The Eyes of Texas are Upon OB/GYNs: Physician Migration and Crowdsourced Enforcement of Abortion Regulations *

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Abstract

A civil liability enforcement mechanism (CLEM) seeks to circumvent constitutionality by replacing criminal prosecution with private civil suits. CLEM imposes higher expected costs on society by lowering the evidentiary burden for the accused and expanding the pool of potentially liable people. Texas Senate Bill 8 (SB-8, 2021) was the first law to apply CLEM: any private citizen could sue anyone who "aids or abets" an abortion after six weeks of gestation for minimum damages of $10,000. We examine the effect of SB-8's civil liability enforcement mechanism on the labor market for reproductive health physicians in Texas. We use a Medicare administrative provider panel (2007–2022) and Wagescape job posting data (2016–2022) to estimate triple-difference models. We find that reproductive health physicians did not leave Texas at differential rates following SB-8. The null result is consistent with the high cost of relocation, estimated at $150,000 to $250,000 in licensing and insurance costs. Neither posted salaries nor job posting volume for reproductive healthcare providers change. Our results stand in contrast to recent news media that claim a large physician migration response. We complement a rapidly emerging literature by showing CLEM in this context had no discernible effect above and beyond the effect of the changing national abortion landscape.

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1 Introduction

Texas Senate Bill 8, enacted in September 2021, introduced a novel civil liability enforcement mechanism (CLEM). Unlike all other abortion restrictions enforced through criminal penalties, SB-8 authorized "any person" to bring civil lawsuits against anyone who "aids or abets" an abortion after detection of a fetal heartbeat (around six weeks of gestation). The so-called "bounty law" could have been challenged in the courts, but the civil liability enforcement mechanism was included for the express purpose of helping Senate Bill 8 survive judicial review.

Civil liability enforcement potentially imposes different deterrent effects and risk compared to criminal prosecution. Criminal liability requires a burden of proof that is "beyond a reasonable doubt," but civil liability only requires a "preponderance of the evidence."[1] Imagine the less politically charged example of shoplifting. If the state uses traditional criminal liability, a store in that state may accuse a customer of shoplifting. Police would gather evidence and may decide to make an arrest. The customer would be arraigned before a grand jury who may decide there is enough evidence to continue with prosecution. Finally, the customer would stand before a judge the determination of their guilt. If the state used civil liability to enforce its shoplifting law, anyone could accuse anyone of "aiding or abetting" shoplifting by filing a lawsuit for a minimum of $10,000 in damages. The accused would be responsible for their own legal fees and can not recover their legal fees if exonerated. Criminal liability imposes a cost on those intending to shoplift, but civil liability imposes a cost on every customer in the store. It would be reasonable for a shopper to avoid shopping in a state with civil liability enforcement.

Becker (1968) establishes the economic framework: physicians weigh the expected benefits against the expected costs of practicing in Texas. Expected costs in this context include the penalty for violating Texas's abortion law multiplied by the probability of detection

[1] A preponderance of evidence means there is more than a fifty percent chance that the party being sued is at fault. Proof beyond a reasonable doubt means that a reasonable person would have no doubt about the defendent's guilt.

and conviction. Under criminal enforcement of abortion restrictions, that expected cost would fall exclusively on the physician who performs the procedure. Physicians who do not directly perform abortions would not weight that expected cost as part of their location decision. Under SB-8's civil enforcement, the expected cost changes in two important ways. First, the "preponderance of the evidence" standard raises the probability of liability relative to criminal prosecution. Second, the "aid or abet" language extends potential liability from exclusively abortion providers to any physician who manages pregnancy complications, counsels patients about their options, or provides emergency obstetric care. The result is an increase in expected cost that applies even to physicians who never perform an abortion. This framework predicts that the structure of SB-8 increased expected operating costs for reproductive health physicians (especially OB/GYNs, family medicine physicians, and emergency medicine physicians) and generated direct financial incentives to exit Texas.

This paper examines migration responses to civil liability enforcement mechanisms in the context of reproductive health physicians responding to Texas Senate Bill 8. SB-8's signing in May 2021 and implementation in September 2021 provide a valuable natural experiment with one treated state. SB-8 took effect nine months before *Dobbs v. Jackson Women's Health Organization* overturned the constitutional right to an abortion from *Roe v. Wade*. This context differs markedly from the post-*Dobbs* period when multiple states enacted abortion regulations. An affected physician has more ability to move to unaffected locations during the SB-8 era compared to the post-*Dobbs* era.

We use two complementary data sources. We first use Medicare administrative data on physician locations from November 2007 through June 2022 (before the *Dobbs* ruling), covering approximately 1.4 million physicians, to estimate triple-difference models comparing reproductive health physicians (OB/GYNs and family medicine physicians) to all other physicians in Texas relative to other states, before and after SB-8's signing on May 19, 2021.[2] Physician counts are normalized per 100,000 women of childbearing age. We also

[2]We measure treatment from SB-8's signing rather than its September 1, 2021 enactment date because Google Trends data on searches for "Texas Heartbeat" show a large spike in attention at the time of signing.

use Wagescape data on physician job postings covering 1,327,394 postings from 2016–2022, including 107,474 OB/GYN and 150,839 family medicine postings. The posted salary is available for approximately half of postings. These data allow us to examine whether employer demand and compensation for reproductive health physicians in Texas shifted following SB-8.

We find no statistically significant migration response for reproductive health physicians in the thirteen months following SB-8's signing. The Wagescape job posting data reinforce this null: both posted salaries and job posting volume for Texas reproductive health providers show no differential change relative to controls. When the sample is expanded to include all family medicine physicians, a salary decline appears in hospitalist and "without OB" postings—the subset least plausibly exposed to SB-8's "aid or abet" language—suggesting employer composition effects rather than a CLEM wage response. The null results across both data sources are consistent with the high fixed costs of interstate practice relocation. These findings stand in contrast to several prominent media narratives that characterized the post-SB-8 period as an exodus of OB/GYNs from Texas (Petterson and Eubank, 2024; Taladrid, 2024); our results do not support the conclusion that a large-scale departure occurred as a result of SB-8.

A growing body of evidence documents that abortion restrictions reduce the supply of reproductive health physicians, and effect sizes scale with the severity of the legal penalties attached to enforcement. Studies examining post-*Dobbs* abortion bans find consistent evidence of workforce contraction. Zhu et al. (2025) find a 4.2 percent decrease in OB/GYN practitioners per 100,000 reproductive-aged women in the most restrictive states relative to controls. Diaz-Campo and Pineda-Torres (2024) similarly find a 3 percent decline in reproductive health physicians in ban states using an NPI panel. The magnitude of exit under criminal-penalty regimes can be dramatic: Rader et al. (2025), studying Idaho under a near-total criminal ban with felony charges, document a 35 percent loss of practicing OB/GYNs within 27 months of implementation. The same pattern appears in the TRAP era predat-

This response suggests that Senate Bill 8 was highly salient at its signing.

ing *Dobbs*: Markowski and Vandenbroeck (2025) estimate that targeted abortion provider regulations reduced OB/GYN density by 4.67 percent on average over 1993–2021, with effects persisting for a decade in nonmetropolitan counties, and Chatterji et al. (2025) find a 6.6 percent reduction following TRAP enactment using a stacked difference-in-differences design; their evidence points to physicians exiting the workforce rather than geographic relocation. The effects extend beyond the current workforce to the training pipeline: Hammoud et al. (2024) document a significant decline in residency applications to OB/GYN programs in abortion-restrictive states post-*Dobbs*, with downstream consequences for long-run supply. Taken together, this literature establishes that abortion-restricting regulation reduces OB/GYN supply, and that the severity and certainty of criminal liability appears to be the primary driver of the exit margin.

Against this backdrop, several studies find null or modest migration effects for established physicians in the short run, consistent with our findings for Texas. Staiger et al. (2025) study practice locations for 60,085 OBGYNs across all policy environments from January 2018 to September 2024 and find no statistically significant change in counts across banned, threatened, and protected states, with approximately 95 percent of OBGYNs remaining in their pre-*Dobbs* policy environment. Strasser et al. (2024), using new-state enrollment flows to approximate relocation, similarly find no significant post-*Dobbs* shift comparing ban and no-ban states in the two years following the decision. Nelson and Witko (2026) document a preference-behavior gap: while physicians in survey experiments express a preference for practicing in non-ban states, actual interstate migration effects remain modest. This behavioral stickiness is consistent with high fixed costs of relocation. Falcettoni (2021) identifies strong preferences for remaining near residency training location as a primary driver of physician location choice, and Gottlieb et al. (2025) document that physician earnings and labor supply respond primarily to financial incentives rather than regulatory amenities. At the population level, Dench et al. (2025) find significant out-migration from states with total criminal bans using USPS address-change data, but no comparable movement in states with

partial restrictions. Despite growing attention to physician responses to abortion restrictions, no prior work has examined whether civil liability enforcement, which broadens the set of affected physicians, produces a different migration effect.

2 Background: SB-8 and Civil Liability Enforcement

Texas Senate Bill 8 (SB-8) was signed on May 19, 2021 and enacted on September 1, 2021. SB-8 prohibits abortion after the detection of embryonic cardiac activity which typically occurs around six weeks of gestation. The statute's enactment predated the Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization* by nine months, placing it within the constitutional framework established by *Roe v. Wade* and *Planned Parenthood v. Casey*. Under precedent, SB-8 could have been ruled unconstitutional. The statute survived pre-enforcement judicial review through an unprecedented enforcement mechanism that delegated enforcement exclusively to private civil litigation rather than state officials. Chief Justice John Roberts characterized this approach as "not only unusual, but unprecedented," warning that "it is the role of the Supreme Court in our constitutional system that is at stake." SB-8 avoided constitutional challenge by eliminating any state official against whom plaintiffs could seek injunctive relief.

The timing and scope of SB-8 merit particular attention for understanding its impact on physician practice patterns. At the time of enactment, approximately 85-90% of abortions performed in Texas occurred after six weeks of gestation, meaning the statute effectively prohibited the vast majority of abortion procedures previously performed in the state. Unlike subsequent abortion restrictions that took effect following *Dobbs*, SB-8 operated in a legal environment where abortion remained constitutionally protected nationally, creating a localized regulatory shock specific to Texas providers and patients.

