



A Proactive Abortion Agenda

Federal and State Policies To Protect and Expand Access

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Introduction and summary

Abortion is a common health care procedure. Specifically, a reported 1 in 4 women in the United States will have an abortion before the age of 45.¹ And the majority of people in the United States, regardless of political or religious affiliation, support a person's² right to obtain an abortion.³ Yet despite the consistent public support across religious and political affiliations, anti-abortion lawmakers' attempts to circumvent abortion rights have persisted for decades.⁴ The U.S. Supreme Court established the right to an abortion in the 1973 decision *Roe v. Wade*, but anti-abortion activists have worked consistently to undermine it. As a result, the right to an abortion has never been realized for all. Even more, barriers to insurance coverage for abortion, stigma, discrimination, and targeted violence have led to many not having the meaningful ability to access this care or even being harmed if they do access or attempt to access an abortion.

In particular, because anti-abortion activists have not been successful at completely overturning the right to an abortion, they have worked to chip away access. From January 2014 to June 2019, states signed into law 227 abortion restrictions or bans.⁵ In 2019 alone, 58 percent of women of reproductive age resided in states that were deemed hostile to abortion rights, according to the Guttmacher Institute.⁶ As a result of these restrictions, more than 11 million women of reproductive age nationwide live more than an hour's drive away from an abortion provider.⁷ Coverage barriers in public and private insurance have also prevented many from accessing abortion. Without insurance coverage, abortion care can be prohibitively expensive, with the average costs ranging from \$400 to \$550 for an abortion performed in a clinic at 10 weeks and \$1,100 to \$1,650 for an abortion performed at 20 to 21 weeks.⁸ Making matters worse, unnecessary restrictive laws—including those that require people to travel, make multiple trips, and delay seeking care until they save money to pay out of pocket—increase the cost of the procedure, on top of increasing the health risks.

Moreover, inflammatory rhetoric and a system designed to stigmatize abortion have led to violence against people seeking to access abortion and providers working to provide this care. According to National Abortion Federation data, there was an increase in violence or threat of violence against abortion clinics in 2018 and 2019.⁹ Even worse, there have been 11 murders, 26 attempted murders, 42 bombings, 189 arsons, and countless other criminal activities directed toward abortion providers since 1977.

The limits on abortion are not equally felt by all. In every Southern state except Florida, more than half of women of reproductive age live in a county with no abortion clinic.¹⁰ And notably, Black women disproportionately reside in states with abortion restrictions.¹¹ It is also important to note that data frequently do not reflect the experiences of transgender and nonbinary people, so researchers, lawmakers, and advocates do not have a complete understanding of abortion access for people who do not identify as women but are capable of becoming pregnant. There are also certain abortion restrictions, such as “reason bans” and parental notification laws, that are intended to undermine abortion access for people of color, young people, and people with disabilities.

Furthermore, populations that have been systemically oppressed are less able to navigate these barriers due to the discrimination and injustices they already face. For instance, pay inequities among Black, Latina, and Indigenous women—as well as people with disabilities, transgender people, and young people—mean that these communities are less able to pay for abortion care out of pocket, travel to access abortion care, or pay the additional costs associated with delays in abortion access.¹² In fact, nearly 50 percent of abortion patients have incomes below the federal poverty level.¹³ Meanwhile, transgender and nonbinary people might face increased stigmatization when accessing abortion given the increased level of discrimination they face when accessing health care generally.¹⁴ Young people are less able to take time off work or school or travel to access an abortion, and they may also have to navigate requirements to disclose to their parent or guardian when they are seeking an abortion.¹⁵ And people with disabilities may not have the legal autonomy to make their own reproductive health care decisions and may have providers or caregivers who do not support their bodily autonomy.¹⁶

Barriers to access that result in a delayed or denied abortion have been associated with adverse health outcomes and depressed economic advancement, compounding the racism, sexism, and other systemic barriers that communities of color, people with disabilities, people with low incomes, LGBTQ people, and young

people experience. Specifically, a delayed or denied abortion has been found to increase the likelihood of certain mental health conditions or illnesses, serious pregnancy complications, and interpersonal violence.¹⁷ According to ANSIRH's Turnaway Study, women denied an abortion are also more likely to be unemployed or impoverished, particularly if they are living below the poverty line before the abortion denial.¹⁸

It is, therefore, a public health, economic, and human rights imperative to ensure that people have not only the right but also meaningful access to abortion care, free from discrimination or fear of violence. Federal and state lawmakers have the ability and obligation to implement systemic changes that remove barriers to health care. Abortion is health care, and policies related to civil and human rights, insurance coverage, health care delivery, and criminalization must treat abortion equally to other services. And lawmakers should support this right regardless of and without question as to the reason why the person is seeking care.

This report outlines federal- and state-level policy recommendations to advance abortion rights and access. Where relevant, the authors offer international and domestic examples of countries and states working to make abortion access meaningful for everyone—and highlight the advocacy of other organizations and providers to achieve some of these policies. Some recommendations have been covered in previous reports from the Center for American Progress, as well as other federal and state organizations leading on various issues; but the objective here is to provide a comprehensive road map for state and federal lawmakers to develop and enact policies that achieve equitable abortion access.

Recommendations within the report include:

- **The right to abortion should be codified into law:** The right to abortion as guaranteed in the 1973 Supreme Court decision *Roe v. Wade* has never been realized for all. Recent attacks on the right to an abortion and abortion access have only exacerbated long-existing barriers to care. Federal courts, including but not limited to the Supreme Court, have grown both increasingly conservative and hostile to abortion rights. As such, state and federal lawmakers must enact proactive policies to guarantee that there is a meaningful right to abortion in the United States.
- **Lawyers with pro-abortion rights records should be selected for the bench:** More than a quarter of the appellate bench and a third of the Supreme Court is now made up of former President Donald Trump's appointees—a slate of individuals overall considered to be extreme far-right in their approach to the law.¹⁹ This ability

to both politicize the court and shift it to become more conservative can have a significant impact on the legality and implementation of proactive abortion policies and state restrictions seeking to undermine abortion. State judges similarly can influence abortion policy. What is more, the judiciary has for generations lacked diversity in terms of race, ethnicity, gender identity, sexual orientation, and disability status. Lawmakers should make an intentional effort to ensure professional and personal diversity in the judiciary, including by supporting lawyers who have a proven record of advocating for abortion rights.

- **No government should be able to interfere with the right to abortion:** Anti-abortion lawmakers and activists have engaged in concerted efforts to force abortion providers and clinics to cease operations in an attempt to limit or undermine abortion access. For instance, targeted regulation of abortion providers (TRAP) laws impose unnecessary restrictions on abortion providers, such as requirements for providers to have hospital admitting privileges or meet certain building requirements.²⁰ Other abortion restrictions take many forms, including but not limited to gestational bans, method bans, reason bans, and medically unnecessary requirements such as waiting periods and biased counseling requirements. Lawmakers should enact proactive policies to rescind and prohibit these unnecessary abortion bans.
- **Abortion must be affordable for all:** Abortion coverage and, subsequently, access are highly dependent on a person's insurance coverage, employment, and geographic location, among other factors.²¹ Federal restrictions on abortion coverage—including but not limited to the Hyde Amendment, which prohibits federal funds from covering abortion except in the instances of rape, incest, and life endangerment—have for decades limited abortion access for people enrolled in Medicaid, federal employees, members of the military, Peace Corps volunteers, people detained in federal prisons, Indigenous people, and more.²² There are also additional administrative and billing hurdles placed on the private insurance coverage of abortion in the Affordable Care Act (ACA) marketplaces, which can discourage private insurers from covering care. And a slew of state restrictions prohibit or limit private insurers' ability to cover abortion. Coverage policies must be inclusive of abortion care.
- **People need access to the full range of options for abortion care—delivered in person, via telemedicine, or self-managed:** The harm imposed by laws targeted at abortion providers and patients is further exacerbated by unnecessary restrictions on medication abortion, or abortion with pills, and telehealth that create barriers to accessing abortion outside of the clinic or hospital setting. The criminalization of self-

managed abortion also prohibits individuals' ability to safely self-administer abortion care. State and federal policymakers must act to remove barriers and expand access to medication abortion, including via telehealth and self-managed abortion.

- **Expand the workforce of abortion providers trained in culturally competent care:** In addition to state laws targeting abortion providers, federal and state anti-abortion lawmakers have also enacted policies that have been prohibitive to abortion providers participating in health care programs, restricting not only abortion access but also preventive and reproductive care more broadly. Moreover, limited access to training for abortion providers and state restrictions on physician assistants', midwives', and nurse practitioners' ability to participate in abortion care further hamper abortion access. Lawmakers must prevent discrimination against abortion providers and direct funding to train and expand the provider workforce.
- **Patient and provider safety must be a priority:** No matter the form, abortion restrictions not only limit access but also further stigmatize abortion care, which can threaten patient and provider safety. Stigmatizing abortion leads to discrimination against abortion patients and providers and can lead to clinic violence. State and federal policies must protect abortion providers and patients from discrimination, harassment, and violence.
- **Abortion must be supported and integrated within the full scope of reproductive health care services:** While the federal right to an abortion has existed for nearly 50 years, abortion has yet to be fully integrated into the U.S. health care system. In order for this to happen, abortion must be treated as the health care service that it is, not siloed out from other health care services. Certain providers and health care support workers do operate in a more holistic manner, integrating abortion care as part of comprehensive reproductive health care, along with contraception, maternal health care, gender-affirming services, HIV prevention and treatment, and more. However, access to these health care workers is limited because they often are not adequately funded. Lawmakers should support the integration of abortion in the health care system and expand access to abortion support workers, such as abortion doulas.

Given the existing barriers to abortion care, the road to meaningfully integrating abortion into the nation's health care and other systems will not be solved with one policy. The recommendations outlined in this report are visionary but also practically achievable. Without comprehensive policy changes, however, the right to abortion will continue to exist in name only for far too many.

Abortion stories: Jordyn

“When I was 18, I found out I was pregnant. I knew immediately that choosing to end my pregnancy was the right choice for me. Thankfully, I found a clinic near me and was able to schedule my abortion. The clinic staff were kind and caring, and their support reaffirmed my choice. I have felt like I had to justify my abortion because of stigmatizing narratives by saying things like, ‘I wasn’t financially stable.’ But what it really comes down to is that I just didn’t want to be pregnant and I didn’t want to be a parent. And that’s all the justification anyone needs. Abortion doesn’t have to be this sad, scary thing. A lot of the time it’s not. It can be empowering. It can be affirming. Mine was great. Other people may want to put their own feelings onto my story and say abortion should be sad, but mine was one of the best decisions I’ve ever made. I celebrate my abortion, and no one can take that away from me.”²³ — Jordyn (as told to *Teen Vogue*)

The right to an abortion must not be left to a court

In *Roe v. Wade*, the U.S. Supreme Court ruled that the constitutional right to privacy includes a “fundamental right” to an abortion.²⁴ The court has affirmed this decision in rulings for nearly 50 years, including in the landmark case *Planned Parenthood of Southeastern Pennsylvania v. Casey*, which declared that reproductive decisions are “too intimate and personal for the State to insist, without more, upon its own vision of the woman’s role.”²⁵ However, the Supreme Court has allowed a number of restrictions that impede or entirely deny access to abortion care, while still maintaining that these restrictions are permissible under *Roe*. Furthermore, the conservative shift of the court represents a direct threat to the judicially designated right to an abortion, and in recent years, states have passed extremely restrictive laws—seemingly to invite a constitutional challenge that might need to be resolved by the Supreme Court.²⁶ The current high court justices’ judicial philosophy suggests that they may be more willing to upend precedent and the rule of law to further erode *Roe*’s protections or overturn it entirely.²⁷ State and federal lawmakers, however, can take action to ensure that abortion rights are protected regardless of the court’s rulings and to rebalance the makeup of the judiciary so that it is more diverse in ideology, professional background, and demographics.

The right to an abortion should be codified into law

A Supreme Court ruling overturning—or even undermining—*Roe* would undoubtedly threaten the legal right to an abortion, especially in Southern and Midwestern states. In particular, such a decision would leave it to states to determine whether there is a legal right to an abortion. This is concerning given the current number of state abortion restrictions: According to data from the Guttmacher Institute, 10 states have laws automatically prohibiting abortion, and seven states have laws expressing intent to prohibit abortions in the state if *Roe v. Wade* were overturned; nine states have laws criminalizing abortion that date back to before *Roe* was decided; and three states have laws explicitly noting that their constitution does not secure or protect abortion rights.²⁸ Meanwhile, a Center for

Reproductive Rights analysis concluded that abortion would likely be prohibited in 24 states and three territories in the event of an adverse *Roe* decision.²⁹ Even in states where abortion access is protected, clinics would likely see an influx of patients forced to travel from out of state to access abortion care, which could result in more limited access for everyone.

While the court's ruling in *Roe v. Wade* set an important floor, establishing abortion as a right, it also left significant flexibility for future courts and lawmakers to undermine this right, as evidenced by the approximately 1,200 abortion restrictions passed at the state level since *Roe* was decided.³⁰ Specifically, the court held that states cannot interfere with a pregnant person's decision to have an abortion before the pregnancy is viable, which refers to the ability of the fetus to live outside of the womb; but the decision has been interpreted by an increasingly conservative Supreme Court to allow for numerous restrictions throughout the pregnancy. In short, *Roe* is an important minimum standard for abortion rights, but it has not guaranteed that everyone has a meaningful right to an abortion.

