Abortions Later in Pregnancy

Published: Dec 05, 2019

Key Takeaways

- Abortions at or after 21 weeks are uncommon, and represent 1% of all abortions in the US. Typically, these procedures cost well over $1,000, excluding the cost of travel and lost wages. They normally require treatment over multiple days, and are only performed by a subset of all abortion providers.
- Reasons individuals seek abortions later in pregnancy include medical concerns such as fetal anomalies or maternal life endangerment, as well as barriers to care that cause delays in obtaining an abortion.
- *Roe v. Wade* made the concept of viability critical to the regulation of abortion, particularly when it comes to abortions later in pregnancy. Viability is not set at a specific date in the pregnancy, rather multiple factors play into the determination of viability, including gestational age, fetal weight and sex, and medical interventions available.
- Many states have passed a range of laws that restrict access to abortions later in pregnancy, by either placing gestational age limits on abortion and/or by banning clinicians from performing certain procedures.

Introduction

Abortions occurring at or after 21 weeks gestational age are rare. They are often difficult to obtain, as they are typically costly, time-intensive and only performed by a small subset of abortion providers. Yet these abortions receive a disproportionate amount of attention in the news, policy and the law, and discussions on this topic are often fraught with misinformation; for example, intense public discussions have been sparked after several policymakers have theorized about abortions occurring "moments before birth (https://www.washingtonpost.com/local/virginia-politics/lawmaker-at-center-of-abortion-bill-firestorm-elected-as-part-of-democratic-wave-that-changed-richmond/2019/01/31/d4f76ecc-2565-11e9-90cd-dedb0c92dc17_story.html)" or even "after birth (https://www.whitehouse.gov/briefings-statements/president-donald-j-trumps-state-union-address-2/)." In reality, these scenarios do not occur, nor are they legal, in the U.S. Discussion of this topic is further obscured due to the terms sometimes used to describe abortions later

in pregnancy– including “late-term,” “post-viability,” “partial birth,” “dismemberment” and “born-alive” abortions—despite many medical professionals criticizing and opposing their use. This fact sheet explains why individuals may seek abortions later in pregnancy, how often these procedures occur, how the concepts of viability and fetal pain play into this topic, and the various laws which regulate access to abortions later in pregnancy.

Clarifying Pregnancy Dating: pregnancies are measured using gestational age (GA), calculated in days and weeks since the first day of the last menstrual period (LMP). Since some people do not know the date of their LMP, ultrasound can also be used to calculate GA. Post-fertilization or fertilization age refers to the time since the egg and sperm fused to create a fertilized egg. Fertilization occurs approximately 2 weeks after menses, thus gestational age by LMP predates fertilization age by ~2 weeks. By convention, gestational age is used to discuss pregnancy dating as most pregnant individuals know their LMP, however certain abortion regulations reference fertilization age instead.

What is a so-called “late-term” abortion?

“Late term” abortion typically refers to abortions obtained at or after 21 weeks (https://www.acog.org/-/media/Departments/Government-Relations-and-Outreach/Facts-Are-Important_Abortion-Care-Later-In-Pregnancy-February-2019-College.pdf?dmc=1&ts=20190726T2009203385), however it is not an accepted medical term, nor is there a consensus around to which gestational ages it refers. Members of the medical community (https://www.cnn.com/2019/02/06/health/late-term-abortion-explainer/index.html) have criticized the term “late-term” abortion, as it implies abortions are taking place after a pregnancy has reached “term” (37 weeks) or “late term” (>41 weeks) which is false. In fact, the American College of Obstetricians and Gynecologists (ACOG (https://www.acog.org/-/media/Departments/Government-Relations-and-Outreach/Facts-Are-Important_Abortion-Care-Later-In-Pregnancy-February-2019-College.pdf?dmc=1&ts=20190726T2009203385)) has written that “late-term abortion” has no medical meaning and should not be used in clinical or legal settings. As such, we will refer to abortions occurring at ≥21 weeks gestation as *abortions later in pregnancy*, but it should be noted that 21 weeks is a largely arbitrary cutoff based on how the CDC (https://www.cdc.gov/mmwr/volumes/68/ss/ss6811a1.htm) collects data on abortions. Abortions at this stage in pregnancy are sometimes referred to as “later abortions (https://laterabortion.org/)” by the medical community as well.

