FIEC

Amendment to Limit Government Interference with Abortion

23-07

2023

Financial Impact Estimating Conference

Amendment to Limit Government Interference with Abortion
Serial Number 23-07

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Tab 1

Authorization

FLORIDA DEPARTMENT of STATE

RON DESANTIS
Governor

CORD BYRD
Secretary of State

September 7, 2023

Financial Impact Estimating Conference
c/o Amy Baker
Office of Economic and Demographic Research
111 West Madison Street, Ste. 574
Tallahassee, Florida 32399-6588

Dear Ms. Baker:

Section 100.371(13), Florida Statutes, provides that at the same time the Secretary of State submits an initiative petition to the Attorney General pursuant to section 15.21, the Secretary shall also submit a copy of the petition to the Financial Impact Estimating Conference.

The criteria in section 15.21, Florida Statutes, has been met for the initiative petition titled **Amendment to Limit Government Interference with Abortion,** Serial Number 23-07 and I have submitted the petition to the Attorney General. Therefore, I am also submitting a copy of the initiative petition to you.

Sincerely,

Cord Byrd
Secretary of State

CB/am

pc: Floridians Protecting Freedom, Inc.

Enclosures

CONSTITUTIONAL AMENDMENT FULL TEXT

Ballot Title: Amendment to Limit Government Interference with Abortion

Ballot Summary: No law shall prohibit, penalize, delay, or restrict abortion before viability or when necessary to protect the patient's health, as determined by the patient's healthcare provider. This amendment does not change the Legislature's constitutional authority to require notification to a parent or guardian before a minor has an abortion.

Article and Section Being Created or Amended: Creates - Article 1, New Section

Full Text of the Proposed Amendment: New Section, Amendment to Limit Government Interference with Abortion

Limiting government interference with abortion.— Except as provided in Article X, Section 22, no law shall prohibit, penalize, delay, or restrict abortion before viability or when necessary to protect the patient's health, as determined by the patient's healthcare provider.

Initiative Information

Date Approved 05/08/2023 **Serial Number** 23-07
Sponsor Name: Floridians Protecting Freedom, Inc.
Sponsor Address: Post Office Box 4068, Sarasota, FL 34230

Tab 2

Current Law

Summary of Current Law

Prepared for the FIEC by House and Senate Staff on October 11, 2023

In 2022, the Legislature passed HB 5 prohibiting a physician from performing an abortion if the physician determines the gestational age of the fetus is more than 15 weeks.[1] The bill became law and maintains medical[2] exceptions to the prohibition that were in effect under prior law while creating a new exception for fatal fetal abnormalities.[3,4] Shortly before the law was to take effect on July 1, 2022, various abortion providers filed a legal challenge to the 15-week prohibition. The case is currently pending before the Florida Supreme Court in *Planned Parenthood of Southwest and Central Florida v. State of Florida*.[5] The law is not enjoined and remains in effect throughout the duration of the pending litigation.

In 2023, the Legislature passed SB 300 prohibiting abortions if the gestational age of the fetus is more than 6 weeks. The bill retains the medical and fatal fetal abnormality exceptions and adds an exception for rape, incest, or human trafficking if the gestational age of the fetus is less than 15 weeks and the pregnant woman provides specified documentation. However, the provisions of SB 300 only take effect if specified events occur that change Florida's jurisprudence on the privacy clause in the state constitution, which include:

- The Florida Supreme Court:
    - Recedes from its decision in *In Re T.W.*[6] or its progeny; or
    - Determines that the Florida Constitution's privacy provision does not include abortion; or
    - Rules in favor of the state in case challenging the 15-week abortion ban (*Planned Parenthood of Southwest and Central Florida v. State of Florida*).

  or

- Florida voters adopt a state constitutional amendment clarifying that the right to privacy does not include abortion.

To date, none of these events have occurred, and the provisions of HB 5 remain in effect.

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[1] 15 weeks is calculated based upon the first day of the woman's last menstrual period.

[2] The medical exception applies if two physicians, or one physician in the case of an emergency, certify in writing that, in reasonable medical judgment, the termination of the pregnancy is necessary to save the pregnant woman's life or avert a serious risk of substantial and irreversible physical impairment of a major bodily function of the pregnant woman other than a psychological condition.

[3] A "fatal fetal abnormality" is a terminal condition that, in reasonable medical judgment, regardless of the provision of life-saving medical treatment, is incompatible with life outside the womb and will result in death upon birth or imminently thereafter.

[4] Section 390.0111, F.S.

[5] The Florida Supreme Court heard oral arguments on September 8, 2023, but to date has not rendered an opinion in this matter.

[6] The Florida Supreme Court held in *In re T.W.* that the express right to privacy contained within Article I, s. 23 of the Florida Constitution "is clearly implicated in a woman's decision whether or not to continue her pregnancy".

CHAPTER 2022-69

Committee Substitute for House Bill No. 5

An act relating to reducing fetal and infant mortality; amending s. 381.84, F.S.; revising the purpose and requirements for the Comprehensive Statewide Tobacco Education and Use Prevention Program; revising a provision relating to a certain report to conform to changes made by the act; creating s. 383.21625, F.S.; providing a definition; requiring the Department of Health to contract with local healthy start coalitions for the creation of fetal and infant mortality review committees in all regions of the state; providing requirements for such committees; requiring local healthy start coalitions to report the findings and recommendations developed by the committees to the department annually; requiring the department to compile such findings and recommendations in a report and submit such report to the Governor and Legislature by a specified date and annually; authorizing the department to adopt rules; amending s. 390.011, F.S.; revising and providing definitions; amending s. 390.0111, F.S.; prohibiting a physician from performing a termination of pregnancy if the physician determines the gestational age of a fetus is more than a specified number of weeks; providing an exception; amending s. 390.0112, F.S.; revising a requirement that the directors of certain medical facilities submit a monthly report to the Agency for Health Care Administration; requiring certain physicians to submit such report to the agency; requiring the report to be submitted electronically on a form adopted by the agency, the Board of Medicine, and the Board of Osteopathic Medicine; requiring the report to include certain additional information; removing obsolete language; creating s. 395.1054, F.S.; requiring that certain hospitals participate in a minimum number of quality improvement initiatives developed in collaboration with the Florida Perinatal Quality Collaborative within the University of South Florida College of Public Health; providing an appropriation; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsections (2), (3), and (7) of section 381.84, Florida Statutes, are amended to read:

381.84 Comprehensive Statewide Tobacco Education and Use Prevention Program.—

(2) PURPOSE, FINDINGS, AND INTENT.—It is the purpose of this section to implement s. 27, Art. X of the State Constitution. The Legislature finds that s. 27, Art. X of the State Constitution requires the funding of a statewide tobacco education and use prevention program that focuses on tobacco use by youth. The Legislature further finds that the primary goals of the program are to reduce the prevalence of tobacco use among youth, adults, ~~and~~ pregnant women, and women who may become pregnant; reduce per capita tobacco consumption; and reduce exposure to environmental tobacco

smoke. Further, it is the intent of the Legislature to base increases in funding for individual components of the program on the results of assessments and evaluations. Recognizing that some components will need to grow faster than inflation, it is the intent of the Legislature to fund portions of the program on a nonrecurring basis in the early years so that those components that are most effective can be supported as the program matures.

(3) PROGRAM COMPONENTS AND REQUIREMENTS.—The department shall conduct a comprehensive, statewide tobacco education and use prevention program consistent with the recommendations for effective program components contained in the 1999 Best Practices for Comprehensive Tobacco Control Programs of the CDC, as amended by the CDC. The program shall include the following components, each of which shall focus on educating people, particularly pregnant women, women who may become pregnant, and youth and their parents, about the health hazards of tobacco and discouraging the use of tobacco:

(a) Counter-marketing and advertising; Internet resource center.—The counter-marketing and advertising campaign shall include, at a minimum, Internet, print, radio, and television advertising and shall be funded with a minimum of one-third of the total annual appropriation required by s. 27, Art. X of the State Constitution.

1. The campaign shall include an Internet resource center for copyrighted materials and information concerning tobacco education and use prevention, including cessation. The Internet resource center must be accessible to the public, including parents, teachers, and students, at each level of public and private schools, universities, and colleges in the state and shall provide links to other relevant resources. The Internet address for the resource center must be incorporated in all advertising. The information maintained in the resource center shall be used by the other components of the program.

2. The campaign shall use innovative communication strategies, such as targeting specific audiences who use personal communication devices and frequent social networking websites.

(b) Cessation programs, counseling, and treatment.—This program component shall include two subcomponents:

1. A statewide toll-free cessation service, which may include counseling, referrals to other local resources and support services, and treatment to the extent funds are available for treatment services; and

2. A local community-based program to disseminate information about tobacco-use cessation, how tobacco-use cessation relates to prenatal care and obesity prevention, and other chronic tobacco-related diseases.

(c) Surveillance and evaluation.—The program shall conduct ongoing epidemiological surveillance and shall contract for annual independent evaluations of the effectiveness of the various components of the program in meeting the goals as set forth in subsection (2).

(d) Youth school programs.—School and after-school programs shall use current evidence-based curricula and programs that involve youth to educate youth about the health hazards of tobacco, help youth develop skills to refuse tobacco, and demonstrate to youth how to stop using tobacco.

(e) Community programs and chronic disease prevention.—The department shall promote and support local community-based partnerships that emphasize programs involving youth, pregnant women, and women who may become pregnant, including programs for the prevention, detection, and early intervention of tobacco-related chronic diseases.

(f) Training.—The program shall include the training of health care practitioners, tobacco-use cessation counselors, and teachers by health professional students and other tobacco-use prevention specialists who are trained in preventing tobacco use and health education. Tobacco-use cessation counselors shall be trained by specialists who are certified in tobacco-use cessation.

(g) Administration and management, statewide programs, and county health departments.—The department shall administer the program within the expenditure limit established in subsection (8). Each county health department is eligible to receive a portion of the annual appropriation, on a per capita basis, for coordinating tobacco education and use prevention programs within that county. Appropriated funds may be used to improve the infrastructure of the county health department to implement the comprehensive, statewide tobacco education and use prevention program. Each county health department shall prominently display in all treatment rooms and waiting rooms counter-marketing and advertisement materials in the form of wall posters, brochures, television advertising if televisions are used in the lobby or waiting room, and screensavers and Internet advertising if computer kiosks are available for use or viewing by people at the county health department.

(h) Enforcement and awareness of related laws.—In coordination with the Department of Business and Professional Regulation, the program shall monitor the enforcement of laws, rules, and policies prohibiting the sale or other provision of tobacco to minors, as well as the continued enforcement of the Clean Indoor Air Act prescribed in chapter 386. The advertisements produced in accordance with paragraph (a) may also include information designed to make the public aware of these related laws and rules. The departments may enter into interagency agreements to carry out this program component.

(i) AHEC tobacco-use cessation initiative.—The AHEC network may administer the AHEC tobacco-use cessation initiative in each county within the state and perform other activities as determined by the department.

(7) ANNUAL REPORT REQUIRED.—By January 31 of each year, the department shall provide to the Governor, the President of the Senate, and the Speaker of the House of Representatives a report that evaluates the program's effectiveness in reducing and preventing tobacco use and that recommends improvements to enhance the program's effectiveness. The report must contain, at a minimum, an annual survey of youth attitudes and behavior toward tobacco, as well as a description of the progress in reducing the prevalence of tobacco use among youth, adults, ~~and~~ pregnant women, and women who may become pregnant; reducing per capita tobacco consumption; and reducing exposure to environmental tobacco smoke.

Section 2. Section 383.21625, Florida Statutes, is created to read:

383.21625 Fetal and infant mortality review committees.—

(1) As used in this section, the term "department" means the Department of Health.

(2) The department shall contract with local healthy start coalitions for the creation of fetal and infant mortality review committees in all regions of the state to improve fetal and infant mortality and morbidity in each region. Each committee shall:

(a) Review and analyze rates, trends, causes, and other data related to fetal and infant mortality and morbidity in a geographic area.

(b) Develop findings and recommendations for interventions and policy changes to reduce fetal and infant mortality and morbidity rates.

(c) Engage with local communities and stakeholders to implement recommended policies and procedures to reduce fetal and infant mortality and morbidity.

(3) Each local healthy start coalition shall report the findings and recommendations developed by each fetal and infant mortality review committee to the department annually. Beginning October 1, 2023, the department shall compile such findings and recommendations in an annual report, which must be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

(4) The department may adopt rules necessary to implement this section.

Section 3. Subsections (6) and (7) of section 390.011, Florida Statutes, are renumbered as subsections (7) and (8), respectively, present subsections (8) through (13) are renumbered as subsections (10) through (15),

respectively, present subsection (6) is amended, and new subsections (6) and (9) are added to that section, to read:

390.011 Definitions.—As used in this chapter, the term:

(6) "Fatal fetal abnormality" means a terminal condition that, in reasonable medical judgment, regardless of the provision of life-saving medical treatment, is incompatible with life outside the womb and will result in death upon birth or imminently thereafter.

(7)~~(6)~~ "Gestation" means the development of a human embryo or fetus as calculated from the first day of the pregnant woman's last menstrual period ~~between fertilization and birth~~.

(9) "Medical abortion" means the administration or use of an abortion-inducing drug to induce an abortion.

Section 4. Subsection (1) of section 390.0111, Florida Statutes, is amended to read:

390.0111 Termination of pregnancies.—

(1) TERMINATION AFTER GESTATIONAL AGE OF 15 WEEKS ~~IN THIRD TRIMESTER~~; WHEN ALLOWED.—A physician may not perform a ~~No~~ termination of pregnancy if the physician determines the gestational age of the fetus is more than 15 weeks ~~shall be performed on any human being in the third trimester of pregnancy~~ unless one of the following conditions is met:

(a) Two physicians certify in writing that, in reasonable medical judgment, the termination of the pregnancy is necessary to save the pregnant woman's life or avert a serious risk of substantial and irreversible physical impairment of a major bodily function of the pregnant woman other than a psychological condition.

(b) The physician certifies in writing that, in reasonable medical judgment, there is a medical necessity for legitimate emergency medical procedures for termination of the pregnancy to save the pregnant woman's life or avert a serious risk of imminent substantial and irreversible physical impairment of a major bodily function of the pregnant woman other than a psychological condition, and another physician is not available for consultation.

(c) The fetus has not achieved viability under s. 390.01112 and two physicians certify in writing that, in reasonable medical judgement, the fetus has a fatal fetal abnormality.

Section 5. Section 390.0112, Florida Statutes, is amended to read:

390.0112 Termination of pregnancies; reporting.—

(1) The director of any medical facility in which abortions are performed, including surgical procedures and medical abortions, ~~including a physician's office,~~ shall submit a report each month to the agency. If the abortion is not performed in a medical facility, the physician performing the abortion shall submit the monthly report. The report must ~~may~~ be submitted electronically on a form adopted by the agency, the Board of Medicine, and the Board of Osteopathic Medicine which~~,~~ may not include personal identifying information~~,~~ and must include:

(a) ~~Until the agency begins collecting data under paragraph (e),~~ The number of abortions performed.

(b) The reasons such abortions were performed. If a woman upon whom an abortion is performed has provided evidence that she is a victim of human trafficking pursuant to s. 390.0111(3)(a)1.b.(IV), such reason must be included in the information reported under this section.

(c) For each abortion, the period of gestation at the time the abortion was performed.

(d) The number of infants born alive or alive immediately after an attempted abortion.

(e) ~~Beginning no later than January 1, 2017,~~ Information consistent with the United States Standard Report of Induced Termination of Pregnancy adopted by the Centers for Disease Control and Prevention.

(f) The number of medication abortion regimens prescribed or dispensed.

(2) The agency shall keep such reports in a central location for the purpose of compiling and analyzing statistical data and shall submit data reported pursuant to paragraph (1)(e) to the Division of Reproductive Health within the Centers for Disease Control and Prevention, as requested by the Centers for Disease Control and Prevention.

~~(3) If the termination of pregnancy is not performed in a medical facility, the physician performing the procedure shall be responsible for reporting such information as required in subsection (1).~~

(3)~~(4)~~ Reports submitted pursuant to this section shall be confidential and exempt from the provisions of s. 119.07(1) and shall not be revealed except upon the order of a court of competent jurisdiction in a civil or criminal proceeding.

(4)~~(5)~~ Any person required under this section to file a report or keep any records who willfully fails to file such report or keep such records may be subject to a $200 fine for each violation. The agency shall be required to impose such fines when reports or records required under this section have not been timely received. For purposes of this section, timely received is defined as 30 days following the preceding month.

Section 6. Section 395.1054, Florida Statutes, is created to read:

395.1054 Birthing quality improvement initiatives.—A hospital that provides birthing services shall at all times participate in at least two quality improvement initiatives developed in collaboration with the Florida Perinatal Quality Collaborative within the University of South Florida College of Public Health.

Section 7. For the 2022-2023 fiscal year, the sum of $1,602,000 in recurring funds from the General Revenue Fund is appropriated to the Department of Health for the purpose of establishing fetal and infant mortality review committees under s. 383.21625, Florida Statutes.

Section 8. This act shall take effect July 1, 2022.

Approved by the Governor April 14, 2022.

Filed in Office Secretary of State April 14, 2022.

HOUSE OF REPRESENTATIVES STAFF FINAL BILL ANALYSIS

BILL #: CS/HB 5 Reducing Fetal and Infant Mortality
SPONSOR(S): Health Care Appropriations Subcommittee, Grall and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 146

FINAL HOUSE FLOOR ACTION: 78 **Y's** 39 **N's** **GOVERNOR'S ACTION:** Approved

SUMMARY ANALYSIS

CS/HB 5 passed the House on February 17, 2022, and subsequently passed the Senate on March 3, 2022.

The bill addresses fetal and infant mortality reduction related to fetal and infant mortality reviews (FIMR), hospital quality initiatives, comprehensive statewide tobacco education and use prevention, and abortion policy.

Fetal and infant mortality review (FIMR) is a community-based fetal and infant mortality review process to identify and address factors that affect infant mortality and morbidity, administered by Department of Health (DOH) contracts with Healthy Start Coalitions, FIMR programs are not available statewide. The bill requires DOH to contract for additional FIMR committees in all regions of the state. Each Coalition must report FIMR committee findings and recommendations to DOH annually and DOH must submit such in a report to the Governor, President of the Senate, and Speaker of the House of Representatives.

The Florida Perinatal Quality Collaborative (FPQC) partners with stakeholders and partners across the state to develop and implement quality initiatives to reduce maternal and infant mortality. FPQC's initiatives provide quality improvement data reports, toolkits, online toolboxes, and technical assistance to hospitals to assist with quality improvement initiatives. While many hospitals participate in FPQC initiatives, participation is voluntary and many do not. The bill requires hospitals that provide birthing services to participate in at least two quality improvement initiatives developed in collaboration with the FPQC.

The Comprehensive Statewide Tobacco Education and Use Prevention Program (Program) is a program based on best practices from the U.S. Centers for Disease Control and Prevention. The Program educates Floridians, particularly youth and their parents, about the hazards of tobacco and preventing use. The bill requires the Program to include a focus on pregnant women and women who may become pregnant.

Florida law prohibits abortions during the third trimester with certain medical exceptions. Current law also requires the physician performing the abortion to determine, by ultrasound, the gestational age of the fetus at the time the abortion is to be performed. The bill prohibits abortions if the physician performing abortion determines the gestational age of the fetus is more than 15 weeks, based on the first day of the woman's last menstrual period. This replaces the current prohibition against abortions during the third trimester. The bill retains the current maternal medical exceptions to prohibited abortions, and adds an exception for fatal fetal abnormalities.

Current law requires abortion providers to submit a monthly report to the Agency for Health Care Administration, but does not require them to report whether the abortion was due to human trafficking, or the number of medication abortion regimens prescribed or dispensed by abortion providers. The bill requires abortion providers to report whether abortions were due to human trafficking. The bill addresses potential data reporting gaps by clarifying that both surgical and medication-induced abortions must be reported and requiring providers to report the number of medication abortion regimens prescribed and dispensed. The bill also requires AHCA, the Board of Medicine and the Board of Osteopathic Medicine to adopt an electronic reporting form.

The bill appropriates $1,602,000 in recurring General Revenue to the DOH, and has no fiscal impact on local governments.

The bill was approved by the Governor on April 14, 2022, ch. 2022-69, L.O.F., and will become effective on July 1, 2022.

I. SUBSTANTIVE INFORMATION

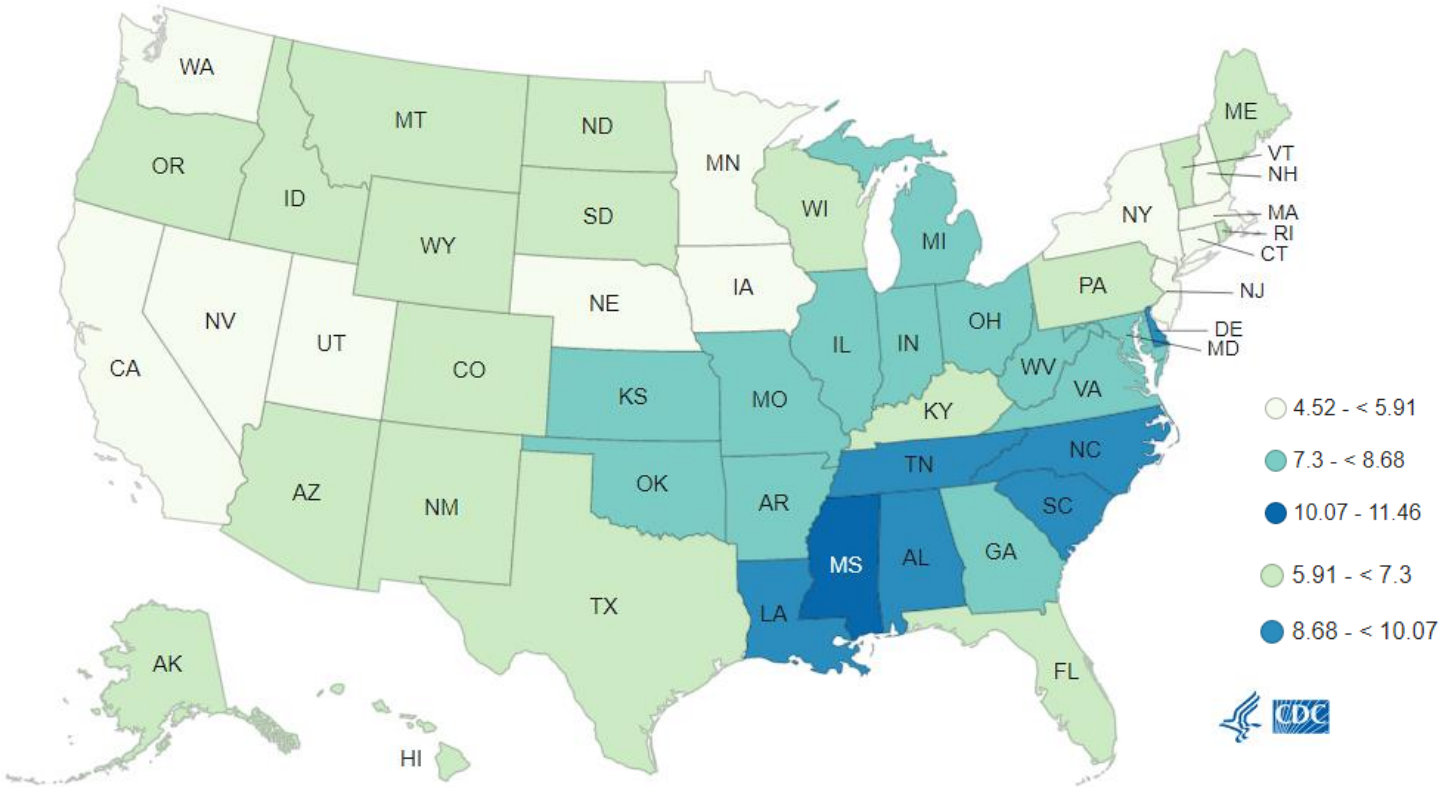
A. EFFECT OF CHANGES:

Background

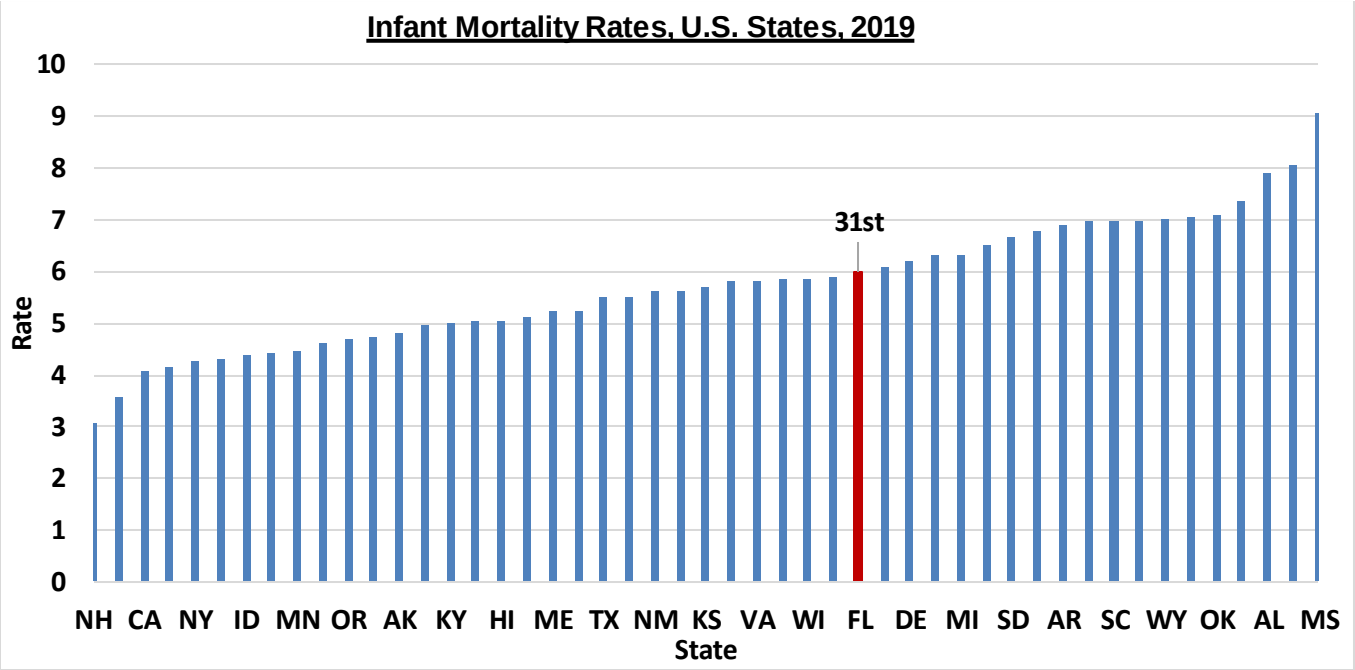
Infant Mortality

Infant mortality is the death of an infant before the first birthday. The infant mortality rate is the number of infant deaths for every 1,000 live births. In addition to giving key information about maternal and infant health, the infant mortality rate is a marker of the overall health of a society. In 2019, the infant mortality rate in the United States was 5.6 deaths per 1,000 live births.[1]

Infant Mortality Rates by State – 2019[2]



[1] Centers for Disease Control and Prevention, *Infant Mortality,* https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm (last visited March 11, 2022).
[2] Centers for Disease Control and Prevention, *Infant Mortality Rates by State,* https://www.cdc.gov/nchs/pressroom/sosmap/infant_mortality_rates/infant_mortality.htm (last visited March 11, 2022).



[3]

Infant Mortality in Florida

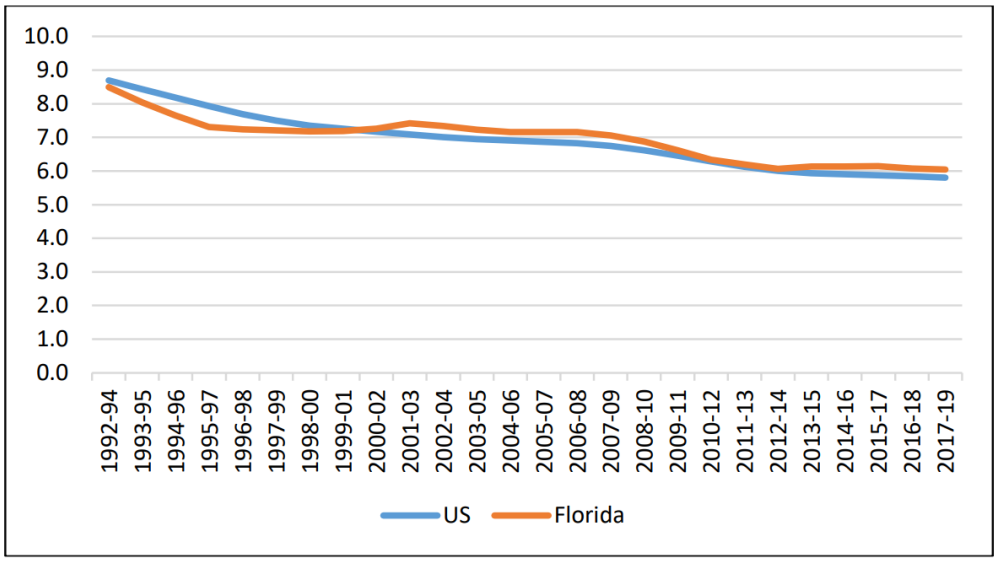
The Department of Health (DOH) reports annually on fetal and infant deaths through the Florida Vital Statistics Annual Report.[4] This report provides the number of fetal deaths per 1,000 live births, the number of deaths by race, and compares that data to national figures. Florida ranks 18th in the nation in infant mortality with a rate of six deaths per 1,000 live births (1,213 in 2020).[5]

In Florida, the leading causes of infant mortality, per 1,000 live births, are:[6]

- Birth defects (1.1);
- Preterm and low birth weight (0.9);
- Unintentional injuries (0.5);
- Maternal complications of pregnancy (0.4);
- Complications of placenta, cord, and membranes (0.3); and
- Sudden Infant Death Syndrome (0.3).

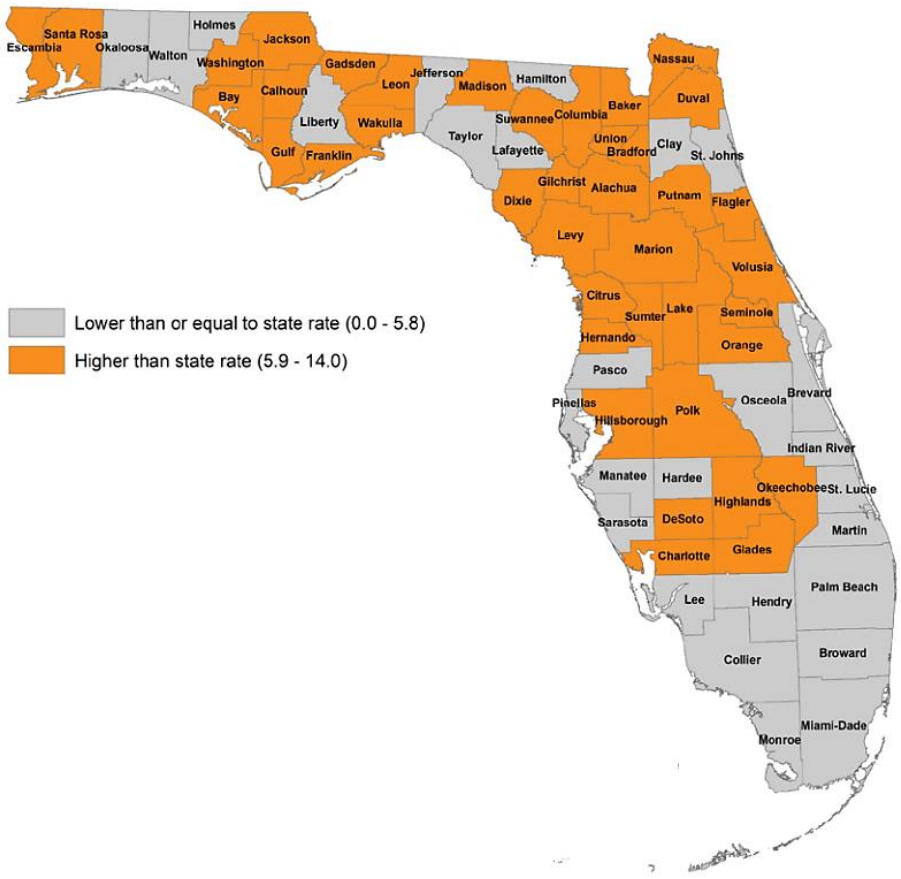
[3] Centers for Disease Control and Prevention, Reproductive Health – Infant Mortality Rates by State, 2019, https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm#infant (last visited March 11, 2022). Note that Vermont's rate was determined unreliable for 2019 by the CDC and is not included in this chart.
[4] Florida Vital Statistics Annual Report 2020, http://www.flpublichealth.com/VSbook/PDF/2020/Fetal.pdf (last visited March 11, 2022).
[5] Id. *See also* Centers for Disease Control and Prevention, Infant Mortality Rates by State (2019), https://www.cdc.gov/nchs/pressroom/sosmap/infant_mortality_rates/infant_mortality.htm (last visited March 11, 2022).
[6] Presentation by Shay Chapman, BSN, MBA, Deputy Division Director, Community Health Promotion, Sept. 21, 2021 meeting of the Professions and Public Health Subcommittee, available at https://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=3093&Session=2022&DocumentType=Meeting+Packets&FileName=pph+9-21-21.pdf (last visited March 11, 2022).

Infant Mortality Rates, 1992-2019, Florida vs. the United States



Source: Florida CHARTS, www.flhealthcharts.com.

Florida Infant Mortality Rates by County[7]



Fetal and Infant Mortality Review

[7] Id.

Fetal and infant mortality review (FIMR) is a process of community-based fetal and infant mortality reviews aimed at addressing factors and issues that affect infant mortality and morbidity. FIMR committees aim to gain knowledge through the reviews to empower communities to enhance services, influence policy, and direct planning efforts that will ultimately lower infant mortality rates. The process is based on the National FIMR model which supports case review and interventions at the local level.[8]

FIMR Process

In Florida, FIMR committees operate in a two-tier structure consisting of Healthy Start Coalitions (Coalition) and Case Review Teams (CRT). The FIMR process begins when infant death cases are selected for review by a committee within the Healthy Start Coalition (Coalition) based on specific criteria, including type of death, residence and race. Information is abstracted from birth, death, medical, hospital and autopsy records. Efforts are also made to interview the family. No information which identifies the family or medical providers is included on the abstraction form.[9]

Case summaries are developed by the Coalition committee and presented to the CRT, a multidisciplinary group of community medical and social service professionals. This group usually includes a district and local health officer, obstetrician, pediatrician, social worker, nurse-midwife, a hospital and community nurse, coroner or medical examiner, interviewer, abstractor, community outreach worker, mental health counselor, and other people important to the individual reviews. The CRT examines each case to determine medical, social, financial and other issues that may have impacted the poor birth outcome. Recommendations for community action are crafted by the CRT based on review findings. These recommendations are shared with the Community Action Group, a group of volunteers working with at-risk families and other partner agencies[10] in the region to implement and develop street-level outreach activities.[11]

FIMR work has several benefits, such as including the perspective of the family, identifying issues unique to a community, allowing for targeted initiatives, and engaging community leaders to identify and implement solutions.[12]

FIMR in Florida

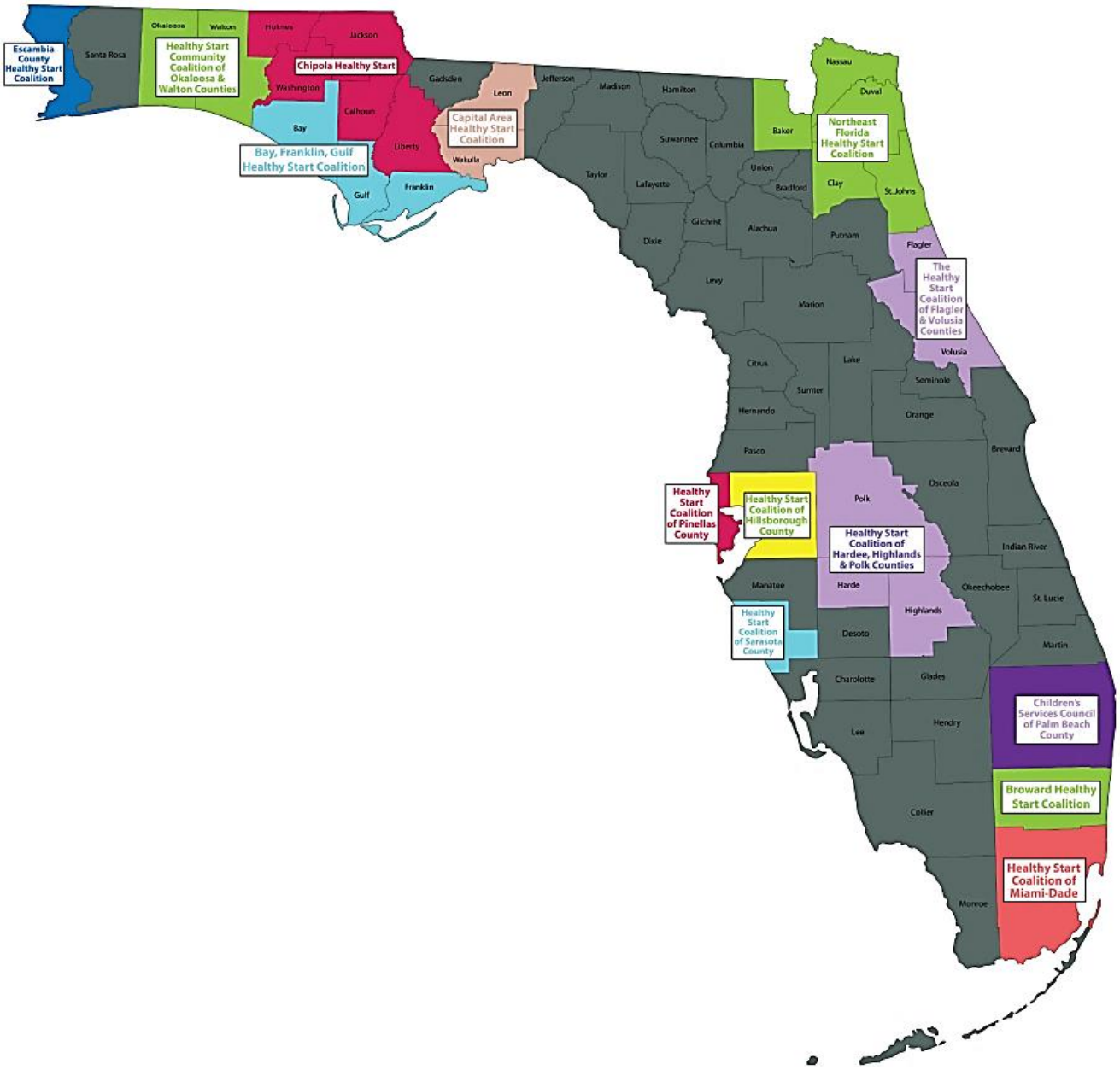
DOH contracts with Healthy Start Coalitions around the state for FIMR programs.[13] FIMR is not a statewide program and there is no statutory directive for the FIMR process; programs are authorized in the General Appropriations Act. Approximately half of the counties in the state participate in a FIMR program.[14] Currently, Florida has:[15]

- 11 state-funded FIMR programs though contracts with Healthy Start;
- 3 FIMRs funded through the County Health Departments (Orange, Osceola, and Palm Beach counties); and
- 2 FIMRs independently funded (Hillsborough and Indian River counties); and

[8] Florida Department of Health, *FIMR, available at* http://www.doh.state.fl.us/family/mch/FIMR/fimr_facts.html (last visited March 11, 2022).
[9] Id.
[10] Partner agencies may include health departments, hospitals, medical societies, schools, community and business leaders, and consumers
[11] *Supra*, note 8.
[12] National Fetal and Infant Mortality Review Program, *A Guide for Communities: Fetal and Infant Mortality Review Manual, 2nd Edition (2008),* https://ncfrp.org/wp-content/uploads/NCRPCD-Docs/FIMRManual.pdf (last visited March 11, 2022).
[13] Email from Andrew Love, Director of Legislative Planning, Department of Health, Infant Mortality Policy Recommendations (Sept. 2, 2021).
[14] Email from Andrew Love, Director of Legislative Planning, Department of Health, Follow Up Documents (July 26, 2021). *See also* Presentation by Cathy Timuta, CEO, Florida Association of Healthy Start Coalitions, Inc., and Faye Johnson, CEO, Northeast Florida Healthy Start Coalition, Inc., Oct. 13, 2021 meeting of the Professions and Public Health Subcommittee, available at https://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=3093&Session=2022&DocumentType=Meeting+Packets&FileName=pph+10-13-21.pdf (last visited March 11, 2022).
[15] Id.

- 1 inactive FIMR (St. Lucie County).

Healthy Start Coalition FIMR Programs[16]



Comprehensive Statewide Tobacco Education and Use Prevention

On November 7, 2006, the voters in the State of Florida adopted Amendment 4, creating the Comprehensive Statewide Tobacco Education and Prevention Program.[17] Pursuant to the amendment, the state is required to create a comprehensive, statewide program consistent with the United States Department of Health and Human Services, Centers for Disease Control and Prevention 1999 best

[16] Presentation by Cathy Timuta, CEO, Florida Association of Healthy Start Coalitions, Inc., and Faye Johnson, CEO, Northeast Florida Healthy Start Coalition, Inc., Oct. 13, 2021 meeting of the Professions and Public Health Subcommittee, available at https://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=3093&Session=2022&DocumentType=Meeting+Packets&FileName=pph+10-13-21.pdf (last visited March 11, 2022).
[17] Art. X, s. 27, Fla. Const.

practices, as periodically amended. The program must consist, at a minimum, of the following components:[18]

- An advertising campaign, funded by at least one-third of the required annual appropriation;
- Evidence-based curricula and programs to educate youth about tobacco and discourage their use of it;
- Programs of local community-based partnerships;
- Enforcement of laws, regulations, and policies against the sale or other provision of tobacco to minors, and the possession of tobacco by minors; and
- Publicly-reported annual evaluations to ensure that moneys appropriated for the program are spent properly.

The Constitution specifies that the Legislature must appropriate 15 percent of the total gross funds that tobacco companies paid to the State of Florida in 2005 under the Tobacco Settlement. This amount must be adjusted annually for inflation using the Consumer Price Index. For Fiscal Year 2021-2022, the mandated appropriation is $73.9 million.[19]

In 2007, the Legislature created section 381.84, Florida Statutes, the Comprehensive Statewide Tobacco Education and Use Prevention Program (Program), to implement the constitutional amendment. The Program consists of nine components:[20]

- Counter-marketing and advertising;
- Cessation programs, counseling and treatment;
- Surveillance and education;
- Youth and school programs;
- Community programs and chronic disease prevention;
- Training of health care practitioners, tobacco-use cessation counselors and teachers;
- Administration and management;
- Enforcement and awareness of related laws; and
- The area health education centers (AHEC) tobacco-use cessation initiative.

The Program requires each component to focus on educating people, particularly youth and their parents, about the hazards of tobacco and discouraging the use of tobacco. The Program does not specifically address pregnant women and women who may become pregnant.

Hospitals and Infant Mortality

Hospitals are regulated by the Agency for Health Care Administration (AHCA) under chapter 395, F.S., and the general licensure provisions of part II, of chapter 408, F.S. Hospitals offer a range of health care services with beds for use beyond 24 hours by individuals requiring diagnosis, treatment, or care.[21] Hospitals must make regularly available at least clinical laboratory services, diagnostic X-ray services, and treatment facilities for surgery or obstetrical care, or other definitive medical treatment.[22] Currently, hospitals that provide birthing services must incorporate information on safe sleep practices and the possible causes of Sudden Unexpected Infant Death into postpartum instruction on the care of newborns. Hospitals must also provide parents with an informational pamphlet on infant and childhood eye and vision disorders.[23]

Florida Perinatal Quality Collaborative

[18] Id.
[19] Fla. General Appropriation Act Fiscal Year 2021-2022, SB 2500 item 458.
[20] S. 381.84(3), F.S.
[21] S. 395.002(12), F.S.
[22] Id.
[23] S. 395.1053, F.S.

The Florida Perinatal Quality Collaborative (FPQC) was established in 2010 and housed in the Chiles Center at the University of South Florida College of Public Health. FPQC aims to improve Florida's maternal and infant health outcomes through evidence-based perinatal care. FPQC partners with stakeholders, such as perinatal-related organizations, individuals, families, health professionals, hospitals, and payers to develop and implement quality improvement initiatives at partner hospitals that provide birthing services (labor and delivery) to address maternal and infant mortality.[24] FPQC's initiatives provide quality improvement data reports, toolkits, online toolboxes, and technical assistance to hospitals to assist with implementing process changes to carry out quality improvement initiatives.

Hospital participation in FPQC initiatives is voluntary.

Currently, FPQC has four active initiatives:[25]

- **Promoting Primary Vaginal Deliveries (PROVIDE):**[26] The goal of the PROVIDE Initiative is to improve maternal and newborn outcomes by applying evidence-based interventions to promote primary vaginal deliveries at Florida delivery hospitals and ultimately reduce Nulliparous, Term, Singleton, Vertex cesareans.[27] Seventy-five hospitals currently participate in PROVIDE.
- **Family-Centered Care in the NICU (PAIRED):**[28] PAIRED helps hospital neonatal intensive care units (NICU) develop and implement unit-specific strategies to improve how a family engages with the NICU staff to assist in the care of their infant in a way that provides value to the family and to the NICU team. As its centerpiece project, this initiative facilitates **adoption or expansion of safe skin-to-skin care,** which has a growing evidence base for achieving better infant and family outcomes. Sixteen hospitals currently participate in PAIRED.
- **Perinatal Quality Indicators System (PQI):**[29] The PQI initiative supports hospital quality improvement efforts by providing hospital-specific semi-annual or quarterly reports of perinatal indicators and related reports. PQI is offered to all Florida delivery hospitals at no charge and hospitals can enroll at any time. Fifty-six hospitals currently participate in PQI.
- **Maternal Opioid Recovery Effort (MORE):**[30] MORE works with providers, hospitals, and other stakeholders to improve identification, clinical care, and coordinated treatment and support for pregnant women with opioid use disorder (OUD) and their infants. MORE focuses on standardization related to OUD screening, prevention, treatment, and comprehensive discharge planning. Thirty-one hospitals are currently participating in MORE.

Since the MORE initiative began in November 2019, participating hospitals have substantially increased screening for substance use disorder, mental health, intimate partner violence, and infectious diseases, as indicated by the graph below.[31]

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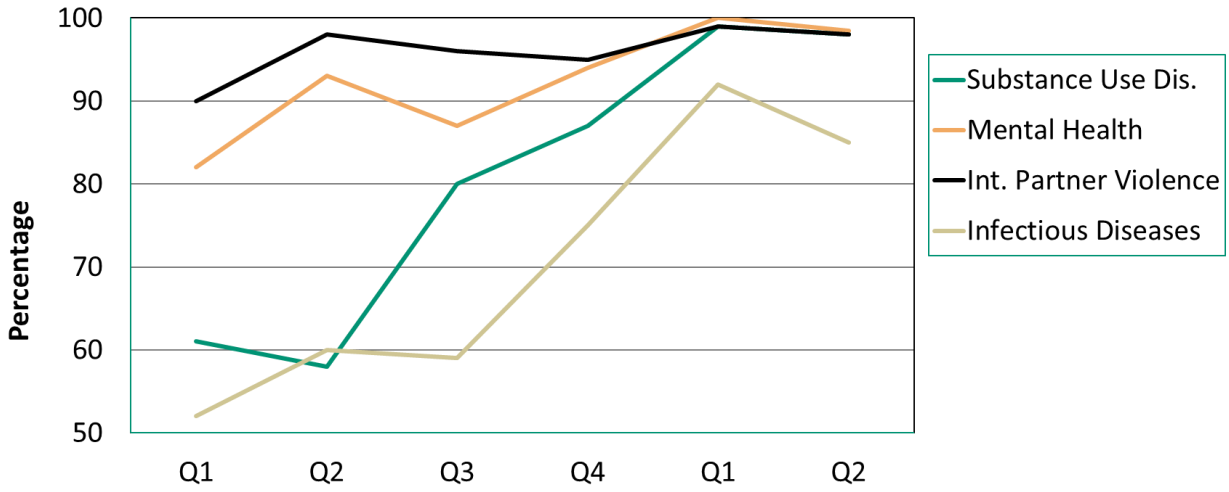
[24] USF Health College of Public Health, *Florida Perinatal Quality Collaborative – About the FPQC,* https://health.usf.edu/publichealth/chiles/fpqc/about (last visited March 11, 2022).
[25] USF Health College of Public Health, *Florida Perinatal Quality Collaborative,* https://health.usf.edu/publichealth/chiles/fpqc (last visited March 11, 2022).
[26] USF Health College of Public Health, *Florida Perinatal Quality Collaborative – Promoting Vaginal Deliveries,* https://health.usf.edu/publichealth/chiles/fpqc/provide (last visited March 11, 2022).
[27] Nulliparous, Term, Singleton, Vertex (NTSV) Cesareans are cesarean births where babies are at or beyond 37.0 weeks gestation to women in their first pregnancy, that are singleton (no twins or beyond) and in the vertex presentation (no breech or transverse positions).
[28] USF Health College of Public Health, *Florida Perinatal Quality Collaborative – PAIRED Initiative,* https://health.usf.edu/publichealth/chiles/fpqc/paired (last visited March 11, 2022).
[29] USF Health College of Public Health, *Florida Perinatal Quality Collaborative – Perinatal Quality Indicators System,* https://health.usf.edu/publichealth/chiles/fpqc/indicators (last visited March 11, 2022).
[30] USF Health College of Public Health, *Florida Perinatal Quality Collaborative – Maternal Opioid Recovery Effort (MORE),* https://health.usf.edu/publichealth/chiles/fpqc/MORE (last visited March 11, 2022).
[31] Presentation by William Sappenfield, MD, MPH, CPH, Professor, Director of Chiles Center, University of South Florida, Oct. 13, 2021 meeting of the Professions and Public Health Subcommittee, available at: https://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=3093&Session=2022&DocumentType=Meeting+Packets&FileName=pph+10-13-21.pdf (last visited March 11, 2022).

Maternal Screening in MORE-Participating Hospitals, 2020-2021[32]



Federal Law on Abortion

In 1973, the foundation of modern abortion jurisprudence, *Roe v. Wade*[33], was decided by the U.S. Supreme Court (Supreme Court). The Supreme Court determined that a woman's right to an abortion is part of a fundamental right to privacy guaranteed under the Due Process Clause of the Fourteenth Amendment of the U.S. Constitution. Further, the Court reasoned that state regulation limiting the exercise of this right is subject to strict scrutiny: it must be justified by a compelling state interest, and must be narrowly drawn.[34] In 1992, the fundamental holding of *Roe* was upheld by the U.S. Supreme Court in *Planned Parenthood v. Casey*.[35]

The Viability Standard

In *Roe v. Wade*, the Supreme Court established a rigid trimester framework dictating when, if ever, states can regulate abortion.[36] The Court held that states could not regulate abortions during the first trimester of pregnancy.[37] With respect to the second trimester, the Court held that states could only enact regulations aimed at protecting the mother's health, not the fetus's life. Therefore, no ban on abortions is permitted during the second trimester. The state's interest in the life of the fetus becomes sufficiently compelling only at the beginning of the third trimester, allowing it to prohibit abortions. Even then, the Court requires states to permit an abortion in circumstances necessary to preserve the health or life of the mother.[38]

The current viability standard is set forth in *Planned Parenthood v. Casey*.[39] Recognizing that medical advancements in neonatal care can advance viability to a point somewhat earlier than the third trimester, the Supreme Court rejected the trimester framework and, instead, limited the states' ability to regulate abortion pre-viability. Thus, while upholding the underlying holding in *Roe*, which authorizes states to "regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother[,]"[40] the Court determined that the line for this authority should be drawn at "viability," because "there may be some medical developments that

[32] Id.
[33] *Roe v. Wade*, 410 U.S. 113 (1973).
[34] Id.
[35] *Casey*, 505 U.S. 833 (1992).
[36] *Roe*, 410 U.S. 113 (1973).
[37] *Id.* at 163-64.
[38] *Id.* at 164-165.
[39] *Planned Parenthood of SE Pa. v. Casey*, 505 U.S. 833 (1992).
[40] *See Roe*, 410 U.S. at 164-65.

affect the precise point of viability . . . but this is an imprecision within tolerable limits given that the medical community and all those who must apply its discoveries will continue to explore the matter."[41] Furthermore, the Court recognized that "[i]n some broad sense it might be said that a woman who fails to act before viability has consented to the State's intervention on behalf of the developing child."[42]

The Undue Burden Standard

In *Planned Parenthood v. Casey*, the Supreme Court established the undue burden standard for determining whether a law places an impermissible obstacle to a woman's right to an abortion. The Court held that health regulations which impose undue burdens on the right to abortion are invalid.[43] State regulation imposes an "undue burden" on a woman's decision to have an abortion if it has the purpose or effect of placing a substantial obstacle in the path of the woman who seeks the abortion of a nonviable fetus.[44] However, the court opined, not every law which makes the right to an abortion more difficult to exercise is an infringement of that right.[45]

The Medical Emergency Exception

In *Doe v. Bolton*, the Supreme Court was faced with determining, among other things, whether a Georgia statute criminalizing abortions (pre- and post-viability), except when determined to be necessary based upon a physician's "best clinical judgment," was unconstitutionally void for vagueness for inadequately warning a physician under what circumstances an abortion could be performed.[46] In its reasoning, the Court agreed with the district court decision that the exception was not unconstitutionally vague, by recognizing that:

> [T]he medical judgment may be exercised in the light of all factors—physical, emotional, psychological, familial, and the woman's age-relevant to the well-being of the patient. All these factors may relate to health. This allows the attending physician the room he needs to make his best medical judgment.[47]

This broad interpretation of what constitutes a medical emergency was later tested in *Casey*[48], albeit in a different context. One question before the Supreme Court in *Casey* was whether the medical emergency exception to a 24-hour waiting period for an abortion was too narrow in that there were some potentially significant health risks that would not be considered "immediate."[49] The exception in question provided that a medical emergency is:

> [T]hat condition which, on the basis of the physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function.[50]

In evaluating the more objective standard under which a physician is to determine the existence of a medical emergency, the Court in *Casey* determined that the exception would not significantly threaten

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[41] *See Casey*, 505 U.S. at 870.
[42] *Id.*
[43] Id. at 878.
[44] Id. at 877
[45] Id. at 873.
[46] *Doe*, 410 U.S. at 179 (1973). Other exceptions, such as in cases of rape and when, "[t]he fetus would very likely be born with a grave, permanent, and irremediable mental or physical defect." *Id.* at 183. *See also, U.S. v. Vuitich*, 402 U.S. 62, 71-72 (1971) (determining that a medical emergency exception to a criminal statute banning abortions would include consideration of the mental health of the pregnant woman).
[47] *Doe*, 410 U.S. at 192.
[48] *Casey*, 505. U.S. 833 (1992).
[49] *Id.* at 880.
[50] *Id.* at 879 (quoting 18 Pa. Cons. Stat. § 3203 (1990)).

the life and health of a woman and imposed no undue burden on the woman's right to have an abortion.[51]

Jackson Women's Health Organization v. Dobbs

In 2018, Mississippi enacted the Gestational Age Act (Act) which prohibited a person from performing an abortion if the probable gestational age of the fetus is greater than 15 weeks. Jackson Women's Health Organization filed a lawsuit challenging the Act alleging that it was an unconstitutional pre-viability ban on abortion. The state argued the Act was a constitutional restriction on abortion. The federal trial court ruled in favor of Jackson Women's Health Organization, which was upheld by the Fifth Circuit of Appeals.[52]

The lawsuit matter is currently pending before the Supreme Court, which held oral arguments on December 1, 2021.[53]

Florida Abortion Law

Right to Abortion

The Florida Constitution, as interpreted by Florida courts, affords greater privacy rights than those provided by the U.S. Constitution. While the federal Constitution traditionally shields enumerated and implied individual liberties from state or federal intrusion, the Supreme Court has noted that state constitutions may provide greater protections.[54] Unlike the U.S. Constitution, Article I, s. 23 of the Florida Constitution contains an express right to privacy:

> Every natural person has the right to be let alone and free from governmental intrusion into the person's private life except as otherwise provided herein. This section shall not be construed to limit the public's right of access to public records and meetings as provided by law.

The Florida Supreme Court opined in *In re T.W.* that this section provides greater privacy rights than those implied by the U.S. Constitution.[55]

The Florida Supreme Court has recognized Florida's constitutional right to privacy "is clearly implicated in a woman's decision whether or not to continue her pregnancy."[56] In *In re T.W.,* the Florida Supreme Court ruled that:[57]

> [P]rior to the end of the first trimester, the abortion decision must be left to the woman and may not be significantly restricted by the state. Following this point, the state may impose significant restrictions only in the least intrusive manner designed to safeguard the health of the mother. Insignificant burdens during either period must substantially further important state interests….Under our Florida Constitution, the state's interest becomes compelling upon viability….Viability under Florida law occurs at that point in time when the fetus becomes capable of meaningful life outside the womb through standard medical procedures.

[51] *Id.* at 880.
[52] See *Jackson Women's Health Organization v. Dobbs,* 945 F.3d 265 (5th Cir. 2019).
[53] *See Dobbs v. Jackson Women's Health Organization*, Case No. 19-1932, available at https://www.supremecourt.gov/search.aspx?filename=/docket/docketfiles/html/public/19-1392.html (last visited March 11, 2022).
[54] *Pruneyard Shopping Center v. Robins*, 100 S.Ct. 2035, 2040 (1980), cited in *In re T.W.*, 551 So.2d 1186, 1191 (Fla. 1989).
[55] Id. at 1191-1192.
[56] Id. at 1192.
[57] Id. at 1193.

The court recognized that after viability, the state can regulate abortion in the interest of the unborn child if the mother's health is not in jeopardy.[58]

The state may regulate abortion pre-viability based upon its interest in maternal health beginning in the second trimester. In *Fla. Women's Medical Clinic, Inc. v. Smith,* the court held that the state has an interest in maternal health only after the first trimester, not before, and may not impose substantive clinical standards in the first trimester.[59]

Abortion Regulation

Abortion clinics are regulated by the Agency for Health Care Administration (AHCA) under ch. 390, F.S. Physicians performing abortions (which may take place in abortion clinics, hospitals, physician offices or other physician settings) are regulated by the Department of Health (DOH) under chs. 458 and 459 F.S.

In Florida, abortion is defined as the termination of a human pregnancy with an intention other than to produce a live birth or to remove a dead fetus.[60] An abortion must be performed by a physician[61] licensed under ch. 458, F.S., or ch. 459, F.S., or a physician practicing medicine or osteopathic medicine in the employment of the United States.[62]

Florida law prohibits abortions after viability, as well as during the third trimester, unless a medical exception exists. Section 390.01112(1), F.S., prohibits an abortion from being performed if a physician determines that, in reasonable medical judgment, the fetus has achieved viability.[63] Section 390.0111, F.S., prohibits an abortion from being performed during the third trimester.[64] Exceptions to both of these prohibitions exist if:

- Two physicians certify in writing that, in reasonable medical judgment, the termination of the pregnancy is necessary to save the pregnant woman's life or avert a serious risk of substantial and irreversible physical impairment of a major bodily function of the pregnant woman other than a psychological condition; or
- One physician certifies in writing that, in reasonable medical judgment, there is a medical necessity for legitimate emergency medical procedures for termination of the pregnancy to save the pregnant woman's life or avert a serious risk of imminent substantial and irreversible physical impairment of a major bodily function of the pregnant woman other than a psychological condition, and another physician is not available for consultation.[65]

Current law requires the physician performing the abortion to verify the probable gestational age of the fetus, by ultrasound, at the time the abortion is performed.[66] The physician performing the abortion, or person qualified to operate an ultrasound who is working with in conjunction with the physician, must perform the ultrasound.[67]

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[58] Id. at 1194.
[59] Fla. Women's Medical Clinic, Inc. v. Smith, 478 F.Supp. 233 (S.D. Fla. 1979); Fla. Women's Medical Clinic, Inc. v. Smith, 536 F.Supp. 1048 (S.D. Fla. 1982).
[60] Section 390.011(1), F.S.
[61] Section 390.0111(2), F.S.
[62] Section 390.011(8), F.S.
[63] Viability is defined as the stage of fetal development when the life of a fetus is sustainable outside the womb through standard medical measures. Section 390.011(13), F.S.
[64] Section 390.011(11), F.S., defines the third trimester to mean the weeks of pregnancy after the 24th week of pregnancy.
[65] Sections 390.0111(1)(a) and (b) and 390.01112(1)(a) and (b), F.S.
[66] Section 390.0111(3)(a)1.b.II, F.S.
[67] Section 390.0111(3), F.S.

Any person who willfully performs, or actively participates in, an abortion in violation of these statutory requirements commits a third degree felony and commits a second-degree felony if the woman dies.[68]

Abortion Data Reporting

Section 390.0112, F.S., requires the medical director of medical facilities where abortions are performed to submit a monthly report to AHCA that must contain information consistent with the United States Standard Report of Induced Termination of Pregnancy adopted by the Centers for Disease Control and Prevention (CDC).[69] If the abortion is performed in a location other than a medical facility, the physician who performed the abortion is responsible for reporting the information to AHCA.[70]

In 2020, there were 209,645 live births in Florida.[71] In the same year, there were 74,868 abortion procedures performed in the state. Of those: [72]

- 70,594 were performed in the first trimester (12 weeks and under);
- 4,274 were performed in the second trimester (13 to 24 weeks); and
- None were performed in the third trimester (25 weeks and over).

The majority of the procedures (65,210) were elective.[73] The remainder of the abortions were performed due to: [74]

- Emotional or psychological health of the mother (1,409);
- Physical health of the mother that was not life endangering (1,111);
- Life endangering physical condition (146);
- Rape (112);
- Incest (9);
- Serious fetal genetic defect, deformity, or abnormality (734); and
- Social or economic reasons (15,271).

AHCA must keep this information in a central location from which statistical data can be drawn and must provide this information to the CDC upon request.[75] The reports are confidential and exempt from public records requirements.[76] AHCA may impose fines for violations of the reporting requirements.[77]

Abortion providers report abortions due to rape or incest, but are not currently required to report whether the abortion was due to human trafficking.

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[68] Section 390.0111(10), F.S. Such regulations include basic clinical standards for abortion clinics performing abortions after the first trimester and informed consent.
[69] The CDC requests the following information from states for the U.S. Standard Report of Induced Termination of Pregnancy: facility name (clinic or hospital); city, town or location; county; hospital or clinic's patient identification number (used for querying for missing information without identifying the patient); age; marital status; date of termination; residence of patient; ethnicity; race; education attainment; date of last menses; clinical estimate of gestation; previous pregnancy history; previous abortion history; type of abortion procedure; and name of attending physician and name of person completing report. Centers for Disease Control, Handbook on the Reporting of Induced Termination of Pregnancy, www.cdc.gov/nchs/data/misc/hb_itop.pdf (last visited on March 11, 2022).
[70] Section 390.0112(2), F.S.
[71] Total Resident Live Births, Department of Health, available at https://www.flhealthcharts.gov/ChartsReports/rdPage.aspx?rdReport=Birth.DataViewer&cid=25 (last viewed March 11, 2022).
[72] Reported Induced Terminations of Pregnancy by Reason, by Trimester, Agency for Health Care Administration, available at https://ahca.myflorida.com/mchq/central_services/training_support/docs/TrimesterByReason_2020.pdf (last viewed March 11, 2022).
[73] Id.
[74] Id.
[75] Id. The CDC compiles statistics voluntarily reported by the 50 states, the District of Columbia and New York City, related to termination of pregnancies to produce a national data report. *Abortion Surveillance- United States, 2019*, Surveillance Summaries, Centers for Disease Control and Prevention, November 26, 2021 / 70(9);1–29 https://www.cdc.gov/mmwr/volumes/70/ss/ss7009a1.htm (last visited on March 11, 2022).
[76] Section 390.0112(3), F.S.
[77] Section 390.0112(4), F.S.

Additionally, potential gaps in abortion date may exist. If an abortion is performed outside of a medical facility, the physician performing the abortion must submit a monthly report to AHCA. Because AHCA has no regulatory oversight of physicians (this authority rests with the Boards), it is unclear whether all physicians performing abortions outside of medical facilities are reporting. It is equally unclear if all medication abortions are being reported as abortion providers are not currently required to report the number of medication abortion regimens[78] prescribed or dispensed.

Effect of the Bill

The bill addresses fetal and infant mortality reduction related to FIMR, hospital quality initiatives, comprehensive statewide tobacco education and use prevention, and abortion policy.

Fetal and Infant Mortality Review

The bill requires DOH to contract with local Healthy Start Coalitions to establish fetal and infant mortality review committees in all regions of the state, to improve fetal and infant mortality in each region. Each committee must:

- Review and analyze the geographic area's fetal and infant mortality rates, trends, causes, and other data;
- Develop findings and recommendations for interventions and policy changes to reduce rates; and
- Engage with local communities and stakeholders to implement recommended policies and procedures.

Each Coalition must report FIMR committee findings and recommendations to DOH annually. Beginning on October 1, 2023, DOH must compile FIMR committee findings and submit a report to the Governor, President of the Senate, and Speaker of the House of Representatives.

Comprehensive Statewide Tobacco Education and Use Prevention

The bill requires the Comprehensive Statewide Tobacco Education and Use Prevention Program to include a focus on pregnant women and women who may become pregnant in the program's components.

Hospitals and Infant Mortality

The bill requires hospitals that provide birthing services (labor and delivery) to participate in at least two quality improvement initiatives developed in collaboration with the FPQC at all times.

Abortion Regulation

The bill prohibits abortions if the physician performing abortion determines the gestational age of the fetus is more than 15 weeks, as calculated from the first day of the woman's last menstrual period. This replaces the current prohibition against abortions during the third trimester.

The bill retains the same medical exceptions to prohibited abortions in existing law:

[78] The FDA approved medication abortion regimen consists of mifepristone and misoprostol which may be taken through 70 days gestation (70 days or less since the first day of a woman's last menstrual period) to end a pregnancy. *Mifeprex (mifepristone) Information*, U.S. Food and Drug Administration, available at https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/mifeprex-mifepristone-information (last visited on March 11, 2022).

- Two physicians certify in writing that, in reasonable medical judgment, the termination of the pregnancy is necessary to save the pregnant woman's life or avert a serious risk of substantial and irreversible physical impairment of a major bodily function of the pregnant woman other than a psychological condition; or
- One physician certifies in writing that, in reasonable medical judgment, there is a medical necessity for legitimate emergency medical procedures for termination of the pregnancy to save the pregnant woman's life or avert a serious risk of imminent substantial and irreversible physical impairment of a major bodily function of the pregnant woman other than a psychological condition, and another physician is not available for consultation.

The bill adds an exception for fatal fetal abnormalities if two physicians certify in writing that, in reasonable medical judgment, the fetus has a fatal fetal abnormality. Because current law prohibits abortions past the gestational stage of viability, with no exceptions for fatal fetal abnormalities, this exception applies until the fetus reaches the gestational stage of viability. A fetal anomaly is a terminal condition that, in reasonable medical judgment, regardless of the provision of life-saving medical treatment, is incompatible with life outside the womb and will result in death upon birth or imminently thereafter.

Abortion Reporting

The bill enhances and clarifies current abortion reporting requirements. The bill requires abortion providers to report whether abortions were due to human trafficking. The bill addresses potential data reporting gaps by requiring abortion providers to report both surgical and medication-induced abortions and to report the number of medication abortion regimens prescribed and dispensed. The bill also requires AHCA and the Boards to adopt an electronic reporting form. This provides greater regulatory oversight over the reporting requirement for physicians performing abortions outside of a medical facility.

The bill provides an effective date of July 1, 2022.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill appropriates $1,602,000 in recurring General Revenue funds to DOH for the purpose of establishing FIMR committees in areas of the state where no state-funded FIMR committees exist and to supplement existing FIMR committees. This allows for a minimum of $60,000 per FIMR committee to implement the bill.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

Some local governments may experience a decrease in expenditures associated with state-funded FIMR programs as such counties may no longer need to fund local FIMR programs.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	SB 146
INTRODUCER:	Senator Stargel
SUBJECT:	Fetal and Infant Mortality Reduction
DATE:	February 1, 2022
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Brown	HP	**Favorable**
2.			AP	

I. Summary:

SB 146 amends several sections of law with the aim of reducing fetal and infant mortality. The bill adds a requirement to the Comprehensive Statewide Tobacco Education and Use Prevention Program to target information towards pregnant women and women who may become pregnant; requires the Department of Health (DOH) to contract with local Healthy Start coalitions to establish fetal and infant mortality review committees (FIMR) in all regions of the state and appropriates $260,000 in recurring funds for State Fiscal Year 2022-23 for this purpose; and requires all hospitals that provide birthing services to participate in at least two quality initiatives developed in collaboration with the Florida Perinatal Quality Collaborative (FPQC) within the University of South Florida College of Public Health.

The bill also amends several sections of law related to abortions.

The bill prohibits a physician from performing an abortion after the fetus has reached 15 weeks of gestational age and redefines the term "gestation" to measure this time period from the first day of the pregnant woman's last menstrual period (LMP).[1] The bill applies current law exceptions to the 15-week ban for emergencies and to save the pregnant woman's life or to prevent a serious risk of substantial and irreversible physical impairment of a major bodily function to the new prohibition. The bill also adds a new exception to the 15-week ban that applies if the fetus has a fatal fetal abnormality[2] and has not reached viability.

Additionally, the bill amends provisions related to reporting abortions to the Agency for Health Care Administration (AHCA). The bill requires the AHCA to adopt by rule a form for reporting abortions that is consistent with the United States Standard Report of Induced Termination of

[1] Generally, the first day of the LMP will be about two weeks earlier than the date of conception. See https://www.betterhealth.vic.gov.au/health/healthyliving/baby-due-date (last visited Jan. 26, 2022).

[2] "Fatal fetal abnormality" is defined in the bill to mean means a terminal condition that, in reasonable medical judgment, regardless of the provision of life-saving medical treatment, is incompatible with life outside the womb and will result in death upon birth or imminently thereafter.

Pregnancy adopted by the U.S. Centers for Disease Control and Prevention (CDC) and includes other specified information. The specified information includes information that is required to be reported under current law as well as adding the number of abortions performed and the number of drug regimens dispensed or prescribed for medical abortions.[3] Additionally, the bill specifies that, should a woman provide evidence of human trafficking under a specified exception, human trafficking must be reported as a reason for the abortion.

The bill makes other technical and conforming changes.

The bill provides an effective date of July 1, 2022.

II. Present Situation:

Abortion in Florida

Under Florida law, abortion is defined as the termination of a human pregnancy with an intention other than to produce a live birth or remove a dead fetus.[4] The termination of a pregnancy must be performed by a physician[5] licensed under ch. 458, F.S., or ch. 459, F.S., or a physician practicing medicine or osteopathic medicine in the employment of the United States.[6]

The termination of a pregnancy may not be performed in the third trimester or if a physician determines that the fetus has achieved viability unless there is a medical necessity. Florida law defines the third trimester to mean the weeks of pregnancy after the 24th week and defines viability to mean the state of fetal development when the life of a fetus is sustainable outside the womb through standard medical measures.[7]

Specifically, an abortion may not be lawfully performed in Florida after viability or within the third trimester unless two physicians certify in writing that, in reasonable medical judgment, the termination of the pregnancy is necessary to save the pregnant woman's life or avert a serious risk of substantial and irreversible physical impairment of a major bodily function of the pregnant woman, other than a psychological condition. If a second physician is not available, one physician may certify in writing to the medical necessity for legitimate emergency medical procedures for the termination of the pregnancy.[8] Additionally, an abortion may not be performed on a minor under the age of 18 without the consent of the minor's parent or guardian or without the minor obtaining authorization for the abortion from a court.[9, 10]

Sections 390.0111(4) and 390.01112(3), F.S., provide that if a termination of pregnancy is performed during the third trimester or during viability, the physician who performs or induces

[3] The bill defines "medical abortion" as the administration or use of an abortion-inducing drug to induce an abortion.
[4] Section 390.011(1), F.S.
[5] Section 390.0111(2), F.S.
[6] Section 390.011(9), F.S.
[7] Sections 390.011(11) and (12), F.S.
[8] Sections 390.0111(1) and 390.01112(1), F.S.
[9] Section 390.01114, F.S.
[10] It is of note that the requirement for parental consent, passed by the Florida Legislature in 2020, could potentially contradict the ruling in the controlling case on abortion in Florida, In re T.W., (discussed below). However, as of Jan. 27, 2022, no challenge of the parental consent requirements has been filed.

the termination of pregnancy must use that degree of professional skill, care, and diligence to preserve the life and health of the fetus, which the physician would be required to exercise in order to preserve the life and health of any fetus intended to be born and not aborted. However, the woman's life and health constitute an overriding and superior consideration to the concern for the life and health of the fetus when the concerns are in conflict. A termination of pregnancy after viability in an emergency situation must be performed in a hospital.[11]

Prior to performing an abortion, s. 390.0111(3), F.S., requires a physician to obtain voluntary and informed written consent from the pregnant woman. Except in the case of emergency, consent is considered voluntary and informed only if the physician who is to perform the procedure, or the referring physician, has, at a minimum, orally, while physically present in the same room, and at least 24 hours before the procedure, informed the woman of:

- The nature and risks of undergoing or not undergoing the proposed procedure that a reasonable patient would consider material to making a knowing and willful decision of whether to terminate a pregnancy.
- The probable gestational age of the fetus, verified by an ultrasound, at the time the termination of pregnancy is to be performed.

The person performing the ultrasound is required to offer the woman the opportunity to view the ultrasound, which the woman may decline. If the woman provides, at the time she schedules or arrives for her appointment to obtain an abortion, to the physician a copy of a restraining order, police report, medical record, or other court order or documentation evidencing that she is obtaining the abortion because she is a victim of rape, incest, domestic violence, or human trafficking, the person performing the ultrasound may not offer the opportunity to view the images and the information required to be provided may be provided less than 24 hours prior to performing the abortion.

Federal Case Law on Abortion

In 1973, the U.S. Supreme Court issued the landmark Roe v. Wade decision. Using the strict scrutiny standard, the Court determined that a woman's right to terminate a pregnancy is protected by a fundamental right to privacy guaranteed under the Due Process Clause of the Fourteenth Amendment of the U.S. Constitution. Further, the Court reasoned that state regulations limiting the exercise of this right must be justified by a compelling state interest and must be narrowly drawn.[12]

In 1992, the U.S. Supreme Court ruled on the constitutionality of a Pennsylvania statute involving a 24-hour waiting period between the provision of information to a woman and the performance of an abortion. In that decision, Planned Parenthood of Southeastern Pennsylvania v. Casey, the Court upheld the statute and relaxed the standard of review in abortion cases involving adult women from "strict scrutiny" to "unduly burdensome." An undue burden exists and makes a statute invalid if the statute's purpose or effect is to place a substantial obstacle in the way of a woman seeking an abortion before the fetus is viable.[13]

[11] Section 797.03(3), F.S.
[12] Roe v. Wade, 410 U.S. 113, 93 S. Ct. 705, 35 L. Ed. 2d 147 (1973).
[13] Planned Parenthood of Se. Pennsylvania v. Casey, 505 U.S. 833, 112 S. Ct. 2791, 120 L. Ed. 2d 674 (1992)

The Court held that the undue burden standard is an appropriate means of reconciling a state's interest in human life with the woman's constitutionally protected liberty to decide whether to terminate a pregnancy. The Court determined that, prior to fetal viability, a woman has the right to an abortion without being unduly burdened by government interference. Before viability, a state's interests are not strong enough to support prohibiting an abortion or the imposition of a substantial obstacle to the woman's right to elect the procedure. However, once viability occurs, a state has the power to restrict abortions if the law contains exceptions for pregnancies that endanger a woman's life or health.[14]

Potential Updates to Federal Case Law on Abortion

Two cases are currently working their way through the legal system, each of which has the potential to overrule or modify the standards on abortion that were established in Roe v. Wade and Casey.

Jackson Women's Health Org. v. Dobbs

Jackson Women's Health Org. v. Dobbs,[15] is a case challenging Mississippi's Gestational Age Act. The Gestational Age Act[16] prohibited all abortions after 15 weeks of gestational age and was permanently enjoined by the lower courts in 2019. The U.S. Supreme Court held oral arguments on the case for Dec. 1, 2021, and will likely rule on the case sometime in mid-2022.

