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The Economic Impact of State Restrictions on Abortion: Parental Consent and Notification Laws and Medicaid Funding Restrictions

Deborah Haas-Wilson

More than six million women in the United States, or 11 percent of women of reproductive age, become pregnant each year. More than half of these pregnancies, or approximately 3.4 million, are unintended, and 1.6 million of the unintended pregnancies are terminated through abortion [Gold, 1990]. For teenagers the problem of unintended pregnancies is even more evident. By age 20, approximately 40 percent of all teenage women (63 percent of black teenage women) have been pregnant. Of these pregnancies, approximately 84 percent were unplanned [Department of Health and Human Services, 1990].

Despite the prevalence of unintended pregnancies and the large number of women who choose to have abortions, very little is known about the determinants of access to abortion services. This is quite surprising given that previous research has suggested that access to abortion services has a significant impact on infants' health [Joyce and Grossman, 1990; Corman, Joyce, and Grossman, 1987; Grossman and Jacobowitz, 1981; Joyce, 1987; Grossman and Joyce, 1990], and the timing of abortion during the pregnancy (which is a function of the cost of abortions, access to abortion services, and other factors) has a significant impact on women's health [Gold, 1990].

In 1973 the United States Supreme Court ruled in *Roe v. Wade* (410 U.S. 113) that a right of personal privacy exists under the Constitution, and this right includes a woman's decision whether or not to terminate her pregnancy. However, the Court also ruled that the right of personal privacy is not unqualified and must be considered against state interests in regulation. The Court's decision did not end the controversy over abortion and did not require either the states or the medical community to provide abortion services. Thus, state-legislative support for liberalized abortion policies, the availability of abortion providers, and actual abortion rates vary widely across states. For example, North Dakota enacted 15 abortion restrictions between 1973 and

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1989,¹ while Connecticut and Alaska did not enact any restrictions [Halva-Neubauer, 1990]. In Delaware and Hawaii, all counties had clinics or hospitals that provided abortion services, while in Nebraska only two out of the 93 counties had abortion providers in 1988. Actual abortion rates varied from five abortions per 1000 women of child-bearing age (15 to 44) in Wyoming to 46 abortions per 1000 women aged 15 to 44 in California [Henshaw and Van Vort, 1990].

This article uses national data to examine the impact of three state abortion restrictions on access to and use of abortion services. Table 1 shows that the three major enforceable restrictions as of 1988 (prior to the Supreme Court's 1989 *Webster* decision) were state restrictions on Medicaid financing of abortions for low-income women (36 states), state requirements for parental consent or parental notification for minors to obtain abortions (11 states), and state restrictions on insurance coverage of abortion for public employees (8 states).²

Parental notification or consent laws require an unmarried minor to notify or obtain the consent of her parent(s) or a judge.³ The judicial bypass permits the minor to petition a judge to authorize the abortion without parental involvement.

The impact of state abortion restrictions on access to abortion is becoming an increasingly important policy issue as the number and types of restrictions that can be enforced in the United States is increasing rapidly. In *Webster v. Reproductive Health Services*, 109 S. Ct. 3040 [1989], the Supreme Court upheld a Missouri law banning abortions in public hospitals and the involvement of public employees in the performance of abortions. The Court's *Webster* decision also added another type of restriction that states are permitted to enforce: mandatory testing for viability after a specified point in the pregnancy.

Then in *Planned Parenthood of Southeastern Pennsylvania v. Robert P. Casey* 112 S. Ct. 2791 [1992], the Supreme Court ruled that state restrictions generally would be upheld unless the restrictions place "an undue burden" on women seeking abortions. As a result of this decision, states can enforce the restrictions of a 24-hour waiting period and a state-prescribed talk on abortion for women seeking abortions.

The number and types of abortion restrictions that have recently been considered by state legislatures is large. As of February 22, 1991 (barely two months into the 1991 legislative year), 135 bills restricting access to abortions had been introduced in 33 state legislatures. These bills included 20 that would make abortion illegal in most cases, 34 that would mandate parental

¹ Many of the restrictions enacted in North Dakota, such as spousal notification requirements, have been found to be inconsistent with *Roe* and have been struck down by the courts.

