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REPORT ON LEGISLATION

A.9511-A / S.7511-A (Budget Article VII) – Parts A, B and K
AN ACT to amend the insurance law, the social services law, the education law and the public health law, in relation to requiring health insurance policies to include coverage of all FDA-approved contraceptive drugs, devices, and products, as well as voluntary sterilization procedures, contraceptive education and counseling, and related follow up services and prohibiting a health insurance policy from imposing any cost-sharing requirements or other restrictions or delays with respect to this coverage (Part A); to amend the penal law, the criminal procedure law, the county law and the judiciary law, in relation to abortion; to repeal certain provisions of the public health law relating to abortion; to repeal certain provisions of the education law relating to the sale of contraceptives; and to repeal certain provisions of the penal law relating to abortion (Part B); to amend the education law, in relation to the creation of the "Be Aware, Be Informed" awareness, prevention and education program (Part K)

THE WOMEN'S AGENDA

THESE PROVISIONS ARE APPOVED

The New York City Bar Association ("City Bar") writes in support of three provisions of the Women's Agenda Budget Article VII bill ("Women's Agenda"). The City Bar applauds the inclusion of a Women's Agenda in this year's budget, which is intended to advance equality and "create opportunity for women to succeed in every area: work, health, safety, education and family life."[1] Our report addresses three provisions of the Women's Agenda: the Comprehensive Contraceptive Coverage Act (Part A); decriminalizing abortion under state law (Part B); and the creation of a "Be Aware, Be Informed" education module (Part K).

PART A: THE COMPREHENSIVE CONTRACEPTIVE COVERAGE ACT – APPROVED

The Sex and Law Committee[2] supports the "Comprehensive Contraception Coverage Act," Part A of the Women's Agenda.[3] In sum, Part A provides that every group or blanket

[1] 2018 State of the State: 2018 Women's Opportunity Agenda for New York, https://www.ny.gov/programs/2018-womens-opportunity-agenda-new-york (all websites last visited March 9, 2018).

[2] The Sex and Law Committee addresses issues pertaining to gender and the law in a variety of areas that aim to reduce barriers to gender equality in health care, the workplace and civic life and to promote respect for the rule of law. The Committee's members work and practice in a wide range of areas, including, violence against women, reproductive rights, gender discrimination, poverty, matrimonial and family law, employment law, and same-sex marriage.

policy that is issued, amended, renewed, effective or delivered on or after January 1, 2019 shall provide coverage for all FDA-approved contraceptive drugs, devices and other products, including emergency contraception. The coverage must allow for the dispensing of twelve months' worth of contraceptive at one time; it must cover voluntary sterilization procedures; and it must cover patient education and counseling on contraception and follow-up services related to the drugs, devices and products. A group or blanket policy cannot impose a deductible, coinsurance, copayment or any other cost-sharing requirement, and cannot impose any restrictions or delays on the required coverage. Enrollee benefits extend to a covered spouse, domestic partner and non-spouse dependents.

We are pleased to support this bill and commend Governor Cuomo and those who have fought for comprehensive contraception coverage in New York State, particularly in the face of federal threats to reproductive health care coverage overall.[4]

Contraception Services are Essential for Women's Health and Equality

First approved by the FDA over 50 years ago, contraception has transformed the cultural landscape in the United States. By providing women[5] the tools and agency to determine whether and when to have children, contraception has been a catalyst for women's equal participation in our political and educational institutions as well as the paid workforce. The United States Supreme Court has held that if personal liberty "means anything, it is the right of the individual, married or single, to be free from unwarranted government intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child."[6] Moreover, the Court has recognized that efforts to make contraceptives less accessible may infringe on this fundamental right.[7]

Beyond these fundamental cultural shifts that give way to equal participation, contraception provides essential health benefits that are both related and unrelated to managing fertility. Indeed, contraception leads to improved birth outcomes and child health, reductions in

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[3] Much of this report first appeared in the Committee's *Report on Proposed DFS Rule Making Regarding Insurance Coverage of Contraception*, March 24, 2017, http://s3.amazonaws.com/documents.nycbar.org/files/201794-ContraceptionCoverageDFSrules_FINAL_3.23.17.pdf. Katharine Bodde, Alyson Zureick, and Hillary Schneller of the Sex & Law Committee were the primary drafters of that report, which drew from model comments issued by the New York Civil Liberties Union.

[4] Richard Wolf, *Second Federal Judge Blocks Trump Contraception Rule*, USA Today, Dec. 21, 2017, https://www.usatoday.com/story/news/politics/2017/12/21/second-federal-judge-blocks-trump-contraception-rule/974820001/.

[5] Not all people who seek contraception are or identify as women. While the comments here reference "women" and "female" they are meant to capture all who seek contraception.

[6] *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972).

