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Perspective

Abortion Policy in the United States: The New Legal Landscape and Its Threats to Health and Socioeconomic Well-Being

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Policy Points:

- The historic 2022 Supreme Court *Dobbs v Jackson Women's Health Organization* decision has created a new public policy landscape in the United States that will restrict access to legal and safe abortion for a significant proportion of the population.
- Policies restricting access to abortion bring with them significant threats and harms to health by delaying or denying essential evidence-based medical care and increasing the risks for adverse maternal and infant outcomes, including death.
- Restrictive abortion policies will increase the number of children born into and living in poverty, increase the number of families experiencing serious financial instability and hardship, increase racial inequities in socioeconomic security, and put significant additional pressure on under-resourced social welfare systems.

Keywords: abortion policy, state policy, women's health, social welfare.

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On June 24, 2022, the Supreme Court of the United States (SCOTUS) issued a historic decision in the *Dobbs v Jackson Women's Health Organization* case[1] overturning previous court rulings regarding privacy rights and abortion, including the *Roe v Wade* decision of 1973.[2] The Dobbs decision reversed a nearly 50-year precedent of constitutionally protected federal access to abortion nationwide, relegating its legal oversight back to individual states and territories. In the absence of a constitutionally protected right to abortion care, states are now free to set strict legal parameters around access to abortion.[3]

It is predicted that at least one-half of US states will either fully ban or severely restrict access to and provision of induced abortion, with 13 states already operating under "trigger laws" that were not struck down after *Roe v Wade* took effect.[4] At this time, the full impact of the 2022 SCOTUS decision remains unclear. However, with an ongoing deluge of lawsuits being filed, new state and federal legislation being introduced, and ballot initiatives being brought to voters across the country, abortion policy will continue to play out in the United States for decades to come. This new landscape for abortion law and policy likely means that a significant proportion of the US population will not have access to safe and legal abortion services—a health care procedure chosen in approximately one out of five pregnancies for a wide variety of reasons.[5]

In this paper, we review the extant social science, public health, and medical research to assess the range and magnitude of the likely negative effects of restrictive abortion policies on key health and socioeconomic outcomes for birthing persons, children, and families. We begin by summarizing the current complex legal landscape for abortion and its implications for public policy for many years to come. Next, we review the social demography of pregnancy and abortion in the United States with a focus on unintended pregnancy, which is the primary reason pregnant people chose abortion. (In this paper, we use the inclusive term "pregnant people" to recognize the fact that people who are gender nonbinary and transgendered males do become pregnant. We use the word "women" when reporting on the stated focus and results of prior research.) We then present the state of the research literature regarding the potential impact of restrictive abortion policies on maternal health and pregnancy outcomes and on the social and economic well-being of individuals, children, families, and state social welfare systems. Although the legal landscape

will be playing out for many years, significant existing research reveals that restrictive abortion policies will have a plethora of negative effects on health, socioeconomic security, and overall well-being in the United States.

A New and Complex Legal Landscape

The *Dobbs* decision of 2022 eradicated a consistent baseline of legal protections for access to abortion at the federal level[1] and thus splintered its regulation by state, set up interstate conflicts, and put increasing pressure on the entire system of federalism in the United States.

Roe v Wade set up the initial "trimester framework" for the regulation of abortion.[2] Under this framework, abortion was considered safe enough in the first trimester to be left to the discretion of pregnant patients and their physicians. In the second trimester, *Roe* recognized both a state interest in the fetus as the "potentiality of human life," as well as regulation of abortion in ways "reasonably related" to protecting material health.[2] In the third trimester, states were given freedom to limit, or even proscribe, abortion, except when necessary to preserve the life or health of the mother. In the wake of *Roe*, however, some states became increasingly aggressive about what, Republican legislatures argued, was "reasonably related" to protecting maternal health in the second trimester. This led to the promulgation of state "TRAP" (Targeted Regulation of Abortion Providers) laws—costly compliance requirements with the intent of setting up barriers to abortion access (e.g., how short a clinic's grass needed to be cut).[6]

