



ABORTION NEEDS AND AVAILABILITY IN NEW JERSEY

A Report Prepared for the New Jersey Family Planning League

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Introduction

Against the backdrop of the US Supreme Court eliminating the constitutional right to abortion established by *Roe v Wade*, this report examines the current landscape of abortion care in New Jersey. It identifies potential opportunities for improvement or expansion of services to both state residents and people traveling from the growing number of states with abortion bans and restrictions.

Report Methodology

In 2023, the Rutgers School of Public Health, in partnership with the New Jersey Family Planning League, undertook an in-depth landscape analysis of the state of abortion access in New Jersey. New Jersey state abortion surveillance is known to be incomplete due to limited reporting requirements and does not provide a complete picture of care in the state. Instead, we drew on national data collection efforts, supplemented this with new analyses of the landscape of New Jersey providers, and contextualized the data by conducting qualitative interviews with abortion providers and key stakeholders in the state. For this landscape, we focused on facilities that perform abortions, either medication or procedural, that would be easy to find for a person seeking care. This conscious choice centers the people seeking abortion in our understanding of accessibility.

Key Findings

New Jersey is a unique abortion environment. Its abortion rate increased by 15% from 2013 to 2020; further increases are expected. In 2020, out-of-state patients accounted for 6% of all abortions performed in New Jersey; since the Dobbs decision, the number of abortions in New Jersey has increased. These increases are likely to continue, especially as more states in the Southeast further restrict abortion care. Providers describe a shifting composition of the patients seen, with an increase in “high-need” patients coming from out of state at later gestations.

Our search strategy identified 41 brick-and-mortar abortion providers in the state. There is a concerning gap in abortion availability in the southern counties of New Jersey. Five counties, Cape May, Cumberland, Hudson, Gloucester, and Salem, have no abortion providers identified in our landscape. Among the counties with abortion providers, not all offer the full range of abortion services that people might need; all identified clinics provide medication abortion, but only 22 (54%) additionally offer procedural abortion services. Six counties only have medication abortion providers, which means they cannot care for patients beyond 11 weeks of gestation. Despite the lack of a legal limit, no clinics in New Jersey provide abortion care through the 3rd-trimester. These patients, who often carry pregnancies with severe fetal abnormalities or face other health challenges, must travel out of state to access needed care, incurring increased costs and delays.

Telemedicine programs for medication abortion could help alleviate travel burdens for those in counties that a brick-and-mortar clinic does not currently serve. None of the providers we interviewed had an active telemedicine abortion program, though some are in development.

The referral systems between clinics and hospitals within the state are informal and inconsistent. When trying to connect patients to hospital care, high costs, delays in scheduling, and pervasive abortion stigma were raised as concerns by clinic providers.

New Jersey has the lowest Medicaid reimbursement rate for abortions of any state in the country, and providers find it inadequate and unsustainable. This low reimbursement has repercussions for the clinic business model and the patient care experience. An emerging challenge for clinics that offer procedural abortions is the increase in higher-need patients as healthier patients shift care to medication abortion-only providers (in person or online). Assuring access to procedural abortion care for patients ineligible or uninterested in medication abortion is essential. This entails attention to cost and reimbursement models and appropriate staffing, especially for medically complex patients who require more intensive care.

Despite considerable financial, legal, and logistical challenges, the New Jersey abortion providers that we interviewed are able to provide abortion care that is timely and patient-centered. Supplemented by practical support organizations and abortion funds, they seem to be able to meet the needs of New Jerseyans at present. However, there are several areas in which specific policy actions or additional research could help expand access to care for New Jerseyans and those traveling to our expanded-access state and reduce the reliance on philanthropic contributions to meet the demand for abortion care in the state.

Recommendations

Given the findings from this Landscape Analysis, several strategies emerged for expanding abortion services and supporting providers and patients. Our recommendations highlight four priority areas.

1 Increase Medicaid insurance reimbursement rates for abortion care to reflect the actual cost of high-quality care and support clinic sustainability.

2 Expand access by growing the number of abortion providers and clinics with a focus on promoting geographic equity and supporting clinics' efforts to adopt innovative models of care.

3 Increase public availability of information about abortion care in New Jersey and strengthen care coordination within and across states.

4 Convene experts and key stakeholders to reassess the role of the State abortion data system to support public health best while minimizing patient stigma and provider burden.

INTRODUCTION

The United States has experienced a surge in abortion-related legislation over the past decade. It climaxed recently with the US Supreme Court eliminating the constitutional right to abortion established by *Roe v Wade* in its *Dobbs v Jackson Women's Health Organization* opinion in June 2022. As of May 4, 2023, abortion is banned in fourteen states with limited exceptions and banned after six weeks gestation in one more;¹ more states are working to enact abortion bans or barriers. These restrictions will deepen profound inequities in abortion access in our country, with consequences for individuals and families' health and well-being.^{2,3}

The dark national picture for abortion access is not uniform. Some states have implemented draconian laws that make it nearly impossible for people to access abortion within their state. But other states are working to not only ensure access to abortion care for their residents but also to pick up the national slack. New Jersey is one of these protective states that has enacted

Box 1. New Jersey Has Expanded Abortion Rights and Access

- Provides statutory protection for abortion as "the fundamental right to reproductive autonomy"
- Prohibits state cooperation with legal actions arising from lawful provision of abortion in the state (shield law)
- Prohibits extradition of people charged with actions arising from the legal provision of abortion (shield law)
- Allows advanced practice clinicians can provide abortion care up to 14 weeks LMP
- Allows Medicaid coverage for abortion care
- Allows minors to consent to their own abortion care without parental involvement

New Jersey guarantees the "fundamental right to reproductive autonomy"

policies and practices to expand and protect abortion rights and access, including enacting a statute that recognized and codified the existing state constitutional right to abortion.⁴ Additionally, New Jersey has adopted laws and policies to safeguard both its providers and patients, even if they are from other states where abortion is restricted.^{5,6} (see Box 1)

A focus on supporting access to abortion care can be an important pillar in New Jersey's efforts to reduce maternal mortality and improve maternal health. Abortion is an essential part of the continuum of reproductive health care that improves the health and well-being of those who

need it.⁷ This calls for services and health systems supporting the full range of people’s reproductive needs.

Despite a surge in research on abortion access and experiences in various states, few studies have focused specifically on abortion care in New Jersey, either before or after the Supreme Court’s *Dobbs v. Jackson Women’s Health* decision. Thus, a base of abortion research specific to the New Jersey context is lacking. To address this gap, we drew on existing resources relevant to New Jersey, including national data collection efforts, supplemented this with new analyses of the landscape of providers, and contextualized the data by conducting qualitative interviews with abortion providers and key stakeholders in the state. (See Box 2 for a description of the interview sample and methodology.) This report examines the current landscape of abortion care in New Jersey and identifies potential opportunities for improvement or expansion of services.

To understand the abortion context in New Jersey before and after the overturning of *Roe v Wade*, we reviewed a range of existing research and surveillance conducted by well-respected organizations, including the Guttmacher Institute, the Society of Family Planning, and Advancing New Standards in Reproductive Health (ANSIRH). We have relied on these resources instead of the New Jersey Department of Health data because New Jersey state abortion surveillance is incomplete due to limited reporting requirements.

