**IN THE UNITED STATES DISTRICT COURT**
**FOR THE WESTERN DISTRICT OF TEXAS**
**AUSTIN DIVISION**

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| PLANNED PARENTHOOD OF GREATER TEXAS SURGICAL HEALTH SERVICES, and on behalf of its patients and physicians, *et al.*, | ) | |
| Plaintiffs, | ) | CIVIL ACTION |
| v. | ) | CASE NO. 1:13-cv-862-LY |
| GREGORY ABBOTT, Attorney General of Texas, in his official capacity, *et al.*, | ) | |
| Defendants. | ) | |

**DECLARATION OF DR. JOSEPH E. POTTER**

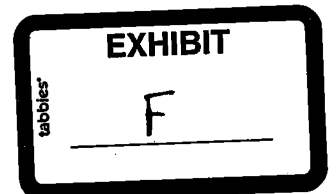
Joseph E. Potter, PhD, declares and states the following:

**Background and Expertise**

1. I am a Professor of Sociology at the University of Texas, Austin. My research interests include reproductive health, population and development, and demographic estimation. Since the fall of 2011, I have been the principal investigator of the Texas Policy Evaluation Project, which evaluates the impact of legislation affecting reproductive health in the state of Texas. This three-year project includes collaborators at Ibis Reproductive Health, the University of Alabama-Birmingham, and focuses especially on the health of low-income and minority women in Texas.

2. I received my PhD in economics from Princeton University in 1975. I worked as a population researcher and visiting professor in Mexico from 1976 through 1983. In 1983, I became an Associate Professor of Demography at the Harvard School of Public Health. I have been at the University of Texas since 1989. I have published extensively in





English and Spanish on family planning, fertility, contraception, and demography. A complete copy of my curriculum vitae is attached as Exhibit 1.

3. I provide the following facts and opinions as an expert in sociology, reproductive health, demography, and the effect of limiting access to reproductive health care on women in the state of Texas. The opinions expressed below are based on my years of experience as a sociologist and the work of the Texas Policy Evaluation Project ("TxPEP"), as well as my review of the relevant literature.

4. I provide these opinions in support of Plaintiffs' Motion for a Preliminary Injunction against enforcement of Texas House Bill 2's requirement that all physicians who perform abortions "have active admitting privileges at a hospital that is located not further than 30 miles from the location at which the abortion is performed or induced [] and provides obstetrical or gynecological health care services."

**Summary of Findings**

5. TxPEP has compared the current spatial distribution and capacity of abortion providers with the distribution and capacity of abortion providers should the admitting privileges requirement go into effect. Our conclusion is that the admitting privileges requirement will substantially negatively affect the ability of Texas women to obtain abortion care in two ways.

6. First, because at least one third of currently licensed clinics will stop providing abortions entirely, many women will be forced to travel significant distances to reach the nearest abortion provider. Over one in twelve Texas women who seek an abortion, or nearly 9%, will have to travel more than 100 miles to reach the nearest abortion provider. For those women who live in particular areas of the state, these

distances will be significant. For instance, the single abortion provider in Lubbock will shut down, leaving no provider between El Paso in the west and San Antonio in the east. Some women in the Panhandle will have to travel more than 350 miles to seek an abortion. The burdens of these trips are magnified by the patchwork of state requirements that may force women to make multiple trips to a clinic. Some women who would otherwise have gotten an abortion will be prevented from doing so by these burdens.

7. Second, those clinics that will remain open will have reduced capacity (health centers often have more than one doctor, and not all of the doctors who currently practice at a particular location will be able to secure privileges), and they will see a sharp increase in the demand for their services (because other clinics in the area have shut down). This reduction in supply and increase in demand will mean that the delays to obtain an appointment with many providers will increase, and some providers may turn patients away entirely. Many women may find it impossible to obtain abortion care in a timely fashion or indeed at all. Abortion is of course a time-sensitive procedure: having to wait a few weeks may make it impossible for women to get an abortion. Under current law, abortions at 16 weeks or more can only be performed in Texas in ambulatory surgery centers (ASCs). Only six abortion clinics in Texas are licensed as ASCs; of those six, three will stop providing abortion care as a direct result of the admitting privileges law, leaving only three providing abortions: one in Dallas, one in Houston, and one in San Antonio. The ASC in San Antonio will have severely reduced capacity and might not be able to provide even limited services until December. This reduction in the capacity of abortion providers in the state of Texas will present an insurmountable obstacle to some Texas women seeking abortions. Those women will be forced by the effects of this law to

carry unwanted pregnancies to term, or attempt to end the pregnancy themselves, possibly through unsafe means. We calculate that the shortfall in capacity due to the admitting privileges requirement will prevent at least 22,286 women from obtaining a safe and legal abortion in the next year, or, in other words, nearly one in three women.

