

Sabina Jia

## Impact of Increased Abortion Access on Female Labor Force Outcomes

### I. Introduction

In the last fifty years, there has been tremendous movement in the expectations and outcomes for women in the workplace. The 1980s witnessed a particularly rapid closing of the pay gap by gender in the U.S, where the median annual wage and salary earnings of full-time female workers rose to 69% of men's earnings within the decade, up from 60% in 1979 (Bailey et al. 2012). This increase is largely attributed to the resurgence of the women's movement in the late 1960s, legal protection against discriminatory hiring and compensation practices with the 1964 Civil Rights Act, the spread of labor-saving household technologies, and the introduction of oral contraception (often noted as "the Pill") in 1960, with literature on the Pill drawing a relationship between maternity and the workplace. Although extensive literature covers the aftermath of these developments, there is another event which occurred around a similar time period and which should also be considered when analyzing female labor outcomes—the national decriminalization of abortion, established in 1973 through the U.S. Supreme Court case of *Roe v. Wade*.

Prior to 1973, abortion was already legalized in seventeen states, but the decision under *Roe v. Wade* established a national three-tiered framework to dictate when states were able to restrict abortions and what sort of restrictions they were allowed to implement. The ruling protects women's rights to abortion from state restrictions up until the first trimester, while allowing states to establish restrictions in the second trimester to ensure maternal health and allowing states to completely outlaw abortion in the third trimester, so long as exceptions are introduced in cases that were necessary to save the life and health of the mother (Chemmerinsky

2019). *Roe* was reaffirmed in the 1992 case of *Planned Parenthood of Southeastern Pennsylvania v. Casey*, which removed the three-tier framework but instead protected a woman's right to abortion up until 'fetal viability,' which is currently defined to be around 24 weeks. Before this point in the pregnancy, states are not allowed to outlaw abortion or introduce an "undue burden" upon a woman's access to abortion (Liptik 2021). The aftermath of these cases has witnessed a decline in fertility (Angrist and Evans 2001) and a rise in female labor force participation (Decker 2020), pointing to the benefits that women can attain with greater control over their childbirth and pregnancies.

In light of this aftermath in the 1980s, this paper investigates whether or not an association between abortion access and workplace outcomes still exists, especially for low-income women, women of color, and other more vulnerable groups, and also specifically in more recent times when there is not as much movement in hiring practices or access to contraceptives. Additionally, this paper seeks to inform future policy by examining modern female workplace outcomes using data from the U.S. Census, and if it is linked to abortion access through state-level reproductive access data from the Guttmacher Institute. When investigating this link, I found a general improvement in labor force statistics across most female groups, as with the aftermath of *Roe*. Moreover, this improvement was found to be greatest among women who were low-income, unmarried, younger, or Black, and especially when they were a combination of these attributes. Women falling into these categories may thus benefit the most from increased access to abortion, even after abortion has already been legalized and protected on a national scale through *Roe* and *Casey*.

This analysis comes as the conversation surrounding abortion and the fate of *Roe v. Wade* actually intensifies in the United States, and low-income women and women of color may be the

ones most affected. *Roe* itself has been reconsidered in the U.S. Supreme Court multiple times, such as in the 1980 case of *Harris v. McRae* which upheld the Hyde Amendment, an amendment in the U.S. Social Securities Act which restricts the use of federal funds for medically necessary abortions only. Even more recently though in the past decade, several states have tightened restrictions on abortion, with over 1,100 restrictions enacted since *Roe* was decided and a third of those restrictions introduced after 2010 alone (Ansari-Thomas et al. 2017). Of these restrictions, Texas's Senate Bill 8 outlaws abortion after six weeks (essentially banning all abortions, since 85 to 90% of procedures occur after the sixth week of pregnancy) and follows similar bans in Georgia and Missouri in 2019. Senate Bill 8 also deputizes citizens and enables them to report women who have had abortions, as well as doctors and providers who practice and provide abortion (Schnell 2021). This bill has already come into effect when the U.S. Supreme Court decided to not take action on an emergency appeal by Texas abortion providers in August 2021, and further ruled in December 2021 to dismiss the federal suit and allow the bill to remain in effect but open to legal challenge (Smith 2021).

Another recent restriction that targets the extent of abortion's legality is the Gestational Age Act in Mississippi, which seeks to ban all abortions after 15 weeks (Cha and Wax-Thibodeaux 2021). This act and the correlating case *Dobbs v. Jackson Women's Health Organization* has recently been heard in December 2021 by the mostly conservative U.S. Supreme Court (Totenburg 2021). Because this is one of the few abortion cases to ascend up to the national level, as most of them are struck down for violating *Roe*, many fear that this will be the case which overturns *Roe* and opens up the possibility for states to issue their own arbitrary gestational age limits for abortion procedures afterward. In fact, 12 states have also already

passed “trigger laws,” which are bans on abortion which will immediately go into effect as soon as *Roe* is overturned (Ellmann and Spitzer 2021).

These recent restrictions have added urgency to the debate while placing many women’s health, lives, and careers in uncertainty, especially since women without legal access to abortion may go to dangerous lengths to abort (Gold 2003). Lack of access to abortion also disproportionately affects low-income women and women of color, groups of interest in this paper (Dehlendorf et al. 2014, Jones and Kavanaugh 2011). About half of U.S. counties do not have OB-GYNs, and only half of reproductive-age rural women live within a 30-min drive of a hospital offering prenatal services (Elwell et al. 2012), which may lead to great financial burden for some women. The aforementioned Hyde Amendment, which prevents federal funds from going to abortion, also restricts abortion largely from low-income women and women of color as well, since they may rely on government funding even more (Culp-Ressler and Hellerstein 2015). One way in which low-income women and women of color rely on government funding is through Medicaid, a joint federal and state health insurance program which awards eligibility on federal standards while also allowing states to choose to cover additional groups. Some groups which have mandatory eligibility include low-income individuals and families, which is calculated based on the Modified Adjusted Gross Income (MAGI) metric that looks at an individual’s current earnings or whether or not an individual receives Social Security Income (SSI) (“Eligibility”). A restriction on government funding for abortion thus disproportionately affects low-income families and women, who in turn may disproportionately be comprised of people of color.

Furthermore, abortion has not received as much academic attention as other developments, such as the birth control pill. Although the effect of the Pill on female labor force

outcomes has already been written about extensively and these findings may be generalized to abortion through the link of both to fertility outcomes, abortion must be studied in conjunction with the Pill. This is because contraceptives cannot fully guarantee that a woman will not have an unplanned pregnancy, and so a ban on abortion will introduce a gap in reproductive access that contraceptives cannot fully fill. In 2011, nearly half of the pregnancies in the U.S. (2.8 million out of 6.1 million) were unintended, with 27% “wanted later” and 18% “unwanted,” even though oral contraceptive options are relatively more widespread (Finer and Zolna 2016). This indicates that not all women in need of reproductive resources have access to or are able to use oral contraceptives before pregnancy, and have instead resorted to abortion. Despite this gap, more attention in literature is given to the Pill as a factor in the increased relative wages and labor force participation rates for women since the 1980s (Bailey 2006, Bailey 2012, Goldin 2002), even though abortion access may also have drastic consequences on a woman’s lifestyle, obligations, and career decisions. Abortion itself is also increasingly more concentrated among lower-income women and women of color, and these groups may be the ones who have the least knowledge of, the least access to, and the least usage rates of the Pill (“Birth”). Thus, without more literature validating the positive results from increased reproductive health access, the group of women who tend to have the lowest wages may also struggle the most in improving these circumstances, as they are most vulnerable to the amount of access available.

## **II. Background and Literature Review**

The link between abortion and a woman’s career decisions usually persists for longer than the duration of pregnancy. This is generally because in the family unit, women are the ones who typically handle home and childcare responsibilities, and this disproportional delegation of responsibilities has economic consequences on a woman’s career and life decisions especially as

women scale back their work responsibilities or leave the labor force entirely after having children (Miller 2011, Loughran and Zissimopoulos 2009). Coupled with the increasingly more expensive childcare facilities and the lack of a nationalized paid leave policy in the US, women are more discouraged from pursuing higher career goals, often having to choose between having a family or a promotion (Hamm et al.). Motherhood is thus seen to be tied with a wage penalty, shown in Budig and England (2001) where new mothers receive lower wages by around 7% per child and have fewer years of experience, a penalty which is even larger for lower-income mothers. The other side of this experience is how additional children are also found to be associated with a “fatherhood bonus,” where men, especially high-income men, will experience an increase in wages after having children (Budig 2014).

This discrepancy between the motherhood penalty and fatherhood bonus may occur due to a number of reasons, one being that women are usually expected to and tend to spend more time taking care of their children, and another being that there may be workplace discrimination against mothers, as they may be labelled as unreliable. On the other hand, there may be more favorable attitudes toward fathers, as they may be seen as more stable or deserving. These societal stigmas may in turn inform both workplace and public policies or norms, such as through hiring discrimination against new mothers or younger women who may have children soon. However, while the link between childcare and female economic outcomes can be seen to exist at least in individual cases and has drawn attention to experiences such as the motherhood penalty in the workplace, economic research on the larger consequences of U.S. reproductive healthcare access and rights still remains relatively sparse, even though this research can potentially bring more attention to the decisions which women face on childbirth and their careers.

One way in which women have been able to retain autonomy over their timing of child-raising and their careers is through abortion. Relatively few amounts of women abort compared to women who use contraceptives, and the proportion of women who do abort has decreased steadily since its peak in the 1980s from around 30 abortions per 1,000 women aged 15-44 years old to around 15 abortions per 1,000 women in a similar age range in 2014 (Dreweke and Nash 2019). However, these numbers fail to account for the women who may have wanted an abortion but who were unable to attain one, either due to the timing along their pregnancies, societal stigma or pressure from others, or the associated costs. Barar et al. (2014) found that every year, more than 4,000 U.S. women are denied abortions solely due to exceeding facility gestational limits, but many had delayed their abortions due to the costs of transportation or the procedure. These women are more likely to be low-income and women of color, as well as without healthcare or enrolled in Medicaid. Moreover, due to the Hyde Amendment restricting federal funds from use for reproductive procedures such as abortion, women in the latter group are especially at risk. Klerman (1999) studies the time period when the Hyde Amendment was first enacted in the late 1970s and early 1980s, finding that the legalization of abortion and the restriction of Medicaid funds had larger effects on the fertility rates of Black women rather than white women. Dehlendorf et al. (2013) also finds that Black and Hispanic women are less likely than white women to use contraceptives and are also more likely than white women to have unintended pregnancies. These results highlight the importance of abortion for female economic outcomes, especially as women of color may rely less on the Pill and thus require more access to abortion, and are also generally of lower income than white women.

