

REPRODUCTIVE RIGHTS & HEALTH

Access to Abortion During the COVID-19 Pandemic and Recession

Abortion is time-sensitive, essential health care¹ that one in four women will need in her lifetime.² The right to abortion is also enshrined in the U.S. Constitution as a fundamental right that helps ensure equal participation in the social and economic life of the country.³ Without meaningful access to abortion, many women—especially women of color and those struggling to make ends meet—are left without the care they need, threatening their health, lives, and futures.⁴ Protecting the right to abortion and expanding access to abortion care is therefore critical – particularly during times of crisis and uncertainty.

Even before the pandemic, many people already faced tremendous barriers to abortion. In 2019 alone, 58 new abortion restrictions were enacted in 17 states.⁵ These restrictions are profoundly unequal in effect, disproportionately impacting people who have low incomes, people of color,⁶ young people,⁷ LGBTQ people,⁸ and people living in rural areas.⁹ But COVID-19 has exacerbated existing inequities in and barriers to abortion access, and some politicians have attempted to exploit the pandemic to close abortion clinics and prevent pregnant people from making decisions about their bodies and futures. Any state or federal

measures to alleviate the financial, medical, and social impacts of the pandemic must include increased access to abortion care.

This issue brief provides an overview of ways that COVID-19 and the accompanying economic instability impact abortion care access. This brief also offers solutions for state and federal policymakers to protect and expand access to abortion care during the pandemic and recession.

COVID-19 IS EXACERBATING THE IMPACT OF EXISTING BARRIERS TO ABORTION CARE

Protecting people's access to abortion, and their ability to make decisions for their own and their families' well-being, is more important than ever during this unprecedented pandemic, when so many face enormous uncertainty. But the fall-out of the coronavirus crisis – including clinic closures, travel and public transportation restrictions, limited childcare, job insecurity, and economic stress – has exacerbated barriers to abortion. What's more, anti-abortion politicians have created new barriers, exploiting the public health crisis to force abortion providers to close their doors to patients.

The pandemic-induced recession has magnified people's need for abortion access

While it is impossible to know the full extent of the impact COVID-19 and the recession will have on reproductive health decisions, data so far suggest that more women are opting to delay pregnancies, consistent with predictions from similar economic recessions. In a May 2020 survey of reproductive-

age women, more than one-third (34%) wanted to get pregnant later or wanted fewer children because of the COVID-19 pandemic, a desire especially prevalent among Black (44%), Latina (48%), and queer women (46%).¹⁰ The pandemic and the recession are likely to continue to shift people's reproductive goals as economic impacts continue to unfold.¹¹

The immediate economic impacts of COVID-19 will likely be prolonged in the recession that is projected to follow. Economic security is tied to the ability to make reproductive decisions. A Gallup poll from 2013 showed that, when asked why couples are not having more children, 65% of Americans mention not having enough money or the cost of raising a child, and an additional 11% say the state of the economy or the paucity of jobs.¹² In a study asking women their reasons for wanting an abortion, among the primary reasons were "feeling not financially prepared" (40%), "not the right time" (36%), and "having a baby now would interfere with future opportunities" (20%).¹³

Since the crisis began, women have been hit hardest by job losses, and have seen an entire decade of job gains erased.¹⁴ Black, Latinx, and Native and Indigenous communities have been hit particularly hard by job losses: In June, 14% of Black workers ages 25 to 54,¹⁵ 12% of Latinx workers ages 25 to 54,¹⁶ and 12% of Native and Indigenous workers ages 25 to 54 were unemployed,¹⁷ compared to 9% of white workers ages 25 to 54.¹⁸ Women, particularly Black women and Latinas, are overrepresented in the front line workforce, and are risking their lives to ensure our essential functions continue operating.¹⁹ Additionally, many women are struggling to keep working as the public health and economic crises have severely strained our country's child care system,²⁰ leaving many with no good options as they juggle work, lack of child care, and unprecedented crises all at once.