**Methodology**

8. TxPEP conducted our analysis at the county level. The county is the smallest area for which the locations of women who have received abortion services are available. For consistency, we also aggregated providers by county.

9. The first question we addressed is the number of women seeking an abortion whose distance from a provider would increase after implementation. We used Texas Department of State Health Services ("DSHS") records on the county of residence of all women who received an abortion in 2011.[1] We associated each of these women with the nearest open provider at the three time points—2011, the present, and a future in which the admitting privileges requirement has gone into effect. We determined which providers were or would be providing services at each point in time using all available sources of information, including the DSHS list of providers, information provided by the plaintiffs about their own facilities, and key informants. *See* Table 1 (all figures and tables attached in Exhibit 2).

10. Texas Health and Safety Code § 171.012 generally requires that a woman receive an ultrasound in person 24 hours prior to an abortion from her abortion provider. However, this rule is waived for women who live more than 100 miles from a clinic. Using the Legislature's acknowledgement that 100 miles is a burdensome distance to

[1] We exclude the small number of women whose record did not have a valid county listed.

travel for abortion care as a guide, we focused on the women who would have to travel this distance or more at two time points: now and after implementation. We also assumed that the number of women seeking an abortion at each of these times would remain at the 2011 levels.[2] This is a conservative assumption because the state of Texas has drastically reduced its funding for family planning in the two years beginning in October 2011; it is instead likely to be the case that significantly more women have and will experience unintended pregnancies. We assessed distance as the distance between the center of the county of residence and the center of the county of the nearest provider.

11. Performing this calculation in the counties having at least one provider currently open, 2,440 women who will seek abortions annually reside more than 100 miles from the nearest provider. Next, we performed the same calculation using the locations of the providers that we expect will still be offering abortion care should the new legislation requiring admitting privileges be implemented. In that scenario, 5,971 women will reside more than 100 miles from the nearest provider—an increase of 145% over the current situation. If the number of women receiving abortion care from each county remains constant, over one in twelve Texas women who seek an abortion will be more than 100 miles from a provider. Figure 1 shows the number of women who would have to travel 100 miles or more because of the law by counties. Figure 2 shows the increase in distance to the nearest abortion provider in each county due to implementing the admitting privileges requirement. In multiple counties, this additional distance exceeds 400 miles.

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[2] 2011 is the last year for which there are complete records of women receiving abortions.

12. The preceding analysis involved projecting the women who received abortions in 2011 onto the map of providers who will continue to perform abortions after implementation of the law. But doing so raises two important questions. The first is whether the reduced numbers of providers would actually be able to provide this volume of abortion care. Table 3 shows past and projected provision of abortion services by county. There are only seven counties that will have an abortion provider after implementation of the new law. We describe the projected demand based on 2011 volume and estimated capacity in each county below:

a. Bexar County

In 2011, the eight clinics then open in Bexar County were the nearest providers for 6,969 women seeking abortion. Three of these clinics have already closed. Of the remaining five clinics currently open, two will close after the law is implemented, and one will have extremely limited capacity. After the admitting privileges requirement is implemented, the projected demand is 7,006 abortions per year. We estimate that 2,000 abortions could be provided by the one Planned Parenthood affiliate in the county that will remain open. Two additional clinics will remain open, but one will have severely limited capacity. We estimate that together these two clinics could provide 2,250 abortions annually, yielding a county capacity of 4,250. The projected volume will thus exceed capacity by 2,750 abortions annually. Additionally, because the clinic in Nueces County is unlikely to be able to meet the needs of all the women seeking abortion from the Rio Grande Valley, the Bexar County providers may need to perform more abortions than the number estimated by our procedures. If women from the Rio Grande Valley do

travel to Bexar County to seek abortion care, the additional volume will result in a greater than expected shortfall in capacity.

b. Dallas County

The five clinics in Dallas County were the nearest providers for 14,947 women seeking abortion in 2011. After the requirement is implemented, two of these five will close and the projected volume will increase dramatically by 51% to 22,598. The capacity of the remaining providers is estimated to be only 12,500 abortions per year, which is barely more than half the projected volume. The projected volume will exceed capacity by 10,098 abortions per year.