New Jersey data relies more on estimation than most other states and may be less precise because of high nonresponse rates from New Jersey abortion providers to national data collection efforts. For example, while the Guttmacher Institute engages in a very intensive data collection effort, reaching out to abortion providers in every state repeatedly to obtain data, due to problems due to challenges in getting data from some New Jersey providers, they have relied on estimates for about 40% of abortions in New Jersey --- more than for any other state.⁸

Box 2. Qualitative Interview Methodology

We conducted interviews with a wide range of key stakeholders in New Jersey. We spoke with clinic administrators and abortion providers, including physicians and advanced practice clinicians, individuals who serve a dual role of clinician and administrator, and clinicians who work across multiple clinics. We included independent providers as well as networks, and both ambulatory care settings and small health centers. To round out our understanding, we also interviewed clinics that offer family planning but do not currently offer abortion services.

We ultimately spoke with representatives of sites in New Jersey that are estimated to represent more than half of the total abortions performed in the state.

Each interview consisted of a series of open-ended questions designed to assess the current services offered, impressions of the state of abortion care in New Jersey, and the barriers and facilitators to improved access. Interviews were conducted via Zoom and transcripts were produced and reviewed for analysis. Rutgers University Institutional Review Board approved this study. (PRO2023000048)

Thus, even the relative gold standard of data on abortion counts is still a partial estimate for New Jersey. It is challenging to provide a clear and comprehensive picture of abortion care in New Jersey due to considerable data gaps.

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NATIONAL PATTERNS

The Guttmacher Institute’s Abortion Provider Census (APC) surveys all facilities known to have provided abortions, including clinics, physicians’ offices, and hospitals. The APC is conducted intermittently but uses consistent methods to allow for trend analysis between data collection rounds. The most recent data collection refers to abortions in 2020.⁸ We have used this data to describe trends in the abortion rate (number of abortions per 1,000 reproductive-age women) and abortion counts in New Jersey and compare them to national patterns.

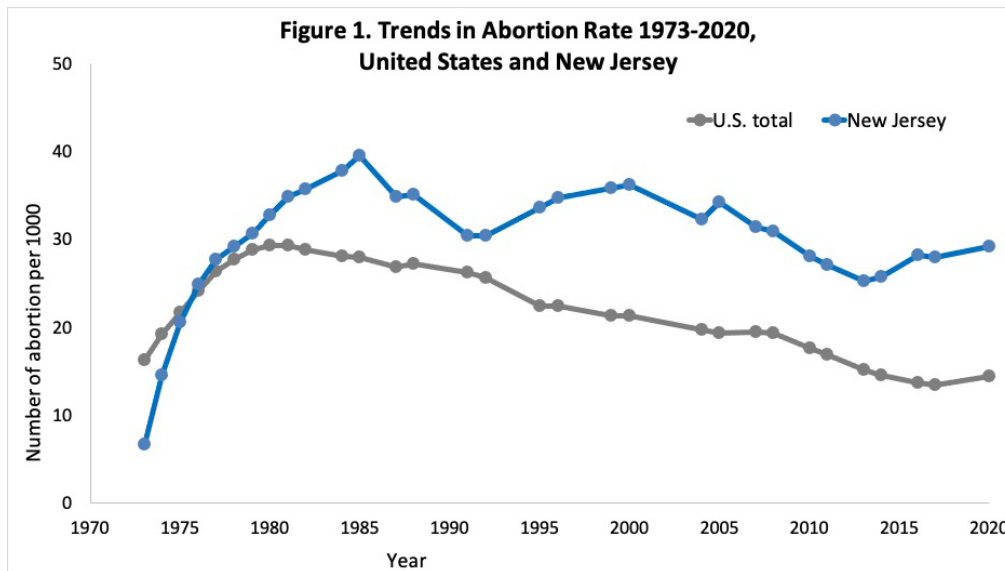
Since the legalization of abortion following the Supreme Court’s *Roe v Wade* decision in 1973, the United States experienced an increase in the facility-based abortion rate until the mid-1980s. However, it declined continuously until 2017, reaching its lowest level since 1973.⁸ The reasons for this national decline are complex and include a broader decline in pregnancy rates, expanding contraceptive options (including long-acting reversible methods with low failure rates), and the proliferation of state-level abortion restrictions.⁹ But this downward trend has reversed recently as the national abortion rate increased by 7% from 2017 to 2020, with substantial variation across states.

There is no one right number of abortions – the public health and justice goal is to provide desired care to everyone who wants or needs an abortion.

HOMING IN ON THE STATE OF NEW JERSEY

New Jersey is one of the states where the abortion rate has increased in recent years. While the national abortion rate started rising in 2016, the New Jersey rate began its rise earlier after hitting a low point in 2013. Between 2013 and 2020, it increased by 15%, rising from 25.3 to 29.2

abortions per 1,000 women of reproductive age (see Figure 1). During the narrower recent period from 2016 to 2020, it increased by 4% overall. In 2020, the New Jersey abortion rate of 29.2 abortions per 1,000 women was more than two times the national rate of 14.4.¹⁰



Focusing on abortion counts offers a similar pattern to that tracked by abortion rates. The Guttmacher Institute estimates that in 2020, 48,830 abortions were provided in New Jersey, reflecting a 12% increase from 2013.⁸ Given its large population and high abortion rate, New Jersey has the sixth-largest number of abortions of any state.^a In 2020, 5.2% of all abortions in the US occurred in New Jersey, making it a significant player in the US abortion landscape.

INTERSTATE TRAVEL FOR ABORTION CARE

Before the Fall of Roe

The number of abortions provided in New Jersey does not mean that all of these abortions were obtained by New Jersey residents or represent the total number of abortions obtained by New Jerseyans. Due to the state’s long, shared borders and ease of interstate travel, combined with the varying laws and access to care in neighboring states, it would be imprudent to limit our understanding of New Jersey’s abortion landscape to simply its geography or its official residents. Some New Jersey residents travel to other states for care and vice versa.

Before the Dobbs decision, there were similar travel patterns for abortion care both in and out of New Jersey (see Figure 2). In 2020, about 6% of New Jersey residents traveled out of state for abortion care; most of those traveling out of state obtained care in NY or PA.¹¹ One reason for

^a California (154,060) New York (110,360) Florida (77,400) Texas (58,020) Illinois (52,780)

this travel may be that for some patients, out-of-state providers were the closest source of care; for example, in Hudson and Salem County, the nearest abortion providers are in New York and Delaware, respectively.

Figure 2. Patterns of Out-of-State Travel for Abortion, New Jersey



New Jersey also serves as a receiving state for residents of other states seeking abortion care. Out-of-state patients accounted for about 6% of all abortions performed in New Jersey, with the majority coming from PA, DE, and NY.¹² Both geography and state policies influence these patterns. For instance, despite having relatively few restrictions on abortion, more than 40% of DE residents obtaining abortion traveled out of state for care due to the geographic location

of large DE cities near other state borders (the majority traveled to NJ, PA, and MD).¹² While proximity to New Jersey clinics may also influence travel from PA, the state's abortion policies are also an essential factor. PA's 24-hour waiting period and parental consent requirement can delay abortion services and create barriers to care, prompting some residents to seek care in New Jersey instead. As New Jersey does not have such requirements, it may better meet the needs of some PA residents seeking abortion care.

