

Undue Burdens: State Abortion Laws in the United States, 1994–2022

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Abstract State laws have influenced access to abortion in the 50 years since *Roe v. Wade*. The 2022 *Dobbs* decision returned questions about the legality of abortion to the states, which increased the importance of state laws for abortion access. The objective of this study is to illustrate trends in abortion-restrictive and abortion-supportive state laws using a unique longitudinal database of reproductive health laws across the United States from 1994 to 2022. This study offers a descriptive analysis of historical trends in state-level pre-viability abortion bans, abortion method bans, efforts to dissuade abortion, TRAP (targeted regulation of abortion providers) laws, other laws that restrict reproductive choice, and laws that expand abortion access and support reproductive health. Data sources include state statutes (from Nexis Uni) and secondary sources. The data reveal that pre-viability bans, including gestation-based bans and total bans, became significantly more prevalent over time. Other abortion-restrictive laws increased from 1994 to 2022, but states also passed a growing number of laws that support reproductive health. Increasing polarization into abortion-restrictive and abortion-supportive states characterized the 1994–2022 period. These trends have implications for maternal and infant health and for racial/ethnic and income disparities.

Keywords abortion, reproductive health law, personhood, reproductive justice

For nearly 50 years, the 1973 *Roe v. Wade* decision defined abortion as a private decision that the state could not regulate without a compelling reason. This decision defined abortion as legal under the right to privacy, and it stood until the 2022 *Dobbs v. Jackson Women's Health* decision overturned it. *Roe* led to decades of fierce political battles as federal and state legislatures fought to control abortion access. A long-term trend of

Under *Roe*, abortion was a fundamental right, and courts had to use strict scrutiny when they evaluated regulations that would excessively burden or restrict an individual's right to make a private decision. However, after the 1992 *Casey* decision, courts applied the weaker undue burden standard, which required them to balance the benefits of an abortion restriction for the state against the burden it placed on those seeking the procedure. Accordingly, states could restrict abortion if they could demonstrate a valid state interest and the regulations did not unduly burden the individual's right to obtain an abortion. This shift in the judicial standard created opportunities for state legislatures to pass reproductive health laws that eroded abortion access or attempted to dissuade pregnant people from seeking abortions.

Data

To understand historical trends, we collected longitudinal data on states' reproductive health laws affecting abortion, contraception, and maternal health during 1994–2022. These data incorporate most of the period since the *Casey* decision shifted abortion regulation to an undue burden standard. Since all aspects of reproductive health are interconnected, the database includes measures of laws regulating contraceptive access, prenatal substance use, fetal homicide, sex education, direct-entry midwives (DEMs), and health care access and quality as well as laws governing abortion.

Notably, most studies of reproductive health laws use cross-sectional data because the best sources of these data are organizations that do not retain historical data, such as the Guttmacher Institute, the Kaiser Family Foundation (KFF), the Center for Reproductive Rights (CRR), and NARAL Pro-Choice America (NARAL). However, relying on cross-sectional legal measures limits our understanding of historical trends and the potential impact of legal changes on abortion access and other reproductive health outcomes over time. Some exceptions include an original longitudinal database of abortion-related laws during 1973–2013 (Kreitzer 2015), longitudinal data on abortion bills in 21 state legislatures during 1997–2012 (Reingold et al. 2021), and a historical database of TRAP (targeted regulation of abortion providers) laws in the United States (Austin and Harper 2019). Our database most resembles Kreitzer's, with more recent data and some additional measures related to birth choice (e.g., licensing of DEMs), maternal health (e.g., maternal mortality review committees [MMRCs]), and health care quality (e.g., adverse event reporting systems).

To create a historical database of state laws, we started with contemporary data from the Guttmacher, KFF, CRR, and NARAL websites (www.guttmacher.org, <https://www.kff.org/statedata/>, <https://reproductiverights.org/>, and www.prochoiceamerica.org/state-law). The CRR and NARAL websites included relevant state statute numbers for a variety of reproductive health laws. We obtained data on statutes and administrative codes that define prenatal substance use as child abuse for each state from Child Welfare Information Gateway (<https://www.childwelfare.gov/>). Data on pharmacist refusal laws and emergency contraception laws came from the National Conference of State Legislatures (<https://www.ncsl.org/>). The Midwives Alliance of North America and the North American Registry of Midwives provided data on statutes governing DEMs. The Sex Ed for Social Change website (<https://siecus.org/state-profiles/>) was the source of statutes for sex education mandates. We obtained some historical data and statute numbers for TRAP laws by state from Austin and Harper (2019). We found guides to state adverse event reporting systems, with details on statutes for states that enacted these systems, from the National Academy for State Health Policy (Hanlon et al. 2015). For each statute that we identified using these sources, we examined detailed legislative records in the Nexis Uni database to obtain the date when these laws went into effect. We also searched the Nexis Uni database state by state using the following search terms: “abortion,” “feticide” or “fetal homicide,” “emergency contraception,” “advance directive” or “living will,” and “maternal mortality review.”

The data contain detailed information about the effective month and year of enactment or repeal, with as much accuracy as possible. If a law took effect in the middle of a month, we coded the new law as effective during the following month. Similarly, if a law was repealed in the middle of a month, we coded the law as in effect for that month and not during the following month. For most abortion restrictions, the data distinguish between laws that are enforced versus laws that have been blocked by the courts. One would expect that laws that the courts have enjoined might influence providers and the public for a short period of time because they express legislative intent, although providers and the public may forget about unenforced laws over time.

Limitations

Although the data represent a comprehensive collection of state-level reproductive health laws, they have some limitations. First, the database includes measures of legislative activity, not of court decisions. It includes voter-passed initiatives only to the extent that they are reflected in state statutes. Secondly, measures from farther back in time are less reliable than more recent data, so we are less certain about data for earlier years than about data for more recent legislation. A challenge with collecting longitudinal data from state statutes is that states follow different conventions: some keep enjoined or repealed laws within their statutory records, and others remove them, leaving no record of earlier laws. As a result, some earlier laws may be missing from the database.

Third, we were unable to obtain the detailed date of passage for some laws. Some states do not indicate if there is a gap between the date of passage and the effective date of a law. Unless laws indicated an effective date, the dates represent the time of passage and may depart from the enforcement date by up to six months. In some cases, we were able to find the year of passage but not the month, and we coded the start date in the middle of the year (July 1). It could also be difficult to discern whether earlier laws had been enjoined by the courts. We had to interpolate enforced versus enjoined laws by cross-referencing with published reports and contemporary data from sources like Guttmacher and KFF, and we may have missed some injunctions.

Fourth, while states often mimicked one another in the details of their legislation, there could also be substantive differences across states, and the data do not capture this variation. For example, many states mandate sex education in public schools, but they vary in what it must (or must not)

include. A fifth limitation of the data is that they do not include some recent trends in antiabortion legislation, such as laws that require providers to follow FDA protocols for medication abortion (e.g., Ohio), laws that require physicians to provide life-sustaining treatment to fetuses that are “born alive” during an abortion, and laws that specify how to treat fetal remains. These laws were uncommon when we began collecting the legal data, but we encountered them in recent searches of states’ abortion statutes. Laws that specifically target medication abortion appear to represent the next frontier in antiabortion restrictions, but these regulations were not common when we began to collect the data and are thus absent from the database.

