

Declining U.S. Abortion Rates and Rising State-Level Costs

Posted on October 17, 2018

Abortion incidence in the United States cannot be summarized accurately through one statement that the national rate is either always declining or always rising. The answer depends on the years studied, the source, the states included, the place where care occurred, and whether telehealth medication abortion is counted. The original essay correctly recognizes the importance of comparing national patterns with state differences and identifies contraception, clinic availability, law, and cost as possible influences. It incorrectly attributes the historical decline to *Roe v. Wade*, a decision that expanded legal access in 1973 rather than beginning a decline, and it relies on data that predate the major legal change produced by *Dobbs v. Jackson Women's Health Organization* in 2022. Current research shows that reported abortion rates declined over much of the period before 2022 in continuously reporting CDC areas, while post-*Dobbs* care has shifted dramatically through travel, telehealth, shield-law provision, and concentration in states where abortion remains available. (*Dobbs v. Jackson Women's Health Organization*, 2022)

Research Question

The central question is: How have U.S. abortion incidence, location, and patient costs changed over time, and why can national trends differ from the experience of particular states? This question requires more than counting procedures. It requires attention to data coverage, legal environment, unintended pregnancy, contraception, provider supply, medication abortion, travel, insurance, gestational timing, and the indirect costs of obtaining care.

Abortion Number, Rate, and Ratio

Three measures are commonly used. The number is the total abortions recorded in a period. The abortion rate is usually the number per 1,000 women of reproductive age, historically defined in CDC reports as ages 15–44. The abortion ratio is the number per 1,000 live births. These measures can move differently. A population may record fewer abortions while the ratio rises if births decline more quickly. Researchers should identify the denominator instead of using “rate” for every count.

CDC and Guttmacher Data

The Centers for Disease Control and Prevention collects aggregate data voluntarily from state and local health agencies. Coverage is incomplete because not every jurisdiction reports every year, and

the details available differ. Guttmacher collects information directly from abortion-providing facilities and, in recent post-*Dobbs* work, incorporates monthly estimates and telehealth provision. The two systems answer related but not identical questions. CDC is valuable for consistent demographic and clinical detail across reporting areas; Guttmacher generally provides more complete national incidence estimates and more current information about provision patterns. (Centers for Disease Control and Prevention, 2024; Guttmacher Institute, 2026)

Why the Sources Produce Different Totals

A CDC total should not be presented as the complete national total when large states are absent. For 2022, CDC received data from 48 reporting areas, excluding California, Maryland, New Hampshire, and New Jersey. California alone represents a substantial population, so omission affects national interpretation. Guttmacher surveys providers and uses estimation methods intended to capture care more comprehensively. Neither source is flawless. Facilities can open, close, report late, or provide incomplete information, while telehealth crossing state lines creates additional classification challenges.

Historical Pattern After Legalization

After nationwide constitutional protection was recognized in 1973, reported abortion numbers and rates rose as legal services became more available and reporting improved. The measures reached their highest levels during the 1980s before beginning a long decline. The decline cannot logically be described as caused simply by *Roe*, because it began years after the decision and occurred within the legal-access framework that *Roe* created. Changes in contraception, pregnancy intentions, sexual behavior, demographics, economics, provider availability, and state policy all contributed.

CDC Trend Through 2022

CDC reported 613,383 abortions from 48 reporting areas in 2022. Among the 47 areas that reported continuously from 2013 through 2022, the number declined 5 percent and the rate declined 10 percent over the decade. From 2021 to 2022, the number decreased 2 percent and the rate decreased 3 percent. These findings support the original essay's observation of a historical decline, but only for the continuously reporting areas and period studied. They should not be generalized automatically to every state or to later post-*Dobbs* provision.

Timing and Method in 2022

Most reported abortions occurred early in pregnancy. CDC found that 92.8 percent were performed at or before 13 weeks, and 78.6 percent at or before nine weeks. Early medication abortion accounted

for 53.3 percent of all reported abortions and 70.2 percent of those eligible under the report's early-medication definition. These figures contradict the common image that abortion care usually occurs late. Later care is uncommon and often connected with delayed recognition, fetal or maternal medical circumstances, provider barriers, travel, and other complex factors.

The *Dobbs* Decision

On June 24, 2022, the Supreme Court held in *Dobbs v. Jackson Women's Health Organization* that the U.S. Constitution does not confer a right to abortion and returned regulatory authority largely to elected governments. The decision overruled *Roe v. Wade* and *Planned Parenthood v. Casey*. It did not create one national rule. Instead, states adopted or enforced widely different bans, gestational limits, protections, funding policies, and provider requirements. This legal fragmentation changed where and how care is obtained.