[7] *Carey v. Population Services International*, 431 U.S. 678 (1977) (holding unconstitutional limiting distribution of contraceptives to licensed pharmacists because it would make contraceptives less accessible and reduced price competition).

morbidity and mortality rates and decreases in the risk of developing several reproductive cancers.[8]

While 99% of sexually active women of reproductive age use or have used contraception at some point in their lives,[9] lack of comprehensive contraceptive insurance coverage and high co-payments are significant barriers to consistent and effective contraceptive use. Fifty percent of pregnancies in the United States are unintended; of these, about half are due to a lack of contraceptive use and most of the other half are a result of inconsistent or incorrect contraceptive use.[10] In 2010, 55% of all pregnancies in New York were unintended, and the state stood to save $448 million if these unintended pregnancies had been prevented.[11]

Improving access to contraception is critical to the health and wellbeing of our families and communities. New York has recognized this since 2002, when the Women's Health and Wellness Act (WHWA) was passed, requiring insurance plans issued in New York that cover prescription drugs to include all FDA approved contraceptive drugs and devices.[12] In 2010 the federal government, recognizing the role that lack of insurance coverage or high copayments play in placing barriers to women's access to contraception, passed the federal Patient Protection and Affordable Care Act (ACA) and promulgated implementation guidelines which require insurance plans to cover at least one form of contraception within each of the FDA approved methods without co-payments.[13]

In 2017, New York issued regulations aimed at ensuring greater contraceptive coverage. According to a January 21, 2017 DFS Circular Letter,

> "[A]n issuer must provide coverage for all contraceptive drugs and devices. In addition, an issuer must provide coverage at no cost-

[8] Megan Kavanaugh & Ragnar Anderson, *Contraception and Beyond: The Health Benefits of Services Provided at Family Planning Center*, Guttmacher Institute (2013), https://www.guttmacher.org/sites/default/files/report_pdf/health-benefits.pdf.

[9] Kimberly Daniels, William D. Mosher, & Jo Jones, *Contraceptive Methods Women Have Ever Used: United States, 1982-2010*, U.S. Centers for Disease Control and Prevention. National Health Statistics Report no.62 (2013), https://www.cdc.gov/nchs/data/nhsr/nhsr062.pdf (finding that 99 percent of sexually active women of reproductive age in 2006–2010 who had ever had sexual intercourse have used at least one contraceptive method at some point in their lifetime).

[10] *Contraception and Beyond: The Health Benefits of Services Provided at Family Planning Centers*, *supra* note 8.

[11] Adam Sonfield, & Kathryn Kost, *Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care: National and State Estimates for 2010*, Guttmacher Institute (2015), http://www.guttmacher.org/pubs/public-costs-of-UP-2010.pdf.

[12] N.Y. Ins. Law § 3221 (l)(16) (requiring all federal Food and Drug Administration approved contraceptive services including oral contraceptives, diaphragms, Norplant, Depo Provera, cervical caps, IUDs and generic equivalents).

[13] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 199 (2010); 42 U.S.C.A. § 300gg–13(a)(4) (in accordance with the ACA and implementing regulations, the Department of Health and Human Services issued *Women's Preventive Services: Required Health Plan Coverage Guidelines*, which adopt the independent Institute of Medicine evidence-based recommendations, and require coverage of eight preventive health care services, including all FDA-approved methods of contraception, without cost-sharing. The guidelines and a list of covered preventive health care services for women are available at http://www.hrsa.gov/womensguidelines/.

> sharing for at least one form of contraception within each of the methods of contraception that the FDA has identified for women. An issuer also must provide coverage with no cost-sharing of contraceptive services related to follow-up and management of side effects, counseling for continued adherence, and device removal. Additionally, issuers must have an exceptions process for a woman to use to gain access to a contraceptive service at no cost-sharing that is easily accessible, transparent, and sufficiently expedient and that is not unduly burdensome for a woman. Further, issuers must provide complete and accurate information regarding contraceptive coverage to insureds and prospective insureds."[14]

This mandate was reaffirmed by the Governor in a June 5, 2017 press release, stating that insurers must "Provide coverage for the dispensing of an initial three-month supply of a contraceptive to an insured person. For subsequent dispensing of the same contraceptive covered under the same policy or renewal, an insurer must allow coverage for the dispensing of the entire prescribed contraceptive supply, up to 12 months, at the same time.[15]

While the ACA and the DFS regulations represent significant dedication to improving access to contraception, they are not enough to fully close the contraception coverage gap. Although the ACA requires contraceptive coverage without a co-payment, it does not require coverage of the full array of contraceptive types available within each of the FDA's approved methods. This means that women may still not be able to afford the form of contraception that's best for them, and men are left out of the coverage requirements entirely. And, while the DFS regulations were a significant and positive step forward, they need to be expanded and codified in order to fully cover contraception needs based on an individual's personal circumstances.

Part A would address these gaps by: (1) requiring insurers to cover any contraception that a health care provider recommends for a woman without a co-payment, (2) providing that women can access 12 months of contraception at one time (which reduces the likelihood of an unintended pregnancy), and (3) fully including and covering emergency contraception.