The recession, in combination with COVID-19, may lead to an increased demand for abortion as more people decide to avoid pregnancy or have fewer children, a trend typical to economic downturns and high-mortality events like pandemics.²¹ In the midst of 2008–09 recession, for example, nearly half of women in a national survey reported that they wanted to avoid or delay childbearing because of the economy, and about two-thirds said they could not afford to have a baby.²²

BUT THE PANDEMIC AND ACCOMPANYING RECESSION HAVE HEIGHTENED BARRIERS TO ABORTION ACCESS

Despite increased need, abortion care has become harder to access for many. In addition to the pre-existing barriers to care, such as medically unnecessary waiting periods and lack of insurance coverage for abortion, new obstacles have made abortion care harder to obtain.

In a national survey of women of reproductive age taken from March to May 2020, one in three (33%) experienced a cancellation or delay of contraceptive or other reproductive health care because of the pandemic—a rate especially high among marginalized communities of women, including Black (38%), Latina (45%), and queer (46%) women.²³ Many women also reported feeling increased worry about their ability to pay for and access reproductive health services, with Latinas (37%) and queer women (37%) being more likely than White (24%) and straight (26%) women to report increased worry. And existing prohibitions on insurance coverage of abortion can magnify that worry;²⁴ at a time when many workers are facing reduced wages or being laid off, coming up with funds to cover out of pocket costs for abortion due to lack of insurance coverage is increasingly difficult or impossible.

Not only do these challenges create delays that can push patients to an abortion later than they would like, but procedures can become more complex and expensive as time goes on. Moreover, 43 states ban abortion at some point in pregnancy,²⁵ so for many pregnant people, delays in abortion care ultimately transform into denials of care. Before COVID, nearly one-fifth of U.S. abortion patients traveled more than 50 miles one-way to receive abortion care.²⁶ The burdens that accompany extended travel include taking time off work, lost wages, and the added costs and challenges of securing childcare, lodging, and transportation. All these challenges are made worse by COVID-19 due to unprecedented financial constraints, school and day-care closures, and social distancing guidance. And during an extremely contagious virus whose incidence is spiking across the country,²⁷ any travel comes with serious health risks.

And although telemedicine has helped people obtain health care during the pandemic, that option is not always available for those seeking abortion care because politicians have imposed medically unnecessary restrictions on medication abortion. Nineteen states prohibit the use of

telemedicine abortion and require the prescribing doctor to meet with the patient in person when the patient takes the medication.²⁸ Restrictions on telemedicine along with other medically unnecessary laws, like in-person counseling or ultrasound, make it harder to access abortion care during a pandemic, when families are already losing jobs and income, are worried about public transport or need to stay home with children who can no longer go to school or daycare. And it is forcing people to risk their safety which is especially dangerous for those – like Black and Latinx people – who are more likely to contract and die from coronavirus.²⁹ Many are having to choose between getting the care they need and risking exposure.

Even in states that do not have laws prohibiting the use of telemedicine for abortion, for much of the pandemic federal restrictions issued by the Food and Drug Administration (FDA) still required patients to go in-person to a hospital, clinic, or medical office just to pick up the medication and sign a form. These restrictions conflict with the best judgment of medical professionals, putting patients and staff at unnecessary risk of spreading the virus. In April 2021, the FDA temporarily removed the in-person restriction for the remainder of the pandemic.³⁰

Providers are facing their own challenges in providing essential healthcare, like abortion. Due to stigma and harassment of abortion providers, many clinics rely on providers that travel from out of state.³¹ These providers are among the most passionate advocates for ensuring patients have access to abortion, but may no longer be able to travel to underserved communities due to health and safety restrictions, leading to a shortage of abortion providers in those areas, which, in many cases, have already experienced a historic decrease in access to abortion providers in the last 25 years.³²

In addition, anti-abortion protestors appear to have increased their targeting of reproductive health clinics and patients. Clinics have reported that since the pandemic, harassment has increased, and protestor tactics have expanded to include COVID-specific tactics like coughing on patients.³³ Clinics have typically relied on volunteer escorts to protect patients from emotional harm and harassment as they walk into the clinic. But in March 2020, during the first wave of COVID-closures, many clinics sent patient escorts home, following local guidelines—yet the protestors remained.

With COVID rates increasing across the country during the

winter and without widespread access to a vaccine yet, patients, providers, and clinic staff continue to experience restricted access to abortion care, prolonged delays and increased costs, not to mention the threat of unwavering clinic protestors.