Despite these limitations, the database represents a comprehensive source of historical data on reproductive health laws across the spectrum, from contraception and abortion to midwifery and maternal mortality.

Empirical Approach

Given that the *Dobbs* decision has increased the impact of state laws on abortion access, this article describes state-level laws that limit or promote abortion rights. Antiabortion laws include pre-viability abortion bans (including total bans and gestation-based bans), bans on specific abortion methods, laws that attempt to dissuade abortion, restrictions on health insurance coverage for abortions, pregnancy exceptions for advance medical directives (“living wills”), pharmacist refusal laws, and TRAP laws. TRAP laws include requirements that abortion clinics meet the standards of ambulatory surgery centers (ASCs), meet physical plant specifications about the size of procedure rooms or hallways, or have a written transfer agreement and/or admitting privileges at a local hospital. Laws that promote reproductive rights include expanded public funding for abortion, laws protecting health clinics from violence, and codification of a right to obtain an abortion in state law. Laws that support reproductive health also include programs that expand contraception coverage under Medicaid, mandatory sexuality education, requirements that emergency departments provide emergency contraception to survivors of sexual assault, licensing for DEMs, and the establishment of an MMRC. Table 1 presents descriptions and descriptive statistics for these measures as well as the average number of pre-viability abortion bans and the average number of TRAP laws.

The data also include laws that define prenatal substance use as child abuse, feticide laws, laws that describe fetal pain, “choose life” license

Table 1 Description and Descriptive Statistics for State Legal Data, 1994–2022

Variable	Description	Mean	SD	Median	Range
<i>Pre-viability abortion bans</i>					
No. of abortion bans	Total no. abortion bans (enforced or enjoined)	0.83	(1.05)	1	[0, 6]
Pre-Roe ban*	Pre-Roe ban not repealed	0.29	(0.45)	0	[0, 1]
20-week ban*	Ban on abortions at 20–24 weeks	0.30	(0.46)	0	[0, 1]
15-week ban*	Ban on abortions at 15–18 weeks	0.04	(0.18)	0	[0, 1]
Heartbeat law*	Ban on abortion if heartbeat detectable (6–8 weeks)	0.03	(0.17)	0	[0, 1]
Trigger ban*	Total ban to take effect when Roe is overturned	0.10	(0.29)	0	[0, 1]
Sex-selective ban*	Ban on sex-selective abortions	0.08	(0.28)	0	[0, 1]
<i>Method bans</i>					
D&X ban*	Ban on partial-birth abortion (D&X)	0.27	(0.45)	0	[0, 1]
D&E ban*	Ban on dilation and evacuation (D&E)	0.05	(0.22)	0	[0, 1]
<i>Laws that aim to dissuade abortion</i>					
Biased counseling	Mandatory dissemination of antiabortion information	0.52	(0.50)	1	[0, 1]
Waiting period	Waiting period between counseling and abortion	0.46	(0.50)	0	[0, 1]
Parental involvement	Parental notification or consent for minors' abortions	0.72	(0.45)	1	[0, 1]
Ultrasound	Providers must perform ultrasound	0.15	(0.36)	0	[0, 1]
Gag rule	Prohibits anyone receiving public funds from providing info about abortion	0.31	(0.46)	0	[0, 1]

Table 1 (continued)

Variable	Description	Mean	SD	Median	Range
<i>TRAP laws</i>					
MD only	Only licensed MDs can perform abortions	0.82	(0.38)	1	[0, 1]
Reporting required	Mandatory reporting to the state	0.79	(0.41)	1	[0, 1]
Special license	Abortion providers require a special license	0.44	(0.50)	0	[0, 1]
ASC*	Clinics licensed as ambulatory surgery centers	0.31	(0.46)	0	[0, 1]
Physical plant*	Clinics must meet room or hall size specifications	0.10	(0.30)	0	[0, 1]
Transfer**	Clinics require a written transfer agreement	0.24	(0.43)	0	[0, 1]
Admitting*	Providers must have hospital admitting privileges	0.21	(0.40)	0	[0, 1]
No. of TRAP laws	Total no. of TRAP laws	2.92	(1.89)	2	[0, 7]
<i>Other laws that restrict reproductive choice</i>					
Insurance restricted	Private insurance may not cover abortion	0.24	(0.43)	0	[0, 1]
Living will	Advance health care directives null if pregnant	0.54	(0.50)	1	[0, 1]
Pharmacist refusal	Pharmacists permitted to refuse to fill prescriptions	0.19	(0.39)	0	[0, 1]
<i>Expanded abortion access</i>					
Public funding	Public funding of abortions	0.23	(0.42)	0	[0, 1]
Clinic protection	Reproductive health clinics protected from violence	0.31	(0.46)	0	[0, 1]
Right to abortion	Codified a right to abortion	0.14	(0.35)	0	[0, 1]

(continued)

Table 1 Description and Descriptive Statistics for State Legal Data, 1994–2022 (continued)

Variable	Description	Mean	SD	Median	Range
<i>Other support for reproductive health</i>					
Birth control expansion	Expanded Medicaid coverage of family planning	0.40	(0.49)	0	[0, 1]
Sex education	Mandatory sex education in schools	0.41	(0.49)	0	[0, 1]
Emergency contraception	Emergency departments must provide emergency contraception to sexual assault survivors	0.22	(0.42)	0	[0, 1]
DEMs licensed	Licenses DEMs	0.50	(0.50)	1	[0, 1]
MMRC	Has an MMRC	0.39	(0.49)	0	[0, 1]
State-years	50 states + DC, 1994–2022		17,748		

Note: D&X = dilation and extraction; D&E = dilation and evacuation; TRAP = targeted regulation of abortion providers; ASC = ambulatory surgery center; DEMs = direct-entry midwives; MMRC = maternal mortality review committee.

* Includes enforced and enjoined laws.

plates, laws that prohibit abortion providers from being within a specified distance of a school, requirements that insurance plans dispense a 12-month supply of prescription contraceptives, participation in Medicaid expansion after passage of the Affordable Care Act, and mandatory medical error reporting (not shown).

The figures and tables below include the percentage of states with each type of law during 1994–2022. They also include indicators for the timing of significant federal legislation (the Partial-Birth Abortion Act of 2003) and US Supreme Court abortion decisions during this period (*Stenberg v. Carhart* 2000, *Gonzales v. Carhart* 2007, *Whole Woman's Health v. Hellerstedt* 2016, *June Medical Services v. Russo* 2020, and *Dobbs v. Jackson Women's Health* 2022). The tables provide additional information by matching states with each type of law and their effective start dates.

Results

Abortion Bans

Abortion restrictions include pre-viability abortion bans, which we define to include bans on all abortions as well as gestation-based bans (Jones and Weitz 2009; Medoff 2012; Nash 2019). The original *Roe* decision permitted abortion as a private decision up to the point of viability, while leaving the definition of viability up to the medical establishment. Some states explicitly prohibit abortion after viability, in line with *Roe*. Others have passed laws that either prohibit all abortions (which the courts typically enjoined before the *Dobbs* decision) or prohibit abortion after specific gestational ages. Some gestation-based abortion bans claim that fetuses are viable at 24, 22, 20, 18, or even 15 weeks. However, these claims define viability much earlier than medical research does. The pre-viability bans in the database include pre-*Roe* bans, trigger laws (total abortion bans, to take effect when *Roe* is overturned), heartbeat bans (at 6 weeks from last menstrual period [LMP], or 4 weeks after conception), bans at 15–18 weeks from LMP, bans at 20–24 weeks from LMP, and bans on sex-selective abortions. Table 2 presents the mean number of abortion bans (including enforced and enjoined bans) and the start date for gestation-based or total abortion bans by state.

