.

Figure 4. State abortion restrictions and social determinants of health
Policies supportive of women’s and children’s well-being

The negative relationship between the number of abortion restrictions and the number of policies that support women’s and children’s well-being was stronger than any of the other sub-topics (see Figure 5). With few exceptions, states that have passed multiple policies to restrict abortion have passed fewer evidence-based policies to support women’s and children’s well-being, compared to states with fewer restrictions on abortion. The three states with the highest women’s and children’s policy scores were Illinois (17 of 22 supportive policies), California (16 of 22), and New Jersey (15 of 22). Five states (New Mexico, New York, Rhode Island, Vermont, and Washington) and the District of Columbia tied for the next highest score of 14. Of these nine top-scorers, all have three or fewer abortion restrictions except Illinois (6 restrictions) and Rhode Island (9 restrictions). Of the six states with five or fewer supportive policies, all but one had 11 or more abortion restrictions. Wyoming is exceptional in that it has few abortion restrictions (4) and few supportive policies (3).

Figure 5. State abortion restrictions and policies supportive of women’s and children’s well-being

![Diagram showing the relationship between number of abortion restrictions and state policies supportive of women’s and children’s well-being.](image-url)
DISCUSSION

This analysis shows that despite the existing evidence base, many states continue to impede abortion access, while also lacking policies that have been documented to support women’s and children’s well-being. We observed a consistently negative relationship between a state’s number of abortion restrictions and its performance on indicators of women’s health, children’s health, social determinants of health, and policies to support women and children. In this analysis, we find that state anti-choice policymakers have not focused their attention on evidence-based policies that improve the health and well-being of women and children. This analysis helps debunk the common claim that anti-choice policymakers in the US are working to protect and support the health and well-being of women, their pregnancies, and their children.

These findings are troubling as ample scientific evidence makes clear that restricting abortion is not beneficial to women and that abortion restrictions can lead to a number of emotional, financial, and physical harms. Some restrictions delay or make it more difficult to access care, contributing to poor emotional and financial well-being as women try to navigate abortion care hurdles. Delays also increase the risk of the abortion procedure. Other restrictions block access to abortion all together, interfering with women’s abilities to make their own reproductive decisions and preventing the achievement of life plans and goals. Women denied abortion care are also at increased risk of experiencing poverty, physical health impairments, and intimate partner violence. See the Appendix for details on the specific impacts of the abortion restrictions included in this analysis.

On the flip side, there is also considerable evidence of the benefits to women and children of putting in place the supportive policies we evaluated and of addressing major social determinants of health. Such benefits include improved health and safety, lower poverty rates, decreased reliance on public assistance, and better developmental and educational outcomes for children. See the Appendix for the specific impacts of each indicator included in this analysis.

Our findings are consistent with prior research. Of our 12 best-ranking states for the fewest abortion restrictions, all scored an “A-” or better on NARAL’s reproductive rights report card except the District of Columbia (not graded), New Hampshire (C+), and Montana (B+); all of our 11 worst-ranking states for the most abortion restrictions scored an “F” on NARAL’s report card. Similarly, of our top 11 states with the highest overall well-being scores, all were ranked in the top quartile for the Commonwealth Fund’s state health system scorecard except New Jersey and Washington (both in the second quartile, ranked 15th of 51). Of our bottom 11 states with the lowest overall well-being scores, all were ranked in the bottom quartile by the Commonwealth Fund except Arizona (third quartile, ranked 36th) and Missouri (third quartile, ranked...
34th). Prior research has also linked reproductive rights and other indicators of women’s status with better outcomes for children, such as lower infant mortality. One study found that between 1964 and 1977, the single most important factor in the reduction of infant mortality was the increase in abortion legalization.

Strengths and Limitations

Our analysis does have some limitations. While we made every effort to select the most meaningful, evidence-based indicators, any attempt to analyze a concept as broad as women’s and children’s well-being is a simplification. Specifically, we did not adjust for poverty, which has been shown to play a major role in women’s and children’s well-being, and is associated with other social issues that may play a role in our findings, such as racism and sexism. However, the data suggest that while household income (an incomplete, but important indicator of poverty) does play a role in our findings, it cannot explain all of the differences observed between states. Some of the lowest well-being scores were among middle-income states with many abortion restrictions, such as Texas and Arizona. Oklahoma, with the 16th lowest median household income in the country, had the worst overall score in our analysis, lower than all ten of the ten poorest states in the country. Montana, West Virginia, and New Mexico were the only three of the ten poorest states that had few abortion restrictions; their overall scores were higher than those of the seven poorest states with many abortion restrictions (total score ranging from 19-23 versus 10-15).

Additionally, our dichotomous scoring methodology is limited in its ability to detect variation between states since states are classified as either meeting the benchmark or not, without any accounting for the degree of difference, nor did we account for differences in specific policies across states (e.g., 24-hour vs. 72-hour waiting periods prior to an abortion). Nevertheless, we feel this simple approach is also a strength in that it facilitates understanding and replicability of our analysis, and makes the information accessible.

