Post-Dobbs Reproductive Health: New Evidence from Nationwide Electronic Health Records

Julie Berry Cullen, *University of California, San Diego and NBER*
Itzik Fadlon, *University of California, San Diego and NBER*

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Abstract: We provide new evidence on equity, efficiency, and effectiveness considerations in post-Dobbs reproductive health in the US. We use a nationwide Electronic Health Records (EHR) dataset that covers more than 50 percent of women of childbearing age, and includes detailed information on healthcare conditions and services. We observe multiple layers of reproductive health choices – pregnancies, elective abortions, contraceptive use, and neonatal demise – with linkages to self-reported demographics and residential location. With respect to equity, we find a considerably higher risk of unwanted pregnancies, as captured by elective abortions, among Black and Hispanic women compared to White women, alongside lower ex-ante use of contraceptives. We similarly find strong gradients along the economic disadvantage of patients' residential locations, which is additionally associated with greater risk of neonatal demise. With respect to efficiency, we find no evidence of marginal moral hazard, in that states with higher elective abortion rates do not exhibit lower contraceptive use, whereas we find a strong negative correlation between elective abortion rates and neonatal demise. With respect to the effectiveness of potential policy levers, we find that the marginal abortion is medical. States that fund abortion-related procedures through their Medicaid programs clearly expand access, particularly for those in more disadvantaged areas. Yet, local variation in abortion rates is as important as cross-state variation, suggesting other aspects of access are as important as legality and public financing.

1. Introduction

Reproductive health rights are among the most contentious topics in the US. The active debate resurfaced preceding and following the Supreme Court's ruling in *Dobbs v. Jackson* in June 2022, which overturned the 1973 *Roe v. Wade* decision and ended the constitutional protection of abortion rights. This has allowed states to become the main regulator, prompting new state-level regulations and bans that are continuously evolving (see, e.g., Brubaker et al. 2022, Rade et al. 2022, Hardin et al. 2023, Aiken et al. 2024). The new landscape has led to concerns about women's access to and usage of reproductive health services across the country.

While the broader moral debate involves thornier issues related to bodily autonomy and when life begins, many of the core issues in the current debate can be framed from the perspective of traditional equity-efficiency tradeoffs. From an equity perspective, restricted access tends to most affect already-marginalized populations, limiting choices for vulnerable subsets that wish to terminate their pregnancies. From an efficiency perspective, economists have focused on externalities. Greater access has been found to reduce crime, increase human capital investments and labor force participation, and reduce financial instability and reliance on the safety net system (e.g., Angrist and Evans 1996, Donohue and Levitt 2001, Miller, Wherry, and Foster 2023). Another aspect of efficiency that is more relevant to what we can observe has to do with risky behaviors and reproductive outcomes. Some express moral hazard concerns, such that regulation leniency could encourage abortions and result in their excessive use as an ex-post contraceptive of last resort (Brubaker et al. 2022, Bell et al. 2025). Counter arguments suggest that limited access to abortion services could increase the prevalence of risky pregnancies, such as pregnancies that might not result in a healthy delivery if carried to full term.

In this paper, we provide new evidence on equity and efficiency considerations of post-Dobbs reproductive health in the US. We use a nationwide Electronic Health Record (EHR) dataset for 2023-2025 that covers roughly 50% of women of reproductive ages in the country. The data include detailed information on health conditions and healthcare services, allowing us to track multiple layers of reproductive health choices including contraception use, pregnancies, elective abortions, and birth outcomes. The records are also linked to self-reported demographics (such as race) and measures of local affluence. To our knowledge, this is the first large-scale study of reproductive health outcomes in the post-Dobbs era.

We first document wide and persistent state-level dispersion. In 2025, elective abortion rates range from 0.01% in South Dakota at the bottom to 2.53% in DC at the top. We find clear partisan patterns across states, with strong positive associations between states' Democratic vote margins in the 2024 Presidential elections and elective abortion rates. We also document wide dispersion in abortion rates across patients' cultural backgrounds, as proxied by preferred language.

In investigating equity, we study reproductive health outcomes by social groups that are traditionally underserved in the healthcare context. We accordingly focus on differences by race and ethnicity and proxies for economic affluence. We find that abortion rates among Black and Hispanic women are 3 and 2 times that of White women, respectively. We further find that,

relative to White women, the variability in the incidence of abortion across states is greater by a factor of 9 for Black women, and by a factor of 5 for Hispanic women. The results together show that Black and Hispanic women are much more likely to experience the event of an unwanted pregnancy and face significantly higher variability in this risk. Black women are also much more likely, compared to White or Hispanic women, to experience neonatal demise.

To explore the role of economic disadvantage, we study differentials across an index of the socioeconomic vulnerability of patients' locations. We find meaningful gradients with respect to disadvantage. Elective abortion rates in the most disadvantaged locations are twice as large compared to the most affluent locations, with a similar pattern in rates of neonatal demise. In investigating the interaction between race/ethnicity and a location's economic affluence, we find that the starkest differentials are across race/ethnicity. Regardless of the level of local affluence, Black and Hispanic women have higher abortion rates and Black women exhibit larger chances of experiencing neonatal demise.

