Demonstrating Resilience:

2025 Proactive State Legislative Trends

NIRH
National Institute for
Reproductive Health
Action Fund

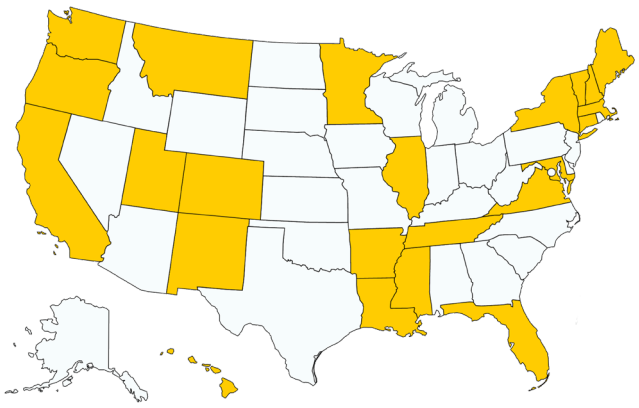
Executive Summary

Movements for civil rights have been essential to securing and expanding protections for historically marginalized communities, and reproductive freedom is no exception. The first year of the second Trump administration encompassed escalating attacks on reproductive health care across all levels of government, which is certain to continue in 2026. Against this backdrop, a resilient movement of advocates and policymakers across the states is working to expand access to the full range of reproductive health care and advance Birth Justice.

In 2025, state advocates and policymakers hit the ground running to shore up protections for reproductive freedom. In response to federal attacks, at least five states enacted unprecedented legislation to mandate hospitals to provide emergency pregnancy care, including abortion. Efforts to expand interstate shield and data privacy protections for patients, providers, and helpers continued with states building upon existing protections to enact first-in-kind legislation permitting providers' names to be removed from abortion and gender-affirming medication prescription labels. While Congressional Republicans worked to decimate Medicaid, states also acted to broaden insurance coverage with a particular focus on covering doula care and birth centers, recognizing the significance of culturally congruent care as essential to Birth Justice.

NIRH works in deep partnership with state and local advocates to advance proactive policy solutions and shares this trend brief to highlight replicable models and inform strategy across the field. As the movement prepares for the second year under a hostile federal administration, advocates and lawmakers can continue working to bolster protections and expand access to reproductive health care both within and across state borders. This report provides an overview of legislation enacted by states to secure reproductive freedom under the law. State lawmakers and advocates can use it to identify opportunities in their state to advance reproductive freedom and bodily autonomy.

Contents



States That Have Enacted Proactive Legislation in 2025

Introduction

Reproductive freedom cannot be achieved without bold action and advocacy.

Without a federal right, abortion access depends on a rapidly changing patchwork of state laws. A person living in a state with a total criminal ban may be a neighbor to a state with robust protections for reproductive health care. Twelve states enforce total abortion bans with criminal penalties, and seven more ban abortion at or before 18 weeks. These restrictions deepen health inequities and economic disparities, especially for Black people and other people of color, immigrants, rural communities, young people, and people with low incomes.[1] People living in states with abortion bans are twice as likely to die during pregnancy, childbirth, or shortly after giving birth than people in states where abortion is accessible.[2] In the face of these threats, access states are stepping in to expand and protect access to reproductive health care. In 2025, at least 23 states enacted over 50 laws to protect reproductive freedom.[3]

States Build on Safeguards for Abortion Access to Protect Gender-Affirming Care

Access to abortion and gender-affirming care are central to a person's ability to control their body, life, and future. Attacks on abortion and gender-affirming care are rooted in the same ideological spaces and aim to strip people of their bodily autonomy.

Medication abortion, which accounts for at least 63% of abortion care,[4] is subject to relentless attacks by anti-abortion lawmakers who want to block access to this safe and effective medication. Mifepristone is the drug most often used in a two-step medication abortion regimen. Despite a 25-year record of safety and efficacy, the Trump administration:

- Has announced it will re-review the drug's FDA approval — a decision prompted by a scientifically unsupported anti-abortion study.[5]
- Has signaled it may reinstate FDA restrictions for mifepristone, including a nationwide prohibition on telehealth for medication abortion; and
- May begin enforcing an 1873 anti-vice law, the Comstock Act, potentially banning anyone from mailing medication abortion.

