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# On the Offense: A Playbook for States to Protect and Expand Abortion Access

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By Arielle Swernoff

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# Introduction

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People across the country are responding to the leaked draft of the Supreme Court’s majority opinion in *Dobbs v. Jackson Women’s Health*, which would overturn *Roe v. Wade* and eliminate the constitutional right to abortion. Activists and experts have been warning of the right-wing desire to overturn *Roe* for years. This unfortunate threat has apparently now come to fruition.

Policymakers in blue states are rushing to pass laws protecting and expanding abortion access for their constituents and for people who may be forced to travel to their states to seek care. This memorandum draws upon the extensive and critical work of the California Future of Abortion Council’s [policy blueprint](#), as well as earlier research [published by Data for Progress](#), to provide a roadmap for blue states to protect and expand abortion access.

This memo provides context for the current abortion policy landscape, and then details policy recommendations under four thematic headlines: supporting people forced to travel for care; expanding **Medicaid**<sup>1</sup> and insurance coverage of abortion; reducing cost as a barrier to care; and ending abortion stigma and misinformation. Each policy section includes recommendations from the California Future of Abortion Council, as well as additional proposals under the same theme. The goal of this memo is to inform policymakers and activists seeking to expand abortion access through policy analysis and national polling in order to help build a world of abortion justice for all.

## National Implications

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If *Roe v. Wade* is overturned, abortion access will be seriously curtailed for millions of Americans, particularly in the South and Midwest. Research published by the [New York Times](#) estimates that 41 percent of women<sup>2</sup> of childbearing age would see their nearest clinic close, and the average distance they would have to drive to access an abortion would go up from 35 miles to 279. While these abortion restrictions will impact everyone, this impact will not be felt equally. For poor people, people of color, undocumented people, trans and gender non-conforming people, minors, and people in rural areas, abortion access could become even more limited.

New Data for Progress [polling](#) shows that Black and Latino/a voters are already more than twice as likely as white voters to report that they or a loved one had trouble accessing care to prevent or terminate a pregnancy, with 19 percent of both Black and Latino/a voters reporting trouble accessing care, and 8 percent of white voters reporting the same. Similarly, voters under 45 were three times as likely (19 percent) as those over 45 (6 percent) to report having trouble accessing care, perhaps reflecting the significant influx of abortion restrictions [since 2011](#). It is likely that the potential overturning of *Roe* will exacerbate this existing racial and economic divide.

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1        Bolded text will be included in the glossary at the end of the memo

2        People of all genders have abortions; the term women is used only when citing research

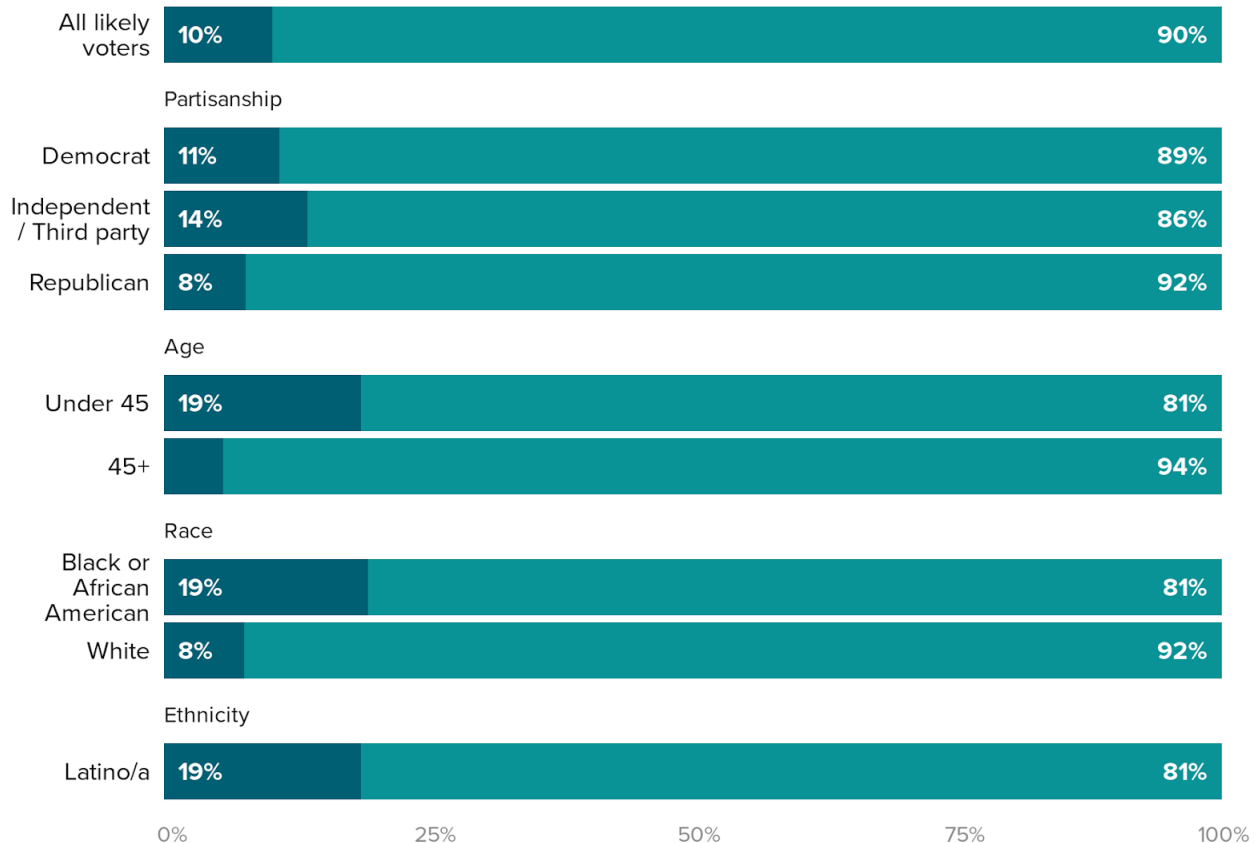


# One in 10 People Know Someone Who Struggled to Access Abortion Care

Have you or anyone close to you had trouble accessing care to prevent or terminate a pregnancy?