In investigating efficiency, we consider moral hazard on one hand and the potential reduction in risky pregnancies on the other. We first consider the moral hazard concern that abortion accessibility could lead to substitution away from ex-ante ways to avoid an unwanted pregnancy. The evidence is inconsistent with this view, as we find no relationship in the state-level equilibrium between rates of contraceptive use and elective abortion rates. Second, we test the hypothesis that greater access to elective abortion may lead to reductions in risky pregnancies. Consistent with this hypothesis, we find a strong negative relationship in state-level rates of neonatal demise and rates of elective abortions.

Lastly, we consider the potential effectiveness of various policies in terms of their impacts on abortion rates. For access-based regulation, we find that medication-based abortion is the marginal elective abortion, highlighting medication abortion as a potentially effective policy lever. When considering the level of jurisdiction that "matters" for reproductive outcomes, we find that states can explain 44% of the variation in elective abortions, but that within-state variation has incremental explanatory power that is just as large. This suggests that interventions targeted at a more localized level could be just as effective as state-level policies in regulating access to reproductive health services. For price-based regulations, we show that abortion rates are higher in states that finance abortion services through Medicaid than in those that do not, and the gap across these two types of states grows along with local disadvantage. This points to a central role for subsidies and coverage in regulating access.

2. Data and Analysis Sample

2.1 Data

We use administrative data from Epic Cosmos for 2023-2025. Epic Cosmos is a nationwide vendor-facilitated data aggregation tool for Electronic Health Records (EHRs), which has been created in collaboration with a community of health systems that use Epic as their EHR software vendor. The dataset integrates and harmonizes inpatient and outpatient charts into one

comprehensive record, and additionally includes information on demographics, such as age and race/ethnicity. Since its inception in 2018, coverage has increased exponentially as more systems have opted in over time (Tarabichi et al. 2021). In the recent years that we use, the records include more than 50% of women of childbearing ages in the US. Specifically, for 2023-2025 combined, the EHR records include 35,590,029 female patients of ages 20-49, whereas Census estimates report 66,653,054 women in this age range in total across the US.[1]

We analyze several reproductive health outcomes and choices. To identify contraceptive use, we look at records of prescriptions for "other gynecological" (ATC code: G02) or "sex hormones and modulators of the genital system" (ATC Code: G03). Pregnancies are identified using the built-in Epic grouper code "pregnancy" that flags all clinical entries related to the condition. For elective abortions, we use the billing code "encounter for elective termination of pregnancy" (ICD-10-CM code: Z33.2). Medication abortion is a sub-category of elective abortions, which we identify in the dataset by prescriptions for "Mifepristone" (ATC Code: G03XB01). In 2020, the FDA removed in-person and clinician-only dispensing requirements for this medication, as part of its Risk Evaluation and Mitigation Strategy (REMS). Since then, the use of medication abortion in lieu of procedural abortion has grown, and many view medication abortion as a key channel that would re-shape access to abortion services across the country (Kumsa et al. 2023, Brander et al. 2024). Finally, we study the event that a pregnancy ends in neonatal demise. Neonatal demise is defined as births in which the baby was born with signs of life but dies within 28 days.

To study patterns across relevant subgroups, we categorize patients based on their race/ethnicity as being non-Hispanic Black (henceforth Black), Hispanic or Latino (henceforth Hispanic), or non-Hispanic White (henceforth White). As a measure of patients' locality economic affluence, we use the Social Vulnerability Index (SVI). The US Centers for Disease Control and Prevention (CDC) calculates a ZIP-code-level index from census tract data, which is a percentile ranking (ranging from 0-100, with 100 indicating the greatest disadvantage). We use a central component of the overall index – the socioeconomic percentile ranking – for the patients' most recent ZIP code of residence. We also use information on the location's rural-urban commuting area classification, using the specified Rural-Urban Commuting Area (RUCA) as defined by the USDA based on the 2010 census.

2.2 Analysis Sample

We limit our analyses to women in the most relevant childbearing age ranges. Figure 1 shows pregnancy rates by age, expressed as percents (or pregnancies per 100 individuals), calculated using Cosmos records for 2023-2025. As expected, rates peak between the ages of 25-39. Our main analysis sample focuses on women ages 18-50, since rates drop off at younger and older ages. Though fertility rates are low among them, we consider teens aged 14-17 as a separate population of interest.

[1] See https://www.census.gov/data/tables/time-series/demo/popest/2020s-national-detail.html.

Figure 1: Pregnancy Rates by Age Group

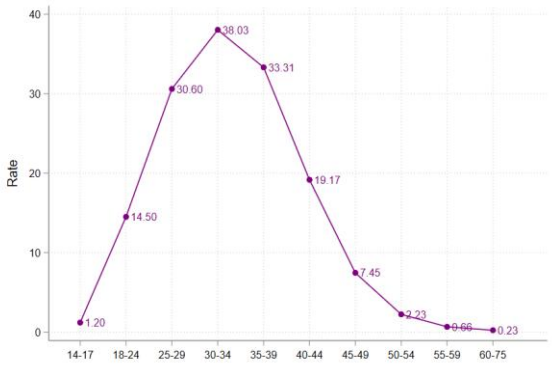


Table 1 reports summary statistics for our analysis sample of women of ages 18-50 by year. In 2025, one in five women experiences a pregnancy, and just over one-third uses contraceptives. Less than one percent (0.578%) undergo an elective abortion, among which two-thirds are medication abortions. The size of the combined sample by race and ethnicity is provided in Table 2. There are overall more than 37 million individuals in the analysis sample, among which 14% identify as Black, 15% identify as Hispanic, and 45% identify as White.