At the end of 2022, the average number of pre-viability bans per state was 1.8, with a range of 0 to 6 and a median of 1, but the average number of pre-viability bans conceals important changes over time in legislation that aimed to ban abortion. Figure 1 presents the average number of abortion bans and the average number of enforced abortion bans during 1994–2022,

Table 2 Pre-Viability Abortion Bans by State, 1994–2022

State	Average no. of bans	Pre-Roe	20–24 weeks	15 weeks	Heartbeat ban	Trigger ban	Sex-selective ban
AL	1.89	Y*	1998–2009, 2011 ¹	N	N	2019	N
AK	0	N	N	N	N	N	N
AZ	1.8	Y* ²	2012	2022	N	2022	2011
AR	2.56	Y*	1999	2019	2013	2019	2018
CA	0	N	N	N	N	N	N
CO	0.67	Y*	N	N	N	N	N
CT	0	N	N	N	N	N	N
DE	1.95	Y*	Y	N	N	N	N
DC	0	N	N	N	N	N	N
FL	0.02	N	N	2022	N	N	N
GA	0.45	N	2013	N	2020	N	N
HI	0	N	N	N	N	N	N
ID	0.51	N	2011	N	2022	2020	N
IL	2.57	N	N	Y*	N	Y*	Y*
IN	0.64	N	2011	N	N	2022	2016
IA	0.35	N	2017	N	2018	N	N
KS	1.18	N	1998	N	N	N	2013
KY	0.79	N	2017	2017	2019	2019	2019
LA	2.08	Y*	2012	2018	N	2006	N
ME	0	N	N	N	N	N	N
MD	0	N	N	N	N	N	N
MA	1.85	Y*	Y	N	N	N	N
MI	1.32	Y*	1999*	N	N	N	N
MN	0	N	N	N	N	N	N
MS	2.2	Y*	2014	2018	2019	2007	2020
MO	0.79	N	2014	2019	2019	2019	2019
MT	0.04	N	2021	N	N	N	N
NE	0.44	N	2010	N	N	N	N
NV	1	N	Y	N	N	N	N
NH	0.16	Y*	2022	N	N	N	N
NJ	0	N	N	N	N	N	N
NM	0.94	Y*	N	N	N	N	N
NY	0.48	N	2009	N	N	N	N
NC	1.32	N	Y	N	N	N	2013
ND	1.54	N	2013	N	2013	2007	2013
OH	0.51	N	2011	N	2019	N	N
OK	1.93	Y*	2011	N	2021	2021	2009
OR	0	N	N	N	N	N	N

Table 2 (continued)

State	Average no. of bans	Pre- <i>Roe</i>	20–24 weeks	15 weeks	Heartbeat ban	Trigger ban	Sex-selective ban
PA	1.48	N	Y	N	N	N	2009
RI	0	N	N	N	N	N	N
SC	0.29	N	2016	N	2021	N	N
SD	1.13	N	2016	N	N	2005	2014
TN	0.65	N	2009	N	N	2020	2020
TX	1.37	Y*	2013	N	2022	2021	N
UT	0.86	N	2004	2019	N	2020	N
VT	0.69	Y*	N	N	N	N	N
VA	0	N	N	N	N	N	N
WA	0.52	Y*	N	N	N	N	N
WV	1.27	Y*	2015	N	2022	N	N
WI	1.26	Y*	2015	N	N	N	N
WY	1	N	N	N	N	Y	N

* = enjoined; Y = yes, since before 1994; N = no, all years.
¹ Alabama repealed its 20-week ban in 2009 and passed a new ban in 2011.
² Arizona reinstated its pre-*Roe* abortion ban in September 2022. The courts enjoined it.

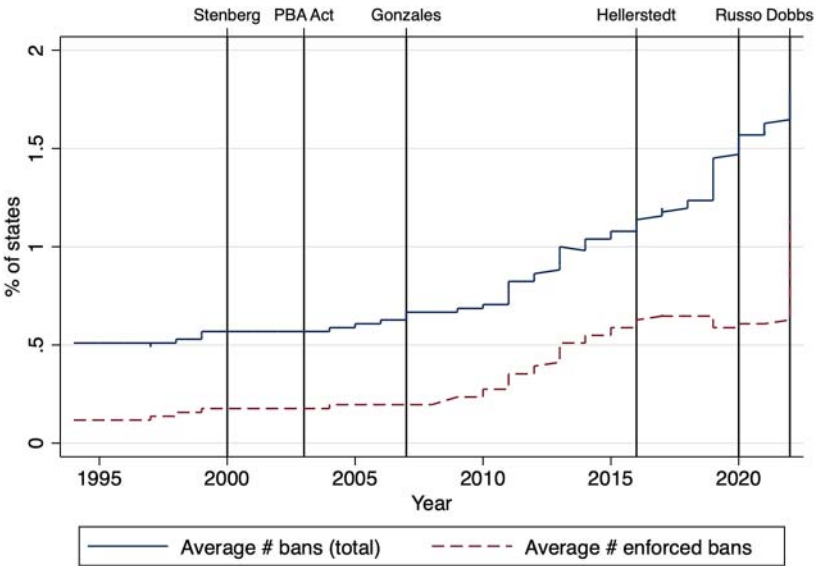


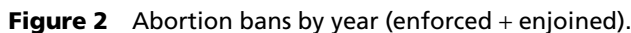
Figure 1 Average number of abortion bans by year.

and it reveals progressive increases in legislative activity to ban abortion before viability. These bans gained momentum after the Supreme Court decision in *Gonzales* upheld a federal ban on the dilation and extraction (D&X) abortion method. At that time, antiabortion movements shifted their attention away from prohibiting what they called “partial-birth abortion” to defining second-trimester fetuses as “pain-capable” and prohibiting most abortions after 20 weeks. The upward slope in figure 1 gained momentum after 2010 and is steepest after 2016, when many abortion opponents anticipated a Supreme Court that was willing to overturn abortion rights. As a result, the 2022 *Dobbs* decision ushered in a dramatic increase in enforced abortion bans after June 2022.

First, 10 states currently retain their unenforced, pre-*Roe* abortion bans. The courts enjoined these laws after *Roe*, but Arizona unblocked its 1864 territorial ban in September 2022. Other states could similarly reinstate pre-*Roe* bans that have not been repealed, although Michigan voters repudiated that state’s pre-*Roe* ban in the 2022 election.

There were also important trends in gestation-based abortion bans. Many state legislatures passed gestation-based abortion bans during the period leading up to *Dobbs*, but the courts enjoined most laws that prohibited abortion before 20 weeks from LMP. Figure 2 reveals the changes in the frequency of each type of abortion ban over time, with increases in all types of bans except pre-*Roe* abortion bans (which were, by definition, passed before 1973). Figure 2 includes enjoined bans because they express legislative intent, and including them reveals the extent of legislative efforts to ban abortion before viability. In contrast, a graph that excluded enjoined laws (not shown) misleadingly suggests that there was little legislative activity that aimed to ban abortion before viability. Figure 2 thus captures the significant legislative activity that attempted to restrict abortion over time, even though some of that legislation never took effect.