c. El Paso County

The two clinics in El Paso County were the nearest providers for 2,230 women seeking abortion in 2011. After the requirement is implemented, one of these clinics will close, while the projected volume will increase by 50% to 3,337. The capacity of the sole remaining provider, based on 2011 volume, was only 800 abortions per year. The projected volume will exceed capacity by about 2,500 abortions per year.

d. Harris County

The nine clinics in Harris County were the nearest providers for 19,181 women seeking abortions in 2011. Since then, an additional clinic has opened. After the requirement is implemented, three or four of these ten providers will close and the projected volume will increase by 16% to 22,258. Given the reduction in the number of clinics, we doubt the remaining clinics will be able to meet the projected demand.

e. Jefferson County

No change.

f. Nueces County

The single clinic in Nueces County was the nearest provider for 1,623 women seeking abortion in 2011. After the requirement is implemented, the clinic is expected to stay open but the projected volume this clinic would need to deliver would be 4,573 abortions. This 182% increase in volume is due to the closure of the two clinics in the Rio Grande Valley. As noted above, it seems very unlikely that this single clinic will be able to meet this projected demand.

g. Travis County

The four clinics in Travis County were the nearest providers for 6,118 abortions in 2011. After the requirement is implemented, three of the four clinics are expected to stay open, while we project the volume to increase 26% to 7,719. The volume of the clinic that will close is about 1,800 abortions per year. This means that the projected volume for the county will exceed capacity by 3,401 abortions per year.

In summary, in five of the seven counties, there will be a substantial increase in the projected volume of services required due to closure of clinics in other counties that will no longer have a provider. Moreover, there will be a substantial reduction in the capacity to provide services in four of these five counties. One of the two counties not projected to experience a substantial increase in volume or loss of capacity, Jefferson County, has a relatively small volume of abortions. The other, Bexar County, will experience a loss in capacity and may in fact see a surge in demand due to the loss of the

clinics in the Rio Grande Valley and the inability of the Nueces County provider to nearly triple its volume. All told, the projected demand for abortion care statewide is 68,889, and the expected capacity after implementation of the law is only 43,850. The implication is that 25,039 women will not be able to access abortion care in the state, even if they could travel the long distances necessary to access the nearest clinic with capacity to serve them. Eighty-nine percent of this deficit, or 22,286 abortions, is due to closures that will occur as a result of the implementation of the challenged provision.

13. Finally, the last and most challenging question concerns the number of women who will be unable to obtain an abortion because of the increase in distance to a provider and the loss of capacity. These women may be forced to carry the pregnancy to term or attempt to end the pregnancy themselves, possibly through unsafe means.

14. Limited access to abortion providers, and abortion provider closings in particular, are associated with reduced abortion service provision and lower abortion rates, an increase in the distance women must travel to obtain an abortion, and an increase in out-of-state travel for abortion care.[3] Several studies have shown that communities with higher travel distance to an abortion provider have lower abortion rates, implying that some women who would seek an abortion cannot access one. Furthermore, the burden of travel is higher for younger women, women of color, and low-income women, who have fewer resources to overcome the increased cost of further

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[3]*See* Silvie Colman & Ted Joyce, *Regulating Abortion: Impact on Patients and Providers in Texas*, 30 J. of Policy Analysis and Management 775 (2011); Sharon Dobie et al., *Abortion Services in Rural Washington State, 1983-1984 to 1993-1994: Availability and Outcomes*, 31 Fam. Plan. Persp. 241 (1999); Theodore J. Joyce et al., *Back to the Future? Abortion Before & After Roe* (Nat'l Bureau of Econ. Res., Working Paper No. 18338, Aug. 2012; Theodore Joyce, *The Supply-Side Economics of Abortion,* 365 New Eng. J. Med. 1466 (2011).

travel.[4] The restrictions will likely have the greatest impact on these vulnerable populations that do not have the resources to travel to clinics in a distant city or out of state. Data from our research in Texas indicate that approximately 40% of women seeking abortion are at or below 100% of Federal Poverty Guidelines.

