The Factors Underlying the 82nd Texas Legislature's Decision to Restrict Access to Reproductive Healthcare in Texas

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Introduction

Since the Supreme Court handed down its decision on Roe v. Wade 40 years ago, abortion has been a high-profile political issue in the United States. Indeed, the debate has surpassed ethical, religious and ideological boundaries to become symbolic of political partisan divisions (Evans 2003). The past few years have seen a surge in state-level proposals to reduce access to abortion care (Gold 2012), and in an increasing number of cases, abortion appears to have become indiscriminately entwined with access to contraception, particularly when both services are provided by the same organization (Gold 2002). Thus, despite its origins in broad bipartisan support, publicly-funded access to contraception has recently become a politically polarized issue in the United States, and since women's health services such as sexually transmitted infection (STI) and cancer screenings tend to be covered by the same programs, these services are also at risk of reduction. Proposals have been put forth at the Congressional level to eliminate Title X; the only federal block grant dedicated exclusively to the provision of contraception and preventative health services for women (Cohen 2011). This, along with repeated and resolute attempts to defund Planned Parenthood, fierce opposition to the mandatory provision of health insurance by employers to cover contraceptives, and political maneuvering to prevent over-the-counter access to emergency contraception paints the picture of a hostile political climate towards reproductive health in America.

One of the most extreme instances of political action to restrict access to family planning occurred in Texas during the 2011 Legislative Session. While legislation aimed at reducing access to abortion is not uncommon in Texas, the 82nd Texas Legislature enacted a series of laws affecting women's access not only to abortion, but also to contraception, and preventative women's health services. HB 1 cut the state family-planning budget by two-thirds from approximately $111 million to $37.9 million per biennium (LBB 2011), while SB 7 mandated the allocation of remaining funds according to a tiered system that prioritizes clinics providing comprehensive primary-care services over those providing family-planning services only. A budget rider ensured that clinics and organizations affiliated with abortion providers could no longer participate in the Women's Health Program—a 90% federally funded Medicaid wavier providing contraception and other reproductive-health services to low-income women in the state, and HB 15 instituted a mandatory sonogram and 24-hour waiting period as requirements for access to abortion services.

The impact of these laws on women's access to reproductive health services throughout the state, particularly for low-income and ethnic minority women, is expected to be severe. Initial research findings already indicate that 35 out of 76 clinics have lost all funding, and organizations that remain funded have had their budgets reduced by upwards of 75% (White et al. 2012). As a result, many clinics have been forced to reduce access to methods with the highest upfront costs, such as IUDs and implants (White et al. 2012). These methods are also the most long-acting and effective, leaving many more women at greater risk of unintended pregnancy (Winner et al. 2012). Furthermore, less expensive methods, such as oral contraceptives now more often come with a high co-pay, which would previously have been covered by public funding, meaning that women must either purchase fewer pill packs,

opt of out of another service such as STI testing , or choose less effective methods such as condoms (White et al. 2012). While the full effects of the legislation on unintended pregnancy, STI, and breast and cervical cancer rates in Texas, along with the cost of the expected accompanying increase in Medicaid births and demand for medical treatment will be reveled over time, the initial picture does not bode well.

Previous experience with abortion restrictions has demonstrated the propensity of policy to diffuse across states (Mooney 2001; Shipan 2008) and it is possible that a similar policy diffusion process may occur with restricted access to contraception and preventative screening services. Recent happenings in Texas also reflect the political climate towards reproductive health at the Congressional level, yet beyond the observation of increasing polarization between Republicans and Democrats in both Congress and in State legislatures, very little is understood about how legislators vote on reproductive health issues. To this end, Texas represents an interesting opportunity to investigate the factors associated with legislative voting behavior on abortion, contraception, and women's health, and to examine whether these factors have changed over time.

The Texas Legislature meets biennially, and has been dominated by Republicans since 2001, following a period of parity between Republicans and Democrats in 1997 and 1999, and a prior Democratic majority. The 2011 Legislative Session in Texas was notable for its Republican super-majority in the House of Representatives, and for the dominance of newly elected Republicans identifying with strongly polarized partisan groups such as the Tea Party. The polarization of American politics has been well documented in the political science literature (Fleisher 2004; Roberts 2003; Theriault 2008), yet the relationship between

partisanship and voting behavior reproductive health issues has not been widely studied. Previous literature examining legislative voting behavior in the United States is mostly concentrated at the Congressional level—although a few studies have examined state-level issues (Shor 2011; Shor 2010)—and tends to assess factors influencing voting behavior in general, rather than focusing on specific issues (Collie 1984). A few notable exceptions, however, have examined legislative voting behavior on abortion issues since the passage of Roe v. Wade in 1973. Using regression techniques to model associations between yea or nay votes and candidate explanatory variables, two such studies suggest that ideological influences are the most important factors underlying legislative voting behavior on abortion (Peltzman 1984; Tatolovich 1993). In these cases, ideology is measured as a score created for legislators based on their voting patterns relative to other legislators, which provides an indication of their position on the political spectrum. In some cases, this is distinct from party affiliation, and in others, especially in more recent years, as party affiliation becomes increasingly linked a particular stance on polarizing issues, partisanship and ideology are closely related. Two other studies, using similar regression techniques, suggest that in legislatures where partisan divides are not deeply entrenched, religious affiliation and gender also influence voting on abortion issues (Burrell 1994; Swers 1998). In their longitudinal study of abortion in the 92nd-100th Congress, Tatolovich & Schier found that gender was a significant predictor of pro-choice voting, particularly among Republican women, and that religion was strongly associated with voting against expected partisan ideology (e.g. Catholic Democrats voting against pro-choice issues). When trends were examined over time between 1973 and 1988, however, ideology began to play an increasingly important role, with legislators voting more in line with their ideological rather than their religious preference on abortion (Tatolovich 1993). More recent work investigating voting on abortion issues in the

Florida House of Representatives shows that partisanship, gender, and religious affiliation (for Catholic and Jewish members only) are the most important predictors of voting behavior, while constituency characteristics are less relevant (Schecter 2001).