Whole Woman's Health v. Jackson

Whole Woman's Health v. Jackson[17] is a case challenging Texas's SB 8 (2021).[18] The Texas law, which is currently in effect, outlaws performing an abortion on an unborn child once a fetal heartbeat has been detected, with an exception for medical emergencies. However, unlike a standard abortion ban, the law specifically prohibits state actors from enforcing its provisions. Instead, the law creates a cause of action for any person, other than an officer or employee of the state or local governmental entity in the state, to sue in civil court over the performance of such an abortion or the aiding and abetting of such an abortion. If the claimant prevails, the law requires that the defendant pay at least $10,000 per abortion performed or aided and abetted as well as court costs and attorney fees.

The status of the case is complicated, but, after multiple appeals and reviews regarding standing and the ability to seek a pre-enforcement review of the law, the U.S. Supreme Court ruled on December 10, 2021, that the pre-enforcement case may proceed, but the petitioners are only authorized to sue executive branch licensing officials. Currently, the case is in the possession of the Texas 5th Circuit Court of Appeals which has certified questions about the licensing-official defendants to the Texas Supreme Court rather than remand the case to the lower court to

[14] *Id.*
[15] Jackson Women's Health Org. v. Currier, 349 F. Supp. 3d 536 (S.D. Miss. 2018), aff'd sub nom. Jackson Women's Health Org. v. Dobbs, 945 F.3d 265 (5th Cir. 2019)
[16] Mississippi HB 1510, available at http://billstatus.ls.state.ms.us/documents/2018/html/HB/1500-1599/HB1510IN.htm#:~:text=AN%20ACT%20TO%20BE%20KNOWN,SECTION%201. (last visited Jan. 25, 2022).
[17] Whole Woman's Health v. Jackson, 142 S. Ct. 522 (2021)
[18] Available at Bill Text: TX SB8 | 2021-2022 | 87th Legislature | Enrolled | LegiScan (last visited Jan. 25, 2022).

continue its proceedings. Additionally, the Court of Appeals has refused to issue an injunction preventing the law from taking effect and, as such, the law is currently effective in Texas.

Florida Case Law on Abortion

In 1989 in the case In re T.W., a Minor,[19] the Florida Supreme Court upheld a lower court ruling striking the requirement that a minor obtain parental consent prior to obtaining an abortion. This ruling is the controlling case law for abortion law in Florida and is of consequence because, rather than standing the ruling upon the established Federal case law of Roe v. Wade and Planned Parenthood v. Casey, the Florida Supreme Court determined that:

> To be held constitutional, the instant statute must pass muster under both the federal and state constitutions. Were we to examine it solely under the federal Constitution, our analysis necessarily would track the decisions noted above. However, Florida is unusual in that it is one of at least four states having its own express constitutional provision guaranteeing an independent right to privacy,… and we opt to examine the statute first under the Florida Constitution. If it fails here, then no further analysis under federal law is required.

The Court determined that the right to privacy enshrined in Art. I, S. 23 of the Florida Constitution "is clearly implicated in a woman's decision of whether or not to continue her pregnancy." Therefore, unlike under the Federal Constitution which requires a state only to show that a restriction on abortion is not "unduly burdensome," in Florida the state must show that the abortion restriction "furthers a compelling state interest through the least intrusive means."

The court further determined that "Under our Florida Constitution, the state's interest becomes compelling upon viability, as defined below. Until this point, the fetus is a highly specialized set of cells that is entirely dependent upon the mother for sustenance. No other member of society can provide this nourishment. The mother and fetus are so inextricably intertwined that their interests can be said to coincide. Upon viability, however, society becomes capable of sustaining the fetus, and its interest in preserving its potential for life thus becomes compelling."

Abortion Data Reporting

Section 390.0112, F.S., requires the medical director of medical facilities where abortions are performed to submit a monthly report to the AHCA that must contain information consistent with the United States Standard Report of Induced Termination of Pregnancy adopted by the CDC.[20] If the abortion is performed in a location other than a medical facility, the physician who performed the abortion is responsible for reporting the information to the AHCA.[21]

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[19] In re T.W., 551 So. 2d 1186 (Fla. 1989)

[20] The CDC requests the following information from states for the U.S. Standard Report of Induced Termination of Pregnancy: facility name (clinic or hospital); city, town or location; county; hospital or clinic's patient identification number (used for querying for missing information without identifying the patient); age; marital status; date of termination; residence of patient; ethnicity; race; education attainment; date of last menses; clinical estimate of gestation; previous pregnancy history; previous abortion history; type of abortion procedure; and name of attending physician and name of person completing report. Centers for Disease Control, Handbook on the Reporting of Induced Termination of Pregnancy, www.cdc.gov/nchs/data/misc/hb_itop.pdf (last visited on Jan. 25, 2022).

[21] Section 390.0112(3), F.S.

In 2020, there were 209,645 live births in Florida.[22] In 2021, there were 68,449 abortion procedures performed in the state. Of those: [23]

- 64,345 were performed in the first trimester (12 weeks and under);
- 4,104 were performed in the second trimester (13 to 24 weeks); and
- None were performed in the third trimester (25 weeks and over).

The majority of the procedures (51,047) were elective.[24] The remainder of the abortions were performed due to: [25]

- Emotional or psychological health of the mother (1,340);
- Physical health of the mother that was not life endangering (927);
- Life endangering physical condition (106);
- Rape (97);
- Incest (8);
- Serious fetal genetic defect, deformity, or abnormality (642); and
- Social or economic reasons (14,282).

The AHCA must keep this information in a central location from which statistical data can be drawn and must provide this information to the CDC upon request.[26] The reports are confidential and exempt from public records requirements.[27] The AHCA may impose fines for violations of the reporting requirements.[28] Abortion providers report abortions due to rape or incest but are not currently required to report whether the abortion was due to human trafficking.

Infant Mortality

Infant mortality is the death of an infant before the first birthday. The infant mortality rate is the number of infant deaths for every 1,000 live births. In addition to giving key information about maternal and infant health, the infant mortality rate is a marker of the overall health of a society. In 2019, the infant mortality rate in the United States was 5.6 deaths per 1,000 live births.[29]

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[22] Total Resident Live Births, Department of Health, available at https://www.flhealthcharts.gov/ChartsReports/rdPage.aspx?rdReport=Birth.DataViewer&cid=25 (last viewed Jan. 25, 2022).
[23] Reported Induced Terminations of Pregnancy by Reason, by Trimester, Agency for Health Care Administration, available at https://ahca.myflorida.com/mchq/central_services/training_support/docs/TrimesterByReason_2021.pdf (last viewed Jan. 25, 2022).
[24] *Id.*
[25] *Id.*
[26] *Id.* The CDC compiles statistics voluntarily reported by the 50 states, the District of Columbia and New York City, related to termination of pregnancies to produce a national data report. *Abortion Surveillance- United States, 2019*, Surveillance Summaries, Centers for Disease Control and Prevention, November 26, 2021 / 70(9);1–29 https://www.cdc.gov/mmwr/volumes/70/ss/ss7009a1.htm (last visited on Jan. 25, 2022).
[27] Section 390.0112(3), F.S.
[28] Section 390.0112(4), F.S.
[29] Centers for Disease Control and Prevention, *Infant Mortality*, https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm (last visited Jan. 25, 2022).

Infant Mortality in Florida

The DOH reports annually on fetal and infant deaths through the Florida Vital Statistics Annual Report.[30] This report provides the number of fetal deaths per 1,000 live births, the number of deaths by race, and compares that data to national figures. Florida ranks 18th in the nation in infant mortality with a rate of six deaths per 1,000 live births (1,213 in 2020).[31]

Fetal and Infant Mortality Review

FIMR is a process of community-based fetal and infant mortality reviews aimed at addressing factors and issues that affect infant mortality and morbidity. FIMR committees aim to gain knowledge through the reviews to empower communities to enhance services, influence policy, and direct planning efforts that will ultimately lower infant mortality rates. The process is based on the National FIMR model which supports case review and interventions at the local level.[32]

FIMR Process

In Florida, a FIMR committee operates in a two-tier structure consisting of a Healthy Start Coalition (Coalition) and a Case Review Team (CRT). The FIMR process begins when infant death cases are selected for review by a committee within a Coalition based on specific criteria, including type of death, residence, and race. Information is abstracted from birth, death, medical, hospital and autopsy records. Efforts are also made to interview the family. No information which identifies the family or medical providers is included on the abstraction form.[33]

Case summaries are developed by the Coalition committee and presented to the CRT, a multidisciplinary group of community medical and social service professionals. This group usually includes a district and local health officer, obstetrician, pediatrician, social worker, nurse-midwife, a hospital and community nurse, coroner or medical examiner, interviewer, abstractor, community outreach worker, mental health counselor, and other people important to the individual reviews. The CRT examines each case to determine medical, social, financial and other issues that may have impacted the poor birth outcome. Recommendations for community action are crafted by the CRT based on review findings. These recommendations are shared with the Community Action Group, a group of volunteers working with at-risk families and other partner agencies[34] in the region to implement and develop street-level outreach activities.[35]

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[30] Florida Vital Statistics Annual Report 2020, http://www.flpublichealth.com/VSbook/PDF/2020/Fetal.pdf (last visited Jan. 25, 2022).
[31] *Id. See also* Centers for Disease Control and Prevention, Infant Mortality Rates by State (2019), https://www.cdc.gov/nchs/pressroom/sosmap/infant_mortality_rates/infant_mortality.htm (last visited Jan. 25, 2022).
[32] Florida Department of Health. *FIMR, available at* http://www.doh.state.fl.us/family/mch/FIMR/fimr_facts.html (last visited Jan. 25, 2022).
[33] *Id.*
[34] Partner agencies may include health departments, hospitals, medical societies, schools, community and business leaders, and consumers
[35] *Supra*, note 31.

Comprehensive Statewide Tobacco Education and Use Prevention

On November 7, 2006, the voters in the State of Florida adopted Amendment 4, creating the Comprehensive Statewide Tobacco Education and Prevention Program.[36] Pursuant to the amendment, the state is required to create a comprehensive, statewide program consistent with the CDC's 1999 best practices, as periodically amended. The program must consist, at a minimum, of the following components:[37]

- An advertising campaign, funded by at least one-third of the required annual appropriation;
- Evidence-based curricula and programs to educate youth about tobacco and discourage their use of it;
- Programs of local community-based partnerships;
- Enforcement of laws, regulations, and policies against the sale or other provision of tobacco to minors, and the possession of tobacco by minors; and
- Publicly-reported annual evaluations to ensure that moneys appropriated for the program are spent properly.

The Constitution specifies that the Legislature must appropriate 15 percent of the total gross funds that tobacco companies paid to the State of Florida in 2005 under the Tobacco Settlement. This amount must be adjusted annually for inflation using the Consumer Price Index. For State Fiscal Year 2021-22, the mandated appropriation is $73.9 million.[38]

In 2007, the Legislature created s. 381.84, F.S., the Comprehensive Statewide Tobacco Education and Use Prevention Program (Program), to implement the constitutional amendment. The Program consists of nine components:[39]

- Counter-marketing and advertising;
- Cessation programs, counseling, and treatment;
- Surveillance and education;
- Youth and school programs;
- Community programs and chronic disease prevention;
- Training of health care practitioners, tobacco-use cessation counselors, and teachers;
- Administration and management;
- Enforcement and awareness of related laws; and
- The area health education centers (AHEC) tobacco-use cessation initiative.

Florida Perinatal Quality Collaborative

The FPQC was established in 2010 and is housed in the Chiles Center at the University of South Florida College of Public Health. FPQC aims to improve Florida's maternal and infant health outcomes through evidence-based perinatal care. FPQC partners with stakeholders, such as perinatal-related organizations, individuals, families, health professionals, hospitals, and payers, to develop and implement quality improvement initiatives at partner hospitals that provide

[36] Art. X, s. 27, Fla. Const.
[37] *Id.*
[38] Fla. General Appropriation Act Fiscal Year 2021-2022, SB 2500 item 458.
[39] Section 381.84(3), F.S.

birthing services (labor and delivery) to address maternal and infant mortality.[40] Hospital participation in FPQC initiatives is voluntary.

Currently, FPQC has four active initiatives:[41]

- **Promoting Primary Vaginal Deliveries (PROVIDE):**[42] The goal of the PROVIDE Initiative is to improve maternal and newborn outcomes by applying evidence-based interventions to promote primary vaginal deliveries at Florida delivery hospitals and ultimately reduce Nulliparous, Term, Singleton, Vertex cesareans.[43] Seventy-five hospitals currently participate in PROVIDE.
- **Family-Centered Care in the NICU (PAIRED):**[44] PAIRED helps hospital neonatal intensive care units (NICU) develop and implement unit-specific strategies to improve how a family engages with the NICU staff to assist in the care of their infant in a way that provides value to the family and to the NICU team. As its centerpiece project, this initiative facilitates adoption or expansion of safe skin-to-skin care, which has a growing evidence base for achieving better infant and family outcomes. Sixteen hospitals currently participate in PAIRED.
- **Perinatal Quality Indicators System (PQI):**[45] The PQI initiative supports hospital quality improvement efforts by providing hospital-specific semi-annual or quarterly reports of perinatal indicators and related reports. PQI is offered to all Florida delivery hospitals at no charge and hospitals can enroll at any time. Fifty-six hospitals currently participate in PQI.
- **Maternal Opioid Recovery Effort (MORE):**[46] MORE works with providers, hospitals, and other stakeholders to improve identification, clinical care, and coordinated treatment and support for pregnant women with opioid use disorder (OUD) and their infants. MORE focuses on standardization related to OUD screening, prevention, treatment, and comprehensive discharge planning. Thirty-one hospitals are currently participating in MORE.

III. Effect of Proposed Changes:

SB 146 amends several sections of law in order to reduce fetal and infant mortality.

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[40] USF Health College of Public Health, *Florida Perinatal Quality Collaborative – About the FPQC,* https://health.usf.edu/publichealth/chiles/fpqc/about (last visited Jan. 25, 2022).
[41] USF Health College of Public Health, *Florida Perinatal Quality Collaborative,* https://health.usf.edu/publichealth/chiles/fpqc (last visited Jan. 25, 2022).
[42] USF Health College of Public Health, *Florida Perinatal Quality Collaborative – Promoting Vaginal Deliveries,* https://health.usf.edu/publichealth/chiles/fpqc/provide (last visited Jan. 25, 2022).
[43] Nulliparous, Term, Singleton, Vertex (NTSV) Cesareans are cesarean births where babies are at or beyond 37.0 weeks gestation to women in their first pregnancy, that are singleton (no twins or beyond) and in the vertex presentation (no breech or transverse positions).
[44] USF Health College of Public Health, *Florida Perinatal Quality Collaborative – PAIRED Initiative,* https://health.usf.edu/publichealth/chiles/fpqc/paired (last visited Jan. 25, 2022).
[45] USF Health College of Public Health, *Florida Perinatal Quality Collaborative – Perinatal Quality Indicators System,* https://health.usf.edu/publichealth/chiles/fpqc/indicators (last visited Jan. 25, 2022).
[46] USF Health College of Public Health, *Florida Perinatal Quality Collaborative – Maternal Opioid Recovery Effort (MORE),* https://health.usf.edu/publichealth/chiles/fpqc/MORE (last visited Jan. 25, 2022).

Section 1 amends s. 381.84, F.S., to add the requirement that the Comprehensive Statewide Tobacco Education and Use Prevention Program must target information towards pregnant women and women who may become pregnant.

Section 2 creates s. 383.21625, F.S., to require the DOH to contract with local Healthy Start coalitions for the creation of FIMRs in all regions of the state. Each FIMR committee is required to:

- Review and analyze rates, trends, causes, and other data related to fetal and infant mortality and morbidity in its geographic area.
- Develop findings and recommendations for interventions and policy changes to reduce fetal and infant mortality and morbidity rates.
- Engage with local communities and stakeholders to implement recommended policies and procedures to reduce fetal and infant mortality and morbidity.

The bill also requires each Healthy Start coalition to report the findings and recommendations developed by its FIMR committee to the DOH annually. The DOH is required to compile the findings and recommendations in an annual report submitted to the Governor and the Legislature beginning October 1, 2023.

The bill gives the DOH rulemaking authority to implement the section and **Section 7** of the bill and appropriates $260,000 in recurring funds from General Revenue to the DOH to establish FIMRs in areas of the state where they do not exist.[47]

Sections 3, 4, and 5 amend ss. 390.011, 390.0111, and 390.0112, F.S., respectively, to amend provisions related to abortion.

Section 3 amends s. 390.011, F.S., to:

- Define the term "fatal fetal abnormality" to mean a terminal condition that, in reasonable medical judgment, regardless of the provision of life-saving medical treatment, is incompatible with life outside the womb and will result in death upon birth or imminently thereafter.
- Redefine the term "gestation" to mean the development of a human embryo or fetus as calculated from the first day of the pregnant woman's LMP. The current law definition is "gestation" as the development of a human embryo or fetus between fertilization and birth.
- Define "medical abortion" to mean the administration or use of an abortion-inducing drug to induce an abortion.

Section 4 amends s. 390.0111, F.S., to prohibit a physician from performing an abortion if the gestational age of the fetus is more than 15 weeks. The bill applies current law exceptions to the 15-week ban for emergencies and to save the pregnant woman's life or to prevent a serious risk of substantial and irreversible physical impairment of a major bodily function to the new

[47] Currently, 19 Healthy Start Coalition areas do not have FIMRs. For a map of the areas that do and do not have FMIRs see: Presentation on FMIRs by Cathy Timuta, CEO, Florida Association of Health Start Coalitions, Inc., in the Florida House Professions and Public Health Subcommittee, October 13, 2021, p. 5, available at https://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=3093&Session=2022&DocumentType=Meeting+Packets&FileName=pph+10-13-21.pdf (last visited Jan. 26, 2022).

prohibition. The bill also adds a new exception to the 15-week ban that applies if the fetus has a fatal fetal abnormality and has not reached viability.

Section 5 amends s. 390.0112, F.S., to require that the AHCA adopt by rule a form for reporting abortions that is consistent with the United States Standard Report of Induced Termination of Pregnancy adopted by the CDC. The bill requires the form to include:

- Information required to be reported under current law;
- The number of abortions performed; and
- The number of drug regimens dispensed or prescribed for medical abortions.

Additionally, the bill specifies that, should a woman provide evidence of human trafficking under the exceptions provided for obtaining informed consent in s. 390.011(3), F.S., human trafficking must be reported as a reason for the abortion.

Section 6 creates s. 395.1054, F.S, to require a hospital that provides birthing services to, at all times, participate in at least two quality improvement initiatives developed in collaboration with the FPQC within the University of South Florida College of Public Health.

The bill provides an effective date of July 1, 2022.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

This bill's provisions may implicate the privacy rights established by Federal case law, as well as privacy rights established in Art. I, s. 23, of the Florida Constitution. For a discussion on the relevant case law, please see the "Present Situation" section of this analysis.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The bill appropriates $260,000 in recurring General Revenue funds to the DOH for the purpose of establishing FIMR committees in areas of the state where no state-funded FIMR committees exist.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 381.84, 390.011, 390.0111, and 390.0112

This bill creates the following sections of the Florida Statutes: 383.21625 and 395.1054

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

CHAPTER 2023-21

Senate Bill No. 300

An act relating to pregnancy and parenting support; providing a short title; creating s. 286.31, F.S.; defining the terms "educational institution" and "governmental entity"; prohibiting any person, governmental entity, or educational institution from expending state funds for a specified purpose; providing exceptions; amending s. 381.96, F.S.; revising the definitions of the terms "eligible client" and "pregnancy and parenting support services"; requiring the Department of Health to contract for the management and delivery of parenting support services, in addition to pregnancy support services; revising the contract requirements to conform to changes made by the act; requiring the department to report specified information to the Governor and the Legislature by a specified date each year; amending s. 390.0111, F.S.; prohibiting physicians from knowingly performing or inducing a termination of pregnancy after the gestational age of the fetus is determined to be more than 6 weeks, rather than 15 weeks, with exceptions; providing an exception if the woman obtaining the abortion is doing so because she is a victim of rape, incest, or human trafficking, subject to certain conditions; requiring physicians to report known or suspected human trafficking of adults to local law enforcement; requiring physicians to report incidents of rape, incest, or human trafficking of minors to the central abuse hotline; prohibiting any person other than a physician from inducing a termination of pregnancy; prohibiting physicians from using telehealth to perform abortions; requiring that medications intended for use in a medical abortion be dispensed in person by a physician; prohibiting the dispensing of such medication through the United States Postal Service or any other courier or shipping service; conforming provisions to changes made by the act; repealing s. 390.01112, F.S., relating to termination of pregnancies during viability; amending s. 390.012, F.S.; revising rules the Agency for Health Care Administration may develop and enforce to regulate abortion clinics; amending s. 456.47, F.S.; prohibiting telehealth providers from using telehealth to provide abortions; providing appropriations; providing effective dates.

Be It Enacted by the Legislature of the State of Florida:

Section 1. <u>This act may be cited as the "Heartbeat Protection Act."</u>

Section 2. Section 286.31, Florida Statutes, is created to read:

<u>286.31 Prohibited use of state funds.—</u>

<u>(1) As used in this section, the term:</u>

<u>(a) "Educational institution" means public institutions under the control of a district school board, a charter school, a state university, a</u>

developmental research school, a Florida College System institution, the Florida School for the Deaf and the Blind, the Florida Virtual School, private school readiness programs, voluntary prekindergarten programs, private K-12 schools, and private colleges and universities.

(b) "Governmental entity" means the state or any political subdivision thereof, including the executive, legislative, and judicial branches of government; the independent establishments of the state, counties, municipalities, districts, authorities, boards, or commissions; and any agencies that are subject to chapter 286.

(2) Any person, governmental entity, or educational institution may not expend state funds as defined in s. 215.31 in any manner for a person to travel to another state to receive services that are intended to support an abortion as defined in s. 390.011, unless:

(a) The person, governmental entity, or educational institution is required by federal law to expend state funds for such a purpose; or

(b) There is a medical necessity for legitimate emergency medical procedures for termination of the pregnancy to save the pregnant woman's life or to avert a serious risk of imminent substantial and irreversible physical impairment of a major bodily function of the pregnant woman other than a psychological condition.

Section 3. Effective upon this act becoming a law, section 381.96, Florida Statutes, is amended to read:

381.96 Pregnancy support and wellness services.—

(1) DEFINITIONS.—As used in this section, the term:

(a) "Department" means the Department of Health.

(b) "Eligible client" means any of the following:

1. A pregnant woman or a woman who suspects she is pregnant, and the family of such woman, who voluntarily seeks pregnancy support services and any woman who voluntarily seeks wellness services.

2. A woman who has given birth in the previous 12 months and her family.

3. A parent or parents or a legal guardian or legal guardians, and the families of such parents and legal guardians, for up to 12 months after the birth of a child or the adoption of a child younger than 3 years of age.

(c) "Florida Pregnancy Care Network, Inc.," or "network" means the not-for-profit statewide alliance of pregnancy support organizations that provide pregnancy support and wellness services through a comprehensive system of care to women and their families.

(d) "Pregnancy and parenting support services" means services that promote and encourage childbirth, including, but not limited to:

1. Direct client services, such as pregnancy testing, counseling, referral, training, and education for pregnant women and their families. ~~A woman and her family shall continue to be eligible to receive direct client services for up to 12 months after the birth of the child.~~

2. Nonmedical material assistance that improves the pregnancy or parenting situation of families, including, but not limited to, clothing, car seats, cribs, formula, and diapers.

3. Counseling or mentoring, education materials, and classes regarding pregnancy, parenting, adoption, life skills, and employment readiness.

4. Network ~~Program~~ awareness activities, including a promotional campaign to educate the public about the pregnancy support services offered by the network and a website that provides information on the location of providers in the user's area and other available community resources.

5.~~3.~~ Communication activities, including the operation and maintenance of a hotline or call center with a single statewide toll-free number that is available 24 hours a day for an eligible client to obtain the location and contact information for a pregnancy center located in the client's area.

(e) "Wellness services" means services or activities intended to maintain and improve health or prevent illness and injury, including, but not limited to, high blood pressure screening, anemia testing, thyroid screening, cholesterol screening, diabetes screening, and assistance with smoking cessation.

(2) DEPARTMENT DUTIES.—The department shall contract with the network for the management and delivery of pregnancy and parenting support services and wellness services to eligible clients.

(3) CONTRACT REQUIREMENTS.—The department contract shall specify the contract deliverables, including financial reports and other reports due to the department, timeframes for achieving contractual obligations, and any other requirements the department determines are necessary, such as staffing and location requirements. The contract shall require the network to:

(a) Establish, implement, and monitor a comprehensive system of care through subcontractors to meet the pregnancy and parenting support and wellness needs of eligible clients.

(b) Establish and manage subcontracts with a sufficient number of providers to ensure the availability of pregnancy and parenting support services and wellness services for eligible clients, and maintain and manage the delivery of such services throughout the contract period.

(c) Spend at least 85 ~~90~~ percent of the contract funds on pregnancy and parenting support services, excluding services specified in subparagraph (1)(d)4., and wellness services.

(d) Offer wellness services through vouchers or other appropriate arrangements that allow the purchase of services from qualified health care providers.

(e) Require a background screening under s. 943.0542 for all paid staff and volunteers of a subcontractor if such staff or volunteers provide direct client services to an eligible client who is a minor or an elderly person or who has a disability.

(f) Annually monitor its subcontractors and specify the sanctions that shall be imposed for noncompliance with the terms of a subcontract.

(g) Subcontract only with providers that exclusively promote and support childbirth.

(h) Ensure that informational materials provided to an eligible client by a provider are current and accurate and cite the reference source of any medical statement included in such materials.

(i) Ensure that the department is provided with all information necessary for the report required under subsection (5).

(4) SERVICES.—Services provided pursuant to this section must be provided in a noncoercive manner and may not include any religious content.

(5) REPORT.—By July 1, 2024, and each year thereafter, the department shall report to the Governor, the President of the Senate, and the Speaker of the House of Representatives on the amount and types of services provided by the network; the expenditures for such services; and the number of, and demographic information for, women, parents, and families served by the network.

Section 4. Subsections (1), (2), (10), and (13) of section 390.0111, Florida Statutes, are amended to read:

390.0111 Termination of pregnancies.—

(1) TERMINATION AFTER GESTATIONAL AGE OF 6 ~~15~~ WEEKS; WHEN ALLOWED.—A physician may not knowingly perform or induce a termination of pregnancy if the physician determines the gestational age of the fetus is more than 6 ~~15~~ weeks unless one of the following conditions is met:

(a) Two physicians certify in writing that, in reasonable medical judgment, the termination of the pregnancy is necessary to save the pregnant woman's life or avert a serious risk of substantial and irreversible

physical impairment of a major bodily function of the pregnant woman other than a psychological condition.

(b) The physician certifies in writing that, in reasonable medical judgment, there is a medical necessity for legitimate emergency medical procedures for termination of the pregnancy to save the pregnant woman's life or avert a serious risk of imminent substantial and irreversible physical impairment of a major bodily function of the pregnant woman other than a psychological condition, and another physician is not available for consultation.

(c) The pregnancy has not progressed to the third trimester ~~fetus has not achieved viability under s. 390.01112~~ and two physicians certify in writing that, in reasonable medical judgment, the fetus has a fatal fetal abnormality.

(d) The pregnancy is the result of rape, incest, or human trafficking and the gestational age of the fetus is not more than 15 weeks as determined by the physician. At the time the woman schedules or arrives for her appointment to obtain the abortion, she must provide a copy of a restraining order, police report, medical record, or other court order or documentation providing evidence that she is obtaining the termination of pregnancy because she is a victim of rape, incest, or human trafficking. If the woman is 18 years of age or older, the physician must report any known or suspected human trafficking to a local law enforcement agency. If the woman is a minor, the physician must report the incident of rape, incest, or human trafficking to the central abuse hotline as required by s. 39.201.

(2) IN-PERSON PERFORMANCE BY PHYSICIAN REQUIRED.—Only a physician may perform or induce a ~~No~~ termination of pregnancy ~~shall be performed at any time except by a physician as defined in s. 390.011~~. A physician may not use telehealth as defined in s. 456.47 to perform an abortion, including, but not limited to, medical abortions. Any medications intended for use in a medical abortion must be dispensed in person by a physician and may not be dispensed through the United States Postal Service or by any other courier or shipping service.

(10) PENALTIES FOR VIOLATION.—Except as provided in subsections (3), (7), and (12):

(a) Any person who willfully performs, or actively participates in, a termination of pregnancy in violation of the requirements of this section ~~or s. 390.01112~~ commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(b) Any person who performs, or actively participates in, a termination of pregnancy in violation of this section ~~or s. 390.01112~~ which results in the death of the woman commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(13) FAILURE TO COMPLY.—Failure to comply with the requirements of this section ~~or s. 390.01112~~ constitutes grounds for disciplinary action under each respective practice act and under s. 456.072.

Section 5. Section 390.01112, Florida Statutes, is repealed.

Section 6. Subsection (1) of section 390.012, Florida Statutes, is amended to read:

390.012 Powers of agency; rules; disposal of fetal remains.—

(1) The agency may develop and enforce rules pursuant to ss. 390.011-390.018 and part II of chapter 408 for the health, care, and treatment of persons in abortion clinics and for the safe operation of such clinics.

~~(a)~~ The rules must ~~shall~~ be reasonably related to the preservation of maternal health of the clients and must.

~~(b) The rules shall be in accordance with s. 797.03 and may not impose an unconstitutional burden on a woman's freedom to decide whether to terminate her pregnancy.~~

~~(c) The rules shall~~ provide for:

(a)~~1.~~ The performance of pregnancy termination procedures only by a licensed physician.

(b)~~2.~~ The making, protection, and preservation of patient records, which must ~~shall~~ be treated as medical records under chapter 458. When performing a license inspection of a clinic, the agency shall inspect at least 50 percent of patient records generated since the clinic's last license inspection.

(c)~~3.~~ Annual inspections by the agency of all clinics licensed under this chapter to ensure that such clinics are in compliance with this chapter and agency rules.

(d)~~4.~~ The prompt investigation of credible allegations of abortions being performed at a clinic that is not licensed to perform such procedures.

Section 7. Paragraph (f) is added to subsection (2) of section 456.47, Florida Statutes, to read:

456.47 Use of telehealth to provide services.—

(2) PRACTICE STANDARDS.—

(f) A telehealth provider may not use telehealth to perform an abortion, including, but not limited to, medical abortions as defined in s. 390.011.

Section 8. (1) For the 2023-2024 fiscal year:

(a) In addition to any funds appropriated in the General Appropriations Act, the sum of $5 million in recurring funds from the General Revenue Fund is appropriated to the Department of Health for the purpose of implementing s. 381.0051(3), (4), and (6), Florida Statutes.

(b) The sum of $25 million in recurring funds from the General Revenue Fund is appropriated to the Department of Health for the purpose of implementing s. 381.96, Florida Statutes.

(2) This section takes effect upon this act becoming a law.

Section 9. Except as otherwise expressly provided in this act and except for this section, which shall take effect upon this act becoming a law, this act shall take effect 30 days after any of the following occurs: a decision by the Florida Supreme Court holding that the right to privacy enshrined in s. 23, Article I of the State Constitution does not include a right to abortion; a decision by the Florida Supreme Court in *Planned Parenthood v. State*, SC2022-1050, that allows the prohibition on abortions after 15 weeks in s. 390.0111(1), Florida Statutes, to remain in effect, including a decision approving, in whole or in part, the First District Court of Appeal's decision under review or a decision discharging jurisdiction; an amendment to the State Constitution clarifying that s. 23, Article I of the State Constitution does not include a right to abortion; or a decision from the Florida Supreme Court after March 7, 2023, receding, in whole or in part, from *In re T.W.*, 551 So. 2d 1186 (Fla. 1989), *North Fla. Women's Health v. State*, 866 So. 2d 612 (Fla. 2003), or *Gainesville Woman Care, LLC v. State*, 210 So. 3d 1243 (Fla. 2017).

Approved by the Governor April 13, 2023.

Filed in Office Secretary of State April 13, 2023.

HOUSE OF REPRESENTATIVES STAFF FINAL BILL ANALYSIS

BILL #: CS/HB 7 Pregnancy and Parenting Support
SPONSOR(S): Health & Human Services Committee, Persons-Mulicka and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 300

FINAL HOUSE FLOOR ACTION: 70 **Y's** 40 **N's** **GOVERNOR'S ACTION:** Approved

SUMMARY ANALYSIS

CS/HB 7 passed the House on April 13, 2023, as SB 300.

The Florida Pregnancy Support Services Program (FPSSP) provides pregnancy support services and wellness services to eligible clients. Pregnancy support services are services that promote and encourage childbirth, including direct client services, program awareness activities, and communication activities. Wellness services are services or activities intended to maintain and improve health or prevent illness and injury. Eligible clients include pregnant women and their families.

CS/HB 7 expands the types of services that may be provided through the FPSSP to include parenting services, nonmedical material assistance, counseling, mentoring, education materials, and classes on pregnancy, parenting, adoption, life skills and employment readiness. The bill also expands eligibility for services to include adoptive parents of children under age three and their families. These provisions become effective upon becoming law.

Current law prohibits abortions if the gestational age of the fetus is more than 15 weeks, with a medical exception and an exception for fatal fetal anomalies. The bill prohibits abortions if the gestational age of the fetus is more than 6 weeks, and retains the medical and fatal fetal anomaly exceptions. The bill adds exceptions for rape, incest and human trafficking if the fetus is less than 15 weeks of age under certain circumstances. The bill also deletes all provisions in current law related to the viability standard, including the prohibition against abortions after viability, as these provisions are no longer necessary.

Medication abortion is a two-step, two-drug, process that does not require surgical intervention. Current law does not regulate how physicians dispense these abortion-inducing drugs, or the use of telehealth to provide abortions. The bill requires abortion-inducing drugs to be dispensed in person by a physician, and expressly prohibits the use of telehealth for abortions.

Currently, Florida law does not prohibit the use of state funds for reimbursement of travel expenses for abortion. The bill prohibits the use of state funds to pay for the travel out-of-state to obtain an abortion except for cases of medical emergencies and when federal law requires states to pay for such travel.

The abortion provisions of the bill will only take effect if specified events occur that change Florida's jurisprudence on the privacy clause in the state constitution.

The bill appropriates $30 million in recurring General Revenue to the Department of Health. The bill has no fiscal impact on local government.

The bill was approved by the Governor on April 13, 2023, ch. 2023-21, L.O.F., and became effective upon becoming law, except as otherwise provided within the bill.

I. SUBSTANTIVE INFORMATION

A. EFFECT OF CHANGES:

Present Situation

Florida Pregnancy Support Services Program

The Florida Pregnancy Support Services Program (FPSSP) was created in 2005, in proviso in the General Appropriations Act, to encourage women to carry their pregnancies to term, and increase awareness of non-abortion counseling options, such as parenting or adoption.[1] In 2018, the Legislature created s. 381.96, F.S. to codify the FPSSP in Florida Statutes.

Current law requires the Department of Health (DOH) to contract with the Florida Pregnancy Care Network, Inc. (FPCN), to manage subcontracts with the direct service providers throughout the state to provide services under the FPSSP.[2] The contract with FPCN must:[3]

- Require that FPCN establish and manage subcontracts with a sufficient number of providers to ensure the availability pregnancy support and wellness services for eligible clients;
- Require that 90 percent of contract funds be used on pregnancy support and wellness services for eligible clients;
- Require that FPCN ensures that all paid staff and volunteers of the providers undergo background screenings if they provide direct client services to eligible clients who are minors, elderly, or have a disability;
- Require FPCN to annually monitor the providers for compliance with subcontract provisions and define the actions to be taken for noncompliance;
- Limit the providers with which FPCN may contract to those that solely promote and support childbirth;
- Provide that any informational materials provided to an eligible client by a provider must be current and accurate, with the reference source of any medical statement made available; and
- Define the contract deliverables, including financial reports and other reports due to DOH, timeframes for achieving contractual obligations, and any other requirements that DOH determines necessary, such as staffing and location requirements.

The FPSSP provides pregnancy support services and wellness services to eligible clients. Pregnancy support services are services that promote and encourage childbirth, including direct client services, program awareness activities, and communication activities[4]. Direct client services include, but are not limited to:

- Pregnancy testing;
- Counseling;
- Training; and
- Education.

Wellness services are services or activities intended to maintain and improve health or prevent illness and injury, including but not limited to:

[1] Florida Pregnancy Care Network, Inc., *Florida Pregnancy Support Services Program (FPSSP), 2016-2017 Compliance Manual*, on file with the Health Quality Subcommittee.
[2] S. 381.96, F.S.
[3] Id.
[4] Communication activities, include the operation and maintenance of a hotline or call center with a single statewide toll-free number that is available 24 hours a day for an eligible client to obtain the location and contact information for a pregnancy center located in the client's area.

- Anemia testing;
- Assistance with smoking cessation; and
- Screenings for high blood pressure, thyroid functioning, cholesterol, and diabetes.

State-funded pregnancy support services and wellness services must be provided in a noncoercive manner and may not include any religious content.

Current law requires the FPSSP to operate a 24-hour toll-free hotline. The hotline must provide an eligible client with the location and contact information for a pregnancy center located in the client's area.[5]

Eligible clients include a pregnant woman or a woman who suspects she is pregnant, and her family, who voluntarily seeks pregnancy support services, and any woman who voluntarily seeks wellness services. A woman and her family are eligible for direct client services for up to 12 months after the birth of the child. Adoptive parents and their families are not expressly eligible for FPSSP services.

Currently, 53 subcontractors, in 102 center locations, provide services in the FPSSP. In Fiscal Year 2021-2022 the FPSSP fielded 9,463 hotline calls and provided 143,000 services to over 42,000 women and their families.[6] The FPSSP is currently funded with $4.5 million recurring General Revenue.[7]

Federal Law on Abortion

In 1973, the foundation of modern abortion jurisprudence, *Roe v. Wade*[8], was decided by the U.S. Supreme Court (Supreme Court). The Supreme Court determined that a woman's right to an abortion is part of a fundamental right to privacy guaranteed under the Due Process Clause of the Fourteenth Amendment of the U.S. Constitution. Further, the Court reasoned that state regulation limiting the exercise of this right is subject to strict scrutiny: it must be justified by a compelling state interest, and must be narrowly drawn.[9] In 1992, the fundamental holding of *Roe* was upheld by the U.S. Supreme Court in *Planned Parenthood v. Casey*.[10]

The Viability Standard

In *Roe v. Wade*, the Supreme Court established a rigid trimester framework dictating when, if ever, states can regulate abortion.[11] The Court held that states could not regulate abortions during the first trimester of pregnancy.[12] With respect to the second trimester, the Court held that states could only enact regulations aimed at protecting the mother's health, not the fetus's life. Therefore, no ban on abortions is permitted during the second trimester. The state's interest in the life of the fetus becomes sufficiently compelling only at the beginning of the third trimester, allowing it to prohibit abortions. Even then, the Court requires states to permit an abortion in circumstances necessary to preserve the health or life of the mother.[13]

The current viability standard is set forth in *Planned Parenthood v. Casey*.[14] Recognizing that medical advancements in neonatal care can advance viability to a point somewhat earlier than the third trimester, the Supreme Court rejected the trimester framework and, instead, limited the states' ability to regulate abortion pre-viability. Thus, while upholding the underlying holding in *Roe*, which authorizes

[5] S. 381.96, F.S.
[6] Florida Pregnancy Care Network, Inc., *Florida Pregnancy Care Network Annual Report 2021-2022*, on file with the Healthcare Regulation Subcommittee.
[7] Id.
[8] *Roe v. Wade*, 410 U.S. 113 (1973).
[9] Id.
[10] *Casey*, 505 U.S. 833 (1992).
[11] *Roe*, 410 U.S. 113 (1973).
[12] *Id.* at 163-64.
[13] *Id.* at 164-165.
[14] *Planned Parenthood of SE Pa. v. Casey*, 505 U.S. 833 (1992).

states to "regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother[,]"[15] the Court determined that the line for this authority should be drawn at "viability," because "there may be some medical developments that affect the precise point of viability . . . but this is an imprecision within tolerable limits given that the medical community and all those who must apply its discoveries will continue to explore the matter."[16] Furthermore, the Court recognized that "[i]n some broad sense it might be said that a woman who fails to act before viability has consented to the State's intervention on behalf of the developing child."[17]

The Undue Burden Standard

In *Planned Parenthood v. Casey*, the Supreme Court established the undue burden standard for determining whether a law places an impermissible obstacle to a woman's right to an abortion. The Court held that health regulations which impose undue burdens on the right to abortion are invalid.[18] State regulation imposes an "undue burden" on a woman's decision to have an abortion if it has the purpose or effect of placing a substantial obstacle in the path of the woman who seeks the abortion of a nonviable fetus.[19] However, the court opined, not every law which makes the right to an abortion more difficult to exercise is an infringement of that right.[20]

The Medical Emergency Exception

In *Doe v. Bolton*, the Supreme Court was faced with determining, among other things, whether a Georgia statute criminalizing abortions (pre- and post-viability), except when determined to be necessary based upon a physician's "best clinical judgment," was unconstitutionally void for vagueness for inadequately warning a physician under what circumstances an abortion could be performed.[21] In its reasoning, the Court agreed with the district court decision that the exception was not unconstitutionally vague, by recognizing that:

> [T]he medical judgment may be exercised in the light of all factors—physical, emotional, psychological, familial, and the woman's age-relevant to the well-being of the patient. All these factors may relate to health. This allows the attending physician the room he needs to make his best medical judgment.[22]

This broad interpretation of what constitutes a medical emergency was later tested in *Casey*[23], albeit in a different context. One question before the Supreme Court in *Casey* was whether the medical emergency exception to a 24-hour waiting period for an abortion was too narrow in that there were some potentially significant health risks that would not be considered "immediate."[24] The exception in question provided that a medical emergency is:

> [T]hat condition which, on the basis of the physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function.[25]

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[15] *See Roe*, 410 U.S. at 164-65.
[16] *See Casey*, 505 U.S. at 870.
[17] *Id.*
[18] Id. at 878.
[19] Id. at 877
[20] Id. at 873.
[21] *Doe*, 410 U.S. at 179 (1973). Other exceptions, such as in cases of rape and when, "[t]he fetus would very likely be born with a grave, permanent, and irremediable mental or physical defect." *Id.* at 183. *See also, U.S. v. Vuitich*, 402 U.S. 62, 71-72 (1971) (determining that a medical emergency exception to a criminal statute banning abortions would include consideration of the mental health of the pregnant woman).
[22] *Doe*, 410 U.S. at 192.
[23] *Casey*, 505. U.S. 833 (1992).
[24] *Id.* at 880.
[25] *Id.* at 879 (quoting 18 Pa. Cons. Stat. § 3203 (1990)).

In evaluating the more objective standard under which a physician is to determine the existence of a medical emergency, the Court in *Casey* determined that the exception would not significantly threaten the life and health of a woman and imposed no undue burden on the woman's right to have an abortion.[26]

Jackson Women's Health Organization v. Dobbs

In 2018, Mississippi enacted the Gestational Age Act (Act) which prohibited a person from performing an abortion if the probable gestational age of the fetus is greater than 15 weeks. Jackson Women's Health Organization filed a lawsuit challenging the Act alleging that it was an unconstitutional pre-viability ban on abortion. The state argued the Act was a constitutional restriction on abortion. The federal trial court ruled in favor of Jackson Women's Health Organization, which was upheld by the Fifth Circuit of Appeals.[27] The state appealed the ruling to the Supreme Court. In June 2021, the Supreme Court ruled in favor of the state and overruled *Roe and Casey*. The Court held that the Constitution does not provide a right to abortion and the authority to regulate abortion is returned to the people and their elected representatives.[28] Thus, whether an abortion regulation is unconstitutional must be determined on the respective constitution of each state rather than the Constitution.

Florida Abortion Law

Privacy Clause

The Florida Constitution, as interpreted by Florida courts, affords greater privacy rights than those provided by the U.S. Constitution. While the federal Constitution traditionally shields enumerated and implied individual liberties from state or federal intrusion, the Supreme Court has noted that state constitutions may provide greater protections.[29] Unlike the U.S. Constitution, Article I, s. 23 of the Florida Constitution contains an express right to privacy:

> Every natural person has the right to be let alone and free from governmental intrusion into the person's private life except as otherwise provided herein. This section shall not be construed to limit the public's right of access to public records and meetings as provided by law.

The Florida Supreme Court opined in *In re T.W.* that this section provides greater privacy rights than those implied by the U.S. Constitution.[30]

The Florida Supreme Court has recognized Florida's constitutional right to privacy "is clearly implicated in a woman's decision whether or not to continue her pregnancy."[31] In *In re T.W.,* the Florida Supreme Court ruled that:[32]

> [P]rior to the end of the first trimester, the abortion decision must be left to the woman and may not be significantly restricted by the state. Following this point, the state may impose significant restrictions only in the least intrusive manner designed to safeguard the health of the mother. Insignificant burdens during either period must substantially further important state interests….Under our Florida Constitution, the state's interest becomes compelling upon viability….Viability under Florida law

[26] *Id.* at 880.
[27] See *Jackson Women's Health Organization v. Dobbs,* 945 F.3d 265 (5th Cir. 2019).
[28] See *Dobbs v. Jackson Women's Health Organization*, 142 S.Ct. 2228 (2021).
[29] *Pruneyard Shopping Center v. Robins*, 100 S.Ct. 2035, 2040 (1980), cited in *In re T.W.*, 551 So.2d 1186, 1191 (Fla. 1989).
[30] Id. at 1191-1192.
[31] Id. at 1192.
[32] Id. at 1193.

occurs at that point in time when the fetus becomes capable of meaningful life outside the womb through standard medical procedures.

The court recognized that after viability, the state can regulate abortion in the interest of the unborn child if the mother's health is not in jeopardy.[33]

The state may regulate abortion pre-viability based upon its interest in maternal health beginning in the second trimester. In *Fla. Women's Medical Clinic, Inc. v. Smith,* the court held that the state has an interest in maternal health only after the first trimester, not before, and may not impose substantive clinical standards in the first trimester.[34]

Abortion Regulation

Abortion clinics are regulated by the Agency for Health Care Administration (AHCA) under ch. 390, F.S. Physicians performing abortions (which may take place in abortion clinics, hospitals, physician offices or other physician settings) are regulated by the Department of Health (DOH) under chs. 458 and 459 F.S.

In Florida, abortion is defined as the termination of a human pregnancy with an intention other than to produce a live birth or to remove a dead fetus.[35] An abortion must be performed by a physician[36] licensed under ch. 458, F.S., or ch. 459, F.S., or a physician practicing medicine or osteopathic medicine in the employment of the United States.[37]

Florida law prohibits abortions if the physician performing abortion determines the gestational age of the fetus is more than 15 weeks, based on the first day of the woman's last menstrual period.[38] Section 390.01112, F.S., prohibits an abortion from being performed if a physician determines that, in reasonable medical judgment, the fetus has achieved viability.[39] Exceptions to both of these prohibitions exist if:

- Two physicians certify in writing that, in reasonable medical judgment, the termination of the pregnancy is necessary to save the pregnant woman's life or avert a serious risk of substantial and irreversible physical impairment of a major bodily function of the pregnant woman other than a psychological condition; or
- One physician certifies in writing that, in reasonable medical judgment, there is a medical necessity for legitimate emergency medical procedures for termination of the pregnancy to save the pregnant woman's life or avert a serious risk of imminent substantial and irreversible physical impairment of a major bodily function of the pregnant woman other than a psychological condition, and another physician is not available for consultation.[40]

[33] Id. at 1194.
[34] Fla. Women's Medical Clinic, Inc. v. Smith, 478 F.Supp. 233 (S.D. Fla. 1979); Fla. Women's Medical Clinic, Inc. v. Smith, 536 F.Supp. 1048 (S.D. Fla. 1982).
[35] Section 390.011(1), F.S. Removal of a deceased fetus due to miscarriage or other causes is not abortion under Florida law.
[36] Section 390.0111(2), F.S.
[37] Section 390.011(8), F.S.
[38] Section 390.0111(1), F.S.
[39] Viability is defined as the stage of fetal development when the life of a fetus is sustainable outside the womb through standard medical measures. Section 390.011(13), F.S.
[40] Sections 390.0111(1)(a) and (b) and 390.01112(1)(a) and (b), F.S.

Florida law also provides an exception to the 15-week prohibition if the fetus has not achieved viability and two physicians certify in writing that, in reasonable medical judgment, the fetus has a fatal fetal abnormality.[41]

In June 2022, shortly before the law was to take effect, various abortion providers filed a legal challenge to the prohibition against abortions after 15 weeks. The case is currently pending before the Florida Supreme Court in *Planned Parenthood of Southwest and Central Florida v. State of Florida*. The law remains in effect throughout the duration of the pending litigation.

Abortion Data

In 2022, there were 224,582 live births in Florida.[42] In the same year, there were 82,192 abortion procedures[43] performed in the state. Of those:

- 75,118 were performed in the first trimester (12 weeks and under);
- 7,074 were performed in the second trimester (13 to 24 weeks); and
- None were performed in the third trimester (25 weeks and over).

The majority of the procedures (59,794) were elective.[44] The remainder of the abortions were performed due to:

- Emotional or psychological health of the mother (1,899);
- Physical health of the mother that was not life endangering (1,207);
- Life endangering physical condition (175);
- Rape (115);
- Incest (7);
- Serious fetal genetic defect, deformity, or abnormality (578); and
- Fatal fetal abnormality (66)
- Social or economic reasons (18,351).

No abortions were reported to have been performed due to human trafficking.

Medication Abortion

Medication abortion is a two-step process that does not require surgical intervention. Medication abortions consist of a health care practitioner, usually a physician, providing a patient with mifepristone and misoprostol. The FDA has approved the use of these drugs during the first 70 days of a pregnancy under the following dosing regimen:[45]

- 200 mg of mifepristone taken by mouth. This blocks progesterone, which is a hormone that is necessary for a pregnancy to continue. Without progesterone, the embryo or fetus detaches from the uterine wall.
- 24 to 48 hours after taking mifepristone: 800 mcg of misoprostol taken buccally (in the cheek pouch), at a location appropriate for the patient. This softens and dilates the cervix and causes uterine contractions that expel the embryo or fetus.

[41] Section 390.0111(1), F.S. A "fatal fetal abnormality" is a terminal condition that, in reasonable medical judgment, regardless of the provision of life-saving medical treatment, is incompatible with life outside the womb and will result in death upon birth or imminently thereafter.
[42] Correspondence from the Department of Health dated March 11, 2023, on file with the Healthcare Regulation Subcommittee.
[43] Reported Induced Terminations of Pregnancy by Reason, by Trimester, Agency for Health Care Administration, available at https://ahca.myflorida.com/mchq/central_services/training_support/docs/TrimesterByReason_2022.pdf (last viewed May 9, 2023).
[44] Id.
[45] *Questions and Answers on Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation*, U.S. Food & Drug Administration, available at https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/questions-and-answers-mifepristone-medical-termination-pregnancy-through-ten-weeks-gestation (last visited May 9, 2023).

- Seven to fourteen days after taking mifepristone: follow-up visit with the healthcare provider to confirm that the abortion is complete.

Originally, the FDA required practitioners to dispense mifepristone only in clinics, medical offices and hospitals.[46] This necessitates an in-person visit to obtain the drugs. This requirement discourages the use of telemedicine, although there is no express federal prohibition against using telemedicine for a medication abortion.

In April 2021, the FDA waived this in-person dispensing requirement for the duration of the COVID-19 federal public health emergency.[47] This allowed patients to receive abortion-inducing drugs through the mail or other home delivery services. This increased the probability of prescribers using telemedicine to perform medication abortion in states where not prohibited by state law.

On December 16, 2021, the FDA permanently removed the in-person dispensing requirement.[48]

The table below illustrates the current and prior FDA rules.

Protocol	Original FDA Regimen	New FDA Regimen (12/16/21)
Maximum gestational age	70 days from LMP	Same
Mifepristone dose	200 mg. orally	Same
Misoprostol dose	800 mg. buccally (in cheek pouch)	Same
Misoprostol timing	24-48 hours after mifepristone	Same
Misoprostol location	Home	Same
Follow-up visit	7-14 days after mifepristone	Same
Dispensing Method	Both drugs may only be dispensed in-person to a patient, in clinics, medical offices and hospitals	In-person requirement eliminated. Both drugs may be dispensed by a pharmacy or mailed directly to a patient

Because this drug regimen for abortion, and Florida law allows only physicians to perform abortions, only physicians can perform medication abortions. However, Florida law does not expressly regulate the manner in which a physician dispenses the abortion-inducing drug regimen.

Telehealth

Telehealth is not a type of health care service; rather, it is a mechanism for delivery of health care services. Health care professionals use telehealth as a platform to provide traditional health care services in a non-traditional manner. These services include, among others, preventative medicine and the treatment of chronic conditions.[49] Section 456.74, F.S., enacted in 2019, regulates the use of telehealth by Florida and out-of-state healthcare providers.

[46] Id.
[47] Id.
[48] Id.
[49] U.S. Department of Health and Human Services, *Report to Congress: E-Health and Telemedicine* (August 12, 2016), available at https://aspe.hhs.gov/system/files/pdf/206751/TelemedicineE-HealthReport.pdf (last visited January 23, 2023).

Current law broadly defines telehealth as the use of synchronous or asynchronous telecommunications technology by a telehealth provider to provide health care services, including, but not limited to: [50]

- Assessment, diagnosis, consultation, treatment, and monitoring of a patient;
- Transfer of medical data;
- Patient and professional health-related education;
- Public health services; and
- Health administration.

A patient receiving telehealth services may be in any location at the time services are rendered and a telehealth provider may be in any location when providing telehealth services to a patient.

Health care services may be provided via telehealth by a Florida-licensed health care practitioner, a practitioner licensed under a multistate health care licensure compact of which Florida is a member,[51] or an out-of-state-health care provider who registers with the Department of Health.[52]

Current law requires telehealth providers to meet the same standard of care required for in-person health care services to patients in this state. This ensures that a patient receives the same standard of care irrespective of the modality used by the health care professional to deliver the services.[53]

Telehealth Abortion

Sixteen states currently have laws prohibiting the use of telemedicine to perform medication abortions.[54] In general, these laws expressly prohibit the use of telemedicine to perform abortions or require the physician to be physically present in the same room as the patient when performing the abortion.

Florida law does not expressly prohibit the use of telehealth to perform medication abortions; however, two requirements in current law prevent the use of telehealth for this purpose. First, current law requires the physician performing the abortion to verify the probable gestational age of the fetus, by ultrasound, at the time the abortion is performed.[55] This nature of the ultrasound procedure, and the requirement that it be contemporaneous with the abortion procedure, likely prevents telehealth use.

Second, current law also requires the physician performing the abortion or the referring physician to engage in an informed consent colloquy with the patient, in the same room as the patient, at least 24 hours before the abortion procedure.[56] While the abortion-inducing drug regimen could be provided by telehealth or mail after this, the need for an in-person appointment would negate the usefulness of telehealth.

Travel Reimbursement for Abortions

Following the Supreme Court's decision in *Dobbs*, several major corporations announced that they would be offering travel reimbursement for abortions to their employees.[57] The type of reimbursement

[50] S. 456.47(1)(a), F.S.
[51] Florida is a member of the Nurse Licensure Compact. *See* s. 464.0095, F.S.
[52] S. 456.47(4), F.S.
[53] S. 456.47(2), F.S.
[54] AZ, AL, IN, KY, LA, MI, MS, MO, NE, NC, ND, SC, SD, TN, WV, WI.
[55] Section 390.0111(3)(b), F.S. The physician performing the abortion, or person qualified to operate an ultrasound who is working in conjunction with the physician, must perform the ultrasound.
[56] Section 390.0111(3)(a), F.S.
[57] *These Companies Will Cover Travel Expenses for Employee Abortions,* The New York Times, Emma Goldberg, August 19, 2022, available at https://www.nytimes.com/article/abortion-companies-travel-expenses.html (last viewed May 9, 2023); *Employer Coverage of Travel Costs for Out-of-State Abortion*, Kaiser Family Foundation, Michelle Long, Laurie Sobel, Alina Salganicoff, and Kaye Pestaina, May 16, 2022, available at https://www.kff.org/policy-watch/employer-coverage-travel-costs-out-of-state-abortion/ (last viewed May 9, 2023); *Companies Are Announcing Abortion-Travel Benefits Following Dobbs Decision*, Society for Human Resource

available varies but often includes expenses for travel and lodging, with one company allowing up to $4,000 for these expenses.[58] Reimbursement is commonly provided through the employers' health insurance plan or through employer-sponsored self-funded plans.[59]

Currently, Florida law does not prohibit the use of state funds for reimbursement of travel expenses for abortion.

Family Planning

DOH administers Florida's comprehensive family planning program through local county health departments or contracted agencies. The program must include, at a minimum:[60]

- Comprehensive family planning education and counseling programs;
- Prescription for and provision of all medically recognized methods of contraception;
- Medical evaluation, including cytological examination and other appropriate laboratory tests; and
- Treatment of physical complications other than pregnancy resulting from the use of contraceptive methods.

DOH must provide these services at locations and times readily available to the population served. Fees for these services are based upon the cost of the service and the individual's ability to pay.[61]

The program may provide maternal health and contraceptive information and services of a nonsurgical nature[62] to a minor if the minor:[63]

- Is married;
- Is a parent;
- Is pregnant;
- Has the consent of a parent or legal guardian; or
- May, in the opinion of the physician, suffer probable health hazards if such services are not provided.

In Fiscal Year 2021-2022 DOH expended approximately $20 million in state and federal funds to provide services in the family planning program.[64]

Effect of the Bill

Pregnancy Support Services

CS/HB 7 expands the types of services that may be provided through the FPSSP. These services include:

- Parenting services.
- Nonmedical material assistance including, but not limited to, cribs, car seats, clothing, diapers and formula.
- Counseling or mentoring.
- Education materials.

Management, Stephen Miller, June 27, 2022, available at https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/companies-announce-abortion-travel-benefits-following-dobbs-decision.aspx (last viewed May 9, 2023).
[58] Id.
[59] Id.
[60] S. 381.0051(3), F.S.
[61] Id.
[62] Application of nonpermanent internal contraceptive devices are not considered to be a surgical procedure.
[63] S. 381.0051(4), F.S
[64] Correspondence from DOH to the staff of the Health and Human Services Committee dated 3/13/23 on file with the committee.

- Classes on pregnancy, parenting, adoption, life skills and employment readiness.

The bill also expands eligibility for services to include adoptive parents of children under age three and their families.

The bill requires the FPSSP to spend at least 85 percent of the contract funds on pregnancy and parenting support services and wellness services.

The bill requires the FPSSP to submit an annual report to the Governor and the Legislature beginning July 1, 2024.

These bill provisions will be effective upon the bill becoming law.

Abortion Regulations

Six-Week Limit

CS\HB 7 names the act the "Heartbeat Protection Act" and prohibits abortions after 6 weeks' gestational age, as determined by the physician using an ultrasound. Gestational age is counted from the first day of the woman's last menstrual period (LMP), consistent with current law. This replaces the current 15-week limit.

The bill retains the same medical exception to prohibited abortions in existing law: [65]

- Two physicians certify in writing that, in reasonable medical judgment, the termination of the pregnancy is necessary to save the pregnant woman's life or avert a serious risk of substantial and irreversible physical impairment of a major bodily function of the pregnant woman other than a psychological condition; or
- One physician certifies in writing that, in reasonable medical judgment, there is a medical necessity for legitimate emergency medical procedures for termination of the pregnancy to save the pregnant woman's life or avert a serious risk of imminent substantial and irreversible physical impairment of a major bodily function of the pregnant woman other than a psychological condition, and another physician is not available for consultation.

The bill also retains the exception for fatal fetal anomalies in current law, but modifies its applicability. Currently, the exception applies until the fetus achieves viability. Under the bill the exception is applicable if the pregnancy has not progressed to the third trimester.

The bill establishes an exception to prohibited abortions for women seeking an abortion because they are victims of rape, incest, or human trafficking. The fetus must be less than 15 weeks, as determined by the physician, and the woman must provide certain documentation when she schedules or arrives for the abortion. The woman must provide a copy of a restraining order, police report, medical record, or other court order or documentation providing evidence that she is obtaining the termination of pregnancy because she is a victim of rape or incest. This is the same documentation currently required for the rape and incest exceptions related to offers to view the ultrasound and the 24-hour waiting period.[66] The bill requires physicians to report incidents of rape, incest, and human trafficking to the central abuse hotline[67] if the woman is a minor and incidents of human trafficking to law enforcement if the woman is an adult.

[65] Sections 390.0111(1)(a) and (b) and 390.01112(1)(a) and (b), F.S.
[66] Sections 390.0111(3) (a), F.S.
[67] Section 39.101, F.S., establishes the central abuse hotline and s. 39.201, F.S., sets forth mandatory reporting requirements.

The bill deletes all provisions in current law related to the viability standard including the prohibition against abortions after viability. These provisions are no longer necessary because the bill bans abortions after six weeks. The bill also deletes certain AHCA rule-making provisions for abortions clinics, related to federal jurisprudence prior to *Dobbs*.

Medication Abortion and Telehealth

Current law does not regulate how physicians dispense abortion-inducing drugs or the use of telehealth to provide abortions. The bill requires abortion-inducing drugs to be dispensed in-person by a physician and expressly prohibits the use of telehealth for abortions.

Travel Reimbursement for Abortions

Currently, Florida law does not prohibit the use of state funds for reimbursement of travel expenses for abortion. The bill prohibits the use of state funds to pay for the travel out-of-state to obtain an abortion except for cases of medical emergencies and when federal law requires states to pay for such travel.

Effective Date

These provisions only take effect if specified events occur that change Florida's jurisprudence on the privacy clause in the state constitution which include:

- The Florida Supreme Court:
  - Recedes from its decision in *In Re T.W*. or its progeny.
  - Determines that the Florida constitution right to privacy provision does not include abortion.
  - Rules in favor of the state in case challenging the 15-week abortion ban (*Planned Parenthood of Southwest and Central Florida v. State of Florida*).

- Florida voters adopt a state constitutional amendment clarifying that the right to privacy does not include abortion.

The bill becomes effective upon becoming law, except the provisions related to abortion regulation which are effective upon the jurisprudential change specified in the bill.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill appropriates an additional $25 million in recurring General Revenue to the DOH for the purpose of expanding the functions of the FPSSP. The bill also appropriates an additional $5 million in recurring General Revenue for family planning services provided by the DOH pursuant to s. 381.0051, F.S.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Fiscal Policy

BILL:	SB 300
INTRODUCER:	Senator Grall and others
SUBJECT:	Pregnancy and Parenting Support
DATE:	March 27, 2023
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Brown	HP	**Favorable**
2.	Looke	Yeatman	FP	**Favorable**

I. Summary:

SB 300 amends and creates multiple provisions of law related to pregnancy support and wellness services, the state's Family Planning Program, and the termination of pregnancies.

The bill prohibits abortion after six weeks of gestation unless an exception is met. Current-law exceptions to abortion time frames are maintained and a new exception is established for cases in which the pregnancy is the result of rape or incest. This new exception is available until the 15th week of gestation under the bill.

The bill specifies that abortions, including medical abortions,[1] may not be provided through telehealth and that medication intended for the use in a medical abortion may only be dispensed by a physician and may not be dispensed via the U.S. Postal Service or by any other carrier. The bill also prohibits any person, educational institution, and governmental entity from expending state funds for a person to travel to another state to receive services that are intended to support an abortion, unless such expenditure is required by federal law or there is a legitimate medical emergency.

SB 300 also amends the pregnancy support and wellness services network established in s. 381.96, F.S., to expand eligibility for such services to women who have given birth in the past 12 months and to parents or guardians of children under the age of three for up to 12 months. The bill adds new services and assistance which the network is required to provide, including counseling, mentoring, educational materials, and classes as well as material assistance including clothing, car seats, cribs formula, and diapers. The bill also requires that the Department of Health (DOH) report to the Governor and the Legislature annually on the types, amount, and costs of services provided as well as demographic information on persons who receive such services.

[1] Section 390.011(9), F.S., provides that "medical abortion" means the administration or use of an abortion-inducing drug to induce an abortion.

The bill appropriates $25 million in recurring general revenue for the expanded network and specifies that contracted organizations in the network must spend at least 85 percent of the funds received on providing services and maintaining a hotline.

The bill also appropriates $5 million in recurring general revenue, above what is currently appropriated in the General Appropriations Act (GAA), for family planning services provided by the Department of Health pursuant to s. 381.0051, F.S.

The bill makes other technical and clean-up changes, including repealing s. 390.01112, F.S., which is unused; clarifying that the current-law exception for fatal fetal anomalies is available until the third trimester of pregnancy, rather than until fetal viability; and repealing rulemaking language that is no longer applicable.

The provisions of the bill, other than the expansion of the pregnancy support network and the appropriations which are effective upon becoming law, are effective 30 days after one of several events occurs. These events include a Florida Supreme court ruling overturning *In re T.W.*,[2] or one of several other related cases; a Florida Supreme court ruling stating that the privacy clause in the Florida Constitution does not protect the right to abortion; or an amendment to the Florida Constitution which provides the same.

II. Present Situation:

Federal Case Law on Abortion

Roe v. Wade

In 1973, the U.S. Supreme Court issued the landmark *Roe v. Wade* decision.[3] Using the strict scrutiny standard, the Court determined that a woman's right to terminate a pregnancy is protected by a fundamental right to privacy guaranteed under the Due Process Clause of the Fourteenth Amendment of the U.S. Constitution. Further, the Court reasoned that state regulations limiting the exercise of this right must be justified by a compelling state interest and must be narrowly drawn.

Casey

In 1992, the U.S. Supreme Court ruled on the constitutionality of a Pennsylvania statute involving a 24-hour waiting period between the provision of information to a woman and the performance of an abortion. In that decision, *Planned Parenthood of Southeastern Pennsylvania v. Casey* (a.k.a. "*Casey*"),[4] the Court upheld the statute and relaxed the standard of review in abortion cases involving adult women from "strict scrutiny" to "unduly burdensome." Under *Casey*, an undue burden exists and makes a statute invalid if the statute's purpose or effect is to place a substantial obstacle in the way of a woman seeking an abortion before the fetus is viable.

[2] The seminal case on abortion, discussed in the present situation.
[3] *Roe v. Wade*, 410 U.S. 113, 93 S. Ct. 705, 35 L. Ed. 2d 147 (1973)
[4] *Planned Parenthood of Se. Pennsylvania v. Casey*, 505 U.S. 833, 112 S. Ct. 2791, 120 L. Ed. 2d 674 (1992)

The Court held that the undue burden standard is an appropriate means of reconciling a state's interest in human life with the woman's constitutionally protected liberty to decide whether to terminate a pregnancy. The Court determined that, prior to fetal viability, a woman has the right to an abortion without being unduly burdened by government interference. Before viability, a state's interests are not strong enough under *Casey* to support prohibiting an abortion or the imposition of a substantial obstacle to the woman's right to select the procedure. However, once viability occurs, a state has the power to restrict abortions if the law contains exceptions for pregnancies that endanger a woman's life or health.

Dobbs

On June 24, 2022, the U.S. Supreme Court ruled on Jackson Women's Health Org. v. Dobbs (a.k.a. "*Dobbs*"),[5] a case involving Mississippi's Gestational Age Act. The Gestational Age Act prohibited all abortions after 15 weeks of gestational age and was permanently enjoined by the lower courts in 2019. In *Dobbs*, the U.S. Supreme Court explicitly and entirely overruled *Roe v. Wade* and *Casey*, returning all abortion regulation decisions back to state control. The Court stated:

> [*Roe v. Wade*] was…egregiously wrong and on a collision course with the Constitution from the day it was decided. *Casey* perpetuated its errors, calling both sides of the national controversy to resolve their debate, but in doing so, *Casey* necessarily declared a winning side. Those on the losing side—those who sought to advance the State's interest in fetal life—could no longer seek to persuade their elected representatives to adopt policies consistent with their views. The Court short-circuited the democratic process by closing it to the large number of Americans who disagreed with *Roe*.[6]

The Court's final holding was that "the Constitution does not confer a right to abortion; *Roe* and *Casey* are overruled; and the authority to regulate abortion is returned to the people and their elected representatives."[7]

In Florida, however, abortion restrictions established under Florida Statutes are still held to the stricter standard established in *In re T.W.* (discussed below) unless the Florida Supreme Court eventually overturns the decision in that case.

Abortion Law in Florida

Under Florida law, abortion is defined as the termination of a human pregnancy with an intention other than to produce a live birth or remove a dead fetus.[8] The termination of a pregnancy must be performed by a physician[9] licensed under ch. 458, F.S., or ch. 459, F.S., or a physician practicing medicine or osteopathic medicine in the employment of the United States.[10] The

[5] Jackson Women's Health Org. v. Currier, 349 F. Supp. 3d 536 (S.D. Miss. 2018), aff'd sub nom. Jackson Women's Health Org. v. Dobbs, 945 F.3d 265 (5th Cir. 2019)
[6] Dobbs v. Jackson Women's Health Org., No. 19-1392, 2022 WL 2276808 (U.S. June 24, 2022).
[7] *Id.*
[8] Section 390.011(1), F.S.
[9] Section 390.0111(2), F.S.
[10] Section 390.011(8), F.S.

Agency for Health Care Administration (AHCA) is responsible for licensing abortion clinics pursuant to ch. 390, F.S.

The termination of a pregnancy may not be performed after 15 weeks gestation[11] unless there is a medical necessity or the fetus has a fatal fetal abnormality. Specifically, an abortion may not be performed after 15 weeks unless two physicians certify in writing that, in reasonable medical judgment, the termination of the pregnancy is necessary to save the pregnant woman's life or avert a serious risk of substantial and irreversible physical impairment of a major bodily function of the pregnant woman, other than a psychological condition. If a second physician is not available, one physician may certify in writing to the medical necessity for legitimate emergency medical procedures for the termination of the pregnancy.[12] Additionally, an abortion may not be performed on a minor under the age of 18 without the consent of the minor's parent or guardian or without the minor obtaining authorization for the abortion from a court.[13]

Sections 390.0111(4) and 390.01112(3), F.S., provide that if a termination of pregnancy is performed during the third trimester or during viability, the physician who performs or induces the termination of pregnancy must use that degree of professional skill, care, and diligence to preserve the life and health of the fetus, which the physician would be required to exercise in order to preserve the life and health of any fetus intended to be born and not aborted. However, the woman's life and health constitute an overriding and superior consideration to the concern for the life and health of the fetus when the concerns are in conflict. A termination of pregnancy after viability in an emergency situation must be performed in a hospital.[14]

Legal Challenge of the 15-Week Time Frame

The portions of ch. 2022-69, L.O.F., related to abortion were challenged by Planned Parenthood (Planned Parenthood v. the State of Florida), and the Second Judicial Circuit Court issued a temporary injunction preventing the law from being enforced, stating that the law does not meet the constitutional standards established under Florida case law in *In re T.W.*, (551 So. 2d 1186 (Fla. 1989)). However, upon appeal, the injunction was automatically stayed and the First District Court of Appeal declined to reverse the automatic stay.

Planned Parenthood of Southwest and Central Florida appealed the order declining to reverse the stay to the Florida Supreme Court. Additionally, Planned Parenthood asked the Supreme Court to accept jurisdiction over the case. On Jan. 23, 2023, the Court both accepted jurisdiction of the case and denied the motion to vacate the automatic stay of the temporary injunction. Currently, the case resides at the Supreme Court. The Petitioner's initial brief on the merits of the case was served on Feb. 27, 2023, and the response to the brief is due 30 days from then.[15]

[11] In the 2022 session the Florida Legislature passed HB 5, a ban on abortions after 15 weeks of gestation with exceptions for emergencies, substantial physical impairment of a major bodily function, and genetic conditions incompatible with life outside of the womb and that will result in death upon birth or imminently thereafter. The law took effect on July 1, 2022.
[12] Sections 390.0111(1) and 390.01112(1), F.S.
[13] Section 390.01114, F.S.
[14] Section 797.03(3), F.S.
[15] PLANNED PARENTHOOD OF SOUTHWEST & CENTRAL FLORIDA, ET AL. vs. STATE OF FLORIDA, ET AL. 1st DCA case no. 1D22-2034 and Supreme Court case number SC22-1050.

Florida Case Law on Abortion: *In re T.W.*

In the 1989 case *In re T.W.*, a Minor,[16] the Florida Supreme Court upheld a lower court ruling striking the requirement that a minor obtain parental consent prior to obtaining an abortion. This ruling is the controlling case law for abortion law in Florida and is of consequence because, rather than standing the ruling upon the established federal case law of *Roe v. Wade* and *Casey*, the Florida Supreme Court determined that:

> To be held constitutional, the instant statute must pass muster under both the federal and state constitutions. Were we to examine it solely under the federal Constitution, our analysis necessarily would track the decisions noted above. However, Florida is unusual in that it is one of at least four states having its own express constitutional provision guaranteeing an independent right to privacy,… and we opt to examine the statute first under the Florida Constitution. If it fails here, then no further analysis under federal law is required.

The Court determined that the right to privacy enshrined in Art. I, S. 23 of the Florida Constitution "is clearly implicated in a woman's decision of whether or not to continue her pregnancy." Therefore, unlike under the Federal Constitution which requires a state only to show that a restriction on abortion is not "unduly burdensome," in Florida the state must show that the abortion restriction "furthers a compelling state interest through the least intrusive means."

The court further determined that "Under our Florida Constitution, the state's interest becomes compelling upon viability, as defined below. Until this point, the fetus is a highly specialized set of cells that is entirely dependent upon the mother for sustenance. No other member of society can provide this nourishment. The mother and fetus are so inextricably intertwined that their interests can be said to coincide. Upon viability, however, society becomes capable of sustaining the fetus, and its interest in preserving its potential for life thus becomes compelling."

Florida Pregnancy Support and Services Network

Section 381.96, F.S., establishes the Florida Pregnancy Care Network (Network) defined as a "not-for-profit statewide alliance of pregnancy support organizations that provide pregnancy support and wellness services through a comprehensive system of care to women and their families." The statute requires the DOH to contract with the network for the management and delivery of pregnancy support and wellness services to eligible clients and draws a distinction between pregnancy support services and wellness services. Pregnancy support services are services that promote and encourage childbirth, including:

- Direct client services, such as pregnancy testing, counseling, referral, training, and education for pregnant women and their families. A woman and her family shall continue to be eligible to receive direct client services for up to 12 months after the birth of the child.
- Program awareness activities, including a promotional campaign to educate the public about the pregnancy support services offered by the network and a website that provides information on the location of providers in the user's area and other available community resources.

[16] In re T.W., 551 So. 2d 1186 (Fla. 1989)

- Communication activities, including the operation and maintenance of a hotline or call center with a single statewide toll-free number that is available 24 hours a day for an eligible client to obtain the location and contact information for a pregnancy center located in the client's area.

Wellness services are services or activities intended to maintain and improve health or prevent illness and injury, including, but not limited to, high blood pressure screening, anemia testing, thyroid screening, cholesterol screening, diabetes screening, and assistance with smoking cessation.

Pregnancy support services are available to a pregnant woman or woman who suspects she is pregnant, and the family of such a woman, while wellness support services are available to any woman who seeks such services.

The section establishes contracting provisions which require the DOH to:
- Establish, implement, and monitor a comprehensive system of care through subcontractors to meet the pregnancy support and wellness needs of eligible clients.
- Establish and manage subcontracts with a sufficient number of providers to ensure the availability of pregnancy support and wellness services for eligible clients, and maintain and manage the delivery of such services throughout the contract period.
- Spend at least 90 percent of the contract funds on pregnancy support and wellness services.
- Offer wellness services through vouchers or other appropriate arrangements that allow the purchase of services from qualified health care providers.
- Require a background screening under s. 943.0542, F.S., for all paid staff and volunteers of a subcontractor if such staff or volunteers provide direct client services to an eligible client who is a minor or an elderly person or who has a disability.
- Annually monitor its subcontractors and specify the sanctions that shall be imposed for noncompliance with the terms of a subcontract.
- Subcontract only with providers that exclusively promote and support childbirth.
- Ensure that informational materials provided to an eligible client by a provider are current and accurate and cite the reference source of any medical statement included in such materials.

This section of statute specifies that services provided pursuant to the section must be provided in a non-coercive manner and may not include religious content.

The Comprehensive Family Planning Act

Section 381.0051, F.S., establishes the Comprehensive Family Planning Act (Act). The Act requires the DOH to implement a comprehensive family planning program which must include, but is not limited to:
- Comprehensive family planning education and counseling programs.
- Prescription for and provision of all medically recognized methods of contraception.
- Medical evaluation, including cytological examination and other appropriate laboratory studies.

- Treatment of physical complications other than pregnancy resulting from the use of contraceptive methods.