Figure 2 depicts a steep increase in second-trimester abortion bans—which often describe fetuses as “pain-capable” at 20–24 weeks after LMP—after 2008. More recent abortion bans have moved the gestational date earlier, claiming without medical evidence that fetuses are viable or can feel pain at 15–18 weeks. Federal courts enjoined these bans before the *Dobbs* decision, but six states had 15-week abortion bans in effect at the end of 2022. (Two more had 15-week bans that remained under injunction.) Thirteen states passed “heartbeat laws” that prohibit abortions if there is detectable heartbeat activity, about 6 weeks from LMP (approximately 4 weeks after fertilization). These laws include the 2021 Texas Heartbeat Act, which permits civilian enforcement. After the US Supreme Court permitted the Texas law to take effect, Oklahoma passed



Many states have passed multiple abortion bans, legislating new bans after courts blocked earlier bans. For example, Mississippi retains its pre-*Roe* abortion ban, which defines providing an abortion by any means as a felony with a prison term of 1–10 years (Miss. Code Ann. § 97-3-3). The state enacted a near-total trigger ban in 2007, to become effective when the Supreme Court overturned *Roe* (Miss. Code Ann. § 41-41-45), and it passed several other bans at different gestational ages. A 2014 law banned abortions after 20 weeks from LMP (approximately 18 weeks after conception), except in the case of a “severe fetal abnormality” or when abortion is necessary to prevent permanent impairment of the life or physical health of the pregnant person (Miss. Code Ann. §§ 41-41-133, –137, –141). A 2018 law claimed that fetuses are viable at 15 weeks and prohibited all

abortions after that point (HB 1510, 133rd Leg. Sess. (Miss. 2018)). The US District Court for the Southern District of Mississippi temporarily enjoined this law, and the state's appeal led to the Supreme Court decision in *Dobbs* that overturned *Roe*, *Casey*, and nearly 50 years of jurisprudence. After the courts enjoined the 15-week ban, the Mississippi legislature passed a "Heartbeat Bill" in 2019 that effectively banned abortion as early as 6 weeks from LMP (approximately 4 weeks after conception). The district judge who had previously enjoined the 15-week ban noted that 6 weeks is fewer than fifteen when he enjoined the heartbeat law (Thebault 2019). However, despite setbacks in the courts, state attorneys and the governor continued to claim that the state has an interest in protecting fetuses, and Mississippi Governor Phil Bryant said, "Please rest assured that I have not abandoned my hope of making Mississippi abortion-free" (Arons 2019).

Laws That Aim to Dissuade Abortion

Many states have also passed laws that aim to dissuade abortion seekers from obtaining the procedure, often with titles such as "The Woman's Right to Know Act." These laws include mandated counseling that reinforces a negative view of abortion and sometimes misinforms patients about fetal pain or a relationship between abortion and breast cancer risk. Biased counseling requirements often include referrals to crisis pregnancy centers (CPCs), which try to convince women considering abortion to continue their pregnancies (Swartzendruber et al. 2019). Research on the effects of CPCs on abortion seekers has found that women who visited a CPC are less likely to obtain an abortion and more likely to still seek one than those who did not visit a CPC (Cartwright, Tumlinson, and Upadhyay 2021). States that refer abortion patients to CPCs also often have gag rules that prohibit employees who receive state funds from discussing abortion or referring women to abortion providers. Other common regulations include mandatory waiting periods between receiving a consultation and obtaining an abortion and requirements that parents be notified or consent to an abortion involving a minor. States have also increasingly tried to convince women not to have abortions by requiring abortion providers to conduct an ultrasound before performing an abortion. The ultrasound measure in our database includes all laws that mandate ultrasounds. Most of these laws require providers to offer patients an opportunity to view the ultrasound, and a subset of them require providers to show patients the images. By 2022, 22 states had mandatory ultrasound laws. Table 3 presents these laws and their start dates by state.

Table 3 Laws That Aim to Dissuade Abortion by State, 1994–2022

State	Biased counseling	Waiting period	Parental involvement	Ultrasound
AL	2002	2002	Y	2002
AK	2004	N	1997*	N
AZ	2009	2009	2000	2009
AR	2001	2005	Y	2021
CA	N	N	Y*	N
CO	N	N	1999–2002, 2003 ¹	N
CT	N	N	N	N
DE	Y*	N	1995	N
DC	N	N	N	N
FL	1997	2016	2005	2005
GA	2005	2005	Y	2020
HI	N	N	N	N
ID	Y	2000	1996–2005, 2007	N
IL	N	N	2006*	N
IN	1995	1995	Y*	2011–2017, 2020 ²
IA	2010	2017–2020, 2022 ³	1997	2011
KS	Y	1997	Y	2011
KY	1998	1998	1994	2017
LA	Y	1995	1999–2009, 2012 ⁴	2012
ME	N	N	Y	N
MD	N	N	Y	N
MA	N	N	Y	N
MI	1994	1994	Y	N
MN	2003	2003*	Y*	N
MS	Y	Y	Y	2007
MO	Y	Y	Y-2005*, 2007 ⁵	N
MT	1995*	Y-2000*, 2009 ⁶	1995	N
NE	Y	Y	Y	2009
NV	N	N	N	N
NH	N	N	2004–2007, 2012 ⁷	N
NJ	N	N	1999*	N
NM	N	N	N	N
NY	N	N	N	N
NC	2011	2011*	1995	2011*
ND	Y	Y	Y	2009
OH	Y	Y	1998	2019
OK	2005	Y	2001	2008
OR	N	N	N	N
PA	Y	Y	Y	N
RI	Y*	N	Y	N

(continued)

Table 3 Laws That Aim to Dissuade Abortion by State, 1994–2022
(continued)

State	Biased counseling	Waiting period	Parental involvement	Ultrasound
SC	1995	Y	Y	2021
SD	Y	Y	Y	2006*
TN	Y	Y	Y	2020
TX	2003	2003	1999	2011
UT	1998	Y	Y	2010
VT	N	N	N	N
VA	2001*	1997*	1997	2012*
WA	N	N	N	N
WV	2003	2003	Y	N
WI	Y	1996	Y	2013
WY	N	N	Y	2017

* = enjoined; Y = yes, since before 1994; N = no, all years.

¹ Colorado's parental involvement law was enjoined in 2002. The state passed a new law in 2003.

² Indiana's mandatory ultrasound law was enjoined in 2017. The state passed a new law in 2020.

³ Iowa's waiting period was enjoined in 2020. The state passed a new law in 2022.

⁴ Louisiana's parental involvement law was enjoined in 2009. The state passed a new law in 2012.

⁵ Missouri's parental involvement law was enjoined in 2005. The state passed a new law in 2009.

⁶ Montana's waiting period was enjoined in 2000. The state passed a new law in 2009.

⁷ New Hampshire's parental involvement law was enjoined in 2007. The state passed a new law in 2012.

Figure 3 graphically illustrates trends in state laws that aimed to dissuade abortion during 1994–2022. As figure 3 illustrates, parental involvement laws were the most common of these laws throughout this period, and all of them became more common from 1994 to 2022. Mandatory ultrasound laws had especially steep increases after 2010.