To our knowledge, no previous studies have examined state legislative voting behavior on reproductive health issues besides abortion. On the surface, it appears that voting on such issues in Texas in the 82nd session took place roughly along party lines, but it is not clear whether party affiliation is the only significant factor, nor whether the contribution of partisanship has changed over time. Was there a time when Republicans and Democrats voted together to expand access to family planning and women's health services? Did religious affiliation, or constituency composition play a role in the 82nd session or in previous sessions, when partisan divisions were less deeply entrenched? In this paper, we address three main questions: 1) What is the trend in reproductive health-related legislation proposed and enacted in Texas between 1991-2011?; 2) To what extent is the passage of bills that restrict access to reproductive health attributable to partisanship, both in the 2011 session, and over time?; and 3) What is the relative influence of other factors? As Texas is the first, but likely not the last state to pass legislation restricting access to reproductive health and family planning to such a severe extent, insights gained from this analysis will shed light on the role of partisanship in legislative voting behavior with respect to reproductive health issues, and help illuminate how voting on such issues might play out at other times and in other places.

Methods

To construct a narrative of the reproductive health legislation both proposed and enacted in
Texas since the 72nd Session in 1991, we conducted a key word search for each of the 11
sessions 72R-82R, using the search terms "Family Planning", "Contraception", "Birth
Control", "Women's Health", "Abortion", "Pregnancy", "Sexual Health", "PAP smear" and
"Mammogram" on the Texas Legislature Online (TLO) website
(http://www.capitol.state.tx.us). Each bill identified by the search was analyzed for content,
and categorized into one of five categories: Contraception, Abortion, Women's Health
(meaning gynecological services, and preventative screening services such as mammography,
PAP smears for cervical cancer, and STI testing), Maternal and Child Health (meaning
obstetric services and pre-natal and postpartum care), and Women's Rights (meaning issues
such as employment concessions for pregnant women, criminal penalties for harm to the
fetus during pregnancy, and female genital mutilation). Bills were also classified according to
whether they restrict or promote reproductive health in each of the five categories, and
according to the stage they reached in the legislative process: Filed (meaning that the bill was
officially proposed by a legislator), left pending in committee, approved by committee,
engrossed (meaning that the bill was voted on by the Senate but not the House, or voted on
by the House but not the Senate), or enrolled (meaning that the bill was voted on by both
the House and the Senate and signed into law). We examine the overall trend in the number
of reproductive health bills filed in the past 20 years, the breakdown of filed bills by
category, and trends in restrictive and promoting bills both filed and engrossed or enrolled
(i.e. bills on which a record vote was taken). In the latter analysis, we omit maternal and child
health bills because although these bills are a useful part of the narrative context, there are

likely to be systematic differences in the way that legislators vote on issues involving non-pregnant women, as opposed to pregnant women and infants, which are generally considered more vulnerable populations.

To examine the factors underlying voting behavior on each of the reproductive health bills identified by our search, we constructed a dataset containing roll-call record votes (votes where each legislator's "yea" or "nay" vote is recorded on the legislative record) for each legislative session in Texas from 1991-2011, along with legislator-specific factors suggested by previous literature to influence voting behavior—party affiliation, religion, and constituency characteristics (percent rural, percent white, percent non-citizen, percent single parent families, and percent with a bachelors degree). Roll-call record votes for the past twenty years in Texas, as well as data on legislator characteristics were obtained via Telicon, a private legislative research company based in Austin, TX. As the Texas Senate contains only 31 members, whereas the House contains 150, the following analyses were performed for the House only.

We examined roll-call record votes in the House of Representatives for each of the eleven sessions 72R-82R, and constructed polarization plots to show both the degree of general agreement between Republicans and Democrats on all bills, and the location of reproductive health bills on a polarization scale. The polarization scale represents the Republican and Democratic margins for each bill, defined as the number of yeas minus the number of nays among legislators in each party (zero would represent equal numbers of Republicans and Democrats voting for a bill).

To identify the factors associated with voting behavior on reproductive health issues, and formally test the role of partisanship, we used multivariate Bayesian factor probit models (Jackman 2001). Bayesian factor analysis is a model-based alternative to principal components analysis for binary outcomes, and works on the assumption that the votes of each individual legislator on each record vote are not independent, but correlated by a set of underlying latent factors. By modeling this co-variation, inferences can be made about the underlying correlation structure of the data. Bayesian factor analysis offers several advantages over conventional principal components analysis (PCA) approaches for addressing our research questions. Firstly, PCA does not allow the quantification of uncertainty about model summaries, whereas a Bayesian approach allows us to have full posterior distribution, and thus a complete description of our uncertainty in light of the data, over latent factors (Clinton 2004). Secondly, Bayesian factor analysis allows the specification of priors, which lend interpretability to the latent factors identified by the model. In PCA, each principal component is forced to explain variation in all of the votes. Here, we specify that a particular set of votes (i.e. the reproductive health votes), will be predicted by given factor, thus allowing us to interpret that factor as specific to reproductive health issues. An additional advantage of factor probit modeling over the logistic regression models traditionally used to model legislative voting behavior is that rather than specifying and constraining the factors we think matter in determining voting behavior over a selected subset of votes, we allow factor probit to identify them, using a matrix of all votes.

