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Chief Executive Officer

July 1, 2022

To: Supervisor Holly J. Mitchell, Chair  
Supervisor Hilda L. Solis  
Supervisor Sheila Kuehl  
Supervisor Janice Hahn  
Supervisor Kathryn Barger

From: Fesia A. Davenport  
Chief Executive Officer

Board of Supervisors  
HILDA L. SOLIS  
First District

HOLLY J. MITCHELL  
Second District

SHEILA KUEHL  
Third District

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Fifth District

## **SECOND REPORT BACK ON PRESERVING REPRODUCTIVE HEALTH ACCESS ON THE ANNIVERSARY OF ROE V. WADE (ITEM NO. 22, AGENDA OF JANUARY 25, 2022)**

### **BACKGROUND**

On January 25, 2022, the Board of Supervisors (Board) unanimously passed a motion by Supervisors Mitchell and Kuehl to ensure women's access to quality reproductive health care services. The Board instructed the Chief Executive Officer, the Directors of the Departments of Health Services, Public Health (DPH), and County Counsel, in coordination with Planned Parenthood and other reproductive health advocates, to meet and develop written recommendations within 30 days on how Los Angeles County (County), could respond should *Roe v. Wade* (*Roe*) be overturned.

On March 9, 2022, a 30-day report was submitted to the Board responding to the directives from the motion in the areas of budget, enhanced medical training, expansion of the reproductive health care workforce, creating a uniform referral system, and opportunities to reduce and address health disparities. In that report, Workgroups representing these directive areas requested 90 days to convene external stakeholders to conduct a more thorough analysis of the reproductive and sexual health care landscape, barriers, and opportunities for improvement to the current system and ways to scale up and meet an increase in demand for individuals traveling from out of state for abortion and other sexual and reproductive health care services in the County.

This 90-day report articulates components of what a safe-haven could be for the County while examining much of what is still unknown about the potential impacts from the overturn of *Roe*. Included are discoveries from meetings with community partners that service many of the most marginalized communities, and insights and recommendations from physicians and other key stakeholders. Lastly, the report contains a recommended path forward to ramp up and continue the work necessary to ensure that everyone who needs reproductive and sexual health services has a right to access a full spectrum of care.

## **DESCRIPTION OF THE LOS ANGELES COUNTY SAFE HAVEN ACCESS PILOT**

The County Safe-Haven Access Pilot (SHAP) is a network of nonprofit partners, reproductive access advocates and health care providers committed to ensuring safe access to reproductive care now. SHAP coordinates a multifaceted process for providing steady and reliable reproductive and sexual health care services for residents of the County, and for those who travel here seeking safe and confidential abortions and other sexual health care services; including the provision of practical support to cover travel expenses. SHAP includes plans to ensure a centralized system of sexual and reproductive health care and facilitates for the coordination of comprehensive, culturally appropriate training for doctors and support staff; and partners with existing workforce development programs to help promote a viable pipeline of health care providers. SHAP informs partners in the network of legal developments to maintain physical and professional safety and supports the development of more a formalized, safe, and appropriate referral system as Los Angeles County continues to provide this important care, expand services, and operate as a safe haven for all who seek assistance for their reproductive care needs.

## **CONDITIONS OF THE REPRODUCTIVE AND SEXUAL HEALTH CARE LANDSCAPE**

Reproductive and sexual health care including access to pregnancy termination is in a great state of flux throughout the country. The impact of states' trigger laws effectuated upon the overturn of *Roe*, the criminalization of providers and individuals, and the full picture of legal implications are still largely unknown. While California is preparing for an influx of patients coming from out of state for abortion care, the numbers of how many individuals and the extent of the impact on the overall system in the County are estimates at best.

The California Governor and Legislature are committed to allocating at least \$120-125 million to California towards abortion access and additional reproductive health care services and support. Additionally, a projected \$20 million dollars in Senate Bill 1245 funding has been earmarked for the County. Details on what will be funded is still largely unknown, but broad areas of funding include: uncompensated care, training, workforce development, internet-based system of referrals, infrastructure, service expansion, insurance coverage, community education, research, and practical assistance.

## RECCOMENDATIONS AND NEXT STEPS

The attachments listed below include recommendation related to budget, training, workforce, uniform referral system and strategies to address health disparities. Furthermore, Attachment I outlines next steps for the leaders of the SHAP, under each recommendation category. Attachment II is UCLA's Law Center report on Reproductive Health, Law, Policy's Modeling which is the best available information on the projected need for reproductive services from out of state clients:

- **Attachment I** – Next Steps for SHAP and Recommendations
- **Attachment II** – *People Traveling to California and Los Angeles for Abortion Care*, Abortion modeling by the UCLA Law Center on Reproductive Health, Law, and Policy

## CONCLUSION

The SHAP, led by the DPH, will convene with stakeholders to monitor trends, gather data, and begin immediate planning to make the County a safe haven. The most pressing need is to broadly communicate that the County is still a safe and legal place to access abortions and sexual and reproductive health care. One of the highest priorities is to establish a reliable method to convey that message and a confidential means for individuals to access information. The next steps are more fully explained in Attachment I, Next Steps for SHAP and Recommendations. Furthermore, summaries of each workgroup's findings are available to your staff upon request.

Should you have any questions concerning this matter, please contact me or Chanel Smith, the Women and Girls Initiative Executive Director, at [csmith@ceo.lacounty.gov](mailto:csmith@ceo.lacounty.gov).

FAD:JMN:JFO  
AL:CS:AW:pp

## Attachments

c: Executive Office, Board of Supervisors  
County Counsel  
Public Health

## **NEXT STEPS FOR THE SAVE-HAVEN ACCESS PILOT AND RECOMMENDATIONS**

### **OVERVIEW**

State funding to support the Safe Haven Access Pilot (SHAP) is expected following the passage of Senate Bill 1245 (SB1245) and will ideally be directed to a third-party organization that can expedite distribution of funds to Los Angeles County (County) area nonprofits and agencies servicing individuals with sexual and reproductive health care needs. If this is not feasible, the Department of Public Health (DPH) will potentially act as a “pass-through” agency to receive the proposed SB 1245 funding for dissemination. If these funds come directly into the County, it is recommended that DPH facilitate the SHAP and DPH will need funding for this administrative role. The DPH’s role will be to convene and engage all stakeholders, gather data, monitor trends, and with partners to begin implementation of steps to pilot the SHAP, all of which will require allocation of resources, including personnel.