15. One of the negative health effects of these restrictions is undoubtedly a rise in attempts to self-induce abortion, and prior research has indicated that young age is a risk factor for attempting abortion self-induction.[5] In 2012, TxPEP conducted a survey with 318 women seeking abortion in six cities across Texas. We found that 7% of women reported taking something on their own in order to try to end their current pregnancy before coming to the abortion clinic. This proportion was even higher—about 12%--among women at clinics near the Mexican border. By comparison, a nationally representative survey of abortion patients in 2008 found that 2.6% reported ever taking something to attempt to self-induce an abortion over the course of their lives.[6] The rate of attempted self-induction was thus significantly higher in Texas than nationwide even before the current restrictions go into place. We anticipate that abortion self-induction will become even more common in the state as access to clinic-based abortion becomes more limited. While abortion is a very safe procedure when performed by a physician, women who attempt to self-induce may put themselves at risk of hemorrhage or uterine

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[4] *See* Robert W. Brown & R. Todd Jewell, *The Impact of Provider Availability on Abortion Demand*, 14 Contemp. Econ. Policy 95 (1996); R. Todd Jewell & Robert W. Brown, *An Economic Analysis of Abortion: The Effect of Travel Cost on Teenagers*, 37 Soc. Sci. J. 113 (2000); James D. Shelton et al., *Abortion Utilization: Does Travel Distance Matter?* 8 Fam. Plan. Persp. 260 (1976).

[5] Daniel Grossman et al., *Self-induction of Abortion Among Women in the United States*, 18 Reprod Health Matters 136 (2010).

[6] Rachel K. Jones, *How Commonly Do US Abortion Patients Report Attempts to Self-Induce?* 204 Am. J. Obstetrics & Gynecology 1 (2011).

rupture.[7] Women frequently use a variety of less effective and more dangerous methods to end a pregnancy on their own, including taking herbs or self-inflicting abdominal trauma.[8]

16. Women's health will also be negatively impacted by a rise in the number of second-trimester abortions in Texas caused by delays accessing care. Even if the remaining clinics were somehow able to meet the demand of women seeking abortion, and women were able to travel the long distances, women will need to wait longer to obtain an appointment. This will push women later in pregnancy, when the procedure is associated with a higher risk of complication[9] and is more expensive, creating even more obstacles for low-income women. Women will also have to spend a longer period of time saving up to pay for increased travel costs, which can in turn further delay the timing of a procedure. Having to raise money for travel and procedure costs is a common reason why women end up presenting beyond the gestational age limit of a clinic.[10]

17. The legal landscape in Texas makes this delay particularly burdensome. Current law requires that all abortions at 16 weeks or more be performed in a facility licensed as an ambulatory surgical center. There are currently only six ASCs which perform abortions throughout the state: two in Houston and one each in San Antonio, Austin, Fort Worth, and Dallas. If the admitting privileges restriction goes into effect, three of these will stop providing abortions, leaving only two ASCs fully open in Dallas

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[7] Premila Ashok et al., *Midtrimester Medical Termination of Pregnancy: A Review of 1002 Consecutive Cases*, 69 Contraception 51 (2004).
[8] *See* Grossman, *supra* note 5.
[9] Linda Bartlett, et al., *Risk factors for Legal Induced Abortion-Related Mortality in the United States.* 103 Obstetrics & Gynecology 729 (2004).
[10] Ushma D. Upadhyay et al., *Denial of Abortion Because of Provider Gestational Age Limits in the United States.* 87 Contraception 3 (2013).

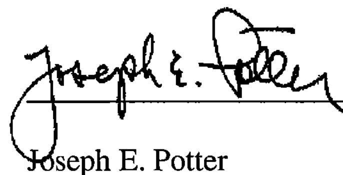
and Houston, and very reduced services in San Antonio. A few weeks' delay in obtaining an abortion, through increased cost, logistical difficulties, or a clinic's inability to see a patient, could force a woman to travel even greater distances; a few more weeks' delay due to those same factors could mean she is unable to obtain an abortion at all.

18. Many women will find the barriers to abortion care too great to overcome and will end up continuing their pregnancies, despite their desire to terminate. Others may attempt to self-induce abortion and fail. All of these women will end up carrying a pregnancy to term and delivering a child they do not want or feel they cannot care for.

