U.S. Government Accountability Office

Abortion Restrictions: Research Suggests Potential Economic and Household Effects of Recent State Changes

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Q&A
Report to Congressional Requesters
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Why This Matters

Research suggests that restrictions on abortion access can have economic implications for individuals who seek or are unable to obtain abortions, their families, and aspects of the economy more broadly. In June 2022, in its decision in *Dobbs v. Jackson Women's Health Organization* (*Dobbs* decision), the U.S. Supreme Court held that the Constitution does not confer a right to abortion.[1] Since the 2022 decision, several states have taken actions to protect or restrict access to abortion. Questions have been raised about the potential economic effects of recent state actions restricting abortion, even as the state-level legal landscape regarding abortion continues to evolve.

We were asked to examine what is known about the potential economic and household effects of state-level restrictions on abortion, as well as efforts of federal agencies to assess these effects. This report provides information on the potential economic effects of state-level abortion restrictions on individuals and households across different demographic groups and on aspects of the economy more broadly. It also looks at the role federal agencies play in collecting abortion-related data and assessing the economic effects of state restrictions.

This report presents findings from our review of 55 studies that met our standards for rigor and quality and were relevant to this study. We also present perspectives from our interviews with four academic researchers, officials from three national organizations with subject matter expertise, and information from the Centers for Disease Control and Prevention (CDC) and the Social Security Administration (SSA). In addition, we present data from the Guttmacher Institute on the number and rate of abortions before and after the *Dobbs* decision. See "How did we identify and review studies examining the potential economic effects of state abortion restrictions?" and "How GAO Did This Study" for additional details on our methodology.

Key Takeaways

- Studies we reviewed report that abortion restrictions can have negative economic effects for women seeking an abortion as well as for women who are unable to obtain an abortion and instead carry their pregnancies to term. Studies also found that laws restricting abortion access can have broader effects, for example, by influencing decisions about where to live, as well as birth and maternal mortality rates. Given how recently the *Dobbs* decision

was issued, most research we reviewed examines the effects of restrictions that existed before the decision in June 2022.

- The federal government collected and published limited data through 2022 on abortions, and one agency we contacted has plans to account for the effect of recent abortion restrictions on total fertility rates in its future economic analyses. The CDC collected some abortion data from states to document the number and characteristics of women obtaining abortions and the number of abortion-related deaths, but reporting was voluntary and not all states provided the agency with this information. In May 2025, agency officials said the future of this data collection is uncertain, given ongoing realignment efforts at the agency. The Social Security Administration (SSA) reported plans to incorporate changes to state abortion laws in its future analyses of the financial condition of the Social Security Trust Funds, but its analyses will be limited to any potential changes to fertility rates. SSA's ability to use federal data to inform this analysis depends on whether CDC continues to collect abortion data from states.

How did we identify and review studies examining the potential economic effects of state abortion restrictions?

To examine the potential economic effects of state abortion restrictions, we conducted a systematic literature review. To identify relevant studies, a research librarian performed iterative keyword searches across multiple databases including Scopus, EconLit, MEDLINE, and Social SciSearch. We used a structured approach that incorporated three key categories of search terms: (1) abortion restrictions (including statutory, regulatory, and policy limits), (2) socioeconomic outcomes and effects, and (3) a focus on the United States. Our search was limited to research published within the last 7 years (to capture 5 years before the *Dobbs* decision and 2 subsequent years). Our searches yielded 611 potentially relevant documents from peer-reviewed journals, government-issued reports, working papers, conferences, and publications from nongovernmental organizations. We also identified studies through interviews with academic researchers and agency officials, as well as open internet searches.[2]

To assess the relevance of these studies, two reviewers separately examined each study's abstract to agree on relevance. We considered studies relevant if they (1) included original research or data analysis; (2) were U.S. focused; and (3) examined the effects of abortion restrictions on abortion rates; travel times and costs to obtain an abortion; socioeconomic outcomes such as educational attainment, financial distress or career trajectories; and population demographics including fertility rates and maternal morbidity and mortality. This initial abstract review yielded 124 studies. We conducted a secondary review for relevance through a discussion of the key points of each study. Specifically, one reviewer conducted a full text review and summarized each study using a series of standardized questions on the study population, outcomes, and time frames. We used this summary to collectively decide which studies to include, resulting in 78 studies we deemed relevant for further review.

We then assessed methodological quality to determine whether a study was sufficiently rigorous to include in the final literature review. Specifically, two specialists independently conducted in-depth full text reviews of the remaining 78 studies. These reviews entailed an assessment of each study's research methodology, including its data quality, research design, and analytic techniques, as well as a summary of each study's major findings and conclusions. We also assessed the extent to which each study's data and methods supported its findings and

conclusions. We prioritized studies based on their methodological rigor and use of empirical data analysis. At the conclusion of our review, we determined that 55 studies met our standards for quality and were relevant to our study. See the bibliography for a full list of relevant articles.

Our report presents key findings from the body of knowledge included in this universe of selected studies. To the extent that findings from these studies vary, we mention the differences in our report. All studies have limitations and face challenges in identifying the effects of abortion restrictions on individual or macroeconomic outcomes. Despite these limitations, we determined that the studies we included provide reliable information about the potential economic effects of abortion restrictions.

To provide context to our literature review, we interviewed four academic researchers we identified from our selected literature. We selected these researchers because they had authored or coauthored four or more studies in our review. See the "How GAO Did This Study" section of our report for additional details on our methodology.

How have state abortion restrictions changed since the *Dobbs* decision, and what types of restrictions have been examined in economic research?

States have enacted various abortion-related restrictions both before and after the *Dobbs* decision. In 1973, the U.S. Supreme Court concluded in *Roe v. Wade* that a woman has a fundamental right protected by the U.S. Constitution to decide whether to terminate her pregnancy.[3] However, the Court also concluded that this right was not unqualified and must be considered against important state interests in regulating abortion. Over time, states adopted a range of abortion-related laws, including parental involvement laws, mandatory waiting periods, and restrictions on abortion providers (e.g., requiring clinics to meet certain building requirements).[4]

Since the *Dobbs* decision, some states have enacted new laws related to abortion, and several states that have chosen to restrict access have lowered gestational age limits or generally prohibited abortion.[5] As states differentiate their approaches, laws related to abortion access continue to evolve. Economic research we reviewed examined the effects of various types of state-level laws, which are detailed below.

Restrictions on abortion access for individuals seeking an abortion

- *Lowering gestational age limits or generally prohibiting abortion*. Since the *Dobbs* decision, certain states have adopted earlier gestational age limits on abortions, such as prohibiting abortion after 12 weeks' gestation. In other states, "trigger" laws that generally prohibit abortions—set to take effect after *Roe v. Wade* was overruled—have gone into effect.

- *Mandatory waiting periods*. Certain states require time periods between pre-abortion counseling and receiving an abortion. These requirements vary by state, and the research we reviewed identified waiting periods from 18 to 72 hours.

- *Parental involvement.* Certain states maintain laws requiring varying degrees of parental involvement—such as notification or consent—before a minor can obtain an abortion.

