

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

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Current Abortion Trends

The title “Declining U.S. Abortion Rates and Rising State-Level Costs” reflects an earlier period when abortion rates generally declined over many years, but current data show a more complicated pattern. U.S. abortion incidence fell substantially from its historical peak in the early 1990s, yet the post-*Dobbs* period has not continued as a straightforward national decline. Guttmacher Institute estimates indicate about 1.126 million clinician-provided abortions in 2025, essentially unchanged from 1.124 million in 2024 and the highest annual number since 2009, although still well below the 1990 peak of more than 1.6 million (Maddow-Zimet & Forouzan, 2026a). Society of Family Planning’s #WeCount project similarly recorded approximately 1.13 million abortions in the formal U.S. healthcare system in 2025 and found that telehealth represented a rapidly growing share of care (Society of Family Planning, 2026). These national totals conceal dramatic differences among states. Since the Supreme Court’s 2022 decision in *Dobbs v. Jackson Women’s Health Organization* returned abortion regulation to elected governments, some states have banned or sharply restricted abortion while others have expanded access. The result is not simply fewer abortions; it is a redistribution of where and how abortion occurs, accompanied by substantial travel, telehealth use, delays, and patient costs.

Abortion statistics should be interpreted carefully because the main data systems do not count exactly the same events. CDC surveillance depends on reports voluntarily submitted by states and reporting areas and does not provide complete national coverage in every year. Guttmacher’s Monthly Abortion Provision Study estimates clinician-provided abortions using data from providers and statistical modeling, including procedural and medication abortions delivered by facilities and telehealth. Society of Family Planning’s #WeCount project collects monthly counts from abortion providers and has become particularly useful for tracking changes after *Dobbs*. Differences in methodology explain why totals from different organizations may not match exactly.

Post-*Dobbs* telehealth also complicates the geographic meaning of an abortion count. A clinician in one state may prescribe medication to a patient living in another state under a shield-law framework, meaning the provider location, patient residence, and legal environment can differ. Guttmacher’s 2026 estimates for the first time incorporated telehealth provision to residents of states with total bans into its national total, showing how changes in measurement can alter apparent trends

(Maddow-Zimet & Forouzan, 2026a). Researchers therefore need to specify whether a statistic refers to abortions occurring within a state, abortions obtained by residents of that state, abortions provided by clinicians, or all known abortions including self-managed care outside the formal system.

Post-Dobbs Geography

The most visible post-2022 change has been the movement of patients and services across state boundaries. In 2025, Guttmacher estimated that approximately 142,000 people traveled to another state for abortion care. Although this was lower than the roughly 154,000 who traveled in 2024 and the peak of about 170,000 in 2023, interstate travel remained far above pre-*Dobbs* levels (Maddow-Zimet & Forouzan, 2026a). Two-thirds of people traveling in 2025 came from states with total, six-week, or twelve-week bans (Maddow-Zimet & Forouzan, 2026b). States such as Illinois, New Mexico, Colorado, Kansas, and others have therefore treated substantial numbers of patients from outside their borders.

The reduction in travel between 2024 and 2025 does not necessarily mean that access became easier. One major reason is the rapid expansion of telehealth medication abortion provided under shield laws. Guttmacher estimated that 91,000 abortions were provided by telehealth to residents of total-ban states in 2025, up from 74,000 in 2024 (Maddow-Zimet & Forouzan, 2026a). #WeCount reported that more than 300,000 abortions nationwide were provided via telehealth in 2025 and that telehealth reached 29 percent of all abortions by December (Society of Family Planning, 2026). The route to care has therefore shifted: some patients who might previously have traveled now receive medication remotely, while others still must travel because of gestational age, clinical circumstances, personal preference, or lack of telehealth access.

Cost of Travel

State restrictions can increase the economic burden even when a patient ultimately receives care. The direct clinical price of abortion is only one component. Travel may require gasoline, airfare or bus fare, lodging, meals, childcare, lost wages, and repeated appointments. A 2025 study of people seeking abortion from states that implemented total bans found that average travel time increased from 2.8 hours before bans to 11.3 hours after bans, overnight stays rose from 5 percent to 58 percent, and mean travel costs increased from \$179 to \$372. Participants also obtained care later in pregnancy on average, which can increase procedure cost and reduce the number of available providers (Upadhyay et al., 2025).

Financial burden is especially important because many abortion patients have limited disposable income. A 2024 *JAMA Network Open* study estimated that 42 percent of abortion patients in its pre-*Dobbs* sample incurred abortion-related catastrophic health expenditures, defined relative to household ability to pay. Among people traveling from out of state, 65 percent met that threshold

compared with 32 percent of those obtaining care within their state (Simmons-Duffin et al., 2024). More recent practical-support data show that costs have increased further after *Dobbs*. In a 2026 analysis of abortion-fund clients, average support provided to post-*Dobbs* patients rose to \$1,732 compared with \$899 before the decision, while median wait time increased from six to nine days (Velarde et al., 2026). These findings demonstrate why state policy can shift costs to patients, abortion funds, providers, employers, families, and receiving states even when national abortion totals remain stable.