Table 1: Reproductive Health Outcomes for Women of Ages 18-50

Year	Number	Contraceptive Use Rate	Pregnancy Rate	Elective Abortion Rate	Medical Abortion Share
2023	30,556,255	33.759	18.133	0.449	61.158
		(0.017)	(0.014)	(0.002)	(0.246)
2024	32,182,493	35.053	19.097	0.603	64.485
		(0.016)	(0.014)	(0.003)	(0.201)
2025	32,749,263	35.803	20.011	0.578	66.643
		(0.016)	(0.014)	(0.003)	(0.200)

Table 2: Number of Patients by Race and Ethnicity, 2023-2025

Number of Patients	N	Percent
All	37,857,330	100%
Black	5,458,796	14%
Hispanic	5,709,234	15%
White	17,086,069	45%

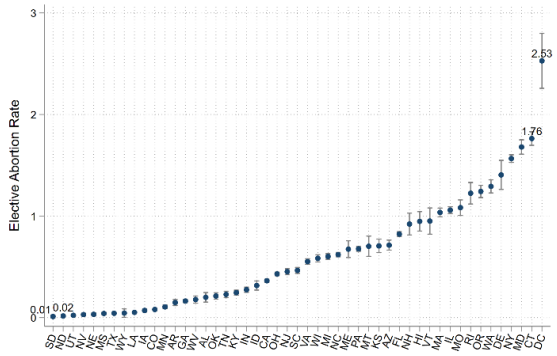
3. Nationwide Patterns in Post-Dobbs Reproductive Health

We start by presenting patterns for reproductive choices across states, as state regulations are at the core of policy discussions on reproductive health. We include states with more than 5,000 annual patients in the denominator, which effectively excludes only Alaska. New Mexico is additionally excluded due to missing data on abortions. The analysis below includes the remaining 48 states and DC.

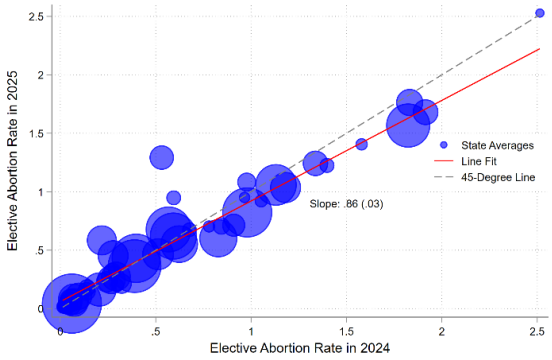
In panel A of Figure 2, we plot elective abortion rates in 2025 in an ascending order. The figure shows wide dispersion, ranging from 0.01 in South Dakota to 2.53 in DC. Panel B of Figure 2 looks at persistence in state-level elective abortions rates across 2024 and 2025. Each circle represents the location of a state's means across the two years, with its size scaled by the number of women in the denominator in 2024. There is a high degree of persistence, with a slope of 0.86 from a state-level regression weighted by the number of patients in 2024.

Figure 2: State-Level Elective Abortion Rates

Panel A: Rates in 2025 by State



Panel B: Persistence across Years



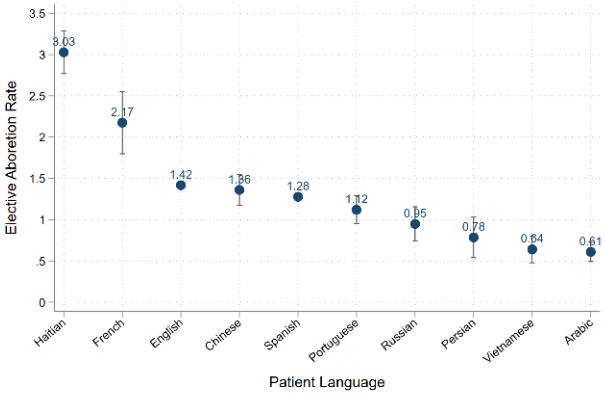
As the moral debate around abortion involves issues related to bodily autonomy and when life begins, it often surrounds culture, religion, and social views. The data allow investigating differences along these lines by looking at heterogeneity by a patient's preferred language (which captures dimensions of culture and, to some extent, religion) and by a location political inclination, with the broader debate's strong association with political views.

Panel A of Figure 3 plots average elective abortion rates by a patient's preferred language. In this plot we use data from years 2023-2025 combined, so that rates are at a 3-year level. The figure illustrates the wide cultural variation, ranging from 0.61 abortions per 100 women among patients whose preferred language is Arabic to 3.03 abortion per 100 women among patients whose preferred language is Haitian. Panel B for Figure 3 plots state-level averages in 2025 against the state's political inclination. Specifically, we categorize locations based on the margin of Democratic versus Republican votes in the 2024 presidential election.[2] We split states into 5 equal groups based on the democratic vote margin, and display each group's mean. We also provide the linear fit using a state-level regression weighted by number of individuals in 2025. The figure provides a clear partisan relationship, with a 1-SD increase in democratic vote margin (0.24 pp) associated with an increase of 0.39 (=1.64×0.24) elective abortions per 100 women (on a state-level mean rate of 0.60).