The program must provide services at locations and times readily available to the population served and must emphasize service to postpartum mothers. The services are to be available to anyone who desires them on a fee schedule based on the cost of service and the individual's ability to pay.[17] Family planning and related health services are available in all 67 counties through local county health departments or contracted agencies.[18]

Minors are able to receive maternal health, contraceptive information, and services of a nonsurgical nature[19] if the services are provided by a physician or by the DOH directly through the program and if the minor:

- Is married;
- Is a parent;
- Is pregnant;
- Has the consent of a parent or legal guardian; or
- May, in the opinion of the physician, suffer probable health hazards if such services are not provided.

Medical Abortion

Medical abortion is a two-step process that does not require surgical intervention. Medical abortions consist of a health care practitioner, usually a physician, providing a patient with mifepristone and misoprostol. The FDA has approved the use of these drugs during the first 70 days of a pregnancy under the following dosing regimen:[20]

- 200 mg of mifepristone taken by mouth. This blocks progesterone, which is a hormone that is necessary for a pregnancy to continue. Without progesterone, the embryo or fetus detaches from the uterine wall.
- 24 to 48 hours after taking mifepristone: 800 mcg of misoprostol taken buccally (in the cheek pouch), at a location appropriate for the patient. This softens and dilates the cervix and causes uterine contractions that expel the detached embryo or fetus.
- Seven to fourteen days after taking mifepristone: follow-up visit with the health care provider to confirm that the abortion is complete.

Originally, the FDA required practitioners to dispense mifepristone only in clinics, medical offices, and hospitals.[21] This necessitates an in-person visit to obtain the drugs. This requirement

[17] One such fee schedule, from Martin County Health Department, for 2020/2021 provides for costs between $28.32 and $166.59 for most family planning items including annual exams and IUD insertion and removal. This fee schedule is available at https://martin.floridahealth.gov/about-us/_documents/familyplanningfees2021.pdf, (last visited March 16, 2023).
[18] Family Planning, DOH website, available at https://www.floridahealth.gov/programs-and-services/womens-health/family-planning/index.html, (last visited March 16, 2023).
[19] The section specifies that the application of a nonpermanent internal contraceptive device is deemed to be nonsurgical.
[20] *Questions and Answers on Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation*, U.S. Food & Drug Administration, available at https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/questions-and-answers-mifepristone-medical-termination-pregnancy-through-ten-weeks-gestation (last visited March 16, 2023).
[21] *Id.*

discourages the use of telemedicine, although there is no express federal prohibition against using telemedicine for a medical abortion.

In April 2021, the FDA waived this in-person dispensing requirement for the duration of the COVID-19 federal public health emergency.[22] This allowed patients to receive abortion-inducing drugs through the mail or other home delivery services. This increased the probability of prescribers using telemedicine to perform medical abortion in states where not prohibited by state law. On December 16, 2021, the FDA permanently removed the in-person dispensing requirement.[23]

Telehealth

Telehealth is a mechanism for delivery of health care services. Health care professionals use telehealth as a platform to provide traditional health care services in a non-traditional manner. These services include, among others, preventative medicine and the treatment of chronic conditions.[24] Section 456.74, F.S., enacted in 2019, regulates the use of telehealth by Florida and out-of-state health care providers.

Current law broadly defines telehealth as the use of synchronous or asynchronous telecommunications technology by a telehealth provider to provide health care services, including, but not limited to: [25]

- Assessment, diagnosis, consultation, treatment, and monitoring of a patient;
- Transfer of medical data;
- Patient and professional health-related education;
- Public health services; and
- Health administration.

A patient receiving telehealth services may be in any location at the time services are rendered and a telehealth provider may be in any location when providing telehealth services to a patient.

Health care services may be provided via telehealth by a Florida-licensed health care practitioner, a practitioner licensed under a multistate health care licensure compact of which Florida is a member,[26] or an out-of-state-health care provider who registers with the Department of Health.[27]

Current law requires telehealth providers to meet the same standard of care required for in-person health care services to patients in this state. This ensures that a patient receives the same standard of care irrespective of the modality used by the health care professional to deliver the services.[28]

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[22] Id.
[23] Id.
[24] U.S. Department of Health and Human Services, *Report to Congress: E-Health and Telemedicine* (August 12, 2016), available at https://aspe.hhs.gov/system/files/pdf/206751/TelemedicineE-HealthReport.pdf (last visited March 16, 2023).
[25] S. 456.47(1)(a), F.S.
[26] Florida is a member of the Nurse Licensure Compact. *See* s. 464.0095, F.S.
[27] S. 456.47(4), F.S.
[28] S. 456.47(2), F.S.

III. Effect of Proposed Changes:

Abortion Restrictions

SB 300 amends several sections of the Florida Statutes, and creates one new section of law, relating to abortion.

The bill amends s. 390.0111, F.S., to prohibit a physician from knowingly performing or inducing an abortion after six weeks of gestation.[29] The bill maintains current-law exceptions to abortion time frames and applies them to the six-week prohibition, including exceptions for the life and health of the mother, for emergency situations, and for a fetus with a fatal fetal abnormality.

The bill adds one new exception for cases in which the pregnancy is the result of rape or incest and the gestational age of the fetus is not more than 15 weeks. In order to qualify for the exception for rape or incest, at the time a pregnant woman schedules or arrives for her appointment to obtain the abortion, she must provide a copy of a restraining order, police report, medical record, or other court order or documentation providing evidence that she is obtaining the abortion because she is the victim of rape or incest. If the woman is a minor, the bill requires that the physician report the incident of rape or incest to the central abuse hotline as required by s. 39.201, F.S.

The bill specifies that only an allopathic or osteopathic physician may perform or induce an abortion and that a physician may not use telehealth to perform an abortion, including, but not limited to, medical abortions. The bill also amends s. 456.47, F.S., to include the prohibition on the use of telehealth in the established practice standards for telehealth.

The bill prohibits medications intended for use in a medical abortion from being dispensed by anyone other than a physician and from being dispensed through the United States Postal Service or by any other courier or shipping service.

Additionally, the bill creates s. 286.31, F.S., to prohibit any person, educational institution, or governmental entity from using state funds[30] for a person to travel to another state to receive services that are intended to support an abortion. The bill defines:

- "Educational institution" to mean any public institutions under the control of a district school board, a charter school, a state university, a developmental research school, a Florida College System institution, the Florida School for the Deaf and the Blind, the Florida Virtual School, private school readiness programs, voluntary prekindergarten programs, private K-12 schools, and private colleges and universities.
- "Governmental entity" to mean the state or any political subdivision thereof, including the executive, legislative, and judicial branches of government; the independent establishments of the state, counties, municipalities, districts, authorities, boards, or commissions; and any agencies that are subject to ch. 286, F.S.

[29] "Gestation" is defined in s. 390.

[30] As defined in s. 215.31, F.S., "state funds" means revenue, including licenses, fees, imposts, or exactions collected or received under the authority of the laws of the state by each and every state official, office, employee, bureau, division, board, commission, institution, agency, or undertaking of the state or the judicial branch

The bill provides exceptions to this prohibition when the person, governmental entity, or educational institution is required by federal law to expend state funds for such a purpose and for cases of a medical necessity for legitimate emergency medical procedures for termination of the pregnancy to save the pregnant woman's life or to avert a serious risk of imminent substantial and irreversible physical impairment of a major bodily function of the pregnant woman, other than a psychological condition.

Expansion of the Florida Pregnancy Care Network

SB 300 amends s. 381.986, F.S., to expand the Network.

The bill amends to the definition of "eligible client" to add eligibility for:
- Women who have given birth in the previous 12 months; and
- Parents, or legal guardians, for up to 12 months after the birth of a child or the adoption of a child younger than three years of age.

The bill also amends the definition of "pregnancy support services" to be "pregnancy and parenting support services" and makes the following services available:
- Nonmedical material assistance that improves the pregnancy or parenting situation of families, including, but not limited to, clothing, car seats, cribs, formula, and diapers; and
- Counseling or mentoring, education materials, and classes regarding pregnancy, parenting, adoption, life skills, and employment readiness.

The bill requires the DOH's contract with the Network to require the Network to spend at least 85 percent of contract funds on pregnancy and parenting support services and to exclude network awareness activities from the services that qualify to make up the required 85 percent.[31]

Additionally, by July 1, 2024, and annually thereafter, the bill requires the DOH to report to the Governor and the Legislature on the amount and types of services provided by the network; the expenditures for such services; and the number of, and demographic information for, women, parents, and families served by the network. The bill also requires DOH's contract with the Network to ensure the DOH is provided with all information necessary for the annual report detailed below.

Funding Provisions

In addition to any funds appropriated in the General Appropriations Act, SB 300 appropriates $5 million in recurring funds from the General Revenue Fund (GR) to the DOH for the purpose of implementing the Family Planning Program, specifically subsections (3), (4), and (6) and s. 381.0051, F.S.

[31] Current law requires the Network to spend at least 90 percent of funds on pregnancy support services, but also includes network awareness activities in the services that count toward the 90 percent. Effectively this change will limit the amount spent on network awareness activates, which includes a promotional campaign and a website, to 5 percent of the contracted funds.

The bill also appropriates $25 million in recurring GR funds to the DOH for the purpose of implementing the expanded Florida Pregnancy Care Network.

Clean-Up Provisions

SB 300 repeals s. 390.01112, F.S., which restricts abortion at the point of viability. This section is obsolete and is not used. Additionally, the bill strikes rule language requiring AHCA rules for abortion clinics to not impose an unconstitutional burden on a woman's freedom to decide whether to terminate her pregnancy. If the bill becomes effective due to one of the effective date triggers (detailed below), this provision will no longer be applicable as there will no longer be constitutional restraints on the ability for the Legislature to restrict abortion.

Effective Date

Other than the expansion of the Network and the appropriation provisions, which are effective upon becoming law, SB 300 provides that the bill is effective 30 days after one of the following occurs:

- A decision by the Florida Supreme Court holding that the right to privacy enshrined in s. 23, Article I of the State Constitution does not include a right to abortion;
- A decision by the Florida Supreme Court in *Planned Parenthood v. State,* SC2022-1050, that allows the prohibition on abortions after 15 weeks in s. 390.0111(1), F.S., to remain in effect, including a decision approving, in whole or in part, the First District Court of Appeal's decision under review or a decision discharging jurisdiction;
- An amendment to the State Constitution clarifying that s. 23, Article I of the State Constitution does not include a right to abortion; or
- A decision from the Florida Supreme Court after March 7, 2023, receding, in whole or in part, from *In re T.W.*, 551 So. 2d 1186 (Fla. 1989), *North Fla. Women's Health v. State*, 866 So. 2d 612 (Fla. 2003), or *Gainesville Woman Care, LLC v. State*, 210 So. 3d 1243 (Fla. 2017).

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

Because the provisions of the bill that might be challenged as unconstitutional do not become law unless specified criteria are met which would render such provisions constitutional, there are likely no constitutional issues with SB 300.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 381.96, 390.0111, 390.012, and 456.47.

This bill creates section 286.31 of the Florida Statutes.

This bill repeals section 390.01112 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

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The 2023 Florida Statutes

Title XXIX
PUBLIC HEALTH

Chapter 390
TERMINATION OF PREGNANCIES

View Entire Chapter

CHAPTER 390
TERMINATION OF PREGNANCIES

390.011 Definitions.—As used in this chapter, the term:

(1) "Abortion" means the termination of human pregnancy with an intention other than to produce a live birth or to remove a dead fetus.

(2) "Abortion clinic" or "clinic" means any facility in which abortions are performed. The term does not include:

(a) A hospital; or

(b) A physician's office, provided that the office is not used primarily for the performance of abortions.

(3) "Agency" means the Agency for Health Care Administration.

(4) "Born alive" means the complete expulsion or extraction from the mother of a human infant, at any stage of development, who, after such expulsion or extraction, breathes or has a beating heart, or definite and voluntary movement of muscles, regardless of whether the umbilical cord has been cut and regardless of whether the expulsion or extraction occurs as a result of natural or induced labor, caesarean section, induced abortion, or other method.

(5) "Department" means the Department of Health.

(6) "Fatal fetal abnormality" means a terminal condition that, in reasonable medical judgment, regardless of the provision of life-saving medical treatment, is incompatible with life outside the womb and will result in death upon birth or imminently thereafter.

(7) "Gestation" means the development of a human embryo or fetus as calculated from the first day of the pregnant woman's last menstrual period.

(8) "Hospital" means a facility as defined in s. 395.002(12) and licensed under chapter 395 and part II of chapter 408.

(9) "Medical abortion" means the administration or use of an abortion-inducing drug to induce an abortion.

(10) "Partial-birth abortion" means a termination of pregnancy in which the physician performing the termination of pregnancy partially vaginally delivers a living fetus before killing the fetus and completing the delivery.

(11) "Physician" means a physician licensed under chapter 458 or chapter 459 or a physician practicing medicine or osteopathic medicine in the employment of the United States.

[1](12) "Reasonable medical judgment" means a medical judgment that would be made by a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved.

[1](13) "Standard medical measure" means the medical care that a physician would provide based on the particular facts of the pregnancy, the information available to the physician, and the technology reasonably available in a hospital, as defined in s. 395.002, with an obstetrical department, to preserve the life and health of the fetus, with or without temporary artificial life-sustaining support, if the fetus were born at the same stage of fetal development.

(14) "Trimester" means one of the following three distinct periods of time in the duration of a pregnancy:

(a) "First trimester," which is the period of time from fertilization through the end of the 11th week of gestation.

(b) "Second trimester," which is the period of time from the beginning of the 12th week of gestation through the end of the 23rd week of gestation.

(c) "Third trimester," which is the period of time from the beginning of the 24th week of gestation through birth.

[1](15) "Viable" or "viability" means the stage of fetal development when the life of a fetus is sustainable outside the womb through standard medical measures.

History.—s. 1, ch. 78-382; s. 1, ch. 86-286; ss. 4, 5, ch. 88-97; s. 4, ch. 91-429; s. 4, ch. 97-151; s. 37, ch. 97-264; s. 3, ch. 98-1; s. 14, ch. 2007-230; s. 1, ch. 2013-121; s. 1, ch. 2014-137; s. 1, ch. 2016-150; s. 6, ch. 2021-112; s. 37, ch. 2022-4; s. 3, ch. 2022-69.

[1]**Note.**—Section 5, ch. 2014-137, provides:

"Severability and reversion.—

"(1) If any provision of this act or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of this act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

"(2) Notwithstanding subsection (1), if s. 390.01112, Florida Statutes, is held unconstitutional and severed by a court having jurisdiction, the amendments made by this act to s. 390.011, Florida Statutes, and subsections (4), (10), and (13) of s. 390.0111, Florida Statutes, will be repealed and will revert to the law as it existed on January 1, 2014."

390.0111 Termination of pregnancies.—

[1](1) TERMINATION AFTER GESTATIONAL AGE OF 15 WEEKS; WHEN ALLOWED.—A physician may not perform a termination of pregnancy if the physician determines the gestational age of the fetus is more than 15 weeks unless one of the following conditions is met:

(a) Two physicians certify in writing that, in reasonable medical judgment, the termination of the pregnancy is necessary to save the pregnant woman's life or avert a serious risk of substantial and irreversible physical impairment of a major bodily function of the pregnant woman other than a psychological condition.

(b) The physician certifies in writing that, in reasonable medical judgment, there is a medical necessity for legitimate emergency medical procedures for termination of the pregnancy to save the pregnant woman's life or avert a serious risk of imminent substantial and irreversible physical impairment of a major bodily function of the pregnant woman other than a psychological condition, and another physician is not available for consultation.

(c) The fetus has not achieved viability under s. 390.01112 and two physicians certify in writing that, in reasonable medical judgment, the fetus has a fatal fetal abnormality.

[1](2) PERFORMANCE BY PHYSICIAN REQUIRED.—No termination of pregnancy shall be performed at any time except by a physician as defined in s. 390.011.

(3) CONSENTS REQUIRED.—A termination of pregnancy may not be performed or induced except with the voluntary and informed written consent of the pregnant woman or, in the case of a mental incompetent, the

voluntary and informed written consent of her court-appointed guardian.

(a) Except in the case of a medical emergency, consent to a termination of pregnancy is voluntary and informed only if:

1. The physician who is to perform the procedure, or the referring physician, has, at a minimum, orally, while physically present in the same room, and at least 24 hours before the procedure, informed the woman of:

a. The nature and risks of undergoing or not undergoing the proposed procedure that a reasonable patient would consider material to making a knowing and willful decision of whether to terminate a pregnancy.

b. The probable gestational age of the fetus, verified by an ultrasound, at the time the termination of pregnancy is to be performed.

(I) The ultrasound must be performed by the physician who is to perform the abortion or by a person having documented evidence that he or she has completed a course in the operation of ultrasound equipment as prescribed by rule and who is working in conjunction with the physician.

(II) The person performing the ultrasound must offer the woman the opportunity to view the live ultrasound images and hear an explanation of them. If the woman accepts the opportunity to view the images and hear the explanation, a physician or a registered nurse, licensed practical nurse, advanced practice registered nurse, or physician assistant working in conjunction with the physician must contemporaneously review and explain the images to the woman before the woman gives informed consent to having an abortion procedure performed.

(III) The woman has a right to decline to view and hear the explanation of the live ultrasound images after she is informed of her right and offered an opportunity to view the images and hear the explanation. If the woman declines, the woman shall complete a form acknowledging that she was offered an opportunity to view and hear the explanation of the images but that she declined that opportunity. The form must also indicate that the woman's decision was not based on any undue influence from any person to discourage her from viewing the images or hearing the explanation and that she declined of her own free will.

(IV) Unless requested by the woman, the person performing the ultrasound may not offer the opportunity to view the images and hear the explanation and the explanation may not be given if, at the time the woman schedules or arrives for her appointment to obtain an abortion, a copy of a restraining order, police report, medical record, or other court order or documentation is presented which provides evidence that the woman is obtaining the abortion because the woman is a victim of rape, incest, domestic violence, or human trafficking or that the woman has been diagnosed as having a condition that, on the basis of a physician's good faith clinical judgment, would create a serious risk of substantial and irreversible impairment of a major bodily function if the woman delayed terminating her pregnancy.

c. The medical risks to the woman and fetus of carrying the pregnancy to term.

The physician may provide the information required in this subparagraph within 24 hours before the procedure if requested by the woman at the time she schedules or arrives for her appointment to obtain an abortion and if she presents to the physician a copy of a restraining order, police report, medical record, or other court order or documentation evidencing that she is obtaining the abortion because she is a victim of rape, incest, domestic violence, or human trafficking.

2. Printed materials prepared and provided by the department have been provided to the pregnant woman, if she chooses to view these materials, including:

a. A description of the fetus, including a description of the various stages of development.

b. A list of entities that offer alternatives to terminating the pregnancy.

c. Detailed information on the availability of medical assistance benefits for prenatal care, childbirth, and neonatal care.

3. The woman acknowledges in writing, before the termination of pregnancy, that the information required to be provided under this subsection has been provided.

Nothing in this paragraph is intended to prohibit a physician from providing any additional information which the physician deems material to the woman's informed decision to terminate her pregnancy.

(b) If a medical emergency exists and a physician cannot comply with the requirements for informed consent, a physician may terminate a pregnancy if he or she has obtained at least one corroborative medical opinion attesting to the medical necessity for emergency medical procedures and to the fact that to a reasonable degree of medical certainty the continuation of the pregnancy would threaten the life of the pregnant woman. If a second physician is not available for a corroborating opinion, the physician may proceed but shall document reasons for the medical necessity in the patient's medical records.

(c) Violation of this subsection by a physician constitutes grounds for disciplinary action under s. 458.331 or s. 459.015. Substantial compliance or reasonable belief that complying with the requirements of informed consent would threaten the life or health of the patient is a defense to any action brought under this paragraph.

[2](4) STANDARD OF MEDICAL CARE TO BE USED IN THIRD TRIMESTER.—If a termination of pregnancy is performed in the third trimester, the physician performing the termination of pregnancy must exercise the same degree of professional skill, care, and diligence to preserve the life and health of the fetus which the physician would be required to exercise in order to preserve the life and health of a fetus intended to be born and not aborted. However, if preserving the life and health of the fetus conflicts with preserving the life and health of the pregnant woman, the physician must consider preserving the woman's life and health the overriding and superior concern.

(5) PARTIAL-BIRTH ABORTION PROHIBITED; EXCEPTION.—

(a) No physician shall knowingly perform a partial-birth abortion.

(b) A woman upon whom a partial-birth abortion is performed may not be prosecuted under this section for a conspiracy to violate the provisions of this section.

(c) This subsection shall not apply to a partial-birth abortion that is necessary to save the life of a mother whose life is endangered by a physical disorder, illness, or injury, provided that no other medical procedure would suffice for that purpose.

(6) EXPERIMENTATION ON FETUS PROHIBITED; EXCEPTION.—No person shall use any live fetus or live, premature infant for any type of scientific, research, laboratory, or other kind of experimentation either prior to or subsequent to any termination of pregnancy procedure except as necessary to protect or preserve the life and health of such fetus or premature infant.

(7) FETAL REMAINS.—Fetal remains shall be disposed of in a sanitary manner pursuant to s. 381.0098 and rules adopted thereunder. Failure to dispose of fetal remains in accordance with this subsection is a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(8) REFUSAL TO PARTICIPATE IN TERMINATION PROCEDURE.—Nothing in this section shall require any hospital or any person to participate in the termination of a pregnancy, nor shall any hospital or any person be liable for such refusal. No person who is a member of, or associated with, the staff of a hospital, nor any employee of a hospital or physician in which or by whom the termination of a pregnancy has been authorized or performed, who shall state an objection to such procedure on moral or religious grounds shall be required to participate in the procedure which will result in the termination of pregnancy. The refusal of any such person or employee to participate shall not form the basis for any disciplinary or other recriminatory action against such person.

(9) EXCEPTION.—The provisions of this section shall not apply to the performance of a procedure which terminates a pregnancy in order to deliver a live child.

[3](10) PENALTIES FOR VIOLATION.—Except as provided in subsections (3), (7), and (12):

(a) Any person who willfully performs, or actively participates in, a termination of pregnancy in violation of the requirements of this section or s. 390.01112 commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(b) Any person who performs, or actively participates in, a termination of pregnancy in violation of this section or s. 390.01112 which results in the death of the woman commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(11) CIVIL ACTION PURSUANT TO PARTIAL-BIRTH ABORTION; RELIEF.—

(a) The father, if married to the mother at the time she receives a partial-birth abortion, and, if the mother has not attained the age of 18 years at the time she receives a partial-birth abortion, the maternal grandparents of

the fetus may, in a civil action, obtain appropriate relief, unless the pregnancy resulted from the plaintiff's criminal conduct or the plaintiff consented to the abortion.

(b) In a civil action under this section, appropriate relief includes:

1. Monetary damages for all injuries, psychological and physical, occasioned by the violation of subsection (5).

2. Damages equal to three times the cost of the partial-birth abortion.

(12) INFANTS BORN ALIVE.—

(a) An infant born alive during or immediately after an attempted abortion is entitled to the same rights, powers, and privileges as are granted by the laws of this state to any other child born alive in the course of natural birth.

(b) If an infant is born alive during or immediately after an attempted abortion, any health care practitioner present at the time shall humanely exercise the same degree of professional skill, care, and diligence to preserve the life and health of the infant as a reasonably diligent and conscientious health care practitioner would render to an infant born alive at the same gestational age in the course of natural birth.

(c) An infant born alive during or immediately after an attempted abortion must be immediately transported and admitted to a hospital pursuant to s. 390.012(3)(c) or rules adopted thereunder.

(d) A health care practitioner or any employee of a hospital, a physician's office, or an abortion clinic who has knowledge of a violation of this subsection must report the violation to the department.

(e) A person who violates this subsection commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. This subsection shall not be construed as a specific provision of law relating to a particular subject matter that would preclude prosecution of a more general offense, regardless of the penalty.

(f) This subsection does not affirm, deny, expand, or contract any legal status or legal right applicable to any member of the species *Homo sapiens* at any point prior to being born alive as defined in s. 390.011.

[3](13) FAILURE TO COMPLY.—Failure to comply with the requirements of this section or s. 390.01112 constitutes grounds for disciplinary action under each respective practice act and under s. 456.072.

(14) RULES.—The applicable boards, or the department if there is no board, shall adopt rules necessary to implement the provisions of this section.

(15) USE OF PUBLIC FUNDS RESTRICTED.—A state agency, a local governmental entity, or a managed care plan providing services under part IV of chapter 409 may not expend funds for the benefit of, pay funds to, or initiate or renew a contract with an organization that owns, operates, or is affiliated with one or more clinics that are licensed under this chapter and perform abortions unless one or more of the following applies:

(a) All abortions performed by such clinics are:

1. On fetuses that are conceived through rape or incest; or

2. Are medically necessary to preserve the life of the pregnant woman or to avert a serious risk of substantial and irreversible physical impairment of a major bodily function of the pregnant woman, other than a psychological condition.

(b) The funds must be expended to fulfill the terms of a contract entered into before July 1, 2016.

(c) The funds must be expended as reimbursement for Medicaid services provided on a fee-for-service basis.

History.—s. 1, ch. 79-302; s. 1, ch. 80-208; s. 6, ch. 88-97; s. 6, ch. 91-223; s. 64, ch. 91-224; s. 694, ch. 95-148; s. 2, ch. 97-151; s. 1, ch. 98-1; s. 201, ch. 99-13; s. 1, ch. 2011-224; s. 2, ch. 2013-121; s. 2, ch. 2014-137; s. 1, ch. 2015-118; s. 2, ch. 2016-150; s. 20, ch. 2018-106; s. 1, ch. 2020-147; s. 4, ch. 2022-69; s. 4, ch. 2023-21.

[1]**Note.**—Section 9, ch. 2023-21, provides that "[e]xcept as otherwise expressly provided in this act and except for this section, which shall take effect upon this act becoming a law, this act shall take effect 30 days after any of the following occurs: a decision by the Florida Supreme Court holding that the right to privacy enshrined in s. 23, Article I of the State Constitution does not include a right to abortion; a decision by the Florida Supreme Court in *Planned Parenthood v. State*, SC2022-1050, that allows the prohibition on abortions after 15 weeks in s. 390.0111(1), Florida Statutes, to remain in effect, including a decision approving, in whole or in part, the First District Court of Appeal's decision under review or a decision discharging jurisdiction; an amendment to the State Constitution clarifying that s. 23, Article I of the State Constitution does not include a right to abortion; or a decision from the Florida Supreme Court after March 7, 2023, receding, in whole or in part, from *In re T.W.*, 551 So. 2d 1186 (Fla. 1989), *North Fla. Women's Health v. State*, 866 So. 2d 612 (Fla. 2003), or *Gainesville Woman Care, LLC v. State*, 210 So. 3d 1243 (Fla. 2017)." Effective 30 days after any of these contingencies occur, subsections (1) and (2), as amended by s. 4, ch. 2023-21, will read:

(1) TERMINATION AFTER GESTATIONAL AGE OF 6 WEEKS; WHEN ALLOWED.—A physician may not knowingly perform or induce a termination of pregnancy if the physician determines the gestational age of the fetus is more than 6 weeks unless one of the following conditions is met:

(a) Two physicians certify in writing that, in reasonable medical judgment, the termination of the pregnancy is necessary to save the pregnant woman's life or avert a serious risk of substantial and irreversible physical impairment of a major bodily function of the pregnant woman other than a psychological condition.

(b) The physician certifies in writing that, in reasonable medical judgment, there is a medical necessity for legitimate emergency medical procedures for termination of the pregnancy to save the pregnant woman's life or avert a serious risk of imminent substantial and irreversible physical impairment of a major bodily function of the pregnant woman other than a psychological condition, and another physician is not available for consultation.

(c) The pregnancy has not progressed to the third trimester and two physicians certify in writing that, in reasonable medical judgment, the fetus has a fatal fetal abnormality.

(d) The pregnancy is the result of rape, incest, or human trafficking and the gestational age of the fetus is not more than 15 weeks as determined by the physician. At the time the woman schedules or arrives for her appointment to obtain the abortion, she must provide a copy of a restraining order, police report, medical record, or other court order or documentation providing evidence that she is obtaining the termination of pregnancy because she is a victim of rape, incest, or human trafficking. If the woman is 18 years of age or older, the physician must report any known or suspected human trafficking to a local law enforcement agency. If the woman is a minor, the physician must report the incident of rape, incest, or human trafficking to the central abuse hotline as required by s. 39.201.

(2) IN-PERSON PERFORMANCE BY PHYSICIAN REQUIRED.—Only a physician may perform or induce a termination of pregnancy. A physician may not use telehealth as defined in s. 456.47 to perform an abortion, including, but not limited to, medical abortions. Any medications intended for use in a medical abortion must be dispensed in person by a physician and may not be dispensed through the United States Postal Service or by any other courier or shipping service.

[2] **Note.**—Section 5, ch. 2014-137, provides:

"Severability and reversion.—

"(1) If any provision of this act or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of this act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

"(2) Notwithstanding subsection (1), if s. 390.01112, Florida Statutes, is held unconstitutional and severed by a court having jurisdiction, the amendments made by this act to s. 390.011, Florida Statutes, and subsections (4), (10), and (13) of s. 390.0111, Florida Statutes, will be repealed and will revert to the law as it existed on January 1, 2014."

[3] **Note.**—

A. Section 5, ch. 2014-137, provides:

"Severability and reversion.—

"(1) If any provision of this act or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of this act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

"(2) Notwithstanding subsection (1), if s. 390.01112, Florida Statutes, is held unconstitutional and severed by a court having jurisdiction, the amendments made by this act to s. 390.011, Florida Statutes, and subsections (4), (10), and (13) of s. 390.0111, Florida Statutes, will be repealed and will revert to the law as it existed on January 1, 2014."

B. Section 9, ch. 2023-21, provides that "[e]xcept as otherwise expressly provided in this act and except for this section, which shall take effect upon this act becoming a law, this act shall take effect 30 days after any of the following occurs: a decision by the Florida Supreme Court holding that the right to privacy enshrined in s. 23, Article I of the State Constitution does not include a right to abortion; a decision by the Florida Supreme Court in *Planned Parenthood v. State*, SC2022-1050, that allows the prohibition on abortions after 15 weeks in s. 390.0111(1), Florida Statutes, to remain in effect, including a decision approving, in whole or in part, the First District Court of Appeal's decision under review or a decision discharging jurisdiction; an amendment to the State Constitution clarifying that s. 23, Article I of the State Constitution does not include a right to abortion; or a decision from the Florida Supreme Court after March 7, 2023, receding, in whole or in part, from *In re T.W.*, 551 So. 2d 1186 (Fla. 1989), *North Fla. Women's Health v. State*, 866 So. 2d 612 (Fla. 2003), or *Gainesville Woman Care, LLC v. State*, 210 So. 3d 1243 (Fla. 2017)." Effective 30 days after any of these contingencies occur, subsections (10) and (13), as amended by s. 4, ch. 2023-21, will read:

(10) PENALTIES FOR VIOLATION.—Except as provided in subsections (3), (7), and (12):

(a) Any person who willfully performs, or actively participates in, a termination of pregnancy in violation of the requirements of this section commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(b) Any person who performs, or actively participates in, a termination of pregnancy in violation of this section which results in the death of the woman commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

* * * * *

(13) FAILURE TO COMPLY.—Failure to comply with the requirements of this section constitutes grounds for disciplinary action under each respective practice act and under s. 456.072.

Note.—Former s. 390.001.

[1]390.01112 Termination of pregnancies during viability.—

(1) No termination of pregnancy shall be performed on any human being if the physician determines that, in reasonable medical judgment, the fetus has achieved viability, unless:

(a) Two physicians certify in writing that, in reasonable medical judgment, the termination of the pregnancy is necessary to save the pregnant woman's life or avert a serious risk of substantial and irreversible physical impairment of a major bodily function of the pregnant woman other than a psychological condition; or

(b) The physician certifies in writing that, in reasonable medical judgment, there is a medical necessity for legitimate emergency medical procedures for termination of the pregnancy to save the pregnant woman's life or avert a serious risk of imminent substantial and irreversible physical impairment of a major bodily function of the pregnant woman other than a psychological condition, and another physician is not available for consultation.

(2) Before performing a termination of pregnancy, a physician must determine if the fetus is viable by, at a minimum, performing a medical examination of the pregnant woman and, to the maximum extent possible through reasonably available tests and the ultrasound required under s. 390.0111(3), an examination of the fetus. The physician must document in the pregnant woman's medical file the physician's determination and the method, equipment, fetal measurements, and any other information used to determine the viability of the fetus.

(3) If a termination of pregnancy is performed during viability, the physician performing the termination of pregnancy must exercise the same degree of professional skill, care, and diligence to preserve the life and health of the fetus that the physician would be required to exercise in order to preserve the life and health of a fetus intended to be born and not aborted. However, if preserving the life and health of the fetus conflicts with preserving the life and health of the woman, the physician must consider preserving the woman's life and health the overriding and superior concern.

History.—s. 3, ch. 2014-137; s. 5, ch. 2023-21.

[1]**Note.**—

A. Section 5, ch. 2014-137, provides:

"Severability and reversion.—

"(1) If any provision of this act or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of this act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

"(2) Notwithstanding subsection (1), if s. 390.01112, Florida Statutes, is held unconstitutional and severed by a court having jurisdiction, the amendments made by this act to s. 390.011, Florida Statutes, and subsections (4), (10), and (13) of s. 390.0111, Florida Statutes, will be repealed and will revert to the law as it existed on January 1, 2014."

B. Section 9, ch. 2023-21, provides that "[e]xcept as otherwise expressly provided in this act and except for this section, which shall take effect upon this act becoming a law, this act shall take effect 30 days after any of the following occurs: a decision by the Florida Supreme Court holding that the right to privacy enshrined in s. 23, Article I of the State Constitution does not include a right to abortion; a decision by the Florida Supreme Court in *Planned Parenthood v. State*, SC2022-1050, that allows the prohibition on abortions after 15 weeks in s. 390.0111(1), Florida Statutes, to remain in effect, including a decision approving, in whole or in part, the First District Court of Appeal's decision under review or a decision discharging jurisdiction; an amendment to the State Constitution clarifying that s. 23, Article I of the State Constitution does not include a right to abortion; or a decision from the Florida Supreme Court after March 7, 2023, receding, in whole or in part, from *In re T.W.*, 551 So. 2d 1186 (Fla. 1989), *North Fla. Women's Health v. State*, 866 So. 2d 612 (Fla. 2003), or *Gainesville Woman Care, LLC v. State*, 210 So. 3d 1243 (Fla. 2017)." Effective 30 days after any of these contingencies occur, s. 390.01112 is repealed by s. 5, ch. 2023-21.

390.01114 Parental Notice of and Consent for Abortion Act.—

(1) SHORT TITLE.—This section may be cited as the "Parental Notice of and Consent for Abortion Act."

(2) DEFINITIONS.—As used in this section, the term:

(a) "Actual notice" means notice that is given directly, in person or by telephone, to a parent or legal guardian of a minor, by a physician, at least 48 hours before the inducement or performance of a termination of pregnancy, and documented in the minor's files.

(b) "Child abuse" means abandonment, abuse, harm, mental injury, neglect, physical injury, or sexual abuse of a child as those terms are defined in ss. 39.01, 827.04, and 984.03.

(c) "Constructive notice" means notice that is given in writing, signed by the physician, and mailed at least 72 hours before the inducement or performance of the termination of pregnancy, to the last known address of the

parent or legal guardian of the minor, by first-class mail and by certified mail, return receipt requested, and delivery restricted to the parent or legal guardian. After the 72 hours have passed, delivery is deemed to have occurred.

(d) "Medical emergency" means a condition that, on the basis of a physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate termination of her pregnancy to avert her death, or for which a delay in the termination of her pregnancy will create serious risk of substantial and irreversible impairment of a major bodily function.

(e) "Sexual abuse" has the meaning ascribed in s. 39.01.

(f) "Minor" means a person under the age of 18 years.

(3) TERMINATION OF THE PREGNANCY OF A MINOR.—A physician may not perform or induce the termination of a pregnancy of a minor unless the physician has complied with the notice and consent requirements of this section.

(4) NOTIFICATION REQUIRED.—

(a) Actual notice shall be provided by the physician performing or inducing the termination of pregnancy before the performance or inducement of the termination of the pregnancy of a minor. The notice may be given by a referring physician. The physician who performs or induces the termination of pregnancy must receive the written statement of the referring physician certifying that the referring physician has given notice. If actual notice is not possible after a reasonable effort has been made, the physician performing or inducing the termination of pregnancy or the referring physician must give constructive notice. Notice given under this subsection by the physician performing or inducing the termination of pregnancy must include the name and address of the facility providing the termination of pregnancy and the name of the physician providing notice. Notice given under this subsection by a referring physician must include the name and address of the facility where he or she is referring the minor and the name of the physician providing notice. If actual notice is provided by telephone, the physician must actually speak with the parent or guardian, and must record in the minor's medical file the name of the parent or guardian provided notice, the phone number dialed, and the date and time of the call. If constructive notice is given, the physician must document that notice by placing copies of any document related to the constructive notice, including, but not limited to, a copy of the letter and the return receipt, in the minor's medical file. Actual notice given by telephone shall be confirmed in writing, signed by the physician, and mailed to the last known address of the parent or legal guardian of the minor, by first-class mail and by certified mail, return receipt requested, with delivery restricted to the parent or legal guardian.

(b) Notice is not required if:

1. In the physician's good faith clinical judgment, a medical emergency exists and there is insufficient time for the attending physician to comply with the notification requirements. If a medical emergency exists, the physician shall make reasonable attempts, whenever possible, without endangering the minor, to contact the parent or legal guardian, and may proceed, but must document reasons for the medical necessity in the patient's medical records. The physician shall provide notice directly, in person or by telephone, to the parent or legal guardian, including details of the medical emergency and any additional risks to the minor. If the parent or legal guardian has not been notified within 24 hours after the termination of the pregnancy, the physician shall provide notice in writing, including details of the medical emergency and any additional risks to the minor, signed by the physician, to the last known address of the parent or legal guardian of the minor, by first-class mail and by certified mail, return receipt requested, with delivery restricted to the parent or legal guardian;

2. Notice is waived in writing by the person who is entitled to notice and such waiver is notarized, dated not more than 30 days before the termination of pregnancy, and contains a specific waiver of the right of the parent or legal guardian to notice of the minor's termination of pregnancy;

3. Notice is waived by the minor who is or has been married or has had the disability of nonage removed under s. 743.015 or a similar statute of another state;

4. Notice is waived by the patient because the patient has a minor child dependent on her; or

5. Notice is waived under subsection (6).

(c) Violation of this subsection by a physician constitutes grounds for disciplinary action under s. 458.331 or s. 459.015.

(5) PARENTAL CONSENT REQUIRED.—

(a) A physician must obtain written consent from a parent or legal guardian before performing or inducing the termination of a pregnancy of a minor.

1. The consenting parent or legal guardian shall provide to the physician a copy of a government-issued proof of identification. The parent or legal guardian shall certify in a signed, dated, and notarized document, initialed on each page, that he or she consents to the termination of the pregnancy of the minor. The document must include the following statement, which must precede the signature of the parent or guardian: "I, _(insert name of parent or legal guardian)_, am the _(select "parent" or "legal guardian," as appropriate)_ of _(insert name of minor)_ and give consent for _(insert name of physician)_ to perform or induce a termination of pregnancy on her. Under penalties of perjury, I declare that I have read the foregoing statement and that the facts stated in it are true." A copy of the parent's or legal guardian's government-issued proof of identification must be attached to the notarized document.

2. The physician shall keep a copy of the proof of identification of the parent or legal guardian and the certified statement in the medical file of the minor for 5 years after the minor reaches the age of 18 years, but in no event less than 7 years.

3. A physician receiving consent from a parent or guardian under this section shall execute for inclusion in the medical record of the minor an affidavit stating: "I, _(insert name of physician)_, certify that, according to my best information and belief, a reasonable person under similar circumstances would rely on the information presented by both the minor and her parent or legal guardian as sufficient evidence of identity."

(b) The consent of a parent or guardian is not required if:

1. Notification is not required as provided in subparagraph (4)(b)1., subparagraph (4)(b)3., subparagraph (4)(b)4., or subparagraph (4)(b)5.;

2. Notification is not required due to the existence of a waiver as provided in subparagraph (4)(b)2., if that waiver is signed by the minor's parent or legal guardian, is notarized, is dated within 30 days before the termination of the pregnancy, contains a specific waiver of the right of the parent or legal guardian to consent to the minor's termination of pregnancy, and a copy of the parent's or legal guardian's government-issued proof of identification is attached to the waiver;

3. Consent is waived under subsection (6); or

4. In the physician's good faith clinical judgment, a medical emergency exists and there is insufficient time for the attending physician to comply with the consent requirement. If a medical emergency exists, the physician must make reasonable attempts, whenever possible, and without endangering the minor, to contact the parent or legal guardian of the minor, and may proceed, but must document reasons for the medical necessity in the minor patient's medical records. The physician shall inform the parent or legal guardian, in person or by telephone, within 24 hours after the termination of the pregnancy of the minor, including details of the medical emergency that necessitated the termination of the pregnancy without the parent's or legal guardian's consent. The physician shall also provide this information in writing to the parent or legal guardian at his or her last known address, by first-class mail or by certified mail, return receipt requested, with delivery restricted to the parent or legal guardian.

(c)1. A physician who intentionally or recklessly performs or induces, or attempts to perform or induce, a termination of a pregnancy of a minor without obtaining the required consent pursuant to this subsection commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. A penalty may not be assessed against the minor upon whom a termination of pregnancy is performed or induced or upon whom a termination of pregnancy is attempted to be performed or induced.

2. It is a defense to prosecution that a minor misrepresented her age or identity to a physician by displaying a driver license or identification card issued by the state or another state which indicated that the minor was 18 years of age or older and that the appearance of the minor was such that a reasonably prudent person would believe that the minor was not under 18 years of age. To use the defense, a physician must provide a copy of the driver license or identification card used by the minor. The defense does not apply if the physician is shown to have had independent knowledge of the minor's actual age or identity or to have failed to use due diligence in determining the minor's age or identity.

(6) PROCEDURE FOR JUDICIAL WAIVER.—

(a) A minor may petition any circuit court in which the minor resides for a waiver of the requirements of this section and may participate in proceedings on her own behalf. The petition may be filed under a pseudonym or through the use of initials, as provided by court rule. The petition must include a statement that the petitioner is pregnant and that the requirements of this section have not been waived. The court shall advise the minor that she has a right to court-appointed counsel at no cost to the minor. The court shall, upon request, provide counsel for the minor at least 24 hours before the court proceeding.

(b)1. Court proceedings under this section must be given precedence over other pending matters to the extent necessary to ensure that the court reaches a decision promptly. The court shall rule, and issue written findings of fact and conclusions of law, within 3 business days after the petition is filed, except that the 3-business-day limitation may be extended at the request of the minor. If the court fails to rule within the 3-business-day period and an extension has not been requested, the minor may immediately petition for a hearing upon the expiration of the 3-business-day period to the chief judge of the circuit, who must ensure a hearing is held within 48 hours after receipt of the minor's petition and an order is entered within 24 hours after the hearing.

2. If the circuit court does not grant judicial waiver of the requirements of this section, the minor has the right to appeal. An appellate court must rule within 7 days after receipt of appeal, but a ruling may be remanded with further instruction for a ruling within 3 business days after the remand. The reason for overturning a ruling on appeal must be based on abuse of discretion by the court and may not be based on the weight of the evidence presented to the circuit court since the proceeding is a nonadversarial proceeding.

(c) If the court finds, by clear and convincing evidence, that the minor is sufficiently mature to decide whether to terminate her pregnancy, the court shall issue an order authorizing the minor to consent to the performance or inducement of a termination of the pregnancy. If the court does not make the finding specified in this paragraph or paragraph (d), it must dismiss the petition. Factors the court shall consider include:

1. The minor's:

a. Age.

b. Overall intelligence.

c. Emotional development and stability.

d. Credibility and demeanor as a witness.

e. Ability to accept responsibility.

f. Ability to assess both the immediate and long-range consequences of the minor's choices.

g. Ability to understand and explain the medical risks of terminating her pregnancy and to apply that understanding to her decision.

2. Whether there may be any undue influence by another on the minor's decision to have an abortion.

(d) If the court finds, by a preponderance of the evidence, that the petitioner is the victim of child abuse or sexual abuse inflicted by one or both of her parents or her guardian, or by clear and convincing evidence that the requirements of this section are not in the best interest of the petitioner, the court shall issue an order authorizing the minor to consent to the performance or inducement of a termination of the pregnancy. The best-interest standard does not include financial best interest or financial considerations or the potential financial impact on the minor or the minor's family if the minor does not terminate the pregnancy. If the court finds evidence of child abuse or sexual abuse of the minor petitioner by any person, the court shall report the evidence of child abuse or sexual abuse of the petitioner, as provided in s. 39.201. If the court does not make the finding specified in this paragraph or paragraph (c), it must dismiss the petition.

(e) A court that conducts proceedings under this section shall:

1. Provide for a written transcript of all testimony and proceedings;

2. Issue a final written order containing factual findings and legal conclusions supporting its decision, including factual findings and legal conclusions relating to the maturity of the minor as provided under paragraph (c); and

3. Order that a confidential record be maintained, as required under s. 390.01116.

(f) All hearings under this section, including appeals, shall remain confidential and closed to the public, as provided by court rule. Subject to a judge's availability as required under s. 26.20, hearings held under this section

must be held in chambers or in a similarly private and informal setting within the courthouse.

(g) An expedited appeal shall be made available, as the Supreme Court provides by rule, to any minor to whom the circuit court denies a waiver of the requirements of this section. An order authorizing a termination of pregnancy under this subsection is not subject to appeal.

(h) Filing fees or court costs may not be required of any pregnant minor who petitions a court for a waiver of the requirements of this section at either the trial or the appellate level.

(i) A county is not obligated to pay the salaries, costs, or expenses of any counsel appointed by the court under this subsection.

(7) PROCEEDINGS.—The Supreme Court is requested to adopt rules and forms for petitions to ensure that proceedings under subsection (6) are handled expeditiously and in a manner consistent with this act. The Supreme Court is also requested to adopt rules to ensure that the hearings protect the minor's confidentiality and the confidentiality of the proceedings.

(8) REPORT.—The Supreme Court, through the Office of the State Courts Administrator, shall report by February 1 of each year to the Governor, the President of the Senate, and the Speaker of the House of Representatives on the number of petitions filed under subsection (6) for the preceding year, and the timing and manner of disposal of such petitions by each circuit court. For each petition resulting in a waiver of the requirements of this section, the reason for the waiver shall be included in the report.

History.—s. 2, ch. 2005-52; s. 43, ch. 2006-1; s. 47, ch. 2011-213; s. 1, ch. 2011-227; s. 2, ch. 2020-147.

390.01116 Public records exemptions; minors seeking waiver of notice requirements.—Any information that can be used to identify a minor petitioning a circuit court for a judicial waiver, as provided in s. 390.01114, of the notice requirements under the Parental Notice of Abortion Act is:

(1) Confidential and exempt from s. 24(a), Art. I of the State Constitution if held by a circuit court or an appellate court.

(2) Confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution if held by the office of criminal conflict and civil regional counsel or the Justice Administrative Commission.

History.—s. 1, ch. 99-321; ss. 1, 2, ch. 2005-104; ss. 1, 3, ch. 2010-41; s. 1, ch. 2015-74.

390.01118 Public records exemptions; minors seeking waiver of consent requirements.—Any information that can be used to identify a minor who is petitioning a circuit court for a judicial waiver, as provided in s. 390.01114, of the consent requirements under the Parental Notice of and Consent for Abortion Act is:

(1) Confidential and exempt from s. 24(a), Art. I of the State Constitution, if held by a circuit court or an appellate court.

(2) Confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution, if held by the office of criminal conflict and civil regional counsel or the Justice Administrative Commission.

This section is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed on October 2, 2025, unless reviewed and saved from repeal through reenactment by the Legislature.

History.—s. 1, ch. 2020-148.

390.0112 Termination of pregnancies; reporting.—

(1) The director of any medical facility in which abortions are performed, including surgical procedures and medical abortions, shall submit a report each month to the agency. If the abortion is not performed in a medical facility, the physician performing the abortion shall submit the monthly report. The report must be submitted electronically on a form adopted by the agency, the Board of Medicine, and the Board of Osteopathic Medicine which may not include personal identifying information and must include:

(a) The number of abortions performed.

(b) The reasons such abortions were performed. If a woman upon whom an abortion is performed has provided evidence that she is a victim of human trafficking pursuant to s. 390.0111(3)(a)1.b.(IV), such reason must be included in the information reported under this section.

(c) For each abortion, the period of gestation at the time the abortion was performed.

(d) The number of infants born alive or alive immediately after an attempted abortion.

(e) Information consistent with the United States Standard Report of Induced Termination of Pregnancy adopted by the Centers for Disease Control and Prevention.

(f) The number of medication abortion regimens prescribed or dispensed.

(2) The agency shall keep such reports in a central location for the purpose of compiling and analyzing statistical data and shall submit data reported pursuant to paragraph (1)(e) to the Division of Reproductive Health within the Centers for Disease Control and Prevention, as requested by the Centers for Disease Control and Prevention.

(3) Reports submitted pursuant to this section shall be confidential and exempt from the provisions of s. 119.07(1) and shall not be revealed except upon the order of a court of competent jurisdiction in a civil or criminal proceeding.

(4) Any person required under this section to file a report or keep any records who willfully fails to file such report or keep such records may be subject to a $200 fine for each violation. The agency shall be required to impose such fines when reports or records required under this section have not been timely received. For purposes of this section, timely received is defined as 30 days following the preceding month.

History.—s. 2, ch. 79-302; s. 1, ch. 90-336; s. 191, ch. 97-101; s. 3, ch. 97-151; s. 2, ch. 98-1; s. 78, ch. 99-8; s. 202, ch. 99-13; s. 3, ch. 2013-121; s. 3, ch. 2016-150; s. 5, ch. 2022-69.

Note.—Former s. 390.002.

390.012 Powers of agency; rules; disposal of fetal remains.—

(1) The agency may develop and enforce rules pursuant to ss. 390.011-390.018 and part II of chapter 408 for the health, care, and treatment of persons in abortion clinics and for the safe operation of such clinics.

(a) The rules shall be reasonably related to the preservation of maternal health of the clients.

(b) The rules shall be in accordance with s. 797.03 and may not impose an unconstitutional burden on a woman's freedom to decide whether to terminate her pregnancy.

(c) The rules shall provide for:

1. The performance of pregnancy termination procedures only by a licensed physician.

2. The making, protection, and preservation of patient records, which shall be treated as medical records under chapter 458. When performing a license inspection of a clinic, the agency shall inspect at least 50 percent of patient records generated since the clinic's last license inspection.

3. Annual inspections by the agency of all clinics licensed under this chapter to ensure that such clinics are in compliance with this chapter and agency rules.

4. The prompt investigation of credible allegations of abortions being performed at a clinic that is not licensed to perform such procedures.

(2) For clinics that perform abortions in the first trimester of pregnancy only, these rules must be comparable to rules that apply to all surgical procedures requiring approximately the same degree of skill and care as the performance of first trimester abortions and must require:

(a) Clinics to have a written patient transfer agreement with a hospital within reasonable proximity to the clinic which includes the transfer of the patient's medical records held by the clinic and the treating physician to the licensed hospital; or

(b) Physicians who perform abortions at the clinic to have admitting privileges at a hospital within reasonable proximity to the clinic.

(3) For clinics that perform or claim to perform abortions after the first trimester of pregnancy, the agency shall adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this chapter, including the following:

(a) Rules for an abortion clinic's physical facilities. At a minimum, these rules shall prescribe standards for:

1. Adequate private space that is specifically designated for interviewing, counseling, and medical evaluations.

2. Dressing rooms for staff and patients.

3. Appropriate lavatory areas.
4. Areas for preprocedure hand washing.
5. Private procedure rooms.
6. Adequate lighting and ventilation for abortion procedures.
7. Surgical or gynecological examination tables and other fixed equipment.
8. Postprocedure recovery rooms that are equipped to meet the patients' needs.
9. Emergency exits to accommodate a stretcher or gurney.
10. Areas for cleaning and sterilizing instruments.
11. Adequate areas for the secure storage of medical records and necessary equipment and supplies.
12. The display in the abortion clinic, in a place that is conspicuous to all patients, of the clinic's current license issued by the agency.

(b) Rules to prescribe abortion clinic supplies and equipment standards, including supplies and equipment that are required to be immediately available for use or in an emergency. At a minimum, these rules shall:

1. Prescribe required clean and sterilized equipment and supplies, including medications, required for the conduct, in an appropriate fashion, of any abortion procedure that the medical staff of the clinic anticipates performing and for monitoring the progress of each patient throughout the procedure and recovery period.
2. Prescribe required equipment, supplies, and medications that shall be available and ready for immediate use in an emergency and requirements for written protocols and procedures to be followed by staff in an emergency, such as the loss of electrical power.
3. Prescribe equipment and supplies for required laboratory tests and requirements for protocols to calibrate and maintain laboratory equipment or equipment operated by clinic staff at the abortion clinic.
4. Require ultrasound equipment.
5. Require that all equipment is safe for the patient and the staff, meets applicable federal standards, and is checked annually to ensure safety and appropriate calibration.

(c) Rules relating to abortion clinic personnel. At a minimum, these rules shall require that:

1. The abortion clinic designate a medical director who is licensed to practice medicine in this state, and all physicians who perform abortions in the clinic have admitting privileges at a hospital within reasonable proximity to the clinic, unless the clinic has a written patient transfer agreement with a hospital within reasonable proximity to the clinic which includes the transfer of the patient's medical records held by both the clinic and the treating physician.
2. If a physician is not present after an abortion is performed, a registered nurse, licensed practical nurse, advanced practice registered nurse, or physician assistant be present and remain at the clinic to provide postoperative monitoring and care until the patient is discharged.
3. Surgical assistants receive training in counseling, patient advocacy, and the specific responsibilities associated with the services the surgical assistants provide.
4. Volunteers receive training in the specific responsibilities associated with the services the volunteers provide, including counseling and patient advocacy as provided in the rules adopted by the director for different types of volunteers based on their responsibilities.

(d) Rules relating to the medical screening and evaluation of each abortion clinic patient. At a minimum, these rules shall require:

1. A medical history including reported allergies to medications, antiseptic solutions, or latex; past surgeries; and an obstetric and gynecological history.
2. A physical examination, including a bimanual examination estimating uterine size and palpation of the adnexa.
3. The appropriate laboratory tests, including:

a. Urine or blood tests for pregnancy performed before the abortion procedure.
b. A test for anemia.
c. Rh typing, unless reliable written documentation of blood type is available.
d. Other tests as indicated from the physical examination.

4. An ultrasound evaluation for all patients. The rules shall require that if a person who is not a physician performs an ultrasound examination, that person shall have documented evidence that he or she has completed a course in the operation of ultrasound equipment as prescribed in rule. The rules shall require clinics to be in compliance with s. 390.0111.

5. That the physician is responsible for estimating the gestational age of the fetus based on the ultrasound examination and obstetric standards in keeping with established standards of care regarding the estimation of fetal age as defined in rule and shall write the estimate in the patient's medical history. The physician shall keep original prints of each ultrasound examination of a patient in the patient's medical history file.

(e) Rules relating to the abortion procedure. At a minimum, these rules shall require:

1. That a physician, registered nurse, licensed practical nurse, advanced practice registered nurse, or physician assistant is available to all patients throughout the abortion procedure.

2. Standards for the safe conduct of abortion procedures that conform to obstetric standards in keeping with established standards of care regarding the estimation of fetal age as defined in rule.

3. Appropriate use of general and local anesthesia, analgesia, and sedation if ordered by the physician.

4. Appropriate precautions, such as the establishment of intravenous access at least for patients undergoing post-first trimester abortions.

5. Appropriate monitoring of the vital signs and other defined signs and markers of the patient's status throughout the abortion procedure and during the recovery period until the patient's condition is deemed to be stable in the recovery room.

(f) Rules that prescribe minimum recovery room standards. At a minimum, these rules must require that:

1. Postprocedure recovery rooms be supervised and staffed to meet the patients' needs.

2. Immediate postprocedure care consist of observation in a supervised recovery room for as long as the patient's condition warrants.

3. A registered nurse, licensed practical nurse, advanced practice registered nurse, or physician assistant who is trained in the management of the recovery area and is capable of providing basic cardiopulmonary resuscitation and related emergency procedures remain on the premises of the abortion clinic until all patients are discharged.

4. A physician sign the discharge order and be readily accessible and available until the last patient is discharged to facilitate the transfer of emergency cases if hospitalization of the patient or viable fetus is necessary.

5. A physician discuss Rho(D) immune globulin with each patient for whom it is indicated and ensure that it is offered to the patient in the immediate postoperative period or will be available to her within 72 hours after completion of the abortion procedure. If the patient refuses the Rho(D) immune globulin, she and a witness must sign a refusal form approved by the agency which must be included in the medical record.

6. Written instructions with regard to postabortion coitus, signs of possible problems, and general aftercare which are specific to the patient be given to each patient. The instructions must include information regarding access to medical care for complications, including a telephone number for use in the event of a medical emergency.

7. A minimum length of time be specified, by type of abortion procedure and duration of gestation, during which a patient must remain in the recovery room.

8. The physician ensure that, with the patient's consent, a registered nurse, licensed practical nurse, advanced practice registered nurse, or physician assistant from the abortion clinic makes a good faith effort to contact the patient by telephone within 24 hours after surgery to assess the patient's recovery.

9. Equipment and services be readily accessible to provide appropriate emergency resuscitative and life support procedures pending the transfer of the patient or viable fetus to the hospital.

(g) Rules that prescribe standards for followup care. At a minimum, these rules shall require that:

1. A postabortion medical visit that includes a medical examination and a review of the results of all laboratory tests is offered.

2. A urine pregnancy test is obtained at the time of the followup visit to rule out continuing pregnancy.

3. If a continuing pregnancy is suspected, the patient shall be evaluated and a physician who performs abortions shall be consulted.

(h) Rules to prescribe minimum abortion clinic incident reporting. At a minimum, these rules shall require that:

1. The abortion clinic records each incident that results in serious injury to a patient or a viable fetus at an abortion clinic and shall report an incident in writing to the agency within 10 days after the incident occurs. For the purposes of this paragraph, "serious injury" means an injury that occurs at an abortion clinic and that creates a serious risk of substantial impairment of a major bodily organ.

2. If a patient's death occurs, other than a fetal death properly reported pursuant to law, the abortion clinic reports it to the department not later than the next department workday.

(4) The rules adopted pursuant to this section shall not limit the ability of a physician to advise a patient on any health issue.

(5) The provisions of this section and the rules adopted pursuant hereto shall be in addition to any other laws, rules, and regulations which are applicable to facilities defined as abortion clinics under this section.

(6) The agency may adopt and enforce rules, in the interest of protecting the public health, to ensure the prompt and proper disposal of fetal remains and tissue resulting from pregnancy termination.

(7) If an owner, operator, or employee of an abortion clinic fails to dispose of fetal remains and tissue in a sanitary manner pursuant to s. 381.0098, rules adopted thereunder, and rules adopted by the agency pursuant to this section, the license of such clinic may be suspended or revoked, and such person commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(8) Beginning February 1, 2017, and annually thereafter, the agency shall submit a report to the President of the Senate and the Speaker of the House of Representatives which summarizes all regulatory actions taken during the prior year by the agency under this chapter.

History.—s. 2, ch. 78-382; s. 1, ch. 80-413; s. 1, ch. 86-286; ss. 1, 4, 5, ch. 88-97; s. 65, ch. 91-224; s. 4, ch. 91-429; s. 5, ch. 97-151; s. 2, ch. 2005-95; s. 15, ch. 2007-230; s. 96, ch. 2008-4; s. 2, ch. 2011-224; s. 2, ch. 2015-118; s. 4, ch. 2016-150; s. 21, ch. 2018-106; s. 6, ch. 2023-21.

[1]**Note.**—Section 9, ch. 2023-21, provides that "[e]xcept as otherwise expressly provided in this act and except for this section, which shall take effect upon this act becoming a law, this act shall take effect 30 days after any of the following occurs: a decision by the Florida Supreme Court holding that the right to privacy enshrined in s. 23, Article I of the State Constitution does not include a right to abortion; a decision by the Florida Supreme Court in *Planned Parenthood v. State*, SC2022-1050, that allows the prohibition on abortions after 15 weeks in s. 390.0111(1), Florida Statutes, to remain in effect, including a decision approving, in whole or in part, the First District Court of Appeal's decision under review or a decision discharging jurisdiction; an amendment to the State Constitution clarifying that s. 23, Article I of the State Constitution does not include a right to abortion; or a decision from the Florida Supreme Court after March 7, 2023, receding, in whole or in part, from *In re T.W.*, 551 So. 2d 1186 (Fla. 1989), *North Fla. Women's Health v. State*, 866 So. 2d 612 (Fla. 2003), or *Gainesville Woman Care, LLC v. State*, 210 So. 3d 1243 (Fla. 2017)." Effective 30 days after any of these contingencies occur, subsection (1), as amended by s. 6, ch. 2023-21, will read:

(1) The agency may develop and enforce rules pursuant to ss. 390.011-390.018 and part II of chapter 408 for the health, care, and treatment of persons in abortion clinics and for the safe operation of such clinics. The rules must be reasonably related to the preservation of maternal health of the clients and must provide for:

(a) The performance of pregnancy termination procedures only by a licensed physician.

(b) The making, protection, and preservation of patient records, which must be treated as medical records under chapter 458. When performing a license inspection of a clinic, the agency shall inspect at least 50 percent of patient records generated since the clinic's last license inspection.

(c) Annual inspections by the agency of all clinics licensed under this chapter to ensure that such clinics are in compliance with this chapter and agency rules.

(d) The prompt investigation of credible allegations of abortions being performed at a clinic that is not licensed to perform such procedures.

390.014 Licenses; fees.—

(1) The requirements of part II of chapter 408 shall apply to the provision of services that require licensure pursuant to ss. 390.011-390.018 and part II of chapter 408 and to entities licensed by or applying for such licensure from the Agency for Health Care Administration pursuant to ss. 390.011-390.018. A license issued by the agency is required in order to operate a clinic in this state.

(2) A separate license shall be required for each clinic maintained on separate premises, even though it is operated by the same management as another clinic; but a separate license shall not be required for separate buildings on the same premises.

(3) In accordance with s. 408.805, an applicant or licensee shall pay a fee for each license application submitted under this chapter and part II of chapter 408. The amount of the fee shall be established by rule and may not be more than required to pay for the costs incurred by the agency in administering this chapter.

(4) Counties and municipalities applying for licenses under this act shall be exempt from the payment of the license fees.

History.—s. 4, ch. 78-382; s. 1, ch. 86-286; ss. 4, 5, ch. 88-97; s. 5, ch. 91-282; s. 4, ch. 91-429; s. 6, ch. 97-151; s. 17, ch. 2007-230; s. 97, ch. 2008-4; s. 5, ch. 2016-150.

390.015 Application for license.—In addition to the requirements of part II of chapter 408, an application for a license to operate an abortion clinic shall be made to the agency and must include the location of the clinic for which application is made and a statement that local zoning ordinances permit such location.

History.—s. 5, ch. 78-382; s. 1, ch. 86-286; ss. 4, 5, ch. 88-97; s. 4, ch. 91-429; s. 7, ch. 97-151; ss. 21, 71, ch. 98-171; s. 61, ch. 2000-349; s. 25, ch. 2001-53; s. 2, ch. 2001-67; s. 148, ch. 2001-277; s. 41, ch. 2004-267; s. 18, ch. 2007-230.

390.018 Administrative fine.—In addition to the requirements of part II of chapter 408, the agency may impose a fine upon the clinic in an amount not to exceed $1,000 for each violation of any provision of this chapter, part II of chapter 408, or applicable rules.

History.—s. 8, ch. 78-382; s. 1, ch. 86-286; ss. 4, 5, ch. 88-97; s. 4, ch. 91-429; s. 10, ch. 97-151; s. 21, ch. 2007-230; s. 98, ch. 2008-4.

390.025 Abortion referral or counseling agencies; penalties.—

(1) As used in this section, an "abortion referral or counseling agency" is any person, group, or organization, whether funded publicly or privately, that provides advice or help to persons in obtaining abortions.

(2) An abortion referral or counseling agency, before making a referral or aiding a person in obtaining an abortion, shall furnish such person with a full and detailed explanation of abortion, including the effects of and alternatives to abortion. If the person advised is a minor, a good faith effort shall be made by the referral or counseling agency to furnish such information to the parents or guardian of the minor. No abortion referral or counseling agency shall charge or accept any fee, kickback, or compensation of any nature from a physician, hospital, clinic, or other medical facility for referring a person thereto for an abortion.

(3) An abortion referral or counseling agency, as defined in subsection (1), shall register with the Agency for Health Care Administration. To register or renew a registration an applicant must pay an initial or renewal registration fee established by rule, which must not exceed the costs incurred by the agency in administering this section. Registrants must include in any advertising materials the registration number issued by the agency and must renew their registration biennially.

(4) The following are exempt from the requirement to register pursuant to subsection (3):

(a) Facilities licensed pursuant to this chapter, chapter 395, chapter 400, or chapter 408;

(b) Facilities that are exempt from licensure as a clinic under s. 400.9905(4) and that refer five or fewer patients for abortions per month; and

(c) Health care practitioners, as defined in s. 456.001, who, in the course of their practice outside of a facility licensed pursuant to this chapter, chapter 395, chapter 400, or chapter 408, refer five or fewer patients for abortions each month.

(5) The agency shall adopt rules to administer this section and part II of chapter 408.

(6) Any person who violates the provisions of subsection (2) commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083. In addition to any other penalties imposed pursuant to this chapter, the Agency for Health Care Administration may assess costs related to an investigation of violations of this section which results in a successful prosecution. Such costs may not include attorney fees.

History.—s. 1, ch. 79-302; s. 66, ch. 91-224; s. 6, ch. 2016-150.

The Florida Senate

2023 Florida Statutes

Title XIX PUBLIC BUSINESS	Chapter 286 PUBLIC BUSINESS: MISCELLANEOUS PROVISIONS Entire Chapter	**SECTION 31** **Prohibited use of state funds; travel to another state for purpose of abortion services.**

[1]**286.31 Prohibited use of state funds; travel to another state for purpose of abortion services.—**

(1) As used in this section, the term:

(a) "Educational institution" means public institutions under the control of a district school board, a charter school, a state university, a developmental research school, a Florida College System institution, the Florida School for the Deaf and the Blind, the Florida Virtual School, private school readiness programs, voluntary prekindergarten programs, private K-12 schools, and private colleges and universities.

(b) "Governmental entity" means the state or any political subdivision thereof, including the executive, legislative, and judicial branches of government; the independent establishments of the state, counties, municipalities, districts, authorities, boards, or commissions; and any agencies that are subject to this chapter.

(2) Any person, governmental entity, or educational institution may not expend state funds as defined in s. 215.31 in any manner for a person to travel to another state to receive services that are intended to support an abortion as defined in s. 390.011, unless:

(a) The person, governmental entity, or educational institution is required by federal law to expend state funds for such a purpose; or

(b) There is a medical necessity for legitimate emergency medical procedures for termination of the pregnancy to save the pregnant woman's life or to avert a serious risk of imminent substantial and irreversible physical impairment of a major bodily function of the pregnant woman other than a psychological condition.

History.—s. 2, ch. 2023-21.

[1]**Note.**—Section 9, ch. 2023-21, provides that "[e]xcept as otherwise expressly provided in this act and except for this section, which shall take effect upon this act becoming a law, this act shall take effect 30 days after any of the following occurs: a decision by the Florida Supreme Court holding that the right to privacy enshrined in s. 23, Article I of the State Constitution does not include a right to abortion; a decision by the Florida Supreme Court in *Planned Parenthood v. State*, SC2022-1050, that allows the prohibition on abortions after 15 weeks in s. 390.0111(1), Florida Statutes, to remain in effect, including a decision approving, in whole or in part, the First District Court of Appeal's decision under review or a decision discharging jurisdiction; an amendment to the State Constitution clarifying that s. 23, Article I of the State Constitution does not include a right to abortion; or a decision from the Florida Supreme Court after March 7, 2023, receding, in whole or in part, from *In re T.W.*, 551 So. 2d 1186 (Fla. 1989), *North Fla. Women's Health v. State*, 866 So. 2d 612 (Fla. 2003), or *Gainesville Woman Care, LLC v. State*, 210 So. 3d 1243 (Fla. 2017)."

The Florida Senate

2023 Florida Statutes

Title IX ELECTORS AND ELECTIONS	Chapter 101 VOTING METHODS AND PROCEDURE Entire Chapter	**SECTION 161** **Referenda; ballots.**

101.161 Referenda; ballots.—

(1) Whenever a constitutional amendment or other public measure is submitted to the vote of the people, a ballot summary of such amendment or other public measure shall be printed in clear and unambiguous language on the ballot after the list of candidates, followed by the word "yes" and also by the word "no," and shall be styled in such a manner that a "yes" vote will indicate approval of the proposal and a "no" vote will indicate rejection. The ballot summary of the amendment or other public measure and the ballot title to appear on the ballot shall be embodied in the constitutional revision commission proposal, constitutional convention proposal, taxation and budget reform commission proposal, or enabling resolution or ordinance. The ballot summary of the amendment or other public measure shall be an explanatory statement, not exceeding 75 words in length, of the chief purpose of the measure. In addition, for every constitutional amendment proposed by initiative, the ballot shall include, following the ballot summary, in the following order:

(a) A separate financial impact statement concerning the measure prepared by the Financial Impact Estimating Conference in accordance with s. 100.371(13).

(b) If the financial impact statement projects a net negative impact on the state budget, the following statement in bold print:

THIS PROPOSED CONSTITUTIONAL AMENDMENT IS ESTIMATED TO HAVE A NET NEGATIVE IMPACT ON THE STATE BUDGET. THIS IMPACT MAY RESULT IN HIGHER TAXES OR A LOSS OF GOVERNMENT SERVICES IN ORDER TO MAINTAIN A BALANCED STATE BUDGET AS REQUIRED BY THE CONSTITUTION.

(c)1. If the financial impact statement projects a net positive impact on the state budget resulting in whole or in part from additional tax revenue, the following statement in bold print:

THIS PROPOSED CONSTITUTIONAL AMENDMENT IS ESTIMATED TO HAVE A NET POSITIVE IMPACT ON THE STATE BUDGET. THIS IMPACT MAY RESULT IN GENERATING ADDITIONAL REVENUE OR AN INCREASE IN GOVERNMENT SERVICES.

2. If the financial impact statement projects a net positive impact on the state budget for reasons other than those specified in subparagraph 1., the following statement in bold print:

THIS PROPOSED CONSTITUTIONAL AMENDMENT IS ESTIMATED TO HAVE A NET POSITIVE IMPACT ON THE STATE BUDGET. THIS IMPACT MAY RESULT IN LOWER TAXES OR AN INCREASE IN GOVERNMENT SERVICES.

(d) If the financial impact statement is indeterminate or the members of the Financial Impact Estimating Conference are unable to agree on the financial impact statement, the following statement in bold print:

THE FINANCIAL IMPACT OF THIS AMENDMENT CANNOT BE DETERMINED DUE TO AMBIGUITIES AND UNCERTAINTIES SURROUNDING THE AMENDMENT'S IMPACT.

The ballot title shall consist of a caption, not exceeding 15 words in length, by which the measure is commonly referred to or spoken of. This subsection does not apply to constitutional amendments or revisions proposed by joint

resolution.

(2) The ballot summary and ballot title of a constitutional amendment proposed by initiative shall be prepared by the sponsor and approved by the Secretary of State in accordance with rules adopted pursuant to s. 120.54. The Department of State shall give each proposed constitutional amendment a designating number for convenient reference. This number designation shall appear on the ballot. Designating numbers shall be assigned in the order of filing or certification and in accordance with rules adopted by the Department of State. The Department of State shall furnish the designating number, the ballot title, and, unless otherwise specified in a joint resolution, the ballot summary of each amendment to the supervisor of elections of each county in which such amendment is to be voted on.

(3)(a) Each joint resolution that proposes a constitutional amendment or revision shall include one or more ballot statements set forth in order of priority. Each ballot statement shall consist of a ballot title, by which the measure is commonly referred to or spoken of, not exceeding 15 words in length, and a ballot summary that describes the chief purpose of the amendment or revision in clear and unambiguous language. If a joint resolution that proposes a constitutional amendment or revision contains only one ballot statement, the ballot summary may not exceed 75 words in length. If a joint resolution that proposes a constitutional amendment or revision contains more than one ballot statement, the first ballot summary, in order of priority, may not exceed 75 words in length.

(b) The Department of State shall furnish a designating number pursuant to subsection (2) and the appropriate ballot statement to the supervisor of elections of each county. The ballot statement shall be printed on the ballot after the list of candidates, followed by the word "yes" and also by the word "no," and shall be styled in such a manner that a "yes" vote will indicate approval of the amendment or revision and a "no" vote will indicate rejection.

(c)1. Any action for a judicial determination that one or more ballot statements embodied in a joint resolution are defective must be commenced by filing a complaint or petition with the appropriate court within 30 days after the joint resolution is filed with the Secretary of State. The complaint or petition shall assert all grounds for challenge to each ballot statement. Any ground not asserted within 30 days after the joint resolution is filed with the Secretary of State is waived.

2. The court, including any appellate court, shall accord an action described in subparagraph 1. priority over other pending cases and render a decision as expeditiously as possible. If the court finds that all ballot statements embodied in a joint resolution are defective and further appeals are declined, abandoned, or exhausted, unless otherwise provided in the joint resolution, the Attorney General shall, within 10 days, prepare and submit to the Department of State a revised ballot title or ballot summary that corrects the deficiencies identified by the court, and the Department of State shall furnish a designating number and the revised ballot title or ballot summary to the supervisor of elections of each county for placement on the ballot. The revised ballot summary may exceed 75 words in length. The court shall retain jurisdiction over challenges to a revised ballot title or ballot summary prepared by the Attorney General, and any challenge to a revised ballot title or ballot summary must be filed within 10 days after a revised ballot title or ballot summary is submitted to the Department of State.

(4)(a) For any general election in which the Secretary of State, for any circuit, or the supervisor of elections, for any county, has certified the ballot position for an initiative to change the method of selection of judges, the ballot for any circuit must contain the statement in paragraph (b) or paragraph (c) and the ballot for any county must contain the statement in paragraph (d) or paragraph (e).

(b) In any circuit where the initiative is to change the selection of circuit court judges to selection by merit selection and retention, the ballot shall state: "Shall the method of selecting circuit court judges in the _(number of the circuit)_ judicial circuit be changed from election by a vote of the people to selection by the judicial nominating commission and appointment by the Governor with subsequent terms determined by a retention vote of the people?" This statement must be followed by the word "yes" and also by the word "no."

(c) In any circuit where the initiative is to change the selection of circuit court judges to election by the voters, the ballot shall state: "Shall the method of selecting circuit court judges in the _(number of the circuit)_ judicial circuit be changed from selection by the judicial nominating commission and appointment by the Governor with subsequent terms determined by a retention vote of the people to election by a vote of the people?" This statement must be followed by the word "yes" and also by the word "no."

(d) In any county where the initiative is to change the selection of county court judges to merit selection and retention, the ballot shall state: "Shall the method of selecting county court judges in _(name of county)_ be changed from election by a vote of the people to selection by the judicial nominating commission and appointment by the Governor with subsequent terms determined by a retention vote of the people?" This statement must be followed by the word "yes" and also by the word "no."

(e) In any county where the initiative is to change the selection of county court judges to election by the voters, the ballot shall state: "Shall the method of selecting county court judges in _(name of the county)_ be changed from selection by the judicial nominating commission and appointment by the Governor with subsequent terms determined by a retention vote of the people to election by a vote of the people?" This statement must be followed by the word "yes" and also by the word "no."

History.—s. 34, ch. 4328, 1895; GS 218; RGS 262; CGL 318; ss. 1-11, ch. 16180, 1933; s. 1, ch. 16877, 1935; s. 4, ch. 17898, 1937; s. 1, ch. 22626, 1945; s. 5, ch. 26870, 1951; ss. 10, 35, ch. 69-106; s. 1, ch. 73-7; s. 13, ch. 77-175; s. 16, ch. 79-365; s. 2, ch. 80-305; s. 32, ch. 84-302; s. 11, ch. 90-203; s. 10, ch. 99-355; s. 1, ch. 2000-361; s. 4, ch. 2001-75; s. 5, ch. 2002-390; s. 5, ch. 2004-33; s. 11, ch. 2005-2; s. 33, ch. 2005-278; s. 29, ch. 2011-40; s. 6, ch. 2013-57; s. 16, ch. 2020-2; s. 4, ch. 2020-15.