New York should be applauded for being at the forefront of responding to federal efforts to limit insurance coverage of contraception. Expanding and codifying these policies into state law will hold New York in good stead as it must respond to the changing landscape of federal law and guidance in this area. As long as there is confusion at the federal level around the future of the ACA and efforts to dismantle the federal contraceptive coverage requirement, there is a void that New York should firmly and quickly fill.[16] If the ACA is repealed and the contraceptive

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[14] *DFS Supplement No. 1 to Insurance Circular Letter No. 1 (2003)*, Jan. 21, 2017, http://www.dfs.ny.gov/insurance/circltr/2017/cl2017_s1_cl01_2003.pdf.

[15] Press Release: Governor Cuomo Announces Aggressive Actions to Protect Access to Quality, Affordable Health Care for All New Yorkers, June 5, 2017, http://www.dfs.ny.gov/about/press/pr1706051.htm.

[16] Michael Shear, *Trump Promises 'Insurance for Everybody' as Health Law Replacement*, The New York Times, Jan. 15, 2017, https://www.nytimes.com/2017/01/15/us/politics/trump-health-law-replacement.html. The Trump Administration's efforts to curtail access to contraception coverage based on an employer's moral or religious objections have been, so far, enjoined by two federal district courts. *See* n. 4, *supra.*

requirement rescinded, and if the DFS regulations remain as they are, insurers may not feel compelled to cover all contraception without co-payments, potentially forcing many individuals to choose less reliable methods of contraception or no contraception at all.

New York needs to strengthen existing protections to close current coverage gaps so that all families have access to the full array of affordable contraceptive methods. Part A does precisely that and we are pleased to support it.

PART B: DECRIMINALIZING ABORTION UNDER STATE LAW TO ENSURE THAT WOMEN CAN MAKE PERSONAL HEALTH CARE DECISIONS - APPROVED

Reproductive Rights in New York State: Reform is Overdue

The Sex and Law Committee and Health Law Committee[17] support New York State's decriminalization of abortion as proposed in Part B of the Women's Agenda. In accordance with the City Bar's long-standing commitment to upholding the principles of individual liberty and tradition of supporting the freedom of women to make private health care decisions and reproductive choices, we urge passage of the bill without delay.[18]

New York State was initially at the forefront in protecting women's health and reproductive freedom. In 1970, three years before the Supreme Court decided *Roe v. Wade*, 410 U.S. 113 (1973), New York State amended sections of its Penal Law to provide an exception to the total ban on abortion, permitting "justifiable abortions" performed "by a duly licensed physician" within 24 weeks of commencement of the pregnancy, or in cases where the woman's life is at risk.[19] While these exceptions represented a critical step at the time, New York's law has not been substantially changed since, and is now outdated and inadequate. It contains archaic provisions that fail to comply with subsequent Supreme Court decisions, prevents health care

[17] The City Bar's Health Law Committee addresses legal issues relating to the rights and welfare of patients and the betterment of our health care system and is comprised of a broad range of attorneys, from law firms to in-house counsel offices, as well as law students interested in pursuing a career in health care law. The members of the Health Law Committee represent clients from virtually all sectors of the health care industry, including not-for-profit and public academic medical centers and health systems, nursing homes, ambulatory care centers, home care agencies and hospice programs; pharmaceutical companies; health and managed care plans; as well as State and City governmental agencies.

[18] *See* City Bar reports in support of the Reproductive Health Act, June 2017, http://s3.amazonaws.com/documents.nycbar.org/files/2017166-ReproductiveHealthAct.pdf, and "Anti-Abortion Proposals Before the 97th Congress" (submitted by the Committee on Federal Legislation), The Record, Vol. 37 (1982). City Bar has also submitted amicus briefs in several landmark cases before the Supreme Court, including in *Webster v. Reproductive Health Services*, 492 U.S. 490 (1989), and most recently, *Whole Women's Health v. Hellerstedt*, 579 U.S. ___ (2016). City Bar has also opposed legislation that would restrict reproductive freedom, including urging rejection of Assembly Bill 8875 in 1998, which proposed criminalizing the performance of certain medical procedures, including banning certain constitutionally protected pre-viability abortions. *See* New York City Bar Association Report on Legislation, Assembly Bill 8875, dated as of June 1998.

[19] *See* N.Y. Penal Law §§ 125.40, 125.45 (defining crimes of abortion in the first and second degrees, with exceptions for when "such abortional act is justifiable"); § 125.05(3) (defining "justifiable" abortion as abortions occurring "(a) under [the physician's] reasonable belief that such is necessary to preserve [the pregnant woman's] life, or, (b) within twenty-four weeks from commencement of her pregnancy").

providers from offering the best reproductive care, impedes women's ability to make the decisions that are right for themselves and their families, and creates a looming threat of prosecution for women who end their own pregnancies.[20] Indeed, the Attorney General has issued an opinion stating that New York's current law on abortion stands in violation of the U.S. Constitution.[21] In light of increasing threats to abortion access across the United States and at the federal level, it is imperative that New York once again step up as a leader committed to protecting and affirming women's ability to effectuate their own reproductive health care decisions.