The Pennsylvania Abortion Control Act of 1982 was one such set of TRAP laws. It required that the pregnant person provide an attestation that her husband had been notified (with some exceptions) and that minors had consent from one parent or a judicial bypass from the court to access abortion.[7,8] The Pennsylvania law also limited the definition of a "medical emergency" exception to "serious risk of substantial and irreversible impairment of a major bodily function" and required additional record keeping.[7,8] These restrictions led to the 1992 SCOTUS case of *Planned Parenthood v Casey*, which led to the explicit rejection of, as the 1992 SCOTUS described it, the "rigid trimester framework" of *Roe*. *Casey* recognized a state's right to encourage potential fetal life at

any point before viability as long as laws were not an "undue burden" (i.e., a "substantial obstacle") on a pregnant person.[9]

In 2018, however, the state of Mississippi pushed the TRAP law envelope by passing the Gestational Age Act, which prohibited abortion, with exceptions for medical emergency or in the case of a severe fetal abnormality, after 15 weeks.[10] It was therefore a *prima facie* violation of *Casey* in that it placed a substantial obstacle (i.e., a complete prohibition) on access to abortion before viability.[11] Yet, *Dobbs* went on to overrule the *Casey* standard for evaluation and eradicated any right to abortion at the federal level. Now, states appear to be allowed to regulate abortion at all stages of pregnancy up to and including prohibition; it is unclear what exceptions remain federally mandatory. Thus, what originally was a political debate on restrictions to desired abortions has shifted to whether pregnant people have the right to an abortion when they are experiencing an emergency medical condition that requires a stabilizing abortion,[12] the fetus is nonviable, or the pregnancy results from rape or incest.[13]

This abrupt and fundamental shift has placed enormous burdens on clinicians who provide abortion-related care.[14] Although many state laws remain civil in nature, some carry criminal charges for patients and/or providers (e.g., South Carolina).[15] Several state laws also prohibit the "aiding or abetting" of an abortion, which is a vague standard intended to prevent assistance or the provision of information to pregnant persons desiring or in clinical need of an abortion.[16]

In legislative battleground states, citizens are using "direct democracy" or ballot initiative procedures to place abortion-related state constitutional amendments in front of voters—initiatives that either nullify or solidify the constitutionality of abortion. For example, in Kansas, a constitutional provision prohibiting abortion was rejected by voters in August, 2022.[17] In the November 2022 midterm elections, four states voted on ballot initiatives to amend their state constitutions in regard to the right—or lack thereof—to abortion.[18]

This splintering among states has led to tensions among them. In states where abortion remains legal, there has already been an influx in people seeking out-of-state care. Some states have claimed the right to charge citizens who travel to other states for abortion care with civil or criminal penalties.[19] Some states have threated to investigate out-of-state practitioners who provide abortions to their citizens. This has led some prochoice governors to sign nonextradition clauses stating that

they will not extradite citizen patients or providers to another state to stand trial under their abortion laws.[20]

Confusion and tensions have also erupted between states and the executive branch of the federal government. The Biden administration has made clear its belief that the judicial branch erroneously overruled *Roe* and *Casey* and has taken several measures to act in support of a federal right to abortion care. For example, the Centers for Medicare and Medicaid Services (CMS) put out a recent guidance related to the Emergency Medical Treatment and Labor Act (EMTALA), which requires that hospitals with emergency departments provide patients presenting in distress with stabilizing care or a transfer or birthing services, whether or not they have insurance coverage.[21] The guidance clarifies that if stabilizing care to protect the life or the health of a pregnant person requires abortion, hospitals subject to EMTALA must provide it or risk civil fines or even termination of their CMS provider agreement.[22]

In response, Texas courts ruled that the US Department of Health and Human Services may not enforce the guidance's interpretation that Texas abortion laws are preempted by EMTALA within the state of Texas,[12] setting up a major question of federalism and what entity will ultimately regulate abortions in this country or even what fundamental right the federal government has to set standards for due process or equal protection rights across state lines.[23] These debates will reverberate for years to come and will impact many more systems of regulation than just those over access to abortion.