In June 2025, the Supreme Court decided to uphold Tennessee's ban on gender-affirming care for trans youth, making efforts to challenge similar bans in other states more difficult.[6] Despite every major medical association's support for age-appropriate gender-affirming care, forty percent of trans youth aged 13-17 live in the 27 states that have passed bans on transgender health care.[7] Eleven states prohibit public funds from being used to provide gender-affirming care for both adults and young people.[8]

States Strengthen Shield Laws and Extend Protections to Prescription Labels

Interstate shield laws aim to protect patients, providers, and helpers from civil lawsuits, and criminal prosecution tied to abortion and gender-affirming care provided to residents of states where care is illegal or restricted. A 2025 report found that one in four abortions are provided via telehealth, with nearly 50% attributed to abortion providers mailing medication abortion from states with shield protections to patients living in states with abortion bans.[9] Since 2023, states have built upon interstate shield laws enacted in response to the Dobbs decision to include protections for gender-affirming care, strengthen data privacy, and protect providers mailing medication across state lines. Since 2022, 22 states have enacted shield laws for abortion, with seventeen states extending shield protection to gender-affirming care, and eight states have shield protections that extend to telemedicine provided across state lines.[10] Threats posed by increased surveillance and misuse of health data specific to abortion and trans health care continue to escalate as hostile states work to enforce abortion and gender-affirming care bans outside of their borders. In response to these growing attacks, states are passing shield and data privacy laws that extend protections to trans health care, which also reflects a growing recognition that bodily autonomy and the right to make decisions about one's health links abortion and gender-affirming care. **The work to safeguard this vital health care must continue in 2026.**

The threat of prosecution is not hypothetical, as anti-abortion state officials currently attempt to enforce their abortion bans on out-of-state providers. A New York doctor was criminally indicted by Louisiana and sued by Texas for over $100,000 for providing vital health care. Texas then moved to sue a New York court clerk for refusing to enter a judgment against the doctor. Last October, a judge dismissed the case because the state's shield law prohibits state and local employees from participating in out-of-state proceedings that

seek to impose penalties for reproductive care that is legal in New York.[11] The judge found the provision of medication abortion via telemedicine fell within the state's shield law definition of legally protected health care.[12] As a further testament to the state's shield law, which protects providers from criminal prosecution for prescribing medication abortion to patients in banned states, New York's governor made clear she would not sign Louisiana's order to extradite the charged provider.[13] Such actions demonstrate some states' commitment to safeguarding reproductive health care within and outside of their borders.

The indictment of the New York provider further ignited efforts to expand and strengthen existing shield protections: nine states introduced shield legislation this year. California,[14] Colorado,[15] Maine,[16] Massachusetts,[17] New York,[18] and Vermont[19] passed innovative new laws that allow medication abortion labels to include the name of the health care facility instead of the prescribing practitioner's name, helping protect the privacy of individual providers. Nevada's[20] legislature passed similar legislation, but it was vetoed by the governor. Shielding information in this way is an effort to lessen the threat of criminalization as anti-abortion state actors target individual providers that mail medication across state lines. California expanded protections through the state's address confidentiality program and prohibited the geofencing of health care facilities. Vermont also expanded the state's shield law to extend protections to abortion and gender-affirming care providers visiting from other shield states.

California A.B. 82 expands confidentiality protections to include address confidentiality protections for gender-affirming care patients and providers. The bill also creates a fund to manage the address confidentiality program and prohibits publicly distributing health care patients and providers personal information. This bill took effect on October 13, 2025.

California A.B. 45 refines and expands the state's existing interstate shield protections, in part, by: preventing the collection of personal information of people located at or within a precise geolocation of an abortion clinic; prohibiting geofencing of health care facilities, and prohibiting internet search information about abortion and gender-affirming care from being released in response to a subpoena that is based on another state's law that prohibits such care. This bill took effect on September 26, 2025.

Colorado S.B. 25-129 allows prescription labels for mifepristone, misoprostol, and their generic alternatives to display the name of the prescribing health care practice instead of the individual practitioner's name. The bill also strengthens existing shield protections, in part, by requiring subpoenas to include an affirmation that it is not sought to investigate legally protected health care which includes abortion and gender-affirming care. This bill took effect on April 25, 2025.

Massachusetts S.2538 strengthens Massachusetts's existing shield law by halting the flow of information to those who seek to criminalize and intimidate people who provide, receive, and assist with abortion and gender-affirming care. The legislation achieves this, in part, by permitting medication abortion, contraception, and medication prescribed for gender-affirming care to be labeled with the health care facility's name instead of the name of the individual health care practitioner. The bill also prohibits state and local authorities from cooperating with any federal or out-of-state investigations into legally protected health care, which includes abortion and gender-affirming care. This bill took effect on July 1, 2025.

Maine L.D. 538 (HP 357) amends Maine's prescription drug labeling law to allow the name of a health care facility to be listed on prescription labels for mifepristone, misoprostol, and their generic alternatives instead of the prescribing practitioner's name, if requested by the practitioner. This bill took effect on May 27, 2025.

New York S. 4587 allows the name of a health care facility to be listed on prescription labels for mifepristone, misoprostol, and their generic alternatives instead of the prescribing practitioner's name, if requested by the practitioner. This bill took effect on February 3, 2025.

