Reproductive Equity and Targeted Regulation of Abortion Providers (TRAP) Laws: The Time, Travel, and Cost of Abortion Access

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April 30, 2018

Abstract

Reproductive health access is impeded by time, travel, and cost of care. These economic factors impact a patient's ability to receive healthcare care and this paper tests if the cost of abortion access is increased by Targeted Regulation of Abortion Providers (TRAP) laws. Disparity in reproductive equity due to state government regulation has implications on equity in public policy and accessibility to reproductive care. For abortion policy to be socially equitable, it must be distributive, providing the greatest benefit to the least advantaged. Assuming abortion demand is constant, this study seeks to understand the real cost associated with barriers to care due to state TRAP legislation creating inequality through supply-side restrictions. This paper uses statistical analysis to examine the cost variables of time, travel, childcare, and lost wages to test for equity in legislation. Findings show a positive relationship between the number of TRAP laws and hardship costs to patients, demonstrating inequitable state healthcare policy. Results indicate that those living in states with higher restrictions and regulations to abortion providers have a higher financial burden to accessing abortion care. Implications include recommendations for lawmakers, nonprofits, and abortion providers to improve access to abortion and lower the cost of care burdened by patients.

Keywords: abortion, reproductive healthcare, public policy, equity

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Introduction

Targeted Regulation of Abortion Provider (TRAP) laws are defined by the Center for Reproductive Rights as "laws that single out the medical practices of doctors who provide abortions and impose on them requirements that are different and more burdensome than those imposed on other medical practices" (Center for Reproductive Rights, n.d.). These laws include policies for patients such as mandatory ultrasounds and waiting periods, as well as requirements for doctors and facilities that range from expensive remodeling, hospital privileges, and complex reporting. In the United States, nearly one in four women will have an abortion during their lifetime and complications are rare (Jones & Jerman, 2017; Upadhyay, 2015). Yet, 44 states have laws and policies that restrict abortion providers above and beyond any other medical profession.

The access to legal abortion was decided 45 years ago in *Roe v. Wade* (1973). This landmark case asserted that laws which criminalized or completely restricted access to abortion were unconstitutional. Civil abortion rights were included under the right to privacy under the Due Process Clause of the 14th Amendment. The Court balanced civil rights with state rights to regulate patient health and the potential of human life by allowing states to place regulations during the third trimester of pregnancy.

Later, in *Planned Parenthood v. Casey* (1992), the Supreme Court eroded *Roe* by allowing states to regulate abortions at all stages if it does not place an undue burden on abortion access. After *Casey*, states could impose laws for informed consent, parental consent, reporting requirements, and legally define what is considered a medical emergency for abortion care. Growing political mobilization from pro-life groups since *Casey* have led to anti-abortion laws in all but six states. The abortion incidence rate in in the United States, which rose after *Roe,* and has been on decline since *Casey*, has now dropped to under one million for the first time since 1973. While the causations for the declining abortion incidence rate are still being studied, the closure of clinics due to TRAP laws are among the leading potential reasons being examined (Jones & Jerman, 2014).

Following the advancing implementation of TRAP laws, clinics across the United States have closed and people have lost access to legal abortion care. In the state of Texas, an area of high political action for TRAP laws, there were more than 40 abortion clinics in 2013. After the passage of Texas House Bill 2, one of the most restrictive TRAP laws seen to date, the number of abortion clinics in Texas dropped to 19 by 2016. Had the Supreme Court not overturned HB2 in *Whole Woman's Health v. Hellerstedt* (2016), Texas would have been left with as few as 10 abortion clinics, all in metropolitan cities, to service 5.4 million women of reproductive age (Ura, 2016).

