



Medication Abortion Care Is Safe and Effective—It's Time Everyone Has Equal Access

SEPTEMBER 28, 2021 – ANNA BERNSTEIN

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Executive Summary

Medication abortion care is incredibly safe and effective, yet it is heavily restricted by the Food and Drug Administration and state-level abortion laws. This report examines the available evidence, with a focus on recent research on the use of telemedicine to provide medication abortion care. The author of this report interviewed researchers, abortion providers, and patients on their experiences with medication abortion care, and their contributions to the evidence are considered as well. This report goes on to discuss barriers to access and recommendations to increasing equity in medication abortion care. The COVID-19 pandemic increased both demand and use of telemedicine provision of abortion care, and demonstrated just how safe and feasible that care is. In order to make equitable access a reality, restrictions on medication abortion care that are based in politics rather than science should be removed, and insurance coverage of abortion must be expanded.

Background: Medication Abortion Care and REMS

What Is Medication Abortion Care?

Medication abortion care, also known as medical abortion or the abortion pill, is the termination of a pregnancy using pills. In the United States, the standard protocol for medication abortion is a combination of the drugs mifepristone and misoprostol. Mifepristone (sometimes referred to as the brand name Mifeprex) was approved by the Food and Drug Administration (FDA) in 2000 for use in early abortion, while misoprostol has many other uses, both indicated and off-label, including prevention of ulcers and miscarriage management. This regimen has long been proven to be safe and effective, and is approved by the FDA for use up to ten weeks gestation. According to experts, this is a conservative restriction: evidence and updated clinical guidelines tell us that patients may safely use medication abortion up to eleven weeks gestation.¹

Medication abortion care is an important option for individuals who do not wish to have an in-clinic abortion procedure. Furthermore, because it can be completed safely from home, the ability to reduce time spent in a medical

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setting has been particularly crucial during the COVID-19 pandemic. Some patients may also prefer medication abortion care because the method is noninvasive.

Mifepristone has had a robust track record of safety in the twenty-one years since its FDA approval. Adverse effects occur in less than 0.3 percent of medication abortions in the United States, making it safer than common medications like Tylenol and Viagra.² Although medication abortions do not yet make up the majority of abortions in the United States, that proportion is increasing: they made up 39 percent of abortions in 2017, up from 29 percent 2014.³

Restrictions on Medication Abortion Provision

Despite the medication's safety, mifepristone is overly regulated in the United States, making access limited. Mifepristone is subject to an onerous form of restriction from the FDA known as a Risk Evaluation and Mitigation Strategy (REMS). The "elements to ensure safe use" imposed by the REMS restrictions on mifepristone are threefold: 1) the medication can only be administered by "certified" providers, which involves registering with the drug manufacturer, 2) it can only be dispensed in certain settings: retail pharmacies are prohibited from dispensing the drug and it cannot be dispensed by mail, and 3) patients must sign an informed consent form acknowledging that they are aware of the drug's risks. It is also required that the provider act as both health care provider and pharmacist by stocking the medication in their office or clinic.

These dispensary requirements remain in place despite the fact that the drug's label allows patients to safely self-administer the drug without clinical supervision. Mifepristone is the only drug—of over 20,000 FDA approved medications—that must be dispensed in a clinical setting but can be taken at home.⁴

The REMS is designed for medications with serious safety concerns in order to ensure that the medical benefits outweigh the risks, and applies to very few drugs.⁵ Because mifepristone does not have safety concerns that meet these criteria, reproductive rights organizations have argued that

the REMS restrictions are unlawful: the regulations burden patients and providers, and act as a barrier to access while not being necessary for patients' safety.⁶

Providing Medication Abortion Care through Telemedicine

What Is Telemedicine?

Telemedicine is the remote provision of health services and is generally defined by insurers as live videoconferencing or remote patient monitoring (whereas telehealth is used more broadly to refer to a wider range of telecommunication tools, including email and online portals)⁷ Although telemedicine has long been proposed as a solution to a variety of public health issues, such as rural hospital closures, its use in the United States was not widespread before the COVID-19 pandemic. The change since the outbreak has been dramatic: telehealth usage in April 2020 was seventy-eight times higher than in February 2020, and has since stabilized at thirty-eight times the pre-pandemic baseline.⁸

Given that medication abortion can safely be administered outside of a clinical setting, the treatment has been offered remotely in many settings globally, and particularly in countries with limited access to safe in-clinic abortion. The pills can be mailed to patients directly in their homes or to their local pharmacies. Women on Web (WoW), one of the pioneers in this space, began delivering medication abortion by mail in 2006 to countries without access to safe abortion. Screening is provided for contraindications, support is provided to those who use the services, and outcomes are similar to abortions provided in outpatient settings.⁹

Other international studies of telemedicine use for abortion show similar results. Abigail Aiken, associate professor of public affairs at the University of Texas at Austin, led a study in Great Britain and spoke with this report's author about the findings. Dr. Aiken described her results thus:

The population of people we were able to study was 85 percent of all medication abortions that took place

in the four month study period. Around 70 percent of people got the telemedicine model. And the safety and effectiveness rates were no different from the in-person service before the pandemic emerged.

Furthermore, Dr. Aiken reported that not only were outcomes comparable, but patients appreciated the service:

...we found that the vast majority of people were very satisfied with the model. And that, in fact, many preferred it, and said, “If I was coming back for abortion care, I would prefer telemedicine over having to go through all of the hoops that are required for in-clinic care.”

In the United States, remote provision of medication abortion has been available since 2016—albeit with more hurdles than in other countries’ models, with some in-person testing requirements—through the TelAbortion Project. By implementing the project as part of a research study, TelAbortion was granted the ability to dispense medication abortion to patients via mail. Screening tests, if needed, (such as ultrasounds, pelvic exams, or blood tests) are done at laboratory sites and radiology centers, and communication with abortion providers is done completely through videoconferencing. A peer-reviewed evaluation of the study found that the service was “safe, effective, efficient, and satisfactory.”¹⁰ A 2019 systematic review of telemedicine use for medication abortion supports the practice: outcomes were similar to in-person care, with high rates of completed abortions, very low rates of complications, and high acceptability on the part of both patients and providers.¹¹

Why Use Telemedicine for Abortion Care?