Policy recommendations

Federal level

Congress should codify into statute the legal right to have an abortion, and this right should go beyond the current framework established in *Roe v. Wade*. In *Roe*, the Supreme Court interpreted the right to privacy to include the right to an abortion, but in subsequent court decisions, it has allowed restrictions before a pregnancy is considered viable. This has afforded the opportunity for anti-abortion state lawmakers to enact—and an increasingly conservative federal court to uphold—restrictions on abortion for various reasons, such as when an individual reaches a certain number of weeks in pregnancy.³¹ Therefore, codifying into law the legal structure created in *Roe* would not resolve existing barriers to care; Congress should enact a federal law that makes clear that there is a fundamental right to abortion in the United States and that the government should not be able to interfere in a pregnant person's ability to exercise this right pre- or post-viability. It should also be made clear that this right extends to all people with the capacity to give birth, not solely those who identify as women.

State level

Additionally, state lawmakers who have not enshrined the right to an abortion should not wait on the federal law but instead guarantee that their residents have this right. State lawmakers can—and 13 states and the District of Columbia have—enacted laws to ensure that their state's residents have a right to an abortion.³² Notably, states have enacted these policies using different approaches,

including legislation, ballot initiatives, and constitutional amendments. All protections are important, but amending state constitutions may provide the strongest legal protection. State-level protections, of course, cannot provide the national protection that a federal right would provide, and if *Roe v. Wade* were overturned, this level of protection would result in access to abortion being contingent on the state in which a person lives, even more so than it is now.

Existing state policies can serve as a model to codify abortion rights

Even before *Roe v. Wade* was decided, states enacted laws to ensure the right to an abortion for those in the states. And in recent years, as federal judges have become increasingly hostile to abortion rights and the Trump administration sought to restrict reproductive health access, including access to contraceptives and well-woman visits, an increasing number of states have enacted policies to protect these rights:

- Four years before *Roe* was decided, the California Supreme Court recognized the right to an abortion under the state constitution. Legislative findings declare, in part: “Every woman has the fundamental right to choose to bear a child or to choose and to obtain an abortion . . . [and] 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.”³³
- The Alaska Supreme Court has interpreted the state’s constitutional right to privacy to provide a broader right to an abortion than the federal right.³⁴
- In 2019, the New York State Legislature enacted the Reproductive Health Act, which declares, in part, that the New York Constitution guarantees “every individual who becomes pregnant has the fundamental right to choose to carry the pregnancy to term, to give birth to a child, or to have an abortion.”³⁵
- Similarly, in 2020, the District of Columbia amended an existing human rights act to “recognize the right of every individual who becomes pregnant to decide whether to carry a pregnancy to term, to give birth, or to have an abortion,” but the territory is unique in that the federal government can interfere with the district’s laws.³⁶
- Illinois has even more comprehensive language to protect the right to an abortion. The law reads: “(a) Every individual has a fundamental right to make autonomous decisions about the individual’s own reproductive health, including the fundamental right to use or refuse reproductive health care. (b) Every individual who becomes pregnant has a fundamental right to continue the pregnancy and give birth or to have abortion, and to make autonomous decisions about how to exercise that right. (c) A fertilized egg, embryo, or fetus does not have independent rights under the laws of this State.”³⁷

Judges who have supported abortion rights should be appointed to the bench

While legislative reform is essential, the courts will continue to play a significant role in interpreting state and federal legislation related to abortion rights in both the immediate and long term. Over the past four years, the federal courts have become overtly politicized and stacked with far-right ideologues.³⁸ President Trump's overwhelmingly white and male judicial appointments regressed progress in judicial diversity in regard to race, ethnicity, and gender, while the bench also remains dominated by those who spent their careers in private practice and as federal prosecutors.³⁹ The lack of diversity on the federal bench may be best summarized by two statistics: Out of the 179 authorized appellate judgeships, only 11 are currently held by women of color.⁴⁰ Furthermore, not one appellate judge spent the majority of their career with a civil rights organization, as Justice Thurgood Marshall did.⁴¹

This lack of diversity translates into policy and real-world implications—particularly for abortion, as well as other civil rights. Federal and state judges may be tasked with interpreting or upholding the federal and state policies, outlined above, that advance or undermine abortion rights. And the threat ideologically driven judges pose is clear. When the U.S. Court of Appeals for the 5th Circuit issued a decision upholding the anti-abortion Louisiana law at issue in *June Medical Services v. Russo*, before the Supreme Court struck it down, the majority was made up of two appointees—one appointed by President Ronald Reagan and the other by President George H.W. Bush—who had long been affiliated with right-wing organizations.⁴² The two judges were so dedicated to dismantling reproductive rights that they issued an opinion brazenly in conflict with Supreme Court precedent, despite their duty to follow that precedent. This overreach was so significant that Chief Justice John Roberts, who has a long record of hostility toward abortion rights himself, joined with the liberal justices to overturn the decision.⁴³

On the impact that judicial nominations and, subsequently, the courts can have on abortion rights and access, legal scholar and author of *Abortion and the Law in America* Mary Ziegler stated:

*Anyone concerned about abortion will have to pay close attention. It may take a long time—and a fair amount of work—to figure out what has become of abortion rights. That also means it's time to start thinking very seriously about what will happen next if we find ourselves in a post-Roe, or practically post-Roe, nation.*⁴⁴

Policy recommendations

Federal and state level

Moving forward, it is essential that policymakers act to rebalance the courts to bring greater diversity both in regard to demographics and professional background. Lawyers who dedicated their careers to advancing civil rights, including reproductive rights, should be selected for the bench. For instance, lawyers from organizations such as the American Civil Liberties Union and the Center for Reproductive Rights have meaningfully advanced abortion rights for decades. It is imperative that the president appoint, and the Senate confirm, federal judges with a proven civil rights record—from the district courts to the Supreme Court.

State-level judges matriculate to the bench through various pathways, with some being appointed by state governors and others being elected by the public. Governors with the authority to appoint judges should also consider the nominees' records on abortion. It is equally important that judicial appointees are diverse with regard to race, disability status, sexual orientation, and gender identity, among other characteristics. Americans deserve a judiciary that reflects the diversity of America, as well as one made up of individuals with expertise in key areas of civil rights, including abortion rights.

The government should not interfere with the right to an abortion

The legal right to an abortion is meaningless if the government can interfere. Unfortunately, due to unrelenting attacks on abortion access, this right has never been meaningful for some in the U.S.—particularly those in Southern and Midwestern states, people with low incomes, young people, and people of color. Abortion restrictions take many forms but are frequently enacted under the guise of protecting women's health. For example, TRAP laws impose medically unnecessary restrictions on health centers and providers, such as requirements for the provider to have admitting privileges with local hospitals or for health centers to be certified ambulatory surgical centers.⁴⁵ Ninety-five percent of abortions in the United States are provided at a health center or clinic;⁴⁶ anti-abortion lawmakers and activists advance these restrictions to force the clinics and providers to cease to provide abortion, thus limiting abortion access.⁴⁷ The impact of TRAP laws can be long-lasting, even if a court ultimately strikes down the law. For example, in the 2016 case *Whole Woman's Health v. Hellerstedt*, the Supreme Court struck down a Texas law that required providers to have admitting privileges to a hospital within 30 miles of a clinic, yet three years after the decision, only slightly more than half of the abortion clinics that were open when the law went into effect remained open.⁴⁸

There have also been other laws aimed at forcing abortion providers to close. In 2020, Tennessee passed an extremely restrictive law that, among other things, would have allowed for the parent of a fetus—or the parent or guardian of the pregnant person if they are a minor—to file litigation against an abortion provider if they provide abortion care in violation of the law.⁴⁹ But a federal court blocked this law shortly after it was signed.⁵⁰

States have enacted outright bans on abortion under certain circumstances. Legislatures have passed gestational bans prohibiting abortion after a certain number of weeks in pregnancy—ranging from 22 weeks to six weeks, before many people even know they are pregnant, to as little as two weeks, which amounts to a near-total ban.⁵¹ Method bans, meanwhile, prohibit certain abortion procedures. State laws requiring people to wait a defined period, such as 24 or 48 hours, before undergoing an abortion procedure force them to make multiple trips to a provider under the paternalistic belief that the state needs to ensure that people take time to think about their decision. Similarly, ultrasound and counseling requirements are medically unnecessary laws that interfere with the patient’s decision-making. Even more egregious, “born alive” bills aim to perpetuate false claims about abortion later in pregnancy by requiring a fetus to receive medical care after an “unsuccessful abortion.”⁵² Eleven states even attempted to use the COVID-19 pandemic as a guise to issue executive orders or take other administrative actions requiring providers to cease performing most or, in some states, all abortions.⁵³ Their claims that abortion was not an essential service that needed to be provided during the pandemic failed to account for the time-sensitive nature of the procedure and the fact that delays could increase risk and cost to the intended patient or even deny care.⁵⁴ Regardless of form, these restrictions are not about protecting the patient’s health; they are patriarchal attempts to control women and birthing people’s bodies.

In fact, these laws are specifically designed to control certain people’s bodily autonomy. Reason bans, for example, prohibit abortion if the pregnant person’s decision to get an abortion is based on the sex, race, or fetal diagnosis of the fetus, using harmful and disingenuous arguments in another attempt to restrict abortion access.⁵⁵ Bans on the basis of race aim to drive the false narrative that women of color, and Black and Latina women, in particular, seek abortions due to the race of the fetus, the race of the person who impregnated them, or even the pregnant person’s race.⁵⁶ Meanwhile, sex-selective abortion bans are based on anti-immigrant stereotypes and often lead to Asian American and Pacific Islander (AAPI) women being racially profiled and harmed.⁵⁷ Similarly, fetal diagnosis bans attempt to co-opt the disability rights movement in service of an anti-abortion agenda, while not

addressing the barriers to health care, including abortion, that people with disabilities actually face.⁵⁸ People with disabilities may not always have the legal authority to make their own reproductive health care decisions; for instance, authority over medical decisions could be granted to parents or guardians. Moreover, they often experience discrimination when providers refuse services or information on reproductive health care services or fail to provide accessible health services, such as wheelchair-accessible facilities and beds that can be raised or lowered.⁵⁹ Young people also face a unique set of barriers to abortion. Thirty-seven states have laws requiring parental involvement for a minor to access an abortion.⁶⁰ And 36 states require minors seeking to access an abortion independently to obtain a judicial bypass through a court order.⁶¹

Overall, people with low incomes—who, due to historical and ongoing oppression, are disproportionately Black, Latinx, transgender or nonbinary, and people with disabilities—experience the most barriers to care as a result of abortion restrictions. People with higher incomes and wealth have historically, even before *Roe v. Wade*, been able to purchase access to abortion. People with lower incomes, on the other hand, often cannot afford to travel to another location, take additional time off work, or incur child care expenses that may be associated with having to navigate a system designed to discourage accessing care. Ultimately, these hurdles prove insurmountable for many.

Abortion stories: Emily

“I had an abortion seven years ago in Indiana, and even then, the abortion restrictions in the Midwest were severe. I had to view a medically unnecessary ultrasound, attend mandatory counseling sessions, and travel an hour back and forth several times that month, and walk into a clinic surrounded by protesters telling me I will burn in hell, all to get two pills to terminate my 8-9 week pregnancy—all of that unnecessary trauma for two pills. I knew what I wanted to do and have never regretted my decision, but I had to contend with unnecessary abortion restrictions designed to shame me into changing my mind, or to have to cancel the procedure because of all the financial strain these restrictions caused.”⁶² — Emily (as told to *Teen Vogue*)

Policy recommendations

Federal level

Congress should pass a law that would protect the right to access abortion care by creating a safeguard against bans and medically unnecessary restrictions that do not apply to similar medical care. In the 116th Congress, Sen. Richard Blumenthal (D-CT) introduced the Women’s Health Protection Act (WHPA), a federal bill that would prevent certain unnecessary limitations on and requirements for abortion care.⁶³ Specifically, WHPA would prohibit government restrictions that impose on providers’ ability to deliver abortion care, including but not limited to bans on abortion prior to viability, such as gestational bans and restrictions on certain abortion procedures; bans on abortion post-viability if prohibition would pose risk to a pregnant person’s life or health; restrictions on providers’ ability to prescribe or dispense medication abortion and teleabortion; requirements that force doctors to provide medically inaccurate information to people seeking abortion care; reason bans; unnecessary requirements related to hospital privileges, transfer arrangements, and other staffing; and state-mandated medical procedures and protocols, such as requiring providers to perform medically unnecessary tests or medical procedures or forcing pregnant people to undergo ultrasounds and endure waiting periods for no medical reason as a way to shame them for their personal decisions.⁶⁴

State level

States can—and some have—signed into law policies that prohibit unnecessary restrictions on abortion care. Specifically, some states have enacted laws that repeal pre-*Roe* abortion bans, repeal barriers to abortion care, regulate so-called crisis pregnancy centers’ distribution of inaccurate information, and repeal judicial bypass laws, among other prohibitions.⁶⁵ One of the most expansive proactive policies enacted in 2020 was Virginia’s Reproductive Health Protection Act, which rolls back medically unnecessary restrictions on abortion, including a mandatory 24-hour waiting period, forced ultrasounds, mandatory biased counseling, and a requirement for abortion providers to meet unnecessary building requirements.⁶⁶ Abortion access is largely dependent on state policies, so states have a significant opportunity to guarantee abortion access for their residents.