Despite the potential impact that abortion has on women's economic outcomes, there still remains a lack of research on how abortion access or restrictions are associated with modern-day

female work statistics, with most focusing instead on fertility such as the aforementioned papers. As one of the few papers which does look at abortion and work outcomes, Decker (2020) examines the impact of *Roe* on female labor force participation rates by comparing rates in states which have legalized abortion before *Roe* to states which only legalized abortion after *Roe*. Its results find that states which legalized abortion after *Roe* experienced higher increases of female labor force participation, indicating that abortion decriminalization correlates with more women entering or staying in the workforce in the 70s and 80s, a time which saw the pay gap by gender closing most rapidly as well.

Also using the national decriminalization of abortion as a natural experiment, Angrist and Evans (2000) found that after *Roe*, teenagers and Black women were the ones who were affected most; teenagers experienced a decrease in out-of-wedlock pregnancies while Black women experienced an increase in high school completion and employment rates. Both Decker (2020) and Angrist and Evans (2000) do discover a link between abortion access and female labor outcomes then; however, the time period that these papers analyze, although monumental in its historical context, does not isolate for the effect of *Roe v. Wade* or increased abortion access since many other substantial shifts were occurring simultaneously. These shifts include the commercialization of the Pill, the resurgence of the feminist movement, an accelerating innovation of technology, etc., all factors which may have had large associations with final labor outcomes and the states which newly legalized abortions. This paper thus builds upon the previous conversation by analyzing abortion access in the context of the restrictions and policies in different time period, the 2010s. Although this decade has its own confounding variables, relative to the 1970s and 1980s, it does not have as dramatic of changes as the introduction of the birth control pill or the second wave of the feminist movement.

The cultural impact of the Pill may be one of the reasons why the relationship it has with female labor statistics is much more closely analyzed than that of abortion. However, although the Pill and abortion are used at different stages of conception and may have different magnitudes of associations with labor outcomes, the results of analyses on the Pill are still important to consider when analyzing abortion. Given that both options present similar effects on fertility, there may be some parallels between the two on labor outcomes as well. Bailey (2006) looks at a natural experiment in the 1960-70s, when state-level changes expanded legal rights of individuals from age 21 to 18 and allowed them to, among other rights, gain access to oral contraceptives without parental consent. The study found that younger women with access to the Pill had a reduced likelihood of becoming a mother before the age of 22 and an increased likelihood of entering the workplace, supporting the argument that the Pill granted freedom for women in the timing of their birth, which they could then use to pursue a career with more flexibility. Broadening this conclusion, these results imply that early childbirth may also serve as a barrier to entering the labor force, an outcome that abortion seeks to correct as well.

Bailey et al. (2012) furthers the investigation through the lens of the increased contraceptive rights for younger women in the 1960s-70s, finding that although early access to the Pill is associated with a decrease in wages for women born in the 1950s during their twenties, it is also associated with an increase in wages in their thirties and forties as they may have been able to take advantage of the increased flexibility in birth timing to instead further on schooling and expanding into higher-income occupations. Goldin and Katz (2002) have also written on the relationship between the diffusion of the Pill with women's education decisions, finding that the Pill lowered the costs of higher-level education opportunities for women, delayed marriage, and allowed women to achieve higher-paying jobs.

Although research on the Pill does not generalize explicitly to abortion, contraception and abortion are linked through the concept of fertility and childcare, as both either prevent or delay childbirth and can thus affect the costs which women incur during and after pregnancy. To further link the effects of the Pill with the effects of abortion through fertility, Bloom et al. (2007) investigated the relationship between fertility and labor force outcomes on a country-level while using abortion legislation as an instrument for fertility. The results found that fertility is negatively associated with labor force participation rates, and that this association is particularly strong for women aged 20-39 years old, a similar conclusion with the previous literature on the impact of the Pill. Bloom et al. also found a high degree of persistence in the association between fertility and labor force participation, concluding that higher total fertility is associated with lower female labor force participation rates even for older ages. However, the study done by Bloom et al. was conducted on a country-level instead of on a state-level, and so may be more prone to omitted factors which are more difficult to control, such as culture or broader historical shifts on a national level.

On the other hand, Foster et al. (2018) presents a more individualized perspective into the link between abortion and economic outcomes by using data from “The Turnaway Study,” a 5-year survey of 813 women which evaluated their socioeconomic outcomes depending on whether or not they were denied abortion care. Most of these women reported seeking abortions for financial reasons; over half were living below the federal poverty level, with 76% reporting that they not enough money to cover basic needs (food, housing, or transportation), and around 60% reporting that they already had children. By studying this group of women, Foster et al.’s results show that women who were denied abortions and gave birth had a higher chance of being in poverty in the short and long-term compared to women who received abortion services.

Additionally, the women who were denied were also less likely to be employed full-time after giving birth. There is thus a link between childbirth and career decisions or outcomes for women, at least on the individual level, which can be affected by public policy. This paper will attempt to investigate the role of public policy in female labor outcomes through the impact of abortion, to examine ways in which we can further support women in their ambitions. To do so, this paper will study the economic outcomes of women on a state-level basis, which will also serve to generalize the findings of the previous literature mentioned.

### **III. Landscape of Abortion Access**

Currently, there are a number of regulations and restrictions on abortion which vary by state, with over 1,100 restrictions enacted since *Roe v. Wade*. Restrictions involve outright bans on abortion, regulations on clinics or insurance coverage, mandatory counseling or waiting periods, required parental consent, and ultrasound or fetal heartbeat tests, which can psychologically affect one's decision to abort. Tables 1-2 display an overview of different restrictions on a state level, taken from the Guttmacher Institute. The highlights of this overview include how 43 states have gestational limits which prohibit abortions after a certain time in the pregnancy and 33 states prohibit the use of state funds for abortion, except when the patient's life is in danger or when the pregnancy is due to crimes such as rape or incest. Additionally, 12 states restrict private insurance plans from covering abortion, 45 states allow individual healthcare providers to refuse abortion services, and 42 states allow institutional healthcare providers to refuse abortion services. Lastly, 25 states require patients to undergo a waiting period with counseling before the procedure, 37 states require some form of parental involvement (consent or notification), and 18 states require counseling before the procedure. Counseling includes topics

such as the alleged link between abortion and breast cancer (5 states), long-term mental health issues (8 states), or the alleged ability of the fetus to feel pain (13 states).

Apart from state regulations and restrictions, patients are also geographically constrained from accessing abortion services due to there being few abortion clinics. The lack of clinics is tied to state regulations as well, usually through restrictions known as targeted restrictions on abortion providers (TRAP) laws. Some examples of these restrictions include mandating abortion providers to build expensive and largely unnecessary ambulatory surgical centers (ACS) or requiring providers to obtain hospital admitting privileges at hospitals which are nearby, which may be very difficult for providers in rural areas. Although these two restrictions were deemed unconstitutional in Texas by the U.S. Supreme Court in the 2016 case *Whole Woman's Health v. Hellerstedt*, which subsequently led to the fall of similar restrictions in Alabama, Wisconsin, and Mississippi, the impact of these restrictions are nontrivial. Between 2011-2014, when these laws were enacted in multiple states, the number of clinics declined 6%, and this decline was even more pronounced in the Midwest and South, where clinics declined by 22 and 13%, respectively (Jones et al. 2019). The decrease in the number of abortion providers creates geographic constraints and burdens on women seeking abortions, adding to the cost of abortions in both time, effort, and dollar amount.

These costs are also nontrivial. Although the Affordable Care Act (ACA) allowed states to expand Medicaid coverage by increasing funding, which led to the number of women without insurance to decline from 18% in 2008 to 11% in 2019, the Hyde Amendment still restricts the use of federal funds for abortions which are not considered medically necessary (“Women’s Health”). Against this restriction, as of 2021, there are sixteen states which allow the use of state funds to cover medically necessary abortions beyond which the Hyde Amendment restricts, but

there are still over seven million women of reproductive age who are enrolled in Medicaid and who live in states which have not expanded Medicaid coverage for abortion procedures (“Medicaid Coverage”). The women enrolled in Medicaid are also disproportionately women of color, with 31% being Black women and 27% being Hispanic women, compared with 16% being white women. Low-income women are also more likely to have unintended pregnancies and abortions, with low-income women making up 75% of U.S. abortions in 2014. This leads to most (around 53% in 2014) of abortions being paid out-of-pocket (Jerman et al. 2016), although the average cost of an abortion at 10 weeks of pregnancy was around \$500 in 2014 and patients often face other nonmedical costs, including transportation and lodging, which increase when the abortion clinic is located farther away (Jones et al. 2018). This amount is almost a third of the family’s monthly income, even when the patient is near the higher end of the spectrum for Medicaid eligibility, indicating that abortion services are disproportionately unaffordable for the groups which may need it most.

#### **IV. Data**

##### **a. Descriptive Statistics**

To investigate the link between abortion access after the Hyde Amendment with labor outcomes, the analysis uses state-level data on individual economic outcomes from 2008-2019, compiled from the U.S. Census American Community Survey (ACS), as well as data on reproductive healthcare access from the Guttmacher Institute. Samples from each year of the ACS are restricted to adults from ages 18-45, which are considered the main years of fertility. Additionally, the sample represents a weighted 0.05% sample of the total U.S. population which participated in the sample. The Guttmacher Institute data details a state’s status on whether or not it provides state funds for abortion processes through Medicaid across the census years. This

specific regulation is investigated to focus the analysis on what extent recent regulations may hurt or benefit the more vulnerable groups, such as low-income women and women of color, since these are the women who are largely covered by Medicaid.

Table 3 displays descriptive statistics of dependent and demographic variables used in the analysis, taken from the 2019 ACS. For the full sample, around half of the surveyed individuals are female. When broken down between the two sexes, a number of differences appear as well. Women are seen to have an average of 0.927 children at home, greater than that of men at 0.659 children. This result implies that women who are not living with the father of their children are more likely to be caregivers for the children, compared to men who are not living with the mother of their children. This difference further confirms that the responsibilities of childcare usually fall upon the mother. Additionally, women have a lower employment and labor force participation rate than men, with the proportion of women who are not in the labor force double that of men. Women also have a lower total individual wage income amount at a mean of \$31,956 compared to a mean of \$47,178 for men. These results occur despite women having a greater rate of higher education attainment than men, with around 33.9% of women completing college and 14.1% pursuing an advanced degree, compared with 28.2% and 9.8% for men, respectively. Despite having more advanced higher-level training then, women are still more discouraged from entering into the workforce or staying employed, and those who do earn a wage tend to earn less, potentially due to working in lower-paying occupations.