SB-8 authorizes "any person, other than an officer or employee of a state or local governmental entity," to bring civil action against anyone who performs or "aids or abets" an

abortion prohibited under the statute. This "aid or abet" language extends potential liability beyond physicians performing procedures to encompass a broad range of supportive activities, including providing transportation, financial assistance, counseling, or administrative support for prohibited abortions.

The incentives embedded in CLEM substantially favor plaintiffs. Successful litigants receive minimum statutory damages of $10,000 per abortion plus injunctive relief and attorney's fees. Defendants cannot recover attorney's fees or costs even if they win in litigation, creating asymmetric exposure to legal expenses. This one-way cost structure distinguishes CLEM from typical civil litigation, where prevailing defendants may recover costs, and from criminal prosecution, where defendants face no financial penalty for successful defense beyond legal fees. The statute further advantages plaintiffs by eliminating the heightened burden of proof required in criminal proceedings; civil litigation requires only a preponderance of evidence rather than proof beyond reasonable doubt.

A single prohibited abortion could generate multiple lawsuits from different plaintiffs, each seeking the $10,000 statutory minimum. For potential defendants, the expected cost of CLEM exposure reflects not only the probability of liability but also the probability of facing litigation itself, multiplied by defense costs that cannot be recovered. Medical malpractice insurance does not cover civil liability. SB-8 litigation imposes defense costs with no possibility of fee recovery and no insurance coverage.

Despite the statute's theoretical enforcement potential, actual litigation activity under SB-8 was limited. Only three lawsuits were filed pursuant to the statute, all between September 20–22, 2021, and all targeting a single physician: Dr. Alan Braid of San Antonio. Dr. Braid had deliberately invited litigation by publishing an op-ed in *The Washington Post* announcing that he had performed an abortion in violation of SB-8. No additional lawsuits have been filed under SB-8's provisions, no plaintiff has collected the statutory bounty, and no case has resulted in a finding of liability. The sole case to reach judicial resolution, *Gomez v. Braid*, was dismissed for lack of standing in December 2022 and affirmed on appeal

in February 2024, establishing that the statute's "any person" language remains subject to Texas constitutional standing requirements.

The absence of broader enforcement activity reflects strategic inaction by abortion opponents rather than lack of interest or resources. Major anti-abortion organizations, including Texas Right to Life and Operation Rescue, explicitly declined to file SB-8 lawsuits to avoid the creation of test cases that could provide grounds for invalidating the statute. By maintaining the threat of enforcement while limiting actual litigation, these organizations preserved SB-8's deterrent effect while minimizing legal risk to the statute. This deterrence mechanism proved highly effective despite minimal enforcement. Abortion providers in Texas ceased performing procedures after detection of embryonic cardiac activity upon SB-8's effective date.

The omnipresent threat inherent in CLEM, whereby any patient, family member, or stranger may initiate litigation, fundamentally differs from criminal enforcement risk. Criminal prosecution requires a willing prosecutor; CLEM requires only a willing plaintiff for whom the statute creates affirmative financial incentives and eliminates downside risk. For physicians evaluating practice location, CLEM exposure represents an uninsurable increase in expected operating costs.

3 Conceptual Framework

Becker's (1968) model of rational deterrence treats the decision to engage in a regulated activity as a function of expected liability costs: the probability of detection multiplied by the penalty conditional on detection, weighed against the expected benefit of the activity. SB-8 is designed to alter both components of this expected cost in ways that are qualitatively distinct from traditional criminal enforcement.

Probability of detection. Criminal enforcement targets the physician who performs the procedure, requiring that a state actor identify, investigate, and prosecute a specific indi-

vidual. SB-8's "aid or abet" language dramatically broadens the set of actors subject to potential liability. A physician who provides standard obstetric care or counseling to a patient who subsequently obtains an abortion may be named in a civil suit without having performed or directly facilitated an abortion. The vagueness of the statute's scope means that even a physician taking no deliberate part in an abortion faces a positive and difficult-to-quantify probability of being drawn into litigation. This ambiguity itself constitutes a cost: physicians cannot insure against risks they cannot precisely estimate.

Penalty structure. Under criminal enforcement, a defendant who prevails at trial bears no financial penalty beyond legal fees typically covered by malpractice insurance. SB-8 inverts this logic. Defendants cannot recover attorney's fees or costs even if they prevail in litigation, meaning a successful defense still imposes a net financial cost. Moreover, a single prohibited procedure can generate multiple independent lawsuits from different plaintiffs, each seeking the $10,000 statutory minimum, creating effectively unbounded aggregate exposure from a single clinical event. Because standard medical malpractice policies do not cover SB-8 civil liability, these costs are uninsurable.

Together, the broader detection margin and the asymmetric penalty structure imply that SB-8 imposes expected costs on a much wider set of physicians than traditional criminal enforcement, including physicians who provide no abortion services but whose routine clinical activities might be characterized as "aiding" a prohibited abortion. The predicted behavioral response is either to relocate away from Texas (the migration margin) or to demand higher compensation for bearing this incremental risk (the wage margin). The evidence in this paper finds no detectable response on either margin, consistent with the high fixed costs of interstate practice relocation estimated at $150,000–$250,000.

4 Data

4.1 Sample Group: "Hostile" and "Restricting" States

Texas was not the only state facing a restrictive abortion environment during the analysis period. Using all states as the control group would contaminate the comparison: physicians in states with open abortion laws are operating in a fundamentally different policy atmosphere compared to a physician in a state that restricts abortion. To address this, we restrict the sample group to the twenty-five states that Dench et al. (2025) classify as "hostile to abortion" or subject to a total abortion ban. The policy environment in these states most closely resembles Texas's policy environment before and around SB-8.[3]

This restriction serves a substantive identification purpose beyond improving pre-period balance. Physicians practicing in hostile or ban states already operate under a restrictive abortion environment. A triple-difference comparison of Texas RHPs against RHPs in these states therefore isolates the *marginal* effect of SB-8's civil liability enforcement mechanism above and beyond the effect of a restrictive abortion policy environment. By contrast, a comparison against physicians in permissive states would conflate the CLEM-specific deterrent with the broader effects of practicing in any abortion-restrictive state.

The balance table in Section 4 confirms that the restricted sample is more similar to Texas on pre-period physician market outcomes than the full pool of states (Table 2).

4.2 Migration Data

This paper uses Medicare administrative data to construct a comprehensive panel tracking physician practice locations over time. The primary data sources are the National Plan and Provider Enumeration System (NPPES) and the Centers for Medicare and Medicaid Services (CMS) Doctor and Clinician (DAC) database. The NPPES serves as the authori-

[3]The 25 control states are: AL, AR, AZ, FL, GA, IA, ID, IN, KY, LA, MO, MS, NC, ND, NE, OH, OK, PA, SC, SD, TN, UT, WI, WV, and WY.

tative registry of all healthcare providers in the United States who hold a National Provider Identifier (NPI), a unique identification number required for billing Medicare and private insurance. The DAC database supplements NPPES by providing detailed practice location information for physicians who bill Medicare. Because practice addresses must be current to receive Medicare reimbursement, these administrative records offer high-quality location data with strong incentives for accuracy and timeliness.

The sample spans November 2007 through June 2022, creating a quarterly panel that covers approximately 1.4 million physicians. This period begins with the earliest available DAC data and concludes with the Supreme Court's *Dobbs* decision in June 2022. The panel includes both physicians already in practice and new physicians entering the workforce from residency programs, providing a complete view of the physician labor market over the study period. For each physician, the data contain the provider's name, NPI, practice street address, and specialty designation.

Five dependent variables capture different dimensions of physician mobility. First, a physician is coded as "active in the state" if she appears in the data with a practice location in that state during a given quarter. Second, a physician is classified as having "exited the state" if she leaves for another state while remaining in active practice. Third, a physician "entered the state" from another state while remaining in active practice. Fourth, "new entrance" identifies each physician's very first active quarter in the data, capturing a new residency graduate making their entry into the workforce. Fifth, "retirement" captures permanent career exit by identifying each physician's final active quarter. Summary statistics are shown in Table 1.

	All	TX RHP	TX Non-RHP	Non-TX RHP	Non-TX Non-RHP	(Min, Max)
Panel A: NPI Physician Panel (per 100k women)						
Active Physicians	826	365	1017	481	1182	(256, 2050)
	(396)	(42.50)	(117)	(89.07)	(251)	
Exit State	6.29	1.39	5.88	3.05	9.76	(0, 140)
	(11.22)	(2.26)	(9.12)	(4.63)	(14.61)	
Entry State	6.57	1.69	6.77	3.02	10.30	(0, 176)
	(11.88)	(2.08)	(8.25)	(4.82)	(15.50)	
New Career Entrants	15.04	7.08	19.08	9.14	21.08	(0, 1226)
	(80.62)	(31.68)	(87.27)	(43.75)	(106)	
Retirements	2.30	1.19	2.77	1.57	3.05	(0, 296)
	(15.50)	(7.61)	(17.35)	(10.31)	(19.45)	
Panel B: Wagescape Job Postings						
Posted Salary (USD, COL-Adj.)	184,510	150,084	180,711	175,857	187,716	(10,266, 863,998)
	(116,651)	(104,744)	(106,084)	(115,855)	(118,228)	
Log Posted Salary	11.93	11.64	11.94	11.83	11.95	(9, 13.67)
	(0.689)	(0.818)	(0.633)	(0.772)	(0.671)	
Job Postings (per 100k women 15–44)	46.13	8.82	37.65	19.37	74.69	(0.1, 927)
	(68.27)	(6.89)	(28.70)	(26.34)	(85.89)	