Why 2022 Is a Difficult Transition Year

Annual 2022 data combine months before and after *Dobbs*. Trigger bans and court orders took effect at different times, while providers and patients adjusted. A national annual figure can therefore hide a sharp decline within one state and an increase in neighboring states receiving travelers. Researchers should examine monthly data, state of residence, state of provision, telehealth, and legal timing rather than treating 2022 as one stable policy environment.

Post-*Dobbs* Redistribution of Care

Abortion provision did not simply disappear when a state banned in-state services. Some people traveled, some received medication through telehealth from providers operating under shield-law protections, some continued pregnancies, and others may have self-managed outside systems captured by conventional data. States protecting access experienced increased demand. Thus, a decline in abortions performed inside a ban state does not equal an identical decline among residents of that state.

Travel in 2025

Guttmacher estimated that more than 140,000 people traveled outside their state of residence for abortion care in 2025. Approximately 98,000 traveled from states enforcing total, six-week, or twelve-week bans. These figures show that geographic access became a major component of incidence. A receiving state can show an increase even when pregnancy patterns among its own residents remain stable because it is serving patients from other states.

Telehealth in 2025

Telehealth medication abortion became another major route. Guttmacher estimated that 142,000 people in states with total, six-week, or twelve-week bans accessed abortion through telehealth from shield-law providers during 2025. Telehealth can reduce travel but requires eligibility, reliable communication, a mailing address, privacy, timely delivery, and access to follow-up or emergency care if needed. Legal disputes remain, and state counts differ according to whether they measure provider location, patient residence, or reported in-state procedures.

Texas as a Case Study

Texas illustrates the shift from travel toward telehealth. Guttmacher estimated that more than 42,000 Texas residents accessed abortion through shield-law telehealth providers in 2025, compared with 12,400 in 2023. The estimated number traveling out of state fell from nearly 34,000 to approximately 23,000. The decline in travel should not be interpreted as disappearance of demand. It partly reflects substitution of one access route for another. (Guttmacher Institute, 2026)

Florida as a Case Study

Florida's six-week ban changed travel patterns in the Southeast. Guttmacher estimated that 8,200 Florida residents traveled out of state in 2025, compared with 2,800 in 2023. Florida had previously served as a regional destination for patients from neighboring states. Restriction in a large provider state can therefore create pressure across several states, increasing appointment delays and travel distances beyond the state imposing the law.

Direct Medical Cost

The price of an abortion depends on method, gestational age, facility, anesthesia, testing, insurance, and local market. Medication abortion and early procedural care are generally less expensive than later procedures, but price lists do not capture the total burden. Insurance coverage varies, and public funding is restricted under federal and state policy except in defined circumstances. People may need to pay before receiving care, creating delays while funds are gathered.

Travel and Indirect Costs

Travel can add transportation, fuel, airfare, hotel, food, childcare, lost wages, time away from school, and costs for a companion. A required waiting period or multiple visit rule can multiply these expenses. A patient may travel hundreds of miles while managing nausea, pain, disability, or privacy

concerns. Indirect costs can exceed the procedure price and affect lower-income patients most severely.

Delay and Gestational Age

Financial and geographic barriers can delay care. Delay can narrow the choice of method, increase price, and require travel to a smaller number of providers. A later procedure is not evidence that the patient was indecisive. It may reflect late pregnancy recognition, changing medical circumstances, delayed diagnosis, clinic capacity, legal requirements, funding, travel, or an abusive partner. Research should examine the process that produced timing rather than judge the patient from gestational age alone.

Insurance Coverage

Employer insurance, private plans, Medicaid, and state programs differ in coverage. Some patients avoid using insurance because they fear disclosure through billing or benefit statements. Others are uninsured or receive care from a provider outside the network. Coverage policy affects both direct price and how quickly a patient can schedule. Analysis of “rising costs” should distinguish provider charges from the amount patients actually pay.

Abortion Funds and Practical Support

Abortion funds and practical-support organizations help with medical expenses, travel, lodging, childcare, and navigation. Their work demonstrates unmet need but cannot substitute for a stable healthcare system. Funds have limited resources and face changing legal risk. Researchers studying access should include assistance networks because patient behavior cannot be understood only through clinics and statutes.