Remote provision of abortion is a key advancement not just because it is feasible and safe, but also because it better meets the needs of the many individuals who do not live within a reasonable distance to an abortion clinic. As of 2017, the vast majority (89 percent) of U.S. counties lacked abortion providers, with 38 percent of women of reproductive age residing in those counties.¹² In 2014, 17 percent of patients traveled between twenty-five and forty-nine miles

for abortion care, and an additional 18 percent traveled fifty miles or more.¹³ Recent research has demonstrated that greater distances to abortion providers are associated with lower rates of abortion, and increasing the availability of telemedicine use for medication abortion care could help address this unmet need for abortion access.¹⁴ For those who are able to travel long distances to abortion providers, travel results in additional costs: for transportation at the least, and often for child care and missed work as well.¹⁵

Black birthing people and other marginalized communities are inevitably hit hardest by obstacles to abortion access. In 2014, three-quarters of abortion patients were low-income, and Black women were substantially overrepresented.¹⁶ These disparities are due to a complex web of factors stemming from structural racism, inequitable access to resources like preventative health care, and a legacy of discrimination and reproductive coercion in the U.S. health system.¹⁷

The COVID-19 pandemic has only increased these disparities in access. Like so many Americans, abortion patients have faced tighter financial constraints and women, low-wage workers, and non-white people have borne the brunt of this recession. Child care options—which are crucial supports in this matter, as most abortion patients are already parents—became more limited due to social distancing requirements, with the greatest impacts being felt among families of color.¹⁸ Particularly at the start of the public health emergency, many states attempted to use the pandemic as an excuse to further limit abortion care, again increasing burdens disproportionately for women and pregnant people of color.¹⁹

There are other reasons abortion patients may want to avoid in-person visits to clinics. The presence of protesters outside of abortion clinics can create stressful situations for patients seeking care.²⁰ This is particularly true for patients of color, as anti-abortion extremists have long had ties to white supremacists. Black patients in particular are often targeted with racist rhetoric employed by the anti-abortion movement.

In addition, the pervasiveness of abortion stigma means that people seeking abortion may not want to disclose their care to the people in their life, and avoiding an in-person visit may help them do that. For other marginalized individuals, including undocumented immigrants, receiving care from home may alleviate concerns around seeking care.²¹ In particular, groups that have experienced historic and present-day abuse at the hands the U.S. health care system, especially Black women and birthing people, may appreciate the ability to separate their abortion from a clinical encounter.²²

Making all options in abortion care available to women and birthing people is key to achieving abortion justice. Whether a patient prefers to receive care in their home, community health center, abortion clinic, or elsewhere, every person should have an opportunity to make that decision free from external interference—including from burdensome and medically unnecessary regulations.

Changes to Telemedicine Abortion Provision During the Pandemic

The pandemic has pushed telehealth technologies to the forefront: many patients prefer to avoid unnecessary in-person appointments, and the same holds true for abortion patients. Providers adopted measures to reduce clinic visits for medication abortion and saw an increase in the number of first-trimester patients choosing medication abortion over in-clinic procedures.²³

Recently published research drives home the popularity, safety, and efficacy of abortion care using telehealth. During the pandemic, enrollment in the TelAbortion study shot up: monthly enrollment tripled in April, May, and June of 2020 compared to the January and March of that year. Study enrollees' satisfaction was overwhelming, with 85 percent stating that they would choose TelAbortion again; nearly all reported that they would recommend the service to a friend. Crucially, clinical outcomes during the pandemic demonstrated high rates of abortions completed without the need for a procedure (95 percent) with very few adverse outcomes.²⁴

To ensure the availability of abortion during the COVID-19 pandemic, researchers developed the telehealth care for medication abortion protocol.²⁵ This model allows for all aspects of the medication abortion process to be completed without in-person encounters.

Ushma Upadhyay, associate professor at Advancing New Standards in Reproductive Health (ANSIRH), a research group at the University of California, San Francisco, has researched the change in telehealth usage by abortion clinics since the start of the pandemic:

In April and May of 2020, we surveyed over a hundred independent abortion providers nationwide and 41 percent said that they started or increased telehealth [for patient consultations and screening] as a result in response to COVID.