Restrictions on abortion providers[6]

- *Provider type*. Certain states maintain laws that only permit physicians, rather than other health care professionals, to provide abortions.
- *Presence of a physician*. In some states, a physician must be in the same room as the patient when abortion medications are administered, which would generally prevent the medication from being prescribed through telemedicine appointments and self-administered outside of a clinical setting.
- *Building requirements*. Some states specify building requirements that clinics must meet to be able to provide abortions. For example, some states only permit abortions to be performed in an ambulatory surgical center or in a facility located within a certain distance of a hospital.

What do available data show about changes to the rate of abortions in the U.S. since the *Dobbs* decision?

Data from the Guttmacher Institute show that the number and rate of abortions was higher in 2023 following the *Dobbs* decision than it was in 2019.[7] However, because state laws affecting abortion access differ and continue to evolve, access to abortion varies nationwide and the rate may change in the future.

We found that the abortion data from the Guttmacher Institute was the most reliable available data. While the CDC has published abortion data through its annual Abortion Surveillance Summaries, we used the Guttmacher Institute's data due to several limitations with CDC's data, including its incompleteness, which we describe in more detail later in our report. In addition, at the time of our reporting, the last available abortion data from CDC was from 2022.

Data from the Guttmacher Institute showed the number of abortions nationwide in 2023 was 1,019,000, an increase from 2019, when the number was 915,000. When taking population changes into account, the estimated nationwide abortion rate in 2023 was 15.4 per 1,000 women aged 15–44, representing a 9.3 percent increase from 2019, when the nationwide abortion rate was 14.1 per 1,000 women aged 15–44.[8] Guttmacher Institute data also showed that over this time period, some states saw significant increases in abortion numbers and rates, while other states saw decreases (see app. 1 for information on abortion rates by state).

Three researchers we spoke to said the increase in the rate of abortions nationwide following the *Dobbs* decision was unexpected. They said two primary factors may help account for the increase from 2019 to 2023:

- **Fewer in-person requirements to obtain an abortion.** At the time of the *Dobbs* decision in June 2022, the use of telehealth appointments had already been increasing in response to the COVID-19 pandemic that began in 2020. In January 2023, the Food and Drug Administration removed the in-person requirement for dispensing abortion medication prescriptions.[9] Two researchers we spoke to said that together these changes eliminated or lessened the need for individuals to go to a medical facility for an abortion or to a pharmacy for abortion medication. In April 2022, medications dispensed through telehealth appointments accounted for an estimated 4 percent of all abortions. By June 2024, this

number had grown to 20 percent of all abortions, according to data from the Society for Family Planning. Researchers also said some states now have laws that allow doctors to provide abortion medication through telehealth appointments to anyone in the country, regardless of the state in which they live.

- **More funding available to cover abortion and travel costs.** Three researchers we spoke with said that, following the *Dobbs* decision, donations increased to organizations that provide direct support for individuals seeking abortion (known as abortion funds), allowing many women to travel for abortions with some or all of their costs covered.

However, the researchers also noted that both factors may change as the legal landscape continues to evolve and donations to abortion funds fluctuate.

Pre-*Dobbs* studies we reviewed that examined the impact of abortion restrictions reported that states that enacted abortion restrictions, including parental involvement laws, mandatory waiting periods, and abortion provider restrictions, tended to decrease the number of abortions obtained within those states.[10] Post-*Dobbs* studies we reviewed reported that state abortion restrictions may have led to increases in the number of abortions and abortion rates in states without restrictions, due to increased numbers of abortions provided to out-of-state residents.[11] Other studies we reviewed that examined pre-*Dobbs* data found a decrease in the number of abortions in states where people had to travel long distances to obtain abortions at brick-and-mortar medical facilities.[12]

How does research suggest state abortion restrictions may affect an individual's access to abortion and related costs?

Studies we reviewed found that state laws that restrict access to abortion led to individuals traveling farther and sometimes waiting longer to obtain abortions, both of which they found can lead to significant costs for low-income families.

Travel to access an abortion. We reviewed five studies that examined various aspects of abortion-related travel, and all found increased travel for individuals seeking abortions following state abortion restrictions. Studies found that as travel time and distances increase, costs—which can include time off from work and hotel stays, for example—increase as well.

Three of these studies were nationwide or covered multiple states.[13] One study of all states except Alaska and Hawaii examined pre-*Dobbs* travel distances and found that the average distance to the nearest abortion provider increased from 18 miles in 1980 to 26 miles in 2016.[14] The study also found that, in cases of minors seeking to avoid parental consent laws, the average distance to obtain an abortion increased from 58 miles in 1992 to 454 miles in 2016. A second, multistate study conducted before the *Dobbs* decision found that states with restrictions on abortion providers were associated with an average 12 to 13 percent increase in travel distance and a 10 percent increase in driving time when compared to states without such restrictions. A third study, of all states except Alaska and Hawaii, found the average travel time to obtain an abortion was 28 minutes in 2021 and 100 minutes in September 2022, although there was significant variation across states.[15]

The two additional studies we reviewed documented changes for specific states, clinics, or populations in average travel before and after abortion restrictions took effect.[16] The first study reviewed the average distance Texas residents must travel to reach a clinic that provides procedural (non-medication) abortion. This study found that after a 2021 Texas law prohibited physicians from performing abortions if they detect a fetal heartbeat, the average distance a Texas resident must travel to the closest clinic performing procedural abortions increased by over 210 miles.[17] Following the *Dobbs* decision in 2022, the average distance increased again, to over 450 miles when compared to average distances prior to the 2021 law. The second study examined changes in travel following the *Dobbs* decision at a specific clinic in Oregon, which does not have laws restricting or prohibiting abortion.[18] Data from the clinic found that the proportion of out-of-state abortions increased from 9.5 percent to 14.3 percent following the *Dobbs* decision, and the proportion of individuals who traveled more than 50 miles to the clinic increased from 23.7 percent to 31.2 percent.

Gestational age at time of abortion. We reviewed four studies that examined the effect of state-level abortion restrictions on the timing of an abortion (measured by gestational age), with two studies finding that restrictions led to later abortions and two finding no significant effect.[19] Gestational age is consequential because studies show as it increases, the cost of obtaining an abortion tends to increase, and the accessibility of abortion can decrease as available options become more limited.

Two studies examined the impact of abortion restrictions within single states.[20] The first study, published before the *Dobbs* decision, found that following Tennessee's 2015 implementation of a mandatory waiting period between pre-counseling and an abortion, the percentage of abortions obtained in the second rather than first trimester increased by an estimated 3 to 5 percentage points.[21] The second study, conducted following the *Dobbs* decision, analyzed a nongeneralizable network of abortion clinics in a state with laws protecting access to abortion that bordered a state with laws restricting access to abortion.[22] Among those clinics, there was an increase in the average gestational age among procedural abortions following the *Dobbs* decision.

The other two studies, both pre-*Dobbs*, used data from multiple states to determine whether parental involvement laws or mandatory waiting requirements affected waiting times to obtain an abortion, with both finding no significant association between restrictions and gestational age at time of abortion.[23]

Cost of obtaining an abortion. Studies we reviewed generally found that the total costs of obtaining an abortion, which can include time off from work, child care expenses, travel costs, and procedure costs, tend to increase in states that restrict abortion access. For example, one study we reviewed estimated that the cost of obtaining an abortion rose by several hundred dollars in one state after it enacted a mandatory waiting period that required two clinic visits rather than one.[24] While the total cost of obtaining an abortion can vary widely depending on gestational age, the amount of travel required, and other factors, two studies we reviewed found that obtaining an abortion can be a significant expense for low-income families.[25]

What does research suggest are the potential economic effects for women who are unable to obtain an abortion and instead carry their pregnancies to term?