Yes, either I or someone close to me has had trouble accessing care to prevent or terminate a pregnancy.

No, neither I nor someone close to me has had trouble accessing care to prevent or terminate a pregnancy.



May 4–9, 2022 survey of 1,157 likely voters

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**“The ability to have an abortion is rooted in the ability to make choices about one’s own body, and for that reason alone, policymakers should work hard to make sure abortion is accessible for their constituents.”**

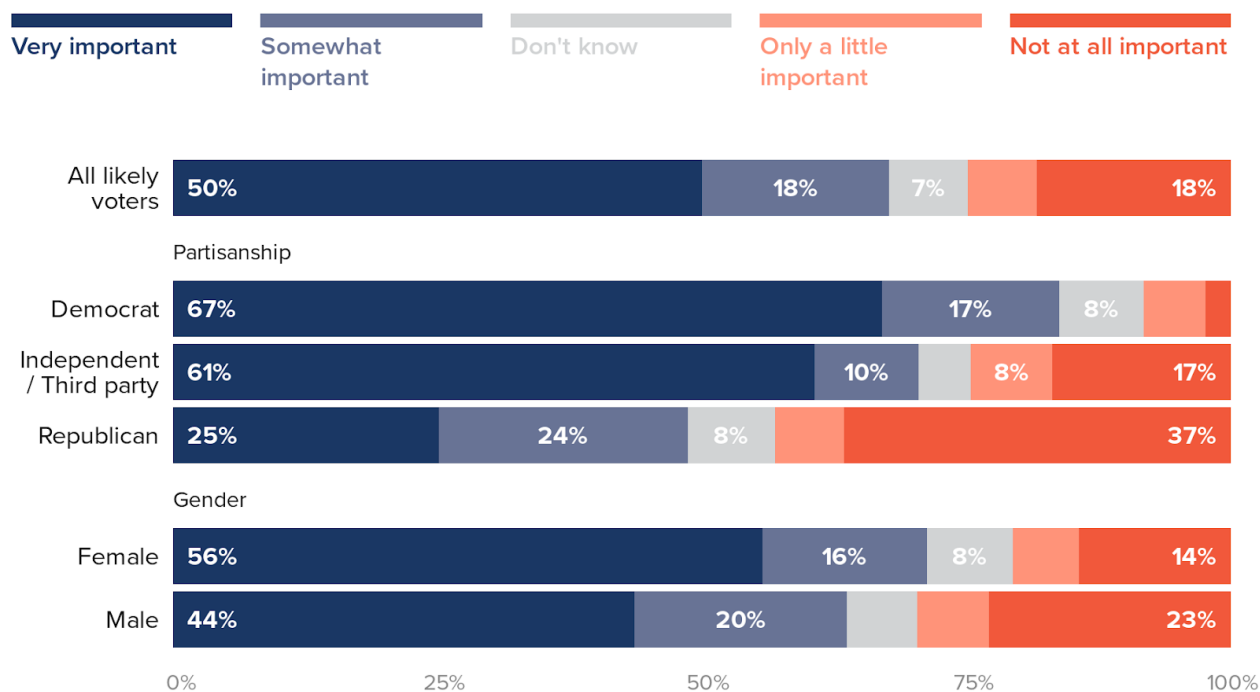
However, the impacts of access to abortion go beyond just one’s own bodily autonomy — abortion is an issue of economic and racial justice. For example, according to UCSF’s groundbreaking [Turnaway Study](#), people denied abortion care who went on to give birth experienced increased poverty, lack of resources for basic living expenses, and greater likelihood that they would still be in contact with a violent partner than those who received a wanted abortion.

The federal government can protect people in states hostile to abortion by codifying the right to abortion into federal law through the **Women's Health Protection Act**. Doing so would require overturning the filibuster. Congress and the president can also expand abortion access by ending the **Hyde Amendment**, which bars the use of federal funds to pay for abortion. A majority of voters support using these policy means to expand and protect access to abortion. Data for Progress polling illustrates that 68 percent of voters indicate it is “somewhat” or “very” important that their state elected leaders incorporate abortion access and protection into law. This issue is particularly salient among Democrats (84 percent), Independents (71 percent), and women (72 percent).

## A Majority of Voters Say It's Important to Protect Abortion in Their State

Lawmakers in some states have recently passed laws to restrict access to abortion.

How important or not important is it that **your state's** policy makers take action to protect and expand access to abortion in your state?



May 4–9, 2022 survey of 569 likely voters

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Policy is not the only solution. **Abortion funds, practical support funds, independent clinics**, and activist groups, both those in friendlier states and those working in hostile territory, must also be supported. **Self-managed abortion** with pills is also likely to become more common, which, while safe, can involve legal risk. Legal resources to protect people whose pregnancy outcomes are criminalized must also receive additional investment.