Young People's Reproductive Justice Policy Agenda

Unite for Reproductive and Gender Equity (URGE) has developed the Young People's Reproductive Justice Policy Agenda, which calls for proactive measures to expand reproductive health, rights, and justice—including meaningful abortion access.⁶⁷

Their recommendations related to abortion access include:

- Ending forced parental involvement in abortions
- Opposing and repealing abortion bans
- Providing access to medication abortion on college and university campuses
- Supporting full insurance coverage for all pregnancy-related care
- Working toward normalizing and decriminalizing self-managed abortion

"Young, progressive voices are calling for policies that will help them build a future that is just and inclusive. Yet bans on abortion coverage, inadequate or nonexistent sex education, state and interpersonal violence, discrimination against LGBTQIA+ people, and stigma against our bodies, genders, sex, and decisions all make it harder for young people to live freely and with dignity. Young people are often pushed to the margins regarding their wants and needs; unfortunately, abortion policy is no different. The time has come to remove that narrative and to instead center young people so that reproductive health, rights, and justice can be achieved for all."⁶⁸ — URGE

Abortion care must be affordable for all

The legal right to abortion is meaningless if people are not able to afford access to care. Without insurance coverage, abortion care can be prohibitively expensive.⁶⁹ What is more, unnecessary restrictive laws, including those that require people to delay seeking care until they save money to pay out of pocket, increase the cost of the procedure, on top of increasing the health risks. The Federal Reserve Board reported that before the coronavirus pandemic, 40 percent of people did not have funds to cover a \$400 unexpected expense, and people of color were even less likely to be able to withstand these costs.⁷⁰ The pandemic has only worsened the ability of many—especially women, who have been hardest hit in this economic downturn⁷¹—to pay out of pocket for unexpected expenses such as an abortion.

Medicaid is the largest public funder of reproductive health care services, covering 75 percent of all public funds spent on family planning, and the program finances nearly half of all births in the United States.⁷² However, federal restrictions impede the program's beneficiaries from using their coverage to access most abortion care. The Hyde Amendment is an annual appropriations rider that prohibits certain federal funds from covering abortion outside of the instances of rape, incest, and life endangerment, limiting the ability of not only Medicaid beneficiaries to use their insurance coverage to access abortion but also many others who rely on public insurance for health coverage, including federal employees, Native Americans, military personnel and veterans, people in federal detention, and residents of the District of Columbia, among others.⁷³ Furthermore, a 2019 Government Accountability Office report found that several states were not covering abortion as federal law requires: 14 states have not even been covering medication abortion within the limited instances of rape, incest, and life endangerment; South Dakota's Medicaid program reported that it did not cover abortion in cases of rape and incest; and half of the states reported a denial rate of 60 percent or more.⁷⁴

The Hyde Amendment disproportionately harms Black and Latina women—who, due to systemic racism and poverty, represent a disproportionate share of the Medicaid program—as well as Native American women receiving health care from the Indian Health Service (IHS).⁷⁵ There is also a high prevalence of poverty among LGBTQ people, particularly transgender people and people of color, making Medicaid a crucial program for their access to health care.⁷⁶

Abortion stories: Brittany

“I’d just turned 23 and was the mother of 3 small children under the age of 7. My youngest daughter was 5 months old. I was sharing a 2 bedroom with my sister and niece. After calling several abortion clinics, I was told that Medicaid, my form of health insurance, would not cover the procedure. I was still in my first trimester but time was ticking. It took me several weeks to raise enough money for a first trimester procedure but by then I was in my second. I didn’t know what to do or think.”⁷⁷ — Brittany (as told to *Teen Vogue*)

Brittany was ultimately able to access abortion care with the support of a local abortion fund.⁷⁸ Abortion funds frequently fill the gaps when the government fails to provide critical support.

Private insurers also face restrictions on their ability to cover comprehensive abortion care. Twenty-six states restrict abortion coverage to limited circumstances in private plans sold on the ACA marketplaces, and 11 states limit abortion coverage in all private plans.⁷⁹ There is no federal prohibition on the private insurance coverage of abortion, but the ACA does impose additional billing requirements on private plans that cover abortion, which might discourage insurers from covering abortion. Making matters worse, in December 2019, the Trump administration finalized a regulation requiring insurers to seek to collect two separate bills from consumers, one for abortion and another for all other health services, creating additional administrative and costly barriers that are anticipated to lead to more insurers dropping abortion coverage.⁸⁰

Congressional lawmakers also have repeatedly attempted to impose the Hyde Amendment on private insurance coverage, particularly ACA marketplace plans. Such an extension or codification of the Hyde Amendment would prohibit individuals from using federal financial assistance, such as premium tax credits and cost-sharing reductions, to purchase plans that include abortion coverage.⁸¹ Similarly,

provisions have been proposed for other private insurance plans—for instance, recent proposals related to federal financial assistance for Consolidated Omnibus Budget Reconciliation Act (COBRA) plans in COVID-19 relief packages.⁸² Given that federal funds already do not go toward paying for abortion, adding Hyde or Hyde-like language would not maintain the status quo, but rather require plans to forgo federal funding or drop abortion coverage. Such drastic policies could unravel private insurance coverage of abortion.

International abortion coverage

Outside of the United States, many countries provide full or partial funding for abortion care, including as part of their national health care system. A 2016 article in *Contraception* journal reviewed coverage policies in 80 countries where abortion is legally accessible. It found that of women of reproductive age in these countries, 46 percent lived in a country with full funding for abortion, 41 percent lived in a country with partial funding, and 13 percent lived in a country with no funding or funding only in exceptional circumstances.⁸³ The countries providing full funding for abortion care include Australia, Barbados, Cambodia, Canada, Cuba, France, Guyana, India, South Africa, Spain, the United Kingdom, and Uruguay, among others. Even more telling, 31 of 40 high-income countries—based on 2016 World Bank classifications—were found to provide full or partial funding for abortion.⁸⁴ The United States is among the minority of countries that does not. In addition, countries that have more recently legalized or decriminalized abortion—such as Ireland in 2018 and Argentina in 2020—made abortion free of cost to patients as soon as it became legal, as it is integrated as part of those countries’ national health care systems.⁸⁵

Policy recommendations

Federal level

Universal health coverage that is inclusive of abortion care, regardless of immigration status or custodial status,⁸⁶ would be the best approach to ensure that abortion is enshrined into the U.S. health care system. CAP has put forth a proposal to achieve universal coverage by building on the current health care system—enrolling certain populations, such as Medicaid and ACA marketplace enrollees, into a newly created government-run program, while also maintaining the employer-sponsored insurance market.⁸⁷ Yet no matter the health care system design to achieve universal coverage, it is necessary to ensure abortion care is enshrined into such a system. Relatedly, a government-run public option should be inclusive of abortion coverage without restrictions—including limits based on rape, incest, or life endangerment—or additional billing requirements and administrative hurdles for insurers, plan administrators, and patients.

Additionally, these policies should prevent public and private plans from discriminating against abortion providers as a means to undermine abortion access. The 116th Congress introduced a number of public option and Medicare for All proposals that included provisions to this end, such as guaranteeing that program beneficiaries have a free choice of provider and prohibiting the exclusion of providers from participating in the program for any reason other than their ability to provide health care. Similarly, provisions should be included in any future proposals.⁸⁸ Section 2706 of the ACA also has language that can be emulated, stating: “A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider’s license or certification under applicable State law.”⁸⁹

But until universal coverage is achieved, it is incumbent on lawmakers to enact proactive policies that make abortion affordable for all. First, the Hyde Amendment should be permanently rescinded and not added to future congressional appropriations packages—and the president’s budget requests should be free from restrictions on the use of federal funds for abortion. Meanwhile, the Equal Access to Abortion Coverage in Health Insurance (EACH) Act, introduced by Rep. Barbara Lee (D-CA), would permanently rescind the Hyde Amendment and guarantee that people with public and private insurance have abortion coverage.⁹⁰ In particular, expanding abortion coverage to people enrolled in the Medicaid program, without regard to the reason they are seeking an abortion, would provide access to those with low incomes; and amending the Medicare program benefit requirements would provide abortion access to people with disabilities who might rely on the program for health care access. At a minimum, the U.S. Department of Health and Human Services (HHS) must take enforcement action to ensure that states are in compliance with the requirement to cover Hyde-permissible abortions—in the instances of rape, incest, and life endangerment—as well as medication abortions, which has not been happening in the majority of states, as outlined above.

Similarly, there are barriers to the private insurance coverage of abortion. Specifically, the ACA federal billing and administrative requirements that treat abortion differently than other health care benefits should be repealed and rescinded to allow states and private insurers to more freely expand abortion coverage. As an initial step, HHS must immediately rescind the Trump-era rule requiring insurers to attempt to collect two separate payments from people enrolled in plans that include abortion coverage. In addition, Congress should reject any further attempts to expand abortion restrictions, including attempts to codify the Hyde Amendment or otherwise place Hyde-like restrictions on private insurance.

State level

In the absence of federal action, sixteen states currently use their own funds to provide abortion coverage beyond Hyde-permissible abortions for Medicaid beneficiaries; others should follow suit.⁹¹ Similarly, six states—California, Illinois, Maine, New York, Oregon, and Washington—have gone a step further to require private plans operating in the states to include abortion coverage among their plan offerings.⁹² However, dozens of states continue to restrict abortion coverage by maintaining federal Medicaid restrictions and restricting coverage in private plans as well as insurance for public employees; indeed, 20 states have more than one coverage restriction in effect.⁹³ Current restrictions on insurance coverage for abortion care make a person’s ability to afford abortion care dependent on their insurance coverage, geographic area, or income, thus inhibiting the ability to have an abortion. Additionally, if states seek to enact their own public option programs, which some have reportedly considered, they should be inclusive of abortion coverage.⁹⁴

All* Above All, an abortion access advocacy organization, has been leading the effort to rescind the Hyde Amendment and enact the EACH Act. It also proposed an agenda for the Biden-Harris administration’s first 100 days, which states:

“Legal abortion has never been enough. It leaves out too many. Those who are denied care because they are struggling financially, or are forced to travel too far, or their clinic was shut down by unjust restrictions. We are not settling. We seek abortion justice.”⁹⁵

New York City acts to fund abortion care

Per the National Network of Abortion Funds, abortion funds provide critical direct support across the country to help people navigate financial and logistical barriers to abortion access—barriers that are often the direct result of state and federal policies restricting access.⁹⁶ In 2019, New York City allocated \$250,000 of its budget to the New York Abortion Access Fund (NYAAF), a first-of-its-kind move for cities to allocate funding specifically to support abortion services.⁹⁷ NYAAF provides funding directly to abortion clinics for people, including those who travel to New York from other states, who lack insurance coverage or otherwise cannot afford to pay for their abortions.⁹⁸ New York City's budget allocation came as a result of advocacy from Fund Abortion NYC, a campaign led by the National Institute for Reproductive Health (NIRH), along with NYAAF and several other partner organizations.⁹⁹ The city's move to directly support an abortion fund was an important recognition of the need for abortion to be affordable for all and the responsibility of government to ensure access to it.

“As other states continue to push abortion care entirely out of reach and the future of the right to legal abortion nationwide remains uncertain, New York City has set the national standard as a place where abortion is not only accessible, but affordable for all.”¹⁰⁰ —
NIRH

People need access to the full range of options for abortion care

There are multiple safe options for abortion care, including via procedure or medication, in a clinic or at home, with the involvement of medical providers, or self-managed. However, access to the full range of safe and effective options for abortion care is not a reality in the United States. State and federal laws and regulations currently restrict and even criminalize many of these proven methods for abortion care, from certain types of abortion procedures to medication abortion, telehealth, and self-managed abortion. These restrictions are part of the anti-abortion movement's efforts to ban abortion entirely. By placing medically unnecessary limits on the methods and settings for abortion care and treating the exercise of reproductive autonomy as a criminal act, policymakers restrict bodily autonomy and push abortion rights further out of reach.

The COVID-19 pandemic has acutely demonstrated the need to have access to the full range of options for abortion care, including medication abortion and telehealth for abortions outside of a clinical setting, as existing restrictions force people to risk contracting the deadly virus, delay care, or lose access to abortion altogether. A proactive vision for abortion must ensure autonomous access to the abortion care that works best for each person.

Medication abortion must be accessible without unnecessary restrictions

Medication abortion, or abortion with pills, expands freedom and autonomy over abortion care, allowing people to safely complete abortions outside of a clinic setting. It is critical to removing barriers to abortion care, especially for people who have experienced health care discrimination or are otherwise uncomfortable in clinical settings, as well as those who have limited access to clinics, including LGBTQ people, people of color, disabled people, and people living in rural areas.