This paper will seek to understand the effect of state TRAP laws on abortion access and evaluate policy implications on the basis of civil rights. Civil rights are individual rights, and abortion rights will be framed through equity variables that impact individuals and their choices. Through statistical analysis, this paper examines the three reproductive health equity variables of time, travel, and cost for people receiving abortion care as it relates to healthcare barriers due to state TRAP legislation. The hypotheses will test if states with TRAP laws place an undue financial burden on patients to access abortion care. In the dialectic between abortion rights and state regulation, public policy implications include equality, healthcare access, and real economic hardship.

Literature Review

As a policy issue, abortion access has been a largely defined by the courts. In B*eal v. Doe* (1977) and *Maher v. Doe* (1977), the court begins to define the freedom asserted in *Roe* in terms of policy and shift in favor of states' rights. The outcome of these two cases relieved states of any requirement to fund nontherapeutic abortions through Medicaid. These rulings established the State's interest in childbirth pregnancy outcomes by making it near impossible for lower income people to access abortion care through state healthcare assistance (Segers, 1977). Today, thirty-two states follow the federal standard, only allowing for Medicaid funding to be used for abortion in cases of rape, incest, or life endangerment.

As abortion services cost between $400-$600, disallowing most claims for Medicaid coverage for abortion creates state controlled economic barriers that favor childbirth pregnancy outcomes that and allow only those with means access to their privacy rights granted in *Roe*.

As demonstrated by Medicaid policy for abortion care, equity in the law and social equity can differ in public policy. Rosenbloom (2005) cautions on law that "constitutional procedural due process is overwhelmingly an individual right, not one that protects large groups from unfair deprivation of liberty or property by government." While abortion is an individual right, the law does not protect against inequities that result from laws. Svara (2005) and Greenberg (2015) find that public policy can solve for social inequity through distributive polices. Distributive policies are defied by Rawls's (2009) second principle as arranging social and economic inequalities to provide the greatest benefit to the least advantaged. For abortion policy to be socially equitable it must be accessible to the least advantaged. An example of a distributive abortion policy is Medi-Cal in California, which uses state funds to cover costs abortion costs for those who meet income qualifications to increase the accessibility of abortion to state citizens.

Previous studies, such as Jones and Jerman (2014), and New (2011), used abortion incidence to measure accessibility of abortion care. Incidence only accounts for those that have accessed care, to understand accessibly is to also account for those unable access care. Understanding abortion as an issue in which demand is constant allows this study to measure the full scope of accessibility. Medoff (2010) analyzed abortion demand as a consumer good and found TRAP laws have limited to no impact on abortion demand. Demand for abortion remains constant when access is limited, thus abortion access is a supply side problem for redistribution.

Abortion is part of the health care industry and supply is met by abortion providers. From the point of view of the lawmakers that propose TRAP laws, the intention of these laws is ensure equal access to quality healthcare by abortion providers. However, these laws do more to restrict access to care than improve quality of care. Internationally, the World Health Organization has established that laws to restrict abortion do not improve health care outcomes (Grimes, 2006). In an analysis of over 160 countries, including the United States, Berer (2004) found countries with broad abortion policies had lower mortality from unsafe abortions than countries with high levels of legislative restricts on abortion. Restricting and regulating abortion does little to improve healthcare outcomes or ensure quality care.

The disconnect between what lawmakers claim TRAP laws accomplish and the actuality of healthcare outcomes as reported by health organizations can be explained through partisanship. Party control of state legislation and governorship have been found to be the most important factor to determine if TRAP laws are enacted, with Republican control being positively associated with TRAP law enactment (Medoff, 2011). TRAP laws are a partisan issue and lawmakers who support such laws are acting more in the interest of partisan politics than public health.

If laws that restrict abortion do not improve healthcare outcomes, then it is important to understand what these laws do accomplish. Predominantly, research on the outcome of TRAP laws have found equity issues with supply-side access. Five years post-*Roe*, Hansen (1980) found people of means have access to abortion, while people in rural, economically depressed areas are unable to access services because of a lack of supply. Hansen found the following policies and factors increased supply subsequently increased abortion rate: (1) the proportion of state hospitals providing abortions (2) Medicaid funds for family planning (3) urban residency. Medoff (2010) supports Hansen and found states with Medicaid funding for abortion report 4% more abortion incident than those that do not. When Medicaid funding is supplied, there are more incidences of abortion in a state as people are able to utilize state funds to pay for care.