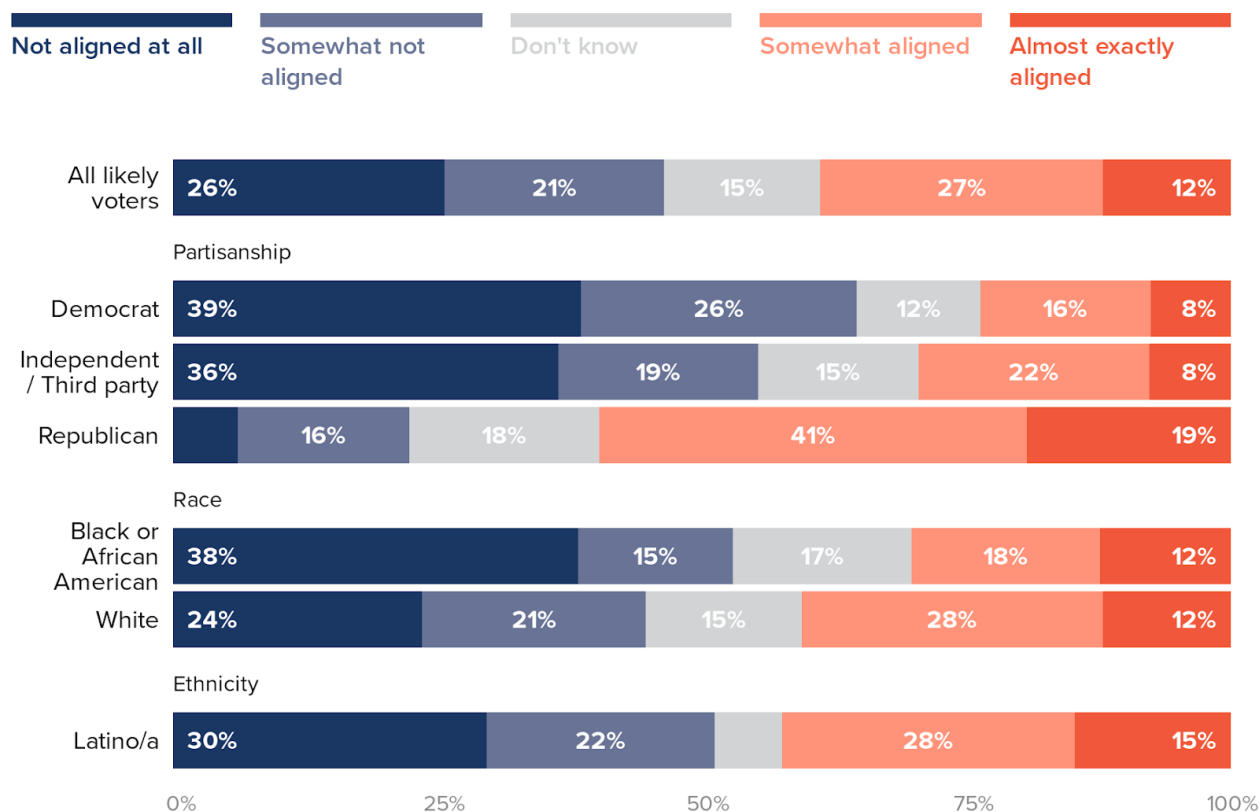
## Importance of State and Local Policy

Federal action remains a long-term goal, but work in the states is sorely and immediately needed to protect and expand abortion access. Conservatives and the far right have been launching attacks against abortion rights at the state level for decades. Reproductive rights activists in red states have been fighting an overwhelming tsunami of abortion restrictions, including those regulating clinics out of existence, creating mandatory waiting periods, and raising additional barriers for people seeking abortions. Progressives must engage on this issue in the states, particularly in light of the imminent threat to Roe.

Despite this proliferation of abortion bans in red states, Data for Progress polling shows that a majority of likely voters do not believe that the actions of policymakers who have banned abortions align with the attitudes of their constituents. Nearly half of all likely voters (47 percent) think that these anti-choice policymakers are “somewhat not aligned” or “not aligned at all” with the preferences of their constituents. Black and Latino/a respondents are particularly concerned that policymakers who ban abortion do not represent the people who elected them, with 53 percent of Black respondents and 52 percent of Latino/a respondents saying that these policymakers are not aligned with their constituents.

## Nearly Half of Voters Think Anti-Abortion Politicians Don't Represent Their Constituents

Thinking of the policy makers that represent **states that have passed laws that ban abortion**, how well do you think their actions on abortion align with the attitudes of their constituents?



May 4–9, 2022 survey of 1,157 likely voters

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As Midwestern and Southern states ban abortion following the Supreme Court decision, many people will be forced to travel to blue states for care. **Reproductive freedom states** such as New York and California must do more to prepare for an influx of abortion travelers, ensuring that in-state capacity to provide abortion care is expanded, and laws are updated to make abortion more accessible. In this context, **reproductive freedom state** refers to states that have relatively unrestricted access to abortion care. However, ensuring access to healthcare, bodily autonomy, and **reproductive justice** for all requires significant changes in housing, climate, education, drug, healthcare, and economic policy beyond the scope of this memo, both at the state and federal level.

State legislation is often the model for federal action. The national landscape is currently grim, but in order to build a future where abortion and reproductive healthcare are accessible and available to all, without barriers, shame, or stigma, we must begin to build it wherever and whenever we can. Legislation passed in California now might be a long way away from becoming federal law, but the timing is right to secure political wins by passing state-level legislation that can serve as a template for federal action in securing abortion care.

## About California Future of Abortion Council

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It's in this context that the [California Future of Abortion Council](#) released [its blueprint](#), including 45 policies California can adopt to protect and expand abortion access for Californians and abortion travelers from outside the state. Some of these are specific to California, but many of the recommendations can be generalized and adopted by other blue states seeking to protect and expand abortion care.

The California Future of Abortion Council's Steering Committee includes ACCESS REPRODUCTIVE JUSTICE, Black Women for Wellness Action Project, Essential Access Health, NARAL Pro-Choice California, National Health Law Program (NHLP), Planned Parenthood Affiliates of California, Office of Senator Toni G. Atkins, Senate President pro Tempore, Training in Early Abortion for Comprehensive Healthcare (TEACH), a cross section of groups experienced both in the provision of reproductive healthcare in California, as well as reproductive justice advocacy and governance.