Two studies we reviewed, both analyzing pre-*Dobbs* decision data, found various adverse economic outcomes for women who are unable to obtain an abortion and instead carry pregnancies to term, including a lower rate of employment in the near term and higher levels of estimated financial distress.[26]

Employment. One study we reviewed found that women who sought but were unable to obtain an abortion were less likely to be working full-time 6 months after their abortion denial compared to women who obtained abortions.[27] However, those who were unable to obtain an abortion gradually increased their employment levels over the 5-year study period, so that after 4 years there was no statistically significant difference between the employment levels of the two groups of women.

Personal finances. Both studies we reviewed found that among a sample of women seeking an abortion, financial outcomes were worse for those unable to obtain an abortion, particularly in the period immediately following the abortion denial.[28] These studies estimated the effect of being denied an abortion on financial indicators such as credit scores, receipt of government assistance, and poverty. Specifically, one study found that women who sought but were unable to obtain an abortion experienced higher levels of estimated financial distress—as measured by an index that included such information as amount of debt and presence of a subprime credit score—than women who obtained an abortion.[29]

The second study analyzing financial indicators found that among individuals seeking an abortion, those unable to obtain an abortion had higher odds of receiving three forms of government assistance aimed at helping low-income individuals and families: Temporary Assistance for Needy Families (for at least the first 6 months), Supplemental Nutrition Assistance Program (for the full 5 years studied), and Special Supplemental Nutrition Program for Women, Infants, and Children (for the first 2 years studied).[30] This study also found that while there was little difference in household income after 6 months among those who were and were not able to obtain an abortion, those who were unable to obtain an abortion had an increase in household size and thus were more likely to live in poverty.

How does research suggest state abortion restrictions may affect educational attainment and decisions about where to live for certain populations?

Studies we reviewed found that state abortion restrictions can decrease educational attainment for certain subgroups of women and men.[31] Studies published after the *Dobbs* decision also found that restrictions can influence decisions about where to live.[32]

Educational attainment for women. One study we reviewed, conducted after the *Dobbs* decision, found that Black women were less likely to enter college (by about 2 percent) and to complete college (by about 6 percent), if as teenagers they lived in states that had restrictions on abortion providers, as compared to Black women in states without these restrictions.[33] The study did not find any statistically significant effect from these laws on educational attainment for White non-Hispanic women.[34]

Educational attainment for men. Another study we reviewed, conducted before the *Dobbs* decision, found that living in a state with parental consent laws can be associated with lower educational attainment for some men.[35] Specifically, this study found that for men whose parents had

not completed high school, living in a state with parental consent laws was associated with lower odds of having completed high school and college.

Decisions about where to live. We reviewed two studies regarding the relationship between abortion laws and individuals' decisions about where to live.[36] One study compared data for states it considered to have banned abortion to states it identified as maintaining or protecting access to abortion and found that the "ban states" saw their population decrease by 4.3 people per 10,000 residents each quarter in the year following the law's adoption.[37] The study found these effects were more prominent for single-person households than for family households. The second study we reviewed found that when choosing to move, working women with at least a bachelor's degree were more than 7 percent more likely to move to a state without restrictions rather than to another state with restrictions.[38] This change was consistent across age groups of women from 20 to 50. In addition, the likelihood of moving to a state without restrictions increased with education, as women with PhDs showed the highest propensity to move to states without abortion restrictions.

How have medical students, medical residents, and health care providers reported being affected by state abortion restrictions following the *Dobbs* decision?

Post-*Dobbs* studies we reviewed found that most medical students stated preferences for completing medical residences in states without abortion restrictions, but data show no changes in residency slots being filled, including within states that enacted restrictions.[39] Other studies we reviewed found that physicians practicing in states that recently implemented abortion restrictions reported changes to the type of care they provide patients.[40]

Medical students and residents. In one study that surveyed a non-generalizable sample of 3rd- and 4th-year medical students applying to U.S. residency programs, most (57.9 percent) respondents indicated that they were unlikely or very unlikely to apply to a residency program in a state with abortion restrictions.[41] Upon follow up, a smaller percentage of respondents (31 percent) did not apply to a single state with restrictions.

Two studies we reviewed analyzed medical residency application data post-*Dobbs* and found that there were fewer applicants to residency programs in states that the studies identified as having abortion bans than in states without such restrictions.[42] An additional study that specifically examined obstetrics and gynecology residency applications found a small but statistically significant decrease in the number of applicants to these programs in states with abortion bans in 2023, compared with the number of applicants in 2022.[43] Researchers we spoke to from the Association of American Medical Colleges said one limitation of residency application data is that they do not include information on why students made the decisions they did, such as whether their decisions were influenced by personal or career considerations. Despite these changes to residency applications, all residency programs continue to fill their slots, regardless of their state's abortion laws. Studies we reviewed attributed this outcome to the number of residency applications nationwide exceeding the number of training slots available.

Health care providers. Two studies we reviewed interviewed non-generalizable samples of women's health care providers (including obstetrician-gynecologists) in states the studies identified as having abortion bans following the *Dobbs* decision to get their perspectives on these changes.[44] In these interviews, physicians mentioned several ways

that abortion restrictions have changed how they provide care, including having to delay care or being unable to provide care, having to consult legal professionals before providing care, and being restricted in what they can say or document to mitigate legal risks. For example, in one study, providers described needing to delay medically necessary care, including abortions, until their patients were at risk of death or permanent impairment, or until the fetal heart stopped spontaneously.[45]

An additional pre-*Dobbs* study we reviewed had similar findings.[46] Specifically, researchers interviewed abortion providers following what the study identified as a 2015 abortion ban in Georgia. The study reported that interviewees said the ban concentrated harm on specific groups of patients who already experience heightened health and social disadvantages related to access and outcomes, including those with limited financial means.

What does research suggest are the potential effects of state abortion restrictions on birth rates?

Studies from before and after the *Dobbs* decision show that states that implemented laws restricting abortion access saw small increases in birth rates.[47]

Two studies we reviewed found that abortion restrictions caused small increases in birth rates, although these rates varied by state and by travel distance required to obtain an abortion.[48] For example, one study found that following the *Dobbs* decision, birth rates in states where abortions were prohibited in nearly all circumstances increased by over 2 percent in the first 6 months of 2023 compared to birth rates in states that did not have these laws.[49] The study also found that states in which individuals have to travel longer distances for an abortion were forecasted to have higher birth rates.

The second study we reviewed found that following Texas's 2021 law prohibiting physicians from performing abortions if they detect a fetal heartbeat, birth rates in the state increased by about 4 percent for women of reproductive age, compared to the estimated birth rate without the law.[50] Specifically, the study found that the law led to increased birth rates for Black and White non-Hispanic women (by over 5 percent and about 2 percent, respectively), but had little effect for Hispanic women.