Table 3 additionally details descriptive statistics for subgroups of the data, including those who are covered by Medicaid, non-college graduates, and Black people. From these numbers, it is seen that Black people constitute the highest proportion of those who are covered by Medicaid, with around 30% of those sampled under Medicaid. Black people are also

disproportionally represented within Medicaid; despite comprising of 5.9% of the full sample, they make up 9.8% of the group covered by Medicaid, which is almost double. Those who are covered by Medicaid also display the lowest employment rates by far, with less than half of the group employed. This translates into the lowest average wage income as well, at \$11,542. Black people and people covered by Medicaid also have the lowest educational attainment levels, and those who are covered by Medicaid have on average 0.869 children at home, compared to 0.791 children from the full sample.

### **b. Explanation of Income**

As denoted in Table 3, the dependent variables in the analysis include the total wage income and labor force participation rate. Total wage income is used instead of total individual income because total individual income is defined the sum of an individual's income streams, which includes wage income as well as Social Security, welfare, retirement, child support, and investing income. While the amount of welfare support, government assistance, and child support may affect an individual's decision for their career, they may also result in an upward bias in income when analyzing the labor force outcomes of groups covered by Medicaid, especially in the states which expanded Medicaid to cover abortion procedures.

Figures 1 and 2 display the differences between these two types of income by showing the trend between the number of children at home and an individual's income in the U.S., which is taken as the median and separated by gender. Figure 1 displays the trend for an individual's total income (including government assistance, welfare support, etc.) and Figure 2 displays the trend for an individual's wage income. Both trends inform a clear downward trend for women as there are more children at home, and overall, women with a certain number of children at home earn less than men with the same number. The gap also slightly widens as the number of children

increases, especially up until 4 children in Figure 2. Although similar, the income figures in Figure 2 are slightly lower than that of Figure 1, especially for women, which confirms that using individual income may present an upward bias.

The fact that women generally earn less than men may be because in heterosexual two-parent households, many women become homemakers or part-time employees, especially since women are traditionally responsible for the domestic duties while their husbands may earn more, have higher potential job trajectories, or feel a greater cultural necessity to work and provide for their families. To investigate whether or not this is the main reason behind the gaps in income in Figures 1 and 2, I plotted a similar relationship between the number of children at home and household income. If there were only heterosexual marriages, and all those who were sampled were married, the income values for men and women should be exactly the same. However, because the sample also includes single-parent households, the trends actually reveal the differences in income experienced by single-parent households. Figure 3 displays how women have lower household incomes than men and the gap widens, as male household income increases more drastically for those with two or five children at home and female household income stays relatively stagnant at the same intervals. This discrepancy indicates that female single-parent households generally earn less and do not enjoy the same income increases that households with a male parent present may enjoy, especially for female-headed households with a higher number of children at home. These results support the concepts of the “motherhood penalty” and the “fatherhood bonus” as detailed before. The trend is also split in roughly two segments; household incomes of both men and women slightly rise from having no children to two children at home, before falling steeply for those with three children, rising slightly again before once again falling for those with six children. Although more analysis must be done to

investigate this segmentation, it may be due to preferences among higher-income households to either have two or five children.

### **c. Explanation of States**

Table 4 displays the states which have expanded Medicaid to cover abortion procedures, detailing the years in which they have expanded Medicaid. The state names marked by an asterisk indicate which states are included in the analysis, and are chosen because they have expanded Medicaid to cover abortion procedures between the years 2010-2014. States which expanded Medicaid after 2014 are not included in the analysis since there is likely to be a delayed response between Medicaid expansion and labor force outcomes but census data at the time of this analysis is only published up until 2019, so the labor force outcomes in these later states cannot be studied completely.

Additionally, I include nine other states in the analysis to use as points of comparison -- three states which expanded Medicaid to cover abortion before the year 2000 (Massachusetts, Montana, and Washington) and six states which have not expanded Medicaid (Colorado, Delaware, Michigan, Nevada, New Hampshire, Wisconsin). The former group is included since these three states are similar to the six states which recently expanded Medicaid in terms of political landscape and population demographic, and are used as controls to attempt to isolate the effect of expanding abortion coverage from other movements in the political or societal spheres that may have happened at the time as well. The latter group of the six states which have not expanded Medicaid is also included to serve as a comparison point, again chosen due to having similar geographic, political, and societal characteristics, such as public sentiment in favor of abortion, to the six states which recently expanded Medicaid. They are thus used as a control group as well, to isolate for the effect of expanding Medicaid coverage to abortion.

## V. Empirical Strategy

This paper attempts to establish a relationship between abortion access and labor force outcomes by comparing individual outcomes due to state-level legislations or variations in access. To do so, I estimate the following form for a linear model, regressing labor force outcomes on a variety of variables which include abortion access indicators and other individual characteristics:

$$Y_{isy} = \alpha_0 + \alpha_1 MEA_{sy} + \beta EDUC_{iy} + \gamma X_i + \delta MARR_{iy} + \mu AGE_i + \omega HCOV_{iy} + \theta_y + \tau_s$$

where  $i$  indexes individuals,  $s$  indexes state of residence, and  $y$  indexes year of census sample;  $Y_{isy}$  denotes individual labor force outcome statistics which includes wage income and labor force participation, with income counted on a dollar level and labor force participation taken as a percentage ratio of the total population from 0 to 1;  $MEA_{sy}$  is a state-level variable equal to 1 if the state  $s$  has expanded Medicaid to cover abortion procedures by year  $y$ ;  $EDUC_{iy}$  is a dummy variable equal to 1 if an individual  $i$  is a college graduate or more by year  $y$ ;  $X_i$  is a dummy variable on race (whether an individual  $i$  is white, Black, or Asian);  $AGE_i$  denotes an individual's age;  $MARR_{iy}$  is a dummy variable equal to 1 if an individual  $i$  is married in a certain year  $y$ ;  $HCOV_{iy}$  is a dummy variable equal to 1 if an individual  $i$  has health insurance in a certain year  $y$ ,  $\theta_y$  denotes year dummies from the years 2008-2019, and  $\tau_s$  denotes state dummies from the states included in the analysis, including the states which are used as controls.

## VI. Results

Table 5-13 detail the results of this model for labor force participation while Tables 14-22 detail the results for income. Both models are conducted over the full sample of the fifteen states included, individuals of these states who are non-college graduates, individuals who are covered by Medicaid, unmarried and married individuals, and Black individuals. The models then

analyze young (18-27 years old), middle-aged (28-35 years old), and older (36-44 years old) individuals, as well as unmarried and married individuals for those who are covered by Medicaid, those who do not have college degrees, and those who are Black. All of the groups are analyzed by sex, as men are studied as well to attempt isolating for more macroeconomic effects and serve as a form of comparison for female outcomes. The latter three groups of those covered by Medicaid, those without college degrees, or those who are Black, are chosen based on being the ones who are potentially the most affected by the expansion of Medicaid to cover abortion.

As shown in Tables 5-6, Medicaid coverage expansion for abortion exhibits a statistically significant relationship with labor force participation for women who are covered by Medicaid, Black women, and curiously, married men. In the case of women who are covered by Medicaid, expansion of Medicaid is associated with a modest, albeit significant, 3 percentage point increase of the labor force participation for women in these states. Modeling for Black women yields a significant positive association of 6.5 percentage points as well. These results indicate that lower-income women and women of color may be taking advantage of the increased coverage for abortion procedures, which leads to them having more time and opportunity to enter the labor force afterward. Moreover, they may be the ones most affected by the abortion coverage as they may be most at risk of unintended pregnancies, and in the case of Black women, be more likely than women of other races to have health coverage through Medicaid.

Additionally, the model for married men yields an unexpected negative, significant association of 1 percentage point, which upon first glance, may be because they are having less children, so there is less of a need for them to work and provide for the family especially if their partners, who are largely women, are more able to work. The association for married women is expected to be positive in this case though (as it implies that more wives are working), but the

association is actually negative, albeit very close to zero with a high p-value of 0.890. The labor force participation rate of married women thus does not have a strong association with the expansion of Medicaid for abortion, possibly due to married women having a lower tendency in having or requiring abortions, especially if married women also tend to be older, have greater financial resources and support from her husband, and are more likely to have planned the pregnancy.

Another explanation for the negative relationship between Medicaid expansion and the labor force participation of married men may be that an expansion to cover abortion may not only affect abortion coverage. Medicaid may actually be expanded more broadly, covering not only abortion but other benefits as well, and making healthcare more financially accessible in general. Although more work must be done on the exact relationship between these broader expansion benefits and the labor force outcomes of married men, the negative association that married men have between their labor force participation and Medicaid expansion for abortion may be a spurious one that is actually acting as a proxy for general Medicaid expansion instead. As seen in Table 9, when the regression is conducted only for the sample of those covered by Medicaid, married men continue to have a negative, albeit small and nonsignificant, association between increased abortion access and their labor force participation rates. Additionally, when looking at married men in the full sample in Table 6, the association of 1 percentage point in their labor force participation rates is small relative to their average labor force participation, which is 93.9%, indicating that the results do not change drastically in response to an expansion.

To further investigate the groups which have displayed significant relationships with Medicaid expansion, Tables 7-8 display results those who are only covered by Medicaid, since these individuals are the ones directly affected by an expansion of Medicaid coverage. The

results show that younger women, unmarried women, and Black women have the greatest movements in labor force participation rates under a Medicaid expansion to cover abortion. The labor force participation rate of women who are 18-27 years old is associated with a positive 6.5 percentage point increase that is significant on the  $p < 0.01$  level and is also an over 10% increase from the average. Women who are 28-35 years old also experience a positive 3.3 percentage point increase (significant on the  $p < 0.05$  level). Younger women may thus be more affected by Medicaid expansion policies for abortion, especially since they are the ones who are earlier in their careers, more likely to be in single-parent households, and more likely to have unintended pregnancies. Unmarried women also have a significant, positive relationship of 4 percentage points between Medicaid expansion and their labor force participation rates, a larger increase by almost double of their married counterparts.