Targeted Regulations of Abortion Providers (TRAP Laws)

State governments also target abortion providers with regulations that do not apply to other types of medical services. Figure 4 presents the proportion of states with TRAP laws during 1994–2022, and table 4 reveals trends in TRAP laws, with an average of 2.9 (out of 7) TRAP laws per state (with a median of 2). This average conceals the dramatic rise in TRAP laws after 2010, especially those imposing onerous licensing requirements on clinic facilities and written transfer agreements or hospital admitting privileges.

Most states (82%) prohibit anyone who is not a licensed physician from performing an abortion, even though physician assistants and advanced-practice nurses can safely perform both aspiration and medication abortions

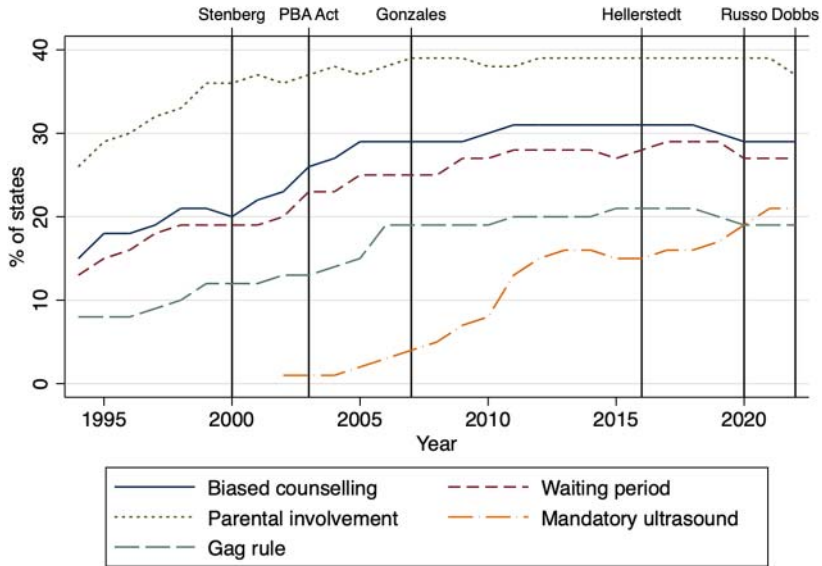


Figure 3 Laws that aim to dissuade abortion (enforced only).

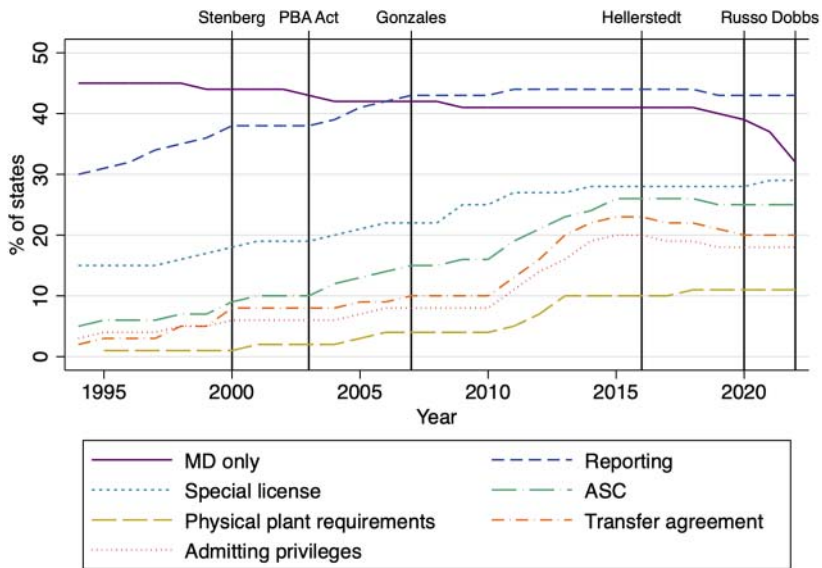


Figure 4 TRAP laws by year (enforced + enjoined).

Notes: TRAP = targeted regulation of abortion providers. Laws for MD only; reporting, special license, and counts are enforced laws only. Counts of ambulatory surgery centers, physical plant requirements, transfer agreements, and admitting privileges include enforced and enjoined laws.

Table 4 TRAP Laws by State, 1994–2022

State	Average no. of TRAP laws	MD only	Reporting	License	ASC	Physical plant	Transfer	Admit
AL	4.28	Y	Y	Y	2013	2013	2014*	2014*
AK	2.63	Y	2004	Y	N	N	N	N
AZ	5.76	Y	2000	1999	2000	N	2012	2000
AR	3.91	Y	2005	Y	2015*	2012	2012	2015*
CA	0.79	Y*	N	2009	N	N	N	N
CO	0.00	N	N	N	N	N	N	N
CT	1.98	Y*	Y	N	N	N	N	N
DE	1.90	Y*	1996	N	N	N	N	N
DC	1.00	Y	N	N	N	N	N	N
FL	4.21	Y	Y	Y	N	N	2005	2005
GA	5.60	Y	2005	Y	Y	N	Y	Y
HI	1.42	Y*	N	2009	N	N	N	N
ID	3.27	Y	Y	N	2009*	N	2000	N
IL	4.40	Y*	Y*	N	Y*	N	Y*	Y*
IN	5.49	Y	Y	2005	Y	2005	1997	2011
IA	1.88	Y	1997	N	N	N	N	N
KS	3.53	Y	1995	2011	2011*	N	2011*	2011*
KY	4.52	Y	Y	1998	1998	N	1998*	N
LA	4.51	Y	Y	2001	2001	2001	N	2014*
ME	1.52	Y*	Y	N	N	N	N	N
MD	2.34	Y*	N	Y	2012	N	N	N
MA	2.00	Y*	Y	2021	N	N	N	N
MI	4.80	Y	2000	2000	2000	2013	2000	N
MN	2.82	Y*	1998	Y	N	N	N	N
MS	4.33	Y	Y	Y	2004*	N	2013	2012*
MO	5.22	Y	Y	Y	2007, 2022	2018	2007*	Y
MT	1.16	1995*	Y	N	N	N	N	N
NE	2.01	Y	Y	N	N	2022	N	N
NV	2.00	Y	Y	N	N	N	N	N
NH	0.00	N	N	N	N	N	N	N
NJ	2.97	Y*	N	Y	Y	N	N	N
NM	1.52	Y*	Y	N	N	N	N	N
NY	1.03	Y*	Y	N	N	N	N	N
NC	4.01	Y	Y	Y	2005	N	2011	N
ND	2.74	Y	Y	N	N	N	2013	2011
OH	2.67	Y	2011	N	2004	N	2013	2013
OK	3.01	Y	2007	2014	2013	2013	2014*	2014*
OR	0.87	N	1997	N	N	N	N	N
PA	4.17	Y	Y	2004	2012	2012	2012	2012

and corridors that are difficult for existing facilities to meet. Other TRAP laws require abortion providers to have a written transfer agreement or hospital admitting privileges at a local hospital.