As Medicaid funding was one of the first incidences of abortion restriction laws, it is a well-documented social policy for abortion access. TRAP laws following *Planned Parenthood v. Casey* (1992) are less understood. From 1983 to 2015 states enacted almost 700 restrictions that impacted providers and patients including: limits on medication abortion, restrictions on private insurance coverage, requirements for parental involvement, mandatory counseling, waiting periods, reporting requirements, and gestational limitations (Dempsey, 2014). In 2011, New found evidence to suggest that anti-abortion legislation is a

factor in abortion incidence decline. However, this study was unable to determine exactly why this decline in abortions after TRAP laws are enacted happens.

To understand why abortion rates are in decline as a result of TRAP laws, public health scholars have studied hardship factors that reduce supply-side factors. House Bill 2 in Texas had a large impact on clinics, reducing the number of facilities from 40 clinics in 2013 to 19 predominately urban located clinics in 2016. Gerdts (2016), through the use of patient surveys before and after the passage of H.B. 2, found increased travel burdens on abortion patients following the law. The average distance for patient travel increased four-fold and 44% of participants traveled over 50 miles in 2014 to obtain an abortion. Patients whose nearest clinic closed following HB2 had a higher probability of other hardship experiences than those whose nearest clinic remained open. These findings demonstrate that TRAP laws which result in clinic closures increase burdens for abortion patients in the form of travel.

Previous studies that focus on abortion incidence or patient hardship only account for people that were able to access services. This paper will assume demand is unchanged by TRAP laws and seek to understand the impact of TRAP laws on all individuals of reproductive means that may utilize abortion services. The often-stated intent of TRAP laws by politics may be to ensure quality abortion care; however, it is unclear how effective these laws are in meeting this goal and whether quality care includes accessibility to care. Due to the relationship between TRAP laws and increased hardships, it is questionable who can access abortion care.

Using policy equity principles, TRAP laws will be analyzed to establish if they are distributive in nature. The conceptual hypothesis will test that if TRAP laws are inequitable, they will impede the least advantaged to access abortion. If TRAP laws are inequitable, abortion access will only be available to those with the means to access care. Equity in access to abortion care will quantified using factors of time, travel, and cost. As abortion care has been established as more accessible in urban locations, this paper will focus on mid-size cities to understand TRAP law equity in a different population.

Data Collection and Analytic Technique

This study seeks to understand the impact of TRAP laws on social equity using statistical analysis. The operationalized hypothesis for analysis is that an increase in the number of TRAP laws will cause an increase in the financial hardship on abortion patients. There are no available data sets from previous studies to analyze the operationalized hypothesis. Using previous literature on abortion access and practical applications from knowledge of patient experience, variables were selected and collected by the researcher. Data collected to test the hypothesis, using cross-sectional regression analysis, focused on laws and equity variables in effect as of January 1, 2018.

Sample

The unit of analysis is mid-size US cities that range in total population from 100,000-300,000. As it has been established that urban residents have better access to abortion care, this study will focus on mid-size cities to understand the redistribution issue for a different population. The sample size of the study is one hundred cities (n=100) that were randomly generated from a list of most populous incorporated US cities (within their defined limits) sourced from the 2016 estimate of the US Census.

Independent variable

The independent variable is the number of TRAP laws in the state. This variable was sourced for the Guttmacher Institute categories for TRAP regulations by state as of February 1, 2018 (Appendix 1). Laws that are permanently enjoined, or are no longer in effect, were not included in the study. The six sample cities located in Oregon and Colorado had the fewest TRAP laws at 2 (Table 1). The four sample cities located in Kansas had the most TRAP laws at 13. The median number of TRAP laws in the sample is 8, the mode is 10. No city in the sample had a zero value for this variable.