After the Fall of Roe

Since the Dobbs decision in July 2022, there have been alarming reports in the media of significant travel from states with new abortion bans and barriers to that travel. However, at this stage, data on the precise travel dynamics and volume is limited as there is a lag in producing abortion statistics. With the rapidly changing political and legal landscape, significant shifts in the patterns of abortion care are expected that are not yet fully visible in existing data.

The Society of Family Planning's #WeCount initiative provides some early insights into these changes by rapidly estimating the number of abortions provided in each state post-*Dobbs*.¹³ More information about #WeCount can be found in Box 3.

Box 3. #WeCount

#WeCount is an effort lead by the Society of Family Planning that seeks to capture shifts in abortion volume by state after the overturning of *Roe v Wade*. Based on a database of clinics, hospitals, and virtual providers, all identified providers were invited to report monthly abortion volume numbers. It is estimated that approximately 83% of all abortion providers known to #WeCount participated; rigorous estimation techniques were used for the nonresponding providers. New Jersey was one of three states where 30% or more of abortions were imputed because of non-response from providers.

According to the #WeCount estimates, New Jersey experienced an overall increase of 14% in the average monthly number of abortions from April and May (pre-Dobbs) to July 2022-June 2023 (post-Dobbs). This resulted in an average of approximately 527 more legal abortions per month in the state. While there are monthly fluctuations, the general trend is an increasing number of abortions. The Guttmacher Institute’s new Monthly Abortion Provision study also tracks monthly changes in abortion provision by state; it finds similar levels to #WeCount estimates, as well as documenting continued increases in the number of abortions in NJ from 2020.¹⁴ Multiple factors, including ongoing increased demand by state residents and an increase

in out-of-state travel for abortion care likely drive these increases in the number of abortions. The Guttmacher Institute will soon release important new data on the state of residence of abortion patients post-Dobbs which will allow us to understand shifts in patient composition better.

Providers also describe a shifting composition of the patients seen. *“We have seen not necessarily a surge in the number of patients that we’re caring for ... but a huge increase in what I would call like ‘high-need patients’.”* While the absolute increase in patient numbers is relatively small, many individuals traveling to New Jersey seek abortions later in pregnancy, present with more complex cases, and have fewer resources (social and financial). These factors demand that clinics to be prepared to provide enhanced support where possible.

Both state and grassroots efforts to support travel to protective states have cushioned the impacts of state bans. This includes substantial fundraising and philanthropic efforts and the expansion of practical support groups’ efforts to connect people in need with services and resources for travel. Time will tell if these efforts can be maintained or if the bans will have more significant impacts over time. Possible increases in self-managed abortion, including efforts to share information and resources, may also have lessened the impact (See Box 4).¹⁵ One provider explained, *“For some people, [self-management] could be the best option, even for somebody in New Jersey.”*

We expect that there will be increasing demand for abortion care in New Jersey, based on both state-level increases in abortion since 2013 and the more recent increases following the *Dobbs* decision. Based on the monthly increase in abortion since the *Dobbs* decision tracked by #WeCount and the Guttmacher Institute, we estimate an increase of 6,000-7,000 abortions annually *under current conditions*. Further expansion of services in New Jersey could increase this even more. We found an openness among New Jersey providers to care for patients from other states *“If you come to New Jersey, I don’t care where your address is. You are my patient. I am taking care of you in state. I can take care of you.”*

Overall, the relative role of New Jersey in the US abortion landscape is likely to increase even further in the evolving post-*Dobbs* legal landscape. While closely neighboring states generally are protective of abortion, most states in the Southeast US have increasingly restrictive laws. With abortion relatively inaccessible in this part of the country, people will need to travel farther for care and may be coming at later gestations. Patients traveling for care to New Jersey will require more support and resources from our state’s providers, state abortion funds, and practical support networks. Efforts are needed to coordinate and facilitate these systems.

We expect that there will be continued increasing demand for abortion care in New Jersey

While New Jersey is relatively geographically distant from banned states, distance alone is only one factor in deciding where to obtain an abortion. Several New Jersey abortion providers are close to multiple airports; however, our discussions with abortion funds and practical support groups emphasized that for patients to take advantage of New Jersey airports, they need greater practical support as this travel is time-consuming and costly. Flying is especially challenging for people with limited travel experience, undocumented immigration status or without legal identification, and those without credit cards. Other relevant factors include knowledge/awareness of available providers, trust in that provider, cost (including the procedure, travel, childcare, etc.), and time. Even among New Jersey residents, transportation costs can be a barrier to care, especially if patients need to take a ride-share service far from their homes or rely on Medicaid-funded transportation.

Our key informant interviews repeatedly suggested that patients coming to New Jersey from out of state often choose to come here because of family or other social connections instead of referrals from providers in their home states. At present, very few New Jersey abortion providers we spoke with had formal relationships with clinics in restrictive states to facilitate referrals. Some clinics tried establishing such relationships but ran into legal or logistical barriers; others preferred to keep connections informal. Building more formal out-of-state referral networks with health care providers, support groups, and abortion funds is an area we think is ripe for

improvement and could help New Jersey to better respond to the needs of people facing abortion bans in their home states.

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Both New Jersey residents and people from out-of-state may turn to abortion navigation services to find a provider in New Jersey. These services offer a means of obtaining information about available providers and building trust for those providers by offering vetted information. The two most extensive online navigation services – IneedanA.com and AbortionFinder.org—use different criteria to identify abortion providers and make this information available online. IneedanA.com requires providers to have an active website that lists abortion as a service, with a specific phone number for direct contact. This is meant to spare patients having to navigate an extensive phone tree to find the abortion provider at a facility that offers many types of care. This also means that many hospital providers do not meet the ‘patient-centered’ criteria for being listed on this site. AbortionFinder.org is slightly more expansive and will provide contacts for providers that meet other quality requirements (such as having Complex Family Planning Fellows on staff). Both services vet on quality and reputation and continually update their listings.

