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Steven H. Aden

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DRIVING OUT BAD MEDICINE: HOW STATE REGULATION IMPACTS THE SUPPLY AND DEMAND OF ABORTION

STEVEN H. ADEN, ESQ.*

INTRODUCTION AND OVERVIEW

Activists on both sides of the debate over legal abortion rely extensively on medical and sociological research regarding the impact of abortion and its regulation in the states.¹ But until recently, this debate has not enjoyed the benefit of a large and growing body of economic research on the impact of state legislation restricting or promoting abortion. This article first offers a

* The author is a constitutional attorney and litigator who serves Alliance Defending Freedom as Vice President for Sanctity of Life in Washington, DC. The author would like to thank research assistant Katherine Wright (U. Dayton Law '14), without whose hard work this article could not have been completed, and Bradford Patterson, Ph.D (U. Va. Law '14), who provided invaluable research guidance on difficult economic issues. Charles A. Donovan of Charlotte Lozier Institute provided valuable comments to the final draft. All errors in analysis or interpretation are the author's own.

1. This practice has been common over the forty-plus years of abortion litigation, as evidenced in the Supreme Court briefs filed by opposing sides. *See, e.g.*, Brief for Appellee, *Roe v. Wade*, 410 U.S. 113 (1973) (No. 70-18), 1971 WL 134281 (citing 25 medical and sociological sources); Brief for Appellants, *Roe v. Wade*, 410 U.S. 113 (1973) (No. 70-18), 1971 WL 128054 (citing 52 medical and sociological sources); *but cf.* CLARKE D. FORSYTHE, *ABUSE OF DISCRETION: THE INSIDE STORY OF ROE V. WADE* 169 (Encounter Books 2013) (criticizing medical sources cited by majority opinion: "None of the [7] articles [cited by the majority] offers a real analysis of the data; none is peer-reviewed."); Brief for Petitioners and Cross-Respondents, *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992) (Nos. 91-744, 91-902), 1992 WL 12006398 (citing 29 sources); Brief of the American Association of Pro-Life Obstetricians and Gynecologists (AAPLOG) and the American Association of Pro-life Pediatricians (AAPLP) as Amici Curiae Supporting Respondents, *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992) (Nos. 91-744, 91-902), 1992 WL 12006428 (citing 22 sources); Brief for the American College of Obstetricians and Gynecologists, et al. as Amici Curiae Supporting Respondents, *Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320 (2006) (No. 04-1144), 2006 WL 2646471 (citing 48 sources); Brief of the Association of American Physicians & Surgeons, and John M. Thorp, Jr., M.D. as Amici Curiae Supporting Petitioner, *Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320 (2006) (No. 04-1144), 2006 WL 1902074 (citing 13 sources); Brief of Amici Curiae American Association of Pro-Life Obstetricians and Gynecologists (AAPLOG), et al. Supporting Petitioner, *Gonzales v. Carhart*, 550 U.S. 124 (2007) (No. 05-380), 2007 WL 1436688 (citing 7 sources); Brief of Amici Curiae American Medical Women's Association, et al. Supporting Respondents, *Gonzales v. Carhart*, 550 U.S. 124 (2007) (No. 05-1382), 2007 WL 2710731 (citing 35 sources).

paradigm of federal regulation and deregulation of abortion from *Roe v. Wade*² through *Planned Parenthood v. Casey*,³ and raises the question whether the federalization of abortion regulation in the period between those decisions operated to subsidize the abortion industry; a subsidy that has progressively come to an end in many states in the two decades since *Casey* with predictable effects. The author then presents an overview of recent economic data analyzing both the supply side of abortion, such as state restrictions on licensing and credentialing of providers and baseline health and safety regulations, and the demand side of abortion, such as Medicaid funding or de-funding of elective abortion, parental involvement provisions and state-imposed wait-and-counsel requirements.⁴ While the conclusions reached by researchers are sometimes tailored to an ideological position on abortion, the data itself strongly suggest that these policy measures not only operate according to the laws of supply and demand, they have a demonstrable and generally predictable impact on the “elasticity” of both supply and demand.⁵ The author also discusses whether the data suggest that supply or demand is more elastic in the face of regulation, which in turn would suggest whether regulation of one or the other is more effective in decreasing the raw number of abortions in a given state.⁶

2. *Roe*, 410 U.S. 113 (1973).

3. *Casey*, 505 U.S. 833 (1992).

4. Used in this article, “supply-side regulations” will refer to regulations that operate on the resources or motivation of abortion providers such as health and safety regulations, and “demand-side regulations” will refer to those that operate on the resources or motivation of prospective abortion patients, such as public funding rules and wait-and-counsel mandates.

5. Briefly stated, for a product or service, Price (P) is generally responsive in a linear fashion to both Supply (S) and Demand (D) at market equilibrium. An increase in demand raises the price, and an increase in supply lowers the price. Conversely, an increase in price lowers both demand and supply. See, Merriam-Webster.com, <http://www.merriam-webster.com/dictionary/elasticity> (last visited Mar. 13, 2014) (definition number 2) (elasticity is defined as “the responsiveness of a dependent economic variable to changes in influencing factors.”).

6. Abortion regulation undoubtedly presents analytical difficulties, principally concerning causation between abortion rates and pregnancy rates. See Andrew Yuengert & Joel Fetzer, *Economic Research into the Abortion Decision: A Literature Review and a New Direction in 15 LIFE AND LEARNING* at 421, 432 (Joseph W. Koterski, S.J. et al., ed., 2005). For example, Yuengert & Fetzer note that state Medicaid restrictions appear to decrease abortion rates even when the restrictions have been blocked by a court – suggesting that there must be a common factor or cause resulting in both decreased abortion rates and Medicaid restrictions. *Id.* While using a method of research that compares one state to itself can help give a clearer picture of cause of effect, the question of which came first – the demand or the supply – is not always easy to ascertain. *Id.*, at 433. For instance, it is important to try to distinguish whether an abortion provider became available because there was demand for abortion, or the demand for abortion increased when the abortion provider became available. *Id.*

I. DEREGULATION AND SUBSIDIZATION

From the Supreme Court's decisions in *Roe v. Wade*⁷ and *Doe v. Bolton*,⁸ announcing a "fundamental right" for women to choose abortion for virtually any reason through all nine months' gestation, until the late 1980s, little regulation of abortion was permitted by the Supreme Court as a constitutional matter.⁹ Insofar as surgical abortion, at least, is a form of ambulatory surgical practice, it should predictably have been subjected upon its legalization to health and safety regulations similarly to other outpatient practices such as hysterectomy, tubal ligation, and vasectomy. But the Court's interventions to protect the industry from state regulation until *Webster*¹⁰ in 1989, and

7. *Roe v. Wade*, 410 U.S. 113 (1973), *holding modified* by *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992).

8. *Doe v. Bolton*, 410 U.S. 179 (1973).