Our model is of the form

$$\Pr\left(y_{ij} = 1\right) = Probit(\alpha_j + \beta_{j1}f_{i1} + \beta_{j2}f_{i2})$$

Where y_{ij} takes the value 1 if legislator i votes in favor of bill j, and 0 otherwise. Here β_{j1} and β_{j2} are the factor loadings associated with each bill, while f_{i1} and f_{i2} are the factor scores associated with each legislator. The intercept term α_j simply reflects how many yea votes overall were cast for bill j. To enforce the interpretation that the first factor corresponds to partisanship, we specify priors for f_{i1} such that Republicans are likely to have positive first factor scores and Democrats negative scores. To enforce the interpretation that the second factor corresponds to reproductive health, we specify that β_{j2} is zero for all bills that are not specifically flagged as reproductive health bills. Therefore, each legislator's second factor score f_{i2} is only allowed to influence his or her vote on the selected reproductive health bills. We estimate the model using the MCMC algorithm in the R package "pscl" (Jackman 2011). Again, due to our expectation that the way in which legislators vote on issues concerning pregnant women and infants is systematically different, we exclude maternal and child bills from these analyses.

Interpreting the results of a factor analysis is notoriously difficult, as the factor scores and the factor loadings β_{j2} are unobserved latent variables. But these interpretational challenges are solved with relative ease under the Bayesian paradigm, as we may choose priors that naturally suggest particular interpretations for particular parameters of the model. We take a two-pronged strategy in this regard. First, to enforce the interpretation that the first factor corresponds to partisanship, we used a prior distribution that put higher probability on f_{i1} being positive for a Republican legislator and negative for a Democratic legislator. Specifically, these were assigned Gaussian priors with variance 1, and means of -1 and +1 for Democrats and Republicans, respectively. This still allows a legislator's first

factor score to be of a sign opposite to most members of his own party, and indeed this happens for at least 1 representative in the 82nd Legislature. (The data, in other words, are still given the biggest say in the matter.) But this assumption codifies our prior expectation that most legislators will vote with their party most of the time, and leads to easily interpretable results.

We also wanted to interpret the second factor as one that corresponds to reproductive-health legislation. To do this, we chose a prior distribution that forced β_{j2} to be exactly zero for all votes, except for those flagged as being relevant to reproductive health. This is sometimes referred to as sparse factor analysis, in the sense that each votes is predicted by a potentially reduced or sparse subset of factors. Imposing this sparsity constraint is sufficient to identify each legislator's factor score (f_{i2}) up to an arbitrary change in sign. We emphasize that, due to the presence of the partisanship factor in the model, the correct interpretation of f_{i2} is not, "Where does this member stand on reproductive health issues?" Rather, it is, "Where does this legislator stand on reproductive health issues, relative to his or her own demonstrated tendency to vote with his or her own party?"

Finally, we examine whether legislator location in reproductive health-specific component of voting behavior has associations with other measurable factors. We specified linear regression models separately for Democrats and Republicans. In each model the response variable is a legislator's location on the reproductive health axis f_{i2} as estimated by our Bayesian model, and the predictor variables, chosen on the basis of previous literature and our priors about the role of constituency characteristics; percent rural, percent white, percent non-citizen, percent single parent families, and percent with a bachelors degree. We

regressed the legislators' reproductive health factor score on these six variables together with an indicator of whether the legislator professed affiliation with the Catholic Church. Because the six constituency variables are highly multi-collinear, the results of this regression are very difficult to interpret. Therefore, we constructed a set of uncorrelated socioeconomic indicators for each constituency using a PCA. We then regressed legislator's factor scores on these indices. All analyses were performed using the R statistical software package.

Results

<<Insert Figure 1>>

Figure 1 shows the dramatic increase in reproductive health bills filed by Texas legislators between 1991 and 2011. The number of bills proposed has risen from 12 in the 72nd session to a high of 60 in the 82nd session, and is a gauge for the increase in political interest in reproductive health over the past 20 years.

<<Insert Figure 2>>

Figure 2 shows the trend in bills filed for each of the five specific categories: abortion, contraception, women's health, women's rights, and maternal & child health. Both restrictive and promoting bills are included in each category. Bills relating to abortion peaked in the 2011 session, but have featured in each of the last 11 sessions, even in the presence of a Democratic majority. The filing of bills relating to contraception has increased significantly from 4 in 1991 to 17 in 2011, with a peak of 19 in 2009. Both maternal and child health, and women's rights have bills have been a steady feature over time, while women's health bills have increased over time (none were filed in 1991,1993, or 1995).

<<Insert Figures 3 and 4>>

Figure 3 shows the trend in filed bills both promoting and restricting reproductive health between 1991 and 2011, and Figure 4 shows the trend in engrossed and enrolled bills restricting and promoting reproductive health from 1991-2011. We consider variation in bills both filed and engrossed/enrolled in each session, and how this relates to the partisan composition of the Legislature over time.