This memo uplifts several themes from California FAB Council's blueprint and provides information for policymakers and activists seeking to expand abortion access in their states. The California FAB Council's work is instrumental for the development of the following policy recommendations.

# Policy Recommendations

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## 1 — SUPPORTING PEOPLE FORCED TO TRAVEL FOR CARE

As hostile states limit or ban abortion within their borders, it will become necessary for **reproductive freedom states** to do more to support people forced to travel to seek care. Already, states neighboring Texas have seen a huge influx of patients forced to travel for care, placing additional strain on existing clinics, abortion funds, and practical support funds (groups that provide assistance for travel costs, childcare, and other logistical barriers). Clinics in Louisiana, New Mexico, Colorado, and Oklahoma are seeing an up to a 2,500 percent increase in out-of-state patients<sup>3</sup>. Abortion funds and practical support funds are allocating more money to abortion seekers, as travel makes getting an abortion more expensive. If *Roe v. Wade* falls, those pressures will increase in states still providing abortion services. **Reproductive freedom states** should be prepared to see an influx of people forced to travel to seek care. To accommodate the expected increase in demand, **reproductive freedom states** should be taking action now to expand their abortion care infrastructure.

### EXAMPLES FROM CALIFORNIA FUTURE OF ABORTION COUNCIL

The California Future of Abortion Council provides several pathways and recommendations to expand the abortion provider workforce, provide an easy transition for providers moving from hostile states, and make **medication abortion** more accessible.

Expanding the abortion provider workforce ensures that more clinicians, especially those in underserved areas, are able to provide abortion care. States can build out their abortion provider education pipeline by 1) supporting medical trainees and 2) supporting training programs. Governments can accomplish the first by creating scholarship programs, such as the proposed California Reproductive Service Corps, which provides financial support to people — particularly those from marginalized or rural backgrounds — training as physicians, nurse practitioners, certified nurse-midwives, or physician assistants to learn the skills to provide abortion care in underserved areas. States can also support trainees by providing loan assistance and forgiveness for people who practice abortion care in rural and underserved areas. Additionally, states can support training by issuing grants to providers, educational institutions, and other training programs, with priority consideration for abortion providers operating in marginalized, low-income, and underresourced areas.

These policies can also serve to increase the diversity of the abortion provider workforce, creating opportunities for those historically excluded from healthcare professions and ensuring abortion workers reflect the communities of the patients they serve. States can consider targeting minority-serving institutions for funding, as well as other programs to specifically increase the diversity of the abortion provider workforce.

If *Roe v. Wade* falls, some abortion providers currently working in hostile states may choose to move to other states. **Reproductive freedom states** can remove barriers for clinicians who move across state lines to continue practicing abortion care. States should approach this not as a grab for qualified doctors and healthcare professionals, but a way to support people whose careers may be displaced by the end of *Roe v. Wade*.

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<sup>3</sup> Oklahoma has since passed its own 6-week abortion ban

Although it is likely that those seeking an abortion will travel to **reproductive freedom states** to get one, the majority of voters are not interested in moving should their state pass legislation banning abortion. Recent polling from Data for Progress shows that 66 percent of likely voters would not consider moving, even if their state passed an abortion ban, with only 24 percent people saying they would consider moving in this case. Democrats and people under the age of 45 are most likely to say that they would consider moving, but these individuals are still in the minority of their peers.

This polling echoes the sentiments of reproductive justice advocates in states where abortion is likely to be restricted. Despite calls for people to move or boycott restrictive states, it's unreasonable to ask people to uproot their lives and families in order to live in a place where necessary healthcare is easily accessible. Supporting people forced to travel for abortion does not include calls for relocation.

States can instead make it easier for people to access abortion across distance by removing barriers to accessing **medication abortions**. Medication abortions, performed up to 11 weeks following a person's last period, involve taking two kinds of pills that induce cramping and bleeding to empty a person's uterus. Because they merely require people to take pills, **medication abortions** can be prescribed in a variety of clinical settings, and often, patients are able to take the pills from the comfort of their home. **Reproductive freedom states** can provide grants to implement and/or reintroduce **medication abortion** in healthcare settings that have not typically or recently provided it. Grants could support federally qualified health centers, community health centers, campus health centers, and **Title X** fund recipients in providing abortion care to their patients.

## **ADDITIONAL EXAMPLES**

As discussed in a previous Data for Progress memo, states can also change their laws to allow all qualified clinicians, including nurse practitioners, certified nurse-midwives, and physician assistants, to provide abortion care. These providers all fall under the category of **advanced practice clinicians** — highly educated and trained healthcare providers who often deliver significant amounts of primary care. Studies show that first-trimester abortions are just as safe when performed by trained advanced practice clinicians as when conducted by physicians. California has long allowed advanced practice clinicians to provide abortion care, and there is significant momentum behind the change in other states — in the past three years, Maine, Hawaii, and New Jersey have all changed their laws to allow these clinicians to provide abortion care.

Additionally, states can expand access to abortion pills via telemedicine. Abortion pills are a highly safe and effective method for terminating a pregnancy up to 11 weeks. Many states now allow doctors and healthcare providers to prescribe abortion pills via telemedicine, eliminating the need to travel to an in-person visit to receive the pills. This is especially useful for people who live in rural areas or lack reliable access to transportation. In December 2021, the FDA permanently approved regulations allowing people to receive abortion pills by mail (restrictions had previously been temporarily lifted due to the coronavirus pandemic). While some hostile states have banned abortion via telemedicine, others such as California, New York, and Massachusetts have used the new regulations to increase availability of abortion pills.