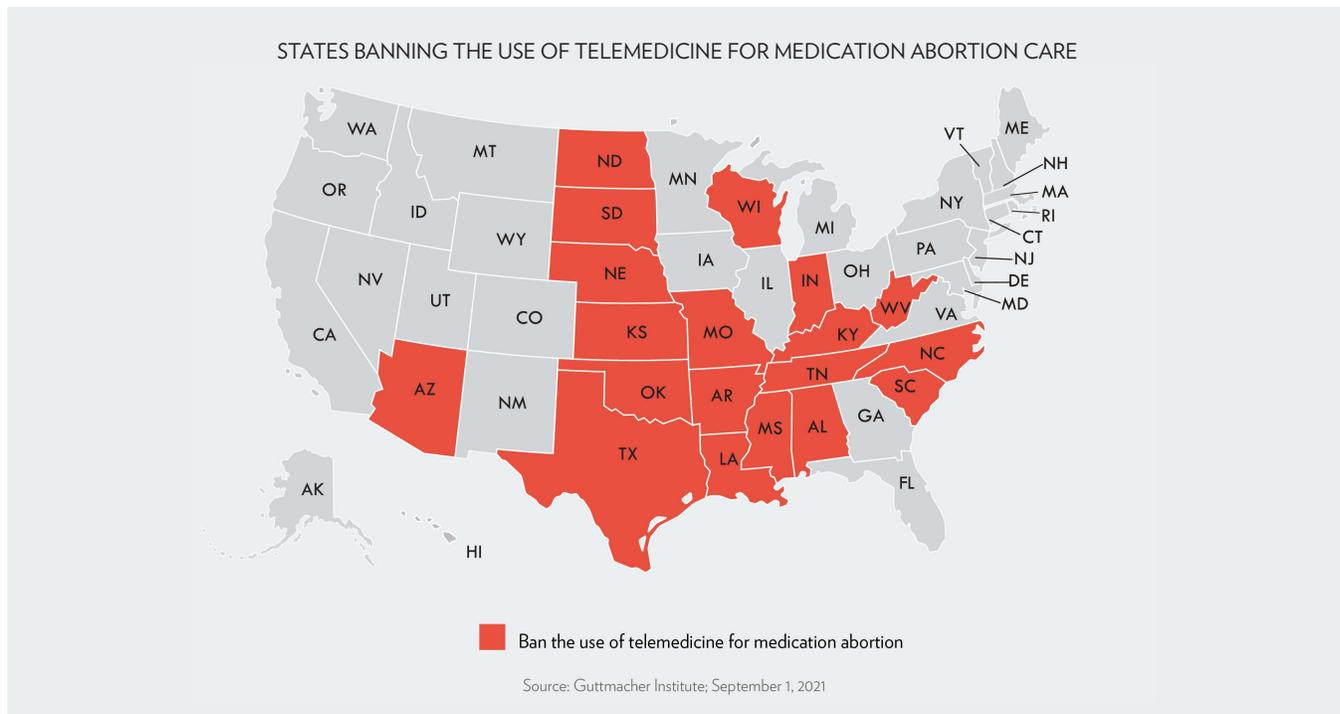
Almost 90 percent of clinics surveyed reported changing their clinical practice in some way in response to the pandemic.²⁶

The legal landscape for telemedicine provision of mifepristone has also changed over the course of the pandemic. In July of 2020, a preliminary injunction was placed by the U.S. District Court for the District of Maryland on the FDA's enforcement of the REMS requirements. The ruling stated that the in-person dispensing requirements placed an undue burden on patients as well as placing their health and economic security at risk—in addition to that of their families and abortion providers—by forcing unnecessary exposure to COVID-19.²⁷ This injunction was in effect until it was stayed by the Supreme Court in January 2021.

One recent analysis, for telehealth medication abortion care provided during the window between July 2020 and January 2021, found that outcomes were comparable to in-person care.²⁸ The 95-percent efficacy rate demonstrates the safety and feasibility of abortion care delivered with telehealth and medication distributed via mail.

Implementation of the REMS requirements was paused again in April 2021, when the FDA notified the American

FIGURE 1



College of Obstetricians and Gynecologists (ACOG) that they would “exercise enforcement discretion” during the public health emergency. In effect, this has allowed for the provision of medication abortion care using telehealth, but only in states that do not have existing restrictions requiring in-person care. Then, in May 2021, the FDA announced that they would conduct a full review of the REMS restrictions on mifepristone. This long-awaited review is currently ongoing, and its results could have important implications for how mifepristone may be dispensed. If the review is not completed by the end of the public health emergency in place during the pandemic, the current enforcement discretion will remain in place for thirty days following the termination of the emergency.

Additional Barriers to Equity

State-Level Abortion Restrictions

Beyond the burden of REMS, states have passed laws that single out medication abortion care to further restrict access. These laws play a key role in determining whether or not telemedicine provision of medication abortion will be permitted, even if the FDA’s review follows the evidence and

removes the REMS restrictions on mifepristone.²⁹ Even now, as the REMS are lifted for the duration of the public health emergency, remote provision is only permitted in certain states. Currently, nineteen states explicitly ban the use of telemedicine for medication abortion.³⁰

These laws are part of a pattern of medication abortion restrictions that are based in politics rather than science. Earlier state laws attempted to restrict how medication abortion is administered, requiring adherence to the FDA regimen. This regimen was not aligned with the contemporary evidence and clinical standards before it was updated in 2016, meaning laws prior to this time mandated use of an outdated protocol. Dr. Upadhyay at ANSIRH studied the effects of one such Ohio law, which went into effect in 2011. In comparing the outcomes with the pre-law period, she says:

We found that patients who received their medication abortion while the law was in effect had three times the likelihood of requiring additional interventions to complete the abortion compared to those who received their abortion in the pre-law period. And so I think it shows that when politicians create policies

*about abortion care, they don't really take into account the latest medical evidence, and it could harm women eventually.*³¹

Even in states that do not ban the use of telemedicine for medication abortion care outright, other restrictions on abortion can make it impossible for patients to receive care without making a trip to a clinic. Mandates on in-person abortion counseling, often paired with waiting periods, act as two-visit requirements, thereby doubling patients' travel time, missed work, and other related burdens.

Another type of abortion restriction limits which health care professionals can legally provide abortion, keeping advanced practice clinicians (APCs) such as nurse practitioners, certified nurse midwives, and physician assistants from delivering abortion care. This is despite the fact that research has shown that APCs can safely provide abortion—both medication abortion and in-clinic (aspiration) abortion.³² Although some states allow for APCs to provide only medication abortion, others do not allow for non-physicians to provide this care, which contradicts guidance from the World Health Organization, the National Academies of Science, Engineering, and Medicine, and the National Abortion Federation.³³ Restrictions that limit abortion provision to physicians have particularly harmful impacts in rural areas, which are much more likely to face physician shortages.³⁴

These state-level restrictions, which are not medically necessary, create unequal access to abortion across the country. By making abortion—including medication abortion care—difficult or impossible to access, the right to abortion becomes a right in name only.