From 1991-1995, during a time of Democratic majority in the House and the Senate, 17 restrictive bills were proposed, mostly relating to abortion, and specifically parental consent before abortion can be performed on a minor. None of these bills passed. 10 bills were filed to promote or expand reproductive health care, and 6 passed, including an increase in family planning funding, and an increase in access to contraception in rural areas. The only restrictive bill that passed was the prioritization of abstinence in the sex education curriculum in public schools.

1997 was the first year that Republicans and Democrats reached virtually equal numbers in the Legislature. In this session, two bills passed requiring compliance with new standards of safety at abortion clinics. Many more bills, with varying degrees of restrictiveness, on parental consent before an abortion can be performed on a minor were proposed, but none passed. Women's health bills to ensure coverage of various services on health benefit plans began to rise in number, with one, covering well-woman exams, being enrolled.

In 1999 and 2001, there were still virtually equal numbers of Republicans and Democrats in the Legislature. During these sessions, a high volume of bills relating to abortion restrictions

continued to be proposed, and the parental consent requirement for minors was finally passed. Prioritization of abstinence education in public schools was also a prevalent issue, and the same bill, seeking to decrease public funding for family planning and direct it into abstinence-only education, was proposed (but never passed) in the two consecutive sessions. Although these filed bills might suggest hostile climate for contraceptive services, bills seeking to expand access to contraception were also proposed, and two that passed increased the coverage of contraceptive methods under health benefit plans, and extended family planning coverage via a proposed Medicaid consolidation (although this was later vetoed by the governor).

In 2003, the Republicans gained a majority for the first time in the period on which we focus. This is a particularly interesting session, both because it was the first where the number of filed bills promoting reproductive health was greater than the number of restrictive bills, and because it highlights some intriguing variability in attitudes to various reproductive health issues. The Women's Right to Know Act, which mandates the provision of printed and web-based informational materials to women 24 hours before an abortion may be performed was passed, but at the same time public funding for family planning funding was increased, and an amendment was passed to maximize the use of federal funding for women's health services, including contraception, paving the way for the Women's Health Program. The number of filed bills restricting access to abortion decreased from the previous two sessions, and the number of bills increasing access to women's health services increased.

In 2005 and 2007, Republicans were still the majority, and the number of promoting bills filed far exceeded the number of restrictive bills. Restrictive bills focused on abortion, with the first proposal of the Women's Right to Know Act, and also, for the first time on emergency contraception. There was a large in increase in the number of promoting bills aimed at reducing or renegotiating previously enacted abortion restrictions, and suggesting milder alternatives to the Woman's Right to Know Act. These sessions also saw the inception of the Women's Health Program, and the passage of other bills to improve women's health, most notably provision of information on the link between HPV and cervical cancer in public schools. However, despite this apparent climate of support for reproductive health, a budget rider was also passed in 2007 to direct federal funding for family planning in FQHCs, which perhaps indicates the beginning of the entanglement of abortion and contraception.

In 2009, Republicans still held the majority, but the number of reproductive health-promoting bills filed still outweighed the number of restrictive bills filed. Many of these involved promoting the Women's Health Program, and further expanding access to family planning by prohibiting a decrease in funding for the WHP, and allowing minors to access emergency contraception without the notification of an adult. The conspicuous change, however, is that no promoting bills were enacted. This trend carries over to 2011, where once again, no promoting bills were enacted. Furthermore, in the 2011 session, the number of restrictive bills far outweighed the number of promoting bills proposed, for the first time since 1999, and the number of proposed promoting bills declined notably from the previous session. In fact, the only bills promoting reproductive health that were enacted in 2009 and 2011 were bills to improve maternal and child health services.

Overall, with the notable exceptions of the 2009 and 2011 sessions, more reproductive health promoting bills were both filed and enrolled in years when Republicans dominated the Legislature, and a significant number of restricting bills were both filed and enrolled when the Democrats were in control. There is an interesting parallel to be drawn between two sessions in particular: 78R in 2003, and 82R in 2011. Both had a large Republican majority, both saw the passage of the two most well-known pieces of legislation restricting abortion in Texas (the Women's Right to Know Act and the Sonogram Bill respectively), yet 78R saw an increase in public funding for contraception, and 82R saw a drastic decrease. With this in mind, we now examine the results of our quantitative analysis, focusing on the results for these two sessions.

<<Insert Figure 5>>

Figure 5 shows the degree of voting polarization in 78R (2003) and 82R (2011) for all votes (grey dots), and for reproductive health bills (yellow dots). Bills clustering in upper left-hand corner were heavily supported by Republicans and heavily opposed by Democrats, whereas bills clustering in the lower right-hand corner were heavily supported by Democrats and heavily opposed by Republicans. Bills in upper right-hand corner received strong support from both parties. As can be seen from the distribution of reproductive health bills, particularly in the upper left-hand corner, these plots support the hypothesis that partisanship plays a role in voting on reproductive health issues.

<<Insert Figure 6>>

Quantifying the contribution of both the partisanship and the reproductive health factors identified by the Bayesian factor probit analyses, Figure 6 shows a Bayesian analysis of variance for the reproductive health votes in 82R and 78R. The ANOVA for 82R shows that the proportion of variation explained by party varies from between 75% to virtually 0%, and the reproductive health factor accounts for between 5% and 55% of the variation. For a significant number of bills, these two factors account for the vast majority of the variation, while for other bills, the residual variation is large. Clearly, and in contradiction to popular belief, partisanship alone does not explain the voting behavior of legislators in the 82R. The ANOVA for 78R looks surprisingly similar to that for 82R, with the party and reproductive health factors accounting for a similar proportion of the variation, even though polarization has increased between 2003 and 2011.

