The Consequences of Abortion Funding Bans

Lauren Hoehn-Velasco* Nikita Dhingra† Mayra Pineda-Torres‡

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Abstract: In the United States, public funding restrictions prohibit the use of federal funding for abortion services. We examine the health and economic consequences of these initial federal funding restrictions through the Hyde Amendment. We exploit variation in exposure to these funding restrictions by comparing high- and low-Medicaid eligibility counties. We find that the federal prohibition of abortion funding raises fertility by two percent for young adult women in counties with high Medicaid eligibility. The Hyde Amendment also disproportionately impacts non-white women, those more likely to be receiving Medicaid. After the Hyde Amendment, there is an increase in non-white hospitalizations for abortion complications, a temporary increase in non-white maternal mortality, and a worsening of non-white economic outcomes (relative to white women). Overall, federal abortion funding restrictions appear to widen health and economic racial disparities.

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*Corresponding author. Department of Economics, Andrew Young School of Policy Studies, Georgia State University, and IZA. Email: lvelasco@gsu.edu

†Department of Economics, Andrew Young School of Policy Studies, Georgia State University. Email: ndhingra1@student.gsu.edu

‡School of Economics, Georgia Institute of Technology and IZA. Email: mpinedat@gatech.edu.

1 Introduction

Public funding restrictions are key policy tools for governments to regulate access to services. These restrictions are often implemented to address budgetary constraints or align with political goals. But funding priorities are seldom neutral. How a government allocates funds affects the targeted populations' opportunities. When governments reduce or prohibit public funding for specific programs, they can deepen existing disparities, particularly for people who depend on the programs' services. Thus, understanding the consequences of such funding bans is essential to evaluate economic and social trade-offs.

When governments set public funding restrictions, they often try to discourage targeted behavior. One example of such a restriction is the Hyde Amendment, which prohibits the use of federal funds for abortion services.[1] Despite being enacted nearly 50 years ago, debates over the Hyde Amendment continue to this day (Aclu, 2024; Tu, 2024; Keith, 2025). These debates typically focus on moral and ethical considerations, ignoring all other concerns. But the restrictions on abortion have important economic consequences, especially for disadvantaged groups (Joyce et al., 2013; Myers, 2017).

In this paper, we consider what happens when a crucial healthcare service is no longer publicly funded. We specifically consider the consequences of the Hyde Amendment, which restricted federal funding for abortion services beginning in the late 1970s and early 1980s. The consequences of this federal ban on abortion funding are far-reaching. Today, in the United States, the Medicaid program provides crucial healthcare coverage for 79 million Americans (CMS, 2019), including 37 million children and 16 million women of reproductive age (Medicaid.gov, 2024; ACOG, 2024). Medicaid covers more than 40% of births, nearly 40% of children, and one in five reproductive-age women (KFF, 2022b,a, 2024a).[2] Restrictions on federal abortion funding directly impact these 16 million reproductive-age women receiving Medicaid. The Hyde Amendment leaves these women without the ability to access federal funding for abortion services despite their reliance on Medicaid for other essential health care (ACOG, 2024).[4] While Medicaid recipients are the group most directly affected, the impacts of the Hyde Amendment extend to all federally funded health plans. For example, today, under the Affordable Care Act (ACA), states have the au-

[1] The Amendment restricts the use of federal funds for abortion, except in extreme circumstances of rape, incest, or the endangerment of the pregnant woman's life.

[2] Although the Medicaid program has grown since the 1970s, Medicaid still funded one in ten hospitalizations for reproductive-age women in 1977 (NHDS, 1972-1981). Medicaid funded health care for a larger proportion of Black hospitalizations, covering one in three reproductive-age hospitalizations, one in three deliveries, and 36% of abortion hospitalizations in 1977.[3]

[4] While 17 states still fund abortions with state funds, the remaining states have public funding restrictions that hinder the ability to obtain an abortion for millions of women in the United States (KFF, 2024a). However, in most cases (with exceptions noted), state funds do not fully compensate for the federal funding restrictions, which we show in Figure I and Figure A.2.

thority to limit abortion coverage in marketplace plans and private insurance policies (KFF, 2024b), further restricting access to health care for many women outside of the Medicaid program.

We begin our analysis by examining the initial impacts of the Hyde Amendment on fertility.[5] We consider areas most likely to be affected by the Hyde Amendment or those with higher levels of Medicaid eligibility. As a proxy for Medicaid eligibility, we use the share of the county-level population receiving cash welfare, measured by Aid to Families with Dependent Children (AFDC) receipt (Haines, 2010; Provost and Hughes, 2000).[6] We then use an event-study design to compare whether high-Medicaid eligibility counties experienced differential changes in fertility relative to low-eligibility counties. Because we consider county-level effects, we can include state-by-year fixed effects that absorb state-level changes in policy, including those that occurred in response to the Hyde Amendment. In our main event-study results, we focus on women most likely to be affected by the abortion funding restrictions: young adult women, those 18 to 29. Women between 18 and 29 are more likely to be directly covered by Medicaid (rather than a parent), those in their 20s experience the majority of unwanted pregnancies (KFF, 2021), and women in their teens and 20s are also more likely to use public funds to pay for an abortion.[7]

Our event-study results show that Hyde Amendment abortion funding restrictions raised fertility for young adult women by 1.8 percent in counties with above-median Medicaid eligibility. We also find a larger increase in fertility in counties in the top quartile of Medicaid eligibility, a 3% increase in fertility relative to the lowest quartile. We see similar increases in fertility if we break out eligibility by decile or if we use continuous measures of eligibility.

Then, we explore the downstream consequences of the Hyde Amendment on health and economic outcomes. In these additional findings, we speculatively examine whether the Hyde Amendment affected outcomes for non-white women. We focus on non-white women for a few reasons. First, hospital stays for Black women are more likely to be paid for by Medicaid (39% versus 7% for white women) (Lincoln et al., 1977, pg 213). Second, non-white women have been shown to be detrimentally affected by abortion restrictions in closely related work (Joyce et al., 2013; Myers,

[5] To consider fertility, we use the Natality Detailed File from 1972 to 1981 to calculate the number of births in each county. We combine these birth certificate data with the county-level number of reproductive-age women measured with the SEER (2020) population data.

[6] AFDC was primarily tied to low-income single-parent households with children. The AFDC program was established in 1935 under the Social Security Act, and offered cash welfare payments for needy children due to parental absence (ASPE, 2024).

[7] Authors calculations based on NHDS, see Figure D.1. Young adult women are also less affected by the Supreme Court decision in 1979 that liberalized consent for minors. This Supreme Court ruling in *Bellotti v. Baird* determined that a Massachusetts law requiring parental consent was unconstitutional (Bellotti v. Baird, 443 U.S. 622, Justia (1979)). However, even if minors were included in our main sample, we would expect the effects of this Supreme Court decision to reduce fertility and increase abortions, and therefore weaken any observable increase in fertility.

2017; Farin et al., 2024; Gardner, 2022). Third, historical narratives from the time also indicate that black women were more affected by the Hyde Amendment than white women (Lincoln et al., 1977)[8]

To measure the health effects of the Hyde Amendment, we consider both maternal mortality and morbidity by race. First, we show speculative results revealing an increase in non-white maternal mortality in high-Medicaid eligibility counties. However, the county-level results are somewhat noisy due to the small number of maternal deaths. To deal with the small number of maternal deaths, we then consider an event study comparing the health of non-white women to white women before and after the Hyde Amendment at the state level. Our state-level event study shows a temporary increase in maternal mortality for non-white relative to white women, especially in high Medicaid eligibility states. We then use the NHDS (1972-1981) to consider maternal morbidity. These results reveal that the Hyde Amendment raised hospitalizations for abortion complications in non-white women relative to white women. Hospitalizations for abortion complications rise by 16% in non-white women relative to their white counterparts.

Finally, we also show that economic outcomes deteriorate for non-white women after the Hyde Amendment. In particular, non-white women are more likely to be receiving welfare directly after the passage of the Hyde Amendment. Non-white women's income and employment also decline after 1977. While these results are speculative, they indicate that the Hyde Amendment may have worsened economic outcomes in non-white relative to white women and exacerbated racial inequities.

Overall, we show that the Hyde Amendment raised fertility rates in high Medicaid eligibility counties while detrimentally impacting non-white women's health and economic outcomes. Our findings provide compelling evidence that financial barriers to obtaining an abortion disproportionately impact those likely to be living in poverty. These financial barriers particularly affect non-white women, raising racial disparities in health and economic outcomes.

We contribute to the existing knowledge of the consequences of public abortion funding by presenting one of the first studies to consider the effects of federal funding restrictions across counties. These funding restrictions through the Hyde Amendment have been in place for 40 years and have affected millions of reproductive-age women (and their families) each year over the past four decades. While related work has considered the effects of this Amendment, studies have focused on state-level responses to these federal restrictions (Garbacz, 1990; Blank et al., 1996; Levine et al., 1996; Haas-

[8] Lincoln et al. (1977) argues that "*we can expect, therefore, that with the sharp reduction in Medicaid-funded abortions, proportionally more black than white women will be forced to bear unwanted children*" (Lincoln et al., 1977, pg 213).

Wilson, 1997; Cook et al., 1999). Levine et al. (1996); Haas-Wilson (1997) both show that state-level Medicaid funding restrictions have no impact on state-level fertility rates. However, Haas-Wilson (1997) does show a reduction in the abortion rate in states without funding restrictions. Our analysis is fundamentally different than these prior state-level analyses because we consider the within-state effects of federal funding restrictions based on Medicaid eligibility. This county-level approach highlights important differences within-state, especially in areas likely to be most affected by the funding restrictions. State-level analyses aggregate out important heterogeneity occurring at the county level. Further, because we include state-by-year fixed effects, we can interpret our findings as absent competing policies that occurred in the wake of the Hyde Amendment, which would not be accounted for in state-level specifications.[9]

Our divergence in methodology from prior work also highlights important increases in fertility *in (most) states that continued funding abortion services* in the wake of the Hyde Amendment. The increase in fertility in states with available funding suggests that state Medicaid programs did not fully compensate for federal funding restrictions. This failure of state funding to effectively prevent unwanted pregnancies could occur for a few reasons. First, the Hyde Amendment received widespread publicity and may have deterred women and providers from attempting to obtain reimbursement from public funding sources (Trussell et al., 1980; Cates, 1981). Second, historical data suggest that most state funding for abortion services did not fully compensate for the decline in federal funds following the Hyde Amendment. Publicly funded abortions fell in the majority of U.S. states, even those with available abortion funding (Trussell et al., 1980; Cates, 1981). Third, women eligible for Medicaid were concentrated in states with Medicaid funding; 85% of Medicaid recipients resided in states with public funding for abortion services (Cates, 1981). Together, these factors (and our heterogeneity analysis) imply that the largest effects of the Hyde Amendment occurred in states that continued funded abortions, but experienced a reduction in funding.

Importantly, we are also one of the first papers to consider the causal impact of abortion *funding restrictions* on health. Our analysis shows that abortion funding restrictions disproportionately harm non-white women's health, aligning with prior

[9]Our study also adds to broader literature studying restrictions on abortion (Haas-Wilson, 1996; Bitler and Zavodny, 2001; Hock et al., 2007; Oreffice, 2007; Guldi, 2008; Myers, 2017; Fischer et al., 2018; Jacobson and Royer, 2011; Miller et al., 2023), the legalization of abortion (Angrist and Evans, 1996; Levine et al., 1999; Donohue and Levitt, 2001; Kalist, 2004; Ananat et al., 2004; Guldi, 2008; Foote and Goetz, 2008; Donohue and Levitt, 2008; Ananat et al., 2009; Lahey, 2014; Myers, 2017; Jones et al., 2021), parental consent and notification requirements (Kane and Staiger, 1996; Joyce and Kaestner, 1996; Matthews et al., 1997; Bitler and Zavodny, 2001; Levine, 2003; Klick and Stratmann, 2008; Joyce et al., 2019; Sabia and Rees, 2013; Sabia and Anderson, 2016; Myers and Ladd, 2020); restrictions on abortion providers (Fischer et al., 2018; Lindo et al., 2020; Jones and Pineda-Torres, 2024), and mandatory waiting periods before abortion (Joyce et al., 1997; Joyce and Kaestner, 2000, 2001; Bitler and Zavodny, 2001; Lindo and Pineda-Torres, 2021; Myers, 2021; Altındağ and Joyce, 2022). Prior work has also shown the importance of fertility control through the pill (Goldin and Katz, 2002; Bailey, 2006; Ananat et al., 2007; Bailey, 2010; Bailey et al., 2012; Zuppann, 2012; Steingrimsdottir, 2016; Myers, 2017). Clarke and Mühlrad (2021) has also shown that legal access to abortion in Mexico City reduced maternal morbidity (with some evidence for declines in maternal mortality).

work. Farin et al. (2024) finds that only non-white maternal mortality declined with abortion legalization. Gardner (2022) finds wider health gaps between black and white infants following related restrictions on abortion services. Our findings similarly demonstrate that abortion restrictions raise racial disparities in health.

2 Background

2.1 The Hyde Amendment: A Ban on Federal Funding for Abortion

In 1976, the United States Congress passed the Hyde Amendment, banning the use of federal funding for abortions (Gold, 1980). While the Hyde Amendment passed Congress in October 1976, enforcement was delayed until August 4th, 1977, when a federal court's injunction was lifted (Lincoln et al., 1977; CDC, 1977; Cates, 1981; Torres et al., 1986). Due to the injunction, at the beginning of 1977, federal funding was still used for abortions, but by the end of 1977, federal funds were barred through the Hyde Amendment. The funding restrictions of the Hyde Amendment continue to this day, except for a 7-month period in 1980 when federal funding resumed while a Supreme Court ruling was pending on the Hyde Amendment (Cates, 1981).[10]

Despite the delay in implementing the Hyde Amendment and the 7-month pause on the Hyde Amendment in 1980, the effects of the Hyde Amendment began in 1977. There was widespread publicity about the Amendment throughout the U.S. beginning in 1976. Due to the extensive publicity, many women may have been deterred from attempting to obtain an abortion with public funds in 1977 (Trussell et al., 1980; Cates, 1981). For example, The Dayton Daily News (Ohio, August 4, 1976) reported "Hyde Amendment is an anti-poor amendment. It is also blatantly unconstitutional on equal protection and privacy laws". The Anchorage Times (Alsaka, September 29, 1976) reported "The Department of Health, Education and Welfare, in 1975 reports that the government financed about 300,000 abortions for poor women at a cost of $40-50$ million, so it is claimed that the new ban on funding will save a large sum for the tax payers". [11] A large portion of low-income women would not have known about the availability of state funds for an abortion, and some abortion providers may not have solicited reimbursement from available state funds (Cates, 1981, pg 1111) By 1978, the Amendment resulted in a 99% reduction in federal funding for abortion (Gold, 1980).

[10] Initially, the Hyde Amendment only allowed federal funding for abortion in cases of life endangerment. However, the language of the Amendment has been revised to include exceptions for rape and incest (Gold, 1980).

[11] We found evidence of about 110 national and local news outlets, from all 50 states, covering the Hyde Amendment.

2.2 Who did the Hyde Amendment affect?

The Hyde Amendment primarily affected reproductive-age women participating in the Medicaid program (Cates, 1981). The Amendment fundamentally impacted Medicaid recipients of childbearing age, of whom 85 percent were part of the Aid to Families with Dependent Children program (AFDC, or welfare) (Lincoln et al., 1977). These women receiving both AFDC and Medicaid were women who lived below the poverty line (Gold, 1980).