What is viability? Why does it matter for abortions later in pregnancy?

Abortions later in pregnancy have been highly debated, in part because some people believe that this stage of pregnancy abuts the time around viability. In 1973, ***Roe v. Wade*** (http://cdn.loc.gov/service/ll/usrep/usrep410/usrep410113/usrep410113.pdf) legalized abortion in the U.S., and in the process made "viability (https://www.acog.org/-/media/Obstetric-Care-Consensus-Series/occ006.pdf?dmc=1&ts=20180129T0128313960)" the delineating factor in the abortion debate; before viability, a person has the right to obtain an abortion, whereas after viability, the state can restrict access to abortion in the interest of protecting the potential for human life, except in cases of health or life endangerment of the pregnant person.

The Supreme court made clear in *Roe v. Wade* that the courts are not in a position to assess when life begins and when viability has been reached, writing, "*We need not resolve the difficult question of when life begins. When those trained in the respective disciplines of medicine, philosophy, and theology are unable to arrive at any consensus, the judiciary, at this point in the development of man's knowledge, is not in a position to speculate as to the answer." (**Roe v. Wade*** (http://cdn.loc.gov/service/ll/usrep/usrep410/usrep410113/usrep410113.pdf)*)* Given viability is case dependent and is only a possibility or probability (https://neoreviews.aappublications.org/content/4/6/e140?sso=1&sso_redirect_count=1&nfstatus=401&nftoken=00000000-0000-0000-0000-000000000000&nfstatusdescription=ERROR%3a+No+local+token) of survival, rather than a guarantee of survival, the decision in *Roe v. Wade* left the right to an abortion after viability up to individual states to determine.

In a subsequent Supreme Court case on abortion (https://supreme.justia.com/cases/federal/us/439/379/), the court defined viability as follows:

> *"Viability is reached when, in the **judgment of the attending physician** on the particular facts of the case before him, there is a **reasonable likelihood of the fetus' sustained survival** outside the womb, **with or without artificial support**. Because this point may **differ with each pregnancy**, neither the legislature nor the courts may proclaim one of the elements entering into the ascertainment of viability – be it weeks of gestation or fetal weight or any other single factor – as the determinant of when the State has a compelling interest in the life or health of the fetus." Colautti v. Franklin (1979)*

Viability depends on many factors, including gestational age, fetal weight and sex, and medical interventions available. While viability does not refer to a specific gestational age, it is often presumed at 24 weeks (https://www.laterabortion.org/sites/default/files/lai_factsheet_viability.pdf) gestation, with "periviability (https://www.uptodate.com/contents/periviable-birth-limit-of-viability)" referring to the time around viability (20 to 26 weeks gestation). For periviable births, the hospital (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5424630/pdf/nihms848969.pdf) at which the infant is delivered can greatly affect viability, and the patient's insurance coverage may dictate where they can seek care. Infants born in resource-rich settings have a higher likelihood of survival than those born in resource-poor settings. This is in part due to access to neonatologists and maternal-fetal-medicine doctors, but also due to hospital-specific policies; in a study of 24 academic hospitals (https://www.ncbi.nlm.nih.gov/pubmed/25946279), active treatment for infants born at 22 weeks ranged from 0% to 100% depending on the hospital, showing that the criteria used to determine viability at one hospital may not be the same at another. If time allows and if the pregnant individual is clinically stable, they may be transferred to a facility better equipped for neonatal resuscitation before delivery, however this is not always possible. Further, insurance coverage and reimbursement for transfers in care varies by state and insurance plan (https://www.nature.com/articles/jp2015109).