Black women who are covered by Medicaid also have a positive 14.6 percentage point association between labor force participation and Medicaid expansion. This is almost a 25% increase from their average labor force participation rate, and is significant on the  $p < 0.01$  level. Because Black women are also more likely to have unintended pregnancies, as well as unmarried or the head of single-parent households, these results could indicate that Black women covered by Medicaid are taking advantage of the additional Medicaid coverage and are benefiting much more than their white counterparts or other Black women who are not covered by Medicaid.

Only analyzing individuals who are covered by Medicaid, however, may create an issue of simultaneous causality with the dependent variables, since labor force participation and wage income are directly tied with one's Medicaid eligibility. This is especially since Medicaid takes into consideration an individual's current monthly income when calculating eligibility. In order to bypass this mechanical issue, I conduct similar regressions for groups who do not have college

degrees and who are Black to serve as proxies for those who are covered by Medicaid. Table 9 displays results when regressing Medicaid coverage expansion against labor force participation rates across education levels, displaying a positive, significant association of 7.4 percentage points for women with less than high school education levels, which is over 10% of their average rates. Tables 10-11 look closer at individuals who do not have college degrees, finding that although women across subgroups generally had more positive associations than their male counterparts, only Black women displayed a large and significant ( $p < 0.01$ ) result. Labor force participation rates for Black women were associated with a 7 percentage point increase, around 10% of the average for this group, which indicates how women who are Black and have lower levels of education may benefit at a greater pace from Medicaid coverage expansion for abortion.

Tables 12-13 investigate the effects within the Black community more closely, and find that Black women across all ages brackets experience a positive and significant increase in their labor force participation rates after Medicaid is expanded. Younger and unmarried Black women also experience the largest proportional increases, with Black women aged 18-27 years old experiencing an 8.6 percentage point increase (slightly over 10% from the average) and unmarried Black women experiencing a 6.7 percentage point increase (slightly under 10% from the average). Additionally, these groups are potentially the most vulnerable to being lower-income or single heads of households if they do have children, due to being young, unmarried, Black, female, or a combination, all of which is associated with more depressed labor force statistics.

Tables 14-22 display the results of the regression of Medicaid expansion to cover abortion on the wage income of an individual, looking at the same groups when investigating the link with labor force participation rates. There are less significant results between wage income

and Medicaid coverage expansion though, potentially due to wage income being more directly tied with one's eligibility and participation in Medicaid. When investigating the full sample in Tables 14-15, only Black women statistically significant results on a  $p < 0.05$  level, where Medicaid expansion is significantly associated with a \$1077.55 increase in annual wage income. This association was also the highest out of all the other subgroups investigated. Because Black women also had a significant and positive correlation between their labor force participation and Medicaid expansion, this wage increase may be due to more Black women being able to enter the workforce. The increase may also be due to more Black women being able to take advantage of promotion opportunities, switching to more demanding but higher-paying jobs, or becoming full-time employees. Since Black women are most at risk of being single mothers or the heads of the family, due in part to higher mortality and incarceration rates of Black men, this group can be one of the highest beneficiaries of Medicaid expansion for abortion, on both a labor force participation and wage increase level.

Curiously, in contrast to the analyses on labor force participation rates, the results on annual wage income for women under Medicaid are not significant. This is possibly due to individuals who are eligible for Medicaid being affected by other factors such as an increasing minimum wage, which may be more common among states which expanded Medicaid. When only accounting for those covered by Medicaid, with results shown in Tables 16-17, men and women across all age groups again did not exhibit any significant associations between wage income and Medicaid coverage expansion, and women sometimes exhibited a lower wage income difference than their male partners. Again, this may be because wage income is too closely tied to Medicaid eligibility and there is a simultaneous causality error in the analysis. For example, in states where Medicaid was expanded to cover abortion, these states may have also

raised their minimum wages. This may boost male income even more considering that the male labor force participation rate is higher than the female rate, and thus may explain the higher increase in male wages.

Table 17 does display a significant and positive increase in the wage income of unmarried men and women covered by Medicaid, with unmarried men experiencing a \$1,236.86 wage hike and unmarried women experiencing a \$1030.97 wage hike, which are both over 10% increases of the average wage incomes for these groups. Unmarried men and women are both more likely to be heads of single-parent households, which could be especially affected by an expansion of Medicaid for abortion, since single individuals may not receive as much help from others (significant other, other parent of the child, etc.) in an unintended pregnancy. Unmarried men did experience a positive, although nonsignificant, association between their labor force participation rates and Medicaid expansion, while unmarried women experienced a positive and significant association. Thus, the wage hike may be due to more unmarried men and women covered by Medicaid having a greater ability to enter the labor force, instead of having to care for children at home. It may also be due to these groups having more time to dedicate to their careers, receive promotions, or transition into higher-paying occupations. However, more precise work must be done to understand whether or not these wage increases are not affected by extraneous factors such as a rising minimum wage.

Due to the simultaneous causality error introduced in looking at wage income for a group that was defined by their income, similar regressions were conducted across education levels, with results shown in Table 18. Women with high school degrees and some college education exhibited a significant \$758.11 increase in their wage income, although this amount is only around 5% of their average annual wage income. Tables 19-20 look closer at non-college

graduates, and although women across all subgroups in this category displayed greater and positive wage income changes due to a Medicaid coverage expansion (their male counterparts all had negative income associations), none of these results were significant. This may again point to the difficulties in regressing a characteristic of Medicaid on wage income as well, where the direct level of income is closely tied with Medicaid.

Tables 21-22 display results for a similar analysis conducted on the Black individuals. Again, although Black women across all subgroups exhibited higher and positive wage income increases than their male counterparts, only Black men aged 28-35 years old had significant results, and curiously, Medicaid expansion for abortion is associated with a negative \$3394.73 wage difference. This result may be due to a number of reasons, one being that Black men may be having a harder time with being hired or promoted, especially if more women enter the workforce due to having more freedom under Medicaid expansion. Assuming that many Black men and women live in similar areas and may apply for similar positions, because Black women in general experienced a wage increase and an increase in their labor force participation rates following an expansion of Medicaid to cover abortion procedures, Black men may face a negative effect. Another reason behind the wage decline experienced by Black men may be because of internal reasons, in that without as many children, men in general may not feel as responsible for the family and may not work as much. However, because these results are at odds with the results seen for unmarried men covered by Medicaid and are different across different categories of men, additional analysis must be conducted on how men are also affected by abortion access.

## **VII. Discussion**

In response to Medicaid expanding coverage to fund abortions in certain states, women residing in these states generally experienced increasing labor force participation rates greater than that of their male counterparts. These increases were especially pronounced for younger women, Black women, unmarried women, and women with less of a college degree, but especially for women falling into two or more of these categories, pointing to how increased abortion access may especially benefit women located at the intersections of different marginalized groups.

Similar results were found when regressing the expansion of Medicaid coverage for abortion procedures on wage income, although there were not as many significant results. In fact, only Black women, unmarried men and women covered by Medicaid, women without college degrees, and Black men aged 28-35 years old experienced significant changes to their wage income after Medicaid was expanded. This lack of significance may expose a limitation of the variables that are chosen, in that wage income is not only intimately tied to Medicaid eligibility and introduces a simultaneous causality issue when only analyzing individuals who are covered by Medicaid, but it is also affected by other factors that may be correlated with whether or not a state expands Medicaid in a certain year, such as a rising state minimum wage. Although I attempt to control for these variables through the inclusion of state and year dummies in my regression, including such events as variables themselves instead of embedded in the dummy variables may make the analysis more specific.

The analysis is also limited in that the data is comprised of repeated cross-sections since the census data takes a random sample for each year instead of following the same sample of individuals across time. In this case, individuals in one group in one year may no longer be considered in that group at a different point in time due to changes in the dependent variable, but

this analysis was unable to capture that shift. For example, individuals who are covered by Medicaid due to being low-income may no longer be eligible for Medicaid after either entering the labor force or increasing their wage income due to the increased abortion coverage. This evolution is important to contextualize the effect of increased abortion coverage, and failure to include it potentially biases the association between labor force outcomes and increased abortion coverage downward.

Similarly, another limitation with the methodology is that the regression used may be too simple, potentially including too little variables. The form of the regression may also have been mistaken to be linear. Thus, more investigation must be done on whether different forms such as higher-order quadratic or logarithmic forms, and whether adding other variables such as ethnicity (i.e. whether or not an individual is Hispanic), industry, or occupation, may improve the fit of the model. Adding in other variables may also make the analysis more complete in that outcomes of individuals across more identities, and across more intersections of identities, can be examined. Even without adding in other variables, looking at higher-order intersections could prove useful; the current analysis only looked at intersections of at most 3 groups, such as looking only at a group comprised of individuals identifying as unmarried, Black, and female, when the labor force outcomes of this group could differ significantly from one comprised of individuals who are unmarried, Black, female, and Hispanic.

This limitation raises questions on how this analysis can inform policy. Due to the infinite number of identities possible, legislation that tries to account for every identity is impossible to draft, and even if it were to be drafted, would be difficult to pass due to its specificity. However, failing to account for certain identities, such as how low-income Black women may both have the highest probability of requiring an abortion and the highest vulnerability to state legislation

restricting the use of Medicaid to fund, may cause more vulnerable groups to become trapped within their respective marginalized identities, especially since an increased number of children is seen to be associated with lower wages and lower job participation. For example, low-income women may struggle to increase their wages, those who are covered by Medicaid may struggle to transfer to private insurance plans, and those with low education levels may struggle to attain higher levels of education, if they are deterred from entering the workforce or receiving higher wages due to having an unintended pregnancy. Additionally, on a racial equity point of view, these groups are also disproportionately comprised of women of color, particularly Black women, and so women of color may be the ones most at risk of being kept in low-income and low-educated conditions. Especially with the growing number of restrictions on abortion access and the potential for *Roe v. Wade* to be overturned in as early as 2023, the plight of these women has become increasingly more urgent and must ideally be considered in any abortion policy, cases, and arguments. Since the inclusion of every intersectionality is not very possible, effort should be made to incorporate as many as logistically possible, under the understanding that not all women are affected in the same way by the degree of access to abortion.

From an academic point of view, these intersectional experiences and identities must also be taken into account as much as possible in research, especially research that affects policy. Since low-income women and women of color are also those with the least amount of representation in academic settings such as higher-education institutions, they do not have as strong of a voice in guiding the research on policies that directly affect them. Compounded with their lack of representation within policymaking and legislative institutions, these groups are particularly at risk when abortion regulations which do not hold their best interests in mind are enacted,

especially since they hold the fewest seats at the table during the subsequent legal, economic, and social conversations that these regulations may spark.