9. *Roe*, 410 U.S. at 166. *Roe* struck down the Texas abortion statutes *in toto*, leaving no regulation of abortion in their place. 410 U.S. at 167 ("Our conclusion that Art. 1196 is unconstitutional means, of course, that the Texas abortion statutes, as a unit, must fall."). Subsequent state attempts to regulate the practice of abortion were routinely struck down or limited by the Supreme Court. *See, e.g.*, *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 79, 83 (1976) (striking down a prohibition on saline abortions, and a requirement that the abortionist take steps to preserve the baby's life and health); *Colautti v. Franklin*, 439 U.S. 379 (1979) (striking down, as unconstitutionally vague, a Pennsylvania statute that required physicians to use the abortion technique providing the best opportunity for the baby to be born alive in abortions if the baby is "viable or may be viable;" holding instead that "actual viability" must be the standard); *Akron v. Akron Center for Reproductive Health, Inc.* 462 U.S. 416 (1983) (holding unconstitutional a misdemeanor ordinance that, *inter alia*, required all abortions performed after the first trimester of pregnancy to be performed in a hospital; required that the attending physician inform his patient of the status of her pregnancy, the development of her fetus, the date of possible viability, the physical and emotional complications that may result from an abortion, and the availability of agencies to provide her with assistance and information with respect to birth control, adoption, and childbirth, and also inform her of the particular risks associated with her pregnancy and the abortion technique to be employed; prohibited a physician from performing an abortion until 24 hours after the pregnant woman signs a consent form; and required physicians performing abortions to ensure that fetal remains are disposed of in a "humane and sanitary manner."); *Planned Parenthood Association of Kansas City, MO. v. Ashcroft*, 462 U.S. 476 (1983) (invalidating a Missouri statute that required all second-trimester abortions be performed in a hospital); *Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747 (1986) (holding unconstitutional provisions of Pennsylvania's Abortion Control Act, including informed consent and reporting requirements). *But cf. Connecticut v. Menillo*, 423 U.S. 9, 10-11 (1975) (*per curiam*) (holding that state could constitutionally restrict the practice of abortion to licensed physicians); *Danforth*, 428 U.S. at 67 (holding Missouri could require written consent by the mother and reporting requirements for completed abortions).

10. *Webster v. Reprod. Health Servs.*, 492 U.S. 490 at 520-21 (1989). The *Webster* plurality upheld provisions specifying that a physician, prior to performing an abortion on any woman whom he has reason to believe is 20 or more weeks pregnant, must ascertain whether the fetus is "viable" by performing "such medical examinations and tests as are necessary to make a finding of [the fetus'] gestational age, weight, and lung maturity;" and prohibiting the use of public employees and facilities to perform or assist abortions not necessary to save the mother's life or the use of public funds, employees, or facilities for the purpose of "encouraging or counseling" a woman to have an abortion not necessary to save her life. 492 U.S. at 520. The plurality stated, "There is no doubt that our holding today will allow some governmental regulation of abortion that would have been prohibited under the language of cases such as *Colautti* and *Akron*." *Id.* at 520-21.

*Planned Parenthood v. Casey*¹¹ in 1992, effectively withheld a substantial portion of the burden of regulatory compliance from providers entering the market, artificially elevating the number of providers and lowering barriers to entry for substandard practitioners. *Webster* and *Casey* largely put an end to the Court's interventionist policy, resulting in an increasingly regulated abortion market over the past twenty years.¹²

The well-known economic principle of Gresham's Law, roughly paraphrased, states that when a government overvalues one type of money and undervalues another, the undervalued money will disappear from circulation into hoards, while the overvalued money will flood the market.¹³ It is commonly stated as, "Bad money drives out good." Gresham's Law has been applied by analogy to circumstances where governmental behavior towards a market has the unintended effect of subsidizing weaker competitors to the detriment of consumers.¹⁴ The impact of unintentional subsidization of an abortion market seems to have operated as a "Gresham's Law of Bad Medicine." It can be seen most clearly in the history and prosecution of Dr. Kermit Gosnell in Philadelphia and its aftermath. According to the grand jury that indicted Kermit Gosnell,¹⁵ resulting ultimately in his conviction on three counts of murder, one count of involuntary manslaughter, and other lesser counts,¹⁶ the Department of Health's determination not to inspect

11. *Planned Parenthood of Se. Pa v. Casey*, 505 U.S. 833 at 878–99 (1992) (citing *Roe*, 410 U.S. at 164–65) (upholding a Pennsylvania law requiring informed consent, and a 24-hour waiting period before the abortion was to be performed, as well as a parental consent mandate where a judicial bypass was also available).

12. ALAN GUTTMACHER INST., AN OVERVIEW OF STATE ABORTION LAWS, *State Policies in Brief* (2013); *See infra* notes 116, 121; Michael J. New, Ph.D., *Analyzing the Effect of Anti-Abortion U.S. State Legislation in the Post-Casey Era*, 11 ST. POL. & POL'Y Q. 28 (2011); S. Colman and T. Joyce, *Regulating Abortion: Impact on Patients and Providers in Texas*, 30 J. OF POL'Y ANALYSIS AND MGMT. 775 (2011).

13. MERRIAM-WEBSTER DICTIONARY (11th ed. 2009), available at [http://www.merriam-webster.com/dictionary/gresham's%20law](http://www.merriam-webster.com/dictionary/gresham%20law).

14. *Id.* ("[B]roadly: any process by which inferior products or practices drive out superior ones Gresham's Law has been applied by analogy to a wide range of human conduct. In its expanded formulation, it stands for the proposition that greed tends to overwhelm refined human impulses for good in a marketplace economy."); *See also* Michael J. McIntyre, *Offshore Banking and Gresham's Law*, 2 TAX NOTES INT'L 819–21 (1990) (analogizing Gresham's Law to the context of offshore banking regulation); Jonathan A. Lesser, *Gresham's Law of Green Energy*, REG., at 12 (2010–2011) ("In effect, 'green' energy mandates like those of California and New Jersey are a new version of 'Gresham's Law,' in which subsidized renewable resources will drive out competitive generators, lead to higher electric prices, and reduce economic growth.").