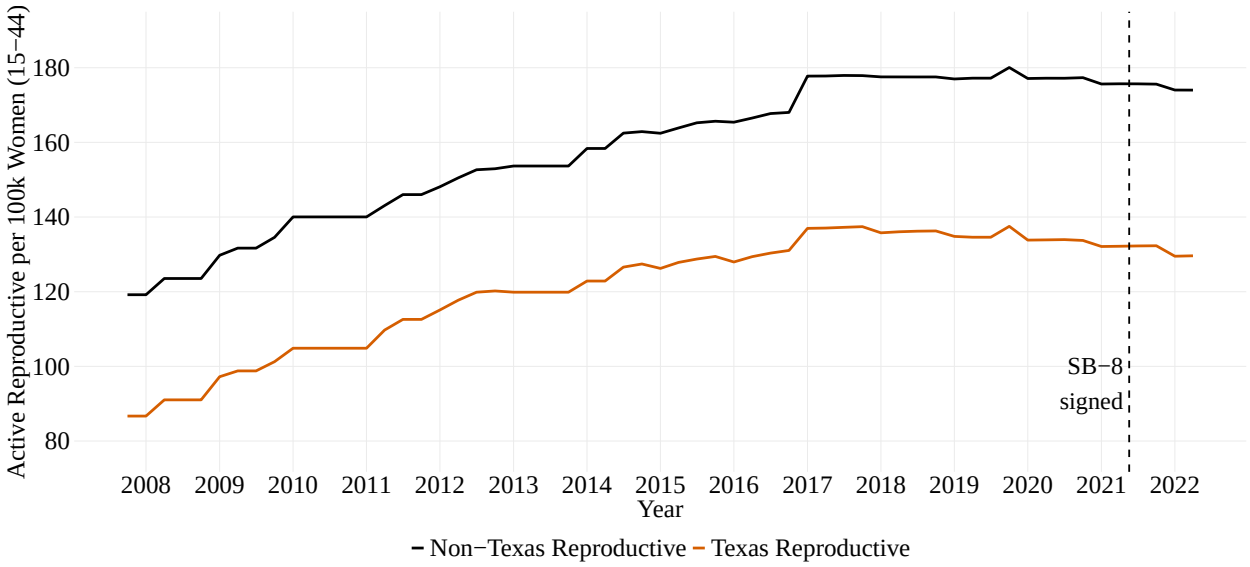
Table 1: Summary statistics for both data sources. Columns show means by group: all observations, Texas RHP, Texas non-RHP, non-Texas RHP, non-Texas non-RHP (restricted control states), and overall (Min, Max). SD in parentheses below means. Panel A: NPI physician panel; unit is the state × quarter cell collapsed to RHP and non-RHP groups; outcomes per 100,000 women of childbearing age. Panel B: Wagescape job postings restricted to the analysis sample; salary unit is the individual posting; postings unit is the state × quarter cell. Sources: NPPES/CMS DAC; Wagescape via Dewey Data Platform.

Physician specialties are grouped into *reproductive health providers* (RHPs) and all other physicians. RHPs include obstetricians and gynecologists (OB/GYNs), family medicine

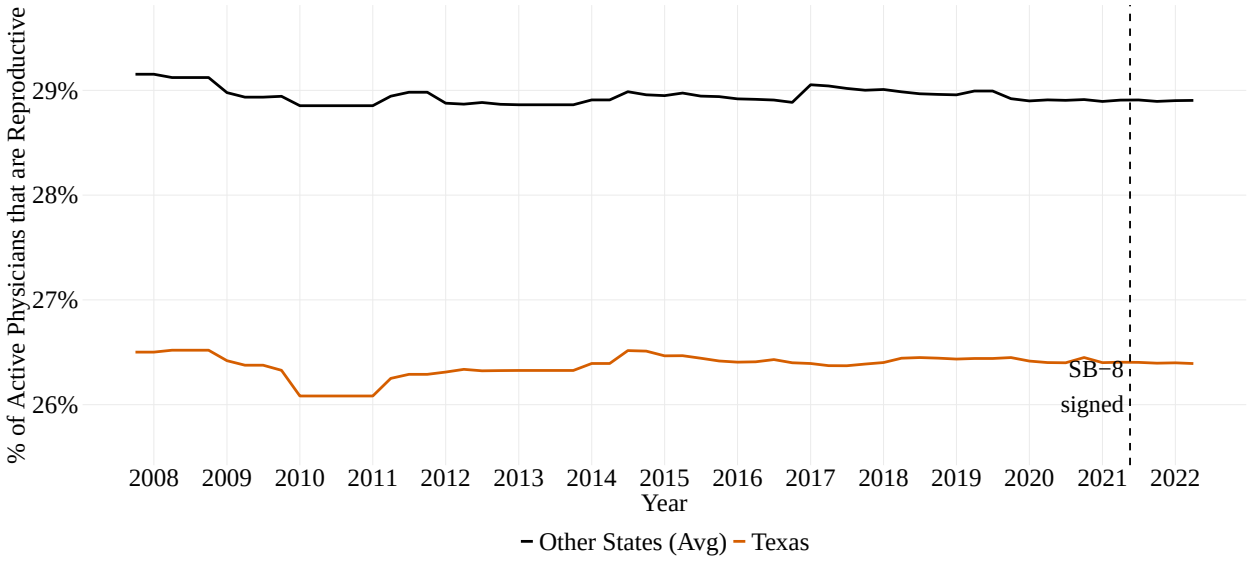
physicians, and emergency medicine physicians. OB/GYNs face the most direct exposure to SB-8's provisions. Family medicine physicians are included because they may serve as the sole maternal healthcare provider in rural communities and encounter pregnancy complications as part of primary care. Emergency medicine physicians are included because they face time-sensitive decisions in obstetric emergencies where the line between permissible and impermissible treatment is ambiguous under the statute's "aid or abet" language. All outcomes are normalized per 100,000 women of childbearing age in each state-quarter to account for the substantial variation in population across states.[4]

Figure 1 shows active reproductive health providers (RHPs) per 100,000 women of childbearing age and RHPs as a share of all active physicians, comparing Texas to the restricted control group (hostile and total-ban states). The series move closely together through the pre-period and show no visible divergence following SB-8's signing in May 2021, consistent with the null result.

[4]Women of childbearing age are defined as ages 15–44, following standard practice in the obstetrics literature.



(a) Active RHPs per 100k women: Texas vs. control states.



(b) RHPs as a share of all active physicians (%): Texas vs. control states.

Figure 1: Active reproductive health provider (RHP: OB/GYN, Family Medicine, and Emergency Medicine) counts per 100,000 women of childbearing age (ages 15–44) from 2007 to 2022. Panel (a) plots RHP counts per 100k women; panel (b) plots the RHP share of all active physicians. Both panels compare Texas to the hostile/ban control states. The dashed vertical line marks May 19, 2021, the date SB-8 was signed. Full-sample (all-states) equivalents are shown in Appendix **??**. Source: NPPES/CMS DAC.

The universal coverage and longitudinal structure of these data make them well-suited for analyzing physician location decisions in response to state-level policy changes, and the administrative nature of the data reduces concerns about survey non-response or selective

attrition. The resulting data are a panel of specialty-state-quarter counts of migration, normalized per 100,000 women of childbearing age.

A limitation in our data is that we observe a lower bound on physician retirements. In general, most physicians do not deactivate their NPIs when they retire, so we substantially undercount true retirements. The retirement margin is particularly important for our analysis because physicians planning to retire in the near future may exit early rather than bear the legal risk of continued practice under SB-8, and the fixed cost of retiring a few years early is lower than the fixed cost of relocating for mid-career physicians. We are seeking methods to bolster our measurement of physician retirement, and a further discussion of this point is included in the limitations and next steps at the end of this paper.

4.3 Wagescape Job Postings Data

We use physician job posting data from Wagescape to analyze the offered salary and job posting volume for reproductive health physicians. These data cover 1,327,394 physician job postings for the period 2016–2022, including 107,474 OB/GYN postings, 150,839 Family Medicine postings, and 49,068 Emergency Medicine postings.[5] Each posting records the position state, date posted, and, if disclosed by the employer, the offered salary. Salary is available for approximately 50 percent of postings, with coverage rising from 5–13 percent in 2016–2017 to 65–80 percent in 2018–2022. After limiting to the 50 US states and the District of Columbia, the salary analysis sample includes all postings with a positive reported salary across all three physician specialties in the RHP group.

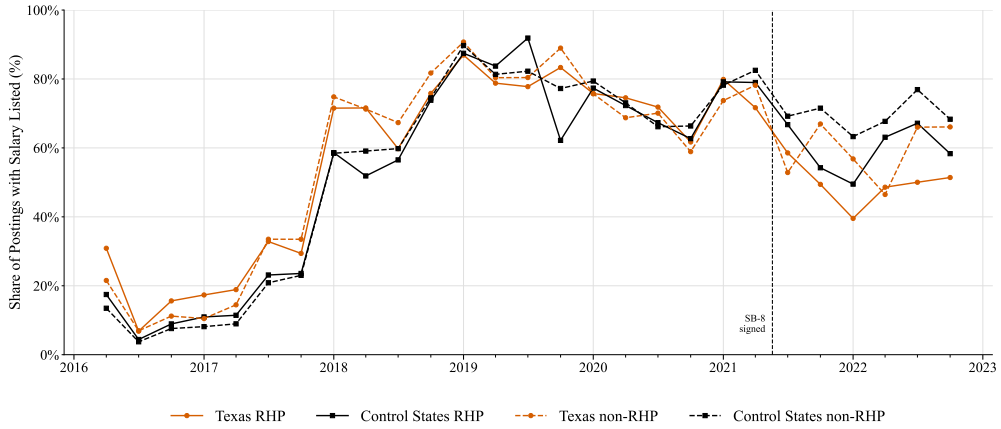
A potential threat to identification in the wage analysis is differential trends in salary

[5]OB/GYN postings are identified using SOC code 29-1218. Family medicine postings are identified using SOC code 29-1215, and we remove Family medicine postings that include "no OB" in the job title. ER physicians are identified using the job title keywords "emergency medicine," "emergency physician," "ER physician," "EM physician," and "ED physician." The NPI analysis classifies all Family Medicine physicians (taxonomy 207Q) as reproductive health providers, while the Wagescape wage analysis restricts to Family Medicine physicians whose job title indicates obstetric, emergency, or otherwise ambiguous reproductive content. In the NPI data, it is not possible to identify which family physicians perform obstetric services from the administrative records alone. This means the NPI RHP group is broader than the Wagescape RHP group.