Conclusion

Ultimately, this analysis used straightforward analytical techniques to demonstrate that, despite their claims that they seek to protect women, their pregnancies, and their children, anti-choice state policymakers focus their efforts on restricting abortion and not on putting in place policies known to promote the health and well-being of women and children. This analysis emphasizes the need for state policymakers to focus broadly on improving the well-being of women and children, rather than restricting access to needed health care services such as abortion.
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20) Foster DG, Dobkin L, Biggs MA, Roberts S, Steinberg J. Mental health and physical health consequences of abortion compared to unwanted birth. APHA Annual Meeting & Expo; October 30, 2012. San Francisco.


**Appendix: Indicators, evidence of impact, and sources**

**ABORTION RESTRICTIONS**

**Below average number of abortion providers**

*Description:* Number of abortion providers per 100,000 women aged 15-44 is below the national average, 2011.

*Data source(s):*

*Impact:* The quality and functionality of any health care delivery system depends on the availability of medical personnel. A limited number of abortion providers likely impedes access to health care and disproportionately impacts those living in medically underserved areas.

*Impact source(s):*

**Ambulatory surgical center standards imposed on facilities providing abortion**

*Description:* Facilities providing abortion must meet standards intended for ambulatory surgical centers.

*Data source(s):*

*Impact:* Imposing ambulatory surgical standards on facilities providing abortion can reduce the number of providers able to stay open and offer care, limiting women’s access to care. These standards also increase the cost of care, which can further impede access.

*Impact source(s):*

**Gestational age limit for abortion set by law**

*Description:* Abortion is restricted beyond a specified gestational age.

*Data source(s):*

*Impact:* Gestational age limits for abortion set by law can prevent women from being able to access care and force them to continue unwanted pregnancies. Not being able to access care because of gestational age limits can also reduce women’s self-esteem and life satisfaction, and increase regret and anger.
Impact source(s):

**Hospital privileges or alternative arrangement required for abortion providers**

*Description:* Abortion providers are required to be affiliated with a local hospital, through admitting privileges or an alternative arrangement.

*Data source(s):*

*Impact:* Requiring abortion providers to have hospital privileges or alternative arrangements reduces access to care without improving patient safety.

*Impact source(s):*

**Mandatory counseling prior to abortion**

*Description:* Women seeking an abortion must undergo counseling before obtaining the procedure.

*Data source(s):*

*Impact:* Mandatory counseling laws can postpone the timing of some abortions, particularly when counseling must be received in person or when a woman must wait a state-specified amount of time between the time she obtains counseling and the time of the abortion. Delays increase the risks and costs of abortion.

*Impact source(s):*

**Parental involvement required before a minor obtains an abortion**

*Description:* Minors seeking an abortion must notify and/or obtain consent from one or both parents.

*Data source(s):*
**Impact:** There is no evidence to suggest that parental involvement laws deter minors from engaging in sexual activity (as is the often-stated thinking behind the laws). However, some minors do try to circumnavigate the laws by obtaining a judicial bypass or traveling outside of their home state to obtain an abortion in a state without parental involvement laws. The laws can delay access to the procedure, which increases the risks and costs of abortion.

**Impact source(s):**

**Only licensed physicians may perform abortions**

**Description:** Only a licensed physician may perform an abortion.

**Data source(s):**

**Impact:** Limiting the types of health care providers able to perform abortions likely impedes or delays access to abortion care as the health care delivery system depends on the availability of medical personnel to function. This may disproportionally impact women living outside of urban areas.

**Impact source(s):**

**Medication abortion restrictions**

**Description:** Medication abortion is required to be administered in accordance with the outdated FDA labeling and/or is required to be provided by a clinician who is physically present during the procedure.

**Data source(s):**

**Impact:** Requiring medication abortion to be administrated in accordance with outdated FDA protocols forces health care providers to administer medication in a way that counters best practice of medicine, denies women access to evidence-based regimens for care, and reduces the number of providers able to offer medication abortion. Requiring a clinician to be physically present during the procedure limits access to abortion, particularly for women living in remote areas. It may also delay access to care and increase women’s travel time to care.
Impact source(s):

Refusal to provide abortion services allowed
Description: Health care providers are allowed to refuse to provide abortion services.
Data source(s):
Impact: Allowing health care providers to refuse to provide abortion services violates standards of medical care and reduces accessibility of abortion. This likely disproportionally impacts women living outside of urban areas.
Impact source(s):

Restrictions on abortion coverage in Medicaid
Description: Restrictions on abortion coverage in Medicaid.
Data source(s):
Impact: Restrictions on abortion coverage in Medicaid can create confusion about when abortion is covered and how to obtain abortion coverage, interfere with women’s personal medical decisions, undermine women’s autonomy by putting care out of financial reach, delay women from obtaining abortion care while they search for the financial resources to pay for an abortion out-of-pocket, force women and their families to endure financial hardships to afford care, and force women who cannot afford abortion care to continue unwanted pregnancies.
Impact source(s):
Restrictions on abortion coverage in private health insurance plans

Description: Restrictions on abortion coverage in all private health plans or in health plans offered through the health insurance exchanges.