15. REPORT OF THE GRAND JURY, IN RE CNTY. INVESTIGATING GRAND JURY XXIII, MISC. NO. 0009901-2008 (Pa. Ct. Com. Pl. Jan. 14, 2011), available at <http://www.phila.gov/districtattorney/pdfs/grandjurywomensmedical.pdf>

16. Brady Dennis, *Abortion Doctor Kermit Gosnell Convicted of Murder in Deaths of Three Infants*, WASHINGTON POST (May 13, 2013), <http://www.washingtonpost.com/national/health-science/jury-in-kermit-gosnell-trial-hung-on-two-charges/2013/05/13/b4444bdc-bbda-11e2->

abortion clinics in the state and to ignore evidence that was presented against Gosnell's clinic was "motivated by a desire not to be 'putting a barrier up to women' seeking abortions."¹⁷

The impact of increased regulation of the abortion industry since *Webster* and *Casey* may demonstrate what happens when states no longer "overvalue" abortion access because of a misplaced belief that as a constitutionally protected right, it cannot be subjected to informed consent, health, and safety regulations, and instead subject market participants to reasonable and constitutional mandates such as full informed consent laws,¹⁸ parental involvement laws,¹⁹ wait-and-counsel requirements,²⁰ and ambulatory surgical provider regulations.²¹ The impact of the new regime in which states no longer indirectly subsidize abortion practice by withholding regulatory mandates that would have otherwise applied to them is becoming apparent as waves of abortion providers, led by larger providers, have exited the industry and demand for abortion has also dropped precipitously.

II. ABORTION AS AN ECONOMIC MARKET

Elective abortion as a licit business dates from the constitutionalization of abortion in all fifty states in 1973 through the Supreme Court's *Roe v. Wade* decision.²² Abortion researcher Andrew Beauchamp of Boston College notes that initially, there was mass entry into the abortion market during the 1970s after the legalization of abortion.²³ This trend reversed in the early 1990s as providers began exiting the market, starting with hospitals and with small providers following suit.²⁴ Abortion prices rose across the board as the market became dominated by large providers and supply dropped.²⁵ This was largely because state regulations had the most significant impact on small

97d4a479289a31f9_story.html.

17. *Report of the Grand Jury*, *supra* note 15, at 147.

18. *Casey*, *supra* note 3, at 833; *Planned Parenthood Minn., N.D., S.D. v. Rounds*, 530 F.3d 724 (8th Cir. 2008); *Texas Med. Providers Performing Abortion Servs. v. Lakey*, 667 F.3d 570 (5th Cir. 2012).

19. *Ohio v. Akron Ctr. for Reprod. Health*, 497 U.S. 502, 511 (1990); *Fargo Women's Health Org. v. Schafer*, 18 F.3d 526 (8th Cir. 1994); *Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320 (2006).

20. *Casey*, *supra* note 3.

21. *Id.*; *Karlin v. Foust*, 188 F.3d 446 (7th Cir. 1999); *Greenville Women's Clinic v. Bryant*, 222 F.3d 157 (4th Cir. 2000); *Tucson Woman's Clinic v. Eden*, 379 F.3d 531 (9th Cir. 2004).

22. *Roe*, *supra* note 2.

23. Andrew Beauchamp, *Abortion Supplier Dynamics 12* (revised March 2010) (unpublished manuscript) (on file with Boston College) *available at* <http://neumann.hec.ca/pages/pierre-thomas.leger/andrew.pdf> (using data from a survey of abortion trends from 1973–2005, and a model of entry, exit, and provision to explain the interplay between state regulations and supply and demand in abortion markets).

24. *Id.*

25. *Id.*

providers (those who perform less than 400 abortions per year).²⁶ Moreover, Beauchamp observes that when a provider leaves a market, it is generally not replaced, meaning that both supply-side restrictions and a reduction in demand are likely making that market not worthwhile.²⁷ Likewise, state laws that required abortion providers to obtain licenses—either to practice medicine, register as a surgical center, or otherwise—increased the cost of entering the market, resulting in keeping small providers out.²⁸ The decrease in small providers had the effect of driving down competition, increasing the price of abortion, and decreasing the overall number of abortions. Additionally, regulations requiring hospitalization at some point in the second trimester were noted to have reduced marginal costs for large providers, because they no longer provide late-term abortion services.²⁹ But they have increased entry costs for large providers that seek to provide late-term services.³⁰

Planned Parenthood Federation of America (“PPFA” or “Planned Parenthood”) emerged as the market leader for abortion services from this period of market instability, and its trajectory is emblematic of the maturation of the abortion market as a whole. In 1973, Planned Parenthood affiliates performed only 4,988, or .67 percent of all U.S. abortions; twenty years later, its market share still remained relatively low at less than ten percent.³¹ During the post-*Casey* era, however, its share of the abortion market surged to 31.59 percent by 2011, as its affiliates performed 333,946 abortions of the reported 1.057 million U.S. procedures.³² Since *Casey*, there has never been a close second to Planned Parenthood in market share for abortion.

PPFA is the oldest U.S. reproductive healthcare organization, dating to a merger in 1939 of two organizations founded by birth control advocate Margaret Sanger.³³ Planned Parenthood played a role in the development of chemical birth control and the Intrauterine Device (IUD) beginning in the

26. *Id.* at 15; JOSEPH W. DELLAPENNA, DISPELLING THE MYTHS OF ABORTION HISTORY 710 (2006), (citing Sara Seims, *Abortion Availability in the U.S.*, 12 FAM. PLANNING PERSPECTIVES 88, 95 (1980).

27. Beauchamp, *supra* note 23, at 40; See also Esme E. Deprez, *The Vanishing Abortion Clinic*, BLOOMBERG BUSINESSWEEK (Nov. 27, 2013), <http://www.businessweek.com/articles/2013-11-27/abortion-clinics-face-shutdown-spiral-as-republicans-push-restrictions> (noting a “tidal wave” of clinic closures, with very few new clinics replacing ones that have gone out of business).

28. Beauchamp, *supra* note 23, at 5.

29. *Id.* at 28.

30. *Id.* at 33.

31. Alliance Defending Freedom, *Planned Parenthood by the Numbers*, <http://www.adfmedia.org/files/plannedparenthoodnumbers.pdf>.

32. *Id.*

33. V. Kasturi Rangan and Elaine V. Backman, *Planned Parenthood Federation of America*, Harv. Bus. Sch. Case Study No. 9-598-001 (1997; rev'd. 2002) at 9, Ex. 1—“Planned Parenthood History.”

1960s, and promoted their use in the U.S. and the developing world.³⁴ Beginning in 1978 with the election of Faye Wattleton as the federation president, PFFA became more active in the legal battle over abortion.³⁵

PPFA is organized as a membership corporation with national offices headquartered in Washington, D.C. and New York City.³⁶ The Federation appears to possess some characteristics of a franchise: affiliates pay an annual dues premium to the national office that is scaled to the size of the affiliate's budget, in return for which affiliates are entitled to the use of the Planned Parenthood brand, representation at PFFA membership meetings, and access to the services provided by the national office.³⁷ The national office sets mandatory medical standards for the affiliate network for reproductive healthcare delivery, provides technical, managerial, legal and advocacy training and support for affiliates, and offers a central medical malpractice insurance policy for affiliates through a captive offshore insurer and other private insurers.³⁸ Each local affiliate is organized as an independent, charitable nonprofit corporation governed by a local board.³⁹ Affiliates commit to operate according to PFFA standards for affiliation, which include medical standards and operating guidelines covering governance, managerial, and financial matters.⁴⁰ A series of Harvard Business School studies of PFFA between 1997 and 2010 found that affiliate revenues came from a variety of sources, the leading source being private fee-for-service payments (39 percent of total affiliate revenue).⁴¹ Medicaid payments accounted for 25 percent of affiliate income, and government grants, particularly Title X—Federal Family Planning, accounted for 15 percent.⁴²

PPFA's affiliate structure and hierarchical management have likely lent several competitive advantages to the organization that have contributed to its domination of the abortion market. Its non-profit group exemption, in addition to enabling its affiliates to solicit private tax-deductible contributions, allows it to operate free of federal, state, and local income and excise taxes on income from clinical services, and in most jurisdictions has probably granted it exemptions from real property taxes on owned property.