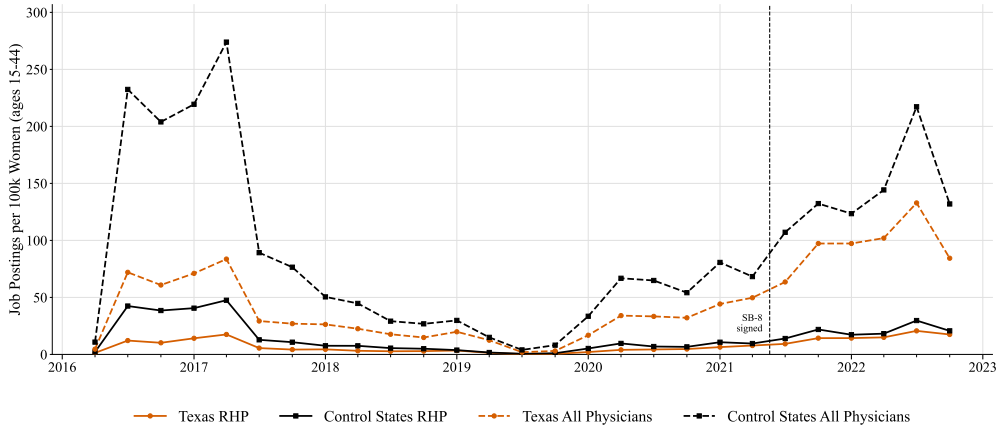
disclosure rates across groups. If Texas RHP employers became more or less likely to disclose posted salaries around SB-8's signing (relative to Texas non-RHPs or to control-state RHPs) the estimated wage effect could reflect a composition change in the salary-reporting sample rather than a true price signal. Panel (a) of Figure 2 plots the quarterly share of postings with a salary listed for four groups: Texas RHP, control-state RHP, Texas non-RHP, and control-state non-RHP. The four series track closely throughout the sample period, including around the May 2021 signing date, with no visible differential break for Texas RHPs relative to any comparison group. This parallel behavior in disclosure rates supports the interpretation that changes in the salary sample composition are not a confounding factor in the wage triple-difference estimates.

Panel (b) shows the total volume of physician job postings per 100,000 women of childbearing age, comparing Texas to the control states for all physicians and for RHPs separately. Across all four series we observe substantial growth from 2016 through 2022, with particularly steep growth beginning in 2020. This growth trend is consistent across all groups and reflects Wagescape's expanding coverage of the job market rather than an underlying increase in actual job openings. The parallel trends in the pre-SB-8 period and absence of a visible discontinuity at SB-8's signing date support the identifying assumption.

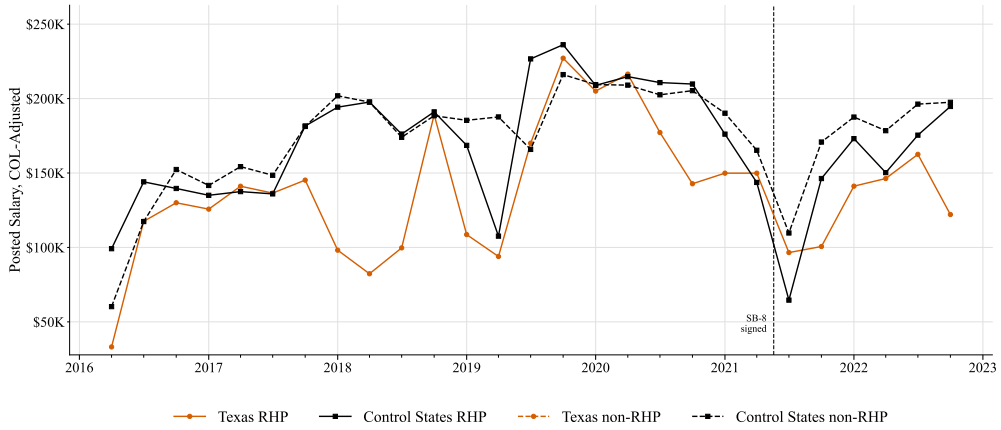
Panel (c) describes the descriptive patterns in posted salaries comparing Texas to the control states for RHP and non-RHP physicians separately. Table **??** presents summary statistics for the regression sample.



(a) Salary disclosure rate: share of postings with salary listed.



(b) Total job postings per 100k women: all physicians and RHP.



(c) Posted salary (COL-adjusted): RHP and non-RHP.

Figure 2: Wagescape descriptive figures, all comparing Texas (orange) to the restricted control group (black), with solid lines for RHP and dashed lines for all physicians. Panel (a): quarterly share of postings with salary disclosed; the four series track in parallel with no differential break around SB-8's signing, supporting the salary-sample validity assumption. Panel (b): total physician job postings per 100,000 women aged 15–44; post-2020 growth reflects Wagescape's expanding coverage rather than actual hiring. Panel (c): posted salary (BEA RPP cost-of-living adjusted) for RHP and non-RHP physicians in Texas and the restricted control states. The dashed vertical line in all panels marks SB-8's signing date (May 19, 2021). Source: Wagescape via Dewey Data Platform.

4.4 Balance: Texas vs. Control States vs. Other States

Table 2 presents pre-period (pre–May 2021) means for all NPI regression outcomes across three groups: Texas, the restricted control group (hostile/ban states), and all other states. The purpose of the balance check is to assess whether the restricted control group is a more credible counterfactual for Texas physicians than the full pool of states.

Texas is a large, growing state with a distinctive physician labor market. In the pre-period, Texas has lower counts of active RHPs per 100k women (120.3) than both the restricted sample (157.0) and other states (161.5), reflecting Texas's rapid population growth relative to its physician supply. The restricted control group is closer to Texas on most flow outcomes (migration in and out, new entrants, retirements) than the full pool of other states, with differences roughly half as large for the restricted-sample comparison. This is the key motivation for using the restricted control group as the main specification: these states faced similar abortion-policy environments to Texas and exhibit more similar pre-period physician market trends, providing more credible parallel-trends counterfactuals for the triple-difference identification. Full-sample (all-states) results are reported in Appendix **??** and are qualitatively unchanged.

	Texas	Restricted	Other	TX − Rest.	TX − Other
Active RHP	120.13	156.95	161.21	-36.82	-41.08
				(0.000)	(0.000)
Active non-RHP	30.97	37.84	49.82	-6.87	-18.86
				(0.000)	(0.000)
Salary, RHP (USD, COL-adj.)	155087	175164	163593	-20078	-8507
				(0.000)	(0.024)
Salary, non-RHP (USD, COL-adj.)	163471	179526	169724	-16055	-6254
				(0.000)	(0.010)
Postings/100k, RHP	5.91	17.74	21.51	-11.83	-15.60
				(0.000)	(0.000)
Postings/100k, non-RHP	25.11	60.69	67.20	-35.58	-42.09
				(0.000)	(0.000)

Table 2: **Balance: Texas compared to control group and other states.** Pre-period (before May 19, 2021) means for NPI regression outcomes across three groups: Texas, the restricted control group (hostile/ban states; 25 states), and all other states. All outcomes are per 100,000 women of childbearing age (ages 15–44). The "TX − Restricted" and "TX − Other" columns show simple mean differences; the restricted control group is closer to Texas on most flow outcomes, motivating its use as the main specification. Source: NPPES/CMS DAC.

5 Results

The identifying assumption is that, had Texas not passed SB-8, reproductive health physicians in Texas would have behaved similarly to reproductive health physicians in other states over the same period. The triple-difference model uses three sources of variation: (1) before vs. after SB-8, (2) Texas vs. all other states, and (3) reproductive health physicians

vs. all other physicians:

$$\begin{aligned}\text{Outcome}_{ist} = \alpha + \beta_1 \cdot \underbrace{\text{Post SB8}_t}_{\substack{=1 \text{ if after} \\ \text{May 19, 2021}}} \times \underbrace{\text{Texas}_s}_{\substack{=1 \\ \text{if Texas}}} \times \underbrace{\text{RHP}_i}_{\substack{=1 \\ \text{if Reprod.} \\ \text{Health Phys.}}} \\ + \bar{\beta} \cdot \Big[\text{Post SB8}_t \times \text{Texas}_s + \text{Post SB8}_t \times \text{RHP}_i + \text{Texas}_s \times \text{RHP}_i \\ + \text{Post SB8}_t + \text{Texas}_s + \text{RHP}_i\Big] + \underbrace{u_{ist}}_{\substack{\text{WCB SE} \\ \text{(by state)}}} \end{aligned} \tag{1}$$

where

$$\text{Outcome}_{ist} \in \{\text{Total Active, Exit State, Enter State, New Entrances, Retirements, Salary, and Job Posting Volume}\}$$

The coefficient β_1 is the triple-difference estimator of interest: the differential change in outcomes for reproductive health physicians in Texas relative to other physicians in Texas and relative to reproductive health physicians in other states, following SB-8's signing. Standard errors use wild cluster bootstrap (Rademacher, $B = 500$, clustered by state), and migration outcomes are measured per 100,000 women of childbearing age.

The identifying assumption requires that non-reproductive-health physicians in Texas provide a valid control for the population trend affecting Texas physicians generally (e.g., population growth, COVID-related disruptions), while reproductive health physicians in other states control for national trends affecting this specialty group. The triple-difference structure thus isolates the differential effect of SB-8 on Texan reproductive health providers specifically.

5.1 Results: Migration

Table 3 presents the central migration estimates. The triple-difference coefficient β_1 is statistically insignificant across all five outcome measures: total active physicians, interstate exit, interstate entry, new career entrances, and retirements. We interpret this as a null

result: reproductive health physicians in Texas did not respond to SB-8's civil liability enforcement mechanism with detectable interstate migration or career-boundary transitions.