Vermont S. 28 strengthens the state's interstate shield protections by allowing health care providers to withhold their names on prescriptions for gender-affirming and reproductive health care services. Additionally, the act extends shield protections to abortion and gender-affirming care providers visiting Vermont from other shield states. This bill took effect on May 13, 2025.

Securing Patient and Provider Data to Reduce Criminalization

Without strong digital privacy protections, anti-abortion actors can collect, purchase, and weaponize sensitive data — such as location, web browsing, and app data—to target patients, providers, and helpers, including across state lines. From 2019-2022, an anti-abortion group used information purchased from a data broker to send ads discouraging people who visited one of 600 Planned Parenthood locations states from obtaining an abortion.[21] As a result of actions like these, lawmakers, advocates, and communities have sought to secure data related to reproductive rights.

In the wake of the *Dobbs* decision, Congress introduced — but failed to pass — the My Body, My Data Act of 2022 which would have prohibited entities from sharing abortion-related data without consumer consent.[22] There is currently no federal privacy law prohibiting entities, including data brokers, from collecting, sharing, and selling certain health related data such as a person's geolocation data and web browsing data. This leaves individuals' data related to abortion and gender-affirming care at risk of being acquired by law enforcement in states where care is criminalized. To address this gap, states have enacted legislation regulating data brokers by prohibiting the collection, sharing, and sale of data that is related to what is often framed as "sensitive health care information" or requiring brokers to obtain separate and informed consent before sharing or selling sensitive data.

In 2025, Virginia[23] joined four other states that have enacted data privacy legislation to prohibit data brokers from sharing reproductive health information. Regulating data brokers is one strategy to halt the flow of personally identifiable information to anti-abortion actors who have purchased information from data brokers to take action against patients, providers, and helpers.

Virginia S.B. 754 prohibits data brokers from obtaining, disclosing, selling, or sharing personally identifiable reproductive or sexual health information without consumer consent. Notably, the definition of "Reproductive or sexual health information" is added to the law and includes efforts to research or obtain reproductive or sexual health information services or supplies, including location information. This bill took effect on July 1, 2025.

In Response to Federal Rollback, States Enact Protections for Emergency Pregnancy Care

For pregnant patients experiencing a medical emergency, abortion care can be lifesaving. The Emergency Medical Treatment and Labor Act (EMTALA) is a federal law that requires hospitals to treat patients during a medical emergency or active labor. EMTALA guarantees patients receive lifesaving care, including abortion, even in states where abortion is illegal or severely restricted. Pregnant people are being denied emergency care, despite EMTALA's mandate, especially in states where abortion is illegal or severely restricted. Denials and delays in emergency pregnancy care have been documented in restrictive states and confusion, institutional policies, and refusal practices can also create barriers even where abortion is broadly protected.

In the face of this ongoing emergency, the Trump Administration rescinded federal guidance clarifying pregnancy care requirements under EMTALA. Originally issued in the wake of the Dobbs decision, this guidance had clarified that hospitals must provide abortion care when necessary to stabilize a patient in an emergency — regardless of state bans. While hospitals' underlying legal obligation remains unchanged, this action deepens uncertainty for emergency room providers already forced to weigh their expertise against confusing abortion ban language. The result: greater risk of delayed or denied care, and harm for pregnant people in medical crisis. In the wake of federal rollbacks, several states codified emergency pregnancy care protections, making explicit that abortion is essential emergency care. These laws provide clarity for providers, reduce delays in treatment, and create replicable frameworks for other states. Colorado, Connecticut, Massachusetts, New York, and Washington enacted such legislation.

Colorado S.B. 25-130 makes abortion an explicit emergency medical service, requires hospitals to log outcomes, prohibits discrimination in emergency care services, and specifies pregnancy-related conditions that trigger emergency care requirements. This bill took effect on May 14, 2025.

Connecticut H.B. 7287 requires hospitals to provide emergency miscarriage care and treatment of an ectopic pregnancy. The policy also establishes anti-discrimination protections for reproductive and gender-affirming care patients by prohibiting emergency departments from denying care based on a list of traits including citizenship and insurance status. This bill took effect on July 1, 2025.

Massachusetts S.2538 is an interstate shield policy that also requires hospitals to provide emergency abortion care, specifies pregnancy-related conditions that trigger emergency care requirements, and prohibits religious refusal for emergency abortion care. This bill will take effect on January 1, 2026.

New York S. 3007 C requires hospitals to provide emergency abortion care, explicitly requires screening of pregnant patients for active labor, and includes anti-retaliation protections for health care providers. This bill took effect on May 9, 2025.

Washington S.B. 5557 incorporates existing state regulations requiring pregnancy termination during a medical emergency in state law and prohibits prioritizing the continuation of the pregnancy or the health of the embryo or fetus over the pregnant person. This bill took effect on April 29, 2025.