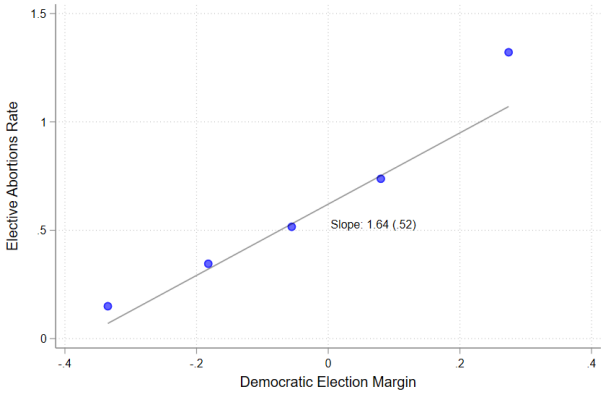
[2] Source: https://www.fec.gov/introduction-campaign-finance/election-results-and-voting-information/

Figure 3: The Role of Culture and Social Views in Elective Abortions

Panel A: Rates by Patient Language



Panel B: State Rates by Democratic Inclination



4. Equity: Disparities in Reproductive Health across Population Subgroups

Our investigation of equity considerations focuses on studying reproductive health outcomes by social groups that are traditionally underserved in the healthcare context. We accordingly focus on differences by race and ethnicity and by a community's economic affluence.

4.1 Race/ethnicity

Figure 4 provides means of reproductive health outcomes by race/ethnicity groups for the years 2023-2025. In each plot, the horizontal dashed line represents the national 3-year mean (including all patients in the calculation, regardless of whether information on race/ethnicity is available in their EHR records).

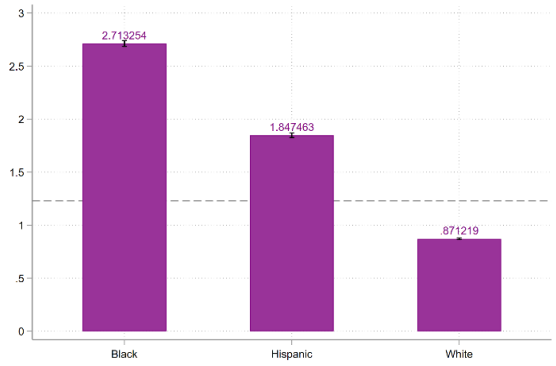
Panel A shows meaningful differences in the prevalence of elective abortions. Among women of ages 18-50, abortion rates among Black women (2.7%) and Hispanic women (1.8%) are 3 and 2 times that of White women (0.9%). Similarly, adolescent Black and Hispanic patients undergo elective abortions at rates that are 3.5 and 2.4 times higher than White adolescent patients (in panel E that includes patients of ages 14-17). Panel B shows that pregnancies are also more common among Black and Hispanic patients of ages 18-50, though the relative rates compared to Whites women are much less dramatic.

In Figure 5, we further split the sample by whether the individual lives in a rural or urban community. We characterize a location as rural if it has "10 Rural areas" as its Rural-Urban Commuting Area (RUCA) classification, and as urban if the classification is "1 Metropolitan area core." We find lower elective abortion rates for all groups in rural areas, relative to metropolitan area cores. But, again, within area types, Black and Hispanic undergo abortions at higher rates, with larger differentials in urban localities.

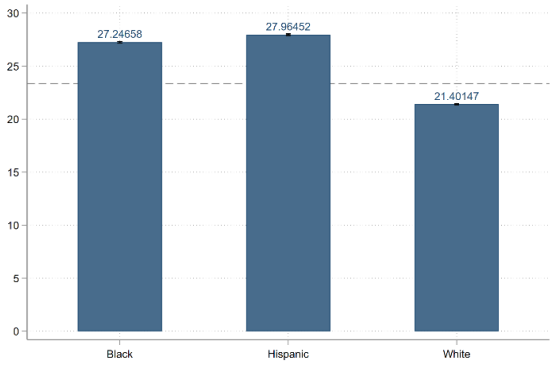
Figure 4: Reproductive Outcomes by Race/Ethnicity