Because the targeted population relied on welfare payments for personal finances and Medicaid for health insurance, AFDC recipients are also expected to have limited means to pay for an abortion after the Hyde Amendment. At the time, *"the average cost of an abortion in the United States-$280-is $42 higher than the average monthly welfare payment for an entire family for food, clothing, shelter and all other necessities"* (Lincoln et al., 1977, pg 210). In some states, the payment discrepancy was even higher. In Mississippi for example, *"the average cost of an abortion is 10 times higher than the monthly family AFDC payment"* (Lincoln et al., 1977, pg 210). The state-level ratios of AFDC payments to the cost of an abortion are outlined in Table 1 (Lincoln et al., 1977).Table 1, columns (3) and (4), show that in most U.S. states, the cost of an abortion is higher than the average AFDC payment.

Women receiving Medicaid also actively used public funds for abortions prior to the Hyde Amendment. In 1976, *"the rate of abortions per 1,000 Medicaid-eligible women aged 15-44, was about three times higher in FY 1976 than among the nonpoor"* (Lincoln et al., 1977, pg 210). Table 1, columns (1) and (2), show that in the vast majority of U.S. states, the Medicaid abortion rate prior to the Hyde Amendment was higher than for non-Medicaid recipients. In 1977, an estimated 295,000 abortions were paid for with federal funds (CDC, 1977), representing one-quarter of the 1.3 million national abortions (Cates, 1981).

In addition to AFDC recipients, Black women are also expected to be more affected by the Hyde Amendment than white women. This differential racial impact is due to the fact that *"an estimated 39 percent of black women rely on Medicaid for their health care-including abortion-compared to just seven percent of white women"* (Lincoln et al., 1977, pg 213). Further, *"the abortion-to-live-birth ratio is nearly two times higher among blacks than whites"* (Lincoln et al., 1977, pg 213). Thus, the Hyde Amendment disproportionately affected poor black women as compared with their white counterparts.

2.3 State Funding for Abortion

The Hyde Amendment primarily changed how abortions were paid for through the Medicaid program, which uses both federal and state funds to pay for the health-care of low-income women. While the Hyde Amendment barred the use of federal funding for abortion, the Amendment did not prohibit states from using their own funding to cover abortions (Gold, 1980). After the Amendment, states could fund abortions entirely with state funds or discontinue the provision of abortion services through their Medicaid programs. To meet the gaps in funding created by the Hyde Amendment, "*eighteen States and the District of Columbia continued to fund abortions under most circumstances; the remaining 32 States did not fund abortions except to save the life of the woman*" (Lang et al., 1983, pg 12).

From 1977 to 1978, Federally funded abortions fell from 295,000 to around 2,000 (Trussell et al., 1980). Meeting this decline in federal funding, in 1978, states fully funded 194,000 abortions (Gold, 1980). Based on those numbers, the Hyde Amendment appears to have directly prevented the public funding of 100,000 abortions throughout the U.S. The majority of subsidized abortions that still occurred were in states with funding available for medical necessity (Gold, 1980). Though, the numbers of prevented abortions could be larger than those observed numbers. Gold (1980); Torres et al. (1986) estimate that in 1978, there were 234,000 women in need of abortion who could not obtain one due to public funding restrictions. After the Hyde Amendment, of the low-income women in need of abortion, *65% used state funds, 29% used other funds, 5% carried their pregnancies to term, and only 1% resorted to an illegal abortion* (Cates, 1981).

To illustrate the different funding practices by state, we collect information on Medicaid-funded abortions and overall abortions for each U.S. state. Figure I plots the aggregate estimates, with the state-level numbers broken out in Table 1, Figure A.2, and Figure A.3. Figure I shows the Medicaid-funded abortions on the left, and all state-level abortions from the CDC Abortion Surveillance Program on the right.

Panel A of Figure I, shows that in states with limited funding, Medicaid abortions drop off almost completely after the Hyde Amendment. In these states without funding, Medicaid-funded abortions fall from 40,000 to less than 10,000. In these 34 states without state funding for abortion (Gold and Cates Jr, 1979), women still continued to obtain abortions. This is apparent in the fact that abortions keep rising after the Hyde Amendment (Panel A.ii). Possible paths to obtain an abortion included self-funded abortions, reduced fees by abortion providers for Medicaid-eligible women, public hospitals with low-cost abortions, private donations, and family planning agencies

(Gold and Cates Jr, 1979; Cates, 1981). However, evidence suggests that women obtained abortions at later gestational ages (roughly two weeks later, Gold and Cates Jr (1979)). Furthermore, a higher proportion of women carried unwanted pregnancies to term. In select unfunded states, Cates (1981) estimates that 18-35% of Medicaid-eligible unwanted pregnancies were carried to term.

Panel B shows even in states with public funding, abortions declined after the Hyde Amendment. Medicaid-funded abortions fall from over 80,000 to 60,000 in 1978 (for the available states) in states with continued funding for abortion. For example, in Illinois, the abortion funding policy changed four times throughout 1978, and *"as a result, Illinois financed fewer than one-fourth the number of Medicaid-funded abortions than it had in the year before the Hyde Amendment"* (Cates, 1981, pg 1111). The decline in Medicaid abortions is large enough that it appears to affect the total number of abortions on the right-hand side, Panel B.ii.

In a few states, though, abortion public funding remained high. Figure I Panels C and D show this continued support for Medicaid-funded abortions after the Hyde Amendment. These states, especially California, fund more abortions through Medicaid after the Hyde Amendment. Because these states had such high support for Medicaid-funded abortions, we omit them from the main sample. However, we acknowledge that these states may still have had hurdles to obtaining an abortion, even if purely informational hindrances to obtaining an abortion.

2.4 Health Effects of the Hyde Amendment

The Hyde Amendment could affect health through three main channels. These three channels include:

1. *If the Hyde Amendment raises fertility, maternal mortality may rise due to pregnancy being riskier than an abortion.*

   Petitti and Cates Jr (1977) estimate that if all women who would have had an abortion before the Hyde Amendment carried their pregnancies to term, maternal mortality rates would unambiguously rise. White maternal mortality would increase by 15 deaths and black maternal mortality by 29 deaths. The relatively larger increase for Black women reflects their higher maternal mortality ratio in 1977 (10 per 100,000 births for white women versus 35 for Black women). Thus, despite more white women obtaining Medicaid-funded abortions in 1974 (160,000 versus 90,000 for Black women), Black women faced greater risks from carrying pregnancies to term.

Post-Hyde Amendment evidence indicates that 5% of Medicaid-eligible women carried pregnancies to term, potentially increasing maternal mortality. Based on the maternal mortality numbers from Petitti and Cates Jr (1977), this would lead to 1–2 additional deaths for non-white women and 0.75 deaths for white women. However, maternal deaths may vary by state, as estimates indicate increased fertility across states between 18 and 35% 35% (Cates, 1981).

2. *The Hyde Amendment could push women to obtain riskier abortions through illegal or self-induced methods.*

   Petitti and Cates Jr (1977) argue that the risk of death from illegal abortions is 40 per 100,000 procedures, compared to 4 per 100,000 for legal abortions, suggesting a potential rise of 90 deaths if all Medicaid recipients sought illegal procedures. However, The CDC's Abortion Monitoring in Sentinel Hospitals indicate most Medicaid-eligible women did not resort to self-induced or unqualified abortions after the Hyde Amendment (CDC, 1977).

   The CDC attributed three deaths and ten complications from illegal abortions to Hyde Amendment funding restrictions (Gold and Cates Jr, 1979). Additionally, roughly 2,000 women in funding-restricted states resorted to illegal or self-induced procedures (Selik et al., 1981; Gold and Cates Jr, 1979). Due to the limited use of alternative abortion methods, we do not expect self-induced abortions or illegal abortions to play a major role in our study of maternal health.

3. *The Hyde Amendment could result in delaying an abortion until later in pregnancy.*

   Delays in abortion due to the need to secure funds could increase the risk of complications, as later procedures are riskier (Petitti and Cates Jr, 1977). First-trimester abortions from reputable clinics offer the safest outcome for pregnant women with an unwanted pregnancy. Estimates indicate that if all Medicaid-eligible women delayed their abortions by two weeks to secure funds, mortality could increase by five additional deaths (Petitti and Cates Jr, 1977).

   Following the Hyde Amendment, studies suggest women delayed abortions due to a lack of public funding (Cates Jr et al., 1979). The CDC reports that women in non-funded states had abortions 1.9 weeks later than those in funded states and 2.4 weeks later than non-Medicaid-eligible women in the same state (CDC, 1977). These delays could increase death-to-case ratios, with a two-week delay raising the national abortion death-to-case rate by 21% and the death-to-case rate of women who would have had Medicaid abortions by 60 % (Lincoln et al., 1977). Each additional week of delay increases complication risks by 40% (with most

women delaying their abortions by two weeks) (Cates Jr et al., 1979).

Overall, we anticipate that there could be two primary observable effects on women's health. First, women face an additional risk if they decide to carry a pregnancy to term rather than getting an abortion. Thus, if fertility rises, maternal mortality should also increase. Second, abortion complications may increase due to later gestation abortions.

2.5 Abortion in the 1970s

The Hyde Amendment followed shortly after the sweeping legalization of abortion through the U.S. Supreme Court decision in *Roe v. Wade* (henceforth, *Roe*). On January 22, 1973, *Roe* legalized abortion nationwide and overturned state-level restrictive abortion laws. Here, we describe the characteristics of abortion in the 1970s.[12]

In the wake of *Roe*, the legal abortion rate steadily increases (top panel of Figure II). Following the Hyde Amendment, the abortion rate dips and then rises again. Much of that rise comes from states with some funding available through state Medicaid programs (Panel B of Figure I). Although the abortion rate is higher for non-white as compared to white women (right-top panel of Figure II), the former falls after the Hyde Amendment, while the latter continues rising. Furthermore, the highest share of abortions occurs in women 20-24, with a large share also occurring in women 15-19 and 25-29. Women in their 30s and older and those under 15 only make up a small share of abortions (second panel of Figure II).

The third panel of Figure II presents the proportion of abortions by each method. By 1974, abortions primarily were performed with suction curettage (vacuum aspiration), replacing earlier methods of using sharp curettage (Kleinman and Senanayake, 1993; Rubin, 1994). Over the period of study, more than 80% of abortions were performed with curettage, mainly suction. Finally, the bottom of Figure II shows that the majority of abortions occurred in the first trimester, with almost half occurring before 9 weeks of gestation. Over the period, abortions at higher than 16 weeks declined, with a noticeable uptick in abortions occurring at 13-15 weeks after 1977.

[12] While this data is informative for understanding the characteristics of abortion in the 1970s and early 1980s, it presents several limitations. First, the abortion surveillance data is only available at the state level. Because we do not have county-level data on abortions, we are unable to understand the effects of the Hyde Amendment in our main county-level specification. Second, the data reported in Figure II do not represent all states. Several states did not report characteristics of abortion, and another group of states only reported characteristics in certain years. In Figure II, we only plot the balanced panel of states. Third, the data reported by the CDC are also known to be under-reported (Elam-Evans et al., 2002). As late as 2000, the "abortion totals for 2000 provided to CDC by central health agencies are 20% lower than that reported for 2000 for the same reporting areas by The Alan Guttmacher Institute, which contacts abortion providers directly. (Elam-Evans et al., 2002) documented a discrepancy of approximately 12%.

3 Fertility

3.1 Data

We assemble a variety of data sources to examine the consequences of the Hyde Amendment. We primarily rely on the Natality Detail Files (or birth certificate records) and the *Surveillance, Epidemiology, and End Results (SEER)* population data for fertility rates. For the health effects, we use the *National Center for Health Statistics Multiple Cause of Death Files* for mortality and the *National Hospital Discharge Survey Series* for maternal morbidity. For the other economic effects, we use the *Current Population Survey (CPS)*. Here, we focus on the main data for the fertility results, and we describe the health and economic data in the relevant sections.

3.1.1 Fertility: U.S. Birth Certificate Records

We rely on the Natality Detail Files (or birth certificate records) from the National Vital Statistics System (NVSS) and National Center for Health Statistics (NCHS) (NCHS, 1970-1990b) for the number of births occurring in each state and county. The records include information on the location of the delivery, including occurrence state, mother's residence state, and occurrence/residence county. For our analysis, we primarily rely on the mother's county of residence.

The Natality Detail File includes all U.S. births, though, in certain early years, states only reported a 50% sample. Throughout the analysis, we use the sample weight to determine whether the delivery represents a 50% or 100% record. We collapse the data to the county level and multiply the number of deliveries by the record weight to account for the 50% samples. This mainly applies to deliveries that occurred before 1972, but some states continued to report a 50% sample until 1985.[13]

The data also includes characteristics of the mother and newborn, though health information beyond birth weight and gestation is relatively limited during the period of study. However, we do have information on the characteristics of the mother, such as age and race. Unfortunately, many variables, even those included on the birth certificate, were not well reported before 1980. These limited variables include the education levels of the mother, as well as marital status. There is also no information regarding the delivery method or related outcomes available prior to 1989.

[13] "Prior to 1972, data are based on a 50-percent sample of birth certificates from all States. Beginning in 1972, data are based on a 100-percent sample of birth certificates from some states and on a 50-percent sample from the remaining States. The number of States from which 100 percent of the records are used has increased from 6 in 1972 to all States and the District of Columbia in 1985" (NBER, 2024).

3.1.2 Population: SEER Population Data

We combine the county-level births with SEER population data to construct fertility rates and controls (SEER, 2024). This data includes the population counts by single-year age, sex, and race. We use this data to compute the exposure for Poisson specifications and the denominator of the fertility rates. The fertility rate is defined as the number of births per 1,000 females in the relevant population. We also use this SEER population data to calculate controls. Our main controls include the share female, the share white, and the share black.[14]

3.1.3 Medicaid Eligibility: AFDC Receipt

To measure Medicaid eligibility, we use the share of the population receiving Aid to Families with Dependent Children (AFDC) colloquially termed "welfare." Specifically, we measure the portion of the population eligible for Medicaid based on the county-level share of the population receiving AFDC in 1976, i.e., a year before the Hyde Amendment. The share receiving AFDC in 1976 comes from Haines (2010). AFDC recipients represent an accurate picture of Medicaid eligibility for reproductive-age women during the period, as Medicaid receipt was "linked to receipt of cash assistance from Aid to Families with Dependent Children (AFDC) and, starting in 1972, Supplemental Security Income (SSI)" (Provost and Hughes, 2000). While Medicaid eligibility did later begin to expand, much of this increase in eligibility occurred during the 1980s. We show the high and low Medicaid eligibility counties (based on this AFDC receipt) in Figure A.5 as well as the share of the population receiving Medicaid. These maps reveal the enormous amount of variation in Medicaid eligibility within states, supporting the potential differential impacts of the Hyde Amendment within states.

3.1.4 Sample Selection

Throughout our county and state-level analysis, we make sample selections to deal with several issues. First, we omit Arizona because the state Medicaid program only began in 1982 (McCall, 1996). Because we end the sample at the maximum in 1981, there is no Medicaid program operating in Arizona during the study time frame.