<<Insert Figure 7 and Figure 8>>

Figure 7 shows reproductive health factor score locations for each legislator in 82R. This score is an indication of legislator's propensity to vote for or against reproductive health issues after adjusting for party. Legislators with a location score of zero vote on reproductive health issues in a way that is indistinguishable from their voting on other types of issues, and the farther the score for zero, the more voting on reproductive health issues differs from voting on other types of issues. Interestingly, out of the ten legislators with the lowest scores (most "pro-reproductive health"), 4 are Republicans, and out of the ten with highest scores (most "anti-reproductive health") 4 are Democrats, further supporting the findings from the ANOVA, that party can explain only a limited amount of variation in voting behavior.

Figure 8 shows the factor score location for each reproductive health-related bill in the 2011 session. Bills with a positive factor score tend to be restrictive, for example, the sonogram bills (HB 15), and the amendments to the general appropriations bills (HB 1) that cut family planning funding. Bills with a negative factors score tend to promote, for example, amendments to lessen the cuts to family planning and to reauthorize the WHP.

<<Insert Table 1>>

Having specified the contribution of the reproductive health factor in explaining variation in reproductive health votes, the natural next question is to ask what latent legislator characteristics are represented by the reproductive health factor? Table 1 shows the results of linear regression modeling the association between reproductive health factor location and legislator's own and constituency characteristics. Results show that for Democrats, Catholic religion is associated with large positive second factor scores, i.e. an increased probability of voting for a bill with a positive score on the second factor (as stated above, examples of such bills include the sonogram bill and the family planning budget cuts). Conversely, the 3rd and 6th components of the constituency characteristics PCA, which represent percent single parent family, and percent non-citizen, are associated with large negative second factor scores, and thus an increased probability of voting against legislation restrictive of reproductive health. These characteristics account 40% of the explained variation in voting behavior, adjusting for party. These associations do not hold for Republicans (results not shown).

Discussion

We find that reproductive health-related legislation has increased dramatically over the past 20 years in Texas. Abortion restrictions recur in every session since the early 1990s, whereas attention to contraception is more recent. Polarization is certainly a feature of voting in the Texas House, but it is not markedly different with respect to reproductive health issues in 2011 than it was in 2003. Likewise, partisanship is an important factor predicting voting behavior on reproductive health issues in the Texas House, but it is far from the whole story, even in 82R. Qualitative analysis demonstrates that a higher proportion of restrictive bills passed in the early to mid 1990s when Democrats were the majority, while funding for family planning increased twice in the early-mid 2000s, when Republicans had a majority. Bayesian ANOVA for both the 2003 and 2011 session indicates that only 5-60% of the variation in any reproductive health vote can be attributed to legislators' party affiliation, while legislator reproductive health scores provide evidence that Republicans and Democrats often voted on reproductive health issues in ways that are systematically different from the way they vote on other kinds of issues, over and above the influence of party. Factors associated with this type of voting for Democrats include Catholic religion and constituency characteristics.

Even after taking into the partisanship and reproductive health factors into account, there is a significant amount of residual or unexplained variation in voting behavior on reproductive health issues. As with political behavior in general, there are likely to be contributory factors that are very difficult, if not impossible, to measure or even observe. Political deal-making and conversations behind closed doors rarely make their way into the public record. Two

factors in particular; relationships with interest groups and advocacy coalitions (such as Texas Right to Life, Texas Alliance for Life, Catholics for Choice, Planned Parenthood, and the Women's Health Advocacy Coalition), and campaign contributions, may account for some of the unexplained variation, but are difficult to accurately assess and operationalize. Future research, including in-depth interviews with legislators or their staff could make such data collection feasible.

Previous work has examined voting behavior on abortion at the state and Congressional level, but our study is the first to enumerate all reproductive health legislation over a period of 20 years, and examine the factors underlying voting behavior on reproductive health issues in a state legislature. Although our study offers several advantages over traditional methods through its Bayesian factor analytic approach, it also has some limitations. We have data only for the past 20 years, and thus cannot study the political climate in Texas on reproductive health issues in the 1960 and 1970s, when the advent of modern contraceptive methods, and Roe vs. Wade were likely to have attracted political attention. Some sessions, such as those in the early 1990s have too few reproductive health votes to permit factor analysis. The same is mostly true for the Senate, where there are too few legislators and thus insufficient variation. We also have limited information on legislator characteristics, and as noted above, cannot test associations between all variables of interest and voting behavior. Further research could further explore these issues, while investigating what connects certain legislators with high and low reproductive health factor scores. Additionally, other Bayesian factor analytic approaches could permit the identification of specific bills with which voting on reproductive health bills is similar, providing additional insight into the underlying factors (Hahn 2012).