Two additional studies we reviewed specifically examined the effect on birth rates of restrictions on abortion providers.[51] The first study examined data from 1995 through 2015 and found that restrictions placed on abortion providers were associated with an average increase in birth rates of about 1-2 percent; however, these findings were not consistently statistically significant.[52] The second study found that teen birth rates increased in states with restrictions on abortion providers by an average of about 6 percent over the first 5 years after laws were implemented.[53]

What does research suggest are the potential effects of abortion restrictions on maternal mortality rates?

Four studies we reviewed from the pre-*Dobbs* period generally found that more restrictive abortion laws were associated with higher maternal mortality, although none of the studies could demonstrate a direct causal link.[54]

One study we reviewed that examined data from 2015–2018 found that states with a higher number of abortion restrictions were associated with higher rates of total maternal mortality.[55] The study also found that the risk of death during pregnancy and up to 1 year postpartum for White women

was higher in states with abortion restrictions compared to states without restrictions, although estimated differences for Black and Hispanic women were not statistically significant.[56]

Another study we reviewed examined data from 2000–2019 to estimate the influence of specific abortion restrictions on rates of maternal mortality. The study found that several types of laws were associated with an increase in maternal deaths, including restrictions on abortion after certain gestational ages, requirements for pre-abortion counseling, requirements for in-person appointments, limitations on access to medication abortion, and restrictions on abortion providers.[57] The study also found that each additional abortion law was associated with an increase of 1.09 maternal deaths per 100,000 live births (95 percent confidence interval 0.36-1.82).

What abortion-related data does the federal government collect, and what are its limitations?

The federal government compiled and published abortion data through 2022 through CDC's Division of Reproductive Health, which focuses on issues related to reproductive health, maternal health, and infant health. However, according to Department of Health and Human Services officials we spoke to in May 2025, the agency, which includes CDC, is undergoing a realignment. Officials were uncertain whether the resulting changes at the agency would affect future data collection efforts, including data on abortions. In prior years, CDC regularly attempted to collect aggregated data on legally induced abortions from the central health agencies in all 50 states, the District of Columbia, and New York City. These data were reported annually in its publicly available Abortion Surveillance Summaries.[58] These reports were used to examine trends and patterns related to abortion in reporting states but do not include information related to any potential economic effects of state abortion laws. When creating these reports, CDC reviewed data from the Guttmacher Institute and used it in developing one of its abortion-related data points.[59] Additionally, CDC officials and agency documentation have identified several limitations of the agency's abortion data, including the following:

- Reporting was voluntary and not all states reported abortion data. For example, in 2022 (the last year for which data are available), California, Maryland, New Hampshire, and New Jersey did not submit abortion data, leading to substantial undercounting.
- Not all states collected the data requested by CDC or reported data in a manner consistent with CDC guidance, which could have affected researchers' ability to examine demographic and other differences among states.

What efforts are federal agencies undertaking to assess the economic effects of state abortion restrictions?

Of the seven federal agencies we contacted, only the Social Security Administration's (SSA) Office of the Chief Actuary reported that it planned to consider the potential economic effects of state abortion restrictions in some of its analyses. Specifically, SSA officials said the agency has analyzed CDC abortion data when making predictions about birth rates. SSA officials reported plans to continue using data from CDC to track the number of abortions and its potential effect on total fertility rates to inform its annual Trustees report on the long-term fiscal outlook for the Social Security Trust Funds, among other forecasts.[60] SSA defines the total fertility rate as the average number of children that would be born to a woman throughout her lifetime if she were to experience, at each age of

her life, the birth rate observed in or assumed for a specific year, and if she were to survive the entire childbearing period.

SSA officials added that if the agency determines that state abortion restrictions have resulted in changes to fertility rates, the agency may try to determine whether that effect is significant enough to affect the broader economy by changing the size of the labor force. SSA officials noted that it will be several years before they are able to make this determination, as the necessary data are reported with a lag of almost 2 years. They also said they will need at least 3 years of abortion and birth data following the *Dobbs* decision before they can attempt to determine the effect of that decision and any subsequent state changes using a statistical or regression-based approach. The officials added that data over this period may be insufficient to provide a reliable indication of the degree and trend of any effect of the *Dobbs* decision on the broader economy. In addition, SSA's ability to conduct this analysis using federal data depends on whether CDC continues to collect abortion data from states in the future.

Agency Comments

We provided a draft of this report to the Social Security Administration and the Department of Health and Human Services for review and comment. The Social Security Administration did not provide comments. The Department of Health and Human Services provided technical comments, which we incorporated as appropriate.

How GAO Did This Study

To examine the potential economic effects of state abortion restrictions, we conducted a systematic literature review. To identify relevant studies, a research librarian performed iterative keyword searches across multiple databases including Scopus, EconLit, MEDLINE, and Social SciSearch. We used a structured approach that incorporated three key categories of search terms: (1) abortion restrictions (including statutory, regulatory, and policy limits), (2) socioeconomic outcomes and effects, and (3) a focus on the United States. Our search was limited to research published within the last 7 years (to capture 5 years before the *Dobbs* decision and 2 subsequent years). Our searches yielded 611 potentially relevant documents from peer-reviewed journals, government-issued reports, working papers, conferences, and publications from nongovernmental organizations. We also identified studies through interviews with academic researchers and agency officials, as well as open internet searches. During and after the conclusion of our formal literature review, we continued to monitor news and academic journals for newly released studies that could be relevant. This monitoring resulted in two additional articles being reviewed by two specialists to determine their methodological rigor and being included in our final count of studies.

To assess the relevance of these studies, two reviewers separately examined each study's abstract to agree on relevance. We considered studies relevant if they (1) included original research or data analysis; (2) were U.S. focused; and (3) examined the effects of abortion restrictions on abortion rates; travel times and costs to obtain an abortion; socioeconomic outcomes such as educational attainment, financial distress or career trajectories; and population demographics including fertility rates and maternal morbidity and mortality. This initial abstract review yielded 124 studies. We conducted a secondary review for relevance through a discussion of the key points of each study. Specifically, one reviewer conducted a full text review and summarized each study using a series of standardized questions on the study population, outcomes, and time

frames. We used this summary to collectively decide which studies to include, resulting in 78 studies we deemed relevant for further review.

We then assessed methodological quality to determine whether a study was sufficiently rigorous to include in the final literature review. Specifically, two specialists independently conducted in-depth full text reviews of the remaining 78 studies. These reviews entailed an assessment of each study's research methodology, including its data quality, research design, and analytic techniques, as well as a summary of each study's major findings and conclusions. We also assessed the extent to which each study's data and methods supported its findings and conclusions. We prioritized studies based on their methodological rigor and use of empirical data analysis. At the conclusion of our review, we determined that 55 studies met our standards for quality and were relevant to our study. See the bibliography for a full list of relevant articles.

Our report presents key findings from the body of knowledge included in this universe of selected studies. To the extent that findings from these studies vary, we mention the differences in our report. All studies have limitations and face challenges in identifying the effects of abortion restrictions on individual or macroeconomic outcomes. Despite these limitations, we determined that the studies we included provide reliable information about the potential economic effects of abortion restrictions.