And, in addition to these challenges, politicians have capitalized on the pandemic to push for anti-abortion restrictions.

ABORTION OPPONENTS EXPLOITED A PUBLIC HEALTH CRISIS TO PUSH THEIR IDEOLOGICAL AGENDA.

At the start of the pandemic, anti-abortion politicians quickly sought to use the health crisis as an excuse to force abortion providers to close their doors. This left people who need time-sensitive care even farther away from the services they need or put that care entirely out of reach.³⁴ Many of these COVID-related abortion bans purported to conserve staff personal protective equipment (PPE), but courts have found that postponing abortion services do not affect facilities' continuing access to PPE.³⁵

Although none of these bans are in effect at the time of this brief's publication, a review of such bans illustrates the scope of anti-abortion policymaking and the lasting impact that even temporary abortion restrictions can have for people who need abortion care. Even temporary bans can be immensely disruptive to the availability of abortion services.

Most of the pandemic-related anti-abortion efforts first took place in Southern and Midwestern states, where abortion access is already disproportionately limited: Governor Greg Abbott of Texas, for example, who said he wants to make Texas the most anti-abortion state,³⁶ issued an executive order categorizing abortion as a "non-essential" service that should be delayed, and even threatened to prosecute clinics that continue to provide abortions during the pandemic.³⁷

Officials in Alabama, Louisiana, Ohio, Oklahoma, and Tennessee similarly exploited this crisis to effectively ban abortion in their states.

Abortion providers know that their patients cannot wait until this crisis is over to get the care they need, and they have successfully challenged these state actions in court. But during the time that these bans made their way through the courts, clinics were forced to react to restrictions that changed daily, and some had to cancel hundreds

of appointments.³⁸ So far, 11 states have attempted to prohibit all or some abortions, except in cases of a medical emergency that threatens a patient's life or health. In 6 states this ban only applied to procedural (also known as surgical) abortion.³⁹ Courts have so far **blocked** COVID-related abortion bans in Ohio, Oklahoma, Tennessee, and Alabama:⁴⁰

- **Ohio:** On March 20, 2020, the Ohio Attorney General's office ordered clinics that provide abortions to stop "non-essential" and "elective" abortions, but a federal court extended a preliminary injunction on the order. On May 1, 2020, the Ohio Department of Health Stay Safe Ohio Order allowed "non-essential" surgeries and procedures to resume.⁴¹
- **Oklahoma:** On March 24, 2020, Governor Stitt issued an order suspending "any type of abortion services . . . which are not a medical emergency . . . or otherwise necessary to prevent serious health risks to" the pregnant person. Then, on April 27, 2020 the Tenth Circuit Court of Appeals upheld a preliminary injunction to stop the order as applied to abortion providers.⁴²
- **Tennessee:** Governor Lee signed an executive order banning certain medical services, including abortion, on March 23, 2020.⁴³ On April 17, 2020, a federal district court blocked the order, which was then upheld by the Sixth Circuit of Appeals on April 20, 2020.⁴⁴
- **Alabama:** On April 23, 2020, the Eleventh Circuit Court of Appeals upheld a preliminary injunction blocking a COVID-19 health order issued by the Alabama Department of Public Health postponing abortion procedures unless they were "required to protect the life or health of the mother[.]"⁴⁵

Some attempted bans failed to become law, and others are no longer in effect, due to settlements outside of court, the expiration of state's executive orders, or the governor's subsequent action:

- **Texas:** Since March, Texas providers have been in a complicated legal battle to ensure the continuation of abortion care throughout the state. On March 22, 2020, Governor Greg Abbott issued an executive order postponing all surgeries/procedures, unless they were "medically necessary," until April 21, 2020. During this time, many abortion procedures were suspended. Abortion providers challenged the executive order in

district court, and the challenge reached the Fifth Circuit Court of Appeals. On April 22, 2020, the Attorney General submitted a filing to the Fifth Circuit stating that abortion services could resume under a revised April 17th executive order, which allowed abortion procedures as long as they "did not deplete" available PPE.⁴⁶