Access to Technology and the Digital Divide

Disparities in access to technology present another barrier to telemedicine provision of abortion. Although the Federal Communications Commission (FCC) estimated in its 2020 report that 14.5 million individuals in the United States lack broadband access, an independent review found that number to be significantly higher, at 42 million people. The

digital divide, and access to home broadband in particular, has the greatest impact on Americans with low incomes, Black and Hispanic households, and older adults.

As of now, most reimbursements for telehealth services are limited to those that require stronger broadband connections and computers or smartphones, such as live video conferencing. Asynchronous communication (such as emailing) and audio-only phone calls are less likely to be reimbursed, and reimbursement policies vary by state. This creates a divide in access to telehealth—including medication abortion via telemedicine—that could exacerbate existing inequities both in abortion access and across other much-needed health care services.

Cost and Insurance Coverage

As is the case with all methods of abortion, insurance coverage of medication abortion care in the United States is heavily restricted. The Hyde Amendment and related abortion riders prohibit coverage of abortion (except in very limited circumstances) for Medicaid, Medicare, and Children's Health Insurance Program (CHIP) enrollees, federal employees, District of Columbia residents, people receiving care through Indian Health Services, veterans, incarcerated individuals, Peace Corps volunteers and others. Although sixteen states allow state Medicaid funding for abortion services, the vast majority of low-income people are barred from using their health coverage for abortion care. Given the makeup of Medicaid and CHIP recipients, these restrictions disproportionately impact people of color and young people. Black and Hispanic individuals are overrepresented among Medicaid recipients, and over half of Medicaid and CHIP recipients are ages 20 and under. People of color are disproportionately covered by public insurance due to a web of interrelated factors including historic and current discrimination, income and resource inequality, and disparities in health care.

Restrictions on abortion coverage are not limited to public insurance, however: privately insured individuals may face barriers to affordable abortion care as well. Half of all states currently restrict abortion coverage on plans offered on the

Marketplace created by the Affordable Care Act (ACA), twenty-two states do so in insurance plans for public employees, and eleven states restrict abortion coverage in all private insurance plans, including those offered under the ACA.

Cost for abortion care is not insignificant and can often be unsurmountable for pregnant people. In 2017, patients paid an average of approximately \$550 for their abortion care.³⁵ As mentioned earlier in this report, restrictions on abortion access and the limited number of providers add costs beyond the price of the procedure or medication itself. These ancillary expenses include transportation, lost wages, and child care. Some patients may delay paying bills or basic living expenses in order to cover the cost of their abortion; a survey fielded in 2011 found that abortion patients delayed or did not pay expenses such as rent (14 percent), for groceries (16 percent), or utilities and other bills (30 percent).³⁶

To help meet the needs of patients struggling to finance their abortion care, communities across the country have established mutual aid organizations that help fund abortion procedures (and often related costs). Abortion funds rely on private donations and play a crucial role in assisting patients who cannot afford to pay for their abortions. However, these organizations cannot fund every patient or every abortion and are only necessary because of the numerous restrictions placed on abortion coverage at the federal and state level. The demand for funding has only increased during the COVID-19 pandemic, with more abortion patients out of work and unable to cover the cost of their care. Funds have seen an increase in calls and greater need for support from their clients.

Perspectives of Abortion Providers

Abortion providers have experienced firsthand the limitations placed on their practice by the mifepristone REMS and other restrictions on abortion provision. Most importantly, providers witness the barriers their patients face accessing medication abortion care, and how advancements like telemedicine impact their experiences. The author of this report interviewed abortion providers that have offered care

both in-person and via telehealth about their experiences, and about their perspectives on how equity might be improved in access to medication abortion care.

Maine

Leah Coplon, at the time of this interview, was a nurse midwife and program director with Maine Family Planning, which has been providing medication abortion care via telemedicine since 2014. For the first several years, though, provision was limited to physicians only, which made access to medication abortion care still challenging:

The nurse practitioners couldn't provide medication abortions independently, and then in 2019, there was legislation that was passed that allowed nurse practitioners, nurse midwives, and physician assistants to provide abortions. So that really changed our whole telehealth model, because now we didn't need to have the patients connect with the physician, they could just go to their local clinic, and that was great.

Maine Family Planning saw demand for telehealth abortion care increase dramatically during the COVID-19 pandemic. Even as restrictions loosen, there is evidence that many patients will continue to choose receiving abortion care via telemedicine—regardless of a public health emergency. As Coplon says:

...even as Maine starts to really open up, most things are pretty back to normal here. There are no more mask mandates, no more gathering limits. But people are still really choosing that telehealth model, so it seems to be really popular with patients to be able to just get their abortion remotely.

Coplon heard a variety of reasons from her patients about why they choose telemedicine for their abortion care:

I think that people have obviously so many associations with an abortion clinic, and protesters, and stigma...I think once they hear, "Oh, I just have to connect the video for someone for like twenty minutes," it just

opens up so many possibilities in terms of the time. They don't have to take half a day off work. They don't have to find child care...I think it just seems to fit in[to] their day.

In addition to allowing APCs to provide abortion care, Maine also now provides coverage of abortion with state funds for Medicaid eligible Mainers. This combination of legislative changes drastically altered the landscape of abortion provision in Maine, Coplon says. But despite gains in abortion coverage, barriers to medication abortion still exist in the state. One of these challenges is a lack of awareness around medication abortion and its safety and efficacy, particularly letting patients know that, with telemedicine, they are “offering something that is evidence-based, it’s safe, it’s equal to the service that we provide in-clinic. It’s just one more option, but it’s not substandard.”

Hawaii

Dr. Bliss Kaneshiro is an obstetrician/gynecologist with the University of Hawaii, where her practice focuses on family planning. Hawaii, though it has relatively liberal abortion laws, has geographic obstacles to abortion access.

Our abortion providers were really limited to Oahu and Maui...every day, we saw patients who [were] flying over from the neighbor islands to get abortion care. And especially in the case of medication abortion, the visits can be short. So you know, they fly over, and they're out of the office in less than an hour...we talk to them for maybe 30 minutes, they get the medication, they're on their way. And it just seemed like such a waste of time and resources and [a] huge inconvenience for patients, they have to find childcare [and] take time off from work.

