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

Julie Cullen, *University of California, San Diego and NBER*

Itzik Fadlon, *University of California, San Diego and NBER*

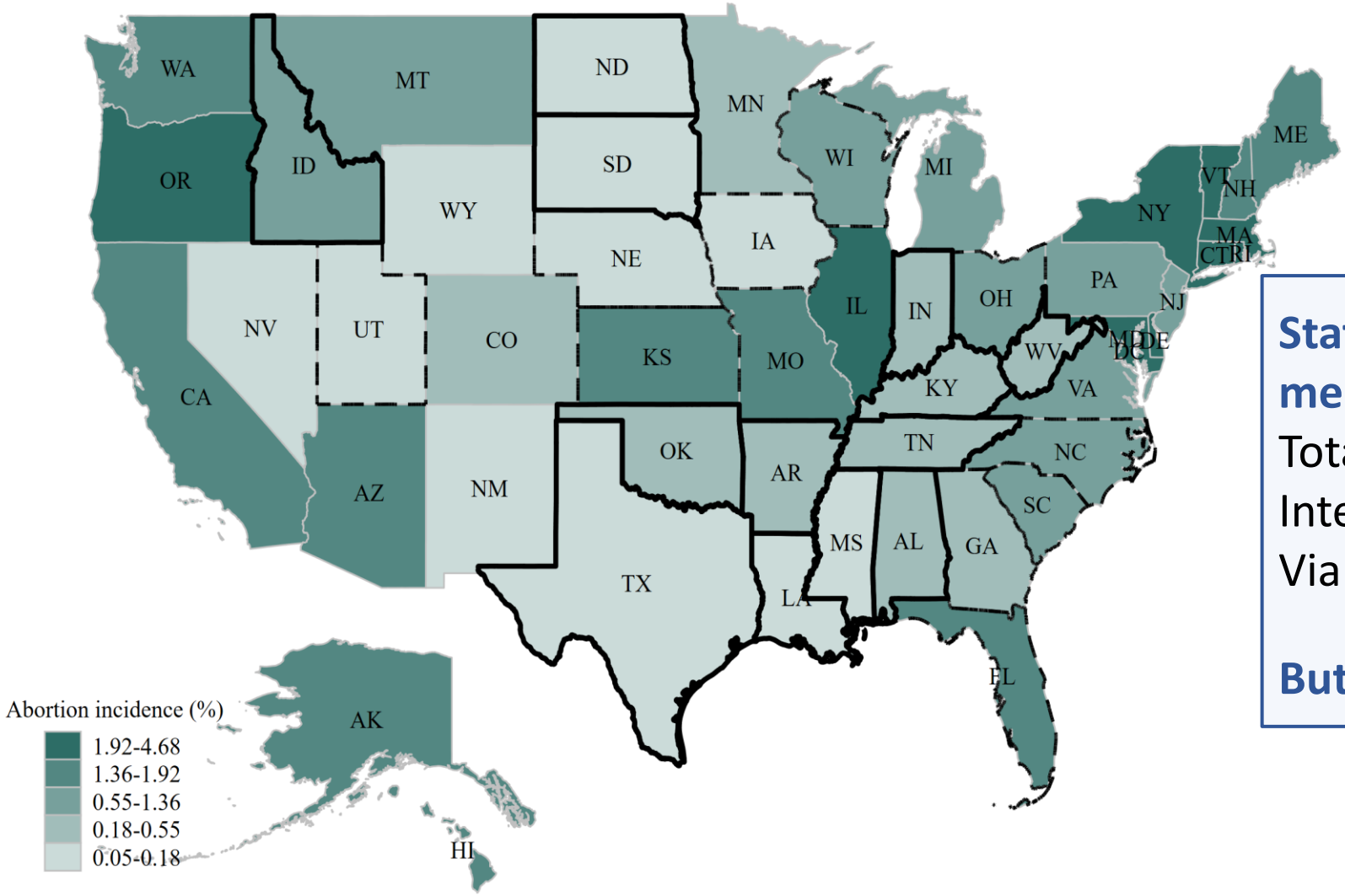
Access, Equity, and Efficiency After Dobbs

- The Supreme Court's ruling in Dobbs v. Jackson in June 2022 returned abortion regulation to states
  - Prompting a rapidly evolving set of state-level regulations and bans
  - Leading to concerns about women's access to and use of reproductive health services across the country
- The economic questions in the debate concern effective access, unequal reproductive-health burdens, and possible behavioral inefficiencies
- In this paper, we use nationwide electronic health records (EHRs) for 34.85 million female patients ages 15-44 in 2024-2025 to:
  - Link clinical pre- and post-pregnancy reproductive health outcomes to geography, demographics, neighborhood vulnerability, and payer, including self-pay
  - Study legal, geographic, technological, and financial margins of access; inequities in adverse outcomes; and ex ante moral hazard behavioral responses