Medication abortion consists of a regimen of two medications: mifepristone and misoprostol.¹⁰¹ Since its approval by the U.S. Food and Drug Administration (FDA) in 2000, the medication abortion regimen has proven extremely safe and effective for abortions earlier in pregnancy.¹⁰² It is more than 95 percent effective, and serious adverse events occur in less than 0.5 percent of cases.¹⁰³ Medication abortion is also an increasingly common method of abortion care. The Guttmacher Institute reports that in 2017, 39 percent of all abortions in the United States were medication abortions, compared with only 14 percent of abortions in 2005.¹⁰⁴

Yet despite the proven safety, effectiveness, and benefits of the medication abortion regimen, the FDA and state legislatures have implemented medically unnecessary restrictions on it. The FDA has imposed a risk evaluation and mitigation strategy (REMS) on mifepristone, one of the two drugs involved in the medication abortion regimen.¹⁰⁵ A REMS imposes certain requirements around prescribing, dispensing, and taking medication—and is typically intended to provide safety protections for medications with high risks of serious adverse events.¹⁰⁶ However, mifepristone, which has proven to have fewer adverse reactions than commonly used medications such as Tylenol and Viagra, does not merit such restrictions.¹⁰⁷ Under the REMS, mifepristone can only be prescribed by a limited number of providers, and it cannot be dispensed at pharmacies or mailed, which significantly restricts access to medication abortion. The REMS for mifepristone is outdated; its continued existence is a result of the politicization of abortion care, not scientific evidence. Medical experts, including the American Medical Association and the American College of Obstetricians and Gynecologists, support lifting the REMS.¹⁰⁸

In addition to the FDA's restrictions, 33 states only allow physicians to provide medication abortion, restricting qualified providers—including advanced practice clinicians such as physician assistants, nurse practitioners, and midwives, who are trained to provide much of the same care that a physician provides—from offering medication abortion care.¹⁰⁹ These policies limit access to essential health care and restrict people's autonomy to decide which method and setting of abortion care works best for them.

Policy recommendations

Federal level

The FDA must lift the REMS on mifepristone during the COVID-19 pandemic and beyond. In July 2020, a federal district court in Maryland ruled that during the COVID-19 public health emergency, the FDA must suspend its requirement that patients pick up the medication in person from their abortion provider, a

decision that the court reaffirmed in December.¹¹⁰ However, in January 2021, the Supreme Court reinstated the requirement, once again forcing people to travel and go to clinics in person to access medication abortion at the height of the coronavirus crisis.¹¹¹ This temporary suspension of the in-person requirement was an important recognition of the importance of access to medication abortion and the burdens of the FDA's restrictions; yet the Trump administration's challenge to the decision and the Supreme Court's reversal demonstrate that a temporary reprieve is not enough—and the harm of the REMS will last long beyond the pandemic.¹¹² The FDA must permanently lift REMS on mifepristone and allow for unrestricted access to medication abortion.

State level

Beyond the FDA, states should undo restrictions that further limit access to medication abortion, such as those requiring abortion care to be provided in person and preventing qualified advanced practice clinicians from providing medication abortion care. States should also take steps to allow for medication abortion to be dispensed from the full range of abortion providers, as well as in pharmacies and by mail.

The United States is an outlier in restricting medication abortion

Internationally, many countries have successfully implemented access to medication abortion via direct-to-patient telemedicine and mailed medications—including in Canada, Australia, and more.¹¹³ Australia also allows for pharmacy prescribing of medication abortion, in contrast to the U.S. model, which restricts dispensation of the medication abortion regimen to a limited number of providers in clinics with onerous requirements.¹¹⁴ Furthermore, in response to the coronavirus pandemic, a number of countries took steps to reduce the need for in-person visits to access abortion care.¹¹⁵ A study of European countries' abortion policy changes during the pandemic, published in the journal *BMJ Sexual and Reproductive Health*, found that 13 countries and regions—specifically England, Scotland, Wales, and Northern Ireland within the United Kingdom—expanded medication abortion care.¹¹⁶ Changes included extending gestational limits for medication abortion at home, removing requirements for in-person visits, allowing telehealth and medication by mail for medication abortion, and more.¹¹⁷

Barriers to telehealth for abortion care must be removed

Telehealth, the delivery of health care services and information to patients through telecommunication technologies, is a critical tool for expanding access to abortion and health care more broadly. However, the FDA's REMS on mifepristone, discussed above, prevents distribution of the medication by mail or in pharmacies, requiring people to come to a provider in person to access care. In addition, 19 states require abortion care to be provided in person, and six states explicitly prohibit coverage of abortion care via live video—for instance, providers and patients meeting using video conferencing technology or mobile apps.¹¹⁸ Requirements that allow only licensed physicians to provide abortion care and that force prescribing providers to be licensed in the state where the patient resides are particularly restrictive for telehealth patients living in health care deserts.¹¹⁹ Broader limitations on telehealth coverage present further barriers. For example, many states have not expanded the list of originating sites—where patients are located when receiving care and which are eligible for coverage—to include patients' homes; do not cover the full range of telehealth modalities, including live video, remote patient monitoring, and mobile-based platforms; do not cover advanced practice clinicians; and do not mandate payment parity—that telehealth be reimbursed at the same rate as in-person care.¹²⁰

By allowing people to access care without having to see a provider in person, telehealth adds to the expanded autonomy and decreased barriers offered by medication abortion and can be critically important for people who face barriers to accessing in-person care, including people living in rural areas, people with disabilities, and young people, among others. This is especially necessary considering the extent to which state restrictions have put abortion providers out of reach.¹²¹ Telehealth has been proven to be as safe and effective for medication abortion as in-person care.¹²² Moreover, the COVID-19 pandemic has demonstrated the effectiveness and critical importance of telehealth in ensuring continued access to care. Guidance from the Centers for Medicare and Medicaid Services, as well as the Coronavirus Aid, Relief, and Economic Security (CARES) Act, encouraged the expansion of telehealth services, and every state followed suit in some respect.¹²³ Yet the ongoing restrictions on abortion care prevent the benefits of telehealth expansion from extending to people seeking abortions.

Policy recommendations

Federal level

As discussed above, the federal government should permanently remove the REMS for mifepristone and rescind the Hyde Amendment and other barriers to insurance coverage for abortion care that limit abortion access via telehealth. The federal government can also take steps to expand access to telehealth that is inclusive of abortion care, including by requiring payment parity between telehealth and in-person services for public and private insurers and by investing in telehealth infrastructure that prioritizes patients' privacy.¹²⁴

State level

State legislators should undo laws that require abortion care to be provided in person, effectively banning telehealth for abortion. In addition to undoing the medication abortion restrictions mentioned above, states should take action to expand equitable access to telehealth for abortion and reproductive health care more broadly. This includes removing insurance limitations to expand coverage to telehealth delivered directly to patients' homes; delivered via multiple modalities such as live video, audio, and smartphone; and delivered by providers beyond physicians, including advanced practice clinicians. In the absence of federal action, state policymakers can also take steps to invest in telehealth infrastructure, require payment parity for telehealth, and allow providers to provide care across state lines.¹²⁵ During the coronavirus pandemic, many states have already taken these steps to expand telehealth access. States that have not yet done so should follow suit, and all states must ensure that telehealth expansion does not exclude abortion care.¹²⁶

Self-managed abortion must be decriminalized and supported

There are many reasons why a person may want to self-manage their abortion without the involvement of a medical provider, including barriers to accessing providers, discomfort or past experiences of trauma or discrimination in the medical system, and personal preference, such as feeling greater autonomy over the abortion experience. Self-managed abortion with pills involves assessing eligibility for medication abortion, taking mifepristone and misoprostol doses, and assessing for side effects and completeness of the abortion without the involvement of a medical provider. The availability of medication abortion allows for abortion to be safely self-managed with access to accurate information and support, much like people self-administer countless other medications without the involvement of a medical

provider. The World Health Organization (WHO) has affirmed that with proper information and guidance, medication abortion can be safely self-managed,¹²⁷ and research continues to support people's ability to safely self-administer the medications with the appropriate instructions.¹²⁸

In spite of this evidence, self-managed abortion is legally restricted in some form across many states. Five states have laws specifically criminalizing self-managed abortion.¹²⁹ Other states have laws that do not explicitly outlaw self-managed abortion but have been used to criminalize people suspected of self-managing.¹³⁰ For example, in 2015, a woman in Georgia named Kenlissia Jones was arrested and held without bond on the charge of “malice murder” for allegedly using misoprostol to have an abortion at home; the charge was eventually dropped.¹³¹ Those who have been subject to this criminalization are overwhelmingly Black women and low-income women.¹³² Significantly, in February 2021, the American Bar Association voted to adopt a resolution against criminalizing people for pregnancy outcomes, including self-managed abortion.¹³³

The restrictions on medication abortion discussed above also create barriers to self-managing abortion care, requiring people to interact with the medical system in order to receive the medication abortion regimen and restricting people's ability to have the medications mailed to their home or to pick them up at a pharmacy. These restrictions may lead some people to seek abortion medications from unconfirmed, unregulated sources, which poses potential health risks.

Supporting people self-managing abortions

A number of organizations are dedicated to ensuring that no one is subject to criminalization for self-managing an abortion and that people who do self-manage have the resources to do so safely. Organizations such as the National Advocates for Pregnant Women and If/When/How: Lawyering for Reproductive Justice provide legal defense for people who are criminalized for self-managing abortions and work to decriminalize self-managed abortion and pregnancy outcomes more broadly.¹³⁴ Women on Web, meanwhile, provides consultations and ships abortion medication to people around the world, including in many countries where abortion is illegal.¹³⁵ And programs such as Women Help Women's SASS (Self-managed Abortion; Safe and Supported) and Plan C work to provide accurate information and support to people seeking to safely self-manage abortions.¹³⁶

"The right to abortion encompasses the right to end one's own pregnancy outside the formal medical system. Yet throughout the country, people have been unjustly arrested and jailed for self-managing their abortions, often using the same pills they would have received at a clinic. Overzealous prosecutors misuse laws never meant to apply in these circumstances. Everyone deserves to self-determine their reproductive lives and choose the abortion that's right for them—free from threat of criminal punishment."¹³⁷ — If/When/How

Policy recommendations

Federal level

Federal policymakers and health officials can take steps to make self-managed abortion as accessible and safe as possible. Specifically, they should ensure access to medication abortion through reliable sources with confirmed safety standards, including by removing the FDA REMS. In addition to accessing the medication itself, people need access to accurate information on how to safely self-manage, including where to access medication and how to assess for eligibility such as gestational age and contraindications. They also need instructions on how to use the medication, as well as information on potential side-effects and warning signs for the rare cases in which medical attention might be necessary. HHS can develop guidance and educational materials to provide this support, as well as guidelines to providers clarifying that laws requiring mandatory reporting to law enforcement do not apply to self-managed abortion. In addition, the U.S. Department of Justice can issue guidance urging states to repeal laws that criminalize self-managing and can ensure that the federal criminal code is not used to prosecute people who self-manage abortions.¹³⁸

State level

State legislatures should undo laws that allow for the criminalization of pregnancy outcomes and decisions and should proactively ensure that no one will be criminalized for self-managing their abortion. For example, in 2019, Nevada enacted legislation decriminalizing self-managed abortion, and in 2020, Washington, D.C., enacted a law that prohibits punishing people who self-manage abortions or experience miscarriage or adverse pregnancy outcomes.¹³⁹ In addition, states can remove restrictions on access to medication abortion and telehealth to expand options for abortion care outside of a clinical setting. Finally, state and local health departments have an important role to play in educating the public and providing accurate information on how to safely self-manage.

It is also important to consider that fully legally accessible self-management would not require any interaction with a medical provider to access the medication. This would require that misoprostol and mifepristone be made available over the counter.¹⁴⁰ Given the regimen's extremely high safety record—with lower rates of serious complications than other over-the-counter drugs such as Tylenol—researchers and policymakers should further explore the possibility of over-the-counter access to medication abortion.¹⁴¹

Abortion must be accessible in a supportive, destigmatized environment

Abortion is health care, and all people have a right to access health care in safe environments free from stigma, harassment, intimidation, and violence. They deserve care that is supportive, culturally competent, and free of discrimination. Unfortunately, people seeking abortion care still contend with a huge amount of stigma and shaming on systemic, cultural, and interpersonal levels. In addition, people of color, LGBTQ people, and people with disabilities, in particular, continue to experience discrimination and lack of cultural humility in the health care system, including in their reproductive decision-making. To build a landscape that truly supports abortions and the people who have them, policymakers, providers, and communities must address the harm of historical and ongoing stigma and discrimination. Abortion care must be treated as the essential health care that it is, integrated within the broader reproductive health and health care systems with access to networks of support for all people, before, during, and after their abortions.