To provide context to our literature review, we interviewed four academic researchers we identified from our selected literature. We selected these researchers because they had authored or coauthored four or more studies in our review. We also interviewed officials from three national organizations with subject matter expertise, including officials from the American College of Obstetricians and Gynecologists (ACOG), the Guttmacher Institute, and the Association of American Medical Colleges (AAMC).[61] ACOG is the largest professional membership organization for obstetrician-gynecologists in the U.S. The Guttmacher Institute is a research and policy institute that publishes the abortion data used in most research we examined. AAMC is a member association of institutions involved in medical education, including medical schools, teaching hospitals, and health systems. It has published research on medical students' decision-making after the *Dobbs* decision. We also attempted to contact associations that represented a wide array of employers. The associations who responded to our outreach said they had no ongoing efforts to study changes to abortion laws and any impact on employers, such as effects on group health plans.

To illustrate the change in the number and rate of abortions following the *Dobbs* decision, we analyzed and compared 2019 and 2023 data from the Guttmacher Institute, which we found to have the most reliable data available on abortions in the U.S. The Guttmacher Institute's 2023 Monthly Abortion Provision Survey data was the most recent at the time of our study. We chose to compare it to the Institute's 2019 Abortion Provider Census data to illustrate abortion incidence before the *Dobbs* decision because 2021 data were unavailable and 2020 data may have been affected by the COVID-19 pandemic. We determined that abortion data from the Guttmacher Institute were reliable for the purposes of describing changes in the incidence of abortion before and after the *Dobbs* decision. We did not use data from CDC's Abortion Surveillance Summaries given its limitations, including its incompleteness, which we discuss in this report.

To examine the extent to which federal agencies are assessing the economic effects of abortion restrictions, we conducted outreach to several

agencies: the Department of Agriculture; the Census Bureau; the Department of Education; the Department of Health and Human Services, including the Centers for Disease Control and Prevention; the Department of Housing and Urban Development; the Department of Labor; and the Social Security Administration. The Department of Health and Human Services and the Social Security Administration were the only agencies that responded that they had or were considering related work. For those two agencies, we interviewed officials and reviewed relevant agency documents.

We conducted this performance audit from March 2024 to May 2025 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

List of Addressees

The Honorable Robert C. “Bobby” Scott
Ranking Member
Committee on Education and Workforce
House of Representatives

The Honorable Richard Blumenthal
United States Senate

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 26 days from the report date. At that time, we will send copies to the appropriate congressional committees, the Commissioner of the Social Security Administration, the Secretary of Health and Human Services, and other interested parties. In addition, the report is available at no charge on the GAO website at http://www.gao.gov.

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Appendix I State Abortion Rates, 2019 and 2023

This appendix shows abortion rates by state for 2019 and 2023, which represent points in time before and after the Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization* (*Dobbs* decision). To illustrate rates prior to the *Dobbs* decision, we used data from 2019 because it predated the COVID-19 pandemic, which may have affected pregnancy rates and abortion access. We compared these to data from 2023, which were the most recently available data at the time of our review. We provide data on abortion rates by both the recipient's state of residence and by the state where the abortion occurred.

Table 1: Rates and Percent Change in Abortions Obtained by Recipient's State of Residence in 2019 and 2023

State of Residence of Abortion Recipient	Abortion Rates, 2019	Abortion Rates, 2023	Percent Change in Abortion Rates, 2019 and 2023
Alabama	8.3	6.7	-18.7
Alaska	9.8	11.8	19.8
Arizona	9.7	11.6	19.5
Arkansas	6.1	4.3	-30.3
California	18.4	21.7	18.3
Colorado	9.5	15.3	61.0
Connecticut	17.8	20.8	16.7
Delaware	16.8	22.6	34.4
District of Columbia	26.4	40.0	51.7
Florida	18.1	19.2	6.4
Georgia	15.8	16.5	4.3
Hawaii	11.7	14.5	24.0
Idaho	5.4	3.2	-40.7
Illinois	17.7	21.5	21.3
Indiana	7.8	8.0	1.8
Iowa	5.7	7.5	32.3
Kansas	6.3	11.1	77.0
Kentucky	5.4	5.1	-4.9
Louisiana	8.3	3.7	-54.7
Maine	8.5	9.1	7.1
Maryland	24.1	27.4	13.7
Massachusetts	13.7	14.9	8.6
Michigan	14.8	18.6	25.9
Minnesota	9.6	10.3	7.9
Mississippi	8.4	5.9	-29.1
Missouri	8.5	9.6	13.7
Montana	7.3	9.4	28.5
Nebraska	5.4	7.1	30.5
Nevada	16.6	24.1	45.0
New Hampshire	9.5	10.3	7.7
New Jersey	38.5	33.1	16.2
New Mexico	9.4	15.9	69.5
New York	29.5	30.4	3.2
North Carolina	11.9	15.3	29.0
North Dakota	5.9	4.9	-16.1
Ohio	9.4	10.5	11.5
Oklahoma	10.7	4.5	-56.6
Oregon	10.3	13.1	27.1
Pennsylvania	13.7	16.5	20.9
Rhode Island	14.2	16.4	16.2
South Carolina	11.4	14.1	24.0
South Dakota	3.9	3.1	-21.0
Tennessee	8.0	7.5	-6.7
Texas	10.0	5.4	-45.7
Utah	4.3	6.1	42.6
Vermont	8.1	9.4	15.5
Virginia	12.9	18.1	40.2
Washington	12.2	14.7	20.6
West Virginia	5.4	7.1	30.7
Wisconsin	7.7	6.8	0.2
Wyoming	5.8	5.8	9.3

Source: GAO Analysis of Guttmacher Institute abortion data. | GAO-25-107477

Note: The estimated abortion rate is the number of abortions for residents in each state per 1,000 women ages 15–44 in that state. Estimated abortions for 2019 come from the Guttmacher Institute's

Abortion Provider Census and estimated abortions for 2023 come from Guttmacher's Monthly Abortion Provider Survey. Guttmacher data estimate the number of abortions provided by clinicians in states the Institute identifies as not having abortion bans. The data do not include self-managed abortions, such as those managed by obtaining abortion medication from a source other than a US clinician. Data are subject to uncertainty due to potential undercounting, incomplete information on abortions provided in hospitals and private practices, and imputation to estimate missing data on abortions in some cases. Population estimates come from the American Community Survey 1-year estimates for 2019 and 2023. While the Centers for Disease Control and Prevention (CDC) publishes abortion data through its Abortion Surveillance Summaries, we elected to use the Guttmacher Institute's data due to several limitations with CDC's data, which we describe in more detail earlier in our report.