### **VIII. Conclusion**

Increased financial access to abortion, due to an expansion of Medicaid coverage for abortion procedures, has a largely positive association with female labor outcomes such as labor force participation and wage income. This access allows women to retain more autonomy over their childbirth and career decisions, particularly for women who are more likely to be covered by Medicaid such as women of color, women with low levels of education, and especially women whose identities reside at the intersection of different marginalized characteristics. By restricting a woman's access to abortion, recent state policies take away a woman's autonomy over childbirth and also impact her autonomy over her career. Thus, women with the least stable careers, the same ones who will benefit the most from increased abortion access, are also the ones who will be most hurt by restrictions. Since these women also have least say in the creation and influence of abortion policies, it is upon the ones who do have the political and academic access to enact change, to study the situations of all women, and to keep their stories in consideration when guiding how policy on abortion evolves.

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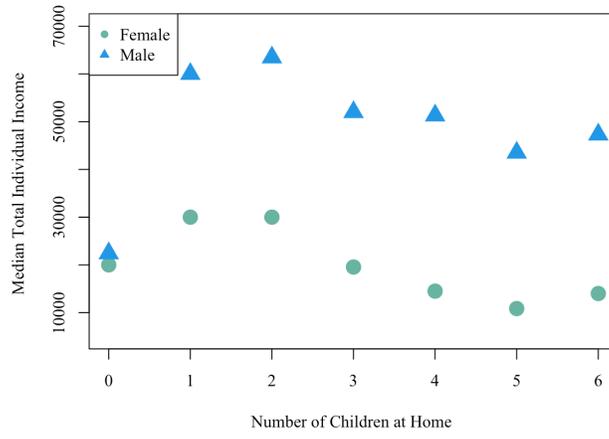


Figure 1: Total Individual Income by Children

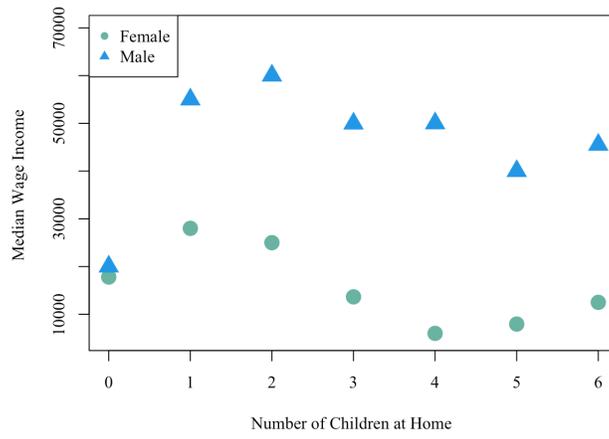


Figure 2: Wage Income by Children

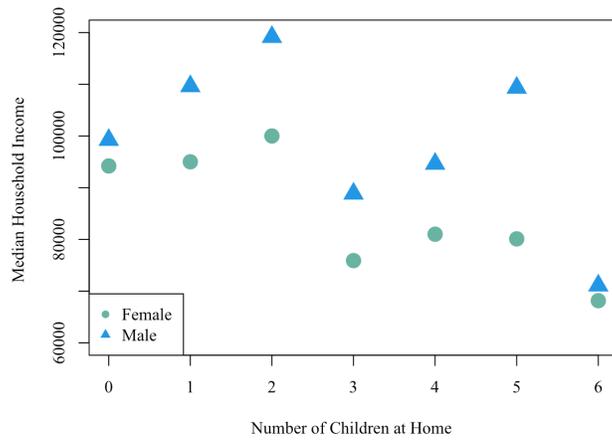


Figure 3: Household Income by Children

State	Expands Medicaid to Cover All or Most Medically Necessary Abortions	Funds limited to Life Endangerment, Rape, or Incest	Individual Providers may Refuse Service	Institutional Providers may Refuse Service
AL		X		
AK	X		X	Private
AZ		X	X	X
AR		Despite Court Order	X	X
CA	X		X	Religious
CO		X		
CT	X		X	
DE		X	X	X
FL		X	X	X
GA		X	X	X
HI	X		X	X
ID		X	X	X
IL	X		X	Private
IN		X	X	Private
IA		X	X	Private
KS		X	X	X
KY		X	X	X
LA		X	X	X
ME	X		X	X
MD	X		X	X
MA	X		X	X
MI		X	X	X
MN	X		X	Private
MS		Or if Fetal Abnormality	X	X
MO		X	X	X
MT	X		X	Private
NE		X	X	X
NV		X	X	Private
NH		X		
NJ	X		X	Private
NM	X		X	X
NY	X		X	
NC		X	X	X
ND		X	X	X
OH		X	X	X
OK		X	X	Private
OR	X		X	Private
PA		X	X	Private
RI		X	X	
SC		X	X	Private
SD		Life Only	X	X
TN		X	X	X
TX		X	X	Private
UT		X	X	Private
VT	X			
VA		Or if Fetal Abnormality	X	X
WA	X		X	X
WV		Or if Fetal Abnormality		
WI		X	X	X
WY		X	X	Private
Total	16	34	45	42

Table 1: Abortion Legislation by State

State	Mandated Counseling on Link to Breast Cancer	Mandated Counseling on Fetal Pain	Mandated Counseling on Negative Psychological Effects	Waiting Period (Hrs) Required after Counseling	Parental Involvement Required for Minors
AL				48	Consent
AK	X	X			
AZ				24	Consent
AR		Only after 20 weeks		72	Consent
CA					
CO					Notice
CT					
DE					Notice
FL					Consent + Notice
GA		X		24	Notice
HI					
ID				24	Consent
IL					Notice
IN		X		18	Consent
IA					Notice
KS	X	X	X	24	Consent
KY				24	Consent
LA		X	X	24	Consent
ME					
MD					Notice
MA					Consent if under 16
MI			X	24	Consent
MN		Only after 20 weeks		24	Notice
MS	X			24	Consent
MO		Only after 22 weeks		72	Consent
MT					
NE			X	24	Consent
NV					
NH					Notice
NJ					
NM					
NY					
NC			X	72	Consent
ND				24	Consent
OH				24	Consent
OK	X	Only after 22 weeks		72	Consent + Notice
OR					
PA				24	Consent
RI					Consent
SC				24	Consent
SD		X	X	72 w/o weekends or holidays	Notice
TN					Consent
TX	X	X	X	24	Consent + Notice
UT		Only after 20 weeks		72	Consent + Notice
VT					
VA					Consent + Notice
WA					
WV			X	24	Notice
WI		X		24	Consent
WY					Consent + Notice
Total	5	13	8	25	37

Table 2: Abortion Legislation by State

	Full Sample	Women	Men	Medicaid Only	Non- College Graduates	Black
Female	0.492			0.531	0.448	0.460
Age	31.3	31.4	31.2	30.2	0.296	30.5
Marital Status	0.411	0.443	0.380	0.251	0.313	0.234
Wage income	39396	31956	47178	11542	22163	24939
Number of Children at Home	0.791	0.927	0.659	0.869	0.748	0.635
Health Insurance	0.898	0.919	0.878		0.858	0.881
Health Insurance (Medicaid)	0.182	0.197	0.168		0.263	0.303
Employed	0.749	0.718	0.779	0.480	0.664	0.639
Unemployed	0.040	0.040	0.041	0.091	0.052	0.075
Not in the Labor Force	0.210	0.242	0.180	0.429	0.284	0.286
White	0.688	0.690	0.686	0.607	0.669	
Black	0.059	0.055	0.062	0.098	0.071	
Asian	0.045	0.047	0.044	0.048	0.036	
Less than High School	0.089	0.079	0.099	0.201	0.156	0.088
High School Diploma	0.234	0.194	0.273	0.345	0.409	0.306
Some College	0.248	0.248	0.249	0.280	0.434	0.297
College	0.310	0.339	0.282	0.154		0.239
Advanced Degree	0.119	0.141	0.098	0.020		0.069
<i>Total</i>	17,428	8,566	8,862	3,177	9,959	1,022

Table 3: Data Summary Statistics

State	Year of Medicaid Expansion
Alaska*	2014
California*	2014
Connecticut*	2010
Hawaii*	2010
Illinois	2017
Maine	2019
Maryland	1980
Massachusetts	1981
Minnesota	1993
Montana	1995
New Jersey	1970
New Mexico*	2013
New York	1970
Oregon*	2014
Vermont	1970
Washington	1990

Table 4: States which have Expanded Medicaid for Abortion Procedures

	Full Sample		Non-College Graduates		Medicaid Coverage Only	
	Men	Women	Men	Women	Men	Women
Average LFP	0.815	0.742	0.767	0.690	0.550	0.568
Medicaid Expansion	-0.003 (0.004)	-0.003 (0.005)	-0.003 (0.006)	0.001 (0.007)	0.024 (0.016)	0.033* (0.015)
College Grad or More	0.116*** (0.003)	0.150*** (0.003)			0.169*** (0.015)	0.149*** (0.013)
White	0.015*** (0.003)	0.024*** (0.004)	0.014*** (0.004)	0.009* (0.005)	0.006*** (0.01)	-0.015 (0.010)
Black	-0.122*** (0.005)	0.036*** (0.006)	-0.141*** (0.006)	0.018* (0.008)	-0.103*** (0.015)	0.027 (0.015)
Asian	-0.099*** (0.006)	-0.060*** (0.007)	-0.138*** (0.009)	-0.099*** (0.010)	-0.062** (0.021)	-0.044* (0.020)
Married	0.127*** (0.003)	-0.102*** (0.003)	0.117*** (0.004)	-0.86*** (0.004)	0.335*** (0.010)	-0.068*** (0.009)
Health Insurance	0.029*** (0.003)	0.046*** (0.004)	0.022*** (0.004)	0.040 (0.005)		
Age	0.005*** (0.000)	0.006*** (0.000)	0.006*** (0.000)	0.007*** (0.000)	-0.003*** (0.001)	-0.001 (0.000)
State Dummies	yes	yes	yes	yes	yes	yes
Year Dummies	yes	yes	yes	yes	yes	yes
Constant	0.559*** (0.009)	0.576*** (0.010)	0.551*** (0.011)	0.553*** (0.013)	0.563*** (0.028)	0.670*** (0.026)
Observations	102,390	100,701	74,295	66,221	13,874	17,030
R <sup>2</sup>	0.112	0.048	0.090	0.022	0.133	0.022