Dependent Variable

The dependent variable is a calculated cost of financial hardship on abortion patients and provides an understanding of the real, often hidden, cost of care. This continuous interval variable represents the concept of "undue burden" as outlined in *Casey v. Planned Parenthood* (1992) as "substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability." The total financial hardship is measured by a sum costs associated with travel, time, wage loss, and childcare. This variable does not account for the cost of the abortion procedure as this is a market driven cost set by providers. The total financial hardship represents the practical substantial obstacles on abortion patients placed by state policies that regulate abortion providers.

The total financial hardship cost was calculated using four different data points that were established and collected by the researcher. The cost of travel is the distance travelled from the city to reach an abortion provider. This is represented as a financial value as the cost per mile. Each distance was turned into the cost per mile using the current average cost of per mile of the American Automobile Association (AAA) of $0.59831. If a patient must drive any distance outside their city to reach a provider, the distance accounts for return trips and any multiple round trips due to laws that require a waiting period.

The value for the cost of time is represented by the lodging and meals accrued for overnight stays at a provider location. The cost of time assumes patients that must drive over fifty miles for care and wait eighteen hours or more between counseling and procedure appointments will need overnight accommodations (n=15) (Appendix 2). The cost of time is calculated by adding the per diem max from General Services Administration (GSA) to the cities in which patients would fit overnight criteria. The GSA per diem is the allowance for lodging (excluding taxes), meals and incidental expenses using average daily rate (ADR) data that is timely, industry accepted, and utilized by the government.

The value for wage loss utilizes Bureau of Labor Statistics data from the Quarterly Census of Employment and Wages, for the second quarter of 2017, by all Metropolitan Statistical Areas (MSAs). This census provides the average weekly wage to find the average daily wage for this value. For patients that can receive an abortion within one day, the average wage of one day is added to the total hardship. For patients that must receive two appointments, due to TRAP law waiting times, the average wage of two days is added to the total hardship. Three days of lost wages were added for patients travelling from Springfield, Missouri where the closest provider is in Fayetteville, AR which requires at 48 hours wait time between appointments.

The literature on patient characteristics finds that the majority of abortion patients have had at least one birth (Jones & Jerman, 2017). To account for this, the cost of child care was added to the total financial hardship value. Cost of child care is collected from recent Care Price Index from Care.com, a comprehensive report of paid child care in the United States. If city level data was not available, the state average was utilized. The derived daily rate of in-home child care reflects if multiple days of care are required and is adjusted by 0.59 to account for rate of abortion patients that are already parents.

Control Variables

Control variables for partisanship, city population, predictive fertility, and the clinic availability were collected. Partisanship is a categorical variable indicating if the state where the city is located has a Republican (GOP) supermajority. States in that have conservative control of the legislator and a Republican governor received dummy variable of "1", all other states receive a "0". The population of the city was derived from the 2016 US Census estimate and is the population per thousands. The predictive fertility is the total fertility rate (TFR). The TFR is a population health statistic from the Center for Disease Control (CDC) and is the average number of children that is expected to be born per "woman" (or person with a uterus) in their lifetime. As the CDC does not track pregnancy rate, the TFR controls for the potential demand for abortion based on fertility.

Clinic availability controls for the diminishing supply side availability of abortion providers as states restrict and regulate practices. This value was collected through the Guttmacher Institute and controls for the percent change in the number of clinics providing abortion services between 2011 and

2014 (Jones & Jerman, 2014). On average, clinic availability was found in the sample to be decreasing at a rate of 12.5%, with 75% of the sample reporting a negative change in provider access by 2014. Controlling for the decline in clinic availability isolates TRAP laws as the potential factor driving the rise in financial hardships to address public policy outcomes from a patient access viewpoint rather than provider closures.