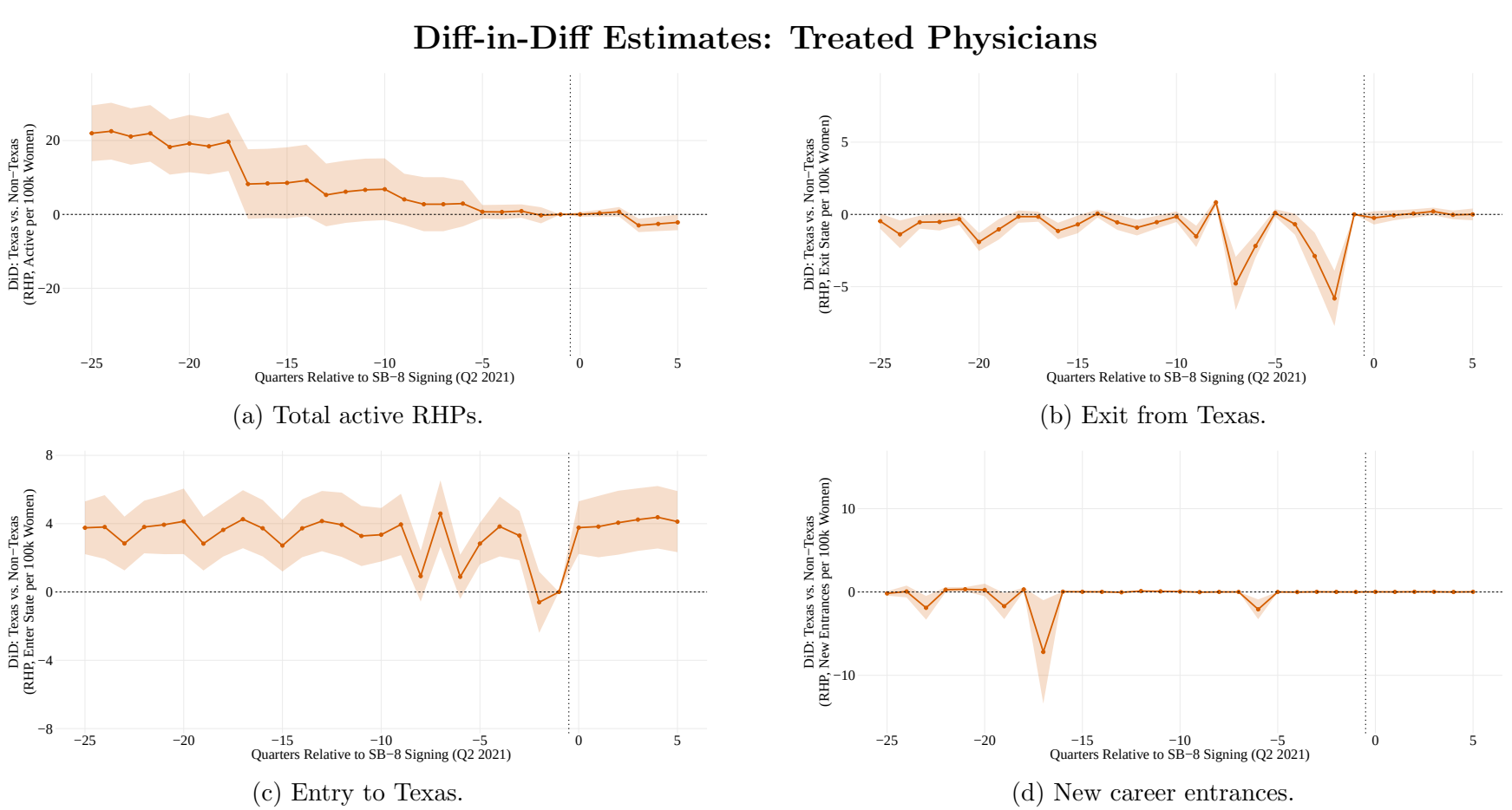
Triple-Difference Estimates: SB-8 Effect on Physician Migration

	(1)	(2)	(3)	(4)	(5)	(6)
Active	23.774	23.774	23.774	23.774	23.774	23.774
	(113.240)	(87.345)	(66.517)	(66.485)	(30.278)	(30.329)
Exit State	-0.156	-0.156	-0.156	-0.156	-0.156	-0.156
	(4.438)	(4.333)	(3.917)	(3.841)	(3.792)	(2.508)
Enter State	-0.745	-0.745	-0.745	-0.745	-0.745	-0.745
	(4.639)	(4.581)	(3.997)	(3.982)	(3.965)	(2.670)
New Entrances	-0.052	-0.052	-0.052	-0.052	-0.052	-0.052
	(53.196)	(53.377)	(23.170)	(23.092)	(23.146)	(22.650)
Retirements	-0.050	-0.050	-0.050	-0.050	-0.050	-0.050
	(2.091)	(2.099)	(1.880)	(1.825)	(1.832)	(0.812)
Observations	3,120	3,120	3,120	3,120	3,120	3,120
State FE	No	Yes	Yes	Yes	—	—
Year FE	No	No	Yes	Yes	Yes	—
Quarter-of-Year FE	No	No	No	Yes	Yes	—
State × Group FE	No	No	No	No	Yes	Yes
Quarter × Year FE	No	No	No	No	No	Yes
IID SE	Yes	Yes	Yes	Yes	Yes	Yes

Table 3: Triple-difference estimates of the effect of SB-8 on physician outcomes per 100,000 women of childbearing age (NPI Panel, 2007–2022). Rows are outcomes; columns vary the fixed-effect structure from no FEs (1) to saturated date FEs (6). The estimating equation is $\text{Outcome}_{ist} = \alpha + \beta_1 \cdot \text{Pass-SB8}_t \times \text{Texas}_s \times \text{RHP}_i + \bar{\beta} \cdot [\text{lower-order interactions}] + \text{FEs} + \varepsilon_{ist}$, where β_1 is the triple-difference coefficient of interest. "—" denotes a fixed effect absorbed by a higher-level FE (Unit subsumes State; Date subsumes Year and Quarter). Control group: states classified as hostile or total-ban under the Dench–Lindo typology (25 states). Source: NPPES/CMS DAC.
(*) $p < 0.10$; (**) $p < 0.05$; (***) $p < 0.01$

The following event studies present estimates of Equation 1 for migration outcomes, tracing the dynamic path of the treatment effect relative to SB-8's signing. Each point is the quarterly $\beta_{1,k}$ coefficient from the saturated event-time specification with state, specialty, and

date fixed effects. The pre-period coefficients are close to zero and statistically indistinguishable from zero across all outcomes, supporting the parallel trends assumption underlying the triple-difference design. There is no visible step change or drift in the post-signing period, reinforcing the null interpretation.



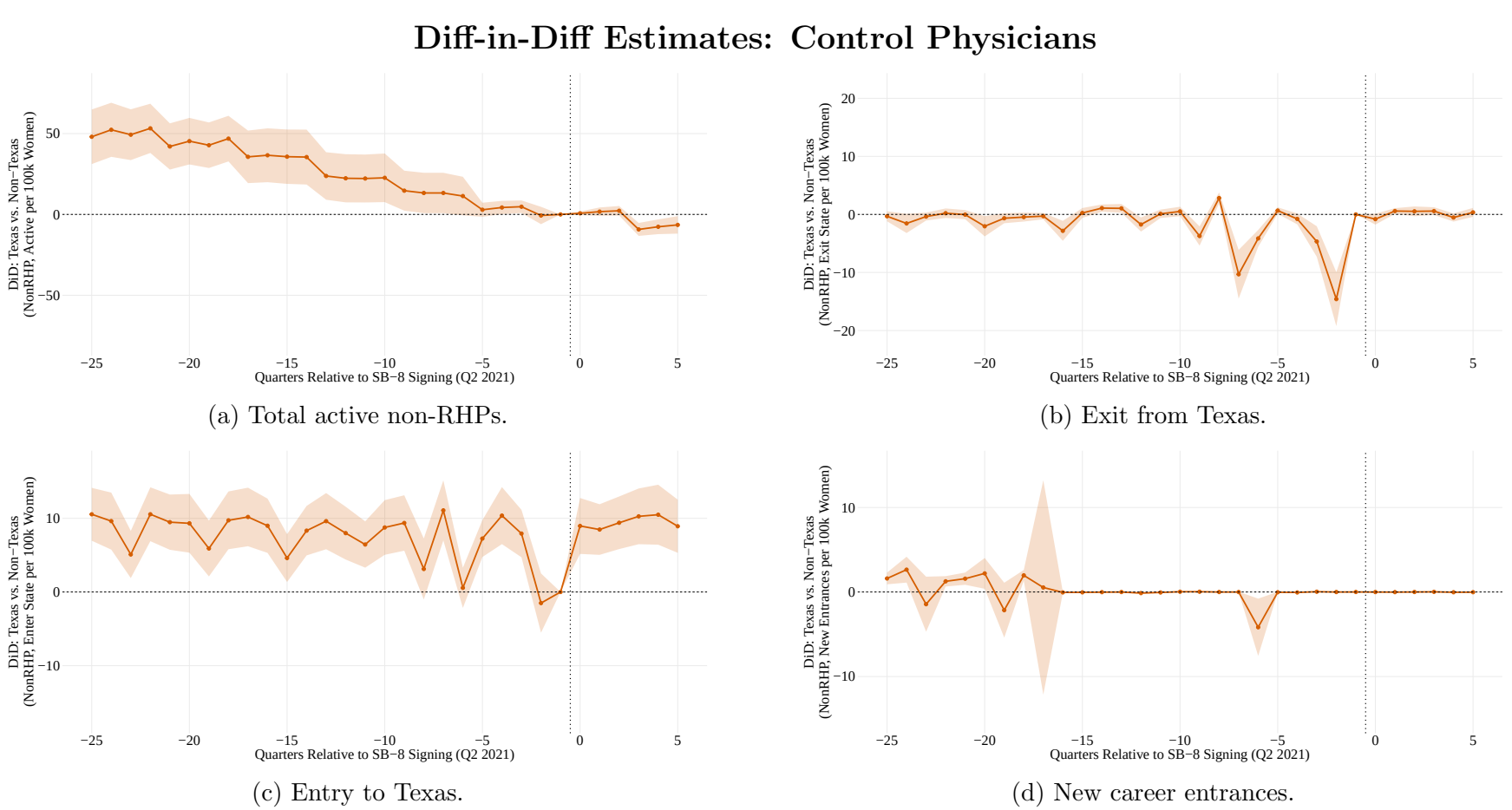
(a) Total active RHPs.