Ages 18-50

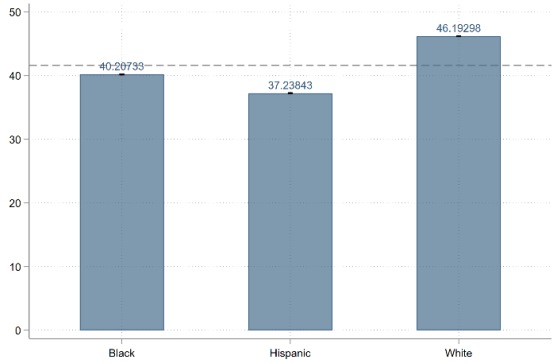
A. Elective Abortions



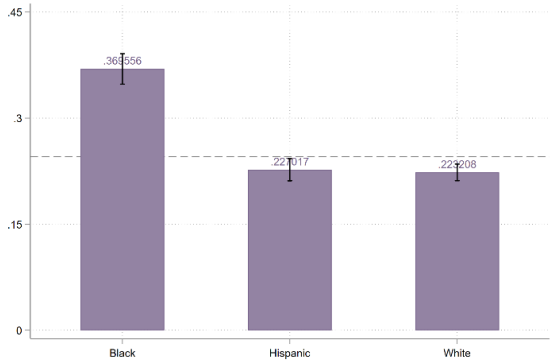
B. Pregnancies



C. Use of Contraceptives

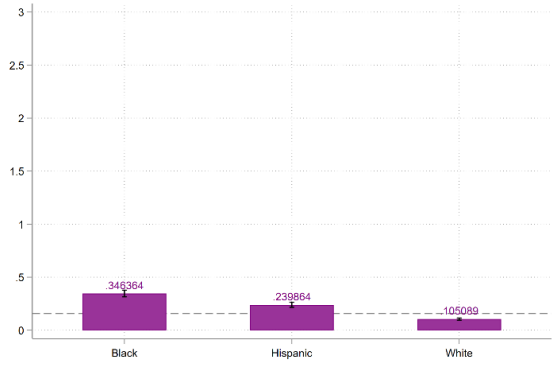


D. Neonatal Demise



Ages 14-17

E. Elective Abortions



F. Pregnancies

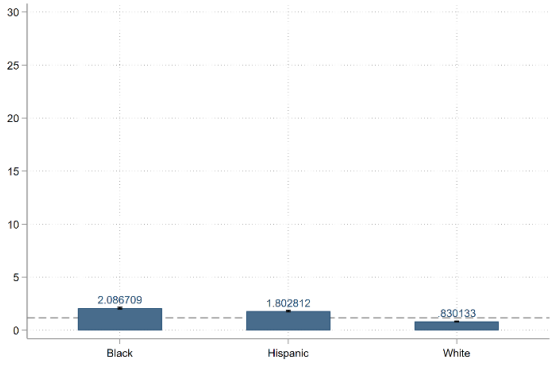
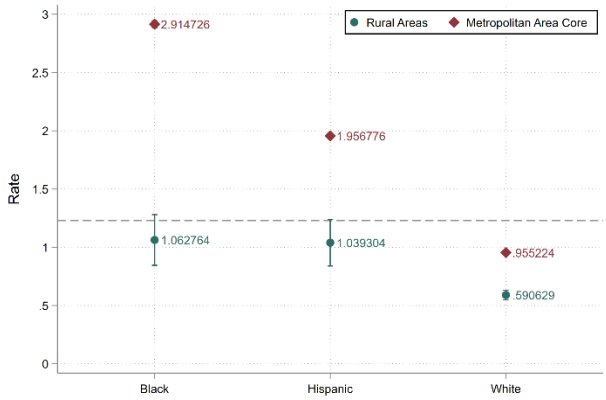


Figure 5: Elective Abortion Rates by Race/Ethnicity and Rural/Urban



One hypothesis for higher rates of elective abortions of unwanted pregnancies among some subgroups is that they could be driven in part by lower use of contraceptives ex-ante. Panel C of Figure 4 shows evidence consistent with this conjecture. Compared to White women, whose take-up of contraceptives is 46%, the average take-up rate is 6 pp lower among Black women and 9 pp lower among Hispanic women.

Finally, we consider the variability in reproductive events that women from different subgroups experience. In Table 3, we present estimates of the variance across US states in reproductive outcomes by subgroups. Specifically, we construct the following statistic. We use y_{im}^{g} to denote the outcome of patient *i* from group g in state m, with a total of M states. We then calculate state-level means for all patients from a particular group in that state (y_{m}^{g}), and the standard errors of those means (s_{m}^{g}). The grand mean of y_{m}^{g} across states is denoted by $\bar{y}_{m}^{g}$. The bias-corrected cross-state variances for each group are calculated as: $\frac{1}{M}\sum_{m=1}^{M}\left[(y_{m}^{g}-\bar{y}_{m}^{g})^{2}-(s_{m}^{g})^{2}\right]$ (Walters 2024).

Table 3: Cross-State Variance in Reproductive Outcomes by Race/Ethnicity, 2023-2025

Race/Ethnicity	Elective Abortions	Pregnancies	Contraceptive Use
Black	11.87	26.73	49.83
Hispanic	6.49	28.30	43.73
White	1.31	12.40	39.74