Social Demography of Unintended Pregnancy and Abortion

Severely restricting abortion access is of particular concern given the high rates of unintended pregnancy in the United States.[24] Currently, nearly half of all pregnancies in the United States are unintended, which includes pregnancies that were either mistimed (occurring at a time when an individual did not plan or desire to be pregnant) or unwanted (experienced by an individual who did not at that time or any time in the future desire to be pregnant, typically among people who have already given birth). This rate of unintended pregnancy is high in both absolute terms and relative to other high-income countries.[5]

Rates of unintended pregnancy are highest among younger people (<30 years), people with low levels of income and education, and those in historically marginalized racial and ethnic groups.[3,5] Rates of unintended pregnancy are over five times higher among women living in poverty than those with incomes at or above 200% of the federal poverty level.[25] The lack of financial and geographic access to effective methods of contraception is a key driver of why unintended pregnancy rates are high in general and especially high in lower-income populations. Access to contraception is most limited for those living in poverty and Black women.[26] In addition, no form of contraception is 100% effective; contraception can and does fail. National survey data suggest that approximately one-half of patients receiving abortion services reported that they had used a contraception method in the month in which they became pregnant.[27]

Another key reason that rates of unintended pregnancy are high is abuse, violence, and other problems in intimate partner relationships. Intimate partner violence (IPV), although common throughout the United States, is significantly more common among younger women living in poverty, transgender women, and those in historically marginalized racial/ethnic groups.[28] Women who experience IPV have lower odds of using contraception, have less condom use, and use condoms less consistently.[29] As a result, unintended pregnancy rates are significantly higher among women experiencing IPV.[29]

Furthermore, a well-documented aspect of human sexuality that is essential to understanding unintended pregnancy is that forced or coerced sexual intercourse is a common experience in the United States and often not labeled or reported to law enforcement as "violence" or "rape." Pregnancies do result from violent sexual assault/rape and incest, comprising a very small proportion (<2%) of abortions; however, a woman is much more likely to become pregnant from forced or coerced sex from an intimate partner than a stranger.[30] National data reveal that unwanted, forced, or coerced sex is experienced by at least 25% of women by the time they reach age 44, with high rates documented among women from all education and economic strata.[31] Experiences of sexual coercion and also "reproductive coercion"—defined as refusal of contraception, interference with use of contraception, or sabotage of contraception effectiveness—increase the risks of unintended pregnancy, sexually transmitted infections, and other adverse health issues.[32]

Abortion in the United States

Although the exact number of induced abortions taking place each year in the United States is somewhat difficult to measure, data from both the Centers for Disease Control and Prevention (CDC) and the Guttmacher Institute suggest that the number of abortions has been trending downward over the past 10 years, with a slight uptick in 2019 and 2020.[33] There were an estimated 14.4 abortions per 1,000 women aged 15–44 in 2020, compared with a rate of 29.3 in 1981. Another important abortion statistic is the ratio of abortions to live births, which provides a sense of the relative incidence of abortions to pregnancies in a population. In 2019, the CDC estimated that 629,898 abortions were performed with a ratio of 195 abortions for every 1,000 live births, compared with a ratio of 225 in 1,000 in 2010.[33] This trend toward a declining number of pregnancies resulting in induced abortion is being observed against the backdrop of significant declines in other measures of reproduction, including birth rates and the total fertility rate.[34]

Demographically, more than half (57%) of all abortions occur among those aged 20–29.[33] CDC abortion surveillance data also show that only 9% of abortions are among people under age 20, 20% are among those aged 30–34, and 14% are among women aged 35 and older. In addition, the majority (60%) of those seeking abortions already have at least one child. Nationwide in 2019, 38% of abortions were among Black women, 33% among non-Hispanic White women, and 21% among Hispanic women.[35] Almost half (49%) of women receiving abortions have incomes below the federal poverty level.[36] In 2019, 92.7% of abortion occurred earlier than or at 13 weeks of gestation.[33]