Access: Variation in Abortion Rates

- Jurisdiction
- Medication Abortion
- Public Insurance Coverage

Geographic Variation in Abortion Rates



Mean: 1.17
SD: 1.05

State policy is a powerful measure of access

Total ban: 0.30

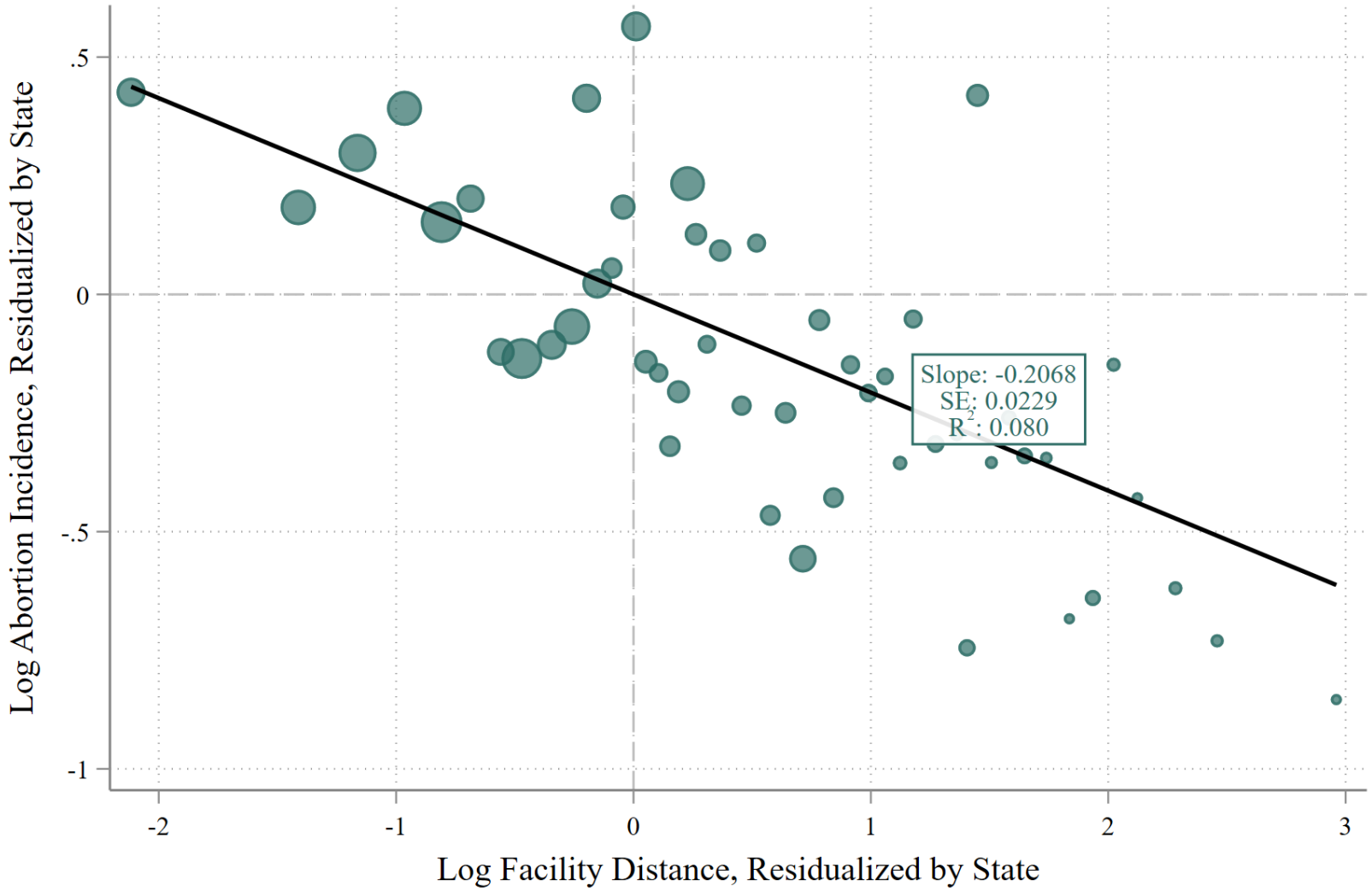
Intermediate: 0.75

Viability/no limit: 1.72 **(5.7x)**

But it is incomplete →

Policy overlay: thick black = total ban; dashed black = intermediate; no extra border = viability/no limit.