34. *Id.*

35. *Id.* at 10.

36. *Id.* at 3 (referencing Washington, D.C.). PFFA's recent 990 filings list New York offices.

37. *Id.* at 2; see generally Howard Yale Lederman, *Franchising and Franchise Law: An Introduction*, 92 MICH. B. J. 34, 34 (2013) ("The franchisor licenses to the franchisee, for a defined period, the right to use the franchisor's business model and intellectual property—such as signs and logos, trademarks and service marks, business plans, and operations manuals—necessary to operate the business. The franchisor also provides marketing and sales assistance, training, and other support to promote and grow the brand.").

38. Rangan & Backman, *supra* note 33, at 2.

39. *Id.* at 1–2.

40. *Id.* at 2.

41. *Id.*

42. *Id.*

By empowering the federation to negotiate for medical supplies and medications as a large-volume provider, inventory costs are presumably lower relative to similar for-profit providers. And its affiliation structure provides many of the benefits of a franchise operation—well-developed trademarks and concomitant goodwill, financial and medical management procedures, marketing, sales assistance and training. As a franchise scholar observes, “A vast distribution system can be quickly accomplished with a relatively [low investment] in sales outlets.”⁴³

Harvard noted that during the late 1970s and the 1980s, PPFA had “experienced rapid growth, with annual revenues exploding from \$80 million to over \$400 million between 1978 and 1990.”⁴⁴ At the beginning of that period, PPFA believed that its high name-recognition and reputation in the reproductive health services market “positioned it to expand its share of this large healthcare market.”⁴⁵ “By the 1990s, however, PPFA revenue growth had flattened, and beginning in 1993 [the year after *Casey*] the net margin had begun to decline.”⁴⁶ The Harvard study in 1994 found Planned Parenthood to be an organization in a state of flux, with “a great deal of variation among the local affiliates” both in size and scope of medical services offered.⁴⁷ At that time, PPFA included 163 local affiliates,⁴⁸ but between 1994 and 2012, roughly the period from the beginning of *Casey*’s regime of deregulation to the present, that total had shrunk to 94 under a wave of consolidations and closings.⁴⁹

Harvard concluded that “[s]ome of the decline in revenue growth was due to demographic shifts, as the number of women in their younger reproductive years (under 25) declined.”⁵⁰ Affiliate fundraising dropped by about five percent in 1993 from a peak of \$120 million in 1992, and national fundraising was also declining.⁵¹ Planned Parenthood insiders preferred to point to the rise of managed care, which was replacing traditional medical indemnity plans with systems that emphasized centralized decision making about health care decisions and referrals for specialized care.⁵² Most managed

43. J. Thomas McCarthy, *Trademark Franchising and Antitrust: The Trouble with Tie-ins*, 58 CAL. L. R. 1085, 1087 (1970).

44. Rangan & Backman, *supra* note 33, at 4.

45. *Id.*

46. *Id.*

47. *Id.*

48. *Id.* at 1.

49. Alliance Defending Freedom, *supra* note 31.

50. Rangan & Backman, *supra* note 33, at 4. It seems evident that since *Roe* legalized abortion in 1973, Planned Parenthood’s target clientele—women ages 18 through 44—would have begun to decline demographically beginning 18 years later, in 1991. Thus, Harvard may have been speaking euphemistically when it remarked, “demographic shifts were clearly affecting clinic revenue.”

51. *Id.* at 8.

52. Rangan & Backman, *supra* note 33, at 4–5 (stating that between 1980 and 1991, the

care systems provided the preventive care that Planned Parenthood affiliates offered. They preferred not to refer patients out of the system to third-party specialized providers like Planned Parenthood, preferring OB/GYN specialists to family planning clinics because physician specialists offered a broader range of specialty services than PPFA clinics.⁵³ Because Planned Parenthood operated “out of the medical mainstream,”⁵⁴ changes wrought by managed care threatened the financial foundation of Planned Parenthood.⁵⁵

Harvard notes that PPFA responded to these challenges in a number of ways. The federation voted to reframe PPFA’s slogan, which had been centered on securing access for reproductive healthcare, in favor of one that promised to be “America’s most trusted provider of reproductive care”⁵⁶ Following that “rebranding” process, a number of affiliates sought to attract more affluent patients and tested new markets in order to develop sources of subsidization for their traditional medical services to indigents.⁵⁷ Criticism of these directions came from within and from outside of the organization. According to the Associated Press, a confidential letter was sent by Planned Parenthood clinic executives in New York City, Chicago and Los Angeles to affiliates complaining, “[n]ever has a document [i.e., the rebranding proposal] seemed so out of touch with our mission”⁵⁸ “The word ‘abortion’ is mentioned only eight times,” the letter reportedly said, “and never in the discussion of our future.”⁵⁹ Competitors have been critical of PPFA’s new businesslike market strategy; one operator of an independent chain of abortion clinics in Texas and Maryland, Amy Hagstrom-Miller, was quoted by the *Wall Street Journal* as saying, “This is not the Planned Parenthood we all grew up with . . . they now have more of a business approach, much more aggressive.”⁶⁰ The *Wall Street Journal* provides context for Hagstrom-Miller’s frustration. “Ms. Hagstrom-Miller competes

percentage of Americans enrolled in managed care grew from 4 percent to 15.1 percent, with 35 percent of enrollees in the Pacific region in 1992).

53. *Id.* at 5–6 (stating managed care companies preferred to contract with larger organizations or organizations with sophisticated information and billing systems that many smaller Planned Parenthood affiliates lacked).

54. *Id.*

55. *Id.* at 6 (stating managed care threatened PPFA in several ways, according to the Harvard study: First, by reducing the pool of individuals with private insurance that did not cover contraceptives; second, by increasing competition for Medicaid patients as managed care drove down public healthcare costs and more providers were able to afford the Medicaid reimbursement rates for public health patients; and third, by increasing the number of uninsured individuals, thereby increasing demand for Planned Parenthood affiliates to partially subsidize services).

56. Stephanie Simon, *Planned Parenthood Hits Suburbia*, WALL STREET JOURNAL ONLINE (June 23, 2008), <http://online.wsj.com/news/articles/SB121417762585295459>.