Note.—Former s. 99.16.

Tab 3

Federal Guidance

(None Provided)

Tab 4

State Reports

Florida Abortion Provisions Relating to HB 5 (2022) or SB 300 (2023)

Subject	Pre-HB 5	HB 5 (2022)	SB 300 (2023) If It Takes Effect
Definitions in Sec. 390.011, F.S.			
Fatal Fetal Abnormality	N/A	"Means a terminal condition that, in reasonable medical judgment, regardless of the provision of life-saving medical treatment, is incompatible with life outside the womb and will result in death upon birth or imminently thereafter."	No change.
Gestation	"Means the development of a human embryo or fetus between fertilization and birth."	"Means the development of a human embryo or fetus as calculated from the first day of the pregnant woman's last menstrual period ~~between fertilization and birth~~."	No change.
Medical Abortion	N/A	"Means the administration or use of an abortion inducing drug to induce an abortion."	No change.
Time frame after which abortion is prohibited: **Sec. 390.0111, F.S.**	Third trimester (s. 390.0111, F.S.) or Viability (s. 390.01112, F.S.)	15 weeks gestation	6 weeks gestation (Repeals s. 390.01112, F.S.)
Exceptions to time frame: **Sec. 390.0111(1), F.S.**	*Two physicians* certify abortion is necessary to save the pregnant woman's life or avert a serious risk of substantial and irreversible physical impairment of a major bodily function other than a psychological condition. or *One physician* certifies the same as above in an emergency situation and a second physician is not available.	Maintains the pre-HB 5 exceptions and adds a new exception that applies if the fetus has not achieved viability and two physicians certify the fetus has a fatal fetal abnormality.	Modifies the exception for fatal fetal abnormalities to be available until the third trimester, rather than until viability. Adds an exception for rape, incest, or human trafficking, until 15 weeks gestation. Provides documentation requirements. Requires the physician to report the rape, incest, or human trafficking to law enforcement or to the DCF central abuse hotline.

Subject	Pre-HB 5	HB 5 (2022)	SB 300 (2023) If It Takes Effect
In-person performance by a physician: **Sec. 390.0111(2), F.S.**	Provides that no termination of pregnancy shall be performed at any time except by a licensed allopathic or osteopathic physician or a physician practicing medicine or osteopathic medicine in the employment of the United States.	No change.	Specifies that only a physician may perform ***or induce*** a termination of pregnancy. Specifically prohibits the use of telehealth for the performance of abortions, including medical abortions. Requires medical abortion medications to be dispensed in-person by a physician and prohibits such medication from being dispensed by mail or other shipping service.
Informed consent requirements: **Sec. 390.0111(3), F.S.**	Requires the physician to inform the patient, while physically in the same room and at least 24 hours prior to the procedure, of: • The nature and risks of undergoing or not undergoing an abortion; • The probable gestational age of the fetus as determined by an ultrasound, and the person performing the ultrasound must offer the woman the opportunity to view the live ultrasound images and hear an explanation of them; and • The medical risks to the woman and fetus of carrying the pregnancy to term. *(See exceptions below.)*	No change.	No change.

Subject	Pre-HB 5	HB 5 (2022)	SB 300 (2023) If It Takes Effect
Exceptions to informed consent requirements: **Sec. 390.0111(3)(a)1.b.(III) and flush-left language for subparagraph (3)(a)1.**	If the woman seeking an abortion provides documentation of rape, incest, domestic violence, or human trafficking as the reason for the abortion: • The 24-hour requirement is set aside; and • The person performing the ultrasound is prohibited from offering the woman an opportunity to view the ultrasound images and to have them explained (unless she requests to see them and hear the explanation).	No change.	No change.
Penalties for violations: **Sec. 390.0111(10), F.S.**	Except for provisions relating to informed consent, fetal remains, and infants born alive: • Any person who willfully performs, or actively participates in, a termination of pregnancy in violation of the requirements of this section or s. 390.01112 (termination of pregnancies during viability) commits a felony of the third degree. • Any person who performs, or actively participates in, a termination of pregnancy in violation of this section or s. 390.01112 which results in the death of the woman commits a felony of the second degree.	No change.	Removes s. 390.01112, F.S., from the penalty provisions since that section is repealed by SB 300.

Subject	Pre-HB 5	HB 5 (2022)	SB 300 (2023) If It Takes Effect
Reporting requirements: **Sec. 390.0112, F.S.**	Requires the director of a medical facility, or the physician performing the abortion if not performed in a facility, to report specified data to the Agency for Health Care Administration (AHCA).	Specifies that the reporting must pertain to both surgical and medical abortions and adds a data point for the number of medication abortion regimens prescribed or dispensed. Requires that the reporting be done on a form adopted by the AHCA, the Board of Medicine, and the Board of Osteopathic Medicine. Requires that, if a woman provides evidence that she is a victim of human trafficking, that reason must be included on the reporting.	No change.
Agency for Health Care Administration (AHCA) rules: **Sec. 390.012, F.S.**	Requires that rules adopted by AHCA for abortion clinics must be reasonably related to the preservation of maternal health of clients and may not impose an unconstitutional burden on a woman's freedom to decide whether to terminate her pregnancy. Specifies that the AHCA must provide separate standards for clinics that only perform first trimester abortions and for clinics that perform first and second trimester abortions.	No change.	Repeals the prohibition on adopting rules that impose an unconstitutional burden on a woman's freedom to decide whether to terminate her pregnancy.

Subject	Pre-HB 5	HB 5 (2022)	SB 300 (2023) If It Takes Effect
Parental Notice and Consent for Abortion Act: **Sec. 390.01114, F.S.**	Requires that parents be notified and provide consent prior to an abortion being performed on a minor (under 18). Allows a minor to go through a judicial bypass to circumvent the notice and consent requirements. Provides other exceptions for minors who are married, have had the disability of nonage removed, or who have other minor children dependent on her.	No change.	No change.

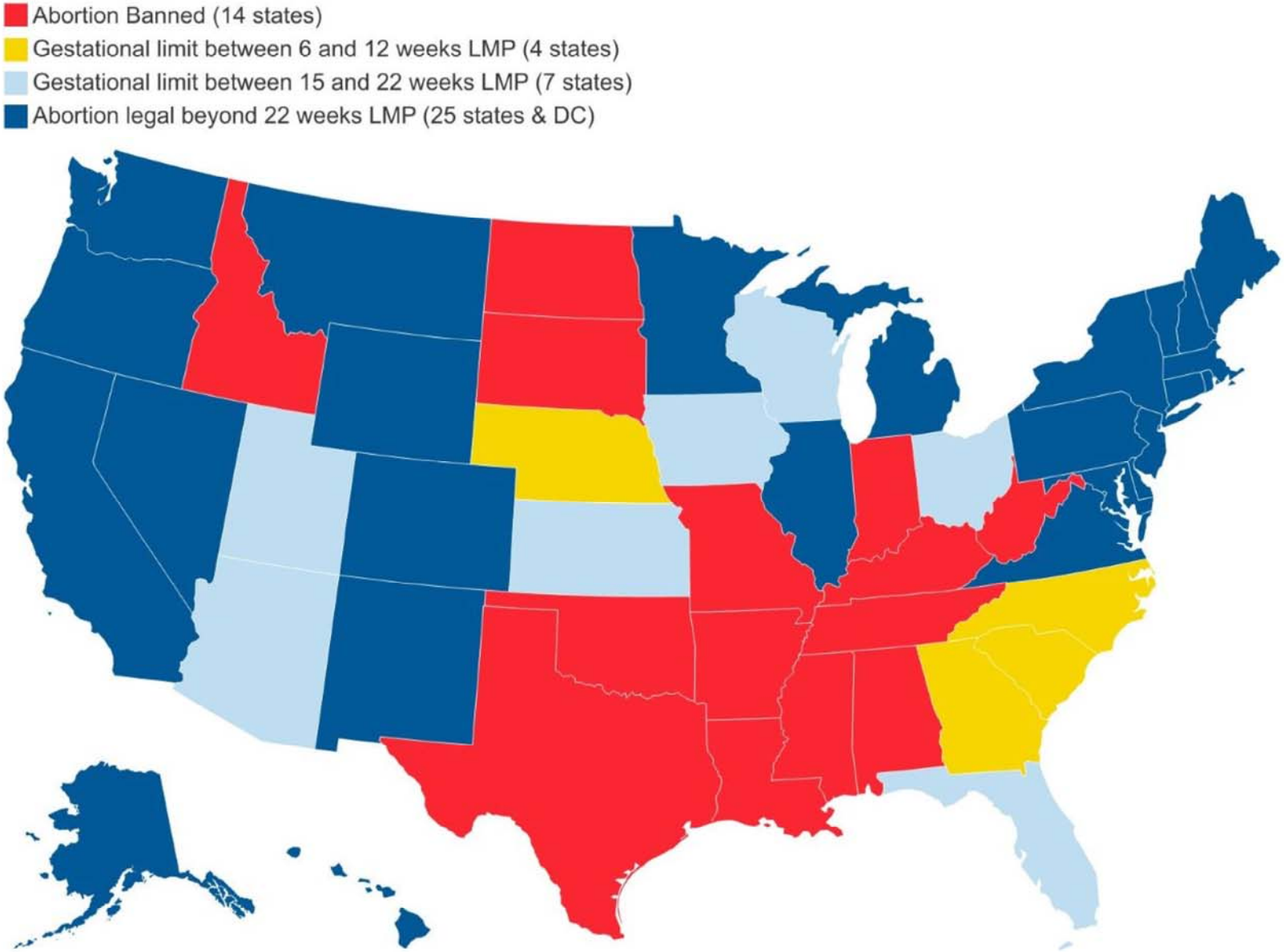
10/9/2023

Tab 5

Reports and Extracts

Status of Abortion Bans in the United States as of September 14, 2023

Hover over state for more details



NOTE: LMP = Last Menstrual Period. For more information on state policies, please see our briefs on state actions to protect abortion, states without laws protecting or restricting abortion, our brief on the *Dobbs* case, our KFF State Health Facts page on abortion policies, our brief on legal challenges to state abortion bans, and our brief on abortion ban exceptions.
Since the Dobbs decision, 25 states have tried to implement a complete ban or a pre-viability ban. In 5 states, these laws are currently blocked by courts. The 25 states are: AL, AZ, AR, FL, GA, ID, IN, IA, KY, LA, MS, MO, NE, NC, ND, OH, OK, SC, SD, TN, TX, UT, WV, WI, and WY.
SOURCE: KFF analysis of state policies and court decisions, as of September 14, 2023.

KFF

Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Surveillance Summaries / Vol. 70 / No. 9
November 26, 2021

Abortion Surveillance — United States, 2019

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

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Abortion Surveillance — United States, 2019

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Abstract

Problem/Condition: CDC conducts abortion surveillance to document the number and characteristics of women obtaining legal induced abortions and number of abortion-related deaths in the United States.

Period Covered: 2019.

Description of System: Each year, CDC requests abortion data from the central health agencies for 50 states, the District of Columbia, and New York City. For 2019, 49 reporting areas voluntarily provided aggregate abortion data to CDC. Of these, 48 reporting areas provided data each year during 2010–2019. Census and natality data were used to calculate abortion rates (number of abortions per 1,000 women aged 15–44 years) and ratios (number of abortions per 1,000 live births), respectively. Abortion-related deaths from 2018 were assessed as part of CDC's Pregnancy Mortality Surveillance System (PMSS).

Results: A total of 629,898 abortions for 2019 were reported to CDC from 49 reporting areas. Among 48 reporting areas with data each year during 2010–2019, in 2019, a total of 625,346 abortions were reported, the abortion rate was 11.4 abortions per 1,000 women aged 15–44 years, and the abortion ratio was 195 abortions per 1,000 live births. From 2018 to 2019, the total number of abortions increased 2% (from 614,820 total abortions), the abortion rate increased 0.9% (from 11.3 abortions per 1,000 women aged 15–44 years), and the abortion ratio increased 3% (from 189 abortions per 1,000 live births). From 2010 to 2019, the total number of reported abortions, abortion rate, and abortion ratio decreased 18% (from 762,755), 21% (from 14.4 abortions per 1,000 women aged 15–44 years), and 13% (from 225 abortions per 1,000 live births), respectively.

In 2019, women in their 20s accounted for more than half of abortions (56.9%). Women aged 20–24 and 25–29 years accounted for the highest percentages of abortions (27.6% and 29.3%, respectively) and had the highest abortion rates (19.0 and 18.6 abortions per 1,000 women aged 20–24 and 25–29 years, respectively). By contrast, adolescents aged <15 years and women aged ≥40 years accounted for the lowest percentages of abortions (0.2% and 3.7%, respectively) and had the lowest abortion rates (0.4 and 2.7 abortions per 1,000 women aged <15 and ≥40 years, respectively). However, abortion ratios in 2019 were highest among adolescents (aged ≤19 years) and lowest among women aged 25–39 years. Abortion rates decreased from 2010 to 2019 for all women, regardless of age. The decrease in abortion rate was highest among adolescents compared with any other age group. From 2018 to 2019, abortion rates decreased or did not change among women aged ≤24 years; however, the abortion rate increased among those aged ≥25 years. Abortion ratios also decreased or did not change from 2010 to 2019 for all age groups, except adolescents aged <15 years. The decrease in abortion ratio was highest among women aged ≥40 years compared with any other age group. From 2018 to 2019, abortion ratios increased for all age groups, except adolescents aged <15 years.

In 2019, 79.3% of abortions were performed at ≤9 weeks' gestation, and nearly all (92.7%) were performed at ≤13 weeks' gestation. During 2010–2019, the percentage of abortions performed at >13 weeks' gestation remained consistently low (≤9.0%). In 2019, the highest proportion of abortions were performed by surgical abortion at ≤13 weeks' gestation (49.0%), followed by early medical abortion at ≤9 weeks' gestation (42.3%), surgical abortion at >13 weeks' gestation (7.2%), and medical abortion at >9 weeks' gestation (1.4%); all other methods were uncommon (<0.1%). Among those that were eligible (≤9 weeks' gestation), 53.7% of abortions were early medical abortions. In 2018, the most recent year for which PMSS data were reviewed for pregnancy-related deaths, two women died as a result of complications from legal induced abortion.

Interpretation: Among the 48 areas that reported data continuously during 2010–2019, overall decreases were observed during 2010–2019 in the total number, rate, and ratio of reported abortions; however, from 2018 to 2019, 1%–3% increases were observed across all measures.

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Public Health Action: Abortion surveillance can be used to help evaluate programs aimed at promoting equitable access to patient-centered quality contraceptive services in the United States to reduce unintended pregnancies.

Introduction

This report summarizes data on legal induced abortions for 2019 that were provided voluntarily to CDC by the central health agencies of 49 reporting areas (47 states, the District of Columbia, and New York City, excluding California, Maryland, and New Hampshire) and comparisons over time for the 48 reporting areas that reported each year during 2010–2019 (47 states and New York City). This report also summarizes abortion-related deaths reported voluntarily to CDC for 2018 as part of the Pregnancy Mortality Surveillance System (PMSS).

Since 1969, CDC has conducted abortion surveillance to document the number and characteristics of women obtaining legal induced abortions in the United States. After nationwide legalization of abortion in 1973, the total number, rate (number of abortions per 1,000 women aged 15–44 years), and ratio (number of abortions per 1,000 live births) of reported abortions increased rapidly, reaching the highest levels in the 1980s, before decreasing at a slow yet steady pace (*1*,*2*). During 2006–2008, a break occurred in the previously sustained pattern of decrease (*3*,*4*), although this break was followed in subsequent years by even greater decreases (*5*,*6*). In 2017, the total number, rate, and ratio of reported abortions reached historic lows, followed by 1%–2% increases across all measures from 2017 to 2018 (*5*). Nonetheless, despite the overall decreases, abortion incidence and practices have varied over the years and continue to vary across subpopulations (*7*–*11*), highlighting the need for continued surveillance.

Methods

Description of the Surveillance System

Each year, CDC requests aggregated data from the central health agencies of the 50 states, the District of Columbia, and New York City to document the number and characteristics of women obtaining legal induced abortions in the United States. Not all persons who obtain abortions identify as women; the term "women" has been maintained in this report to be consistent with the collection and reporting of denominator data used to calculate abortion rates and ratios. This report contains data voluntarily reported to CDC as of April 9, 2021. For the purpose of surveillance, legal induced abortion is defined as an intervention performed within the limits of state law by a licensed clinician (e.g., a physician, nurse-midwife, nurse practitioner, or physician assistant) intended to terminate a suspected or known intrauterine pregnancy and that does not result in a live birth. All abortions in this report are considered to be legally induced unless stated otherwise.

In most states and jurisdictions, collection of abortion data is facilitated by a legal requirement for hospitals, facilities, or physicians to report abortions to a central health agency (*12*); however, reporting is not complete in all areas, including in some areas with reporting requirements (*13*). Because the reporting of abortion data to CDC is voluntary, many reporting areas have developed their own data collection forms and might not collect or provide all the information requested by CDC. As a result, the level of detail reported by CDC on the characteristics of women obtaining abortions might vary from year to year and by reporting area. To encourage uniform collection of data, CDC has collaborated with the National Association for Public Health Statistics and Information Systems to develop reporting standards and provide technical guidance for vital statistics personnel who collect and summarize abortion data within the United States.

Variables and Categorization of Data

Each year, CDC sends a suggested template to central health agencies in the United States for compilation of aggregated abortion data among women obtaining legal induced abortions. Aggregate abortion numbers, without individual-level records, are requested for the following variables:

- Age group in years of women obtaining legal induced abortions (<15, 15–19 [age group and by individual year], 20–24, 25–29, 30–34, 35–39, or ≥40)
- Gestational age of pregnancy in completed weeks at the time of abortion (≤6, 7–20 by individual week, or ≥21)
- Race (Black, White, or other [including Asian, Pacific Islander, other races, and multiple races]), ethnicity (Hispanic or non-Hispanic), and race by ethnicity
- Method type (surgical abortion, intrauterine instillation, medical [nonsurgical] abortion, or hysterectomy/hysterotomy)
- Marital status (married [including currently married or separated] or unmarried [including never married, widowed, or divorced])
- Number of previous live births (zero, one, two, three, or four or more)
- Number of previous induced abortions (zero, one, two, or three or more)
- Residence (the state, jurisdiction, territory, or foreign country in which the women obtaining the abortion lived, or, if additional details are unavailable, in-reporting area versus out-of-reporting area)

In addition, the template provided by CDC requests that aggregate numbers for certain variables be cross-tabulated by a second variable. The cross-tabulations presented in this report include weeks of gestation separately by method type, by age group, and by race/ethnicity.

Beginning with 2014 data, instead of reporting the clinicians' estimates of gestational age or estimates of gestational age based on last menstrual period, some areas have reported "probable postfertilization age," "clinician's estimate of gestation based on date of conception," and "probable gestational age" to CDC. To ensure consistency between data reported as postfertilization age and the data collection practices for gestational age recommended by CDC's National Center for Health Statistics (*14*), 2 weeks were added to probable postfertilization age. This method was used to account for time after last menstrual period until ovulation in a standard 28-day cycle because fertilization occurs around the time of ovulation (*15*). No modifications were made to data reported as clinician's estimate of gestational age based on date of conception or data reported as probable gestational age.

In this report, medical and surgical abortions are further categorized by gestational age when available in the categories reported by CDC. Early medical abortion is defined as the administration of medications (typically mifepristone followed by misoprostol) to induce an abortion at ≤9 completed weeks' gestation consistent with the current Food and Drug Administration (FDA) labeling for mifepristone (implemented in 2016) (*16*). CDC collects information only on the estimated number of weeks (not days) of gestation and acknowledges the conventional use of completed weeks of gestation to describe pregnancy duration; therefore, CDC's category of ≤9 weeks' gestation includes abortions through 9 weeks and 6 days. Medications (typically serial prostaglandins, sometimes administered after mifepristone) may also be used to induce an abortion at >9 weeks' gestation. Surgical abortions, which include uterine aspiration (i.e., dilation and curettage, aspiration curettage, suction curettage, manual vacuum aspiration, menstrual extraction, or sharp curettage) and dilation and evacuation procedures, are categorized as having been performed at ≤13 weeks' gestation or at >13 weeks' gestation because of differences in surgical technique at these gestational ages (*17*). Finally, because intrauterine instillations are unlikely to be performed early in gestation (*18*), abortions reported to have been performed by intrauterine instillation at ≤12 weeks' gestation are excluded from calculation of the percentage of abortions by known method type and are grouped with unknown type. The cutoff of ≤12 weeks was selected because this procedure is unlikely to be performed at earlier gestational ages.

Measures of Abortion

Four measures of abortion are presented in this report: 1) the number of abortions in a given population, 2) the percentage of abortions among women by selected characteristics, 3) the abortion rate (number of abortions per 1,000 women within a given population), and 4) the abortion ratio (number of abortions per 1,000 live births within a given population). Abortion rates adjust for differences in population size. Abortion ratios measure the relative number of pregnancies in a population that end in abortion compared with live birth.

The U.S. Census Bureau estimates of the resident female population were used as the denominator for calculating abortion rates (*19–28*). Overall abortion rates were calculated from the population of women aged 15–44 years living in the reporting areas that provided continuously reported data. For adolescents aged <15 years, abortion rates were calculated using the number of adolescents aged 13–14 years; for women aged ≥40 years, abortion rates were calculated using the number of women aged 40–44 years. For the calculation of abortion ratios, live birth data were obtained from CDC natality files and included births to women of all ages living in the reporting areas that provided abortion data (*29,30*). For calculation of the total abortion rates and total ratios only, women with unknown data on selected characteristics (e.g., age, race/ethnicity, and marital status) were distributed according to the distribution of abortions among those with known information on the characteristic. For calculation of totals only, abortions for women with an unknown gestational age of pregnancy but known method type were distributed according to the distribution of abortions among those with known information on method type by gestational age to the following categories: surgical, ≤13 weeks' gestation; surgical, >13 weeks' gestation; medical ≤9 weeks' gestation; and medical >9 weeks' gestation.

Data Presentation and Analysis

This report provides aggregate and reporting area–specific abortion numbers, rates, and ratios for the 49 areas that reported to CDC for 2019, which excluded California, Maryland, and New Hampshire. In addition, this report describes characteristics of women who obtained abortions in 2019. The data in this report are presented by the reporting area in which the abortions were performed.

The completeness and quality of data received vary by year and by variable; this report only describes the characteristics of women obtaining abortions in reporting areas that met CDC reporting standards (i.e., reported at least 20 abortions overall, provided data categorized in accordance with requested variables, and had <15% unknown values for a given characteristic). Cells with a value in the range of 1–4 or cells that would allow for calculation of these values have been suppressed in this report to maintain confidentiality in tables presented by reporting area of occurrence.

Trends in the number, rate, and ratio of reported abortions and annual data are presented for the 48 areas that reported every year during 2010–2019. The percentage change in abortion measures from the most recent past year (2018 to 2019) and during the 10-year period of analysis (2010 to 2019) were calculated for these 48 reporting areas.

Trends are also reported for abortions by age group, weeks of gestation, and early medical abortions (≤9 completed weeks' gestation). Annual data are presented for areas that met reporting standards every year during 2010–2019; the percentage change was calculated from the beginning to the end of the 10-year period of analysis (2010–2019), in 5-year increments from the beginning to the end of the first and second halves of this period (2010–2014 and 2015–2019), and from the most recent past year (2018 to 2019). Consistent with previous reports (*5*), key findings for trends are presented to highlight observed changes over time and differences between groups. Trends for early medical abortions are reported to monitor any changes in clinical practice that might have occurred with the accumulation of evidence on the safety and effectiveness of medical abortion past 63 days of gestation (8 completed weeks' gestation) (*31*), changes in professional practice guidelines published in 2013 and 2014 (*32*,*33*), and the 2016 FDA extension of the gestational age limit for the use of mifepristone for early medical abortion from 63 days to 70 days (9 completed weeks' gestation) (*34*). No statistical testing was performed. Comparisons do not imply statistical significance, and lack of comment regarding the difference between values does not imply that no statistically significant difference exists.

Data from reporting areas are not included in trends if the data did not meet reporting standards every year during 2010–2019. As a result, aggregate measures for 2019 in trend analyses might differ from the point estimates reported for 2019.

Abortion Mortality

CDC has reported data on abortion-related deaths periodically since information on abortion mortality first was included in the 1972 abortion surveillance report (*5*,*35*). An abortion-related death is defined as a death resulting from a direct complication of an abortion (legal or illegal), an indirect complication caused by a chain of events initiated by an abortion, or an aggravation of a preexisting condition by the physiologic or psychologic effects of abortion (*36*). An abortion is categorized as legal when it is performed by a licensed clinician within the limits of state law.

Since 1987, CDC has monitored abortion-related deaths through PMSS (*37*). Sources of data to identify abortion-related deaths have included state vital records; media reports, including computerized searches of full-text newspaper and other print media databases; and individual case reports by public health agencies, including maternal mortality review committees, health care providers and provider organizations, private citizens, and citizen groups. For each death that is possibly related to abortion, CDC requests clinical records and autopsy reports. Two medical epidemiologists independently review these reports to determine the cause of death and whether the death was abortion related. Discrepancies are discussed and resolved by consensus. Each death is categorized by abortion type as legal induced, illegal induced, spontaneous, or unknown type.

This report provides PMSS data on induced abortion-related deaths that occurred in 2018, the most recent year for which PMSS data are available. Data on induced abortion-related deaths that occurred during 1972–2017 have been published (*1*,*5*,*38*). For 1998–2018, abortion surveillance data reported to CDC cannot be used alone to calculate national case-fatality rates for legal induced abortions (number of legal induced abortion-related deaths per 100,000 reported legal induced abortions in the United States) because eight reporting areas did not report abortion data every year during this period (Alaska, 1998–2000; California, 1998–2018; District of Columbia, 2016; Louisiana, 2005; Maryland, 2007–2018; New Hampshire, 1998–2018; Oklahoma, 1998–1999; and West Virginia, 2003–2004). Thus, denominator data for calculation of national legal induced abortion case-fatality rates were obtained from a published report by the Guttmacher Institute that includes estimated total numbers of abortions in the United States from a national survey of abortion-providing facilities (*6*). For 2018, the case-fatality rate was calculated using denominator data for 2017, the most recent year for which data from the Guttmacher Institute are available. Because rates determined on the basis of a numerator of <20 deaths are unstable (*39*), national case-fatality rates for legal induced abortion were calculated for consecutive 5-year periods during 1973–2012 and then for a consecutive 6-year period during 2013–2018.

Results

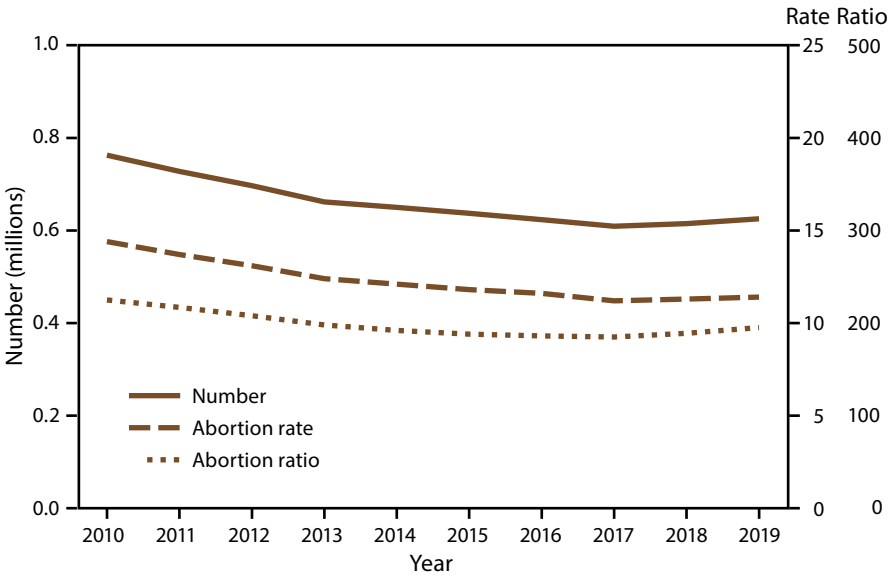
Total Abortions Reported to CDC by Occurrence

Among the 49 reporting areas that provided data for 2019, a total of 629,898 abortions were reported. Of these abortions, 625,346 (99.3%) were from 48 reporting areas that provided data every year during 2010–2019. In 2019, these continuously reporting areas had an abortion rate

of 11.4 abortions per 1,000 women aged 15–44 years and an abortion ratio of 195 abortions per 1,000 live births (Table 1). From 2018 to 2019, the total number of reported abortions increased 2% (from 614,820 total abortions), the abortion rate increased 0.9% (from 11.3 abortions per 1,000 women aged 15–44 years), and the abortion ratio increased 3% (from 189 abortions per 1,000 live births). From 2010 to 2019, the total number of reported abortions decreased 18% (from 762,755), the abortion rate decreased 21% (from 14.4 abortions per 1,000 women aged 15–44 years), and the abortion ratio decreased 13% (from 225 abortions per 1,000 live births) (Figure).

In 2019, a considerable range existed in abortion rates by reporting area of occurrence (from 0.3 to 27.2 abortions per 1,000 women aged 15–44 years in Wyoming and New York City) and abortion ratios (from 5 to 501 abortions per 1,000 live births in Wyoming and the District of Columbia) (Table 2). The percentage of abortions obtained by out-of-state residents also varied among reporting areas (from 0.5% in Arizona to 68.7% in the District of Columbia). Overall, 0.9% of abortions were reported to CDC with unknown residence.

FIGURE. Number, rate,* and ratio† of abortions performed, by year — selected reporting areas,§ United States, 2010–2019



* Number of abortions per 1,000 women aged 15–44 years.
† Number of abortions per 1,000 live births.
§ Data are for 48 reporting areas; excludes California, District of Columbia, Maryland, and New Hampshire.

Age Group, Race/Ethnicity, and Marital Status

Among the 49 areas that reported abortion numbers by women's age for 2019, women in their 20s accounted for the majority (56.9%) of abortions (Table 3). Women aged 20–24 and 25–29 years accounted for the highest percentages of abortions (27.6% and 29.3%, respectively) and had the highest abortion rates (19.0 and 18.6 abortions per 1,000 women aged 20–24 and 25–29 years, respectively). By contrast, those in the youngest (<15 years) and oldest (≥40 years) age groups accounted for the smallest percentages of abortions (0.2% and 3.7%) and had the lowest abortion rates (0.4 and 2.7 abortions per 1,000 women aged <15 and ≥40 years). However, abortion ratios in 2019 were highest among adolescents (873 and 348 abortions per 1,000 live births among those aged <15 years and 15–19 years) and lowest among women aged 25–39 years (194, 132, and 145 abortions per 1,000 live births among those aged 25–29, 30–34, and 35–39 years, respectively).

Among the 44 reporting areas that provided data each year by women's age for 2010–2019, this pattern across age groups was stable, with the majority of abortions and the highest abortion rates occurring among women aged 20–29 years and the lowest percentages of abortions and abortion rates occurring among those in the youngest and oldest age groups (Table 4). From 2010 to 2019, abortion rates decreased among all age groups, although the decreases for adolescents (60% and 50% for adolescents aged <15 and 15–19 years) were greater than the decreases for all older age groups. From 2010 to 2014, the abortion rates decreased for all age groups, and from 2015 to 2019, the abortion rates decreased or did not change for all age groups except women aged 30–34 years and ≥40 years. From 2018 to 2019, abortion rates decreased or did not change for women aged ≤24 years; however, the abortion rate increased among those aged ≥25 years. During 2010–2019, abortion ratios decreased or did not change among all age groups, except for adolescents aged <15 years. The abortion ratio decreased for all age groups from 2010 to 2014; however, from 2015 to 2019, abortion ratios only decreased for women aged ≥35 years. From 2018 to 2019, abortion ratios increased for all age groups, except adolescents aged <15 years, for which it decreased.

Among the 47 areas that reported age by individual year among adolescents for 2019, adolescents aged 18–19 years accounted for the majority (70.2%) of adolescent abortions and had the highest adolescent abortion rates (8.6 and 12.2 abortions per 1,000 adolescents aged 18 and 19 years, respectively) (Table 5). Adolescents aged <15 years accounted for the smallest percentage of adolescent abortions (2.6%) and had the lowest adolescent abortion rate (0.4 abortions

per 1,000 adolescents aged 13–14 years). In 2019, the abortion ratio for adolescents was highest among adolescents aged <15 years (853 abortions per 1,000 live births) and was lowest among adolescents aged 17–19 years (344, 358, and 294 abortions per 1,000 live births among adolescents aged 17, 18, and 19 years).

Among the 30 areas that reported race by ethnicity data for 2019, non-Hispanic White women and non-Hispanic Black women accounted for the largest percentages of all abortions (33.4% and 38.4%, respectively), and Hispanic women and non-Hispanic women in the other race category accounted for smaller percentages (21.0% and 7.2%, respectively) (Table 6). Non-Hispanic White women had the lowest abortion rate (6.6 abortions per 1,000 women) and ratio (117 abortions per 1,000 live births), and non-Hispanic Black women had the highest abortion rate (23.8 abortions per 1,000 women) and ratio (386 abortions per 1,000 live births).

Among the 42 areas that reported by marital status for 2019, 14.5% of women who obtained an abortion were married, and 85.5% were unmarried (Table 7). The abortion ratio was 46 abortions per 1,000 live births for married women and 394 abortions per 1,000 live births for unmarried women.

Previous Live Births and Previous Induced Abortions

Among the 45 areas that reported the number of previous live births for 2019, 40.2%, 24.5%, 20.0%, 9.2%, and 6.0% of women had zero, one, two, three, or four or more previous live births (Table 8). Among the 44 areas that reported the number of previous induced abortions for 2019, the majority of women (58.2%) had previously had no abortions, 23.8% had previously had one abortion, 10.5% had previously had two abortions, and 7.5% had previously had three or more abortions (Table 9).

Weeks of Gestation and Method Type

Among the 43 areas that reported gestational age at the time of abortion for 2019, 79.3% of abortions were performed at ≤9 weeks' gestation, and nearly all (92.7%) were performed at ≤13 weeks' gestation (Table 10). Fewer abortions were performed at 14–20 weeks' gestation (6.2%) or at ≥21 weeks' gestation (<1.0%). Among the 34 reporting areas that provided data every year on gestational age for 2010–2019, the percentage of abortions performed at ≤13 weeks' gestation changed negligibly, from 91.9% to 92.0% (Table 11). However, within this gestational age range, a shift occurred toward earlier gestational ages, with the percentage of abortions performed at ≤6 weeks' gestation increasing 8% and the percentage of abortions performed at 7–9 weeks' and 10–13 weeks' gestation decreasing 0.5% and 14%, respectively.

Among the 47 areas that reported by method type for 2019 and included medical abortion on their reporting form, 49.0% of abortions were surgical abortions at ≤13 weeks' gestation, 42.3% were early medical abortions (a nonsurgical abortion at ≤9 weeks' gestation), 7.2% were surgical abortions at >13 weeks' gestation, and 1.4% were medical abortions at >9 weeks' gestation; other methods, including intrauterine instillation and hysterectomy/hysterotomy, were both uncommon (<0.1%) (Table 12). During 2010–2019, 35 reporting areas (excludes Alabama, Arizona, California, Delaware, District of Columbia, Florida, Hawaii, Illinois, Louisiana, Maine, Maryland, New Hampshire, New Mexico, Tennessee, Vermont, Wisconsin, and Wyoming) provided continuous data and included medical abortion on their reporting form. Among these 35 areas, use of early medical abortion increased 10% from 2018 to 2019 (from 37.5% of abortions to 41.1%) and 123% from 2010 to 2019 (from 18.4% of abortions to 41.1%).

Among the 42 areas that reported abortions categorized by individual weeks of gestation and method type for 2019, surgical abortion accounted for the largest percentage of abortions within every gestational age category, except ≤6 weeks' gestation (Table 13). At ≤6 weeks' gestation, surgical abortion accounted for 41.3% of abortions. Surgical abortion accounted for 52.2% of abortions at 7–9 weeks' gestation, 93.2% of abortions at 10–13 weeks' gestation, 96.9%–99.2% of abortions at 14–20 weeks' gestation, and 87.0% of abortions at ≥21 weeks' gestation. In contrast, medical abortion accounted for 58.6% of abortions at ≤6 weeks' gestation, 47.8% of abortions at 7–9 weeks' gestation, 6.8% of abortions at 10–13 weeks' gestation, 0.8%–2.3% of abortions at 14–20 weeks' gestation, and 11.6% of abortions at ≥21 weeks' gestation. For each gestational age category as applicable, abortions performed by intrauterine instillation or hysterectomy/hysterotomy were rare (<0.1%–1.3% of abortions).

Weeks of Gestation by Age Group and Race/Ethnicity

In selected reporting areas, abortions that were categorized by weeks of gestation were further categorized by age and by race/ethnicity (Table 14). In every subgroup for these characteristics, the largest percentage of abortions occurred at ≤9 weeks' gestation. In 43 reporting areas, by age, 61.3% of adolescents aged <15 years and 73.6% of adolescents aged 15–19 years obtained an abortion at ≤9 weeks' gestation, compared with ≥78.6% among women in older age groups. Conversely, 19.8% of adolescents aged <15 years and 9.6% of adolescents aged 15–19 years obtained an abortion after 13 weeks' gestation,

compared with 6.8%–7.5% for women in older age groups. In 29 reporting areas, by race/ethnicity, 76.2% of non-Hispanic Black women obtained an abortion at ≤9 weeks' gestation, compared with 80.6%–82.4% of women in other racial/ethnic groups. Differences in abortions after 13 weeks' gestation across race/ethnicity were minimal (7.8% among non-Hispanic Black women, compared with 6.1%–7.7% among women in other racial/ethnic groups).

Abortion Mortality

Using national PMSS data (*37*), CDC identified two abortion-related deaths for 2018, the most recent year for which data were reviewed for abortion-related deaths (Table 15). Investigation of these cases indicated that both deaths were related to legal abortion.

The annual number of deaths related to legal induced abortion has fluctuated from year to year since 1973 (Table 15). Because of this variability and the limited number of deaths related to legal induced abortions every year, national case-fatality rates for legal abortion were calculated for consecutive 5-year periods during 1973–2012 and then for a consecutive 6-year period during 2013–2018. The national case-fatality rate for legal induced abortion for 2013–2018 was 0.41 deaths related to legal induced abortions per 100,000 reported legal abortions. This case-fatality rate was lower than the rates for the previous 5-year periods.

Discussion

For 2019, a total of 629,898 abortions were reported to CDC by 49 areas. Of these reporting areas, 48 submitted data every year for 2010–2019, thus providing the information necessary for consistently reporting trends. Among these 48 areas, for 2019, the abortion rate was 11.4 abortions per 1,000 women aged 15–44 years, and the abortion ratio was 195 abortions per 1,000 live births. From 2018 to 2019, the number of abortions increased 2%, the abortion rate increased 0.9%, and the abortion ratio increased 3%. Although the rate of reported abortions declined overall from 2010 to 2019, after reaching a historic low in 2017, the abortion rates increased overall between 2017 and 2019.

Approximately 18% of all pregnancies in the United States end in induced abortion (*6*). Multiple factors influence the incidence of abortion, including access to health care services and contraception (*40–43*); the availability of abortion providers (*4,6,44–47*); state regulations, such as mandatory waiting periods (*48–50*), parental involvement laws (*51,52*), and legal restrictions on abortion providers (*53–57*); and changes in the economy and the resulting impact on family planning decisions and contraceptive use (*58*).

Among areas that reported data continuously by age during 2010–2019, women in their 20s accounted for the majority of abortions and had the highest abortion rates, whereas adolescents aged <15 years had the lowest abortion rates, and adolescents aged <15 years and 15–19 years had the highest abortion ratios. During 2010–2019, women aged ≥40 years accounted for a relatively small proportion of reported abortions (3.4%–3.7%). However, the abortion ratio among women aged ≥40 years continues to be higher than among women aged 25–39 years. These data underscore important age differences in abortion measures.

The trends in adolescent abortions described in this report are important for monitoring trends in adolescent pregnancies in the United States. From 2010 to 2019, national birth data indicate that the birth rate for adolescents aged 15–19 years decreased 51% (*30*), and the data in this report indicate that the abortion rate for the same age group decreased 50%. These findings highlight that decreases in adolescent births in the United States have been accompanied by large decreases in adolescent abortions (*30*).

As in previous years, abortion rates and ratios differ across racial/ethnic groups. For example, in 2019, compared with non-Hispanic White women, abortion rates and ratios were 3.6 and 3.3 times higher among non-Hispanic Black women and 1.8 and 1.5 times higher among Hispanic women. Similar differences have been demonstrated in other U.S.-based studies (*2,7–10,59*). The factors leading to higher abortion rates among certain racial/ethnic minority groups are complex. In addition to disparities in rates of unintended pregnancies, structural factors, including unequal access to quality family planning services (*60,61*), economic disadvantage, and distrust of the medical system (*62*), might contribute to observed differences. Strategies are needed to address these broader structural inequities.

In 2019, the majority of abortions occurred early in gestation (≤9 weeks), when the risks for complications are lowest (*63–66*). In addition, over the past 10 years, approximately three fourths of abortions were performed at ≤9 weeks' gestation, and this percentage increased from 74.8% in 2010 to 77.4% in 2019. Moreover, among areas that reported abortions at ≤13 weeks' gestation by individual week, the distribution of abortions by gestational age continued to shift toward earlier weeks of gestation, with the percentage of early abortions performed at ≤6 weeks' gestation increasing from 34.7% in 2010 to 37.5% in 2019. Previous research indicates that the distribution of abortions by gestational age differs by various sociodemographic characteristics (*67–69*).

In this report, the percentage of adolescents aged ≤19 years who obtained abortions at >13 weeks' gestation was higher than the percentage of abortions obtained among older age groups. The gestational age when abortions are performed might be influenced by multiple factors, including state abortion restrictions, accurate estimation of gestational age, income level, age, and presence of pregnancy-related health conditions (*48*,*59*,*66*,*68*–*73*).

Changes in abortion practices have facilitated the trend of obtaining abortions earlier in pregnancy. Research conducted in the United States during the 1970s indicated that surgical abortion procedures performed at ≤6 weeks' gestation, compared with 7–12 weeks' gestation, were less likely to result in successful termination of the pregnancy (*74*). However, subsequent advances in technology (e.g., improved transvaginal ultrasonography and sensitivity of pregnancy tests) have allowed very early surgical abortions to be performed with completion rates exceeding 97% (*75*–*78*). Likewise, the development of early medical abortion regimens has allowed for abortions to be performed early in gestation, with completion rates for regimens that combine mifepristone and misoprostol reaching 96%–98% (*78*–*81*). Among those that were eligible (≤9 weeks' gestation), 53.7% were reported as early medical abortions. Moreover, among areas that reported by method type and included medical abortion on their reporting form, the percentage of all abortions performed by early medical abortion increased 123% from 2010 to 2019.

Because the annual number of deaths related to legal induced abortion is small and statistically unstable, case-fatality rates were calculated for consecutive 5-year periods during 1973–2012 and then for a consecutive 6-year period during 2013–2018. The national case-fatality rate for legal induced abortion for 2013–2018 was 0.41 deaths per 100,000 abortions; since the late 1970s, all rates for the preceding 5-year periods have been fewer than 1 death per 100,000 abortions, demonstrating the low risk for death associated with legal induced abortion.

Limitations

The findings in this report are subject to at least four limitations. First, because reporting to CDC is voluntary and reporting requirements vary by the individual reporting areas (*13*), CDC is unable to report the total number of abortions performed in the United States. Of the 52 areas from which CDC requested data for 2019, California, Maryland, and New Hampshire did not submit abortion data. In 2017, the most recent year for which data are available through the Guttmacher Institute's national survey of abortion-providing facilities, abortions performed in these states accounted for approximately 19% of all abortions in the United States (*6*). In addition, New Jersey did not have abortion reporting requirements to a centralized health agency during the period covered in this report (*12*), which potentially affects the representativeness of data provided to CDC. Some reporting areas (the District of Columbia and Wyoming) implemented new legislation that could improve reporting of 2019 abortion data. Nonetheless, even in reporting areas that legally require clinicians to submit a report for every abortion they perform, enforcement of this requirement varies.

Second, many states use abortion reporting forms that differ from the technical guidance that CDC developed in collaboration with the National Association for Public Health Statistics and Information Systems. Consequently, some reporting areas do not collect all variables requested by CDC (e.g., age and race/ethnicity) or do not report the data in a manner consistent with this guidance (e.g., gestational age). Missing demographic information can reduce the extent to which the statistics in this report represent women who have had abortions. Findings in this report on the age of women seeking abortions were generally similar to previously published data from Guttmacher Institute's national survey of abortion patients in 2014, although the percentage of abortions among non-Hispanic Black women was lower and among Hispanic women was higher compared with data provided to CDC (*82*). Differences might be attributable to the fact that only 30 reporting areas reported race/ethnicity data to CDC that met CDC's reporting standards. Some areas that either do not report to CDC (e.g., California) or do not report race/ethnicity data (e.g., Illinois) have sufficiently large populations of racial/ethnic minority groups that the absence of data from these areas likely reduces the representativeness of CDC data for these variables. In addition, some areas collect gestational age data that are based on estimated date of conception or probable postfertilization age, which are not consistent with medical conventions for gestational age reporting. Without medical guidance on how to report these data, the validity and reliability of gestational age for these reporting areas is uncertain.

Third, abortion data are compiled and reported to CDC by the central health agency of the reporting area in which the abortion was performed rather than the reporting area in which the person lived. Thus, the available population (*19*–*28*) and birth data (*29*,*30*), which are organized by the states in which women live, might differ from the population of women who undergo abortions in a given reporting area. This likely results in an overestimation of abortions for reporting areas in which a higher percentage of abortions are obtained by out-of-state residents and an underestimation of abortions for reporting areas where residents more frequently obtain abortions out of state. Limited abortion services, stringent regulatory

requirements for obtaining an abortion, or geographic proximity to services in another state might influence where women obtain abortion services (*83*).

Finally, CDC reporting of sociodemographic characteristics of women obtaining abortions is limited to data collected on jurisdiction reporting forms. Therefore, examining additional demographic variables (e.g., socioeconomic status) is not possible.

Public Health Implications

Ongoing surveillance of legal induced abortion is important for several reasons. First, abortion surveillance can be used to help evaluate programs aimed at promoting equitable access to patient-centered contraceptive care in the United States to reduce unintended pregnancies. Cost, inadequate provider reimbursement and training, insufficient patient-centered counseling, lack of youth-friendly services, and low client awareness of available contraceptive methods are reported barriers to accessing contraception (*40–42*,*84–90*). Reducing these barriers might help ensure equitable access to patient-centered contraceptive care and promote equitable reproductive health in the United States (*91*).

Second, routine abortion surveillance is needed to assess trends in clinical practice patterns over time. Information in this report on the number of abortions performed through different methods (e.g., medical or surgical) and at different gestational ages provides the denominator data that are necessary for analyses of the relative safety of abortion practices (*38*). Finally, information on the number of pregnancies ending in abortion is needed in conjunction with data on births and fetal losses to estimate the number of pregnancies in the United States and determine rates for various outcomes of public health importance (e.g., adolescent pregnancies) (*11*).

Conflicts of Interest

All authors have completed and submitted the International Committee of Medical Journal Editors form for disclosure of potential conflicts of interest. No potential conflicts of interest were disclosed.

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TABLE 1. Number, percentage, rate,* and ratio† of reported abortions — selected reporting areas, United States, 2010–2019

	Selected reporting areas§	Continuously reporting areas¶		
Year	No.	No. (%)**	Rate	Ratio
2010	765,651	762,755 (99.6)	14.4	225
2011	730,322	727,554 (99.6)	13.7	217
2012	699,202	696,587 (99.6)	13.1	208
2013	664,435	661,874 (99.6)	12.4	198
2014	652,639	649,849 (99.6)	12.1	192
2015	638,169	636,902 (99.8)	11.8	188
2016	623,471	623,471 (100.0)	11.6	186
2017	612,719	609,095 (99.4)	11.2	185
2018	619,591	614,820 (99.2)	11.3	189
2019	629,898	625,346 (99.3)	11.4	195

* Number of abortions per 1,000 women aged 15–44 years.
† Number of abortions per 1,000 live births.
§ For each given year, excludes reporting areas that did not report that year's abortion numbers to CDC: California (2010–2019), District of Columbia (2016), Maryland (2010–2019), and New Hampshire (2010–2019).
¶ For all years, excludes reporting areas that did not report abortion numbers every year during the period of analysis (2010–2019): California, District of Columbia, Maryland, and New Hampshire.
** Abortions from areas that reported every year during 2010–2019 as a percentage of all reported abortions for a given year.

TABLE 2. Number, rate,* and ratio† of reported abortions, by reporting area of occurrence and number of abortions obtained by out-of-state residents§ — United States, 2019¶

	Abortions reported by area of occurrence**			Abortions obtained by out-of-state residents
State/Area	No.	Rate	Ratio	No. (%)
Alabama	6,009	6.3	103	1,040 (17.3)
Alaska	1,270	8.8	129	19 (1.5)
Arizona	13,097	9.4	165	67 (0.5)
Arkansas	2,963	5.1	81	338 (11.4)
Colorado	9,002	7.6	143	946 (10.5)
Connecticut	9,202	13.7	269	334 (3.6)
Delaware	2,042	11.3	193	277 (13.6)
District of Columbia	4,552	23.9	501	3,126 (68.7)
Florida	71,914	18.5	327	2,256 (3.1)
Georgia	36,907	16.9	292	6,500 (17.6)
Hawaii	2,003	7.6	119	49 (2.4)
Idaho	1,513	4.4	69	78 (5.2)
Illinois	46,517	18.6	332	7,534 (16.2)
Indiana	7,637	5.8	94	618 (8.1)
Iowa	3,566	6.0	95	490 (13.7)
Kansas	6,894	12.3	195	3,372 (48.9)
Kentucky	3,664	4.3	69	643 (17.5)
Louisiana	8,144	8.8	138	1,358 (16.7)
Maine	2,021	8.7	172	107 (5.3)
Massachusetts	18,593	13.3	269	631 (3.4)
Michigan	27,339	14.6	253	1,435 (5.2)
Minnesota	9,940	9.2	151	888 (8.9)
Mississippi	3,194	5.5	87	335 (10.5)
Missouri	1,471	1.2	20	128 (8.7)
Montana	1,568	8.0	142	169 (10.8)
Nebraska	2,068	5.5	84	267 (12.9)
Nevada	8,414	14.0	240	434 (5.2)
New Jersey††	22,178	13.2	223	1,309 (5.9)
New Mexico	3,942	9.9	172	939 (23.8)
New York	78,587	20.3	355	~~6,989 (8.9)~~
New York City	49,784	27.2	472	4,668 (9.4)
New York State	28,803	14.1	248	2,321 (8.1)
North Carolina	28,450	13.8	240	5,079 (17.9)
North Dakota	1,121	7.6	107	289 (25.8)
Ohio	20,102	9.1	150	1,186 (5.9)
Oklahoma	4,995	6.4	102	407 (8.1)
Oregon	8,688	10.5	208	795 (9.2)
Pennsylvania	31,018	13.0	231	2,222 (7.2)
Rhode Island	2,099	10.1	206	274 (13.1)
South Carolina	5,101	5.2	89	312 (6.1)
South Dakota	414	2.6	36	82 (19.8)
Tennessee	9,719	7.3	121	1,823 (18.8)
Texas	57,275	9.5	152	1,303 (2.3)
Utah	2,922	4.2	62	146 (5.0)
Vermont	1,195	10.4	223	265 (22.2)
Virginia	15,601	9.2	160	867 (5.6)
Washington	17,262	11.4	203	848 (4.9)
West Virginia	1,183	3.8	65	168 (14.2)
Wisconsin	6,511	6.0	103	139 (2.1)
Wyoming	31	0.3	5	5 (16.1)
Total	**629,898**	**NA**	**NA**	**NA**

Abbreviation: NA = not applicable.

* Number of abortions per 1,000 women aged 15–44 years.

† Number of abortions per 1,000 live births.

§ Additional details on the reporting area in which abortions were provided, cross-tabulated by the state/area of residence, are available at https://www.cdc.gov/reproductivehealth/data_stats/Abortion.htm.

¶ Data from 49 reporting areas; excludes three reporting areas (California, Maryland, and New Hampshire) that did not report or did not meet reporting standards.

** The total abortions include those with known and unknown residence status.

†† Reporting to the central health agency is not required. Data are requested from hospitals and licensed ambulatory care facilities only.

TABLE 3. Number of reported abortions, by known age group and reporting area of occurrence — selected reporting areas,* United States, 2019

	Age group (yrs)							Total abortions reported by known age
	<15	15–19	20–24	25–29	30–34	35–39	≥40	
State/Area	No. (%)†	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (% of all reported abortions)§
Alabama	23 (0.4)	526 (8.8)	1,807 (30.1)	1,783 (29.7)	1,119 (18.6)	565 (9.4)	183 (3.0)	**6,006 (100.0)**
Alaska	—¶	123 (9.7)	351 (27.6)	363 (28.6)	246 (19.4)	137 (10.8)	—¶	**1,270 (100.0)**
Arizona	19 (0.1)	1,163 (8.9)	3,932 (30.0)	3,631 (27.7)	2,446 (18.7)	1,420 (10.8)	482 (3.7)	**13,093 (100.0)**
Arkansas	10 (0.3)	294 (9.9)	892 (30.1)	901 (30.4)	513 (17.3)	260 (8.8)	90 (3.0)	**2,960 (99.9)**
Colorado	27 (0.3)	812 (9.0)	2,596 (28.9)	2,557 (28.4)	1,735 (19.3)	948 (10.5)	319 (3.5)	**8,994 (99.9)**
Connecticut	20 (0.2)	788 (8.7)	2,382 (26.3)	2,600 (28.8)	1,885 (20.9)	1,042 (11.5)	323 (3.6)	**9,040 (98.2)**
Delaware	8 (0.4)	240 (11.8)	575 (28.2)	574 (28.1)	388 (19.0)	209 (10.2)	48 (2.4)	**2,042 (100.0)**
District of Columbia	10 (0.2)	386 (8.5)	1,262 (27.7)	1,388 (30.5)	870 (19.1)	483 (10.6)	152 (3.3)	**4,551 (100.0)**
Florida	118 (0.2)	5,231 (7.3)	18,889 (26.5)	20,741 (29.1)	15,051 (21.1)	8,425 (11.8)	2,907 (4.1)	**71,362 (99.2)**
Georgia	71 (0.2)	2,832 (7.7)	10,185 (27.6)	11,361 (30.8)	7,254 (19.7)	3,932 (10.7)	1,272 (3.4)	**36,907 (100.0)**
Hawaii	6 (0.3)	190 (9.5)	549 (27.4)	546 (27.3)	381 (19.0)	238 (11.9)	93 (4.6)	**2,003 (100.0)**
Idaho	—¶	187 (12.4)	477 (31.5)	378 (25.0)	252 (16.7)	161 (10.6)	—¶	**1,512 (99.9)**
Illinois**	75 (0.2)	3,492 (9.1)	10,960 (28.4)	11,819 (30.6)	7,166 (18.6)	3,813 (9.9)	1,255 (3.3)	**38,580 (99.5)**
Indiana	18 (0.2)	768 (10.1)	2,324 (30.4)	2,168 (28.4)	1,354 (17.7)	745 (9.8)	260 (3.4)	**7,637 (100.0)**
Iowa	12 (0.3)	357 (10.0)	957 (26.8)	1,000 (28.1)	679 (19.0)	401 (11.2)	159 (4.5)	**3,565 (100.0)**
Kansas	12 (0.2)	632 (9.2)	2,148 (31.2)	1,932 (28.0)	1,239 (18.0)	692 (10.0)	239 (3.5)	**6,894 (100.0)**
Kentucky	11 (0.3)	294 (8.0)	1,071 (29.2)	1,069 (29.2)	719 (19.6)	384 (10.5)	116 (3.2)	**3,664 (100.0)**
Louisiana	26 (0.3)	726 (8.9)	2,302 (28.3)	2,521 (31.0)	1,534 (18.8)	782 (9.6)	253 (3.1)	**8,144 (100.0)**
Maine	5 (0.2)	198 (9.8)	585 (29.0)	534 (26.4)	381 (18.9)	254 (12.6)	63 (3.1)	**2,020 (100.0)**
Massachusetts	28 (0.2)	1,306 (7.0)	4,613 (24.8)	5,313 (28.6)	4,028 (21.7)	2,390 (12.9)	910 (4.9)	**18,588 (100.0)**
Michigan	51 (0.2)	2,328 (8.6)	7,538 (27.7)	8,697 (32.0)	5,201 (19.1)	2,545 (9.4)	831 (3.1)	**27,191 (99.5)**
Minnesota	26 (0.3)	823 (8.3)	2,693 (27.1)	2,837 (28.6)	2,015 (20.3)	1,205 (12.1)	336 (3.4)	**9,935 (99.9)**
Mississippi	7 (0.2)	295 (9.2)	970 (30.4)	1,003 (31.4)	574 (18.0)	276 (8.6)	69 (2.2)	**3,194 (100.0)**
Missouri	5 (0.3)	141 (9.6)	422 (28.7)	436 (29.6)	253 (17.2)	156 (10.6)	58 (3.9)	**1,471 (100.0)**
Montana	5 (0.3)	157 (10.0)	458 (29.2)	454 (29.0)	269 (17.2)	161 (10.3)	64 (4.1)	**1,568 (100.0)**
Nebraska	7 (0.3)	187 (9.0)	625 (30.2)	534 (25.8)	400 (19.3)	234 (11.3)	81 (3.9)	**2,068 (100.0)**
Nevada	19 (0.2)	691 (8.6)	2,200 (27.2)	2,257 (27.9)	1,630 (20.2)	918 (11.4)	363 (4.5)	**8,078 (96.0)**
New Jersey††	50 (0.2)	1,958 (8.8)	5,648 (25.5)	6,497 (29.3)	4,462 (20.1)	2,604 (11.7)	959 (4.3)	**22,178 (100.0)**
New Mexico	22 (0.6)	507 (13.8)	1,111 (30.3)	921 (25.1)	621 (16.9)	379 (10.3)	104 (2.8)	**3,665 (93.0)**
New York	186 (0.2)	6,919 (8.8)	20,238 (25.8)	22,267 (28.4)	16,014 (20.4)	9,438 (12.0)	3,386 (4.3)	**78,448 (99.8)**
New York City	109 (0.2)	4,052 (8.1)	12,471 (25.1)	14,159 (28.4)	10,414 (20.9)	6,260 (12.6)	2,318 (4.7)	**49,783 (100.0)**
New York State	77 (0.3)	2,867 (10.0)	7,767 (27.1)	8,108 (28.3)	5,600 (19.5)	3,178 (11.1)	1,068 (3.7)	**28,665 (99.5)**
North Carolina	60 (0.2)	2,252 (8.3)	7,768 (28.8)	8,270 (30.6)	5,095 (18.9)	2,687 (9.9)	880 (3.3)	**27,012 (94.9)**
North Dakota	0 (—)	121 (10.8)	349 (31.1)	326 (29.1)	189 (16.9)	107 (9.5)	29 (2.6)	**1,121 (100.0)**
Ohio	63 (0.3)	1,737 (8.6)	5,887 (29.3)	6,057 (30.1)	3,720 (18.5)	1,983 (9.9)	655 (3.3)	**20,102 (100.0)**
Oklahoma	89 (1.8)	440 (8.8)	1,517 (30.4)	1,384 (27.7)	901 (18.0)	491 (9.8)	172 (3.4)	**4,994 (100.0)**
Oregon	19 (0.2)	837 (9.6)	2,373 (27.3)	2,326 (26.8)	1,702 (19.6)	1,049 (12.1)	382 (4.4)	**8,688 (100.0)**
Pennsylvania	71 (0.2)	2,474 (8.0)	8,435 (27.2)	9,529 (30.7)	6,188 (19.9)	3,244 (10.5)	1,077 (3.5)	**31,018 (100.0)**
Rhode Island	—¶	185 (8.8)	611 (29.1)	584 (27.8)	411 (19.6)	222 (10.6)	—¶	**2,098 (100.0)**
South Carolina	10 (0.2)	499 (9.8)	1,403 (27.5)	1,500 (29.4)	961 (18.8)	544 (10.7)	184 (3.6)	**5,101 (100.0)**
South Dakota	—¶	—¶	129 (31.2)	117 (28.3)	61 (14.7)	45 (10.9)	—¶	**414 (100.0)**
Tennessee	17 (0.2)	830 (8.6)	2,884 (29.8)	2,982 (30.8)	1,791 (18.5)	913 (9.4)	275 (2.8)	**9,692 (99.7)**
Texas	106 (0.2)	5,041 (8.8)	16,647 (29.1)	16,327 (28.5)	10,907 (19.0)	6,152 (10.7)	2,095 (3.7)	**57,275 (100.0)**
Utah	6 (0.2)	371 (12.7)	915 (31.3)	761 (26.0)	470 (16.1)	305 (10.4)	94 (3.2)	**2,922 (100.0)**
Vermont	—¶	108 (9.1)	305 (25.6)	322 (27.0)	247 (20.7)	153 (12.8)	—¶	**1,191 (99.7)**
Virginia	25 (0.2)	1,108 (7.1)	4,162 (26.7)	4,626 (29.7)	3,186 (20.4)	1,869 (12.0)	605 (3.9)	**15,581 (99.9)**
Washington	32 (0.2)	1,647 (9.6)	4,598 (26.7)	4,723 (27.4)	3,367 (19.5)	2,095 (12.2)	765 (4.4)	**17,227 (99.8)**
West Virginia	8 (0.7)	115 (9.7)	377 (31.9)	320 (27.0)	194 (16.4)	136 (11.5)	33 (2.8)	**1,183 (100.0)**
Wisconsin	17 (0.3)	690 (10.6)	1,917 (29.4)	1,806 (27.7)	1,202 (18.5)	637 (9.8)	242 (3.7)	**6,511 (100.0)**
Wyoming	—¶	—¶	6 (19.4)	10 (32.3)	8 (25.8)	6 (19.4)	—¶	**31 (100.0)**

See table footnotes on the next page.

TABLE 3. (*Continued*) Number of reported abortions, by known age group and reporting area of occurrence — selected reporting areas,* United States, 2019

	Age group (yrs)							Total abortions reported by known age
	<15	15–19	20–24	25–29	30–34	35–39	≥40	
State/Area	No. (%)†	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (% of all reported abortions)§
Total	1,410 (0.2)	53,049 (8.6)	171,043 (27.6)	181,052 (29.3)	121,279 (19.6)	67,835 (11.0)	23,121 (3.7)	618,789 (99.5)§§
Abortion rate¶¶	0.4	6.0	19.0	18.6	13.0	7.4	2.7	NA
Abortion ratio* **	873	348	275	194	132	145	224	NA

Abbreviation: NA = not applicable.

* Data from 49 reporting areas; excludes three reporting areas (California, Maryland, and New Hampshire) that did not report, did not report by age, or did not meet reporting standards.

† Percentages for the individual component categories might not add to 100% because of rounding.

§ Percentage is calculated as the number of abortions reported by known age divided by the sum of abortions reported by known and unknown age. Values ≥99.95% are rounded to 100.0%.

¶ Cells with a value in the range of 1–4 or cells that would allow for calculation of these small values have been suppressed.

** Includes residents only.

†† Reporting to the central health agency is not required. Data are requested from hospitals and licensed ambulatory care facilities only.

§§ Percentage based on a total of 622,137 abortions reported among the areas that met reporting standards for age; reporting standards for age were applied to abortions for residents of Illinois only.

¶¶ Number of abortions obtained by women in a given age group per 1,000 women in that same age group. Adolescents aged 13–14 years were used as the denominator for the group of adolescents aged <15 years, and women aged 40–44 years were used as the denominator for the group of women aged ≥40 years. For the total abortion rate only, abortions for women of unknown age were distributed according to the distribution of abortions among women of known age.

*** Number of abortions obtained by women in a given age group per 1,000 live births to women in that same age group. For the total abortion ratio only, abortions for women of unknown age were distributed according to the distribution of abortions among women of known age.

TABLE 4. Percentage, rate,* and ratio† of reported abortions, by known age group and year — selected reporting areas,§ United States, 2010–2019

Age group (yrs)	Year										% Change			
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010 to 2014	2015 to 2019	2018 to 2019	2010 to 2019
Reported abortions by known age (%)														
<15	0.5	0.4	0.4	0.3	0.3	0.3	0.3	0.2	0.2	0.2	−40.0	−33.3	0.0	−60.0
15–19	14.6	13.5	12.2	11.4	10.4	9.8	9.4	9.1	8.8	8.7	−28.8	−11.2	−1.1	−40.4
20–24	32.9	32.9	32.8	32.7	32.1	31.1	30.0	29.3	28.5	27.8	−2.4	−10.6	−2.5	−15.5
25–29	24.5	24.9	25.4	25.9	26.8	27.6	28.5	29.0	29.4	29.3	9.4	6.2	−0.3	19.6
30–34	15.3	15.8	16.4	16.8	17.2	17.7	18.0	18.3	18.8	19.4	12.4	9.6	3.2	26.8
35–39	8.9	8.9	9.1	9.2	9.7	10.0	10.3	10.5	10.7	10.8	9.0	8.0	0.9	21.3
≥40	3.4	3.6	3.7	3.6	3.6	3.6	3.6	3.6	3.5	3.7	5.9	2.8	5.7	8.8
Abortion rate														
<15	1.0	0.9	0.8	0.6	0.5	0.5	0.4	0.4	0.4	0.4	−50.0	−20.0	0.0	−60.0
15–19	11.7	10.5	9.2	8.2	7.3	6.7	6.2	5.9	5.8	5.8	−37.6	−13.4	0.0	−50.4
20–24	26.8	25.0	23.3	21.9	20.9	19.9	19.0	18.4	18.2	18.1	−22.0	−9.0	−0.5	−32.5
25–29	20.2	19.5	18.9	18.2	18.1	17.9	17.7	17.3	17.6	17.8	−10.4	−0.6	1.1	−11.9
30–34	13.2	12.7	12.4	11.8	11.7	11.7	11.6	11.5	11.9	12.3	−11.4	5.1	3.4	−6.8
35–39	7.6	7.5	7.3	7.0	7.1	7.0	6.9	6.7	6.8	7.0	−6.6	0.0	2.9	−7.9
≥40	2.8	2.8	2.8	2.5	2.5	2.5	2.5	2.5	2.5	2.6	−10.7	4.0	4.0	−7.1
Abortion ratio														
<15	848	839	804	791	745	699	729	777	853	851	−12.1	21.7	−0.2	0.4
15–19	332	326	304	300	291	289	295	301	318	332	−12.3	14.9	4.4	0.0
20–24	291	284	272	262	256	250	249	249	256	260	−12.0	4.0	1.6	−10.7
25–29	184	178	174	169	167	167	169	171	178	183	−9.2	9.6	2.8	−0.5
30–34	138	132	128	122	116	115	113	114	119	124	−15.9	7.8	4.2	−10.1
35–39	171	165	158	148	145	140	136	134	135	137	−15.2	−2.1	1.5	−19.9
≥40	274	275	269	245	239	228	218	211	206	213	−12.8	−6.6	3.4	−22.3
Total (no.)¶,**	**672,271**	**640,719**	**611,540**	**579,406**	**565,691**	**553,596**	**542,922**	**528,308**	**533,557**	**539,634**	**NA**	**NA**	**NA**	**NA**

Abbreviation: NA = not applicable.

* Number of abortions obtained by women in a given age group per 1,000 women in that same age group. Adolescents aged 13–14 years were used as the denominator for the group of adolescents aged <15 years, and women aged 40–44 years were used as the denominator for the group of women aged ≥40 years. Abortions for women of unknown age were distributed according to the distribution of abortions among women of known age.

† Number of abortions obtained by women in a given age group per 1,000 live births to women in that same age group. Abortions for women of unknown age were distributed according to the distribution of abortions among women of known age.

§ Data from 44 reporting areas; excludes eight reporting areas (California, District of Columbia, Florida, Maine, Maryland, New Hampshire, Vermont, and Wyoming) that did not report, did not report by age, or did not meet reporting standards for ≥1 year.

¶ By year, the total number of abortions represents 99.4%–99.7% of all abortions reported to CDC among the areas that met reporting standards for age during 2010–2019; reporting standards for age were applied to abortions for residents of Illinois only.

** The total number is different than previously reported because the totals by known age are presented and data for out-of-state residents were subsequently added for Wisconsin.

TABLE 5. Number of reported abortions among adolescents, by known age and reporting area of occurrence — selected reporting areas,* United States, 2019

	Age group (yrs)						
	<15	15	16	17	18	19	
State/Area	No. (%)†	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	Total no.
Alabama	23 (4.2)	23 (4.2)	43 (7.8)	65 (11.8)	171 (31.1)	224 (40.8)	**549**
Alaska	—§	—§	—§	—§	—§	—§	—§
Arizona	19 (1.6)	40 (3.4)	79 (6.7)	150 (12.7)	367 (31.0)	527 (44.6)	**1,182**
Arkansas	10 (3.3)	22 (7.2)	33 (10.9)	36 (11.8)	87 (28.6)	116 (38.2)	**304**
Colorado	27 (3.2)	39 (4.6)	62 (7.4)	130 (15.5)	259 (30.9)	322 (38.4)	**839**
Delaware	8 (3.2)	12 (4.8)	21 (8.5)	43 (17.3)	70 (28.2)	94 (37.9)	**248**
District of Columbia	10 (2.5)	19 (4.8)	35 (8.8)	74 (18.7)	99 (25.0)	159 (40.2)	**396**
Florida	118 (2.2)	199 (3.7)	402 (7.5)	689 (12.9)	1,585 (29.6)	2,356 (44.0)	**5,349**
Georgia	71 (2.4)	115 (4.0)	209 (7.2)	383 (13.2)	860 (29.6)	1,265 (43.6)	**2,903**
Hawaii	6 (3.1)	9 (4.6)	15 (7.7)	31 (15.8)	48 (24.5)	87 (44.4)	**196**
Idaho	—§	—§	—§	—§	—§	—§	—§
Indiana	18 (2.3)	35 (4.5)	67 (8.5)	103 (13.1)	234 (29.8)	329 (41.9)	**786**
Iowa	12 (3.3)	24 (6.5)	36 (9.8)	49 (13.3)	108 (29.3)	140 (37.9)	**369**
Kansas	12 (1.9)	28 (4.3)	46 (7.1)	75 (11.6)	216 (33.5)	267 (41.5)	**644**
Kentucky	11 (3.6)	16 (5.2)	24 (7.9)	33 (10.8)	82 (26.9)	139 (45.6)	**305**
Louisiana	26 (3.5)	54 (7.2)	74 (9.8)	134 (17.8)	200 (26.6)	264 (35.1)	**752**
Maine	5 (2.5)	14 (6.9)	16 (7.9)	33 (16.3)	54 (26.6)	81 (39.9)	**203**
Massachusetts	28 (2.1)	43 (3.2)	100 (7.5)	169 (12.7)	383 (28.7)	611 (45.8)	**1,334**
Michigan	51 (2.1)	134 (5.6)	191 (8.0)	318 (13.4)	658 (27.7)	1,027 (43.2)	**2,379**
Minnesota	26 (3.1)	43 (5.1)	68 (8.0)	122 (14.4)	255 (30.0)	335 (39.5)	**849**
Mississippi	7 (2.3)	26 (8.6)	24 (7.9)	44 (14.6)	90 (29.8)	111 (36.8)	**302**
Missouri	5 (3.4)	15 (10.3)	12 (8.2)	27 (18.5)	37 (25.3)	50 (34.2)	**146**
Montana	5 (3.1)	10 (6.2)	17 (10.5)	26 (16.0)	42 (25.9)	62 (38.3)	**162**
Nebraska	7 (3.6)	10 (5.2)	15 (7.7)	34 (17.5)	37 (19.1)	91 (46.9)	**194**
Nevada	19 (2.7)	37 (5.2)	62 (8.7)	101 (14.2)	219 (30.8)	272 (38.3)	**710**
New Jersey¶	50 (2.5)	84 (4.2)	206 (10.3)	344 (17.1)	539 (26.8)	785 (39.1)	**2,008**
New Mexico	22 (4.2)	34 (6.4)	65 (12.3)	93 (17.6)	120 (22.7)	195 (36.9)	**529**
New York	186 (2.6)	316 (4.4)	657 (9.2)	1,218 (17.1)	2,026 (28.5)	2,702 (38.0)	**7,105**
New York City	109 (2.6)	192 (4.6)	406 (9.8)	735 (17.7)	1,170 (28.1)	1,549 (37.2)	**4,161**
New York State	77 (2.6)	124 (4.2)	251 (8.5)	483 (16.4)	856 (29.1)	1,153 (39.2)	**2,944**
North Carolina	60 (2.6)	112 (4.8)	186 (8.0)	282 (12.2)	689 (29.8)	983 (42.5)	**2,312**
North Dakota	0 (—)	6 (5.0)	13 (10.7)	16 (13.2)	33 (27.3)	53 (43.8)	**121**
Ohio	63 (3.5)	89 (4.9)	147 (8.2)	239 (13.3)	516 (28.7)	746 (41.4)	**1,800**
Oklahoma	89 (16.8)	19 (3.6)	29 (5.5)	67 (12.7)	145 (27.4)	180 (34.0)	**529**
Oregon	19 (2.2)	35 (4.1)	76 (8.9)	136 (15.9)	218 (25.5)	372 (43.5)	**856**
Pennsylvania	71 (2.8)	116 (4.6)	224 (8.8)	346 (13.6)	736 (28.9)	1,052 (41.3)	**2,545**
Rhode Island	—§	—§	—§	—§	—§	—§	—§
South Carolina	10 (2.0)	16 (3.1)	42 (8.3)	115 (22.6)	138 (27.1)	188 (36.9)	**509**
South Dakota	—§	—§	—§	—§	—§	—§	—§
Tennessee	17 (2.0)	38 (4.5)	76 (9.0)	108 (12.8)	238 (28.1)	370 (43.7)	**847**
Texas	106 (2.1)	213 (4.1)	426 (8.3)	677 (13.2)	1,449 (28.2)	2,276 (44.2)	**5,147**
Utah	6 (1.6)	13 (3.4)	23 (6.1)	49 (13.0)	119 (31.6)	167 (44.3)	**377**
Vermont	—§	—§	—§	—§	—§	—§	—§
Virginia	25 (2.2)	57 (5.0)	82 (7.2)	138 (12.2)	325 (28.7)	506 (44.7)	**1,133**
Washington	32 (1.9)	74 (4.4)	145 (8.6)	277 (16.5)	477 (28.4)	674 (40.1)	**1,679**
West Virginia	8 (6.5)	5 (4.1)	7 (5.7)	19 (15.4)	35 (28.5)	49 (39.8)	**123**
Wisconsin**	17 (2.5)	27 (4.0)	73 (10.8)	77 (11.4)	195 (28.8)	289 (42.6)	**678**
Wyoming	—§	—§	—§	—§	—§	—§	—§

See table footnotes on the next page.

TABLE 5. (*Continued*) Number of reported abortions among adolescents, by known age and reporting area of occurrence — selected reporting areas,* United States, 2019

	Age group (yrs)						
	<15	15	16	17	18	19	
State/Area	No. (%)†	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	Total no.
Total	1,315 (2.6)	2,248 (4.5)	4,175 (8.3)	7,148 (14.3)	14,378 (28.7)	20,791 (41.5)	50,055
Abortion rate††	0.4	1.4	2.6	4.4	8.6	12.2	NA
Abortion ratio§§	853	559	415	344	358	294	NA

Abbreviation: NA = not applicable.

* Data from 47 reporting areas; excludes five reporting areas (California, Connecticut, Illinois, Maryland, and New Hampshire) that did not report, did not report age among adolescents by individual year, or did not meet reporting standards.

† Percentages for the individual component categories might not add to 100% because of rounding.

§ Cells with a value in the range of 1–4 or cells that would allow for calculation of these small values have been suppressed.

¶ Reporting to the central health agency is not required. Data are requested from hospitals and licensed ambulatory care facilities only.

** Includes residents only.

†† Number of abortions obtained by women in a given age group per 1,000 women in that same age group. Adolescents aged 13–14 years were used as the denominator for the group of adolescents aged <15 years. For the total abortion rate only, abortions for women of unknown age were distributed according to the distribution of abortions among women of known age.

§§ Number of abortions obtained by women in a given age group per 1,000 live births to women in that same age group. For the total abortion ratio only, abortions for women of unknown age were distributed according to the distribution of abortions among women of known age.