We also exclude Alaska and Hawaii due to inconsistent county-level reporting during the period. County-level consistency in reporting is a problem for select other

[14] Note that any state-level analyses use the same county-level data collapsed to the state level.

counties in our data. Then, we exclude some counties because we do not have SEER population data for these counties or because they are not a balanced panel in our sample.[15] We also exclude the District of Columbia because it is composed of only one county. As discussed in the background section, we also exclude states with very high funding for Medicaid-funded abortions after the Hyde Amendment. We omit California, North Carolina, Pennsylvania, West Virginia, and Washington, the states with increased funding for abortions after the Hyde Amendment (see Figure I, Panel C). Thus, our final sample includes 42 states.

Throughout the analysis, we also focus on births to young adult women aged 18-29. We make this sample selection for a few reasons. First, women between 18 and 29 are more likely to be directly covered by Medicaid (rather than a parent), and those in their 20s represent the majority of unwanted pregnancies (KFF, 2021). Women in their teens and 20s are also more likely to use non-private funds to pay for an abortion.[16,17]

3.2 Empirical Strategy: County-level Event Study

For our main empirical strategy, we use an event-study design to consider the effect of the Hyde Amendment on county-level fertility. Because the Hyde Amendment has a national impact, we consider the effect of the Amendment on fertility in counties with high vs. low Medicaid eligibility (within a state). More specifically, we compare the impact of the Hyde Amendment in counties with above-median Medicaid eligibility to counties with below-median Medicaid eligibility (within state). We proxy for Medicaid eligibility using the share of the county-level population that are AFDC recipients, which accurately gauges Medicaid eligibility during the period of focus (Provost and Hughes, 2000).

More formally, our event study for county j in state s and year $t = 1972, \ldots, 1981$ appears as follows:

$$\ln(\text{Fertility})_{jst} = \alpha + \sum_{m=1972}^{1981} \beta_m \text{ Hyde Amendment}_m \times 1(\text{Above-Median Share AFDC})_{js} + \mathbf{X}'_{jt}\gamma + a_j + \eta_{s(j)t} + \psi_{u(j)t} + \epsilon_{jst} \quad (1)$$

where the outcome variable $\ln(\text{Fertility})_{jst}$ reflects the natural log of the fertility rate, or the number of births to young adult women 18-29 per 1,000 young adult women 18-29. The effect of restricted funding for abortion is captured by the indicator variables

[15] We remove two counties in Colorado, one county in New Mexico, and four counties in Virginia because the data sources do not all align for these counties.

[16] Authors calculations based on NHDS, see Figure D.1.

[17] We also show summary statistics by above and below median AFDC receipt in Table A.3.

Hyde Amendment$_m \times$ 1(Above-Median Share AFDC)$_{js}$. The Hyde Amendment$_m$ represents a set of indicators variable that captures the effect of the Hyde Amendment, which passed in 1976 and went into effect in 1977. These event-study dummy variables will equal one from 1977 to 1981 and are relative to the pre-Hyde amendment period 1976. 1(Above-Median Share AFDC) is an indicator of whether the county is above the state-level median in the share of AFDC recipients. 1(Above-Median Share AFDC)$_{js}$ captures "high" Medicaid eligibility status for each county. This indicator will equal zero in below-median share AFDC counties, or low-Medicaid eligibility counties. This indicator will equal one in counties with an above-median share of AFDC recipients or high-Medicaid eligibility counties. Together, the interaction term will capture the effect of the Hyde Amendment in counties above the state-level median in Medicaid eligibility relative to counties below the state-level median in Medicaid eligibility.

a_j represents county fixed effects. η_{st} represent state-by-year fixed effects. These state-by-year fixed effects capture all state-level changes, including state-level policies that could differentially affect fertility by state. Including state-by-year fixed effects allows us to interpret the effect absent state-level changes in policy that may affect fertility. We cluster the standard errors at the county level. We also include population-size-by-year fixed effects and urbanicity-by-year fixed effects, $\psi_{u(j)t}$.[18] These additional fixed effects capture differential changes in fertility in urban areas and counties with large populations.

$\mathbf{X}_{jt}$ represents the county-level controls. Our main set of controls includes the share white, the share of other race, and the share female. We also include additional controls in Figure IV, but several controls, such as income and controls for the characteristics of births, are "bad controls" (Angrist and Pischke, 2008), which we demonstrate when we consider welfare receipt and income for reproductive-age women in Section 5. Throughout the results, the regressions are weighted by the denominator of the fertility rate. We also exclusively rely on the canonical two-way fixed effects (TWFE) estimator because there is no staggered treatment timing in our analysis.

The main underlying assumption in Equation 1 is that no other factors uniformly affected counties above the state-level median in share AFDC receipt in 1977 (and onward). Because we include state-by-year fixed effects, any state-level effects are not a concern in our main empirical strategy; only a national policy that uniformly affects those eligible for Medicaid throughout the United States would cause potential contamination bias. All reported effects are relative effects, describing the impact of the Hyde Amendment in areas with high Medicaid eligibility relative to areas with

[18] These fixed effects are defined as the national quartiles of the share urban and the national quartiles of the county-level population interacted with year dummies.

low eligibility.

3.3 Main Results: Fertility Rises in High Medicaid Eligibility Counties

Figure III presents the impact of the Hyde Amendment on county-level fertility. The plotted points represent the effect of the Hyde Amendment in above-median Medicaid eligibility counties compared to below-median Medicaid eligibility counties (based on AFDC recipients). Panel A shows the overall effect, comparing above-median eligibility counties to below-median counties. Panel B breaks out each quartile of the county-level share of AFDC recipients relative to the first quartile.

In the sample of all U.S. counties in Panel A, fertility increases for young adult women in high Medicaid eligibility counties. Following the passage of the Hyde Amendment, fertility increases in 1977 and trends upward until 1980. Then in 1981, the increase in fertility slightly dips downward, but the higher fertility rate remains significant. This dip in 1981 may partially result from abortions that occurred in 1980 due to the federal injunction on the Hyde amendment (Cates and Rochat, 1976). Overall, the Hyde Amendment raises fertility by 1.8% in high-eligibility counties.

Then, in Panel B, we show that the largest increase in fertility comes from counties with the highest Medicaid eligibility. We break out counties into quartiles and compare each quartile of Medicaid eligibility to the bottom quartile (proxied with AFDC receipt). Panel (i) shows the second relative to the bottom quartile in Medicaid eligibility. Panel (ii) presents the third quartile relative to the bottom quartile, and Panel (iii) displays the fourth quartile relative to the bottom quartile. Panel (iii) displays the clearest increase in fertility–a more than 3% rise in fertility after the Hyde amendment. Panels (i)-(ii) show smaller increases in fertility, a less than 1% rise in fertility that is statistically insignificant. The largest and clearest increase in fertility occurs for the counties in the highest quartile of AFDC receipt or those counties with the most eligibility for Medicaid.[19]

Overall, Figure III displays a clear increase in county-level fertility with the Hyde Amendment. Counties with higher Medicaid eligibility experience an increase in fertility by 1-3% relative to lower eligibility counties. In our primary specification, counties with higher Medicaid eligibility (above median) experience a roughly two percent increase in births relative to counties with low Medicaid eligibility.

[19] In Appendix Figure B.1, we also compare the top (4th) quartile of AFDC receipt to the second and third quartiles of receipt. Here, there is a clear increase in fertility in the 4th versus the 2nd quartile – 2.5%. In the 4th versus the 3rd quartile, there are less noticeable changes in fertility. These relative effects also align with the effect by deciles in Figure B.2, where there is the clearest effect across the top five deciles relative to the first decile.

Is this effect size in line with the number of abortions that occurred under Medicaid? Cates and Rochat (1976)'s estimate that 5% of Medicaid-eligible women carried their pregnancies to term after the Hyde Amendment, meaning the Amendment caused an additional 15,000 births to occur in the U.S. High medicaid-eligibility counties in 1976 had 1.14 million births in 1976, while low-eligibility counties had 665,000 A 1.8% increase in births in high-eligibility counties relative to low-eligibility counties means there would be an additional 8,000-9,000 births in high relative to low AFDC counties.[20] Thus, our estimated effect size is in line with the estimated increase from historical narratives (Cates and Rochat, 1976).[21]

These event-study results reveal increases in fertility, a conclusion that differs from prior work with state-level effects. Levine et al. (1996); Haas-Wilson (1997) found little-to-no-change in fertility after the Hyde Amendment. However, these papers focused on the differences across states with and without funding for abortions. As discussed in the background section, states that funded abortions still may have experienced a reduction in abortions. For example, in Illinois, publicly financed abortions fell after the Hyde amendment (Cates, 1981, pg 1111). Further, publicity about the Amendment and confusion regarding state versus federal funding may have deterred both women and abortion providers from accessing available state funds (Cates, 1981). In our analysis, we deal with these challenges by considering the effect of eligibility rather than state funding. An advantage of our approach is the inclusion of state-by-year fixed effects, which remove differences in state-level policies before and after the Hyde Amendment. Our updated findings reveal that the Hyde Amendment did increase fertility for young-adult women in counties with higher Medicaid eligibility relative to low-eligibility counterparts. The increase in fertility in high-eligibility counties better aligns with the historical narratives suggesting that abortions were deterred, and additional pregnancies were carried to term in the wake of the Hyde Amendment (Cates, 1981).

3.4 Where is the Fertility Effect Clearest?

3.5 Individual-level Heterogeneity: Fertility Increases the Most for Unmarried Women and Women who Already Have Children

Next, in Table 2, we consider within-state heterogeneity for both individuals and state-level policies. First, in Column (1), we interact the effect of the Hyde Amendment

[20] In the lowest quartile of AFDC receipt, there were 328,988 births in 1978, while there were 671,248 births in the highest quartile of AFDC. And the increase in births would be roughly 10,000 additional births over the lowest quartile of AFDC.

[21] The smaller relative effect size reflects the fact that our estimates compare highly treated groups to less treated groups, and represents a relative effect. The Hyde Amendment still treats our comparison group, and thus our main estimates underestimate the total fertility effect of the Hyde Amendment. Unfortunately, in this setting with a national policy, there is no perfectly "clean" control group.

with marital status. We consider Hyde Amendment$_m$ $\times$ 1(Above-Median Share AFDC)$_{js}$ $\times$ 1(Unmarried)$_m$, where 1(Unmarried)$_m$ captures the effect of being unmarried with an indicator variable that equals one if an individual is single. Here, the data is collapsed to the county j marriage m level. We also include marital status-by-year fixed effects to absorb the time-varying effect of being married.[22]

Column (1) shows that the effect of the Hyde Amendment is primarily on the fertility of unmarried women. The baseline coefficient is negative, and the effect of the Hyde Amendment on the interaction term of high eligibility x unmarried is positive and significant. These findings are as expected, as unmarried women are more likely to be receiving Medicaid/AFDC than married women (as shown in Figure F.1, using CPS data). During the period of focus, Medicaid primarily covered single women.[23]

The results are similar considering subsequent births in Column (2). Here, we replace the indicator variable for unmarried with an indicator variable capturing subsequent deliveries. Women with children are more likely to be receiving Medicaid than women who have no children (as shown in Figure F.1, using CPS data). In Column (2), the coefficient on the interaction term is positive and significant, as with unmarried deliveries. Overall, the Hyde Amendment appears to increase fertility the most for unmarried women who already have children.

3.6 State-level Heterogeneity: Fertility Increases the most in States with High Demand for a Medicaid Abortion and in States that Continue to Fund Abortions

Next, we interact the above-median eligibility indicator with state-level characteristics. Fertility increases the most in states with greater demand for abortion and in states with continued funding for abortion under the state Medicaid programs.[24]

Medicaid Abortion Demand. In Table 2 Columns (3)-(5), we consider the effect in states with higher demand for Medicaid-funded abortions prior to the Hyde Amendment. Table 1 and Table A.1 display the specific measures of abortion demand by state (Lincoln et al., 1977). We interact high eligibility with an indicator for states with: 1) the AFDC recipients in 1976 (Column 3), 2) an above-median number of Medicaid abortions in 1976 (Column 4), and 3) states with an above-median abortion rate for Medicaid recipients (Column 5). The results show the main increase in fertility occurs in states with high AFDC recipients and in states with more Medicaid abortions prior

[22] The fertility rate is still defined per 1,000 women 18-29 for both unmarried and married women.
[23] A limitation of this analysis is that marital status is not reported for all states in all years of our sample.
[24] These results are also shown in event study form in Figures B.3 and B.4.

to the Hyde Amendment.

Abortion Cost. Next, we interact high-Medicaid-eligibility post-Hyde Amendment with the average abortion cost. We take the average cost of an abortion from Lincoln et al. (1977) and consider the above and below-median cost of obtaining an abortion as well as the ratio of the cost of an abortion to the average AFDC payment. Columns (6)-(7) of Table 2 reveal no significant differences across high-cost states versus low-cost states. However, the coefficient on high-cost states is positive–indicating that high cost states have a larger increase in fertility.

Public Funding for Abortion. Following the Hyde Amendment, certain states continued to fund abortion services. While some of these states with exceptionally high funding are excluded from our analysis (e.g., California), other states like New York still fund abortions, though at a reduced rate. Even though Medicaid abortions fell in these states, state budgets filled the federal funding gaps with 100% state funding for Medicaid abortion services. Several states funded abortions in cases of medical need, while other states funded abortions only in severe cases, such as endangerment of the mother. Columns (8)-(9) interact high-eligibility with an indicator for states funding more than 10% of abortions and states providing any funding for abortion. The interaction term suggests that both groups of states show an increase in county-level fertility in high-eligibility counties. Rather counterintuitively, states with funding available experience a larger increase in fertility after the Hyde Amendment.

The more apparent increase in fertility in states with funding for abortion services is explained by a few factors. First, the Hyde Amendment received widespread publicity. Women may have been deterred from attempting to obtain an abortion regardless of the state funding status (Trussell et al., 1980; Cates, 1981). Many low-income women would not have known about the availability of state funds for an abortion, and some abortion providers may not have solicited reimbursement from state funds (Cates, 1981, pg 1111). Second, publicly funded abortions fell even in states with funding available (Cates, 1981). Third, women eligible for Medicaid were concentrated in states with Medicaid funding (Cates, 1981). Thus, if there is a reduction in abortions due to the Hyde Amendment, we would expect the effect to be clearest in states with the most Medicaid recipients or those states with continued funding for abortion services.

3.7 Fertility By Region/Race: Non-white Fertility Increases in the Northeast; White Fertility Increases in the Northeast and Midwest

In Figure V, we show the increase in fertility by race and region. We split the results by both race and region because non-white individuals are known to vary more in their characteristics throughout the U.S. than white individuals (Motel and Patten, 2012; Cox and Tamir, 2022). Figure V shows that the increase in fertility appears the clearest in the Midwest and Northeast. In the Northeast, the increase in fertility is clearer for non-white births, and in the Midwest, the fertility increase is clearest for white births.

3.8 Robustness

We briefly describe in this section a set of robustness checks for our fertility results. Most of these results are shown in Figure IV unless otherwise indicated. Appendix B provides further details on these analyses.

Alternative handling of the standard errors. Panels A and B present alternative methods of handling the standard errors. First, Panel A adjusts the standard errors for spatial and serial correlation using the method described in Hsiang (2010). Second, Panel B shows the standard errors clustered at the state level. Overall, the increase in fertility in high-eligibility counties is robust to these alternative methods.

Poisson estimates and linear fertility with OLS coefficients. Panel C shows the Poisson estimates for the number of births to women 18-29. These estimates indicate an increase in fertility by 1.7%–similar to the baseline effect of 1.8%. Panel D shows the estimates for the linear fertility rate (the number of births per 1,000 reproductive-age women 18-29) in an OLS specification. This analysis indicates that fertility increases by six births per 1,000 18-29-year-old women. This effect size with the linear fertility rate is similar to the baseline Poisson estimates.