Findings

The cross-sectional data set was examined for multivariable linear regression analysis using IBM SPSS software. The model yielded a 60.3% R Square score with moderate associated strength to explain the variance in hardship costs (Table 2). ANOVA testing of the multivariable regression model showed statistically significance difference between group means ($p < 0.01$), therefore, the model is statistically significant (Table 3).

The independent variable, TRAP laws, was found to be significant ($p < 0.001$) and produced a coefficient score of 41.68. These results indicate that there is a positive relationship between TRAP laws and hardship costs to support the operationalized hypothesis. This result can be interpreted as if the number of TRAP laws raises by 1, then the cost of financial hardship is likely to raise by $41.68. All other variables and the constant did not meet significance thresholds ($p > 0.05$).

The regression equation produced a negative coefficient for partisanship which would indicate a decreasing effect by which hardship costs would be reduced by a GOP majority. The variables for TRAP laws and partisanship were expected to be positively linearly related, as Medoff (2011) found Republican supermajorities in states to be an indicator for TRAP law enactment. Validity diagnostics explains this error and found multicollinearity among the variables for TRAP laws and partisanship ($VIF > 3$). When the variable for partisanship was removed, the collinearity was solved ($VIF < 1.95$). A better value for this variable is needed.

Implications and Recommendations

This understanding of total abortion cost factoring in hardship costs demonstrates how TRAP laws impact everyday people attempting to access reproductive healthcare in midsize cities across the United States. While Planned Parenthood estimates the cost of abortion fluctuates nationwide between $350-950 (depending on method and timing), the average hardship cost of the study added $448 in travel, time, lost wages, and childcare costs. Even in ideal political climates, people pay more than the basic cost of care for an abortion procedure. This study found the people of Eugene (OR), who have provider in town and a democratic supermajority in the state, still suffer a hardship cost of $225. We must account for the true cost of care when evaluating the equity of abortion policy.

Policymakers and advocates should account for the real cost of seeking abortion care when promoting reproductive equity and access. To achieve best health outcomes and respect human rights, the World Health Organization (2012) recommends that countries “eliminate barriers that impede women’s access to health services, such as high fees for health-care services, the requirement for preliminary authorization by spouse, parent or hospital authorities, long distances from health facilities”. To eliminate barriers, lawmakers should enact distributive abortion policies that increase the availability of supply (providers) and decrease the cost of care placed on patients.

Expanding state Medicaid to cover all abortion services would serve to both reduce patient costs and help support providers in areas that rely on state insurance programs. Jones and Jerman (2014) found that while the majority of patients nationally paid out of pocket for their abortion, Medicaid was the most common form of payment in the 15 states that do not restrict Medicaid funding for abortion. Attempting to repeal and replace Medicaid laws state by state would be costly and extremely difficult for abortion advocates and lawmakers. Repealing the Hyde amendment would expediate the expansion of Medicaid for abortion by removing the federal limits on benefits. Several advocacy groups, including the Center for Reproductive Rights, currently have campaigns to end Hyde and have framed the issue as one of economic justice.

Due to restrictive state policies, the burden of cost falls to patients. Abortion providers and charities work to mitigate these costs and assist patients in accessing care. Nonprofit advocates, such as the National Network of Abortion Funds (NAAF), provide practical support for patients through financial

aid and by removing logistical barriers. NAAF is constantly fundraising and can utilize the findings of this paper to sum the expected additional costs. Understanding a more complete cost of abortion care can allow NAAF to realistic goals for charitable abortion funding and drive donations.

Additionally, to solve for inequity, abortion providers should open new clinics in areas facing extreme barriers due to high travel costs such as Springfield, MO (hardship cost of $1,168). Returning access to an area will be a difficult and costly task due to hostile environments that closed previous clinics. Abortion providers should seek innovative solutions such as grant funding, community advocacy partnerships, and expanded relationships with area medical providers to reintroduce care to a community. To achieve this abortion providers may choose to transition to a 501(c)3 structure as Whole Woman's Health did to reopen their Austin (TX) clinic under Whole Woman's Health Alliance (WWHA). The nonprofit structure allows WWHA to collect donations to offset operating expenses. While a nonprofit model might not lower the cost of the abortion procedure, providing access to care close to home will lower the overall hardship costs paid by patients through time, travel, childcare, and lost wages.