² Although states have continued to legislate extensively on the issue of abortion, most states attempts to restrict abortion have been found to be inconsistent with *Roe vs. Wade* and have thus been struck down by the courts. Restrictions struck down by the courts have included provisions that require spousal notification and that require all abortions after the first trimester to be performed in hospitals, even when there is no medical reason for doing so.

³ As of August 1992, 17 states were enforcing parental consent or notification laws [Ms. Ann Kolker, National Women's Law Center]. In addition, laws in Connecticut and Wisconsin require that the abortion provider counsel and encourage the minor to notify a parent or other adult family member. In Maine the law requires consent of one parent or other adult family member or counseling of the minor [Greenberger and Connor, 1991].

Table 1. Abortion regulation by state.

State	Medicaid funding restriction—1988	Parental notification law—1988	Parental consent law—1988	Insurance restriction
Alabama	Yes	—	Yes	—
Alaska	—	—	—	—
Arizona	Yes	—	—	—
Arkansas	Yes	—	—	—
California	—	—	—	—
Colorado	Yes	—	—	—
Connecticut	—	—	—	—
Delaware	Yes	—	—	—
DC	—	—	—	—
Florida	Yes	—	—	—
Georgia	Yes	—	—	—
Hawaii	—	—	—	—
Idaho	Yes	—	—	Yes
Illinois	Yes	—	—	Yes
Indiana	Yes	—	Yes	—
Iowa	Yes	—	—	—
Kansas	Yes	—	—	—
Kentucky	Yes	—	—	Yes
Louisiana	Yes	—	Yes	—
Maine	Yes	—	—	—
Maryland	—	—	—	—
Massachusetts	—	—	Yes	Yes
Michigan	—	—	—	—
Minnesota	Yes	Yes	—	—
Mississippi	Yes	—	—	—
Missouri	Yes	—	Yes	—
Montana	Yes	—	—	—
Nebraska	Yes	—	—	Yes
Nevada	Yes	—	—	—
New Hampshire	Yes	—	—	—
New Jersey	—	—	—	—
New Mexico	Yes	—	—	—
New York	—	—	—	—
North Carolina	—	—	—	—
North Dakota	Yes	—	Yes	Yes
Ohio	Yes	Yes	—	—
Oklahoma	Yes	—	—	—
Oregon	—	—	—	—
Pennsylvania	Yes	—	—	Yes
Rhode Island	Yes	—	Yes	Yes
South Carolina	Yes	—	—	—
South Dakota	Yes	—	—	—
Tennessee	Yes	—	—	—
Texas	Yes	—	—	—
Utah	Yes	Yes	—	—
Vermont	—	—	—	—
Virginia	Yes	—	—	—
Washington	—	—	—	—
West Virginia	—	Yes	—	—
Wisconsin	Yes	—	—	—
Wyoming	Yes	—	—	—

Sources: Gold and Guarado (1988); Bush (1983); Greenberger and Connor [1991].

consent or notification for a minor's abortion, 20 that would specify a detailed "informed consent" process, 16 that would restrict funding for abortion services for low-income women or restrict the use of state employees and facilities, 8 that deal with clinic licensing and regulations, 7 that would limit insurance coverage, 4 that would restrict abortion after fetal viability, 2 that would forbid abortion based on the sex of the fetus, and 2 that would require spousal/partner notification [Alan Guttmacher Institute, 1991].