The convenience of telemedicine for her patients has become clear to Dr. Kaneshiro. They can fit their consultation into their day, and telemedicine may even allow patients to more easily keep their abortion confidential, which can be critical to the safety of patients with abusive partners or partners who do not support their pregnancy decisions.

It's allowed [us] to make what would usually be even for a patient who lives on Oahu, who [are] going to need a couple hours to come to the office, they can do the visit in 30 minutes, and so they don't need to take the time off from work and drive any place and commute anywhere.

...we had a patient who mentioned that the partner—she was in an abusive relationship—that relationship that she was trying to get out of, and her partner had a tracker on her phone, so he knew where she went. So being able to just be in her own space was important for her to be able to get the care she needed.

It is important to note that providers are able to make a connection with their patients via telehealth. Dr. Kaneshiro noted that even from the provider perspective, seeing patients via telemedicine has some advantages over in-person visits:

It reminds me of why I became a doctor—having that connection with patients. It's nice. It's almost nicer than when you're in an office kind of rushing around in between rounds.

A Multi-State Model: Abortion on Demand

Dr. Jamie Phifer provides care through Abortion on Demand (AOD), which offers medication abortion care via telemedicine in over twenty states. By becoming licensed in all of the states in which AOD operates, and partnering with a mail-order pharmacy, Dr. Phifer is able to see patients across the country at a much higher volume than she would through an in-person practice.

Similar to Dr. Kaneshiro, Dr. Phifer finds that the connection with patients over telehealth can be even more comfortable than in-person visits. This may be in part because of the removal of external stressors and stigma like clinic protesters.

They're so happy, they're relaxed. The questions that people ask are so different, I'd say, on a telemedicine visit when they're in their own homes. They're sitting

in their own car...for the most part, I think that the patients are more engaged in the counseling itself, because they're not running through like their escape plan from the protesters in the back of their mind. They're not going through what some people consider a traumatic experience, they're not having to engage in traditional, frankly, patriarchal healthcare systems. They're just in their car, they're in their living room. They're breastfeeding their baby.

Models like AOD are promising and can provide additional options for people seeking abortion, but the expansion of telemedicine provision of abortion must be balanced with access to in-person services. Both because of personal preferences and the need for different methods of abortion care, it is crucial that telemedicine is not expanded at the expense of physician clinics. For this reason, AOD donates a majority of its profits to Keep Our Clinics.

Because as we accelerate telemedicine abortion care, we have to consider the impact it's going to have on in-person clinics...some people just want to be seen in person.

Patients' Experiences, in their Own Words

Interviews with Abortion Storytellers

Patients opt for medication abortion care over in-clinic procedures for a number of reasons. The author of this report spoke with several people who had medication abortions about why they chose that method and what the experience was like for them.

Kristine Kippins, a storyteller with We Testify who received medication abortion care during college in the late 1990s, emphasized the intersections of her own abortion story. Kippins noted the duality of accessing abortion as a Black woman and child of West Indian immigrants, while also holding a number of privileges: having received comprehensive sexual health education, living in a state

(New York) with few restrictions on abortion, and holding a job that allowed her to pay for care out-of-pocket.

It's possible that my insurance would have covered my abortion, but you know, I didn't want my parents to know and I had the ability to circumnavigate my parents in all of this. I was 19. I was of age where I didn't have to get their permission, or ask the judge, and I had really compassionate, caring, competent care at Planned Parenthood. I had a lot of privileges, including my sex ed, which gave me so much education on pregnancy and my fertility, that I was able to know what I want, and be able to monitor my body and know what's going on with my body and take care of it in the manner that was consistent with how I wanted it to be."

Comprehensive sexual health education is key for all adolescents, but given the gestational constraints on medication abortion, being able to recognize early pregnancy can mean the difference between having the option for medication abortion or not: "...I think comprehensive sex ed is incredibly important. And I might have even been further along, past the point of medication abortion if it wasn't for my sex ed education, and being able to track my period, track my fertility."

These privileges notwithstanding, the reality of abortion access still meant inconveniences for Kippins, who had to travel from through several New York boroughs via public transportation to pick up the medication. As she puts it, "if I could have just gone down the street to my pharmacist, and just pick up a packet of pills that would have been so easy."

Still, the ability to choose medication abortion and access it so early in her pregnancy brought enormous relief to Kippins. Immediately after confirming her pregnancy, she went into a clinic and that day "I got the injection in my arm and a prescription for the pills. And I picked up the prescription [and] went home."³⁷

Lexi, also an abortion storyteller with We Testify, received medication abortion care while attending college in

Massachusetts. Like most people who have abortions, Lexi had more than one reason for that decision, including feeling physically ill during her pregnancy. When she called the obstetrician-gynecologist (ob-gyn) in her health care practice, her concerns were essentially dismissed:

...I know that people get sick when they're pregnant, but this just—I know my body and this is not right, I feel like I'm dying. And they were essentially like 'we can't see you till you're ten weeks [gestation]' like 'I don't know what to tell you, that's normal'. And...I didn't really have anyone to go with me to the ER and was scared that the people I was living with would find out [about my pregnancy]. So at that point, I was just like, I need an abortion, because if I continue my pregnancy like, I'm gonna die. So just that alone, like as a young Black woman, not having to be pregnant in a space where I felt like I was not going to get care, even if I was pregnant was just the utmost relief that I've ever felt in my life.

Because Massachusetts allows state Medicaid funding for abortion care, Lexi was able to avoid the financial strain that so many abortion patients face. “It was fairly easy, in financial terms, for me to go and access an abortion at Planned Parenthood,” she said. “I didn’t have to worry about—I didn’t even have a copay. And that was great for me, because I literally only [had] \$30 in my pocket. And that was just enough for gas to get to the clinic.”