Limitations

Limitations of this research include sample size, TRAP law assessment, and variable redundancy with partisanship values. Trends in the sample found midsize cities often located proximal to large urban areas that had access to abortion care. In the sample only 16% of cities would require travel 50 miles or more. Incorporating the 200 additional midsize cities in the United States in the sample may solve for this issue. This paper also approached TRAP laws as a comparable total and further research could better define which laws are causing which trends in rising cost. Additionally, this paper focused on laws with restrict abortion providers and did not include regulations that encourage patients to access state funds for services such as the California Reproductive FACT Act.

Conclusion

Patients seeking abortion care face a high hidden cost of care due to access barriers created by TRAP laws. Statistical analysis shows a positive relationship between the number of TRAP laws a state has enacted and higher costs to abortion patients seeking care. These results indicate that TRAP laws are not distributive in nature and are not socially equitable laws. The link between increasing abortion regulation and the increasing cost of abortion care in midsize U.S. cities demonstrates an undue financial burden that is contrary to legal standards under *Casey* (1992). TRAP laws do not meet the legal or social standards for equitable policy.

Previous studies have focused on the effects of TRAP laws on the abortion incidence and the availability of providers. It is known that TRAP laws close clinics that provide abortion services as providers are unable to comply with costly and difficult policies imposed by states. Abortion incidence is a complex issue that is impacted by decline in unintended pregnancy from contraceptive access, in addition to a drop-in clinic availably (Jones & Jerman, 2014). However, little is known about people who are unable access abortion services. By understanding the barriers to access, a clearer picture of who is denied care due to financial hardships emerges.

The cost of an abortion procedure can range between $350-900 depending on method and provider. There are only five states in the United States that voluntarily provide Medicaid funds for abortions, the majority of states follow the federal Hyde amendment restrictions. The Hyde amendment (1976) restricts Medicaid funding from the federal government to pay for abortion procedures except in cases of sexual crime or the life of the pregnant person. Additionally, there are 26 states also have laws that restrict private insurance plans offered through exchanges from covering abortions. These laws restrict the known cost of care for abortion procedures and many abortion providers offer charitable funding to offset the cost of an abortion procedure.

This paper is interested in the hidden cost of care on abortion patients and whether TRAP laws impact these access barriers. The hidden cost of care represents the financial hardships that are increased when providers are unavailable or unwelcome in a state. These costs include the travel to and from clinics,

the time spent due to mandatory wait laws, the cost of childcare, and lost wages. As the availability of abortion providers declines due TRAP laws, the factors of time, travel, and associated costs rise for patients.

Statistical analysis finds a positive correlation between the number of TRAP laws a state has in effect as of the beginning of 2018 and the financial hardships on abortion patients. As the number of TRAP laws rises by 1, there is an expected rise of $45.68 in financial hardship. On average, states have 7.28 TRAP laws which would assume an average hardship cost of $332.55, in addition to the cost of the abortion procedure. This paper finds a relationship between a rise in abortion regulation and a rise in abortion cost that must be accounted for in policy making.

Lawmakers are tasked with enacting equitable policy that benefits the least advantaged. TRAP laws are regulatory policies that control the behavior of a specific group rather than provide equitable access to abortion care. Healthcare has been a policy area that has struggled with equity issues and governments have taken steps to enact redistributive policies that improve access to care. The 2010 Patient Protection and Affordable Care Act (ACA) offered redistributive polices for reproductive health by providing provisions for free birth control. The 2017 Reproductive Health Equity Act guarantees that the people of Oregon regardless of citizenship, gender identity, or insurance have access to reproductive health services including family planning, abortion, and postpartum care. The trend is reproductive healthcare policy shows a country divided with states that seek to provide equity in care and those that continue to restrict access.