Continuous measure of eligibility. Panels E to G present event studies that consider continuous eligibility measures interacted with event-study indicators. Panel E considers the dose-response of Medicaid eligibility, allowing counties with more Medicaid recipients to have a larger treatment weight than counties with fewer recipients. Panel F uses the national percentile of AFCD receipt, and panel G relies on the interaction between the decile with the event study indicator. These event studies indicate that the effects on fertility are larger for counties with higher eligibility.

Alternative eligibility comparisons. Figures B.1 and B.2 present comparisons between the top eligibility quartile (decile) and the remaining quartiles (deciles). These figures support that fertility increased for the highest eligibility quartile (decile), although the increases in fertility become much more modest the closer the eligibility of the comparison quartile (decile) is to the eligibility of the treated quartile (decile).

Alternative measures of eligibility. Figure IV also presents estimates using an alternative measure of Medicaid eligibility. Panel H relies on the share of households living in poverty and considers as treated those counties with above-median levels of household heads in poverty (within state). Panel I relies on the same alternative measure but considers as treated the top quartile of households in poverty rather than the median. Panel J uses the above median share of AFDC recipients for the entire US rather than within the state. Panel K considers as treated counties those in the highest quartile of national AFDC receipt. Overall, these analyses find similar increases in fertility to our baseline estimates.

Are the results driven by larger cities? Panel L relies on an alternative measure of eligibility based on county population. Treated counties are those with above-median population (within the state). Overall, the results do not indicate to be disproportionally driven by changes in fertility in the largest population cities and counties.

Dropping certain states. Panel M excludes MD and MI from the analysis as they had (arguably) the most funding for abortions under Medicaid after the Hyde Amendment. Panel N omits states that expanded Medicaid eligibility before 1982, based on East et al. (2023). Both analyses show similar increases in fertility to our baseline results.

Extra controls. Panels O to T show estimates adding county-level controls to Equation 1. This includes controls for mothers' marital status and educational attainment (Panel O), age and parity (panel P), income and AFDC payment (panel Q), either the number of abortion providers per reproductive age women or the presence of an abortion provider in the county and the presence of Title X program in the county (panels R and S), and all these controls together (panel T). These analyses show increases in fertility that are a little bit larger to our baseline results.

Tests for pretrends. Figure B.5 shows pretrends calculated based on Roth (2022); Caceres-Bravom (2024). While there is evidence of pretrends, the pretrends are well below the estimated coefficient, and even outside of the estimated confidence interval over 1977-1980, confirming that pretrends are not a concern for our baseline results.

Results by age. Figure B.6 presents results for the five-year age-groups of women

of reproductive age. These analyses confirm that the Hyde Amendment affected the most women aged 18-29. Other age groups also show increases in fertility after the Hyde Amendment, with the most modest to no changes among the women under 18 and 30 and over.

Permutation test. Figure B.7 presents the plotted cumulative distribution function (CDF) of a permutation placebo test that randomizes the counties in the above-median AFDC group a thousand times. The non-parametric p-value of this analysis suggests that our baseline estimate is highly statistically significant.

Dropping one state at a time. In Figures B.8-B.9, we drop each state individually from the sample and show a similar increase in fertility, indicating that no single state is driving our baseline results.

Controls as outcomes. Figure B.10 considers various potential controls as outcomes. The first two panels display little change in the number of abortion providers in high-eligibility counties after the Hyde Amendment. The next panels indicate that births shirt away from being college-educated and married births. We also see a temporary shift towards more non-white births and black births, and a temporary decline in white births. These results indicate that black/non-white births do increase more than white births initially after the Hyde Amendment. The fact that the shift in race of delivery is only temporary helps to explain why there is only a temporary change in non-white maternal mortality (in the next section of results, Section 4).

State-level changes in abortion and fertility. Finally, we consider the fertility rate, abortion rate, and the gestation of abortion in states with high eligibility in Figures C.1 and C.2. These analyses show a small increase in state-level fertility in high-eligibility states and some evidence of a reduction in abortions. High-eligibility states also show more abortions earlier in gestation and later in gestation, even pushing abortions to the (early) second trimester. Unfortunately, we do not have information on county-level abortions during the period of focus, so these state-level changes in abortions are the best information available.

4 Health Effects of the Hyde Amendment

In our main results, we find a clear increase in fertility in high-eligibility counties relative to low-eligibility counties. Based on these fertility results, we next examine the direct health consequences of the Hyde Amendment. We switch to a new specification because we do not have accurate health measures available at the county level for our two measures of maternal health: maternal mortality and morbidity. The lack of

county-level measures is because, first, maternal mortality was relatively low in 1980 (around 200 deaths per year) and is not well populated in many U.S. counties. Second, the NHDS data that we use to measure morbidity is only nationally representative and available by U.S. region. Thus, we switch to a specification that considers health by race instead of by county.

Why consider health by race? Figures VI and D.1 reveal that from 1977 onward, Medicaid funded a larger proportion of abortions for non-white women than for white women. Because of this heavy reliance on Medicaid for non-white women, a larger proportion of non-white abortions will be affected by the funding restrictions in the wake of the Hyde Amendment. Section 3.8 (Figure B.10) also shows that, after the Hyde Amendment, births temporarily shift towards black/non-white births and away from white births. Comparing non-white to white health outcomes also allows us to include state-by-year fixed effects in the mortality specification, as well as region-by-year fixed effects in the morbidity analysis.

We anticipate that there could be two main health consequences of abortion restrictions.

1. *Maternal mortality may increase due to the increase in fertility.* This increase in maternal mortality occurs because carrying a pregnancy to term is higher risk than an abortion (Gold, 1980; Petitti and Cates Jr, 1977). We would expect increases in maternal mortality to be most noticeable in areas with greater changes in fertility. Based on Table 2, this will mean larger maternal mortality changes in states with higher demand for an abortion, states with continued funding for an abortion, and states in the Northeast (see Figure V).

2. Evidence from the period suggests that funding restrictions *delayed abortions by two weeks*. Due to the funding restrictions, women scrambled to pay for abortions in the wake of the Hyde Amendment, causing delays in accessing the procedure (Petitti and Cates Jr, 1977; CDC, 1977). We anticipate that the shift towards later-gestation abortions could push up abortion complications. Because these abortions still occur, but later in time, the change in abortion complications will not necessarily correspond to the changes in fertility. As discussed in robustness Figure C.2, abortions are shifting later in gestation in high-Medicaid eligibility states (or high AFDC) states, with a higher proportion of abortions occurring at 8 weeks and 13-20 weeks.

Beyond these two effects on maternal health, we anticipate there will be only a small effect of illegal and self-induced abortion on health. Based on evidence from the pe-

riod (CDC, 1977), illegal/self-induced abortions played a small role after the Hyde Amendment. However, a switch to illegal or self-induced abortions will still show up in both our measure of maternal mortality and abortion complications.

4.1 Maternal Mortality

Data. We calculate maternal mortality from the Vital Statistics *National Center for Health Statistics Multiple Cause of Death Files* available through the *Centers for Disease Control and Prevention (CDC)* and the *National Bureau of Economic Research (NBER)* (NCHS, 1970-1990a). This mortality data includes all deaths in the United States, but we focus on maternal deaths. We classify maternal deaths according to the underlying cause of death (ucod) and the International Classification of Disease (ICD) codes. Over our analysis period, the ICD codes were revised, between 1978 and 1979. Table A.2 shows the specific causes within maternal causes of death. These maternal causes of death include any death related to "complications of pregnancy, childbirth, and the puerperium" (NCHS, 1985). We highlight the specific causes of abortion deaths in detail in Panel B of Table A.2.[25]

Empirical Strategy. We aggregate maternal deaths to the state level and year level by race. While we show our main county-level specification over maternal deaths due to the low number of maternal deaths (roughly 200 per year), we also consider the effects of the Hyde Amendment on non-white maternal mortality relative to white maternal mortality at the state level. In this adjusted specification, we use an event-study design in a Poisson pseudo-maximum likelihood framework (similar to our main even study in Equation 1), but comparing non-white to white deaths within state. Formally, this revised event study by race r in state s and year t appears as follows:

$$\text{Maternal Mortality}_{rst} = exp(\alpha + \sum_{m=1973}^{1979} \beta_m \text{ Hyde Amendment}_m \times \\ 1(\text{Non-white})_{rs} + \mathbf{X}'_{rst}\gamma + a_r + \eta_{st} + \epsilon_{rst} \tag{2}$$

where the outcome variable maternal mortality$_{rst}$ represents the maternal mortality for non-white women and white women in each state s during year $t = 1973, ..., 1979$. In the Poisson model, the mortality rate is modeled as the number of observations in the outcome per the exposure; in this case, the exposure is the number of births. In the expression, race r includes two groups, white and non-white. As in Equation 1, the effect of the Hyde Amendment is captured by the interaction Hyde Amendment$_m$ $\times$

[25] Abortion-related mortality is too low during the study period to be of interest. For example, in 1976, 27 women died from abortion, and in 1977, 33 women died from abortion (CDC, 1970-1981). The relatively low number of abortion deaths means that, on average, there was fewer than one abortion-related death in each state. Still, as highlighted in Table A.2, abortion complications are a subset of maternal deaths, and any changes in abortion-related mortality would be captured in maternal deaths.

1(Non-white)$_{rs}$. In this case, we consider the mortality for non-white women relative to white women, 1(Non-white)$_{rs}$. Together, the combined expression will capture the effect of the Hyde Amendment for non-white women relative to white women.

$\mathbf{X}_{rt}$ id a vector of controls. In this case, controls include the share of each race (white and non-white).[26] Indicators for race are represented by a_r. We also include state-by-year fixed effects as η_{st}. These state-by-year fixed effects capture all state-level changes, including state-level policies that could differentially affect maternal mortality by state. Throughout the results, the standard errors are clustered at the state level. We also rely on the canonical TWFE estimator because there is no staggered treatment timing in our analysis.

The main underlying assumption in Equation 2 is that no other factors differentially affect maternal mortality by racial group in 1977. Because we include state-by-year fixed effects, any state-level effects are not a concern; only a national policy that differentially affects either non-white or white maternal deaths throughout the United States would cause potential contamination bias. Equation 2 also assumes that the effects of the Hyde Amendment are larger for non-white maternal health than for white maternal health. All effects are relative between the racial groups and represent racial disparities rather than the absolute health effects of the Hyde Amendment.

Results: Non-white Maternal Mortality Temporarily Increases. Figure VII displays the effect of the Hyde Amendment on maternal mortality. Panels (i)-(iii) show the county-level results (from Equation 1), while Panels (iv)-(viii) show maternal mortality aggregated to the state level from Equation 2.

These figures indicate that there is a decline in white maternal mortality (Panel (i)) and a slight increase in non-white maternal mortality (Panel (ii)). If we consider the effect of the Hyde Amendment on non-white relative to white mortality at the county level (Panel (iii)), there is a clearer increase in maternal mortality for non-white relative to white women. These plotted points in Panel (iii) reflect the effects of the Hyde Amendment on non-white mortality in high-AFDC counties relative to white mortality in high-AFDC counties and non-white and white mortality in low-AFDC counties. This finding suggests an 18% increase in non-white relative to white mortality in high AFDC counties.

Next, in Panel (iv), we aggregate maternal mortality to the state level. This figure indicates that after the Hyde Amendment, non-white maternal mortality increases relative to white maternal mortality, and the increase in non-white maternal mortality

[26] In our main results, we include the share female, but this is absorbed by the state-by-year fixed effects because it does not vary within state.

is statistically significant. The percent increase in maternal mortality in Panel (iv) is similar to the percent increase in Panel (iii). Non-white maternal mortality rises by 18% after the Hyde Amendment relative to white mortality.

To further test whether the increase in non-white maternal mortality is clearest in areas most affected by the Hyde Amendment, we also consider maternal mortality in states where the changes in fertility are larger, such as the Northeast, high AFDC states, and states with funding for abortions under Medicaid (panels (v)-(viii)). Panel (iv) shows non-white maternal mortality in the Northeast relative to other regions. Based on Figure V, non-white mortality increases the most in the Northeast, and if there is an increase in non-white maternal mortality, we would expect the Northeast to be differentially impacted. As expected, Panel (iv) displays a clear increase in non-white maternal mortality in the Northeast relative to white maternal mortality in the Northeast and both races elsewhere in the country. Because the fertility effects for non-white women are mainly contained to the Northeast, comparing non-white women to the non-white and white women in the remainder of the U.S. aligns with this observed heterogeneity. However, this increase in non-white maternal mortality is temporary, with an initial jump in non-white maternal mortality in the Northeast over 1977-1978 that disappears by 1979.

Panels (vi)-(viii) consider other state-level heterogeneity based on where the fertility effects are clearest. These three panels show that Non-white maternal mortality temporarily increases after the Hyde Amendment. The increase in non-white maternal mortality is especially noticeable in states with high Medicaid eligibility (Panel vi) and in states that fund a large portion of abortions under Medicaid (Panel viii). Both of these effects reflect the clearer increase in fertility in states with more demand for Medicaid abortions and more funding for abortions under Medicaid.

Overall, the increase in maternal mortality that appears for non-white women over the first two years of the Hyde Amendment disappears before 1980. The increase in maternal mortality is most noticeable in areas with larger increases in fertility, indicating that the increase in maternal mortality is likely from more births being carried to term rather than an increase in abortion deaths. A potential explanation for the increase in maternal deaths and subsequent decline is a gradual increase in access to abortions for non-white women over time. Alternative sources of financing of abortions may have taken time to operate and disseminate. Services such as private donations and low-cost abortions through public hospitals may have become more readily available as time went on. The temporary increase in non-white maternal mortality is also consistent with the temporary increase in non-white births reported in Section 3.8 and Figure B.10.

4.2 Maternal Morbidity

NHDS Data. Next, we consider maternal morbidity in the National Hospital Discharge Survey Series (NHDS). The NHDS is based on administrative hospital records and provides discharge-level information. The data is based on a national sample and is a representative sample of non-federal, short-stay hospitals. The dataset includes information on the ICD codes associated with the hospital stay, as well as other information on the individual's age, race, marital status, and the expected payer for the years 1977 onwards. In our analysis, we focus on comparisons by race but also make comparisons by payer status in additional results.

Using the NHDS data, we consider whether abortion complications rise after the Hyde Amendment for non-white women, similar to the maternal mortality results. In this analysis, we take each hospitalization for delivery and pregnancy. We consider whether hospitalizations for abortion complications rise relative to all observed hospitalizations for pregnancy and delivery.[27] As with maternal mortality, there was a transition in ICD codes during the study window, from 1978 to 1979, which somewhat limits our analysis of general pregnancy and delivery complications.[28]

Empirical Strategy. We revise Equation 2 to include region-by-year rather than state-by-year fixed effects because only region is available in the NHDS data. We show the results for all non-white relative to white women, as well as the sample of unmarried non-white women relative to unmarried white women. Unmarried non-white women are more likely to be receiving Medicaid than the full non-white sample. In 1977, 43% of abortions to single non-white women were paid for by Medicaid, while only 24% of non-single non-white abortions were paid for by Medicaid (NHDS, 1972-1981).