While pending legislation and funding, lack of data, legal impediments and liabilities, infrastructure, security/cyber security, other issues, and unknowns named throughout this report, currently limit full-scale implementation of the important work necessary to run a fully functioning safe haven, DPH can address the most immediate need of broadly communicating through a County-wide campaign that the County is still a safe and legal place to access abortion and sexual and reproductive health care. Other needs include developing training strategies and implementation plans for medical and non-clinical providers and planning for expanded health navigation services. To effectively meet these demands, if SB 1245 is signed by the governor, administrative costs would need to come from the proposed funding to provide DPH with the proper staff support and infrastructure.

### **RECOMMENDATIONS**

The following recommendations are based on the findings from each of the Workgroups. Accompanying metrics have been captured and will be included in a full report that will be provided to the SHAP.

#### **Budget**

The SHAP will continue evaluating the landscape, emerging trends, and begin prioritizing dollars based on gaps in services and highest priority needs. Once SB 1245 is funded, DPH, working with either the third-party administrator or acting as a “pass-through” agency, will oversee a process to distribute funds to community initiatives consistent with the allocation designations in the bill to ramp up the SHAP. As more funding is identified, the SHAP will work with relevant stakeholders to broaden efforts. It is anticipated that the County will receive \$20 million in SB 1245 funding, specifically for the SHAP, in addition to its share of other state funding designated for safe and accessible reproductive health care.

## **Training**

A portion of the SB 1245 funding should be set aside to address reproductive care workforce issues. While more planning and evaluation are required, the recommended initial steps are:

- Determine what agencies within the County currently offer training on different aspects of sexual and reproductive health care and begin the process of engagement.
- Where training gaps among health care providers are identified from the first two phases of this project, convene a specialized taskforce comprising medical doctors, advanced practice clinicians, nurses, and other licensed professionals to modify and develop existing curricula, or develop curricula as needed. Trainings will incorporate the management of abortion and early pregnancy loss side effects and complications, with mindful inclusion of professional ethics, cultural humility, reproductive justice, post-abortion client-centered contraceptive counseling, California law and policy around abortion, and the legal landscape of restrictive laws within other states and their impact on practice, among other important factors.
- Develop training plan and identify/implement curricula for social service providers, public health professionals, community health workers, and other frontline staff serving women of reproductive age to address abortion as a common pregnancy outcome, decrease stigma, and promote professional ethics, prompt referrals, and cultural humility.
- As soon as possible, broadly communicate to the public that the County is still a safe and legal place to access abortion and sexual and reproductive health care.
- Use chosen communication strategies to start a messaging campaign ensuring communications include countering intentional mis/disinformation campaigns about abortion and de-stigmatize abortion as a common pregnancy outcome.

## **Workforce**

We recommend that the Workforce Action Plan, that can be found in the Workgroup's summary, available upon request, be shared with staff and relevant subcommittees of appropriate clinician associations, colleges, universities, and other applicable workforce-focused groups. The plan lays out a long-term strategy to further assess the gaps and the needs in the workforce, opportunities to increase access to care through utilization of advanced practice providers and telehealth, and how to train and maintain the current abortion workforce and guard against burnout. While the SHAP will support workforce partners to increase a pipeline of providers to the County, the recommendation for how this is implemented rests with the organizations and workforce agencies who

directly influence the decisions of this workforce. The SHAP will play an active advocacy role to push for the types of programs, services, education reimbursements, loan forgiveness programs, and other strategies to increase the sexual and reproductive health workforce recommended by this Workgroup.

### **Uniform Referral System**

The idea of a uniform referral system for abortion and related services has been greatly debated from the start of this process by providers, clinics, nonprofits, and hospitals, citing that a more fragmented system will be more difficult to attack than one centralized system that contains patient and provider data. This is one of the many, many hard challenges faced by the abortion provider network and the SHAP moving forward into this next phase of implementation, planning and execution. While there is much consternation on whether to develop and/or how to develop a safe, secure, uniform referral system immune from security breaches, County liability and provider malpractice, DPH feels that there may be options for establishing or using an existing centralized number/system to provide abortion navigation services for patients needing assistance.

It is recommended that the requirements for establishing a Uniform Referral System undergo extensive examination before deciding whether it is safe to implement. Our partners from Planned Parenthood explicitly want to elevate the very critical need to protect provider and patient safety and security. The concern is having resources, algorithms, providers, etc., in a centralized, uniform system, as there have already been unfortunate increases in security threats and breaches. Creating a comprehensive network of providers, clinics, and services makes many of these entities vulnerable to a host of negative outcomes and potential liability.

Conversely, others feel a centralized system is a critical element to reduce redundancies and set the foundation for an expanded system of care that would include broadening how telehealth services are rendered. Currently, appointments for pregnancy terminations are oftentimes managed in one clinic or setting that will make recommendations to other clinics for services they cannot provide. At times, a client will need to schedule several appointments at multiple clinics before finding out that they have come to or contacted a clinic that cannot service them due to a cut-off date for abortion services or that a particular clinic does not offer the services that they need. This causes inefficiencies, jams up the overall system, and reduces appointment availability for others who could be scheduled in that slot. Also, with a centralized system of referrals, doctors, nurses, and providers could more effectively navigate patients to the proper points of care while handling lower-complexity care patients directly through virtual or telephonic appointments and referring more mid-level and higher-complexity cases in real time.

While requiring further review to determine which model is best suited to address the comprehensive security/privacy issues inherent in any referral system, some of the beginning steps include:

- Facilitate on-going conversations with the network partners regarding next steps, action items, and development or streamlining of systems.
- Consult with counsel and other privacy experts regarding mechanisms to protect both patient and provider data. These include information technology platforms, user access rights, cyber security, liability, etc.
- Review existing triage and navigation tools currently in use by some providers to assess for scalability and relevance to goals of the uniform referral system. Discuss and develop tools for triage and assessment processes to be recommended for proposed referral system and navigation/triage.
- Discuss and develop proposal for data dashboards to track changes in volume, acuity, access, and equity.
- Discuss and develop proposal for patient facing tools to assist with care navigation which integrate with triage and assessment tools described above.
- Discuss and develop proposal for staffing model for referral system.
- Pilot implementation of triage and assessment workflows, patient navigation and transitions of care. Track pilot data.
- Work with California State partners on patient facing materials for proposed state-wide directory of care providers and benefits information to integrate with the County area network triage and referral system.
- Regularly convene stakeholders, including community-based organizations and DPH to ensure referral system is meeting the needs of historically marginalized communities and addressing equity gaps in sexual and reproductive health care.

### **Health Disparities**

Given the broad outreach conducted by, and the extensive input offered to this Workgroup, the process resulted in far too many recommendations to include here. The SHAP will receive a detailed report replete with all of the Workgroup's recommendations and a full review of the process of discovery. What is included here is a snapshot of some of the long-term systemic change recommendations that will require time and resources to adequately address.