The Supreme Court has shaped reproductive freedom in this country three times, in *Roe* (1972), *Casey* (1992), and *Whole Woman's Health v. Hellerstedt* (2016). In each of these cases, states were required to redefine the Constitutional limits on regulating abortion policy. The “undue burden” standard set by *Casey* (1992) and "[u]nnecessary health regulations that have the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion impose an undue burden on the right." The holding in *Whole Woman's Health v. Hellerstedt* (2016) found the portions of the Texas TRAP law H.B. 2 requiring abortion providers to have hospital admitting privileges and surgical center requirements for facilities to fail the undue burden test as they place obstacles on abortion patients. The Supreme Court has held abortion access is a right and laws that restrict access do not meet Constitutional standards.

This study provides new information to examine the barriers to abortion care created by TRAP laws across mid-size cities in the United States. A positive relationship exists between the number of TRAP laws in a state and the cost to abortion patients to access care. Policymakers utilize this understanding of the hidden cost of care to deter additional TRAP laws and as a basis to repeal existing legalization. To achieve equity in reproductive policy, barriers to access care must be reduced and eliminated. Abortion patients deserve care that does not come with a hidden cost and governments that support all choices.

Tables and Graphs

Graph 1: Scatterplot of key variables

a. $y = 43.428x + 120.53$

b. $R^2 = 0.5806$

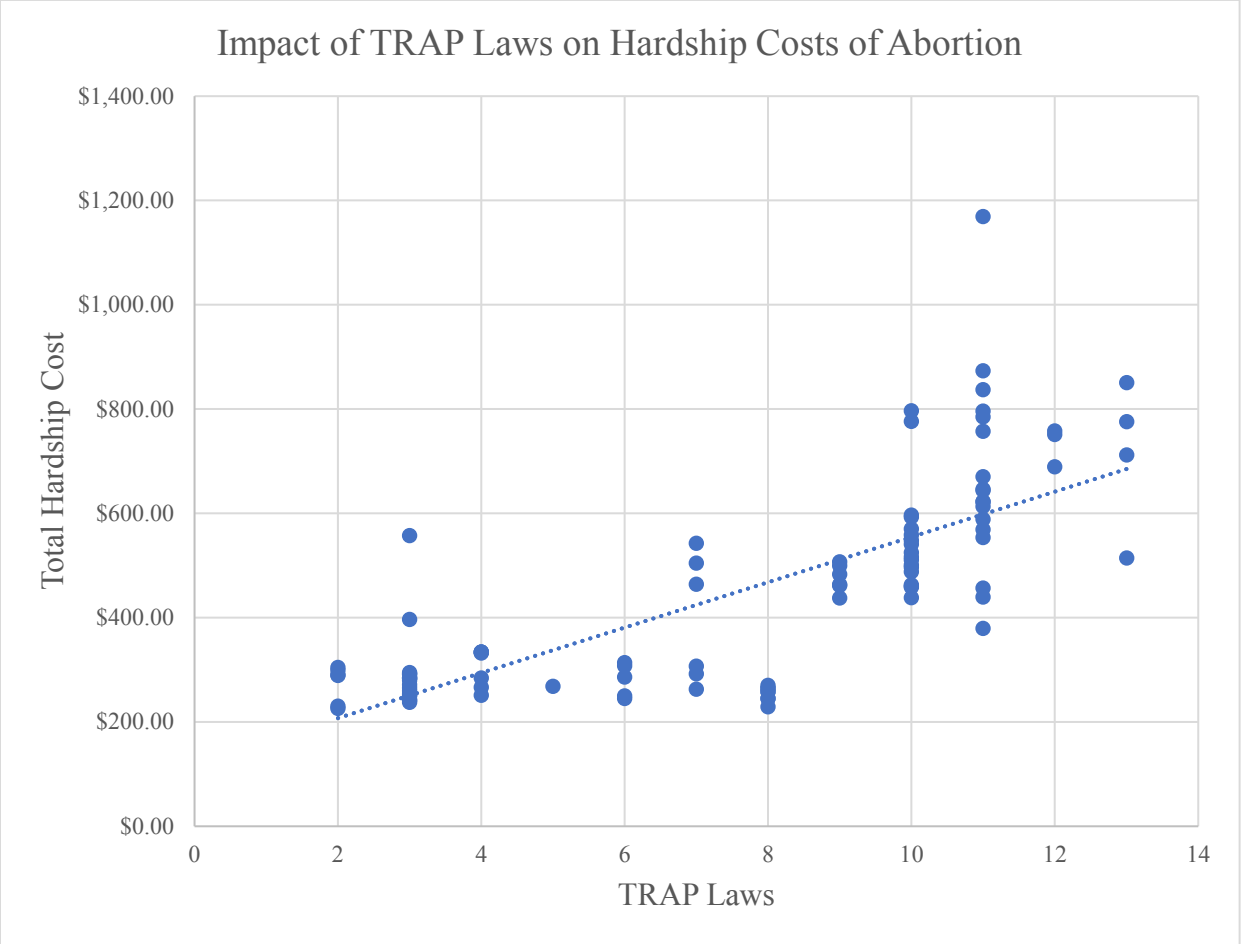

Table 1: Descriptive Statistics

Variables	Minimum	Maximum	Mean	Std. D.	Variance	Range
Hardship Cost	$225.89	$1,168.87	$448.41	196.83	38,743.92	$942.98
TRAP Laws	2.00	12.00	7.55	3.45	11.93	11.00
Population	91.00	298.00	155.63	51.07	2,608.36	207.00
Partisanship	-	1.00	0.54	0.50	0.25	1.00