Abortion stories: Nikiya

"I had two abortions, simply because I was not ready to be a parent. There is a misconception that people who have abortions struggle with their decisions to do so, but this is not the case for many of us. For me, these were two of the easiest decisions I have ever made in my life. I am grateful that I had access to the healthcare I needed to so that I was not forced into starting a family when I was not ready."¹⁴² — Nikiya (as told to Refinery29)

Expand the abortion provider workforce and prohibit discrimination against providers

Abortion cannot be accessible for everyone if there are not enough providers to meet people's needs. The number of abortion providers is extremely limited—six states have only one remaining abortion clinic.¹⁴³ And in many of the states that are most hostile to abortion rights, such as Texas and South Dakota, clinics rely on providers who fly in from other parts of the country.¹⁴⁴ When there is a short-

age of providers, people are forced to travel farther and wait longer to access care, and they may be pushed out of access to abortion entirely. A number of factors may contribute to this shortage on the individual provider level, including the exclusion of abortion training in medical education, stigma and threats of violence against abortion providers, and state laws restricting qualified professionals—including advanced practice clinicians such as nurse practitioners, physician assistants, and midwives—from providing abortion care. On the systemic level, state restrictions such as TRAP laws, discussed above, impose medically unnecessary restrictions on providers that force clinics to close; and a lack of funding and inadequate reimbursements for abortion providers limit clinics' ability to stay open and provide affordable, accessible care.¹⁴⁵

Federal and state actions have also targeted abortion providers by removing or forcing them to leave coverage and safety net programs, including the Title X family planning program and several state Medicaid programs, instead directing funding to anti-choice “crisis pregnancy centers.”¹⁴⁶ For instance, the domestic gag rule, which prevents Title X grantees from providing the full-range of pregnancy-related options, including abortion care, forced 19 grantees to leave the program, reducing the network's capacity by almost half.¹⁴⁷ Similarly, several states have sought—and Texas recently succeeded—at removing family planning providers from their Medicaid program, for no other reason than that these providers offer abortion care.¹⁴⁸ These attacks and restrictions limit people's ability to access not only abortion but also comprehensive reproductive health services, such as contraceptives and cervical cancer screenings. Moreover, the Weldon Amendment—an appropriations rider that prohibits “discrimination” against health care entities that refuse to provide, refer for, or cover abortion care—has allowed providers to deny people access to abortion care based on their personal beliefs and has been used to punish states such as California that seek to protect abortion access.¹⁴⁹

Increasing access to abortion providers through funding and expanding the provider workforce is critical but not enough on its own. Everyone who is part of the abortion care experience—from physicians to nurses to front office staff—must be trained to provide culturally competent care, recognizing the many factors in people's lives that shape their reproductive decisions and experience of care. This includes providing necessary resources such as language access and accessible services for people with disabilities, as well as understanding the harm and discrimination that many have experienced in the health care system.

Policy recommendations

Federal level

Federal policymakers can take many steps to build a culturally competent abortion provider workforce. Congress should undo harmful restrictions such as the Hyde and Weldon Amendments, and the federal government should rescind the domestic gag rule to ensure that abortion providers can equally participate in federal health programs, receive adequate reimbursement rates from public and private insurance, and guarantee that funds are not redirected from evidence-based providers to entities, such as crisis pregnancy centers, that engage in deceptive practices. In addition, Congress should pass the Women's Health Protection Act, as discussed above, which would prevent medically unnecessary restrictions that target providers.

Federal lawmakers can also support expanding the pipeline of abortion education to train new providers, including physicians, physician assistants, nurse practitioners, and midwives. This may include grants to educational programs that provide abortion training in their curricula and require training on bias, anti-racism, and cultural humility. Funding can also support expanding the diversity of the abortion provider workforce, particularly providers of color, through scholarships and training and mentorship programs. This support may include direct funding for community-based providers, as well as funding for bias and cultural humility training for all members of clinic or hospital staff.

State level

State legislators can and should provide grants to expand abortion training. They should also remove requirements that only physicians can provide abortion care, and proactively expand the definition of abortion providers to include advanced practice clinicians—following the lead of states such as Virginia, Maine, and New York.¹⁵⁰ Additionally, providers participating in state health programs, such as Medicaid, should receive adequate reimbursement. States should also undo laws that force providers to close, including TRAP laws that impose admitting privileges and ambulatory surgical center requirements. Finally, state and local lawmakers can take action to prevent the deceptive practices of crisis pregnancy centers by establishing the dissemination of false or intentionally misleading information about their services as unlawful fraud and by imposing penalties and fines.¹⁵¹

The safety of patients and providers must be a priority

No one should be harassed or intimidated for obtaining health care, and no one should be harmed for providing health care. Yet accessing abortion today often requires walking through a crowd of protesters seeking to shame and scare people for their reproductive decision-making. And abortion providers face constant threats that have escalated to violence, including the bombing of abortion clinics and the murder of providers.¹⁵² In response to escalating violence aimed at abortion providers, Congress passed the Freedom of Access to Clinic Entrances (FACE) Act of 1994, which prohibits using or threatening violence and physical obstructions to harm, intimidate, or interfere with people seeking and providing abortion care.¹⁵³ However, while important, the law has been unevenly enforced and has not provided sufficient protection from harassment and violence.

In addition, significant concerns remain about protecting the confidentiality and private information of abortion providers and patients to prevent harassment and stigmatization. These concerns are all the more pressing given the anti-abortion movement's deep and strengthening ties to white supremacists, including far-right militias; in fact, many of the same anti-abortion activists who have harassed patients and providers participated in the January 6 coup attempt at the U.S. Capitol.¹⁵⁴ Abortion access that requires enduring harassment and fear of violence should not be acceptable in a society that values reproductive autonomy.

Truly accessible abortion must be free of barriers on both a systemic and interpersonal level. People of color, people with disabilities, and LGBTQ people, in particular, have experienced significant discrimination and trauma in the medicalized health care system, which includes reproductive health care. They have faced eugenics and forced sterilization, nonconsensual medical experimentation, implicit and explicit bias from institutions and providers, inaccessible health care services, and discrimination and denial of care, just to name a few examples.¹⁵⁵ These efforts to control people's reproduction and violate bodily autonomy have created a legacy of distrust of medical institutions. The Trump administration further eroded access to stigma-free health care by undermining Section 1557 of the ACA, known as the Health Care Rights Law, opening the door for discrimination in health care based on gender identity, sexual orientation, and history of abortion and pregnancy loss.¹⁵⁶ Providers and policymakers must acknowledge these experiences to proactively prevent discrimination and work to rebuild trust and provide community-based care so that every person's abortion experience is one of support and care.

Abortion stories: Cazembe

“Often when we think of abortion access or even pregnancy and childbirth we call these ‘women’s issues.’ This erases the experience of trans and gender nonconforming folks who also have abortions and give birth to children. It is important for trans folks to know that they are included in this movement and that there is safe comprehensive care available for them too. I want to do everything in my power to make this a reality. I wish that folks understood that men have abortions too. That gender is separate from the ability to reproduce children. That every person who has the ability to create children is capable of determining when if ever is the right time to do it.”¹⁵⁷ — Cazembe (as told to *Teen Vogue*)

Policy recommendations

Federal level

Policymakers have a responsibility to take action to protect abortion providers and patients. The federal government must vigorously enforce Section 1557 of the ACA, which prohibits discrimination in health care, including based on race, national origin, sex, age, and disability.¹⁵⁸ As part of this effort, policymakers should reinstate Obama-era regulations that included protections against discrimination on the basis of gender identity, sexual orientation, and pregnancy status, including termination of pregnancy; and it is vital for these identities to be explicitly included in anti-discrimination protections going forward. Specifically, there must be a prohibition against health care providers and insurers being able to deny abortion care, as well as other reproductive health services, on the basis of gender identity or sexual orientation. The federal government must also actively enforce the FACE Act to prevent violence targeting abortion providers and patients.

State level

A number of states and localities have expanded on the federal FACE Act to provide additional protections to abortion patients and providers, including by prohibiting blocking entrances to clinics, threatening or intimidating clinic staff and patients, damaging clinic property, and other actions around clinics, such as excessive noise, possession of a weapon, and trespassing.¹⁵⁹ Other states and localities have passed “buffer zone” laws requiring protesters to stay a certain distance away from clinic entrances; however, some of these laws have been struck down by the courts.¹⁶⁰ States and localities have also enacted legislation to protect the privacy of providers and patients and prevent discrimination against people who have had or provided abortions.¹⁶¹ Additionally, 24 states prohibit transgender exclusions in health insurance, and 16 states and Washington, D.C., prohibit health insurance

discrimination based on sexual orientation and gender identity, according to data from the Movement Advancement Project. Meanwhile, more than 20 states that prohibit discrimination based on sexual orientation and gender identity in public accommodations extend these protections to health care settings.¹⁶² More states and localities should follow suit to enact these protections.

Abortion must be part of integrated, supported, full-spectrum reproductive health care

Abortion care must be part of holistic work toward reproductive justice—the human rights-based framework that encompasses the rights to have children, to not have children, and to parent in sustainable communities.¹⁶³ Treating abortion as separate from other types of health care is inherently stigmatizing. To achieve reproductive justice, abortion must be integrated with other reproductive health services such as contraception and maternal health care, and policymakers must address the systemic barriers that prevent people from having full autonomy over their reproductive lives. For example, at CHOICES: Memphis Center for Reproductive Health, the comprehensive reproductive health services offered include abortion care, midwifery care and a birth center, HIV services, transgender health care, and more, centering patients’ needs regardless of their ability to pay.¹⁶⁴

Everyone seeking abortion care should have access to a network of support, from clinic staff to abortion funds to loved ones to doulas—people trained to provide emotional, physical, and informational support before, during, and after abortions. All people deserve access to an abortion experience that is surrounded by love and care, not stigma and shame.

Policy recommendations

Federal and state

Policymakers have an important role to play in building this supportive, integrated landscape of abortion care. Federal and state legislatures can provide grants to providers who give full-spectrum reproductive health care, prioritizing community-based providers—those who are part of and/or embedded in the communities they serve—that center cultural humility, anti-racism, and patient-centered care. Furthermore, grant programs could support training and funding for abortion doulas, abortion funds, and other support people, prioritizing those who are part of the communities they plan to serve. This could be achieved through direct funding to community-based organizations and through insurance coverage for

abortion support workers with reimbursement at a living wage. In addition to funding, public health bodies such as HHS and state and local health departments can promote integrating abortion care as part of comprehensive reproductive health care through guidance documents and public education to remove abortion stigma and actively support abortion as health care.

Insurers, including the government in its role as payor through Medicaid and Medicare, should also incorporate quality standards and measures to encourage providers to deliver the full range of reproductive health care, including abortion. For example, One Key Question, a program of Power to Decide, an organization focused on reducing teen and unplanned pregnancy rates, trains providers to ask patients, “Do you plan to become pregnant within the next year?”, which can assess whether the patient needs contraceptives, preconception health care, a referral for an abortion, or another service.¹⁶⁵ Similarly, the Person-Centered Reproductive Health Program (PCRHP) at the University of California, San Francisco developed a Person-Centered Contraceptive Counseling Measure that centers patient experience and satisfaction—notably asking about the patient’s preferences regarding birth control. The program seeks to provide a counterbalance and complement to existing contraceptive provision measures that assess the percentage of patients receiving evidenced-based contraceptive care.¹⁶⁶ Such anti-coercion standards can help to ensure that patients seeking reproductive health care are not pushed into any particular contraceptive method or reproductive care, leaving the decision to the patient about whether to access contraceptives, preconception care, abortion, or nothing at all.

The Blueprint for Sexual and Reproductive Health, Rights, and Justice

In July 2019, a coalition of more than 90 organizations, led by Planned Parenthood Federation of America and In Our Own Voice, published the Blueprint for Sexual and Reproductive Health, Rights, and Justice—a policy agenda to advance sexual and reproductive health and rights in the United States and abroad.¹⁶⁷ The report includes specific recommendations related to improving access and quality for not only abortion but also contraceptive access, maternal health, and a range of other services. The Blueprint centers five key principles, including:

- Sexual and reproductive health care that is accessible to all people
- The elimination of discriminatory barriers in health care
- Research and innovation to advance sexual and reproductive health, rights, and justice now and in the future
- Health, rights, justice, and wellness for all communities
- The need for judges and executive officials to advance sexual and reproductive health, rights, and justice¹⁶⁸

Conclusion

From laws banning and restricting abortion care to limits on insurance coverage for abortion to the criminalization and stigmatization of reproductive decision-making, efforts to undermine abortion rights have been widespread. Yet in the face of these attacks, communities, providers, advocates, and policymakers have been unrelenting in their commitment to protect and expand access to abortion. In the new administration and beyond, the United States must build on that work to ensure that all people with the capacity for pregnancy have autonomy over their reproductive lives and have access to abortion in the safe, supportive environment of their choice.

Protecting the constitutional right to access abortion is critical, especially as that right appears more threatened than ever from state attacks and a growing conservative majority in the Supreme Court. Yet simply “codifying *Roe*” is not enough; abortion policy must go beyond baseline legal protections to ensure meaningful access to abortion for all. Policymakers must address the legal, cultural, and systemic barriers that have put abortion rights out of reach for so many in the United States for decades—especially people of color, people with low incomes, LGBTQ people, young people, people with disabilities, immigrants, and people in rural areas. Leaders must transform how abortion is treated in this country, building a cultural and systemic framework that values abortion as one critical piece in the broader landscape of health equity and reproductive autonomy.