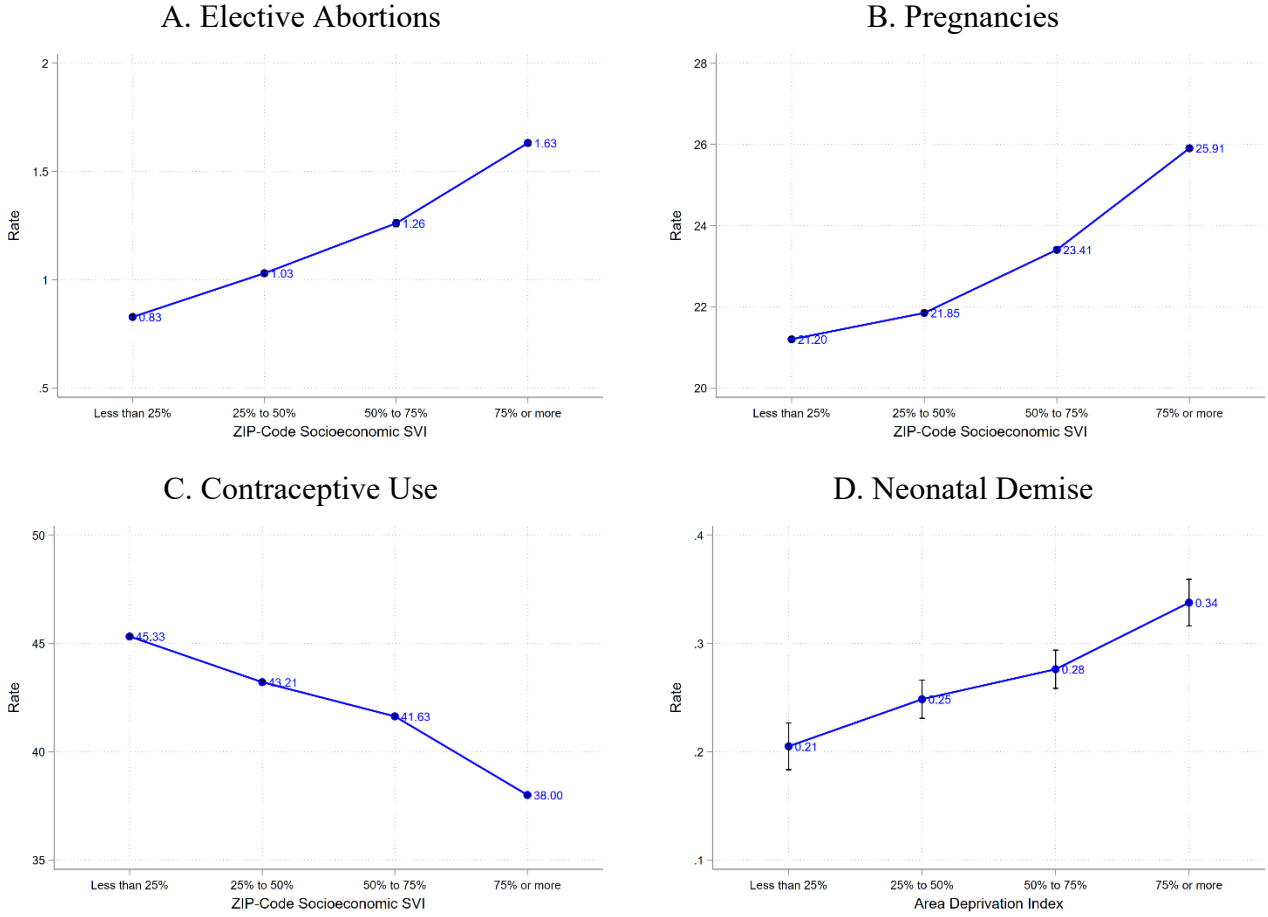
Relative to White women, the variability in the risk of an abortion is greater by a factor of 9 for Black women, and by a factor of 5 for Hispanic women. The results overall show that Black and Hispanic women are more likely to experience the event of an unwanted pregnancy and face higher variability in this risk as compared to White women.

In the context of risk in reproductive outcomes, we further investigate neonatal demise. Panel D of Figure 4 provides means for rates of neonatal demise by race/ethnicity. The most pronounced differential is the higher rate among Black women as compared to White or Hispanic women.

4.2 Locality economic disadvantage

To explore the role of economic disadvantage, we look at variation across a patient's location economic affluence. Specifically, we use the SVI socioeconomic value of the ZIP code of a patient's residence, where we split location based on quartiles of the disadvantage index (with the highest quartile being most disadvantaged). The results are provided in Figure 6. There are clear gradients in local economic disadvantage. Panel A shows that elective abortion rates in the most disadvantage locations (1.63%) are double that in the least disadvantaged locations (0.83%). A similar gradient appears in pregnancy rates (panel B), and we again see that the higher abortion rates go in tandem with lower rates of using contraceptives (panel C). Lastly, we see higher rates of neonatal demise in locations that are more economically disadvantaged (in panel D).[3]

Figure 6: Reproductive Outcomes by a Patient Locality's Economic Affluence



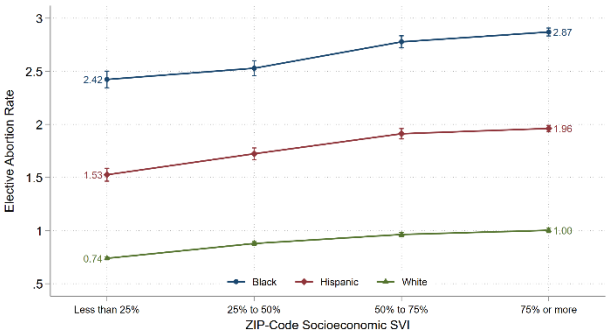
[3] Note that for neonatal demise, the available locality-level economic index is the "Area Deprivation Index." The Area Deprivation Index (ADI) was created by the University of Wisconsin to measure the socioeconomic disadvantage of areas at a Census Block Group. The 2020 ADI (v3.2) was constructed using the 2016-2020 5-year estimates from the U.S. Census' American Community Survey. The measure's scale in rank with 100 representing the most disadvantaged areas and 1 represents the least disadvantaged areas .For more information, see: https://www.neighborhoodatlas.medicine.wisc.edu/.