In the analysis, we collapse the main individual-level data to the race, region, age, and year level. In the main specifications using a Poisson model, the outcome is the count of abortion complications, and the exposure is the sum of the individual weights from the NHDS. In the appendix, we take the rate of complications per 1,000

[27] However, in additional results, we consider whether abortion complications rise as a share of all hospitalizations for females aged 15-44. Abortion-related complications are the most consistent across the study period due to a change in the ICD codes in 1979. When we consider pregnancy complications only take unified complications, including all abortion/miscarriage/ectopic pregnancy complications, preeclampsia, infections of the genital tract, and antepartum hemorrhages. The summary statistics for the NHDS data split by white versus non-white are in Table A.4.

[28] We have to select causes that are consistent across ICD codes. For abortion complications, we calculate three different categories. First, we use the standard abortion complication as classified by the ICD codes as shown in Panel B of Table A.2. Second, we include all possible abortion complications, including the standard abortion complications (Panel B of Table A.2), ectopic pregnancies (631 in ICD-8 and 630, 631, and 633 in ICD-9), and missed abortions (634.2 in ICD-8 and 632 in ICD-9). This expanded version of abortion complications captures potential abortion complications that are not formally categorized as an abortion. If providers adjusted the cause of complications to obtain reimbursement, this expanded definition would capture these other potential causes. Third, we select the standard set of abortion complications but exclude miscarriage or spontaneous abortion, or ICD 643 in ICD-8 and ICD 634 in ICD-9. However, these three definitions generally produce similar results, and we focus on the standard abortion complications in the main text.

deliveries for the log of the abortion complication rate. We include fixed effects at the collapsed data level. Confidence intervals from robust standard errors are reported in the event-study figures.

Results: Abortion Morbidity Rises for Non-white Women. Figure VIII Panel A shows the increase in abortion complications after the Hyde Amendment for non-white women relative to their white counterparts. The plotted points display an increase in hospitalizations for non-white abortion complications relative to white abortion complications. The increase in hospitalizations represents a rise in non-white abortion complications by 16% relative to white abortion complications. This rise in non-white abortion complications begins in 1978 and continues to be elevated at the end of the sample.

Panel B subsets to the sample of single women. We present results for this group of women because they are more likely to be on Medicaid and, indeed, there is a clearer increase in non-white hospitalizations for abortion complications. From 1978- 1982, out of all the single woman patients in the NHDS dataset, 82-87 %. are on Medicaid, while the corresponding share of married women is 0.07 %. Abortion complications increase by over 30% in this sample of unmarried women. Overall, there is a clear increase in abortion hospitalizations for non-white relative to white women after the Hyde Amendment, being the effects stronger among those more likely to be receiving Medicaid–unmarried women.

In Section D.1, we also show the rise in abortion complications for non-white women in several alternative specifications. The results consistently show an increase in non-white hospitalization for abortion complications after the Hyde Amendment. We also confirm that hospitalizations for abortions rise in the sample of patients with public insurance relative to private insurance. Though we see little evidence of delivery or postpartum complications increasing, we do see an increase in select pregnancy complications. From the mortality and morbidity results, the Hyde Amendment appears to disproportionately impact non-white women and increase racial disparities in maternal health. Overall, non-white maternal mortality and abortion hospitalizations increase following the removal of federal public funds for abortion. See Section D.1 for further details on these results.

4.3 Other Health Effects

For completeness, we also consider other health effects of the Hyde Amendment in Figures E.1 (infant mortality), E.2 (birth weight/gestation), and E.3 (prenatal care). We anticipate that abortion funding restrictions could affect infant health because re-

lated work has shown that general abortion restrictions impact infant health (Gardner, 2022), especially racial disparities in infant health.

First, we return to our main county-level specification and consider infant and neonatal mortality. Figure E.1 presents the impact of the Hyde Amendment on the log of the infant or neonatal mortality rate per 1,000 births, displaying little change in infant or neonatal mortality after the Hyde Amendment.

Second, we also consider available outcomes from the birth certificate data in Figures E.2 and E.3. In these results, we use our county-level specification from Equation 1 and, as in the main sample, focus on births to women ages 18-29. In Figure E.2, the only clearly noticeable health effect is a small reduction in birth weight. This figure also shows some evidence that low birth weight (<2,500 grams) and low-normal birth weight deliveries (2,500-3,249 grams) increase at least temporarily after the Hyde Amendment. There is also a reduction in the birth weight of high-normal birth weight deliveries (3,250-4,000 grams) after the Hyde Amendment. Despite the adjustment in birth weight, there is little change in newborn gestation or prenatal care. However, birth weight is potentially more objective and reliable than either prenatal care receipt or gestation.

5 Welfare Receipt, Employment, and Income

Empirical Strategy. Finally, we speculatively consider whether the Hyde Amendment forces more women to claim welfare using the *Current Population Survey* (CPS) data (*IPUMS CPS*, 1973-1981). We view these results as descriptive or speculative rather than definitive because, during the study timeframe, smaller states are grouped together and reported by census division. The lack of state-level information for many U.S. states is a similar limitation to the NHDS data, where we consider the effects by race with region-by-year fixed effects.[29]

When we consider economic outcomes, we proceed similarly to the analysis with the NHDS. We collapse the CPS data to the census division, age, and year level. In the main text, we consider the effect of the Hyde Amendment on non-white women, and for this analysis, the data are also collapsed to the level of race (white and non-white). In the appendix, though, we also consider the effects of the Hyde Amendment on unmarried versus married women, collapsing the data additionally by marital status (unmarried vs. married). While in the main analysis we consider nonwhite versus white women, the results are largely similar with unmarried versus married women.

[29] A difference in the CPS data (from the NHDS) is that large states are available in the CPS. We therefore exclude the large states available from the analysis, California and Pennsylvania, to more closely correspond to our fertility results.

Figure F.1 reveals that both single and non-white women are more likely to be receiving welfare and thus be eligible for Medicaid. 18% of reproductive-age non-white women receive welfare payments, while only 4% of white reproductive-age women receive welfare payments. For unmarried non-white women, 24% receive welfare, while only 3% of white women do.[30]

We perform the event-study analysis in a way that is similar to the results with the NHDS. In the main results, we include fixed effects for the census division, year, age, and non-white/white. We show the results with and without the census-division-by-year fixed effects. Here, the reported region is more granular than with the NHDS because we have nine census divisions, not just the four census regions.

Results: More Unmarried and Non-white Women Receive Welfare After the Hyde Amendment. Figure IX presents the impact of the Hyde Amendment on non-white versus white welfare receipt, income, and employment. The plotted points show the change in each outcome post-1977 in non-white relative to white women (ages 18-29). Figure IX shows an increase in welfare receipt, a decline in income, and a decline in employment for non-white relative to white women (18-29).

Figure F.2 displays similar findings if we consider unmarried versus married women or single non-white women versus single white women. Figure F.2 shows an increase in participation in the welfare program, a decline in income, and a decline in employment. With the increase in welfare receipt, there is a rise in welfare income, but it is not large enough to compensate for the income reduction that comes from lower participation in the labor force (see Figure F.3). This figure reveals a decline in employment and income that is specific to welfare versus non-welfare recipients (after 1976).

These speculative results indicate that the Hyde Amendment may have worsened economic outcomes in non-white relative to white women, unmarried versus married women, and welfare recipients versus non-welfare recipients. We would expect the Hyde Amendment to affect these economic outcomes, including income, employment, and welfare receipt, for a few reasons. First, as shown in the main results, the abortion funding restrictions increase unplanned pregnancies carried to term, especially among low-income unmarried women and non-white women in the short run. These low-income women facing unintended pregnancies will be forced to turn to welfare programs for financial assistance (to begin with). Further, women who already are receiving AFDC/welfare may have additional children, perpetuating their participation in public programs. Second, having children, regardless of welfare receipt, will reduce women's ability to obtain employment. Even women working may be forced to

[30] In all samples, we select those ages 18-29 to correspond with our fertility results. In the unmarried versus married results, we only include those who are single and married.

reduce their intensive margin labor supply due to the presence of additional children. The abortion restrictions will most impact women with fewer financial resources, who will be forced to rely on public support in the absence of public funding for abortion. For example, evidence from the Turnaway Study indicates that women who were denied an abortion due to gestational age limits were less likely to be employed and receive public assistance even four years after the abortion denial relative to their counterparts who obtained an abortion (Foster et al., 2022).

6 Conclusion

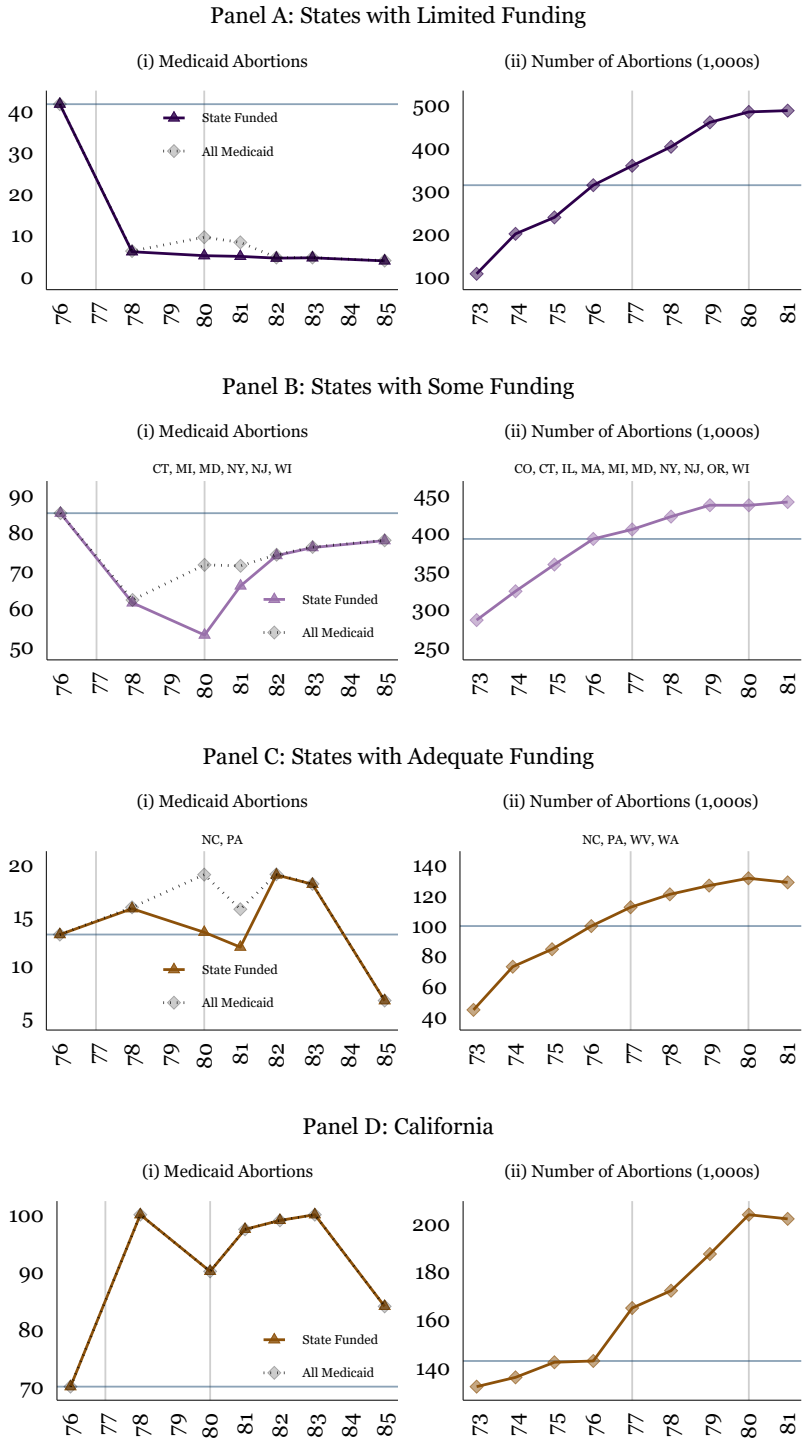
In this paper, we show that the Hyde Amendment raised fertility and detrimentally impacted non-white women's outcomes. Our analysis reveals that counties with high (relative to low) Medicaid eligibility experienced an increase in fertility by 2% following the Hyde Amendment. We also find worsening racial disparities in health and economic outcomes for non-white women after the Hyde Amendment. Non-white women experience a higher risk of hospitalizations due to abortion complications, a temporary increase in maternal mortality, and a higher likelihood of receiving welfare relative to their white counterparts.

These findings indicate that funding restrictions not only constrain access to necessary reproductive healthcare but also serve as a critical determinant of fertility rates, overall health, and economic outcomes. The results underscore the critical influence of abortion funding on health and economic well-being and show that federal funding restrictions primarily affect disadvantaged groups: individuals living in poverty (measured by AFDC receipt) and non-white women.

The importance of public abortion funding for non-white women aligns with other findings in the literature showing that non-white women are more impacted by abortion restrictions than white women (Gardner, 2022; Farin et al., 2024; Jones and Pineda-Torres, 2024). The present analysis underscores how federal funding restrictions adversely affect the health outcomes of Black women. The ramifications of the Hyde Amendment persist today in the United States. These federal funding restrictions continue to shape health and reproductive outcomes for the millions of women eligible for the Medicaid program and other federal health plans. The persistent effects of abortion restrictions have the potential to add to existing racial disparities in health. Today, in the U.S., non-Hispanic black women suffer three times the maternal mortality of white women (Carroll, 2017; Artiga et al., 2020). Our analysis shows that abortion funding restrictions should be considered as a potential factor in explaining such health disparities.

7 Figures

Figure I: State Medicaid Funding for Abortion, Number of Medicaid Abortions, and Number of Total Abortions



SOURCES: Lincoln et al. (1977), Gold (1980), Gold (1982), Nestor and Gold (1984), Gold and Nestor (1985), Gold and Macias (1986), Abortion data from the CDC Abortion Surveillance Program. This data is only available by state. .