Local Access Within States

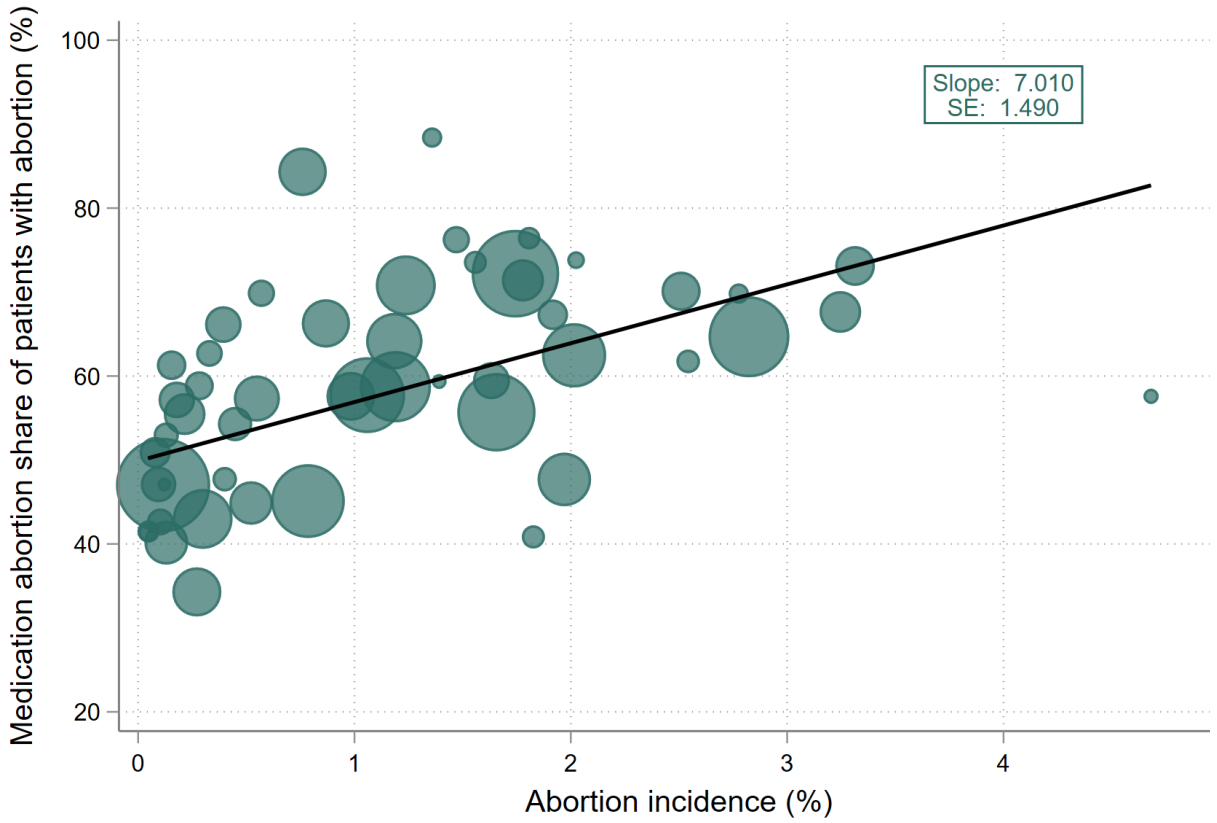


69% of cross-county variation remains with state fixed effects

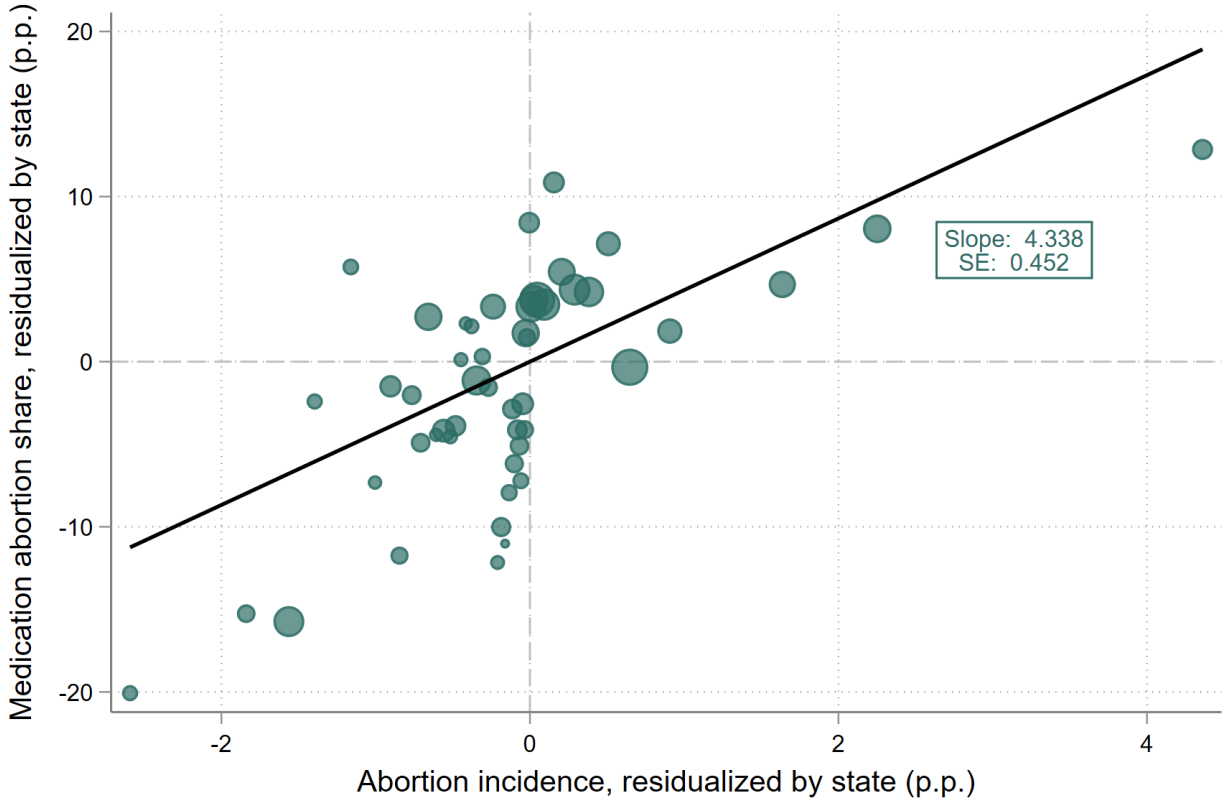
Strong association with distance to nearest abortion provider, but can explain only 8%