- Enhance and expand existing health navigation services for abortion care through funding appropriate [Community Health Outreach Initiatives \(CHOI\)](#) agencies



including [Maternal Child Health Access](#), or other contractors, and [Access Reproductive Justice](#), the only abortion fund that specifically serves California.

- Improve access to enabling services for health care for low-income populations in the County, with specific outreach to marginalized or vulnerable communities. Services should include expansion of existing community health worker programs, medical and social service transportation, free or subsidized childcare/eldercare/dependent care, lodging for those visiting the County for abortion care, and access to technology—free phones, free access to computers and internet not requiring identification.
- Continue to provide sexual and reproductive health (SRH) training to agencies specifically funded to serve pregnant and parenting women (PPW) through DPH's Substance Abuse Prevention and Control (SAPC) division. Because not all women or people capable of pregnancy receive SAPC services at PPW programs, DPH will expand this training to all substance use disorders providers. Implement similar training programs for the Department of Mental Health's staff and mental health contracted agencies, along with homeless and re-entry service providers.
- Share tools with substance use disorder, mental health, homeless, and re-entry service providers to facilitate conversations about SRH with clients and expedite referrals for SRH care through warm hand-offs to trusted, culturally competent and trauma informed providers.
- Expand access to field-based pregnancy testing and emergency contraception at diverse non-clinical sites such as drop-in centers, homeless service centers, etc.
- Expand pharmacy access to emergency contraception and other forms of hormonal birth control through training and/or incentives for County pharmacies and pharmacists, especially in areas of the County with pharmacy deserts.
- Decrease rigidity and increase flexibility in DHS hospitals for time-sensitive care.
- Dismantle misinformed and misguided beliefs and practices that directly undergird harmful protocols and instead provide harm reduction approaches. For example, conduct drug testing only through shared decision making with patients and for specific medical indications. This will improve access to care for substance users and people engaged in underground economies, such as sex workers.
- Implement Countywide trauma awareness training. County agencies and contractors must improve provision of compassionate care through [trauma-informed service delivery](#). [Transformation of service delivery models to reflect the common experience of trauma and promote healing](#) will also benefit staff, improving morale and retention. Training on working with LGBTQIA+ populations is also needed throughout County and community health and social service agencies.



- Ensure Medi-Cal is re-activated or enrollment occurs before discharge from Century Regional Detention Facility (CRDF), or other County jails and that upon re-entry to the community, people know where and how to access needed health services. Appointments for urgent issues should be scheduled prior to release whenever possible with clear instructions and arrangements made for transportation, any co-pays, etc.
- Implement operational and cultural changes to improve care and achieve health equity for adults and minors in County correctional facilities. These include: bringing the CRDF into compliance with Assembly Bill 732; employment of social workers to support correctional health staff in caring for the general jail population and specifically to meet the needs of incarcerated pregnant people; expansion of contraception services at CRDF and routine offering of emergency contraception at entry and contraceptive method of choice at discharge; better connections between Juvenile Court Health Services and sexual and reproductive health service providers, including services for minors who have experienced sexual assault; sexual and reproductive health training for all staff and educational programming for incarcerated adults and minors; improved alignment between the Sheriff's Department/Probation and Correctional Health Services goals – to prioritize health and well-being among incarcerated individuals; and improved staff recruitment, retention, and morale.

# People Traveling to California and Los Angeles for Abortion Care if *Roe v. Wade* is Overturned

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Brad Sears, Cathren Cohen, Lara Stemple

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*Roe v. Wade* is very likely to be overturned in the summer of 2022.<sup>1</sup> If that happens, 26 states are likely to ban all, or nearly all, abortions,<sup>2</sup> some via “trigger” bans set to go into effect nearly immediately after *Roe* falls.<sup>3</sup> This data brief estimates that as result of these new restrictions, between 8,000 and 16,100 more people will travel to California each year for abortion care. Of those, we estimate that between 4,700 and 9,400 will come to Los Angeles County.

Our mid-level scenario estimates that when the Supreme Court overturns *Roe v. Wade*, approximately 10,600 more people will come to California each year for abortion care, 6,200 of whom will come to Los Angeles County. Put differently, approximately 900 additional people will come to California each month for an abortion, 500 of whom will come to Los Angeles County.

While our model is based on the best available data and relevant prior research, it is also based on a number of assumptions that are further explained below. Accordingly, our estimate should be used to indicate the order of scale of the number of out-of-state residents traveling to California and Los Angeles County for abortion services. In other words, the impact will not be that only hundreds of people travel to the state, nor is it likely that multiple tens of thousands will do so.

We also do not anticipate that this impact will be felt all at once. Rather, people will adjust to the dramatic shift in over half of states’ abortion laws over time. We anticipate that as criminalization for

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<sup>1</sup> POLITICO Staff, *Read Justice Alito’s Initial Draft Abortion Opinion which Would Overturn Roe v. Wade*, POLITICO (May 2, 2022), <https://www.politico.com/news/2022/05/02/read-justice-alito-initial-abortion-opinion-overturn-roe-v-wade-pdf-00029504>.

<sup>2</sup> Elizabeth Nash & Lauren Cross, *26 States Are Certain or Likely to Ban Abortion Without Roe: Here’s Which Ones and Why*, GUTTMACHER INST. (Oct. 2021), <https://www.guttmacher.org/article/2021/10/26-states-are-certain-or-likely-ban-abortion-without-roe-heres-which-ones-and-why>.

<sup>3</sup> Jesus Jimenez, *What is a trigger law? And which states have them?*, NEW YORK TIMES, May 4, 2022, <https://www.nytimes.com/2022/05/04/us/abortion-trigger-laws.html>.

abortion care increases and as abortion clinics close in many states, the number of people traveling to California will grow. The large number of abortion restrictions that have been passed by state legislatures in the past several years also means that it is likely that this level of legislative activity will continue in restrictive states, as will enforcement efforts once new restrictions are passed. This will include attempts to criminalize people who travel out of state for abortion care, and those that attempt to assist them.

Prior research suggests several characteristics of those who currently travel to obtain abortion services, some of which may be relevant to predicting the population of people who will travel to California for abortion care in the future:

- In terms of demographic and socio-economic characteristics, all types of people will travel to California for abortion services.
- Studies have shown that under the current landscape of state laws and availability of care, women of color, those without insurance, those who live in states without Medicaid expansion, and those with fewer resources are currently more likely to have to travel longer distances.<sup>4</sup>
- Other research suggests that those with greater resources are more likely to travel to obtain abortion care, including white, college-educated people with more economic and social resources.<sup>5</sup>
- Those aged 17 and younger may be more likely to travel to California for abortion access, particularly from states with parental consent laws.<sup>6</sup>
- Those with longer gestational lengths and/or greater complications are more likely to travel further for abortion care.<sup>7</sup>

<sup>4</sup> Jill Barr-Walker et al., *Experiences of Women who Travel for Abortion: A Mixed Methods Systematic Review*, 14 PLoS ONE (Apr. 2019), <https://doi.org/10.1371/journal.pone.0209991>.