Lexi chose medication abortion so that she could end her pregnancy at home, in a setting where she was most comfortable: “I was in my room, my best friend came over—I wasn’t in a very safe environment, [in the sense] that I couldn’t tell the people I was living with that I was pregnant. So we were just in my room. I took them and we put on Beyonce’s Homecoming on Netflix, and I laid there.”

I'm [an] introvert. I love my room. I love being cozy in my home...that's really why I chose it. And because I didn't know much about abortion at all. And so just hearing the word surgery and not having any type of reproductive health care experience before, [an

in-clinic procedure] seemed very overwhelming and terrifying to me.

Still, Lexi did have to go to the clinic in person to take the first set of pills—a situation that could be avoided with telemedicine provision of medication abortion.

It would have been easier if I could have taken the first set of pills at home, just because I was kind of in—not even kind of—I was in a panic when I was [at] the first appointment. And it wouldn't have changed my decision. But it definitely would have allowed me to calm down and just take care of myself while I did it.

Stigma around abortion and the stress it places on people seeking abortion can create trauma for patients. As Lexi puts it:

It wasn't my abortion that was traumatizing. It was every single external barrier that I was facing, like the stigma that my family and people around me had regarding abortion, that I didn't feel safe to tell them, or having to go and tell all my professors my situation, because, in academics, if you don't have a 10 page note about why you need to miss a class on Wednesday, then you're going to fail. And not even having money to go get heating pads, so I could be comfortable. Those were things that made my abortion harder.

Similar to Kippins, being in a state with relatively few abortion restrictions did not mean abortion clinics were conveniently accessible to Lexi.

Even though we do have a good number of clinics, there's some places that are still far out [where] it's a whole day process if you need to get care. And what if you don't have a car? We don't have good [public] transportation systems, really only in Boston... so there's still a lot of places where you can go get [abortion care], you might not have to pay for one, but can you even get there? Do you have internet to even make the appointment?

Researchers' Findings from TelAbortion Patients

Patients who received abortion care via telemedicine through the TelAbortion study reported an appreciation of the greater convenience and privacy afforded to them by remote provision of abortion care. A qualitative study consisting of interviews with TeleAbortion participants found that the process was highly acceptable and often much more convenient than going to a clinic in-person, and also alleviated concerns about privacy.³⁸

As one of the study's interviewees described: "When this all [TelAbortion] was offered to me, it was kind of a no-brainer. It was more affordable, and also with a child and also being in school, it makes it difficult to make an appointment and then make arrangements for childcare...so it was just incredibly convenient."

The issue of cost was also salient, with another participant noting that an in-person care "definitely would have cost more, just I would have had to travel. And it was from what I saw online, I feel like it was going to be an all-day type of thing...Maybe I would have even had to stay the night...It would have been more expensive."

The benefits offered by telemedicine abortion care only increased in the light of the COVID-19 pandemic. As one participant described: "With the coronavirus being an issue, I didn't want to expose myself medically to any risk that I didn't need to take. So the fact that it was all video conference, phone calls, and mail made it an easier choice for me."

A Holistic Approach to Reproductive Health

Medication Abortion: Just One Aspect of Abortion Care

Critical as medication abortion care is, it is only one piece of the full spectrum of reproductive health care. Medication abortion access cannot be expanded at the expense of other methods of abortion care and the existence of brick and mortar clinics; medication abortion care will not be

appropriate for every patient and each individual should have options and be free to choose how they receive their care.³⁹

There will be no single solution to make abortion, and medication abortion care specifically, accessible. Searching for a quick fix or panacea to guarantee equity in abortion care is a trap we must avoid, says Dr. Jamila Perritt, president and CEO of Physicians for Reproductive Health. She adds:

Some people will always want clinic-based care, some people will never want clinic-based care, and then there's a huge spectrum in between. Somebody will only want medication abortion, somebody would never want medication abortion, and then there's spectrums in between, right. So again, pushing back on this monolithic thought, this homogeneous thought about what abortion is supposed to look like, I think will only free us in being creative around designing equitable situations, systems, and circumstances.

Reproductive Justice and the Spectrum of Reproductive Health Care

Efforts to expand equity in abortion must go hand-in-hand with ensuring access to maternal and postpartum health care and contraceptive care. This is particularly important among people whose pregnancies put them at higher risk for dangerous and potentially life-threatening complications, most notably Black and Native women and birthing people. Women and birthing people must have the ability to access the services they need to both support healthy pregnancies and be themselves mentally and physically healthy before, during, and after pregnancy.

The use of a reproductive justice (RJ) framework is necessary in achieving equity: RJ uses a human rights framework to address the needs of birthing people holistically, including the right to have children, not have children, and parent safely. Reproductive justice also acknowledges the root causes of disparities in health access and outcomes, particularly as they relate to intersections of race, class, and gender. No matter how accessible or affordable medication abortion

access becomes—and that itself is far from becoming reality—abortion access alone is not enough. Reproductive justice cannot be realized without also providing access to high-quality, equitable maternity and postpartum care.

As Dr. Perritt points out, RJ is a community-building framework, based on people organizing to meet the needs of their own communities. In true reproductive justice work, she says, this requires introspection for providers, advocates, and leaders in the reproductive health field:

How far removed am I from the community that I claim to care about and am charged professionally with caring for? And how can I continue to reground myself in the work from that frame? I don't know that the right folks are doing this work. And so what does a power shift look like in that space as well?

In the long term, equity in reproductive health will require a power shift, and that must include channeling resources and autonomy to community-based organizations, particularly those led by Black, Indigenous, and other people of color. The recommendations put forth below represent immediate policy changes that would make progress towards achieving equity in medication abortion care.