CURRENT ABORTION PROVIDER LANDSCAPE IN NEW JERSEY

RESEARCH APPROACH

To further understand the abortion provider landscape in New Jersey, we sought to identify abortion providers in the state. Abortion services in New Jersey are provided in various settings, from Planned Parenthood health centers to independent clinics, large hospitals, and online telehealth providers. While some of these facilities advertise widely, others are discreet or silent about their services. For this landscape, we focused on facilities that perform abortions, either medication or procedural, that would be easy to find for a person seeking care. This conscious

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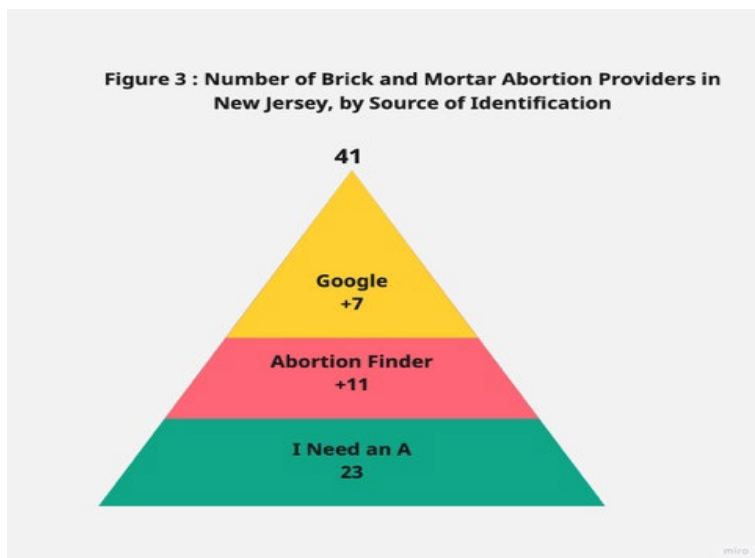
choice centers the people seeking abortion in our understanding of accessibility. Services that are difficult to find for the people who need them or require insider connections and referrals, might be available but not accessible.

To do this, we limited our sample to facilities advertised on the major abortion service navigators (IneedAnA.com and AbortionFinder.org) or through a simple Google search for “abortion in New Jersey.” We recognize that with this approach, we are likely missing small providers and hospital systems that offer abortion services to their patients but do not advertise them externally. However, people seeking abortion – especially from out of state—are unlikely to find these providers either. Thus, our approach best parallels real-world access. Our focus on clinics is likely to capture most abortions in the state; for example, in New Jersey, it is estimated that fewer than 2% of abortions were provided in hospitals in 2020.¹⁶

To describe the abortion landscape in New Jersey, we collected information including the number of publicly identifiable abortion facilities, their location by county, the types of abortion services offered, gestational limits, and whether the facility was independently run or a Planned Parenthood affiliate. We utilized U.S. Census data to estimate the population of women (defined as those assigned female at birth) of reproductive age [aged 15-49 years old] per facility overall and by region within the state.¹⁷ We used this information and insights from our key informant interviews to describe the adequacy of abortion access in terms of clinic availability, staffing, and service quality. Together, this information describes the current landscape for abortion care in the state and identifies gaps and needs for supporting access.

CLINIC LANDSCAPE

Our search strategy identified 41 brick-and-mortar abortion providers in the state (see Figure 3). We identified 24 abortion providers through IneedAnA.com and an additional 10 providers through AbortionFinder.org, which uses a relatively broader set of criteria. Using Google, we also identified seven additional providers not listed on the other navigation websites.



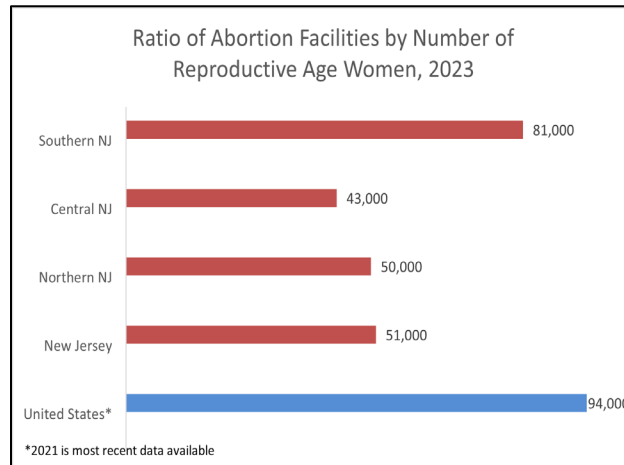
Of the identified clinics, 19 belong to one of two Planned Parenthood affiliates, and the remainder were independent clinics. Among the independent clinics, there is one group of 7 affiliated clinics and two additional clinic families with

two clinics each. The remaining clinics have single New Jersey sites.

New Jersey has greater abortion availability than most other states. Efforts to track the number of abortion clinics in New Jersey have documented declining numbers in recent years; ANSIRH recorded 50 clinics in 2017 and 43 in 2021¹⁸; using a slightly different methodology, we documented 41 clinics in 2023. The only states with more clinics than New Jersey in 2021 (the last year with data for every state) were New York (89), Florida (55) and California (168).¹⁸ Adoption of increased abortion restrictions in Florida would likely reduce their number.

The decline in the number of New Jersey facilities over time means that the number of reproductive-age women per facility has increased, estimated to have risen from <40,000 in 2017 to about 46,000 in 2021 and 51,000 in 2023. Still, the facility ratio is much better in New Jersey than in the mid-Atlantic region (62K) or the United States (94K).¹⁸

Overall, our county-level analysis for New Jersey finds wide variation in the number of reproductive-age women per abortion facility in 2023, ranging from approximately 43,000 per clinic in central New Jersey to 50,000 in northern New Jersey to 81,000 in southern New Jersey.



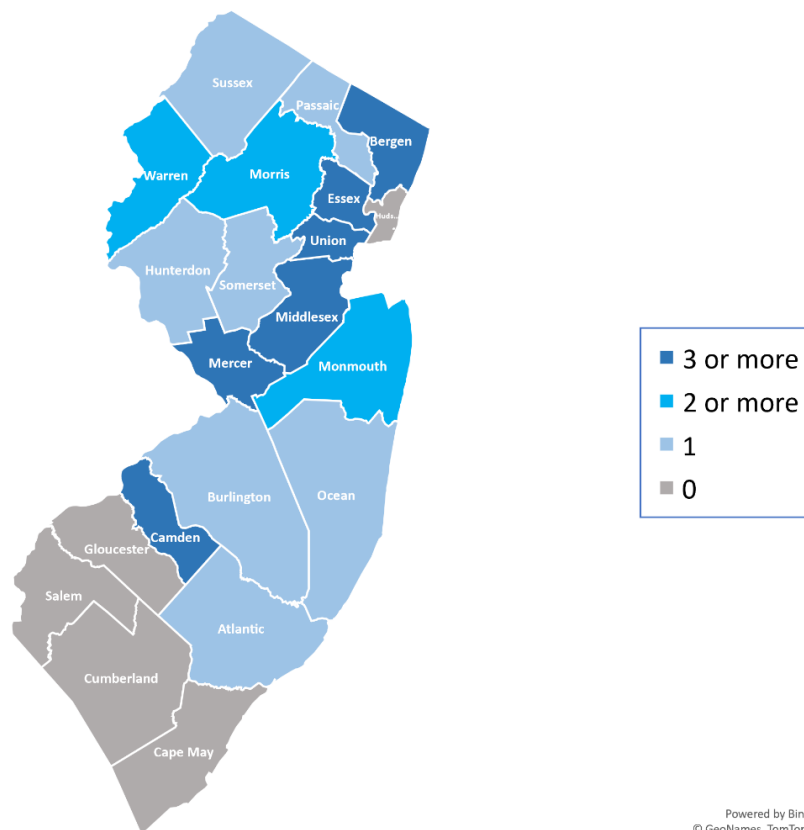
Our discussions with providers revealed short wait times, with many providers saying they could see patients the same day or on a walk-in basis. *“We can get people in within 24 hours. We don’t have a wait time...And you know, if somebody really needs something, an appointment today or tomorrow, they can get it.”* This contrasts sharply with states reporting long waiting periods and inadequate abortion access, even in settings where abortion remains legal.