Data source(s):

Impact: Though little research has documented the specific impacts of restricting abortion coverage in private health insurance plans, there is ample data showing the harms of limiting public insurance coverage of the procedure. Such restrictions can create confusion about when abortion is covered and how to obtain abortion coverage, interfere with women’s personal medical decisions, undermine women’s autonomy by putting care out of financial reach, delay women from obtaining abortion care while they search for the financial resources to pay for an abortion out-of-pocket, and force women and their families to endure financial hardships to afford care.

Impact source(s):

Restrictions on abortion coverage in public employee health insurance plans

Description: Restrictions on abortion coverage in state employee health plans.

Data source(s):

Impact: Though little research has documented the specific impacts of restricting abortion coverage in public employee health insurance plans, there is ample data showing the harms of limiting public insurance coverage of the procedure. Such restrictions can create confusion about when abortion is covered and how to obtain abortion coverage, interfere with women’s personal medical decisions, undermine women’s autonomy by putting care out of financial reach, delay women from obtaining abortion care while they search for the financial resources to pay for an abortion out-of-pocket, and force women and their families to endure financial hardships to afford care.

Impact source(s):
Requirement to have or be offered an ultrasound

**Description:** Women seeking an abortion must either undergo or be offered an ultrasound procedure.

**Data source(s):**

**Impact:** Viewing an ultrasound generally does not impact women’s abortion decision making (though that is the reasoning behind the law).

**Impact source(s):**

Waiting periods required between time of first appointment and abortion

**Description:** Women seeking an abortion must wait a specified period of time between required counseling and obtaining the procedure.

**Data source(s):**

**Impact:** Mandatory waiting periods can postpone the timing of abortions, increase the proportion of second-trimester abortions occurring in a state, and increase the number of women traveling out of state for an abortion. They can also negatively impact women’s emotional well-being.

**Impact source(s):**
WOMEN’S HEALTH OUTCOMES

Asthma prevalence

Description: Percentage of women reporting current asthma.

Data source(s):

Impact: Asthma causes adults to miss days of work, interferes with daily activities, and can lead to hospitalizations and even death. Women are more likely to have asthma, and more women than men die from asthma. Healthy People 2020 includes a number of objectives related to decreasing the impact of asthma.

Impact source(s):

Cervical cancer screening

Description: Percentage of women aged 18 or older who received a Pap test in the past 3 years, 2012.

Data source(s):

Impact: Having cervical cancer increases the risks of medical, psychological, social, and relational concerns, as well as mortality. Women of color, women with low incomes, and women with low educational attainment disproportionately experience cervical cancer. However, when found early, it is highly treatable and associated with long survival and good quality of life. The US Preventive Services Task Force recommends screening for cervical cancer every three years. Increasing the proportion of women who receive recommended cervical cancer screenings is a Healthy People 2020 objective.

Impact source(s):

Chlamydia incidence

Description: Number of new chlamydia infections among women per 100,000 women, 2012.

Data source(s):

Impact: Chlamydia is strongly associated with ectopic pregnancy, infertility, and chronic pelvic pain. Maternal chlamydia may result in fetal death or substantial physical and developmental disabilities for a child, including mental retardation and blindness. Reducing chlamydia infections among adolescents and young adults is a Healthy People 2020 objective.
Impact source(s):


HIV incidence

Description: Number of new HIV diagnoses among women per 100,000 women, 2011.

Data source(s):


Impact: Among women ever diagnosed with AIDS, an estimated 4,014 died during 2010, and by the end of 2010, an estimated 111,940 had died since the beginning of the epidemic. HIV affects the immune system, and, for women, this can cause specific gynecological issues, including cervical dysplasia, anal/rectal dysplasia, invasive cervical cancer, extensive herpes simplex 2, recurrent yeast infections, and recurrent genital warts. HIV can also potentially lead to other related health problems (such as opportunistic infections, Hepatitis, tuberculosis, oral health issues, cancer, cardiovascular problems, diabetes, kidney disease, and dementia), which can lead to increased morbidity and mortality.

Impact source(s):


Lifetime prevalence of sexual violence

Description: Percentage of women who reported ever experiencing sexual assault other than rape by any perpetrator, 2010.

Data source(s):


Impact: Sexual violence can cause long-term physical consequences such as chronic pelvic pain, premenstrual syndrome, gastrointestinal disorders, gynecological and pregnancy complications, migraines and other frequent headaches, back pain, facial pain, and disability that prevents work. Sexual violence can also cause psychological consequences such as shock, anxiety, symptoms of PTSD (including flashbacks, emotional detachment, and sleep disturbances), depression, and attempted or completed suicide, among others.

Impact source(s):


Low birth weight

Description: Percentage of infants born weighing less than 2,500 grams/5.5lbs.