Table 5: Medicaid Expansion to Abortion and Labor Force Participation (2008-2019)

	Unmarried		Married		Black	
	Men	Women	Men	Women	Men	Women
Average LFP	0.732	0.756	0.939	0.727	0.655	0.761
Medicaid Expansion	0.003 (0.007)	-1.20e-04 (0.007)	-0.010* (0.005)	-0.008 (0.008)	0.009 (0.022)	0.065** (0.021)
College Grad or More	0.186*** (0.005)	0.189*** (0.004)	0.042*** (0.002)	0.104*** (0.004)	0.241*** (0.016)	0.175*** (0.013)
White	0.021*** (0.005)	0.014** (0.005)	0.002 (0.003)	0.031*** (0.005)		
Black	0.021*** (0.007)	0.003 (0.008)	-0.087*** (0.006)	0.111*** (0.012)		
Asian	-0.127*** (0.009)	-0.097*** (0.009)	-0.049*** (0.007)	-1.014 (0.011)		
Married					0.184*** (0.014)	-0.014 (0.013)
Health Insurance	0.021*** (0.021)	0.005 (0.005)	0.127*** (0.004)	0.040 (0.007)	0.122*** (0.013)	0.019 (0.015)
Age	0.007*** (0.000)	0.007*** (0.000)	0.001** (0.000)	0.002*** (0.000)	0.001 (0.001)	0.005*** (0.001)
State Dummies	yes	yes	yes	yes	yes	yes
Year Dummies	yes	yes	yes	yes	yes	yes
Constant	0.513*** (0.013)	0.558*** (0.013)	0.863*** (0.010)	0.554*** (0.017)	0.273*** (0.040)	0.476*** (0.042)
Observations	61,476	54,335	40,914	43,366	6,972	6,349
R <sup>2</sup>	0.066	0.070	0.027	0.004	0.115	0.053

Table 6: Medicaid Expansion to Abortion and Labor Force Participation (2008-2019)

	18-27 Years Old		28-35 Years Old		Over 36 Years Old	
	Men	Women	Men	Women	Men	Women
Average LFP	0.508	0.575	0.559	0.568	0.571	0.540
Medicaid Expansion	0.023 (0.027)	0.065** (0.024)	0.024 (0.016)	0.033* (0.015)	0.019 (0.028)	-0.034 (0.027)
College Grad or More	0.139*** (0.031)	0.108*** (0.004)	0.149*** (0.015)	0.104*** (0.013)	0.149*** (0.014)	0.156*** (0.020)
White	-0.002 (0.016)	-0.001 (0.015)	0.006 (0.010)	-0.0155 (0.010)	0.021 (0.019)	-0.036* (0.018)
Black	-0.102*** (0.023)	0.020 (0.022)	-0.103*** (0.015)	0.027 (0.015)	-0.086** (0.026)	0.011 (0.027)
Asian	-0.115*** (0.033)	-0.107*** (0.032)	-0.062** (0.021)	-0.044* (0.020)	-0.023 (0.036)	0.033 (0.035)
Married	0.301*** (0.002)	-0.122*** (0.017)	0.335*** (0.010)	-0.068*** (0.009)	0.346*** (0.014)	-0.039** (0.014)
Age	0.009*** (0.002)	0.016*** (0.002)	-0.003*** (0.001)	-0.001 (0.000)	-0.007** (0.002)	-0.007** (0.002)
State Dummies	yes	yes	yes	yes	yes	yes
Year Dummies	yes	yes	yes	yes	yes	yes
Constant	0.290*** (0.064)	0.289*** (0.057)	0.564*** (0.028)	0.670*** (0.026)	0.742*** (0.106)	0.854*** (0.103)
Observations	5,731	6,902	13,874	17,030	4,298	5,179
R <sup>2</sup>	0.069	0.035	0.118	0.022	0.161	0.022

Table 7: Medicaid Covered Only: Medicaid Expansion to Abortion and Labor Force Participation (2008-2019)

	Unmarried		Married		Black	
	Men	Women	Men	Women	Men	Women
Average LFP	0.457	0.588	0.787	0.519	0.398	0.608
Medicaid Expansion	0.040 (0.020)	0.040* (0.018)	-0.007 (0.026)	0.027 (0.028)	0.018 (0.046)	0.146** (0.046)
College Grad or More	0.235*** (0.020)	0.163*** (0.016)	0.122*** (0.020)	0.104*** (0.021)	0.300*** (0.059)	0.193*** (0.047)
White	0.009 (0.013)	-0.023* (0.012)	-0.003 (0.017)	-0.002 (0.017)		
Black	-0.087*** (0.017)	0.002 (0.016)	-0.150*** (0.028)	0.141*** (0.034)		
Asian	-0.045 (0.026)	-0.087*** (0.024)	-0.111** (0.034)	-0.036 (0.037)		
Married					0.296*** (0.031)	0.056 (0.033)
Age	-0.003*** (0.001)	-0.001* (0.001)	-0.003** (0.001)	0.000 (0.001)	-0.004** (0.001)	-0.002 (0.001)
State Dummies	yes	yes	yes	yes	yes	yes
Year Dummies	yes	yes	yes	yes	yes	yes
Constant	0.547*** (0.035)	0.698*** (0.030)	0.933*** (0.053)	0.527*** (0.054)	0.405*** (0.072)	0.633*** (0.074)
Observations	9,981	12,031	3,893	4,999	1,778	1,883
R <sup>2</sup>	0.040	0.021	0.019	0.018	0.109	0.036

Table 8: Medicaid Covered Only: Medicaid Expansion to Abortion and Labor Force Participation (2008-2019)

	Less than HS		HS and Some College		College		Graduate Degree	
	Men	Women	Men	Women	Men	Women	Men	Women
Average LFP	0.658	0.516	0.791	0.720	0.936	0.828	0.957	0.872
Medicaid Expansion	-0.016 (0.015)	0.074** (0.010)	0.000 (0.026)	0.002 (0.007)	-0.006 (0.007)	0.013 (0.010)	-0.006 (0.008)	0.015 (0.012)
White	-0.028** (0.009)	-0.037** (0.012)	0.017*** (0.004)	-0.004 (0.005)	0.019*** (0.005)	0.043*** (0.007)	0.009 (0.006)	0.075*** (0.009)
Black	-0.305*** (0.015)	-0.054* (0.022)	-0.096*** (0.007)	0.020* (0.008)	0.018 (0.010)	0.086*** (0.014)	-0.023 (0.013)	0.086*** (0.017)
Asian	-0.117*** (0.022)	-0.032 (0.026)	-0.144** (0.009)	-0.120*** (0.010)	-0.061*** (0.009)	-0.028* (0.121)	-0.173* (0.009)	0.020 (0.013)
Married	0.245*** (0.009)	-0.095*** (0.011)	0.146*** (0.009)	-0.084*** (0.004)	0.042*** (0.004)	-0.145*** (0.005)	0.037*** (0.005)	-0.010*** (0.007)
Age	-0.003*** (0.000)	0.008*** (0.001)	0.005*** (0.000)	0.007*** (0.000)	-0.002** (0.000)	0.001** (0.000)	0.002*** (0.000)	0.001 (0.001)
State Dummies	yes	yes	yes	yes	yes	yes	yes	yes
Year Dummies	yes	yes	yes	yes	yes	yes	yes	yes
Constant	0.473*** (0.029)	0.325*** (0.039)	0.565*** (0.012)	0.600*** (0.014)	0.758*** (0.015)	0.837*** (0.021)	0.719*** (0.022)	0.804*** (0.031)
Observations	13,581	9,864	60,714	56,357	18,938	22,759	9,157	11,721
R <sup>2</sup>	0.162	0.020	0.019	0.023	0.033	0.042	0.035	0.036

Table 9: Education Level: Medicaid Expansion to Abortion and Labor Force Participation (2008-2019)

	18-27 Years Old		28-35 Years Old		Over 36 Years Old	
	Men	Women	Men	Women	Men	Women
Average LFP	0.678	0.655	0.767	0.690	0.842	0.719
Medicaid Expansion	0.005 (0.010)	0.005 (0.011)	-0.003 (0.006)	0.001 (0.007)	-0.008 (0.009)	0.004 (0.012)
White	0.008 (0.006)	0.020** (0.007)	0.014*** (0.004)	-0.004 (0.005)	0.019*** (0.005)	0.009* (0.005)
Black	-0.101*** (0.011)	-0.012 (0.012)	-0.141*** (0.006)	0.020* (0.008)	0.018 (0.010)	0.018* (0.008)
Asian	-0.180*** (0.014)	-0.162*** (0.015)	-0.138*** (0.009)	-0.120*** (0.010)	-0.061*** (0.009)	-0.099*** (0.010)
Health Insurance	0.008 (0.006)	-0.007 (0.008)	0.022*** (0.004)	0.040*** (0.005)	0.060*** (0.006)	0.096 (0.008)
Married	0.125*** (0.009)	-0.136*** (0.008)	0.167*** (0.004)	-0.086*** (0.004)	0.169*** (0.005)	-0.071 (0.006)
Age	0.037*** (0.001)	0.034*** (0.001)	0.006*** (0.000)	0.007*** (0.000)	-0.002** (0.001)	0.005*** (0.001)
State Dummies	yes	yes	yes	yes	yes	yes
Year Dummies	yes	yes	yes	yes	yes	yes
Constant	-0.130*** (0.026)	0.020 (0.029)	0.551*** (0.011)	0.553*** (0.013)	0.829*** (0.035)	0.535*** (0.047)
Observations	32,219	28,265	74,295	66,221	23,283	21,822
R <sup>2</sup>	0.086	0.049	0.115	0.019	0.091	0.079

Table 10: Non College Graduate Only: Medicaid Expansion to Abortion and Labor Force Participation (2008-2019)