BACKGROUND

Previous research has shown that the Medicaid funding restriction decreases women's use of abortion services [Trussell, Menken, Lindheim, and Vaughan, 1980; Singh, 1986; Medoff, 1988; Garbacz, 1990; Lundberg and Plotnick, 1990].⁴ This is not surprising since restrictions on Medicaid funding for abortions increase the costs of abortion services for low-income women and thus, *ceteris paribus*, reduce the use of abortion services by low-income women.⁵

Other empirical evidence, however, suggests that abortion restrictions do not have a significant impact on abortion rates. Johnson and Bond [1980] found that 17 restrictions, including requirements for spousal or parental consent, requirements for consultations by more than one doctor, and facility requirements, had a statistically insignificant impact on the number of abortions per 1000 live births in each state in 1976. Hansen [1990] found that such restrictions as requirements for fetal viability tests and prohibitions on the use of public facilities and public employees had a statistically insignificant impact on abortion rates in 1988. Lundberg and Plotnick [1990] found that the restrictiveness of the state's abortion laws had a statistically insignificant impact on the probability of teenagers obtaining an abortion.

However, case studies in individual states suggest that parental consent and notification laws reduce minors' abortion rates within those states. Donovan [1983] reported that the number of abortions obtained by minors decreased by 33 percent (from 2327 to 1565) in Minnesota between 1980, the last full year without a notification law, and 1982, the first full year during which the notification law was in effect. The results of Cartoof and Klerman [1986]

⁴ Trussell, Menken, Lindheim, and Vaughan [1980] estimated that 23 percent of Medicaid-eligible women in Ohio and 18 percent in Georgia who would have obtained an abortion in 1977, before the cutoff of Medicaid funding, did not do so in 1978. Singh [1986] showed that for teenagers, the availability of Medicaid funds increased abortion rates. Medoff [1988] and Garbacz [1990] found that the availability of state Medicaid funding had a positive and statistically significant impact on abortion rates in 1980 and 1982, respectively. Lundberg and Plotnick [1990] showed that white women aged 14–16 in 1979 were less likely to abort in states that restricted Medicaid funding of abortions.

⁵ However, in states that restrict Medicaid funding, reduced-cost abortions may still be available to some low-income women. Prior to *Webster*, large metropolitan public hospitals still provide reduced-cost abortions for their low-income patient populations [Gold and Cates, 1979]. Further, abortion clinics adopt a variety of policies to reduce the costs of abortion for those women unable to pay the full price. For example, National Abortion Federation (NAF) members are required to "have policies to accommodate low-income women," and "specific financial arrangements," available to a "minimum of ten percent of the patient load," are strongly recommended. Planned Parenthood Federation of America (PPFA) has the Justice Fund for the purpose of helping low-income women afford abortions [Brief of the NAF and PPFA in *Turnock v. Ragsdale*, 1989].

suggest that the major impact of the Massachusetts parental consent law was to increase the number of minors crossing state lines to obtain an abortion.

This is not surprising, since parental notification and consent laws for minors increase the psychological costs of abortion for some minors and may increase the monetary costs for those using the judicial bypass procedure. Justice Marshall wrote in *Hodgson v. Minnesota* [1990], "a notification requirement can also have severe physical and psychological effects on a young woman. First, forced notification of one parent, like forced notification of both parents, can be extremely traumatic for a young woman, depending on the nature of her relationship with her parents. The disclosure of a daughter's intention to have an abortion often leads to a family crisis, characterized by severe parental anger and rejection. The impact of any notification requirement is especially devastating for minors who live in fear of physical, psychological, or sexual abuse."

On the additional monetary costs of the judicial bypass procedure, Justice Marshall wrote, "Furthermore, in several counties in Minnesota, no judge is willing to hear bypass petitions, forcing women in those areas to travel long distances to obtain a hearing. . . . The burden of such travel, often requiring an overnight stay in a distant city, is particularly heavy for poor women from rural areas."