As figure 4 illustrates, the number of TRAP laws began to increase after 2005, and that increase accelerated after 2010. TRAP laws compelled many reproductive health clinics to close, leading to a shortage of abortion providers in numerous states and forcing many women to travel long distances to obtain an abortion (Jerman et al. 2017). For example, there were 41 abortion clinics in Texas in 2013, but more than half of them closed after Texas passed TRAP legislation, and only 19 remained open in October 2015 (Grossman et al. 2014; Center for Reproductive Rights 2023). The US Supreme Court struck down these provisions in *Whole Woman's Health v. Hellerstedt* (2016), but Texas still had only 22 open clinics 3 years later (Lopez 2019). However, the growth of TRAP laws slowed after *Hellerstedt* and a similar decision in *June Medical Services v. Russo* (2020).

Other Reproductive Health Restrictions

State legislatures have enacted other laws that restrict reproductive choice, presented in table 5.

During the late 1990s, antiabortion groups focused on banning the D&X abortion method, which they referred to as “partial-birth abortion” (a nonmedical term). Figure 5 shows the number of states with method bans during 1994–2022. Thirty states enacted bans on this abortion method, producing a steep slope in the late 1990s in figure 5. (Courts permanently enjoined 11 of these bans.) Then the federal government passed the 2003 Partial-Birth Abortion Act (18 U.S.C. § 1531), which the US Supreme Court upheld in *Gonzales v. Carhart* (550 U.S. 124 (2007)). After *Gonzales* established a federal D&X ban, antiabortion groups shifted their focus away from method bans until 2013, when some legislatures passed bans on another second-trimester abortion procedure, dilation and evacuation (D&E). The courts have enjoined nine of 12 D&E bans, leaving them in effect in only three states (Mississippi, Nebraska, and West Virginia).

Table 5 includes other restrictions on reproductive choice, such as laws prohibiting private insurance plans from covering abortions, the nullification of advance health care directives if the patient is pregnant, and laws that permit pharmacists to refuse to dispense medication (e.g., emergency contraception) that conflicts with their religious or moral beliefs. By 2022, 25% of states either prohibited abortion coverage for state employees, prohibited coverage for abortion in policies on the state insurance exchanges, or both. Twenty-nine percent also required life-sustaining

Table 5 Other Reproductive Health Restrictions by State, 1994–2022

State	<i>Method bans</i>		<i>Other restrictions</i>		Pharmacist refusal	RRI
	D&X ban	D&E ban	No insurance coverage	Living will		
AL	1997	2016	2012	1997	2017	7.49
AK	1997	N	N	2004	N	4.77
AZ	2009	N	2010	N	Y	6.74
AR	1997*	2017	2013	2003	Y	6.24
CA	N	N	N	N	N	1.38
CO	N	N	N	2011	N	3.79
CT	N	N	N	Y*	N	2.67
DE	N	N	N	1996	2007	4.40
DC	N	N	N	N	N	3.57
FL	1998	2000*	2011	Y	N	5.95
GA	2009	N	2014	N	2006	5.55
HI	N	N	N	N	N	3.20
ID	1998	N	1997	2005	2010	7.27
IL	1998*	N	Y*	Y	N	3.61
IN	N	2019	2014	Y	2019	7.51
IA	1998	N	N	Y	N	4.92
KS	N	2015	2011	1994	2012	8.04
KY	1998	2019	Y	Y	N	7.66
LA	N	2016	2010	N	N	7.90
ME	N	N	N	N	1995	3.49
MD	N	N	N	Y	1997	3.56
MA	N	N	N	N	N	5.22
MI	N	N	2014	N	N	7.25
MN	N	N	1996*	Y	N	5.33
MS	2009	2016	2010	N	N	7.63
MO	N	N	2010	Y	2012	6.94
MT	2009	N	N	Y	N	2.62
NE	1997	2020	2011	Y	N	8.32
NV	N	N	N	Y	N	3.69
NH	N	N	N	2007	N	2.41
NJ	1998	N	N	Y	N	2.24
NM	2000	N	N	N	N	1.30
NY	N	N	N	N	2006	1.52
NC	N	N	2013	N	2005	5.59
ND	N	2022	Y	2001	N	8.44
OH	N	2019	2012	Y	N	6.91
OK	N	2015	2011	N	2008	6.61
OR	N	N	N	N	N	0.00

(continued)

Table 5 Other Reproductive Health Restrictions by State, 1994–2022
(continued)

State	Method bans		Other restrictions			RRI
	D&X ban	D&E ban	No insurance coverage	Living will	Pharmacist refusal	
PA	N	N	Y	Y	2007	8.46
RI	1997*	N	Y*	Y	N	4.85
SC	N	N	2012	Y	2022	5.62
SD	N	N	2012	Y	Y	7.94
TN	N	N	2010	N	N	7.00
TX	N	2017	2017	Y	2017	6.47
UT	2004	N	2011	2008	N	7.64
VT	N	N	N	N	N	0.52
VA	N	N	2014	N	N	5.29
WA	N	N	N	Y	N	1.07
WV	1998	2016	N	N	N	5.49
WI	1998	N	N	Y	N	6.19
WY	N	N	N	N	N	4.71

Note: D&X=dilation and extraction; D&E=dilation and evacuation.

* =enjoined; Y=yes, since before 1994; N=no, all years.

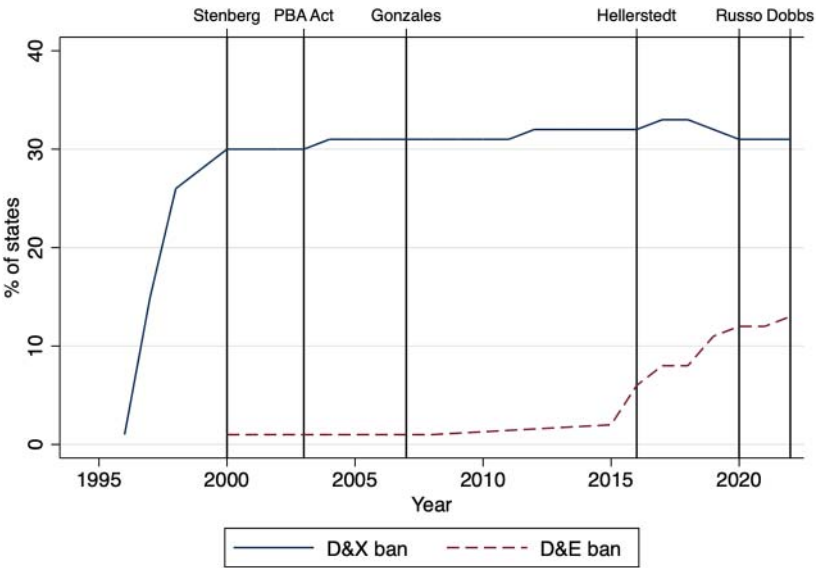


Figure 5 Bans on abortion methods (enforced + enjoined).