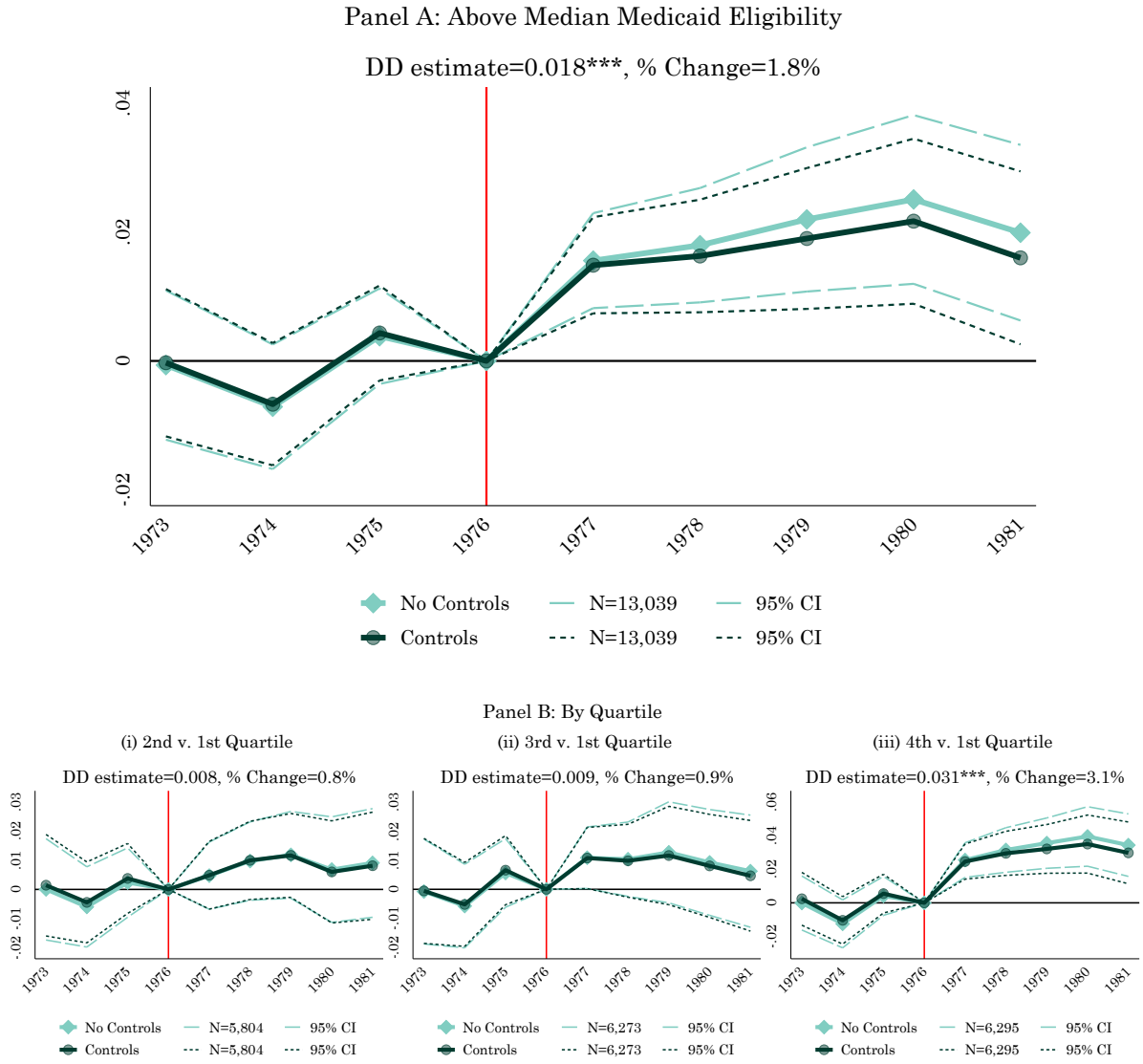
NOTES: The left side of the graph shows the number of Medicaid abortions in 1,000s, both the total Medicaid abortions (federal + state funded abortions, gray diamonds) and state-funded abortions (colored triangle/solid line). In the right panel (i), only states with a balanced panel are reported. Thus, the sum of the panels of Medicaid abortions will not necessarily reflect the total number of *national* Medicaid abortions due to missing state information. The right side of the graph, panel (ii), shows all abortions in 1,000s. See Figure A.2 and Figure A.3 for the individual state-level graphs. Panel A shows states with only limited funding for Medicaid abortions. Note that the states reported in (i) of Panel A are not the complete set of states reported in (ii). Only certain states have complete Medicaid funding available in the right panel, which is more apparent in the state-by-state results (Figure A.2). Panel B shows states with limited, but available, funding for Medicaid abortions. Panel C shows states with adequate funding for abortion (a similar level of Medicaid funded abortions after the Hyde Amendment). Panel D shows California separately because it is an outlier for the number of Medicaid-funded abortions performed after the Hyde Amendment. The horizonal blue line shows the starting number of Medicaid abortion.

Figure II: Characteristics of Abortions



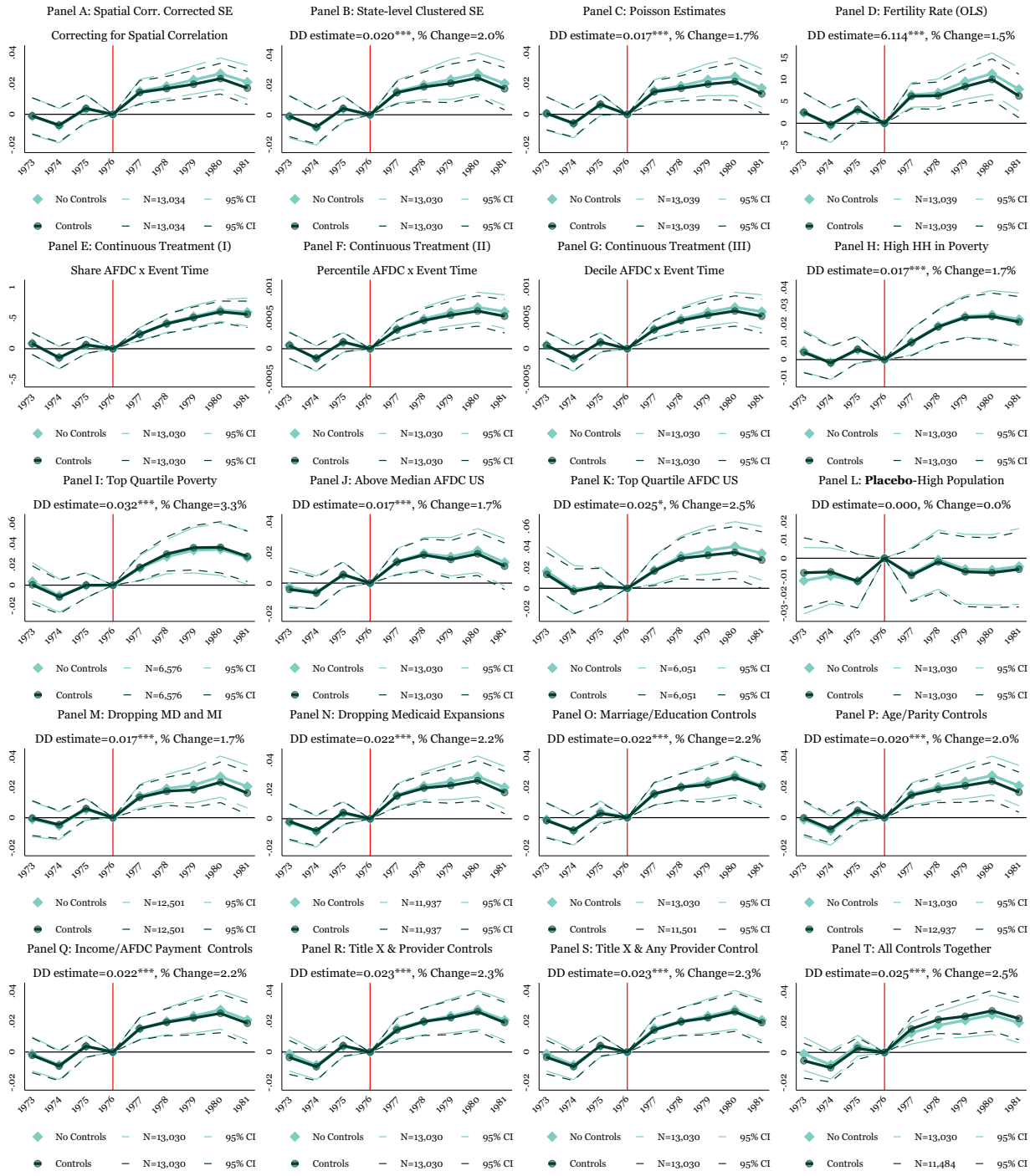
SOURCES: Abortion data from the CDC Abortion Surveillance Program. This data is only available by state.
NOTES: Graphs only include the 42 states in our main sample. For all panels except the top left, graphs show the balanced panel of states. The top-left graph includes all 42 states in the main sample because the data for the total number of abortions is well reported. Data for suction and sharp curettage missing between 1977 and 1980, but this data is available before 1977 and in 1981.

Figure III: The Hyde Amendment and High Medicaid Eligibility Counties: Fertility for Young Adult Women (18-29)



SOURCES: Vital Statistics Natality Birth Data (Birth Certificate Records) from the National Vital Statistics System of the National Center for Health Statistics. SEER Population data used for the controls and the population counts. Medicaid eligibility determined by the share of the population in the county receiving AFDC in 1976 (Haines, 2010).
NOTES: Displays OLS coefficients. The outcome is the log of the fertility rate. The fertility rate is the number of births to women 18-29 per 1,000 women 18 to 29. Regressions are weighted by the denominator of the rate. Baseline fixed effects include county fixed effects, state-by-year fixed effects, quartile of the share urban-by-year fixed effects, and quartile of the population-size-by-year fixed effects. Plotted coefficients are dummy variables on each year before and after the Hyde amendment went into effect (see Equation 1). The period just before the legal change is the excluded period (1976)–indicated by the vertical line. Dashed and dotted lines reflect 95% confidence intervals. Robust standard errors clustered at the county level. The main binary variable represents the effect of funding restrictions on abortion from the Hyde Amendment in counties with high Medicaid eligibility. Our main set of controls includes the share white, the share of other race, and the share female. The main sample includes 42 states. Throughout our analysis, we omit AZ because the state Medicaid program only began in 1982 (McCall, 1996). We also do not include CA, WA, WV, NC, or PA because of high funding for abortions after the Hyde Amendment (see Figure I) Data for AK and HI are incomplete and excluded. Medicaid eligibility based on the county-level share of AFDC receipt in 1976, with high eligibility calculated within state. In Panel A, high receipt is above median AFDC recipients, and low receipt is below the median of the share AFDC recipients. In Panel B low receipt is in the 1st quartile of the share AFDC recipients. All other quartiles in Panel B are removed from the sample except the 1st and the noted quartile.

Figure IV: Robustness Checks on Figure III



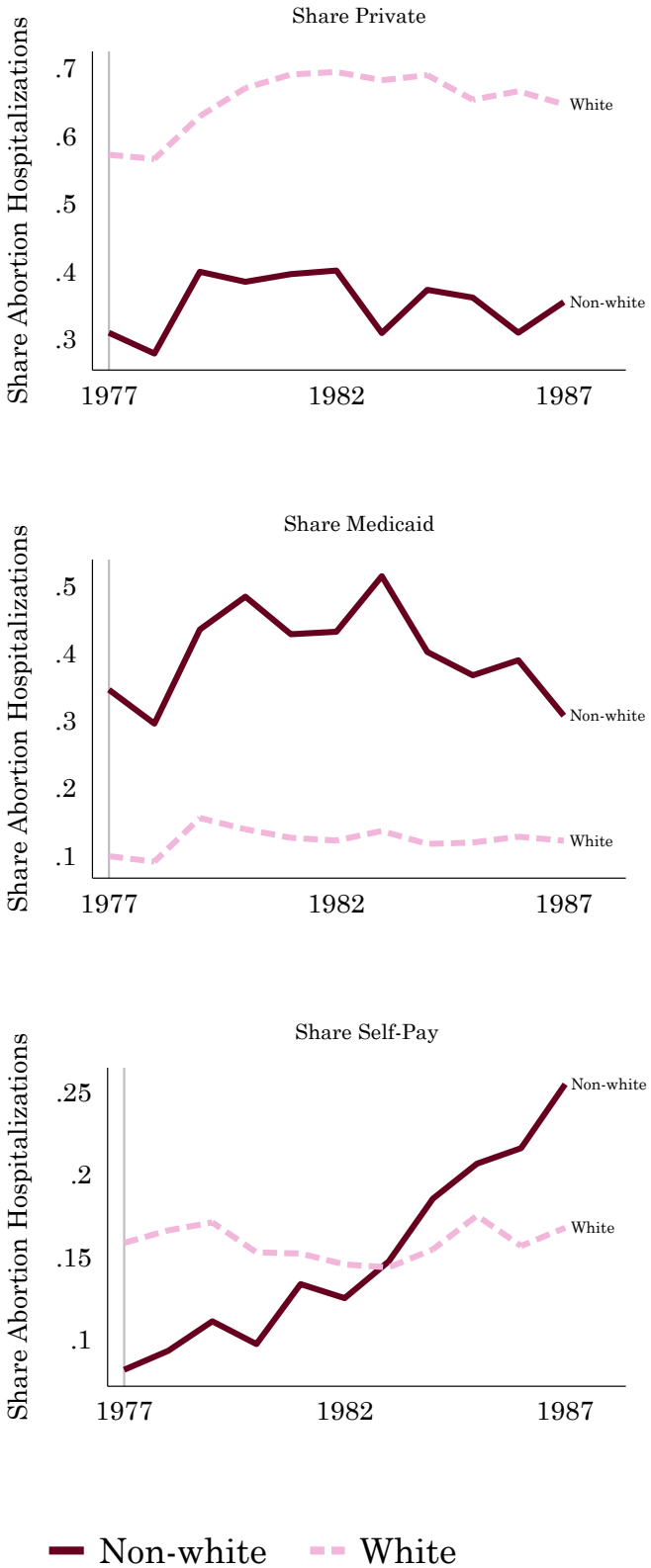
NOTES: Represents county-level specification from Figure III, except with the following modifications. Panel A adjusts the standard errors for spatial and serial correlation using the method described in Hsiang (2010) and with the Stata wrapper from Forouzandeh (2024) (used in Baum-Snow and Han (2024)). Panel B clusters the standard errors at the state level. Panel C shows the Poisson estimates, where the outcome is the number of births to women aged 18-29, and the exposure is the number of young adult women (18-29) in each county. Panel D shows the OLS coefficients with the fertility rate as the outcome and the regressions weighted by the population of women 18-29 in each county. Panels E-G interact the continuous measures of eligibility with event-study indicators. Panel E uses the county-level share receiving AFDC, Panel F uses the percentile of AFDC receipt (nationally), and Panel G uses the decile of eligibility (within state). Panels H-I use the share of county-level households living in poverty, replacing the share of the population receiving AFDC as our measure of Medicaid eligibility. Panels J-K use the above-median and top quartile of AFDC for all U.S. households (rather than within state). Panel L replaces our measure of high Medicaid eligibility with a high population count (above the state-level median), a placebo test for whether large cities drive the results. Panel M, we remove MD and MI, two states that had arguably the most funding for abortions under Medicaid following the Hyde Amendment. Panel N omits states that expanded Medicaid eligibility before 1982, based on East et al. (2023). Panel O adds controls for the share of married deliveries and the share of deliveries with a high school and college education. Panel P adds controls for the share of first deliveries, the total birth order, and the share of delivered to each age group, 20-24 and 25-29 (omitting 18-19). Panel Q adds controls for the quartile of median income interacted with year-fixed effects (across the US), and the quartile of average AFDC payment across the US interacted with year-fixed effects. Panel R controls for the number of abortion providers per reproductive age female at the county level from Bailey et al. (2012). Panel R also controls for whether the county had a Title X program interacted with year-fixed effects, with Title X programs from Bailey et al. (2012). Panel S controls for the same Title X program and whether the county has any abortion provider. Panel T controls for all these controls together.