TABLE 6. Number of reported abortions, by known race/ethnicity and reporting area of occurrence — selected reporting areas,* United States, 2019

	Non-Hispanic				
	White	Black	Other	Hispanic	Total abortions reported by known race/ethnicity
State/Area	No. (%)†	No. (%)	No. (%)	No. (%)	No. (% of all reported abortions)§
Alabama	1,823 (30.4)	3,717 (61.9)	142 (2.4)	323 (5.4)	**6,005 (99.9)**
Alaska	584 (49.0)	85 (7.1)	470 (39.5)	52 (4.4)	**1,191 (93.8)**
Arizona	4,821 (38.4)	1,376 (10.9)	1,241 (9.9)	5,130 (40.8)	**12,568 (96.0)**
Arkansas	1,277 (44.0)	1,370 (47.2)	68 (2.3)	190 (6.5)	**2,905 (98.0)**
Connecticut	3,122 (37.4)	2,754 (33.0)	506 (6.1)	1,971 (23.6)	**8,353 (90.8)**
Delaware	863 (42.5)	850 (41.9)	72 (3.5)	244 (12.0)	**2,029 (99.4)**
District of Columbia	831 (18.8)	2,365 (53.4)	517 (11.7)	717 (16.2)	**4,430 (97.3)**
Florida	20,576 (30.9)	23,072 (34.6)	3,189 (4.8)	19,829 (29.7)	**66,666 (92.7)**
Georgia	7,102 (21.2)	21,709 (64.9)	1,724 (5.2)	2,924 (8.7)	**33,459 (90.7)**
Idaho	939 (67.5)	39 (2.8)	68 (4.9)	346 (24.9)	**1,392 (92.0)**
Indiana	3,919 (51.6)	2,404 (31.6)	583 (7.7)	691 (9.1)	**7,597 (99.5)**
Kansas	3,722 (54.0)	1,631 (23.7)	534 (7.8)	1,000 (14.5)	**6,887 (99.9)**
Kentucky	2,041 (55.7)	1,236 (33.7)	133 (3.6)	253 (6.9)	**3,663 (100.0)**
Michigan	10,578 (39.9)	13,687 (51.6)	1,201 (4.5)	1,041 (3.9)	**26,507 (97.0)**
Minnesota	4,310 (46.8)	2,569 (27.9)	1,392 (15.1)	937 (10.2)	**9,208 (92.6)**
Mississippi	619 (19.5)	2,352 (74.0)	114 (3.6)	95 (3.0)	**3,180 (99.6)**
Montana	1,293 (82.5)	—¶	142 (9.1)	—¶	**1,568 (100.0)**
Nevada	2,841 (37.0)	1,409 (18.4)	924 (12.0)	2,497 (32.6)	**7,671 (91.2)**
New Jersey**	5,133 (26.7)	7,453 (38.8)	3,206 (16.7)	3,427 (17.8)	**19,219 (86.7)**
New Mexico	930 (27.6)	160 (4.8)	380 (11.3)	1,897 (56.3)	**3,367 (85.4)**
North Carolina	8,096 (30.7)	12,968 (49.2)	1,990 (7.6)	3,298 (12.5)	**26,352 (92.6)**
South Carolina	2,481 (48.8)	1,986 (39.0)	232 (4.6)	390 (7.7)	**5,089 (99.8)**
South Dakota	259 (62.6)	46 (11.1)	69 (16.7)	40 (9.7)	**414 (100.0)**
Tennessee	3,688 (38.9)	4,842 (51.0)	363 (3.8)	595 (6.3)	**9,488 (97.6)**
Texas††	15,066 (26.3)	15,921 (27.8)	3,989 (7.0)	22,217 (38.8)	**57,193 (99.9)**
Utah	1,721 (60.4)	133 (4.7)	214 (7.5)	779 (27.4)	**2,847 (97.4)**
Vermont	1,045 (89.7)	47 (4.0)	41 (3.5)	32 (2.7)	**1,165 (97.5)**
Virginia	4,802 (33.6)	6,515 (45.5)	1,512 (10.6)	1,476 (10.3)	**14,305 (91.7)**
West Virginia	987 (83.4)	153 (12.9)	—¶	—¶	**1,183 (100.0)**
Wyoming	17 (60.7)	—¶	—¶	8 (28.6)	**28 (90.3)**
Total	**115,486 (33.4)**	**132,878 (38.4)**	**25,056 (7.2)**	**72,509 (21.0)**	**345,929 (94.5)§§**
Abortion rate¶¶	**6.6**	**23.8**	**13.0**	**11.7**	**NA**
Abortion ratio* **	**117**	**386**	**236**	**170**	**NA**

Abbreviation: NA = not applicable.

* Data from 30 reporting areas; excludes 22 reporting areas (California, Colorado, Hawaii, Illinois, Iowa, Louisiana, Maine, Maryland, Massachusetts, Missouri, Nebraska, New Hampshire, New York City, New York State, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Washington, and Wisconsin) that did not report, did not report by race/ethnicity, or did not meet reporting standards.

† Percentages for the individual component categories might not add to 100% because of rounding.

§ Percentage is calculated as the number of abortions reported by known race/ethnicity divided by the sum of abortions reported by known and unknown race/ethnicity. Values ≥99.95% are rounded to 100.0%.

¶ Cells with a value in the range of 1–4 or cells that would allow for calculation of these small values have been suppressed.

** Reporting to the central health agency is not required. Data are requested from hospitals and licensed ambulatory care facilities only.

†† Reporting form contains only one question for race/ethnicity; therefore, abortions reported for women of White, Black, and other races (Asian and Native American) are not explicitly identified as non-Hispanic.

§§ Percentage based on a total of 366,130 abortions reported among the areas that met reporting standards for race/ethnicity.

¶¶ Number of abortions obtained by women in a given racial/ethnic group per 1,000 women in that same racial/ethnic group. For the total abortion rate only, abortions for women of unknown race/ethnicity were distributed according to the distribution of abortions among women of known race/ethnicity.

*** Number of abortions obtained by women in a given racial/ethnic group per 1,000 live births to women in that same racial/ethnic group. For the total abortion ratio only, abortions for women of unknown race/ethnicity were distributed according to the distribution of abortions among women of known race/ethnicity.

TABLE 7. Number of reported abortions, by known marital status and reporting area of occurrence — selected reporting areas,* United States, 2019

	Marital status		Total abortions reported by known marital status
	Married	Unmarried	
State/Area	No. (%)†	No. (%)	No. (% of all reported abortions)§
Alabama	663 (11.0)	5,342 (89.0)	**6,005 (99.9)**
Alaska	253 (21.1)	945 (78.9)	**1,198 (94.3)**
Arizona	1,878 (14.3)	11,219 (85.7)	**13,097 (100.0)**
Arkansas	376 (12.7)	2,575 (87.3)	**2,951 (99.6)**
Colorado	1,559 (19.1)	6,596 (80.9)	**8,155 (90.6)**
Connecticut	939 (11.5)	7,232 (88.5)	**8,171 (88.8)**
Delaware	224 (11.0)	1,818 (89.0)	**2,042 (100.0)**
Florida	10,136 (16.1)	52,629 (83.9)	**62,765 (87.3)**
Georgia	4,410 (12.8)	30,033 (87.2)	**34,443 (93.3)**
Idaho	302 (21.6)	1,094 (78.4)	**1,396 (92.3)**
Illinois¶	3,575 (9.5)	33,868 (90.5)	**37,443 (96.6)**
Indiana	1,094 (14.3)	6,543 (85.7)	**7,637 (100.0)**
Iowa	633 (17.8)	2,925 (82.2)	**3,558 (99.8)**
Kansas	1,063 (15.5)	5,811 (84.5)	**6,874 (99.7)**
Kentucky	525 (14.3)	3,139 (85.7)	**3,664 (100.0)**
Louisiana	828 (10.5)	7,063 (89.5)	**7,891 (96.9)**
Maine	308 (16.0)	1,612 (84.0)	**1,920 (95.0)**
Michigan	2,660 (10.3)	23,095 (89.7)	**25,755 (94.2)**
Minnesota	1,535 (16.2)	7,959 (83.8)	**9,494 (95.5)**
Mississippi	290 (9.1)	2,893 (90.9)	**3,183 (99.7)**
Missouri	224 (16.0)	1,179 (84.0)	**1,403 (95.4)**
Montana	286 (18.2)	1,282 (81.8)	**1,568 (100.0)**
Nebraska	306 (15.0)	1,732 (85.0)	**2,038 (98.5)**
New Jersey**	2,515 (11.5)	19,372 (88.5)	**21,887 (98.7)**
New Mexico	563 (15.3)	3,128 (84.7)	**3,691 (93.6)**
New York City	8,269 (18.5)	36,518 (81.5)	**44,787 (90.0)**
North Carolina	3,622 (14.4)	21,547 (85.6)	**25,169 (88.5)**
North Dakota	162 (14.5)	958 (85.5)	**1,120 (99.9)**
Ohio	2,603 (14.0)	16,027 (86.0)	**18,630 (92.7)**
Oklahoma	941 (18.9)	4,043 (81.1)	**4,984 (99.8)**
Oregon	1,573 (20.3)	6,193 (79.7)	**7,766 (89.4)**
Pennsylvania	3,766 (12.2)	27,221 (87.8)	**30,987 (99.9)**
Rhode Island	263 (12.9)	1,782 (87.1)	**2,045 (97.4)**
South Carolina	726 (14.4)	4,331 (85.6)	**5,057 (99.1)**
South Dakota	85 (20.5)	329 (79.5)	**414 (100.0)**
Tennessee	1,295 (14.0)	7,985 (86.0)	**9,280 (95.5)**
Texas	9,784 (17.1)	47,363 (82.9)	**57,147 (99.8)**
Utah	724 (24.9)	2,182 (75.1)	**2,906 (99.5)**
Vermont	216 (20.3)	847 (79.7)	**1,063 (89.0)**
Virginia††	2,349 (15.1)	13,252 (84.9)	**15,601 (100.0)**
West Virginia	203 (17.2)	979 (82.8)	**1,182 (99.9)**
Wisconsin	852 (13.2)	5,615 (86.8)	**6,467 (99.3)**
Total	**74,578 (14.5)**	**438,256 (85.5)**	**512,834 (94.5)§§**
Abortion ratio¶¶	**46**	**394**	**NA**

Abbreviation: NA = not applicable.

* Data from 42 reporting areas; excludes 10 reporting areas (California, District of Columbia, Hawaii, Maryland, Massachusetts, Nevada, New Hampshire, New York State, Washington, and Wyoming) that did not report, did not report by marital status, or did not meet reporting standards.

† Percentages for the individual component categories might not add to 100% because of rounding.

§ Percentage is calculated as the number of abortions reported by known marital status divided by the sum of abortions reported by known and unknown marital status. Values ≥99.95% are rounded to 100.0%.

¶ Includes residents only.

** Reporting to the central health agency is not required. Data are requested from hospitals and licensed ambulatory care facilities only.

†† Recorded as patient married or not married to father.

§§ Percentage based on a total of 542,479 abortions reported among the areas that met reporting standards for marital status; reporting standards for marital status were applied to abortions for residents of Illinois only.

¶¶ Number of abortions obtained by marital status per 1,000 live births to women of the same marital status. For the total abortion ratio only, abortions for women of unknown marital status were distributed according to the distribution of abortions among women of known marital status.

TABLE 8. Number of reported abortions, by known number of previous live births and reporting area of occurrence — selected reporting areas,* United States, 2019

	No. of previous live births					Total abortions reported by known number of previous live births
	0	1	2	3	≥4	
State/Area	No. (%)†	No. (%)	No. (%)	No. (%)	No. (%)	No. (% of all reported abortions)§
Alabama	2,030 (33.8)	1,660 (27.6)	1,369 (22.8)	602 (10.0)	348 (5.8)	**6,009 (100.0)**
Alaska	575 (45.3)	233 (18.4)	258 (20.3)	103 (8.1)	100 (7.9)	**1,269 (99.9)**
Arizona	5,707 (44.0)	2,784 (21.5)	2,426 (18.7)	1,195 (9.2)	846 (6.5)	**12,958 (98.9)**
Arkansas	1,042 (35.2)	771 (26.0)	650 (21.9)	295 (10.0)	205 (6.9)	**2,963 (100.0)**
Colorado	5,167 (57.7)	1,644 (18.3)	1,268 (14.1)	573 (6.4)	310 (3.5)	**8,962 (99.6)**
Connecticut	3,731 (40.6)	2,319 (25.2)	1,833 (20.0)	839 (9.1)	465 (5.1)	**9,187 (99.8)**
Delaware	849 (42.1)	501 (24.8)	390 (19.3)	159 (7.9)	118 (5.9)	**2,017 (98.8)**
Florida	27,510 (38.3)	18,129 (25.2)	14,878 (20.7)	6,660 (9.3)	4,737 (6.6)	**71,914 (100.0)**
Georgia	14,313 (38.8)	9,116 (24.7)	7,405 (20.1)	3,646 (9.9)	2,425 (6.6)	**36,905 (100.0)**
Hawaii	1,096 (54.8)	338 (16.9)	313 (15.7)	160 (8.0)	92 (4.6)	**1,999 (99.8)**
Idaho	694 (46.3)	316 (21.1)	277 (18.5)	130 (8.7)	83 (5.5)	**1,500 (99.1)**
Indiana	3,045 (39.9)	1,831 (24.0)	1,558 (20.4)	780 (10.2)	423 (5.5)	**7,637 (100.0)**
Iowa	1,430 (40.4)	781 (22.1)	705 (19.9)	356 (10.1)	268 (7.6)	**3,540 (99.3)**
Kansas	2,795 (40.5)	1,686 (24.5)	1,327 (19.2)	681 (9.9)	405 (5.9)	**6,894 (100.0)**
Kentucky	1,300 (35.5)	934 (25.5)	871 (23.8)	338 (9.2)	221 (6.0)	**3,664 (100.0)**
Louisiana	2,627 (32.3)	2,231 (27.5)	1,807 (22.2)	894 (11.0)	564 (6.9)	**8,123 (99.7)**
Maine	1,002 (49.7)	431 (21.4)	362 (18.0)	148 (7.3)	73 (3.6)	**2,016 (99.8)**
Massachusetts	7,765 (46.2)	3,910 (23.3)	3,147 (18.7)	1,324 (7.9)	645 (3.8)	**16,791 (90.3)**
Michigan¶	9,472 (34.7)	7,075 (25.9)	6,209 (22.7)	2,827 (10.3)	1,748 (6.4)	**27,331 (100.0)**
Minnesota	3,954 (40.1)	2,265 (23.0)	1,944 (19.7)	964 (9.8)	730 (7.4)	**9,857 (99.2)**
Mississippi	996 (31.2)	924 (28.9)	714 (22.4)	342 (10.7)	218 (6.8)	**3,194 (100.0)**
Missouri	561 (38.1)	353 (24.0)	301 (20.5)	146 (9.9)	110 (7.5)	**1,471 (100.0)**
Montana	746 (47.6)	357 (22.8)	260 (16.6)	129 (8.2)	76 (4.8)	**1,568 (100.0)**
Nebraska	819 (39.6)	445 (21.5)	429 (20.8)	216 (10.4)	158 (7.6)	**2,067 (100.0)**
Nevada	3,606 (42.9)	1,954 (23.2)	1,496 (17.8)	790 (9.4)	567 (6.7)	**8,413 (100.0)**
New Jersey**	8,148 (36.9)	6,140 (27.8)	4,303 (19.5)	2,105 (9.5)	1,411 (6.4)	**22,107 (99.7)**
New Mexico	1,502 (42.6)	801 (22.7)	621 (17.6)	357 (10.1)	248 (7.0)	**3,529 (89.5)**
New York City	20,793 (45.8)	11,596 (25.5)	8,380 (18.4)	2,987 (6.6)	1,680 (3.7)	**45,436 (91.3)**
North Carolina	9,498 (37.4)	6,067 (23.9)	5,016 (19.8)	2,660 (10.5)	2,154 (8.5)	**25,395 (89.3)**
North Dakota	452 (40.3)	243 (21.7)	223 (19.9)	118 (10.5)	85 (7.6)	**1,121 (100.0)**
Ohio††	7,074 (36.1)	4,963 (25.3)	4,176 (21.3)	2,049 (10.4)	1,360 (6.9)	**19,622 (97.6)**
Oklahoma	1,890 (37.9)	1,208 (24.2)	1,055 (21.1)	507 (10.2)	332 (6.7)	**4,992 (99.9)**
Oregon	4,366 (50.6)	1,759 (20.4)	1,501 (17.4)	590 (6.8)	407 (4.7)	**8,623 (99.3)**
Pennsylvania	11,760 (37.9)	7,926 (25.6)	6,367 (20.5)	3,046 (9.8)	1,919 (6.2)	**31,018 (100.0)**
Rhode Island	963 (45.9)	506 (24.1)	393 (18.7)	144 (6.9)	92 (4.4)	**2,098 (100.0)**
South Carolina	2,129 (41.7)	1,294 (25.4)	1,027 (20.1)	409 (8.0)	242 (4.7)	**5,101 (100.0)**
South Dakota	165 (39.9)	72 (17.4)	94 (22.7)	—§§	—§§	**414 (100.0)**
Tennessee	3,484 (36.3)	2,498 (26.0)	1,974 (20.6)	940 (9.8)	695 (7.2)	**9,591 (98.7)**
Texas	22,862 (39.9)	13,628 (23.8)	11,985 (20.9)	5,483 (9.6)	3,317 (5.8)	**57,275 (100.0)**
Utah	1,496 (51.2)	555 (19.0)	470 (16.1)	230 (7.9)	171 (5.9)	**2,922 (100.0)**
Vermont	597 (50.0)	235 (19.7)	231 (19.3)	88 (7.4)	43 (3.6)	**1,194 (99.9)**
Virginia	5,531 (35.5)	4,095 (26.2)	3,326 (21.3)	1,646 (10.6)	1,003 (6.4)	**15,601 (100.0)**
Washington	8,035 (46.7)	3,845 (22.3)	3,163 (18.4)	1,370 (8.0)	805 (4.7)	**17,218 (99.7)**
West Virginia	421 (35.6)	347 (29.4)	255 (21.6)	97 (8.2)	62 (5.2)	**1,182 (99.9)**
Wyoming	17 (54.8)	5 (16.1)	7 (22.6)	—§§	—§§	**31 (100.0)**
Total	**214,015 (40.2)**	**130,771 (24.5)**	**106,764 (20.0)**	**49,178 (9.2)**	**31,991 (6.0)**	**532,719 (98.0)¶¶**

* Data from 45 reporting areas; excludes seven reporting areas (California, District of Columbia, Illinois, Maryland, New Hampshire, New York State, and Wisconsin) that did not report, did not report by number of previous live births, or did not meet reporting standards.
† Percentages for the individual component categories might not add to 100% because of rounding.
§ Percentage is calculated as the number of abortions reported by known number of previous live births divided by the sum of abortions reported by known and unknown number of previous live births. Values ≥99.95% are rounded to 100.0%.
¶ Recorded as the number of previous pregnancies carried to term.
** Reporting to the central health agency is not required. Data are requested from hospitals and licensed ambulatory care facilities only.
†† Recorded as the number of living children.
§§ Cells with a value in the range of 1–4 or cells that would allow for calculation of these small values have been suppressed.
¶¶ Percentage based on a total of 543,515 abortions reported among the areas that met reporting standards for the number of previous live births.

TABLE 9. Number of reported abortions, by known number of previous induced abortions and reporting area of occurrence — selected reporting areas,* United States, 2019

	No. of previous induced abortions				Total abortions reported by known number of previous induced abortions
	0	1	2	≥3	
State/Area	No. (%)†	No. (%)	No. (%)	No. (%)	No. (% of all reported abortions)§
Alabama	4,008 (66.7)	1,332 (22.2)	443 (7.4)	226 (3.8)	**6,009 (100.0)**
Alaska	819 (64.5)	271 (21.4)	109 (8.6)	70 (5.5)	**1,269 (99.9)**
Arizona	8,472 (65.6)	3,047 (23.6)	955 (7.4)	445 (3.4)	**12,919 (98.6)**
Arkansas	1,915 (64.6)	587 (19.8)	233 (7.9)	228 (7.7)	**2,963 (100.0)**
Colorado	6,287 (69.9)	1,852 (20.6)	601 (6.7)	251 (2.8)	**8,991 (99.9)**
Connecticut	4,883 (53.2)	2,163 (23.5)	1,123 (12.2)	1,018 (11.1)	**9,187 (99.8)**
Delaware	1,244 (61.5)	472 (23.3)	197 (9.7)	109 (5.4)	**2,022 (99.0)**
Florida	41,693 (58.0)	17,171 (23.9)	7,405 (10.3)	5,645 (7.8)	**71,914 (100.0)**
Georgia	22,534 (61.1)	8,778 (23.8)	3,605 (9.8)	1,990 (5.4)	**36,907 (100.0)**
Hawaii	1,244 (62.2)	452 (22.6)	178 (8.9)	125 (6.3)	**1,999 (99.8)**
Idaho	1,228 (81.8)	209 (13.9)	44 (2.9)	21 (1.4)	**1,502 (99.3)**
Indiana	5,160 (67.6)	1,712 (22.4)	539 (7.1)	226 (3.0)	**7,637 (100.0)**
Iowa	2,675 (75.6)	565 (16.0)	186 (5.3)	114 (3.2)	**3,540 (99.3)**
Kansas	4,647 (67.4)	1,467 (21.3)	499 (7.2)	281 (4.1)	**6,894 (100.0)**
Kentucky	2,324 (63.4)	866 (23.6)	293 (8.0)	181 (4.9)	**3,664 (100.0)**
Louisiana	5,098 (62.7)	2,006 (24.7)	732 (9.0)	291 (3.6)	**8,127 (99.8)**
Maine	1,314 (65.1)	455 (22.6)	153 (7.6)	95 (4.7)	**2,017 (99.8)**
Massachusetts	9,507 (52.6)	4,868 (26.9)	2,240 (12.4)	1,466 (8.1)	**18,081 (97.2)**
Michigan	14,134 (51.7)	6,797 (24.9)	3,684 (13.5)	2,712 (9.9)	**27,327 (100.0)**
Minnesota	6,030 (61.1)	2,197 (22.3)	937 (9.5)	708 (7.2)	**9,872 (99.3)**
Mississippi	2,159 (67.6)	685 (21.4)	249 (7.8)	101 (3.2)	**3,194 (100.0)**
Missouri	882 (60.0)	367 (24.9)	141 (9.6)	81 (5.5)	**1,471 (100.0)**
Montana	643 (41.0)	622 (39.7)	199 (12.7)	104 (6.6)	**1,568 (100.0)**
Nebraska	1,429 (69.1)	430 (20.8)	142 (6.9)	67 (3.2)	**2,068 (100.0)**
Nevada	5,281 (62.8)	1,874 (22.3)	744 (8.8)	512 (6.1)	**8,411 (100.0)**
New Jersey¶	13,486 (60.9)	4,195 (18.9)	2,251 (10.2)	2,223 (10.0)	**22,155 (99.9)**
New York City	16,911 (37.9)	11,024 (24.7)	8,392 (18.8)	8,244 (18.5)	**44,571 (89.5)**
North Carolina	15,400 (61.4)	5,874 (23.4)	2,474 (9.9)	1,329 (5.3)	**25,077 (88.1)**
North Dakota	778 (70.7)	200 (18.2)	92 (8.4)	31 (2.8)	**1,101 (98.2)**
Ohio	11,689 (59.7)	4,727 (24.2)	1,915 (9.8)	1,242 (6.3)	**19,573 (97.4)**
Oklahoma	3,558 (71.3)	975 (19.5)	304 (6.1)	155 (3.1)	**4,992 (99.9)**
Oregon	5,182 (60.1)	2,064 (23.9)	809 (9.4)	574 (6.7)	**8,629 (99.3)**
Pennsylvania	16,327 (52.6)	7,699 (24.8)	3,829 (12.3)	3,163 (10.2)	**31,018 (100.0)**
Rhode Island	1,286 (61.4)	480 (22.9)	218 (10.4)	110 (5.3)	**2,094 (99.8)**
South Carolina	3,320 (65.1)	1,160 (22.7)	414 (8.1)	207 (4.1)	**5,101 (100.0)**
South Dakota	285 (68.8)	88 (21.3)	—**	—**	**414 (100.0)**
Tennessee	6,230 (64.7)	2,326 (24.2)	724 (7.5)	348 (3.6)	**9,628 (99.1)**
Texas	35,902 (62.7)	14,039 (24.5)	4,874 (8.5)	2,460 (4.3)	**57,275 (100.0)**
Utah	2,251 (77.0)	506 (17.3)	114 (3.9)	51 (1.7)	**2,922 (100.0)**
Vermont	746 (62.5)	266 (22.3)	111 (9.3)	70 (5.9)	**1,193 (99.8)**
Virginia	8,520 (54.6)	4,322 (27.7)	1,670 (10.7)	1,089 (7.0)	**15,601 (100.0)**
Washington	9,911 (57.6)	4,219 (24.5)	1,713 (10.0)	1,363 (7.9)	**17,206 (99.7)**
West Virginia	728 (61.5)	298 (25.2)	106 (9.0)	51 (4.3)	**1,183 (100.0)**
Wyoming	20 (64.5)	9 (29.0)	—**	—**	**31 (100.0)**
Total	**308,140 (58.2)**	**125,716 (23.8)**	**55,669 (10.5)**	**39,792 (7.5)**	**529,317 (98.1)††**

* Data from 44 reporting areas; excludes eight reporting areas (California, District of Columbia, Illinois, Maryland, New Hampshire, New Mexico, New York State, and Wisconsin) that did not report, did not report by number of previous induced abortions, or did not meet reporting standards.
† Percentages for the individual component categories might not add to 100% because of rounding.
§ Percentage is calculated as the number of abortions reported by known number of previous induced abortions divided by the sum of abortions reported by known and unknown number of previous induced abortions. Values ≥99.95% are rounded to 100.0%.
¶ Reporting to the central health agency is not required. Data are requested from hospitals and licensed ambulatory care facilities only.
** Cells with a value in the range of 1–4 or cells that would allow for calculation of these small values have been suppressed.
†† Percentage based on a total of 539,573 abortions reported among the areas that met reporting standards for the number of previous induced abortions.

TABLE 10. Number of reported abortions, by known weeks of gestation* and reporting area of occurrence — selected reporting areas,† United States, 2019

	Weeks of gestation							Total abortions reported by known gestational age
	≤6	7–9	10–13	14–15	16–17	18–20	≥21	
State/Area	No. (%)§	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (% of all reported abortions)¶
Alabama**	1,280 (21.3)	2,807 (46.8)	1,257 (20.9)	317 (5.3)	163 (2.7)	133 (2.2)	46 (0.8)	**6,003 (99.9)**
Alaska	292 (23.0)	639 (50.4)	271 (21.4)	64 (5.0)	—††	—††	0 (—)	**1,269 (99.9)**
Arizona	3,863 (29.5)	5,985 (45.7)	2,079 (15.9)	496 (3.8)	261 (2.0)	245 (1.9)	168 (1.3)	**13,097 (100.0)**
Arkansas**	479 (16.2)	1,265 (42.7)	862 (29.1)	150 (5.1)	82 (2.8)	97 (3.3)	28 (0.9)	**2,963 (100.0)**
Colorado	3,639 (40.4)	3,666 (40.7)	1,062 (11.8)	198 (2.2)	150 (1.7)	110 (1.2)	173 (1.9)	**8,998 (100.0)**
Connecticut	4,046 (45.7)	3,155 (35.7)	947 (10.7)	263 (3.0)	175 (2.0)	164 (1.9)	95 (1.1)	**8,845 (96.1)**
Delaware	536 (26.3)	1,071 (52.5)	328 (16.1)	73 (3.6)	16 (0.8)	6 (0.3)	9 (0.4)	**2,039 (99.9)**
Florida	52,850 (73.5)	11,641 (16.2)	4,843 (6.7)	973 (1.4)	691 (1.0)	699 (1.0)	217 (0.3)	**71,914 (100.0)**
Georgia	16,086 (43.6)	13,864 (37.6)	4,396 (11.9)	927 (2.5)	653 (1.8)	752 (2.0)	229 (0.6)	**36,907 (100.0)**
Hawaii	678 (33.9)	861 (43.0)	268 (13.4)	80 (4.0)	43 (2.1)	49 (2.4)	22 (1.1)	**2,001 (99.9)**
Idaho	493 (32.9)	707 (47.1)	257 (17.1)	37 (2.5)	—††	—††	—††	**1,500 (99.1)**
Indiana	1,924 (25.2)	4,055 (53.1)	1,618 (21.2)	9 (0.1)	8 (0.1)	17 (0.2)	6 (0.1)	**7,637 (100.0)**
Iowa	1,652 (46.3)	1,305 (36.6)	412 (11.6)	68 (1.9)	58 (1.6)	54 (1.5)	17 (0.5)	**3,566 (100.0)**
Kansas	2,761 (40.0)	2,722 (39.5)	921 (13.4)	195 (2.8)	121 (1.8)	137 (2.0)	37 (0.5)	**6,894 (100.0)**
Kentucky	1,302 (35.5)	1,493 (40.7)	550 (15.0)	116 (3.2)	65 (1.8)	109 (3.0)	29 (0.8)	**3,664 (100.0)**
Louisiana	2,815 (34.6)	3,567 (43.8)	1,274 (15.7)	273 (3.4)	173 (2.1)	38 (0.5)	0 (—)	**8,140 (100.0)**
Maine	595 (29.5)	996 (49.3)	317 (15.7)	48 (2.4)	33 (1.6)	31 (1.5)	0 (—)	**2,020 (100.0)**
Michigan	9,016 (33.0)	11,496 (42.1)	4,055 (14.9)	1,110 (4.1)	667 (2.4)	584 (2.1)	353 (1.3)	**27,281 (99.8)**
Minnesota	3,597 (36.7)	3,845 (39.2)	1,381 (14.1)	379 (3.9)	194 (2.0)	216 (2.2)	187 (1.9)	**9,799 (98.6)**
Mississippi	1,117 (35.0)	1,421 (44.5)	468 (14.7)	171 (5.4)	16 (0.5)	—††	—††	**3,194 (100.0)**
Missouri	86 (5.8)	496 (33.7)	505 (34.3)	130 (8.8)	87 (5.9)	112 (7.6)	55 (3.7)	**1,471 (100.0)**
Montana	599 (38.2)	628 (40.1)	211 (13.5)	51 (3.3)	34 (2.2)	34 (2.2)	11 (0.7)	**1,568 (100.0)**
Nebraska	976 (47.2)	683 (33.0)	284 (13.7)	62 (3.0)	46 (2.2)	16 (0.8)	0 (—)	**2,067 (100.0)**
Nevada	3,214 (38.6)	3,510 (42.1)	1,078 (12.9)	250 (3.0)	142 (1.7)	89 (1.1)	52 (0.6)	**8,335 (99.1)**
New Jersey§§	8,513 (39.3)	7,499 (34.6)	2,923 (13.5)	961 (4.4)	638 (2.9)	613 (2.8)	514 (2.4)	**21,661 (97.7)**
New Mexico	1,487 (42.7)	957 (27.5)	381 (10.9)	80 (2.3)	73 (2.1)	101 (2.9)	406 (11.6)	**3,485 (88.4)**
New York City	22,364 (44.9)	17,579 (35.3)	5,579 (11.2)	1,335 (2.7)	897 (1.8)	934 (1.9)	1,096 (2.2)	**49,784 (100.0)**
North Carolina	9,598 (33.9)	12,098 (42.8)	4,432 (15.7)	982 (3.5)	672 (2.4)	484 (1.7)	15 (0.1)	**28,281 (99.4)**
North Dakota	435 (38.8)	447 (39.9)	180 (16.1)	42 (3.7)	17 (1.5)	0 (—)	0 (—)	**1,121 (100.0)**
Ohio	5,523 (27.5)	9,070 (45.1)	3,558 (17.7)	848 (4.2)	531 (2.6)	477 (2.4)	95 (0.5)	**20,102 (100.0)**
Oklahoma	2,177 (43.6)	1,835 (36.8)	710 (14.2)	125 (2.5)	64 (1.3)	64 (1.3)	16 (0.3)	**4,991 (99.9)**
Oregon	4,064 (47.2)	2,924 (33.9)	949 (11.0)	241 (2.8)	129 (1.5)	149 (1.7)	160 (1.9)	**8,616 (99.2)**
Rhode Island	929 (44.4)	705 (33.7)	270 (12.9)	90 (4.3)	52 (2.5)	32 (1.5)	13 (0.6)	**2,091 (99.6)**
South Carolina**	1,063 (20.8)	1,970 (38.6)	1,740 (34.1)	298 (5.8)	8 (0.2)	13 (0.3)	9 (0.2)	**5,101 (100.0)**
South Dakota	64 (15.6)	224 (54.8)	—††	—††	0 (—)	—††	7 (1.7)	**409 (98.8)**
Tennessee	1,836 (18.9)	4,939 (50.9)	2,188 (22.5)	436 (4.5)	176 (1.8)	119 (1.2)	9 (0.1)	**9,703 (99.8)**
Texas**	22,356 (39.0)	22,721 (39.7)	8,232 (14.4)	1,870 (3.3)	957 (1.7)	838 (1.5)	301 (0.5)	**57,275 (100.0)**
Utah	1,018 (34.8)	1,185 (40.6)	478 (16.4)	92 (3.1)	51 (1.7)	67 (2.3)	31 (1.1)	**2,922 (100.0)**
Vermont	550 (46.0)	423 (35.4)	129 (10.8)	32 (2.7)	21 (1.8)	22 (1.8)	18 (1.5)	**1,195 (100.0)**
Virginia	7,917 (50.8)	5,215 (33.5)	1,938 (12.4)	121 (0.8)	131 (0.8)	170 (1.1)	90 (0.6)	**15,582 (99.9)**
Washington	7,046 (41.0)	6,768 (39.4)	2,061 (12.0)	420 (2.4)	265 (1.5)	273 (1.6)	363 (2.1)	**17,196 (99.6)**
West Virginia	325 (27.5)	536 (45.3)	235 (19.9)	58 (4.9)	18 (1.5)	—††	—††	**1,183 (100.0)**
Wyoming	18 (58.1)	12 (38.7)	—††	—††	0 (—)	0 (—)	0 (—)	**31 (100.0)**
Total	**211,179 (42.9)**	**178,985 (36.4)**	**65,739 (13.4)**	**14,471 (2.9)**	**8,581 (1.7)**	**8,064 (1.6)**	**4,882 (1.0)**	**491,901 (99.6)¶¶**

* Gestational age based on clinician's estimate (Alaska, Arizona, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, New York City, North Carolina, North Dakota, Ohio, Oregon, Rhode Island, South Dakota, Tennessee, Vermont, Washington, West Virginia, and Wyoming); gestational age calculated from the last normal menstrual period (Oklahoma and Utah); clinician's estimate of gestation based on estimated date of conception (Virginia); probable postfertilization age (Alabama, Arkansas, South Carolina, and Texas).

† Data from 43 reporting areas; excludes nine reporting areas (California, District of Columbia, Illinois, Maryland, Massachusetts, New Hampshire, New York State, Pennsylvania, and Wisconsin) that did not report, did not report by gestational age, or did not meet reporting standards.

§ Percentages for the individual component categories might not add to 100% because of rounding.

¶ Percentage is calculated as the number of abortions reported by known gestational age divided by the sum of abortions reported by known and unknown gestational age. Values ≥99.95% are rounded to 100.0%.

** Two weeks were added to the probable postfertilization age to provide a corresponding measure to gestational age based on the clinician's estimate.

†† Cells with a value in the range of 1–4 or cells that would allow for calculation of these small values have been suppressed.

§§ Reporting to the central health agency is not required. Data are requested from hospitals and licensed ambulatory care facilities only.

¶¶ Percentage based on a total of 493,904 abortions reported among the areas that met reporting standards for gestational age.

TABLE 11. Percentage of reported abortions, by known weeks of gestation and year — selected reporting areas,* United States, 2010–2019

Weeks of gestation	Year										% Change			
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010 to 2014	2015 to 2019	2018 to 2019	2010 to 2019
≤13 weeks' gestation (%)†	**91.9**	**91.5**	**91.4**	**91.6**	**91.0**	**91.0**	**91.0**	**91.1**	**91.5**	**92.0**	**−1.0**	**1.1**	**0.5**	**0.1**
≤6	34.7	34.3	35.1	34.7	33.8	34.3	34.2	35.1	36.2	37.5	−2.6	9.3	3.6	8.1
7–9	40.1	40.1	39.4	39.9	40.0	40.0	40.3	40.4	40.0	39.9	−0.2	−0.3	−0.3	−0.5
10–13	17.0	17.1	16.9	17.0	17.2	16.7	16.4	15.7	15.2	14.6	1.2	−12.6	−3.9	−14.1
>13 weeks' gestation (%)†	**8.1**	**8.5**	**8.6**	**8.4**	**9.0**	**9.0**	**9.0**	**8.9**	**8.5**	**8.0**	**11.1**	**−11.1**	**−5.9**	**−1.2**
14–15	3.3	3.4	3.5	3.4	3.5	3.5	3.6	3.4	3.4	3.2	6.1	−8.6	−5.9	−3.0
16–17	1.8	1.9	1.9	1.9	2.2	2.1	2.1	2.2	2.1	1.9	22.2	−9.5	−9.5	5.6
18–20	1.8	1.9	1.9	1.8	1.9	2.0	2.0	2.0	1.9	1.8	5.6	−10.0	−5.3	0.0
≥21	1.2	1.4	1.3	1.3	1.3	1.3	1.3	1.3	1.2	1.1	8.3	−15.4	−8.3	−8.3
Total (no.)§	**508,841**	**481,667**	**457,201**	**435,881**	**426,636**	**414,914**	**408,903**	**394,181**	**395,960**	**398,505**	**NA**	**NA**	**NA**	**NA**

Abbreviation: NA = not applicable.

* Data from 34 reporting areas; excludes 18 areas (California, Connecticut, Delaware, District of Columbia, Florida, Illinois, Maine, Maryland, Massachusetts, Mississippi, Nebraska, New Hampshire, New York State, Pennsylvania, Rhode Island, Vermont, Wisconsin, and Wyoming) that did not report, did not report by weeks of gestation, or did not meet reporting standards for ≥1 year.

† Percentages for the individual component categories might not add to 100% because of rounding.

§ By year, the total number of abortions represents 74.6%–98.2% of all abortions reported to CDC among the areas that met reporting standards for gestational age during 2010–2019.

TABLE 12. Number of reported abortions, by known method type and reporting area of occurrence — selected reporting areas,* United States, 2019

	Surgical†			Medical					
State/Area	Surgical, ≤13 weeks' gestation No. (%)¶	Surgical, >13 weeks' gestation No. (%)	Surgical, unknown gestational age No. (%)	Medical, ≤9 weeks' gestation No. (%)	Medical, >9 weeks' gestation No. (%)	Medical, unknown gestational age No. (%)	Intrauterine instillation§ No. (%)	Hysterectomy/ Hysterotomy No. (%)	Total abortions reported by known method type No. (% of all reported abortions)**
Alabama††	3,257 (54.2)	653 (10.9)	—§§	2,030 (33.8)	58 (1.0)	—§§	0 (—)	0 (—)	**6,004 (99.9)**
Alaska	895 (70.5)	65 (5.1)	0 (—)	305 (24.0)	—§§	—§§	—§§	0 (—)	**1,269 (99.9)**
Arizona	6,768 (51.7)	992 (7.6)	0 (—)	5,031 (38.4)	159 (1.2)	0 (—)	137 (1.0)	0 (—)	**13,087 (99.9)**
Arkansas††	1,369 (46.2)	356 (12.0)	0 (—)	829 (28.0)	408 (13.8)	0 (—)	0 (—)	0 (—)	**2,962 (100.0)**
Colorado	2,989 (35.9)	400 (4.8)	—§§	4,819 (57.8)	120 (1.4)	0 (—)	—§§	0 (—)	**8,334 (92.6)**
Connecticut	3,747 (41.0)	687 (7.5)	136 (1.5)	4,367 (47.8)	25 (0.3)	173 (1.9)	0 (—)	0 (—)	**9,135 (99.3)**
Delaware	722 (36.0)	101 (5.0)	—§§	1,136 (56.6)	46 (2.3)	—§§	0 (—)	0 (—)	**2,007 (98.3)**
District of Columbia¶¶	2,170 (47.7)	382 (8.4)	0 (—)	NA	NA	2,000 (43.9)	0 (—)	0 (—)	**4,552 (100.0)**
Florida	32,315 (47.1)	2,505 (3.7)	0 (—)	33,428 (48.7)	352 (0.5)	0 (—)	0 (—)	8 (0.0)	**68,608 (95.4)**
Georgia	15,801 (42.8)	2,555 (6.9)	0 (—)	18,240 (49.4)	309 (0.8)	0 (—)	0 (—)	0 (—)	**36,905 (100.0)**
Hawaii	1,030 (51.4)	194 (9.7)	—§§	776 (38.8)	—§§	0 (—)	0 (—)	0 (—)	**2,002 (100.0)**
Idaho	826 (54.7)	42 (2.8)	10 (0.7)	621 (41.1)	8 (0.5)	—§§	—§§	0 (—)	**1,511 (99.9)**
Indiana	4,241 (55.5)	36 (0.5)	0 (—)	3,297 (43.2)	62 (0.8)	0 (—)	0 (—)	0 (—)	**7,636 (100.0)**
Iowa	948 (26.8)	190 (5.4)	0 (—)	2,364 (66.7)	40 (1.1)	0 (—)	0 (—)	0 (—)	**3,542 (99.3)**
Kansas	1,959 (28.4)	486 (7.1)	0 (—)	4,364 (63.3)	82 (1.2)	0 (—)	0 (—)	0 (—)	**6,891 (100.0)**
Kentucky	1,512 (41.3)	306 (8.4)	0 (—)	1,828 (49.9)	18 (0.5)	0 (—)	0 (—)	0 (—)	**3,664 (100.0)**
Maine	888 (44.0)	106 (5.3)	—§§	960 (47.6)	63 (3.1)	—§§	0 (—)	0 (—)	**2,018 (99.9)**
Massachusetts***	NA	NA	10,377 (56.4)	NA	NA	7,958 (43.2)	67 (0.4)	0 (—)	**18,402 (99.0)**
Michigan	12,984 (47.6)	2,649 (9.7)	42 (0.2)	11,213 (41.1)	386 (1.4)	10 (0.0)	0 (—)	0 (—)	**27,284 (99.8)**
Minnesota	5,187 (52.2)	958 (9.6)	54 (0.5)	3,589 (36.1)	61 (0.6)	87 (0.9)	—§§	—§§	**9,940 (100.0)**
Mississippi	725 (22.7)	186 (5.8)	0 (—)	2,228 (69.8)	55 (1.7)	0 (—)	0 (—)	0 (—)	**3,194 (100.0)**
Missouri	1,076 (73.5)	367 (25.1)	0 (—)	5 (0.3)	10 (0.7)	0 (—)	—§§	—§§	**1,463 (99.5)**
Montana	524 (33.4)	128 (8.2)	0 (—)	900 (57.4)	16 (1.0)	0 (—)	0 (—)	0 (—)	**1,568 (100.0)**
Nebraska	686 (33.2)	122 (5.9)	0 (—)	1,245 (60.2)	13 (0.6)	—§§	0 (—)	—§§	**2,068 (100.0)**
Nevada	4,599 (55.0)	527 (6.3)	38 (0.5)	3,113 (37.2)	51 (0.6)	37 (0.4)	—§§	—§§	**8,367 (99.4)**
New Jersey†††	12,938 (58.3)	2,692 (12.1)	481 (2.2)	5,896 (26.6)	134 (0.6)	35 (0.2)	0 (—)	0 (—)	**22,176 (100.0)**
New Mexico	1,394 (39.9)	301 (8.6)	58 (1.7)	1,332 (38.2)	338 (9.7)	65 (1.9)	—§§	—§§	**3,490 (88.5)**
New York	40,495 (52.9)	6,130 (8.0)	1,399 (1.8)	23,809 (31.1)	2,125 (2.8)	2,555 (3.3)	24 (0.0)	32 (0.0)	**76,569 (97.4)**
New York City	29,516 (59.4)	4,113 (8.3)	0 (—)	15,505 (31.2)	525 (1.1)	0 (—)	9 (0.0)	32 (0.1)	**49,700 (99.8)**
New York State	10,979 (40.9)	2,017 (7.5)	1,399 (5.2)	8,304 (30.9)	1,600 (6.0)	2,555 (9.5)	15 (0.1)	0 (—)	**26,869 (93.3)**
North Carolina	12,295 (45.9)	1,992 (7.4)	32 (0.1)	12,209 (45.6)	190 (0.7)	36 (0.1)	0 (—)	12 (0.0)	**26,766 (94.1)**
North Dakota	698 (62.3)	59 (5.3)	—§§	361 (32.2)	—§§	0 (—)	0 (—)	0 (—)	**1,121 (100.0)**
Ohio	10,350 (51.5)	1,937 (9.6)	—§§	7,716 (38.4)	91 (0.5)	0 (—)	0 (—)	—§§	**20,097 (100.0)**
Oklahoma	2,152 (43.8)	263 (5.4)	—§§	2,460 (50.1)	33 (0.7)	—§§	—§§	0 (—)	**4,914 (98.4)**
Oregon	3,494 (40.2)	646 (7.4)	21 (0.2)	4,337 (49.9)	133 (1.5)	51 (0.6)	—§§	—§§	**8,684 (100.0)**
Pennsylvania§§§	NA	NA	17,159 (55.3)	NA	NA	13,845 (44.6)	—§§	—§§	**31,013 (100.0)**

See table footnotes on the next page.

TABLE 12. (*Continued*) Number of reported abortions, by known method type and reporting area of occurrence — selected reporting areas,* United States, 2019

	Surgical†			Medical					
State/Area	Surgical, ≤13 weeks' gestation No. (%)¶	Surgical, >13 weeks' gestation No. (%)	Surgical, unknown gestational age No. (%)	Medical, ≤9 weeks' gestation No. (%)	Medical, >9 weeks' gestation No. (%)	Medical, unknown gestational age No. (%)	Intrauterine instillation§ No. (%)	Hysterectomy/ Hysterotomy No. (%)	Total abortions reported by known method type No. (% of all reported abortions)**
Rhode Island	1,010 (48.3)	179 (8.6)	7 (0.3)	884 (42.2)	12 (0.6)	—§§	—§§	0 (—)	**2,093 (99.7)**
South Carolina††	1,676 (32.9)	319 (6.3)	—§§	2,334 (45.8)	766 (15.0)	0 (—)	5 (0.1)	—§§	**5,101 (100.0)**
South Dakota	272 (65.7)	0 (—)	—§§	124 (30.0)	13 (3.1)	—§§	0 (—)	0 (—)	**414 (100.0)**
Tennessee	4,034 (41.5)	716 (7.4)	8 (0.1)	4,765 (49.0)	183 (1.9)	8 (0.1)	0 (—)	5 (0.1)	**9,719 (100.0)**
Texas††	30,824 (53.8)	3,906 (6.8)	0 (—)	22,234 (38.8)	305 (0.5)	0 (—)	—§§	—§§	**57,272 (100.0)**
Utah	1,455 (49.8)	229 (7.8)	0 (—)	1,223 (41.9)	11 (0.4)	0 (—)	—§§	—§§	**2,921 (100.0)**
Vermont	394 (33.1)	87 (7.3)	—§§	683 (57.4)	25 (2.1)	0 (—)	—§§	0 (—)	**1,190 (99.6)**
Virginia	9,252 (59.3)	500 (3.2)	15 (0.1)	5,744 (36.8)	74 (0.5)	—§§	—§§	0 (—)	**15,589 (99.9)**
Washington	7,491 (43.4)	1,317 (7.6)	30 (0.2)	8,320 (48.2)	56 (0.3)	36 (0.2)	0 (—)	0 (—)	**17,250 (99.9)**
West Virginia	617 (52.2)	77 (6.5)	0 (—)	454 (38.4)	35 (3.0)	0 (—)	0 (—)	0 (—)	**1,183 (100.0)**
Wisconsin***,¶¶¶	NA	NA	4,207 (66.0)	NA	NA	2,165 (34.0)	0 (—)	0 (—)	**6,372 (100.0)**
Wyoming	0 (—)	0 (—)	—§§	30 (96.8)	—§§	0 (—)	0 (—)	0 (—)	**31 (100.0)**
Total	**277,789 (49.0)**	**40,699 (7.2)**	—****	**239,770 (42.3)**	**7,787 (1.4)**	—††††	**252 (0.0)**	**81 (0.0)**	**566,378 (98.5)§§§§**

Abbreviation: NA = not available.

* Data from 47 reporting areas; excludes five reporting areas (California, Illinois, Louisiana, Maryland, and New Hampshire) that did not report, did not report by method type, or did not meet reporting standards. Areas reporting by method type with unknown gestational age or gestational age reported was not compatible with categorizations presented in this table are included.

† Includes uterine aspiration (might also be called dilation and curettage, aspiration curettage, suction curettage, manual vacuum aspiration, menstrual extraction, sharp curettage) and dilation and evacuation procedures.

§ Intrauterine instillations reported at ≤12 weeks' gestation were considered as unknown for method type.

¶ Percentages for the individual component categories might not add to 100% because of rounding.

** Percentage is calculated as the number of abortions reported by known method type divided by the sum of abortions reported by known and unknown method type. Values ≥99.95% are rounded to 100.0%.

†† Two weeks were added to the probable postfertilization age to provide a corresponding measure to gestational age based on the clinician's estimate.

§§ Cells with a value in the range of 1–4 or cells that would allow for calculation of these small values have been suppressed.

¶¶ Numbers for medical abortions at ≤9 weeks versus >9 weeks are not presented because gestational age reported was not compatible with these categorizations.

*** Numbers for surgical abortions at ≤13 weeks versus >13 weeks and for medical abortions at ≤9 weeks versus >9 weeks are not presented because gestational age data were not provided by method type.

††† Reporting to the central health agency is not required. Data are requested from hospitals and licensed ambulatory care facilities only.

§§§ Numbers for surgical abortions ≤13 weeks and >13 weeks and medical abortions ≤9 weeks versus >9 weeks are not presented as gestational age reported was not compatible with these categorizations.

¶¶¶ Includes residents only. Wisconsin reports as surgical, unspecified and does not differentiate surgical abortions from hysterectomy/hysterotomy. All abortions were reported as surgical or chemically induced. For this report, all surgical abortions were classified as surgical and all chemical abortions as medical.

**** For the total only, surgical abortions reported without a gestational age were distributed among the surgical abortion categories according to the distribution of surgical abortions at known gestational age.

†††† For the total only, medical abortions reported without a gestational age were distributed among the medical abortion categories according to the distribution of medical abortions at known gestational age.

§§§§ Percentage based on a total of 575,098 abortions reported among the areas that met reporting standards for method type.

TABLE 13. Number of reported abortions, by known weeks of gestation and method type — selected reporting areas,* United States, 2019

	Weeks of gestation							
	≤6	7–9	10–13	14–15	16–17	18–20	≥21	Total
Method type	**No. (%)†**	**No. (%)**	**No. (%)**	**No. (%)**	**No. (%)**	**No. (%)**	**No. (%)**	**No. (%)**
Surgical§								
≤13 weeks' gestation	84,850 (41.3)	90,714 (52.2)	59,346 (93.2)	NA	NA	NA	NA	**234,910 (49.2)**
>13 weeks' gestation	NA	NA	NA	13,965 (99.2)	8,199 (98.3)	7,686 (96.9)	4,094 (87.0)	**33,944 (7.1)**
Medical¶								
≤9 weeks' gestation	120,333 (58.6)	82,966 (47.8)	NA	NA	NA	NA	NA	**203,299 (42.6)**
>9 weeks' gestation	NA	NA	4,339 (6.8)	109 (0.8)	94 (1.1)	185 (2.3)	545 (11.6)	**5,272 (1.1)**
Intrauterine instillation	—**	—**	1 (0.0)	2 (0.0)	48 (0.6)	58 (0.7)	60 (1.3)	**169 (0.0)**
Hysterectomy/ Hysterotomy	19 (0.0)	28 (0.0)	5 (0.0)	4 (0.0)	3 (0.0)	6 (0.1)	7 (0.1)	**72 (0.0)**
Total	**205,202 (100.0)**	**173,708 (100.0)**	**63,691 (100.0)**	**14,080 (100.0)**	**8,344 (100.0)**	**7,935 (100.0)**	**4,706 (100.0)**	**477,666 (100.0)**

Abbreviation: NA = not applicable.

* Data from 42 reporting areas; excludes 10 reporting areas (California, District of Columbia, Illinois, Louisiana, Maryland, Massachusetts, New Hampshire, New York State, Pennsylvania, and Wisconsin) that did not report, did not report by weeks of gestation, did not meet reporting standards, or did not have medical abortion as a specific category on their reporting form.

† For each gestational age category, percentages of all method types might not add to 100% because of rounding.

§ Includes uterine aspiration (might also be called dilation and curettage, aspiration curettage, suction curettage, manual vacuum aspiration, menstrual extraction, sharp curettage) and dilation and evacuation procedures.

¶ The administration of medication or medications to induce an abortion; at ≤9 weeks' gestation, typically involves the use of mifepristone and misoprostol, and at >9 weeks' gestation, typically involves the use of vaginal prostaglandins.

** Intrauterine instillations reported at ≤12 weeks' gestation have not been included with known values.

TABLE 14. Number of reported abortions, by known weeks of gestation, age group, and race/ethnicity — selected reporting areas, United States, 2019

	Weeks of gestation							
	≤6	7–9	10–13	14–15	16–17	18–20	≥21	Total
Characteristic	**No. (%)**	**No. (%)**	**No. (%)**	**No. (%)**	**No. (%)**	**No. (%)**	**No. (%)**	**No. (%)**
Age group (yrs)*,†								
<15	306 (27.2)	384 (34.1)	214 (19.0)	73 (6.5)	53 (4.7)	47 (4.2)	50 (4.4)	**1,127 (100.0)**
15–19	14,886 (35.7)	15,785 (37.9)	7,007 (16.8)	1,536 (3.7)	948 (2.3)	962 (2.3)	561 (1.3)	**41,685 (100.0)**
20–24	56,003 (41.3)	50,599 (37.3)	19,052 (14.1)	4,179 (3.1)	2,398 (1.8)	2,142 (1.6)	1,226 (0.9)	**135,599 (100.0)**
25–29	61,791 (43.3)	52,298 (36.7)	18,882 (13.2)	3,925 (2.8)	2,294 (1.6)	2,189 (1.5)	1,242 (0.9)	**142,621 (100.0)**
30–34	43,257 (45.1)	34,165 (35.6)	11,747 (12.3)	2,654 (2.8)	1,523 (1.6)	1,473 (1.5)	1,022 (1.1)	**95,841 (100.0)**
35–39	24,816 (46.1)	18,652 (34.7)	6,425 (11.9)	1,501 (2.8)	960 (1.8)	880 (1.6)	588 (1.1)	**53,822 (100.0)**
≥40	9,053 (49.4)	5,919 (32.3)	1,990 (10.9)	523 (2.9)	344 (1.9)	334 (1.8)	165 (0.9)	**18,328 (100.0)**
Total	**210,112 (43.0)**	**177,802 (36.4)**	**65,317 (13.4)**	**14,391 (2.9)**	**8,520 (1.7)**	**8,027 (1.6)**	**4,854 (1.0)**	**489,023 (100.0)**
Race/Ethnicity*,§								
Non-Hispanic								
White	51,748 (45.4)	40,580 (35.6)	14,205 (12.5)	2,978 (2.6)	1,741 (1.5)	1,767 (1.6)	963 (0.8)	**113,982 (100.0)**
Black	49,644 (38.1)	49,659 (38.1)	20,818 (16.0)	4,464 (3.4)	2,543 (2.0)	2,190 (1.7)	903 (0.7)	**130,221 (100.0)**
Other	11,606 (47.6)	8,047 (33.0)	2,861 (11.7)	697 (2.9)	409 (1.7)	477 (2.0)	279 (1.1)	**24,376 (100.0)**
Hispanic	35,358 (49.5)	23,471 (32.9)	8,211 (11.5)	1,897 (2.7)	1,020 (1.4)	962 (1.3)	499 (0.7)	**71,418 (100.0)**
Total	**148,356 (43.6)**	**121,757 (35.8)**	**46,095 (13.6)**	**10,036 (3.0)**	**5,713 (1.7)**	**5,396 (1.6)**	**2,644 (0.8)**	**339,997 (100.0)**

* Percentages for the individual component categories might not add to 100% because of rounding.

† Data from 43 reporting areas; excludes nine reporting areas (California, District of Columbia, Illinois, Maryland, Massachusetts, New Hampshire, New York State, Pennsylvania, and Wisconsin) that did not report, did not report weeks of gestation by age, or did not meet reporting standards.

§ Data from 29 reporting areas; excludes 23 reporting areas (California, Colorado, District of Columbia, Hawaii, Illinois, Iowa, Louisiana, Maine, Maryland, Massachusetts, Missouri, Nebraska, New Hampshire, New York City, New York State, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Washington, and Wisconsin) that did not report, did not report weeks of gestation by race/ethnicity, or did not meet reporting standards.

TABLE 15. Number of deaths and case-fatality rates* for abortion-related deaths reported to CDC, by type of abortion — United States, 1973–2018†

Year	Type of abortion				CFR per 100,000 legal abortions
	Induced				
	Legal§	Illegal¶	Unknown**	Total	
1973–1977					**2.09**
1973	25	19	3	**47**	
1974	26	6	1	**33**	
1975	29	4	1	**34**	
1976	11	2	1	**14**	
1977	17	4	0	**21**	
1978–1982					**0.78**
1978	9	7	0	**16**	
1979	22	0	0	**22**	
1980	9	1	2	**12**	
1981	8	1	0	**9**	
1982	11	1	0	**12**	
1983–1987					**0.66**
1983	11	1	0	**12**	
1984	12	0	0	**12**	
1985	11	1	1	**13**	
1986	11	0	2	**13**	
1987	7	2	0	**9**	
1988–1992					**0.74**
1988	16	0	0	**16**	
1989	12	1	0	**13**	
1990	9	0	0	**9**	
1991	11	1	0	**12**	
1992	10	0	0	**10**	
1993–1997					**0.52**
1993	6	1	2	**9**	
1994	10	2	0	**12**	
1995	4	0	0	**4**	
1996	9	0	0	**9**	
1997	7	0	0	**7**	
1998–2002					**0.63**
1998	9	0	0	**9**	
1999	4	0	0	**4**	
2000	11	0	0	**11**	
2001	7	1	0	**8**	
2002	10	0	0	**10**	
2003–2007					**0.60**
2003	10	0	0	**10**	
2004	7	1	0	**8**	
2005	7	0	0	**7**	
2006	7	0	0	**7**	
2007	6	0	0	**6**	
2008–2012					**0.65**
2008	12	0	0	**12**	
2009	8	0	0	**8**	
2010	10	0	0	**10**	
2011	2	0	0	**2**	
2012	4	0	0	**4**	
2013–2018					**0.41**
2013	4	0	0	**4**	
2014	6	0	0	**6**	
2015	2	0	1	**3**	
2016	6	1	1	**8**	
2017	2	0	0	**2**	
2018	2	0	0	**2**	

Abbreviation: CFR = case-fatality rate.

* Number of legal induced abortion-related deaths per 100,000 reported legal induced abortions. Because a substantial number of legal induced abortions occurred outside reporting areas that provided data to CDC, national CFRs (i.e., number of legal induced abortion-related deaths per 100,000 reported legal induced abortions in the United States) were calculated with denominator data from the Guttmacher Institute's national survey of abortion-providing facilities; for 2018, the CFR was calculated using denominator data for 2017, the most recent year for which data are available. Case-fatality rates were computed for consecutive 5-year periods during 1973–2012 and then for a consecutive 6-year period during 2013–2018 because rates based on <20 cases might be unstable.

† Certain numbers might differ from those in reports published previously because additional information has been supplied to CDC subsequent to publication.

§ An abortion is defined as legal if it was performed by a licensed clinician within the limits of state law.

¶ An abortion is defined as illegal if it was performed by any person other than a licensed clinician.

** Unknown whether abortion was induced or spontaneous.

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Abortion Surveillance — United States, 2020

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Abstract

Problem/Condition: CDC conducts abortion surveillance to document the number and characteristics of women obtaining legal induced abortions and number of abortion-related deaths in the United States.

Period Covered: 2020.

Description of System: Each year, CDC requests abortion data from the central health agencies for the 50 states, the District of Columbia, and New York City. For 2020, a total of 49 reporting areas voluntarily provided aggregate abortion data to CDC. Of these, 48 reporting areas provided data each year during 2011–2020. Census and natality data were used to calculate abortion rates (number of abortions per 1,000 women aged 15–44 years) and ratios (number of abortions per 1,000 live births), respectively. Abortion-related deaths from 2019 were assessed as part of CDC's Pregnancy Mortality Surveillance System (PMSS).

Results: A total of 620,327 abortions for 2020 were reported to CDC from 49 reporting areas. Among 48 reporting areas with data each year during 2011–2020, in 2020, a total of 615,911 abortions were reported, the abortion rate was 11.2 abortions per 1,000 women aged 15–44 years, and the abortion ratio was 198 abortions per 1,000 live births. From 2019 to 2020, the total number of abortions decreased 2% (from 625,346 total abortions), the abortion rate decreased 2% (from 11.4 abortions per 1,000 women aged 15–44 years), and the abortion ratio increased 2% (from 195 abortions per 1,000 live births). From 2011 to 2020, the total number of reported abortions decreased 15% (from 727,554), the abortion rate decreased 18% (from 13.7 abortions per 1,000 women aged 15–44 years), and the abortion ratio decreased 9% (from 217 abortions per 1,000 live births).

In 2020, women in their 20s accounted for more than half of abortions (57.2%). Women aged 20–24 and 25–29 years accounted for the highest percentages of abortions (27.9% and 29.3%, respectively) and had the highest abortion rates (19.2 and 19.0 abortions per 1,000 women aged 20–24 and 25–29 years, respectively). By contrast, adolescents aged <15 years and women aged ≥40 years accounted for the lowest percentages of abortions (0.2% and 3.7%, respectively) and had the lowest abortion rates (0.4 and 2.6 abortions per 1,000 women aged <15 and ≥40 years, respectively). However, abortion ratios were highest among adolescents (aged ≤19 years) and lowest among women aged 25–39 years.

Abortion rates decreased from 2011 to 2020 among all age groups. The decrease in abortion rate was highest among adolescents compared with any other age group. From 2019 to 2020, abortion rates decreased or did not change for all age groups. Abortion ratios decreased from 2011 to 2020 for all age groups, except adolescents aged 15–19 years and women aged 25–29 years for whom abortion ratios increased. The decrease in abortion ratio was highest among women aged ≥40 years compared with any other age group. From 2019 to 2020, abortion ratios decreased for adolescents aged <15 and women aged ≥35 years and increased for women aged 15–34 years.

In 2020, 80.9% of abortions were performed at ≤9 weeks' gestation, and nearly all (93.1%) were performed at ≤13 weeks' gestation. During 2011–2020, the percentage of abortions performed at >13 weeks' gestation remained consistently low (≤9.2%). In 2020, the highest percentage of abortions were performed by early medical abortion at ≤9 weeks' gestation (51.0%), followed by surgical abortion at ≤13 weeks' gestation (40.0%), surgical abortion at >13 weeks' gestation (6.7%), and medical abortion at >9 weeks' gestation (2.4%); all other methods were uncommon (<0.1%). Among those that were eligible (≤9 weeks' gestation), 63.9% of abortions were early medical abortions. In 2019, the most recent year for which PMSS data were reviewed for pregnancy-related deaths, four women died as a result of complications from legal induced abortion.

Interpretation: Among the 48 areas that reported data continuously during 2011–2020, overall decreases were observed during 2011–2020 in the total number, rate, and ratio of reported abortions. From 2019 to 2020, decreases also were observed in the total number and rate of reported abortions; however, a 2% increase was observed in the total abortion ratio.

Public Health Action: Abortion surveillance can be used to help evaluate programs aimed at promoting equitable access to patient-centered quality contraceptive services in the United States to reduce unintended pregnancies.

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Introduction

This report summarizes data on legal induced abortions for 2020 that were provided voluntarily to CDC by the central health agencies of 49 reporting areas (47 states, the District of Columbia, and New York City, excluding California, Maryland, and New Hampshire) and comparisons over time for the 48 reporting areas that reported each year during 2011–2020 (47 states and New York City). This report also summarizes abortion-related deaths reported voluntarily to CDC for 2019 as part of the Pregnancy Mortality Surveillance System (PMSS). Since 1969, CDC has conducted abortion surveillance to document the number and characteristics of women obtaining legal induced abortions in the United States. After nationwide legalization of abortion in 1973, the total number, rate (number of abortions per 1,000 women aged 15–44 years), and ratio (number of abortions per 1,000 live births) of reported abortions increased rapidly, reaching the highest levels in the 1980s, before decreasing at a slow yet steady pace (*1*,*2*). During 2006–2008, a break occurred in the previously sustained pattern of decrease (*3*,*4*), although this break was followed in subsequent years by even greater decreases (*5*,*6*). In 2017, the total number, rate, and ratio of reported abortions reached historic lows (*5*); however, from 2018 to 2019, 1%–3% increases were observed across all measures (*7*). Nonetheless, despite the overall decreases, abortion incidence and practices have varied over the years and continue to vary across subpopulations (*8*–*12*), highlighting the utility of continued surveillance.

Methods

Description of the Surveillance System

Each year, CDC requests aggregate data from the central health agencies of the 50 states, the District of Columbia, and New York City to document the number and characteristics of women obtaining legal induced abortions in the United States. Not all persons who obtain abortions identify as women; the term "women" has been maintained in this report to be consistent with the collection and reporting of denominator data used to calculate abortion rates and ratios. This report contains data voluntarily reported to CDC as of August 19, 2022. For the purpose of surveillance, legal induced abortion is defined as an intervention performed within the limits of state law by a licensed clinician (e.g., a physician, nurse-midwife, nurse practitioner, or physician assistant) intended to terminate a suspected or known intrauterine pregnancy and that does not result in a live birth. This definition excludes management of intrauterine fetal death, early pregnancy failure/loss, ectopic pregnancy, or retained products of conception. All abortions in this report are considered to be legally induced unless stated otherwise.

In most states and jurisdictions, collection of abortion data are facilitated by a legal requirement for hospitals, facilities, or physicians to report abortions to a central health agency (*13*); however, reporting is not complete in all areas, including in certain areas with reporting requirements (*14*). Because the reporting of abortion data to CDC is voluntary, many reporting areas have developed their own data collection forms and might not collect or provide all the information requested by CDC. As a result, the level of detail reported by CDC might vary from year to year and by reporting area. To encourage uniform collection of data, CDC has collaborated with the National Association for Public Health Statistics and Information Systems (NAPHSIS) to develop reporting standards and provide technical guidance for vital statistics personnel who collect and summarize abortion data within the United States.

Variables and Categorization of Data

Each year, CDC sends a suggested template to central health agencies in the United States for compilation of aggregate abortion data among women obtaining legal induced abortions. Aggregate abortion numbers, without individual-level records, are requested for the following variables:

- Age group in years of women obtaining legal induced abortions (<15, 15–19 [age group and by individual year], 20–24, 25–29, 30–34, 35–39, or ≥40)
- Gestational age of pregnancy in completed weeks at the time of abortion (≤6, 7–20 by individual week, or ≥21)
- Race (Black, White, or other [including Asian, Pacific Islander, other races, and multiple races]), ethnicity (Hispanic or non-Hispanic), and race by ethnicity
- Method type (surgical abortion, intrauterine instillation, medical [nonsurgical] abortion, or hysterectomy/hysterotomy)
- Marital status (married [including currently married or separated] or unmarried [including never married, widowed, or divorced])
- Number of previous live births (zero, one, two, three, or four or more)
- Number of previous induced abortions (zero, one, two, or three or more)
- Residence (the state, jurisdiction, territory, or foreign country in which the women obtaining the abortion lived, or, if additional details are unavailable, in-reporting area versus out-of-reporting area)

In addition, the template provided by CDC requests that aggregate abortion numbers for certain variables be cross-tabulated by a second variable. The cross-tabulations presented

in this report include weeks of gestation separately by method type, by age group, and by race or ethnicity.

Beginning with 2014 data, instead of reporting the clinician's estimates of gestational age or estimates of gestational age based on last menstrual period, certain areas have reported "probable postfertilization age," "clinician's estimate of gestation based on date of conception," and "probable gestational age" to CDC. To ensure consistency between data reported as postfertilization age and the data collection practices for gestational age recommended by CDC's National Center for Health Statistics (*15*), 2 weeks were added to probable postfertilization age. This method was used to account for time after last menstrual period until ovulation in a standard 28-day cycle because fertilization occurs around the time of ovulation (*16*). No modifications were made to data reported as clinician's estimate of gestational age based on date of conception or data reported as probable gestational age.

In this report, medical and surgical abortions are further categorized by gestational age when available in the categories reported to CDC. Early medical abortion is defined as the administration of medications (typically mifepristone followed by misoprostol) to induce an abortion at ≤9 completed weeks' gestation consistent with U.S. Food and Drug Administration (FDA) labeling for mifepristone that was implemented in 2016 (*17*). CDC collects information only on the estimated number of weeks (not days) of gestation and acknowledges the conventional use of completed weeks of gestation to describe pregnancy duration; therefore, CDC's category of ≤9 weeks' gestation includes abortions through 9 weeks and 6 days. Medications (typically serial prostaglandins, sometimes administered after mifepristone) also might be used to induce an abortion at >9 weeks' gestation. Surgical abortions, which include uterine aspiration (i.e., dilation and curettage, aspiration curettage, suction curettage, manual vacuum aspiration, menstrual extraction, or sharp curettage) and dilation and evacuation procedures, are categorized as having been performed at ≤13 weeks' gestation or at >13 weeks' gestation because of differences in surgical technique at these gestational ages (*18*). Finally, because intrauterine instillations are unlikely to be performed early in gestation (*19*), abortions reported to have been performed by intrauterine instillation at ≤12 weeks' gestation are excluded from calculation of the percentage of abortions by known method type and are grouped with unknown type.

Measures of Abortion

Four measures of abortion are presented in this report: 1) the number of abortions in a given population, 2) the percentage of abortions by selected characteristics, 3) the abortion rate (number of abortions per 1,000 women within a given population), and 4) the abortion ratio (number of abortions per 1,000 live births within a given population). Abortion rates adjust for differences in population size. Abortion ratios measure the relative number of pregnancies in a population that end in abortion compared with live birth.

The U.S. Census Bureau estimates of the resident female population were used as the denominator for calculating abortion rates (*20*–*29*). Overall abortion rates were calculated from the population of women aged 15–44 years living in the reporting areas that provided continuously reported data. For adolescents aged <15 years, abortion rates were calculated using the number of adolescents aged 13–14 years as the denominator; for women aged ≥40 years, abortion rates were calculated using the number of women aged 40–44 years as the denominator. For the calculation of abortion ratios, live birth data were obtained from CDC natality files and included births to women of all ages living in the reporting areas that provided abortion data (*30*,*31*). For calculation of the total abortion rates and total ratios only, women with unknown data on selected characteristics (e.g., age, race or ethnicity, and marital status) were distributed according to the distribution of abortions among those with known information on the characteristic. For calculation of totals only, abortions for women with an unknown gestational age of pregnancy but known method type were distributed according to the distribution of abortions among those with known information on method type by gestational age to the following categories: surgical, ≤13 weeks' gestation; surgical, >13 weeks' gestation; medical, ≤9 weeks' gestation; and medical, >9 weeks' gestation.

Data Presentation and Analysis

This report provides aggregate and reporting area–specific abortion numbers, rates, and ratios for the 49 areas that reported to CDC for 2020, which excluded California, Maryland, and New Hampshire. In addition, this report describes characteristics of women who obtained abortions in 2020. The data in this report are presented by the reporting area in which the abortions were performed.

The completeness and quality of data received vary by year, by variable, and by reporting area; this report only describes the characteristics of women obtaining abortions in reporting areas that met CDC reporting standards (i.e., reported at least 20 abortions overall, provided data categorized in accordance with requested variables, and had <15% unknown values for a given characteristic). Cells with a numerical value in the range of 1–4 and cells that would allow for calculation of these values have been suppressed in this report to maintain confidentiality in tables presented by reporting area of occurrence.

The percentage change in abortion measures (number, rate, and ratio of reported abortions) from the most recent past year (2019 to 2020) and during the 10-year period of analysis (2011–2020) were calculated for the 48 areas that reported every year during 2011–2020. The percentage change was also calculated and reported for abortions by age group, weeks of gestation, and early medical abortions (≤9 completed weeks' gestation) for areas that met reporting standards for these variables every year during 2011–2020. As a result, aggregate measures for 2020 in percentage change analyses might differ from the point estimates reported for 2020. These data describe the percentage changes in abortion measures over time and abortions measures among groups for each characteristic. No statistical testing was performed. Comparisons do not imply statistical significance, and lack of comment regarding the difference between values does not imply that no statistically significant difference exists.

Abortion Mortality

CDC has reported data on abortion-related deaths periodically since information on abortion mortality first was included in the 1972 abortion surveillance report (*7*,*32*). An abortion-related death is defined as a death resulting from a direct complication of an abortion (legal or illegal), an indirect complication caused by a chain of events initiated by an abortion, or an aggravation of a pre-existing condition by the physiologic effects of abortion. An abortion is categorized as legal when it is performed by a licensed clinician within the limits of state law.

Since 1987, CDC has monitored abortion-related deaths through PMSS, which includes data from all 50 states, the District of Columbia, and New York City (*33*). Sources of data to identify abortion-related deaths have included state vital records; media reports, including computerized searches of full-text newspaper and other print media databases; and individual case reports by public health agencies, including maternal mortality review committees, health care providers and provider organizations, private citizens, and citizen groups. For each death that is possibly related to abortion, CDC requests clinical records and autopsy reports. Two medical epidemiologists independently review these reports to determine the cause of death and whether the death was abortion related. Discrepancies are discussed and resolved by consensus. Each death is categorized by abortion type as legal induced, illegal induced, spontaneous, or unknown type.

This report provides PMSS data on induced abortion-related deaths that occurred in 2019, the most recent year for which PMSS data are available. For 1998–2019, abortion surveillance data reported to CDC cannot be used alone to calculate national case-fatality rates for legal induced abortions (number of legal induced abortion-related deaths per 100,000 reported legal induced abortions in the United States) because eight reporting areas did not report abortion data every year during this period (Alaska, 1998–2000; California, 1998–2019; the District of Columbia, 2016; Louisiana, 2005; Maryland, 2007–2019; New Hampshire, 1998–2019; Oklahoma, 1998–1999; and West Virginia, 2003–2004). Thus, denominator data for calculation of national legal induced abortion case-fatality rates were obtained from a published report by the Guttmacher Institute that includes estimated total numbers of abortions in the United States from a national survey of abortion-providing facilities (*6*,*34*). The case-fatality rate was calculated using denominator data for 2019. Because rates determined on the basis of a numerator <20 are unstable (*35*), national case-fatality rates for legal induced abortion were calculated for consecutive 5-year periods during 1973–2012 and then for a consecutive 7-year period during 2013–2019.

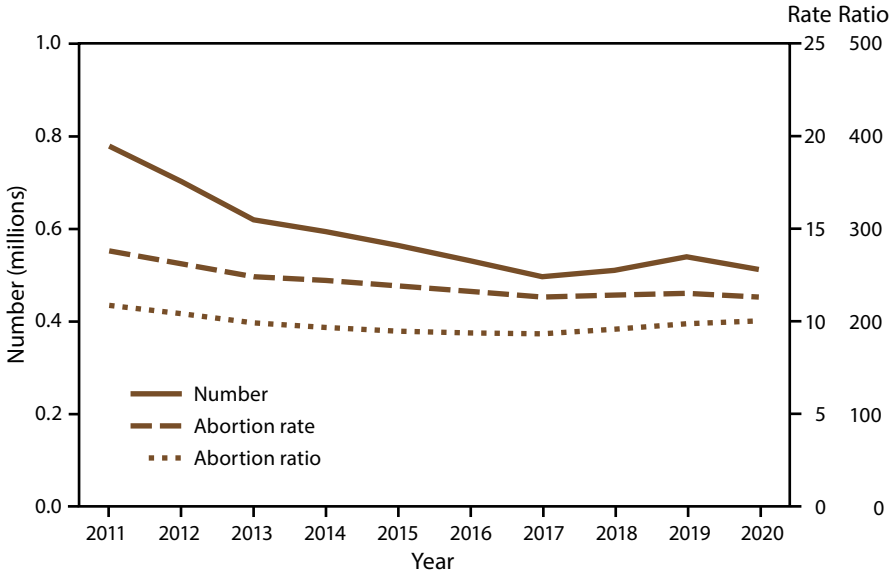
Results

Total Abortions Reported to CDC by Occurrence

Among the 49 reporting areas that provided data for 2020, a total of 620,327 abortions were reported. Of these abortions, 615,911 (99.3%) were from 48 reporting areas that provided data every year during 2011–2020. In 2020, these continuously reporting areas had an abortion rate of 11.2 abortions per 1,000 women aged 15–44 years and an abortion ratio of 198 abortions per 1,000 live births (Table 1). From 2019 to 2020, the total number of reported abortions decreased 2% (from 625,346 total abortions), the abortion rate decreased 2% (from 11.4 abortions per 1,000 women aged 15–44 years), and the abortion ratio increased 2% (from 195 abortions per 1,000 live births). From 2011 to 2020, the total number of reported abortions decreased 15% (from 727,554), the abortion rate decreased 18% (from 13.7 abortions per 1,000 women aged 15–44 years), and the abortion ratio decreased 9% (from 217 abortions per 1,000 live births) (Figure).