GEOGRAPHIC DISTRIBUTION

Overall, the distribution of these facilities is not uniform across the state. There is a concerning gap in abortion availability in the southern counties of New Jersey. Of the 21 counties in New Jersey, five, Cape May, Cumberland, Hudson, Gloucester, and Salem, have no abortion providers identified in our landscape (Figure 4). We estimate that 15% of reproductive-age women 15-49 in New Jersey live in a county without an abortion provider. Even when counties have a provider, the closest provider for a county resident might be in another county or even in another state. In contrast, every county in New Jersey has a Crisis Pregnancy Center (a location that seeks to dissuade people from having an abortion).¹⁹

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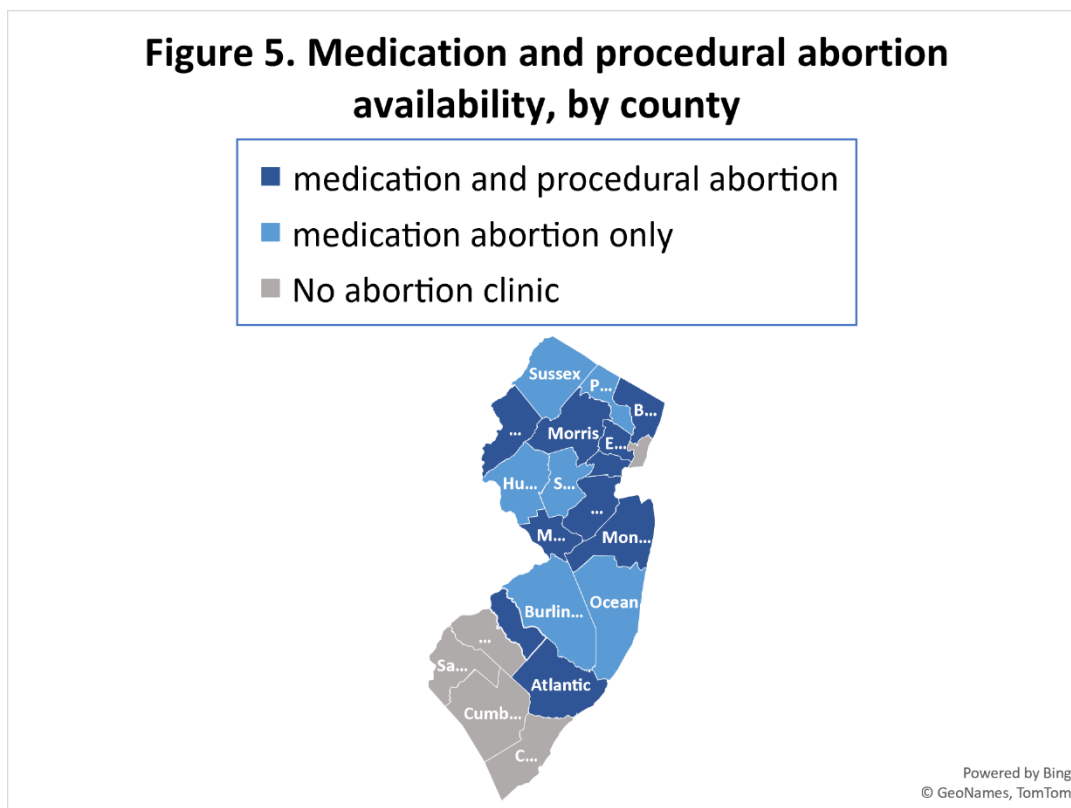
Figure 4. Number of Abortion Clinics, by County



An additional seven counties have a single provider available to the 27% of reproductive-age women in the states. These sole providers include six Planned Parenthood clinics offering only medication abortions and one clinic of a single chain not listed on the abortion navigation sites due to quality concerns. However, that can be found through Google. Among these single-county providers, some have limited hours of availability, with some clinics only providing abortion services a few days a week.

TYPE OF PROCEDURE

Among the counties that have abortion providers, not all of them offer the full range of abortion services that people might want or need (see Box 5). All identified clinics provide medication abortion, and 22 (54%) additionally offer procedural abortion services (Figure 5). Six counties *only* have medication abortion providers. In these counties, those who prefer a procedural abortion or who are beyond the gestational limits of medication abortion would need to travel to receive their care.



Box 5: Types of Abortion Care

There are currently two main methods for providing abortion care, abortion with pills, or medication abortion, or procedural abortions. Medication abortion is only available early in pregnancy. Since the Food and Drug Administration first approved medication abortion in 2000, its use has increased as the share of abortions nationally. For this reason, we are interested in the landscape of both procedural and medication abortion in the state.

Although recent data show that more than half of all abortions nationally are medication abortions²⁰, this detailed information on procedure type is not available by state. Complete information for New Jersey is not available, but the state Department of Health estimates a similar distribution among its select subsample of providers that they report to the Centers for Disease Control.²¹

A recent spate of anti-choice legislation and litigation has focused on limiting access to mifepristone – one of the two drugs commonly used in medication abortion. The repercussions of these efforts could pierce the borders of a protective state like New