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Endnotes

- 1 Guttmacher Institute, "Abortion Is a Common Experience for U.S. Women, Despite Dramatic Declines in Rates," Press release, October 19, 2017, available at <https://www.guttmacher.org/news-release/2017/abortion-common-experience-us-women-despite-dramatic-declines-rates>.
- 2 This report uses gender-neutral language such as "people" or "individuals" in recognition of the fact that those who have abortions do not all identify as women, including some transgender men and nonbinary people. When the term "women" is used in this report, it is in reference to research that was specifically focused on those who identify as women.
- 3 Domenico Montanaro, "Poll: Majority Want To Keep Abortion Legal, But They Also Want Restrictions," NPR, June 7, 2019, available at <https://www.npr.org/2019/06/07/730183531/poll-majority-want-to-keep-abortion-legal-but-they-also-want-restrictions>; Eric Levitz, "The Assault on Abortion Rights Is Tyranny of the Minority," The Cut, May 16, 2019, available at <https://www.thecut.com/2019/05/alabama-abortion-ban-heartbeat-law-rape-incest-polls-republicans.html>.
- 4 T.J. Raphael and Amber Hall, "In the 45 years since Roe v. Wade, states have passed 1,193 abortion restrictions," The World, January 22, 2018, available at <https://www.pri.org/stories/2018-01-22/45-years-roe-v-wade-states-have-passed-1193-abortion-restrictions>.
- 5 Rachel K. Jones, Elizabeth Witwer, and Jenna Jerman, "Abortion Incidence and Service Availability in the United States, 2017" (Washington: Guttmacher Institute, 2019), available at <https://www.guttmacher.org/report/abortion-incidence-service-availability-us-2017>.
- 6 Guttmacher Institute, "Induced Abortion in the United States" (Washington: 2019), available at https://www.guttmacher.org/sites/default/files/factsheet/fb_induced_abortion.pdf.
- 7 K.K. Rebecca Lai and Jugal K. Patel, "For Millions of American Women, Abortion Access Is Out of Reach," *The New York Times*, May 31, 2019, <https://www.nytimes.com/interactive/2019/05/31/us/abortion-clinics-map.html>.
- 8 Alina Salganicoff and Laurie Sobel, "Abortion Coverage in Marketplace Plans, 2015" (Menlo Park, CA: Kaiser Family Foundation, 2015), available at <http://files.kff.org/attachment/issue-brief-abortion-coverage-in-marketplace-plans-2015>.
- 9 National Abortion Federation, "NAF Releases 2019 Violence & Disruption Statistics," Press release, July 30, 2020, available at <https://prochoice.org/naf-releases-2019-violence-disruption-statistics/>.
- 10 Guttmacher Institute, "Data Center: Abortion clinics," available at <https://data.guttmacher.org/states/map?topics=59&dataset=data> (last accessed February 2021).
- 11 Jamila Taylor, "Women of Color Will Lose the Most if Roe v. Wade Is Overturned," Center for American Progress, August 23, 2018, available at <https://www.americanprogress.org/issues/women/news/2018/08/23/455025/women-color-will-lose-roe-v-wade-overturned/>; Jamille Fields Allsbrook and Nora ElJmann, "June Medical Services v. Russo: The Potential Impact on Abortion, Civil, and Human Rights" (Washington: Center for American Progress, 2020), available at <https://www.americanprogress.org/issues/women/reports/2020/02/06/480156/june-medical-services-v-gee/>.
- 12 Robin Bleiweis, "Quick Facts About the Gender Wage Gap" (Washington: Center for American Progress, 2020), available at <https://www.americanprogress.org/issues/women/reports/2020/03/24/482141/quick-facts-gender-wage-gap/>; Robin Bleiweis, Diana Boesch, and Alexandra Cawthorne Gaines, "The Basic Facts About Women in Poverty" (Washington: Center for American Progress, 2020), available at <https://www.americanprogress.org/issues/women/reports/2020/08/03/488536/basic-facts-women-poverty/>; Advocates for Youth, "Abortion and Young People in the United States" (Washington: 2019), available at <https://www.advocatesforyouth.org/resources/factsheets/abortion-and-young-people-in-the-united-states/>.
- 13 Guttmacher Institute, "Abortion Patients More Likely to be Poor in 2014 than in 2008," Press release, May 10, 2016, available at <https://www.guttmacher.org/news-release/2016/abortion-patients-more-likely-be-poor-2014-2008>.
- 14 Sharita Gruberg, Lindsay Mahowald, and John Halpin, "The State of the LGBTQ Community in 2020" (Washington: Center for American Progress, 2020), available at <https://www.americanprogress.org/issues/lgbtq-rights-reports/2020/10/06/491052/state-lgbtq-community-2020/>.
- 15 Advocates for Youth, "Abortion and Young People in the United States."
- 16 Maya Lorey and Shene Cavallo, "Affirming Disability Rights in Sexual and Reproductive Health Care," International Women's Health Coalition, December 3, 2018, available at <https://iwhc.org/2018/12/affirming-disability-rights-in-sexual-and-reproductive-health-care/>; Mia Mingus, "Disabled Women and Reproductive Justice," The Pro-Choice Public Education Project, available at https://www.law.berkeley.edu/php-programs/centers/crrj/zotero/loadfile.php?entity_key=9DPI88WW (last accessed February 2021).
- 17 Advancing New Standards In Reproductive Health, "The Harms of Denying a Woman a Wanted Abortion: Findings from the Turnaway Study" (Oakland, CA: Bixby Center for Global Reproductive Health, 2020), available at https://www.ansirh.org/sites/default/files/publications/files/the_harms_of_denying_a_woman_a_wanted_abortion_4-16-2020.pdf.
- 18 Advancing New Standards In Reproductive Health, "Socioeconomic outcomes of women who receive and women who are denied wanted abortions" (Oakland, CA: Bixby Center for Global Reproductive Health, 2018), available at https://www.ansirh.org/sites/default/files/publications/files/turnaway_socioeconomic_outcomes_issue_brief_8-20-2018.pdf.
- 19 John Gramlich, "How Trump compares with other recent presidents in appointing federal judges," Pew Research Center, January 13, 2021, available at <https://www.pewresearch.org/fact-tank/2021/01/13/how-trump-compares-with-other-recent-presidents-in-appointing-federal-judges/>.
- 20 Planned Parenthood Action Fund, "What Are TRAP Laws?," available at <https://www.plannedparenthoodaction.org/issues/abortion/trap-laws> (last accessed February 2021).
- 21 Anusha Ravi, "How the U.S. Health Insurance System Excludes Abortion" (Washington: Center for American Progress, 2018), available at <https://www.americanprogress.org/issues/women/reports/2018/07/20/453572/u-s-health-insurance-system-excludes-abortion/>.

- 22 All* Above All, "Fact Sheet: About the Hyde Amendment" (Washington: 2019), available at <https://allaboveall.org/resource/hyde-amendment-fact-sheet/>.
- 23 Danielle Campoamor, "39 Abortion Stories Show Just How Important Abortion Access Is," *Teen Vogue*, January 9, 2020, available at <https://www.teenvogue.com/story/abortion-stories>.
- 24 *Roe v. Wade*, 410 U.S. 113 (January 22, 1973), available at <https://www.oyez.org/cases/1971/70-18>.
- 25 *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (June 29, 1992), available at <https://www.oyez.org/cases/1991/91-744>.
- 26 Public Broadcasting Service, "With abortion measures, states see chance to challenge *Roe v. Wade*," May 15, 2019, available at <https://www.pbs.org/newshour/show/with-abortion-measures-states-see-chance-to-challenge-roe-v-wade>.
- 27 Nina Totenberg, "Supreme Court's New Supermajority: What It Means For *Roe v. Wade*," NPR, December 31, 2020, available at <https://www.npr.org/2020/12/31/951620847/supreme-courts-new-supermajority-what-it-means-for-roe-v-wade>.
- 28 Guttmacher Institute, "Abortion Policy in the Absence of *Roe*," available at <https://www.guttmacher.org/state-policy/explore/abortion-policy-absence-roe> (last accessed March 2021).
- 29 Center for Reproductive Rights, "What If *Roe* Fell?" (Washington: 2019), available at <https://reproductiverights.org/sites/default/files/2019-11/USP-2019-WIRF-Report-Web.pdf>.
- 30 National Institute for Reproductive Health, "Gaining Ground: Proactive Reproductive Health and Rights Legislation in the States: 2020 Year In Review" (New York: 2020), available at https://www.nirhealth.org/wp-content/uploads/2020/12/NIRH_2020_End-of-Year.pdf.
- 31 Guttmacher Institute, "An Overview of Abortion Laws," available at <https://www.guttmacher.org/state-policy/explore/overview-abortion-laws> (last accessed February 2021); Nora Ellmann, "State Actions Undermining Abortion Rights in 2020" (Washington: Center for American Progress, 2020), available at <https://www.americanprogress.org/issues/women/reports/2020/08/27/489786/state-actions-undermining-abortion-rights-2020/>.
- 32 Center for Reproductive Rights, "What If *Roe* Fell?"
- 33 California Legislative Information, "Health & Safety Code § 123468," available at https://leginfo.ca.gov/faces/codes_displayText.xhtml?lawCode=HSC&division=106.&title=&part=2.&chapter=2.&article=2.5 (last accessed March 2021).
- 34 *State v. Planned Parenthood of Alaska*, Alaska Supreme Court, 171 P.3d 577 (November 2, 2007), available at <https://cite.case.law/p3d/171/577/>.
- 35 Reproductive Health Act, N.Y. Public Health Law 2599-aa, 2019-2020 sess. (January 22, 2019), available at https://nyassembly.gov/leg/?default_fld=&leg_video=&bn=S00240&term=2019&Summary=Y&Actions=Y&Committee%26nbspsVotes=Y&Floor%26nbspsVotes=Y&Memo=Y&Text=Y.
- 36 Strengthening Reproductive Health Protections Amendment Act of 2020, D.C. Law 23-90 (May 6, 2020), available at <https://code.dccouncil.us/dc/council/laws/23-90.html>.
- 37 Reproductive Health Act, 775 ILCS 55 (June 12, 2019), available at <https://www.ilga.gov/legislation/ilcs/ilcs5.asp?ActID=3987&ChapterID=64>.
- 38 Maggie Jo Buchanan, "Trump's Politicization of the Justice System," Center for American Progress, February 20, 2020, available at <https://www.americanprogress.org/issues/courts/news/2020/02/20/480659/trumps-politicization-justice-system/>.
- 39 Danielle Root, Jake Faleschini, and Grace Oyenubi, "Building a More Inclusive Federal Judiciary" (Washington: Center for American Progress, 2019), available at <https://www.americanprogress.org/issues/courts/reports/2019/10/03/475359/building-inclusive-federal-judiciary/>.
- 40 Maggie Jo Buchanan, "Pipelines to Power: Encouraging Professional Diversity on the Federal Appellate Bench" (Washington: Center for American Progress, 2020), available at <https://www.americanprogress.org/issues/courts/reports/2020/08/13/489312/pipelines-power-encouraging-professional-diversity-federal-appellate-bench/>.
- 41 Maggie Jo Buchanan, "The Startling Lack of Professional Diversity Among Federal Judges," Center for American Progress, June 17, 2020, available at <https://www.americanprogress.org/issues/courts/news/2020/06/17/486366/startling-lack-professional-diversity-among-federal-judges/>.
- 42 *June Medical Services LLC v. Gee*, U.S. Court of Appeals for the 5th Circuit, No. 17-30397 (September 26, 2018), available at https://reproductiverights.org/sites/default/files/documents/2018-09-26_Opinion.pdf; American Constitution Society, "Who is Edith Brown Clement?," July 19, 2005, available at <https://www.acslaw.org/expertforum/who-is-edith-brown-clement/>; Gregory G. Katsas and others, "Letter to Robert P. Deyling," *The New York Times*, March 18, 2020, available at <https://int.nyt.com/data/documenthelper/6928-judges-respond-to-draft-ethics/53eaddfaf39912a26ae7/optimized/full.pdf>.
- 43 *June Medical Services LLC v. Russo*, 59 U.S. ____ (June 29, 2020), available at https://www.supremecourt.gov/opinions/19pdf/18-1323_c07d.pdf.
- 44 Mary Ziegler, "What Trump Supreme Court nominee Amy Coney Barrett means for *Roe v. Wade*," NBC News, September 27, 2020, available at <https://www.nbcnews.com/think/opinion/what-trump-supreme-court-nominee-amy-coney-barrett-means-roe-ncna1241086>.
- 45 Planned Parenthood Action Fund, "What Are TRAP Laws?"
- 46 Guttmacher Institute, "Induced Abortion in the United States."
- 47 Soumya Karlamangla, "60 hours, 50 abortions: A California doctor's monthly commute to a Texas clinic," *Los Angeles Times*, January 24, 2019, available at <https://www.latimes.com/local/great-reads/la-me-col1-abortion-doctor-20190124-htmlstory.html>.
- 48 Ashley Lopez, "For Supporters Of Abortion Access, Troubling Trends In Texas," NPR, November 18, 2019, available at <https://www.npr.org/sections/health-shots/2019/11/18/741117422/for-supporters-of-abortion-access-troubling-trends-in-texas>.
- 49 Abortion, S.B. 2196, Tennessee General Assembly, Public Chapter 764 (July 13, 2020), available at <http://wapp.capitol.tn.gov/apps/BillInfo/Default.aspx?BillNumber=SB2196&GA=111>.
- 50 Jonathan Mattise, "Tennessee governor signs, court blocks 6-week abortion ban," *The Washington Post*, July 13, 2020, available at https://www.washingtonpost.com/health/tennessee-governor-signs-court-blocks-6-week-abortion-ban/2020/07/13/f6602046-c52c-11ea-a825-8722004e4150_story.html.