Data source(s):

Impact: Low birth weight can lead to lifelong disabilities for a child (including visual and hearing impairments, developmental delays, and behavioral and emotional problems that range from mild to severe).
Impact source(s):

Maternal mortality ratio
Description: Number of maternal deaths per 100,000 live births.
Data source(s):
Impact: Many women still die in childbirth or of pregnancy related causes. Maternal mortality can negatively impact the health of a woman’s baby, the health of her other children, and the social and economic standing of her family. Reducing the maternal mortality ratio is a Millennium Development Goal Indicator.
Impact source(s):

Overweight/obesity prevalence
Description: Percentage of women with BMI ≥ 25.0.
Data source(s):
Impact: Obesity-related conditions include heart disease, stroke, and type 2 diabetes, which are among the leading causes of death. Also, obesity at the beginning of pregnancy places women at a higher risk of high blood pressure and diabetes during pregnancy. Adults who are obese is a Healthy People 2020 leading health indicator.
Impact source(s):

Poor mental health status
Description: Percentage of women who reported their mental health was “not good” between one to 30 days over the past 30 days.
Data source(s):
Impact: People with untreated mental health disorders are at high risk for many unhealthy and unsafe behaviors, including substance abuse, violent or self-destructive behavior, and suicide. Also, mental health disorders (most often depression) are strongly associated with the risk, occurrence, management, progression, and outcome of serious chronic diseases and health conditions, including diabetes, hypertension, stroke, heart disease, and cancer.
Impact source(s):

Preterm birth
Description: Percentage of infants born at less than 37 weeks completed gestation.
Data source(s):
Impact: Preterm birth can lead to lifelong disabilities for a child (including visual and hearing impairments, developmental delays, and behavioral and emotional problems that range from mild to severe). Preterm birth is a Healthy People 2020 leading health indicator.
Impact source(s):

Proportion of pregnancies unintended
Description: Percentage of all pregnancies that were unintended, 2008.
Data source(s):
Impact: Risks associated with unintended pregnancy include low birth weight, postpartum depression, delays in receiving prenatal care, and family stress.
Impact source(s):

Smoking prevalence
Description: Percentage of women that report currently smoking.
Data source(s):
Impact: Tobacco use causes several diseases and health problems, including several kinds of cancer (lung, bladder, kidney, pancreas, mouth, and throat), heart disease and stroke, lung diseases (emphysema, bronchitis, and chronic obstructive pulmonary disease), pregnancy complications (preterm birth, low birth weight, and birth defects), gum disease, and vision problems. Adults who are current cigarette smokers is a Healthy People 2020 leading health indicator.
Impact source(s):

Suicide deaths
Description: Number of suicide deaths among women per 100,000 women, 2008-2010.
Data source(s):
**Impact:** Suicide results in the death for the individual and has impacts on families such as decreases in cohesion and adaptability and feelings of guilt and blaming. Adolescents who have experienced a suicide death in the family are more likely to engage in risky behaviors and experience emotional distress. Suicide is a Healthy People 2020 leading health indicator.

**Impact source(s):**

**Women without health insurance**

**Description:** Percentage of women aged 15-44 without health insurance, 2012-2013.

**Data source(s):**

**Impact:** People without health insurance are more likely than the insured to skip routine medical care, which increases the risk of serious and disabling health conditions. They are also often burdened with large medical bills and out-of-pocket expense. Persons with medical insurance is a Healthy People 2020 leading health indicator.

**Impact source(s):**

**Women with no personal health care provider**

**Description:** Percentage of women with no personal doctor or health care provider, 2006-2008.

**Data source(s):**

**Impact:** Having a usual personal health care provider increases patient trust in the provider, patient-provider communication, and the likelihood that patients will receive appropriate care. Persons with a usual provider is a Healthy People 2020 leading health indicator.

**Impact source(s):**
CHILDREN’S HEALTH OUTCOMES

Child mortality rate
Description: Number of deaths per 100,000 children aged 1-14, 2010 (excl. DE, DC, ND, VT); 2008 (DE, DC, ND, VT).
Data source(s)
Impact: Parents who experience the loss of a child experience more depressive symptoms, poorer well-being, and cardiovascular health problems than comparison parents. Parents who lose a child are also more likely to experience marital disruption. Bereaved parents have significantly worse health-related quality of life than comparison group parents.
Impact source(s):

Children receiving medical and dental preventive care
Description: Percentage of children aged 0-17 who had both a medical and dental preventive care visit in the past 12 months, 2011.
Data source(s):
Impact: Clinical preventive services prevent and detect illnesses and diseases in their earlier, more treatable stages, significantly reducing the risk of illness, disability, early death, and medical care costs. Regular visits to the dentist can help prevent oral diseases including cavities and oral cancers. A growing body of evidence has also linked oral health, particularly periodontal disease, to several chronic diseases, including diabetes, heart disease, and stroke. Persons aged two or older who used the oral health care system in the past 12 months is a Healthy People 2020 leading health indicator.
Impact source(s):

Children receiving needed mental health care
Description: Percentage of children aged 2-17 with emotional, developmental, or behavioral problems that received mental health care.
Data source(s):
Impact:
Compared to children without developmental problems, children with developmental problems are more likely to have lower self-esteem, depression and anxiety, problems with learning, missed school days, and less involvement in sports and other community activities. Families of children with emotional, developmental, or behavioral problems are more likely to experience difficulty in the areas of childcare, employment, parent-child relationships, and caregiver burden. Receiving needed mental health care can help ameliorate some of these outcomes. Increasing the proportion of children with mental health problems who receive treatment is a Healthy People 2020 objective.