In 2020, there was a considerable range by reporting area of occurrence in abortion rates (from 0.1 to 23.0 abortions per 1,000 women aged 15–44 years in Missouri and the District of Columbia) and abortion ratios (from two to 498 abortions per 1,000 live births in Missouri and the District of Columbia) (Table 2). The percentage of abortions obtained by out-of-area residents also varied among reporting areas (from 0.5% in Arizona to 70.7% in the District of Columbia).

FIGURE. Number, rate,* and ratio† of abortions performed, by year – selected reporting areas,§ United States, 2011–2020



* Number of abortions per 1,000 women aged 15–44 years.
† Number of abortions per 1,000 live births.
§ Data are for 48 reporting areas; excludes California, the District of Columbia, Maryland, and New Hampshire.

Age Group, Race or Ethnicity, and Marital Status

Among the 48 areas that reported abortion numbers by women's age for 2020, women in their 20s accounted for more than half of abortions (57.2%) (Table 3). Women aged 20–24 and 25–29 years accounted for the highest percentages of abortions (27.9% and 29.3%, respectively) and had the highest abortion rates (19.2 and 19.0 abortions per 1,000 women aged 20–24 and 25–29 years, respectively). By contrast, adolescents aged <15 years and women aged ≥40 years accounted for the lowest percentages of abortions (0.2% and 3.7%, respectively) and had the lowest abortion rates (0.4 and 2.6 abortions per 1,000 women aged <15 and ≥40 years, respectively). However, abortion ratios were highest among adolescents (859 and 363 abortions per 1,000 live births among those aged <15 years and 15–19 years, respectively) and lowest among women aged 25–39 years (205, 136, and 144 abortions per 1,000 live births among those aged 25–29, 30–34, and 35–39 years, respectively).

Among the 43 reporting areas that provided data each year by women's age for 2011–2020, this pattern across age groups was stable, with the highest percentages of abortions and the highest abortion rates occurring among women aged 20–29 years and the lowest percentages of abortions and lowest abortion rates occurring among adolescents aged <15 years and women aged ≥40 years (Table 4). From 2011 to 2020, abortion rates decreased among all age groups, although the decreases for adolescents (56% and 48% for adolescents aged <15 and 15–19 years, respectively) were greater than the decreases for women aged ≥20 years. From 2019 to 2020, abortion rates decreased or did not change for all age groups. During 2011–2020, abortion ratios decreased for all age groups, except among adolescents aged 15–19 years and women aged 25–29 years for whom abortion ratios increased. The decrease in abortion ratio was highest among women aged ≥40 years. From 2019 to 2020, abortion ratios decreased for adolescents aged <15 and women aged ≥35 years and increased for women aged 15–34 years.

Among the 46 areas that reported age by individual year among adolescents for 2020, adolescents aged 18–19 years accounted for highest percentage (71.1%) of adolescent abortions and had the highest abortion rates (8.3 and 11.9 abortions per 1,000 adolescents aged 18 and 19 years, respectively) (Table 5). Adolescents aged <15 years accounted for the lowest percentage of adolescent abortions (2.7%) and had the lowest abortion rate (0.4 abortions per 1,000 adolescents aged 13–14 years). The abortion ratio for adolescents was highest among adolescents aged <15 years (828 abortions per 1,000 live births) and was lowest among adolescents aged 17–19 years (343, 371, and 313 abortions per 1,000 live births among adolescents aged 17, 18, and 19 years, respectively).

Among the 30 areas that reported race by ethnicity data for 2020, non-Hispanic White women (White) and non-Hispanic Black women (Black) accounted for the highest percentages of all abortions (32.7% and 39.2%, respectively), and Hispanic women and non-Hispanic women in the other race category accounted for lower percentages (21.1% and 7.0%, respectively) (Table 6). White women had the lowest abortion rate (6.2 abortions per 1,000 women aged 15–44 years) and ratio (118 abortions per 1,000 live births), and Black women had the highest abortion rate (24.4 abortions per 1,000 women aged 15–44 years) and ratio (426 abortions per 1,000 live births).

Among the 40 areas that reported by marital status for 2020, 13.7% of women who obtained an abortion were married, and 86.3% were unmarried (Table 7). The abortion ratio was 46 abortions per 1,000 live births for married women and 412 abortions per 1,000 live births for unmarried women.

Previous Live Births and Previous Induced Abortions

Among the 43 areas that reported the number of previous live births for 2020, 39.1%, 24.5%, 20.3%, 9.7%, and 6.4% of abortions reported were among women who had zero, one, two, three, or four or more previous live births, respectively (Table 8). Among the 42 areas that reported the number of previous induced abortions for 2020, 57.7%, 24.1%, 10.5%, and 7.8% of abortions reported were among women who had had zero, one, two, or three or more previous induced abortions, respectively (Table 9).

Weeks of Gestation and Method Type

Among the 41 areas that reported gestational age at the time of abortion for 2020, 80.9% of abortions were performed at ≤9 weeks' gestation, and nearly all (93.1%) were performed at ≤13 weeks' gestation (Table 10). Fewer abortions were performed at 14–20 weeks' gestation (5.8%) or at ≥21 weeks' gestation (0.9%). Among the 33 reporting areas that provided data every year on gestational age for 2011–2020, the percentage of abortions performed at ≤13 weeks' gestation changed from 91.3% to 92.5% (Table 11). However, within this gestational age range, a shift occurred toward earlier gestational ages, with the percentage of abortions performed at ≤6 weeks' gestation increasing 17% and the percentage of abortions performed at 7–9 weeks' and 10–13 weeks' gestation decreasing 2% and 21%, respectively.

Among the 46 areas that reported by method type for 2020 and included medical abortion on their reporting form, 51.0% were early medical abortions (a nonsurgical abortion at ≤9 weeks' gestation), 40.0% of abortions were surgical abortions at ≤13 weeks' gestation, 6.7% were surgical abortions at >13 weeks' gestation, and 2.4% were medical abortions at >9 weeks' gestation; other methods, including intrauterine instillation and hysterectomy/hysterotomy, were rare (<0.1%) (Table 12). During 2011–2020, a total of 37 reporting areas (excludes Alabama, California, the District of Columbia, Florida, Hawaii, Illinois, Louisiana, Maine, Maryland, New Hampshire, New Mexico, Tennessee, Vermont, Wisconsin, and Wyoming) provided continuous data and included medical abortion on their reporting form. Among these 37 areas, use of early medical abortion increased 22% from 2019 to 2020 (from 41.1% to 50.0% of abortions) and 154% from 2011 to 2020 (from 19.7% to 50.0% of abortions).

Among the 40 areas that reported abortions categorized by individual weeks of gestation and method type for 2020, surgical abortion accounted for the highest percentage of abortions at >10 weeks' gestation (Table 13). Surgical abortion accounted for 32.1% of abortions at ≤6 weeks' gestation, 41.2% of abortions at 7–9 weeks' gestation, 84.3% of abortions at 10–13 weeks' gestation, 96.2%–98.8% of abortions at 14–20 weeks' gestation, and 86.3% of abortions at ≥21 weeks' gestation. In contrast, medical abortion accounted for 67.9% of abortions at ≤6 weeks' gestation, 58.7% of abortions at 7–9 weeks' gestation, 15.7% of abortions at 10–13 weeks' gestation, 1.2%–2.9% of abortions at 14–20 weeks' gestation, and 11.8% of abortions at ≥21 weeks' gestation. For each gestational age category as applicable, abortions performed by intrauterine instillation or hysterectomy/hysterotomy were rare (<0.1%–1.7% of abortions).

Weeks of Gestation by Age Group and Race or Ethnicity

In reporting areas that provided data that met CDC reporting standards, abortions that were categorized by weeks of gestation were further categorized by age and by race or ethnicity (Table 14). In every subgroup for these characteristics, the highest percentage of abortions occurred at ≤9 weeks' gestation. In 41 reporting areas, by age, 61.0% of adolescents aged <15 years and 75.5% of adolescents aged 15–19 years obtained an abortion at ≤9 weeks' gestation, compared with ≥80.6% among women aged ≥20 years. Conversely, 18.7% of adolescents aged <15 years and 9.1% of adolescents aged 15–19 years obtained an abortion after 13 weeks' gestation, compared with 6.3%–7.2% for women aged ≥20 years. In 28 reporting areas, by race or ethnicity, 80.1% of abortions obtained by Black women occurred at ≤9 weeks' gestation, compared with 81.5% of non-Hispanic women in the other race category, 82.0% of White women, and 83.9% of Hispanic women. Conversely, 5.4% of abortions obtained by Hispanic women occurred after 13 weeks' gestation, followed by 6.2% of White women, 6.3% of Black women, and 6.9% of non-Hispanic women in the other race category.

Abortion Mortality

Using national PMSS data (*33*), CDC identified four abortion-related deaths for 2019, the most recent year for which data were reviewed for abortion-related deaths (Table 15). Investigation of these cases indicated all deaths were related to legal abortion.

The annual number of deaths related to legal induced abortion has fluctuated from year to year since 1973 (Table 15). The national case-fatality rate for legal induced abortion for 2013–2019 was 0.43 deaths related to legal induced abortions per 100,000 reported legal abortions. This case-fatality rate was lower than the rates for the previous 5-year periods.

Discussion

For 2020, a total of 620,327 abortions were reported to CDC by 49 areas. Among the 48 continuously reporting areas, for 2020, the abortion rate was 11.2 abortions per 1,000 women aged 15–44 years, and the abortion ratio was 198 abortions per 1,000 live births. From 2019 to 2020, the number of abortions decreased 2%, the abortion rate decreased 2%, and the abortion ratio increased 2%. Although the rate of reported abortions declined overall from 2011 to 2020, after reaching a historic low in 2017, the overall abortion rate increased between 2018 and 2019, before declining again in 2020.

Using data from their national survey of abortion-providing facilities, the Guttmacher Institute estimated that approximately 21% of all pregnancies in the United States ended in induced abortion in 2020 (*34*). Multiple factors influence the incidence of abortion, including access to health care services and contraception (*36–38*); the availability of abortion providers and clinics (*6*,*39*,*40*); state regulations, such as mandatory waiting periods (*41–43*), parental involvement laws (*44*,*45*), and legal restrictions on abortion providers and clinics (*46–52*); and changes in the economy and the resulting impact on family planning decisions and contraceptive use (*53*).

Abortion measures in 2020 might have been affected by the COVID-19 pandemic. Factors include temporary changes that defined abortion as a nonessential service at the hospital, local, or jurisdiction level (*54*,*55*), clinic closures, and changes in practice (e.g., shift from surgical abortions to medical abortions, implementation, and uptake of telehealth) (*56–60*). In addition, there might have been changes in pregnancy rates because of reduced sexual activity (*61*,*62*).

Abortion measures also differ by demographic characteristics. Among areas that reported data continuously by age during 2011–2020, women in their 20s accounted for the highest percentages of abortions and had the highest abortion rates, whereas adolescents aged <15 years accounted for the lowest percentage of abortions and had the lowest abortion rate, and adolescents aged <15 years and 15–19 years had the highest abortion ratios. During 2011–2020, women aged ≥40 years accounted for a relatively small percentage of reported abortions (≤3.8%). However, the abortion ratio among women aged ≥40 years continues to be higher than among women aged 25–39 years.

The percentage change in adolescent abortions described in this report are important for monitoring changes in adolescent pregnancies in the United States. From 2011 to 2020, national birth data indicate that the birth rate for adolescents aged 15–19 years decreased 51% (*31*), and the data in this report indicate that the abortion rate for the same age group decreased 48%. These findings highlight that decreases in adolescent births in the United States have been accompanied by large decreases in adolescent abortions (*31*).

As in previous years, abortion rates and ratios differ across racial or ethnic groups. For example, in 2020, compared with White women, abortion rates and ratios were 3.9 and 3.6 times higher among Black women and 1.8 and 1.5 times higher among Hispanic women. Similar differences by race or ethnicity have been demonstrated in other U.S.-based studies (*2*,*8–11*,*63*). The factors leading to higher abortion rates among certain racial or ethnic minority groups are complex. In addition to disparities in rates of unintended pregnancies, structural factors, including unequal access to quality family planning services (*64*,*65*), economic inequities, and mistrust of the medical system (*66*), can contribute to observed differences.

In 2020, approximately four out of five abortions occurred early in gestation (≤9 weeks), when the risks for complications are lowest (*67–70*). Over the past 10 years, this percentage increased from 74.3% in 2011 to 79.1% in 2020. Moreover, among areas that reported abortions at ≤13 weeks' gestation by individual week, the distribution of abortions by gestational age continued to shift toward earlier weeks of gestation, with the percentage of early abortions performed at ≤6 weeks' gestation increasing from 34.2% in 2011 to 39.9% in 2020. Previous research indicates that the distribution of abortions by gestational age differs by various sociodemographic characteristics (*71–73*). In this report, the percentage of adolescents aged ≤19 years who obtained abortions at >13 weeks' gestation was higher than the percentage among women aged ≥20 years. The gestational age when abortions are performed can be influenced by multiple factors, including jurisdiction abortion restrictions, accurate estimation of gestational age, income level, age, and presence of pregnancy-related health conditions (*41*,*63*,*70*,*72–77*).

Changes in clinical practices have facilitated the trend of obtaining abortions earlier in pregnancy. Research conducted in the United States during the 1970s indicated that surgical abortion procedures performed at ≤6 weeks' gestation, compared with 7–12 weeks' gestation, were less likely to result in successful termination of the pregnancy (*78*). However, subsequent advances in technology (e.g., improved transvaginal ultrasonography and sensitivity of pregnancy tests) have allowed very early surgical abortions to be performed with completion rates exceeding 97% (*79–82*). Likewise, the development of early medical abortion regimens has allowed for abortions to be performed early in gestation, with completion rates for regimens that combine mifepristone and misoprostol reaching 96%–98% (*82–85*).

Trends for early medical abortions are reported to monitor any changes in clinical practice that might have occurred with the accumulation of evidence on the safety and effectiveness

of medical abortion past 63 days of gestation (8 completed weeks' gestation) (*86*), changes in professional practice guidelines published in 2013 and 2014 (*87*,*88*), and the 2016 FDA extension of the gestational age limit for the use of mifepristone for early medical abortion from 63 days to 70 days (9 completed weeks' gestation) (*89*). Among abortions occurring at ≤9 weeks' gestation in 2020, 63.9% of abortions were reported as early medical abortions. In 2020, the most common method among abortions reported overall was early medical abortion at ≤9 weeks' gestation (51.0%). Among areas that reported by method type and included medical abortion on their reporting form, the percentage of all abortions performed by early medical abortion increased 154% from 2011 to 2020 and increased 22% from 2019 to 2020.

Because the annual number of deaths related to legal induced abortion is small and statistically unstable, case-fatality rates were calculated for consecutive 5-year periods during 1973–2012 and then for a consecutive 7-year period during 2013–2019. The national case-fatality rate for legal induced abortion was 0.43 per 100,000 abortions. Since the late 1970s, all rates for the preceding 5-year periods have been fewer than 1 death per 100,000 abortions, demonstrating the low risk for death associated with legal induced abortion.

Limitations

The findings in this report are subject to at least four limitations. First, because reporting to CDC is voluntary and reporting requirements vary by the individual reporting areas (*13*,*14*), CDC is unable to report the total number of abortions performed in the United States. Of the 52 areas from which CDC requested data for 2020, California, Maryland, and New Hampshire did not submit abortion data. In 2020, the most recent year for which data are available through the Guttmacher Institute's national survey of abortion-providing facilities, abortions performed in these states accounted for approximately 20% of all abortions in the United States (*34*). CDC receives aggregated data from the central health agencies of reporting areas, which might result in different estimates than reported by the Guttmacher Institute. New Jersey did not have abortion reporting requirements to a centralized health agency during the period covered in this report (*13*), which potentially affects the representativeness of data provided to CDC. Certain reporting areas (the District of Columbia and Wyoming) have recently implemented new legislation that could improve reporting of abortion data. Nonetheless, even in reporting areas that legally require clinicians to submit a report for every abortion they perform, enforcement of this requirement varies.

Second, many states use abortion reporting forms that differ from the technical guidance that CDC developed in collaboration with NAPHSIS. Consequently, certain reporting areas do not collect all variables requested by CDC (e.g., age and race or ethnicity) or do not report the data in a manner consistent with this guidance (e.g., gestational age). Missing demographic information can reduce the extent to which the statistics in this report represent women who have had abortions. Only 30 reporting areas reported race or ethnicity data to CDC that met CDC's reporting standards. Certain areas that either do not report to CDC (e.g., California) or do not report race or ethnicity data (e.g., Illinois) have sufficiently large populations of racial or ethnic minority groups that the absence of data from these areas likely reduces the representativeness of CDC data for these variables. In addition, because of the variability in data collection for race or ethnicity among reporting areas, data for specific racial or ethnic groups beyond White, Black, and Hispanic are not requested or reported. In addition, certain areas collect gestational age data that are based on estimated date of conception or probable postfertilization age, which are not consistent with medical conventions for gestational age reporting. Without medical guidance on how to report these data, the validity and reliability of gestational age for these reporting areas is uncertain.

Third, abortion data are compiled and reported to CDC by the central health agency of the reporting area in which the abortion was performed rather than the reporting area in which the person lived. Thus, the available population (*20*–*29*) and birth data (*30*,*31*), which are organized by the states/jurisdictions in which women live, might differ from the population of women who undergo abortions in a given reporting area. This likely results in an overestimation of abortions for reporting areas in which a higher percentage of abortions are obtained by out-of-area residents and an underestimation of abortions for reporting areas where residents more frequently obtain abortions out of area. Limited abortion services, stringent regulatory requirements for obtaining an abortion, or geographic proximity to services in another state might influence where women obtain abortion services (*90*,*91*).

Finally, CDC reporting of sociodemographic characteristics of women obtaining abortions is limited to data collected on jurisdiction reporting forms. Therefore, the examination of additional demographic variables (e.g., income and education) is not possible.

Public Health Implications

Ongoing surveillance of legal induced abortion is important for several reasons. First, abortion surveillance can be used to help evaluate programs aimed at promoting equitable access to patient-centered contraceptive care in the United States to reduce unintended pregnancies. Up to 42% of unintended pregnancies in the United States end in abortion (*92*), and use of effective contraception is a strategy to reduce unintended pregnancy (*93*). Efforts to improve contraceptive access have been associated with declines in the rate of abortions (*36*,*38*). Reported barriers to accessing contraception include cost, inadequate provider reimbursement and training, insufficient patient-centered counseling, lack of youth-friendly services, and low client awareness of available contraceptive methods (*36–38*,*94–100*). Reducing these barriers might help ensure equitable access to patient-centered contraceptive care and promote equitable reproductive health in the United States (*101*).

Second, routine abortion surveillance can be used to assess changes in clinical practice patterns over time. Information in this report on the number of abortions performed through different methods (e.g., medical or surgical) and at different gestational ages provides the denominator data that are necessary for analyses of the relative safety of abortion practices (*102*,*103*). Finally, information on the number of pregnancies ending in abortion is used in conjunction with data on births and fetal losses to estimate the number of pregnancies in the United States and determine rates for various outcomes of public health importance (*12*).

Conflicts of Interest

All authors have completed and submitted the International Committee of Medical Journal Editors form for disclosure of potential conflicts of interest. No potential conflicts of interest were disclosed.

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TABLE 1. Number, percentage, rate,* and ratio† of reported abortions — selected reporting areas, United States, 2011–2020

	Selected reporting areas§	Continuously reporting areas¶		
Year	No.	No. (%)**	Rate	Ratio
2011	730,322	727,554 (99.6)	13.7	217
2012	699,202	696,587 (99.6)	13.1	208
2013	664,435	661,874 (99.6)	12.4	198
2014	652,639	649,849 (99.6)	12.1	192
2015	638,169	636,902 (99.8)	11.8	188
2016	623,471	623,471 (100.0)	11.6	186
2017	612,719	609,095 (99.4)	11.2	185
2018	619,591	614,820 (99.2)	11.3	189
2019	629,898	625,346 (99.3)	11.4	195
2020	620,327	615,911 (99.3)	11.2	198

* Number of abortions per 1,000 women aged 15–44 years.
† Number of abortions per 1,000 live births.
§ For each given year, excludes reporting areas that did not report that year's abortion numbers to CDC: California (2011–2020), the District of Columbia (2016), Maryland (2011–2020), and New Hampshire (2011–2020).
¶ For all years, excludes reporting areas that did not report abortion numbers every year during the analysis period: California, the District of Columbia, Maryland, and New Hampshire.
** Abortions from areas that reported every year during the analysis period as a percentage of all reported abortions for a given year.

TABLE 2. Number, rate,* and ratio† of reported abortions, by reporting area of occurrence and number of abortions obtained by out-of-area residents§ — United States, 2020¶

Area	Abortions reported by area of occurrence**			Abortions obtained by out-of-area residents
	No.	Rate	Ratio	No. (%)
Alabama	5,713	6.0	99	875 (15.3)
Alaska	1,206	8.4	127	8 (0.7)
Arizona	13,273	9.3	172	72 (0.5)
Arkansas	3,154	5.4	89	390 (12.4)
Colorado	9,869	8.3	160	1,283 (13.0)
Connecticut	9,115	13.6	272	456 (5.0)
Delaware	2,281	12.5	219	272 (11.9)
District of Columbia	4,416	23.0	498	3,123 (70.7)
Florida	74,868	19.1	357	3,988 (5.3)
Georgia	37,533	17.1	306	6,411 (17.1)
Hawaii	1,809	7.0	115	32 (1.8)
Idaho	1,680	4.8	78	102 (6.1)
Illinois	46,243	18.7	347	9,686 (20.9)
Indiana	7,756	5.9	99	384 (5.0)
Iowa	4,058	6.8	112	679 (16.7)
Kansas	7,526	13.4	219	3,901 (51.8)
Kentucky	4,104	4.8	79	617 (15.0)
Louisiana	7,473	8.1	130	1,240 (16.6)
Maine	2,064	8.8	179	115 (5.6)
Massachusetts	16,452	11.8	248	593 (3.6)
Michigan	29,669	15.8	285	1,620 (5.5)
Minnesota	10,349	9.5	163	971 (9.4)
Mississippi	3,559	6.1	100	360 (10.1)
Missouri	167	0.1	2	33 (19.8)
Montana	1,675	8.4	155	177 (10.6)
Nebraska	2,378	6.3	98	374 (15.7)
Nevada	8,633	14.1	257	471 (5.5)
New Jersey††	22,972	13.7	235	1,593 (6.9)
New Mexico	4,293	10.7	196	1,301 (30.3)
New York	63,142	16.5	302	3,670 (5.8)§§
New York City	37,523	20.9	388	3,195 (8.5)
New York State	25,619	12.6	227	2,469 (9.6)
North Carolina	30,004	14.4	257	5,117 (17.1)
North Dakota	1,174	7.9	117	338 (28.8)
Ohio	20,605	9.3	159	1,167 (5.7)
Oklahoma	3,797	4.9	80	598 (15.7)
Oregon	6,991	8.4	176	672 (9.6)
Pennsylvania	32,123	13.5	246	2,144 (6.7)
Rhode Island	2,611	12.6	258	424 (16.2)
South Carolina	5,468	5.5	98	278 (5.1)
South Dakota	125	0.8	11	19 (15.2)
Tennessee	11,243	8.4	143	—¶¶
Texas	55,132	9.0	150	1,183 (2.1)
Utah	2,362	3.3	52	118 (5.0)
Vermont	1,227	10.7	239	213 (17.4)
Virginia	15,604	9.2	165	1,067 (6.8)
Washington	16,909	11.0	204	852 (5.0)
West Virginia	1,001	3.2	58	152 (15.2)
Wisconsin	6,430	5.9	106	94 (1.5)
Wyoming	91	0.8	15	22 (24.2)
Total	**620,327**	**N/A**	**N/A**	**N/A**

Abbreviation: N/A = not applicable.

* Number of abortions per 1,000 women aged 15–44 years.

† Number of abortions per 1,000 live births.

§ Additional details on the reporting area in which abortions were provided, cross-tabulated by the area of residence, are available at https://www.cdc.gov/reproductivehealth/data_stats/Abortion.htm.

¶ Data from 49 reporting areas; excludes three reporting areas (California, Maryland, and New Hampshire) that did not report.

** The total abortions include those with known and unknown residence status.

†† Reporting to the central health agency is not required. Data are requested from hospitals and licensed ambulatory care facilities only.

§§ Residents of New York State who had abortions in New York City and residents of New York City who had abortions in New York State were excluded from the number and percentage of abortions obtained by out-of-area residents in New York.

¶¶ Tennessee did not report data by residence; therefore, the percentage of abortions obtained in Tennessee by out-of-area residents cannot be calculated.

TABLE 3. Number of reported abortions, by known age group and reporting area of occurrence — selected reporting areas,* United States, 2020

	Age group (yrs)							Total abortions reported by known age
	<15	15–19	20–24	25–29	30–34	35–39	≥40	
Area	No. (%)†	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (% of all reported abortions)§
Alabama	21 (0.4)	483 (8.5)	1,746 (30.6)	1,768 (31.0)	1,019 (17.9)	533 (9.3)	137 (2.4)	**5,707 (99.9)**
Alaska	7 (0.6)	121 (10.0)	361 (29.9)	319 (26.5)	238 (19.7)	121 (10.0)	39 (3.2)	**1,206 (100.0)**
Arizona	24 (0.2)	1,202 (9.1)	4,033 (30.4)	3,656 (27.5)	2,519 (19.0)	1,371 (10.3)	468 (3.5)	**13,273 (100.0)**
Arkansas	11 (0.3)	293 (9.3)	965 (30.6)	961 (30.5)	556 (17.7)	279 (8.9)	84 (2.7)	**3,149 (99.8)**
Colorado	28 (0.3)	929 (9.4)	2,897 (29.4)	2,812 (28.5)	1,890 (19.2)	953 (9.7)	357 (3.6)	**9,866 (100.0)**
Connecticut	15 (0.2)	770 (8.5)	2,575 (28.3)	2,556 (28.1)	1,849 (20.3)	1,017 (11.2)	325 (3.6)	**9,107 (99.9)**
Delaware	8 (0.4)	221 (9.7)	656 (28.8)	646 (28.3)	424 (18.6)	248 (10.9)	78 (3.4)	**2,281 (100.0)**
District of Columbia	11 (0.2)	407 (9.2)	1,273 (28.8)	1,366 (31.0)	819 (18.6)	407 (9.2)	130 (2.9)	**4,413 (99.9)**
Florida	124 (0.2)	5,157 (6.9)	20,017 (26.8)	21,866 (29.3)	15,876 (21.2)	8,613 (11.5)	3,087 (4.1)	**74,740 (99.8)**
Georgia	66 (0.2)	2,666 (7.1)	10,444 (27.8)	11,572 (30.8)	7,674 (20.4)	3,814 (10.2)	1,297 (3.5)	**37,533 (100.0)**
Hawaii	—¶	157 (8.7)	501 (27.7)	499 (27.6)	334 (18.5)	218 (12.1)	—¶	**1,809 (100.0)**
Idaho	9 (0.5)	195 (11.6)	546 (32.5)	423 (25.2)	279 (16.6)	174 (10.4)	54 (3.2)	**1,680 (100.0)**
Illinois	88 (0.2)	3,775 (8.2)	13,022 (28.3)	14,343 (31.2)	8,809 (19.1)	4,554 (9.9)	1,438 (3.1)	**46,029 (99.5)**
Indiana	16 (0.2)	699 (9.0)	2,367 (30.5)	2,232 (28.8)	1,417 (18.3)	771 (9.9)	254 (3.3)	**7,756 (100.0)**
Iowa	14 (0.3)	409 (10.1)	1,177 (29.0)	1,133 (27.9)	732 (18.0)	458 (11.3)	135 (3.3)	**4,058 (100.0)**
Kansas	20 (0.3)	694 (9.2)	2,355 (31.3)	2,154 (28.6)	1,288 (17.1)	761 (10.1)	254 (3.4)	**7,526 (100.0)**
Kentucky	13 (0.3)	353 (8.6)	1,192 (29.0)	1,229 (29.9)	779 (19.0)	399 (9.7)	139 (3.4)	**4,104 (100.0)**
Louisiana	22 (0.3)	634 (8.5)	2,098 (28.1)	2,257 (30.2)	1,446 (19.4)	762 (10.2)	253 (3.4)	**7,472 (100.0)**
Maine	7 (0.3)	164 (8.0)	553 (26.8)	584 (28.3)	419 (20.3)	267 (13.0)	67 (3.3)	**2,061 (99.9)**
Massachusetts	19 (0.1)	1,118 (6.8)	4,216 (25.7)	4,430 (27.0)	3,643 (22.2)	2,192 (13.4)	761 (4.6)	**16,379 (99.6)**
Michigan	74 (0.3)	2,360 (8.0)	8,492 (28.8)	9,275 (31.4)	5,810 (19.7)	2,625 (8.9)	881 (3.0)	**29,517 (99.5)**
Minnesota	28 (0.3)	857 (8.3)	2,766 (26.8)	2,938 (28.4)	2,142 (20.7)	1,186 (11.5)	419 (4.1)	**10,336 (99.9)**
Mississippi	12 (0.3)	296 (8.3)	1,077 (30.3)	1,145 (32.2)	636 (17.9)	315 (8.9)	78 (2.2)	**3,559 (100.0)**
Missouri	—¶	8 (4.8)	36 (21.6)	40 (24.0)	39 (23.4)	35 (21.0)	—¶	**167 (100.0)**
Montana	6 (0.4)	200 (11.9)	460 (27.5)	445 (26.6)	304 (18.1)	191 (11.4)	69 (4.1)	**1,675 (100.0)**
Nebraska	9 (0.4)	245 (10.3)	711 (29.9)	671 (28.2)	423 (17.8)	217 (9.1)	102 (4.3)	**2,378 (100.0)**
Nevada	22 (0.3)	795 (9.5)	2,243 (26.8)	2,308 (27.6)	1,709 (20.4)	955 (11.4)	331 (4.0)	**8,363 (96.9)**
New Jersey**	42 (0.2)	1,983 (8.6)	5,929 (25.8)	6,625 (28.8)	4,721 (20.6)	2,634 (11.5)	1,033 (4.5)	**22,967 (100.0)**
New Mexico	23 (0.6)	491 (11.9)	1,296 (31.5)	1,060 (25.8)	707 (17.2)	411 (10.0)	123 (3.0)	**4,111 (95.8)**
New York	126 (0.2)	5,338 (8.5)	16,336 (25.9)	17,895 (28.4)	13,126 (20.8)	7,396 (11.7)	2,745 (4.4)	**62,962 (99.7)**
New York City	58 (0.2)	2,931 (7.8)	9,339 (24.9)	10,729 (28.6)	8,114 (21.6)	4,562 (12.2)	1,790 (4.8)	**37,523 (100.0)**
New York State	68 (0.3)	2,407 (9.5)	6,997 (27.5)	7,166 (28.2)	5,012 (19.7)	2,834 (11.1)	955 (3.8)	**25,439 (99.3)**
North Carolina	56 (0.2)	2,201 (7.6)	8,204 (28.3)	8,818 (30.4)	5,832 (20.1)	2,950 (10.2)	906 (3.1)	**28,967 (96.5)**
North Dakota	—¶	109 (9.3)	352 (30.0)	336 (28.6)	225 (19.2)	109 (9.3)	—¶	**1,174 (100.0)**
Ohio	52 (0.3)	1,702 (8.3)	5,915 (28.7)	6,285 (30.5)	3,945 (19.1)	1,993 (9.7)	713 (3.5)	**20,605 (100.0)**
Oklahoma	21 (0.6)	373 (9.8)	1,208 (31.9)	1,061 (28.0)	687 (18.1)	318 (8.4)	121 (3.2)	**3,789 (99.8)**
Oregon	20 (0.3)	653 (9.3)	2,089 (29.9)	1,819 (26.0)	1,303 (18.6)	775 (11.1)	332 (4.7)	**6,991 (100.0)**
Pennsylvania	102 (0.3)	2,437 (7.6)	8,627 (26.9)	9,841 (30.6)	6,682 (20.8)	3,344 (10.4)	1,090 (3.4)	**32,123 (100.0)**
Rhode Island	—¶	203 (7.8)	770 (29.5)	755 (28.9)	519 (19.9)	265 (10.2)	—¶	**2,610 (100.0)**
South Carolina	14 (0.3)	495 (9.1)	1,556 (28.5)	1,590 (29.1)	1,050 (19.2)	581 (10.6)	182 (3.3)	**5,468 (100.0)**
South Dakota	—¶	9 (7.2)	38 (30.4)	37 (29.6)	28 (22.4)	9 (7.2)	—¶	**125 (100.0)**
Texas	107 (0.2)	4,611 (8.4)	16,276 (29.5)	15,793 (28.6)	10,486 (19.0)	5,900 (10.7)	1,959 (3.6)	**55,132 (100.0)**
Utah	6 (0.3)	276 (11.7)	760 (32.2)	583 (24.7)	402 (17.1)	234 (9.9)	96 (4.1)	**2,357 (99.8)**
Vermont	6 (0.5)	94 (7.7)	330 (26.9)	329 (26.8)	255 (20.8)	157 (12.8)	56 (4.6)	**1,227 (100.0)**
Virginia	21 (0.1)	1,065 (6.8)	4,130 (26.5)	4,576 (29.3)	3,271 (21.0)	1,904 (12.2)	631 (4.0)	**15,598 (100.0)**
Washington	36 (0.2)	1,597 (9.5)	4,698 (27.8)	4,473 (26.5)	3,347 (19.8)	2,032 (12.0)	698 (4.1)	**16,881 (99.8)**
West Virginia	—¶	90 (9.0)	306 (30.6)	317 (31.7)	170 (17.0)	85 (8.5)	—¶	**1,001 (100.0)**
Wisconsin	14 (0.2)	627 (9.8)	1,908 (29.7)	1,864 (29.0)	1,196 (18.6)	617 (9.6)	204 (3.2)	**6,430 (100.0)**
Wyoming	0 (—)	7 (7.7)	22 (24.2)	24 (26.4)	21 (23.1)	10 (11.0)	7 (7.7)	**91 (100.0)**
Total	**1,333 (0.2)**	**49,569 (8.2)**	**169,529 (27.9)**	**177,709 (29.3)**	**121,046 (19.9)**	**65,160 (10.7)**	**22,407 (3.7)**	**606,753 (99.6)††**
Abortion rate§§	**0.4**	**5.8**	**19.2**	**19.0**	**13.0**	**7.2**	**2.6**	**N/A**
Abortion ratio¶¶	**859**	**363**	**296**	**205**	**136**	**144**	**219**	**N/A**

Abbreviation: N/A = not applicable.

* Data from 48 reporting areas; excludes four reporting areas (California, Maryland, New Hampshire, and Tennessee) that did not report, did not report by age, or did not meet reporting standards.

† Percentages for the individual component categories might not add to 100% because of rounding.

§ Percentage is calculated as the number of abortions reported by known age divided by the sum of abortions reported by known and unknown age. Values ≥99.95% are rounded to 100.0%.

¶ Cells with a numerical value in the range of 1–4 and cells that would allow for calculation of these small values have been suppressed.

** Reporting to the central health agency is not required. Data are requested from hospitals and licensed ambulatory care facilities only.

†† Percentage based on a total of 609,084 abortions reported among the areas that met reporting standards for age.

§§ Number of abortions obtained by women in a given age group per 1,000 women in that same age group. Adolescents aged 13–14 years were used as the denominator for the group of adolescents aged <15 years, and women aged 40–44 years were used as the denominator for the group of women aged ≥40 years. For the total abortion rate only, abortions for women of unknown age were distributed according to the distribution of abortions among women of known age.

¶¶ Number of abortions obtained by women in a given age group per 1,000 live births to women in that same age group. For the total abortion ratio only, abortions for women of unknown age were distributed according to the distribution of abortions among women of known age.

TABLE 4. Percentage, rate,* and ratio† of reported abortions, by known age group and year — selected reporting areas,§ United States, 2011–2020

Age group (yrs)	Year										% Change	
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2019 to 2020	2011 to 2020
Reported abortions by known age (%)												
<15	0.4	0.4	0.3	0.3	0.3	0.3	0.2	0.2	0.2	0.2	0.0	−50.0
15–19	13.5	12.2	11.4	10.4	9.8	9.4	9.1	8.8	8.7	8.3	−4.6	−38.5
20–24	32.9	32.7	32.7	32.1	31.1	30.0	29.3	28.5	27.8	28.1	1.1	−14.6
25–29	24.9	25.3	25.9	26.7	27.6	28.5	29.0	29.3	29.3	29.3	0.0	17.7
30–34	15.8	16.4	16.9	17.2	17.7	18.0	18.3	18.8	19.4	19.8	2.1	25.3
35–39	8.9	9.1	9.2	9.7	10.0	10.3	10.5	10.7	10.9	10.6	−2.8	19.1
≥40	3.6	3.8	3.6	3.6	3.6	3.6	3.6	3.6	3.7	3.6	−2.7	0.0
Abortion rate												
<15	0.9	0.8	0.6	0.5	0.5	0.4	0.4	0.4	0.4	0.4	0.0	−55.6
15–19	10.5	9.2	8.2	7.3	6.7	6.3	5.9	5.8	5.9	5.5	−6.8	−47.6
20–24	25.0	23.3	21.9	21.0	20.0	19.1	18.4	18.3	18.2	18.2	0.0	−27.2
25–29	19.5	18.9	18.2	18.2	18.0	17.8	17.4	17.7	17.9	17.9	0.0	−8.2
30–34	12.7	12.4	11.9	11.7	11.8	11.7	11.5	11.9	12.4	12.2	−1.6	−3.9
35–39	7.5	7.4	7.0	7.1	7.0	6.9	6.8	6.9	7.0	6.8	−2.9	−9.3
≥40	2.8	2.8	2.6	2.6	2.5	2.5	2.5	2.5	2.6	2.5	−3.8	−10.7
Abortion ratio												
<15	846	801	791	744	706	743	799	878	875	816	−6.7	−3.5
15–19	328	306	302	294	293	299	306	323	338	346	2.4	5.5
20–24	286	273	264	258	253	252	252	259	264	278	5.3	−2.8
25–29	178	174	169	167	168	170	172	179	185	191	3.2	7.3
30–34	132	128	121	116	116	113	115	119	125	127	1.6	−3.8
35–39	164	157	147	144	140	136	134	135	138	135	−2.2	−17.7
≥40	274	269	244	240	228	219	211	207	214	206	−3.7	−24.8
Total no.¶,**	**624,711**	**595,784**	**565,418**	**553,940**	**542,330**	**531,735**	**517,522**	**522,703**	**529,942**	**524,221**	**N/A**	**N/A**

Abbreviation: N/A = not applicable.

* Number of abortions obtained by women in a given age group per 1,000 women in that same age group. Adolescents aged 13–14 years were used as the denominator for the group of adolescents aged <15 years, and women aged 40–44 years were used as the denominator for the group of women aged ≥40 years. Abortions for women of unknown age were distributed according to the distribution of abortions among women of known age.

† Number of abortions obtained by women in a given age group per 1,000 live births to women in that same age group. Abortions for women of unknown age were distributed according to the distribution of abortions among women of known age.

§ Data from 43 reporting areas; excludes nine reporting areas (California, the District of Columbia, Florida, Maine, Maryland, New Hampshire, Tennessee, Vermont, and Wyoming) that did not report, did not report by age, or did not meet reporting standards for ≥1 year.

¶ By year, the total number of abortions represent 99.5%–99.7% of all abortions reported to CDC among the areas that met reporting standards for age during 2011–2020; reporting standards for age were applied to abortions for residents of Illinois only during 2011–2019.

** The total number is different than previously reported because the total by known age is presented, and data for out-of-area residents were subsequently added for Wisconsin.

TABLE 5. Number of reported abortions among adolescents, by known age and reporting area of occurrence — selected reporting areas,* United States, 2020

	Age (yrs)						
	<15	15	16	17	18	19	
Area	No. (%)†	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	Total no.
Alabama	21 (4.2)	29 (5.8)	48 (9.5)	58 (11.5)	146 (29.0)	202 (40.1)	**504**
Alaska	7 (5.5)	5 (3.9)	16 (12.5)	23 (18.0)	15 (11.7)	62 (48.4)	**128**
Arizona	24 (2.0)	47 (3.8)	71 (5.8)	134 (10.9)	362 (29.5)	588 (48.0)	**1,226**
Arkansas	11 (3.6)	15 (4.9)	21 (6.9)	41 (13.5)	81 (26.6)	135 (44.4)	**304**
Colorado	28 (2.9)	49 (5.1)	78 (8.2)	137 (14.3)	270 (28.2)	395 (41.3)	**957**
Delaware	—§	—§	—§	—§	—§	—§	—§
District of Columbia	11 (2.6)	15 (3.6)	52 (12.4)	81 (19.4)	102 (24.4)	157 (37.6)	**418**
Florida	124 (2.3)	186 (3.5)	372 (7.0)	633 (12.0)	1,489 (28.2)	2,477 (46.9)	**5,281**
Georgia	66 (2.4)	94 (3.4)	211 (7.7)	317 (11.6)	814 (29.8)	1,230 (45.0)	**2,732**
Hawaii	—§	—§	—§	—§	—§	—§	—§
Idaho	9 (4.4)	7 (3.4)	20 (9.8)	17 (8.3)	66 (32.4)	85 (41.7)	**204**
Indiana	16 (2.2)	39 (5.5)	60 (8.4)	82 (11.5)	199 (27.8)	319 (44.6)	**715**
Iowa	14 (3.3)	21 (5.0)	45 (10.6)	60 (14.2)	107 (25.3)	176 (41.6)	**423**
Kansas	20 (2.8)	29 (4.1)	65 (9.1)	87 (12.2)	222 (31.1)	291 (40.8)	**714**
Kentucky	13 (3.6)	23 (6.3)	41 (11.2)	49 (13.4)	91 (24.9)	149 (40.7)	**366**
Louisiana	22 (3.4)	42 (6.4)	64 (9.8)	90 (13.7)	194 (29.6)	244 (37.2)	**656**
Maine	7 (4.1)	6 (3.5)	25 (14.6)	34 (19.9)	47 (27.5)	52 (30.4)	**171**
Massachusetts	19 (1.7)	46 (4.0)	88 (7.7)	150 (13.2)	296 (26.0)	538 (47.3)	**1,137**
Michigan	74 (3.0)	104 (4.3)	198 (8.1)	348 (14.3)	696 (28.6)	1,014 (41.7)	**2,434**
Minnesota	28 (3.2)	39 (4.4)	65 (7.3)	132 (14.9)	261 (29.5)	360 (40.7)	**885**
Mississippi	12 (3.9)	18 (5.8)	25 (8.1)	36 (11.7)	87 (28.2)	130 (42.2)	**308**
Missouri	—§	—§	—§	—§	—§	—§	—§
Montana	6 (2.9)	9 (4.4)	16 (7.8)	39 (18.9)	61 (29.6)	75 (36.4)	**206**
Nebraska	9 (3.5)	16 (6.3)	18 (7.1)	30 (11.8)	86 (33.9)	95 (37.4)	**254**
Nevada	22 (2.7)	39 (4.8)	66 (8.1)	108 (13.2)	253 (31.0)	329 (40.3)	**817**
New Jersey¶	42 (2.1)	77 (3.8)	186 (9.2)	398 (19.7)	558 (27.6)	764 (37.7)	**2,025**
New Mexico	23 (4.5)	30 (5.8)	42 (8.2)	100 (19.5)	125 (24.3)	194 (37.7)	**514**
New York	126 (2.3)	248 (4.5)	459 (8.4)	914 (16.7)	1,515 (27.7)	2,202 (40.3)	**5,464**
New York City	58 (1.9)	135 (4.5)	233 (7.8)	502 (16.8)	787 (26.3)	1,274 (42.6)	**2,989**
New York State	68 (2.7)	113 (4.6)	226 (9.1)	412 (16.6)	728 (29.4)	928 (37.5)	**2,475**
North Carolina	56 (2.5)	94 (4.2)	186 (8.2)	252 (11.2)	665 (29.5)	1,004 (44.5)	**2,257**
North Dakota	—§	—§	—§	—§	—§	—§	—§
Ohio	52 (3.0)	100 (5.7)	133 (7.6)	236 (13.5)	524 (29.9)	709 (40.4)	**1,754**
Oklahoma	21 (5.3)	9 (2.3)	32 (8.1)	40 (10.2)	118 (29.9)	174 (44.2)	**394**
Oregon	20 (3.0)	32 (4.8)	53 (7.9)	78 (11.6)	210 (31.2)	280 (41.6)	**673**
Pennsylvania	102 (4.0)	130 (5.1)	212 (8.3)	311 (12.2)	713 (28.1)	1,071 (42.2)	**2,539**
Rhode Island	—§	—§	—§	—§	—§	—§	—§
South Carolina	14 (2.8)	16 (3.1)	42 (8.3)	118 (23.2)	130 (25.5)	189 (37.1)	**509**
South Dakota	—§	—§	—§	—§	—§	—§	—§
Texas	107 (2.3)	179 (3.8)	388 (8.2)	603 (12.8)	1,339 (28.4)	2,102 (44.6)	**4,718**
Utah	6 (2.1)	13 (4.6)	16 (5.7)	27 (9.6)	85 (30.1)	135 (47.9)	**282**
Vermont	—§	—§	—§	—§	—§	—§	—§
Virginia	21 (1.9)	51 (4.7)	86 (7.9)	136 (12.5)	321 (29.6)	471 (43.4)	**1,086**
Washington	36 (2.2)	77 (4.7)	130 (8.0)	238 (14.6)	465 (28.5)	687 (42.1)	**1,633**
West Virginia	—§	—§	—§	—§	—§	—§	—§
Wisconsin**	14 (2.2)	34 (5.4)	54 (8.6)	83 (13.2)	199 (31.6)	246 (39.0)	**630**
Wyoming	—§	—§	—§	—§	—§	—§	—§
Total	**1,230 (2.7)**	**1,997 (4.3)**	**3,765 (8.1)**	**6,354 (13.7)**	**13,198 (28.5)**	**19,699 (42.6)**	**46,243**
Abortion rate††	**0.4**	**1.2**	**2.3**	**4.0**	**8.3**	**11.9**	**N/A**
Abortion ratio§§	**828**	**517**	**404**	**343**	**371**	**313**	**N/A**

Abbreviation: N/A = not applicable.

* Data from 46 reporting areas; excludes six reporting areas (California, Connecticut, Illinois, Maryland, New Hampshire, and Tennessee) that did not report, did not report age among adolescents by individual year, or did not meet reporting standards.

† Percentages for the individual component categories might not add to 100% because of rounding.

§ Cells with a numerical value in the range of 1–4 and cells that would allow for calculation of these small values have been suppressed.

¶ Reporting to the central health agency is not required. Data are requested from hospitals and licensed ambulatory care facilities only.

** Includes residents only.

†† Number of abortions obtained by women in a given age group per 1,000 women in that same age group. Adolescents aged 13–14 years were used as the denominator for the group of adolescents aged <15 years. For the total abortion rate only, abortions for women of unknown age were distributed according to the distribution of abortions among women of known age.

§§ Number of abortions obtained by women in a given age group per 1,000 live births to women in that same age group. For the total abortion ratio only, abortions for women of unknown age were distributed according to the distribution of abortions among women of known age.

TABLE 6. Number of reported abortions, by known race or ethnicity and reporting area of occurrence — selected reporting areas,* United States, 2020

	Non-Hispanic				
	White	Black	Other†	Hispanic	Total abortions reported by known race or ethnicity
Area	No. (%)§	No. (%)	No. (%)	No. (%)	No. (% of all reported abortions)¶
Alabama	1,485 (26.0)	3,769 (66.1)	116 (2.0)	334 (5.9)	**5,704 (99.8)**
Alaska	530 (47.2)	77 (6.9)	459 (40.9)	56 (5.0)	**1,122 (93.0)**
Arizona	4,705 (36.4)	1,606 (12.4)	1,244 (9.6)	5,374 (41.6)	**12,929 (97.4)**
Arkansas	1,145 (36.5)	1,704 (54.4)	103 (3.3)	182 (5.8)	**3,134 (99.4)**
Connecticut	3,037 (33.8)	2,452 (27.3)	551 (6.1)	2,951 (32.8)	**8,991 (98.6)**
Delaware	858 (37.6)	1,065 (46.7)	48 (2.1)	310 (13.6)	**2,281 (100.0)**
District of Columbia	651 (16.2)	31 (0.8)	2,610 (64.9)	727 (18.1)	**4,019 (91.0)**
Florida	20,706 (29.6)	26,213 (37.5)	2,684 (3.8)	20,299 (29.0)	**69,902 (93.4)**
Georgia	6,888 (19.5)	23,534 (66.5)	1,689 (4.8)	3,256 (9.2)	**35,367 (94.2)**
Idaho	1,107 (70.0)	38 (2.4)	67 (4.2)	369 (23.3)	**1,581 (94.1)**
Indiana	3,603 (47.2)	2,648 (34.7)	557 (7.3)	832 (10.9)	**7,640 (98.5)**
Kansas	3,889 (51.8)	1,913 (25.5)	613 (8.2)	1,097 (14.6)	**7,512 (99.8)**
Kentucky	2,192 (53.7)	1,412 (34.6)	170 (4.2)	310 (7.6)	**4,084 (99.5)**
Michigan	10,498 (36.9)	15,470 (54.4)	1,418 (5.0)	1,028 (3.6)	**28,414 (95.8)**
Minnesota	4,646 (49.7)	2,853 (30.5)	1,229 (13.2)	616 (6.6)	**9,344 (90.3)**
Mississippi	624 (17.6)	2,749 (77.3)	79 (2.2)	103 (2.9)	**3,555 (99.9)**
Missouri	87 (56.1)	49 (31.6)	12 (7.7)	7 (4.5)	**155 (92.8)**
Montana	1,381 (82.4)	28 (1.7)	165 (9.9)	101 (6.0)	**1,675 (100.0)**
Nevada	2,766 (34.4)	1,753 (21.8)	1,000 (12.4)	2,529 (31.4)	**8,048 (93.2)**
New Mexico	966 (25.6)	218 (5.8)	393 (10.4)	2,190 (58.1)	**3,767 (87.7)**
North Carolina	7,871 (27.9)	14,738 (52.3)	2,049 (7.3)	3,548 (12.6)	**28,206 (94.0)**
Oregon	4,143 (61.8)	395 (5.9)	738 (11.0)	1,430 (21.3)	**6,706 (95.9)**
South Carolina	2,404 (44.0)	2,363 (43.2)	244 (4.5)	457 (8.4)	**5,468 (100.0)**
South Dakota	80 (64.0)	—**	—**	6 (4.8)	**125 (100.0)**
Texas††	14,473 (26.6)	16,393 (30.1)	3,450 (6.3)	20,152 (37.0)	**54,468 (98.8)**
Utah	1,326 (56.4)	106 (4.5)	182 (7.7)	736 (31.3)	**2,350 (99.5)**
Vermont	1,054 (87.7)	56 (4.7)	57 (4.7)	35 (2.9)	**1,202 (98.0)**
Virginia	4,895 (33.9)	6,746 (46.7)	1,457 (10.1)	1,356 (9.4)	**14,454 (92.6)**
West Virginia	836 (83.5)	143 (14.3)	17 (1.7)	5 (0.5)	**1,001 (100.0)**
Wyoming	58 (68.2)	—**	—**	24 (28.2)	**85 (93.4)**
Total	**108,904 (32.7)**	**130,538 (39.2)**	**23,427 (7.0)**	**70,420 (21.1)**	**333,289 (95.5)§§**
Abortion rate¶¶	**6.2**	**24.4**	**12.7**	**11.4**	**N/A**
Abortion ratio* **	**118**	**426**	**186**	**173**	**N/A**

Abbreviation: N/A = not applicable.

* Data from 30 reporting areas; excludes 22 reporting areas (California, Colorado, Hawaii, Illinois, Iowa, Louisiana, Maine, Maryland, Massachusetts, Nebraska, New Hampshire, New Jersey, New York City, New York State, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, Tennessee, Washington, and Wisconsin) that did not report, did not report by race or ethnicity, or did not meet reporting standards.

† Including Asian (Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, or other Asian), Pacific Islander (Native Hawaiian, Guamanian or Chamorro, Samoan, or other Pacific Islander), other races, and multiple races.

§ Percentages for the individual component categories might not add to 100% because of rounding.

¶ Percentage is calculated as the number of abortions reported by known race or ethnicity divided by the sum of abortions reported by known and unknown race or ethnicity. Values ≥99.95% are rounded to 100.0%.

** Cells with a numerical value in the range of 1–4 and cells that would allow for calculation of these small values have been suppressed.

†† Reporting form contains only one question for race or ethnicity; therefore, abortions reported for women of White, Black, and other races (Asian and Native American) are not explicitly identified as non-Hispanic.

§§ Percentage based on a total of 348,975 abortions reported among the areas that met reporting standards for race and ethnicity.

¶¶ Number of abortions obtained by women in a given racial or ethnic group per 1,000 women aged 15–44 years in that same racial or ethnic group. For the total abortion rate only, abortions for women of unknown race or ethnicity were distributed according to the distribution of abortions among women of known race or ethnicity.

*** Number of abortions obtained by women in a given racial or ethnic group per 1,000 live births to women in that same racial or ethnic group. For the total abortion ratio only, abortions for women of unknown race or ethnicity were distributed according to the distribution of abortions among women of known race or ethnicity.

TABLE 7. Number of reported abortions, by known marital status and reporting area of occurrence — selected reporting areas,* United States, 2020

Area	Marital status		Total abortions reported by known marital status
	Married	Unmarried	
	No. (%)†	No. (%)	No. (% of all reported abortions)§
Alabama	560 (9.8)	5,142 (90.2)	**5,702 (99.8)**
Alaska	253 (22.0)	898 (78.0)	**1,151 (95.4)**
Arizona	1,944 (14.6)	11,329 (85.4)	**13,273 (100.0)**
Arkansas	322 (10.3)	2,805 (89.7)	**3,127 (99.1)**
Colorado	1,645 (18.0)	7,469 (82.0)	**9,114 (92.3)**
Delaware	289 (12.7)	1,992 (87.3)	**2,281 (100.0)**
Florida	9,800 (15.2)	54,764 (84.8)	**64,564 (86.2)**
Georgia	4,112 (11.6)	31,188 (88.4)	**35,300 (94.1)**
Idaho	349 (21.7)	1,258 (78.3)	**1,607 (95.7)**
Illinois	4,037 (9.1)	40,475 (90.9)	**44,512 (96.3)**
Indiana	1,163 (15.0)	6,592 (85.0)	**7,755 (100.0)**
Iowa	601 (14.8)	3,451 (85.2)	**4,052 (99.9)**
Kansas	1,099 (14.7)	6,380 (85.3)	**7,479 (99.4)**
Kentucky	523 (12.7)	3,581 (87.3)	**4,104 (100.0)**
Louisiana	701 (9.5)	6,641 (90.5)	**7,342 (98.2)**
Maine	296 (16.3)	1,524 (83.7)	**1,820 (88.2)**
Michigan	2,957 (10.5)	25,198 (89.5)	**28,155 (94.9)**
Minnesota	1,586 (15.9)	8,371 (84.1)	**9,957 (96.2)**
Mississippi	285 (8.1)	3,255 (91.9)	**3,540 (99.5)**
Missouri	63 (38.9)	99 (61.1)	**162 (97.0)**
Montana	269 (16.1)	1,405 (83.9)	**1,674 (99.9)**
Nebraska	315 (13.5)	2,010 (86.5)	**2,325 (97.8)**
New Jersey¶	2,910 (13.0)	19,523 (87.0)	**22,433 (97.7)**
New Mexico	621 (15.3)	3,439 (84.7)	**4,060 (94.6)**
New York City	5,661 (17.3)	27,126 (82.7)	**32,787 (87.4)**
North Carolina	3,841 (13.9)	23,756 (86.1)	**27,597 (92.0)**
North Dakota	183 (15.6)	991 (84.4)	**1,174 (100.0)**
Ohio	2,658 (13.9)	16,466 (86.1)	**19,124 (92.8)**
Oklahoma	699 (18.4)	3,090 (81.6)	**3,789 (99.8)**
Oregon	1,298 (21.3)	4,804 (78.7)	**6,102 (87.3)**
Pennsylvania	3,755 (11.7)	28,281 (88.3)	**32,036 (99.7)**
Rhode Island	325 (12.7)	2,242 (87.3)	**2,567 (98.3)**
South Carolina	724 (13.2)	4,743 (86.8)	**5,467 (100.0)**
South Dakota	18 (14.4)	107 (85.6)	**125 (100.0)**
Texas	8,776 (15.9)	46,346 (84.1)	**55,122 (100.0)**
Utah	505 (21.5)	1,840 (78.5)	**2,345 (99.3)**
Vermont	242 (22.2)	846 (77.8)	**1,088 (88.7)**
Virginia**	1,800 (11.5)	13,804 (88.5)	**15,604 (100.0)**
West Virginia	160 (16.0)	840 (84.0)	**1,000 (99.9)**
Wisconsin	792 (12.4)	5,578 (87.6)	**6,370 (99.1)**
Total	**68,137 (13.7)**	**429,649 (86.3)**	**497,786 (94.6)††**
Abortion ratio§§	**46**	**412**	**N/A**

Abbreviation: N/A = not applicable.

* Data from 40 reporting areas excludes 12 reporting areas (California, Connecticut, the District of Columbia, Hawaii, Maryland, Massachusetts, Nevada, New Hampshire, New York State, Tennessee, Washington, and Wyoming) that did not report, did not report by marital status, or did not meet reporting standards.

† Percentages for the individual component categories might not add to 100% because of rounding.

§ Percentage is calculated as the number of abortions reported by known marital status divided by the sum of abortions reported by known and unknown marital status. Values ≥99.95% are rounded to 100.0%.

¶ Reporting to the central health agency is not required. Data are requested from hospitals and licensed ambulatory care facilities only.

** Recorded as patient married or not married to father.

†† Percentage based on a total of 526,040 abortions reported among the areas that met reporting standards for marital status.

§§ Number of abortions obtained by marital status per 1,000 live births to women of the same marital status. For the total abortion ratio only, abortions for women of unknown marital status were distributed according to the distribution of abortions among women of known marital status.

TABLE 8. Number of reported abortions, by known number of previous live births and reporting area of occurrence — selected reporting areas,* United States, 2020

	No. of previous live births					Total abortions reported by known number of previous live births
	0	1	2	3	≥4	
Area	No. (%)†	No. (%)	No. (%)	No. (%)	No. (%)	No. (% of all reported abortions)§
Alabama	1,854 (32.5)	1,601 (28.0)	1,263 (22.1)	619 (10.8)	376 (6.6)	**5,713 (100.0)**
Alaska	559 (46.4)	241 (20.0)	194 (16.1)	133 (11.0)	79 (6.6)	**1,206 (100.0)**
Arizona	5,752 (43.7)	2,760 (21.0)	2,403 (18.3)	1,278 (9.7)	962 (7.3)	**13,155 (99.1)**
Arkansas	1,041 (33.0)	827 (26.2)	713 (22.6)	337 (10.7)	236 (7.5)	**3,154 (100.0)**
Colorado	5,549 (56.4)	1,846 (18.8)	1,395 (14.2)	654 (6.7)	386 (3.9)	**9,830 (99.6)**
Delaware	903 (39.6)	589 (25.8)	482 (21.1)	187 (8.2)	120 (5.3)	**2,281 (100.0)**
Florida	28,028 (37.4)	19,048 (25.4)	15,952 (21.3)	7,113 (9.5)	4,727 (6.3)	**74,868 (100.0)**
Georgia	14,273 (38.0)	9,300 (24.8)	7,644 (20.4)	3,717 (9.9)	2,594 (6.9)	**37,528 (100.0)**
Hawaii	980 (56.4)	286 (16.5)	264 (15.2)	126 (7.3)	81 (4.7)	**1,737 (96.0)**
Idaho	851 (50.7)	330 (19.7)	278 (16.6)	138 (8.2)	81 (4.8)	**1,678 (99.9)**
Indiana	2,890 (37.3)	1,947 (25.1)	1,622 (20.9)	809 (10.4)	487 (6.3)	**7,755 (100.0)**
Iowa	1,721 (42.4)	848 (20.9)	755 (18.6)	429 (10.6)	302 (7.4)	**4,055 (99.9)**
Kansas	3,005 (39.9)	1,762 (23.4)	1,475 (19.6)	797 (10.6)	487 (6.5)	**7,526 (100.0)**
Kentucky	1,379 (33.6)	1,091 (26.6)	932 (22.7)	426 (10.4)	276 (6.7)	**4,104 (100.0)**
Louisiana	2,227 (29.8)	2,025 (27.1)	1,739 (23.3)	908 (12.2)	574 (7.7)	**7,473 (100.0)**
Maine	997 (48.3)	443 (21.5)	383 (18.6)	160 (7.8)	81 (3.9)	**2,064 (100.0)**
Massachusetts	6,306 (43.3)	3,586 (24.6)	2,857 (19.6)	1,235 (8.5)	578 (4.0)	**14,562 (88.5)**
Michigan¶	9,856 (33.2)	7,724 (26.0)	6,631 (22.4)	3,224 (10.9)	2,220 (7.5)	**29,655 (100.0)**
Minnesota	3,986 (38.6)	2,435 (23.6)	2,080 (20.1)	1,067 (10.3)	764 (7.4)	**10,332 (99.8)**
Mississippi	1,048 (29.4)	1,028 (28.9)	776 (21.8)	434 (12.2)	273 (7.7)	**3,559 (100.0)**
Missouri	65 (38.9)	49 (29.3)	33 (19.8)	—**	—**	**167 (100.0)**
Montana	823 (49.2)	330 (19.7)	298 (17.8)	134 (8.0)	89 (5.3)	**1,674 (99.9)**
Nebraska	904 (38.0)	529 (22.3)	491 (20.7)	263 (11.1)	189 (8.0)	**2,376 (99.9)**
Nevada	3,672 (42.8)	1,841 (21.5)	1,661 (19.4)	800 (9.3)	604 (7.0)	**8,578 (99.4)**
New Jersey††	9,063 (39.5)	5,831 (25.4)	4,415 (19.2)	2,135 (9.3)	1,494 (6.5)	**22,938 (99.9)**
New Mexico	1,607 (41.5)	851 (22.0)	714 (18.5)	378 (9.8)	319 (8.2)	**3,869 (90.1)**
New York City	14,915 (43.5)	9,023 (26.3)	6,496 (18.9)	2,440 (7.1)	1,414 (4.1)	**34,288 (91.4)**
North Carolina	9,207 (34.6)	6,330 (23.8)	5,445 (20.5)	2,918 (11.0)	2,712 (10.2)	**26,612 (88.7)**
North Dakota	452 (38.5)	259 (22.1)	228 (19.4)	142 (12.1)	93 (7.9)	**1,174 (100.0)**
Ohio§§	6,485 (33.4)	5,010 (25.8)	4,326 (22.3)	2,140 (11.0)	1,447 (7.5)	**19,408 (94.2)**
Oklahoma	1,490 (39.3)	916 (24.2)	755 (19.9)	402 (10.6)	227 (6.0)	**3,790 (99.8)**
Oregon	3,608 (51.8)	1,377 (19.8)	1,149 (16.5)	506 (7.3)	326 (4.7)	**6,966 (99.6)**
Pennsylvania	11,674 (36.3)	8,349 (26.0)	6,726 (20.9)	3,306 (10.3)	2,068 (6.4)	**32,123 (100.0)**
Rhode Island	1,196 (45.8)	640 (24.5)	479 (18.4)	205 (7.9)	90 (3.4)	**2,610 (100.0)**
South Carolina	2,226 (40.7)	1,348 (24.7)	1,121 (20.5)	489 (8.9)	284 (5.2)	**5,468 (100.0)**
South Dakota	44 (35.2)	31 (24.8)	24 (19.2)	15 (12.0)	11 (8.8)	**125 (100.0)**
Texas	21,628 (39.2)	13,169 (23.9)	11,334 (20.6)	5,581 (10.1)	3,420 (6.2)	**55,132 (100.0)**
Utah	1,142 (48.4)	482 (20.4)	401 (17.0)	197 (8.3)	138 (5.8)	**2,360 (99.9)**
Vermont	630 (51.3)	252 (20.5)	207 (16.9)	91 (7.4)	47 (3.8)	**1,227 (100.0)**
Virginia	5,659 (36.3)	4,007 (25.7)	3,245 (20.8)	1,594 (10.2)	1,099 (7.0)	**15,604 (100.0)**
Washington	7,979 (47.3)	3,669 (21.7)	3,041 (18.0)	1,371 (8.1)	821 (4.9)	**16,881 (99.8)**
West Virginia	317 (31.7)	282 (28.2)	239 (23.9)	111 (11.1)	52 (5.2)	**1,001 (100.0)**
Wyoming	42 (46.7)	20 (22.2)	16 (17.8)	—**	—**	**90 (98.9)**
Total	**198,033 (39.1)**	**124,312 (24.5)**	**102,682 (20.3)**	**49,026 (9.7)**	**32,643 (6.4)**	**506,696 (98.0)¶¶**

* Data from 43 reporting areas; excludes nine reporting areas (California, Connecticut, the District of Columbia, Illinois, Maryland, New Hampshire, New York State, Tennessee, and Wisconsin) that did not report, did not report by number of previous live births, or did not meet reporting standards.
† Percentages for the individual component categories might not add to 100% because of rounding.
§ Percentage is calculated as the number of abortions reported by known number of previous live births divided by the sum of abortions reported by known and unknown number of previous live births. Values ≥99.95% are rounded to 100.0%.
¶ Recorded as the number of previous pregnancies carried to term.
** Cells with a numerical value in the range of 1–4 and cells that would allow for calculation of these small values have been suppressed.
†† Reporting to the central health agency is not required. Data are requested from hospitals and licensed ambulatory care facilities only.
§§ Recorded as the number of living children.
¶¶ Percentage based on a total of 517,261 abortions reported among the areas that met reporting standards for the number of previous live births.

TABLE 9. Number of reported abortions, by known number of previous induced abortions and reporting area of occurrence — selected reporting areas,* United States, 2020

	No. of previous induced abortions				Total abortions reported by known number of previous induced abortions
	0	1	2	≥3	
Area	No. (%)†	No. (%)	No. (%)	No. (%)	No. (% of all reported abortions)§
Alabama	3,721 (65.1)	1,300 (22.8)	465 (8.1)	227 (4.0)	**5,713 (100.0)**
Alaska	788 (65.3)	277 (23.0)	83 (6.9)	58 (4.8)	**1,206 (100.0)**
Arizona	8,557 (65.2)	3,108 (23.7)	1,013 (7.7)	442 (3.4)	**13,120 (98.8)**
Arkansas	2,011 (63.8)	635 (20.1)	293 (9.3)	215 (6.8)	**3,154 (100.0)**
Colorado	6,784 (68.8)	2,111 (21.4)	642 (6.5)	328 (3.3)	**9,865 (100.0)**
Delaware	1,391 (61.0)	529 (23.2)	215 (9.4)	145 (6.4)	**2,280 (100.0)**
Florida	41,715 (55.7)	18,992 (25.4)	8,142 (10.9)	6,019 (8.0)	**74,868 (100.0)**
Georgia	23,266 (62.0)	8,693 (23.2)	3,522 (9.4)	2,047 (5.5)	**37,528 (100.0)**
Hawaii	1,128 (64.9)	379 (21.8)	138 (7.9)	92 (5.3)	**1,737 (96.0)**
Idaho	1,339 (79.7)	250 (14.9)	66 (3.9)	24 (1.4)	**1,679 (99.9)**
Indiana	5,292 (68.2)	1,628 (21.0)	572 (7.4)	263 (3.4)	**7,755 (100.0)**
Iowa	2,771 (68.3)	798 (19.7)	298 (7.3)	188 (4.6)	**4,055 (99.9)**
Kansas	5,265 (70.0)	1,473 (19.6)	507 (6.7)	281 (3.7)	**7,526 (100.0)**
Kentucky	2,685 (65.4)	925 (22.5)	310 (7.6)	184 (4.5)	**4,104 (100.0)**
Louisiana	4,589 (61.4)	1,900 (25.4)	640 (8.6)	344 (4.6)	**7,473 (100.0)**
Maine	1,364 (66.2)	459 (22.3)	161 (7.8)	77 (3.7)	**2,061 (99.9)**
Massachusetts	8,263 (52.1)	4,264 (26.9)	1,931 (12.2)	1,391 (8.8)	**15,849 (96.3)**
Michigan	15,291 (51.6)	7,421 (25.0)	3,975 (13.4)	2,969 (10.0)	**29,656 (100.0)**
Minnesota	5,988 (58.0)	2,485 (24.0)	1,056 (10.2)	804 (7.8)	**10,333 (99.8)**
Mississippi	2,388 (67.1)	806 (22.6)	269 (7.6)	96 (2.7)	**3,559 (100.0)**
Missouri	127 (77.4)	23 (14.0)	9 (5.5)	5 (3.0)	**164 (98.2)**
Montana	722 (43.1)	631 (37.7)	218 (13.0)	104 (6.2)	**1,675 (100.0)**
Nebraska	1,630 (68.5)	496 (20.9)	148 (6.2)	104 (4.4)	**2,378 (100.0)**
Nevada	5,070 (59.2)	1,939 (22.7)	898 (10.5)	650 (7.6)	**8,557 (99.1)**
New Jersey¶	12,844 (55.9)	4,995 (21.7)	2,572 (11.2)	2,559 (11.1)	**22,970 (100.0)**
New York City	12,826 (38.2)	8,133 (24.2)	5,757 (17.1)	6,897 (20.5)	**33,613 (89.6)**
North Carolina	15,089 (56.8)	6,900 (26.0)	2,912 (11.0)	1,651 (6.2)	**26,552 (88.5)**
North Dakota	778 (66.3)	255 (21.7)	93 (7.9)	48 (4.1)	**1,174 (100.0)**
Ohio	11,085 (57.7)	4,757 (24.8)	2,056 (10.7)	1,304 (6.8)	**19,202 (93.2)**
Oklahoma	2,631 (69.5)	784 (20.7)	247 (6.5)	126 (3.3)	**3,788 (99.8)**
Oregon	4,408 (63.3)	1,535 (22.1)	598 (8.6)	418 (6.0)	**6,959 (99.5)**
Pennsylvania	16,900 (52.6)	7,839 (24.4)	3,917 (12.2)	3,467 (10.8)	**32,123 (100.0)**
Rhode Island	1,513 (58.0)	640 (24.5)	278 (10.7)	178 (6.8)	**2,609 (99.9)**
South Carolina	3,629 (66.4)	1,143 (20.9)	446 (8.2)	250 (4.6)	**5,468 (100.0)**
South Dakota	82 (65.6)	28 (22.4)	10 (8.0)	5 (4.0)	**125 (100.0)**
Texas	34,757 (63.0)	13,278 (24.1)	4,669 (8.5)	2,428 (4.4)	**55,132 (100.0)**
Utah	1,742 (74.3)	477 (20.3)	101 (4.3)	25 (1.1)	**2,345 (99.3)**
Vermont	817 (66.6)	267 (21.8)	91 (7.4)	52 (4.2)	**1,227 (100.0)**
Virginia	8,087 (51.8)	4,585 (29.4)	1,776 (11.4)	1,156 (7.4)	**15,604 (100.0)**
Washington	10,056 (59.5)	3,910 (23.1)	1,612 (9.5)	1,322 (7.8)	**16,900 (99.9)**
West Virginia	636 (63.5)	232 (23.2)	77 (7.7)	56 (5.6)	**1,001 (100.0)**
Wyoming	65 (71.4)	21 (23.1)	5 (5.5)	0 (0.0)	**91 (100.0)**
Total	**290,090 (57.7)**	**121,301 (24.1)**	**52,788 (10.5)**	**38,999 (7.8)**	**503,178 (98.1)****

* Data from 42 reporting areas; excludes 10 reporting areas (California, Connecticut, the District of Columbia, Illinois, Maryland, New Hampshire, New Mexico, New York State, Tennessee, and Wisconsin) that did not report, did not report by number of previous induced abortions, or did not meet reporting standards.
† Percentages for the individual component categories might not add to 100% because of rounding.
§ Percentage is calculated as the number of abortions reported by known number of previous induced abortions divided by the sum of abortions reported by known and unknown number of previous induced abortions. Values ≥99.95% are rounded to 100.0%.
¶ Reporting to the central health agency is not required. Data are requested from hospitals and licensed ambulatory care facilities only.
** Percentage based on a total of 512,968 abortions reported among the areas that met reporting standards for the number of previous induced abortions.