- **Louisiana:** On March 21, 2020, the Louisiana Department of Health issued a directive postponing procedures unless they were to "treat an emergency medical condition" or to "avoid further harms from [an] underlying condition or disease."⁴⁷ Attorney General Jeff Landry used this directive to target abortion clinics in the state, threatening to shut down clinics by claiming that they violated the directive.⁴⁸ On April 13, 2020, the clinics filed a legal challenge in federal court asking for a temporary restraining order against Attorney General Landry's actions, and the clinics settled with the state on May 1, 2020, allowing abortions to go forward.⁴⁹
- **Iowa:** On March 26, 2020, Governor Kim Reynolds announced that procedural abortions were included in the non-essential surgeries prohibited by the state's March 26 ban.⁵⁰ But on April 1, 2020 the ACLU of Iowa and Iowa state officials reached an agreement, allowing "essential" abortion procedures to move forward.⁵¹
- **Alaska:** On April 8, 2020, the Alaska Department of Health and Social Services (ADH), the governor, and the chief medical officer issued a mandate specifying that providers were to postpone "surgical abortion."⁵² But as of April 28, 2020, the ACLU of Alaska reported that procedural abortions were still available in the state, since the original mandate had been suspended by a new policy.⁵³
- **West Virginia:** On April 29, 2020, Governor Jim Justice lifted an executive order which suspended all elective procedures, including abortion.⁵⁴
- **Kentucky:** The Kentucky State legislature passed SB 9, which would have given the attorney general power to seek injunctive relief against and impose penalties against abortion providers during the public health emergency. However, Governor Andrew Beshear vetoed this bill on April 24, 2020.⁵⁵
- **Arkansas:** On May 7, 2020, a district court in Arkansas denied a temporary restraining order that would have stopped the Arkansas Department of Health from

requiring women seeking surgical abortion to obtain a negative COVID-19 test 48 hours before the procedure.⁵⁶ On May 25, 2020, the Department of Health rescinded its negative COVID test requirement for “elective” procedures including abortion.⁵⁷

- **Mississippi:** On May 11, 2020, Governor Tate Reeve’s executive order requiring the postponement of “elective surgeries,” which included abortion, expired.⁵⁸

While none of these bans are in effect as of the time of this brief’s publication, the ongoing litigation created chaos for patients who needed immediate abortion care.⁵⁹ Even temporary closures of clinics result in many pregnant people being denied abortion care. For example, when clinics were forced to close in Texas due to Governor Abbott’s executive order, the average one-way driving distance to an abortion clinic increased from 12 miles to 243 miles.⁶⁰ This distance can quickly push abortion out of reach for many. Patients in other states face similar challenges.

PUTTING ABORTION ACCESS AT THE HEART OF RECOVERY: POLICY RECOMMENDATIONS

Ensuring that reproductive health care, including abortion, is accessible and affordable must be a core part of the response to COVID-19 and the economic crisis, and to any effort to build back better. The new federal administration and state governments must take immediate action to protect access to abortion care and ensure that people have the tools to make decisions for themselves and their families and ensure that any responses to COVID-19 include a focus on accessing reproductive health care. Federal and state governments also should focus on expanding access to abortion care services, eliminating existing barriers.

Federal Policy Recommendations

Review and modify or withdraw FDA restrictions on medication abortion.

The FDA has imposed harmful restrictions on mifepristone, part of a standard medication abortion regimen, for more than two decades.⁶¹ These types of restrictions, known as Risk Evaluation and Mitigation Strategies (REMS), are typically used to regulate drugs that carry serious risks.⁶² But medication abortion is exceedingly safe and effective, as demonstrated by substantial research since mifepristone was approved twenty years ago.⁶³ While the Biden Administration lifted the in-person dispensing restriction for

the duration of the crisis, beyond this pandemic, the FDA must review the full set of REMS imposed on mifepristone to determine whether the REMS remains necessary, or whether they should be modified or removed to best reflect real-world use and the accumulation of scientific evidence.