At the time of *Roe v. Wade* (https://supreme.justia.com/cases/federal/us/410/113/), the Supreme Court wrote that viability "is usually placed at about seven months (28 weeks), but may occur earlier, even at 24 weeks." With medical advances, extremely preterm infants can now survive (https://neoreviews.aappublications.org/content/4/6/e140?sso=1&sso_redirect_count=3&nfstatus=401&nftoken=00000000-0000-0000-0000-000000000000&nfstatusdescription=ERROR%3A%20No%20local%20token&nfstatus=401&nftoken=00000000-0000-0000-0000-000000000000&nfstatusdescription=ERROR%3a+No+local+token) at lower gestational ages than previously thought possible, particularly at hospitals with Level IV neonatal intensive care units (https://www.marchofdimes.org/baby/levels-of-medical-care-for-your-newborn.aspx) (NICUs). The question we come up against is this: with viability possible at lower gestational ages, will abortions be prohibited at lower gestational ages as well? Many favor leaving that decision up to the patient and their provider, given viability depends on the *individual* pregnancy. Others, including some policymakers, desire early gestational age limits on abortion, well before the possibility of viability. In subsequent sections, we outline policies that regulate the provision of abortions later in pregnancy, including gestational age restrictions.

How common are abortions later in pregnancy?

Abortions occurring at or after 21 weeks gestation are rare. According to the CDC's Abortion Surveillance Data (https://www.cdc.gov/mmwr/volumes/68/ss/ss6811a1.htm), the vast majority of abortions (91%) occur at or before 13 weeks gestation, while 7.7% occur from weeks 14 to 20 gestation, and just 1.2% of abortions are performed at or after 21 weeks (**Figure 1**). This amounts to approximately 5,200 abortions per year occurring at

or after 21 weeks, however this is an underestimate as only 33 reporting areas report abortions to the CDC by gestational age. The percentage of abortions occurring at or before 13 weeks gestation has remained stable over the last few decades (https://www.cdc.gov/mmwr/volumes/68/ss/ss6811a1.htm#T8_down) at 91-92%, however within this timeframe, more abortions are occurring earlier in pregnancy, at or before 8 weeks. This is likely in part due to the greater availability of medication abortions (https://www.guttmacher.org/fact-sheet/induced-abortion-united-states) over the last two decades.

Figure 1: The Vast Majority of Abortions Occur Early in Pregnancy

The CDC does not elaborate on the breakdown by gestational age for abortions occurring past 21 weeks, but it is likely that the vast majority occur soon after 21 weeks rather than in the later in the pregnancy. While very limited data exists on this issue, a study (https://jamanetwork.com/journals/jama/article-abstract/187908) from 1992 estimated 0.02% of all abortions occurred after 26 weeks gestation (320 to 600 cases per year). This may overestimate current day numbers, given the abortion rate is currently at a historic low (https://www.guttmacher.org/fact-sheet/induced-abortion-united-states), and restrictions on abortions later in pregnancy have increased.

Why do people have abortions later in pregnancy?

Non-Medical Reasons: Individuals seek abortions later in pregnancy for a number of reasons (https://www.acog.org/-/media/Departments/Government-Relations-and-Outreach/Facts-Are-Important_Abortion-Care-Later-In-Pregnancy-February-2019-College.pdf?dmc=1&ts=20190726T2009203385). As part of the Turnaway study (https://www.ansirh.org/research/turnaway-study) out of the University of California San Francisco, from 2008-2010 over 440 women (https://onlinelibrary.wiley.com/doi/full/10.1363/4521013) were asked about why they experienced delays in obtaining abortion care, if any (**Figure 2**). Almost half of individuals who obtained an abortion after 20 weeks did not suspect they were pregnant until later in pregnancy, and other barriers to care included lack of information about where to access an abortion, transportation difficulties, lack of insurance coverage and inability to pay for the procedure. This is unsurprising, given abortions can be cost-prohibitive for many; in a study (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4946165/) from 2011-2012, the median cost of a surgical abortion at 10 weeks was $495, jumping to $1,350 at 20 weeks (range $750-$5,000) excluding the cost of travel and lost wages. Yet the Federal Reserve Board (https://www.federalreserve.gov/publications/2018-economic-well-being-of-us-households-in-2017-dealing-with-unexpected-expenses.htm) found 40% of U.S. adults do not have enough in savings to pay for a $400 emergency expense, meaning many individuals may need to delay having an abortion until they can raise the necessary funds.