States Repeal Laws That Restrict or Criminalize Reproductive Health Care

At least 412 people faced prosecution after being charged with crimes related to their pregnancy within two years following the Dobbs decision.[24] Several of the sixteen states that initiated prosecutions have protections for reproductive health care, proving protections alone are not enough.[25] People with low incomes, especially those who use drugs, are disproportionately prosecuted for crimes related to their own pregnancy.[26] The rise of extremists' efforts to enact laws that grant legal rights to fetuses and embryos is central to pregnancy criminalization. Prosecutors use these laws and arguments to prosecute pregnant people for activities that are otherwise legal if the person was not pregnant.[27] Unlike other types of health care, the regulation of abortion often lives in a state's criminal code. Health care providers who violate abortion restrictions are often subject to increasingly harsh criminal penalties, including up to a life sentence in Alabama.[28] Even states with protections for reproductive freedom maintain criminal penalties related to abortion. States committed to reducing the risk of pregnancy-related criminalization must repeal laws that restrict or criminalize care.

In 2025, Virginia[29] enacted legislation to clarify that abortion-related criminal penalties do not apply to miscarriage management, while Maine[30] eliminated a state law requiring the reporting of miscarriages before 20 weeks' gestation. These reforms underscore the importance of dismantling laws that create a chilling effect for providers and further disparities in access to quality reproductive health care. As anti-abortion lawmakers continue their efforts to criminalize patients, providers, and helpers, in response, the work to repeal laws that restrict or criminalize care in states supportive of reproductive freedom will continue to trend in 2026.

Virginia S.B. 1279 provides that the criminal penalties applicable to the performance of an abortion do not apply to the treatment of a nonviable pregnancy. This bill took effect on July 1, 2025.

Maine H.P. 59 eliminates the requirement that health care professionals report to the Department of Health and Human Services for each occurrence of a miscarriage of a fetus of less than 20 weeks' gestation. This bill took effect on April 25, 2025.

States Fund Reproductive Health Care

For people with low incomes, young people, immigrants, and people of color, cost is often the most significant barrier to care, which is why funding remains one of the strongest tools to expand access. By funding programs that provide and assist with abortion care, including expanding Medicaid coverage to include the full range of reproductive health care, states can reduce barriers to care.

Public Funding for Abortion Care

Even in states where abortion is legal, cost can be a barrier to many. States can take the lead on increasing access to abortion by appropriating funds to state programs that assist with abortion care, as well as sending funds directly to abortion clinics or organizations that facilitate access to care, including abortion and practical support funds.

In 2025, California,[31] Maryland,[32] New York,[33] and Washington[34] appropriated funding to state grants and programs to further reproductive health care access. Under the Affordable Care Act, insurance plans that offer abortion coverage through the Marketplace must collect $1 per enrollee each month to cover abortion services. Although these funds have accrued for over a decade, they have mostly gone unused.

This year, Maryland became the first state to enact innovative legislation that requires private insurance companies that offer abortion coverage to transfer $25 million in surplus funds to the Public Health Abortion Grant Program. The law authorizes the grant program to direct $2.5 million annually to abortion funds to support people with low incomes, and those lacking insurance coverage.[35] Soon after, California also passed legislation to use these funds. Recognizing reproductive health care across the pregnancy spectrum is central to advancing Birth Justice, California also passed legislation creating a midwifery education fund which aims to enhance maternal health outcomes and overall reproductive health care access in the state.

California S.B. 520 establishes an education fund to create master's level nurse-midwifery education programs within the state's university systems. The fund is set to receive $2 million from the General Fund for the 2025–26 state fiscal year, with the aim of supporting the annual operating costs of the education programs for up to five years. This bill took effect on October 11, 2025.

California A.B. 144 requires insurance companies to use premium funds collected for abortion coverage to provide abortion care clinical services, with any surplus funds being transferred to a state managed fund, established by the bill, to expand access to abortion care. This bill took effect on September 17, 2025, and required the initial transfer by October 30,2025.

Maryland H.B. 930 requires insurance companies to use premium funds collected for abortion coverage to provide abortion care clinical services, with any surplus funds being transferred to the Public Health Abortion Grant Program Fund which the bill establishes to provide funding for folks with low incomes to access abortion. This bill took effect on July 1, 2025.

New York S. 3003D allocates $25,000,000 to state grants for abortion access, including the Reproductive Freedom and Equity Grant Program. This bill took effect on May 20, 2025.

Washington S.B. 5167 allocates $8,469,250 from the general fund for fiscal year 2026 and $7,853,000 for fiscal year 2027 to fund programs and grants for maintaining access to abortion care. The bill also directs the department of health to purchase and distribute medication abortion to health care providers at cost. This bill took effect on May 20, 2025.