Table 2: Rates and Percent Change in Abortions Obtained by State of Occurrence for 2019 and 2023

State Where Abortion Was Obtained	Abortion Rates, 2019	Abortion Rates, 2023	Percent Change in Abortion Rates, 2019 and 2023
Alabama	6.1	N/A	N/A
Alaska	9.1	11.0	20.7
Arizona	9.2	11.0	3.3
Arkansas	4.9	N/A	N/A
California	18.6	22.4	20.8
Colorado	10.2	21.2	106.6
Connecticut	17.9	21.3	19.1
Delaware	11.1	18.2	64.9
District of Columbia	50.6	48.0	-5.1
Florida	18.4	20.7	12.8
Georgia	18.3	13.6	-25.5
Hawaii	11.7	15.0	28.6
Idaho	4.2	N/A	N/A
Illinois	20.9	36.5	74.8
Indiana	5.8	3.3	-42.5
Iowa	5.7	6.4	11.5
Kansas	11.8	32.6	176.2
Kentucky	4.2	N/A	N/A
Louisiana	8.8	N/A	N/A
Maine	8.9	9.1	2.5
Maryland	25.3	31.6	25.2
Massachusetts	13.6	15.1	10.7
Michigan	15.4	19.6	26.9
Minnesota	10.2	12.9	26.3
Mississippi	5.3	N/A	N/A
Missouri	1.3	N/A	N/A
Montana	7.8	9.4	21.7
Nebraska	5.6	6.0	8.3
Nevada	16.3	26.7	63.6
New Hampshire	8.1	9.1	13.1
New Jersey	28.7	34.0	18.3
New Mexico	11.1	51.1	361.0
New York	30.1	31.6	5.2
North Carolina	14.1	21.0	49.6
North Dakota	7.0	N/A	N/A
Ohio	9.2	10.6	16.3
Oklahoma	11.7	N/A	N/A
Oregon	10.8	14.0	29.7
Pennsylvania	13.1	15.3	16.7
Rhode Island	13.7	13.3	-2.9
South Carolina	5.0	9.1	82.9
South Dakota	2.0	N/A	N/A
Tennessee	7.4	N/A	N/A
Texas	9.8	N/A	N/A
Utah	4.2	5.9	40.9
Vermont	10.1	11.3	12.7
Virginia	9.7	19.8	104.7
Washington	12.1	15.0	24.0
West Virginia	3.6	N/A	N/A
Wisconsin	6.6	1.1	-83.3
Wyoming	0.7	3.1	378.1

Source: GAO Analysis of Guttmacher Institute abortion data. | GAO-25-107477

Notes: "N/A" means that the Guttmacher Institute identified each of these states as having enacted a total ban on abortion following the *Dobbs* decision and is no longer collecting data on abortions conducted in the state.

The estimated abortion rate is the number of abortions performed in each state per 1,000 women ages 15–44 in that state. Estimated abortions for 2019 come from Guttmacher's Abortion Provider Census and estimated abortions for 2023 come from Guttmacher's Monthly Abortion Provider Survey. Guttmacher data estimate the number of abortions provided by clinicians in states the Institute identifies as not having abortion bans. The data do not include self-managed abortions, such as those managed by obtaining abortion medication from a source other than a U.S. clinician. Data are subject to uncertainty due to potential undercounting, incomplete information on abortions provided in hospitals and private practices, and imputation to estimate missing data on abortions in some cases. Population estimates come from the American Community Survey 1-year estimates for 2019 and 2023. While the Centers for Disease Control and Prevention (CDC) publishes abortion data through its Abortion Surveillance Summaries, we elected to use the Guttmacher Institute's data due to several limitations with CDC's data, which we describe in more detail earlier in our report.

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Endnotes

[1]597 U.S. 215 (2022).

[2]During and after the conclusion of our formal literature review, we continued to monitor news and academic journals for newly released studies that could be relevant. This monitoring resulted in two additional articles being reviewed by two specialists to determine their methodological rigor and being included in our final count of studies.

[3]410 U.S. 113 (1973).

[4]The information we present in this report is based on what the studies we reviewed found; we did not independently analyze state laws or their potential effects.

[5]In contrast, certain states have expanded access to abortion by increasing gestational age limits or by providing legal protections for abortion providers and patients.

[6]In the literature we reviewed, these types of laws are frequently referred to as Targeted Regulation of Abortion Providers, or TRAP laws.

[7]We used data from 2019 because it predated the COVID-19 pandemic, which may have affected pregnancy rates and abortion access. We compared these to data from 2023, which were the most recently available data at the time of our review.

[8]These abortion rates come from the Guttmacher Institute's State of Residence data, which estimate the number of individuals who obtained an abortion, by the state where they lived. They include abortions obtained through health care systems and via medication prescribed during telehealth appointments. According to Guttmacher Institute staff, limitations of the abortion data include potential undercounting due to some abortions being performed outside of the formal health care system and to incomplete data from hospitals and private practices. Measuring abortion rates also requires some amount of estimation—and thus uncertainty—because of issues such as stigma and incomplete reporting, according to Guttmacher Institute staff. The staff added that they seek to mitigate these issues by combining data collected directly from abortion providers with statistical modeling to help estimate caseloads at facilities for which they do not have data. This modeling is only needed to impute data for a small percentage of abortions as the majority of abortions are counted directly from facility data. Guttmacher staff also said they backfill historical data as they ask for monthly counts starting from the previous year.

[9]On December 16, 2021, the Food and Drug Administration (FDA) announced modifications to the mifepristone safety program that included removing the in-person dispensing requirement and adding a requirement that pharmacies that dispense the drug be certified. The FDA gave final approval for these changes in January 2023.

[10]Jason M. Lindo and Mayra Pineda-Torres, "New Evidence on the Effects of Mandatory Waiting Periods for Abortion," *Journal of Health Economics,* vol. 80 (2021); Theodore J. Joyce, Robert Kaestner, and Jason Ward, "The Impact of Parental Involvement Laws on the Abortion Rate of Minors," *Demography*, vol. 57 (2020): 323–346; Graham Gardner, "Notification and Consent: The Differential Effects of Parental Involvement Laws on Teen Abortion," *Review of the Economics of the Household,* vol. 22, no. 4 (2024): 1517–1550; Ushma D. Upadhyay, Ashley A. McCook, Ariana H. Bennett, Alice F. Cartwright, and Sarah C.M. Roberts, "State Abortion Policies and Medicaid Coverage of Abortion are Associated with Pregnancy Outcomes Among Individuals Seeking Abortion Recruited Using Google Ads: A National Cohort Study," *Social Science & Medicine*, vol. 274 (2021); Raymond Caraher, "Do Abortion Bans Affect Reproductive and Infant Health? Evidence from Texas's 2021 Ban and its Impact on Health Disparities," *Political Economy Research Institute*, Working Paper no. 606 (2024).

[11]Megan Fuerst, Ava Mandelbaum, Erin Nacev, and Maria Rodriguez, "Trends in Interstate Abortion Travel to Oregon Following the Dobbs Court Decision," *Contraception*, vol. 138 (2024); Taylor Riley, Anne E. Fiastro, Lyndsey S. Benson, Anuj Khattar, Sarah Prager, and Emily M. Godfrey, "Abortion Provision and Delays to Care in a Clinic Network in Washington State After *Dobbs*," *JAMA Network Open,* vol. 7, no. 5 (2024); Ava D. Mandelbaum, Erin C. Nacev, Megan F. Fuerst, Alyssa Colwill, Shaalini Ramanadhan, and Maria Rodriguez, "Impact of the Dobbs decision on Abortion Services from a Large Tertiary Center in Oregon," *Contraception*, vol. 136 (2024); Caraher, "Do Abortion Bans Affect Reproductive and Infant Health?"

[12]Caitlin Myers, "Forecasts for a Post-Roe America: The Effects of Increased Travel Distance on Abortions and Births," *Journal of Policy Analysis and Management*, vol. 43 (2024): 39–62; Kristen M. Thompson, J. Hugh J.W. Sturrock, Diana Greene Foster, and Ushma D. Upadhyay, "Association of Travel Distance to Nearest Abortion Facility with Rates of Abortion," *JAMA Network Open,* vol. 4, no. 7 (2021); Elizabeth A. Pleasants, Alice F. Cartwright, and Ushma D. Upadhyay, "Association Between Distance to an Abortion Facility and Abortion or Pregnancy Outcome Among a Prospective Cohort of People Seeking Abortion Online," *JAMA Network Open*, vol. 5, no. 5 (2022).