<sup>5</sup> Liza Fuentes & Jenna Jerman, *Distance Traveled to Obtain Clinical Abortion Care in the United States and Reasons for Clinic Choice*, 28 J. WOMEN'S HEALTH 1623 (Dec. 2019); Rachel K. Jones & Jenna Jerman, *How Far Did US Women Travel for Abortion Services in 2008?*, 22 J. OF WOMEN'S HEALTH 706 (Aug. 2013), <https://www.liebertpub.com/doi/10.1089/jwh.2013.4283> (finding that women of color were less likely to travel long distances compared to non-Hispanic white women).

<sup>6</sup> Barr-Walker et al, *supra* note 4; Fuentes & Jerman, *supra* note 5. See also Amanda Dennis et al., *The Impact of Laws Requiring Parental Involvement for Abortion: A Literature Review*, GUTTMACHER INST. (Mar. 2009), <https://www.guttmacher.org/report/impact-laws-requiring-parental-involvement-abortion-literature-review> ("the clearest documented impact of parental involvement laws is an increase in the number of minors traveling outside their home states to obtain abortion services in states that do not mandate parental involvement or that have less restrictive laws;" two studies of parental involvement laws in Mississippi and Texas found no decline in minor's abortion rate once out-of-state abortions were considered.).

<sup>7</sup> Fuentes & Jerman, *supra* note 5; Barr-Walker et al., *supra* note 4; ("Gestational age played a role as both an exposure and outcome related to travel in the reviewed studies: women at higher gestational ages often traveled farther distances to access abortion, and women whose limited access to abortion necessitated farther travel distances experienced delays that resulted in higher gestational ages or prevented them from obtaining an abortion altogether"); Rachel K. Jones & Jenna Jerman, *How Far Did US Women Travel for Abortion Services in 2008?*, 22 J. OF WOMEN'S HEALTH 706 (Aug. 2013), <https://www.liebertpub.com/doi/10.1089/jwh.2013.4283>

- Those who are seeking specialized or higher quality care or who have concerns about privacy, legal concerns, and safety will be more likely to travel.<sup>8</sup> This suggests that the efforts by California and Los Angeles to serve as safe havens for reproductive freedom will cause some to travel to this area instead of to closer locations.

## METHODOLOGY

We base our estimates on the following:

If *Roe v. Wade* is overturned, the Guttmacher Institute has estimated that in the short-term, 26 states are likely to ban all, or nearly all, abortions.<sup>9</sup> (See Table III).

We use estimates from a 2022 study published in *The Lancet Regional Health – Americas* for the number of abortions among state residents in each of these twenty-six states.<sup>10</sup> Using the same study, we subtract those who are already leaving their states for abortion care.<sup>11</sup> (See Tables I and II). The Lancet study found that in 2017 “an average of 8% of patients left their state of residence for abortion care.”<sup>12</sup> We assume that people who are already leaving their states for California are reflected in the current number of abortions being performed in California (i.e., they will not be part of an increase in people coming to California for abortion services if *Roe* is overturned).

Those in the 26 states with new abortion restrictions will respond in several ways, including by increasing the use of contraception,<sup>13</sup> carrying pregnancies to term,<sup>14</sup> engaging in self-managed

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(finding that women of who obtained a second semester abortion were more likely to travel greater distances); Ushma D. Upadhyay et al., *Denial of Abortion Because of Provider Gestational Age Limits in the United States*, 104 J. OF PUB. HEALTH 1687 (Sept. 2014), <https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2013.301378> (finding that needing to raise money for travel is often a reason for seeking an abortion in the second trimester).

<sup>8</sup> Barr-Walker et al., *supra* note 4.

<sup>9</sup> Nash & Cross, *supra* note 2.

<sup>10</sup> Mikaela H. Smith et al., *Abortion Travel Within the United States: An Observational Study of Cross-State Movement to Obtain Abortion Care in 2017*, 10 THE LANCET REGIONAL HEALTH – AMERICAS (Mar. 2022), <https://www.sciencedirect.com/science/article/pii/S2667193X2200031X?via%3Dihub#>.

<sup>11</sup> *Id.*

<sup>12</sup> *Id.* The percent leaving varied widely by state. For example, 74% left Wyoming, 57% left South Carolina, and 56% left Missouri, while thirteen states had fewer than 4% of patients leaving.

<sup>13</sup> Josephine Jacobs & Maria Stanfors, *State Abortion Context and U.S. Women’s Contraceptive Choices, 1995-2010*, 47 PERSPECTIVES ON SEXUAL AND REPRO HEALTH 71 (June 2015), <https://www.jstor.org/stable/48576720> (finding that women who live in states where abortion access was low or in states characterized by abortion hostility were more likely than women living in a state with greater access or states with less hostility to use highly effective contraceptives rather than no method).

<sup>14</sup> Elizabeth A. Pleasants, Alice F. Cartwright, & Ushma D. Upadhyay, *Association Between Distance to an Abortion Facility and Abortion or Pregnancy Outcome Among a Prospective Cohort of People Seeking Abortion Online*, 5; JAMA NETWORK OPEN (2022), <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2792291>; Joanna Venator & Jason Fletcher, *Undue Burden Beyond Texas: An Analysis of Abortion Clinic Closures, Births, and Abortions in Wisconsin*, 40 J. OF POL’Y ANALYSIS & MANAGEMENT 774 (Nov. 2020),

abortion,<sup>15</sup> seeking medication abortion in increasing proportions, and traveling out-of-state for abortion care.<sup>16</sup> For example, when Texas made abortion care after 16 weeks gestation more difficult to obtain, “the effect was immediate and dramatic. The number of abortions performed in Texas at or after 16 weeks gestation dropped 88%, from 3,642 in 2003 to 446 in 2004, while the number of residents who left the state for a late abortion almost quadrupled.”<sup>17</sup> In our model, we use a low, middle, and high scenario, assuming that 25%, 33%, or 50% of those who would have had an abortion in their home state will travel out of state if *Roe* is overturned. (See Tables IV and V).