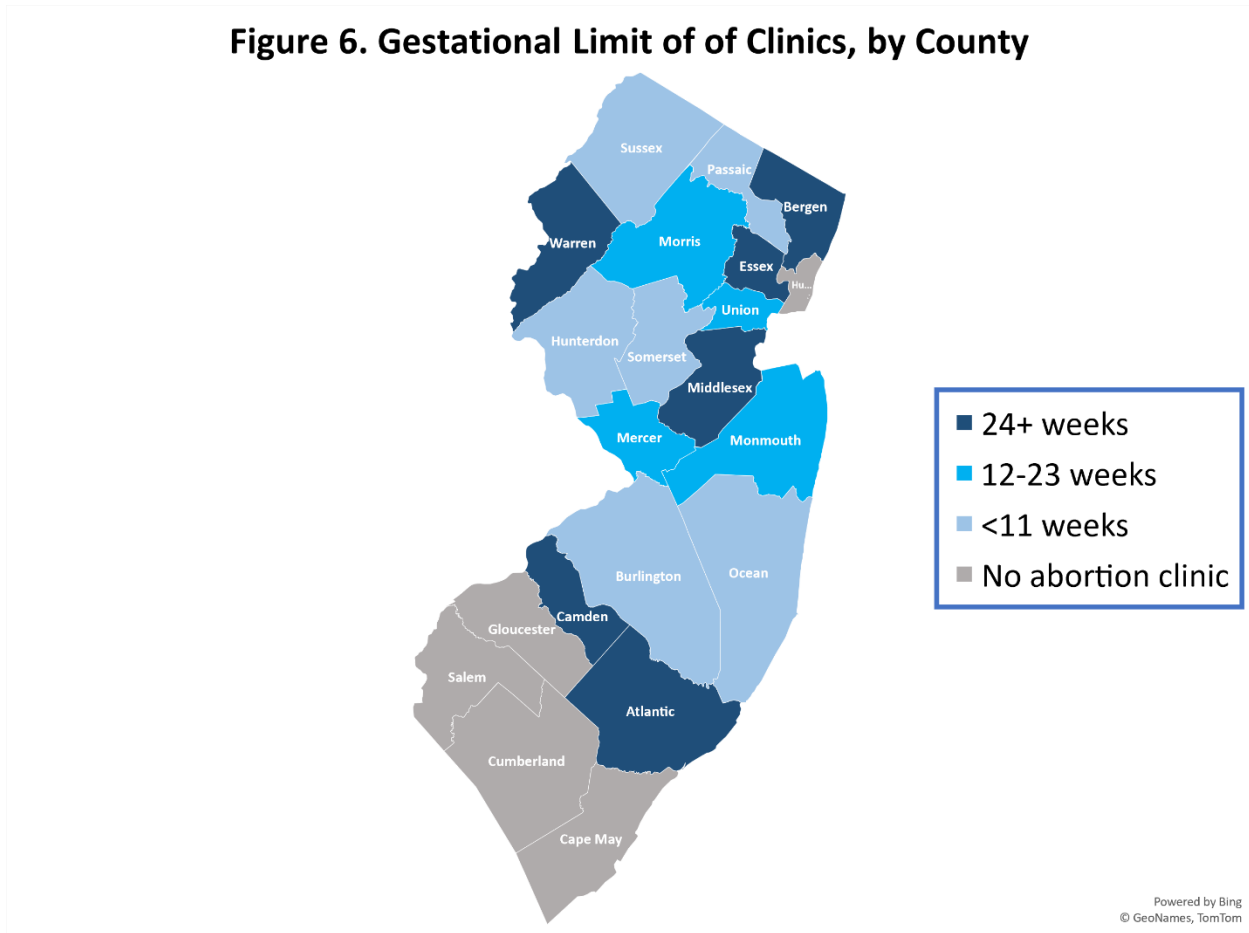
Jersey and create new challenges to providing medication abortion care. New evidence-based practice guidelines support the use of misoprostol only in medication abortion if mifepristone use is banned²², and we expect many NJ clinics would shift to this approach if necessary. If legal limits on mifepristone go into effect, the State can play an important role in providing guidance and resources for new approaches that support the continued provision of medication abortion.

AVAILABILITY OF SERVICES BY GESTATION

The average gestational limit at clinics in New Jersey is around 15 weeks, with one provider extending to 28 weeks. Providers who only offer medication abortion are constrained by the evidence base for this method and only go up to 11 weeks maximum. Six New Jersey counties only have abortion care through 11 weeks (first trimester) (Figure 6). While first-trimester abortions are the most common in the United States, individuals may need an abortion after that time for various reasons. These include delays in pregnancy recognition, requiring time to decide what to do about an unintended pregnancy, later emerging health issues for the pregnant person or fetus, difficulties accessing care, and needing the time to raise money to pay for the procedure or make travel arrangements to a more distant provider.^{23–25}

In New Jersey, only six counties have providers with the capacity to perform procedures through 22 weeks. An additional six counties have providers advertising the capacity to provide abortion services beyond 23 weeks. These counties are spread throughout the state in Northern, Central, and Southern New Jersey.

Figure 6. Gestational Limit of of Clinics, by County



Despite the lack of a legal gestational limit, no clinics in New Jersey provide abortions through the 3rd-trimester. Patients seeking abortions in the third trimester often carry pregnancies with severe fetal abnormalities or have complex health issues. Yet, New Jersey residents must travel to Washington DC or beyond to access the care they need. As one provider explained, *“We should have a third tri provider in our state, and we don’t...there’s no legal reason for us to [refer to other states]. It’s just that there are no providers.”* This later abortion care is far more expensive than care in the first or second trimester, and travel adds to logistical and financial costs. Additionally, people who need to travel for care also experience emotional costs, including distress, anxiety, and feelings of shame and exclusion.²⁶

TELEMEDICINE

Telemedicine programs for medication abortion could help alleviate travel burdens for those in counties that a brick-and-mortar clinic does not currently serve. None of the providers we interviewed had an active telemedicine abortion program. Supporting the development of

telehealth services was suggested by some providers. One said, *“I don’t think they’re not doing it because they don’t want to be tech savvy... if there are programs that help with funding to help implement telemedicine or EMRs. Like I think that will be helpful.”* However, interest was not uniform, and other providers seemed fairly negative about this type of shift in service provision.

Virtual-only providers (sometimes referred to as “Direct-to-consumer”) also fill needs without geographic boundaries; see BOX 6. There has been a growth in the number of these virtual-only providers nationally.²⁷ Nationally, the estimated monthly number of abortions provided by virtual-only providers increased by 72% in the 12 months following the Dobbs decision. In New Jersey, the increase was larger, as the number of telehealth-only abortions increased by nearly 300%. #WeCount estimates that telehealth-only providers provided about one in ten abortions in New Jersey in the first year post-*Dobbs*.¹³

Virtual-only providers provided more than one in ten abortions in New Jersey post-Dobbs.

There are opportunities for the continued growth of virtual-only providers as well as the inclusion of telehealth care in the services provided by brick-and-mortar clinics in the state. However, the lack of clarity about future funding for telehealth services is a concern, making a commitment to growing these services difficult. During the pandemic, emergency legislation created pay parity so that virtual healthcare visits were paid for at the same rate as in-person appointments across all types of healthcare, including abortion. However, this pay parity is set to expire on December 31, 2023. Passing legislation to make telehealth pay parity permanent would help support the expansion of telehealth abortion services in the state.

There also are opportunities to expand access to abortion care in New Jersey through updating some clinical procedures, such as adopting lower-burden screening and follow-up procedures.^{28,29} Training new abortion providers across a range of professional licensures on the most up-to-date evidence-based practices would support such efforts. Additionally, the state could take the lead in facilitating the convening of providers for shared learning on clinical practices to expand access.

The State recently has funded new efforts to train healthcare professionals on abortion care.³⁰ The New Jersey Reproductive Training and Education Initiative (RTEI), implemented by Rutgers University will provide abortion and reproductive health education and training for students and currently practicing advanced practice providers (APPs or nurse practitioners, midwives, and physician assistants), medical residents (OB/GYN, family medicine) and other applicable fields, and fellows in the State of New Jersey. This training will include skills in pregnancy options counseling, referrals, and direct delivery of abortion care provision. Importantly, this project also aims to develop longer-term infrastructure for ongoing training. Training new and existing

providers would lead to workforce expansion and the ability to meet the increased demand for abortion and reproductive health services in NJ.

Box 6. Virtual-Only Providers

In addition to the brick-and-mortar clinics we identified in the state, there are **currently at least 7 virtual-only telemedicine abortion providers that serve New Jersey**. Each of these are listed with the key abortion navigation sites. These include an international provider, several providers who serve many states, and a provider only serving New Jersey. Some offer a fully asynchronous model of care where patients submit information for review by a provider and are then mailed medications if appropriate. Others include a telehealth video or phone visit before dispensing medications or offer the option to speak to a provider if desired.