Implications of Restrictive Abortion Policies on Health

Policies restricting access to legal abortion care will bring with them significant harm to the physical health of pregnant people through four specific types of serious health risks, including risks associated with 1) restrictions and delays regarding essential evidence-based obstetric, gynecological, and maternal/fetal health care; 2) the inability to seek legal abortion care within one's own state; 3) the experience of unintended pregnancy and childbirth; and 4) the inability to access abortion

services when desired. All of these health risks are heightened for people from historically marginalized racial/ethnic groups and those who are socioeconomically disadvantaged.

First, laws that severely restrict abortion services with narrow exemptions and criminalization of providers both directly and indirectly increase the risk of adverse health outcomes, including death. Prohibitions on and administrative/approval delays for a wide variety of standard-of-care medical interventions, including the treatment of pregnancy loss (e.g., ectopic pregnancy, spontaneous miscarriage, or preterm premature rupture of membranes), assisting those with life-limiting fetal diagnoses, treatment of life-threatening maternal conditions, and prescribing misoprostol for its many purposes other than a medication abortion, are already severely constraining the provision of effective and in some cases life-saving medical care.[37] In addition, it is well-established that surgeons who perform fewer procedures of a specific type have lower-quality outcomes, including surgical abortions.[38] As such, if abortion is allowed only in an extremely limited number of situations, there will be few providers—all with a low volume of experience—to perform complex abortion procedures for women in need.

Second, the inability to seek legal abortion care within one's home state creates a number of serious potential health threats. Many pregnant people living in states with bans or significant restrictions on abortion will not be able to travel out of state because of a lack of money, logistical challenges, and work and family constraints, and some will resort to self-managed abortions.[39] Although most people should be able to safely self-manage an abortion up to 10 weeks gestation by obtaining abortion pills online, self-management is not recommended because there can be serious complications from medication abortions that need immediate clinical care.[40] Those self-managing their abortions will be less likely to seek clinical care for complications, especially in policy situations in which they or their provider could be charged with a crime. Also, some people who do not know about medical abortion options or are beyond 10 weeks and cannot travel out of state for a desired abortion might resort to risky and harmful options for inducing miscarriage or seek "underground" abortion services, as has already been observed in states with very limited abortion services and more generally during the COVID-19 pandemic.[41]

Third, it is well documented from numerous recent studies and meta-analyses across countries that people who have unintended

pregnancies experience significantly higher rates of severe adverse pregnancy outcomes. Such complications include preterm delivery and low birth weight (which are risk factors for myriad severe lifelong health problems such as intellectual and developmental disabilities, cerebral palsy, lung disease, and vision problems), infant mortality, and maternal mortality.[41,42] The risks are even higher for women of color and those who are economically disadvantaged.[12,22] As such, an increase in the proportion of unintended pregnancies that result in a birth will lead to an increase in the already unacceptably high rates of adverse pregnancy outcomes, including infant and maternal death.

Fourth, serious health risks are associated with pregnancy and childbirth whether or not the pregnancy was planned or unintended. Carrying a pregnancy to term involves numerous health risks and harms, including death. It has been estimated that the mortality risk from childbirth is 14 times greater than induced abortion.[43] This risk is significantly higher for Black women in the United States, who are already three times more likely to die during pregnancy and childbirth than non-Hispanic White women.[44]

A study from researchers at the University of Colorado, using well-established evidence regarding the risks of pregnancy/childbirth and conservative demographic estimation methods, predicts that current and forthcoming state-level abortion bans will likely lead to at least a 14% increase in maternal mortality annually in the United States, with rates significantly higher for Black women.[45] This research also estimated that a total abortion ban in the United States would likely lead to a 24% increase in maternal mortality overall, with a 39% increase among Black women.