Prior research suggests that travel distance is a primary determinant in where people go to have an abortion.<sup>18</sup> A study published in 2019 found that, “the provider being the closest was a main reason abortion patients chose their facility and that nearly half of all abortion patients traveled to their nearest provider, indicating that distance is an important determinant of abortion access.”<sup>19</sup>

Prior research also suggests that people, when forced to do so, will travel longer distances to get the care they need<sup>20</sup> and that when states restrict abortion, people travel greater distances to seek abortion care, including out of state.<sup>21</sup> For example, a 2019 systematic review of the literature on women’s experiences traveling for abortion<sup>22</sup> considered 59 studies and found that “legal restrictions and the limited availability of abortion providers “resulted in women needing to travel long distances for abortion services, often crossing state or country borders to seek care . . . [s]tudies describe the substantial distances that women often need to travel in order to obtain abortion services; in these

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<https://doi.org/10.1002/pam.22263> (estimate the impacts of abortion clinic closures in Wisconsin and finding that a 100-mile increase in distance to the nearest clinic is associated with 30.7 percent fewer abortions and 3.2 percent more births); *but see* Dennis et al., *supra* note 6 (many studies of the impact of parental involvement laws find that a decline in minor’s abortion rate, but most did not measure out-of-state abortions; two that did found no impact on the abortion rate; further, several studies found no short-term impact on pregnancy rates).

<sup>15</sup> Lauren Ralph et al., *Prevalence of Self-Managed Abortion Among Women of Reproductive Age in the United States*, 3 JAMA NETWORK OPEN (Dec. 2020), <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2774320> (finding that as abortion becomes more restriction, self-managed abortion may become more common).

<sup>16</sup> Dennis et al., *supra* note 6 (“the clearest documented impact of parental involvement laws is an increase in the number of minors traveling outside their home states to obtain abortion services in states that do not mandate parental involvement or that have less restrictive laws.”).

<sup>17</sup> Silvie Colman & Ted Joyce, *Regulating Abortion: Impact on Patients and Providers in Texas*, 30 J. OF POL’Y ANALYSIS & MGMT 775 (July 2011), <https://onlinelibrary.wiley.com/doi/10.1002/pam.20603>.

<sup>18</sup> Fuentes & Jerman, *supra* note 5 (“travel distance is an important determinant of abortion care access in the United States”).

<sup>19</sup> *Id.* (“travel distance is an important determinant of abortion care access in the United States”).

<sup>20</sup> *See e.g.*, Caitlin Gerdt, et al., *Impact of Clinic Closures on Women Obtaining Abortion Services After Implementation of a Restrictive Law in Texas*, 106 AM. J. OF PUB HEALTH 857 (May 2016), <https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2016.303134>.

<sup>21</sup> Barr-Walker et al., *supra* note 4 (“When stated, almost all reasons were framed in the contexts of increased legal restrictions that limited women’s access to clinics or where residence in regions in which legal barriers to care necessitated travel, including presenting beyond gestational age limits for termination.”).

<sup>22</sup> *Id.*

studies, many participants traveled over 50, 100, or even 200 miles to reach an abortion provider.”<sup>23</sup>

In terms of out-of-state travel, one study found that 6.4% of people were already traveling out of state to obtain abortion care in 2014, before hundreds of recent abortion restrictions had been enacted, and that 17% of those seeking abortion (estimated to be 155,000 people) traveled 50 miles or more for abortion care.<sup>24</sup> Moreover, it found that for those who live outside of urban areas (in non-MSA regions), 36% of patients traveled more than 100 miles for abortion services.<sup>25</sup> It also found that “among abortion patients aged 17 and younger, 11% of those in a parental involvement states traveled more than 100 miles compared with 2% in states with no such law.”<sup>26</sup> The Lancet study described above found that “states with more restrictive laws averaged 12% of patients leaving the state for abortion care while states with middle ground or supportive laws averaged 10% and 3% leaving, respectively.”<sup>27</sup>

A more recent study<sup>28</sup> analyzed the impact of Texas Senate Bill 8 (SB 8), which bans abortion upon detection of embryonic cardiac activity, which can take place as early as five to six weeks after a person’s last menstrual period and before many people know that they are pregnant.<sup>29</sup> The study found that “[m]any pregnant Texans have been traveling to neighboring states to obtain abortion care, and some have traveled as far as Illinois, Maryland, and Washington.”<sup>30</sup> More specifically, in just looking at 34 of the 44 open abortion facilities in seven nearby states (Arkansas, Colorado, Kansas, Louisiana, Mississippi, New Mexico, and Oklahoma), the study found that the number abortions for Texas residents jumped from 235 a month to an average of 1,391 a month. In other words, an increase of over 1,156 per month.<sup>31</sup>

Research also suggests that those who do travel out of state for abortion care are more likely to travel to a neighboring state, when compared to nearby, but not neighboring, states. The study on the impact of Texas’s SB 8 found that, among seven nearby states, 75% of Texans traveled to just two states: Oklahoma (45%) and New Mexico (27%).<sup>32</sup> (Notably, Oklahoma recently enacted an abortion

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<sup>23</sup> *Id.*

<sup>24</sup> Fuentes & Jerman, *supra* note 5. *Id.*

<sup>25</sup> *Id.*

<sup>26</sup> *Id.*

<sup>27</sup> Smith et al., *supra* note 10.

<sup>28</sup> Kari White et al., *Out-of-State Travel for Abortion Following Implementation of Texas Senate Bill 8*, TEXAS POL’Y EVAL. PROJECT (Mar. 2022), <https://sites.utexas.edu/txpep/files/2022/03/TxPEP-out-of-state-SB8.pdf>.

<sup>29</sup> *Id.*

<sup>30</sup> *Id.*

<sup>31</sup> *Id.* These data undercount the total number of Texans receiving care out of state since it did not obtain data from ten facilities in these states, and it does not include Texans who have traveled to other states.

<sup>32</sup> *Id.*



ban that is now the strictest in the nation,<sup>33</sup> which means Texans and people from other states no longer have an incentive to travel there.) Similarly, an earlier study that looked at the impact of Texas limiting abortions performed after 16 weeks gestation and that tracked Texans traveling to nine neighboring states, found that 99% of people traveled to the five closest of those nine states.<sup>34</sup>

It is also important to keep in mind that “travel” isn’t simply measured by looking at a map or the straight distance between states, counties, or abortion clinics. People will travel by car, public transportation, and airplanes to seek abortion.<sup>35</sup> Transportation routes, travel time, and a full consideration of transportation and other costs need to be accounted for when considering the burden of travel.<sup>36</sup> For these reasons, the World Health Organization recommends using travel time, rather than travel distance, as a measure of accessibility for health care access.<sup>37</sup>

Los Angeles serves as a major hub for airlines, hosts several airports, and is home to LAX, the fifth largest airport in the U.S. With frequent flights and a number of discount airlines serving the area, we anticipate that Los Angeles will be easier to reach than many smaller cities. For example, a flight from Dallas to Los Angeles may take less time than driving to a closer state or clinic, which may be important for those with work and/or childcare responsibilities and who wish to tell fewer people about the trip or the purpose of the trip.<sup>38</sup>

However, because flying is usually more expensive than driving, the proportion of people who will choose these options may depend on the extent to which abortion funds or others are helping to pay the cost of the flight and lodging. To the extent that such funds are available and are widely known, and for those who can afford it without such help, the best choice for a person in Texas might be to fly to Los Angeles as opposed to driving or taking a bus or train to a clinic in a closer state.