Arguments for public funding for family planning and women's health services are underpinned both by 1) scientific evidence demonstrating the efficacy of preventative health services in reducing mortality and morbidity from gynecological cancers, and the negative health consequences of unintended pregnancy, and 2) the economic benefits of averting the cost to health systems of the prenatal care, delivery, postpartum care, and infant health associated with unintended pregnancies, and the cost of treatment for breast and cervical cancer and STIs. In Texas, women's health and contraception first appeared on the political agenda in the 1990s because of a growing awareness of the financial and logistical barriers to accessing services, particularly for low-income women in the state. At that time, and many years hence, these issues received a broad base of support. We cannot say for sure whether the dramatic cuts of public funding for family planning in the 2011 session were due to a rising moral antipathy towards contraception, antiquated attitudes towards women, or whether contraception has become simply another avenue through which to restrict access to abortion. What we can say, however, is that partisan polarization does not fully explain the situation in which Texas now finds itself, and that constituency pressures in particular might play a role. Given the seeming intractability of current partisan divisions, and the difficultly of arguing against ideological rhetoric, this is perhaps good news for those who seek to influence the trajectory of reproductive health legislation both in Texas and in the United States as a whole.

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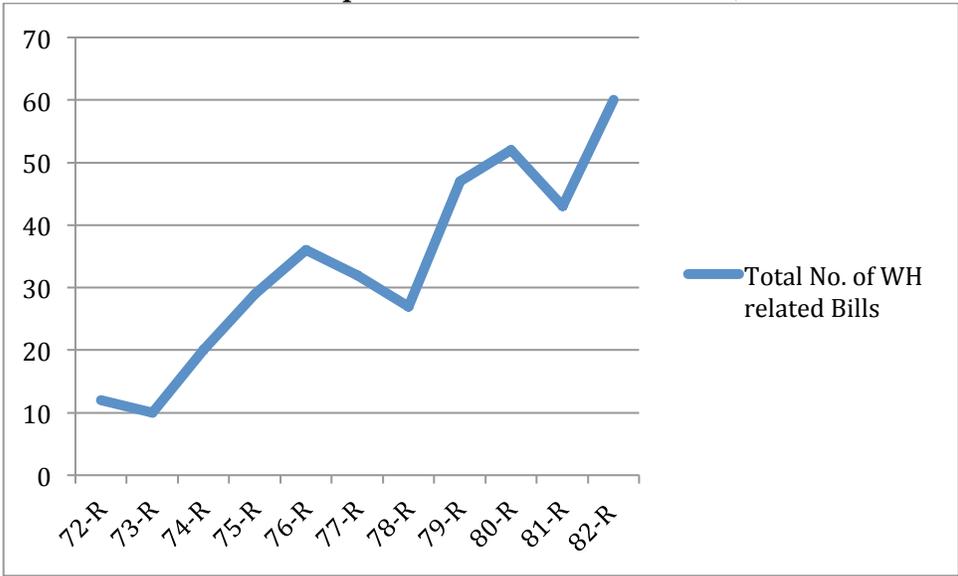**FIGURE 1—Trend in Reproductive Health Bills Filed, 1991-2011**

FIGURE 2—Reproductive Health Bills Filed by Category, 1991-2011
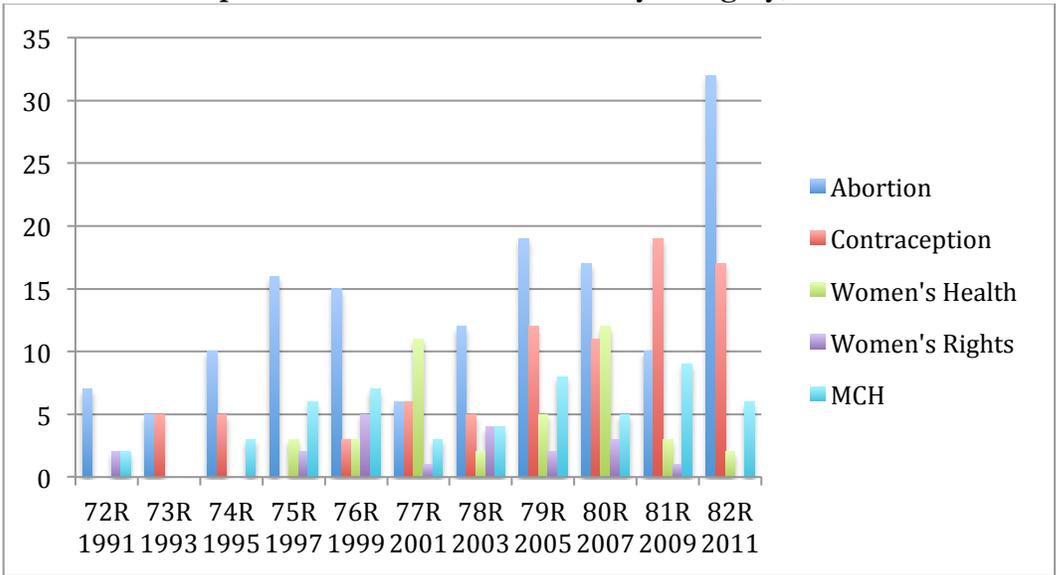
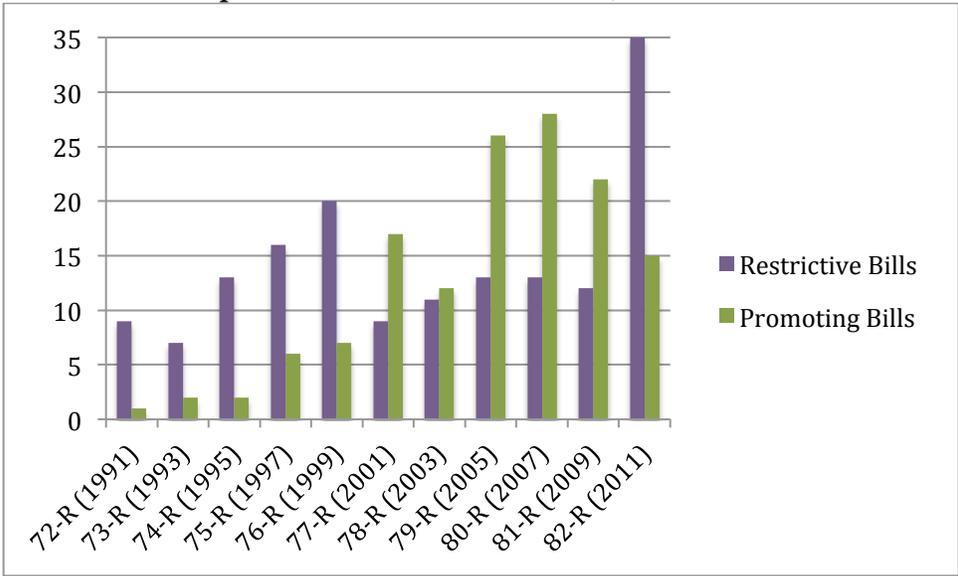**FIGURE 3—Reproductive Health Bills Filed, Restrictive and Promoting 1991-2011**