(b) Exit from Texas.

(c) Entry to Texas.

(d) New career entrances.

Figure 3: Difference-in-differences event study estimates for reproductive health providers (RHP: OB/GYN, Family Medicine, and Emergency Medicine), comparing Texas RHP physicians to non-Texas RHP physicians over time. The estimating equation includes state and date fixed effects; the reference period is Q1 2021 (event time -1). Each coefficient represents the quarterly Texas–non-Texas differential for RHP physicians relative to the reference quarter. The four panels show: total active RHPs per 100k women, out-migration (exit from Texas), in-migration (entry to Texas), and new career entrances. Sample: 2015–2022 quarterly, restricted control group; 95% confidence intervals shown. Source: NPPES/CMS DAC. Wild cluster bootstrap SEs (Rademacher, $B = 500$, clustered by state) in parentheses.
(*) $p < 0.10$; (**) $p < 0.05$; (***) $p < 0.01$



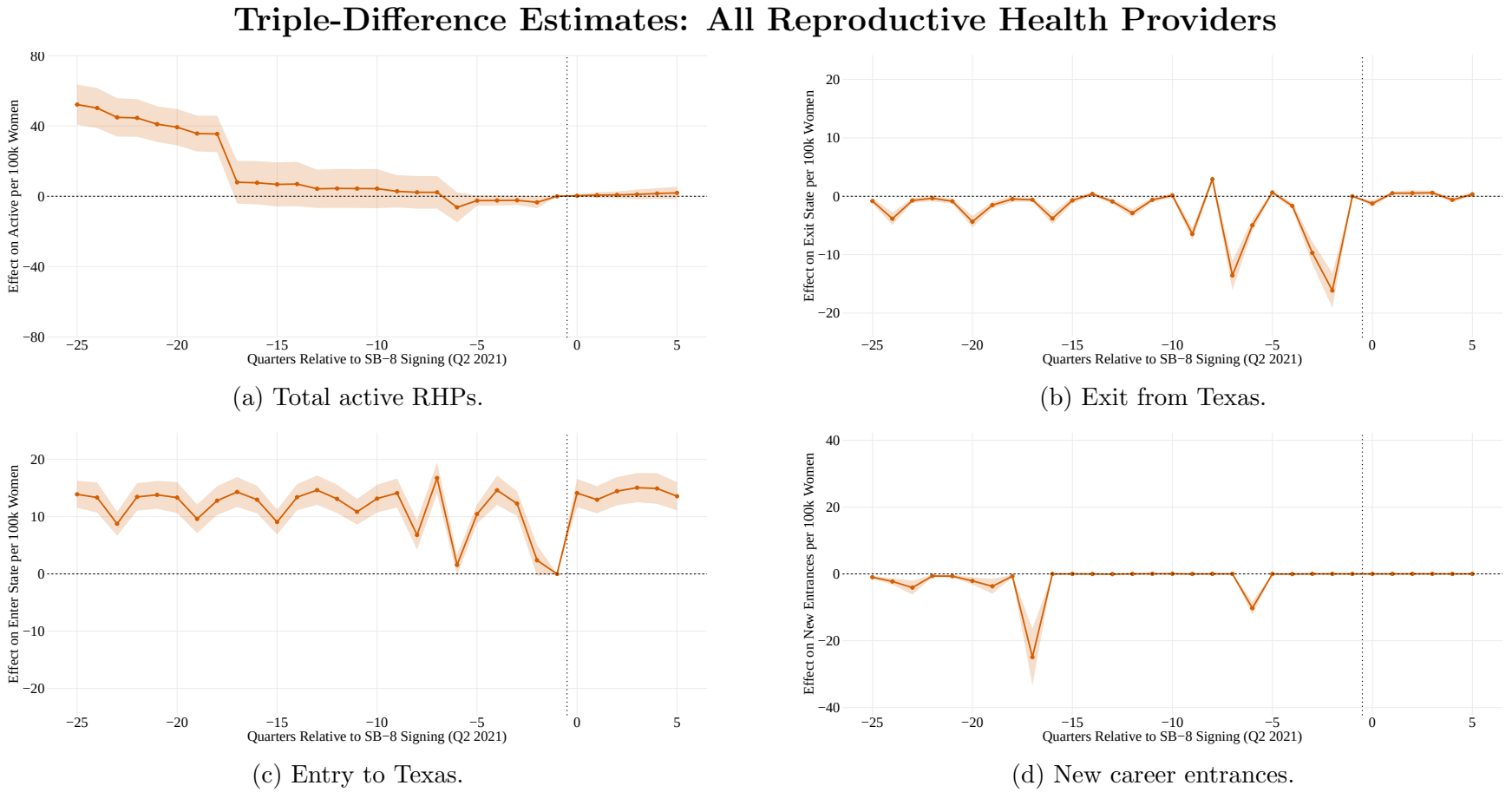
(a) Total active non-RHPs.

(b) Exit from Texas.

(c) Entry to Texas.

(d) New career entrances.

Figure 4: Difference-in-differences event study estimates for non-reproductive-health physicians (the control group), comparing Texas non-RHP physicians to non-Texas non-RHP physicians over time. The estimating equation includes state and date fixed effects; the reference period is Q1 2021 (event time −1). The four panels show: total active non-RHPs per 100k women, out-migration (exit from Texas), in-migration (entry to Texas), and new career entrances. These figures serve as a placebo check: absent SB-8 exposure, the Texas differential should be flat throughout. Sample: 2015–2022 quarterly, restricted control group; 95% confidence intervals shown. Source: NPPES/CMS DAC.
Wild cluster bootstrap SEs (Rademacher, $B = 500$, clustered by state) in parentheses.
(*) $p < 0.10$; (**) $p < 0.05$; (***) $p < 0.01$



(a) Total active RHPs.

(b) Exit from Texas.

(c) Entry to Texas.

(d) New career entrances.

Figure 5: Triple-difference event study estimates for reproductive health provider (RHP: OB/GYN, Family Medicine, and Emergency Medicine) outcomes. The estimating equation is $\text{Outcome}_{ist} = \alpha + \sum_{k \neq -1} \beta_k \cdot \mathbf{1}[\text{event\_time} = k] \times \text{Texas}_s \times \text{RHP}_i + [\text{FEs and lower-order terms}] + \varepsilon_{ist}$. Coefficients β_k are quarterly treatment effects relative to Q1 2021 (reference period: event time -1). The four panels show: total active RHPs, out-migration (exit from Texas), in-migration (entry to Texas), and new career entrances. All outcomes are per 100,000 women of childbearing age. Unit (state × group) and date fixed effects are included. Sample: 2015–2022 quarterly, restricted control group. Shaded regions show 95% confidence intervals. Source: NPPES/CMS DAC.
Wild cluster bootstrap SEs (Rademacher, $B = 500$, clustered by state) in parentheses.
(*) $p < 0.10$; (**) $p < 0.05$; (***) $p < 0.01$

5.2 Results: Job Postings and Wage

To complement the NPI migration analysis, we estimate triple-difference models using Wagescape job posting data. The treated group is defined consistently with the CLEM mechanism: OB/GYN, Emergency Medicine, and OB-doing Family Medicine (Family Medicine physicians whose job title indicates obstetric, emergency, or ambiguous reproductive content). Panel A of Table 4 presents the full-sample results for three outcomes—log COL-adjusted posted salary, RHP job postings per 100,000 women of childbearing age, and COL-adjusted salary in USD levels—across six fixed-effect specifications. Columns progress from no fixed effects (1) to unit (state × group) and quarter-year fixed effects (6).

Log salary and COL salary results are statistically significant but not of the expected sign: Texas RHP salaries appear lower than the comparison group in the pre-period, and the pattern persists post-SB-8 without a differential break. Job posting volume is statistically indistinguishable from zero across all specifications. The event study in Figure 6 shows no post-SB-8 break in either outcome. Pre-period salary and posting coefficients are statistically indistinguishable from zero throughout the sample window, supporting the parallel trends assumption.

Wage Triple-Difference Estimates by Employment Type and Fixed-Effect Specification