19. The requirement for physicians to have hospital privileges within 30 miles of their place of work will result in the closure of many clinics in the state, causing significant barriers to care for women seeking abortion. These restrictions are thus likely to severely burden Texas women's access to abortion care and negatively impact their health.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: October 1, 2013 At: Austin, Texas



Joseph E. Potter

VITAE

# Joseph E. Potter

Population Research Center
The University of Texas at Austin
1 University Station – Mail Stop G1800
CLA 2.620C
Austin, Texas 78712
W: (512) 471-8341
H: (512) 494-1958
Fax: (512) 471-4886
E-Mail: joe@prc.utexas.edu

**Present Position:**

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| Since 1989 | Professor, Department of Sociology; Faculty Research Associate, Population Research Center, The University of Texas at Austin. |

**Previous Positions:**

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| 1983 - 1989 | Associate Professor of Demography, Department of Population Sciences, Harvard School of Public Health, Harvard University |
| 1979 - 1983 | Associate, Regional Office for Latin America and the Caribbean, The Population Council (Mexico City) |
| 1976 - 1983 | Visiting Professor and Research Associate, Center for Studies of Demography and Urban Development, El Colegio de México (Mexico City) |
| 1976 - 1979 | Staff Associate, International Review Group of Social Science Research on Population and Development, El Colegio de México |
| 1976 – 1976 | Staff Associate, Center for Policy Studies, The Population Council (New York) |
| 1975 - 1976 | Research Associate, Office of Population Research, Princeton University |
| 1970 - 1971 | Capital Development Officer, U.S. Agency for International Development (Panamá, R. de P.; on loan from US Army) |
| 1968 - 1971 | United States Army |

**Education:**

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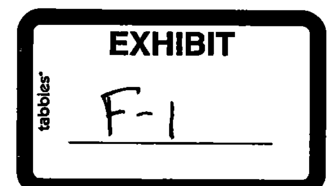
| 1975 | Ph.D. in Economics, Princeton University |
| 1973 | M.P.A. in Economics and Public Affairs, Woodrow Wilson School of Public and International Affairs, Princeton University |
| 1968 | B.A. in Economics, Yale University |



**Advisory and Editorial Boards:**

International Outreach Committee of the Population Association of America, 1996-2002
Editorial Advisory Committee, International Family Planning Perspectives, 1994-2000
Board of Directors, Population Communications International, 1994-2000
Editorial Advisory Committeee, Papeles de Población, 2002-
Editorial Advisory Board, Estudios Demográficos y Urbanos, 2002-2011
Board of Directors, Population Association of America, 2004-2006
Committee for Robert Lapham Prize, Population Association of America, 2007- 2009
Nominating Committee, Society of Family Planning, 2009-

**Professional Associations:**

International Union for the Scientific Study of Population (IUSSP)
Population Association of America (PAA)
Brazilian Population Studies Association (ABEP)
Mexican Demographic Society (SOMEDE)
Latin American Population Association (ALAP)
Society of Family Planning (SFP)

**Fellowships**:

Ritchie H. Reed Fellowship in Population and Economics, The Population Council, 1973-1975.
Fulbright Teaching and Research Fellowship, University of Campinas, Brazil, 1994-1996.
Faculty Research Assignments, Univ. of Texas, Spring 1995, Fall 2001, and Spring 2008.
Faculty Research Leave, Lozano Long Institute of Latin American Studies, U. Texas, Fall 2008.
Big XII Faculty Fellowships, U. of Texas-Colorado U., Fall 2001, Spring 2007, Spring 2009.

**Research and Training Grants Support (since 2001):**

Principal Investigator – Demand for Postpartum Contraception in Texas, Society of Family Planning, 20013-2015, $120,000.

Principal Investigator – Evaluating the Impact of Reproductive Health Legislation Enacted by the 82nd Texas Legislature, Anonymous Foundation, 2011-2014, $1,901,368.

Principal Investigator – Postpartum Contraception in the United States, Population Research Center, 2010-2011, $12,000.

Principal Investigator – Oral Contraceptive Use Along the US-Mexico Border, NICHD, ARRA Supplement to R01HD047816, 2009-2011, $164,158.

Principal Investigator -- Unmet Demand for Surgical Sterilization among Mexican Origin Women, Society of Family Planning, 2009-2011, $120,000.

Principal Investigator – Oral Contraceptive Use Along the US-Mexico Border, NICHD, R01HD047816-01A1, 2005-2012, $2,129,977.

Principal Investigator - Demographic Change and Economic Wellbeing at the Local Level in Mexico and Brazil, The John D. and Catherine T. MacArthur Foundation, 2005-2009, $250,000.

Principal Investigator - Childbearing Preferences in Times of Crisis: Economic and Sociocultural Processes and Explanations (Doctoral Dissertation Research: Sara Yeatman), NSF Award No. 0623543, 2006-2007, $7,495.