Medicaid and State Coverage for Reproductive Health Care

Medicaid is the largest health insurance program in the United States, covering 83 million people with low incomes, including 16 million women of reproductive age (ages 15-49).[36] The joint federal-state program also serves as the largest public payer for family planning services. Although the Hyde Amendment prohibits federal dollars from paying for abortion care, federal funds are used for other health care services, and states can use their own funds to provide Medicaid coverage for abortion and other reproductive health care.

The U.S. has the highest rate of maternal deaths, compared to other high-income countries, and Black women have a mortality rate that is three times higher than that of white women.[37] These disparities are rooted in racism and discrimination, which require broad systemic change. Medicaid innovations that are rooted in culturally competent, patient-centered care are one way to address the pregnancy care crisis, especially given 80% of pregnancy-related deaths are deemed preventable. While the federal-state program covers 4 in 10 births nationwide, and more than half of all births in rural areas, it does not require access to doula care or equitable reimbursement rates for community birth centers. Insurance coverage for doula care is vital to improving health outcomes, as having a doula reduces the rate of cesarean delivery by 47% and preterm delivery by 29%.[38] Similarly, midwife-led birth centers utilize the midwifery model of care which prioritizes centering the patient versus a medicalized approach to childbirth. The patient-centered approach leads to increased rates of vaginal birth, reduced preterm births, and fewer medical interventions.[39]

H.R. 1, a federal budget bill enacted in July of 2025, prohibits Medicaid payments to providers that meet certain criteria. The bill was clearly designed to target Planned Parenthood but may also implicate independent abortion providers that offer comprehensive reproductive health care services. These Planned Parenthoods and independent clinics provide contraception, cancer and disease screenings, STI testing and treatment, pre- and postnatal care, and other preventative services to over 1 million Medicaid recipients annually. The attack is deliberate and devastating: over 50 health centers were forced to close in 2025.[40] While Planned Parenthood filed a lawsuit challenging the defunding provision, a court has allowed the Medicaid payment prohibition to take effect while the case continues.[41] To stabilize care, champion governors have allocated funds to Planned Parenthood health centers, and to date include California, Colorado, Massachusetts, New Jersey, New Mexico, New York, Oregon, and Washington. In addition to funding reproductive health care amid federal rollbacks, state policymakers also enacted legislation to expand Medicaid coverage for reproductive health care.

With a particular focus on expanding access to doula coverage and birth centers, several states, including those that protect and those that otherwise restrict reproductive health care, worked to expand state Medicaid coverage for reproductive health care. Expanding doula and midwifery care, alongside equitable birth center coverage, reflects a growing recognition that Birth Justice is central to reproductive freedom. Arkansas,[42] California,[43] Illinois,[44] Louisiana,[45] Maine,[46] Mississippi,[47] Minnesota,[48] Montana,[49] New Mexico,[50] Oregon,[51] Utah,[52] Vermont,[53] and Virginia[54] enacted legislation reshaping Medicaid to support culturally congruent care — a key step toward addressing racial disparities in maternal health outcomes. Florida[55] passed a bill requiring fertility preservation coverage for state employee health plans.

Birth Center Equity

Arkansas H.B. 1826 mandates that starting January 1, 2026, health benefit plans in Arkansas must provide the same coverage for birth services in licensed birth centers as they do for birthing services in hospitals. This bill will take effect on January 1, 2026.

California A.B. 55 requires the State Department of Health Care Services to provide Medi-Cal reimbursements to birth centers for delivery-related costs, capped at 80% of the average reimbursement received by general acute care hospitals. The bill also repeals a certification requirement for birth centers to be recognized as providers of comprehensive perinatal services and eliminates a proximity requirement to hospitals. This bill took effect on October 11, 2025.

New Mexico H.B. 56 mandates Medicaid reimbursement for services provided at licensed birth centers at the same rate as equivalent services provided at hospitals. This bill took effect on June 20, 2025.

Vermont S. 18 requires prenatal, maternity, postpartum, and newborn coverage under health insurance plans and Medicaid to include birth center services. This bill took effect on May 13, 2025.

Doula Coverage

Illinois S.B. 2437 amends the Medical Assistance Article of the Illinois Public Aid Code to require hospitals and birthing centers to establish policies that allow patients enrolled in Medicaid to select a certified doula to accompany them during labor, childbirth, and postpartum care. This bill took effect on June 16, 2025.

Louisiana H.B. 454 mandates Medicaid coverage for maternity care provided by doulas before, during, and after childbirth. This bill took effect on August 1, 2025.

Maine H.P. 1008 (LD 1523) requires the Department of Health and Human Services to reimburse doula services, including attendance during childbirth and up to four prenatal and four postpartum visits, starting January 1, 2026.

Mississippi H.B. 1401 establishes a community health worker certification program in the state department of health and requires the department seek approval from the centers for Medicare and Medicaid services for a state plan amendment, waiver, or alternative payment model to provide reimbursement for services provided by certified community health workers. This bill took effect on July 1, 2025.