57. *Id.*; E.g., Michael Blood, *Planned Parenthood Debates a New Focus: Primary Care*, SEATTLE TIMES, Mar. 2, 1995, available at <http://community.seattletimes.nwsourc.com/archive/?date=19950302&slug=2107745>.

58. Blood, *supra* note 57; Rangan & Backman, *supra* note 33, at 2.

59. *Id.*

60. Simon, *supra* note 56.

with Planned Parenthood for abortion patients—and finds it deeply frustrating. She does not receive the government grants or tax-deductible contributions that bolster Planned Parenthood, and says she can't match the nonprofit's budget for advertising or clinic upgrades."⁶¹ Hagstrom-Miller concludes, "[t]hey're not unlike other big national chains They put local independent businesses in a tough situation."⁶²

III. SUPPLY-SIDE ABORTION REGULATION: LICENSING, CREDENTIALING, AND HEALTH AND SAFETY REGULATIONS

In 2013, Bloomberg *Businessweek* recorded, "Amy Hagstrom-Miller fired 34 people in November,"⁶³ and further, Hagstrom-Miller "had to stop or sharply curtail abortions at four of her six Texas clinics because a new state law requires doctors performing the procedure to have admitting privileges at local hospitals."⁶⁴ Overall, "[a]t least twelve clinics in Texas have closed their doors or stopped offering the procedure in the past month after a federal appeals court and the U.S. Supreme Court let the new statute take effect."⁶⁵ The journal chronicled a wave of state regulations that have made it increasingly difficult for small and independent operators like Hagstrom-Miller to stay open. Since 2011, 30 states have passed 203 abortion restrictions.⁶⁶ At least seventy-three clinics have reportedly closed or stopped doing abortions.⁶⁷ *Businessweek* estimates that new laws were responsible for roughly half the closures, with declining demand, consolidation, and crackdowns also contributing.⁶⁸ In this instance, surgical center regulations were a potent force: "Laws aimed at the clinics, such as mandates to widen hallways and install high-tech surgical scrub sinks, are proving more powerful than those aimed at patients, such as waiting periods or parental notification requirements."⁶⁹

61. *Id.*

62. *Id.*

63. Esme E. Deprez, *The Vanishing Abortion Clinic*, BLOOMBERG BUSINESSWEEK (Nov. 27, 2013), <http://www.businessweek.com/articles/2013-11-27/abortion-clinics-face-shutdown-spiral-as-republicans-push-restrictions>.

64. *Id.*

65. *Id.*; See also *Planned Parenthood v. Abbott*, 951 F. Supp. 2d 891 (W.D. Tex. 2013) *emergency stay granted in part*, 734 F.3d 406 (5th Cir.), *mot'n to stay den'd*, 134 S.Ct. 506 (2013), — F.3d —, 2014 WL 1257965 (Mar. 27, 2014) (affirming in part, reversing in part and remanding).

66. Deprez, *supra* note 63.

67. *Id.*; See also Esme E. Deprez, *Abortion Clinics Close at Record Pace After States Tighten Rules*, BLOOMBERG NEWS (Sep. 03, 2013), <http://www.bloomberg.com/news/2013-09-03/abortion-clinics-close-at-record-pace-after-states-tighten-rules.html>.

68. Deprez, *supra* note 63.

69. *Id.* (litigation over surgical center regulations continues apace, with admitting privileges requirements currently taking center stage); See, e.g. *Planned Parenthood of Wisc., Inc. v. Van*

As noted above, medical licensing mandates for abortion physicians, credentialing requirements such as mandating admitting privileges, and ambulatory surgical center regulations have a substantial impact upon the cost of doing business for abortion providers, and thus reduce the number of providers entering and staying in the market. Abortion researcher Andrew Beauchamp concludes that 22 percent of the decline in abortions from 1991–2005, covering much of the post-*Casey* era, was due to state regulations, with supply-side regulations decreasing abortions by 3.2 percent annually.⁷⁰

Theodore Joyce of the Guttmacher Institute and his colleagues studied the impact of earlier surgical center regulations in Texas, which in 2004 passed a law mandating that after 15 weeks abortions must be performed in surgical centers.⁷¹ Because none of the 56 Texas abortion providers qualified as surgical centers, the effective result was to make abortions after 15 weeks unavailable in Texas. Abortions among Texas residents after 15 weeks fell by 64 percent in the first year.⁷² While the number of Texas residents obtaining late-term abortions out-of-state tripled, less than five percent of abortions for Texas residents were performed at 16 weeks or after.⁷³

IV. DEMAND-SIDE ABORTION REGULATION

In economic research and analysis, abortion is typically viewed as a form of insurance against having “unwanted children.”⁷⁴ However, research has indicated that a decrease in abortion rates does not always lead to an increase in birth rates.⁷⁵ Rather, decreases in abortion can be correlated with a decrease in pregnancy rates.⁷⁶ Yuengert and Fetzer postulate that the same factors that discourage abortion likely discourage pregnancy.⁷⁷ Thus, when abortion costs

Hollen, 963 F.Supp.2d 858 (W.D. Wis. 2013), *Planned Parenthood of Wisconsin, Inc. v. Van Hollen*, 2013 WL 3989238 (W.D.Wis. Aug 02, 2013) (NO. 13-CV-465-WMC), *aff'd*, *Planned Parenthood of Wisconsin, Inc. v. Van Hollen*, 738 F.3d 786 (7th Cir. Dec 20, 2013), *Petition for Certiorari Filed*, 82 USLW 3591 (Mar 19, 2014) (NO. 13-1127); *Jackson Women’s Health Org. v. Currier*, 940 F. Supp. 2d 416, 420 (S.D. Miss. 2013); *Planned Parenthood Se., Inc. v. Bentley*, 951 F. Supp. 2d 1280 (M.D. Ala. 2013), *Planned Parenthood Southeast, Inc. v. Strange*, 2014 WL 1320158 (M.D.Ala. Mar 31, 2014) (denying motions for summary judgment and setting trial).

70. Beauchamp, *supra* note 23, at 40 (suggesting that the remaining percentage is due to contraception, an increase in desired pregnancies and a decrease in unwanted pregnancies).

71. Colman & Joyce, *supra* note 12, at 806.

72. *Id.*

73. *Id.*

74. Yuengert & Fetzer, *supra* note 6, at 422.

75. *Id.* at 423.

76. *Id.* at 425 (concluding that legal abortion has reduced birth rates by eight percent, but has increased the pregnancy rate).