## 2 — MEDICAID AND INSURANCE COVERAGE

Abortion care is expensive, and lack of insurance coverage is a barrier for many hoping to receive care. The Hyde Amendment prohibits federal funds from being used to pay for abortion, effectively banning abortion care from all federal health insurance plans — meaning that people on Medicaid, members of the military, federal employees and their dependents, Peace Corps volunteers, people incarcerated in federal prisons or immigration detention centers, people receiving healthcare through the Bureau of Indian Affairs, and others are unable to access insurance coverage for abortion services. In addition, not all private insurance plans cover abortion. Without insurance, the mean cost for a medication abortion in 2018 was \$535, while the cost for an aspiration abortion (an **in-clinic abortion** procedure which can be performed up to 14-16 weeks past a person's last period) ranged from \$435 to \$955. Abortions performed later in pregnancy can cost thousands of dollars.

Some states, including California, use state funds to cover abortion on Medicaid plans, making up the funding gap caused by the Hyde Amendment. Still, insurance coverage, or lack thereof, remains a barrier to care for many.

### EXAMPLES FROM CALIFORNIA FUTURE OF ABORTION COUNCIL

The California Future of Abortion Council has several recommendations for removing insurance as a barrier to care, even in states that have already taken the step of allowing Medicaid to cover abortion.

#### Uncompensated Care Program

The first is to create and fund an uncompensated care program for abortion-related services. Uncompensated care is healthcare provided by clinics, doctor's offices, or hospitals that doesn't get reimbursed, usually because the patient doesn't have insurance or their insurance doesn't cover this type of care. An uncompensated care program would allow the state to reimburse abortion providers for services to patients who aren't able to pay for their procedures. Such a program would allow clinics to be paid for their costs, without having to turn away people who cannot afford to pay. An uncompensated care program could specifically benefit out-of-state patients who would have qualified for Medi-Cal (California's Medicaid program) and related in-state, low-income insurance programs had the patients lived in California.

This type of program would particularly benefit not only low-income people and those without insurance, but also people who, for whatever reason, are not able to have the procedure appear on their explanation of benefits statement. This is particularly relevant to young people who may be on a parent's health insurance plan, and people in abusive relationships.

#### Gap Coverage Program

States can also establish a gap coverage program for abortion care. Gap coverage programs are supplementary health insurance schemes that tend to cover high-cost, unexpected medical care. States can set up abortion-related gap coverage programs for patients whose insurance does not cover the cost of an abortion. Such a program would immediately enroll patients into a plan that covers all abortions,

abortion-related services, contraception, and other benefits, including transportation and translation. A gap coverage program could remove a significant cost barrier for abortion seekers.

### ADDITIONAL EXAMPLES

California is one of 16 states that provide state dollars to cover abortion for Medicaid patients. However, four states (Colorado, Delaware, Nevada, Rhode Island) with Democratic trifectas still do not provide funds for Medicaid recipients to receive abortion care, and others bar state-level public sector health insurance plans, or plans purchased on the Affordable Care Act marketplace, from covering abortion. States that seek to be sites of reproductive freedom should ensure, at the very minimum, that low-income people on Medicaid have abortion covered. Because 85 percent of Medicaid recipients identify as non-white, lifting restrictions on Medicaid coverage would particularly benefit people of color.

## 3 — REDUCING COST AS A BARRIER TO CARE

Abortion seekers, particularly those in hostile states, face numerous barriers to care: People need to take (often unpaid) time off from work, travel hundreds or sometimes thousands of miles, find childcare, face stigma from their communities, and pay, often out-of-pocket, for the cost of the abortion procedure itself. As discussed above, the average cost of an abortion can range from hundreds of dollars into the thousands, and that does not include travel, lodging, childcare, and missed work. In January 2020, before the pandemic, only 41 percent of Americans would be able to cover the cost of a \$1,000 emergency from savings. The high cost of abortion care is a significant barrier, both for people already living in **reproductive freedom states** and those traveling across state lines.

### EXAMPLES FROM CALIFORNIA FUTURE OF ABORTION COUNCIL

The California Future of Abortion Council provides several policy models to reduce cost as a barrier to care. The first is to provide direct money to abortion funds, clinics, and practical support funds. These funds can cover the cost of the procedure itself, as well as help patients with associated costs, including childcare, transportation, lodging, doula support, lost wages, and food. As people travel longer distances to access care, and as clinics in states such as California feel the strain of people forced to travel across state lines, it's imperative to ensure independent clinics, abortion funds, and practical support funds have the money they need to support abortion seekers. Abortion funds both within and outside of **reproductive freedom states** have been supporting thousands of patients for decades, but the unmet need still outpaces the resources available. States can provide funding to help fill these gaps.

States can also provide funding to strengthen the abortion support infrastructure. That includes not just providing funding that will be directly passed on to patients via practical support, but increasing the amount of money abortion funds, clinics, and practical support funds have for staffing and operational costs. States can also provide support to ensure resources for abortion seekers are easily available in languages other than English, specific resources exist for queer and trans abortion seekers, and resources available are responsive to racial and economic discrimination in the healthcare system.

Too often, people seeking abortion care have to cobble together support from a variety of sources, most of which are underfunded. The California Future of Abortion Council also suggests that people seeking abortion services should be able to have one point of entry to connect to the nearest abortion provider, obtain coverage or financial support for their appointment, and get practical assistance and resources for logistical and economic needs. Abortion patient care navigators or case managers could

help — in multiple languages — connect people to clinics, funding, and services provided by a variety of organizations.

Additionally, states can eliminate cost-sharing (including copays and coinsurance) for abortion care and abortion-related services. States can do this for both public health insurance plans and private and commercial plans. California recently passed the Abortion Accessibility Act (SB 245), which eliminates cost-sharing for abortion care for all state-licensed commercial health plans; other states can follow suit.