Impact source(s):

Complete vaccination (children 19-35 months)
Description: Percentage of children aged 19-35 months that received the full combined vaccination series, 2012.
Data source(s):
Impact: Immunizations can protect children and adolescents from serious and potentially fatal diseases, including mumps, tetanus, and chicken pox. Children's vaccination rates are a Healthy People 2020 leading health indicator.
Impact source(s):

Confirmed child maltreatment
Description: Number of children reported to be victimized per 1,000 children less than 18 years old, confirmed by child protective services, 2011.
Data source(s)
Impact: A history of exposure to childhood maltreatment is associated with health risk behaviors such as smoking, alcohol and drug use, and risky sexual behavior, as well as obesity, diabetes, sexually transmitted diseases, attempted suicide, and other health problem. Reducing fatal injuries and homicide (which can be related to child maltreatment) is a Healthy People 2020 leading health indicator.
Evaluating Priorities: Measuring Women’s and Children’s Health and Well-being against Abortion Restrictions in the States Research Report

Impact source(s):

Exclusive breastfeeding for 6 months
Description: Percentage of children fed only breast milk and no additional food, water, or other fluids. Exceptions are made for necessary medicines and vitamins, 2011.
Data source(s):
Impact: Breast milk promotes sensory and cognitive development, and protects the infant against infectious and chronic diseases. Exclusive breastfeeding reduces infant mortality due to common childhood illnesses such as diarrhea or pneumonia, and helps for a quicker recovery during illness.
Impact source(s):

Infant mortality rate
Description: Number of infant deaths (aged 0-364 days) per 100,000 live births, 2008-2010.
Data source(s):
Impact: Infant mortality is one of the most important indicators of the health of a nation, as it is associated with a variety of factors such as maternal health, quality and access to medical care, socioeconomic conditions, and public health practices. The U.S. infant mortality rate is higher than those in most other developed countries. Infant mortality rates are above the U.S. average for non-Hispanic black, Puerto Rican, and American Indian or Alaska Native women. Reducing infant mortality is a Healthy People 2020 leading health indicator.
Impact source(s):

Percentage of children aged 10-17 who are overweight or obese
Description: Calculated using BMI for children, which is age and gender specific. A child is considered overweight if their BMI is at or above the 85th percentile of the CDC growth charts for age and gender.
Data source(s):
Impact: Obesity-related conditions include heart disease, stroke, and type 2 diabetes, which are among the leading causes of death. Reducing the percentage of children or adolescents who are considered obese is a Healthy People 2020 leading health indicator.
Impact source(s):

Percentage of children living in a home with someone who smokes
**Description:** Percentage of children aged 0-17 whose household includes someone who smokes tobacco.
**Data source(s):**
**Impact:** Secondhand smoke exposure contributes to heart disease and lung cancer. Children may be more vulnerable to smoke exposure than adults because their bodily systems are still developing and their behavior can expose them more to chemicals and organisms. Reducing the percentage of children living in a home with someone who smokes Healthy People 2020 leading health indicator.
**Impact source(s):**

Percentage of children with health insurance
**Description:** Health insurance coverage of children under age 18, 2012.
**Data source(s):**
**Impact:** Children without health insurance are more likely to have unaddressed health needs, including delayed care, unmet medical care, and unfilled prescriptions. The risk of going without a usual source of care, which is higher among children without insurance, is associated with decreased use of preventive care and increased use of emergency departments for nonemergency conditions. Persons with medical insurance is a Healthy People 2020 leading health indicator.
**Impact source(s):**

Percentage of children with a medical home
**Description:** Children aged 0-17 who received health care that meets criteria of having a medical home: child had a personal doctor/nurse; had a usual source for sick care; received family-centered care from all health care providers; had no problems getting needed referrals; and received effective care coordination when needed.
**Data source(s):**
**Impact:** Having a usual personal health care provider increases patient trust in the provider, patient-provider communication, and the likelihood that patients will receive appropriate care. Increasing the proportion of children and youth aged 17 years and under who have a specific source of ongoing care is a Healthy People 2020 objective.
**Impact source(s):**
Percentage of children with asthma problems

**Description:** Children under 18 who have been diagnosed with asthma by a doctor or health professional and still have asthma, 2011-2012.

**Data source(s):**

**Impact:** Children with asthma miss more days of school, and experience more limitation in activity and hospitalizations than children without asthma. Asthma is the third ranking cause of non-injury-related hospitalization among children age 14 and younger.

**Impact source(s):**

Teen alcohol or drug abuse

**Description:** Children aged 12 to 17 who reported dependence on or abuse of illicit drugs or alcohol in the past year, 2011-2012.

**Data source(s):**

**Impact:** Alcohol and drug abuse is associated with a range of destructive social conditions, including family disruptions, financial problems, lost productivity, failure in school, domestic violence, child abuse, and crime. Substance abuse also contributes to a number of negative health outcomes including cardiovascular conditions, pregnancy complications, HIV, STIs, motor vehicle crashes, homicide, and suicide. Also, reducing adolescent use of alcohol or any illicit drugs is a Healthy People 2020 leading health indicator.