Although research suggests that the consent and notification laws affect abortion rates for minors and the Medicaid funding restriction affects abortion rates for low-income women, very little is known about the effect of abortion restrictions on abortion providers. For example, do state restrictions decrease the willingness of abortion providers to locate in more restrictive states? Do the restrictions affect the optimal size for abortion providers, which may then alter the costs of abortion services? The mean charges in 1986 for a nonhospital abortion with local anesthesia were \$306, \$266, \$223, \$211, and \$203 in facilities providing, respectively, fewer than 30 abortions, 30 to 390 abortions, 400 to 990 abortions, 1000 to 4990 abortions, and more than 5000 abortions [Henshaw, Forrest, and Van Vort, 1987]. Do the restrictions affect the type of abortion provider—hospital, clinic, or physician's office—best able to compete in the market? This may also affect the cost, since hospitals on average charge significantly more than clinics.⁶ The charge for a first trimester outpatient abortion in a hospital was \$735 (in 1982), compared to \$190 (in 1981) for a clinic abortion [Henshaw, Forrest, and Van Vort, 1987]. Do the restrictions affect an abortion provider's willingness and ability to offer free or low-cost abortions to low-income women?

If the restrictions affect providers' willingness to supply abortions in restrictive states, then those restrictions affect the ability of *all* women to obtain abortion services, not just low-income women, minors, or public employees. Reducing the availability of providers may increase the distance some women must travel in order to obtain an abortion, and thus may increase the costs of obtaining an abortion (higher travel expenses, the expenses of overnight

⁶ One could argue that altering the market share of hospitals, clinics, and physicians' offices could also affect the quality of abortion services. However, researchers at the CDC concluded that "abortions may be performed as safely in nonhospital settings as in hospitals, at least until the middle of the second trimester of pregnancy for women who are not considered to be high risk" [Gold, 1990, p. 49].

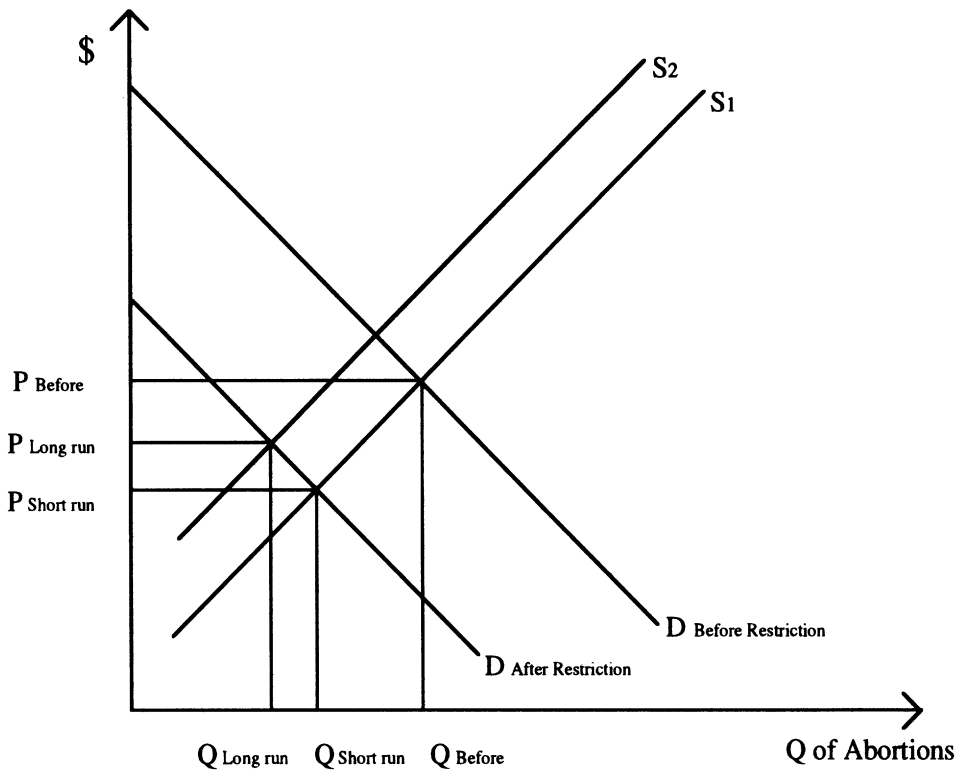


Figure 1. Potential economic impact of abortion restrictions.

lodging, the loss of pay due to absence from work). Further, lack of local abortion services makes it more difficult for women to obtain information about abortion providers, makes diagnosis and treatment of potential post-abortion complications more difficult, and may increase the risk of jeopardizing women's privacy due to longer absences from home or work. Shelton, Brann, and Schulz [1976] have shown that the farther a woman has to travel to obtain an abortion, the less likely she is to obtain one.