4.3 Race/ethnicity and economic affluence interactions

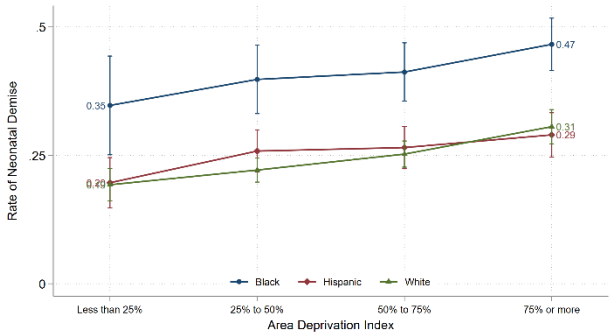
Finally, we look at the strength of the associations with race/ethnicity and a patient location's economic affluence by investigating cross interactions. In Figure 7, we display the gradient in economic disadvantage within each race/ethnicity subgroup separately. Panel A looks at elective abortion rates. With comparable gradients in a location's economic disadvantage, the most pronounced differentials are the uniform level shifts across race/ethnicity in each socioeconomic quartile. A similar pattern emerges for neonatal demise in Panel B, where again the gradients in socioeconomic percentiles are of similar magnitudes, but the level shift among Black women is distinctive.

Figure 7: Reproductive Outcomes by Race/Ethnicity and Economic Affluence

A. Elective Abortions



B. Neonatal Demise



5. Efficiency: Risky Behaviors

There are two aspects of efficiency in the context of greater access to elective abortion services that are measurable in the data. The first aspect relates to one of the moral hazard concerns of abortion accessibility, which is that it could lead to substitution away from ex-ante ways to avoid an unwanted pregnancy, such as the use of contraceptives. To investigate this conjecture, we look at the relationship between the state-level equilibrium rates of contraceptive use and elective abortion.

Table 4 provides estimates of annual state-level regressions pooled across 2023-25, with observations weighted by the number of patients. The specifications include year dummies and standard errors are clustered at the state level. In column 1, we see that higher elective abortion rates have no association with rates of contraceptive use. This provides evidence inconsistent with the specific moral hazard concern we are able to study, though we note that these equilibrium relationships are shaped by both supply and demand factors.

Table 4: Effectiveness of Expanded Utilization in the State-Level Equilibrium

Outcome	Contraceptives Use	Neonatal Demise
	(1)	(2)
Elective Abortion Rate	0.121	-0.037***
	(1.530)	(0.013)
Constant	33.705***	0.289***
	(1.324)	(0.016)
Year FEs	X	X
Number of Obs.	149	144
Number of States	50	50

The second aspect of the efficiency of greater access to elective abortion is the conjecture that it may reduce risky pregnancies. In this respect, we can study whether the marginal abortion is of higher risk as captured by neonatal demise. In column 2 of Table 4, we regress state-level rates of neonatal demise on rates of elective abortions. The results reveal a negative relationship, consistent with the hypothesis that increased access could reduce the incidence of pregnancies that would otherwise conclude in an adverse outcome.

6. Effectiveness: Policy levers

We first consider whether access is primarily moderated by state or local policies and contexts, and then how the type of abortion and availability of insurance matter. We provide an analysis of the degree of variation in elective abortion rates that can be explained by the state, and then the incremental amount that can be explained by the county. In Table 5, we run a regression of annual county elective abortion rates in 2023-25 on a set of state fixed effects in column 1, and we then use a finer set of county fixed effects in column 2. In both columns, standard errors are clustered at the county level and regressions are weighted by the size of the denominator in the county-year. Given data disclosure rules, we analyze the top 1,000 counties in terms of the denominator, since these have sufficient counts for these rate outcomes.[4]

The findings are quite surprising in face of the policy discussion's emphasis on state-level regulation. States are the natural unit of focus since they are in charge of reproductive health policies post-Dobbs. Indeed, column 1 of Table 5 shows that states can explain 44% of the variation. However, in column 2, we see that cross-county within-state variation has an incremental share of explanatory power that is just as large (as county fixed effect absorb 86% of the variation). In terms of policy targeting, the results suggest that interventions at a more localized level could be just as effective as state-level policies in regulating access to reproductive health services.

A natural follow-on question is then how to reach more effectively a wider set of localities. Some prior research has studied the effects of physical clinics that offer reproductive services, and more recent discussions emphasize the potential reach of medication abortion that

[4] Data on outcomes are not reported for cells with less than 10 counts of a given procedure or diagnosis.

in combination with telemedicine could offer more effective solutions to access-based policies. This leads to our second investigation in the context of geographic access, where we are interested in analyzing whether expansions in elective abortions materialize via medication abortions on the margin. In such a case, access to medication abortion could be an effective lever for policies that aim to regulate access to reproductive services.

To do so, we study the equilibrium relationship between the share of medication abortion out of elective abortions and the rate of elective abortions. We investigate the potential efficacy of regulations at different levels by studying state-level observations (in column 3 of Table 5) and county-level observations (in column 4 of Table 5), where in the latter we include state fixed effects to focus on the within-state variation. At both levels of location, we see a strong correlation, implying that medication-based abortion is the marginal elective abortion both across states and across localities within states.

Table 5: Degree of Locality in Reproductive Outcomes in 2023-2025

	Explanatory Power of Localities in Spatial Differences in Elective Abortion Rate		Share of Medication Abortion out of All Elective Abortions	
	State Level	County Level	State Level	County Level
	(1)	(2)	(3)	(4)
Adjusted R-Squared	0.4377	0.8616		
F-Test for County FEs		35.37		
Elective Abortion Rate			12.96	5.12
			(1.77)	(1.21)
State FEs	X			X
County FEs		X		
Year FEs	X	X	X	X
Number of Obs.	1,994	1,994	141	1,641
Number of Clusters	749	749	48	639

Finally, we assess the potential effectiveness of price-based regulations via the scope of insurance coverage of reproductive services. We simply investigate the primary payer for electives abortions. The key importance of the analysis that we provide here is that the data cover over 50 percent of the US population, which to the best of our knowledge provides the widest analysis of payers for reproductive health services in the country than has been feasible to conduct so far.