Figure V: The Hyde Amendment in High Medicaid Eligibility Counties: Fertility for Young Adult Women By Race/Region



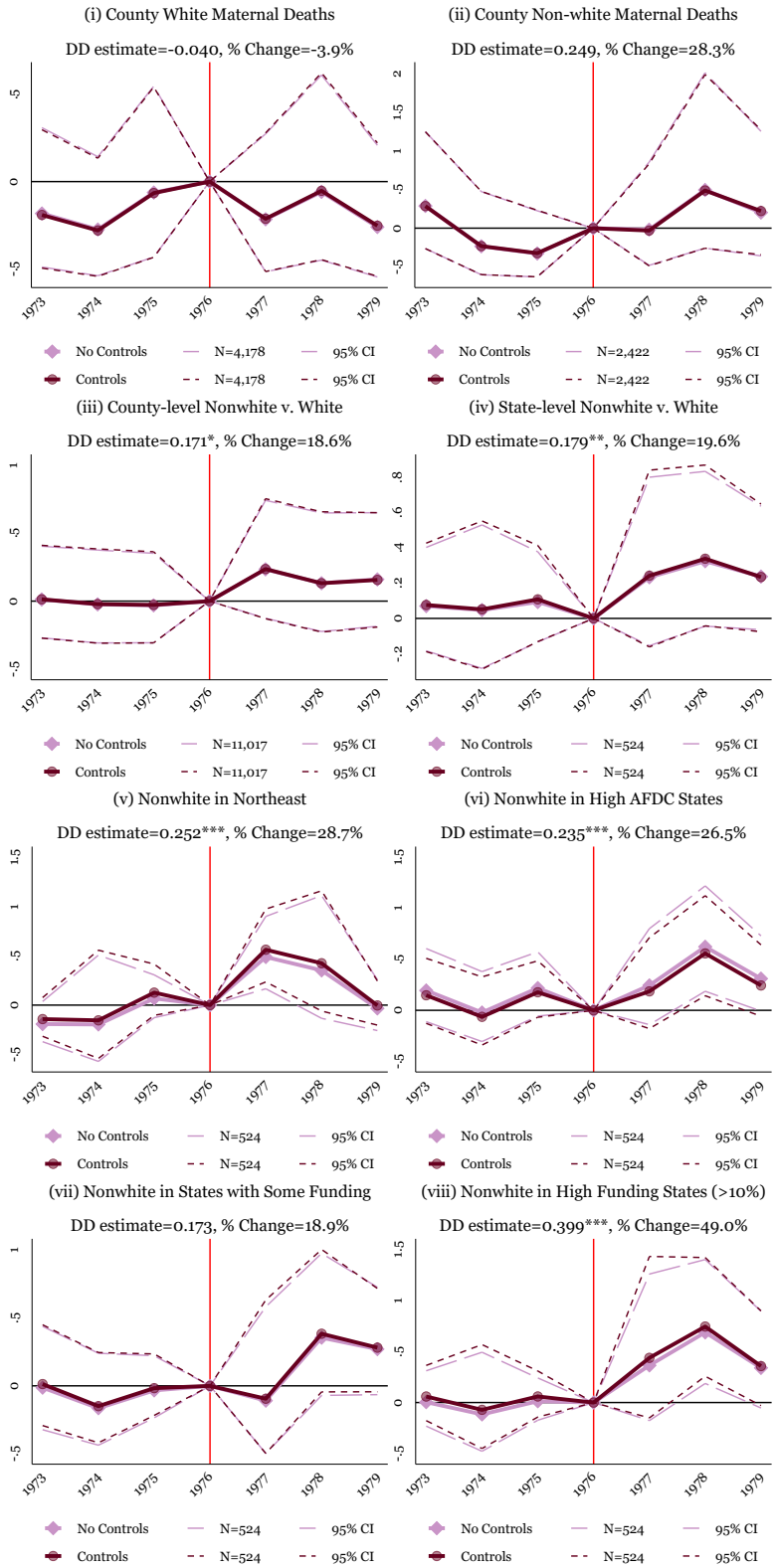
NOTES: Represents county-level specification from Figure III, except breaking out fertility by race and by region.

Figure VI: NHDS Abortion Complications – Share Race by Payer



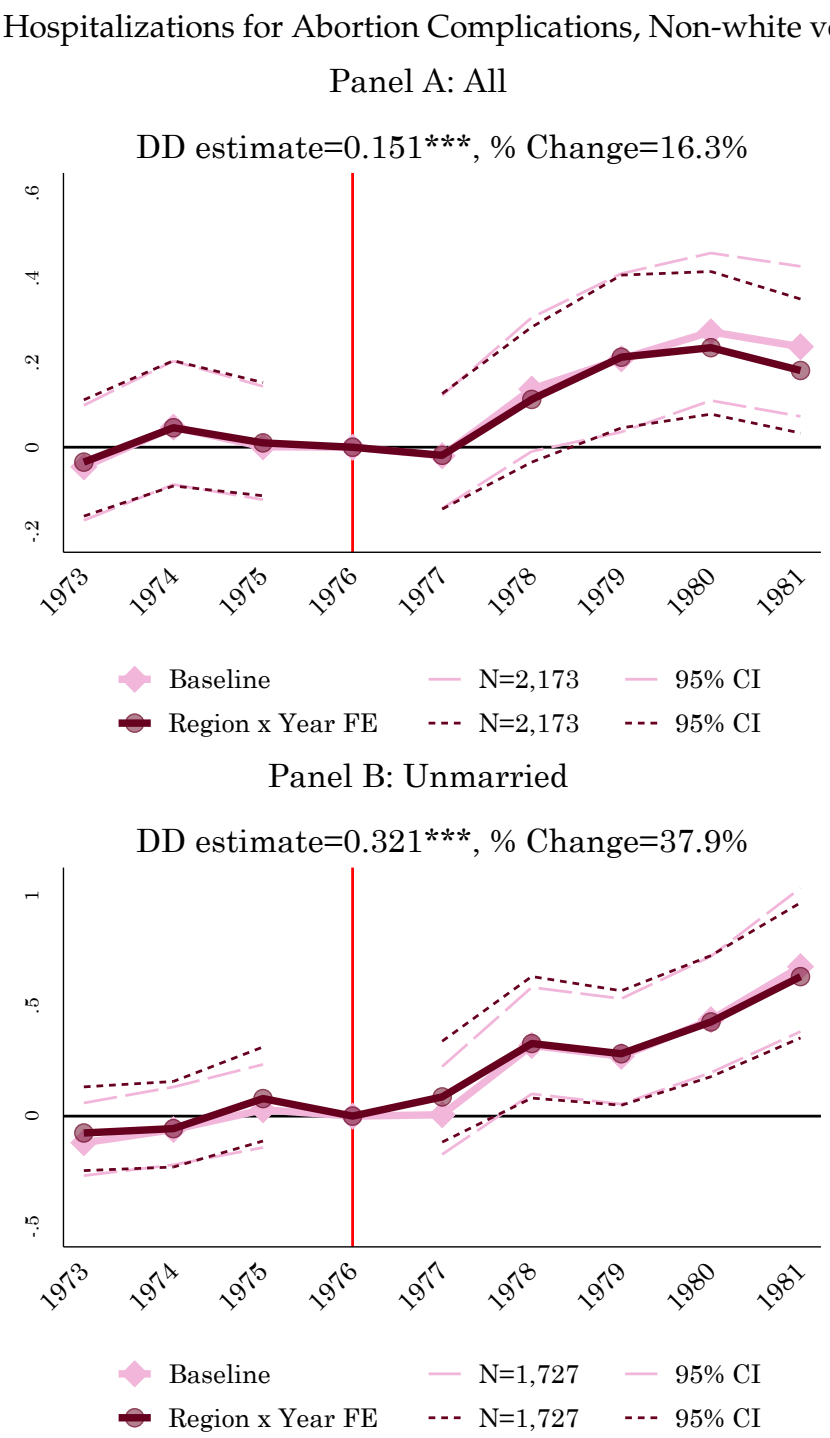
SOURCE: National Hospital Discharge Survey (NHDS) Files.

Figure VII: Maternal Mortality



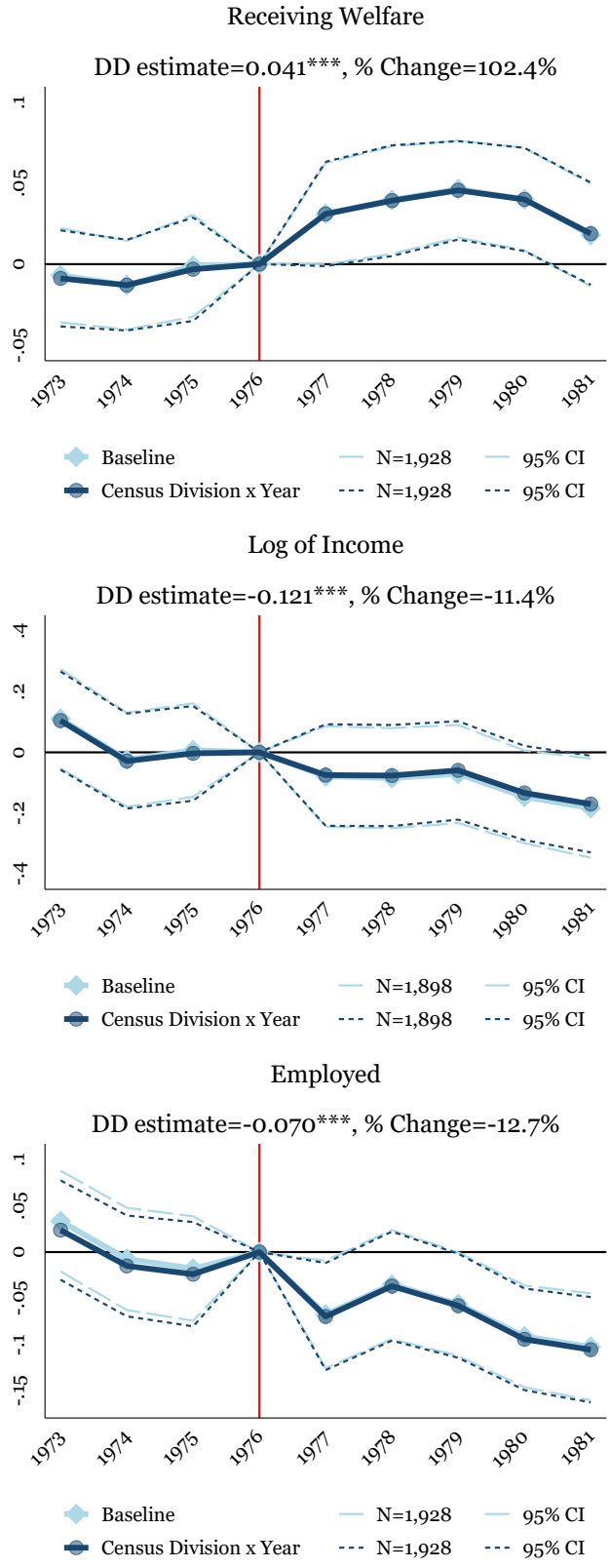
SOURCES: NCHS/NVSS/CDC Multiple Cause of Death Files. Vital Statistics Natality Birth Data (Birth Certificate Records) from the National Vital Statistics System of the National Center for Health Statistics. SEER Population data used for the controls and the population counts.
NOTES: First three panels (i)-(iii) show the county-level specification from Equation 1 except displays Poisson estimates. Here, the outcome is maternal deaths (white and non-white separately), and the exposure is the relevant reproductive age population of women (white and non-white separately considered). Only state-by-year fixed effects and county-level fixed included. Urban-by-year and county-population-by-year fixed effects excluded because of low number of the observations. In Panel (iii), race-fixed effects included. Standard errors clustered at the county level.
Subsequent panels (iv)-(viii) represent a state-level specification comparing non-white to white outcomes from Equation 2. State-by-year fixed effects and race-fixed effects are included. Standard errors clustered at the state level. Panel (iv) panel shows non-white maternal mortality relative to white maternal mortality at the state level. The remainder of the panels show the effect of the Hyde Amendment on non-white mortality across the noted state-level policies. Non-white in the Northeast compared non-white mortality to white maternal mortality in the Northeast, and both groups for the remainder of the states. Non-white in high share AFDC states compares non-white mortality in high eligibility states relative to white maternal mortality and non-white maternal mortality in low eligibility states. Panel (vii) compares non-white mortality in states with funding available, and Panel (viii) compared non-white mortality in states with h a high funding rate for Medicaid abortions, or more than 10% of state-level abortions funded by Medicaid.

Figure VIII: Hospitalizations for Abortion Complications, Non-white versus White



SOURCE: National Hospital Discharge Survey (NHDS) Files.
NOTES: Compares non-white and white hospitalizations for abortion complications before and after the Hyde Amendment. Represents estimates from a Poisson specification as outlined in Equation 2. The outcome is the hospitalizations for abortion complications per delivery as the exposure. Data are collapsed to the region, age, and race level. The exposure is the sample weight assigned by the NHDS summed over the collapsed sample of deliveries (see Figure D.6 for per female graphs). Fixed effects include age, region-by-year, and indicators for white. Robust standard errors are calculated to compute confidence intervals. Poisson coefficients are reported in the solid plotted points. Dashed lines represent 95% confidence intervals. The graph includes all ages, but women 18-29 are shown in Figure D.6. An ICD change occurred between 1978 and 1979. See table A.2 for the abortion complication ICD codes.

Figure IX: Income and Labor Supply, Non-white versus White Women 18-29



SOURCE: *IPUMS CPS* (1973-1981)
NOTES: CPS data collapsed to the region (census division), age, race, and year level. Considers the impact of the Hyde Amendment on noted outcomes for non-white versus white women. However, we also show the findings for unmarried versus married women in Figure F.2. Only includes women ages 18-29 to correspond with fertility results. California and Pennsylvania. Fixed effects for the region (i.e. census division), year, age, race included. Census division-by-year fixed effects included where noted. Robust standard errors are calculated to compute confidence intervals. See also outcomes in Figure F.3.

8 Tables

Table 1: State Medicaid Abortion Characteristics

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
State	Medicaid Abortion Rate 1976	Non-Medicaid Abortion Rate 1976	Average Abortion Cost 1976	Average AFDC Payment 1976	Medicaid Abortions 1976	State Funded Abortions 1978	State Funded Abortions 1980	State Funded Abortions 1981	State Funding for Abortion 1976	State Funding for Abortion 1978	State Funding for Abortion 1980	State Funding for Abortion 1981
CA	100	24	307	135	70000	100000	90108	97437	24412	32237	33880	36636
NY	85	35	289	140	50000	41326	37500	37500	7875	5600	5300	5300
MI	52	16	218	300	14800	13700	6750	19400	2432	2568	2079	5452
PA	39	17	415	260	10000	14535	7596	6125	1913	3566	1949	1142
MA	21	28	280	175	5100		0	6934	1105	1680	0	1029
MD	56	21	274	193	5000	6009	5179	2766	1675	1326	1231	885
DC	190	171	460	207	7400	5782	4921	4753	1420	1382	935	959
NC	29	15	309	363	3100	1123	5730	5730	1110	223	1230	1230
NJ	52	17	321	217	10000	0	421	5399	3500	0	105	979
IL	60	19	400	256	18300	4400			2667	666		
WA	37	27	253	191	2700		3840	3326	640		749	896
CO	77	20	379	297	2800	404	2125	823	110	90	475	177
HI	56	27	214	97	1200	1406	2100	2100	212	605	1	1
OR	43	25	169	203	2000	1191			547	481		
WI	34	11	460	196	2500	29	997	45	250	3	184	12
KS	82	24	310	247	3700	904			300	242		
WV	13	1	223	252	300	459	325		92	138	84	
AK	74	16	310	113	300	312			18	174		
NM	41	17	280	263	900	109	0	0	165	25	0	0
VA	65	15	181	255	5200	0	21	19	463	0	6	7
DE	30	17	409	266	400	2	0	0	44		0	0
AL	20	7	280	238	1300	0	0	1	339	0	0	
LA		9	199	171		0	0	0		0	0	0
KY	7	12	379	229	900	0	0	0	197	0	0	0
SD		11	226	85		0	0	0		0	0	0
NV	60	25	202	210	400	0	0	0	200	0	0	0
FL	16	28	239	242	1600	0	0	0	229	0	0	0
OK	14	12	202	195	700	0			59	0		
WY	28	5	241	296	100	0	0	0	13	0	0	0
RI	30	16	298	283	1000	0	0	0	96	0	0	0
GA	30	21	211	139	3700	0	0	0	949	0	0	0
NE	16	14	383	173	300	0			12	0		
VT	32	21	184	246	300	0	0	0	180	0	0	0
ME	17	7	160	119	500	0	0	0	212	0	0	0
TX	91	16	196	104	13300	0	0	0	3500	0	0	0
ND		10	331	154		0	0	0		0	0	0
MT	46	5	167	137	700	0	0	0	210	0	0	0
MS		1	278	266		0	0	0		0	0	0
TN	15	22	160	205	1200	0	0	0	275	0	0	0
AR	11	6	207	141	500	0	0	0	61	0	0	0
ID		7	430	363		0	0	0		0	0	0
MO	25	10	460	48	2400	0	0	0	180	0	0	0
IN		7	225	269		0	0	0		0	0	0
OH	46	16	160	256	10000	0			2000	0		
NH	18	12	250	157	200	0	0	0	31	0	0	0
UT	18	8	208	104	300	0	0	0	25	0	0	0
MN	22	14	232	296	1300	0			216	0		
CT	37	17	301	205	2000	0			428	0		
SC	25	8	448	263	1400	0	0	0	249	0	0	0
AZ		16	293	297								
IA	25	10	244	168	1000				297	185		14

SOURCE: Lincoln et al. (1977) Gold (1980), Gold (1982).