Finally, patients sometimes require additional medical procedures and doctor's visits, and are charged for this care beyond the already high cost of the abortion itself. For example, patients will sometimes be asked to take a pregnancy test, undergo a sonogram to confirm gestational age, or return to a clinic for follow-up care. States can reduce these costs by making pregnancy tests free over the counter. They can also institute bundled payment codes that reduce the need for and cost of ultrasounds and follow-up visits.

### **ADDITIONAL EXAMPLES**

Outside of California, other states and cities have provided government funding to abortion funds and practical support funds, as I previously wrote about. In March 2022, Oregon passed a \$15 million Reproductive Equity Fund, which would help cover abortion costs, travel, and lodging for those seeking abortion care, including both Oregon residents and people forced to travel to the state. In 2019, New York City included \$250,000 in its budget for the New York Abortion Access Fund (NYAAF), a group that helps people seeking abortions cover the cost of their procedures. According to NYAAF, roughly one-third of the people they supported in 2019 came from out-of-state, a figure that is likely to increase. More recently, New York State introduced legislation to provide significant funding for abortion providers and abortion support organizations. Also in 2019, the city of Austin set aside \$150,000 to support abortion seekers in paying for travel expenses, lodging, and childcare. As Texas continues to enforce its regressive six-week abortion ban, funds providing for travel and related costs for Texans are increasingly critical.

## **4 — END ABORTION STIGMA AND MISINFORMATION**

Nearly one in four American women (and many trans men and nonbinary people) will have an abortion in their lifetime. The procedure is incredibly safe, with low risk of complications. Despite this, abortion remains highly stigmatized. Stigma around abortion leads people to think it's rare, or only for "certain types" of people. Stigma, shame, and misinformation are, in and of themselves, a barrier to care.

Stigma and shame harm people who have abortions. They can prevent people who have abortions from seeking emotional, financial, and logistical support from their friends and community, and can increase isolation. Shame and secrecy can have economic consequences: There is evidence that some people who have insurance still elect to pay for the procedure out-of-pocket to avoid it showing up on their benefits statement. Stigma can also make people vulnerable to misinformation about abortion peddled by the anti-choice movement.

In addition, shame and stigma have significant effects on abortion providers, shrinking the abortion care workforce and putting workers at risk. Shame and stigma can lead to decreased training opportunities for healthcare providers, and make it difficult for providers and clinic staff who work in abortion care to

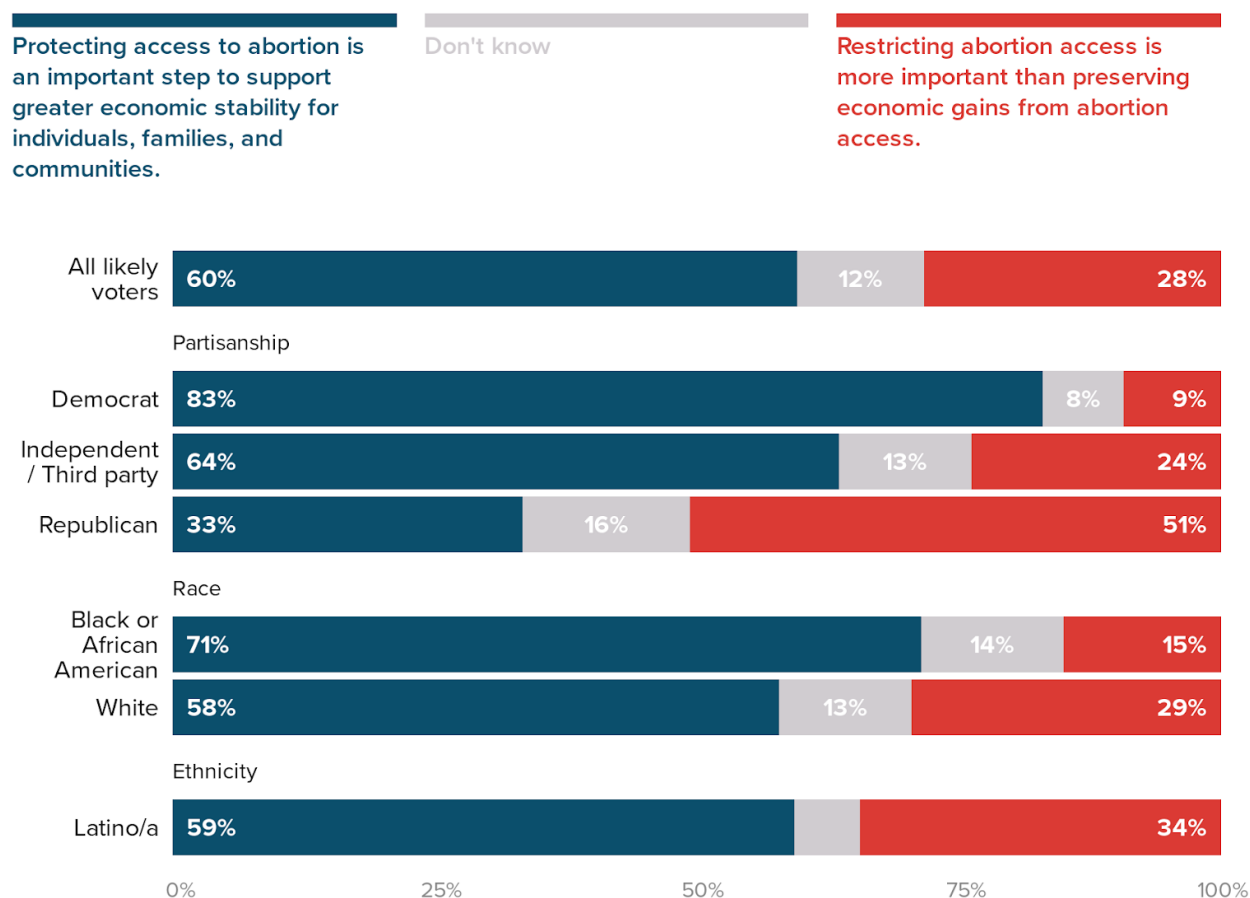
find other jobs. In some cases, this stigma has led to violence, as in the case of Dr. George Tiller, an abortion provider in Wichita, Kan., who survived an assassination attempt in 1993 before being murdered at his church in 2009. Tiller is one of 11 people murdered by anti-choice zealots between 1993 and 2016.