Figure 2: Many Factors Contribute to Delays in Obtaining Abortion Care

Additionally, of all the abortion-providing facilities (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4946165/) in the U.S., only 34% offer abortions at 20 weeks and just 16% at 24 weeks, meaning individuals may need to travel a significant distance to find an available, trained provider. Abortions at this stage also typically require two days to complete with inpatient care, as opposed to outpatient or at-home management that is possible earlier in pregnancy.[1] In the years since these data were collected, dozens of abortion restrictions (https://thehill.com/policy/healthcare/445460-states-passing-and-considering-new-abortion-laws-in-2019) have been enacted (https://www.guttmacher.org/state-policy/explore/overview-abortion-laws) across the county, including mandated waiting periods (https://www.kff.org/womens-health-policy/state-indicator/mandatory-waiting-periods/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D); it is therefore possible that individuals seeking abortion today may face even more delays in care than these data reflect.

Fetal Anomalies: Individuals also seek abortions later in pregnancy due to medical reasons. With medical advances, many genetic fetal anomalies can be detected early in pregnancy; for example, chorionic villus sampling (https://www.mayoclinic.org/tests-procedures/chorionic-villus-sampling/about/pac-20393533) can diagnose Down Syndrome or cystic fibrosis as earlier as 10 weeks (https://www.acog.org/Patients/FAQs/Prenatal-Genetic-Diagnostic-Tests?IsMobileSet=false#villus) gestation. Structural fetal anomalies, however, are often detected much later in pregnancy. As part of routine care, a fetal anatomy scan (https://www.whattoexpect.com/pregnancy/pregnancy-health/prenatal-testing-level-two-ultrasound-anatomy-scan/) is performed around 20 weeks, which entails ultrasound imaging of all the developing organs. Many structural anomalies are discovered at this time that would not have been apparent previously. A proportion of these are lethal fetal anomalies (https://www.ncbi.nlm.nih.gov/pubmed/2404299), meaning that the fetus will almost certainly die before or shortly after birth, meaning the fetus may be nonviable.[2] In these cases, many individuals wish to terminate their pregnancies, rather than carrying the pregnancy until the fetus or newborn passes away. Very often these pregnancies are desired, making this decision exceedingly difficult for parents. Inadequate data (https://fas.org/sgp/crs/misc/R45161.pdf) exist to know how many abortions later in pregnancy occur due to fetal anomalies, but a study (https://www.sciencedirect.com/science/article/pii/S0029784401016738) by Washington University Hospital showed almost all women whose fetuses had lethal fetal anomalies chose to terminate their pregnancies.

A study of maternal fetal medicine (https://www.sciencedirect.com/science/article/pii/S0010782414006994) (MFM) doctors—specialists who manage pregnancies with fetal anomalies— found most agreed that

termination of pregnancy due to a lethal fetal anomaly should be allowed in all circumstances (76%). The majority (75%) discuss abortion as a management option soon after diagnosing a lethal fetal anomaly, but services for terminating pregnancies in these scenarios are limited. Only 40% of MFMs worked at healthcare centers offering abortions past 24 weeks for lethal fetal anomalies. An additional 12% knew of available services <50 miles away.

Health Risk to the Pregnant Person: Life threatening conditions may also develop later in pregnancy. These include conditions like early severe preeclampsia (https://www.mayoclinic.org/diseases-conditions/preeclampsia/symptoms-causes/syc-20355745), newly diagnosed cancer (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5070264/) requiring prompt treatment, and intrauterine infection (chorioamnionitis (https://my.clevelandclinic.org/health/diseases/12309-chorioamnionitis)) often in conjunction with premature rupture of the amniotic sac (PPROM (https://www.urmc.rochester.edu/encyclopedia/content.aspx?ContentTypeID=90&ContentID=P02496)). If these conditions arise before the fetus is viable, the pregnant individual may pursue termination of pregnancy to preserve their own health. If these conditions arise after the fetus is considered viable, *Roe v. Wade* still protects the right for these individuals to obtain an abortion in cases of health or life endangerment, however it may be difficult to find a provider for this service as previously mentioned. Typically every effort is made to save the life of both the pregnant individual and the fetus, pursuing delivery rather than abortion.

How do states regulate abortions later in pregnancy?