77. *Id.*; *accord* Beauchamp, *supra* note 23, at 8 (stating that the fact that both birth and abortion rates fall when the travel distance to a provider increases demonstrates that the same factors that reduce abortions also reduce pregnancies).

increase slightly, they predict that both abortion and birth rates will fall.⁷⁸ This effect seems limited, because when abortion costs increase heavily, the abortion rate will fall and the birth rate will rise.⁷⁹

Using economic variables from three decades, ten years apart, Marshall Medoff of Long Beach State and his co-authors added abortion price to the demand equation in order to explore how abortion restrictions, abortion price, and income affect demand.⁸⁰ Medoff found that there is generally greater demand for abortion among women in the workforce and lower demand among educated and evangelical women.⁸¹ Medoff found demand for abortion is more sensitive to price than previous research indicated.⁸² Further, the price of abortion also may alter a woman's decision to avoid becoming pregnant in the first place.⁸³ When abortion costs increase, women may engage in pregnancy-avoiding behavior, driving down abortion demand, Medoff concludes.⁸⁴

A brief look at the microeconomics of abortion helps explain why this is so. Rachel Jones and her co-authors at the Guttmacher Institute conducted a voluntary poll of 639 women at six abortion clinics in diverse locations to examine how women pay for abortion.⁸⁵ The study indicated that women with private health insurance are more likely to pay for abortions out of pocket than women with Medicaid.⁸⁶ While 64 percent of women polled had insurance, 69 percent of them did not use their insurance to cover the abortion.⁸⁷ Among women who did not use private insurance, half said that it was difficult to find the money to pay for the abortion.⁸⁸ Women covered by Medicaid were half as likely to pay for an abortion out-of-pocket as women with private insurance.⁸⁹

In a review of prior literature, Jones and her co-authors found that in

78. Yuengert & Fetzer, *supra* note 6, at 424–29 (asserting demand is related to supply as well, since research has demonstrated that access to providers increases abortion rates); *See also* Beauchamp, *supra* note 23, at 40.

79. Yuengert & Fetzer, *supra* note 6, at 424–29.

80. Marshall H. Medoff, *Price, Restrictions and Abortion Demand*, 28 J. OF FAM. ECON. ISS. 583 at 583 (2007).

81. *Id.* at 591; *accord* Beauchamp, *supra* note 23, at 26 (noting that factors such as religious and ethnic composition can vary demand, and that inclusion of those variables is essential to studying impacts on demand).

82. Medoff, *supra* note 80, at 592–93.

83. *Id.*

84. *Id.*

85. Rachel K. Jones et al., *At what cost?: Payment for abortion care*, WOMEN'S HEALTH ISSUES, May 7, 2013.

86. *Id.* at 2.

87. *Id.*

88. *Id.* at 9.

89. *Id.* at 2.

2008, 20 percent of total U.S. abortions were covered by Medicaid,⁹⁰ and those took place only in the 17 states that provide Medicaid coverage for abortion.⁹¹ Only 12 percent of U.S. abortions in 2008 were paid for with private insurance.⁹² Half of the women polled received assistance, either from an abortion fund, from a male partner, a family member, a discount from the abortion provider, or other sources.⁹³ Without counting those who had no out-of-pocket costs, the average price was \$485.⁹⁴ Including the 21 percent of those women who had no out-of-pocket costs, the average price paid was \$382.⁹⁵ The average cost for second-trimester abortions was \$854.⁹⁶

There are also hidden costs imposed by abortion. The average amount of lost wages attributed to abortion costs (such as childcare, transportation and taking time off work) was \$198, according to Jones.⁹⁷ Two-thirds of women were affected by the \$44 average cost of traveling to an abortion provider.⁹⁸

Medicaid Funding

It is generally recognized that the availability of state Medicaid funding results in increased abortion demand.⁹⁹ In 2001, six states implemented expanded Medicaid programs that provided family planning funding for individuals with incomes too high for overall Medicaid eligibility.¹⁰⁰ By 2006, eight more states offered expansion programs for abortion and family planning.¹⁰¹ Since 1994, Medicaid spending on family planning has tripled in those 14 states.¹⁰² Between the state and federal governments, \$89 million was spent on 177,000 abortions in 2006.¹⁰³ Nearly all of that money was spent

90. *Id.* at 3.

91. Jones et al., *supra* note 85.

92. *Id.*; see generally Alan Guttmacher Institute, *State Policies in Brief: Restricting Insurance Coverage of Abortion*, Nov. 1, 2003 at 1 (explaining eight states restrict insurance coverage of abortion in all private insurance plans written in the state, including those offered through the health insurance exchanges under the federal health care reform law, twenty-four restrict abortion coverage in plans that will be offered through the insurance exchanges created by the Affordable Care Act, and eighteen restrict abortion coverage in insurance plans for public employees).

93. Alan Guttmacher Institute, *supra* note 92, at 1.

94. *Id.*

95. Jones et al., *supra* note 85, at 9.

96. *Id.*

97. Tara Culp-Ressler, *By the Numbers: Why Most U.S. Women Struggle to Afford Abortion*, THINK PROGRESS (May 8, 2013, 11:20 AM), <http://thinkprogress.org/health/2013/05/08/1979831/women-struggle-to-afford-abortion>.

98. *Id.*

99. Medoff, *supra* note 80, at 593; ADAM SONFIELD, ET AL., GUTTMACHER INST., PUBLIC FUNDING FOR FAMILY PLANNING, STERILIZATION AND ABORTION SERVICES FY 1980-2006, Occasional Report No. 38 (2008).

100. SONFIELD, ET AL., *supra* note 99, at 6.

101. *Id.*

102. *Id.*

103. *Id.*

in the 17 states with nonrestrictive abortion policies allowing Medicaid to cover nearly all “medically necessary” abortions, and nearly all of the abortions were covered by state dollars.¹⁰⁴ Comparing the results of a 2006 survey of public expenditures for family planning with surveys from prior years, Adam Sonfield and his co-authors at the Guttmacher Institute demonstrated the growth of public spending on abortion in these 17 states with nonrestrictive abortion funding policies.¹⁰⁵ In those states, the inclusion of family planning has substantially increased the Medicaid client base, compared to more restrictive states.¹⁰⁶

Conversely, there is general agreement that state Medicaid restrictions decrease abortion rates. Marshall Medoff of Long Beach State believes that Medicaid restrictions substantially reduce the number of unintended pregnancies that end in abortion. While Medicaid restrictions reduce the rate of terminations of unintended pregnancies by 10.7 per 1,000 women, the restrictions reduce the ratio of abortions to unintended pregnancies by 121.5 per 1,000 unintended pregnancies.¹⁰⁷ Therefore, Medoff concludes, Medicaid restrictions have less effect on sexual behavior and more effect on what women decide to do after they become unintentionally pregnant.

Stanley Henshaw of the Guttmacher Institute and his co-authors in 2009 utilized 38 studies, ranging from the years 1979–2008, to demonstrate the national and statewide effects of restrictions on Medicaid funding for elective abortion.¹⁰⁸ Thirty-two states and the District of Columbia have restricted the use of Medicaid dollars to abortion cases involving life endangerment and rape.¹⁰⁹ Studies found that among Medicaid-restricted states, there were 16.4 abortions per 1,000 women of childbearing age.¹¹⁰ That ratio was substantially less than in the 17 Medicaid-expanded states, where there were 24.1 abortions per 1,000 women.¹¹¹ Henshaw and his co-authors concluded that among pregnancies that would have been eligible for Medicaid-funded abortion, between 18 and 37 percent were carried to term when funding was

104. *Id.* at 10.