The Role of Telehealth beyond Abortion

Crucially, advancements in telehealth have promising implications for areas of reproductive health beyond medication abortion. Telehealth has been used in the delivery of pregnancy care, including remote patient monitoring of health issues that lead to maternal mortality and morbidity.⁴⁰ One such effort, the Maternal Telehealth Access Project (MTAP), was created in response to the COVID-19 pandemic to meet the needs of birthing people of color, particularly Black women.

Just as with abortion care, telehealth capabilities must be strengthened alongside access to in-person maternity care. This is vitally important given that 2.2 million women of childbearing age already reside in maternity care deserts where there is no access to obstetric care.

In the field of contraceptive care, “telecontraception” platforms are gaining popularity. These models allow individuals to access birth control without an in-person visit, receiving prescriptions directly to their home or local pharmacy.⁴¹ Access to abortion, including medication abortion, must be integrated into the delivery of reproductive care, including contraceptive access and maternity and postpartum care.

Looking Forward: Recommendations to Improve Equity in Abortion Care

Updating the Mifepristone REMS and Label

The FDA is in the midst of reviewing the available evidence and evaluating the necessity of the outdated REMS restrictions. This rigorous and non-partisan process should follow the science to eliminate the medically unnecessary REMS restrictions, removing barriers to medication abortion access. It is well established that mifepristone can be dispensed safely outside of clinical settings. Abortion patients should be able to avoid burdensome in-person visits to receive medication taken at home.

Removing the REMS requirements would have immediate impacts on the availability of medication abortion care. A recent study examining willingness of ob-gyns to provide medication abortion care found that removal of the in-person dispensing requirement may double the number of clinicians providing mifepristone.⁴² Elimination of the requirements could also help decrease stigma around the medication. This mitigation of stigma, along with removing barriers to stocking, may make more clinicians such as primary care providers more likely to provide mifepristone—both for medication abortion and as treatment for early pregnancy loss.⁴³ The combination of mifepristone and misoprostol is the most effective treatment for miscarriage management, yet providers are often unable to offer this care because of the politically-motivated restrictions on mifepristone.⁴⁴

In August, a congressional resolution was announced urging policies around medication abortion care to be equitable

and grounded in science, including removing the REMS restrictions. The resolution was introduced in the House of Representatives by Representative Carolyn Maloney (D-NY-12) along with seventy-five cosponsors.

Beyond changes to the REMS, the FDA could decide to make additional changes to the mifepristone label. One major change that is supported by the evidence base would be extending the recommended gestational limit for medication abortion. While mifepristone is currently indicated for seventy days according to the FDA label, research has demonstrated that it is safe and effective up to seventy-seven days gestation.⁴⁵

Eliminating Medically Unnecessary State Abortion Restrictions

As discussed earlier in this report, restrictions in many states mandate in-person dispensation of mifepristone even if the FDA lifts the REMS requirements. Laws that apply specifically to telemedicine provision of abortion, in addition to in-person counseling requirements and other restrictions, will make it so that limitations on medication abortion access remain in place regardless of the FDA review. It is well-established that the ongoing barrage of politically motivated restrictions at the state level make abortion harder (or even impossible) to access without increasing the safety or well-being of patients.⁴⁶

In response to these laws, the Women's Health Protection Act (WHPA) has been re-introduced in Congress. WHPA would create a right to abortion for both patients and providers, so that states cannot pass burdensome, medically unnecessary restrictions on abortion access, including those that restrict access to medication abortion care. It is crucial that WHPA is signed into law to make the right to abortion more than a right in name only, regardless of what state you live in.

Passing WHPA has only become even more important in recent weeks. As of September 1, a Texas law is in place prohibiting abortion after six weeks of pregnancy, effectively banning almost all abortions in the state, while the state

legislature also considers further restricting medication abortion care to seven weeks gestation. The Supreme Court has allowed this six week-ban to remain in place despite directly contradicting the core holding of *Roe v Wade*. This comes months after the Supreme Court announced that it would take up a case regarding a fifteen-week abortion ban law from Mississippi, which also presents a direct challenge to *Roe v Wade*. Regardless of the outcome of the Texas law and this upcoming case, *Roe* alone has never been enough, and WHPA is needed to equitably bolster the right to abortion.

It is worth noting that, in addition to defending against burdensome restrictions, there are opportunities to proactively increase access to medication abortion care. Some states have explored laws to make medication abortion more accessible for students on college campuses. In 2019, California passed a law requiring college campus health centers to provide medication abortion care, with operating costs covered by donations from private funders.⁴⁷ Offering this care on campus mitigates many of the barriers facing students seeking abortion, including travel to facilities which often interferes with class schedules and potentially higher costs at off-campus providers.⁴⁸ Massachusetts is currently considering a similar law, suggesting that other states could expand access to medication abortion care through college health centers.

Insurance Coverage

In order for medication abortion to be truly accessible, it must be affordable. Abortion is health care and should be treated as such, meaning it must be covered by insurance like any other medical procedure or service. As discussed in this report, people working to make ends meet and people of color are disproportionately insured by government health care programs that are currently prohibited from providing abortion coverage. Abortion coverage should be available for pregnant people insured or receiving care through programs including Medicaid, Medicare, the IHS, and the VA, as well as Peace Corps volunteers, individuals incarcerated in federal prisons, and others reliant on government programs subject to harmful abortion riders. To make this a reality, Congress

should pass the Equal Access to Abortion Coverage in Health Insurance (EACH) Act and pass budgets that do not include riders prohibiting federal funding of abortion. A key first step in this direction has recently been taken, with the House of Representatives' passage of appropriations bills without the Hyde Amendment and related restrictions.

Restrictions on abortion coverage in private insurance plans must also be removed, including Marketplace coverage and plans for public state employees. Policymakers can follow the lead of states that mandate coverage of abortion care within private plans, including some that require coverage without copayments.