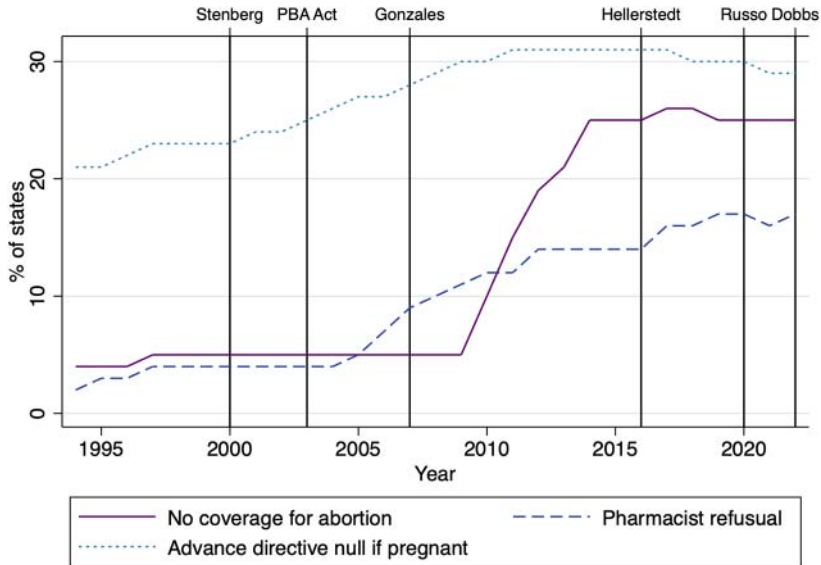


Figure 6 Other choice restrictions by year (enforced only).

treatment for anyone who is pregnant, regardless of the preferences that they express in an advance health care directive or living will. Seventeen percent of states permitted pharmacists to refuse to fill prescriptions if they had religious or moral objections, primarily affecting access to contraception and especially emergency contraception. Figure 6 illustrates changes in these laws over time, revealing that pharmacist refusal clauses increased after 2005, while laws that nullify advance health directives for pregnant patients rose more gradually during this period. There were significant increases in prohibition of insurance coverage for abortion after passage of the Affordable Care Act (ACA) in 2010.

Support for Reproductive Health and Abortion Rights

On the other hand, a growing number of states began to shore up abortion rights, especially in recent years. Table 6 presents laws that support reproductive health by state, including public funding for abortions beyond what federal law requires, legal protection against violence for reproductive health clinics, and codification of abortion rights.

Figure 7 illustrates change over time in state laws that support abortion choice. In figure 7, clinic protections and expanded public funding for abortions fluctuate over time. In contrast, the number of states that

Table 6 Support for Reproductive and Maternal Health by State, 1994–2022

State	Sex education	Expanded family planning	Emergency contraception	Midwifery licensed	MMRC	Public funding	Clinic protection	Right to Choose
AL	N	2000	N	2017	N	N	N	N
AK	N	N	N	Y	N	2014	N	N
AZ	N	N	N	Y	2011	2002*	N	N
AR	N	1998	2007	Y	N	N	N	N
CA	2016	1999	Y	Y	N	Y	Y	2003
CO	N	N	2007*	Y	2008*	N	2020*	2022
CT	N	2014	2007	2009	2018	Y	Y*	Y
DE	Y	1998	N	Y	2011	N	N	2017
DC	2010	N	2009	N	2018	N	1996	N
FL	2022	2000	N	Y	1996	N	N	N
GA	Y	2011	N	N	2012	N	N	N
HI	2015	N	2013	2019	2015	2009	2011	2006
ID	N	N	N	2009	N	Y*	N	N
IL	N	2004	2002	2022	2000	1995, 2017 ¹	N	2019
IN	N	2012	N	2013	2018	N	N	N
IA	2007	2006	N	N	Y	N	N	N
KS	2009	N	N	N	2018	N	Y	N
KY	2011	N	N	N	2018	N	N	N
LA	N	2007	N	Y	Y	N	N	N
ME	2002	2017	N	2020	2006	2019	Y	Y
MD	2011	2012	N	2015	2000	2004	2002	Y

Table 6 (continued)

State	Sex education	Expanded family planning	Emergency contraception	Midwifery licensed	MMRC	Public funding	Clinic protection	Right to Choose
MA	N	2017	2005	N	1998	Y, 2022	2000, 2014	2021
MI	N	2006*	N	2017	2004	N	1999	N
MN	1998	2006	2007	Y	2001	N	Y	N
MS	N	2004	N	N	2016	N	N	N
MO	N	2010	N	N	2011	N	N	N
MT	Y	2011	N	Y	1997*	1995	2005	N
NE	N	N	N	N	2013	N	N	N
NV	Y	2014	N	N	2020	N	Y	Y
NH	Y	N	N	1999	2010	Y*	2014	N
NJ	Y	N	2006	Y	Y	2001	Y-1996, 2019 ²	2022
NM	2005	2000	2003	Y	2019	1998	N	N
NY	N	1998	2004	2004	2010	Y	1999	2019
NC	2005	2005	N	2009	2014	N	Y	N
ND	2012	N	N	N	Y	N	N	N
OH	1999	N	N	N	2010	N	N	N
OK	N	Y	N	N	Y	N	N	N
OR	Y	Y	1999	Y	2007–2009, 2019 ³	Y	Y	2017
PA	N	2007	2012	2009	N	N	N	N
RI	1996	Y	N	2002	N	N	N	2019
SC	Y	Y	1997	Y	2014	N	N	N
SD	N	N	N	2017	2020	N	N	N

(continued)

Table 6 Support for Reproductive and Maternal Health by State, 1994–2022 (continued)

State	Sex education	Expanded family planning	Emergency contraception	Midwifery licensed	MMRC	Public funding	Clinic protection	Right to Choose
TN	Y	N	N	2002	2017	N	N	N
TX	N	2007	2005	Y	2014	N	N	N
UT	2002	N	2009	2005	1995	N	N	N
VT	Y	2009	2005*	2001	2012	Y	N	2019
VA	Y	2007	N	Y	2019	N	N	N
WA	2007	2001	2006	Y	2016	Y	Y	Y
WV	2005	N	N	N	2008	N	N	N
WI	Y*	2003	2008	2006	N	N	Y	N
WY	N	2008	N	2010	2020	N	N	N

Note: MMRC= maternal mortality review committee.

* = enjoined; Y = yes, since before 1994; N = no, all years.

¹ Illinois's public funding law was enjoined in 2009. The state passed a new law in 2017.

² New Jersey's clinic protection law was enjoined in 1996. The state passed a new law in 2019.

³ Oregon's MMRC was disbanded in 2009. A new law passed in 2019.

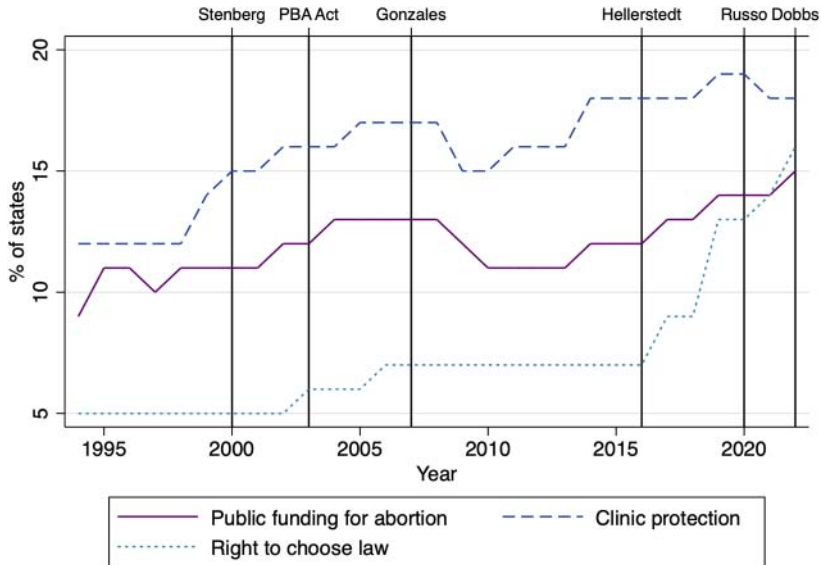


Figure 7 Support for abortion choice by year (enforced only).

have codified a right to abortion has increased since 2015. As states have polarized into abortion-restrictive and abortion-supportive regimes, more abortion-supportive states have passed legislation protecting freedom of choice.