[13]Kelly M. Jones, and Mayra Pineda-Torres, "TRAP'd Teens: Impacts of Abortion Provider Regulations on Fertility & Education," *Journal of Public Economics*, vol. 234 (2024); Caitlin Myers and Daniel Ladd, "Did Parental Involvement Laws Grow Teeth? The Effects of State Restrictions on Minors' Access to Abortion," *Journal of Health Economics*, vol. 71 (2020); Benjamin Rader, Ushma D. Upadhyay, Neil K. R. Sehgal, Ben Y. Reis, John S. Brownstein, and Yulin Hswen, "Estimated Travel Time and Spatial Access to Abortion Facilities in the US before and after the *Dobbs v Jackson Women's Health* Decision," *JAMA*, vol. 328, no. 20 (2022): 2041–2047.

[14]Myers and Ladd, "Did Parental Involvement Laws Grow Teeth?"

[15]Rader, Upadhyay, Sehgal, Reis, Brownstein, and Hswen, “Estimated Travel Time and Spatial Access to Abortion Facilities,” 2041–2047.

[16]Mandelbaum, Nacev, Fuerst, Colwill, Ramanadhan, and Rodriguez, “Impact of the Dobbs decision on Abortion Services”; Sydney R. Sauter, Maeve E. Wallace, and Julie H. Hernandez, “Unequal Spatial Consequences of Abortion Restrictions in Texas, 2021–2023,” *American Journal of Public Health*, vol. 114, no. 10 (2024).

[17]Texas Senate Bill 8 prohibits physicians from performing or inducing an abortion after a fetal heartbeat has been detected, with exceptions for medical emergencies. Sauter, Wallace, and Hernandez, “Unequal Spatial Consequences of Abortion Restrictions.”

[18]Mandelbaum, Nacev, Fuerst, Colwill, Ramanadhan, and Rodriguez, “Impact of the Dobbs decision on Abortion Services.”

[19]Fidel Gonzalez, Troy Quast, and Alex Venanzi, “Factors Associated With the Timing of Abortions,” *Health Economics,* vol. 29 (2020): 223–233.; Lindo and Pineda-Torres, “Effects of Mandatory Waiting Periods for Abortion”; Riley, Fiastro, Benson, Khattar, Prager, and Godfrey, “Abortion Provision and Delays to Care”; Alexa L. Solazzo, “Different and Not Equal: The Uneven Association of Race, Poverty, and Abortion Laws on Abortion Timing,” *Social Problems*, vol. 66 (2019): 519–547.

[20]Lindo and Pineda-Torres, “Effects of Mandatory Waiting Periods for Abortion”; Riley, Fiastro, Benson, Khattar, Prager, and Godfrey, “Abortion Provision and Delays to Care.”

[21]Lindo and Pineda-Torres, “Effects of Mandatory Waiting Periods for Abortion.”

[22]Riley, Fiastro, Benson, Khattar, Prager, and Godfrey, “Abortion Provision and Delays to Care.”

[23]Gonzalez, Quast, and Venanzi, “Factors Associated with the Timing of Abortions,” 223–233.; Solazzo, “Different and Not Equal,” 519–547.

[24]Lindo and Pineda-Torres, “Effects of Mandatory Waiting Periods for Abortion.”

[25]Lindo and Pineda-Torres, “Effects of Mandatory Waiting Periods for Abortion”; Zuniga, Carmela, Terry-Ann Thompson, and Kelly Blanchard, “Abortion as a Catastrophic Health Expenditure in the United States,” *Women's Health Issues*, vol. 30, no. 6 *(*2020): 416–425.

[26]These two studies analyzed survey data from the Turnaway Study, in which researchers collected data on women who sought abortions from 30 clinics across the country. Women were recruited to the study from 2008 to 2010 and then interviewed via phone over a period of five years. Some women in the study were slightly under a clinic’s gestational limit, and therefore able to receive an abortion, and some were slightly over the limit and therefore were denied an abortion. Outcomes for these two groups were compared in the studies we reviewed. See Diana Greene Foster, M. Antonia Biggs, Lauren Ralph, Caitlin Gerdts, Sarah Roberts, and M. Maria Glymour, “Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States,” *American Journal of Public Health*, vol. 108, no. 3 (2018); Sarah Miller, Laura R. Wherry, and Diana Greene Foster, “The Economic Consequences of Being Denied an Abortion,” *American Economic Journal: Economic Policy*, vol. 15, no. 1 (2023): 394–437.

[27]Foster, Biggs, Ralph, Gerdts, Roberts, and Glymour, “Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions.”

[28]Foster, Biggs, Ralph, Gerdts, Roberts, and Glymour, “Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions”; Miller, Wherry, and Foster, “Economic Consequences of Being Denied an Abortion,” 394–437.

[29]This effect was consistent across the 5 years studied after the abortion encounter but lost statistical significance in the 3rd year. Miller, Wherry, and Foster, “Economic Consequences of Being Denied an Abortion,” 394–437.

[30]Foster, Biggs, Ralph, Gerdts, Roberts, and Glymour, “Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions.” The Temporary Assistance for Needy Families program provides cash assistance for living expenses to low-income families with children. The Supplemental Nutrition Assistance Program provides nutrition benefits to low-income individuals and families that are used at stores to

purchase food. The Special Supplemental Nutrition Program for Women, Infants, and Children provides nutrition education, supplemental food, healthcare referrals, and breastfeeding support to low-income pregnant and postpartum women, infants, and children up to age 5. The study's analysis of receipt of assistance from the Special Supplemental Nutrition Program for Women, Infants, and Children was limited to the first 2 years of the study because of rapidly declining participation in the program over time.

[31]Jones and Pineda-Torres, "TRAP'd Teens"; Bethany G. Everett, Jessica N. Sanders, and Jenny A. Higgins, "Abortion Policy Context in Adolescence and Men's Future Educational Achievement," *Population Research & Policy Review*, vol. 42, no. 3 (2023): 1–20.

[32]Daniel Dench, Kelly Lifchez, Jason Lindo, and Jancy Ling Liu, "Are People Fleeing States with Abortions Bans?" NBER Working Paper Series, National Bureau of Economic Research (2025); Yupeng Lin, Michael Shen, Rui Shi, and Jean (Jieyin) Zeng, "The Falling Roe and Relocation of Skilled Women," SSRN (2023). https://ssrn.com/abstract=4324172

[33]Jones and Pineda-Torres, "TRAP'd Teens."

[34]This study first examined if restrictions on abortion providers affected fertility rates for Black, Hispanic, and White non-Hispanic women. The study reported there were effects for Black and White non-Hispanic women, but no significant effects for Hispanic women. It then examined if there were effects on educational attainment for Black and White non-Hispanic women but did not conduct this analysis for Hispanic women since their fertility rates were not affected. See Jones and Pineda-Torres, "TRAP'd Teens."

[35]Everett, Sanders, and Higgins, "Abortion and Men's Educational Achievement," 1–20.