	Unmarried		Married		Black	
	Men	Women	Men	Women	Men	Women
Average LFP	0.690	0.701	0.918	0.673	0.611	0.719
Medicaid Expansion	0.003 (0.008)	0.000 (0.009)	-0.012 (0.007)	0.001 (0.011)	0.017 (0.025)	0.070** (0.026)
White	0.021*** (0.005)	0.012 (0.006)	0.002 (0.005)	-0.004 (0.005)		
Black	-0.149*** (0.008)	-0.002 (0.009)	-0.116*** (0.009)	0.020* (0.008)		
Asian	-0.155*** (0.012)	-0.126*** (0.012)	-0.083*** (0.011)	-0.120*** (0.010)		
Health Insurance	0.014** (0.005)	-0.009 (0.006)	0.060*** (0.005)	0.128*** (0.008)	0.124*** (0.014)	0.020 (0.018)
Married					0.222*** (0.016)	-0.010 (0.016)
Age	0.007*** (0.000)	0.008*** (0.000)	0.000*** (0.000)	0.004*** (0.000)	-0.001 (0.001)	0.005*** (0.001)
State Dummies	yes	yes	yes	yes	yes	yes
Year Dummies	yes	yes	yes	yes	yes	yes
Constant	0.513*** (0.015)	0.557*** (0.017)	0.551*** (0.011)	0.514*** (0.024)	0.265*** (0.044)	0.471*** (0.049)
Observations	49,432	40,170	24,863	26,051	6,010	4,971
R <sup>2</sup>	0.033	0.028	0.115	0.024	0.073	0.020

Table 11: Non College Graduate Only: Medicaid Expansion to Abortion and Labor Force Participation (2008-2019)

	18-27 Years Old		28-35 Years Old		Over 36 Years Old	
	Men	Women	Men	Women	Men	Women
Average LFP	0.596	0.699	0.655	0.761	0.701	0.802
Medicaid Expansion	0.000 (0.037)	0.086* (0.037)	0.009 (0.021)	0.065** (0.021)	0.040 (0.036)	0.069* (0.035)
College Grad or More	0.236*** (0.036)	0.145*** (0.029)	0.241*** (0.016)	0.175*** (0.013)	0.201*** (0.024)	0.165*** (0.019)
Health Insurance	0.099*** (0.021)	0.001 (0.026)	0.122*** (0.013)	0.019 (0.015)	0.137*** (0.022)	0.017 (0.026)
Married	0.100** (0.037)	-0.055 (0.105)	0.184*** (0.014)	-0.014 (0.013)	0.210*** (0.019)	0.020 (0.017)
Age	0.018*** (0.003)	0.031*** (0.003)	0.002 (0.001)	0.005*** (0.001)	-0.001** (0.003)	0.002 (0.003)
State Dummies	yes	yes	yes	yes	yes	yes
Year Dummies	yes	yes	yes	yes	yes	yes
Constant	-0.107 (0.094)	-0.031 (0.097)	0.273*** (0.040)	0.476*** (0.042)	0.364** (0.138)	0.583*** (0.135)
Observations	2,825	2,457	6,972	6,349	2,275	2,185
R <sup>2</sup>	0.062	0.065	0.115	0.053	0.149	0.038

Table 12: Black Only: Medicaid Expansion to Abortion and Labor Force Participation (2008-2019)

	Unmarried		Married	
	Men	Women	Men	Women
Average LFP	0.592	0.749	0.851	0.798
Medicaid Expansion	0.009 (0.026)	0.067** (0.025)	0.007 (0.034)	0.050 (0.042)
College Grad or More	0.325*** (0.022)	0.204*** (0.016)	0.109*** (0.019)	0.114*** (0.022)
Health Insurance	0.106*** (0.015)	0.006 (0.017)	0.210*** (0.025)	0.093** (0.036)
Age	0.001 (0.001)	0.005*** (0.001)	0.002 (0.001)	0.005*** (0.002)
State Dummies	yes	yes	yes	yes
Year Dummies	yes	yes	yes	yes
Constant	0.269*** (0.047)	0.514*** (0.047)	0.503*** (0.081)	0.305** (0.099)
Observations	5,278	4,785	1,694	1,564
R <sup>2</sup>	0.068	0.057	0.084	0.036

Table 13: Black Only: Medicaid Expansion to Abortion and Labor Force Participation (2008-2019)

	Full Sample		Non-College Graduates		Medicaid Coverage Only	
	Men	Women	Men	Women	Men	Women
Average Wage Income	38823.90	25694.25	24532.22	15282.31	10840.01	8061.49
Medicaid Expansion	213.50 (572.70)	-65.49 (414.00)	677.05 (411.44)	540.02 (314.14)	184.65 (722.50)	654.64 (436.82)
College Grad or More	38562.68*** (348.45)	25608.33*** (234.84)			12778.50*** (659.29)	8402.32*** (366.89)
White	3763.98*** (396.24)	1037.44*** (285.88)	3470.07*** (282.44)	908.28* (213.72)	-158.00 (457.43)	12.98 (280.95)
Black	-6042.76*** (672.34)	-61.03 (502.54)	-4657.20*** (454.61)	362.95 (357.29)	-2990.11*** (648.32)	935.72* (420.89)
Asian	-33.50 (796.68)	2158.48*** (546.72)	-4192.17*** (618.33)	-1930.71*** (445.76)	-912.58 (932.67)	-991.52 (583.00)
Married	18830.50*** (349.90)	-1204.83*** (242.08)	14220.46*** (256.58)	-582.26** (186.67)	13317.21*** (422.64)	314.38 (250.40)
Health Insurance	13917.43*** (392.45)	9341.64*** (323.19)	10500.71*** (256.30)	6402.36 (217.55)		
Age	1334.34*** (20.71)	929.18** (14.63)	992.45 (14.17)	713.62 (10.45)	164.17*** (22.81)	154.04*** (14.04)
State Dummies	yes	yes	yes	yes	yes	yes
Year Dummies	yes	yes	yes	yes	yes	yes
Constant	-32255.53*** (1106.48)	-18336.30*** (811.46)	-17332.35*** (774.77)	-8361.86*** (596.96)	4603.12*** (1256.11)	5493.05*** (760.02)
Observations	102,390	100,701	74,295	66,221	13,874	17,030
R <sup>2</sup>	0.289	0.198	0.205	0.095	0.137	0.057

Table 14: Medicaid Expansion to Abortion and Wage Income (2008-2019)

	Unmarried		Married		Black	
	Men	Women	Men	Women	Men	Women
Average Wage Income	23149.55	20809.36	62375.73	31418.71	20912.15	21435.45
Medicaid Expansion	-247.78 (491.54)	-238.96 (434.49)	1428.59 (1210.81)	391.81 (739.85)	-3394.73 (1282.67)	1077.55* (469.15)
College Grad or More	27252.42*** (328.86)	24130.19*** (263.09)	48498.26*** (660.07)	26248.88*** (395.12)	28359.99*** (1083.97)	24274.40*** (780.50)
White	2379.61*** (338.08)	1040.09*** (301.92)	5746.11*** (843.95)	1032.51* (506.86)		
Black	-5024.14*** (530.85)	-1357.02** (470.36)	-13106.66*** (1712.21)	2802.85* (1134.12)		
Asian	-651.95 (665.52)	63.07 (572.31)	242.19 (1760.07)	4682.44*** (981.65)		
Married					12969.87*** (931.13)	3219.66*** (777.08)
Health Insurance	10370.30*** (308.97)	7716.66*** (314.60)	24226.62*** (995.27)	12986.31*** (644.95)	10105.65*** (863.62)	7872.58 (921.17)
Age	1224.19*** (1224.19)	1061.12*** (14.14)	1671.24*** (51.42)	676.23*** (29.92)	732.26*** (47.42)	850.15*** (40.22)
State Dummies	yes	yes	yes	yes	yes	yes
Year Dummies	yes	yes	yes	yes	yes	yes
Constant	-22127.99** (929.42)	-20277.45*** (834.63)	-41432.56*** (2697.94)	-11797.41*** (1621.97)	-18811.42*** (2691.79)	-19831.95*** (2519.35)
Observations	61,476	54,335	40,914	43,366	6,972	6,349
R <sup>2</sup>	0.231	0.268	0.202	0.140	0.239	0.254

Table 15: Medicaid Expansion to Abortion and Wage Income (2008-2019)

	18-27 Years Old		28-35 Years Old		Over 36 Years Old	
	Men	Women	Men	Women	Men	Women
Average Wage Income	6429.63	6195.50	10840.01	8061.49	14660.23	9463.551
Medicaid Expansion	290.89 (580.43)	-5.89 (514.18)	184.65 (722.50)	654.64 (436.82)	-919.40 (1678.90)	-71.35 (976.48)
College Grad or More	3855.62*** (684.08)	2556.09*** (553.16)	12778.50*** (659.29)	8402.32*** (366.89)	20552.70*** (1393.40)	11387.30*** (718.11)
White	-104.88 (350.09)	-217.70 (322.48)	-158.00 (457.43)	12.98 (280.95)	457.90 (116.80)	171.51 (641.59)
Black	-2533.97*** (498.59)	-635.99 (479.90)	-2990.11*** (648.32)	935.72* (420.89)	-2792.50 (1583.90)	1854.36 (963.86)
Asian	-2533.97*** (717.12)	-2496.99*** (690.95)	-912.58 (932.67)	-991.52 (583.00)	2233.00 (2173.80)	643.77 (1264.24)
Married	8849.34*** (484.02)	-862.01* (368.90)	13317.21*** (422.64)	314.38 (250.40)	14281.50*** (855.50)	552.13 (507.45)
Age	663.09*** (39.05)	675.01*** (44.92)	164.17*** (22.81)	154.04*** (14.04)	-209.20 (145.30)	-64.08 (83.91)
State Dummies	yes	yes	yes	yes	yes	yes
Year Dummies	yes	yes	yes	yes	yes	yes
Constant	-6432.57*** (1396.08)	-5743.85*** (1241.28)	4603.12*** (1256.11)	5493.05*** (760.02)	20104.40** (6338.10)	12316.68*** (3671.02)
Observations	5,731	6,902	13,874	17,030	4,298	5,179
R <sup>2</sup>	0.145	0.059	0.137	0.057	0.131	0.057

Table 16: Medicaid Covered Only: Medicaid Expansion to Abortion and Wage Income (2008-2019)