However, proximity, ease of travel, and cost are not the only things people consider when deciding

<sup>33</sup> ASSOCIATED PRESS, *Oklahoma governor signs the nation's strictest abortion ban*, NPR (May 26, 2022), <https://www.npr.org/2022/05/26/1101428347/oklahoma-governor-signs-the-nations-strictest-abortion-ban/oklahoma-governor-signs-the-nations-strictest-abortion-ban>.

<sup>34</sup> Colman & Joyce, *supra* note 17 (“Almost all women who left Texas for a late termination in 2004 went to a neighboring state. Of the 736 abortions by Texas residents recorded by state health departments in nine nearby states, 726 (99 percent) occurred in the five neighboring states (Arkansas, Kansas, Louisiana, Oklahoma, and New Mexico). The remaining ten abortions (1 percent) obtained out of state occurred in Colorado (9) and Missouri (1). Data collected from Mississippi and Tennessee indicated that there were no abortions after 15 weeks’ gestation by Texas residents in those states from 2004 to 2006. Given the very small number of women who traveled beyond the five neighboring states for a late abortion, we are confident that our results are not affected by the lack of data on abortions to residents of Texas obtained from other states.”).

<sup>35</sup> Barr-Walker et al., *supra* note 4 (“Almost all studies in this review contained descriptions of the modes of transportation women used when traveling for abortion services. Participants described traveling for abortion via airplane, private car, and public transportation.”).

<sup>36</sup> *Id.*

<sup>37</sup> WORLD HEALTH ORG., BACKGROUND PAPER FOR THE TECHNICAL CONSULTATION ON EFFECTIVE COVERAGE OF HEALTH SYSTEMS (2001).

<sup>38</sup> Barr-Walker et al., *supra* note 4 (“Other burdens related to travel, such as time away from work and the inability to keep one’s abortion confidential, were reported more often in qualitative studies.”).



between abortion clinics. One study found that most people will consider multiple clinics and take into account the reputation of the clinic, wait times, online reviews, references from people they know, privacy concerns, legal concerns, and safety.<sup>39</sup> This indicates that people may be willing to travel further to clinics in California and Los Angeles, and that those preferences will be shaped by the extent to which the state and county are affirmatively creating safe havens for abortion care. For example, when Poland recently prohibited abortion, affirmative outreach and support efforts by organizations and countries in the Europe Union led to the assistance of over 1,000 people who traveled to clinics outside of Poland.<sup>40</sup>

Accordingly, we use geographic proximity as well as the additional factors described above to create different assumptions for different sets of states about what percentage people will travel to California to have an abortion (See Table IV):

- **Arizona** – We assume 50% of those who travel out of state for abortion care from Arizona will travel to California. Arizona shares a long border with California. More people from Arizona than from any other state visit California for tourism each year, indicating that this travel pattern and its infrastructure are well established.<sup>41</sup> We also note that Arizona borders Mexico,<sup>42</sup> although it is unclear how many people will travel outside of the country to get an abortion.
- **Utah and Texas** – We assume 25% of those who travel out of state for abortion services from Utah and Texas will travel to California. Utah and Texas are close to California and many people from these states also visit California for tourism each year, indicating that these travel patterns and their infrastructure are well established.<sup>43</sup> We also note that Texas borders

<sup>39</sup>Orlaith Heymann et al., *Selecting an Abortion Clinic: The Role of Social Myths and Risk Perception in Seeking Abortion Care*, 63 J HEALTH SOC. BEHAV. 90 (2021), <https://pubmed.ncbi.nlm.nih.gov/34605701/>. In another study, women reported traveling to the United States for abortion care because of perceived lack of safety of the procedure in Mexico (their country of residence). See Barr-Walker et al., *supra* note 4.

<sup>40</sup>WOMEN HELP WOMEN, *Abortion Without Borders Helps More Than 34,000 People in Poland Access Abortions* (Oct. 21, 2021), <https://womenhelp.org/en/page/1363/abortion-without-borders-helps-more-than-34-000-people-in-poland>.

<sup>41</sup>VISIT CALIFORNIA, *California Travel-Related Spend & Visitation Forecast (May Update)* (May 17, 2022), <https://industry.visitcalifornia.com/research/travel-forecast> (slide 33 of the PowerPoint). More people traveled to California in 2019 for domestic leisure trips from Arizona (12.3 million trips) and Texas (9.9 million trips) than any other states).

<sup>42</sup>While Mexico's Supreme Court rule that some restrictions on abortion in the country could be unconstitutional, the extent of that decision's impact will be worked out by state legislatures and future court decisions. At this point, it is not clear to what extent abortion will be more available in Mexico than in states in U.S. that border Mexico and that will ban abortion. See Natalie Kitroeff & Oscar Lopez, *Abortion is No Longer a Crime in Mexico. But Most Women Still Can't Get One*, N.Y. TIMES (Sept. 8, 2021), <https://www.nytimes.com/2021/09/08/world/americas/mexico-abortion-access.html>. An earlier analysis questioned the extent to which people would travel outside of the country to obtain abortions and suggests that, at least in Texas, abortions in counties that border Mexico are a small fraction of all abortions in border states. See Colman & Joyce, *supra* note 17.

<sup>43</sup>VISIT CALIFORNIA, *supra* note 41 (slide 33 of the PowerPoint). More people traveled to California in 2019 for domestic leisure trips from Arizona (12.3 million trips) and Texas (9.9 million trips) than any other states. Among states that are likely to ban abortion if *Roe v. Wade* is overruled, Utah had the largest number of domestic leisure trips (3.4 million trips). Among all states, Utah ranks eighth in

Mexico,<sup>44</sup> although, again, it is unclear how many people will travel outside of the country to get an abortion. While other states near Utah (Nevada, Colorado, and New Mexico) and Texas (New Mexico, Colorado, and Kansas) are likely to continue to allow abortion in the short term, the limited number of clinics in these states might push residents to travel farther to California. The study of the impact of Texas' SB 8, described above, found that wait times at clinics in neighboring states, including New Mexico and Kansas, increased after the passage of SB 8: about half of the facilities "had wait times of two weeks or more, which may push pregnant people past the limit for medication abortion or into the second trimester of pregnancy."<sup>45</sup> More specifically, Kansas has only four abortion clinics, and half the abortions currently performed there are already for out-of-state residents.<sup>46</sup> New Mexico has only six abortion clinics and wait times already extend to up to three weeks.<sup>47</sup>