TABLE 10. Number of reported abortions, by known weeks of gestation* and reporting area of occurrence — selected reporting areas,† United States, 2020

	Weeks of gestation							Total abortions reported by known gestational age
	≤6	7–9	10–13	14–15	16–17	18–20	≥21	
Area	No. (%)§	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (% of all reported abortions)¶
Alabama**	1,333 (23.4)	2,746 (48.2)	1,072 (18.8)	234 (4.1)	144 (2.5)	130 (2.3)	37 (0.6)	**5,696 (99.7)**
Alaska	308 (25.5)	614 (50.9)	198 (16.4)	56 (4.6)	30 (2.5)	0 (—)	0 (—)	**1,206 (100.0)**
Arizona	3,799 (28.6)	6,252 (47.1)	2,060 (15.5)	524 (3.9)	211 (1.6)	258 (1.9)	169 (1.3)	**13,273 (100.0)**
Arkansas**	429 (13.6)	1,471 (46.6)	915 (29.0)	138 (4.4)	90 (2.9)	85 (2.7)	26 (0.8)	**3,154 (100.0)**
Colorado	4,671 (47.3)	3,495 (35.4)	970 (9.8)	195 (2.0)	147 (1.5)	130 (1.3)	261 (2.6)	**9,869 (100.0)**
Delaware	628 (27.6)	1,209 (53.2)	337 (14.8)	79 (3.5)	9 (0.4)	—††	—††	**2,272 (99.6)**
Florida	55,834 (74.6)	11,686 (15.6)	4,768 (6.4)	1,005 (1.3)	652 (0.9)	704 (0.9)	219 (0.3)	**74,868 (100.0)**
Georgia	17,478 (46.6)	14,184 (37.8)	3,877 (10.3)	833 (2.2)	483 (1.3)	526 (1.4)	152 (0.4)	**37,533 (100.0)**
Hawaii	717 (39.6)	719 (39.7)	215 (11.9)	50 (2.8)	42 (2.3)	36 (2.0)	30 (1.7)	**1,809 (100.0)**
Idaho	512 (30.6)	814 (48.6)	271 (16.2)	53 (3.2)	16 (1.0)	—††	—††	**1,675 (99.7)**
Indiana	2,061 (26.6)	4,244 (54.7)	1,382 (17.8)	14 (0.2)	10 (0.1)	19 (0.2)	26 (0.3)	**7,756 (100.0)**
Iowa	2,001 (49.3)	1,407 (34.7)	442 (10.9)	79 (1.9)	67 (1.7)	51 (1.3)	11 (0.3)	**4,058 (100.0)**
Kansas	3,120 (41.5)	2,748 (36.5)	1,092 (14.5)	238 (3.2)	135 (1.8)	152 (2.0)	40 (0.5)	**7,525 (100.0)**
Kentucky	1,320 (32.2)	1,773 (43.2)	590 (14.4)	147 (3.6)	104 (2.5)	135 (3.3)	35 (0.9)	**4,104 (100.0)**
Louisiana	2,351 (31.5)	3,185 (42.6)	1,389 (18.6)	316 (4.2)	179 (2.4)	52 (0.7)	0 (—)	**7,472 (100.0)**
Maine	746 (36.2)	955 (46.3)	267 (12.9)	43 (2.1)	27 (1.3)	25 (1.2)	0 (—)	**2,063 (100.0)**
Michigan	11,427 (38.7)	11,775 (39.8)	3,891 (13.2)	956 (3.2)	643 (2.2)	524 (1.8)	349 (1.2)	**29,565 (99.6)**
Minnesota	4,202 (41.4)	3,813 (37.5)	1,213 (11.9)	347 (3.4)	201 (2.0)	186 (1.8)	200 (2.0)	**10,162 (98.2)**
Mississippi	1,181 (33.2)	1,716 (48.2)	485 (13.6)	160 (4.5)	14 (0.4)	—††	—††	**3,559 (100.0)**
Missouri	6 (3.6)	30 (18.0)	—††	22 (13.2)	—††	24 (14.4)	39 (23.4)	**167 (100.0)**
Montana	717 (43.0)	658 (39.4)	201 (12.0)	39 (2.3)	29 (1.7)	—††	—††	**1,669 (99.6)**
Nebraska	963 (40.5)	914 (38.4)	330 (13.9)	86 (3.6)	43 (1.8)	30 (1.3)	12 (0.5)	**2,378 (100.0)**
Nevada	3,426 (40.0)	3,405 (39.7)	1,119 (13.1)	239 (2.8)	150 (1.7)	138 (1.6)	97 (1.1)	**8,574 (99.3)**
New Jersey§§	9,704 (43.2)	7,927 (35.3)	2,567 (11.4)	840 (3.7)	550 (2.4)	461 (2.1)	424 (1.9)	**22,473 (97.8)**
New Mexico	1,467 (40.0)	1,081 (29.5)	419 (11.4)	103 (2.8)	90 (2.5)	132 (3.6)	372 (10.2)	**3,664 (85.3)**
New York City	16,732 (44.6)	13,281 (35.4)	4,256 (11.3)	1,003 (2.7)	652 (1.7)	825 (2.2)	773 (2.1)	**37,522 (100.0)**
North Carolina	11,310 (38.2)	12,314 (41.6)	4,118 (13.9)	870 (2.9)	503 (1.7)	473 (1.6)	48 (0.2)	**29,636 (98.8)**
North Dakota	448 (38.2)	483 (41.1)	183 (15.6)	47 (4.0)	11 (0.9)	—††	—††	**1,174 (100.0)**
Ohio	5,695 (27.6)	9,396 (45.6)	3,405 (16.5)	891 (4.3)	562 (2.7)	543 (2.6)	113 (0.5)	**20,605 (100.0)**
Oklahoma	1,768 (46.9)	1,362 (36.1)	484 (12.8)	69 (1.8)	28 (0.7)	48 (1.3)	14 (0.4)	**3,773 (99.4)**
Oregon	3,286 (47.0)	2,436 (34.9)	761 (10.9)	181 (2.6)	120 (1.7)	95 (1.4)	110 (1.6)	**6,989 (100.0)**
Rhode Island	983 (37.7)	1,065 (40.9)	373 (14.3)	66 (2.5)	55 (2.1)	48 (1.8)	16 (0.6)	**2,606 (99.8)**
South Carolina**	1,210 (22.1)	2,003 (36.6)	1,936 (35.4)	294 (5.4)	—††	—††	12 (0.2)	**5,468 (100.0)**
South Dakota	17 (13.7)	55 (44.4)	49 (39.5)	—††	—††	—††	—††	**124 (99.2)**
Texas**	22,093 (40.1)	21,849 (39.6)	7,205 (13.1)	1,902 (3.4)	1,016 (1.8)	784 (1.4)	283 (0.5)	**55,132 (100.0)**
Utah	857 (36.3)	864 (36.6)	430 (18.2)	83 (3.5)	48 (2.0)	51 (2.2)	29 (1.2)	**2,362 (100.0)**
Vermont	590 (48.1)	455 (37.1)	97 (7.9)	37 (3.0)	13 (1.1)	18 (1.5)	16 (1.3)	**1,226 (99.9)**
Virginia	8,578 (55.0)	4,883 (31.3)	1,695 (10.9)	101 (0.6)	99 (0.6)	139 (0.9)	108 (0.7)	**15,603 (100.0)**
Washington	7,291 (43.2)	6,457 (38.3)	1,818 (10.8)	433 (2.6)	247 (1.5)	279 (1.7)	346 (2.1)	**16,871 (99.8)**
West Virginia	286 (28.6)	440 (44.0)	195 (19.5)	57 (5.7)	15 (1.5)	—††	—††	**1,001 (100.0)**
Wyoming	49 (54.4)	38 (42.2)	—††	—††	0 (—)	0 (—)	0 (—)	**90 (98.9)**
Total	**211,594 (45.3)**	**166,202 (35.6)**	**57,108 (12.2)**	**12,830 (2.7)**	**7,456 (1.6)**	**7,154 (1.5)**	**4,382 (0.9)**	**466,726 (99.6)¶¶**

* Gestational age based on clinician's estimate (Alaska, Arizona, Colorado, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, New York City, North Carolina, North Dakota, Ohio, Oregon, Rhode Island, South Dakota, Vermont, Washington, West Virginia, and Wyoming); gestational age calculated from the last normal menstrual period (Oklahoma and Utah); clinician's estimate of gestation based on estimated date of conception (Virginia); and probable postfertilization age (Alabama, Arkansas, South Carolina, and Texas).

† Data from 41 reporting areas; excludes 11 reporting areas (California, Connecticut, the District of Columbia, Illinois, Maryland, Massachusetts, New Hampshire, New York State, Pennsylvania, Tennessee, and Wisconsin) that did not report, did not report by gestational age, or did not meet reporting standards.

§ Percentages for the individual component categories might not add to 100% because of rounding.

¶ Percentage is calculated as the number of abortions reported by known gestational age divided by the sum of abortions reported by known and unknown gestational age. Values ≥99.95% are rounded to 100.0%.

** Two weeks were added to the probable postfertilization age to provide a corresponding measure to gestational age based on the clinician's estimate.

†† Cells with a numerical value in the range of 1–4 and cells that would allow for calculation of these small values have been suppressed.

§§ Reporting to the central health agency is not required. Data are requested from hospitals and licensed ambulatory care facilities only.

¶¶ Percentage based on a total of 468,686 abortions reported among the areas that met reporting standards for gestational age.

TABLE 11. Percentage of reported abortions, by known weeks of gestation and year — selected reporting areas,* United States, 2011–2020

Weeks of gestation	Year										% Change	
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2019 to 2020	2011 to 2020
≤13 weeks' gestation (%)†	**91.3**	**91.2**	**91.4**	**90.8**	**90.9**	**90.9**	**91.1**	**91.5**	**92.0**	**92.5**	**0.5**	**1.3**
≤6	34.2	34.9	34.6	33.8	34.4	34.6	35.5	36.8	38.0	39.9	5.0	16.7
7–9	40.1	39.5	39.9	39.9	39.9	40.1	40.1	39.7	39.6	39.2	−1.0	−2.2
10–13	17.0	16.9	16.9	17.1	16.5	16.2	15.5	15.0	14.4	13.4	−6.9	−21.2
>13 weeks' gestation (%)†	**8.7**	**8.8**	**8.6**	**9.2**	**9.1**	**9.1**	**8.9**	**8.5**	**8.0**	**7.5**	**−6.3**	**−13.8**
14–15	3.4	3.5	3.4	3.6	3.5	3.5	3.4	3.3	3.2	3.0	−6.3	−11.8
16–17	1.9	1.9	2.0	2.3	2.2	2.2	2.2	2.0	1.9	1.8	−5.3	−5.3
18–20	1.9	2.0	1.9	2.0	2.1	2.1	2.0	1.9	1.8	1.7	−5.6	−10.5
≥21	1.4	1.4	1.4	1.4	1.4	1.3	1.3	1.2	1.2	1.1	−8.3	−21.4
Total no.§	**465,754**	**441,667**	**421,900**	**414,437**	**403,641**	**397,773**	**383,417**	**385,163**	**388,802**	**377,664**	**N/A**	**N/A**

Abbreviation: N/A = not applicable.

* Data from 33 reporting areas; excludes 19 areas (California, Connecticut, Delaware, the District of Columbia, Florida, Illinois, Maine, Maryland, Massachusetts, Mississippi, Nebraska, New Hampshire, New York State, Pennsylvania, Rhode Island, Tennessee, Vermont, Wisconsin, and Wyoming) that did not report, did not report by weeks of gestation, or did not meet reporting standards for ≥1 year.

† Percentages for the individual component categories might not add to 100% because of rounding.

§ By year, the total number of abortions represent 72.8%–94.4% of all abortions reported to CDC among the areas that met reporting standards for gestational age during 2011–2020.

TABLE 12. Number of reported abortions, by known method type and reporting area of occurrence — selected reporting areas,* United States, 2020

	Surgical†			Medical					
Area	Surgical, ≤13 weeks' gestation No. (%)¶	Surgical, >13 weeks' gestation No. (%)	Surgical, unknown gestational age No. (%)	Medical, ≤9 weeks' gestation No. (%)	Medical, >9 weeks' gestation No. (%)	Medical, unknown gestational age No. (%)	Intrauterine instillation§ No. (%)	Hysterectomy/ hysterotomy No. (%)	Total abortions reported by known method type No. (% of all reported abortions)**
Alabama††	2,641 (46.3)	541 (9.5)	8 (0.1)	2,411 (42.3)	94 (1.6)	9 (0.2)	0 (—)	0 (—)	**5,704 (99.8)**
Alaska	669 (55.5)	85 (7.1)	—§§	433 (35.9)	17 (1.4)	0 (—)	0 (—)	—§§	**1,205 (99.9)**
Arizona	5,506 (41.5)	933 (7.0)	0 (—)	6,329 (47.7)	343 (2.6)	0 (—)	154 (1.2)	0 (—)	**13,265 (99.9)**
Arkansas††	1,091 (34.6)	338 (10.7)	0 (—)	1,236 (39.2)	489 (15.5)	0 (—)	0 (—)	0 (—)	**3,154 (100.0)**
Colorado	2,320 (25.2)	390 (4.2)	0 (—)	6,217 (67.6)	263 (2.9)	0 (—)	0 (—)	0 (—)	**9,190 (93.1)**
Connecticut¶¶	N/A	N/A	3,157 (34.7)	N/A	N/A	5,942 (65.3)	—§§	—§§	**9,100 (99.8)**
Delaware	672 (29.7)	94 (4.2)	—§§	1,385 (61.3)	100 (4.4)	7 (0.3)	—§§	0 (—)	**2,260 (99.1)**
District of Columbia***	1,737 (39.3)	321 (7.3)	0 (—)	N/A	N/A	2,358 (53.4)	0 (—)	0 (—)	**4,416 (100.0)**
Florida	27,408 (38.2)	2,489 (3.5)	0 (—)	41,395 (57.7)	436 (0.6)	0 (—)	0 (—)	6 (0.0)	**71,734 (95.8)**
Georgia	12,673 (33.8)	1,984 (5.3)	0 (—)	22,174 (59.1)	702 (1.9)	0 (—)	0 (—)	0 (—)	**37,533 (100.0)**
Hawaii	767 (42.4)	158 (8.7)	0 (—)	875 (48.4)	9 (0.5)	0 (—)	0 (—)	0 (—)	**1,809 (100.0)**
Idaho	708 (42.2)	75 (4.5)	—§§	841 (50.1)	47 (2.8)	—§§	—§§	0 (—)	**1,677 (99.8)**
Indiana	3,439 (44.3)	58 (0.7)	0 (—)	4,165 (53.7)	94 (1.2)	0 (—)	0 (—)	0 (—)	**7,756 (100.0)**
Iowa	634 (15.6)	201 (5.0)	0 (—)	3,071 (75.7)	151 (3.7)	0 (—)	0 (—)	0 (—)	**4,057 (100.0)**
Kansas	1,918 (25.5)	561 (7.5)	—§§	4,749 (63.1)	297 (3.9)	—§§	0 (—)	0 (—)	**7,526 (100.0)**
Kentucky	1,598 (38.9)	419 (10.2)	0 (—)	2,080 (50.7)	7 (0.2)	0 (—)	0 (—)	0 (—)	**4,104 (100.0)**
Maine	527 (25.5)	92 (4.5)	—§§	1,343 (65.1)	101 (4.9)	—§§	0 (—)	0 (—)	**2,064 (100.0)**
Massachusetts†††	N/A	N/A	8,669 (52.7)	N/A	N/A	7,773 (47.3)	—§§	—§§	**16,443 (99.9)**
Michigan	11,771 (39.8)	2,377 (8.0)	54 (0.2)	14,444 (48.9)	844 (2.9)	45 (0.2)	—§§	—§§	**29,539 (99.6)**
Minnesota	3,688 (35.7)	913 (8.8)	50 (0.5)	5,221 (50.5)	335 (3.2)	135 (1.3)	0 (—)	0 (—)	**10,342 (99.9)**
Mississippi	388 (10.9)	170 (4.8)	—§§	2,788 (78.3)	212 (6.0)	0 (—)	0 (—)	—§§	**3,559 (100.0)**
Missouri	—§§	70 (43.5)	0 (—)	0 (—)	22 (13.7)	0 (—)	—§§	—§§	**161 (96.4)**
Montana	488 (29.1)	91 (5.4)	—§§	1,037 (61.9)	51 (3.0)	6 (0.4)	0 (—)	—§§	**1,675 (100.0)**
Nebraska	527 (22.2)	167 (7.0)	0 (—)	1,602 (67.4)	81 (3.4)	0 (—)	0 (—)	0 (—)	**2,377 (100.0)**
Nevada	3,357 (40.0)	617 (7.4)	27 (0.3)	4,133 (49.3)	219 (2.6)	27 (0.3)	—§§	—§§	**8,383 (97.1)**
New Jersey§§§	11,156 (48.6)	2,238 (9.7)	340 (1.5)	8,783 (38.2)	296 (1.3)	159 (0.7)	0 (—)	0 (—)	**22,972 (100.0)**
New Mexico	1,171 (31.4)	364 (9.8)	117 (3.1)	1,579 (42.3)	351 (9.4)	149 (4.0)	0 (—)	0 (—)	**3,731 (86.9)**
New York	30,161 (49.0)	4,948 (8.0)	1,234 (2.0)	20,588 (33.4)	2,229 (3.6)	2,287 (3.7)	72 (0.1)	34 (0.1)	**61,553 (97.5)**
New York City	20,957 (55.9)	3,094 (8.2)	—§§	12,850 (34.2)	558 (1.5)	—§§	25 (0.1)	34 (0.1)	**37,519 (100.0)**
New York State	9,204 (38.3)	1,854 (7.7)	—§§	7,738 (32.2)	1,671 (7.0)	—§§	47 (0.2)	0 (—)	**24,034 (93.8)**
North Carolina	9,731 (33.8)	1,818 (6.3)	62 (0.2)	16,395 (56.9)	735 (2.6)	72 (0.2)	—§§	—§§	**28,822 (96.1)**
North Dakota	372 (31.7)	58 (4.9)	—§§	740 (63.0)	—§§	0 (—)	0 (—)	0 (—)	**1,174 (100.0)**

See table footnotes on the next page.

TABLE 12. (*Continued*) Number of reported abortions, by known method type and reporting area of occurrence — selected reporting areas,* United States, 2020

	Surgical†			Medical					
Area	Surgical, ≤13 weeks' gestation No. (%)¶	Surgical, >13 weeks' gestation No. (%)	Surgical, unknown gestational age No. (%)	Medical, ≤9 weeks' gestation No. (%)	Medical, >9 weeks' gestation No. (%)	Medical, unknown gestational age No. (%)	Intrauterine instillation§ No. (%)	Hysterectomy/ hysterotomy No. (%)	Total abortions reported by known method type No. (% of all reported abortions)**
Ohio	8,659 (42.0)	2,090 (10.1)	—§§	9,711 (47.1)	140 (0.7)	0 (—)	0 (—)	—§§	**20,602 (100.0)**
Oklahoma	1,087 (29.3)	154 (4.2)	5 (0.1)	2,287 (61.7)	156 (4.2)	19 (0.5)	0 (—)	0 (—)	**3,708 (97.7)**
Oregon	2,407 (34.6)	447 (6.4)	—§§	3,911 (56.1)	197 (2.8)	—§§	0 (—)	—§§	**6,966 (99.6)**
Pennsylvania¶¶	N/A	N/A	15,757 (49.1)	N/A	N/A	16,349 (50.9)	—§§	—§§	**32,115 (100.0)**
Rhode Island	1,084 (41.6)	182 (7.0)	—§§	1,252 (48.0)	84 (3.2)	—§§	—§§	0 (—)	**2,608 (99.9)**
South Carolina††	1,463 (26.8)	311 (5.7)	0 (—)	2,546 (46.6)	1,142 (20.9)	0 (—)	—§§	—§§	**5,467 (100.0)**
South Dakota	75 (60.5)	—§§	0 (—)	41 (33.1)	7 (5.6)	—§§	0 (—)	0 (—)	**124 (99.2)**
Texas††	22,331 (40.5)	3,932 (7.1)	—§§	28,359 (51.4)	507 (0.9)	0 (—)	0 (—)	—§§	**55,130 (100.0)**
Utah	1,252 (53.0)	202 (8.6)	0 (—)	878 (37.2)	30 (1.3)	0 (—)	0 (—)	0 (—)	**2,362 (100.0)**
Vermont	223 (18.2)	77 (6.3)	—§§	890 (72.6)	35 (2.9)	—§§	0 (—)	0 (—)	**1,226 (99.9)**
Virginia	7,673 (49.3)	441 (2.8)	—§§	7,315 (47.0)	147 (0.9)	—§§	0 (—)	0 (—)	**15,577 (99.8)**
Washington	6,305 (37.4)	1,288 (7.6)	12 (0.1)	9,023 (53.5)	219 (1.3)	25 (0.1)	0 (—)	0 (—)	**16,872 (99.8)**
West Virginia	421 (42.1)	66 (6.6)	0 (—)	445 (44.5)	69 (6.9)	0 (—)	0 (—)	0 (—)	**1,001 (100.0)**
Wisconsin¶¶,¶¶¶	N/A	N/A	3,837 (60.6)	N/A	N/A	2,499 (39.4)	0 (—)	0 (—)	**6,336 (100.0)**
Wyoming	—§§	0 (—)	0 (—)	86 (96.6)	—§§	0 (—)	0 (—)	0 (—)	**89 (97.8)**
Total	**218,734 (40.0)**	**36,531 (6.7)**	—****	**278,947 (51.0)**	**12,943 (2.4)**	—††††	**241 (0.0)**	**72 (0.0)**	**547,468 (98.6)§§§§**

Abbreviation: N/A = not applicable.

* Data from 46 reporting areas; excludes six reporting areas (California, Illinois, Louisiana, Maryland, New Hampshire, and Tennessee) that did not report, did not report by method type, or did not meet reporting standards. Areas reporting by method type with unknown gestational age or gestational age reported was not compatible with categorizations presented in this table are not included.

† Includes uterine aspiration (might also be called dilation and curettage, aspiration curettage, suction curettage, manual vacuum aspiration, menstrual extraction, sharp curettage) and dilation and evacuation procedures.

§ Intrauterine instillations reported at ≤12 weeks' gestation were considered as unknown for method type.

¶ Percentages for the individual component categories might not add to 100% because of rounding.

** Percentage is calculated as the number of abortions reported by known method type divided by the sum of abortions reported by known and unknown method type. Values ≥99.95% are rounded to 100.0%.

†† Two weeks were added to the probable postfertilization age to provide a corresponding measure to gestational age based on the clinician's estimate.

§§ Cells with a numerical value in the range of 1–4 and cells that would allow for calculation of these small values have been suppressed.

¶¶ Numbers for surgical abortions ≤13 weeks and >13 weeks and medical abortions ≤9 weeks versus >9 weeks are not presented as gestational age reported was not compatible with these categorizations.

*** Gestational age based on clinician's estimate. Numbers for medical abortions at ≤9 weeks versus >9 weeks are not presented because gestational age reported was not compatible with these categorizations.

††† Numbers for surgical abortions at ≤13 weeks versus >13 weeks and for medical abortions at ≤9 weeks versus >9 weeks are not presented because gestational age data were not provided by method type.

§§§ Reporting to the central health agency is not required. Data are requested from hospitals and licensed ambulatory care facilities only.

¶¶¶ Includes residents only. Wisconsin reports as surgical, unspecified and does not differentiate surgical abortions from hysterectomy/hysterotomy. All abortions were reported as surgical or chemically induced. For this report, all surgical abortions were classified as surgical and all chemical abortions as medical.

**** For the total only, surgical abortions reported without a gestational age were distributed among the surgical abortion categories according to the distribution of surgical abortions at known gestational age.

†††† For the total only, medical abortions reported without a gestational age were distributed among the medical abortion categories according to the distribution of medical abortions at known gestational age.

§§§§ Percentage based on a total of 555,274 abortions reported among the areas that met reporting standards for method type.

TABLE 13. Number of reported abortions, by known weeks of gestation and method type — selected reporting areas,* United States, 2020

	Weeks of gestation							
	≤6	7–9	10–13	14–15	16–17	18–20	≥21	Total
Method type	**No. (%)†**	**No. (%)**	**No. (%)**	**No. (%)**	**No. (%)**	**No. (%)**	**No. (%)**	**No. (%)**
Surgical§								
≤13 weeks' gestation	66,200 (32.1)	66,659 (41.2)	46,364 (84.3)	N/A	N/A	N/A	N/A	**179,223 (39.5)**
>13 weeks' gestation	N/A	N/A	N/A	12,282 (98.8)	7,068 (97.7)	6,724 (96.2)	3,511 (86.3)	**29,585 (6.5)**
Medical¶								
≤9 weeks' gestation	140,098 (67.9)	94,922 (58.7)	N/A	N/A	N/A	N/A	N/A	**235,020 (51.8)**
>9 weeks' gestation	N/A	N/A	8,645 (15.7)	150 (1.2)	116 (1.6)	200 (2.9)	482 (11.8)	**9,593 (2.1)**
Intrauterine instillation	—**	—**	5 (0.0)	1 (0.0)	50 (0.7)	63 (0.9)	70 (1.7)	**189 (0.0)**
Hysterectomy/Hysterotomy	17 (0.0)	26 (0.0)	9 (0.0)	1 (0.0)	1 (0.0)	5 (0.1)	7 (0.2)	**66 (0.0)**
Total	**206,315 (100.0)**	**161,607 (100.0)**	**55,023 (100.0)**	**12,434 (100.0)**	**7,235 (100.0)**	**6,992 (100.0)**	**4,070 (100.0)**	**453,676 (100.0)**

Abbreviation: N/A = not applicable.

* Data from 40 reporting areas; excludes 12 reporting areas (California, Connecticut, the District of Columbia, Illinois, Louisiana, Maryland, Massachusetts, New Hampshire, New York State, Pennsylvania, Tennessee, and Wisconsin) that did not report, did not report by weeks of gestation, did not meet reporting standards, or did not have medical abortion as a specific category on their reporting form.

† For each gestational age category, percentages of all method types might not add to 100% because of rounding.

§ Includes uterine aspiration (might also be called dilation and curettage, aspiration curettage, suction curettage, manual vacuum aspiration, menstrual extraction, sharp curettage) and dilation and evacuation procedures.

¶ The administration of medication or medications to induce an abortion; at ≤9 weeks' gestation, typically involves the use of mifepristone and misoprostol and at >9 weeks' gestation, typically involves the use of vaginal prostaglandins.

** Intrauterine instillations reported at ≤12 weeks' gestation have not been included with known values.

TABLE 14. Number of reported abortions, by known weeks of gestation, age group, and race or ethnicity — selected reporting areas, United States, 2020

	Weeks of gestation							
	≤6	7–9	10–13	14–15	16–17	18–20	≥21	Total
Characteristic	**No. (%)**	**No. (%)**	**No. (%)**	**No. (%)**	**No. (%)**	**No. (%)**	**No. (%)**	**No. (%)**
Age group (yrs)*,†								
<15	259 (25.6)	358 (35.4)	205 (20.3)	68 (6.7)	40 (4.0)	46 (4.5)	35 (3.5)	1,011 (100.0)
15–19	14,336 (37.9)	14,230 (37.6)	5,837 (15.4)	1,346 (3.6)	810 (2.1)	803 (2.1)	507 (1.3)	37,869 (100.0)
20–24	57,008 (43.7)	48,095 (36.9)	16,649 (12.8)	3,601 (2.8)	2,087 (1.6)	1,916 (1.5)	1,090 (0.8)	130,446 (100.0)
25–29	62,751 (46.3)	48,366 (35.7)	16,062 (11.8)	3,497 (2.6)	2,072 (1.5)	1,846 (1.4)	1,064 (0.8)	135,658 (100.0)
30–34	43,986 (47.5)	32,087 (34.6)	10,599 (11.4)	2,434 (2.6)	1,319 (1.4)	1,350 (1.5)	921 (1.0)	92,696 (100.0)
35–39	23,761 (47.5)	16,931 (33.9)	5,696 (11.4)	1,362 (2.7)	807 (1.6)	859 (1.7)	562 (1.1)	49,978 (100.0)
≥40	8,846 (50.7)	5,505 (31.6)	1,823 (10.5)	481 (2.8)	294 (1.7)	303 (1.7)	182 (1.0)	17,434 (100.0)
Total	**210,947 (45.4)**	**165,572 (35.6)**	**56,871 (12.2)**	**12,789 (2.7)**	**7,429 (1.6)**	**7,123 (1.5)**	**4,361 (0.9)**	**465,092 (100.0)**
Race or ethnicity*,§								
Non-Hispanic								
White	49,617 (47.3)	36,387 (34.7)	12,313 (11.7)	2,692 (2.6)	1,481 (1.4)	1,520 (1.4)	867 (0.8)	104,877 (100.0)
Black	55,749 (43.6)	46,628 (36.5)	17,308 (13.5)	3,608 (2.8)	1,972 (1.5)	1,809 (1.4)	714 (0.6)	127,788 (100.0)
Other	9,564 (47.4)	6,876 (34.1)	2,325 (11.5)	555 (2.8)	331 (1.6)	286 (1.4)	219 (1.1)	20,156 (100.0)
Hispanic	34,236 (51.6)	21,446 (32.3)	7,059 (10.6)	1,514 (2.3)	878 (1.3)	816 (1.2)	425 (0.6)	66,374 (100.0)
Total	**149,166 (46.7)**	**111,337 (34.9)**	**39,005 (12.2)**	**8,369 (2.6)**	**4,662 (1.5)**	**4,431 (1.4)**	**2,225 (0.7)**	**319,195 (100.0)**

* Percentages for the individual component categories might not add to 100% because of rounding.

† Data from 41 reporting areas; excludes 11 reporting areas (California, Connecticut, the District of Columbia, Illinois, Maryland, Massachusetts, New Hampshire, New York State, Pennsylvania, Tennessee, and Wisconsin) that did not report, did not report weeks of gestation by age, or did not meet reporting standards.

§ Data from 28 reporting areas; excludes 24 reporting areas (California, Colorado, Connecticut, the District of Columbia, Hawaii, Illinois, Iowa, Louisiana, Maine, Maryland, Massachusetts, Nebraska, New Hampshire, New Jersey, New York City, New York State, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, Tennessee, Washington, and Wisconsin) that did not report, did not report weeks of gestation by race or ethnicity, or did not meet reporting standards.

TABLE 15. Number of deaths and case-fatality rates* for abortion-related deaths reported to CDC, by type of abortion — United States, 1973–2019†

	Type of abortion				
	Induced				
Year	Legal§	Illegal¶	Unknown**	Total	CFR per 100,000 legal abortions
1973–1977					**2.09**
1973	25	19	3	**47**	
1974	26	6	1	**33**	
1975	29	4	1	**34**	
1976	11	2	1	**14**	
1977	17	4	0	**21**	
1978–1982					**0.78**
1978	9	7	0	**16**	
1979	22	0	0	**22**	
1980	9	1	2	**12**	
1981	8	1	0	**9**	
1982	11	1	0	**12**	
1983–1987					**0.66**
1983	11	1	0	**12**	
1984	12	0	0	**12**	
1985	11	1	1	**13**	
1986	11	0	2	**13**	
1987	7	2	0	**9**	
1988–1992					**0.74**
1988	16	0	0	**16**	
1989	12	1	0	**13**	
1990	9	0	0	**9**	
1991	11	1	0	**12**	
1992	10	0	0	**10**	
1993–1997					**0.52**
1993	6	1	2	**9**	
1994	10	2	0	**12**	
1995	4	0	0	**4**	
1996	9	0	0	**9**	
1997	7	0	0	**7**	
1998–2002					**0.63**
1998	9	0	0	**9**	
1999	4	0	0	**4**	
2000	11	0	0	**11**	
2001	7	1	0	**8**	
2002	10	0	0	**10**	
2003–2007					**0.60**
2003	10	0	0	**10**	
2004	7	1	0	**8**	
2005	7	0	0	**7**	
2006	7	0	0	**7**	
2007	6	0	0	**6**	
2008–2012					**0.65**
2008	12	0	0	**12**	
2009	8	0	0	**8**	
2010	10	0	0	**10**	
2011	2	0	0	**2**	
2012	4	0	0	**4**	
2013–2019					**0.43**
2013	4	0	0	**4**	
2014	6	0	0	**6**	
2015	2	0	1	**3**	
2016	6	1	1	**8**	
2017	3	0	0	**3**	
2018	2	0	0	**2**	
2019	4	0	0	**4**	

Abbreviation: CFR = case-fatality rate.

* Number of legal induced abortion-related deaths per 100,000 reported legal induced abortions. Because a substantial number of legal induced abortions occurred outside reporting areas that provided data to CDC, national CFRs (i.e., number of legal induced abortion-related deaths per 100,000 reported legal induced abortions in the United States) were calculated with denominator data from the Guttmacher Institute's national survey of abortion-providing facilities. Case-fatality rates were computed for consecutive 5-year periods during 1973–2012 and then for a consecutive 7-year period during 2013–2019 because rates based on <20 cases might be unstable.

† Certain numbers might differ from those in reports published previously because additional information has been supplied to CDC subsequent to publication.

§ An abortion is defined as legal if it was performed by a licensed clinician within the limits of state law.

¶ An abortion is defined as illegal if it was performed by any person other than a licensed clinician.

** Unknown whether abortion was induced or spontaneous.

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Florida Data from the Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report Tables

Abortions by Area of Occurrence[1]	2020 Number	2020 Rate*	2020 Ratio**	2019 Number	2019 Rate*	2019 Ratio**
Abortions reported by area of occurrence	74,868	19.1	357	71,914	18.5	327
	Number	Percent		Number	Percent	
Abortions obtained by out-of-area residents	3,988	5.3		2,256	3.1	

Age Group[2]	2020 Number	2020 Percent	2019 Number	2019 Percent
<15	124	0.2	118	0.2
15–19	5,157	6.9	5,231	7.3
20–24	20,017	26.8	18,889	26.5
25–29	21,866	29.3	20,741	29.1
30–34	15,876	21.2	15,051	21.1
35–39	8,613	11.5	8,425	11.8
≥40	3,087	4.1	2,907	4.1
Total abortions reported by known age	74,740		71,362	

Weeks of Gestation[3]	2020 Number	2020 Percent	2019 Number	2019 Percent
≤6	55,834	74.6	52,850	73.5
7–9	11,686	15.6	11,641	16.2
10–13	4,768	6.4	4,843	6.7
14–15	1,005	1.3	973	1.4
16–17	652	0.9	691	1.0
18–20	704	0.9	699	1.0
≥21	219	0.3	217	0.3
Total abortions reported by known gestational age	74,868		71,914	

Abortions by Method Type[4]	2020 Number	2020 Percent	2019 Number	2019 Percent
Surgical*				
≤13 weeks' gestation	27,408	38.2	32,315	47.1
>13 weeks' gestation	2,489	3.5	2,505	3.7
unknown gestational age	0	(—)	0	(—)
Medical				
≤9 weeks' gestation	41,395	57.7	33,428	48.7
>9 weeks' gestation	436	0.6	352	0.5
unknown gestational age	0	(—)	0	(—)
Intrauterine instillation	0	(—)	0	(—)
Hysterectomy/Hysterotomy	6	0.0	8	0.0
Total abortions reported by known method type	71,734		68,608	

Sources: Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report (MMWR), November 25, 2022, Surveillance Summaries / Vol. 71 / No 10, Abortion Surveillance -- United States, 2020; Centers for Disease Control and Prevention MMWR, November 26, 2021, Surveillance Summaries / Vol. 70 / No 9, Abortion Surveillance -- United States, 2019

[1] MMWR Table 2

*Number of abortions per 1,000 women aged 15–44 years.

**Number of abortions per 1,000 live births.

The total abortions include those with known and unknown residence status.

Additional details on the reporting area in which abortions were provided, cross-tabulated by the area of residence, are available at https://www.cdc.gov/reproductivehealth/data_stats/Abortion.htm.

[2] MMWR Table 3

Percentages for the individual component categories might not add to 100% because of rounding.

[3] MMWR Table 10

Percentages for the individual component categories might not add to 100% because of rounding.

2020 -- Gestational age based on clinician's estimate (Alaska, Arizona, Colorado, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, New York City, North Carolina, North Dakota, Ohio, Oregon, Rhode Island, South Dakota, Vermont, Washington, West Virginia, and Wyoming); gestational age calculated from the last normal menstrual period (Oklahoma and Utah); clinician's estimate of gestation based on estimated date of conception (Virginia); and probable postfertilization age (Alabama, Arkansas, South Carolina, and Texas).

2019 -- Gestational age based on clinician's estimate (Alaska, Arizona, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, New York City, North Carolina, North Dakota, Ohio, Oregon, Rhode Island, South Dakota, Tennessee, Vermont, Washington, West Virginia, and Wyoming); gestational age calculated from the last normal menstrual period (Oklahoma and Utah); clinician's estimate of gestation based on estimated date of conception (Virginia); probable postfertilization age (Alabama, Arkansas, South Carolina, and Texas).

[4] MMWR Table 12

*Includes uterine aspiration (might also be called dilation and curettage, aspiration curettage, suction curettage, manual vacuum aspiration, menstrual extraction, sharp curettage) and dilation and evacuation procedures.

Percentages for the individual component categories might not add to 100% because of rounding.

Florida Abortions by Area of Residence	2020	2019
Alabama	1,170	309
Florida	70,880	69,658
Georgia	1,452	1,202
Louisiana	268	--
Mississippi	408	--
New York (City and State)	72	--
Texas	95	--
Out-of-area (exact residence unknown)	145	225
Total by location of service*	74,868	71,914
Outside of Florida	3,988	2,256
Alabama and Georgia	2,622	1,511
Percent that live in Alabama and Georgia	65.7%	67.0%

"--" Reporting area did not report, or data not reportable by CDC.

* Totals may not add, since 1) Not all states reported data, 2) Data not reportable by CDC, 3) Data for some states not reported by area of residence. The states that meet one or more of these conditions are: CA, MD, NH, and TN in 2020 and CA, MD, and NH in 2019.

Source: CDC, Abortions Distributed by Area of Residence and Area of Clinical Service, https://www.cdc.gov/reproductivehealth/data_stats/abortion.htm; https://www.cdc.gov/reproductivehealth/data_stats/excel/Abortions-Distributed-by-Area-2011-2020.xlsx

Florida Abortion Statistics				
Year	Total	Growth	Out-of-State	Growth
2017	69,102	-	2,771	-
2018	70,239	2%	2,654	-4%
2019	71,914	2%	2,256	-15%
2020	74,868	4%	3,988	77%
2021	79,817	7%	4,873	22%
2022	82,581	3%	6,726	38%

Prepared for the FIEC by the Office of Economic & Demographic Research, October 13, 2023. source: https://ahca.myflorida.com/health-care-policy-and-oversight/bureau-of-central-services/frequently-requested-data

Agency for Health Care Administration
Reported Induced Terminations of Pregnancy (ITOP)
Total Cases by Patient County of Residence

2022 - Year to Date Total Cases =57067

County Name	Total
Alachua	604
Baker	51
Bay	304
Bradford	51
Brevard	921
Broward	7562
Calhoun	*
Charlotte	202
Citrus	135
Clay	332
Collier	502
Columbia	118
Dade	11072
Desoto	61
Dixie	25
Duval	3134
Escambia	525
Flagler	175
Franklin	*
Gadsden	81
Gilchrist	*
Glades	*
Gulf	*
Hamilton	31
Hardee	28
Hendry	92
Hernando	277
Highlands	100
Hillsborough	4782

* : County totals of 20 or fewer are included in the statewide total, but are not displayed for patient confidentiality.

Agency for Health Care Administration
Reported Induced Terminations of Pregnancy (ITOP)
Total Cases by Patient County of Residence

2022 - Year to Date Total Cases = 57067

County Name	Total
Holmes	*
Indian River	218
Jackson	47
Jefferson	*
Lafayette	*
Lake	474
Lee	1363
Leon	887
Levy	49
Liberty	*
Madison	29
Manatee	641
Marion	592
Martin	196
Monroe	75
Nassau	94
Okaloosa	324
Okeechobee	68
Orange	3695
Osceola	836
Palm Beach	3694
Pasco	902
Pinellas	2283
Polk	1444
Putnam	109
St Johns	291
St Lucie	696
Santa Rosa	136
Sarasota	561

* : County totals of 20 or fewer are included in the statewide total, but are not displayed for patient confidentiality.

Agency for Health Care Administration
Reported Induced Terminations of Pregnancy (ITOP)
Total Cases by Patient County of Residence

2022 - Year to Date Total Cases =57067

County Name	Total
Seminole	778
Sumter	59
Suwannee	51
Taylor	27
Union	*
Volusia	817
Wakulla	43
Walton	76
Washington	*
Out of State	4201

* : County totals of 20 or fewer are included in the statewide total, but are not displayed for patient confidentiality.

Agency for Health Care Administration
Reported Induced Terminations of Pregnancy (ITOP)
Total Cases by Patient County of Residence

2023 - Year to Date Total Cases = 58230

County Name	Total
Alachua	567
Baker	41
Bay	269
Bradford	35
Brevard	839
Broward	7395
Calhoun	*
Charlotte	212
Citrus	134
Clay	341
Collier	549
Columbia	102
Dade	11835
Desoto	49
Dixie	31
Duval	2918
Escambia	354
Flagler	125
Franklin	*
Gadsden	79
Gilchrist	*
Glades	*
Gulf	*
Hamilton	32
Hardee	39
Hendry	99
Hernando	258
Highlands	115
Hillsborough	4849

* : County totals of 20 or fewer are included in the statewide total, but are not displayed for patient confidentiality.

Agency for Health Care Administration
Reported Induced Terminations of Pregnancy (ITOP)
Total Cases by Patient County of Residence

2023 - Year to Date Total Cases = 58230

County Name	Total
Holmes	*
Indian River	228
Jackson	35
Jefferson	*
Lafayette	*
Lake	484
Lee	1425
Leon	818
Levy	58
Liberty	*
Madison	25
Manatee	630
Marion	574
Martin	224
Monroe	52
Nassau	93
Okaloosa	245
Okeechobee	60
Orange	3825
Osceola	829
Palm Beach	3537
Pasco	842
Pinellas	2336
Polk	1656
Putnam	102
St Johns	247
St Lucie	675
Santa Rosa	108
Sarasota	597

* : County totals of 20 or fewer are included in the statewide total, but are not displayed for patient confidentiality.

Agency for Health Care Administration
Reported Induced Terminations of Pregnancy (ITOP)
Total Cases by Patient County of Residence

2023 - Year to Date Total Cases = 58230

County Name	Total
Seminole	811
Sumter	64
Suwannee	48
Taylor	23
Union	*
Volusia	856
Wakulla	41
Walton	67
Washington	*
Out of State	5216

* : County totals of 20 or fewer are included in the statewide total, but are not displayed for patient confidentiality.

Texas' 2021 Ban on Abortion in Early Pregnancy and Changes in Live Births

Texas' Senate Bill 8 (SB8) became law on September 1, 2021, banning abortions as early as 5 weeks after the start of one's last menstrual period. In the first month after SB8 went into effect, the total number of facility-based abortions provided to pregnant Texas residents in Texas or 1 of the 6 adjacent states decreased by 38% (2171 fewer abortions).[1] Many have speculated that as abortion becomes more difficult to access, people will be forced to carry pregnancies to term, thereby increasing births. However, no studies, to our knowledge, have examined fertility changes related to recent abortion restrictions. This study evaluated changes in the number of births in Texas associated with Texas' SB8 policy.

Supplemental content

Methods | We used publicly available monthly counts of live births in all 50 states plus the District of Columbia for 2016 through 2022 from National Center for Health Statistics birth certificate data.[2,3] The Johns Hopkins University Bloomberg School of Public Health institutional review board deemed this study exempt from ethical review.

We used a comparative interrupted time series with an augmented synthetic control approach to estimate differences between observed birth counts and counterfactual predictions of expected birth counts in Texas without SB8.[4] This approach used a weighted combination of states to create a synthetic "Texas" based on prepolicy (January 2016-March 2022) outcome and covariate trends. The covariates included the percentage of monthly births to birthing people who were non-US-born Hispanic, non-Hispanic Black, aged 35 years or older, college educated, and using Medicaid. We also used state fixed effects to account for unobserved state-specific factors. We treated births in April 2022 as the first birth cohort exposed to the policy change because they (if full term) were at most 7 to 10 weeks' gestation when SB8 went into effect on September 1, 2021. To evaluate whether our Texas results could be explained by a factor other than SB8 that was influencing fertility more broadly, we conducted 50 separate placebo tests in which we considered all states (and the District of Columbia) other than Texas as the "treated" state. We also confirmed that none of the states most heavily weighted in our synthetic control enacted new abortion restrictions during the relevant exposure period. We determined statistical significance by whether the 95% CI of the difference between the observed and predicted number of monthly births included 0; 95% CIs were estimated with a conformal inference procedure.[5] All analyses were performed in R version 4.3.0 with the AugSynth package.[4]

Results | We estimated that the SB8 policy was associated with 9799 additional births in Texas between April and December 2022 (observed births, 297 088; expected births based on counterfactual estimate, 287 289). We detected increases in monthly birth counts above expectation of 1.7% to 5.1%, although April, May, and July differences were not significant (**Table; Figure**). The largest difference occurred in December 2022, with 1674 (95% CI, 671.7-2675.2) births occurring above the predicted 32 913. Placebo test results indicate this pattern was only evident in Texas.

Discussion | This study found a greater than expected number of births in Texas in the months after a restrictive abortion law went into effect. Although there was an increase in abortions provided to Texans out of state[1] and requests for medication abortion pills obtained outside the formal health care system,[6] results suggest not everyone who might have received an abortion in the absence of SB8 was able to obtain one.

Limitations include the use of aggregate provisional birth count data from 2022 that lack information on birthing people's characteristics.[2] Additionally, results cannot be generalized because the analysis was restricted to 1 state.

Since the Supreme Court's 2022 *Dobbs v Jackson Women's Health Organization* decision, Texas has prohibited nearly all abortions, as have most neighboring states that provided key abortion access during the initial months of SB8. It is therefore crucial to continue closely monitoring any increases in the number of births that result from abortion restrictions because this may signal a curtailing of reproductive autonomy.

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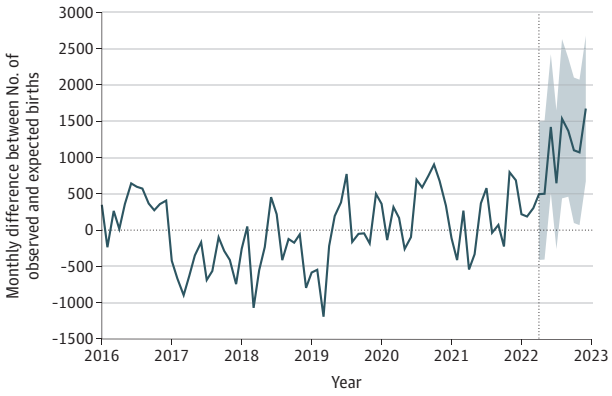
Table. Estimated Difference in Observed vs Expected Births in Texas in Months Affected by Senate Bill 8[a]

Month	Observed births	Expected births	Difference (95% CI)	% Increase (95% CI)
April	29 757	29 263.0	494.0 (−412.4 to 1495.7)	1.7 (−1.4 to 5.3)
May	30 387	29 887.2	499.8 (−406.5 to 1501.5)	1.7 (−1.4 to 5.2)
June	32 127	30 707.0	1420.0 (513.7 to 2421.7)	4.6 (1.6 to 8.2)
July	33 494	32 849.8	644.2 (−262.2 to 1645.9)	2.0 (−0.8 to 5.2)
August	36 539	35 005.9	1533.1 (436.0 to 2630.3)	4.4 (1.2 to 7.8)
September	33 799	32 433.3	1365.7 (459.3 to 2367.4)	4.2 (1.4 to 7.5)
October	33 018	31 919.2	1098.8 (97.1 to 2100.6)	3.4 (0.3 to 6.8)
November	33 381	32 311.4	1069.6 (67.9 to 2071.4)	3.3 (0.2 to 6.6)
December	34 586	32 912.5	1673.5 (671.7 to 2675.2)	5.1 (2.0 to 8.4)

[a] Observed birth data are for 2022 from the National Center for Health Statistics. Expected birth counts and corresponding statistics were calculated using a comparative interrupted time series with an augmented synthetic control approach.

Figure. Monthly Differences in the Number of Observed vs Expected Births in Texas, January 2016-December 2022



Horizontal line at 0 indicates no difference between the observed and expected number of monthly births; dotted vertical line is March 2022, corresponding to the last birth cohort not exposed to Texas' Senate Bill 8 that was used to generate the exposure period counterfactual; shading indicates the 95% CI in the policy exposure period. Observed birth data were from the National Center for Health Statistics. Expected birth counts and corresponding statistics were calculated using a comparative interrupted time series with an augmented synthetic control approach.

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Acquisition, analysis, or interpretation of data: All authors.
Drafting of the manuscript: Bell, Gemmill.
Statistical analysis: All authors.
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COMMENT & RESPONSE

Increasing All-Cause Mortality in US Children and Adolescents

To the Editor As public health researchers, we applaud the recent Viewpoint[1] that called attention to recent increases in child mortality. However, we believe that this Viewpoint did not acknowledge a child population that has been markedly underserved and generally understudied—rural children.

Rural children in the US have experienced marked disparities in mortality for years. In 1999, mortality among rural children (estimated 77.6 deaths per 100 000 residents) exceeded the parallel rate among urban children (estimated 66.4 deaths per 100 000 residents) by 17%.[2] By 2017, death rates had dropped among rural children in the US to 62.6 per 100 000 and among urban children in the US to 50.2 per 100 000, but the rural disparity increased to 25%.[2]

As we strive to meet the national *Healthy People 2030* goal of reducing US child mortality to 18.4 deaths per 100 000,[3] we must examine patterns among rural children to ascertain preventable causes of death and points of intervention. In 2016, motor vehicle crashes were the leading cause of death among children; the rate of such deaths was significantly higher for rural children than for suburban or urban children in the US.[4] Other conditions associated with higher death rates among rural children were drowning and fire and/or burns. All 3 of these conditions are influenced by parental actions, and all require rapid medical interventions that are less likely to be available in rural counties.

The Viewpoint's[1] focus on firearms and mental health issues, while reflecting current concerns, neglects the actual causes of death. Attention to policy factors that can influence child well-being, such as lack of uniformity in state laws governing the use of child restraints, might be more feasible and more effective. In addition, lack of clinicians and health care facilities in rural communities can have effects beyond direct health care. Research suggests that parents obtaining care from a pediatrician are more likely to remember seat belt guidance than those visiting family medicine physicians,[5] but most rural counties lack a pediatrician. Developing more pediatric rotations and residencies in rural areas could help address this gap and foster better anticipatory guidance for parents regarding rural risk exposures more generally.

Bringing about change and improving outcomes for rural children cannot happen unless we pay attention to these children and their unique circumstances. Without ongoing

FERTILITY EFFECTS OF ABORTION AND BIRTH CONTROL PILL ACCESS FOR MINORS*

MELANIE GULDI

This article empirically assesses whether age-restricted access to abortion and the birth control pill influence minors' fertility in the United States. There is not a strong consensus in previous literature regarding the relationship between laws restricting minors' access to abortion and minors' birthrates. This is the first study to recognize that state laws in place prior to the 1973 Roe v. Wade decision enabled minors to legally consent to surgical treatment—including abortion—in some states but not in others, and to construct abortion access variables reflecting this. In this article, age-specific policy variables measure either a minor's legal ability to obtain an abortion or to obtain the birth control pill without parental involvement. I find fairly strong evidence that young women's birthrates dropped as a result of abortion access as well as evidence that birth control pill access led to a drop in birthrates among whites.

Previous studies examining the impact of abortion legalization on birthrates have not recognized that at the time of abortion legalization, minors' access to abortion was limited by parental involvement laws in some U.S. states; and these studies have not considered the impact of a minor's access to the birth control pill (Levine 2004; Levine et al. 1999). Although the finding of a negative relationship between abortion legalization and birthrates is robust across studies, these results suffer from potential omitted variables bias because they do not account for minors' access to birth control pills (the Pill). More recently, authors have considered abortion legalization and legal access to the Pill in the same analysis. However, abortion access is measured by whether abortion is legal for adults in the state when a woman is a particular age (usually 18 or 21), and not by whether a minor had legal access to abortion (Ananat and Hungerman 2007; Bailey 2006; and Goldin and Katz 2002). Although these authors have found a negative relationship between early legal access to the Pill and births, the impact that minors' access to oral contraceptives had on birthrates during this period has not been studied extensively, and the contemporaneous impact of minors' legal access to abortion has not been examined. Unlike previous research, this study constructs policy variables to measure minors' legal access to abortion during the late 1960s and early 1970s and examines the impact that minors' access to abortion and the Pill have on birthrates.

Laws changing minors' access to abortion or the Pill alter the costs of preventing or terminating pregnancies. These cost changes have theoretically ambiguous impacts on birthrates.[1] Consequently, to determine the size and direction of the change in birthrates attributable to changes in minor access, data must be examined empirically.

*Melanie Guldi, Department of Economics, Mount Holyoke College, 50 College Street, South Hadley, MA 01075; e-mail: mguldi@mtholyoke.edu. I owe thanks to the editors of Demography and two anonymous referees as well as Martha Bailey, Elizabeth Cascio, Hilary Hoynes, Lisa Jepsen, Douglas L. Miller, Marianne Page, and Ann Stevens for insightful feedback on earlier drafts of this article. I am also grateful for the helpful comments from participants of the 2005 Western Economic Association International Conference, UC–Davis Brown Bag Seminar, and Sacramento State Brown Bag Seminar. Any remaining errors are my own.

1. An existing body of literature develops the economic theory of fertility and provides more technical detail (see, e.g., Akerlof, Yellen, and Katz 1996; Ananat et al. 2006; Becker 1960, 1981; Becker and Lewis 1973; Heckman and Willis 1975; Kane and Staiger 1996; Levine 2004; Levine and Staiger 2002; and Willis 1999). When the cost of the Pill and of abortion change simultaneously, the predicted impact on the birthrate is theoretically ambiguous and depends on (a) the cost of abortion relative to the cost of giving birth; (b) the cost of the Pill relative to its expected decrease in the probability of pregnancy; (c) the distribution of these costs across the population.

It is important to understand how large the behavioral response to the policy is because changes may affect minors' own outcomes as well as outcomes of the next generation. Recent work has shown that women's short- and long-term fertility as well as career and labor force outcomes are influenced by access to abortion and/or the Pill (Ananat, Gruber, and Levine 2007; Ananat and Hungerman 2007; Bailey 2006; and Goldin and Katz 2002). Additionally, children's outcomes—such as educational attainment, welfare use, criminal activity, and child fatal injury rates—have been associated with access to abortion and/or the Pill (Ananat et al. 2006; Charles and Stephens 2006; Donohue and Levitt 2001; Gruber, Levine, and Staiger 1999; Lott and Whitley 2007; Pantano 2007; Sen 2007). Some authors have argued that the impact on the next generation operates via a change in cohort size, while others have argued that the impact is due to a selection mechanism (Ananat et al. 2006; Lott and Whitley 2007). Still others have questioned the magnitude of the effect on the next generation (Foote and Goetz 2005; Joyce 2004). Regardless, it is important to understand how much fertility policies influence birthrates. This article explores the relative impacts of minors' access to abortion and the Pill on birthrates.

Previous work has found that abortion legalization decreased the teen birthrate by 2%–13% (Angrist and Evans 1999; Levine et al. 1999; Sklar and Berkov 1974). Other state-level research shows that laws restricting minors' access to abortion (beginning in the mid-1970s) had little effect on the birthrate (Bitler and Zavodny 2001; Blank, George, and London 1996; Cartoof and Klerman 1986; Joyce and Kaestner 1996; Joyce, Kaestner, and Colman 2006; Kane and Staiger 1996; Levine 2003; Rogers et al. 1991). However, these authors generally failed to account for access to contraception, and no author has examined the relationship between the birthrate and parental involvement laws that governed minors' access to abortion in the United States during the late 1960s and the 1970s.

This article explores the relationship among *minors'* access to abortion, *minors'* access to the Pill, and the birthrate. The impact of state law changes on the birthrates of women ages 15–21 is analyzed using a model that controls for age, state, year, and unrestricted state-year fixed effects. I find that for whites, providing minors with abortion access and/or access to the Pill leads to a reduction in birthrates. These effects are strongest among unmarried first-time mothers.

STATE LAWS REGULATING MINORS' ACCESS TO THE PILL AND TO ABORTION

The cost of pregnancy prevention was drastically reduced when the U.S. Food and Drug Administration (FDA) approved the nearly 100%-effective birth control pill (the Pill) in 1960. Almost immediately, married women began using it to control their fertility. However, unmarried women and minors were not afforded the same access as married women. The age at which a minor could obtain contraception without the consent of her parent(s) varied by state during the late 1960s and early 1970s. For some states during this period, the age of consent was simply the age of majority; for others, it was governed by a mature minor doctrine or an explicit medical consent law for minors.[2] Table 1 shows the number of states where minors of a particular age had legal access to the Pill without parental involvement for each year examined in this article.[3]

Even with the availability of the Pill, the cost of terminating unplanned pregnancies remained high until legislative and judicial action gave *adult* women legal access to

2. Bailey (2006) and Goldin and Katz (2002) discussed the legal environment related to the Pill more extensively.

3. The age at which a minor could have obtained the Pill without parental involvement is, in some states, the same age at which a minor could obtain other less-effective forms of contraception without parental involvement. In this article, *access to the Pill* can be thought of as access to contraception. Therefore, the interpretation of any results in this article could be construed more broadly as access to contraception rather than simply the birth control pill.

Table 1. Number of States With Minor Access, by Age of Minor and Year Giving Birth

		Access Measure					Access Measure		
Year	Age	Pill	Abortion	Both	Year	Age	Pill	Abortion	Both
1968	15	3	0	0	1972	15	14	3	0
1968	16	3	0	0	1972	16	16	3	0
1968	17	3	0	0	1972	17	16	4	1
1968	18	7	0	0	1972	18	32	7	5
1968	19	8	0	0	1972	19	35	7	6
1968	20	9	0	0	1972	20	37	7	6
1968	21	51	0	0	1972	21	51	7	7
1969	15	4	0	0	1973	15	17	14	8
1969	16	4	0	0	1973	16	20	14	9
1969	17	4	0	0	1973	17	20	15	10
1969	18	9	0	0	1973	18	43	42	38
1969	19	10	0	0	1973	19	46	44	42
1969	20	11	0	0	1973	20	46	44	42
1969	21	51	0	0	1973	21	51	51	51
1970	15	6	1	0	1974	15	17	17	8
1970	16	7	1	0	1974	16	20	18	10
1970	17	7	1	0	1974	17	20	19	11
1970	18	13	1	0	1974	18	49	48	47
1970	19	14	1	0	1974	19	51	50	50
1970	20	17	1	1	1974	20	51	50	50
1970	21	51	2	2	1974	21	51	51	51
1971	15	6	2	0	1975	15	21	22	12
1971	16	7	2	0	1975	16	24	23	14
1971	17	7	3	0	1975	17	24	24	15
1971	18	13	5	0	1975	18	50	49	49
1971	19	15	5	2	1975	19	51	51	51
1971	20	17	5	2	1975	20	51	51	51
1971	21	51	5	5	1975	21	51	51	51

(continued)

abortions beginning in the late 1960s.[4] In 1973, the landmark *Roe v. Wade* court decision legalized abortion for adult women, although not necessarily minors, in all states. Prior to *Roe v. Wade*, some states had reformed laws to allow for abortion under a number of circumstances, such as rape, incest, severe defect of the fetus, or when the health or life of the woman was in danger (Alan Guttmacher Institute 2003). Nine of these states incorporated

4. Prior authors (e.g., Bitler and Zavodny 2002; Levine et al. 1999; Merz, Jackson, and Klerman 1995; U.S. DHEW 1974) discussed the timing of legalized abortion in detail. In this article, I assume the following timing: California in 1969; Alaska, Hawaii, New York, and Washington in 1970; New Jersey and Vermont in 1972; and all other states in 1973.

(Table 1, continued)

		Access Measure					Access Measure		
Year	Age	Pill	Abortion	Both	Year	Age	Pill	Abortion	Both
1976	15	26	26	17	1977	19	51	51	51
1976	16	28	27	19	1977	20	51	51	51
1976	17	28	28	20	1977	21	51	51	51
1976	18	50	50	49	1978	15	27	35	19
1976	19	51	51	51	1978	16	29	35	21
1976	20	51	51	51	1978	17	29	36	22
1976	21	51	51	51	1978	18	50	50	49
1977	15	27	35	20	1978	19	51	51	51
1977	16	29	35	22	1978	20	51	51	51
1977	17	29	36	23	1978	21	51	51	51
1977	18	50	50	49					

Notes: Number of states that would have allowed a minor mother giving birth at age *a* access to the Pill at the time of pregnancy or to abortion within the first three months of pregnancy. Minors acquire access when state laws enable them to obtain an abortion or the Pill without parental involvement. Across data sources, there is sometimes disagreement with regard to laws governing minor access. When this is the case, I use the age that is most consistent across sources. This necessarily results in some mismatch relative to other articles using similar policy variables. If no specific access age is given in the data source or if the minimum falls below age 14, I code the age as 14 because this is the youngest age in the data I use.

Sources: Alan Guttmacher Institute (2003, 1978); Council of State Governments (1972, 1973); Merz et al. (1995); Paul and Pilpel (1979); Paul, Pilpel, and Wechsler (1974, 1976); and Pilpel and Wechsler (1969, 1971); U.S. DHEW (1974).

a parental involvement feature into their reformed statutes. Even after *Roe v. Wade*, some states continued to enforce the parental involvement component of the existing abortion laws, at least for some period. For example, South Carolina passed a parental consent law in January 1970. Although this law was ruled unconstitutional in July 1973, a new parental consent law was passed in 1974 (Merz et al. 1995; U.S. DHEW 1974). Also, some states passed parental involvement laws very shortly after *Roe v. Wade*. For example, South Dakota had a parental consent law for abortions beginning March 1973 (Merz et al. 1995). However, the majority of states did not have explicit parental involvement laws during the early 1970s, and such legislation did not become widespread until the 1980s (Greenberger and Connor 1991; Haas-Wilson 1996; Levine 2004; Merz et al. 1995).

The absence of parental involvement laws did not necessarily mean that minors had legal access to abortion. Abortion is considered a surgical procedure. Consequently, without an explicit parental involvement law, the legal ability of a minor to consent to medical treatment governed whether a minor had legal access to abortion. For some states, the laws that determined a minor's access to abortion and oral contraceptives were the same. In other states, minors of a certain age had access to the Pill but not to abortion (e.g., California and South Carolina) or vice versa (e.g., Nebraska and Washington).

States that enacted parental consent laws during the 1970s sometimes did not include a health exception. This meant that even if a young woman's life were at risk, parental consent would still be required to obtain an abortion. In July 1976, the U.S. Supreme Court ruled this to be unconstitutional in the case of *Planned Parenthood of Central Missouri v. Danforth*. Consequently, state parental consent laws without health exceptions were invalidated and presumably unenforceable after this ruling. After this ruling, minors in a subset of states gained legal access to abortion. In contrast, state parental-consent laws with a health exception but without a judicial-bypass feature could have been enforced

until the U.S. Supreme Court decision for *Bellotti v. Baird* in July 1979 (Paul and Pilpel 1979). Table 1 shows the number of states where minors could legally consent to having an abortion, taking the Pill, or doing both without parental involvement by age for each year from 1968 to 1978.

EMPIRICAL MODEL

Vital statistics data (U.S. DHHS 1968–1979), U.S. census data (1970–1980), and state-level policy variables described in Table 1 are combined into one data set. The dependent variable is the natural log of the birthrate. The birthrate is constructed by dividing the number of births by population (in thousands) for each age, race, and state group constructed. The empirical model employs a difference-of-difference-of-difference (DoDoD) estimator (Gruber 1994; Meyer 1995), which measures the impact of access to abortion and oral contraceptives on the birthrates of young women. Regressions are of the following form:

$$\begin{aligned}\text{Ln}(Birthrate)_{sat} = {} & \beta_1 + \beta_2 Pill_{sat} + \beta_3 Abortion_{sat} + \boldsymbol{\beta_4 \delta_s} + \boldsymbol{\beta_5 \tau_t} + \boldsymbol{\beta_6 A_a} \\ & + \boldsymbol{\beta_7 \delta_s X \tau_t} + \varepsilon_{sat}, \end{aligned} \tag{1}$$

where s is state of residence, a represents age of mother at birth, and t is the year when the mother gives birth. The dependent variable is the natural log of the number of births per thousand women in an age (see Eq. (2)):

$$\text{Ln}(Birthrate)_{sat} = \text{Ln}(Number\ of\ Births_{sat} / (Population_{sat} / 1{,}000). \tag{2}$$

Access is measured with two variables—$Pill_{sat}$ and $Abortion_{sat}$—and is determined by laws in place during the year in which a minor would have become pregnant (year $t - 1$) instead of the year when she would have given birth (year t) to take account of the difference in timing between law change and birth outcome. $Pill_{sat}$ is an indicator equal to 1 if a minor age a in state s in year t was old enough in the previous year to obtain birth control pills without her parent's consent. $Abortion_{sat}$ is an indicator equal to 1 if a minor of age a in state s and year t was old enough to obtain an abortion without parental consent in year $t - 1$.[5] Summary statistics are provided in Table 2.

The differences by race in minors' responses to changes in access to either the Pill or abortion (Angrist and Evans 1999; Henshaw and Kost 1992; Levine et al. 1999; Reddy, Fleming, and Swain 2002; and Zavodny 2004) suggest that it is important to examine the impact of these policies by race rather than by averaging the effect over a less-stratified group. Therefore, I perform the analysis separately by race. Age, state, and year fixed effects, as well as state-year fixed effects (a full set of indicator variables for state and year, fully interacted, that create coefficient vector $\boldsymbol{\beta_7}$), are included in all regressions to control for factors that may be correlated with the policy as well as the birthrate. The baseline specification compares different-aged individuals within states using age, state, year, and state-year fixed effects. The data are analyzed using ordinary least-squares (OLS) regression, weighted by the population of the state-year-age cell. Estimated heteroskedastic, robust standard errors take into account clustering[6] at the state level because errors may be serially correlated within state (Bertrand, Duflo, and Mullainathan 2004).

RESULTS

Results are presented in Table 3 separately for whites and nonwhites. Each column represents a separate regression. All regressions control for age, state, and year fixed effects, as

5. Alternatives to the timing used in these definitions of the policy variables are discussed later in the article.
6. These standard errors are computed using the cluster command in Stata version 9.2.

Table 2. Summary Statistics

	Observations	Mean	*SD*	Minimum	Maximum
Pill	8,568	0.480	0.500	0	1
Abortion	8,568	0.373	0.484	0	1
Age	8,568	18	2	15	21
Year	8,568	1973.5	3.5	1968	1979
Whites					
Birthrate	4,283	70.23	49.11	1.49	332.40
Ln(Birthrate)	4,284	3.89	0.99	–0.69	5.81
Population	4,284	33,154	34,876	652	192,621
Nonwhites					
Birthrate	4,194	127.19	64.86	4.20	602.57
Ln(Birthrate)	4,284	4.57	0.99	–0.69	6.40
Population	4,284	5,806	6,609	9	34,069

Notes: Each observation is at the state-year-age cell. *Birthrate* is the number of births per 1,000 women in the state-year-age cell, computed separately by race. When the birthrate = 0, ln(Birthrate) is replaced with ln(1 / 2). Pill = 1 if minor age a in state s in year t had access to the birth control pill without parental involvement in year $t - 1$. Abortion = 1 if minor age a in state s in year t had access to an abortion without parental involvement in year $t - 1$.

Source: As described in the text of the article, data on births come from the 1968–1979 Vital Statistics Natality Detail Files, and population estimates come from the U.S. Census Bureau. Policy Variables come from sources listed in the notes to Table 1.

well as state-year fixed effects.[7] Among whites, a minor's access to abortion and the Pill are associated with a drop in birthrates, whereas the evidence is much weaker for nonwhites. The findings are fairly robust across different specifications for abortion access, but less so for access to oral contraceptives.

The baseline results are reported in column 1 of Table 3. Access to the Pill ($Pill_{sat}$) is associated with a 8.5% drop in whites' birthrates, which is consistent with previous work showing that access to oral contraceptives increases age at first birth (Ananat and Hungerman 2007; Bailey 2006). Abortion access ($Abortion_{sat}$) is associated with a 10% drop in whites' birthrates.[8] This is in contrast to the near zero effect found by other authors examining 1980s state laws restricting minors' access to abortion (Bitler and Zavodny 2001; Blank et al. 1996; Cartoof and Klerman 1986; Joyce and Kaestner 1996; Joyce et al. 2006; Kane and Staiger 1996; Levine 2003; Rogers et al. 1991). The estimates in column 1 indicate that access to oral contraceptives and abortion have similar negative effects on whites' birthrates. In the baseline specification, no statistically significant relationship is found for nonwhites.

Birth Order, Nonmarital Births, and Marital Births

During the period considered, minors who were married or who were already mothers were usually emancipated, meaning that they would have had access to the Pill and/or abortion prior to many of the law changes discussed earlier in this article. Consequently, changes in laws governing minors' access would be expected to have little or no effect on the fertility decisions of minors who were already mothers or who were married when they became pregnant. This could attenuate the estimated relationship between births and access

7. Including state annual crime rate, unemployment rate, and state income per capita rather than state-year fixed effects yields results that are similar to those in the baseline specification.

8. The magnitude and significance of the Pill and abortion estimates do not change appreciably when they are estimated in separate regressions, rather than in the same regression.

Table 3. OLS Regression Coefficients Predicting the Birthrate, by Access to the Pill, Access to Abortion, and Type of Birth

	Births Data Used to Compute Dependent Variable							
	All Births (1)	Nonmarital Births (2)	First Births (3)	Nonmarital First Births (4)	Second+ Births (5)	All Births Monthly (6)	All Births (7)	All Births in Levels (8)
Whites								
Access to the Pill	–0.085*	–0.052	–0.090†	–0.083*	–0.036	0.019	–0.020	–7.599*
	(0.041)	(0.038)	(0.045)	(0.038)	(0.059)	(0.032)	(0.045)	(3.243)
Access to abortion	–0.100†	–0.172**	–0.098	–0.164**	–0.080	–0.155**	–0.137**	–14.412**
	(0.054)	(0.049)	(0.063)	(0.029)	(0.053)	(0.032)	(0.037)	(3.654)
Nonwhites								
Access to the Pill	0.009	0.016	–0.005	–0.048	0.088	0.051	0.051	–5.971
	(0.051)	(0.036)	(0.062)	(0.057)	(0.066)	(0.037)	(0.077)	(3.846)
Access to abortion	–0.030	–0.080*	–0.012	–0.001	0.006	–0.052	–0.104†	–12.834**
	(0.058)	(0.034)	(0.077)	(0.070)	(0.068)	(0.034)	(0.054)	(3.293)
Different Between Races?								
Access to the Pill	Yes	Yes	No	No	Yes	No	No	No
Access to abortion	No	Yes	No	Yes	No	Yes	No	No
Age, State, Year Fixed Effects	x	x	x	x	x	x	x	x
State × Year Unrestricted Fixed Effects	x	x	x	x	x	x	x	x
Month Fixed Effects						x		
Weighted by Population?	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
Number of Observations	4,284	4,284	4,284	4,284	4,284	47,124	4,284	4,284

Notes: Robust standard errors taking account of clustering at the state level are shown in parentheses. Regressions are weighted by population for each state-year-age cell. Each column in each panel represents a different regression. When birthrate = 0, ln(Birthrate) is replaced with ln(1 / 2) except in column 8, where it is zero. Access to the Pill = 1 if minor age *a* in state *s* in year *t* had access to the birth control pill without parental involvement in year $t-1$. Access to abortion = 1 if minor age *a* in state *s* in year *t* had access to abortion without parental involvement in year $t-1$. Because of space constraints, the coefficient estimates for the other variables are not reported.

†$p < .10$; *$p < .05$; **$p < .01$

in the current analysis. To address this issue, I first perform the analysis using only births to unmarried women to construct birthrates. Although marital status cannot be accurately measured in the vital statistics data for all states over the period, using proxies for marital status—such as fathers' characteristics reported (or not reported) on the birth certificate in conjunction with marital status information[9]—I construct birthrates of unmarried mothers. These results (column 2, Table 3) show that abortion access is associated with a larger decrease in the nonmarital birthrate (17.2% for whites; 8% for nonwhites) relative to the baseline, which is expected if the original results were attenuated by including marital births in the analysis. Access to oral contraceptives is not measured with statistical significance. Next, I examine first births (column 3, Table 3). There is weak evidence that access to the Pill decreases first birthrates for whites. However, no other conclusions can be drawn. This leads to the next specification. If the group of women most likely to have been affected by any law changes is unmarried women having first births, then the estimate for each policy variable should be least attenuated for this group. When only nonmarital first-time births are used to construct birthrates, estimates show that access to the Pill and access to abortion each have a significant negative relationship with whites' birthrates (column 4, Table 3). All estimates based on second or higher-order births are statistically insignificant (column 5, Table 3). A test of the null hypothesis that there are no differences by race indicates that when differences do exist, both access to abortion and access to the Pill have a larger (more negative) relationship with birthrates for whites than nonwhites. Taken together, these results indicate that abortion access has a slightly larger impact on birthrates than access to oral contraceptives; whites responded to laws governing minors' access to the Pill, whereas conclusions cannot be drawn for nonwhites. Finally, adjusting for birth order and/or marital status increases the magnitude of the abortion estimates.

Robustness Checks

The results from the baseline specification are compared with regressions performed on monthly data, regressions in which the dependent variable is measured in levels rather than logs, and regressions performed without weighting by population. Tightening the time period between observed policy change and observed birth, using monthly data, reduces measurement error attributable to (1) the different timing of taking oral contraceptives versus abortion technology (the Pill must be taken prior to pregnancy, whereas abortion occurs after pregnancy); and (2) the inability to observe the mother's exact birthday in the vital statistics data. Monthly policy variables are defined as whether a woman age a had access in month $m - 6$ (abortion) or in month $m - 9$ (the Pill). The specification also includes month fixed effects. Estimates obtained from monthly data are reported in column 6 (Table 3). The estimates for abortion access are slightly higher than those found in the baseline regression, which supports a measurement error explanation. The estimate for oral contraceptives is not statistically significant, which is a finding that I discuss in more detail later within this article. Columns 7 and 8 (Table 3) report results from unweighted regressions and regressions in which birthrate is measured in levels rather than in logs. From these three robustness checks, the finding that abortion access is associated with a decrease in birthrates is supported. However, these robustness checks reveal that the estimated relationship between access to the Pill and birthrates is more tenuous.

DISCUSSION

Using robust DoDoD methods, the results presented in this article offer evidence that birthrates fall with increases in minors' access to abortion, and that this drop is larger for whites than nonwhites. Among whites, access to oral contraceptives is also negatively related to birthrates. These results indicate that granting minors access to these means of reproductive

9. I am grateful for an anonymous referee who suggested this approach.

control has an impact on birthrates above and beyond any impact that changes in adult access laws have. The magnitude of the coefficient estimates is meaningful from a policy perspective. For example, they indicate that minors' access to abortion leads to an additional 8%–15% drop in birthrates in addition to any changes resulting from legalized abortion.

The coefficient estimates for access to oral contraceptives are generally smaller in magnitude than those for abortion access. One reason that the estimated relationship between access to the Pill and birthrates is smaller in general is that oral contraceptive technology is inherently different from abortion technology. To avert a birth, abortion requires a one-time action, whereas taking the Pill requires continual action. In addition, the impact of access to oral contraceptives on birthrates may be muted by the Pill's failure rate, which is different across age and race categories (Ranjit et al. 2001). Because of technological differences, gaining access to the Pill may produce a fuzzier break in the birthrate trend than gaining access to abortion. These two features of oral contraceptive technology may work together to attenuate any observed relationship between access to the Pill and birthrates.

CONCLUSION

This article contributes to the existing literature on the Pill and abortion by empirically analyzing the relative impact of access to each on birthrates of young women. U.S. state law changes during the late 1960s and 1970s, which altered the age at which a minor could legally gain access to abortion and/or to the Pill, are used to construct new policy variables that measure abortion and oral contraceptive access differently by single year of age. When performing policy analysis, ignoring other factors that may be correlated with the policy change (such as state-specific trends) could bias estimates. To mitigate this potential source of bias, unrestricted, state-year fixed effects are incorporated into the model. Overall, the results show that laws that increased minors' access to abortion in the 1960s and 1970s had a larger impact on minors' birthrates than laws that increased oral contraceptive access. The changes in minors' abortion and oral contraceptive access brought about by the changes in state and national laws in the late 1960s and early 1970s altered the costs that young women faced when making fertility decisions. Taken together, results presented in this article indicate that abortion access has a slightly larger estimated impact on birthrates than oral contraceptive access; that the magnitude of these results are meaningful; and that the group most affected by these changes are unmarried women experiencing a first birth. Although historical, the results in this article can inform contemporary debate on minors' access to reproductive control.

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Roe v Wade and American Fertility

ABSTRACT

Objectives. This article examines the effect of abortion legalization on fertility rates in the United States.

Methods. Fertility rates were compared over time between states that varied in the timing of abortion legalization.

Results. States legalizing abortion experienced a 4% decline in fertility relative to states where the legal status of abortion was unchanged. The relative reductions in births to teens, women more than 35 years of age, non-White women, and unmarried women were considerably larger. If women did not travel between states to obtain an abortion, the estimated impact of abortion legalization on birth rates would be about 11%.

Conclusions. A complete recriminalization of abortion nationwide could result in 440 000 additional births per year. A reversal of the *Roe v Wade* decision leaving abortion legal in some states would substantially limit this impact because of the extent of travel between states. (*Am J Public Health.* 1999;89:199–203)

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January 1998 marked the 25th anniversary of the Supreme Court decision in *Roe v Wade* (410 US 113) that legalized abortion nationwide. Since that decision, abortion policy has remained one of the most contentious of issues in American politics; as recently as 1992, the Supreme Court came within 1 vote of reversing the *Roe* decision (*Planned Parenthood of Southeastern Pennsylvania v Casey*, 505 US 833).[1] Although positions are largely developed on philosophical and moral grounds, the empirical magnitude of the effect of legal access to abortion is both important and rarely studied. Our purpose in this article is to estimate the effects of abortion legalization on fertility rates in the United States.

Surprisingly, little research has looked directly at the impact of *Roe v Wade* on births. The work that has been done has focused on the experience in those states that legalized abortion prior to *Roe*.[2-7] However, the experience of these states may result in a misleading impression of the impact of *Roe* for several reasons. First, since abortion was already effectively legalized in a handful of states, the effect of *Roe* may have been less pronounced than the effect of initial legalization because many women were already traveling across state lines to receive abortions.[8,9] Second, women in states where abortion was not legalized until the 1973 court decision may have been less likely to make use of abortion services, even if they were available, than women in states that chose to legalize abortion earlier. Third, many of the evaluations of legalization simply compared birth rates before and after legalization, thereby conflating the effect of abortion legalization with ongoing declines in fertility around that time that may have been attributable to changes in the availability of contraception, shifts in social attitudes, improved labor market opportunities for women, and the like.

In this study, we applied quasi-experimental methods to estimate the effects of initial abortion legalization in a handful of states and the later *Roe v Wade* decision that legalized abortion nationwide. We used variation in the timing of abortion liberalization across states to create (pseudo) control and treatment groups and compare birth data between groups. Our findings indicate that states that legalized abortion prior to the 1973 *Roe v Wade* Supreme Court ruling experienced a 4% decline in fertility rates relative to other states. Following the *Roe* decision, fertility rates in these other states fell by a similar magnitude relative to fertility rates in states that had legalized abortion earlier. The relative reductions in births to teens, women more than 35 years of age, non-White women, and unmarried women were considerably larger. In addition, we found that travel between states to obtain an abortion was significant. Estimates obtained from comparisons between early repeal states and distant states (where travel to obtain an abortion was least likely) indicate that abortion legalization reduced births by 11%. These findings imply that a nationwide prohibition of abortion would have a considerably larger impact on

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births than would a repeal of *Roe v Wade* in which abortion remained legal in a handful of states.