Principal Investigator - Training Grant in Population Studies, NICHD, 5T32-HD007081-27, 2003-2008, $1,093,237.

Co-Investigator - Project on Religion and Economic Change, Metanexus Institute, $500,000, 2005-2008 (R. Woodberry, PI).

Principal Investigator - The Fertility Transition in Brazil: 1960-2000, NICHD, R01HD041528-01A1, 2002-2007, $540,000 (direct costs).

Co-Principal Investigator (with R. Hummer and B. Roberts) - Center for the Study of Urbanization and Internal Migration in Developing Countries, The Andrew Mellon Foundation, 2000-2003, $510,000; 2003-2005, $450,000.

Principal Investigator - Preservation, Integration and Dissemination of Public-Use Microdata Series-Brazil, Subcontract with Univ. of Minnesota (NSF grant to S. Ruggles, P.I.), 2000-2003, $140,100 in direct costs.

Principal Investigator - Research and Training Program in Quantitative Analysis for Brazilian Social Scientists, The Ford Foundation, 2000-2002, $130,000; 2003-2006, $195,000.

Principal Investigator - Research and Training in Latin American Population Issues, The William and Flora Hewlett Foundation, 2000-2003, $360,000; 2004-2006, $360,000.

Principal Investigator - Sterilizations, Cesareans, and Contraceptive Choice, NICHD, R01-HD33761, 1996-2002, $502,641 (direct costs).

## PUBLICATIONS

### Articles:

"Potential unintended pregnancies averted and cost savings associated with a revised Medicaid sterilization policy," *Contraception*, forthcoming, 2013 (with Sonya Borrero, Nikki Zite, James Trussell, and Kenneth Smith)

"Are Latina Women Ambivalent about Pregnancies They are Trying to Prevent: Evidence from the Border Contraceptive Access Study," *Perspectives on Sexual and Reproductive Health*, forthcoming, 2013 (with Abigail Aiken).

"Interest in Over-the-Counter Access to Oral Contraceptives among Women in the United States," *Contraception,* forthcoming, 2013 (with Daniel Grossman, Kate Grindlay, Rick Li, James Trussell, and Kelly Blanchard).

"Hypertension Among Oral Contraceptive Users in El Paso, Texas," forthcoming, *Journal of Health Care for the Poor and Underserved*, forthcoming, 2013 (with Kari White, Kristine Hopkins, Jon Amastae, and Daniel Grossman).

"Lessons for Border Research: The Border Contraceptive Access Study," in *Uncharted Terrains: New Directions in Border Research Methodology, Ethics, and Practice* edited by Anna Ochoa O'Leary, Colin M. Deeds, and Scott Whiteford, University of Arizona Press, forthcoming, 2013 (with Jon Amastae, Dan Grossman, Kristine Hopkins, Michele Shedlin, and Kari White).

"Bayes plus Brass: A New Procedure for Estimating Total Fertility in a Large Set of Small Areas from Sparse Census Data," *Population Studies*, forthcoming, 2013 (with Carl P. Schmertmann, Suzana Cavenaghi, and Renato M. Assunção).

"Knowledge and Attitudes about Long-Acting Reversible Contraception among Latina Women Who Desire Sterilization," *Women's Health Issues* 23(4): e257-e263, 2013 (with Kari White, Kristine Hopkins, and Daniel Grossman).

"Patterns of Contraceptive Use among Mexican-Origin Women," *Demographic Research* **28**(41): 1199-1212, 2013 (with Kari White).

"Age, Education and Earnings in the Course of Brazilian Development: Does Composition Matter?" *Demographic Research* **28**: 581-612, 2013 (with Ernesto F. L. Amaral, Daniel S. Hamermesh, and Eduardo L. G. Rios-Neto).

"Knowledge and Beliefs about Reproductive Anatomy and Physiology among Mexican-Origin Women in the U.S.A -- Implications for Effective Oral Contraceptive Use," *Culture, Health & Sexuality* 15(4): 466-479, 2013 (with Michele Shedlin, Jon Amastae, Kristine Hopkins, and Daniel Grossman).

"The Impact of Outmigration of Men on Fertility and Marriage in the Migrant-Sending States of Mexico, 1995–2000," *Population Studies* **67**(1): 83-95, 2013 (with Kari White).