	Unmarried		Married		Black	
	Men	Women	Men	Women	Men	Women
Average Wage Income	6619.62	7677.94	21660.39	8984.58	5901.15	8229.23
Medicaid Expansion	1236.86*	1030.97*	-2215.63	-26.98	569.94	1461.51
	(543.81)	(450.92)	(2109.37)	(1019.22)	(1180.17)	(959.70)
College Grad or More	5785.65***	6287.68***	22640.00***	11663.40***	5260.36***	10428.59***
	(542.84)	(407.55)	(1621.00)	(739.77)	(1496.62)	(1412.71)
White	-839.82*	-221.41	1675.54	292.76		
	(343.83)	(295.74)	(1333.73)	(625.83)		
Black	-2497.73***	157.77	-6837.26**	4255.08***		
	(463.28)	(411.03)	(2280.15)	(1240.82)		
Asian	-1058.07	-2206.23***	-36.99	1278.06		
	(695.55)	(608.34)	(2773.51)	(1325.46)		
Married					7031.14***	3617.01***
					(786.29)	(1412.71)
Age	151.04***	168.28***	254.13**	119.12**	111.99**	178.04***
	(16.15)	(13.88)	(81.14)	(37.23)	(35.04)	(42.00)
State Dummies	yes	yes	yes	yes	yes	yes
Year Dummies	yes	yes	yes	yes	yes	yes
Constant	4077.76***	6284.89***	17302.93***	4411.00*	1993.83	5550.89*
	(925.71)	(767.19)	(4254.92)	(1959.98)	(1848.92)	(2205.49)
Observations	9,981	12,031	3,893	4,999	1,778	1,883
R <sup>2</sup>	0.048	0.062	0.072	0.058	0.091	0.068

Table 17: Medicaid Covered Only: Medicaid Expansion to Abortion and Wage Income (2008-2019)

	Less than HS		HS and Some College		College		Graduate Degree	
	Men	Women	Men	Women	Men	Women	Men	Women
Average Wage Income	15117.48	7663.27	26638.18	16615.85	64601.51	38431.12	101467.50	59787.78
Medicaid Expansion	-718.74 (733.30)	569.16 (586.61)	-804.69 (470.21)	758.11* (349.61)	1453.52 (1795.91)	1369.71 (1080.73)	1007.70 (3739.70)	2856.70 (5679.37)
White	-845.40 (436.03)	-433.00 (336.43)	3545.84*** (334.81)	278.70 (246.04)	8773.63*** (1292.36)	2023.75** (765.35)	-623.90 (2556.60)	-1804.83 (1551.49)
Black	-7697.21*** (748.98)	-1534.16* (645.44)	-4549.44*** (529.17)	-139.49 (400.00)	-10634.40 (2690.77)	-590.72 (1570.30)	-27776.20*** (5844.00)	-4719.64 (3083.01)
Asian	-5157.66*** (1069.82)	-147.83 (736.98)	-4425.44*** (710.75)	-2822.24*** (502.08)	1081.51 (2346.48)	311.01 (1352.23)	518.80 (3997.90)	8562.09*** (2419.90)
Married	10365.09*** (441.29)	-881.70*** (326.57)	14888.21*** (294.80)	-654.37*** (209.37)	21130.25*** (1044.92)	-4566.60*** (616.70)	28533.10*** (2234.70)	-3106.18* (1230.79)
Age	509.63*** (23.61)	307.25*** (18.29)	1127.63*** (16.41)	812.77*** (11.76)	2495.23*** (75.39)	1287.53*** (43.63)	3611.90*** (175.40)	1686.98*** (8.37)
State Dummies	yes	yes	yes	yes	yes	yes	yes	yes
Year Dummies	yes	yes	yes	yes	yes	yes	yes	yes
Constant	-1471.06 (1426.34)	971.90 (1151.31)	-21154.87*** (883.90)	-9725.16*** (662.83)	-68863.84*** (3929.57)	-20440.74*** (2342.46)	- (9966.60)	-28856.70*** (5679.37)
Observations	13,581	9,864	60,714	56,357	18,938	22,759	9,157	11,721
R <sup>2</sup>	0.145	0.037	0.220	0.108	0.165	0.121	0.035	0.055

Table 18: Education Level: Medicaid Expansion to Abortion and Wage Income (2008-2019)

	18-27 Years Old		28-35 Years Old		Over 36 Years Old	
	Men	Women	Men	Women	Men	Women
Average Wage Income	12408.61	8961.40	26395.76	16221.94	37117.15	21387.25
Medicaid Expansion	-442.17 (342.75)	355.98 (285.05)	-687.43 (465.92)	578.00 (352.13)	-345.82 (977.89)	347.332 (721.89)
White	1229.27*** (231.61)	428.41* (191.78)	3959.59*** (320.18)	904.26*** (239.76)	5882.90*** (694.60)	2054.74*** (500.51)
Black	-3180.53*** (373.64)	-519.91 (320.08)	-4830.47*** (710.37)	437.04 (400.39)	-6343.25*** (1106.99)	1396.07 (836.311)
Asian	-3495.77*** (487.88)	-2694.95*** (398.36)	-4311.66*** (710.37)	-1801.49*** (499.25)	-4649.48** (1510.24)	8.432 (1007.82)
Health Insurance	4003.85*** (220.44)	1918.64 (201.46)	11678.06*** (289.48)	7256.03*** (243.39)	19917.26*** (626.71)	12031.69*** (505.91)
Married	9608.70*** (316.13)	-740.77*** (221.233)	14310.72*** (279.51)	-747.18*** (203.16)	13757.05*** (524.22)	-1665.39*** (387.66)
Age	2207.45*** (32.48)	1663.60*** (27.49)	958.49*** (16.04)	698.02*** (11.75)	194.27* (86.91)	358.33*** (64.09)
State Dummies	yes	yes	yes	yes	yes	yes
Year Dummies	yes	yes	yes	yes	yes	yes
Constant	-36606.00*** (925.06)	-25647.21 (765.94)	-17674.42*** (884.09)	-8465.92*** (678.94)	3383.65 (3824.40)	-471.28 (2857.28)
Observations	32,219	28,265	74,295	66,221	23,283	21,822
R <sup>2</sup>	0.208	0.137	0.189	0.085	0.107	0.034

Table 19: Non College Graduate Only: Medicaid Expansion to Abortion and Labor Force Participation (2008-2019)

	Unmarried		Married		Black	
	Men	Women	Men	Women	Men	Women
Average Wage Income	16520.53	13183.90	40460.86	18518.02	15851.63	15170.71
Medicaid Expansion	-786.15 (397.36)	518.55 (343.54)	-389.62 (934.97)	623.57 (595.69)	-1201.81 (1321.89)	785.73 (1143.82)
White	1569.15*** (2722.22)	797.08*** (235.43)	0.002 (643.38)	6727.34*** (400.10)		
Black	-5352.48*** (413.81)	-518.92 (359.02)	-5998.82*** (1220.03)	2599.25** (840.07)		
Asian	-4059.35*** (573.57)	-2288.35*** (475.91)	-5808.45*** (1536.00)	-1114.93 (881.81)		
Health Insurance	7287.75*** (238.51)	4399.38*** (233.86)	19824.77*** (642.91)	10322.72*** (425.25)	8810.77*** (748.30)	5230.95*** (782.70)
Married					12875.88*** (861.73)	2456.68 (722.79)
Age	1016.21*** (12.92)	807.15*** (10.74)	805.32*** (37.61)	468.39*** (22.44)	634.41 (41.35)	711.68*** (34.33)
State Dummies	yes	yes	yes	yes	yes	yes
Year Dummies	yes	yes	yes	yes	yes	yes
Constant	-13843.50*** (739.92)	-10333.34 (644.95)	-7298.96*** (2001.46)	-1858.19 (1251.04)	15726.54*** (2349.27)	-10711.88*** (2172.97)
Observations	49,432	40,170	24,863	26,051	6,010	4,971
R <sup>2</sup>	0.033	0.134	0.081	0.049	0.145	0.111

Table 20: Non College Graduate Only: Medicaid Expansion to Abortion and Wage Income (2008-2019)

	18-27 Years Old		28-35 Years Old		Over 36 Years Old	
	Men	Women	Men	Women	Men	Women
Average Wage Income	10054.07	10685.92	20912.15	21435.45	31536.26	30870.69
Medicaid Expansion	305.20 (1350.20)	2.99 (1150.60)	-3394.73* (1069.15)	1077.55 (582.67)	-4357.60 (4504.90)	1393.70 (2883.30)
College Grad or More	15192.70*** (1333.80)	11654.56*** (897.01)	28359.99*** (1083.97)	24274.40*** (780.50)	34723.70*** (2274.40)	31940.40*** (1616.30)
Health Insurance	4557.40*** (779.40)	2488.25** (807.44)	10105.65*** (863.62)	7872.58*** (921.17)	17496.30*** (2106.20)	12051.10*** (2170.90)
Married	6877.10** (1346.00)	1266.68 (1046.63)	12969.87*** (931.13)	3219.66 (777.08)	12471.50*** (1790.60)	3524.80* (1451.20)
Age	1320.90*** (123.20)	1629.64*** (103.38)	732.26*** (732.26)	850.15*** (40.22)	237.60 (290.40)	559.90* (244.10)
State Dummies	yes	yes	yes	yes	yes	yes
Year Dummies	yes	yes	yes	yes	yes	yes
Constant	-23025.30*** (3463.10)	-28074.95*** (3014.47)	-18811.42*** (2691.79)	-19831.95*** (2519.35)	-8290.10 (12996.30)	-19343.70 (11228.40)
Observations	2,825	2,457	6,972	6,349	2,275	2,185
R <sup>2</sup>	0.151	0.229	0.239	0.254	0.197	0.189

Table 21: Black Only: Medicaid Expansion to Abortion and Wage Income (2008-2019)

	Unmarried		Married	
	Men	Women	Men	Women
Average Wage Income	14908.85	18362.48	39616.63	30837.08
Medicaid Expansion	-2363.93 (1518.46)	1291.50 (1268.70)	-5860.90 (3777.80)	1261.10 (3523.30)
College Grad or More	26733.74*** (1264.25)	22421.80*** (819.20)	29944.60*** (2170.40)	27867.30*** (1850.20)
Health Insurance	8532.65*** (845.74)	6871.60*** (873.30)	18458.50*** (2820.60)	11938.30*** (2981.60)
Age	691.18*** (46.86)	847.10*** (38.20)	906.70*** (146.00)	926.90*** (130.20)
State Dummies	yes	yes	yes	yes
Year Dummies	yes	yes	yes	yes
Constant	-15753.12*** (2668.87)	-18270.60*** (2416.30)	-23305.50** (9007.40)	-26642.90** (8284.20)
Observations	5,278	4,785	1,694	1,564
R <sup>2</sup>	0.156	0.261	0.169	0.188

Table 22: Black Only: Medicaid Expansion to Abortion and Wage Income (2008-2019)