105. *Id.* at 7.

106. SONFIELD ET AL., *supra* note 99, at 7.

107. Marshall H. Medoff, *Unintended Pregnancies, Restrictive Abortion Laws, and Abortion Demand*, ISRN ECON., 2012, at 5 [hereinafter Medoff, *Unintended Pregnancies*] (noting that abortion is a function of unintended pregnancies, using data from a state-specific survey and plugging it into an empirical formula that demonstrated the changes in abortion rate, to examine the impact of abortion price and state restrictions on unintended pregnancies); *See also* Medoff, *supra* note 80, at 596 (concluding that in states where state Medicaid funding is available for abortions, demand increased by 3.3 percent, but with a much more significant impact among minors).

108. STANLEY HENSHAW, ET AL., GUTTMACHER INST., *RESTRICTIONS ON MEDICAID FUNDING FOR ABORTIONS; A LITERATURE REVIEW*, 2009.

109. *Id.* at 1.

110. *Id.* at 9.

111. *Id.*

unavailable.¹¹² While the results showed no significant increase in birth rates for low-income women,¹¹³ among teenagers and adults Medicaid restrictions resulted in an overall reduction in the number of pregnancies that end in abortion.¹¹⁴ Unlike Medoff, the authors found it inconclusive whether restrictions reduce pregnancy rates for teenagers or adults.¹¹⁵

Parental Involvement Laws

As of 2007, 35 states mandated some form of parental involvement in a minor's decision to have an abortion.¹¹⁶ Of these, 22 required some form of consent by one or both parents, while 11 states required parental notification only.¹¹⁷ In keeping with Supreme Court decisions prohibiting states from allowing parental "vetos" over the abortion decision, all states that have enforceable parental involvement statutes also maintain some form of judicial bypass procedure.¹¹⁸

Some scholars, such as Long Beach State's Medoff, believe that parental notification mandates have little to no effect on overall abortion rates, but are connected with lower pregnancy rates.¹¹⁹ Dr. Michael New's recent comprehensive analysis of minor abortion data from nearly all fifty states between 1985 and 1999, however, demonstrates that parental involvement laws, once enacted, cause abortion rates to fall by an average of

112. *Id.* at 27.

113. *Id.*

114. HENSHAW, ET AL., *supra* note 108, at 27–8.

115. *Id.*

116. GUTTMACHER INSTITUTE, STATE POLICIES IN BRIEF: PARENTAL INVOLVEMENT IN MINORS' ABORTIONS, 2014 at 1, *available at*, http://www.guttmacher.org/statecenter/spibs/spib_PIMA.pdf.

117. *Id.*

118. *See, e.g.*, *Planned Parenthood of Cent. Missouri v. Danforth*, 428 U.S. 52, 74 (1976) (“[T]he State may not impose a blanket provision . . . requiring the consent of a parent . . . as a condition for abortion of an unmarried minor during the first 12 weeks of her pregnancy.”); *Bellotti v. Baird*, 443 U.S. 622, 643 (1979) (“[I]f the State decides to require a pregnant minor to obtain one or both parents’ consent to an abortion, it also must provide an alternative procedure whereby authorization for the abortion can be obtained.”); *Hodgson v. Minnesota*, 497 U.S. 417, 450 (1990) (“[T]he requirement that both parents be notified, whether or not both wish to be notified or have assumed responsibility for the upbringing of the child, does not reasonably further any legitimate state interest.”); *Ohio v. Akron Ctr. for Reprod. Health*, 497 U.S. 502, 511 (1990) (upholding a parental consent requirement that included a judicial bypass procedure); *H. L. v. Matheson*, 450 U.S. 398, 409 (1981) (“A statute setting out a ‘mere requirement of parental notice’ does not violate the constitutional rights of an immature, dependent minor.”).

119. Medoff, *Unintended Pregnancies*, *supra*, note 107, at 5 (suggesting that parental involvement statutes have a “spillover effect” as they result in permanent changes in teenagers’ sexual behavior, which include avoiding risky sexual behavior, follow them into adulthood and serve to continue driving down the number of unintended pregnancies); *But see* Medoff, *supra* note 80, at 596–97 (finding that parental involvement statutes had small to no impact on the general number of abortions, but parental consent, parental notification and parental involvement were significantly related to reduced abortion demand among minors, reducing demand by four to five percent).

approximately 13.6 percent.¹²⁰

Wait-and-Counsel Mandates

A majority of states require counseling for women considering abortion.¹²¹ As of 2013, 35 states require that women receive counseling before an abortion, with 25 states requiring specific information about the procedure, including the ability of the fetus to feel pain (12); psychological impacts of abortion (22), and the link between abortion and decreased resistance to breast cancer (7).¹²² Twenty-six of these states also mandate that women wait a specified period, usually 24 hours, between the counseling and the abortion.¹²³

A diversity of opinion exists over the efficacy of wait-and-counsel mandates in reducing abortion rates. Yuengert and Fetzer's review of economic literature concludes that informed consent and mandatory waiting periods decrease abortion rates, and abortion policies in general affect pregnancy rates, contraception use and marriage.¹²⁴ Andrew Beauchamp believes that on the demand side, only waiting period laws have been shown to decrease the number of abortions.¹²⁵ Marshall Medoff demurs, concluding that mandatory counseling and waiting periods have no statistically significant effect on the rate or ratio of abortions to unintended pregnancies.¹²⁶

Theodore Joyce and his Guttmacher Institute co-authors reviewed 12 studies on waiting period and mandatory counseling laws.¹²⁷ Four out of six studies found a significant reduction in abortion rates based on mandatory counseling and waiting period laws, while two did not.¹²⁸ The most important variable, according to the authors, was whether the law required a woman to make at least two visits to the provider before obtaining an abortion.¹²⁹ Laws which require two visits to an abortion provider are substantially related to reduced abortions, they concluded, while laws that enable one visit have no

120. New, *supra* note 12.

121. GUTTMACHER INSTITUTE, STATE POLICIES IN BRIEF: MANDATORY COUNSELING AND WAITING PERIODS FOR ABORTION, Dec. 1, 2013, at 7, *available at*, http://www.guttmacher.org/statecenter/spibs/spib_MWPA.pdf.

122. *Id.*

123. *Id.*; *Planned Parenthood Minnesota, N. Dakota, S. Dakota v. Daugaard*, 799 F. Supp. 2d 1048 (D.S.D. 2011) (South Dakota mandated a 72-hour waiting period, but that provision was enjoined in litigation).