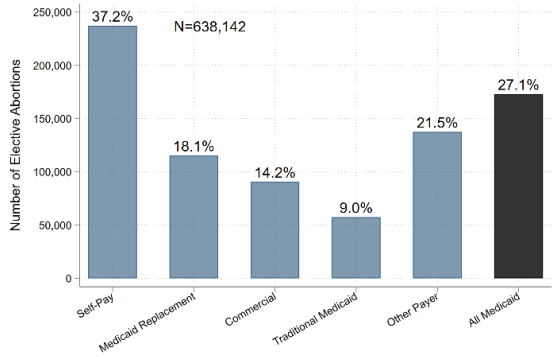
We first look at the distribution of payers of all abortions in the data in years 2023-2025 (in panel A of Figure 8). The data include 638,142 procedures related to elective abortions,[5]

[5] We include the following codes for induced abortion procedures (either medical or surgical): 59840 "Induced abortion - dilation and curettage," 59841 "Induced abortion - dilation and evacuation," 59850 "Induced abortion -

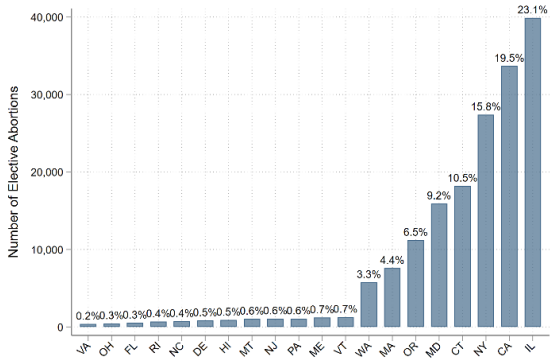
where most are self-paid (37.2%). The single largest primary payer class is Medicaid, which pays for 27.1% of all abortions (9% via "Traditional Medicaid" and 18.1% via "Medicaid Replacement" which include non-fee-for-service plans). The share paid by the commercial market is meaningfully lower at 14.2%. In panel B of Figure 8, we look at the total abortion-related procedures paid by Medicaid, and present the share paid by specific states' Medicaid programs, including the top 20 paying states. The figure illustrates the massive variation and that most Medicaid expenses related to elective abortions are driven by a subset of states. In panel C, we investigate again the gradient in economic disadvantage, where we split states by whether they use their own funds to cover abortions for Medicaid enrollees beyond the federal Hyde Amendment restrictions (which cover cases of life endangerment, rape, or incest). We find that abortion rates are higher in states that finance abortion services through Medicaid than in those that do not, and that the gap across these two types of states grows along with local disadvantage. The pivotal role of state Medicaid in financing abortion services is indicative of high potential effectiveness of priced-based regulations (i.e., subsidies and coverage) in governing access to reproductive health services around the county.

Figure 8: Payers of Elective Abortions in Years 2023-2025

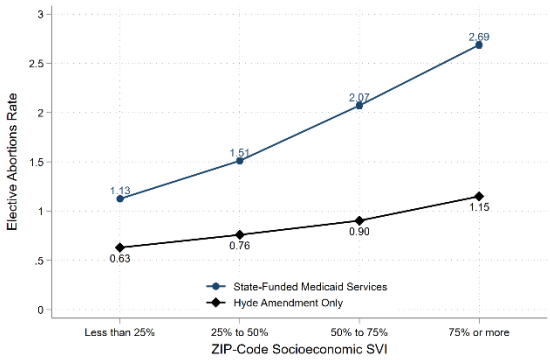
A. Distribution of Payers



B. Distribution of Medicaid Paid Abortions



C. State Medicaid Coverage and Economic Disadvatange



amniotic injection with evacuation," S0199 "Medical abortion - mifepristone regimen," S2260 "Induced abortion - 17 to 24 weeks," S2265 "Induced abortion - 25 to 28 weeks," S2266 "Induced abortion - 29 to 31 weeks," and 01966 "Anesthesia for induced abortion."

7. Conclusion

We provide new evidence on equity and efficiency considerations in post-Dobbs reproductive health in the US, using a nationwide Electronic Health Records (EHR) dataset that covers more than 50 percent of women of childbearing age. On equity, we find considerably greater rates of abortion rates among Black and Hispanic women compared to White women, as well as elevated risk of neonatal demise among Black women. We additionally show that elective abortions and neonatal demise events are meaningfully larger in locations with greater economic disadvantage. On efficiency, we find no evidence of the moral hazard concern that observed higher elective abortions rates may "compensate" for lower contraceptive use, and that higher elective abortion rates are strongly negatively correlated with the incidence of neonatal demise. We also find that both state level and county level variations are important in explaining the spatial differences, so that interventions at both levels could by just as effective; and we show that the marginal abortion is medication-based, highlighting its potential effectiveness for policies that target access. Finally, we show that Medicaid plays a pivotal role in elective abortions, which additionally emphasizes the potential strength of price-based regulations (via copays and insurance coverage) in governing access to reproductive services across the country. The nuanced landscape requires nuanced policies, which should carefully balance between maintaining autonomy, respecting preferences, assuring access to variety of services and options, and medical safety. The results of this work aim to provide objective, data-based inputs into that discussion.

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