FIGURE 4—Reproductive Health Bills Enrolled or Engrossed, Restrictive and Promoting, 1991-2011
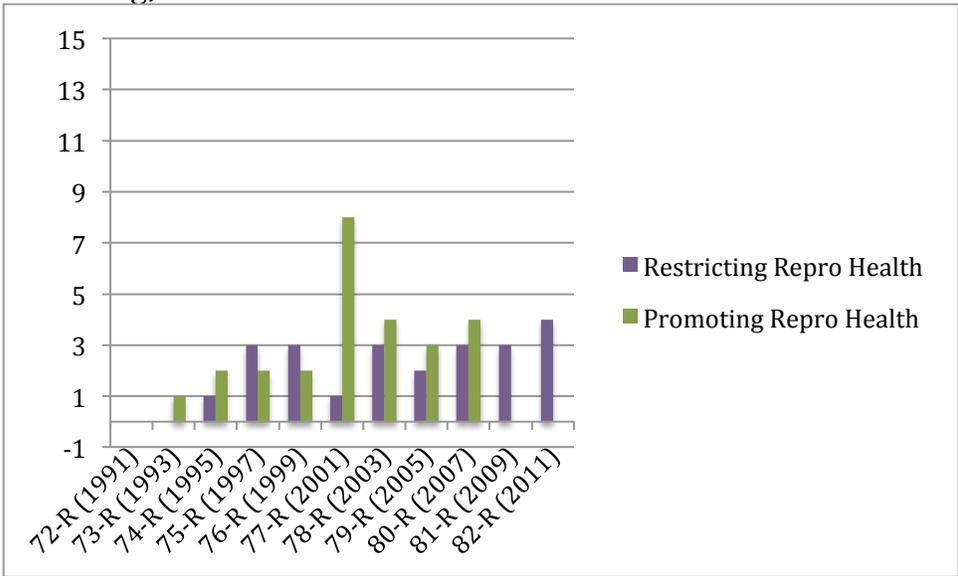
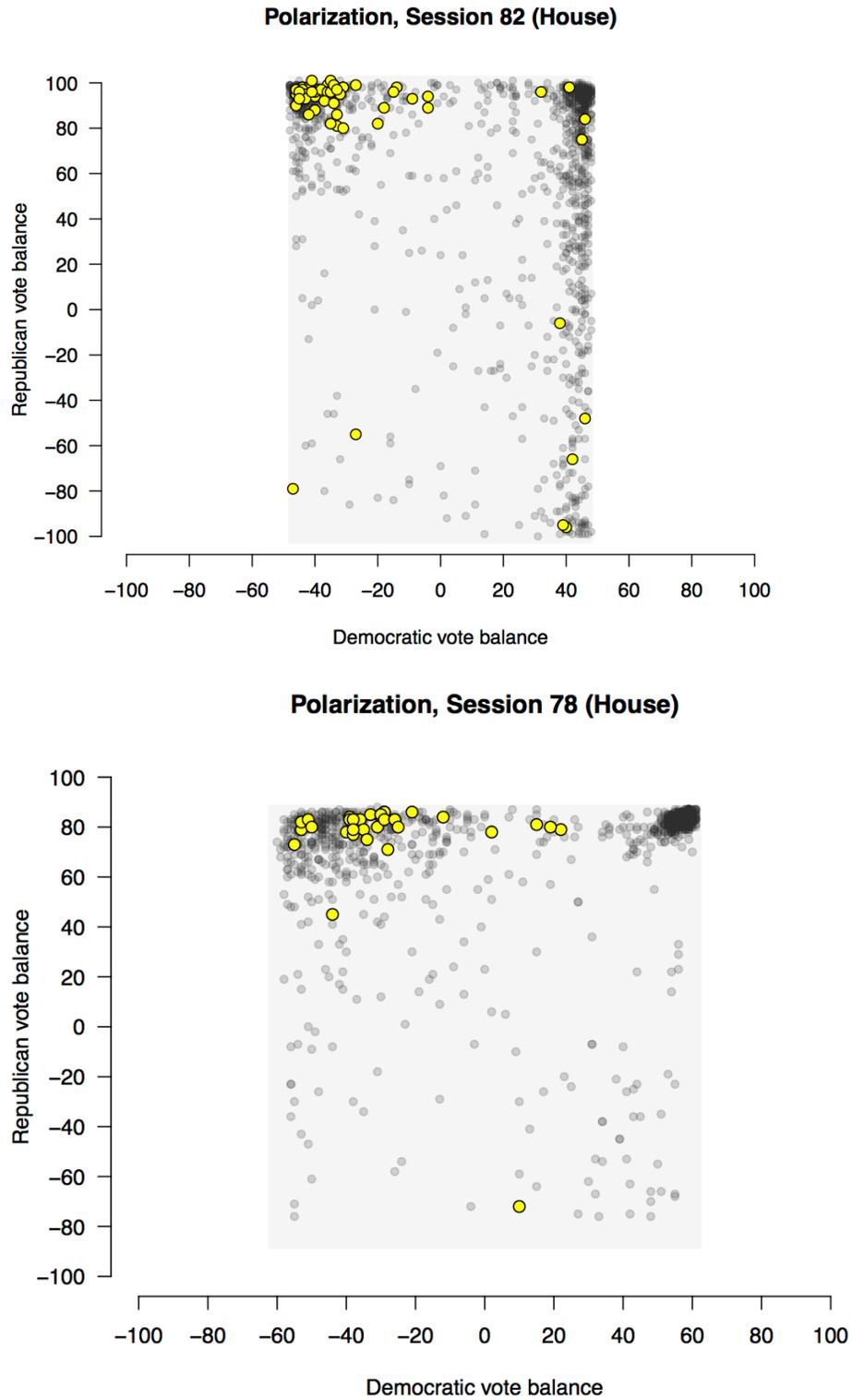**FIGURE 5—Polarization in the Texas House in 82R (2011) and 78R (2003)**