Research results from a national longitudinal study that compared women who received abortion services with those who sought abortions but were declined because they were past either the facility or legal gestational age (the "Turnaway study") reveal a wide array of negative health and socioeconomic effects of abortion denial on women, children, and families. The Turnaway study results indicate that women who were denied an abortion and gave birth reported a higher incidence of serious ongoing health problems after their pregnancy, including chronic pain, hypertension, and experiences of IPV.[46] Furthermore, carrying an unwanted pregnancy to term increases the risk of poor maternal bonding, including feelings of entrapment or newborn resentment, compared with women with planned/wanted pregnancies.[47]

The risks of serious negative effects from pregnancy resulting from rape and incest are even greater, although research on this complex topic is still formative. It is estimated that approximately 2.5% of US women will experience a rape-related pregnancy during their lifetime, and approximately 12,000 women deliver and keep infants born from sexual assault each year in the United States.[48] Those who have been sexually assaulted are at much higher risk for sexually transmitted infections, drug/alcohol abuse, and mental health problems including rape trauma syndrome and posttraumatic stress disorder.[49] Also, those with a history of sexual assault are at a higher risk for several adverse pregnancy and birth outcomes (net of age) including prolonged labor, antepartum bleeding, and emergency instrumental delivery.[50]

Implications for Social Welfare

In addition to a broad range of serious physical health effects, limiting abortion access in the United States will also likely have profound and long-lasting economic consequences for women, children, and families. Access to reproductive autonomy allows women to choose the timing of childbearing, allowing them to delay childbearing to invest in their education, personal development, and household financial stability. Limiting access to legal abortion will decrease women's ability to control their own fertility and in turn reduce educational attainment, employment opportunities, income, and financial outcomes. This will also lead to a host of negative consequences for children, including increased risk for child poverty and other social welfare outcomes.

Education and Economic Outcomes

Research demonstrates that states that had legal abortion before *Roe v Wade* recognized a right to abortion access in 1973 experienced relatively larger declines in teen fertility and marriage and subsequent increases in educational attainment among women, relative to states that did not have legal abortion prior to 1973.[51] The educational effects of access to abortion and other reproductive health services were particularly large among Black women. For example, Black women whose state legalized abortion during their adolescence experienced large and significant increases in high school completion, college attendance, and college completion, markedly larger than the effect estimated for

White women.[51] This effect has also been documented in reverse: The implementation of state laws restricting abortion access has been shown to reduce educational attainment. For example, living in states with more restrictive abortion laws before the age of 18 led to reductions in college enrollment and completion, with a greater negative impact on enrolling in or graduating from college for Black women.[51] Limiting access to legal abortion is therefore likely to perpetuate and exacerbate existing racial inequality in educational outcomes.

Analysis of historical data surrounding access to abortion and other reproductive health services also demonstrates the importance of abortion access in regard to economic outcomes for women. Furthermore, studies of changes in abortion legalization at the state level before *Roe v Wade* have demonstrated that abortion access has significant economic benefits for Black women. Taking advantage of state policy variation and controlling for many historical factors, one study showed that increased abortion access in the 1960s and 1970s led to increased employment specifically for Black women,[51] and another showed that early access to abortion in the 1960s led to a 10% increase in earnings among Black women.[52]

Evidence from the Turnaway study indicates that women who were denied an abortion and went on to give birth were more likely to live in poverty and less likely to work full time compared with those who were able to obtain an abortion.[53] These differences in economic outcomes persist for at least four years after the denial of an abortion and indicate that women unable to access abortion care services face significant barriers to work. In addition, researchers have linked data from the Turnaway study to credit report data covering three years before and six years after the abortion or the refusal of abortion services.[54] The results reveal that immediately after the abortion denial, those who were turned away experienced a large relative increase in negative financial outcomes, with past due bills rising by 78% when compared with their predenial averages. These measures of financial distress remained high for the six years after the refusal of abortion care services. No such pattern was observed among women who sought and received abortions.