A few states have sought to expand access to abortions later in pregnancy. The New York Reproductive Health Act (https://www.nysenate.gov/legislation/bills/2019/s240) enacted in January 2019 expands protections for abortion providers and pregnant individuals who have abortions after 24 weeks *in cases of health or life endangerment or lethal fetal anomalies.* Virginia (http://lis.virginia.gov/cgi-bin/legp604.exe?191+ful+HB2491) similarly proposed loosening restrictions on abortions later in pregnancy, by reducing the number of physicians who would need to approve an abortion after 28 weeks gestation from three to one, and by broadening maternal exceptions to include more general threats to mental and physical health. This bill failed to pass, but sparked national discussion about regulation of abortions later in pregnancy.

Many states have directed their efforts in the opposite direction, aiming to increase restrictions on abortions later in pregnancy. States most often do so by (1) placing gestational age limits on abortion, and/or (2) restricting the methods providers can use to perform abortions later in pregnancy. In discussion of these laws, it is important to note that most policymakers are not clinicians, therefore many of the terms used to discuss abortions later in pregnancy are designed to communicate a political message,

not a precise medical concept. In the Appendix, we mention several terms written into policy and the law so that readers may be familiar with their meaning, but they are not medical terms.

Abortion bans by gestational age

43 states (https://www.kff.org/womens-health-policy/state-indicator/gestational-limit-abortions/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D) prohibit abortions after a certain point in pregnancy, with almost half of states prohibiting abortion at "viability" or when viability is often presumed, at 24 weeks. Other states (https://www.guttmacher.org/state-policy/explore/state-policies-later-abortions) seek earlier gestational age limits on abortion. For example, so-called "heartbeat (https://rewire.news/legislative-tracker/law-topic/heartbeat-bans/)" bans propose banning abortion after the detectable presence of cardiac activity as early as 6 weeks gestation, months before viability. To date, all such "heartbeat" bans, along with others that seek to ban abortions before 20 weeks, are not in effect due to ongoing or resolved litigation. However, some states have enacted abortion bans from 20-22 weeks gestational age, using the rationale of fetal pain.

FETAL PAIN

Many states restrict abortions at 22 weeks gestational age or 20 weeks post-fertilization, arguing the fetus has the ability to feel pain at this point in development, contrary to medical evidence. A systematic review (https://jamanetwork.com/journals/jama/fullarticle/201429) of literature on fetal pain found that pain perception is unlikely before weeks 29 or 30 gestational age. ACOG (https://www.govinfo.gov/content/pkg/CHRG-109hhrg24284/pdf/CHRG-109hhrg24284.pdf) has found "no legitimate scientific data or information" that supports the assertion that fetuses feel pain at 20 weeks post-fertilization, and the Royal College of Obstetricians and Gynecologists (https://www.rcog.org.uk/globalassets/documents/guidelines/rcogfetalawarenesswpr0610.pdf) has also concluded fetal pain is not possible before 24 weeks, given immature brain development and neural networks.

Despite the medical evidence, policymakers have enacted gestational limits using the rationale that a fetus can feel pain at earlier stages in pregnancy. Mississippi bans abortion (https://www.guttmacher.org/state-policy/explore/state-policies-later-abortions) at 20 weeks gestation while abortion at 22 weeks gestation is banned by 17 other states (AL, AR, GA, IN, IA, KS, KY, LA, NE, ND, OH, OK, SC, SD, TX, WV, WI). Additionally, 13 states (https://www.guttmacher.org/state-policy/explore/counseling-and-waiting-periods-abortion) provide verbal or written counseling on fetal pain as part of pre-abortion counseling (AK, AR, GA, IN, KS, LA, MN, MO, OK, SD, TX, UT, WI) (**Figure 3**). Some states mandate this information be given to those seeking abortion later in pregnancy, while in others, this counseling is required at any stage of pregnancy. In Utah legislation (https://le.utah.gov/~2016/bills/static/SB0234.html) was introduced, but not passed, that would

have required providers to administer "fetal anesthesia" during abortions later in pregnancy. There is, however, no standard practice for how to provide fetal anesthesia during abortions, nor is there adequate safety (https://ibisreproductivehealth.org/sites/default/files/files/publications/LAI_factsheet_fetal_pain_Apr18.pdf) data on how this would affect pregnant individuals.