Support for reproductive and maternal health also includes mandatory sex education, expanded family planning access under Medicaid, emergency contraception for sexual assault survivors, licensing of DEMs, and establishment of an MMRC. We included a measure for mandatory sex education because some reproductive health indices, such as the one created by the Institute for Women’s Policy Research, include this measure (Mason et al. 2022). This is an important measure because it indicates a state’s support for providing information about reproductive health to young people, although states vary in the content of their mandatory sex education programs. Similarly, we include a measure for whether a state has a waiver that expands Medicaid coverage for family planning by covering contraception for low-income individuals who do not qualify for full Medicaid coverage. These Medicaid waivers express a commitment to family planning for low-income state residents, and NARAL tracks this indicator in its state-level data. NARAL’s state-level data also include an indicator for whether a state requires medical providers (especially hospital emergency departments) to provide emergency contraception to sexual

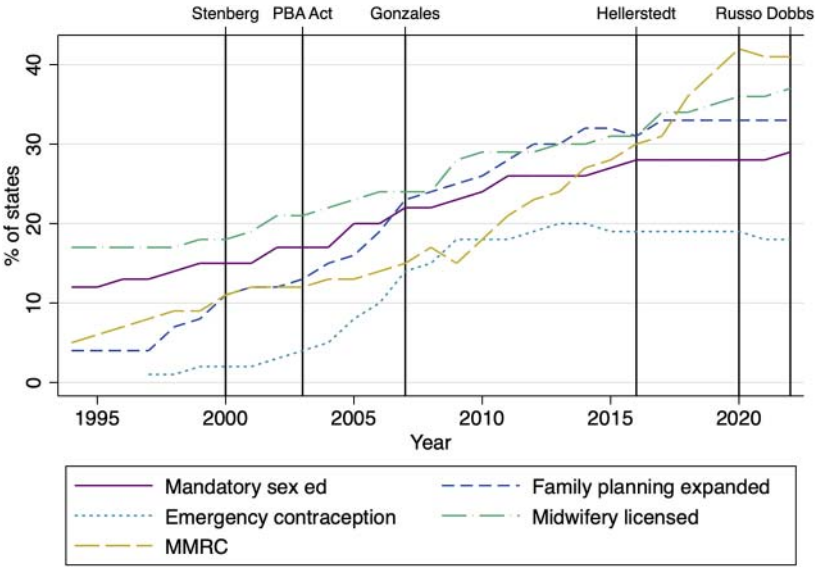


Figure 8 Support for reproductive health (enforced only).

assault survivors. These mandates became popular around 2007, and they represent an effort to support an expansive view of reproductive health.

We also collected data on whether states license DEMs as a maternal health policy, since licensing of DEMs expresses legal support for birth choices, and specifically for the option of home birth with a midwife. Although some states have antiabortion laws while supporting direct-entry midwifery, legal recognition for home birth midwives has long been a priority for birth advocates. We also included it in the database because choice and bodily autonomy during pregnancy and birth are interconnected (Shaw 2013). Similarly, we included a measure of whether states had established an MMRC because these committees signify a state's effort to address adverse maternal health outcomes. Maternal mortality is significantly higher in the United States than in other developed nations, especially among African American populations (Bongaarts 2016; Bryant et al. 2010; Creanga et al. 2017; Lawton 2011; Main et al. 2015; WHO et al. 2014). Efforts to address this problem represent an important public health and policy emphasis on improving maternal health.

Figure 8 presents the percentage of states that support reproductive choice and maternal health by mandating sex education in schools, expanding Medicaid coverage of family planning services, requiring hospitals to provide emergency contraception to sexual assault survivors,

licensing DEMs, and establishing MMRCs to review maternal deaths. The percentage of states with each of these laws has increased over time, with larger increases in emergency contraception mandates around 2005–2010 and the establishment of more MMRCs after 2010.

Conclusions

This study used a unique longitudinal database to describe trends in reproductive health laws across US states from 1994 to 2022. The database measures state statutes and administrative codes (but not court decisions) for most of the period since *Casey*, and it extends past the 2022 *Dobbs* decision that overturned *Roe*. The figures and tables reveal that legal access to abortion and other reproductive health policies depend significantly on the state in which one lives. The figures also graphically depict the polarization of more abortion-restrictive and more abortion-supportive states across the United States over time. After *Roe*, and especially following the *Casey* decision that lowered the judicial bar for abortion restrictions, the antiabortion movement cultivated a successful long-term strategy of incrementally chipping away at abortion rights at the state level. Even before the *Dobbs* decision, their success segregated states into those that protect the right to choose and those with extremely limited abortion access. These differences among states became increasingly important after the Supreme Court overturned *Roe* in the *Dobbs* case. In the wake of this decision, abortion access will become even more of a patchwork: those in restrictive states will face greater obstacles to reproductive health services than they did during the decades before 2022.

After *Dobbs*, some states passed new abortion restrictions, while others shored up legal protection for the right to choose. In the November 2022 midterm elections, voters in three states (California, Michigan, and Vermont) voted to protect the right to abortion (Nash and Guarnieri 2022). The Michigan ballot initiative also permanently blocked Michigan's pre-*Roe* abortion ban. Additionally, voters in Kentucky and Montana rejected ballot initiatives that would further restrict abortion rights. Public opinion seems to be overwhelmingly in favor of support for legal abortion (Jozkowski, Crawford, and Hunt 2018). However, states that protect abortion rights are overwhelmingly on the coasts, while vast swaths of the middle of the United States are deserts for abortion care. Many abortion seekers will have to travel long distances at great expense to obtain the procedure, and this will disproportionately burden low-income and rural women, as it always does.

Understanding these historical trends in reproductive health laws across states is important for at least three reasons. First, anyone who can become pregnant will lose their ability to plan their work and family lives if they lose the ability to choose when to bear children and how many to bear. Secondly, they will lose access to essential medical care, as physicians in restrictive states face uncertainty about whether they can provide evidence-based care to patients who, for example, need medical assistance to safely complete a miscarriage. Third, these laws have important implications for maternal and infant health in pregnancies that end in birth. Previous research has demonstrated that restrictive abortion laws are associated with higher rates of maternal and infant mortality, more preterm births, and more low birthweight (Sudhinaraset et al. 2020; Vilda et al. 2021). They are also associated with lower odds of vaginal birth after cesarean section and of home birth, both of which represent maternal choices to reject standard obstetrical care (Roth 2021). These laws also exacerbate racial/ethnic and income inequality in maternal and infant health (Solazzo 2019; Vilda et al. 2019). Data on historical trends in state-level reproductive health laws can help researchers and policy makers anticipate where maternal and infant outcomes are most vulnerable and most unequal.

■ ■ ■

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