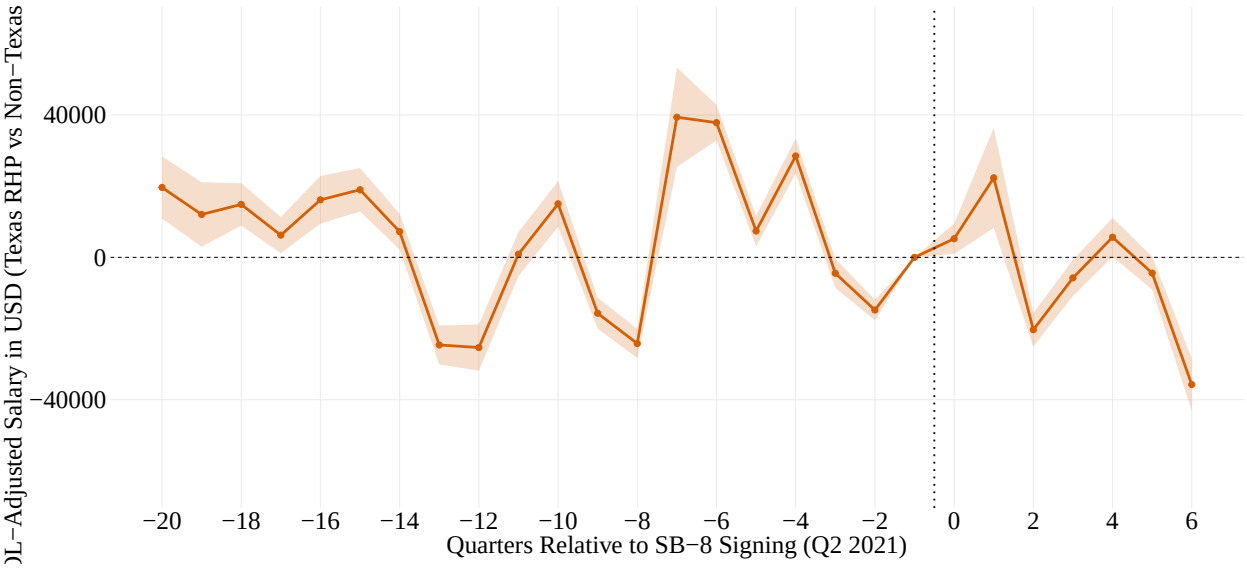
	(1)	(2)	(3)	(4)	(5)	(6)
Panel A: Total (Full Sample)						
Log Salary	-0.271***	-0.263***	-0.231***	-0.229***	-0.116***	-0.163***
	(0.004)	(0.004)	(0.004)	(0.004)	(0.012)	(0.009)
Postings/100k	-34.005***	-33.046***	14.386**	15.787**	-5.303*	5.101
	(4.633)	(4.331)	(6.239)	(6.450)	(2.718)	(3.348)
Salary (USD, COL-adj.)	-41263***	-39214***	-27759***	-26531***	-15983***	-19696***
	(554)	(516)	(538)	(591)	(1039)	(851)
Panel B: Full-Time (Non-Locum)						
Log Salary	-0.281***	-0.272***	-0.239***	-0.238***	-0.134***	-0.168***
	(0.008)	(0.007)	(0.008)	(0.008)	(0.009)	(0.009)
Postings/100k	-32.561***	-31.890***	5.767	6.876	-11.383***	-2.986
	(3.915)	(3.677)	(4.364)	(4.496)	(2.655)	(2.762)
Salary (USD, COL-adj.)	-42921***	-40707***	-29362***	-28725***	-19599***	-20397***
	(600)	(645)	(593)	(597)	(905)	(925)
Panel C: Locum Tenens						
Log Salary	-0.017	-0.020	-0.000	0.003	0.174**	0.032
	(0.052)	(0.052)	(0.076)	(0.058)	(0.071)	(0.084)
Postings/100k	-0.302	0.040	9.259***	9.793***	5.974***	8.249***
	(1.059)	(1.124)	(2.649)	(2.769)	(1.710)	(2.088)
Salary (USD, COL-adj.)	-9655	-9217	1447	6187	31123*	11867
	(12309)	(11975)	(16471)	(13627)	(17440)	(19921)
State FE	No	Yes	Yes	Yes	—	—
Year FE	No	No	Yes	Yes	Yes	—
Quarter-of-Year FE	No	No	No	Yes	Yes	—
State × Group FE	No	No	No	No	Yes	Yes
Quarter × Year FE	No	No	No	No	No	Yes
WCB SE ($B = 500$)	Yes	Yes	Yes	Yes	Yes	Yes

Table 4: Wage triple-difference β_1 estimates across employment-type subsamples and six fixed-effect specifications (columns). Panel A is the full sample; Panel B restricts to full-time (non-locum) postings; Panel C shows locum tenens postings only (identified by "locum" in job title, ≈10% of postings). The Postings outcome is postings per 100,000 women of childbearing age. Columns (5)–(6) use state × group (RHP/non-RHP) unit fixed effects. Wild cluster bootstrap SEs (Rademacher, $B = 500$, clustered by state). Control group: Dench–Lindo hostile/ban states (25 states).

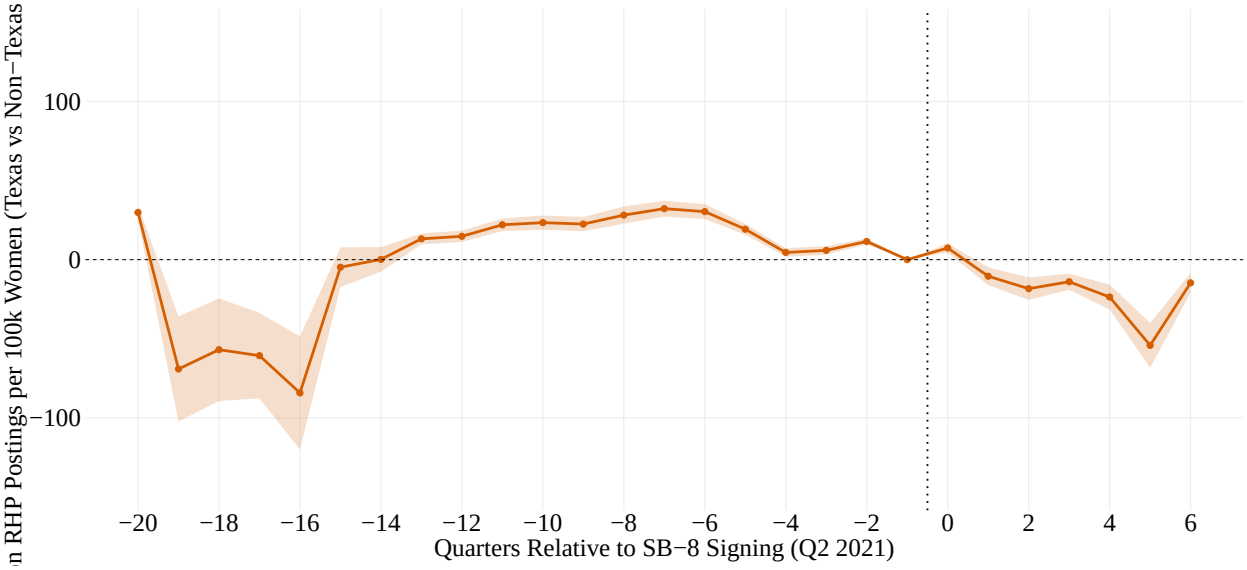
Wage Triple-Difference Estimates by Geography and Fixed-Effect Specification

	(1)	(2)	(3)	(4)	(5)	(6)
Panel A: Total (Full Sample)						
Log Salary	-0.271***	-0.263***	-0.231***	-0.229***	-0.116***	-0.163***
	(0.004)	(0.004)	(0.004)	(0.004)	(0.012)	(0.009)
Postings/100k	-34.005***	-33.046***	14.386**	15.787**	-5.303*	5.101
	(4.633)	(4.331)	(6.239)	(6.450)	(2.718)	(3.348)
Salary (USD, COL-adj.)	-41263***	-39214***	-27759***	-26531***	-15983***	-19696***
	(554)	(516)	(538)	(591)	(1039)	(851)
Panel B: Urban						
Log Salary	-0.250***	-0.240***	-0.199***	-0.197***	-0.122***	-0.148***
	(0.008)	(0.008)	(0.009)	(0.007)	(0.019)	(0.021)
Postings (Count)	-2808***	-2815***	-2391***	-2379***	-1778***	-1705***
	(22.582)	(21.165)	(109)	(112)	(73.752)	(86.872)
Salary (USD, COL-adj.)	-36312***	-34050***	-22999***	-22313***	-17061***	-17047***
	(1437)	(1300)	(1489)	(1326)	(3719)	(3856)
Panel C: Rural						
Log Salary	-0.347***	-0.334***	-0.341***	-0.356***	-0.284***	-0.355***
	(0.076)	(0.074)	(0.074)	(0.069)	(0.078)	(0.077)
Postings (Count)	-134***	-135***	-71.646***	-70.135***	-37.662***	-32.112**
	(4.091)	(4.107)	(11.915)	(12.104)	(8.691)	(9.767)
Salary (USD, COL-adj.)	-63822***	-61239***	-56572***	-58365***	-45410***	-51419***
	(6374)	(6688)	(6212)	(5848)	(4505)	(4657)
State FE	No	Yes	Yes	Yes	—	—
Year FE	No	No	Yes	Yes	Yes	—
Quarter-of-Year FE	No	No	No	Yes	Yes	—
State × Group FE	No	No	No	No	Yes	Yes
Quarter × Year FE	No	No	No	No	No	Yes
WCB SE ($B = 500$)	Yes	Yes	Yes	Yes	Yes	Yes

Table 5: Wage triple-difference β_1 estimates across geographic subsamples and six fixed-effect specifications (columns). Panel A is the full sample; Panels B and C split by posting zip code urbanicity (USDA RUCA 2020); zip codes with no RUCA match (≈30% of postings) are excluded from Panels B–C. The Postings outcome in Panel A is postings per 100,000 women of childbearing age; in Panels B–C it is raw posting count (levels), since the per-100k denominator is state-level and does not vary by urbanicity. Columns (5)–(6) use state × group (RHP/non-RHP) unit fixed effects. Wild cluster bootstrap SEs (Rademacher, $B = 500$,



(a) COL-adjusted salary in USD: Texas RHP vs. non-Texas RHP triple-difference, quarterly.

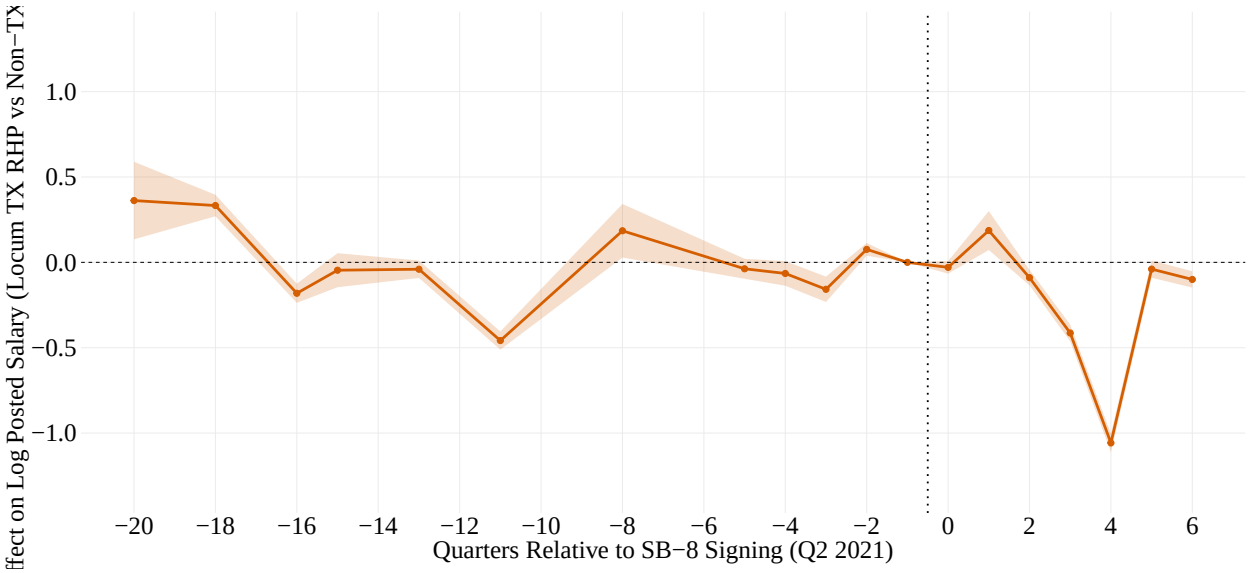


(b) RHP postings per 100k women: Texas vs. non-Texas triple-difference, quarterly.