"Hospital Variation in Postpartum Tubal Sterilization Rates in California and Texas," *Obstetrics and Gynecology* **121**(1): 152-158, 2013 (with Amanda J. Stevenson, Kari White, Kristine Hopkins, and Daniel Grossman).

"Changes in Service Delivery Patterns after Introducing Telemedicine Provision of Medical Abortion in Iowa," *American Journal of Public Health* **103**(1): 73-78, 2013 (with Daniel Grossman, Kate Grindlay, Todd Buchacker, and Carl P. Schmertmann)

"Cutting Family Planning in Texas," *New England Journal of Medicine* **367**(13): 1179-81, 2012 (with Kari White, Daniel Grossman, and Kristine Hopkins).

"Frustrated Demand for Sterilization Among Low-Income Latinas in El Paso, Texas," *Perspectives on Sexual and Reproductive Health* **44**(4): 228-235, 2012 (with Kari White, Kristine Hopkins, Sarah McKinnon, Daniel Grossman, Michele Shedlin, and Jon Amastae).

"Reproductive Health Preventive Screening Among Clinic vs. Over-the-Counter Oral Contraceptive Users," *Contraception 86(4): 376-382*, 2012 (with Kristine Hopkins, Daniel Grossman, Kari White and Jon Amastae).

"Contraindications to Progestin-only Oral Contraceptive Pills among Reproductive-aged Women," *Contraception* **86**(3): 199-203, 2012 (with Kari White, Kristine Hopkins, Leticia Fernández, Jon Amastae, and Daniel Grossman).

"Long Term Influences of Age-Education Transition on the Brazilian Labour Market," *Bulletin of Latin American Research* **31**(3): 302-319, 2012 (with Ernesto Friedrich De Lima Amaral and Eduardo Luiz Gonçalves Rios-Neto).

"Continuation of Prescribed Compared With Over-the-Counter Oral Contraceptives," *Obstetrics & Gynecology* **117**(3): 551-557, 2011 (with Sarah McKinnon, Kristine Hopkins, Jon Amastae, Michele G. Shedlin, Daniel A. Powers, and Daniel Grossman).

"Contraindications to Combined Oral Contraceptives Among Over-the-Counter Compared With Prescription Users," *Obstetrics & Gynecology* **117**(3): 558-565, 2011 (with Daniel Grossman, Kari White, Kristine Hopkins, Jon Amastae, and Michele Shedlin).

"An Innovative Methodology for Space-Time Analysis with an Application to the 1960-2000 Brazilian Mortality Transition," in *Navigating Time and Space in Population Studies*, International Studies in Population, Vol. 9, edited by Myron P. Gutmann, Glenn D. Deane, Kenneth M. Sylvester, and Emily R. Merchant, Springer, pp. 19-36, 2011 (with Carl P. Schmertmann and Renato M. Assunção).

"O Papel da Demografia e da Educação no Rendimento Medio de Longo Prazo dos Homens no Brasil: Simulações com o Modelo de Oferta e Demanda por Trabalho," in *O Estado da Arte em Economia*, edited by Antonio Delfim Netto. São Paulo: Editora Saraiva, pp. 201-217, 2011 (with Eduardo Luiz Gonçalves Rios-Neto and Ernesto Friedrich De Lima Amaral).

"Religión e Iniciación Sexual Pre-Marital en México," *Revista Latinoamericana de Población* Año 4, No. **7,** pp. 7-30, 2010 (with Eunice Vargas Valle and Georgina Martínez Canizales).

"Sobre 'Se Perder', 'Vacilar' e Não Encontrar o 'Homem Certo': Mudanças Ideacionais, Instituições e a Fecundidade Abaixo do Nível de Reposição," *Revista Brasileira de Estudos de População* **27**(1): 227-231, 2010 (with Paula Miranda-Ribeiro).

"Knox meets Cox: Adapting Epidemiological Space-Time Statistics to Demographic Studies," *Demography* **47**(3): 629-650, 2010 (with Carl P. Schmertmann and Renato M. Assunção).