It is difficult to quantify the contribution of these services to abortion care in New Jersey. The online providers do not contribute data to the Department of Health and are not universally assessed in the counts of trusted institutions. It is important to note that while these services may expand access to abortion care for some people in New Jersey, they have several features that might limit the population they serve.

1. **Internet Access and Digital Literacy:** Identifying these services and engaging with their online platforms require some degree of internet skill. In addition, the services that require a video visit have minimum computing requirements.
2. **Gestation:** As these services use medication abortion, they are limited to early gestations.
3. **Cost:** Advertised costs for these telemedicine services range from \$105 to \$600 with some providers offering a sliding scale. They are largely self-pay with only one provider advertising accepting a single private insurance carrier and none accepting Medicaid.
4. **Payment:** Most of these providers require a credit card or other online payment mechanism and unbanked and underbanked individuals might find this requirement difficult to meet.

ASSURING HIGH-QUALITY ABORTION CARE

To support public health, it is important to both have enough abortion providers in the state and to ensure that people can obtain high-quality clinical care. Assessing quality is difficult, and information is typically unavailable to a patient at the time of appointment booking. Unlike family planning care, national quality guidelines for abortion care do not exist³¹; there is no consensus on the metrics for quality abortion care.³² Generally, most abortion patients report high satisfaction with their care, but it is unclear if this indicates overall high quality.³³

A person seeking abortion care could look for a provider's membership in the National Abortion Federation (NAF) as one quality indicator. NAF is a professional association of abortion providers that produces clinical standards, guidelines, and an ethical framework for care. Members are required to meet specific quality standards. Among the identified abortion providers in New Jersey, fewer than half were members of NAF. This lack of professional connection to other

providers may inhibit adopting newer evidence-based practices. For example, NAF has adopted guidance on when ultrasound is required for abortion care, which patients require rhesus testing, and how to manage pregnancies of unknown locations.³⁴ Adapting newer clinic guidelines not only helps provide more patient-centered care but can also reduce burdens on patients and staff and increase clinic capacity for care.

Concerns about unequal quality across providers in the state were raised multiple times in our background interviews and in-depth interviews with providers. Representatives at the navigation websites indicated that they did not include multiple clinics in NJ run by a specific for-profit chain due to concerns about their quality of care. This provider has faced lawsuits related to quality of care in New Jersey and other states.^{35,36} In our interviews, concerns were also raised about abortion procedures by this provider that were described as outdated and not evidence-based and their poor patient follow-up. The State should take seriously threats that poor quality providers pose to its reputation as a place to obtain safe and appropriate care.

Another critical quality component is ensuring that when a particular patient's needs exceed the capacity at a given site, there is a smooth means of referring them to a higher level of care. Clinic representatives spoke of smooth handoffs among themselves when an individual patient exceeded the gestational limit for their sites. However, when it came to referring patients to the hospital system, the process seemed fraught. While several interviewees mentioned that when their clinicians also work at hospitals, they can facilitate a warm patient handoff, overall, the referral system within the state was informal and inconsistent. Additionally, hospital costs, delays in scheduling needed care, and pervasive abortion stigma were raised as concerns by the clinic providers.

When it came to referring patients to the hospital system, the process seemed fraught... the referral system within the state was informal and inconsistent

One provider explained, *"So most of the OBs at [clinic] used to work there, and so there's like a transfer agreement to that facility, which doesn't make a lot of sense to me because like, there's ...three other hospitals that are closer. But I think it's because of that relationship and making sure that they had a provider there that they knew would cover like the hospital care. They didn't want it necessarily to go to some stranger. It seems like they had tried to create a relationship with a closer hospital ...but it seems like because of abortion stigma that they couldn't create that relationship for whatever reason."*

But another said, *"When I refer a patient to a hospital, they have to go one day, they have one window of time once a week to do a consult. Right. Then they have to come back the following*

week. And now they're 24 weeks, right? It's insanity that in the state of New Jersey, and it's not the providers, it's the systems people."

STAFFING OF FACILITIES

Assuring access to abortion in New Jersey means paying attention to not just the number of clinics but also having an adequate provider base. Currently, providers in our interviews noted staffing challenges.

"We aren't able to right now keep up with the payment rates and signing bonuses of the hospitals. And, you know, so we can't pay as much, we certainly can't pay more, which means people have to sign up sort of for walking through a gauntlet, getting videotape being screened, potentially being targeted at home, you know, and do that when they could be getting paid more at a hospital where that's not even a question."

"The barrier to abortion access at least from a provider perspective is staffing, I mean since COVID, there's been this what we call 'great resignation,' you know, staff going in and out of different institution, leaving a lot of shortage,"

The greying of providers was raised as a future challenge, as aging providers leaving the workforce may create staffing gaps. Additionally, older providers may not be adapting more recent practices and protocols.

However changes in state regulations that now allow certain healthcare providers other than physicians, such as Nurse Practitioners and Physician Assistants, to perform an abortion could help to fill these staffing gaps and could lead to the expansion of the number of providers over time.³⁷ Currently, clinics vary widely in which health professions provide abortions, with some only relying on board-certified OB-GYNs and others staffing with Advanced Practice Clinicians (APCs). Still, limits on the scope of care allowed by APCs, such as the ability to provide procedures requiring moderate sedation, were raised as barriers to expanding care. Other providers call for further expansion and diversification of the abortion provider workforce in the state.

"I would love to see more midwives in New Jersey in general, because we just don't have a lot and I would love to see more nurse practitioners and physicians trained in abortion care."

Concerns were raised about the staffing challenges faced by clinics when it comes to having anesthesiologists available for procedural abortion services, as they can be integral to these procedures. Both physicians specializing in anesthesiology and Certified Registered Nurse Anesthesiologists (CRNA) could meet these needs. One approach to expand the workforce is to grow the CRNA pipeline. For example, the Rutgers School of Nursing is actively working to grow its CRNA program, and it would be beneficial to incorporate exposure and training specifically tailored to abortion care.³⁸ Anesthesiologists often make decisions regarding the need to refer patients with co-morbidities from the clinic to hospitals. Therefore, providing training that

enhances their skills and experience with care for a diverse range of patients within the clinic setting would be valuable.

COST TO PATIENTS AND PROVIDERS

The cost of an abortion varies depending on many factors, including location, facility, timing, and type of procedure. For example, the cost of a procedural abortion increases the later in the pregnancy the procedure is performed. Thus, if patients find they have to delay their abortion while they take time to raise funds or arrange travel, or they first learn of a fetal anomaly in the second trimester, the costs increase.

We heard nearly universal concern among the providers we interviewed that the Medicaid reimbursement for abortion in New Jersey was inadequate.

All the clinics with whom we spoke reported that they accepted Medicaid. However, we heard nearly universal concern among the providers we interviewed that the Medicaid reimbursement for abortion in New Jersey was inadequate. *“We would really appreciate a fair market wage for the work that is done and the care that we give to our patients. The [fee] that we get from Medicaid is unsustainable and does not honor the work that is done by providers.”* Providers also mentioned that this inadequate reimbursement fee has repercussions for both the clinic business model and the patient care experience.