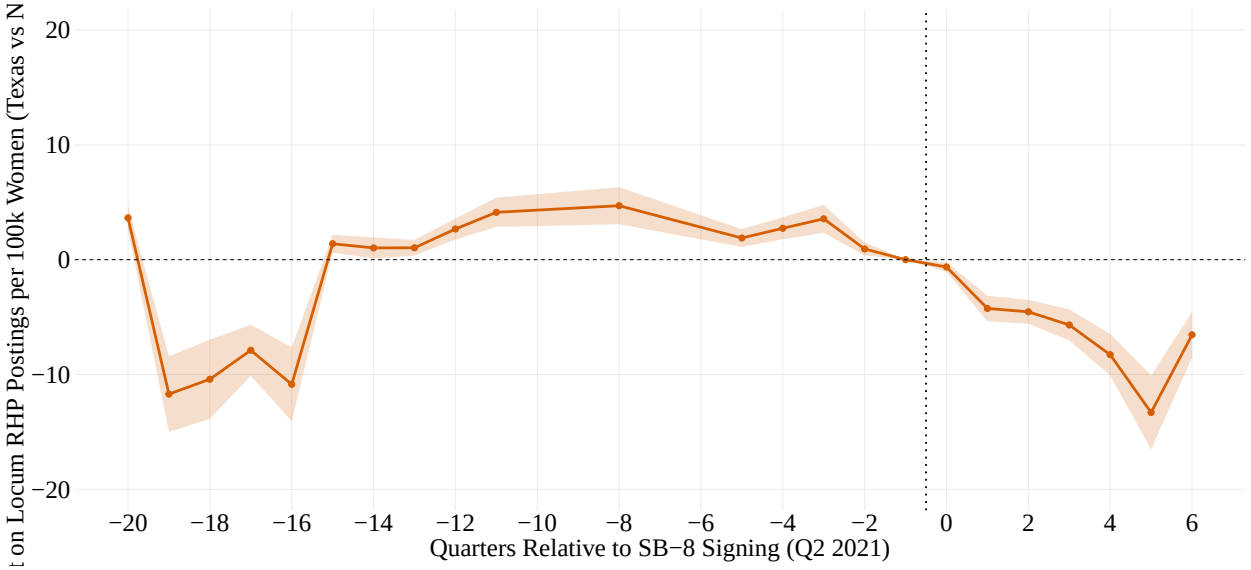
Figure 6: Triple-difference event study estimates for wage and posting outcomes using Wagescape data. Coefficients β_k are the quarterly treatment effects (TX × RHP × Post interaction) relative to Q1 2021 (reference period: event time −1). Panel (a) uses BEA RPP cost-of-living adjusted posted salary in USD as the outcome; panel (b) uses treated RHP job postings per 100,000 women of childbearing age. Unit (state × group) and quarter-year fixed effects are included. Sample: Wagescape physician job postings, 2016–2022, restricted control group. Shaded regions show 95% confidence intervals. Pre-period coefficients are flat and the post-SB-8 period shows no break in either salary or posting volume. Source: Wagescape via Dewey Data Platform.

Wild cluster bootstrap SEs (Rademacher, $B = 500$, clustered by state) in parentheses.
(*) $p < 0.10$; (**) $p < 0.05$; (***) $p < 0.01$

Locum Tenens Subsample. To examine a potentially more mobile segment of the physician labor market, we restrict the Wagescape sample to postings containing "locum" in the job title (N = 49,584 salary observations; N = 2,299 state-quarter cells for the posting-volume outcome). Locum tenens physicians work on temporary assignments and face lower relocation costs than permanently placed physicians, making them a potentially more responsive margin to policy shocks like SB-8. Panel C of Table 4 presents triple-difference estimates for this subsample. The salary DDD estimator is statistically indistinguishable from zero, consistent with the null in the full sample. The posting-volume DDD is positive and statistically significant, indicating that Texas reproductive health providers saw a differential increase in locum postings per 100,000 women. This pattern is directionally consistent with a supply disruption: if permanent physicians reduced their Texas presence following SB-8, employers would need to fill gaps with temporary staff. The event study analogs are presented in Figure 7. We note that the posting-volume series is sensitive to thin state-quarter cells, and the positive DDD could also partly reflect differential growth in Wagescape's locum coverage in Texas during this period; we interpret the posting result cautiously.



(a) Log posted salary: Texas RHP locum vs. non-Texas RHP locum differential, quarterly.



(b) Locum RHP postings per 100k women: Texas vs. non-Texas differential, quarterly.

Figure 7: Triple-difference event study estimates for the locum tenens subsample. Coefficients β_k are the quarterly treatment effects (TX × RHP × Post) relative to Q1 2021 (reference period: event time −1). Panel (a) uses log BEA RPP cost-of-living adjusted posted salary; panel (b) uses locum RHP job postings per 100,000 women of childbearing age. State, year, and quarter fixed effects are included. Sample: Wagescape physician job postings with "locum" in the job title, 2016–2022, all U.S. states and D.C. Shaded regions show 95% confidence intervals. Source: Wagescape via Dewey Data Platform.
Wild cluster bootstrap SEs (Rademacher, $B = 500$, clustered by state) in parentheses.
(*) $p < 0.10$; (**) $p < 0.05$; (***) $p < 0.01$

6 Discussion

SB-8's civil liability enforcement mechanism did not produce a detectable disruption to the Texas market for reproductive health physicians in the thirteen months before *Dobbs* above or beyond the dynamics already involved in Texas's abortion landscape.

In the NPI migration data, the triple-difference estimate is statistically indistinguishable from zero for all five outcomes—total active physicians, interstate exit, interstate entry, new career entrants, and retirements. The pre-period event-study coefficients are flat and centered on zero, supporting the parallel-trends assumption. Physicians did not leave Texas at differential rates following SB-8's signing on May 19, 2021, and career entrances did not shift in a way consistent with a deteriorating practice environment.

In the Wagescape data, the evidence is equally consistent. The log salary triple-difference is close to zero and precisely estimated: reproductive health providers in Texas did not command a compensating wage differential for CLEM exposure, nor did they experience a differential wage decline. The same null appears in the dollar-value COL-adjusted salary specification and in the posting-volume outcome. The locum tenens subsample shows a positive and statistically significant effect on posting volume, which could indicate temporary staffing substitution; however, this result is also consistent with differential expansion of Wagescape's locum coverage in Texas during this period, and we interpret it cautiously.

Taken together, the null across eight outcome measures, two complementary identification strategies, and a restricted control group of similarly abortion-hostile states constitutes strong evidence that SB-8 did not materially alter the willingness of reproductive health physicians to practice in Texas. The most plausible interpretation is that the marginal expected cost of CLEM exposure was insufficient to overcome the substantial financial and professional costs of interstate relocation for established physicians (estimated at \$150,000–\$250,000 in licensing, credentialing, and transition costs).

Current Limitations and Next Steps

1. The retirement margin (likely the most responsive behavioral channel) is poorly measured. Physicians do not deactivate their National Provider Identifiers when they retire, so exit from the workforce is severely undercounted. Improvements to the retirement measure are a priority; candidate approaches include Medicare prescribing data (feasible for family medicine, less so for OB/GYNs who have few Medicare-eligible obstetric patients) and vital statistics restricted-access data (birth certificates include provider identifiers, which could be used to track whether physicians stop delivering babies).

2. Given Texas's abortion regulatory environment predating SB-8 (TRAP regulations), the physicians most likely to respond to a marginal increase in operating costs may have already left Texas. The triple-difference design controls for pre-existing differential trends between Texas and other states by comparing the change in RHP outcomes to the change in non-RHP outcomes within Texas, but cannot fully rule out that the pool of "marginal movers" was depleted before May 2021.

3. **Next Step: Heterogeneity by physician age.** New physicians choosing an initial practice location bear no relocation cost and may be the most sensitive margin. Physicians 4–6 years out of medical school (corresponding to the OB/GYN residency length) are the target cohort. CMS Physician Compare data include medical school graduation year. Near-retirees may also be a high-mobility group, choosing early retirement over the alternative of an expensive relocation.

4. **Next Step: County-level analysis.** County-level data would permit two extensions. First, testing whether physicians in politically liberal (blue) counties in Texas are more responsive than those in conservative (red) counties, where community pressure from SB-8 may differ. Second, testing whether physicians in border counties (where changing states of practice does not require moving one's family, e.g., Texarkana, TX to Arkansas) are more responsive, consistent with the prediction that physicians facing

lower relocation costs should be more mobile.

5. **Next Step: Robustness to control group definition.** Our main results restrict the control group to states classified as "hostile" or carrying a total abortion ban under the Dench-Lindo typology, as these states faced similar abortion-policy environments and are thus more credible counterfactuals for Texas physicians than physicians in states with protective abortion laws. We can also compare RHP's to other physician specialties that are certainly untreated by abortion laws (such as optometrists, rheumatists, etc.).

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