Overview

Part B of the Women's Agenda will fully decriminalize abortion by repealing the crimes of abortion and self-abortion in the criminal code and removing all reference to criminal abortion in the criminal procedure law, county law, and judiciary law. Additionally, the Part B will remove unconstitutional provisions governing abortion within the public health and education law.

As a result, like all other medical procedures, the regulation of abortion will default to the public health law and education law and related regulations. Therefore, medical providers and facilities that provide abortion care will continue to be regulated in the same manner as those providers and facilities are already regulated, including licensure requirements and other standard of care requirements, without the unrelated and unconstitutional threat of criminal penalties for providing necessary health care.

Additionally, because New York law does not currently allow for abortion care after 24 weeks when a woman's health is at risk or the fetus is not viable, a woman faced with such a situation may be forced to make an impossible decision of either traveling out of state for care, should she have the resources to do so, or waiting until her health has deteriorated to a point that her life is at risk. Part B will effectively remove this unconstitutional conflict in our law and ensure that the constitutional protections of *Roe* continue to apply in New York State.

[20] *See* N.Y. Penal Law §§ 125.50, 125.55 (defining the crimes of self-abortion in the first and second degrees for a woman who "commits or submits to an abortion act upon herself" unless the abortional act is "justifiable"); § 125.05(3) (a woman's commission of an abortional act upon herself is justifiable "when she acts upon the advice of a duly licensed physician (1) that such act is necessary to preserve her life, or, (2) within twenty-four weeks from the commencement of her pregnancy," and submission to an abortion act is justifiable when the woman "believes that it is being committed by a duly licensed physician, acting under a reasonable belief that such act is necessary to preserve her life, or, within twenty-four weeks from the commencement of her pregnancy."

[21] *See* Press Release: A.G. Schneiderman Issues Legal Opinion Clarifying That New York State's Criminal Law Does Not Interfere With Reproductive Health Rights Ensured By Roe V. Wade And Later Cases, Sept. 8, 2016, https://ag.ny.gov/press-release/ag-schneiderman-issues-legal-opinion-clarifying-new-york-states-criminal-law-does-not.

The Need for New York to Decriminalize Abortion Now

The U.S. Supreme Court has, of course, long recognized a fundamental privacy right in matters "relating to procreation, childbirth, child rearing, and family relationships,"[22] which was later held to encompass decisions regarding contraception and whether to continue or terminate a pregnancy.[23] New York State, too, has long recognized that reproductive choice and the right to bodily integrity are fundamental rights subject to strict scrutiny.[24]

Currently, New York regulates abortion under an outdated, pre-*Roe* presumption that abortion is a criminal act except under certain circumstances. The "justifiable abortion" exception carved out of the penal code effectively permits abortion for any reason until twenty-four weeks of pregnancy, or in cases where, in the reasonable medical judgment of a physician, the abortion is necessary to protect the woman's life.[25] The persistence of the regulation of abortion in New York's Penal Law has the extraordinary effect of targeting not only health care professionals who provide abortions, but women who engage in self-directed care, for risk of prosecution based solely upon the type of medical care at issue -- a phenomenon which is otherwise unprecedented in New York law. No New Yorker should fear prosecution for needing an abortion, whatever the circumstances, and no health care provider should fear prosecution for providing it within their best medical judgment.

Although the law includes an exception for performance of an abortion after 24 weeks when a woman's *life* is at risk, the law currently does not contain an exception for women's *health*, or for cases of fetal nonviability. Accordingly, it fails to comply with United States Supreme Court precedent requiring that statutes governing abortion permit abortion *at any time* prior to fetal viability or in cases where a woman's health is at risk.[26] Thus, although the existing

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[22] *Zablocki v. Redhail*, 434 U.S. 374, 383-386 (1978); *see also Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942) (recognizing the right to procreate as "one of the basic civil rights of man . . . fundamental to the very existence and survival of the race."); *Carey*, 431 U.S. at 685 (recognizing a fundamental right to privacy in matters of marriage and procreation).

[23] *See Griswold v. Connecticut*, 381 U.S. 479, 485-486 (1965) (recognizing the fundamental right of married persons to purchase and use contraceptives); *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972) (extending right to use contraceptives to unmarried persons, and stating that "[i]f the right to privacy means anything, it is the right . . . to be free from unwarranted state intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child."); *Roe*, 410 U.S. at 153 (recognizing right to privacy encompassed abortion decision); *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992) (upholding core principle of *Roe*).

[24] *Hope v. Perales*, 83 N.Y.2d 563 (1994); 67; *Rivers v. Katz*, 67 N.Y.2d 485, 495 N.E.2d 337 (1986).

[25] *See* N.Y. Penal Law §§ 125.40, 120.45; 120.25(3).