[36]Dench, Lifchez, Lindo, and Liu, "Are People Fleeing States with Abortions Bans?"; Lin, Shen, Shi, and Zeng, "Roe and Relocation of Skilled Women."

[37]Dench, Lifchez, Lindo, and Liu, "Are People Fleeing States with Abortions Bans?"

[38]Lin, Shen, Shi, and Zeng, "Roe and Relocation of Skilled Women."

[39]Luci Hulsman, Paige K. Bradley, Amy Caldwell, Megan Christman, Debra Rusk, and Anthony Shanks, "Impact of the Dobbs v Jackson Women's Health Organization Decision on Retention of Indiana Medical Students for Residency," *American Journal of Obstetrics & Gynecology Maternal-Fetal Medicine*, vol. 5, no. 11 (2023); Kellen Mermin-Bunnell, Ariana M. Traub, Kelly Wang, Bryan Aaron, Louise Perkins King, and Jennifer Kawwass, "Abortion Restrictions and Medical Residency Applications," *Journal of Medical Ethics,* vol. 51, no. 2 (2025): 79-86.

[40]Anna-Grace Lilly, Isabelle P. Newman, and Sophie Bjork-James, "Our Hands Are Tied: Abortion Bans and Hesitant Medicine," *Social Science & Medicine*, vol. 350 (2024); Erika L. Sabbath, Samantha M. McKetchnie, Kavita S. Arora, and Mara Buchbinder, "U.S. Obstetrician-Gynecologists' Perceived Impacts of Post-Dobbs v Jackson State Abortion Bans" *JAMA Network Open,* vol. 7, no. 1 (2024).

[41]Mermin-Bunnell, Traub, Wang, Aaron, King, and Kawwass, "Abortion Restrictions and Medical Residency Applications," 79-86.

[42]Kendal Orgera and Atul Grover, "States with Abortion Bans See Continued Decrease in U.S. MD Senior Residency Applicants," *Association of American Medical Colleges,* 2024; Kendal Orgera, Hasan Mahmood, and Atul Grover, "Training Location Preferences of U.S. Medical School Graduates Post Dobbs v. Jackson Women's Health," *Association of American Medical Colleges,* 2023.

[43]Maya M. Hammoud, Helen K. Morgan, Karen George, et al., "Trends in Obstetrics and Gynecology Residency Applications in the Year After Abortion Access Changes," *JAMA Network Open*, vol. 7, no. 2 (2024).

[44]Lilly, Newman, and Bjork-James, "Abortion Bans and Hesitant Medicine"; Sabbath, McKetchnie, Arora, and Buchbinder, "Perceived Impacts of Post- Dobbs Abortion Bans."

[45]Sabbath, McKetchnie, Arora, and Buchbinder, "Perceived Impacts of Post-Dobbs Abortion Bans."

[46]Sophie A. Hartwig, Awa Youm, Alyssa Contreras, et al., “The Right Thing to Do Would be to Provide Care… and We Can't”: Provider Experiences with Georgia's 22-week Abortion Ban,” *Contraception*, vol. 124 (2023).

[47]Birth rates are generally calculated by dividing the number of live births in a population in a year by the midyear population.

[48]Daniel Dench, Mayra Pineda-Torres, and Caitlin Myers, “The Effects of Post-Dobbs Abortion Bans on Fertility,” *Journal of Public Economics,* vol. 234 (2024); Caraher, “Do Abortion Bans Affect Reproductive and Infant Health?”

[49]Dench, Pineda-Torres, and Myers, “Effects of Post-Dobbs Abortion Bans on Fertility.”

[50]Caraher, “Do Abortion Bans Affect Reproductive and Infant Health?”

[51]Grace E. Arnold, "The Impact of Targeted Regulation of Abortion Providers Laws on Abortions and Births," *Economics Faculty Publications and Presentations,* no. 152 (Portland, OR: Portland State University, 2022). https://archives.pdx.edu/ds/psu/37824; Jones and Pineda-Torres, “TRAP'd Teens.”

[52]Arnold, “Impact of Targeted Regulation of Abortion Providers Laws on Abortions and Births.”

[53]Jones and Pineda-Torres, “TRAP'd Teens.”

[54]Amy N. Addante, David L. Eisenberg, Mark C. Valentine, Jennifer Leonard, Karen E. Joynt Maddox, and Mark H. Hoofnagle, “The Association Between State-Level Abortion Restrictions and Maternal Mortality in the United States, 1995–2017,” *Contraception*, vol. 104 (2021): 496–501; Dovile Vilda, Maeve E. Wallace, Clare Daniel, Melissa Goldin Evans, Charles Stoecker, and Katherine P. Theall, “State Abortion Policies and Maternal Death in the United States, 2015–2018,” *American Journal of Public Health*, vol. 111, no. 9 (2021); Lorie M. Harper, Justin M. Leach, Lindsay Robbins, et al., “All-Cause Mortality in Reproductive-Aged Females by State: An Analysis of the Effects of Abortion Legislation,” *Obstetrics and Gynecology,* vol. 141, no. 2 (2023); Andrew S. Bossick, Ian Painter, Emily C. Williams, and Jodie G. Katon, “Development of a Composite Risk Index of Reproductive Autonomy Using State Laws: Association with Maternal and Neonatal Outcomes,” *Women's Health Issues*, vol. 33, no. 4 (2023): 359–366.

[55]While the study examined the effect of the number of state abortion restrictions in place on maternal mortality rates, it did not examine the effect of specific types of restrictions on these rates.

[56]Vilda, Wallace, Daniel, Evans, Stoecker, and Theall, “State Abortion Policies and Maternal Death.”

[57]Harper, Leach, Robbins, et al., “All-Cause Mortality in Reproductive-Aged Females by State.” The study reported that for maternal mortality, trigger laws were associated with an increase of 5.69 maternal deaths per 100,000 live births (95% confidence interval 2.38-9.01); laws prohibiting abortion after certain gestational ages were associated with an increase of 3.13 maternal deaths per 100,000 live births (95% confidence interval 0.22-6.04); laws requiring pre-abortion counseling were associated with an increase of 4.52 maternal deaths per 100,000 live births (95% confidence interval 0.55-8.50); laws requiring in-person appointments were associated with an increase of 3.88 maternal deaths per 100,000 live births (95% confidence interval 0.47-7.29); laws limiting access to abortion medication were associated with an increase of 5.29 maternal deaths per 100,000 live births (95% confidence interval 1.01-9.57); and laws placing restrictions on abortion providers were associated with an increase of 5.09 maternal deaths per 100,000 live births (95% confidence interval 1.76-8.43).

[58]In addition to the CDC and SSA, we contacted five other federal agencies: the Department of Agriculture, the Census Bureau, the Department of Education, the Department of Housing and Urban Development, and the Department of Labor. None of these agencies reported collecting abortion-related data.

[59]Stephanie Ramer, Antoinette T. Nguyen, Lisa M. Hollier, et al*., Abortion Surveillance – United States, 2022*, MMWR Surveillance Summaries 2024; vol. 73, no. 7 (Centers for Disease Control, November 28, 2024).

[60]*The 2024 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds* (The Board of Trustees, Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds, 2024).

[61]We contacted a range of organizations for interviews, but not all accepted our request.