**Impact source(s):**

Teen birth rate

**Description:** Number of live births to 15-19 year olds per 1,000 female persons, 2012.

**Data source(s):**

**Impact:** Children of teen parents are more likely to have lower cognitive attainment and exhibit more behavior problems. Sons of teen mothers are more likely to be incarcerated, and daughters are more likely to become adolescent mothers.

**Impact source(s):**

Teen mortality rate

**Description:** Number of deaths per 100,000 teens aged 15-19, 2010 (excl. VT); 2009 (VT).

**Data source(s):**
Impact: Parents who experience the loss of a child experience more depressive symptoms, poorer well-being, and cardiovascular health problems than comparison parents. Parents who lose a child are also more likely to experience marital disruption. Bereaved parents have significantly worse health-related quality of life than comparison group parents.

Impact source(s):
SOCIAL DETERMINANTS OF HEALTH

Children aged 3-5 not enrolled in nursery school, preschool, or kindergarten

**Description:** Percentage of children aged 3-5 not enrolled in nursery school, preschool, or kindergarten during the previous two months, 2012 (excl. VT); 2011 (VT).

**Data source(s):**

**Impact:** High-quality child care before age five is related to higher levels of school readiness, academic achievement, educational attainment, and behavioral/emotional functioning during elementary, middle, and high school.

**Impact source(s):**

Gender wage gap

**Description:** Earnings ratio between full-time, year-round employed women and men.

**Data source(s):**

**Impact:** Women who work full time still earn, on average, 77 cents for every dollar men earn, which increases women’s risk of falling into poverty. The wage gap exists for almost every occupation. The gap is worst for women of color. Increases in education do not account for the wage gap. Women’s loss of wages reduces their families’ income, a loss which accumulates greatly over time.

**Impact source(s):**

Homelessness

**Description:** Rate of homelessness per 10,000 population, 2012 (includes several subpopulations such as: chronic, veterans, family households, people in families, individuals, unsheltered, and sheltered).

**Data source(s):**

**Impact:** People experiencing homelessness experience higher levels of poverty and the associated risk factors. They often lack ready access to certain medical services and have a high occurrence of conditions that increase the risk of Tuberculosis, including substance abuse, HIV infection, and congregation in crowded shelters.

**Impact source(s):**
On-time high school graduation rates

**Description:** The percentage of all students who graduated from high school based on an average freshman graduation rate defined by the National Center for Education Statistics (NCES), 2009-2010.

**Data source(s):**

**Impact:** Not graduating from high school on time can lead to poor academic skills and limited employment opportunities and earning potential, which in turn increases the risk of experiencing poverty. Additionally, education level, and high school graduation in particular, is a strong predictor of health. The more schooling people have, the lower their levels of risky health behaviors such as smoking, being overweight, or having low levels of physical activity.

**Impact source(s):**

Percentage of children living in poverty

**Description:** Children under the age of 18 who live in families with incomes below the national poverty line, 2012.

**Data source(s):**

**Impact:** Children living in poverty are more likely than children not in poverty to experience food insecurity, have frequent emergency room visits, and go without health insurance coverage.

**Impact source(s):**

Percentage of women aged 15-44 living in poverty, 2011-2012

**Description:** Persons in poverty are defined here as those living in “health insurance units” with incomes less than 100% of the Federal Poverty Level (FPL) as measured by the U.S. Department of Health and Human Services’ (HHS) poverty guidelines.

**Data source(s):**

**Impact:** From 2011-2012, 20% of women aged 12-44 were living in poverty, compared to 18% of men. Women of color are more likely to be poor than white women. Compared to women not in poverty, women living in poverty are three times more likely to be in poor health; poverty is associated with numerous chronic diseases (such as HIV, asthma, diabetes, and coronary heart disease), poor mental health, and exposure to violence. Women in poverty also have diminished access to nutritious food and high-quality health care. Compared to women with higher incomes, they are also at a higher risk of having children with higher infant mortality rates and post-neonatal mortality rates.
Impact source(s):

Prevalence of household food insecurity
Description: Food insecurity defined as the food intake of one or more household members was reduced and their eating patterns were disrupted at times during the year because the household lacked money and other resources for food, 2010-2012.
Data source(s):
Impact: With limited resources, food insecure families often resort to low-cost, low nutrient-dense food. Individuals living in food insecure households may be at greater risk for malnutrition, diabetes, obesity, hospitalizations, poor health, iron deficiency, and developmental risk and behavior problems (such as aggression, anxiety, depression, and attention deficit disorder), compared to individuals living in food secure households.
Impact source(s):

Unemployment
Description: Rates as a percentage of the labor force.
Data source(s):
Impact: Unemployment prevalence in the US increased from 4.7% in 2006 to 9.4% in 2010, yielding an estimated 14.5 million unemployed people. The unemployed tend to have higher annual illness rates, lack health insurance and access to health care, and have an increased risk of mortality.
Impact source(s):

Violent crime rate
Description: Rates are per 100,000 inhabitants.
Data source(s):
Impact: Violent crime increases the risk of injury, disability, and mortality. Also, victims of violent crime, families and friends of victims of violent crime, and witnesses of violent crime experience long-term physical, social, and emotional consequences. Healthy People 2020 includes fatal injuries and homicides (which are related to violent crime) as leading health indicators.