- Other states in nearby census regions and divisions** – We next consider additional states in nearby U.S. Census Bureau Divisions<sup>48</sup> that will ban abortion if *Roe v. Wade* is overturned. In the *West*: Mountain Division, Idaho, Montana, and Wyoming will ban abortion. In the *South*: *West South-Central Division*, Arkansas, Louisiana and Oklahoma will ban abortion. We note that these states have between one and four other nearby states closer than California, where abortion will remain legal (Nevada, Washington, Oregon, Colorado, New Mexico, Kansas). In addition, residents from some of the Mountain Division states might go to Canada for abortions.<sup>49</sup> However, the limited number of clinics in these states, such as Kansas and New Mexico, might push residents to travel farther to California.<sup>50</sup> For these states we assume 10% of those who travel out of state for abortion care will travel to California. Since no states in the *West: Pacific Division* are poised to ban abortion in the short-term (Alaska, Hawaii, Oregon, and Washington), we do not assume any increase in those traveling to California from these states.
- Remaining states that will ban abortion** – For all other states that will ban abortion, falling in the Eastern half of the United States, we assume that only 5% of those who travel out of state for abortion care will travel to California. Residents of these states will have a number of options on the East Coast, as well as other parts of the United States, Mexico, and Canada.

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terms of domestic leisure trips to California (by comparison New York accounts for 4.8 million trips).

<sup>44</sup> See Colman & Joyce, *supra* note 17.

<sup>45</sup> White et al., *supra* note 28.

<sup>46</sup> GUTTMACHER INST., *State Facts About Abortion: Kansas* (May 2022), <https://www.guttmacher.org/sites/default/files/factsheet/sfaa-ks.pdf>; Josh Merchant, *Nearly Half of Abortions in Kansas are for Missouri Residents, but Voters Could End That*, KCUR (Nov. 20, 2022), <https://www.kcur.org/news/2021-11-20/nearly-half-of-abortions-in-kansas-are-for-missouri-residents-but-voters-could-end-that>.

<sup>47</sup> White et al., *supra* note 28.

<sup>48</sup> U.S. CENSUS BUREAU, *Census Regions and Divisions of the United States*, [https://www2.census.gov/geo/pdfs/maps-data/maps/reference/us\\_regdiv.pdf](https://www2.census.gov/geo/pdfs/maps-data/maps/reference/us_regdiv.pdf) (last visited June 3, 2022).

<sup>49</sup> Andy Blatchford, *Canada is Open to Americans Who May Lose Access to Abortions, but There's a Catch*, POLITICO (May 5, 2022), <https://www.politico.com/news/2022/05/05/canada-americans-access-abortions-00030209>.

<sup>50</sup> GUTTMACHER INST., *supra* note 46; Merchant, *supra* note 46.

However, we assume that because 12% of the United States population lives in California,<sup>51</sup> some will travel to California because they have friends, family, and other forms of support in the state. Further, a number of closer states have more limited capacity to handle out-of-state residents. Finally, California and Los Angeles are already among the country's top domestic travel destinations, again indicating established travel patterns and infrastructure.<sup>52</sup>

- **Remaining states that will not ban abortion** – We do not assume any increase in people traveling to California from other states that will continue to permit abortion over the number who are already traveling to California.

To estimate the number of people who will travel to Los Angeles County more specifically (See Table V), we use geographic proximity and the additional factors described above. For example, Arizona is closer to Los Angeles than other parts of the state, so we assume most (67%) of those traveling to California for abortion from Arizona will come to Los Angeles County (we assume that others, for example, will go to clinics closer to the border, or near San Diego, Palm Springs, Riverside, etc.). Likewise, we assume that most people traveling from Idaho, Montana, and Wyoming (75%) will not travel to Los Angeles and will most likely travel to Northern California.

## LIMITATIONS

Because this publication represents an attempt to predict the future behavior of a group of diverse people across a large and populous country, it necessarily includes uncertainty. We note the following limitations to our analysis. First, we are facing a dramatic and unprecedented change in the legality of abortion in the United States. Some changes will happen right away, and others will happen over time. People who are in urgent need of abortion care may find creative and unanticipated ways to access abortion. For example, there exists uncertainty concerning the extent to which people in newly restrictive states will pursue legal and extralegal access to medication abortion, which may or may not require travel. With so many states poised to change their laws, we do not know what this wholly new landscape will seem like for people, and whether, for example, abortion patients will turn to countries like Canada and Mexico in hopes of avoiding penalties altogether, or whether states like California will succeed in creating what is perceived as a truly safe destination. Additionally, we do not know what this significant legal shift may inspire in terms of new laws, policies, and elected lawmakers seeking to address this unprecedented restriction on access to abortion in the US. Nevertheless, we offer an estimate based on assumptions grounded in the current literature, in the hopes of proving some sense of the scale of what California and Los Angeles may face in the coming months and years.

<sup>51</sup> U.S. CENSUS BUREAU, *QuickFacts: California; United States* (July 1, 2021), <https://www.census.gov/quickfacts/fact/table/CA,US/PST045221>; U.S. CENSUS BUREAU, *QuickFacts: United States* (July 1, 2021), <https://www.census.gov/quickfacts/fact/table/US/PST045221>.

<sup>52</sup> See GLOBENEWSWIRE, *The Best of the US—New Study Reveals the Most Popular Travel Destinations Among Americans* (June 2, 2022), <https://www.globenewswire.com/news-release/2022/06/02/2455472/0/en/The-Best-of-the-US-New-Study-Reveals-the-Most-Popular-Travel-Destinations-Among-Americans.html>; Carly Dodd, *America's 10 Most Visited Cities*, WORLD ATLAS (Sept. 23, 2021), <https://www.worldatlas.com/cities/america-s-10-most-visited-cities.html>.

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## ABOUT THE CENTER ON REPRODUCTIVE HEALTH, LAW, AND POLICY (CRHLP)

Founded in 2021 through a budget allocation from the state of California, CRHLP is an interdisciplinary, national academic research center dedicated to training the next generation of reproductive health and rights leaders, while producing research-informed strategies to transform current debates. CRHLP amplifies UCLA Law's current work on reproductive health, law, and policy and builds capacity by attracting new leaders, scholars, and students. CRHLP is committed to the highest standards of independent inquiry, academic excellence, and rigor. Research findings and conclusions are never altered to accommodate other interests, including those of funders, other organizations, or government bodies and officials.