This article uses national data to analyze the three state abortion restrictions that were enforceable prior to the *Webster* decision in 1989—state restrictions on Medicaid financing, state restrictions on insurance coverage of abortion for public employees, and state parental consent and notification laws for minors—for their economic impacts on abortion providers' supply decisions, and thus on access to abortion services for all women. This type of analysis, however, could also be used to examine the economic impact of the additional abortion restrictions that are currently enforceable.

THE ECONOMIC IMPACT OF ABORTION RESTRICTIONS

The potential economic impacts of the three specified state abortion restrictions are shown in Figure 1. As discussed earlier, each of the three abortion restrictions has the potential to shift the market demand curve for abortions

inward. In the short run, economic theory predicts that the market price will fall ($P_{\text{short-run}}$) and the quantity of abortions demanded and supplied will decrease ($Q_{\text{short-run}}$). In the long run, economic theory predicts that abortion providers will exit the market, and thus the number of abortion providers practicing in the state will decrease. As a result, the quantity of abortions demanded and supplied will decrease further ($Q_{\text{long-run}}$).⁷

The Data and Method

The Alan Guttmacher Institute (AGI) conducts a periodic national survey of all known abortion providers. In 1986 and 1989, questionnaires were sent to hospitals, clinics, and physicians' offices known to have provided abortions. Each survey collected information for the preceding year. Abortion providers were identified through queries to the executive directors of all Planned Parenthood affiliates and state coordinators of the National Abortion Rights Action League; from lists provided by state health departments; through newspaper articles; and by checks of the telephone Yellow Pages in all U.S. cities. Follow-up letters and telephone calls enabled the AGI to obtain information on 94 percent of known providers in 1986 and 95 percent in 1989. The 1986 survey obtained information for 2680 providers that provided abortions in 1985—1191 hospitals, 837 clinics, and 652 physicians' offices. The 1989 survey obtained information for 2582 providers that provided abortions in 1988.

Data on abortion restrictions by state were obtained from several sources. Greenberger and Connor [1991] report the parental consent and notification laws for minors by state and date of enactment. Bush [1983] lists the eight states with restrictions on insurance coverage of abortions for public employees. Gold and Guardado [1988] report the eight states and the District of Columbia that voluntarily provided Medicaid funding for all medically necessary abortions for poor women in 1987, and the six states that have been ordered by their state courts to pay for all medically necessary abortions.

Data on the use of abortion services were obtained from the Center for Disease Control (CDC), including rates of legal abortions for minors in 36 states in 1988 [CDC, 1991] and rates of legal abortions for *all* women in 1987 [CDC, 1990].

Abortion rates and the availability of providers are compared across states, depending on whether or not the state has an enforceable abortion restriction. The significance of the differences between the sample means in restrictive and nonrestrictive states is tested by calculating *t*-tests. Both pooled and separate variance estimates have been calculated, along with the *F* value, to test homogeneity of variances and its significance level.

⁷ The supply curve of abortions may also shift inward due to the cost-increasing impact of the restrictions. In states with parental consent or notification laws, providers may need to provide additional counseling services to minors. For example, abortion clinics in Minnesota often provide the service of making appointments with the public defender (lawyers who represent minors seeking abortions) for its minor patients electing to use the judicial bypass procedure and often provide the service of sending a counselor to accompany the minor during the court proceedings [Donovan, 1983]. Further, in states with parental involvement laws, abortion providers are required to document that each minor has either involved her parents or obtained a court order [National Abortion Federation, 1991]. Providing these additional services and completing the required documentation increases the costs of providing abortions.