Impact source(s):

Women's participation in the labor force
Description: Percentage of women aged 16 or older with earnings.
Data source(s):

Impact: Over the last 50-75 years, women’s participation in the labor force has increased greatly. Women’s labor force participation increases gender equity and the available workforce, and reduces the risk of poverty. It also increases women’s purchasing power, and their access to employee-sponsored benefits, such as health insurance.

Impact source(s):
POLICIES SUPPORTIVE OF WOMEN AND CHILDREN

Improving access to health care

Moving forward with the Affordable Care Act’s Medicaid expansion

Description: State is implementing the Medicaid expansion under the Affordable Care Act in 2014, as of June 10, 2014.

Data source(s):

Impact: In states that do not expand Medicaid, many women will fall into a coverage gap, making too much to qualify for Medicaid but not enough to qualify for subsidized health coverage through the exchanges. Low-income women without health insurance are more likely to report going without needed care, are less likely to have a regular health care provider, and are less likely to access preventive services than low-income women with health insurance.

Impact source(s):

Allows telephone, online, and/or administrative renewal of Medicaid/CHIP

Description: State facilitates renewal of Medicaid and/ or CHIP by allowing enrollees to renew by telephone or online, or by sending enrollees a pre-populated form with all available eligibility information.

Data source(s):

Impact: Streamlined renewal processes for Medicaid/CHIP helps prevent lapses in health care coverage for enrolled women and children, and reduces the administrative burden for both states and enrolled families.

Impact source(s):

Requires domestic violence protocols, training, or screening for health care providers

Description: State has attempted to reduce the impact of domestic violence by requiring health care protocols, training, and screening for domestic violence for health care providers.

Data source(s):

Impact: Routine screening for intimate partner violence can increase early detection and intervention and reduce violence, abuse, and physical or mental harms. Routine screening is recommended by the United States Preventive Services Task Force, the American Congress of Obstetricians and Gynecologists, and the American Medical Association.

Impact source(s):
Supporting pregnant women

Medicaid income limit for pregnant women is at least 200% of the federal poverty line

**Description:** State Medicaid eligibility criteria for pregnant women includes an income limit of 200% of the federal poverty line or higher.

**Data source(s):**

**Impact:** Increased Medicaid eligibility limits for pregnant women has been shown to increase health care coverage of pregnant women and to reduce infant mortality and low birthweight.

**Impact source(s):**

Has expanded family/medical leave beyond the FMLA

**Description:** State has set standards that are more expansive than the federal Family Medical Leave Act (for example, expanding either the amount of leave available or the classes of persons for whom leave may be taken).

**Data source(s):**

**Impact:** Parental leave has been associated with numerous positive outcomes, including lower rates of premature birth, increased birth weight, higher rates of breastfeeding and well-baby care, stronger labor force attachment, positive changes in wages, and lower levels of public assistance receipt.

**Impact source(s):**

Provides temporary disability insurance

**Description:** State has a social insurance program that partially compensates for the loss of wages caused by temporary nonoccupational disability or maternity.

**Data source(s):**

**Impact:** Temporary disability insurance programs allow more mothers to take paid leave following the birth of a child. Parental leave has been associated with numerous positive outcomes, including lower rates of premature birth, increased birth weight, higher rates of breastfeeding and well-baby care, stronger labor force attachment, positive changes in wages, and lower levels of public assistance receipt.

**Impact source(s):**
Maternal mortality review board in place

**Description:** State has set up a maternal mortality review committee to track maternal health patterns and develop effective solutions to address maternal mortality.

**Data source(s):**

**Impact:** Maternal mortality review boards monitor and analyze maternal deaths and propose recommendations to improve maternal health. Maternal mortality review boards are recommended by Amnesty International and the American Public Health Association.

**Impact source(s):**

Requires reasonable accommodations for pregnant workers

**Description:** State has a law requiring some employers to provide reasonable accommodations to pregnant workers.

**Data source(s):**

**Impact:** Despite the federal Pregnancy Discrimination Act, many pregnant workers are at risk of losing their jobs or being forced to take unpaid leave due to their pregnancy.

**Impact source(s):**

Prohibits or restricts shackling pregnant prisoners

**Description:** State has a law prohibiting or restricting the shackling of pregnant prisoners.

**Data source(s):**

**Impact:** Restraining pregnant women increases the risk of injury to the woman and the fetus and can interfere with medical care during labor, delivery, and recovery. The American Congress of Obstetricians and Gynecologists, the American Medical Association, and the American Public Health Association oppose shackling pregnant women.

**Impact source(s):**
**Promoting children’s and adolescents’ health, education, and safety**

**Allows children to enroll in CHIP with no waiting period**

**Description:** State does not require children to be without health insurance for a minimum amount of time prior to being considered eligible for CHIP.