124. Yuengert & Fetzer, *supra* note 6, at 429.

125. Beauchamp, *supra* note 23, at 25.

126. Medoff, *supra* note 80, at 593.

127. THEODORE J. JOYCE ET AL., GUTTMACHER INSTITUTE, THE IMPACT OF STATE MANDATORY COUNSELING AND WAITING PERIOD LAWS ON ABORTION, 2009.

128. *Id.* at 7.

129. *Id.* at 9.

statistically significant impact on abortion rates.¹³⁰ Likewise, they concluded that laws that allow for counseling via telephone or that only require a one-hour waiting period do not have a statistically significant impact on abortion rates or delays.¹³¹

One study surveyed by Joyce's team examined abortion rates before and after a 24-hour waiting period law was implemented in Mississippi,¹³² effectively requiring a woman to make two separate visits to the provider in order to obtain an abortion.¹³³ The actual number of abortions in Mississippi was 22 percent lower than expected based on previous years.¹³⁴ Abortions performed in Mississippi on out-of-state residents fell by 30 percent, while abortions obtained by Mississippi residents out of state increased by 17 percent.¹³⁵ The study concluded that the law resulted in approximately 11-13 percent fewer abortions.¹³⁶

Joyce and his co-authors concluded that abortion rates will likely decrease in a state requiring more than one visit to a provider, especially if neighboring states have similar restrictions.¹³⁷ However, Medoff, Joyce, and others agree that women are willing to travel across state lines to avoid their state's restrictions and obtain an abortion.¹³⁸

V. CONCLUSION

The impact of making abortion effectively unavailable, either geographically as clinics close, or by regulatory processes, is much debated. Theodore Joyce and his Guttmacher Institute colleagues studied abortion and birth rates before and after *Roe*'s legalization of abortion in 1973 to examine how abortion rates may be impacted by regulations that increase the distance to a legal provider.¹³⁹ Prior to the national legalization of abortion in 1973, tens of thousands of women traveled to "legal abortion" states to obtain abortion.¹⁴⁰ For instance, in 1971 and 1972, 29,227 women traveled from Michigan to New York to obtain abortions.¹⁴¹ After abortion became legal in every state and more widely available, travel to New York fell dramatically among abortion-minded women, largely among non-whites, low-income

130. *Id.* at 15.

131. *Id.*

132. *Id.* at 7.

133. Joyce et al., *supra* note 127, at 7.

134. *Id.*

135. *Id.*

136. *Id.*

137. *Id.*

138. Medoff, *supra* note 80, at 593; Ted Joyce et al., *Back to the Future? Abortion Before and After Roe*, 32 J. HEALTH ECON. 815 (2013) [hereinafter Joyce et al., *Abortion Before and After Roe*].

139. Joyce et al., *Abortion Before and After Roe*, *supra* note 138, at 804.

140. *Id.*

141. *Id.*

women and young women.¹⁴² While long distances to abortion providers were connected with high teen birth rates before *Roe*, after abortion became legal, distance only had a moderate impact on teen birth rates.¹⁴³ Based on these findings, the authors posit that efforts to reduce providers and increase distances will have more of an impact on teenagers, non-whites and low-income women.¹⁴⁴ Joyce and his co-authors conclude that if abortion providers decrease, the vast majority of women will still travel to states where abortion is available.¹⁴⁵ “What is apparent from the pre-*Roe* abortion data,” Joyce states, “is that although distance matters, women were willing to travel hundreds of miles to terminate an unwanted pregnancy. We predict that most women would continue to travel long distances to terminate a pregnancy, if abortion were no longer legal in their state.”¹⁴⁶

Thus, despite the demonstrable impact of abortion regulations on supply and demand for abortion, abortion advocates and opponents should recognize that there are limits to their effectiveness. State activity and political debate over this issue are unlikely to end, whether extreme regulation or extreme deregulation occurs. The latter goal is typically embodied in efforts to pass a federal Freedom of Choice Act (“FOCA”). Introduced in 2004, FOCA would have resulted in courts overturning nearly all state abortion regulations, with the exception of the physician requirement for surgical abortions. Andrew Beauchamp of Boston College simulated passage of such a law.¹⁴⁷ Plugging the FOCA scenario into his supply-and-demand equations, the author determined that the number of large providers would remain the same, while the number of small providers would increase by 11 percent and hospital providers would increase by 13 percent.¹⁴⁸ Abortions would increase only by 6.6 percent, Beauchamp concluded.¹⁴⁹ The author posited that removing state regulations would only moderately affect access to abortions because the decline in access is mainly due to shifts in demand.¹⁵⁰ Even the entry of new providers under the simulated scenario took place in existing markets instead of creating new markets.¹⁵¹

On the other end of the political spectrum, studies have attempted to simulate the resulting regime of state abortion regulation if *Roe v. Wade* were

142. *Id.* at 805.

143. *Id.*

144. *Id.*

145. Joyce et al., *Abortion Before and After Roe*, *supra* note 138, at 815.

146. *Id.*

147. Beauchamp, *supra* note 23, at 37.

148. *Id.* at 38.

149. *Id.*

150. *Id.*

151. *Id.*

overturned by the Supreme Court and the issue returned to the states.¹⁵² Theodore Joyce and his co-authors computed the change in distance to the nearest legal provider under several scenarios and applied their pre-*Roe* estimates to predict changes in abortion and birth rates.¹⁵³ One scenario assumed that only 20 states with state constitutional protections for abortion or with historically strong support for the practice would continue to permit it.¹⁵⁴ Another assumed that abortion was banned or extremely restricted in 17 states: those with bans pre-dating *Roe* or statutes that would ban abortion if *Roe* was overturned, and states that have signaled a desire to restrict abortion to the maximum legally possible.¹⁵⁵ The authors concluded that nationally, abortions would be expected to fall by 14.9 percent under the first scenario of a 31-state ban (including the District of Columbia), but only by 6.0 percent under the latter scenario of a 17-state ban.¹⁵⁶

The fact that these projections predict roughly a 12 to 21 percent swing in abortion between a regime of unregulable abortion, and one of state plenary authority to regulate, strongly suggests that the potential impact of abortion regulation is contained within a fairly narrow band of net change. The lesson taught by the data and conclusions contained in the studies reviewed herein seems to be that legal and cultural efforts to reduce abortion on the demand side are likely to have a greater long-term impact on the abortion rate than legislative efforts to restrict supply, although clearly both approaches are working in tandem to lower the overall national abortion rate.

152. See, e.g., Joyce et al., *Abortion Before & After Roe*, *supra* note 138; Levine, Phillip et al., *Roe v. Wade and American Fertility*, 89 AM. J. OF PUB. HEALTH 199 (1999).

153. Joyce et al., *Abortion Before & After Roe*, *supra* note 138, at 3–21 (projecting as to which states would likely ban or restrict abortion came from analyses provided by the Center for Reproductive Rights, NARAL Pro-Choice America and the Guttmacher Institute).

154. *Id.*

155. *Id.*

156. *Id.*