Figure 3: The Concept of Fetal Pain Plays a Role in Many Abortion Regulations

Bans on abortion methods used later in pregnancy

Almost all abortions performed at ≥21 weeks are performed by a dilation and evacuation (D&E (https://www.acog.org/Clinical-Guidance-and-Publications/Practice-Bulletins/Committee-on-Practice-Bulletins-Gynecology/Second-Trimester-Abortion)) procedure (93 (https://www.cdc.gov/mmwr/volumes/68/ss/ss6811a1.htm#T8_down)–95% (https://www.cdc.gov/mmwr/volumes/67/ss/ss6713a1.htm) per CDC data). This involves dilating the cervix and evacuating the pregnancy tissue using forceps, with or without suction. D&Es can be performed safely up to at least 28 weeks gestational age, and when compared to their alternative of labor induction, have been found to be quicker and result in fewer complications (https://www.sciencedirect.com/science/article/pii/S0002937816311802); further, many women prefer surgical management as they will be sedated and do not have to undergo labor and delivery of the fetus.

Several states have sought to ban D&E procedures, which would significantly limit how providers are able to perform abortions later in pregnancy. Currently, Mississippi (http://billstatus.ls.state.ms.us/documents/2016/pdf/HB/0500-0599/HB0519SG.pdf) and West Virginia (http://www.wvlegislature.gov/Bill_Status/bills_text.cfm?billdoc=SB10%20SUB1%20ENR.htm&yr=2016&sesstype=RS&billtype=B&houseorig=S&i=10) have enacted D&E bans, while bans are temporarily enjoined in 6 states and over 25 states (https://rewire.news/legislative-tracker/law-topic/dilation-and-evacuation-bans/) have attempted to pass such legislation. 20 states ban dilation and extractions (D&Xs), a rarely used abortion procedure also referred to as an intact D&E or a "partial birth abortion" by policymakers (**Appendix**). In total, 21 states have enacted bans on abortion methods used later in pregnancy (**Figure 4**).

Figure 4: Many States Ban Certain Abortion Procedures Used Later in Pregnancy

In addition to gestational age limits and method bans used for abortions later in pregnancy, it is important to remember these abortions are also subject to the same regulations that apply for abortions earlier in pregnancy, including mandatory waiting

periods (https://www.guttmacher.org/state-policy/explore/overview-abortion-laws) and physician and hospital requirements (https://www.guttmacher.org/state-policy/explore/targeted-regulation-abortion-providers).

The authors would like to acknowledge Jennifer Karlin, MD, PhD (University of California, San Francisco) for her review of an earlier draft of this fact sheet.

Appendix

Non-Medical Terminology Used to Describe Abortions in Policy and Law	
Term	**Description**
Late-term abortion:	Non-medical term that typically refers to abortions occurring at or after 21 weeks gestational age, but does not consistently refer to a specific gestational age cutoff.
Post-viability abortion:	Non-medical term used to refer to abortions occurring after the fetus is considered viable, and sometimes used synonymously with late-term abortions.
Born-alive abortion:	Non-medical term used to refer to the exceedingly rare circumstance in which a newborn shows signs of life after an abortion, including breathing, a beating heart and voluntary movement. These cases are the subject of the proposed "Born-Alive Abortion Survivors Protection Act (https://www.congress.gov/bill/116th-congress/senate-bill/130)," mandating healthcare workers provide care to infants who show signs of life after an attempted abortion.
Partial birth abortion:	Non-medical term often used to refer to a rarely used abortion procedure called dilation and extraction (D&X, also known an intact D&E). Has sometimes been used to refer to all dilation and evacuations (D&Es), the most common abortion procedure used from 14-28 weeks gestational age.
Dismemberment abortion:	Non-medical term sometimes used to refer to D&Es (https://rewire.news/legislative-tracker/law-topic/dilation-and-evacuation-bans/).

NOTES: KFF does not endorse use of these terms.

Endnotes

1. Some facilities in the U.S. perform abortions later in pregnancy as outpatient procedures (up to certain gestational ages), but it is less common than offering inpatient care for these cases.

   ← Return to text (https://www.kff.org/womens-health-policy/fact-sheet/abortions-later-in-pregnancy/#endnote_link_441779-1)

2. Consensus does not always exist as to which anomalies are fatal, and thus nonviable.