Data and Methods

We used the legislative history of abortion legalization across states (summarized in Levine et al.[10]) to identify the effects of policy changes on fertility rates. Before 1967, abortion was illegal nationwide except when necessary to save the life of the mother. Between 1967 and 1970, 12 states implemented modest reforms legalizing abortions under special circumstances such as rape or incest. Abortion was fully legalized in 4 states (New York, Washington, Alaska, and Hawaii) in 1970 and became widely available in California at about that time after a 1969 state supreme court ruling.[1,9] Following the 1973 US Supreme Court decision in *Roe v Wade*, abortion became legal in all states.

This legislative history enabled us to categorize states by abortion legality in different years and provided the means to estimate the nationwide impact of legalization. We used a quasi-experimental design and analyzed 3 different quasi-experiments. First, the effects of changes in state abortion laws prior to *Roe* were identified through comparison of fertility rates in these states before and after these changes with fertility rates in states where the legal status of abortion was unaltered before 1973. Second, in 1973 the effect of *Roe v Wade* was identified through comparison of fertility rates after 1973 in states that had not previously legalized abortion with fertility rates in states that had legalized earlier. In our empirical specifications, we also estimated whether this effect took place immediately or gradually.

The results of these analyses may understate the impact of abortion legalization if, prior to the *Roe* decision, birth rates fell in all states as women traveled to early legalization states to have an abortion. Therefore, we considered a third quasi-experiment comparing fertility rates in states that legalized abortion before 1973 with rates in other states that varied by their distance to a legalization state. Since women could travel to a state where abortion was legal (and were more likely to do so if they were closer), such comparisons allowed us to address the extent to which fertility rates in the control group states also declined. Among states that had not legalized abortion before 1973, we calculated whether the state was within 250 miles of, within 250 to 750 miles of, or more than 750 miles from a repeal state. These distances were chosen to roughly divide control group states into thirds, but one could interpret them according to the length of time it might take to drive to a repeal state (a half day or less, 1 day or less, or more than 1 day).

Within this quasi-experimental framework, we used regression analysis to estimate the differences in log fertility rates (the number of births observed per 1000 women of childbearing age) between groups of states following liberalization and whether these differences dissipated after abortion was legalized in all states in 1973. These regressions controlled for factors that could influence fertility, including demographic characteristics, the socioeconomic environment, state-specific indicator variables (to control for time-invariant differences in birth rates across states), year indicator variables (to control for national trends in birth rates), and interaction terms between state-specific indicators and a linear time trend (to control for differences in linear trends in birth rates across states). We also estimated comparable models for subgroups of women differing in terms of age, race, and marital status. Regressions were weighted by state population and involved more than 800 observations.

Most of the birth data for this analysis were obtained from *Vital Statistics of the United States*.[11] Fertility rates for each group were calculated via population estimates obtained from the US Bureau of the Census. We also used the 1980 census to estimate fertility rates by marital status. Using vital statistics data for this purpose was not possible, because administrative birth records in California and New York did not include marital status at that time. From the census data, we identified a "nonmarital" birth as one in which the child was born before the mother's first marriage. In comparison with the available data from *Vital Statistics of the United States*, these census estimates tend to understate the number of nonmarital births, particularly later in the sample period. Although they represent the best available data, some caution should be used in interpreting the results.

Results

Nationwide Patterns

Figure 1 displays the difference in fertility rates between repeal states and states with no law change. The pattern shows that differences were roughly constant through 1970. A sharp drop of about 6% observed in 1971 remained through 1973, indicating that fertility rates fell in repeal states relative to states with no law change during this period. Through 1974/75, the difference narrowed, and beginning in 1976 there were few differences between the states. The relative decline in fertility rates in repeal states occurred in exactly the years in which abortion was legal only in repeal states. The partial rebound in 1974/75 may indicate that abortion access in states affected by *Roe v Wade* increased less quickly following this decision relative to the rapid introduction of abortion services in repeal states in 1970. (A corresponding figure for reform states vs states with no legal changes showed no obvious difference in fertility rates over time and for purposes of brevity is not displayed here.)

Regression results are reported in Table 1, where the dependent variable is the log fertility rate. The coefficients shown are for a series of dummy variables indicating whether the state was a repeal or reform state during the years of abortion liberalization before *Roe* (e.g., 1971–1973 in repeal states), in one of the years immediately following *Roe* (1974/75), or in a later year (1976–1980). The omitted category is that comprising states with no law change prior to *Roe*; thus, all estimates are relative to these states.

The results reported in Table 1 indicate that abortion legalization had an effect on fertility rates among all women. Overall, births in repeal states fell by 4% relative to states with no law change between 1971 and 1973. No statistically significant difference in births between the 2 sets of states was observed in 1974/75 or from 1976 to 1980. In addition, these results provide no evidence that modest abortion reforms reduced birth rates, since the estimated differences between fertility rates in reform states and states with no law change were small in magnitude and imply that, if anything, modest reforms were associated with increased birth rates.

Table 1 also reports estimates from similar models for fertility among women in different population subgroups. Results indicate that abortion legalization reduced the relative fertility rates of teens and women 35 years of age and older by 12% and 8%, respectively, but only by 2% for women between 20 and 34 years of age. Estimates show that births to non-White women in repeal states (vs states with no law change) fell by 12% just following repeal, more than 3 times the effect on White women's fertility. Nonmarital births fell by almost twice the rate of marital births (5.5% [significant at the 10% level] vs 3.1%) in repeal states between 1971 and 1973 relative to states with no law change. All of these differences disappeared in the years following *Roe v Wade*.

Geographic Patterns

If women traveled to repeal states, the relative decline in fertility in repeal states

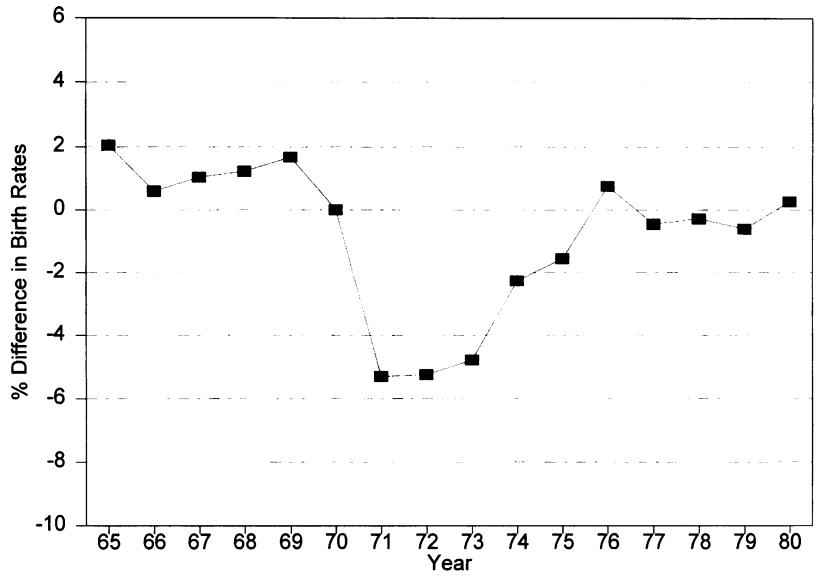

FIGURE 1—Normalized percentage differences in birth rates between repeal states and states with no law change (percentage differences were normalized to equal zero in 1970).

would understate the true effect of abortion legalization. To examine this hypothesis, we estimated models (see Table 2) analogous to those reported in Table 1, except that separate regressions were used, each including repeal states and one subgroup of nonrepeal states (including reform states) varying in their distance to a repeal state. Coefficient estimates represent the difference in birth rates between repeal states and nearby (less than 250 miles from a repeal state), middle-distance (between 250 and 750 miles), and distant (greater than 750 miles) nonrepeal states in the 3 time periods considered here. If travel occurred, then the relative decline in births in repeal states should be greater when compared with distant nonrepeal states than when compared with those less distant.

The results indicate that travel between states to obtain abortions was important. Births in repeal states fell by almost 11% relative to births in nonrepeal states more than 750 miles away but only by 4.5% relative to births in states less than 250 miles away and those in states between 250 and 750 miles away. Although not reported here, similar evidence was obtained indicating that travel was roughly equally common across all age groups, including teens. Assuming that no travel took place from distant states, these estimates for all births indicate that abortion legalization in New York, California, and a few other states in 1970 reduced the fertility rate in these states by almost 11%. The *Roe v Wade* decision had a similar effect on births in this group of distant states in the years following 1973.

These estimates can also be used to examine the extent to which birth rates fell between 1971 and 1973 in nonrepeal states as the result of travel to repeal states to obtain an abortion. To do so, we again assumed that women in states more than 750 miles away from repeal states did not travel to obtain abortions. Then the difference between the estimated reduction in birth rates in repeal states relative to that in states less than 250 miles away and states more than 750 miles away (6.32%) represents the extent to which births fell in the closest nonrepeal states owing to travel. A similar exercise for nonrepeal states between 250 and 750 miles away indicated that birth rates fell in those states by 6.25%. Taking a weighted average of all women by their distance from a repeal state, these estimates imply that travel to obtain an abortion led to a 4.5% decline in births to women in all nonrepeal states following legalization of abortion in repeal states.

Another interesting pattern in the results reported in Table 2 involves the rate at which the difference in fertility rates converged between early legalization states and states legalizing in 1973. In the set of states closest to early legalization states, there was no statistically significant difference in fertility rates as of the 1974/75 period. In the set of states farthest from early legalization states, a smaller but still statistically significant difference in fertility rates was observed during the 1974/75 period before convergence was observed by the 1976 to 1980 period. This pattern is consistent with slower growth in abortion access in these states. As reported in Table 3, states farther from repeal states still

TABLE 1—Effect of Abortion Legislation on Birth Rates

	Coefficient (× 100) (SE)							
		Age, y			Race		Marital Status	
Type of State	All Women of Childbearing Age	15–19	20–34	35–44	White	Non-White	Nonmarried	Married
Repeal								
1971–1973	–4.13 (0.81)	–12.08 (1.18)	–2.05 (0.79)	–7.86 (1.38)	–3.38 (0.90)	–11.63 (1.53)	–5.49 (3.12)	–3.05 (1.12)
1974/75	–0.14 (1.16)	–9.40 (1.68)	2.23 (1.13)	–1.64 (2.00)	–0.06 (1.30)	–3.16 (2.15)	4.90 (4.55)	–0.80 (1.71)
1976–1980	2.31 (1.60)	–4.25 (2.33)	3.74 (1.56)	3.65 (2.76)	2.49 (1.78)	4.91 (3.03)	8.23 (6.17)	2.59 (2.32)
Reform								
Enactment–1973	1.59 (0.51)	1.39 (0.72)	1.50 (0.50)	0.28 (0.88)	2.60 (0.57)	–2.21 (0.98)	–0.75 (1.85)	1.85 (0.70)
1974/75	1.59 (0.85)	1.33 (1.20)	1.44 (0.82)	1.56 (1.51)	1.82 (0.96)	1.93 (1.54)	1.24 (3.11)	0.95 (1.17)
1976–1980	0.14 (0.85)	0.06 (1.21)	0.66 (0.82)	3.95 (1.52)	–1.02 (0.96)	0.50 (1.57)	1.95 (3.09)	–1.09 (1.16)

Note. Dependent variables in these models were the natural logarithms of birth rates; thus, all coefficients can be interpreted as percentage changes. All specifications included the following control variables: share of women aged 15 to 19, 20 to 24, and 25 to 34 among women of childbearing age; share of state population that was non-White; per capita income; crime rate; insured unemployment rate; state and year fixed effects; and state-specific trends. Coefficients for repeal and reform state variables were estimated relative to states with no legislative change in abortion policies.

TABLE 2—Effect of Abortion Legislation on Birth Rates, by Year and Distance From Repeal State

Year of Repeal	Coefficient (× 100) (SE) Distance Less Than 250 Miles	Distance Between 250 and 750 Miles	Distance Greater Than 750 Miles
1971–1973	−4.45 (0.82)	−4.52 (1.04)	−10.77 (1.34)
1974/75	−1.70 (1.20)	−0.63 (1.44)	−5.50 (1.72)
1976–1980	−0.59 (1.64)	2.05 (1.94)	−0.60 (2.22)

Note. Dependent variables in these models were the natural logarithms of birth rates; thus, all coefficients can be interpreted as percentage changes. All specifications included the following control variables: share of women aged 15 to 19, 20 to 24, and 25 to 34 among women of childbearing age; share of state population that was non-White; per capita income; crime rate; insured unemployment rate; state and year fixed effects; and state-specific trends. Coefficients for repeal state variables were estimated relative to nonrepeal states, including those that instituted modest abortion reforms.

had lower abortion rates in 1976, along with a lower percentage of women in counties with abortion providers and a much larger fraction of women living more than 50 miles from the nearest abortion provider.

Discussion

What do these results reveal about the potential effects on birth rates if *Roe v Wade* were ever to be overturned? The answer depends on the uniformity of the ban on abortions across states. If *Roe* were supplanted by a constitutional amendment outlawing abortion nationwide, we might expect an 11% rise in fertility rates based on the experience of the early 1970s. Applying this estimate to the current level of births (roughly 4 million per year), we estimate that a complete recriminalization of abortion would result in perhaps as many as 440 000 additional births per year.

On the other hand, the effect might be considerably smaller if a future Supreme Court decision returned to states the authority to determine the legality of abortion. The increase in births would then depend on the number of states in which abortion remained legal and their geographic distribution (currently, 13 states have laws on the books to recriminalize abortion if *Roe v Wade* is overturned[12]). If the 5 repeal states were to maintain the legality of abortion, then our findings indicate that birth rates might still increase by perhaps 4.5% in the remaining states that recriminalize abortion. This would result in an increase in births on the order of 135 000 per year (4.5% of the roughly 3 million births in those states that recriminalize). If more states were to keep abortion legal, the effect on births probably would be smaller since interstate travel to obtain abortions would increase.

While our results provide a useful frame of reference, they have important limitations. Changes since 1973 in contraceptive technology, employment opportunities for women, social attitudes, and other factors have altered the environment in which fertility decisions are made. Moreover, a complete evaluation of the impact of overturning *Roe v Wade* would require consideration of other social, health, and demographic effects. Nevertheless, our results suggest that if *Roe v Wade* were overturned today, one of the effects would be a substantial rise in American fertility. □

Contributors

All authors conceived and designed the study and contributed to the construction of the data set. Drs Levine and Staiger analyzed the data and wrote the paper. Drs Kane and Zimmerman edited the final manuscript. All authors are guarantors of the integrity of the research.

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TABLE 3—Abortion Use and Access After *Roe v Wade*, by Distance From Repeal State

	Repeal States	Nonrepeal States: Less Than 250 Miles From a Repeal State	Nonrepeal States: Between 250 and 750 Miles From a Repeal State	Nonrepeal States: More Than 750 Miles From a Repeal State
Abortions per 1000 women aged 15–44 years, 1976	37.3	25.5	19.1	17.8
Women aged 15–44 years in 1976 living in counties with an abortion provider, %	96.8	77.0	52.1	55.9
Women aged 15–44 years in 1976 living in counties more than 50 miles from nearest county with an abortion provider, %	0.2	2.2	8.8	20.6

Note. Abortion rates by state of residence and data on counties with an abortion provider were provided by the Alan Guttmacher Institute. For each county, miles to nearest county with an abortion provider were calculated as straight-line distance between county population centroids. Population estimates for 1976, by county, were obtained from the National Cancer Institute.

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Tab 6

Media Sources

Republicans look to end Florida's abortion-haven legacy

Florida's proposal signals that the battle over reproductive rights will continue long after the Supreme Court's decision.

By **AREK SARKISSIAN**
03/12/2023 07:00 AM EDT

TALLAHASSEE, Fla. — Thousands of people have traveled to Florida from as far away as Texas to end their pregnancies since the Supreme Court dismantled *Roe v. Wade* in June — and Republicans want to put a stop to it.

Florida Republicans, who hold supermajorities in the Legislature, proposed a ban last week on abortions after six weeks of pregnancy — or two weeks after someone misses their period — and with Gov. Ron DeSantis' support, passage is almost guaranteed.

Abortion providers and Democrats are reeling over the proposed ban and what it means for people in Florida and those who travel to the Sunshine State specifically to get abortions. In the wake of the Supreme Court's decision, roughly 4,000 people traveled to Florida for the procedure, including from Texas and Alabama, where abortion is outlawed at any stage of pregnancy with some narrow exceptions when a patient's life is in danger.

"We're talking about thousands of people whose care will be delayed or new travel plans have to be made," Florida Rep. Anna Eskamani, a Democrat who previously worked at Planned Parenthood, said. "It shows this is truly a bill to be cruel just to be cruel."

Florida last year banned people from getting abortions after 15 weeks of pregnancy, with no exceptions for victims of rape or incest. But that law is still much less restrictive than other states across the South.

Florida's proposal signals that the battle over reproductive rights will continue long after the high court's decision and will be a major factor in the 2024 election cycle, especially as DeSantis eyes a likely presidential bid. DeSantis' support for the bill shows he's eager to continue courting the right wing of the GOP, regardless of how further restricting abortion will be received during a general election.

But Florida's legislation also highlights how a network of providers in the state, who created an infrastructure to help patients from Georgia, Mississippi and elsewhere get abortions in the state, will need to change tactics if the six-week ban is approved.

Monthly reports obtained from the Florida Agency for Health Care Administration show that 6,708 people came from outside the state to get an abortion last year, a more than 37 percent increase compared to 2021. The sharpest increase in visitors began after the Supreme Court ruling was handed down. There were 3,917 out-of-state abortions last year between June 1 and Dec. 31, a more than 140-percent increase compared to the same time period in 2021.

More than 82,000 people total received abortions in 2022.

Clara Trullenque, a spokesperson for Planned Parenthood of South, East and North Florida, said caseloads at clinics along the state's northern border quadrupled after the high court ruling.

“Our health centers in Tallahassee and Jacksonville receive more patients from other states where abortion access is even more restricted than it is in Florida,” Trullenque said in an email. “We are continuing to hire additional staff, extend hours and make every accommodation we can to ensure we can serve all of our patients.”

Amber Gavin, a vice president for A Woman’s Choice, an abortion clinic in Jacksonville, Fla., said a patchwork of national funding organizations, regional abortion support groups and local clinics emerged to help manage the skyrocketing number of patients.

“We’re working really closely with local and national abortion funds to make sure people who reach out to us can get care they need and that we get the care we need,” Gavin said. “There’s specialized funding to make sure they are able to get the funds to get their care.”

A Woman’s Choice’s clinic also provides information to patients from outside Florida who are looking to the Sunshine State for help. Its website states: “Need Help? We help with feeds, travel, and more. We provide abortion care from everywhere. In fact, your abortion could be fully covered if your State has banned or Severely Restricted Abortion Care, including: AL, AK, GA, KY, LA, MS, MO, OK, TN, and WV.”

Another complication is Florida’s 24-hour wait period law. A state circuit court ruling threw out a lawsuit challenging a requirement that people wait a day between an initial clinic visit and receiving an abortion. Gavin said that rule requires most out-of-state patients to make a two-day trip to Florida, and the subsequent costs of airfare, lodging, and child care quickly pile up.

“It’s already a barrier to have to come here,” Gavin said. “We’re talking about folks who are having to take off one to two days at work, the cost of travel and lodging.”

Data provided by AHCA, the state health agency, shows that most people who came to the state for an abortion over the past few years hailed from Alabama and Georgia but the number of clinics in North Florida has since dropped. In May of last year, AHCA shut down the only clinic in Pensacola after at least three patients suffered complications that were investigated for malpractice. With the Pensacola clinic closed, people were forced to seek access in already overwhelmed offices in Tallahassee and Jacksonville.

“They’ve just been coming from all over,” Gavin said.

The June Supreme Court ruling that led to the explosion of out-of-state visitors prompted regional support and logistics organizations, such as the Atlanta-based ARC Southeast, to reallocate the dollars it receives from much larger abortion fundraising groups to switch from covering doctor’s bills to paying for travel and lodging.

ARC Southeast Healthline Manager Elsie Vazquez said before the *Roe* ruling, only a small fraction of the money her group received went to those logistical costs. Now, at least half of that money goes toward those ancillary costs, which she called “practical support.”

“Due to the bans in many of the [southeast] states, hundreds of folks are having to travel long distances to get care,” Vazquez said. “And it’s one of the biggest barriers they face apart from paying for their abortion.”

Tab 7

EDR Supporting Materials

Criminal Justice System
October 19, 2023

Under current law, there are four felonies related to abortion that exist under Chapter 390. Section 390.0111, F.S., includes a Level 1, 3rd degree felony for "any person who willfully performs, or actively participates in, a termination of pregnancy in violation of the requirements of" how pregnancies should be terminated, including when it is permitted to terminate a pregnancy after the gestational age of 15 weeks, and when a partial-birth abortion or experimentation on a fetus are permitted. A Level 4, 2nd degree felony is also included for "any person who performs, or actively participates in, a termination of pregnancy in violation of this section or s. 390.01112 which results in the death of the woman." Additionally, it includes a Level 1, 3rd degree felony for a person who violates the requirements that an infant "born alive during or immediately after an attempted abortion" be treated like "any other child born alive in the course of natural birth." Section 390.01112, F.S., states that "no termination of pregnancy shall be performed on any human being if the physician determines that, in reasonable medical judgment, the fetus has achieved viability," with exceptions. Section 390.01114, F.S., includes a Level 1, 3rd degree felony for "a physician who intentionally or recklessly performs or induces, or attempts to perform or induce, a termination of a pregnancy of a minor without obtaining the required consent" from a parent or legal guardian.

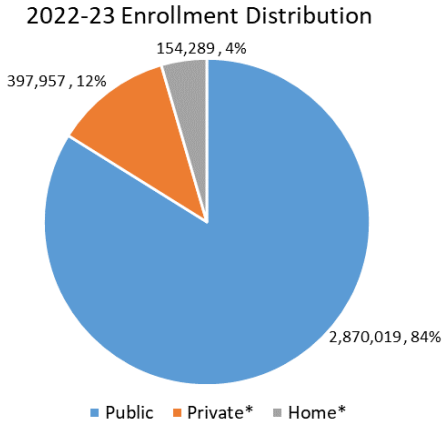
Given the historical data available from the Florida Department of Corrections, there have been no commitments to prison for any of the felonies described above—either before or after the enactment of the 2022 legislative change to 15 weeks (ch. 2022-69, L.O.F.). It should be noted that the 15-week language just went into effect last year, and given the time it would take from arrest to adjudication, it is likely that few, if any, current or future offenders would have moved through the criminal justice system at this point.

Education Services – October 19, 2023

Florida resident births directly influence the state's future preschool and school age populations. The initial effects of policies that impact birth rates may be seen in the school system beginning three to four years following. The first educational setting that could experience differences would be Florida's Exceptional Student Education programs, including public schools and the Family Empowerment Scholarship Program for Students with Unique Abilities. In 2022-23, these two programs for three and four year olds with additional needs for learning support served roughly 15% of this age group. The next program preschoolers can participate in is Florida's universal Voluntary Prekindergarten Program (VPK), which serves 65.7% of four year olds.

The full-effect of policies that influence birth rates and their interactions with Florida's schools would begin five to six years following, once students reach the age of compulsory education. Florida's school choice landscape would result in the effects of the policies being felt across public, private, and home education settings beginning in Kindergarten. Once students are eligible for Kindergarten, impacts are cumulative – stretching across 13 grades from Kindergarten to 12th grade. After 18 years of policy change, all 15 years of education across three settings (public, private, and home), two key scholarship programs (Family Empowerment Scholarship and Florida Tax Credit Scholarship programs) and five major funding programs (Florida Education Finance Program, VPK within the General Appropriations Act, Florida Tax Credit Scholarship Program, Hope Scholarship Program, and Sales Tax Credit Scholarship Program) would ultimately feel the full effect of policies influencing birth rates.

In 2023-24, the typical VPK cost is $2,839 per student. As of July 2023, the 2023-24 statewide funds per unweighted PreK-12 FTE was $8,667.66, with average scholarship amounts ranging from $7,800 for a private school scholarship to $10,900 for a unique abilities scholarship. Further, costs across the public school setting and scholarship programs depends on the grade, level of needs, and residence of each student.



**Private and Home education settings include FES and FTC scholarship students*

FY2022-23 through FY2028-29 Unweighted FTE and Scholarship Forecast

	FY2022-23 SE* 4/14/2023	FY2023-24 Forecast 8/7/2023	FY2024-25 Forecast 8/7/2023	FY2025-26 Forecast 8/7/2023	FY2026-27 Forecast 8/7/2023	FY2027-28 Forecast 8/7/2023	FY2028-29 Forecast 8/7/2023
	- 3 -	- 4 -	- 5 -	- 6 -	- 7 -	- 8 -	- 9 -
Total PreK-12 FEFP FTE *(Excl. Scholarships)*	2,832,245.68	2,867,519.67	2,871,839.55	2,872,278.24	2,861,645.30	2,862,122.51	2,865,228.89
Family Empowerment Scholarship (FES)	155,183	219,790	274,265	324,878	364,761	402,109	437,073
FES-Education Opportunity (EO)	*87,402*	*126,433*	*156,128*	*181,194*	*195,326*	*206,443*	*214,744*
FES-Unique Ability (UA)	*67,781*	*93,357*	*118,137*	*143,684*	*169,435*	*195,666*	*222,329*
Florida Tax Credit Scholarship (FTC)	94,518	134,891	114,576	101,721	100,377	99,111	97,840

* 2022-23 SE = recalibrated survey 3 (February 2023) data excluding scholarship FTE, with adjustments to reflect scholarship payment data

Health and Human Services – October 19, 2023

Florida offers a wide range of social services to support residents with medical, food, and cash assistance. While there are programs that are purely federally funded, many programs use a mix of state and federal funding. The Medicaid Program provides medical assistance to individuals and families to cover or assist in the cost of services that are medically necessary. The Temporary Cash Assistance program provides financial assistance to pregnant women in their third trimester and families with dependent children to assist in the payment of rent, utilities and other household expenses. As many of these programs serve children as well as new or expecting mothers, any changes in Florida resident births affect the number of people potentially eligible for these various social services for both the birthed and the birthing.

For children in Florida needing medical assistance, the state offers Medicaid and Kidcare (Title XXI Children's Health Program—CHIP). Children from birth until their first birthday are eligible for Medicaid if their household income is below 200 percent of the federal poverty level. After their first birthday, the household income threshold against FPL drops to 133 percent to remain Medicaid eligible up until their nineteenth birthday (there are special programs for those 19 and 20 years old based on a fixed income dollar amount). If their household income is above 133 percent but below 300 percent of FPL, they are eligible for Medikids Title XXI. If their income is above 300 percent, they are eligible for Medikids Full Pay. Eligibility for both Medikids programs covers the child until his or her fifth birthday. From ages 5 to 18 years old, under the same FPL thresholds, the child is eligible for Florida Healthy Kids Title XXI or Full Pay. If a child is income eligible and has special healthcare needs that require extensive preventive and ongoing care, he or she is eligible for the Children's Medical Services health plan (CMS).

Florida Medicaid and CHIP Income Requirements (Children)	
Medicaid	
Children Under Age 1	200% FPL
Children ages 1 through 18	133% FPL
Parents, Caretakers, Children ages 19-20	Fixed dollar amount
Children's Health Insurance Program (CHIP)	
Medikids (Ages 1-4)	
Title XXI	133% up to 300%
Full Pay	300%
Florida Healthy Kids (Ages 5-18)	
Title XXI	133% up to 300%
Full Pay	300%
CMS	133% up to 300%

With coverage beginning as early as birth, the effects of any changes to the birth rate can be cumulative and varying. Medicaid covers almost half the births (45.47% CY 2021) in the state. They maintain that coverage until first birthday when their eligibility is reassessed. Many remain on Medicaid, move to a CHIP program, or are able to find health insurance elsewhere. As of August 2023, 47.4 percent (2,490,633) the 5.3 million Medicaid enrollees were under the age of 18 with ages from 0 to five years making up approximately 33 percent of the total under 18. CHIP covers a further 138,293 children under the age of 18 with Medikids covering 12,281, Healthy Kids covering 118,281 and CMS covering 7,731. The federal Public Health Emergency significantly affected enrollment. The tables below show current

enrollment as of August 2023 and December 2019, the month before the PHE retroactively went into effect (the PHE began in March 2020 but continuous enrollment was retroactive to January 1, 2020).

Florida Medicaid Enrollment by Age Group and Date				
	8/31/2023		12/31/2019	
Group	Enrolled	% of Total	Enrolled	% of Total
Ages 0-5	827,024	15.7%	769,120	19.9%
Ages 6 -10	661,289	12.6%	543,814	14.1%
Ages 11-18	1,002,320	19.1%	770,549	19.9%
Total 0-18	2,490,633	47.4%	2,083,483	53.9%
Total	5,254,460	100.0%	3,868,723	100.0%

Florida Children's Health Insurance Program (CHIP) Enrollment by Age Group and Date					
	MK XXI	MK Full Pay	HK XXI	HK Full pay	CMS
	9/30/2023				
Ages 1-5	9,014	3,267	-	-	574
Ages 6 -10	-	-	28,709	8,540	2,458
Ages 11-18	-	-	67,614	13,418	4,699
	12/31/2019				
Ages 1-5	31,830	8,847	-	-	1,196
Ages 6 -10	-	-	63,334	6,939	4,102
Ages 11-18	-	-	129,784	9,614	8,227

While Children under the age of 18 make up almost half the Medicaid enrollees, they account for approximately a quarter of the total Medicaid expenditure. In SFY 2021-22, children were 49.06 percent of enrollees and 24.5 percent of expenditures. The 2023 Rate Year (October 2022 – September 2023) statewide average MMA capitation rate for a child between the age of one month and eleven months without a serious mental illness (SMI) was $274.25 per month ($3,291.00 per year). For a similar child between a year and 13 years old, that rate was $134.86 per month ($1,618.32 per year). There are circumstances were the expenditure on a child is higher than these statewide averages. Children on the CMS plan typically have higher per person per month expenditures, but they account for a small portion of the total of children on Medicaid.

As mentioned above, Medicaid covers a significant number of births in Florida (see table below). With this many births being covered, there is also pre- and postnatal public assistance for the mothers. Medical assistance for pregnant women is also available through Medicaid through various programs. A pregnant woman who is eligible for regular Medicaid (income below 185 percent FPL) for at least one month, including a retroactive month, is eligible to receive Medicaid through her pregnancy and until the end of the 12th month after the birth (postpartum period). The family planning waiver program covers family planning services to eligible women, ages 14 through 55. Services are provided up to 24 months. Eligibility is limited to women with family incomes at or below 191 percent of the FPL who have lost or are losing Florida Medicaid State Plan eligibility and are not otherwise eligible for Medicaid,

Children's Health Insurance Program, or health insurance coverage that provides family planning services.

Recipients losing SOBRA (pregnancy Medicaid) eligibility will have passive enrollment during the first 12 months of losing Medicaid. Non-SOBRA women will have to actively apply for the first year of benefits at their local county health department. All women enrolled in the family planning waiver will have active re-determination of eligibility through their local county health department after 12 months of family planning waiver eligibility. In order to receive the second year of benefits, recipients must reapply at their local county health department.

As of August 2023, there were 333,510 individuals receiving Medicaid or the Family Planning waiver to assist with the pregnancies. Of the total, 150,546 receive Pregnant Women Medicaid and 182,964 utilize the Family Planning Waiver.

Florida Births Covered by Medicaid, Percent of Total births			
CY	Medicaid	Total	Rate
2017	109,225	223,579	48.85%
2018	106,695	221,508	48.17%
2019	102,636	220,010	46.65%
2020	98,018	209,645	46.75%
2021	98,297	216,189	45.47%

Pregnant Women and Family Planning Enrollment by Program and Date				
	SOBRA PREGNANT WOMEN UP TO 100% FPL	SOBRA PREGNANT WOMEN OVER 100% OF FPL UP TO 185% OF FPL	Family Planning Waiver	Total
8/31/2023	114,432	36,043	182,964	333,439
% of Total	34.32%	10.81%	54.87%	100.00%
12/31/2019	67,810	19,124	69,250	156,184
% of Total	43.42%	12.24%	44.34%	100.00%

The Temporary Assistance for Needy Families – Temporary Cash Assistance program provides cash assistance to families with children under the age of 18 or under age 19 if full time secondary (high school) school students. The program helps families become self-supporting while allowing children to remain in their own homes. Pregnant women may also receive TCA, either in the third trimester of pregnancy if unable to work, or in the 9th month of pregnancy. Eligibility for the TCA programs is similar to Medicaid eligibility with a few other technical requirements. Gross income must be less than 185% of the Federal Poverty level and countable income cannot be higher than the payment standard for the family size. Individuals get a $90 deduction from their gross earned income. Some people must participate in work activities unless they meet an exemption. Regional Workforce Boards provide work activities and services needed to get or keep a job. Individuals who receive Temporary Cash Assistance (TCA) are eligible for Medicaid. Individuals who are eligible for TCA, but choose not to receive it, may still

be eligible for Medicaid. Florida law creates four categories of families who may be eligible for TANF cash assistance. While many of the basic eligibility requirements apply to all of these categories, there are some distinctions between the categories in terms of requirements and restrictions:

Child-Only Families: These families include situations where the child is living with a relative or situations where a custodial parent is not eligible to be included in the eligibility group.

Relative Caregiver Program: A specialized program for child-only families where the child has been adjudicated dependent due to abuse or neglect and has been placed with a grandparent or other relative by the court. These relatives are eligible for a payment that is higher than the typical child-only payment, but less than the payment for licensed foster care

Single-Family Parents with Children: Parents with children can receive cash assistance for the parent and the children.

Two-Parent Families with Children: Are eligible on the same basis as single-parent families except the work requirement for two-parent families includes a higher number of hours of participation per week (35 hours or 55 hours if childcare is subsidized) than required for single-parent families (30 hours).

In FY 2022-23, these four programs assisted 67,224 individuals (in FY 2019-20 that number was 61,260). Both the Child-Only Families and Relative Caregiver programs have experienced steady declines in terms of cases and persons served. The other two programs have seen increases over the last few fiscal years that are mostly driven by increased activity among non-citizens seeking assistance.

TANF Temporary Cash Assistance by Program and Date		
Programs	FY 2022-23	FY 2019-20
Child Only Cases	13,840	19,191
Relative Caregiver	9,495	16,461
Single-Family Parents with Children	21,613	22,884
Unemployed Two-Parent Families with Children Parent	22,276	2,723
Total	67,224	61,260

Looking at the age groups served by the TCA programs, ages six and over represent the majority of those receiving assistance (approximately 70 percent). Children from birth to 5 years old make up a smaller proportion of TCA recipients, but are usually also receiving other forms of public assistance as well. While these individuals are treated separately from Medicaid, they are included in the total caseload counts reported each month.

TANF Temporary Cash Assistance by Age and Date				
	9/30/2023		12/31/2019	
	Eligible	%total	Eligible	%total
Age 0 to 5	12,795	29%	16,014	32%
Age 6 to 12	18,755	42%	21,137	42%
Age 13 to 17	13,209	30%	12,989	26%
Total	44,759	100%	50,140	100%

Revenue Impact from Out-of-State Abortions Occurring in Florida
October 19, 2023

In the post-Roe landscape, where many states have enacted stricter regulations on abortion, many people seeking an abortion are traveling across state lines to get the medical care they want. In 2020, approximately 9% of all abortions were obtained by individuals traveling across state lines.[1] This percentage has increased dramatically. For example, Illinois, where abortion laws are not restrictive, reported a 54% increase in abortions in 2022.[2] In 2023, in the first six months of the year, Illinois saw nearly a 70% increase in abortions when compared to 2020.[3] This documented increase in abortion travel has been witnessed in several states, including Colorado, Kansas, and New Mexico.

Geographically, the most restrictive region in the United States is the Southeast. A 2022 study of the estimated travel time to the nearest abortion clinic found Texas, Louisiana, Mississippi, Alabama, and Arkansas to have the longest travel times to the nearest abortion clinic that did post-6 week abortions.[4] For example, the study estimated that the nearest abortion clinic to a Louisiana resident was a 9.61 hour drive.[5] With its 15-week threshold, Florida should be a prime destination for abortion travel since it is located within the Southeast region.

In 2022, Florida reported 82,581 abortions.[6] Of those 82,851 abortions, 6,726 were related to out-of-state individuals.[7] When compared to 2021, total abortions increased by 3%, but out-of-state abortions increased by 38%. While this signals that more individuals are traveling to Florida for abortions, the total level of out-of-state abortions remains low. In comparison, Florida's total visitors in 2022 reached approximately 137.6 million.[8]

For 2023, only nine months of data are currently available. To project the 2023 annual number, the growth rate between 2023Q1-Q3 and 2022Q1-Q3 was used to grow the 2022Q4 level, producing an estimate for 2023Q4. This estimate was then added to the data for the current year. The results indicate a small increase in total abortions (2% percent growth) and a significant increase in out-of-state abortions (24% percent growth). Charts and graphs of Florida's abortion data can be found below.

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[1] https://www.guttmacher.org/article/2022/07/even-roe-was-overturned-nearly-one-10-people-obtaining-abortion-traveled-across

[2] https://www.wbez.org/stories/illinois-sees-spike-in-abortions-since-roe-v-wade-overturned/c34edc98-9efa-42bb-acc1-5ac460015948

[3] https://www.npr.org/2023/10/11/1202456541/billboards-supporting-women-seeking-abortions-are-popping-up-along-i-55-heading

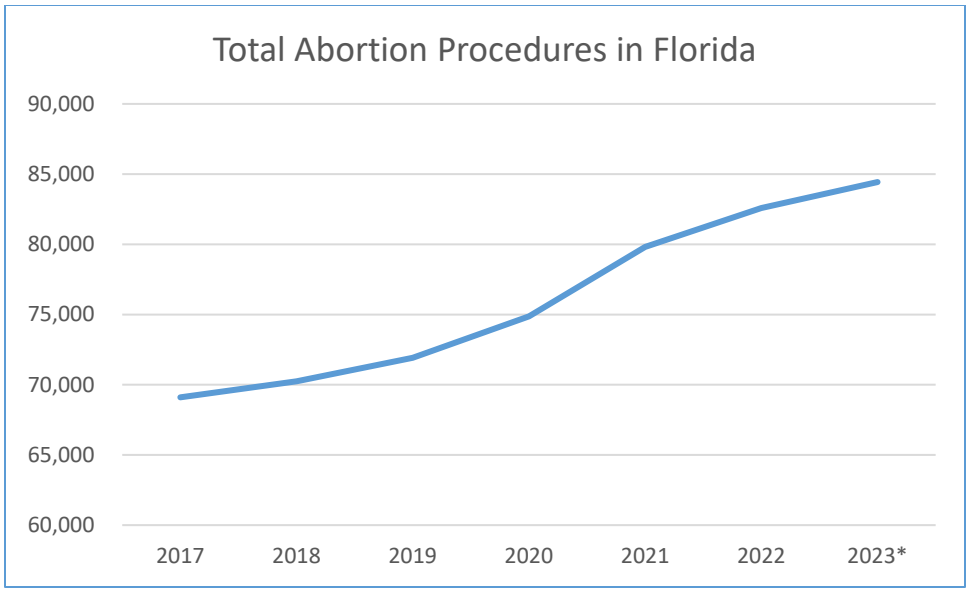
[4] Rader, Benjamin, "Estimated Travel Time and Spatial Access to Abortion Facilities in the US Before and After the *Dobbs v Jackson Women's Health* Decision" Published: November 1, 2022. Journal of American Medical Association.

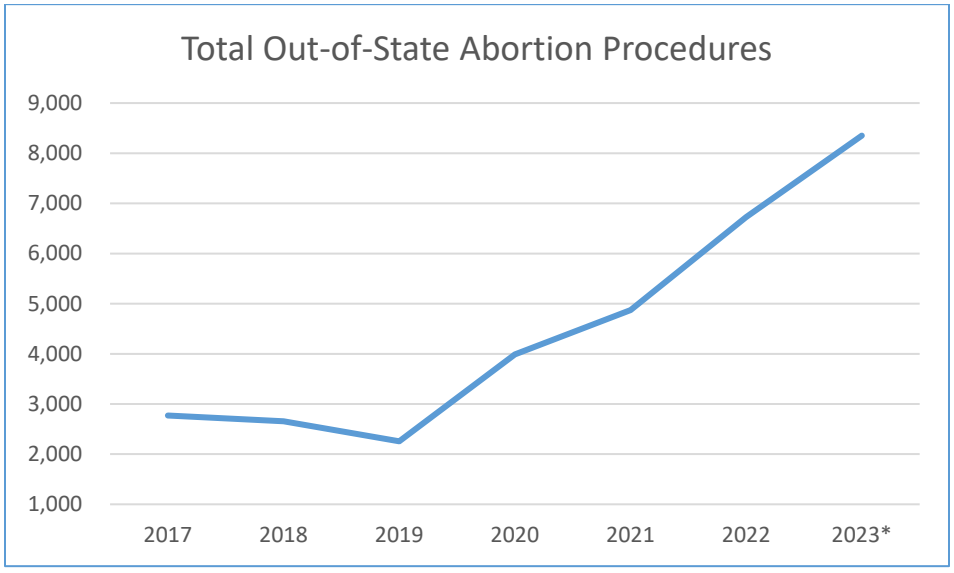
[5] Ibid.

[6] https://ahca.myflorida.com/health-care-policy-and-oversight/bureau-of-central-services/frequently-requested-data

[7] Ibid

[8] https://www.visitflorida.org/resources/research/research-faq/





Florida Abortion Statistics				
Year	Total	Growth	Out-of-State	Growth
2017	69,102	-	2,771	-
2018	70,239	2%	2,654	-4%
2019	71,914	2%	2,256	-15%
2020	74,868	4%	3,988	77%
2021	79,817	7%	4,873	22%
2022	82,581	3%	6,726	38%
2023*	84,263	2%	8,351	24%

* 2023 Data is a forecast based-on the first 9 months of data and an estimate of Q4 data.

Tab 8

Materials from the Sponsor

"Amendment to Limit Government Interference with Abortion (23-07)."

Floridians Protecting Freedom's Submission to the
Financial Impact Estimating Conference (FIEC)

October 18, 2023

The Amendment to Limit Government Interference with Abortion would increase access to abortion care in Florida. Currently the state has a 15-week ban in effect which is being challenged in court. Any day now, the Florida Supreme Court will rule on the constitutionality of the 15-week ban. If the Supreme Court upholds the 15-week ban, a 6-week ban will go into effect 30 days later. In order to assist the FIEC in assessing fiscal impacts, the Sponsor (Floridians Protecting Freedom) is submitting the below materials estimating a net increase in revenues/decrease in costs to state and local governments, and discussing the overall impact to the state budget, resulting from the proposed initiative.

Procedural Background: On Sept. 8, 2023, Florida's Legislative Office of Economic and Demographic Research received notification from the Secretary of State that our petition initiative had triggered the need for a Financial Estimating Conference (FIEC).

Ballot Language

Ballot Title: Amendment to Limit Government Interference with Abortion

Ballot Summary: No law shall prohibit, penalize, delay, or restrict abortion before viability or when necessary to protect the patient's health, as determined by the patient's healthcare provider. This amendment does not change the Legislature's constitutional authority to require notification to a parent or guardian before a minor has an abortion.

Full Text of the Proposed Amendment: Limiting government interference with abortion.—Except as provided in Article X, Section 22, no law shall prohibit, penalize, delay, or restrict abortion before viability or when necessary to protect the patient's health, as determined by the patient's healthcare provider.

Current Context of Abortion in Florida

Abortion has been constitutionally protected in Florida under Florida's state constitution for decades. In 1980, the people of Florida amended the state Constitution to add an explicit right of privacy. The Florida Supreme Court has repeatedly held that this fundamental right of privacy encompasses an individual's right to make the profoundly personal decision of whether to terminate a pregnancy before viability. Despite Florida's Constitutional protections and decades of Florida Supreme Court caselaw, the Florida Legislature in 2022 passed HB 5, criminalizing abortions after 15 weeks. This law is currently being challenged in the courts, oral argument has been held, and we expect a Florida Supreme Court ruling any day.

Despite the legal challenge, the 15-week ban has been in effect since July 1, 2022, forcing pregnant people in Florida to remain pregnant against their will and suffer risks to their health or flee their home state to access the essential abortion care they need.[1]

In 2023, the legislature passed a 6-week abortion ban,[2] which is a near-total abortion ban. The 6-week ban is not currently in effect. It will go into effect if the Florida Supreme Court upholds the 15-week ban.

Supreme Court Case

Any day now, the Florida Supreme Court will render a decision on the challenge to the 15-week ban. The outcome of that decision will trigger whether a 6-week ban goes into effect within 30 days of the decision.[3]

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[1] Cohen, E., Hassan, C., Musa, A. (May 2, 2023). Florida's new abortion law bans the procedure after 15 weeks of pregnancy. CNN. https://www.cnn.com/2023/05/02/health/florida-abortion-term-pregnancy/index.html; Bella, T. (February 7, 2023). State of the Union: Abortion in Florida. The Washington Post. https://www.washingtonpost.com/politics/2023/02/07/state-of-union-abortion-florida-anabely-lopes.

[2] Senate Bill 300 (2023).

[3] According to Senate Bill 300 (2023), the 6-week ban "shall take effect 30 days after any one of the following occurs": the Florida Supreme Court holds that the Florida Constitution's right to privacy does not include a right to abortion; the Florida Supreme Court, through a decision in the *Planned Parenthood v. State* case, allows the 15-week abortion to remain in effect, including a decision approving, in whole or part, the decision under review or a decision discharging jurisdiction; the Florida Constitution is amended to clarify that the right to privacy does not include a right to abortion; or the Florida Supreme Court decides, in any case, to recede in whole or in part from previous cases determining that there is a state constitutional right to abortion.

In effect, the six-week ban will be a near total abortion ban as it bans abortion six weeks after the first day of the person's last menstrual period, which is approximately two weeks after a missed period in people with regular menstrual periods of average length. Many people will not even know they are pregnant in this short timeframe. For those who realize they are pregnant, they will likely be unable to satisfy the state requirement that they have two in-person OB/GYN appointments, separated by 24 hours, within this short time frame.

What the Amendment Will Do

The Amendment to Limit Government Interference with Abortion will prevent laws that prohibit, penalize, delay, or restrict abortion access before viability or when necessary to protect patient health, as determined by the patient's healthcare provider, consistent with protections that existed under *Roe v. Wade* and decades of Florida jurisprudence. This will ensure that pregnant patients are able to make the best decisions for themselves and their families, without government interference in their personal medical decisions.

For this reason, it is helpful to compare states with 6-week near total abortion bans to states with greater access to abortion. Additionally, it is useful to look at state and local economic vitality pre- and post-Roe to understand the economic impact of abortion restrictions. Research on abortion-access states as compared to abortion-restricted states is informative.[4]

Positive Impacts to State and Local Economies of Ballot Initiative Passage (and Harms to State/Local Economies Under Legislatively Adopted Abortion Bans in Absence of Ballot Initiative Passage)

The ballot initiative will ensure that pregnant people are able to determine for themselves, based on their own personal circumstances and beliefs, whether and when to have a child, and will

[4] Institute for Women's Policy Research (IWPR). Costs of Reproductive Health Restrictions. https://iwpr.org/costs-of-reproductive-health-restrictions/?location=fl; Joint Economic Committee Democrats. (September 29, 2022). States that Most Restrict Access to Abortion Have Worse Economic Conditions for Families. https://www.jec.senate.gov/public/index.cfm/democrats/issue-briefs?id=119E736A-0B77-499D-B4CE-A64C6565F366; Economic Policy Institute (EPI). (January 18, 2023). Economics of Abortion Bans https://www.epi.org/publication/economics-of-abortion-bans/; Hoffman, L., et al. (August 25, 2022). State Abortion Bans Will Harm Women and Families' Economic Security Across the U.S. Center for American Progress. https://www.americanprogress.org/article/state-abortion-bans-will-harm-women-and-families-economic-security-across-the-us/; Institute for Women's Policy Research (IWPR). (2020). Abortion Access in the United States. https://iwpr.org/wp-content/uploads/2020/07/B379_Abortion-Access_rfinal.pdf.

ensure that such decisions are made by the pregnant people themselves and not by politicians. The initiative will ensure that patients are able to avail themselves of the safest and best-practice medical care and that doctors are able to provide their patients with the best medical care based on the patient's medical history and individualized circumstances.

The amendment will lead to economic growth and positively impact state and local economies because it will allow pregnant people to be able to make the best decisions for them and their families. When women and all people who can become pregnant are able to make their own decisions, based on their own individualized circumstances and their personal assessment of whether they are ready, willing and/or able to love, care for, provide for and financially support a growing family, state and local economies thrive.[5] These impacts are seen in many ways, including but not limited to, increased education and workforce participation and thus increased revenues, lower costs to the state due to individual financial independence, increased revenue due to attracting businesses and employees to the state; increased revenue due to attracting students and employees to our institutions of higher education; positive impacts on state and local budgets due to freeing up resources that would otherwise need to be spent on enforcement of abortion bans (state and local resources spent on surveillance, arrests, prosecution, incarceration) and defensive litigation costs.

Conversely, when pregnant people are forced to carry pregnancies to term against their will when they are not ready, willing, and/or able to love, care for, provide for and support a child, there will be a host of unintended consequences that negatively impact state and local budgets, as well as the financial independence of women and all those who can become pregnant, and their families. This will result in increased costs to the state and decreases in revenues as women are forced to leave the workforce and families are forced to depend more on state benefits.[6]

[5] Hoffman, et. al., *supra* at n. 4.
[6] *Id.*

State and Local Impacts

Public Safety

The initiative will reduce state and local spending on public safety. Currently, Florida law provides that "any person who willfully performs, or actively participates in, a termination of pregnancy [after 15 weeks from the first day of the last menstrual period], commits a felony of the third degree." As discussed above, a six-week ban will take effect if the Florida Supreme Court upholds the 15-week ban. A felony conviction is punishable by up to five years in prison at a cost to the state of approximately $25,000 per year of incarceration.

If the initiative passes, there will be a cost savings to state and local governments as resources and expenditures will not be allocated toward surveilling, arresting, prosecuting, and incarcerating medical providers for providing safe abortion healthcare. Additionally, resources can be reallocated to other public safety priorities, making our communities safer.

Because the felony provisions of the 6-week and 15-week bans will not be enforceable if the initiative passes, it is likely that fewer people will be caught up in the criminal legal system resulting from providing abortion care. Additionally, research has suggested a direct correlation between abortion access and decreases in crime, which would have a positive impact on state and local budgets.[7]

Poverty

States with greater abortion access have greater opportunity for women, children, and families to economically thrive. Conversely, states with the most restricted access have less favorable economic conditions for families. Data show that in states with more restrictive abortion laws women have lower median earnings and child poverty rates are higher.[8] Lower median earnings mean that women and families are less able to cover basic necessities like food and childcare, and more likely to need access to state- or local-funded support. A 2022 report found that Florida

[7] Donohue III, J. J., & Levitt, S. D. (2001). "The Impact of Legalized Abortion on Crime." https://pricetheory.uchicago.edu/levitt/Papers/DonohueLevittTheImpactOfLegalized2001.pdf
[8] Joint Economic Committee Democrats, *supra* at n. 4.

had the third-highest rate in the nation of children living in households struggling to meet basic needs.[9]

Abortion access lowers the chances of child poverty. A 1997 study found "that the so-called marginal child who was not born due to abortion access—and who would have been born absent abortion legalization—would have been 40 percent more likely than the average U.S. child at the time to live in poverty."[10] In Florida, 32% of women of reproductive age have incomes below 200% of the federal poverty line.[11]

States with greater access to abortion lead to greater economic self-sufficiency and earnings capacity for pregnant people and their families.

In states with greater abortion access, those at or near the poverty line will have increased educational and employment opportunities available to them, and thus less need to rely on state and local benefits to cover basic necessities. Restrictive abortion laws push those at or near the poverty line further into poverty and debt. States with more restrictive abortion laws may see greater eviction rates, more reliance on government benefits, increased healthcare costs, increased state expenditures on the state foster care system and abuse and neglect enforcement actions.[12]

There are over 20,000 children in Florida's foster care system.[13] Without this initiative, it is likely Florida will see an increase in its foster care system and an increase in child poverty generally. This will have impacts on the state budget, state and local expenditures, and state social services.

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[9] Lauren Peace, "Childhood Poverty in Florida Is Far Worse Than Federal Data Show, Report Says," Tampa Bay Times (April 19, 2022), https://www.tampabay.com/news/hillsborough/2022/04/19/childhood-poverty-in-florida-is-far-worse-than-federal-data-show-report-says/.
[10] Hoffman, et. al., *supra* at n. 4.
[11] Guttmacher Institute. "State Policy Information: Florida - Demographic Information," https://states.guttmacher.org/policies/florida/demographic-info.
[12] Caitlin Knowles Myers & Morgan Welch, "What Can Economic Research Tell Us About the Effect of Abortion Access on Women's Lives?" Brookings Institute (November 30, 2021), https://www.brookings.edu/articles/what-can-economic-research-tell-us-about-the-effect-of-abortion-access-on-womens-lives/.
[13] Child Welfare Outcomes Data. Florida. U.S. Office of Administration for Children and Families, Children's Bureau https://cwoutcomes.acf.hhs.gov/cwodatasite/pdf/florida.html

Education

Access to abortion also increases the attainment of higher education for women, increasing their earning potential and disposable income and reducing their risk of poverty. One study found that access to abortion "increased the probability of their entering college by 41 percent and completing college by 71 percent. These positive effects were particularly pronounced for Black women experiencing early pregnancies: Access to abortion increased their probability of entering college by up to 200 percent."[14]

"Access to abortion increased women's probability of graduating college by 72%. The effect was even larger for Black women, whose chances of completing college increased 2- to 3-fold.[15]

Abortion-access states are also more likely to attract women of reproductive age to their universities, colleges, and employment opportunities, resulting in a more educated workforce with higher earnings potential and potential impact on state revenues. Conversely, without this initiative, Florida may see a brain drain as reproductive age women may choose not to live in abortion-ban states.

Healthcare Costs and Health Outcomes

Access to abortion care under the initiative will likely decrease state healthcare costs and improve health outcomes due to pregnancy-related complications and maternal morbidity and mortality rates.[16] Florida is the most expensive state for emergency room visits.[17] Particularly for Florida's uninsured population, Medicaid recipients, as well as state employees, these healthcare and hospital costs may negatively impact state budgets.

Abortion bans force people to continue pregnancies even when there are significant health concerns that would make abortion care the safer option. Researchers have found that a total abortion ban could increase the number of maternal deaths by 24 percent, with the greatest

[14] Hoffman, et. al., *supra* at n. 4.
[15] Joint Economic Committee Democrats, *supra* at n. 4.
[16] The Commonwealth Fund, "New Report: Pregnancy and Delivery Complications Cost the United States Billions," https://www.commonwealthfund.org/press-release/2021/new-report-pregnancy-and-delivery-complications-cost-united-states-billions.
[17] Jessica Learish, 'Emergency Room Visit Cost: The Most Expensive States,' CBS News (December 4, 2020), https://www.cbsnews.com/pictures/emergency-room-visit-cost-most-expensive-states/52/.

impact on Black women, at 39 percent.[18] A 2021 study found that abortion legalization reduced maternal mortality among Black women by 30-40%.[19]

Impact on State Revenues as Businesses and Employees Relocate

State and local economies in abortion-ban states may lose business revenue, as some employers may decide to relocate to abortion-access states in order to attract and retain top talent. Additionally, talented employees may relocate out of state or decide to not move into abortion-ban states. Recruitment and retention of top talent in employment and institutions of higher education may be most impacted among women of reproductive age.[20]

According to a survey of 2,020 U.S. adults in 2022, over half of women between 18-44 years and 45% of college-educated male and female workers would not consider a job in a state that banned abortion.[21]

A March 2022 poll conducted by the research firm Morning Consult found that 52% of employed adults prefer to live in a state where abortion is legal, compared with 24% who preferred to live in a state where abortion is illegal. Among students 18 and older, the gap was wider: 78% preferred to live in a state with legal abortion.[22]

As an example, after Indiana Gov. Eric Holcomb signed the state's near-total abortion ban into law in August 2022, the pharmaceutical company Eli Lilly—one of Indiana's largest employers—issued a statement saying that it "will be forced to plan for more employment growth out of [its] home state."[23]

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[18] Hoffman, et. al., *supra* at n. 4.
[19] Myers & Welch, *supra* at n. 12.
[20] Liz Hampton & Sabrina Valle, 'How Texas Abortion Ban Hurts Big Oil's Effort to Transform Its Workforce,' Reuters (September 23, 2022), https://www.reuters.com/business/energy/how-texas-abortion-ban-hurts-big-oils-effort-transform-its-workforce-2022-09-23/ (accompanying chart available at https://www.reuters.com/graphics/USA-ABORTION/zjvqkrdrmvx/chart.png).
[21] *Id*.
[22] Josh Nathan-Kazis, "Abortion Bans Hit Company Offices and Jobs," Barron's, July 18, 2022, https://www.barrons.com/articles/abortion-bans-company-offices-jobs-51657913227.
[23] "Eli Lilly Says Some Staff Want to Leave Indiana Because of Abortion Ban," Reuters (November 6, 2022), https://www.reuters.com/world/us/eli-lilly-says-some-staff-want-leave-indiana-because-abortion-ban-ft-2022-11-06/; Ian Fisher, "Eli Lilly Says Indiana Abortion Law Forces Hiring Out of State," Bloomberg (August 6, 2022), https://www.bloomberg.com/news/articles/2022-08-06/eli-lilly-says-indiana-abortion-law-forces-hiring-out-of-state.

Initiative May Increase Enrollment and Retention at State Universities and Attract Women of Reproductive Age to Move to/Stay in Florida

States with greater access to abortion may see higher student enrollment. Nearly three-quarters of currently enrolled college students (72%) report that the reproductive health laws in the state where their college is located are at least somewhat important to their decision to stay enrolled.

Among those who say reproductive health services are an important consideration in their college enrollment decisions, more than eight in 10 currently enrolled students (81%) and unenrolled students (85%) say they would prefer to attend a university in a state with greater access to reproductive health services, while fewer than two in 10 would prefer to attend college in a more restrictive state.[24]

The initiative limiting government interference with abortion is likely to attract young people to move to/continue residing in Florida, as well as employers and businesses, especially since Florida will be the only abortion-access state in the Southeast.

Potential Demographic Shift in Abortion-Ban States

With the state-by-state approach to access since the Dobbs decision,[25] we can expect to see demographic shifts over time related to abortion-access versus abortion-restricted states. What will be the long-term economic impacts to abortion-restricted states if women and girls of reproductive age (roughly between the ages of 14-46) who have the means to relocate out of state choose to relocate to abortion-access states? What will be the long-term demographic implications to abortion-restricted states if women and girls of reproductive age do not move into those states? With Florida's increasing aging population, this demographic of reproductive-age women is even more important to retain and attract.[26]

[24] Stephanie Marken & Zach Hrynowski, "Reproductive Health Laws a Factor in College Decisions," Gallup (April 20, 2023), https://news.gallup.com/poll/474365/reproductive-health-laws-factor-college-decisions.aspx.
[25] Guttmacher Institute, "Abortion Statistics: Florida," https://states.guttmacher.org/policies/florida/abortion-statistics.
[26] Florida Office of Economic and Demographic Research, "Population Demographics: Data from Census Day 2021," http://edr.state.fl.us/Content/population-demographics/data/Pop_Census_Day-2021.pdf.

Compiled Research

Below we have compiled several additional articles and research discussing the harms to state and local economies under abortion bans, as well as the harms to women and families from abortion bans that in turn negatively impact state budgets.

For ease of reference, we included various excerpts in italics from the articles and research as well (internal citations omitted from excerpts and can be found in the inked source material):

Florida State Specific Economic Impacts: Positive Impact on Florida's State Economy Estimated $6 Billion Per Year

- Florida: The Costs of Reproductive Restrictions to States[27]

According to research by the Institute for Women's Policy Research in 2021, prior to the 15-week ban and 6-week ban being passed by the legislature, it was estimated that in Florida, "abortion bans and other restrictive reproductive health care policies could cost the state $6.6 billion per year."[28] Presumably these costs to the state would increase upon enactment of the near total abortion ban passed by the legislature in 2023 and the state resources associated with enforcement of the criminal penalties attached.

Positive Economic Effects of Abortion Access on a Numerous Economic Indicators, Including Labor Force Participation, Educational Attainment, Earnings, and Child Poverty

- State Abortion Bans Will Harm Women and Families' Economic Security Across the U.S. - Center for American Progress[29] (discussing how abortion bans lead pregnant people "to fall even further through the cracks—with downstream effects on their children, communities, and local and state economies.")

[27] Institute for Women's Policy Research, "Costs of Reproductive Restrictions: State Fact Sheets - Florida," Institute for Women's Policy Research (September 2021), https://iwpr.org/wp-content/uploads/2021/09/Costs-of-Repro-Restrictions_State-Fact-Sheets_Florida.pdf. *See also*, Robyn Watson Ellerbe, Nina Besser Doorley, Afet Dundar, Institute for Women's Policy Research, "Status of Women in Florida: Reproductive Rights" (March 2023), https://iwpr.org/wp-content/uploads/2023/03/Status-of-Women-in-Florida-Reproductive-Rights-FINAL.pdf; Institute for Women's Policy Research, "Florida," https://iwpr.org/project_states/florida/; Institute for Women's Policy Research, "Costs of Reproductive Health Restrictions: Research Summary" (May 2021), https://iwpr.org/wp-content/uploads/2021/05/Costs-of-Reproductive-Health-Restrictions_Research-Summary.pdf.
[28] *Id.*
[29] Hoffman, et. al., *supra* at n. 4.

"Abortion legalization under Roe was integral to women's advancement in the United States. During a recent Senate Banking Committee hearing, Secretary of the Treasury Janet Yellen stated that "Roe v. Wade and access to reproductive health care, including abortion, helped lead to increased labor force participation. It enabled many women to finish school. That increased their earning potential. It allowed women to plan and balance their families and careers."

"Research confirms the positive effects of abortion legalization on a range of economic indicators, including labor force participation, educational attainment, earnings, and child poverty—with particularly notable gains for Black women. Moreover, when women are denied access to abortion, it can negatively affect their economic security and that of their families, and state and local economies can suffer significant financial losses."

One study found that access to abortion for women facing early, undesired pregnancies increased the probability of their entering college by 41 percent and completing college by 71 percent. These positive effects were particularly pronounced for Black women experiencing early pregnancies: Access to abortion increased their probability of entering college by up to 200 percent."

"Given that many women are their families' sole or primary breadwinner, and that abortion legalization also lowered the chances of a child living in poverty. One 1997 study found that the so-called marginal child who was not born due to abortion access—and who would have been born absent abortion legalization—would have been 40 percent more likely than the average U.S. child at the time to live in poverty."

"Additional studies have found that laws restricting access to abortion widened the gender pay gap for women of childbearing age by pushing them out of the labor force and into lower-paying jobs. In fact, one study found that abortion restrictions led to a drop of between 5 percent and 6.5 percent in average monthly salaries of women of childbearing age compared with the rest of the population."

"The Institute for Women's Policy Research found in 2021 that restrictive abortion laws cost state and local economies $105 billion annually by reducing labor force participation and earnings levels while also increasing time off and turnover among women ages 15 to 44 years old. The reasons behind these costs are clear: When women lack access to necessary benefits and support to balance work and family—such as paid family and medical leave and workplace flexibility—and face increased caregiving responsibilities, they are forced to cut back on work hours or leave the workforce entirely. Such costs will only worsen in a post-Roe world as abortion is banned in many more states."

"State and local economies in states with abortion bans will also stand to lose even more money in a post-Roe world, as some employers will relocate to states with abortion protections to attract and retain top talent and fulfill their public pledges of diversity and inclusion. For example, after Indiana Gov. Eric Holcomb (R) signed the state's near-total abortion ban into law in August 2022, the pharmaceutical company Eli Lilly—one of Indiana's largest employers—issued a statement saying that it "will be forced to plan for more employment growth out of [its] home state."

"Because, among other things, abortion bans force people to continue pregnancies even when there are significant health concerns that would make abortion care the safer option, there will likely be increases in maternal mortality due to people pursuing unsafe abortion care or experiencing fatal pregnancy-related complications. Researchers have found that a total abortion ban could increase the number of maternal deaths by 24 percent, with the greatest impact on Black women, at 39 percent."

"State abortion bans are unequivocally harmful to women and families' economic security as well as state and local economies."

Increase in Economic Independence, Consumer Spending, and State Revenues and Budget

Increasing abortion access directly impacts women's earning capacity, economic independence, educational attainment, and employment opportunities. These in turn greatly impacts overall economic growth in the state, increases revenues to state and local governments, and impacts the state budget.[30]

- Brief of Amici Curiae[31] - Amicus Brief by Economists in *Dobbs*

  "Studies also demonstrate that for women experiencing unintended pregnancies, access to abortion has increased the probability that they attend college and enter professional occupations.

  "For instance, one such study showed that young women who utilized legal abortion to delay an unplanned start to motherhood by just one year realized an 11% increase in hourly wages later in their careers. Another found that, for young women who experienced an unintended pregnancy, access to abortion increased the probability they finished college by nearly 20 percentage points, and the probability that they entered a professional occupation by nearly 40 percentage points. Again, these effects tended to be greater among Black women.

  One study showed that legalization in repeal states reduced the number of children who lived in single parent households, who lived in poverty, and who received social services. Another found that abortion legalization reduced cases of child neglect and abuse. Yet other studies have explored long-run downstream effects as the children of the Roe era grew into adulthood. One such study showed that as these children became adults, they had higher rates of college graduation, lower rates of single parenthood, and lower rates of welfare receipt."

  "While the past 50 years have seen remarkable social and economic progress for women in the United States, significant hurdles remain—particularly for working mothers. Studies show that up to the point of parenthood, men's and women's earnings evolve similarly. But

[30] Joint Economic Committee Democrats, *supra* at n. 4.
[31] Brief of Economists as Amici Curiae in Support of Respondents, Supreme Court of the United States (September 2021), https://www.supremecourt.gov/DocketPDF/19/19-1392/193084/20210920175559884_19-1392bsacEconomists.pdf.

as parents, their earnings diverge sharply: mothers experience an immediate and persistent one-third drop in expected earnings while fathers' earnings remain largely unaffected."

Although women experience unintended pregnancies and seek abortions at varying stages of life, one common thread is that many of these women already face difficult financial circumstances. Approximately 49% of women who seek abortions are poor, 75% are low income, 59% already have children, and 55% report a recent disruptive life event such as the death of a close friend or family member, job loss, the termination of a relationship with a partner, or overdue rent or mortgage obligations.

Given these circumstances, questions abound as to what happens to women who cannot obtain an abortion they wanted to have. The Turnaway Study is a longitudinal study that focuses on financial outcomes for women in this situation.

…the average woman in the turnaway group experienced a 78% increase in past-due debt and an 81% increase in public records related to bankruptcies, evictions, and court judgments. The financial effects of being denied an abortion are thus as large or larger than those of being evicted, losing health insurance, being hospitalized, or being exposed to flooding due to a hurricane.…

Turnaway Study's conclusions are clear: being denied an abortion has significant deleterious financial consequences."

- The Economics of Abortion Bans[32] - Economic Policy Institute

"Abortion access is an economic issue because access to, and inversely, denial of, abortion services directly impacts labor market experiences and economic outcomes."

"A 2014 study found that about half of all abortion patients had a family income at or below the federal poverty level (Jones and Jerman 2017)."

[32] EPI, *supra* at n. 4.

"Abortion access is crucial for policymakers to consider because of its impact on racial and economic disparities, in addition to the limitations on reproductive health and freedom (Robbins and Goodman 2022)."

"Research on the economic benefits of abortion access has also found especially important effects for Black women, including increased schooling, employment, educational attainment, wages, labor force participation, and career outcomes and earnings (Angrist and Evans 1996; Kalist 2004; Abboud 2019; Jones 2021)."

"Further, abortion is an economic issue because of the intersections between the economy and other key systems and institutions that people seeking abortions encounter, including the medical and health care system, government social services and insurance programs, and the incarceration and criminal justice system. These systems—economic, health, social safety net, prison—and the flaws and inequities embedded in each overlap and interact with each other."

"The full effect, and the full loss, of eliminating millions of peoples' ability to make their own choices in the economy and of altering their paths and potential will be immeasurable."

- Abortion Access Is Key to Economic Freedom[33] - Joint Economic Committee Democrats

"Many states put unnecessary restrictions on women seeking abortions, restrictions that have no basis in medical science and imperil women's health and well-being. These unnecessary restrictions cost local economies $105 billion per year. If these unnecessary restrictions were eliminated, U.S. GDP would be almost 0.5% higher."

***"Educational attainment**. Access to abortion increased women's probability of graduating college by 72%. The effect was even larger for Black women, whose chances of completing college increased 2- to 3-fold.*

[33]Joint Economic Committee Democrats, *supra* at n. 4.

Earnings. *Being able to delay motherhood by one year due to access to legal abortion increased women's wages by 11% on average.*

Labor force participation. *Access to abortion increased women's workforce participation, "increasing the probability of a woman working 40 weeks or more per year by almost 2 percentage points (from 29 percent)."*

Additional Resources

In addition to the research referenced above and, in the footnotes, please also see the following:

- What can economic research tell us about the effect of abortion access on women's lives? | Brookings
- The Devastating Economic Impacts of an Abortion Ban | The New Yorker
- Research on abortion care Introduction to the Turnaway Study

Tab 9

Materials from Proponents

(None Provided)

Tab 10

Materials from Opponents

FIEC Public Workshop – October 19th at 9 am Room 117, Knott Building, 415 W. St. Augustine Street, Tallahassee, Florida.

My name is Katie Glenn Daniel, and I serve as state policy director for Susan B. Anthony Pro-Life America. While my role is national in scope, I earned my JD at UF, am a member of the Florida Bar, and live in Tampa.

SBA's mission is to protect vulnerable human life. Our nonprofit research arm, the Charlotte Lozier Institute, has extensively studied and published peer-reviewed papers showing the harms of abortion and the good that flows from laws that protect the unborn. We regularly testify around the country, and members of our team, including a Florida-based retired Ob-gyn and former abortion provider, testified in all four hearings on the Heartbeat Protection Act this spring.

SBA will provide the committee with a written report demonstrating the negative financial impact Florida will suffer if this initiative takes effect and makes Florida a late-term abortion destination.

Any increase or decrease in abortions will affect the birth rate, which affects our population, which then affects the state budget and economy. A US Joint Economic Committee report found that the cost of abortion was $6.9T in 2019 alone. But I would also like to highlight two other points of analysis for you today:

First, how Michigan is implementing a similar initiative

- In 2022, Michigan passed Prop 3, establishing a broad right to abortion into the state constitution. Just this week a proponent of this amendment compared it to Michigan in the Tampa Bay Times.
- Prop 3 has been interpreted to ***require*** state Medicaid funding of elective abortions, which the House fiscal agency predicts will increase costs by $2-6M each year.
- Citing Prop 3, Michigan lawmakers introduced bills to repeal longstanding pro-life laws, including informed consent, coercion counseling and medical screening, all laws tied to better physical and mental health outcomes.

Second, the use of undefined terms like "viability" and "provider" makes this an unrestricted late-term abortion amendment. Therefore, the insurance and healthcare costs of permitting abortions throughout pregnancy must be considered.

- Numerous studies show that removing health and safety regulations increases health utilization and costs due to higher rates of and more serious physical complications and worse mental health outcomes.
- In the 17 states that pay for abortions using Medicaid, the **hospitalization rate increased by 500% from 1999 to 2015**.
- In 2016 and 2023, the FDA removed critical safeguards on chemical abortions which are only backstopped by state laws. Should the amendment repeal those laws, Florida's emergency room utilization would increase.
- European data shows that the "fail rate" for chemical abortion in the second trimester is up to 40%. Allowing late-term abortions to be performed by non-physician "providers" who are not trained in gynecology will increase complication rates, and expensive follow up treatment.
- These costs extend beyond immediate utilization; "no test" abortions increase the risks of future fertility problems for women with a negative blood type who must be treated for Rh D isoimmunization concurrently with their abortions.

The research shows that this amendment's fiscal impact is not limited to population counts. Abortion on demand would increase emergency healthcare utilization, may overburden state Medicaid, and cost Florida taxpayers.

Tab 11

Materials from Interested Parties

(None Provided)

Tab 12

Requested Agency Material

Abortion Clinic Licensure

Fiscal Impact Estimating Conference

October 19, 2023

Statute and Rule Authority

Service-Specific:

- Chapter 390, Florida Statutes
- Chapter 59A-9, Florida Administrative Code

General Licensure:

- Chapter 408, Part II, Florida Statutes
- Chapter 59A-35 Florida Administrative Code

Abortion

- May only be performed by a physician.
- May be performed in a:
  - Licensed abortion clinic
  - Licensed hospital
    - Procedures after the 23rd week must be done in a hospital.
  - Physician's office
    - Any medical office if the number of procedures performed does not exceed 50% of the services provided at that office.

Abortion

- The procedure may be medical or surgical.
- Requires informed consent except in an emergency.
- Requirements and Restrictions based on gestational age.

Procedural Requirements

Applicable to all health care providers performing abortions:

- Provide a safe and sanitary environment;
- If physician does not have admitting privileges at a hospital in reasonable proximity, the clinic must have a transfer agreement with the hospital;
- Obtain informed consent, including parental consent if the patient is under the age of 18 years;
- Perform an ultrasound to determine gestational age;
- Disposal of fetal remains;
- Data reporting;
- Florida Statutes require 24 Hour voluntary and informed written consent.

Agency Oversight

- As of October 6, 2023, there are 51 licensed abortion clinics
- The Agency is responsible for the regulatory oversight of abortion clinics and hospitals.
- Abortion clinics are licensed for a two-year period.
- Licensure inspections are conducted at each abortion clinic annually prior to license renewal and for complaint investigations.

Abortion Clinic Application

Items required on the application include:

- Provider Information and Primary Contact
- Owner, Controlling Interest, and Management Company Information
- Required Disclosures (convictions, adverse actions)
- Hours of Operation
- Outstanding Fines

Onsite Survey Process

The Agency has the right to enter an abortion clinic to make or cause to be made such inspections and investigations as are necessary to assure compliance with the licensure requirements and standards as specified in statute and rule.

Survey Tasks

- Off-site pre-survey review
- Entrance conference
- Tour of the clinic
- Sample selection
- Interviews with staff
- Review of patient and personnel records
- Decision Making
- Exit conference

Abortion Clinic Applications: 2013-2023

Number of Initial Licensure Applications Including Previously Licensed Clinics												
	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023*	Total
Approved	1	2	1		3	2	1	1				11
Denied											1	1
Withdrawn						1					1	2
Grand Total	1	2	1		3	3	1	1			2	14

* Includes applications received January through October 6, 2023

Abortion Clinic Closure: 2013-2023

Number of Abortion Clinics No Longer in Service by Year												
	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023*	Total
CLOSED	1	2	1	2		4	1			4	1	16
REVOKED						4					1	5
WITHDRAWN			2									2
Grand Total	1	2	3	2		8	1			4	2	23

* Includes status changes effective January through October 6, 2023

Abortion Data Collected

- Each abortion clinic, hospital and physician's office is required by section 390.0112, F.S., to report the number of procedures performed during the preceding month.
- The reporting facility provides a unique identifier for the patient, the date of pregnancy termination, Last Menstrual Period (LMP) date if accurately known, and the clinician's estimated date of fertilization.

Abortion Data Collected, cont.

Data collected includes :

- Patient's state and county of residence (other if outside the U.S.)
- Marital status
- Race and ethnicity
- Level of education
- Number of previous births and terminations
- Method for termination, including number of regimens prescribed or dispensed if a medical abortion is performed
- Reason for termination

Abortion Clinic Procedures: 2013-2023

YEAR	TOTAL PROCEDURES REPORTED
2013	72,727
2014	72,107
2015	72,023
2016	69,770
2017	69,102
2018	70,239
2019	71,914
2020	74,868
2021	79,817
2022	82,581
2023*	58,230

* Includes data reported January through October 1, 2023

Data Available to the Public

For more information regarding Induced Termination of Pregnancy Reports please visit the Agency website at:

https://ahca.myflorida.com/health-care-policy-and-oversight/bureau-of-central-services/frequently-requested-data -

QUESTIONS?

Tab 13

Impact

(Pending Conference Decision)