Fertility (TFR)	1.54	2.24	1.84	0.13	0.02	0.70
Clinic Availability	(75.00)	71.00	(12.58)	23.50	23.50	146.00
N	100					

Table 2: Regression analysis results on hardship cost

Variables	Coefficient	t-value	Sig.	VIF
TRAP Laws***	45.68	7.10	0.00	3.02
Clinic Availability	(1.05)	(1.74)	0.09	1.24
Population	(0.00)	(1.03)	0.30	1.06
Partisanship	(56.62)	(1.40)	0.17	2.52
Fertility (TFR)	76.12	0.54	0.59	1.92
(Constant)	22.28	0.09	0.93	
R Square	0.603			
F-Value	28.56			
N	100			

*Note: *p<.05, **p<.01, ***p<.001*

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Appendix

Appendix 1

Guttmacher Institute Categories for Targeted Regulation of Abortion Providers

1. Must be performed by a licensed physician
2. When must be performed in a hospital
3. When second physician must participate
4. Prohibited after a time (except in cases of life or health endangerment)
5. "Partial-birth" abortion banned
6. Public funding of abortion (except in cases of life or health endangerment)
7. Private insurance coverage limited
8. Providers may refuse to participate: Individuals
9. Providers may refuse to participate: Institutions
10. Mandated counseling includes information on: breast cancer
11. Mandated counseling includes information on: fetal pain
12. Mandated counseling includes information on: negative psychological effects
13. Waiting period (in hours) after counseling
14. Parental involvement required for minors

Appendix 2

List of cities where patients must drive over fifty miles for care and wait eighteen hours or more between counseling and procedure appointments

City	Travel Distance (by mile)	Waiting Time (in hours)
Brownsville, TX	60	18
Kansas City, KS	64	24
Topeka, KS	64	24
South Bend, IN	67	24
Beaumont, TX	76	24
Springfield, MO	88	48
North Charleston, SC	90	24
Evansville, IN	100	24
Charleston, SC	115	18
Wichita Falls, TX	123	24
Fort Wayne, IN	127	24
Laredo, TX	147	24
San Angelo, TX	175	24
Baton Rouge, LA	179	24
Lafayette, KS	210	24