Medication Abortion Is the Marginal Mode

Across states



Across counties within states

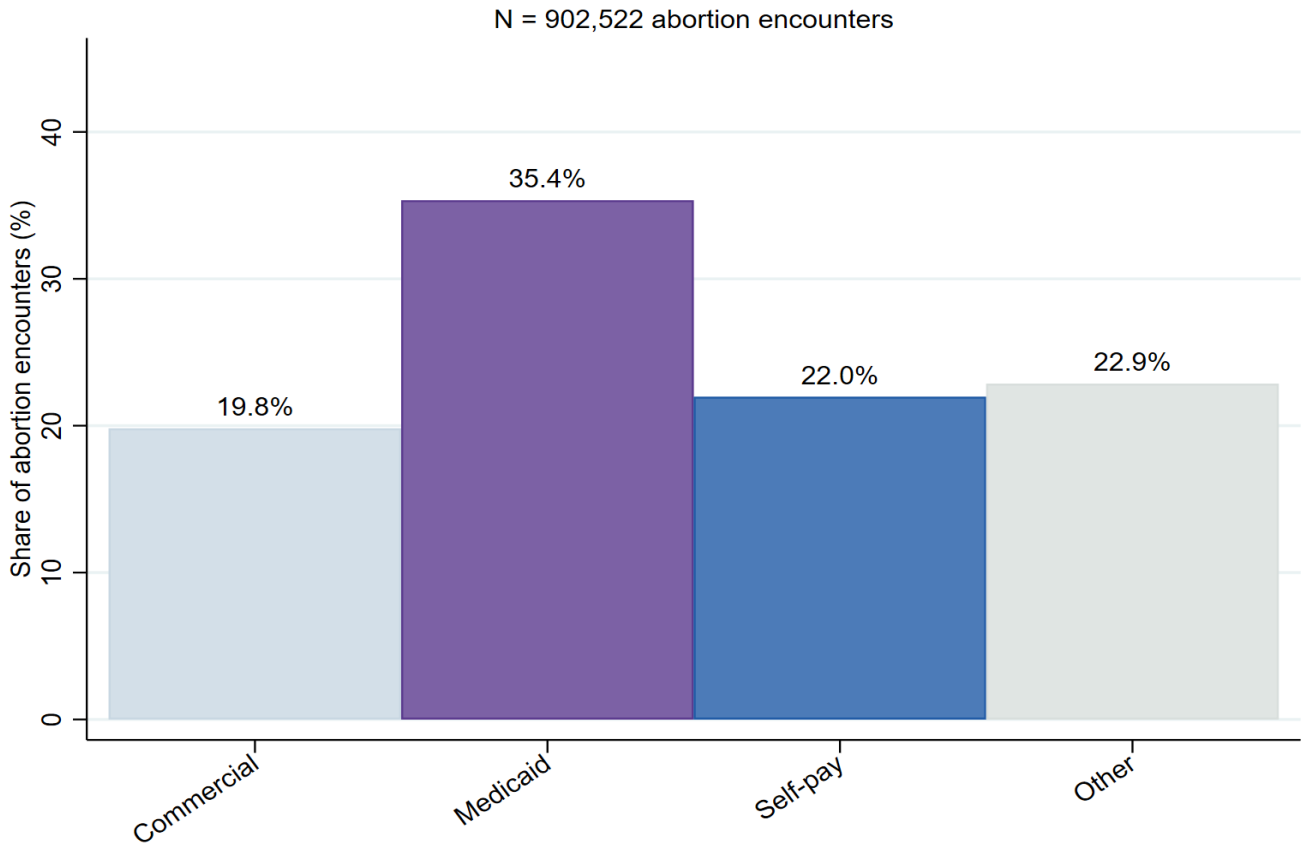


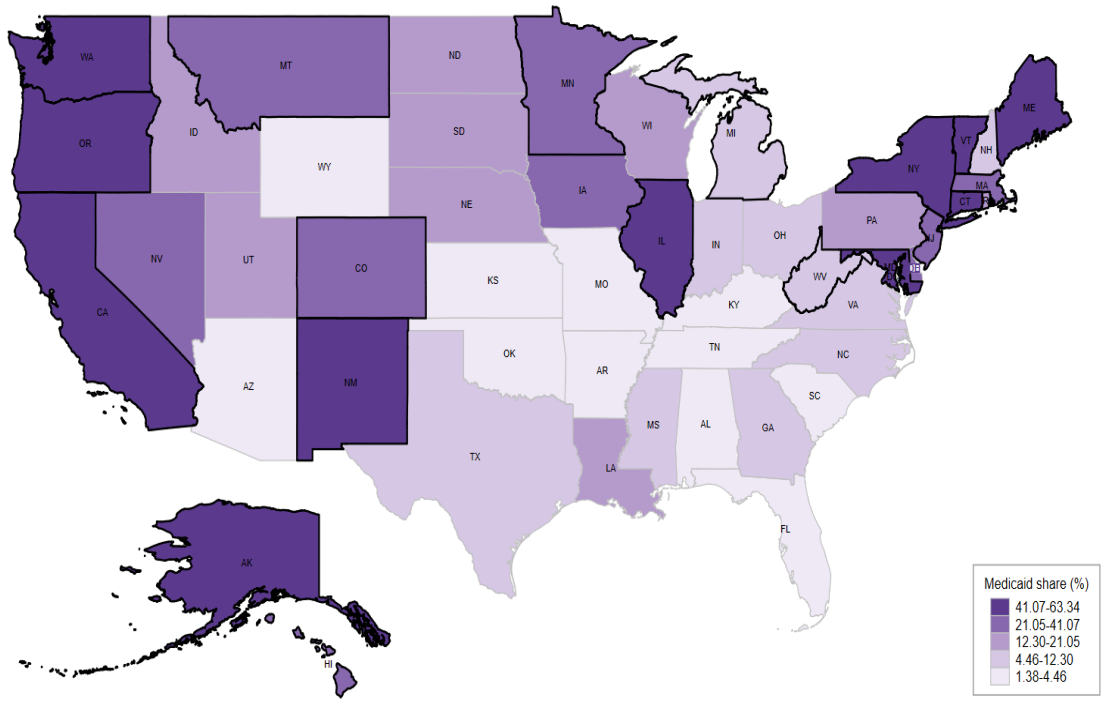