Reducing abortion access and reproductive care more broadly also has workforce implications across all labor sectors. Researchers have found that abortion access increases women's participation in the labor force, and improves women's educational outcomes, thus contributing to long-term economic security, especially for people from minority groups. When informed about the positive effects of abortion access on women's participation in the labor force, a majority of likely voters (60 percent) agree that protecting access to abortion means supporting economic stability for individuals, families, and communities. This message resonates differentially across party lines, with 83 percent of Democrats and 64 percent of Independents supporting this statement, as compared to 33 percent of Republicans.

## A Majority of Voters Agree Abortion Access Is Key to Economic Stability

Researchers have found abortion access increases women's participation in the labor force and improves women's educational outcomes. These benefits contribute to greater long-term economic security, especially for people from minority demographic groups.

When thinking about this, which of these statements comes closer to your view, even if neither is exactly right?



May 4–9, 2022 survey of 1,157 likely voters

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Beyond the notable economic impacts, stigmatization of abortion is related to the stigmatization of sexuality in general. A person choosing to terminate a pregnancy is in violation of socially enforced roles equating women with motherhood. Policies to promote healthy, judgment-free attitudes toward sex, and policies that disrupt misogynistic ideas of womanhood, would help to reduce abortion stigma.

## **EXAMPLES FROM CALIFORNIA FUTURE OF ABORTION COUNCIL**

The California Future of Abortion Council has several recommendations to reduce stigma.

States should enact, fund, and implement comprehensive sexual health education for all public school students. Comprehensive sexual health education goes beyond HIV, sexually transmitted infection, and pregnancy prevention, and includes content tailored toward LGBTQIA+ students, promotes sexuality as a normal part of human development, gives students the skills to have healthy and safe relationships, and provides accurate, science-based information about bodies and sexuality. In 2016, California passed the California Healthy Youth Act, which requires comprehensive sexual health education for public school students, but it has not been evenly implemented across the state. States that have comprehensive sexual health education should ensure it's fully funded and equitably implemented.

Additionally, states can support community-based organizations that work with marginalized communities to combat misinformation and stigma, and provide culturally competent sexual health education. Organizations that already have existing community relationships are best positioned to counter myths and disinformation, and to provide stigma-free, medically accurate, and culturally competent information about abortion, as well as practical support to abortion seekers within their communities.

Finally, states can invest in research, community surveys, and reporting to identify remaining barriers to care. In particular, states should investigate the needs and obstacles of BIPOC communities, youth, non-English speakers, LGBTQIA+ individuals, people with low incomes, immigrants, undocumented people, unhoused pregnant people, and pregnant people using drugs or alcohol who are seeking abortion care. These communities face multiple and overlapping barriers to abortion and other healthcare, and only through deep and intentional work can the state adequately meet the needs of all its residents.

## **ADDITIONAL EXAMPLES**

Abortion misinformation and stigma are perpetuated by a constellation of organizations and institutions, including crisis pregnancy centers. Crisis pregnancy centers are fake clinics (often with no trained healthcare providers on staff) that advertise themselves as places of support for pregnant people, and then, once people are in the door, share misinformation about abortion, with the goal of delaying the person from receiving care.

These clinics are challenging to regulate, as attempts at requiring disclosures and limiting the spreading of misinformation have faced First Amendment court challenges. However, some municipalities have tried to regulate CPCs: Austin and San Francisco require CPCs to disclose that they are not medical facilities, and New York City and Oakland, Calif., have levied fines on clinics that have not made these disclosures.

Beyond the policy space, advocacy organizations such as We Testify, Shout Your Abortion, and Advocates for Youth have engaged in campaigns asking people to tell their abortion stories publicly to reduce stigma. Abortion storytelling can change public perceptions around abortions, who has them, and why, providing fertile ground for a necessary public narrative shift.

## Conclusion

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We are at a critical moment in the fight for reproductive freedom. *Roe v. Wade* is likely to be overturned, thus eliminating the constitutional right to an abortion and further jeopardizing the health and safety of those who no longer wish to be pregnant. By supporting people forced to travel for care, expanding Medicaid and insurance coverage of abortion, reducing cost as a barrier to care, and ending abortion stigma and misinformation, policymakers can help expand and protect abortion access.

*Roe v. Wade* has always been the floor, not the ceiling. Now more than ever, state and federal legislators have a moral imperative to protect not only the right to an abortion, but to remove financial, logistical, and social barriers to abortion care and protect access to vital reproductive care for all.

# Glossary

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**ABORTION FUND:** Autonomous organizations that help remove financial and logistical barriers to abortion access. Many funds work with clinics to help people pay for the cost of their procedure, and some offer support such as transportation, childcare, translation, or doula services.

**ADVANCED PRACTICE CLINICIANS:** Physician assistants, nurse practitioners, certified nurse-midwives and other highly trained healthcare providers who are not doctors.

**HYDE AMENDMENT:** Language in the yearly federal appropriations legislation restricting federal funds from covering abortion care.