Texas demonstrates how telehealth can partially substitute for interstate travel. Guttmacher estimated that more than 42,000 Texans obtained abortions through shield-law telehealth provision in 2025, up sharply from about 12,400 in 2023. During the same period, the number of Texans traveling out of state fell from nearly 34,000 to approximately 23,000 (Maddow-Zimet & Forouzan, 2026b). Travel remained substantial because telehealth does not meet every clinical need, and patients in central, southern, and eastern Texas may live hundreds of miles from the nearest in-person provider.

Florida followed a different pattern after implementation of a six-week ban in 2024. Guttmacher reported that out-of-state travel by Florida residents nearly tripled, from about 2,800 people in 2023 to approximately 8,200 in 2025 (Maddow-Zimet & Forouzan, 2026b). These two states show why national statistics can obscure local consequences. A restrictive law may reduce abortions performed within the state while increasing travel, telehealth provision from other states, financial support needs, or later care elsewhere. Whether a state's own abortion count falls therefore does not reveal how many residents ultimately obtain abortions.

Later Care and Access

Delays matter because the number of providers offering abortion generally decreases as pregnancy advances and quoted prices tend to rise. A 2026 study of later abortion care found substantial increases in self-pay prices across later gestational ranges and documented limited provider availability even in states where later abortion remained legally permitted (Jones et al., 2026). Legal restrictions can therefore affect costs indirectly by delaying care while patients locate a provider, secure funding, arrange travel, obtain time off work, or navigate changing state rules.

A qualitative 2026 study of patients traveling to Illinois after *Dobbs* found that participants often spent weeks identifying a clinic, understanding laws, obtaining financial support, and organizing travel. Many relied on abortion funds or friends and family, and participants commonly lost work time. The mean interval between deciding to seek abortion and reaching the appointment was approximately one month in the study sample (White et al., 2026). These delays matter clinically and economically without implying that every traveler has the same experience. The burden varies by income, location, gestational age, childcare responsibility, employment flexibility, immigration status, and availability of social support.

Researchers have also begun estimating the wider economic effects of state abortion bans. A 2026 modeling study examining fourteen states with total bans estimated \$339.6 million in personal and external costs in the first year after bans were enacted. The model attributed approximately \$104.7 million to interstate travel for in-clinic abortion and larger costs to pregnancies carried to term among people unable to obtain desired in-clinic abortions; telemedicine reduced some projected costs (Koenig et al., 2026). These are modeled estimates rather than direct accounting data, so the figures depend on assumptions about behavior, healthcare utilization, travel, and pregnancy outcomes.

This distinction is important in a politically contested area. Supporters and opponents of abortion may evaluate moral and social consequences differently, but economic analysis should still state clearly what is being measured. Patient travel expenses, state Medicaid expenditures, maternal healthcare costs, charitable support, lost wages, and provider capacity are different categories and should not be combined without explanation. The related Academic Master discussion of [abortion](#) addresses ethical arguments, but incidence and cost analysis requires separate attention to measurement and policy effects.

Conclusion

U.S. abortion trends can no longer be described accurately as a continuous national decline. Abortion rates and totals did fall over much of the period after the early 1990s, but current post-*Dobbs* data show national clinician-provided abortion numbers remaining high and relatively stable between 2024 and 2025. The largest recent changes involve geography and method: patients are traveling across state lines in historically large numbers, telehealth provision has expanded rapidly, and state restrictions have shifted costs rather than simply eliminating demand. Research consistently finds that interstate travel increases transportation, lodging, childcare, lost-wage, and clinical expenses and can delay care. At the same time, shield-law telehealth has reduced the need to travel for some patients, particularly in total-ban states. State-level abortion counts therefore should not be interpreted as complete measures of resident behavior or access. A careful analysis must distinguish incidence, place of care, state of residence, telehealth provision, travel, and economic burden. The post-2022 landscape is best understood as a fragmented national system in which legal geography increasingly determines the route, timing, and cost of abortion care.

References

Koenig, L., et al. (2026). Societal costs of total abortion bans in 14 U.S. states after *Dobbs*. *American Journal of Public Health*.

Maddow-Zimet, I., & Forouzan, K. (2026a). *Full-Year Estimates Show Overall Stability in Abortion Incidence, Decreased Travel and Increased Telehealth Provision*. Guttmacher Institute.

Maddow-Zimet, I., & Forouzan, K. (2026b). *Patterns of Travel for Abortion Care Continued to Shift in*

2025. Guttmacher Institute.

Society of Family Planning. (2026). *#WeCount Report: April 2022 Through December 2025*.
<https://doi.org/10.46621/793758dfrane>

Simmons-Duffin, S., et al. (2024). Catastrophic health expenditures for in-state and out-of-state abortion care. *JAMA Network Open*.

Upadhyay, U. D., et al. (2025). Changes in abortion access, travel, and costs since the implementation of state abortion bans, 2022–2024. *American Journal of Public Health*.

Velarde, M., et al. (2026). Changes in travel patterns, funding, and wait times for abortion care following the Dobbs decision among recipients of practical support, 2019–2023.

White, K., et al. (2026). Seeking abortion care across state lines after the Dobbs decision. *JAMA Network Open*.

Jones, R. K., et al. (2026). Later abortion care availability, quoted self-pay prices, and state Medicaid acceptance. *JAMA Network Open*.