"Mapping the Timing, Pace, and Scale of the Fertility Transition in Brazil," *Population and Development Review* **36**(2): 283-307, 2010 (with Carl P. Schmertmann, Renato Assunção, and Suzana M. Cavenaghi). NIHMS# 221748

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**Table 1. Counties with an abortion provider by period**

| County | Any 2011 | Any now | Any post |
|---|---|---|---|
| Bell | Y | Y | N |
| Bexar | Y | Y | Y |
| Brazos | Y | N | N |
| Cameron | Y | Y | N |
| Dallas | Y | Y | Y |
| El Paso | Y | Y | Y |
| Fort Bend | Y | N | N |
| Harris | Y | Y | Y |
| Hidalgo | Y | Y | N |
| Jefferson | Y | Y | Y |
| Lubbock | Y | Y | N |
| McLennen | Y | Y | N |
| Midland | Y | N | N |
| Nueces | Y | Y | Y |
| Tarrant | Y | Y | N |
| Taylor | Y | N | N |
| Tom Green | Y | N | N |
| Travis | Y | Y | Y |

**Table 2. Projected abortions to women living at least 100 miles from nearest provider**

| | Abortions |
|---|---|
| Present | 2,440 |
| Post law | 5,971 |

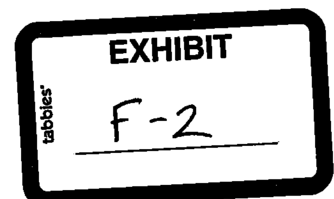

**Table 3. Past and projected provision of abortion services by county**

| County | Annual estimated provision 2011 | Annual estimated provision present | Annual estimated demand after law is implemented | % increase | Change in capacity 2011 to post law | Estimated capacity post law | Capacity deficit post law |
|---|---|---|---|---|---|---|---|
| Bell | 1,192 | 1,317 | | | | | |
| Bexar | 6,969 | 7,000 | 7,006 | 1% | Lose 5 of 8 providers, with one remaining provider at extremely limited capacity | 4,250 | 2,756 |
| Brazos | 957 | | | | | | |
| Cameron | 786 | 786 | | | | | |
| Dallas | 14,947 | 14,999 | 22,598 | 51% | Lose 2 of 5, with one remaining provider at 1/3 prior capacity | 12,500 | 10,098 |
| El Paso | 2,230 | 2,256 | 3,337 | 50% | Lose 1 of 2 providers | 800 | 2,537 |
| Fort Bend | 2,317 | | | | | | |
| Harris | 19,181 | 21,748 | 22,258 | 16% | Lose 3 or 4 of 10 providers | 19,000 | 3,258 |
| Hidalgo | 2,164 | 2,164 | | | | | |
| Jefferson | 1,398 | 1,398 | 1,398 | 0% | No change | 1,400 | |
| Lubbock | 1,077 | 2,015 | | | | | |
| McLennen | 716 | 1,286 | | | | | |
| Midland | 543 | | | | | | |
| Nueces | 1,623 | 1,623 | 4,573 | 182% | No change | 1,600 | 2,973 |
| Tarrant | 6,044 | 6,130 | | | | | |
| Taylor | 399 | | | | | | |
| Tom Green | 228 | | | | | | |
| Travis | 6,118 | 6,167 | 7,719 | 26% | Lose 1 of 4 providers | 4,300 | 3,419 |
| State | 68,889 | 68,889 | 68,889 | 0% | | 43,850 | 25,039 |

Note: It assumes that women obtain abortion care in the county with the nearest provider. It also assumes a constant number of women from each county receiving abortion care in Texas in 2011, the present, and after implementation of the admissions privileges requirement.

**Figure1. Women having to travel more than 100 miles due to admitting privileges requirement**

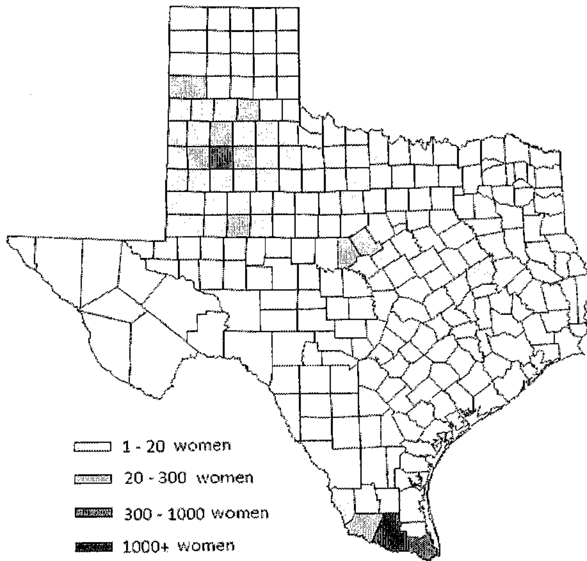


**Figure 2. Additional distance women would have to travel due to admitting privileges requirement**