Polarization, Session 82 (House)

Polarization, Session 78 (House)

FIGURE 6—ANOVA for Reproductive Health Bills in the Texas House, 82R (2011) and 78R (2003)

Bayesian Analysis of Variance for Reproductive Health Bills, Session 82R (House)

Bayesian Analysis of Variance for Reproductive Health Bills, Session 78R (House)

FIGURE 7—Legislator Reproductive Health Factor Score Locations, Texas House, 82R (2011)

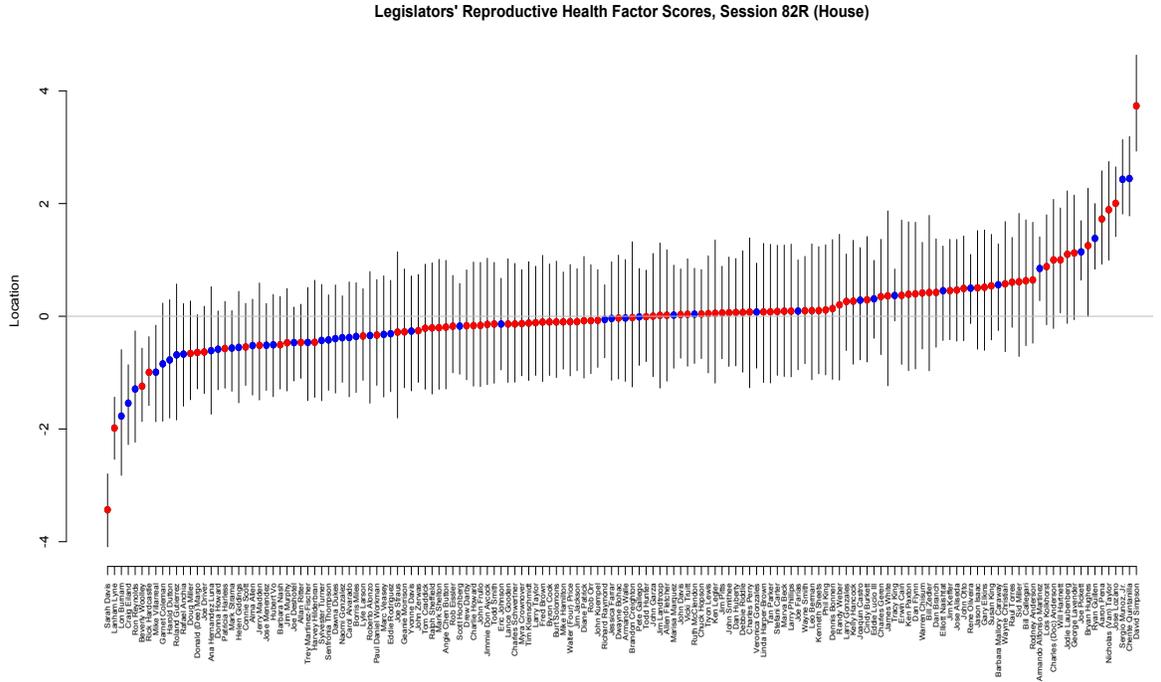Legislators' Reproductive Health Factor Scores, Session 82R (House)

FIGURE 8—Reproductive Health Factor Score Locations by Vote 82R (2011) (Figure omitted due to file size constraints, but available upon request).

TABLE 1—Linear Regression Modeling the Association Between Legislator Reproductive Health Scores and Underlying Factors, 82R (2011)

	Democrats
Catholic	0.45 (0.13)*
Constituency Characteristics Comp 3	-0.022 (0.01)
Constituency Characteristics Comp 6	-0.062 (0.02)**

Standard errors in parentheses

Adjusted-R^2 for Democrats: 0.41

** $p\_<0.01$ * $p\_<0.05$