[26] *See Roe*, 410 U.S. at 163-64 ("If the State is interested in protecting fetal life after viability, it may go so far as to proscribe abortion during that period, except when it is necessary to preserve the life *or health* of the mother.") (emphasis added); *Doe v. Bolton*, 410 U.S. 179, 192 (1973) (defining "health" to include "all factors – physical, emotional, psychological, familial, and the woman's age – relevant to the well-being of the patient."); *Casey*, 505 U.S. at 878-79 (affirming "*Roe*'s holding that 'subsequent to viability, the State in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.'") (*quoting Roe*, 410 U.S. at 164-65); *Stenberg v. Carhart*, 530 U.S. 914, 921 (2000) (same); *but c.f. Gonzales v. Carhart*, 550 U.S. 124, 166-67 (2007) (upholding the federal Partial Birth Abortion Act's ban on a particular abortion procedure, despite the law's lack of a health exception, but noting the availability of alternative procedures to terminate the pregnancy should the women's health require it).

Penal Law provisions operate with the effect of permitting abortions performed up until 24 weeks of pregnancy, the lack of these explicit exceptions in the context of a criminal provision has a chilling effect when it comes to pregnancies near or beyond 24 weeks. Fearing prosecution, and in the absence of an explicit exception for health or nonviability, most providers will not provide abortions under those circumstances. This has resulted in a significant obstacle for women who find themselves in the tragic circumstances of needing an abortion later in pregnancy due to a severe fetal anomaly or a risk to their own health. Women have had to travel out of state in order to obtain the care they need, often at great financial cost and further risk to their health. Part B would remedy this by fully decriminalizing abortion and regulating the procedure under New York's Public Health Law and current scope of practice rules.

Among the many outdated and harmful facets of New York's abortion-related penal laws, the continued criminalization of self-abortion stands as an outlier in the nation. At common law, even where abortion was considered a crime, it was not a crime that a woman could commit upon herself. To treat it as such, the Florida Supreme Court warned, would "abrogate willy-nilly a centuries-old principle of the common law—which is grounded in the wisdom of experience and has been adopted by the legislature—and install in its place a contrary rule bristling with red flags and followed by no other court in the nation."[27] New York is one of only seven states that elected to break with that tradition. Even among these outliers, the Ninth Circuit has ruled at least one self-abortion ban unconstitutional,[28] another has been declared unenforceable by the state Attorney General,[29] and a third has been declared unconstitutional by a federal district court[30] — calling into question the constitutionality of the remaining few. New York's self-abortion provision, though potentially unconstitutional, is not inert: it has led to arrests within the past decade.[31]

The current law authorizes abortions performed by a "duly licensed physician." However, the law's enactment predates advances in the intervening decades in the provision of routine medical care by advanced practice clinicians ("APCs"), including nurse practitioners, nurse midwives, and physician assistants. By only authorizing abortions performed by a "physician"

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[27] *See, e.g., State v Ashley*, 701 So. 2d 338, 342-43 (Fla. 1997). *See also Hillman v. State*, 232 Ga. App. 741, 503 S.E.2d 610 (1998) (refusing to extend Georgia's felony abortion statute to abrogate the common law principle that the woman who had the abortion was neither accomplice nor perpetrator); *State v. Carey*, 76 Conn. 342, 56 A. 632, 636 (1904) ("At common law an operation on the body of a woman quick with child, with intent thereby to cause her miscarriage, was an indictable offense, but it was not an offense in her to so treat her own body, or to assent to such treatment from another").

[28] *McCormack v. Hiedeman*, 694 F.3d 1004, 1015 (9th Cir. 2012) (invalidating Idaho's law penalizing women who end their own pregnancies as an undue burden on the right to seek abortion, potentially affecting Arizona and Nevada's similar laws).

[29] *See Delaware Women's Health Org. v. Wier*, 441 F. Supp. 497, 499 n.9 (D. Del. 1977); Statement of Policy, Att'y Gen. of Del. (Mar. 24, 1977) (declaring 11 Del. Code § 652, which criminalizes self-abortion, unconstitutional under *Roe* and declaring that it would not be enforced).

[30] *Henrie v. Derryberry*, 358 F. Supp. 719 (N.D. Okla. 1973) (declaring 21 Okla. Stat. § 862, which criminalizes women who "solicit" or "submit to" abortions unconstitutional).

[31] *See, e.g. NYPD: Manhattan Woman Charged With Performing Self-Abortion*, CBS N.Y., (Dec. 1, 2011, 8:30 PM), http://cbsloc.al/2pxAnrZ; Pedro Ramirez III, *Self Abortion: Woman took Tylenol, Motrin***,** Syracuse.com, Apr. 12, 2007, http://bit.ly/2r8Yy3d.

the law has placed an obstacle in the path of APCs acting in their lawful scope of practice in the provision of early, non-surgical abortion. There is no valid medical justification for a physician-only limitation, as leading medical associations have endorsed the provision of abortion by appropriately trained APCs.[32] Clarifying this legal ambiguity is critical, particularly in rural areas of the state where providers are few and far between. By removing the outdated physician language from New York's penal code, the Budget bill accordingly allows for physicians and APCs to provide early abortion care within their competency and licensure. This will treat provision of abortion consistently with the regulation of the provision of all other forms of health care routinely provided by APCs in accordance with their training and scope of practice and ensure that women, especially those in rural areas and low-income women, have greater access to safe and early abortion care.