- 51 Megan K. Donovan, “Gestational Age Bans: Harmful at Any Stage of Pregnancy” (Washington: Guttmacher Institute, 2020), available at <https://www.guttmacher.org/gpr/2020/01/gestational-age-bans-harmful-any-stage-pregnancy>.
- 52 Ellmann, “State Actions Undermining Abortion Rights in 2020.”
- 53 Elizabeth Nash and others, “State Policy Trends at Mid-Year 2020: Reproductive Health and Rights Take a Back Seat to Pandemic” (Washington: Guttmacher Institute, 2020), available at <https://www.guttmacher.org/article/2020/07/state-policy-trends-mid-year-2020-reproductive-health-and-rights-take-back-seat>.
- 54 Jamille Fields Allsbrook, “The Coronavirus Confirms the U.S. Health Care System Fails Women” (Washington: Center for American Progress, 2020), available at <https://www.americanprogress.org/issues/women/reports/2020/04/23/483828/coronavirus-crisis-confirms-u-s-health-care-system-fails-women/>.
- 55 Center for Reproductive Rights, “What If Roe Fell?”
- 56 Center for American Progress and others, “Abortion ‘Reason Bans’ in Cases of Sex or Race Selection or Fetal Diagnosis: Message Guidance” (Washington: 2020), on file with author.
- 57 Ibid.
- 58 Ibid.
- 59 Lorey and Cavallo, “Affirming Disability Rights in Sexual and Reproductive Health Care”; Mingus, “Disabled Women and Reproductive Justice.”
- 60 Guttmacher Institute, “Parental Involvement in Minors’ Abortions,” available at <https://www.guttmacher.org/state-policy/explore/parental-involvement-minors-abortions> (last accessed February 2021).
- 61 Ibid.
- 62 Campoamor, “39 Abortion Stories Show Just How Important Abortion Access Is.”
- 63 Act For Women, “The Women’s Health Protection Act,” available at <https://actforwomen.org/the-womens-health-protection-act/> (last accessed February 2021).
- 64 Ibid.
- 65 National Institute for Reproductive Health, “Gaining Ground.”
- 66 Abortion; expands who can perform in first trimester, informed consent required, S.B. 733, Virginia General Assembly, Chapter 899, 2020 sess. (April 9, 2020), available at <https://lis.virginia.gov/cgi-bin/legp604.exe?201+sum+SB733&201+sum+SB733>.
- 67 URGE: Unite for Reproductive and Gender Equity, “Young People’s Reproductive Justice Policy Agenda” (Washington: 2020), available at <https://urge.org/yppa2020/>.
- 68 Ibid. Quote provided directly to the authors by URGE: Unite for Reproductive and Gender Equity.
- 69 Salganicoff and Sobel, “Abortion Coverage in Marketplace Plans, 2015.”
- 70 Board of Governors of the Federal Reserve System, “Report on the Economic Well-Being of U.S. Households in 2018 – May 2019,” available at <https://www.federalreserve.gov/publications/2019-economic-well-being-of-us-households-in-2018-dealing-with-unexpected-expenses.htm> (last accessed March 2021); Connor Maxwell and Danyelle Solomon, “The Economic Fallout of the Coronavirus for People of Color,” Center for American Progress, April 14, 2020, available at <https://www.americanprogress.org/issues/race/news/2020/04/14/483125/economic-fallout-coronavirus-people-color/>.
- 71 Diana Boesch and Shilpa Phadke, “When Women Lose All the Jobs: Essential Actions for a Gender-Equitable Recovery” (Washington: Center for American Progress, 2021), available at https://www.americanprogress.org/issues/women/reports/2021/02/01/495209/women-lose-jobs-essential-actions-gender-equitable-recovery/?utm_medium=email&utm_source=amprog_en&utm_campaign=default&utm_content=wom+rpt+01+20210204+When-Women-Lose-Jobs+grp+1+x.
- 72 Kaiser Family Foundation, “Medicaid’s Role for Women” (Menlo Park, CA: 2019), available at <https://www.kff.org/womens-health-policy/fact-sheet/medicaids-role-for-women/>.
- 73 All* Above All, “Fact Sheet: About the Hyde Amendment,” available at <https://allaboveall.org/resource/hyde-amendment-fact-sheet/> (last accessed February 2021).
- 74 U.S. Government Accountability Office, “Medicaid: CMS Action Needed to Ensure Compliance with Abortion Coverage Requirements” (Washington: 2019), available at <https://www.gao.gov/assets/700/696338.pdf>.
- 75 Heather D. Boonstra, “Abortion in the Lives of Women Struggling Financially: Why Insurance Coverage Matters” (Washington: Guttmacher Institute, 2016), available at <https://www.guttmacher.org/gpr/2016/07/abortion-lives-women-struggling-financially-why-insurance-coverage-matters>; Dr. Katherine Glaser, “For Native Women Seeking Abortion, Hyde Amendment Is Another Broken Promise,” Rewire News Group, September 27, 2016, available at <https://rewirenewsgroup.com/article/2016/09/27/native-women-seeking-abortion-hyde-amendment-another-broken-promise/>.
- 76 Caroline Medina and Lindsay Mahowald, “Repealing the Affordable Care Act Would Have Devastating Impacts on LGBTQ People,” Center for American Progress, October 15, 2020, available at <https://www.americanprogress.org/issues/lgbtq-rights/news/2020/10/15/491582/repealing-affordable-care-act-devastating-impacts-lgbtq-people/>.
- 77 Campoamor, “39 Abortion Stories Show Just How Important Abortion Access Is.”
- 78 Ibid.
- 79 Alina Salganicoff, Laurie Sobel, and Amrutha Ramaswamy, “Coverage for Abortion Services in Medicaid, Marketplace Plans and Private Plans” (Menlo Park, CA: Kaiser Family Foundation, 2019), available at <https://www.kff.org/womens-health-policy/issue-brief/coverage-for-abortion-services-in-medicaid-marketplace-plans-and-private-plans/>.
- 80 Ibid.
- 81 Ibid.
- 82 Peter Sullivan, “Abortion battle threatens to upend health insurance push,” *The Hill*, May 3, 2020, available at <https://thehill.com/policy/healthcare/495737-abortion-battle-threatens-to-upend-new-health-insurance-push>.

- 83 Daniel Grossman, Kate Grindlay, and Bridgit Burns, "Public funding for abortion where broadly legal," *Contraception* (2016), available at https://www.law.berkeley.edu/php-programs/centers/crrj/zotero/loadfile.php?entity_key=RW826BU9.
- 84 Ibid.
- 85 BBC News, "Argentina abortion: Senate approves legalisation in historic decision," December 30, 2020, available at <https://www.bbc.com/news/world-latin-america-55475036>; Caelainn Hogan, "Why Ireland's battle over abortion is far from over," *The Guardian*, October 3, 2019, available at <https://www.theguardian.com/lifeandstyle/2019/oct/03/why-irelands-battle-over-abortion-is-far-from-over-anti-abortionists>.
- 86 In this context, "custodial status" refers to whether that individual is incarcerated or in detention.
- 87 The CAP Health Policy Team, "Medicare Extra for All: A Plan to Guarantee Universal Health Coverage in the United States" (Washington: Center for American Progress, 2018), available at <https://www.americanprogress.org/issues/healthcare/reports/2018/02/22/447095/medicare-extra-for-all/>.
- 88 Jamille Fields Allbrook and Osub Ahmed, "Medicare Extra: A Tool To Improve Reproductive Health Care Access" (Washington: Center for American Progress, 2020), available at <https://www.americanprogress.org/issues/women/reports/2020/07/23/488017/medicare-extra-tool-improve-reproductive-health-care-access/>.
- 89 Legal Information Institute, "42 U.S. Code § 300gg-5 - Non-discrimination in health care," available at <https://www.law.cornell.edu/uscode/text/42/300gg-5> (last accessed March 2021).
- 90 All* Above All, "EACH Woman Act Fact Sheet," available at <https://allaboveall.org/resource/each-woman-act-fact-sheet/> (last accessed February 2021).
- 91 Alina Salganicoff, Laurie Sobel, and Amrutha Ramaswamy, "The Hyde Amendment and Coverage for Abortion Services" (Menlo Park, CA: Kaiser Family Foundation, 2020), available at <https://www.kff.org/womens-health-policy/issue-brief/the-hyde-amendment-and-coverage-for-abortion-services/>.
- 92 Guttmacher Institute, "Regulating Insurance Coverage of Abortion," available at <https://www.guttmacher.org/state-policy/explore/regulating-insurance-coverage-abortion> (last accessed February 2021).
- 93 Ibid.
- 94 Michael Ollove, "What States Mean by a 'Public Option,'" The Pew Charitable Trusts, June 6, 2019, available at <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2019/06/06/what-do-states-mean-when-they-say-public-option>.
- 95 All* Above All, "First 100 Days Agenda for Abortion Justice," available at <https://allaboveall.org/campaign/100-days-agenda/> (last accessed February 2021).
- 96 National Network of Abortion Funds, "About," available at <https://abortionfunds.org/about/> (last accessed February 2021).
- 97 Nikita Stewart, "New York City Allocates \$250,000 for Abortions, Challenging Conservative States," *The New York Times*, June 14, 2019, available at <https://www.nytimes.com/2019/06/14/nyregion/abortion-funding-ny.html>.
- 98 New York Abortion Access Fund, "About," available at <https://www.nyaaf.org/about/> (last accessed February 2021).
- 99 National Institute for Reproductive Health, "Fund Abortion NYC," available at <https://www.nirhealth.org/fund-abortion-nyc/> (last accessed February 2021).
- 100 Ibid. Quote provided directly to the authors by the National Institute for Reproductive Health.
- 101 Kaiser Family Foundation, "The Availability and Use of Medication Abortion," June 8, 2020, available at <https://www.kff.org/womens-health-policy/fact-sheet/medication-abortion/>.
- 102 Nora Ellmann and Jamila Taylor, "Rhetoric vs. Reality: Setting the Record Straight on Medication Abortion" (Washington: Center for American Progress, 2019), available at <https://www.americanprogress.org/issues/women/reports/2019/06/10/470885/rhetoric-vs-reality-setting-record-straight-medication-abortion/>.
- 103 Advancing New Standards in Reproductive Health, "Safety and effectiveness of first-trimester medication abortion in the United States" (Oakland, CA: Bixby Center for Global Reproductive Health, 2016), available at <https://www.an-sirh.org/sites/default/files/publications/files/medication-abortion-safety.pdf>.
- 104 Megan K. Donovan, "Self-Managed Medication Abortion: Expanding the Available Options for U.S. Abortion Care," *Guttmacher Policy Review* 21 (2018): 41–47, available at <https://www.guttmacher.org/gpr/2018/10/self-managed-medication-abortion-expanding-available-options-us-abortion-care#>; Jones, Witwer, and Jerman, "Abortion Incidence and Service Availability in the United States, 2017."
- 105 U.S. Food and Drug Administration, "Mifeprex (mifepristone) Information," available at <https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/mifeprex-mifepristone-information> (last accessed February 2021).
- 106 U.S. Food and Drug Administration, "What's in a REMS?," available at <https://www.fda.gov/drugs/risk-evaluation-and-mitigation-strategies-rems/whats-rems> (last accessed February 2021).
- 107 Advancing New Standards in Reproductive Health, "Safety and effectiveness of first-trimester medication abortion in the United States."
- 108 Donovan, "Self-Managed Medication Abortion"; American College of Obstetricians and Gynecologists, "ACOG Statement on Medication Abortion," Press release, March 30, 2016, available at <https://www.acog.org/news/news-releases/2016/03/acog-statement-on-medication-abortion>.
- 109 Kaiser Family Foundation, "The Availability and Use of Medication Abortion."
- 110 American Civil Liberties Union, "Federal Court Blocks FDA Restriction That Unnecessarily Imposes COVID-19 Risks on Patients Seeking Abortion Care," Press release, July 13, 2020, available at <https://www.aclu.org/press-releases/federal-court-blocks-fda-restriction-unnecessarily-imposes-covid-19-risks-patients>; Ann E. Marimow, "Abortion medication restrictions remain blocked during pandemic, judge rules," *The Washington Post*, December 10, 2020, available at https://www.washingtonpost.com/local/legal-issues/abortion-medication-restrictions-loosened-during-pandemic/2020/12/10/332528fe-2db6-11eb-bae0-50bb17126614_story.html.
- 111 Adam Liptak, "Supreme Court Revives Abortion-Pill Restriction," *The New York Times*, January 12, 2021, available at https://www.nytimes.com/2021/01/12/us/supreme-court-abortion-pill.html?campaign_id=9&emc=edit_nn_20210113&instance_id=25950&nl=the-morning®i_id=71952627&segment_id=49160&te=1&user_id=424092f43c79aa25ccdb37555f8944cf.