Montana S.B. 319 revises laws related to the certification and regulation of doulas by establishing voluntary certification requirements and granting the Department of Public Health and Human Services the authority to provide Medicaid coverage for state-certified doula services. This bill will take effect on January 1, 2026.

New Mexico H.B. 214 is a doula credentialing and access bill that establishes a framework for credentialing doulas, requires hospitals and birth centers to adopt policies to ensure credentialed doulas can accompany patients, and creates a "Doula Fund" to support relevant activities. This bill took effect on June 20, 2025.

Virginia S.B. 1418 expands the state plan for medical assistance, which is submitted to the U.S. Secretary of Health and Human Services, to include a provision for the payment of postpartum doula care. This doula care will be provided at up to 10 doula visits, with up to 4 visits during pregnancy and 6 visits during the 12 months following birth, with additional visits permitted if deemed medically necessary. This bill took effect on July 1, 2025.

Utah S.B. 284 authorizes the Medicaid program in Utah to cover doula services. The bill is set to take effect on May 7, 2025.

Oregon S.B. 692 mandates Medicaid coverage for doula services, postpartum doula services, and lactation consultations through health insurance policies, with specific service requirements, including a minimum number of visits and hours. Additionally, the authority will track and report data on doula services, utilization, and related birth outcomes. This bill will take effect on January 1, 2026.

Vermont S. 53 ensures Medicaid will reimburse certified doulas for services during pregnancy, childbirth, and postpartum, though travel costs will not be reimbursed. The legislative intent is to provide reasonable reimbursement rates for doulas that align with those in other states' Medicaid programs. The bill is set to take effect in July 2026, with the certification process beginning before that date.

Midwifery Coverage

Minnesota H.F. 2 enacts the Minnesota Certified Midwife Practice Act which establishes licensure requirements, scope of practice, and permits Medicaid coverage to include services provided by licensed certified midwives. This bill took effect on June 15, 2025.

Fertility Care Coverage

Florida H.B. 677 requires state group health insurance to cover fertility preservation for state employees and their dependents undergoing cancer treatments that may lead to infertility. This bill took effect on July 1, 2025.

Private Insurance Coverage for Reproductive Health Care

Private insurance coverage of reproductive and gender-affirming care can increase access by reducing out-of-pocket costs, time, and financial stressors related to time-sensitive, affirming, and life-saving care. States have broad authority to mandate private insurance coverage for specific reproductive health services, including contraception, abortion, and perinatal care.[56] Currently, twelve states mandate private insurance coverage for abortion care, nine of which require no cost-sharing.[57] In 2025, Maryland,[58] Oregon,[59] and Vermont[60] passed legislation expanding private insurance coverage for reproductive health care services. California[61] enacted a law requiring private insurance coverage for mifepristone even if the Food and Drug Administration (FDA) moves to limit its use. Similarly, Illinois[62] passed legislation to permit the prescribing of drugs removed from the FDA's approval list, as long as the World Health Organization still recommends them. This would include medication abortion. Given the appointment of anti-abortion heads of federal agencies, states must take innovative approaches to maintain access to care in 2026.

California A.B. 260 requires health insurance plans with prescription drug benefits to cover mifepristone even if the FDA moves to limit its use through labeling or federal risk evaluation strategies. This bill took effect on September 26, 2025.

Illinois H.B. 3637 permits the prescribing and dispensing of medications approved before January 1, 2025, despite whether the FDA revokes approval, if the World Health Organization recommends the drug, and the label was accurate when manufactured. This bill took effect on August 22, 2025, and will become inoperative after January 1, 2035.

Maryland SB 674 establishes the Maryland Collaborative to Advance Implementation of Coverage of Over-the-Counter Birth Control under the Maryland Commission for Women. The Collaborative will study and recommend ways to improve access to OTC birth control, addressing barriers in pharmacies, retail platforms, and public health initiatives. This bill took effect on July 1, 2025.

Oregon S.B. 692 mandates private insurance coverage for doula services, postpartum doula services, and lactation consultations through health insurance policies, with specific service requirements, including a minimum number of visits and hours. Additionally, the authority will track and report data on doula services, utilization, and related birth outcomes. This bill will take effect on January 1, 2026.

Vermont S. 18 requires prenatal, maternity, postpartum, and newborn coverage under health insurance plans and Medicaid to include birth center services. This bill took effect on May 13, 2025.

Vermont S. 30 amends the state's private insurance coverage for abortion care by mandating health insurance plans to cover care delivered through telemedicine to the same extent as if the services were provided in person. Insurers must reimburse telehealth services at the same rate as in-person care. This bill took effect on September 1, 2025.