Conclusion

Given the shift in U.S. Supreme Court abortion jurisprudence in recent years, and a possible shift in the composition of the Supreme Court itself, it is more important than ever that the State of New York update its laws regulating reproductive health.[33] For this reason as well, New York should act now to finally decriminalize abortion and ensure that access to care is not out-of-step with the constitutional protections *Roe* guarantees all women.[34]

PART K: IMPLEMENTING THE "BE AWARE, BE INFORMED" LEARNING MODULE – APPROVED WITH SUGGESTED MODIFICATION

The Education and the Law Committee[35] and Sex and the Law Committee supports, with some recommended modifications, the enactment of Part K of the Women's Agenda, which would amend New York's Education Law to establish a "Be Aware, Be Informed" learning module.

Under the proposed budget provision, the State Education Department, in consultation with the Department of Health, would develop a model K-12 curriculum on healthy relationships. This curriculum would provide age appropriate information on confronting and avoiding sexual harassment, assault and teen dating violence, as well as medically accurate sexual health. The curriculum would also reinforce the definition of affirmative consent as established in the "Enough is Enough" law to foment a common understanding for all students.

[32] The provision of abortion care by appropriately trained clinicians has been endorsed by: American College of Obstetricians and Gynecologists (http://bit.ly/2s1WM4O), the American Public Health Association (http://bit.ly/2rbxzkl), the International Confederation of Midwives (http://bit.ly/2r1hFtp), and Physicians for Reproductive Health (https://prh.org/abortion/), among others. *See also* Nat'l Abortion Federation & Clinicians for Choice, *Role of CNMs, NPs, and PAs in Abortion Care*, http://bit.ly/2skPx8K (collecting policy statements).

[33] *Compare Gonzales*, 550 U.S. at 166-67 (discussed *supra* at n. 15) *with Stenberg*, 530 U.S. at 945-46 (striking down a similar Nebraska "partial-birth" abortion ban for vagueness and for failing to provide a health exception).

[34] Should New York adopt the Part B, it will join at least seven other states that have adopted reproductive rights laws generally protecting the right of a woman to obtain an abortion either before fetal viability or, in the case of post-fetal viability, to protect the life or health of the pregnant woman. *See* Appendix A.

[35] The Education and Law Committee addresses legal and policy issues affecting education across New York. Its members serve institutions and organizations supporting both K-12 and higher education learning environments.

The curriculum would be made publicly available on a the Department's website and provided at no cost to every school district, board of cooperative educational services, charter school and nonpublic school upon request.

The Committees believe the instructional effort contemplated by this legislation is a necessary complement to federal and state efforts to decrease the prevalence of sexual and interpersonal violence in our schools and communities. Under the Violence Against Women Act (VAWA) amendments to the Clery Act, Congress recognized the importance of prevention training by requiring higher education institutions to offer primary and ongoing prevention and awareness programs on dating violence, domestic violence, sexual assault, and stalking to all students and employees.[36] New York's Enough is Enough law adopted VAWA's training mandates, but also took them a step further in 2015, by requiring athletes and student leaders to actually *complete* training in these areas.[37]

These laws apply only to higher education, but young adults form beliefs – and sometimes misconceptions – about relationships and related conduct well before they arrive on a college campus. Age-appropriate training efforts therefore must begin earlier, before students' ideas become relatively fixed. A common statewide educational module available for K-12 students will create a better understanding of safe, healthy relationships, while helping to prevent violence not only in primary and secondary schools, but also across our communities and on college campuses. Consistent with Enough is Enough, educating K-12 students on appropriate relationships will allow higher education institutions to build upon a strong foundation of healthy perspectives already introduced in K-12, thus making later prevention efforts more effective.

While the Committees support this provision to develop the "Be Aware, Be Informed" module, the Committees recommend an amendment to ensure that appropriate instruction reaches every student in New York State. As currently drafted, the legislation would only *provide* model curriculum, lesson plans, and instructional materials to schools throughout the state. It does not go so far as to affirmatively require public schools to offer this instruction. Such a requirement – akin to the mandates from VAWA and "Enough is Enough" to offer training at every institution of higher education – should be included in the proposed legislation. *Requiring* schools to offer this instruction would ensure that students across the state consistently receive the benefit of age-appropriate, evidence-informed training. The City Bar has long supported the need for mandatory, comprehensive, age-appropriate, medically accurate sexual health education for school age children.[38]

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[36] *See* 20 U.S.C. § 1092(f)(8); 34 C.F.R. § 668.46(a), (b)(11), (j).