Table 2. Utilization and availability of abortion in Alabama and Colorado.

	Alabama	Colorado
Abortion providers per 10,000 women aged 15–44 per state, 1985	0.0291	0.0853
Abortion providers per 10,000 women aged 15–44 per state, 1988	0.0216	0.0733
Total abortions per 1000 births per state, 1985	261	257
Total abortions per 1000 births per state, 1988	243	233

Before discussing the results, some of the limitations of the analysis should be noted. First, state abortion policies are continually changing, and the measure of abortion restrictions used in this article looks at only one point in time. However, the results presented in Table 2 are for the two states, Alabama and Colorado, that changed their enforceable abortion restrictions between 1985 and 1988. Second, the analysis attributes differences in abortion rates and differences in abortion availability to the presence or absence of enforceable state restrictions. It is possible that the differences are actually due to other variables, such as state residents' ideological preferences, which may be associated with the presence or absence of state abortion restrictions. However, there is empirical evidence that suggests state differences in abortion policies are not explained by differences in ideological preferences. Gohman and Ohsfeld [1990] found that states with a higher percentage of Catholics or a higher percentage of population classified as fundamentalist or conservative Protestant are not more likely to have abortion restrictions. Hansen [1990] concludes that her measure of a state's political culture and her measure of the attitudes toward abortion rights by a state's political elites show no association with the state's abortion policies.

THE RESULTS

The Impact on Use of Abortion Services

Analysis of data from 36 states suggests that state parental notification and consent laws reduced both the rate of minors' abortions per 1000 women aged 15–19 in 1988 and the percentage of abortions obtained by minors in 1988 (see Table 3). In states without parental notification or consent laws, minors obtained an average of 13.22 abortions per 1000 women aged 15–19. In states *with* such laws, minors obtained an average of only 9.87 abortions per 1000 women aged 15–19. Likewise, minors obtained an average of 12 percent of the total abortions in states without notification or consent laws and only 9 percent of the total abortions in states with these laws. These differences are statistically significant at the 5 percent level using a one-tail probability test. Analysis of 1985 data from all 50 states and the District of Columbia suggests that state parental notification and consent laws also reduced the rate of minors' abortions per 1000 teenage pregnancies.

Table 3. Utilization of abortion services and availability of abortion providers in states with and without parental notification or consent laws for minors as of 1988.

	States with law (<i>n</i> = 11)	States without law (<i>n</i> = 40)
Minors' abortions per 1000 teenage pregnancies per state, 1985	320.8	382.6**
Minors' abortions per 1000 women aged 15–19, 1988 ^a	9.87	13.22**
Percentage of abortions obtained by minors, 1988 ^a	9.0%	12.0%**
Abortion providers per 10,000 women aged 15–44 per state, 1988	0.21	0.54***
Average percentage of countries per state without provider, 1988	82.0%	67.9%*
Hospitals providing abortions per 10,000 women aged 15–44 per state, 1985	0.09	0.21***
Clinics providing abortions per 10,000 women aged 15–44 per state, 1985	0.09	0.13**
Private physicians' offices providing abortions per 10,000 women aged 15–44 per state, 1985	0.06	0.23***
Percentage of large providers per state, 1985	46.7%	33.0%**
Percentage of nonhospital providers offering free or reduced cost (excluding Medicaid) abortions per state, 1985	33.6%	30.3%
Market share of hospitals, 1985	6.9%	10.2%
Market share of clinics, 1985	85.2%	63.1%***
Market share of private physicians, 1985	7.9%	24.9%***

^a Total number of states with data is 36.

* Difference is statistically significant at 10% level, 1-tail probability.