Underscores the potential role of telehealth in moderating access

Public Financing Shapes Who Pays

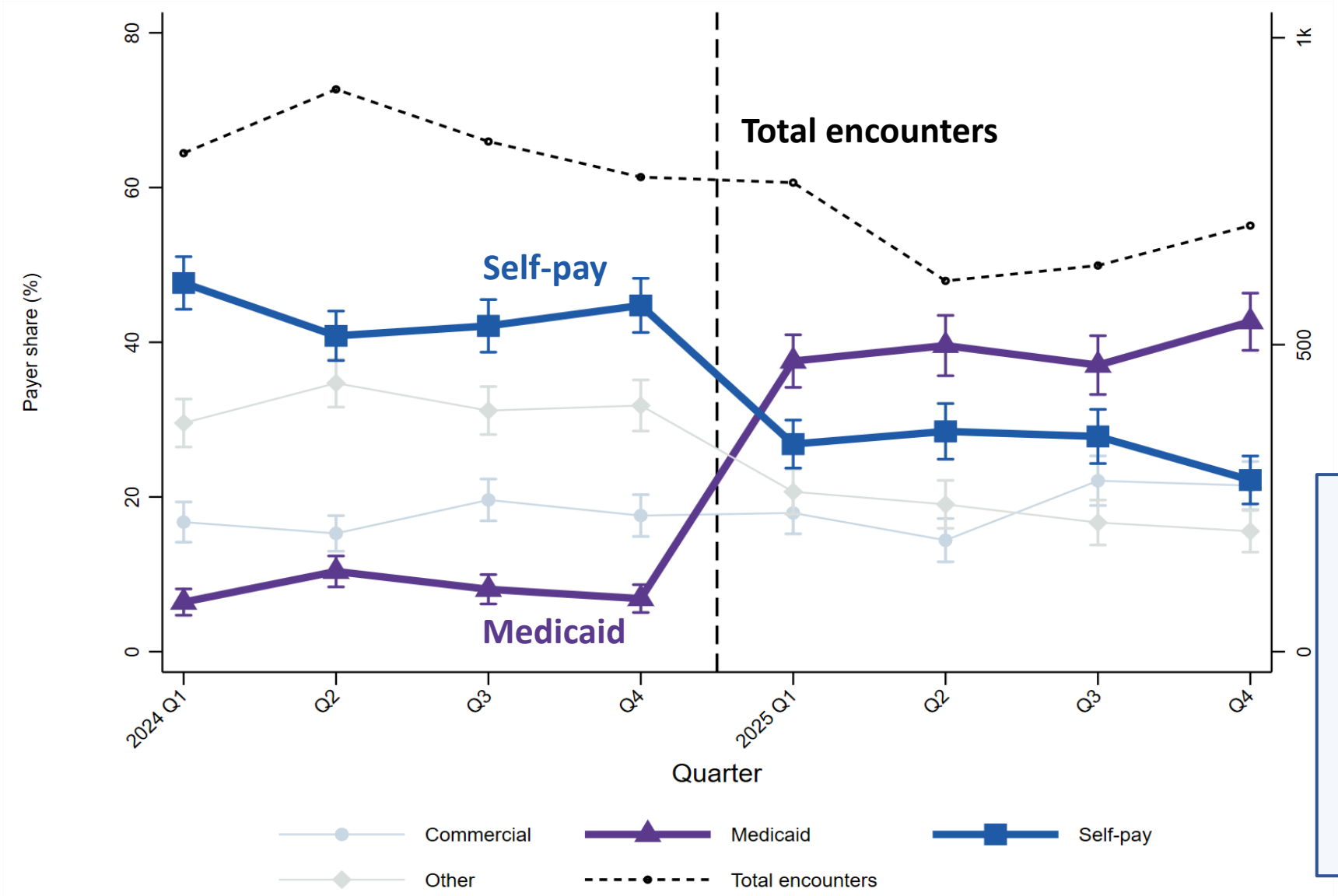
Medicaid is largest national payer (35.4%)