Contraception and Unintended Pregnancy

Improved contraceptive use contributed to historical reductions in unintended pregnancy and abortion. Long-acting reversible contraceptives became more widely used, and effective methods can reduce pregnancy risk when desired and accessible. Contraception does not eliminate every abortion because methods fail, people cannot always obtain or use them, reproductive intentions change, pregnancies develop medical complications, and sexual coercion occurs. Abortion and contraception are related but not interchangeable services.

Economic Conditions

Economic insecurity can influence pregnancy intentions and the ability to continue a pregnancy. Housing, employment, childcare, healthcare, and existing family responsibilities matter. The same economic conditions can also make abortion harder to afford. Researchers should therefore avoid assuming that recession or poverty moves incidence in one predictable direction. Policy effects depend on access to services and social support.

Provider Availability

Clinic closures, staffing, legal compliance, security threats, and hospital policy affect provider supply. A state may technically permit care while offering few facilities. Provider concentration creates long travel within a large state and long waits. Telehealth expands access for eligible medication abortion but cannot replace every procedural service, ultrasound, emergency evaluation, or care later in pregnancy.

Self-Managed Abortion

Self-managed abortion can include the use of abortion medications outside a traditional clinic setting. It should not be equated automatically with unsafe methods. Evidence-based medication regimens can be highly effective, while counterfeit products, incorrect instructions, delayed emergency care, and legal fear create risks. Conventional surveillance may not capture every self-managed event, adding uncertainty to state incidence estimates.

Legal Risk and Data Privacy

Post-*Dobbs* research must consider digital privacy, records, messaging, payment, and location data. Patients and providers may fear investigation across state lines. Researchers should minimize identifying data, obtain appropriate consent, secure records, and explain legal limitations. Data collection intended to improve health should not expose participants to avoidable legal or social harm.

How State Trends Should Be Interpreted

A state's in-state procedure count can rise because residents have more abortions, because patients arrive from elsewhere, or because reporting improves. It can fall because pregnancy incidence declines, care moves to another state, telehealth is counted elsewhere, providers close, or events go unreported. State comparisons need at least two perspectives: occurrence, where care was provided,

and residence, where the patient lived. Mixing them produces misleading conclusions.

Research Design

A strong study would combine CDC surveillance, Guttmacher provider estimates, state vital statistics, facility information, telehealth measures, travel data, policy timelines, insurance coverage, and cost surveys. A panel design could follow monthly state changes before and after major laws. Researchers should predefine outcomes and distinguish association from causation. Neighboring states can serve as comparisons, but they may be affected by the same regional shifts.

Qualitative Research

Counts cannot show how patients experienced delays, travel, stigma, childcare, work loss, medical risk, or telehealth. Interviews can reveal mechanisms behind quantitative patterns. Recruitment should include adolescents, rural patients, disabled people, immigrants, people of color, low-income patients, and those continuing pregnancies after being unable to obtain care. Ethical design must protect confidentiality and avoid treating participants as symbols in a political debate.

Challenges in Obtaining Data

The original essay anticipates difficulty obtaining state-level data, and that challenge has increased. State reporting requirements vary, some agencies publish slowly, several jurisdictions do not report to CDC, and telehealth crosses borders. Legal definitions and gestational limits change through legislation and litigation. Researchers must document the date on which each law was actually enforceable, not only when it was enacted. Revisions to estimates should be expected as providers report additional information.

Distinguishing Incidence From Access

A lower in-state count can be presented politically as fewer abortions, but it may represent displaced care rather than fewer abortions among residents. Conversely, a national increase does not mean access improved equally; the burden may have shifted toward travel and private support. Incidence describes events. Access describes the practical ability to obtain wanted care safely and promptly. Both need measurement.

Patient-Centered Interpretation

Statistics represent people making decisions under varied circumstances. Research should avoid language that assumes irresponsibility, regret, or one universal motive. Patients may seek abortion because of financial constraints, health, family needs, fetal conditions, coercion, timing, or personal values. Public policy analysis can examine consequences while respecting moral disagreement and patient dignity.

Conclusion

The historical U.S. abortion rate declined substantially after its peak in the 1980s, and CDC data for continuously reporting areas show further decline from 2013 through 2022. That finding does not establish a universal continuing decline after *Dobbs*. The 2022 decision fragmented access by state, and subsequent data show major shifts toward interstate travel and shield-law telehealth. In 2025, more than 140,000 people traveled out of state, while large numbers in ban states obtained telehealth care. State procedure counts can therefore move in opposite directions without reflecting equivalent changes in residents' pregnancy decisions. Future research must combine national and state data, distinguish residence from occurrence, and include the full costs of travel, delay, lost work, childcare, insurance, and legal uncertainty.

References

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