** Difference is statistically significant at 5% level, 1-tail probability.

*** Difference is statistically significant at 1% level, 1-tail probability.

Regarding the impact of restrictions on Medicaid funding, analysis of the data from 50 states suggests that the funding restriction reduced the rate of abortions per births, the rate of abortions per women of childbearing age, the rate of abortions by minors per births to teenagers, and the rate of abortions by minors per women aged 15–19 (see Table 4). In the District of Columbia and the states with Medicaid financing of abortions, women obtained an average of 370.5 abortions per 1000 births, and minors obtained an average of 433.5 abortions per 1000 births to teenagers. In the states that restrict Medicaid financing, women obtained an average of only 245.1 abortions per 1000 births, and minors obtained an average of only 215.9 abortions per 1000 births to teenagers. These differences are statistically significant at the 1 percent level, using a one-tail or a two-tail probability test.

A similar analysis of the significance of differences between states with and without restrictions on insurance coverage of abortions for public em-

Table 4. Utilization of abortion services and availability of abortion providers in states with and without medicaid funding for abortions as of 1987.

Availability measures	States with funding (<i>n</i> = 15)	States without funding (<i>n</i> = 36)
Total abortions per 1000 births per state, 1987	370.5	245.1***
Total abortions per 1000 women aged 15–44, 1987	24.1	16.4***
Minors' abortions per 1000 births to teenagers per state, 1988 ^a	433.5	215.9***
Minors' abortions per 1000 women aged 15–19, 1988 ^a	17.54	10.91***
Abortion providers per 10,000 women aged 15–44 per state, 1988	0.76	0.35***
Average percentage of counties per state without providers, 1988	41.7%	83.1%***
Hospitals providing abortions per 10,000 women aged 15–44 per state, 1985	0.31	0.14***
Clinics providing abortions per 10,000 women aged 15–44 per state, 1985	0.18	0.10**
Private physicians' offices providing abortions per 10,000 women aged 15–44 per state, 1985	0.30	0.15*
Percentage of large providers per state, 1985	30.4%	38.1%
Percentage of nonhospital providers offering free or reduced cost (excluding Medicaid) abortions per state, 1985	25.7%	33.1%**
Market share of hospitals, 1985	17.2%	6.2%***
Market share of clinics, 1985	59.8%	71.2%*
Market share of private physicians' offices, 1985	17.9%	22.6%

^a Total number of states with data is 36.

* Difference is statistically significant at 10% level, 1-tail probability.

** Difference is statistically significant at 5% level, 1-tail probability.

*** Difference is statistically significant at 1% level, 1-tail probability.

ployees was completed. State restrictions on insurance coverage of abortion for public employees do not appear to be associated with statistically significant differences in abortion rates or abortion availability; thus the results are not reported in this study.

The Impact on Abortion Providers' Location and Supply Decisions

Analysis of data from 50 states in 1988 and 1985 suggests that in states with restrictions on Medicaid funding for abortions (Table 4) and parental consent and notification laws for minors' abortions (Table 3), there are significantly fewer abortion providers than in states without those restrictions. In 1988 the average number of abortion providers per 10,000 women of childbearing age in states that provided Medicaid funding for abortions was 0.76, compared

to only 0.35 in states that restricted funding. Looking at the numbers broken down by type of abortion provider—hospital, clinic, and private practice physician's office—yields similar results. In states that restricted Medicaid funding, 83.1 percent of the counties had no abortion provider in 1988. In states that provided Medicaid funding, only 41.7 percent of the counties had no abortion provider. These differences are all statistically significant at the 1 percent level.

In 1988 the average number of abortion providers per 10,000 women of childbearing age in states without a parental consent or notification law was 0.54, compared to only 0.21 in states with such a law. Again, looking at the numbers broken down by type of provider yields similar results. In 1985 there were 0.21 hospitals, 0.13 clinics, and 0.23 private physicians' offices per 10,000 women of childbearing age in states without consent or notification laws, compared to only 0.09 hospitals, 0.09 clinics, and 0.06 private physicians' offices in states *with* the laws. All these differences are statistically significant at the 1 percent or 5 percent level.