Medicaid share: 38% in funding versus 10% in non-funding states

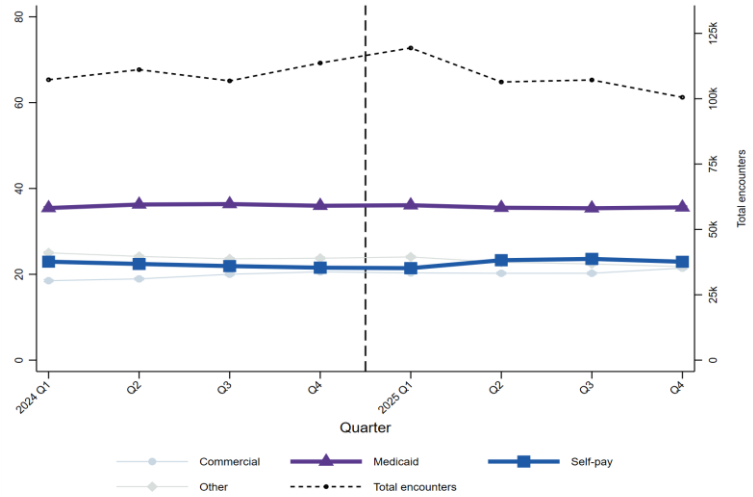




Delaware: Coverage Shifted Who Pays



All other states

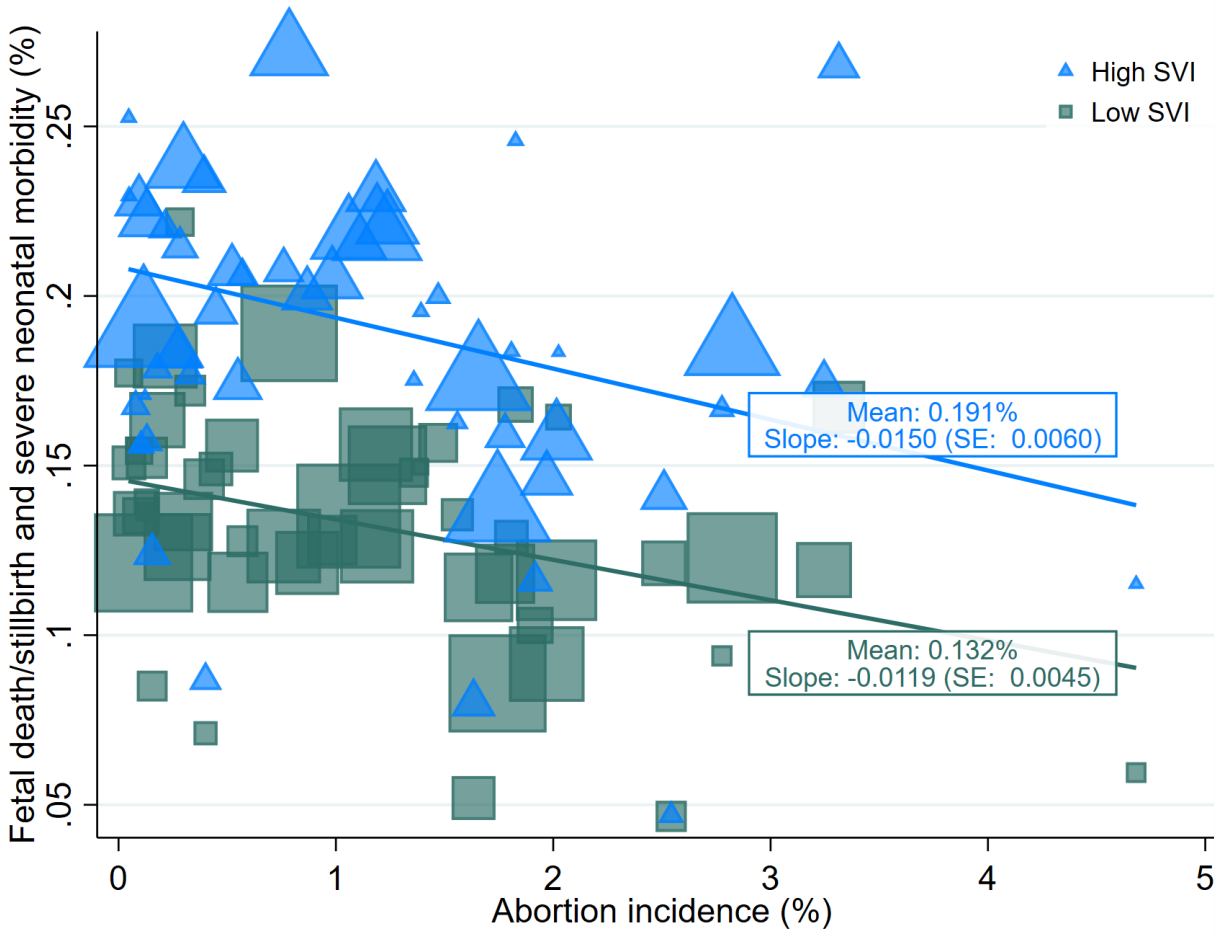


Medicaid share rose from 7% to 38%

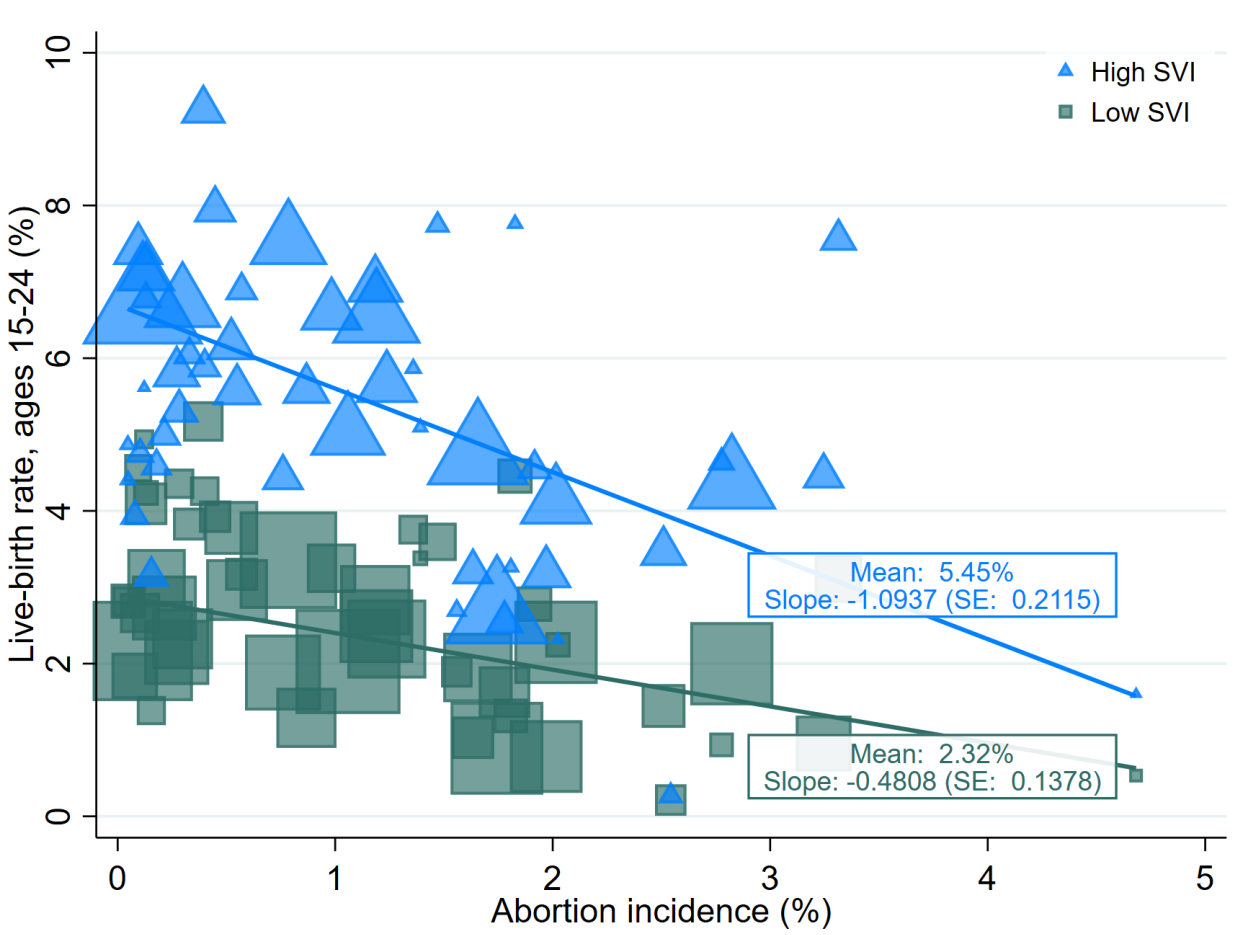
Financing shifted, but total abortion encounters did not increase