Rescind the “Domestic Gag Rule” and expand Title X

For 50 years, the Title X family planning program has served as the only dedicated source of federal funding for family planning.⁶⁴ In 2019, however, the Department of Health and Human Services (HHS) under President Trump finalized a rule commonly known as the “Domestic Gag Rule,” which devastated the evidence-based and historically bipartisan Title X family planning program, by prohibiting Title X-funded health centers from referring patients for abortion care or providing that care with non-Title X funds,⁶⁵ at just the time that more and more people are seeking to delay or prevent pregnancy. Moreover, for 60 per cent of Title X clients, a Title X health center is the only provider they see each year, and Title X-funded clinics can be an integral part of coronavirus vaccination efforts to reach those individuals.⁶⁶ While HHS under the Biden Administration has proposed a new rule that would reverse the Domestic Gag Rule and improve the Title X program⁶⁷, its impact will not be felt until the rule is finalized. The Biden administration should finalize the rule expeditiously to ensure that the Title X program can provide care to those who need it, as intended by the law. It previously served nearly 4 million people, the vast majority of whom have incomes at or below the federal poverty level,⁶⁸ but its need has grown as more people face unemployment and financial difficulties during the pandemic and recession.

Eliminate budget riders that impede access to abortion.

Congress must remove existing appropriations riders, including the Hyde-Weldon Amendment, that prevent individuals who receive health care coverage through federal programs from obtaining coverage for abortion care or otherwise impede abortion access. Congress must pass the EACH Act, which would require coverage for abortion care through public health insurance programs, including Medicaid, Medicare, and the Children’s Health Insurance Program, as well as insurance plans for federal employees.

Pass the Women’s Health Protection Act.

Congress must pass, and the president must sign, the Women’s Health Protection Act (WHPA). This federal legislation would protect abortion access by establishing

a statutory right for a provider to provide abortion services, and a corresponding right for their patients to obtain abortion services, free from bans and restrictions that single out abortion and impede access to care.⁶⁹

Ensure abortion providers receive small business assistance and loans that other small businesses receive.

Abortion providers, including independent providers, are struggling to keep their doors open during the economic downturn caused by the COVID-19 pandemic. While 58% of people seeking abortions get them in independent clinics, these clinics historically do not have access to federal supports because of the politicization of abortion care.⁷⁰ To help prevent further clinic shutdowns, Congress and the Administration needs to ensure that all abortion providers, including independent abortion providers, not only qualify for – but also receive – the small business relief they need by making such allocations widely available.

State Policy Recommendations

Broaden access to telehealth for medication abortion.

State policymakers should require insurance coverage of telehealth, without cost-sharing, and eliminate bans on the use of telehealth for medication abortion and any other medically unnecessary restrictions on the use of telehealth for abortion.⁷¹ In order to meet the increased need for abortion care, states should both increase the types of health providers who are able to provide telehealth services, such as certified nurse midwives and nurse practitioners, and waive licensing requirements to allow out-of-state providers to provide telehealth.⁷²

Decriminalize self-managed abortion.

During this crisis, more people may want or need to manage their abortions at home, due to fear of contracting COVID-19, caregiving responsibilities, or the inability to pay for or travel to a clinic.⁷³ Self-managed abortions with pills can be safe and effective, so long as people have access to accurate information and backup medical care.⁷⁴ Instead of criminalizing pregnant people, state policymakers must recognize that every person needs access to abortion, free from fear of arrest or prosecution.

Ensure that abortion care is included within essential health care.

Governors must work together to reduce the spread of COVID-19, and they must also ensure timely access to reproductive health services. Policymakers should deem

reproductive health services, like abortion, as essential, and consider abortion providers as essential workers.⁷⁵ Repealing medically unnecessary restrictions.

State legislators must repeal and roll back medically unnecessary and burdensome abortion restrictions, such as mandatory waiting periods and in-person counseling requirements, which force patients to make multiple in-person trips to a clinic, endangering the health of patients and their providers.⁷⁶

Expand public and private insurance coverage of abortion care.

State policymakers should repeal laws that prohibit insurance coverage of abortion and work to ensure that private insurers, state Medicaid programs, and state employee plans cover abortions.⁷⁷

Eliminate refusal laws that allow providers, insurers, and health care facilities to discriminate against patients.

Refusal laws enable hospitals and individual health care providers to determine a patient's care based on their personal beliefs, dismissing what is best for the patient's health and circumstances.⁷⁸ These laws allow health entities to refuse to provide, refer for, or give patients information about abortion care, which patients need to make important medical decisions. A health care provider's personal beliefs should never determine the care a patient receives.⁷⁹

Notes

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