**Data source(s):**


**Impact:** Requiring children to be uninsured before enrolling in CHIP disrupts continuity of care and affects children’s ability to access needed health care; 23 organizations, including the American Academy of Pediatrics, Children’s Defense Fund, and March of Dimes, have signed onto a letter calling on the United States Department of Health and Human Services to eliminate waiting periods.

**Impact source(s):**


**Requires physical education for elementary, middle, and high school**

**Description:** State mandates, elementary, middle/junior high, and high school physical education.

**Data source(s):**


**Impact:** Physical activity among children and adolescents can improve bone health, cardiorespiratory and muscular fitness, and decrease body fat and symptoms of depression; increasing the proportion of schools requiring physical education is a Healthy People 2020 objective.

**Impact source(s):**


**Mandates sex education**

**Description:** State requires sex education in schools. Content requirements vary between states.

**Data source(s):**


**Impact:** Comprehensive sex education programs have been shown to result in lower rates of teen pregnancy, later sexual initiation, fewer sexual partners, and increased use of condoms and contraception.

**Impact source(s):**


**Mandates HIV education**

**Description:** State requires HIV education in schools. Content requirements vary between states.

**Data source(s):**


**Impact:** Comprehensive sex education programs have been shown to reduce transmission of HIV and other STIs.
Impact source(s):

Has broad eligibility criteria for Early Intervention services for children at risk of developmental delay

Description: State Early Intervention eligibility criteria are defined as broad, moderate, or narrow based on the degree of developmental delay required to receive services.

Data source(s):

Impact: Early Intervention services for children who have or are at risk of development delay have been shown to improve children’s outcomes in language and cognitive and social development, reduce the need for special education, and improve parents’ skills and confidence.

Impact source(s):

Initiative(s) to expand Early Head Start in place

Description: State has adopted one or more initiatives to expand access to Early Head Start.

Data source(s):

Impact: Early Head Start has been shown to improve children’s cognitive, language, and social-emotional development; and to improve parenting outcomes.

Impact source(s):

Requires districts to provide full-day kindergarten without tuition

Description: Full-day kindergarten is provided at no charge to all children per state statute and funding.

Data source(s):

Impact: Children who attend full-day kindergarten have better educational outcomes than children who attend half-day kindergarten, including a smoother transition to first grade and better academic achievement and attendance in later grades. The National Association for the Education of Young Children supports full-day kindergarten being available and affordable to all children.

Impact source(s):
Has firearm safety law(s) designed to protect children

**Description:** State has one or more of the following firearm laws: safe storage requirement, trigger locks required to be sold or offered at point of gun sales, assault weapons ban.

**Data source(s):**

**Impact:** In 2010, more than 2,500 children and teens were killed by guns. Gun safety laws have been shown to reduce accidental shootings, suicides, and mass shootings. The American Academy of Pediatrics supports gun safety regulation, including an assault weapons ban, safe storage requirements, and trigger locks.

**Impact source(s):**

### Supporting families’ financial health

**Allows families receiving TANF to keep child support collected on their behalf**

**Description:** Under federal law, families receiving income assistance, known as Temporary Assistance for Needy Families (TANF), must assign their rights to child support payments to the state. States, however, have the option of allowing some of the child support payment to be passed through to the parent and child.

**Data source(s):**

**Impact:** Receipt of child support reduces families’ need for public assistance programs, and has other economic, social, and academic benefits to children and families.

**Impact source(s):**

**State minimum wage is above the federal minimum**

**Description:** State law requires a minimum wage that is higher than the federal minimum wage.

**Data source(s):**

**Impact:** Increases in the minimum wage can increase family earnings, reduce enrollment in public assistance programs (such as food stamps), and bring families out of poverty.

**Impact source(s):**
Income limit for child care assistance is greater than 55% of state median income

**Description:** The federal limit for income eligibility is 85% of the state median income, but no state has adopted a limit that high. The 55% benchmark comes from the average across states, which is 55.9%.

**Data source(s):**

**Impact:** Child care assistance helps low-income parents participate in the workforce, helps keep families out of poverty, and increases children’s access to high-quality child care and early education programs.

**Impact source(s):**

Does not have a family cap policy or flat cash assistance grant

**Description:** Welfare benefits are most often calculated based on family size. Many states passed family cap policies, which deny additional benefits or reduce the cash grant to families who have additional children while on assistance.

**Data source(s):**

**Impact:** Family cap policies have no effect on their stated goal of reducing childbearing among women receiving welfare. Family caps result in higher poverty rates among mothers and children.

**Impact source(s):**

**Promoting a healthy environment**

Requires worksites, restaurants, and bars to be smoke free

**Description:** Data are for state-wide laws that apply to private-sector worksites, restaurants, and bars. States without statewide smoking restrictions may have local smoke-free laws. Private-sector worksites are places of work other than a building leased, owned, or operated by the state.

**Data source(s):**

**Impact:** Exposure to secondhand smoke has numerous negative health consequences, including increased risk of asthma and other respiratory problems in children as well as lung cancer and heart disease in adults. The World Health Organization recommends all indoor workplaces and all indoor public spaces be 100% smoke free.
Impact source(s):