Children's Outcomes

Approximately two-thirds of women who seek abortions already have children.[33] Being denied an abortion affects the existing children and the children born by the refusal of abortion. A number of studies have

directly examined the link between access to abortion and child outcomes, using a variety of causal inference methods. For example, the Intergenerational Panel Study of Parents and Children study revealed that children born from unintended pregnancies are less healthy as they become adults and that other children in families with an unintended child also suffer relatively poorer health status and fewer family resources.[55–57] These results are consistent with studies that also show those who are either a child born from an unintended pregnancy or a child growing up in a family with unintended siblings suffer lower health, well-being, and resource outcomes.[58]

Extant research also demonstrates that access to abortion reduces child poverty for children already born. Turnaway study results suggest that 6 months to 4.5 years after women sought abortions, existing children of those denied abortions were substantially more likely to live in poverty compared with the children of women who received abortions.[54] This is supported by natural experiments examining state policy variation in the 1970s, which found that state legalization of abortion led to reductions in child poverty.[59] This research also estimated that the additional child born as a result of lack of abortion access is nearly 50% more likely to live in poverty compared with the average child in their birth cohort.

In addition to reducing child poverty, previous research finds that access to legal abortions reduces the number of child maltreatment and neglect reports.[60] Conversely, it is likely that limiting access to legal abortion will increase child maltreatment and neglect. Children who experience maltreatment and have contact with child protective services more broadly perform worse on standardized achievement tests, are more likely to repeat a grade, and are more likely to require special education services in grade school.[61] These adverse outcomes in childhood are also likely to translate into worse outcomes in adulthood because the consequence of child poverty across the life course are well documented.[61–63] Available research also suggests that the intergenerational poverty link is particularly strong among Black children, implying that increased child poverty due to abortion restrictions will likely exacerbate Black–White income inequality, including for future generations.[64]

Social Safety Net Participation

As described above, approximately 50% of women who receive an abortion live below the federal poverty level and often already have one or more children. Thus, it is important to understand the potential

adverse effects of severely restrictive abortion policies on individual women, children, and families in the context of the social welfare and safety net systems that are ostensibly in place to support them. The relationship between access to abortion services and the use of social support programs is well documented. Analyses of Turnaway study data found that women who were denied abortions were more likely to receive support from federally funded programs such as the Supplemental Nutrition Assisted Program (SNAP); Women, Infants, and Children (WIC); and Temporary Assistance for Needy Families six months after refusal of an abortion compared with women receiving abortion services.[47,54] Even five years later, women who were denied an abortion were significantly more likely to receive SNAP benefits than their peers who were able to obtain abortions, with elevated rates of WIC receipt remaining statistically significant for two years.

Summary

Limiting access to legal abortion in the United States will increase the incidence of serious adverse birth outcomes (including maternal and infant mortality), the number of children born into and living in poverty, and the number of families experiencing serious financial instability and hardship and will thwart the educational and economic achievements of women. Restrictive abortion access will also likely exacerbate existing income and racial gaps in child outcomes because those with the fewest resources will be least likely to afford the costs associated with traveling to seek abortions, whereas those with higher financial status or resources will be able to avert unintended births by traveling to other states to receive abortions. These inequities will be further exacerbated if the public safety net and social welfare programs and systems are not adequately resourced, strengthened, and reformed to address the increased demand.

It is clear that the United States will be enduring a complex set of legal and policy battles in executive branches, legislatures, and the courts for years to come. The policy decisions being made will not only be about abortion. Policymakers restricting or banning abortion care also need to make additional policy decisions related to health and socioeconomic welfare that are the direct and expected outcomes of their abortion policy decisions. Resources and programs related to primary health care and contraception need to be strengthened and expanded. In addition, already burdened and beleaguered social safety net systems related to

income security, housing, food, health care, and child welfare services also need to be strengthened and expanded. This will take economic resources, political acumen, and leadership.

In the meantime, researchers and funders need to quickly launch new research programs that will allow for a clear and objective understanding of the myriad effects of the new abortion policy landscape on individuals, families, communities, and social welfare systems, including effects across socioeconomic strata, geography, and racial/ethnic groups. The stakes are high for the health and social welfare of the US population.

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