Medicaid reimbursement rates for abortion care in New Jersey are shockingly low compared to other states and compared to other reimbursement rates. In a study of 2017 reimbursement rates, New Jersey has the lowest Medicaid reimbursement rate for abortions of any state in the country.³⁹ The Medicaid rate in New Jersey of \$79 was about half the median value across states for a procedural first-trimester abortion; since 2017, some states, including New York, Illinois, and California, have increased their Medicaid reimbursement rate while New Jersey’s has remained flat for more than a decade. Although second-trimester abortions are more resource-intensive than first-trimester abortions, New Jersey is one of only five states nationwide that have no difference in the Medicaid reimbursement amount for different abortion procedures. Additionally, the Medicaid reimbursement rate for abortion is less than 1/3 of the Medicare reimbursement rate for the same procedure.

Thus, providing abortion care to Medicaid-eligible patients in New Jersey is challenging to the long-term sustainability of abortion providers. This is particularly true as more affluent privately insured or self-pay patients choose medication abortion, shifting the patient pool for procedural abortion to patients more likely to be medically complex. Assuring access to procedural abortion care for patients ineligible or uninterested in medication abortion is essential. Additionally, an

influx of out-of-state patients increases uncompensated care charges for clinics, such as a greater need for travel support. Increasing the Medicaid reimbursement rates for eligible patients can help providers support all who come to them for care.⁴⁰

Another financial challenge mentioned is that clinics' patient navigation services are unreimbursed and thus involve unbilled staff time that other funds must cover. One clinic reported training staff to respond to about 300,000 calls for information, connection to financial and other support services, and pre-visit medical evaluations but noted, *"The challenge with that... although it's a great model for patient care, it is basically all unreimbursed."*

Increasing Medicaid reimbursement rates for eligible patients can help providers support all who come to them for care

Despite the inadequacy of government reimbursement, many providers we spoke with avowed a commitment to never turning a patient away for inability to pay.

"If somebody comes with their pockets out and says I have zero, we will accept zero, so we turn away no one for their inability to pay for the fee."

Some providers can rely on donors to underwrite the costs of serving Medicaid and other patients, but not all have this option. There is concern that fundraising and philanthropic support may decline as energy created by the *Dobbs* decision potentially weakens; we are already seeing evidence of this in giving reports.

Providers' reliance on private fundraising and philanthropic efforts to meet patient needs for clinical care, transportation, child care and other expenses is not a sustainable model for care.

Not only are some providers finding ways to cover clinical care costs, but there is also a focus on meeting patients' other needs. Abortion Funds and practical support groups offer financial and informational resources to those seeking an abortion. Providers in all our interviews spoke of the full range of support their patients need, including transportation, childcare, lodging, and meals. They spoke of internally raising funds to meet these needs or tapping into national networks or local practical support groups. *"They're looking for cash support, like financial support...Procedure, hotel, gas, food."* Increasing state funding for abortion providers to meet

patients' needs for clinical care and practical support, including robust navigation and intake systems that can reduce delays in care, would better support public health.

POLICY AND RESEARCH RECOMMENDATIONS

Despite considerable financial, legal, and logistical challenges, the New Jersey abortion providers that we interviewed seem to be offering high-quality and patient-centered care. Supplemented by practical support organizations and abortion funds, they seem to be able to meet the needs of New Jerseyans at present. However, there are several areas in which specific policy actions or additional research could expand access to care for both New Jerseyans and those traveling to our expanded access state.

Given the findings from this Landscape Analysis, several strategies emerged related to expanding abortion services and supporting providers and patients. Key recommendations that address policy and practice strategies for improving abortion access highlight four priority areas: 1) increasing Medicaid insurance reimbursement; 2) expanding access by growing the number of providers and clinics and adopting innovative models of care 3) increasing public availability of information about abortion care in New Jersey residents and strengthen care coordination; and 4) reassessing the State abortion surveillance system on how it can best support public health. In addition to actions by providers, the State of New Jersey can continue to play an important leadership role in improving the landscape of abortion care. Action is needed to bring about changes in funding, support efforts to fill gaps in service availability, and for the State to use its leadership role to support convening working groups on key issues such as data collection and use, care coordination, and best clinical practices.

Policy Recommendations

1 Increase Medicaid insurance reimbursement rates for abortion care to reflect the actual cost of high-quality care and support clinic sustainability

- Increase and differentiate Medicaid reimbursement rates for abortion care by gestational age
- Expand and make more accessible coverage for transportation for Medicaid patients

2 Expand access by growing the number of abortion providers and clinics with a focus on promoting health equity and supporting clinics' efforts to adopt innovative models of care

- Address the lack of availability in the southern part of the state and Hudson County, possibly in the short term through the expansion of telemedicine services
- Support training of new abortion providers across a range of professional licensures
- Facilitate convening providers to support opportunities for shared learning, focusing on clinical practices to expand access, such as embracing telemedicine and adopting lower-burden screening and follow-up procedures
- Support the expansion of telehealth abortion services by passing state legislation for pay parity for virtual and in-person care
- Increase public funding of abortion care to support providers in serving higher-need patients
- Incorporate a focus on health equity and reducing barriers by geography.

3 Increase public availability of information about abortion care in New Jersey and strengthen care coordination both within and out of state

- Create and promote a state website in multiple languages providing links to external abortion navigation resources or providing links to New Jersey abortion providers directly to improve access to information about providers and services
- Expand public outreach and awareness through multiple approaches, including social media, patient education materials, and provider resources
- Develop strategies for building stronger cross-state collaborations for referrals and connections to New Jersey abortion providers, including engagement with abortion funds and practical support groups.

4 Convene experts and key stakeholders to reassess the role of the State abortion data system to best support public health while minimizing patient stigma and provider burden

- Identify the relative value and risks of state abortion tracking and data collection
- Propose an optimal state strategy for abortion data collection
- Identify the minimum data elements needed for public health, focusing on clinic-level metrics (i.e., volume) and not individual-level measures to protect and respect patients and limit the burden on providers

RESEARCH RECOMMENDATIONS

1 Improve understanding of the role of hospitals in abortion care in New Jersey and the landscape and availability of these providers

- Our work has not been able to assess the availability of hospital-provided abortion care, which is more likely to be needed by patients at later gestations or those with more medically complex cases
- Research with hospitals, including those reluctant to provide abortion care, could help identify barriers and facilitators to expanding abortion access

2 Investigate patterns in patient needs, including complex case management and social supports

- Consider how the shifting national policy environment influences the patient mix of who comes to New Jersey for care
- Identify how shifts in procedure type and service modality change resources and services required to meet patient needs
- Think broadly beyond clinical cost about social supports needed for a patient to access care (transport, lodging, childcare) for both in and out-of-state patients
- Bring needed attention to the needs of varying needs of patients, including by economic status, spoken language, immigration status, and gender identity
- Assess patient experiences directly through both qualitative and quantitative research

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