Access and Adverse Outcomes by SVI

Fetal/neonatal mortality or morbidity

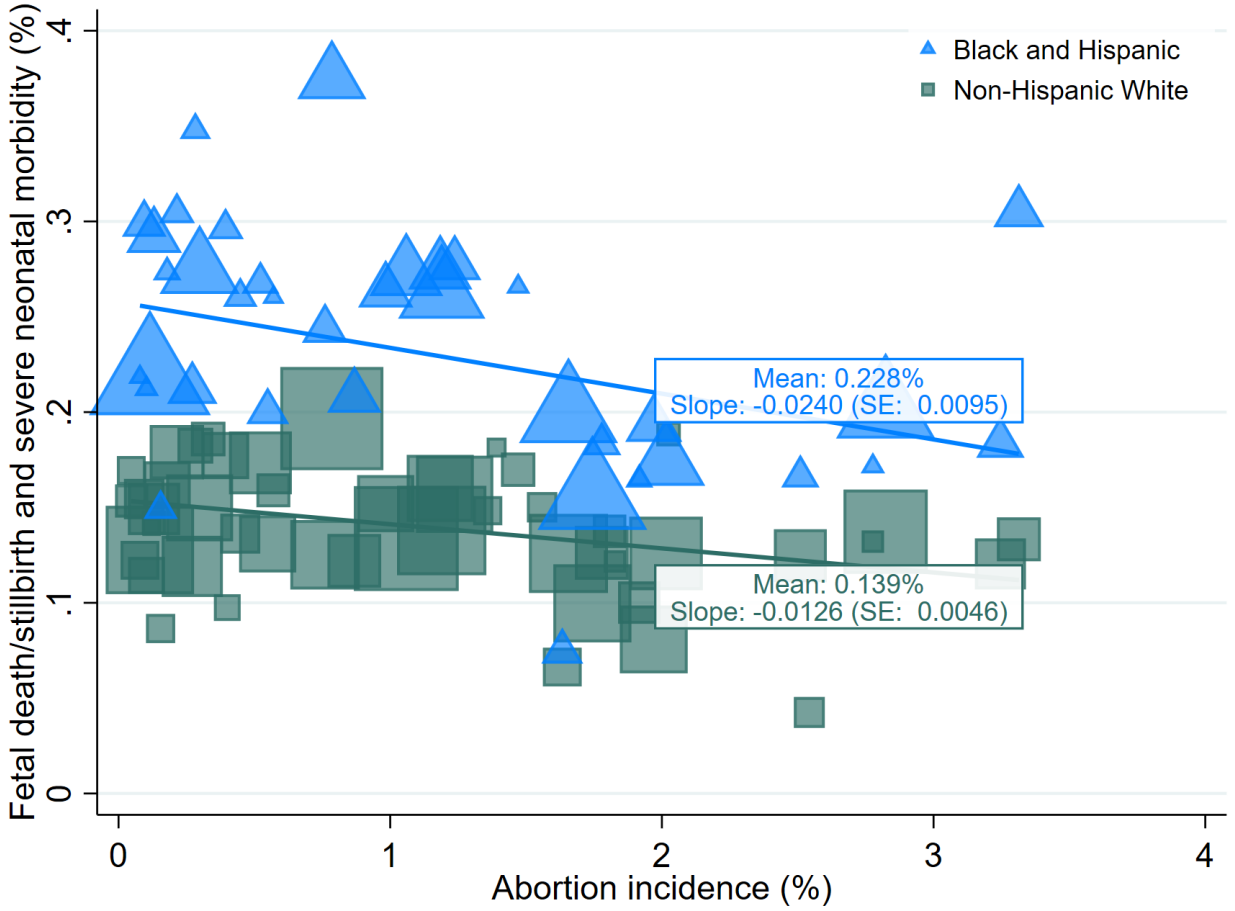


Births ages 15-24

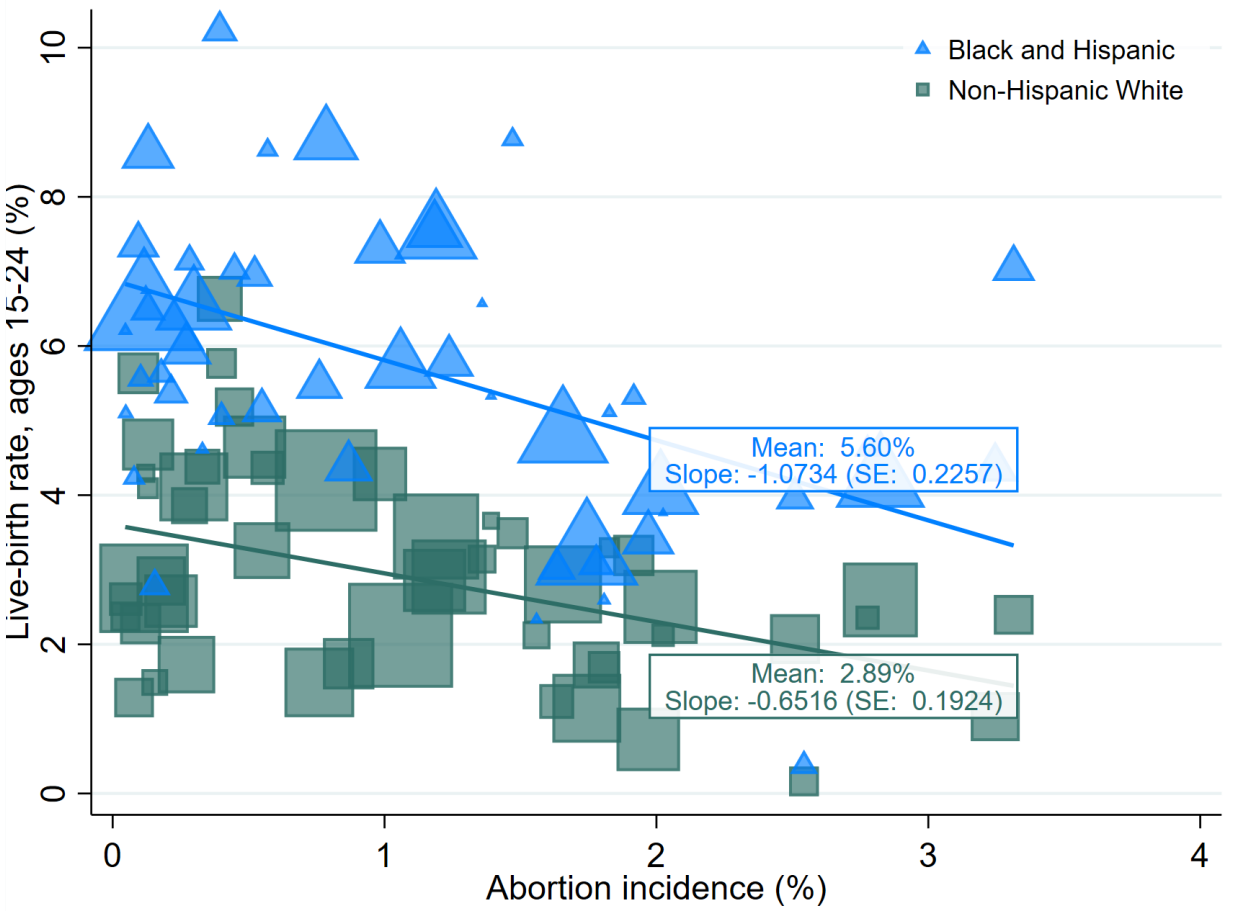


Access and Adverse Outcomes by Race/Ethnicity

Fetal/neonatal mortality or morbidity



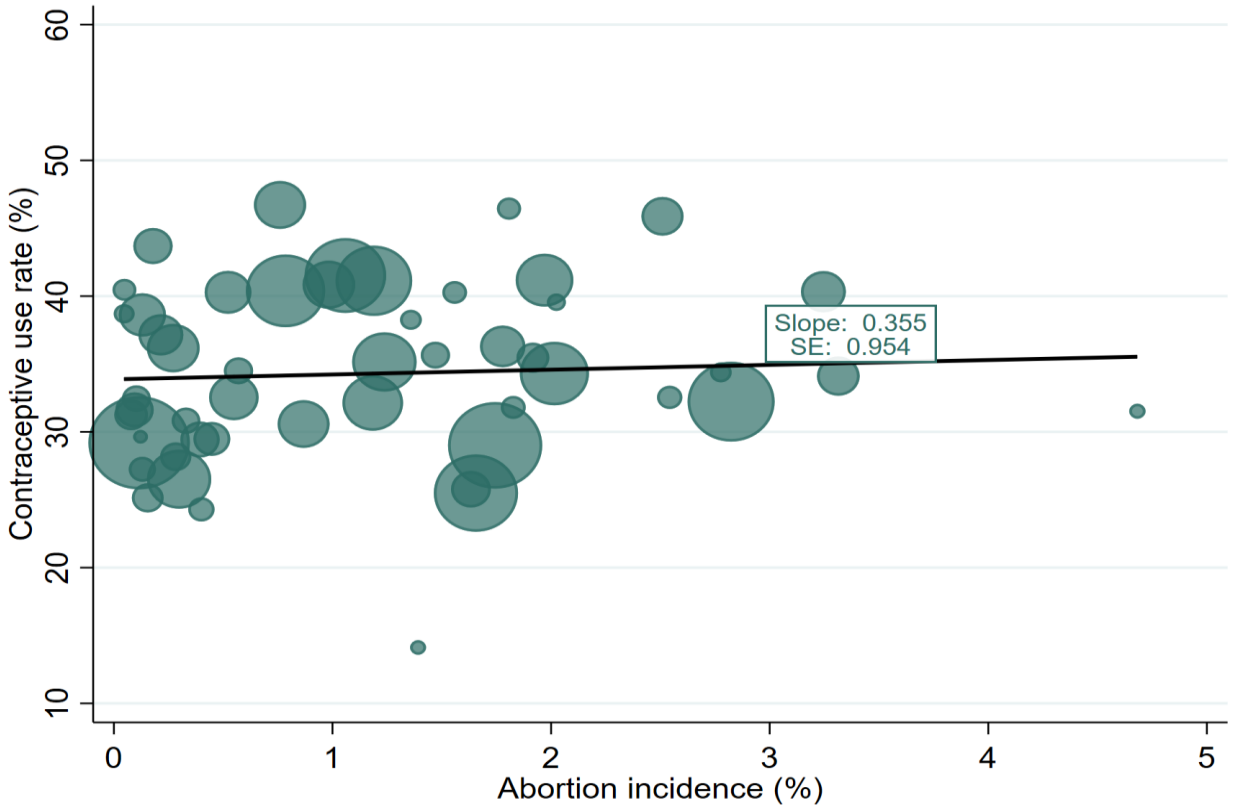
Births ages 15-24



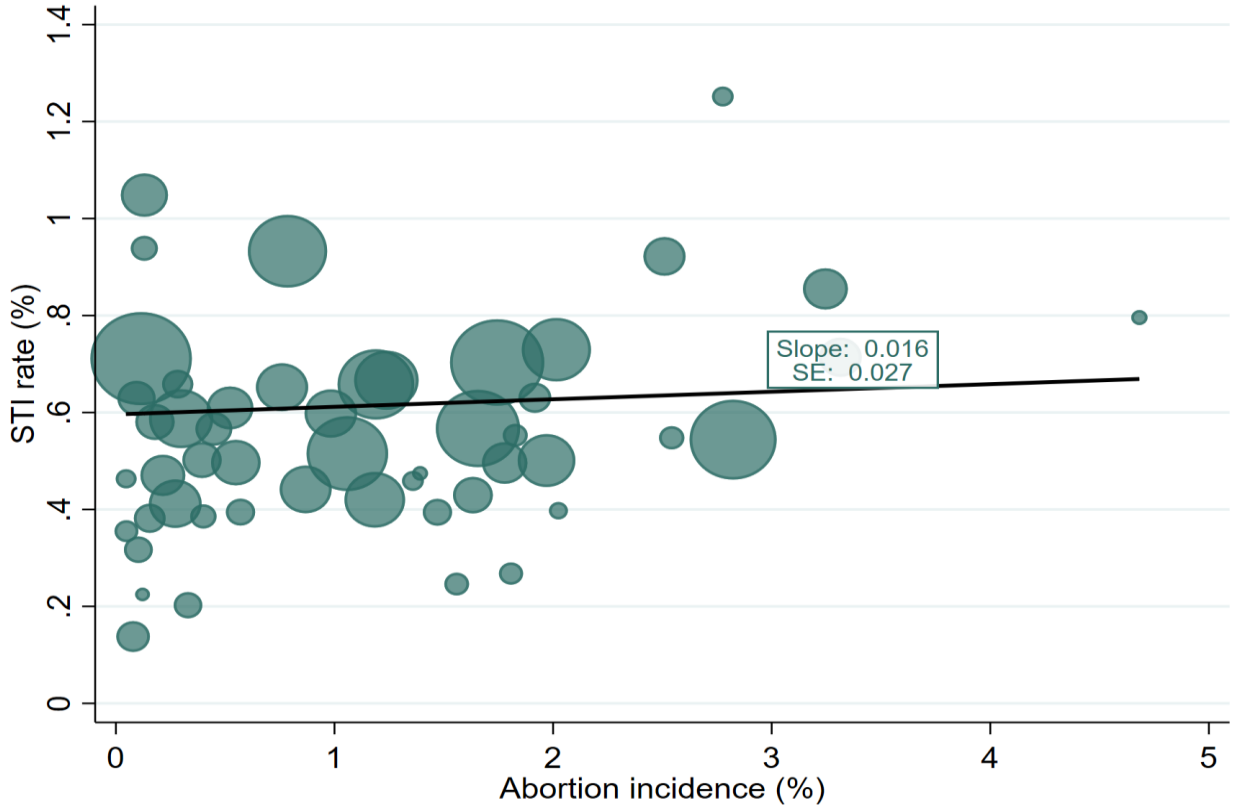
Consistent with greater access reducing risk, while also narrowing existing disparities

No Evidence of Ex Ante Moral Hazard

Contraceptive use



STI diagnoses (chlamydia, gonorrhea)



No support for weaker pregnancy prevention or riskier sexual behavior

Summary: From Legal Status to Effective Access

Access:	State policy establishes the legal environment, while provider proximity, medication abortion, and public financing shape realized access
Equity:	Disadvantaged populations face greater reproductive-health burdens, which decline as abortion incidence rises
Efficiency:	Broader coverage reduces financial burden without increasing abortions, weakening prevention, or encouraging riskier behavior

Effective access is jointly shaped by geography, technology, and financing, with no evidence of offsetting behavioral inefficiencies