When it comes to telemedicine use for medication abortion, state Medicaid agencies that do provide abortion coverage should cover abortion care via telehealth at the same rate as in-person services, and should expand telehealth reimbursement to audio-only and other delivery models that will better serve individuals with less access to technology.⁴⁹

Access to Technology

In order for telehealth to be accessible to the individuals who need it most, gaps in broadband access in the United States must be addressed. The COVID-19 pandemic has highlighted inequities in internet access as formerly in-person activities, from schooling to health care visits, have gone remote. Regardless of geographic location, there must be access to affordable and high-speed internet. The Biden administration, Congress, and state legislatures must work to bridge the digital divide and bring broadband access to all individuals, including providing subsidies to low-income families.

The Consolidated Appropriations Act of 2021 and the American Rescue Plan have made progress on this front by including funding for digital equity, including building physical infrastructure, lowering consumer prices, and training in digital literacy. The Senate's proposed bipartisan infrastructure bill includes an additional \$65 million for broadband, with the majority of that funding going towards broadband implementation grants in high-need areas.

Crucially, the proposal includes the Digital Equity Act, which would fund broadband projects in historically underserved communities. Congress should ensure that broadband and digital equity measures are included in the final infrastructure plan, with increased funding for programs focused on low-income households and communities of color that have been hit hardest by the digital divide.

Self-Managed Abortion

As this report has demonstrated, medication abortion care can be done safely from a patient's home, or the location of their choosing. Self-managed abortion (SMA) is generally defined as any action taken to terminate pregnancy outside of a medical setting, and can include self-sourcing and self-administering misoprostol and mifepristone without clinical supervision, as well as other less safe methods, such as other medications, ingesting herbs, inserting objects into the vagina. People may choose to self-manage their abortions for a variety of reasons, including inaccessibility of abortion providers, inability to pay for abortion care at a clinic, and the desire to avoid an in-clinic visit because of the stigmatization of abortion care. Data are limited on how many individuals self-manage their abortions in the United States; a recent study, however, estimated that approximately 7 percent of U.S. women attempt SMA at some point during their lifetime.⁵⁰ Given the scope of this report, this section focuses on use of medication abortion to self-manage. A recent review found that studies reporting on self-managed medication abortion (using misoprostol alone, or in combination with mifepristone) reported high levels of effectiveness.⁵¹

But even when pregnant people can access medication abortion to safely self-manage, terminating a pregnancy outside of a clinical setting can put them at legal risk. There have been a number of cases in which women have been prosecuted for self-managed abortion, under various state statutes.⁵² Not only do these laws threaten those who may not have other options for ending their pregnancies, particularly low-income individuals and those living in areas with limited abortion access, but they also pose a risk to pregnant people in need of substance use treatment and

women who have miscarried. As with the implementation of any law, enforcement is rarely equitable. Black women, girls, and birthing people are already disproportionately criminalized and are likely at greater risk of prosecution for SMA.

If/When/How: Lawyering for Reproductive Justice has an initiative devoted to decriminalizing SMA, as well as a recently launched legal defense fund to provide bail and defense for people who are investigated, arrested, or prosecuted for SMA. Other resources, such as Plan C and Women Help Women, offer information for individuals who are interested in self-managing their abortions by sourcing the medication online. Support systems such as these are particularly critical, and must be combined with access to non-judgemental, evidence-based, and respectful care for those that also present to a clinical setting before, during, or after a self-managed abortion.⁵³

The COVID-19 pandemic has demonstrated how people are already routinely trusted and empowered to manage many aspects of their own health care.⁵⁴ As with any health care decision, people seeking abortion care interact with the health care system to varying degrees. Dr. Perritt highlights this nuance in self-managed abortion care, that is often not captured in the narrative around SMA:

We kind of talk about self-managed abortion like it's an either/or kind of thing. Either you're self-managing your abortion, or you're seeking care inside the traditional, clinical health care system. And the truth is, I think that there's like all of this gray in between, I think people pop in and out of care. Sometimes we know that they've self-managed their care, sometimes we don't. Right? And I think that there's just a wider spectrum of what self-managed care looks like, including self-managed abortion.

Lifting the REMS on mifepristone and eliminating other laws that criminalize SMA would pave the way for a fully-supported SMA model in which individuals can access medication abortion in consultation with health care

providers and access to medical care if they need or prefer it at any stage.⁵⁵

Conclusion

Medication abortion care is an incredibly safe and effective method of pregnancy termination, yet more must be done to ensure that it is available to those who need it most. Currently, abortion, and mifepristone in particular, is heavily restricted and often inaccessible—physically and financially—to pregnant people.

Because medication abortion is typically taken at home, telemedicine is one way of ensuring that patients can receive the care they need without burdensome travel and logistical hurdles. The current FDA review of the mifepristone REMS offers a crucial opportunity for guidance to be aligned with the evidence base so that patients can receive mifepristone at the location that best meets their needs. Equitable delivery of medication abortion care via telemedicine also requires states to repeal laws that prohibit the service or mandate unnecessary in-person visits. As the circumstances forced by the pandemic demonstrated, medication abortion care can be offered safely and effectively using telehealth. The knowledge base to support remote provision of medication abortion care is robust, and guidance must be updated to reflect this evidence.

Even for those individuals that have the technological capability to use telehealth, it is crucial that in-person options remain. Many people, including abortion patients, may prefer to conduct visits in-person. Telehealth access must be increased without diminishing access to physical health facilities.

For medication abortion care to be truly equitable, though, solutions must go beyond telemedicine. To ensure that patients are able to use their insurance for abortion care, Congress should pass the EACH Act, and states should remove politically-motivated restrictions on abortion coverage within private insurance plans. Congress must also pass WHPA to make the right to abortion reality for providers and patients, rather than a right in name only.

Abortion care will only be equitable once it is affordable, accessible, void of unnecessary barriers, and available to all individuals in the method and location that they prefer.

Author

Anna Bernstein is a health care policy fellow at The Century Foundation, where she works on issues related to maternal and reproductive health.

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