[37] *See* N.Y. Educ. L. § 6447(6).

[38] *See i.e.* Written Testimony of the New York City Bar Association Sex and Law Committee, New York City Council Committees on Health, Education and Women's Issues on Sex Education in NYC Schools, Int. 0771-2015, Int. 0952-2015, Int. 0957-2015, Oct. 27, 2015, https://www2.nycbar.org/pdf/report/uploads/20072981-SexEducationNYCSchoolsSexLawTestimonyFINAL102715.pdf ("A problem as prevalent and deeply rooted as sexual violence requires a multidimensional, multi-sector response. At the core of any such policy response must be a comprehensive sex education program that reaches all of our students."); *see also*, "Sexuality Education" reports list at http://tinyurl.com/y9dj3tom.

The Committees further believe, however, that such a requirement must be accompanied by consistent funding sources. All of New York's students deserve information on healthy, positive relationships and sexual health – not just those who attend schools with the resources to offer it. While development of a common statewide instructional module will certainly help alleviate the resource burden on individual schools, implementing such training – and doing it well – will still require expenditure of time and financial resources, particularly to ensure that those delivering the instruction are themselves qualified and effective. Training conducted by teachers who are themselves well-versed in the topics covered by Be Aware, Be Informed will ensure that lessons learned from the module can be safely implemented by students in their relationships, homes, and communities.

The Committees look forward to efforts that promote healthy, safe relationships and meaningfully reach students across New York. Accordingly, the Committees support the enactment of Part K with the modifications discussed above.

Sex and Law Committee
Mirah Curzer & Melissa Lee, Co-Chairs

Education and the Law Committee
Laura Barbieri, Chair

Health Law Committee
Kathleen M. Burke, Chair

March 2018

APPENDIX A

Reproductive Rights Laws In Other States

CALIFORNIA

Cal. Health and Safety Code § 123462. *Legislative findings and declarations*
The legislature finds and declares that every individual possesses a fundamental right of privacy with respect to personal reproductive decisions. Accordingly, it is the public policy of the State of California that:
(a) Every individual has the fundamental right to choose or refuse birth control.
(b) Every woman has the fundamental right to choose to bear a child or to choose and to obtain an abortion, except as specifically limited by this article.
(c) The state shall not deny or interfere with a woman's fundamental right to choose to bear a child or to choose to obtain an abortion, except as specifically permitted by this article.

Health and Safety Code §123466. *Denial or interference with a woman's right*
The state may not deny or interfere with a woman's right to choose or obtain an abortion prior to viability of the fetus, or when the abortion is necessary to protect the life or health of the woman.

CONNECTICUT

Conn. Gen. Stat. Ann. § 19a-602. *Termination of pregnancy prior to viability. Abortion after viability prohibited; exception*
Termination of pregnancy prior to viability. Abortion after viability prohibited; exception.
(a) The decision to terminate a pregnancy prior to the viability of the fetus shall be solely that of the pregnant woman in consultation with her physician.
(b) No abortion may be performed upon a pregnant woman after viability of the fetus except when necessary to preserve the life or health of the pregnant woman

HAWAII

Haw. Rev. Stat. § 453-16.[39] *Intentional termination of pregnancy; penalties; refusal to perform.*
(a) No abortion shall be performed in this state unless:
1. The abortion is performed by a licensed physician or surgeon, or by a licensed osteopathic physician and surgeon; and
2. The abortion is performed in a hospital licensed by the department of health or operated by the federal government or an agency thereof, or in a clinic or physician's or osteopathic physician's office.

(b) Abortion shall mean an operation to intentionally terminate the pregnancy of a nonviable fetus. The termination of a pregnancy of a viable fetus is not included in this section.
(c) The State shall not deny or interfere with a female's right to choose or obtain an abortion of a nonviable fetus or an abortion that is necessary to protect the life or health of the female.

[39] One bill currently being considered would expand the range of practitioners who can provide aspiration abortions to include advanced practice registered nurses. 2017 Hawaii Senate Bill No. 124, Hawaii Twenty-Ninth Legislature.

(d) Any person who knowingly violates subsection (a) shall be fined not more than $1,000 or imprisoned not more than five years, or both.
(e) Nothing in this section shall require any hospital or any person to participate in an abortion nor shall any hospital or any person be liable for a refusal.