On the issue of whether the abortion restrictions have an impact on the optimal size abortion provider⁸ the results suggest that in states with parental consent and notification laws and states that restrict Medicaid funding, a higher percentage of providers are large—that is, they provide more than 400 abortions per year. In more restrictive states there are fewer providers, and those providers are more likely to be large providers. Large providers appear better able to compete and more likely to survive in restrictive states.

It also appears that the abortion restrictions affect the ability of different types of providers to compete in the market. For example, the market share of hospitals, measured as the percent of abortions provided by hospital providers, is significantly lower in states that restrict Medicaid funding—6.2 percent, compared to 17.2 percent in states with Medicaid funding. The market share of clinics is significantly higher and the market share of physicians' offices is significantly lower in states with parental consent or notification laws. The market share of clinics is 85.2 percent in states with consent or notification laws, compared to 63.1 percent in states without such laws.

The data in Table 4 also show that a higher percentage of nonhospital abortion providers offer free or reduced cost (excluding Medicaid) abortions in states without Medicaid funding. This may be explained by differences in providers' willingness and ability to cross-subsidize—that is, charge high-income women a higher price in order to offer reduced fees or free abortions to low-income women. In states with Medicaid funding, there is less need for abortion providers to cross-subsidize.

The Impact on Use and Supply in Alabama and Colorado

Between 1985 and 1988, two states altered their enforceable abortion restrictions. Alabama enacted and began to enforce a parental consent restriction, and Colorado began to restrict the use of Medicaid funds for abortion services. The data in Table 2 provide additional support that these abortion restrictions decrease both use and availability. The ratios of abortions per births and

⁸ Optimal size does not necessarily reflect scale economies, but rather the size firm best able to meet "any and all problems the entrepreneur actually faces: strained labor relations, rapid innovation, government regulation . . ." [Stigler, 1958, p. 56].

abortion providers per women of childbearing ages decreased in both Alabama and Colorado between 1985 and 1988.

DISCUSSION

With an increasing prevalence of unplanned pregnancies and an increasing consensus that the consequences of adolescent premarital childbearing are undesirable for mother, child, and society, state legislators face an interesting dilemma over proposed abortion legislation.⁹ On the one hand, adult support and guidance may be very helpful to pregnant minors. In fact, the Supreme Court has identified several state interests to justify parental consent and notification laws—promoting family integrity or parental authority, aiding the decisionmaking of immature minors, giving parents the opportunity to provide medical information, and protecting potential life [Benshoof and Pilpel, 1986].

On the other hand, parental consent and notice requirements for minors appear to decrease the availability of abortion services—not only to minors, but also to other women. The research results reported in this article suggest that in states with parental consent or notification laws, there are significantly fewer hospitals, clinics, and private physicians' offices providing abortions. Further, the rate of minors' abortions per 1000 teenage pregnancies is 16 percent lower, and the rate of minors' abortions per 1000 women aged 15–19 is 25 percent lower in states with parental consent or notification laws as compared to states without these laws.

It is unclear whether parental consent and notification laws actually increase parental involvement for those minors who, for one reason or another, feel they cannot involve their parents. Data collected from abortion clinics and referral services in Massachusetts, Minnesota, and Rhode Island suggest that 20 to 55 percent of minors are going to court rather than confiding in their parents. Another 35 percent of minors who contacted a clinic in Massachusetts, and 49 percent in Rhode Island (states from which it is relatively easy for minors to travel to another state to obtain abortion services), decide to go out of state [Donovan, 1983].

Looking at the impact of Medicaid funding restrictions, the research results presented in this study suggest that there are significantly fewer hospitals, clinics, and private physicians' offices providing abortions in states that restrict Medicaid funding of abortions as compared to states that do not. Further, the rate of minors' abortions per births to teenagers is 50 percent lower, and the rate of minors' abortions per women aged 15–19 is 38 percent lower, in states that restrict Medicaid funding as compared to states that do not.

These results suggest that public policies that alter the costs of abortion services can affect individuals' reproductive choices.

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⁹ For a discussion of the consequences of adolescent childbearing, see Hayes [1987].

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