States Broaden the Scope of Practice for Reproductive Health Care Providers

Too few reproductive health care providers and long wait times pose significant barriers to care. Nearly half of the counties in the United States lack an OB-GYN.[63] These problems existed before Dobbs but have only gotten worse. Even with the advancements in the provision of medication abortion by telemedicine, including the mailing of medication abortion into banned states, there will always be a need for in-person care. With over half the states banning or severely restricting abortion, forcing hundreds of clinics to close, those seeking care must travel hundreds of miles to the nearest provider or forego care altogether.[64] Abortion bans impact pregnancy care broadly and contribute to a rising maternal mortality. Following the Dobbs decision, in states like Idaho, dozens of obstetricians have left the states which has led to the closure of labor and delivery units.[65] Pregnant people living in states where abortion is banned are two times as likely to die during pregnancy, compared to states where abortion is legal; the risk of pregnancy related death in Texas is 155% higher than in California.[66]

Integrating advanced practice clinicians (APCs), such as certified nurse–midwives, nurse practitioners, and physician assistants, into reproductive care, for instance, by allowing providers other than physicians to provide abortion care or creating additional certification pathways for doulas and midwives, can help expand and increase access to this essential care. APCs are not only equipped to provide this essential health care but may also help alleviate the burden on overburdened providers as care for out-of-state patients surge.[67] This can improve access to high-quality care, especially for those who face multiple barriers, including people of color, immigrants people living in rural areas, young people, and those with low incomes. States supportive of evidence-supported ways to expand access to reproductive health care must broaden the scope of practice for health care professionals.

In 2025, at least twelve states introduced bills that would expand the scope of practice for health care practitioners able to provide abortion or other pregnancy-related care including efforts to provide pharmacists prescribing authority for contraception. This year, Hawai'i,[68] Illinois,[69] and Virginia,[70] passed legislation that expands the scope of practice for midwives.

Hawai'i H.B. 1194 makes midwife regulatory laws permanent. It clarifies midwifery practice scope and establishes licensure requirements for certified midwives and certified professional midwives. It further grants licensed midwives global signature authority and sets continuing education and prescriptive authority. This bill took effect on May 5, 2025.

Illinois H.B. 2688 establishes full practice authority for advanced practice registered nurses (APRNs), enabling them to operate without a written collaborative agreement under specific conditions. This aims to enhance maternal health care delivery, particularly in areas where access to obstetric care is limited. This bill will take effect on January 1, 2026.

Virginia H.B. 1635 permits licensed certified midwives who have completed 1,000 hours of practice under a practice agreement to practice without a practice agreement upon receipt of an attestation from the licensed physician or midwife with whom they entered into a practice agreement. This bill took effect on July 1, 2025.

Protecting the Right to Contraception

Almost all women – 99% – will use some form of contraception in their lifetimes. Even though 4 out of 5 Americans support the right to contraception,[71] the Trump administration has sought to roll back access by slashing tens of millions of dollars in funding from Title X, the federal program dedicated to providing people with low incomes family planning services, and firing most of the Office of Population Affairs, the department that runs the nation's family planning program.[72] Recognizing this increasing threat, states enacted laws to protect and expand contraception access, even in states with oppositional governors and legislatures.

At least seven states introduced bills to establish a right to reproductive health care in state law. California,[73] Illinois,[74] New Hampshire[75] and Tennessee[76] enacted legislation aimed to protect the right to or expand access to certain reproductive health care decisions. California's law permits pharmacists to provide contraception over the counter. Illinois enacted two laws expanding access to contraception; one allows pharmacists to prescribe and dispense contraception, and the other requires public universities to offer contraception and medication abortion services on campus. New Hampshire's law provides patients with greater autonomy to choose sterilization care. Tennessee's law aims to protect access to fertility treatments and contraception. Virginia[77] and New York's[78] legislatures passed bills that would establish a right to contraception or expand health insurance coverage for contraceptive care, but both states' governors vetoed the legislation.

California A.B. 50 allows pharmacists to provide over-the-counter contraception, including up to a 12-month supply at the patient's request. This bill took effect on September 26, 2025.

Illinois H.B. 3489 expands the scope of practice for pharmacists to include assessing, consulting, and dispensing all contraceptives, including emergency contraception. It also amends the Illinois Public Aid Code to ensure that the medical assistance program covers pharmacist-provided patient care services for all contraceptives, including emergency contraception. This bill will take effect on January 1, 2026.

Illinois H.B. 3709 requires public universities to provide students with access to contraception and medication abortion beginning with the 2025-2026 school year. This bill took effect on August 22, 2025.

New Hampshire H.B. 606 prohibits physicians from denying sterilization procedures based on a patient's age, number of children, or perceived future reproductive desires, provided the patient is 18 years or older and has a physiological medical condition that warrants such treatment. This bill will take effect on September 13, 2025.