MAINE

Me. Rev. Stat. Ann. tit. 22 § 1598. *Abortions*
1. *Policy*. It is the public policy of the State that the State not restrict a woman's exercise of her private decision to terminate a pregnancy before viability except as provided in section 1597-A. After viability an abortion may be performed only when it is necessary to preserve the life or health of the mother. It is also the public policy of the State that all abortions may be performed only by a physician.
2. *Definitions*. As used in this section, unless the context otherwise indicates, the following terms shall have the following meanings.
   A. "Abortion" means the intentional interruption of a pregnancy by the application of external agents, whether chemical or physical or by the ingestion of chemical agents with an intention other than to produce a live birth or to remove a dead fetus.
   B. "Viability" means the state of fetal development when the life of the fetus may be continued indefinitely outside the womb by natural or artificial life-supportive systems.
3. *Persons who may perform abortions; penalties*.
   A. Only a person licensed under Title 32, chapter 36 or chapter 48, to practice medicine in Maine as a medical or osteopathic physician, may perform an abortion on another person.
   B. Any person not so licensed who knowingly performs an abortion on another person or any person who knowingly assists a nonlicensed person to perform an abortion on another person is guilty of a Class C crime.
4. *Abortions after viability; criminal liability*. A person who performs an abortion after viability is guilty of a Class D crime if:
   A. He knowingly disregarded the viability of the fetus; and
   B. He knew that the abortion was not necessary for the preservation of the life or health of the mother.

MARYLAND

Md. Code Ann. Health Gen. § 20-209. *State interference with abortions*
(a) *Viable defined* - In this section, "viable" means that stage when, in the best medical judgment of the attending physician based on the particular facts of the case before the physician, there is a reasonable likelihood of the fetus's sustained survival outside the womb.
(b) *In general* - Except as otherwise provided in this subtitle, the State may not interfere with the decision of a woman to terminate a pregnancy:
   1. Before the fetus is viable; or
   2. At any time during the woman's pregnancy, if:
      i. The termination procedure is necessary to protect the life or health of the woman; or
      ii. The fetus is affected by genetic defect or serious deformity or abnormality.
(c) *Regulations* - The Department may adopt regulations that:
   1. Are both necessary and the least intrusive method to protect the life or health of the

woman; and

2. Are not inconsistent with established medical practice.

(d) *Liability*.- The physician is not liable for civil damages or subject to a criminal penalty for a decision to perform an abortion under this section made in good faith and in the physician's best medical judgment in accordance with accepted standards of medical practice.

NEVADA

Nev. Rev. Stat. Ann. § 442.250. *Conditions under which abortion is permitted***.**

1. No abortion may be performed in this state unless the abortion is performed:

a. By a physician licensed to practice in this state or by a physician in the employ of the government of the United States who:

i. Exercises his best clinical judgment in the light of all attendant circumstances including the accepted professional standards of medical practice in determining whether to perform an abortion; and

ii. Performs the abortion in a manner consistent with accepted medical practices and procedures in the community.

b. Within 24 weeks after the commencement of the pregnancy.

c. After the 24th week of pregnancy only if the physician has reasonable cause to believe that an abortion currently is necessary to preserve the life or health of the pregnant woman.

2. All abortions performed after the 24th week of pregnancy or performed when, in the judgment of the attending physician, there is a reasonable likelihood of the sustained survival of the fetus outside of the womb by natural or artificial supportive systems must be performed in a hospital licensed under chapter 449 of NRS.

3. Before performing an abortion pursuant to subsection 2, the attending physician shall enter in the permanent records of the patient the facts on which he based his best clinical judgment that there is a substantial risk that continuance of the pregnancy would endanger the life of the patient or would gravely impair the physical or mental health of the patient.

WASHINGTON

Wash. Rev. Code Ann. § 9.02.100. *Reproductive privacy -- Public policy.*

The sovereign people hereby declare that every individual possesses a fundamental right of privacy with respect to personal reproductive decisions. Accordingly, it is the public policy of the state of Washington that:

(1) Every individual has the fundamental right to choose or refuse birth control;

(2) Every woman has the fundamental right to choose or refuse to have an abortion, except as specifically limited by RCW 9.02.100 through 9.02.170 and 9.02.900 through 9.02.902;

(3) Except as specifically permitted by RCW 9.02.100 through 9.02.170 and 9.02.900 through 9.02.902, the state shall not deny or interfere with a woman's fundamental right to choose or refuse to have an abortion; and

(4) The state shall not discriminate against the exercise of these rights in the regulation or provision of benefits, facilities, services, or information.

Rev. Code Ann. § 9.02.110. *Right to have and provide.*

The state may not deny or interfere with a woman's right to choose to have an abortion prior to viability of the fetus, or to protect her life or health.

A physician may terminate and a health care provider may assist a physician in terminating a pregnancy as permitted by this section.

Rev. Code Ann. § 9.02.140. *State regulation.*
Any regulation promulgated by the state relating to abortion shall be valid only if:
(1) The regulation is medically necessary to protect the life or health of the woman terminating her pregnancy,
(2) The regulation is consistent with established medical practice, and
(3) Of the available alternatives, the regulation imposes the least restrictions on the woman's right to have an abortion as defined by RCW 9.02.100 through 9.02.170 and 9.02.900 through 9.02.902.

Rev. Code Ann. § 9.02.160. *State-provided benefits.*
If the state provides, directly or by contract, maternity care benefits, services, or information to women through any program administered or funded in whole or in part by the state, the state shall also provide women otherwise eligible for any such program with substantially equivalent benefits, services, or information to permit them to voluntarily terminate their pregnancies.