**IN-CLINIC ABORTION:** An abortion provided by a healthcare professional in a clinical setting, usually an office. There are two types of in-clinic abortion: vacuum aspiration, which uses a gentle suction to empty the uterus, and dilation and evacuation (D&E), which uses both suction and medical tools to empty the uterus. Vacuum aspiration is usually used up to 14-16 weeks after a person's last menstrual period, while D&E can be used after 16 weeks.

**INDEPENDENT CLINICS:** The majority of abortions provided by healthcare professionals in the United States are provided by independent clinics, community-based reproductive health clinics unaffiliated with major hospitals or national organizations.

**MEDICAID:** A federal health insurance program that provides coverage to eligible low-income people, children, pregnant people, and people with disabilities. It is jointly funded by states and the federal government and administered by the states. It often has state-specific names, including Medi-Cal (California) or MassHealth (Massachusetts).

**MEDICATION ABORTION:** An abortion performed by the patient taking two medications, mifepristone and misoprostol. Mifepristone blocks progesterone to stop a pregnancy from growing, and misoprostol causes contractions to empty the uterus. **Medication abortion** is typically performed up to 11 weeks past a patient's last menstrual period.

**PRACTICAL SUPPORT FUND:** Organizations which provide logistical and practical support to people seeking abortions by providing assistance with transportation, hotels, gas, childcare, translation, doulas, or other related services.

**REPRODUCTIVE FREEDOM STATE:** A state where abortion and reproductive healthcare are widely available and accessible.

**REPRODUCTIVE JUSTICE:** According to SisterSong, reproductive justice is “the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities.”

**SELF-MANAGED ABORTION:** An abortion performed without the support of a doctor or healthcare provider. Self-managed abortion is commonly done using the same medications used in a **medication abortion**. Self-managed abortion with pills is very safe but can be legally risky.

**TITLE X:** A federal grant program for clinics providing sexual, reproductive, and preventative healthcare, including birth control, STI testing and treatment, and breast cancer and cervical cancer screenings.

**WOMEN'S HEALTH PROTECTION ACT:** A federal bill that would codify the right to abortion in the United States.

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<a href="#"><u>Where Abortion Access Would Decline if Roe v. Wade Were Overturned - The New York Times</u></a>	<a href="#"><u>FDA Will Permanently Allow Abortion Pills by Mail - The New York Times</u></a>	<a href="#"><u>Council OKs ordinance mandating disclosure signs at pregnancy centers - Austin MonitorAustin Monitor</u></a>
<a href="#"><u>For the First Time Ever, US States Enacted More Than 100 Abortion Restrictions in a Single Year - Guttmacher Institute</u></a>	<a href="#"><u>How Much Does an Abortion Cost? Learn the Facts - New York Magazine</u></a>	<a href="#"><u>US Supreme Court denies review of SF crisis pregnancy law, ordinance stands - City Attorney of San Francisco</u></a>
<a href="#"><u>The Harms of Denying a Woman a Wanted Abortion Findings from the Turnaway Study - UC San Francisco</u></a>	<a href="#"><u>Medicaid Coverage Rates for the Nonelderly by Race/Ethnicity - Kaiser Family Foundation</u></a>	<a href="#"><u>Two Years After Rule Change, NYC Issues First Fines Against Anti-Abortion Fake Clinics - Rewire News Group</u></a>
<a href="#"><u>Text - HR3755 - 117th Congress (2021-2022): Women's Health Protection Act of 2021</u></a>	<a href="#"><u>41% of Americans would be able to cover \$1,000 emergency with savings - CNBC</u></a>	<a href="#"><u>PREGNANCY CENTERS AND THE LIMITS OF MANDATED DISCLOSURE - Columbia Law Review</u></a>
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<a href="#"><u>California Future of Abortion Council</u></a>	<a href="#"><u>New York City Allocates \$250,000 for Abortions, Challenging Conservative States</u></a>	<a href="#"><u>Keep Our Clinics</u></a>
<a href="#"><u>Most Women Denied Abortions by Texas Law Got Them Another Way - The New York Times</u></a>	<a href="#"><u>Austin, Texas passes abortion access funding, going around Senate Bill 22</u></a>	<a href="#"><u>Reproductive Justice — Sister Song</u></a>
<a href="#"><u>Texas abortion seekers flooded out-of-state clinics after six-week ban went into effect, Planned Parenthood records show - CNN</u></a>	<a href="#"><u>Abortion Is a Common Experience for US Women, Despite Dramatic Declines in Rates - Guttmacher Institute</u></a>	
<a href="#"><u>Oklahoma governor signs Texas-style abortion ban into law - NPR</u></a>	<a href="#"><u>Landmark Report Concludes Abortion In U.S. Is Safe - NPR</u></a>	
<a href="#"><u>Bill Text - AB-1918 Health care education; reproductive health education scholarship</u></a>	<a href="#"><u>Abortion stigma: A reconceptualization of constituents, causes, and consequences - Guttmacher Institute</u></a>	
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<a href="#"><u>Study: Abortions Are Safe When Performed By Nurse Practitioners, Physician Assistants, Certified Nurse Midwives - UC San Francisco</u></a>	<a href="#"><u>What can economic research tell us about the effect of abortion access on women's lives? - Brookings Institute</u></a>	
<a href="#"><u>Maine Abortion Law Lets Nurse Practitioners and Others Perform Procedure - The New York Times</u></a>	<a href="#"><u>Comprehensive Sexual Health &amp; HIV/AIDS Instruction - Health (CA Dept of Education)</u></a>	
<a href="#"><u>Hawaii to allow some nurses to perform abortions - ABC News</u></a>	<a href="#"><u>The Public Health Risks of Crisis Pregnancy Centers - Guttmacher Institute</u></a>	

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