- 112 Ian Millhiser, "The first abortion case of the Amy Coney Barrett era is now before the Supreme Court," *Vox*, December 17, 2020, available at <https://www.vox.com/cdn.ampproject.org/c/s/www.vox.com/platform/amp/2020/12/17/22178362/supreme-court-abortion-amy-coney-barrett-fda-american-college-obstetricians-gynecologists>.
- 113 Advancing New Standards In Reproductive Health, Gynuity Health Projects, and Ibis Reproductive Health, "A roadmap for research on self-managed abortion in the United States" (2018), available at <https://ibisreproductivehealth.org/publications/roadmap-research-self-managed-abortion-united-states>.
- 114 Daniel Grossman and Philip Goldstone, "Mifepriston by prescription: a dream in the United States but reality in Australia," *Contraception* 92 (3) (2015): 186–189, available at [https://www.contraceptionjournal.org/article/S0010-7824\(15\)00252-8/fulltext](https://www.contraceptionjournal.org/article/S0010-7824(15)00252-8/fulltext).
- 115 Caroline Moreau and others, "Abortion regulation in Europe in the era of COVID-19: a spectrum of policy responses," *BMJ Sexual and Reproductive Health* (2020), available at <https://srh.bmj.com/content/early/2020/09/25/bmj.srh-2020-200724>.
- 116 Ibid.
- 117 Ibid.
- 118 Guttmacher Institute, "Medication Abortion," available at <https://www.guttmacher.org/state-policy/explore/medication-abortion> (last accessed February 2021); Osob Ahmed, "States Must Expand Telehealth To Improve Access to Sexual and Reproductive Health Care" (Washington: Center for American Progress, 2020), available at <https://www.americanprogress.org/issues/women/reports/2020/05/21/485297/states-must-expand-telehealth-improve-access-sexual-reproductive-health-care/>.
- 119 Ibid.
- 120 Ibid.
- 121 Lai and Patel, "For Millions of American Women, Abortion Access Is Out of Reach."
- 122 Daniel Grossman and Kate Grindlay, "Safety of Medical Abortion Provided Through Telemedicine Compared With In Person," *Obstetrics and Gynecology* 130 (4) (2017): 778–782, available at <https://www.ncbi.nlm.nih.gov/pubmed/28885427>; Ibis Reproductive Health, "Telemedicine projects to improve access to abortion care," available at <https://ibisreproductivehealth.org/projects/telemedicine-projects-improve-access-abortion-care> (last accessed February 2021).
- 123 Ahmed, "States Must Expand Telehealth To Improve Access to Sexual and Reproductive Health Care."
- 124 Ibid.
- 125 Ibid.
- 126 Ibid.
- 127 World Health Organization, "Health worker roles in providing safe abortion care and post-abortion contraception" (Geneva: 2015), available at https://apps.who.int/iris/bitstream/handle/10665/181041/9789241549264_eng.pdf;jsessionid=8268B51C2E2CE04A26BFFESC9A45969E?sequence=1.
- 128 Donovan, "Self-Managed Medication Abortion"; N. Kapp and others, "A research agenda for moving early medical pregnancy termination over the counter," *BJOG* 124 (11) (2017): 1646–1652, available at <https://obgyn.onlinelibrary.wiley.com/doi/full/10.1111/1471-0528.14646>.
- 129 If/When/How: Lawyering for Reproductive Justice, "Self-Managed Abortion, the Law, and COVID-19 Fact Sheet" (2020), available at https://www.ifwhenhow.org/wp-content/uploads/2020/04/20_04_Final_SMA_TheLaw_COVID-19_FactSheet_PDF.pdf.
- 130 Ibid.; Donovan, "Self-Managed Medication Abortion"; National Advocates for Pregnant Women, "Abortion," available at <https://www.nationaladvocatesforpregnantwomen.org/issues/abortion/> (last accessed February 2021).
- 131 National Advocates for Pregnant Women, "Woman Prosecuted for Seeking to End Her Own Pregnancy (GA)," available at <https://www.nationaladvocatesforpregnantwomen.org/tag/jones/> (last accessed February 2021).
- 132 Lynn M. Paltrow and Jeanne Flavin, "Arrests of and Forced Interventions on Pregnant Women in the United States, 1973–2005: Implications for Women's Legal Status and Public Health," *Journal of Health Politics, Policy and Law* 38 (2) (2013): 299–342, available at <https://read.dukeupress.edu/jhpl/article/38/2/299/13533/Arrests-of-and-Forced-Interventions-on-Pregnant>; Andrea Rowan, "Prosecuting Women for Self-Inducing Abortion: Counterproductive and Lacking Compassion," *Guttmacher Policy Review* 18 (3) (2015): 70–76, available at <https://www.guttmacher.org/gpr/2015/09/prosecuting-women-self-inducing-abortion-counterproductive-and-lacking-compassion#>.
- 133 If/When/How: Lawyering for Reproductive Justice, "Press Release: ABA Takes Historic Vote Against Criminalizing People Who Have Abortions," Press release, February 22, 2021, available at <https://www.ifwhenhow.org/press-release-aba-resolution-self-managed-abortion-criminalization/>.
- 134 National Advocates for Pregnant Women, "Abortion"; If/When/How: Lawyering for Reproductive Justice, "Strategic Initiative: Decriminalizing Self-Managed and Supported Non-Clinical Abortion," available at <https://www.ifwhenhow.org/get-involved/strategic-initiatives-2/strategic-initiative-sma-may-2019-update/> (last accessed February 2021).
- 135 Olga Khazan, "Women in the U.S. Can Now Get Safe Abortions by Mail," *The Atlantic*, October 18, 2018, available at <https://www.theatlantic.com/health/archive/2018/10/women-on-web-safe-abortion-mail/573322/>.
- 136 Women Help Women, "About SASS: Self Managed Abortion; Safe and Supported," available at <https://abortionpillinfo.org/en/sass> (last accessed February 2021).
- 137 Quote provided directly to the authors by If/When/How: Lawyering for Reproductive Justice.
- 138 Blueprint for Sexual and Reproductive Health, Rights, and Justice, "The Blueprint for Sexual and Reproductive Health, Rights, and Justice," available at <https://reproblueprint.org/> (last accessed February 2021).
- 139 S.B. 179, Nevada Public Law 265, 80th sess. (May 31, 2019), available at <https://www.leg.state.nv.us/App/NELIS/REL/80th2019/Bill/6300/Overview; Strengthening Reproductive Health Protections Amendment Act of 2020, D.C. Law 23-90>.
- 140 Donovan, "Self-Managed Medication Abortion"; National Women's Health Network, "Our View: Self-Managed Abortion with FDA-Approved Medication Is Safe and Effective," October 1, 2018, available at <https://nwhn.org/taking-abortion-pills-nwhns-position-self-induced-abortion-using-fda-approved-medication/>.
- 141 Advancing New Standards In Reproductive Health, Gynuity Health Projects, and Ibis Reproductive Health, "A roadmap for research on self-managed abortion in the United States."

- 142 Mirel Zaman, "This Is The Perfect Reason To Have An Abortion," Refinery29, October 20, 2020, available at <https://www.refinery29.com/en-us/2020/10/1015330/reasons-for-abortion-stories-women>.
- 143 American Civil Liberties Union, "The Last Clinics Standing," available at <https://www.aclu.org/issues/reproductive-freedom/abortion/last-clinics-standing> (last accessed February 2021).
- 144 Becca Andrews, "The Network of Abortion Providers in Red States Was Already Delicate. Then Came the Coronavirus," *Mother Jones*, March 31, 2020, available at <https://www.motherjones.com/coronavirus-updates/2020/03/abortion-access-red-states-coronavirus/>; Elly Belle, "This Is Why Abortions Weren't Available In South Dakota For The Past 7 Months," Refinery29, available at <https://www.refinery29.com/en-us/2020/11/10183223/south-dakota-abortion-7-month-stop-covid-pandemic>.
- 145 Planned Parenthood Action Fund, "What Are TRAP Laws?"
- 146 Osob Ahmed, "Politicians' Efforts to Undermine Providers Are Imperiling Women's Health" (Washington: Center for American Progress, 2019), available at <https://www.americanprogress.org/issues/women/reports/2019/07/17/472194/politicians-efforts-undermine-providers-imperiling-womens-health/>; Osob Ahmed, Shilpa Phadke, and Diana Boesch, "Women Have Paid the Price for Trump's Regulatory Agenda" (Washington: Center for American Progress, 2020), available at <https://www.americanprogress.org/issues/women/reports/2020/09/10/490241/women-paid-price-trumps-regulatory-agenda/>; Erin Heger, "Documents Show Government Funding of Anti-Choice Clinics a 'Futile Project,'" Rewire News Group, January 28, 2020, available at <https://rewirenewsgroup.com/article/2020/01/28/documents-show-government-funding-of-anti-choice-clinics-a-futile-project/>.
- 147 Ruth Dawson, "Trump Administration's Domestic Gag Rule Has Slashed the Title X Network's Capacity by Half" (Washington: Guttmacher Institute, 2020), available at <https://www.guttmacher.org/article/2020/02/trump-administrations-domestic-gag-rule-has-slashed-title-x-networks-capacity-half>; Ahmed, "Politicians' Efforts to Undermine Providers Are Imperiling Women's Health"; Ahmed, Phadke, and Boesch, "Women Have Paid the Price for Trump's Regulatory Agenda"; Heger, "Documents Show Government Funding of Anti-Choice Clinics a 'Futile Project.'"
- 148 Dawson, "Trump Administration's Domestic Gag Rule Has Slashed the Title X Network's Capacity by Half"; Jessie Hellmann, "Planned Parenthood files emergency lawsuit to stay in Texas Medicaid program," *The Hill*, February 3, 2021, available at <https://thehill.com/policy/healthcare/537225-planned-parenthood-files-emergency-lawsuit-to-stay-in-texas-medicare/>; Caroline Kelly, "Judge allows Texas to remove Planned Parenthood from Medicaid program," CNN, March 10, 2021, available at <https://www.cnn.com/2021/03/10/politics/judge-planned-parenthood-texas-medicare/index.html>.
- 149 National Women's Law Center, "The Trump Administration Weaponized the Weldon Amendment: It's Time for it to Go" (Washington: 2021), available at <https://nwlc.org/wp-content/uploads/2020/12/WeaponizingWeldon.pdf>.
- 150 NARAL Pro-Choice Virginia, "Reproductive Health Protection Act," available at <https://naralva.org/reproductive-health-protection-act/> (last accessed February 2021); An Act To Authorize Certain Health Care Professionals To Perform Abortions, Maine Public Law 262 (June 10, 2019), available at <https://legislature.maine.gov/LawMakerWeb/summary.asp?ID=280072502>; Office of Sen. Liz Krueger, "FAQs about the Reproductive Health Act," February 12, 2019, available at <https://www.nysenate.gov/newsroom/articles/2019/liz-krueger/faqs-about-reproductive-health-act>.
- 151 Public Leadership Institute, "Crisis Pregnancy Center Fraud Prevention Act," available at <https://publicleadershipinstitute.org/abortion-rights/crisis-pregnancy-center-fraud-prevention-act/> (last accessed February 2021).
- 152 NARAL Pro-Choice America, "Anti-Abortion Violence," available at <https://www.prochoiceamerica.org/issue/anti-abortion-violence/> (last accessed February 2021).
- 153 U.S. Department of Justice, "Freedom of Access to Clinic Entrances & Places of Religious Worship," available at <https://www.justice.gov/crt-12> (last accessed February 2021).
- 154 Tina Vásquez, "How the anti-abortion movement fed the Capitol insurrection," Prism, January 22, 2021, available at https://www.prismreports.org/article/2021/1/22/how-the-antiabortion-movement-fed-the-capitol-insurrection?utm_source=The+19th&utm_campaign=cbb3db9e18-19th-newsletters-daily&utm_medium=email&utm_term=0_a35c3279be-cbb3db9e18-365999348.
- 155 Gruberg, Mahowald, and Halpin, "The State of the LGBTQ Community in 2020."
- 156 Timothy S. Jost, "Trump Administration Amends ACA Antidiscrimination Rule, Cutting Transgender and Other Civil Rights Protections, but Supreme Court Decision Calls Amendments into Question," *The Commonwealth Fund*, June 15, 2020, available at <https://www.commonwealthfund.org/blog/2020/trump-administration-amends-aca-antidiscrimination-rule-cutting-transgender-and-other>.
- 157 Campoamor, "39 Abortion Stories Show Just How Important Abortion Access Is."
- 158 Advocates for Youth, "Section 1557: Protecting the Health of Trans Youth," available at <https://www.advocatesforyouth.org/resources/policy-advocacy/section-1557-protecting-the-health-of-trans-youth/> (last accessed March 2021).
- 159 Guttmacher Institute, "Protecting Access to Clinics," available at <https://www.guttmacher.org/state-policy/explore/protecting-access-clinics> (last accessed February 2021); Local Progress and National Institute for Reproductive Health, "Abortion Access" (2019), available at <https://localprogress.org/wp-content/uploads/2019/01/Abortion-Access.pdf>.
- 160 Center for Reproductive Rights, "U.S. Supreme Court Strikes Buffer Zones for Massachusetts Abortion Clinics, Hinders Women's Access to Constitutionally Protected Health Care in the State," Press release, June 26, 2014, available at <https://www.reproductiverights.org/press-room/us-supreme-court-strikes-buffer-zones-for-massachusetts-abortion-clinics>.
- 161 National Institute for Reproductive Health, "2019 Report: Gaining Ground: Proactive Reproductive Health and Rights Legislation in the States" (Washington: 2020), available at <https://www.nirhealth.org/blog/2020/01/03/2019-report-gaining-ground/>; Local Progress and National Institute for Reproductive Health, "Abortion Access."
- 162 Movement Advancement Project, "Nondiscrimination Laws," available at https://www.lgbtmap.org/equality-maps/non_discrimination_laws (last accessed February 2021).
- 163 SisterSong, "Reproductive Justice," available at <https://www.sistersong.net/reproductive-justice#:~:text=What%20is%20Reproductive%20Justice%3F,in%20safe%20and%20sustainable%20communities> (last accessed February 2021).
- 164 CHOICES: Memphis Center for Reproductive Health, "About Us," available at <https://memphischoices.org/about-us/> (last accessed February 2021).

165 Power to Decide, "One Key Question: Overview" (Washington: 2020), available at https://powertodecide.org/sites/default/files/2020-07/One%20Key%20Question_Overview.pdf.

166 University of California, San Francisco, "The Person-Centered Contraceptive Counseling Measure," available at <https://pcccmeasure.ucsf.edu/> (last accessed February 2021).

167 Blueprint for Sexual and Reproductive Health, Rights, and Justice, "The Blueprint for Sexual and Reproductive Health, Rights, and Justice."

168 Ibid.

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