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## APPENDIX

Table I. Number of state residents seeking abortions in-state that will lose access if *Roe v. Wade* is overturned; states closest to California

State of residence	All or almost all abortions restricted	No. abortions among state residents	% of abortions obtained out of state	No. abortions obtained out of state	No. accessing in state abortion currently who will no longer have access to in state abortion
<b>West: Pacific</b>					
Alaska	N				
California	N				
Hawaii	N				
Oregon	N				
Washington	N				
<b>West: Mountain</b>					
Arizona	Y	13,270	8.0%	1,065	12,205
Idaho	Y	1,790	30.7%	550	1,240
Montana	Y	1,510	5.2%	78	1,432
Utah	Y	3,020	6.6%	198	2,822
Wyoming	Y	720	74.4%	536	184
Colorado	N				
Nevada	N				
New Mexico	N				
<b>South: West South Central</b>					
Arkansas	Y	3,710	23.6%	876	2,834
Louisiana	Y	9,280	8.2%	764	8,516
Oklahoma	Y	4,780	7.0%	333	4,447
Texas	Y	56,340	3.8%	2,122	54,218
<b>All Other Regions</b>					
Remainder of States that will Ban All or Almost All Abortions (see Table II)	Y	229,940	13.5%	31,080	198,860
<b>TOTAL</b>		<b>324,360</b>		<b>37,602</b>	<b>286,758</b>

Source: Mikaela H. Smith et al. *supra* note 10

Table II. Number of state residents seeking abortions in-state that will lose access if *Roe v. Wade* is overturned; states father from California

State of Residence	No. abortions among state residents	No. abortions obtained out of state	% abortions obtained out of state
Alabama	7,660	2,397	31.3%
Florida	68,640	439	0.6%
Georgia	32,520	1,618	5.0%
Indiana	10,270	3,159	30.8%
Iowa	3,650	389	10.7%
Kentucky	4,780	1,994	41.7%
Michigan	26,130	338	1.3%
Mississippi	4,930	2,505	50.8%
Missouri	9,690	5,440	56.1%
Nebraska	2,250	444	19.7%
North Dakota	970	127	13.1%
Ohio	20,560	1,192	5.8%
Oklahoma	4,780	333	7.0%
South Carolina	11,380	6,536	57.4%
South Dakota	750	324	43.2%
Tennessee	11,060	1,361	12.3%
West Virginia	2,380	1,109	46.6%
Wisconsin	7,540	1,375	18.2%
<b>TOTAL</b>	<b>229,940</b>	<b>31,080</b>	<b>13.5%</b>

Source: <https://www.sciencedirect.com/science/article/pii/S2667193X2200031X?via%3Dihub>

Table III: Legal and geographic considerations

State of residence	All or almost all abortions restricted	Borders California	Other bordering/near bordering states with abortion access	Borders Mexico	Borders Canada	Estimated % going out of state for abortions who will travel to CA
<b>West: Pacific</b>						
Alaska	N					
California	N					
Hawaii	N					
Oregon	N					
Washington	N					
<b>West: Mountain</b>						
Arizona	Y	Yes	Nevada, Colorado, New Mexico			50%
Idaho	Y		Washington, Oregon, Nevada, Colorado	Yes		10%
Montana	Y		Washington, Oregon, Colorado	Yes		10%
Utah	Y		Nevada, Colorado, New Mexico			25%
Wyoming	Y		Nevada, Colorado			10%
Colorado	N					
Nevada	N					
New Mexico	N					
<b>South: West South Central</b>						
Arkansas	Y		Kansas			10%
Louisiana	Y		Kansas, Colorado, New Mexico			10%
Oklahoma	Y		Kansas, Colorado, New Mexico			10%
Texas	Y		New Mexico, Colorado, Kansas	Yes		25%
<b>All Other Regions</b>						
Remainder of States that will Ban All or Almost All Abortions (see Table II)	Y		Multiple			5%

Source: Source: Nash & Cross, *supra* note 2.



Table IV: Estimate of people traveling to California annually if *Roe v. Wade* is overturned

State of residence	No. accessing in state abortions currently who will no longer have access to in state abortion	% traveling out of state who will travel to CA	Low scenario: annual estimated increase in non-resident abortions in CA (if 25% of those losing access to abortion will travel out of state to any state)	Middle scenario: annual estimated increase in non-resident abortions in CA (if 33% of those losing access to abortion will travel out of state to any state)	High scenario: annual estimated increase in non-resident abortions in CA (if 50% of those losing access to abortion will travel out of state to any state)
<b>West: Pacific</b>					
Alaska					
California					
Hawaii					
Oregon					
Washington					
<b>West: Mountain</b>					
Arizona	12,205	50%	1,526	2,014	3,051
Idaho	1,240	10%	31	41	62
Montana	1,432	10%	36	47	72
Utah	2,822	25%	176	233	53
Wyoming	184	10%	5	6	9
Colorado					
Nevada					
New Mexico					
<b>South: West South Central</b>					
Arkansas	2,834	10%	71	94	142
Louisiana	8,516	10%	213	281	426
Oklahoma	4,447	10%	111	147	222
Texas	54,218	25%	3,389	4,473	6,777
<b>All Other Regions</b>					
Remainder of States that will Ban All or Almost All Abortions (see Table II)	198,860	5%	2,486	3,281	4,972
<b>TOTAL</b>	<b>286,758</b>		<b>8,043</b>	<b>10,616</b>	<b>16,085</b>

Table V: Estimate of people traveling to Los Angeles annually if *Roe v. Wade* is overturned

State of residence	% of new non-resident abortions statewide in CA performed in Los Angeles	Low scenario: annual estimated increase in non-resident abortions in Los Angeles (if 25% of those losing access to abortion will travel out of state to any state)	Middle scenario: annual estimated increase in non-resident abortions in Los Angeles (if 33% of those losing access to abortion will travel out of state to any state)	High scenario: annual estimated increase in non-resident abortions in Los Angeles (if 50% of those losing access to abortion will travel out of state to any state)
<b>West: Pacific</b>				
Alaska				
California				
Hawaii				
Oregon				
Washington				
<b>West: Mountain</b>				
Arizona	67%	1,022	1,349	2,044
Idaho	25%	8	10	16
Montana	25%	9	12	18
Utah	50%	88	116	176
Wyoming	25%	1	2	2
Colorado				
Nevada				
New Mexico				
<b>South: West South Central</b>				
Arkansas	50%	35	47	71
Louisiana	50%	106	141	213
Oklahoma	50%	56	73	111
Texas	50%	1,694	2,236	3,389
<b>All Other Regions</b>				
Remainder of States that will Ban All or Almost All Abortions (see Table II)	67%	1,665	2,198	3,331
<b>TOTAL</b>		<b>4,685</b>	<b>6,185</b>	<b>9,371</b>