Tennessee S.B. 449 defines contraception broadly to include medications, devices, sterilization, and fertility care explicitly and affirms an individual's right to access these services, stating that Tennessee law does not prohibit any activity related to fertility treatment or contraception. This bill took effect on July 1, 2025. While it is important that people have access to contraception and fertility care, Tennessee continues to enforce a trigger ban, which prohibits abortion at all stages of pregnancy.

Expanding Access for Young People

Young people face additional logistical and legal barriers when accessing abortion care, and anti-abortion lawmakers also treat people under 18 as canaries in the coal mine. Laws in Idaho and Tennessee that criminalize people for helping young people get out of the state for an abortion demonstrate how extreme abortion restrictions can target minors first.[79] Against this backdrop is the rise of the so-called "parental rights" movement, an extremist effort to weaponize the rights of parents to blanketly prohibit abortion, gender-affirming care, and sexual health education for young people.[80]

Over 7 million adolescent girls aged 13 to 17 live in states with abortion bans, restrictive gestational limits, or parental involvement requirements.[81] Among the states where abortion is legal, 25 require parental notification, parental consent, or both for a person under 18 to have an abortion.[82] Forced parental involvement laws can affect timing, cost, and method of care available, harming young people and blocking their access to care overall. Lawmakers supportive of abortion can improve access to care for young people by recognizing their autonomy, which at minimum includes the capacity to consent to reproductive health care.

This year, at least ten states introduced legislation to expand access to reproductive health care for minors by not only eliminating parental notification and consent requirements for abortion but expressly permitting young people to consent to reproductive care without parental involvement. Connecticut's[83] new law recognizes the autonomy of young people to consent to reproductive health care, including abortion, without parental interference, offering a replicable model for advancing youth access in other states. Acknowledging the particular difficulties young people face when accessing abortion care, coupled with the rise of the "parental rights" movement, states must continue the work to reduce barriers to care for this group in 2026.

Connecticut H.B. 7213 permits minors to consent to reproductive care, including abortion, without parental notification or consent. The bill prohibits health care providers from disclosing information, including billing details, without the minor's express consent. This bill took effect on June 9, 2025.

Protecting Reproductive Freedom in State Law

Following the Supreme Court's decision ending the federal right to abortion, state legislators and advocates worked to secure the right to reproductive health care within their borders. Despite the absence of federal protection, numerous states have amended their constitutions and passed laws establishing reproductive freedom as a fundamental right protected from government interference. This effort continued in 2025, and currently, the right to reproductive freedom is recognized in law or state constitutions in 22 states and Washington, D.C.[84]

State Constitutional Amendments for Reproductive Freedom

A state constitutional amendment is the strongest protection available to secure the right to reproductive freedom at the state level. Enshrining the right to reproductive freedom in a state's constitution ensures abortion and the full range of reproductive health care remains legal and accessible while barring anti-abortion lawmakers from enforcing abortion bans and other restrictions. Voters overwhelmingly support reproductive freedom when it is on the ballot: In 2022 and 2023, voters supported a state constitutional right to abortion in four states where it appeared on the ballot (California, Michigan, Ohio, Vermont) and defeated anti-abortion measures in an additional three states (Kansas, Kentucky, and Montana).[85] In 2024, reproductive freedom ballot measures succeeded in an additional seven states (in Arizona, Colorado, *Nevada, Maryland, Missouri, Montana, and New York).[86]

This year, Virginia[87] was the only state to refer a constitutional amendment to the ballot. If approved by the legislature a second time and then voters, the amendment would provide every individual with the right to make decisions about all matters related to one's pregnancy.[88]

Virginia S.J. 247 is a legislatively referred state constitutional amendment, that, if approved, would establish a right to reproductive freedom. The amendment would prohibit the state from discriminating against a person because they exercised their right to reproductive freedom or for assisting another person in exercising that right. The amendment first passed the legislature in 2025. Because Virginia requires amendments to pass in two successive legislative sessions to appear on the ballot, it will be introduced again for approval during the 2026 session. If passed again, the amendment will appear on the November 2026 ballot.

Forging Ahead — Securing Reproductive Freedom in 2026 and Beyond

NIRH is committed to advancing a policy vision that meets this moment with urgency and clarity. We work in deep partnership with state and local governments to expand access to reproductive health care, protect patients and providers, and create policy solutions that affirm reproductive autonomy. Through our partnership model, we provide state and local advocates with strategic guidance, hands-on support, and funding to create just and equitable access to reproductive health care.

The progress across states in 2025 demonstrates that state lawmakers are not only holding the line but leading the way: expanding rights, dismantling criminalization, and creating new standards for reproductive freedom. NIRH is fighting to pass laws in cities and states to cement just and equitable access to all forms of reproductive health care, including abortion. With the federal legal foundation for abortion access destroyed and growing disparities in reproductive health care, we can't cede an inch. These trends provide a roadmap for advocates and policymakers committed to building durable infrastructure for reproductive freedom in 2026 and beyond.

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