Table 2: Heterogeneity: Interactions of Above-Median AFDC Receipt x State and Individual Characteristics

	Characteristics		Demand			Cost		Funding	
	(1) Un-Married	(2) # Birth	(3) High State Share AFDC	(4) High Medicaid Abortions	(5) High Rate Medicaid Abortions	(6) High Cost of Abortion	(7) High Ratio Cost to AFDC	(8) State Funds >10% Abortions	(9) State Funding Abortion
1(High Eligibility)=1	-0.1869***	-0.0312**	-0.0005	0.0011	0.0143**	0.0101	0.0134**	0.0082	0.0057
	(0.0571)	(0.0124)	(0.0099)	(0.0075)	(0.0067)	(0.0079)	(0.0062)	(0.0057)	(0.0066)
1(High Eligibility)=1 × 1(Unmarried)=1	0.5156***								
	(0.0767)								
1(High Eligibility)=1 × 1(Subsequent Birth)=1		0.0940***							
		(0.0189)							
1(High Eligibility)=1 × 1(High State Share AFDC)=1			0.0281**						
			(0.0119)						
1(High Eligibility)=1 × 1(High Medicaid Abortions)=1				0.0211**					
				(0.0106)					
1(High Eligibility)=1 × 1(High Rate Medicaid Abortions)=1					0.0055				
					(0.0114)				
1(High Eligibility)=1 × 1(High Cost of An Abortion)=1						0.0177			
						(0.0112)			
1(High Eligibility)=1 × 1(High Cost-to-AFDC Payment)=1							0.0082		
							(0.0108)		
1(High Eligibility)=1 × 1(State Funds >10% Abortions)=1								0.0337**	
								(0.0142)	
1(High Eligibility)=1 × 1(Any State Funding Abortion)=1									0.0281**
									(0.0115)
N	23,145	25,888	13,039	11,323	11,323	13,039	13,039	12,867	12,867
Adjusted R-squared	0.957	0.926	0.963	0.964	0.964	0.963	0.963	0.963	0.963
F-stat from Joint F-test	22.703	13.293	8.430	4.444	4.442	6.658	5.441	6.357	6.937
P-value from Joint F-test	0.000	0.000	0.000	0.012	0.012	0.001	0.004	0.002	0.001
Coutny FE and State x Year FE	X	X	X	X	X	X	X	X	X
Controls	X	X	X	X	X	X	X	X	X

NOTES: Reflects grouped post-period from Figure III, except interacting high Medicaid eligibility with various factors. High eligibility is measured with above-median share of the county-level population receiving AFDC. In Column (1), we interact high Medicaid eligibility with marital status, focusing on births to unmarried women. The coefficient on the interaction term will be relative to married births. We also include marital-status-by-year fixed effects. In Column (2), we interact high Medicaid eligibility with subsequent/non-first births. The coefficient on the interaction term will be relative to first births. In this specification, we include nulliparous x year FE. Columns (3)-(9) interact state-level demand, cost, and reliability with the indicator for high Medicaid eligibility. These state-level policies are time-invariant. See also the event studies in Figures B.3 and B.4. For the specific state-level policies, see Table A.1.

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Online Appendix

A Background

Figure A.1: Newspaper Excerpts on Hyde Amendment

Newspapers by ancestry
https://www.newspapers.com/image/191298781/

The Minneapolis Star (Minneapolis, Minnesota) · Fri, 22 Oct 1976 · Page 7
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Fri., Oct. 22, 1976 THE MINNEAPOLIS STAR 7A

U.S. abortion-funds ban to be challenged

By GWENYTH JONES
Minneapolis Star Staff Writer

A lawsuit challenging a recently signed law prohibits the use of federal funds for most abortions was to be filed early today in the U.S. District Court in St. Paul.

The suit is one of four being filed in different parts of the country charging that the so-called "Hyde Amendment" is unconstitutional.

IT IS a class action on behalf of "Jane Doe" and all other women who need abortions but won't be able to get them, and Dr. Patricia Maitland and all doctors who have been performing abortions paid for by federal medicaid assistance funds.

Also a plaintiff is the Midwest Health Center for Women, 825 S. 8th St., Minneapolis, where about 30 abortions have been performed monthly on patients eligible for medicaid assistance.

F. David Mathews, secretary of Health, Education and Welfare, is the defendant.

The suit alleges that the Hyde Amendment unconstitutionally discriminates against poor women who need abortions and those women who can afford to pay for them, and between poor women needing abortions and those for whom Medical Assistance patients of the right to practice medicine according to their best medical judgment, free of income from abortion services.

IT asks the court to declare the Hyde Amendment unconstitutional and to order the Health Education and Welfare Department (HEW) to continue to pay federal matching funds for abortions.

The Hyde Amendment was tacked on to a massive spending bill for HEW and the Labor Department, which President Ford vetoed as inflationary. Congress overrode the veto.

NCAA

Continued from Page 1A

not done anything to warrant ineligibility, Magrath said.

"Due process hearings under the circumstances are nothing short of sham," he said, "both for students and the universities they attend."

The NCAA announcement yesterday climaxed a lengthy appeal procedure regarding the eligibility of Thompson, Saunders and Wiley.

The ACIA, a Twin Cities organization made up of university faculty members, has been active for ruling on university eligibility questions. It ruled last spring that the three players should remain eligible.

But the NCAA had told the university that the players would have to be ruled ineligible. However, the university recognizes the ACIA's authority to rule on eligibility, because it is a member of the Big Ten Conference.

Thompson's eligibility was challenged after he told university officials he had sold a pair of basketball season tickets in 1974 for $25. Wiley was declared ineligible because he allegedly spent a holiday weekend with a school alumnus in 1974. Saunders violated NCAA rules because he allegedly had free use of an assistant coach's mother-in-law's car and played in a summer league in Musselshell summer basketball camp.

The NCAA accuses the university of allowing the three players to play in seven remaining games last season after being notified of the NCAA's ineligibility ruling before replying in a court order for a hearing.

After meetings with NCAA officials last December, the university declared Thompson ineligible, but not Saunders or Wiley.

Wiley's and Saunders' ineligibility was made to the NCAA but he was suspended for the rest of the season. Thompson successfully won an injunction against the suspension and played the rest of the season.

Two brothers charged in city armed robberies

Two St. Paul brothers have been charged with armed robbery in connection with two separate incidents in Minneapolis.

They are Brian Curtis Page, 21, 862 Hague Av., and Barry Mitchell Page, 19, no permanent address.

Brian Page is accused of robbing the Nokomis Cleaners, 2000 Diffee Av. S., of about $70 Aug. 23.

When the brothers were arrested Oct. 16, Minneapolis robbery detectives said the men also were suspects in the June 27 slaying of a Perkins Cake & Steak manager in the same area.

Police said yesterday, however, that they no longer believe the pair was involved in the shooting death of Lloyd Bryce Hubbard, 31, manager of the Perkins Cake & Steak House, 6020 Nicollet Av.

Brian Page is charged with the Aug. 23 robbery. Barry Page, also charged with a St. Paul robbery, is in custody at Ramsey County Jail.

Morton police chief suffers stab wound

MORTON, Minn. (AP)—Morton Police Chief Bob Schlick was slightly wounded early today while investigating a traffic violation, the Renville County sheriff's office said.

The sheriff's office said Schlick suffered a stab wound while attempting to stop a car following an alleged stop-sign violation in the small western Minnesota community.

The driver left the scene and no arrests have been made, the sheriff's office said.

Schlick was treated at a Redwood Falls hospital and released.

Las Vegas performer dies

LAS VEGAS (AP)—Las Vegas entertainer Wayne Newton was found dead in his apartment Wednesday of an apparent heart attack. He was 36.

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MEDICALLY UNNECESSARY CASES

Justices Uphold Ban On U.S. Funds For Abortions

WASHINGTON (AP) — The Supreme Court handed pro-abortion forces a severe legal defeat Wednesday by upholding a lower court decision that cutting off federal funds for poor women's abortions was unconstitutional.

The high court sent the case back to U.S. District Judge John Dooling in Brooklyn, N.Y., with orders that he reconsider his ruling in light of the Supreme Court's June 20 decision that states are not obliged to pay for medically unnecessary abortions.

Dooling had issued an injunction to prevent the Department of Health, Education and Welfare from complying with the Hyde Amendment, which Congress passed in October to bar federal payments for an abortion needed to save the lives of mothers.

But the justices did not say Congress acted within its authority in passing the Hyde amendment. They vacated Dooling's ruling with no comment except that it should reready the question in light of their ruling.

At the same time, the court dismissed a request by congressmen and others opposed to abortions to immediately cut off federal funds for abortions.

It was unclear when the cut-off would take effect.

HEW Secretary Joseph A. Califano Jr., whose department controls the flow of Medicaid funds, interpreted the ruling as clearing the way for a cut-off within 30 days.

Califano said, "The department is ready to implement the Hyde Amendment" as soon as the Supreme Court sends its decision to the district court — normally in 25 days — or sooner if Dooling lifts the injunction.

But pro-abortion lawyers stressed that the court's decision blocks any funding cut-off, at least for the time being.

Rep. Thomas C. Kelly, general secretary of the National Conference of Catholic Bishops, said he was pleased by the Supreme Court's action and said he hoped it would "provide the impetus for speedy action by Congress" to ban federal funding for abortions.

But the National Abortion Rights Action League said it was encouraged and believed that "the state and federal governments may continue to fund therapeutic abortions."

The confusion stemmed from the legal mechanism involved. The court took two actions in the case.

• It set aside Dooling's finding that the law passed by Congress was unconstitutional and sent the issue back to his court.

• It denied the request by Rep. Henry Hyde, R-Ill., who sponsored the bill to ban it, who wanted an immediate cutoff.

The House recently passed a new, broader version of Hyde's amendment.

Last week the court ruled that nothing in the Constitution or federal law requires states to use welfare money to pay for medically unnecessary, therapeutic abortions. But it did not prohibit them from doing so.

After last week's ruling, anti-abortion attorneys interpreted it as applying to federal funding as well as state funding.

But pro-abortion lawyers argued that the 1976 Hyde amendment went beyond the rationale used in the court's decisions on state aid and therefore could not be used as the basis for ending federal funding of abortions.

Statements by the parties that successfully challenged the federal law before Dooling said the state regulations upheld by the court "are a far cry from the Hyde amendment."

They said that the federal legislation would end the money flow for medically necessary abortions which a physician has determined are needed to save a mother's life.

The pro-abortion attorneys said last week's decision only allows states to refuse to pay for "non-therapeutic abortions, which a doctor could not certify to be medically necessary.

They said the proposed Senate Bill calling for abortions for 50,000 poor women last year, mostly through the Medicaid program The government estimates that 1.1 million legal abortions will be performed this year.

In 1973, the Supreme Court ruled that most abortions are legal, and that the government cannot interfere with a woman's choice to have one performed.

The court's action appeared to leave Dooling with these options:

• He could find that the Supreme Court's rationale in the state funding cases applies as well to federal funding.

• He could find some other legal rationale for distinguishing the state laws upheld by the high court from the federal legislation.

In his October decision, Dooling said that the Hyde amendment treats poor women unequally and bears "no legitimate relation to abortion as an alternative to childbirth, while wealthier women have that alternative.

Measure To Expand Abortion Payments

WASHINGTON (AP) — The Senate voted Wednesday to broaden the conditions where the federal government will pay for abortions for poor women.

Besides cases where a woman's life would be endangered by a full-term pregnancy, the Senate said federally funded abortions should be allowed in cases of rape or incest or where a fetus is likely to suffer deformity or debility because of disease.

These conditions were written into law by the Senate-House conference for the Department of Labor and Health, Education and Welfare. They also permit abortions in cases of kidney disease, multiple sclerosis and ectopic pregnancy, which occurs outside the uterus.

The vote was on an amendment offered by Sen. Bob Packwood, R-Ore., to delete any limits on the use of federal funds for abortions. By rejecting this proposal, 56 to 41, the Senate adopted language written by its Appropriations Committee that set forth the new conditions.

The vote places the Senate in conflict with the House over the abortion question for the second straight year. The House voted earlier this month to bar federally funded abortions under any conditions.

The vote came on the same day that the Supreme Court returned to a lower court a ruling challenging restrictions on abortion funding that Congress approved in 1976.

This restriction, known as the Hyde amendment, said abortions under such federal programs as Medicaid should be paid for only when a woman's life would be in jeopardy because of a full-term pregnancy.

On June 20, the federal court judge stayed the restriction, saying it was an unconstitutional infringement on the rights of poor women.

The Supreme Court said the judge should take another look at his ruling in light of its decision last week that states have discretion in deciding whether to pay for abortions under Medicaid.

The Senate rejected by a 49-35 vote an attempt by Sen. Jesse Helms, R-N.C., to reinstate the Hyde amendment.

Packwood argued that Congress should adopt the Supreme Court's view that the abortion question should be resolved between a woman and her physician. To deny poor women abortions because the practice is thought immoral is "a disdainful, haughty arrogance that should demean this Congress," he said.

"It is not the business of government to put its particular stamp of morality on the people," he said.

Sen. Charles Percy, R-Ill., advanced the argument that abortion is a means of population control, a field in which the United States has traditionally taken the lead.

"As the rest of the world is catching up with us, suddenly we are not suddenly we become regressive — we become emotional," he said.

But Helms described abortion as "the deliberate termination of an innocent human life." He warned that it could lead "to disposing of other socially undesirable persons, like the elderly."

The Supreme Court decision had no direct impact on the Hyde amendment, which still cannot be enforced for the time being. The appropriations bill to which it was attached expires Sept. 30.

But HEW Secretary Joseph A. Califano Jr. said Wednesday his department was ready to begin enforcing the Hyde amendment as soon as the Supreme Court's action officially will reach Dooling's court in Brooklyn.

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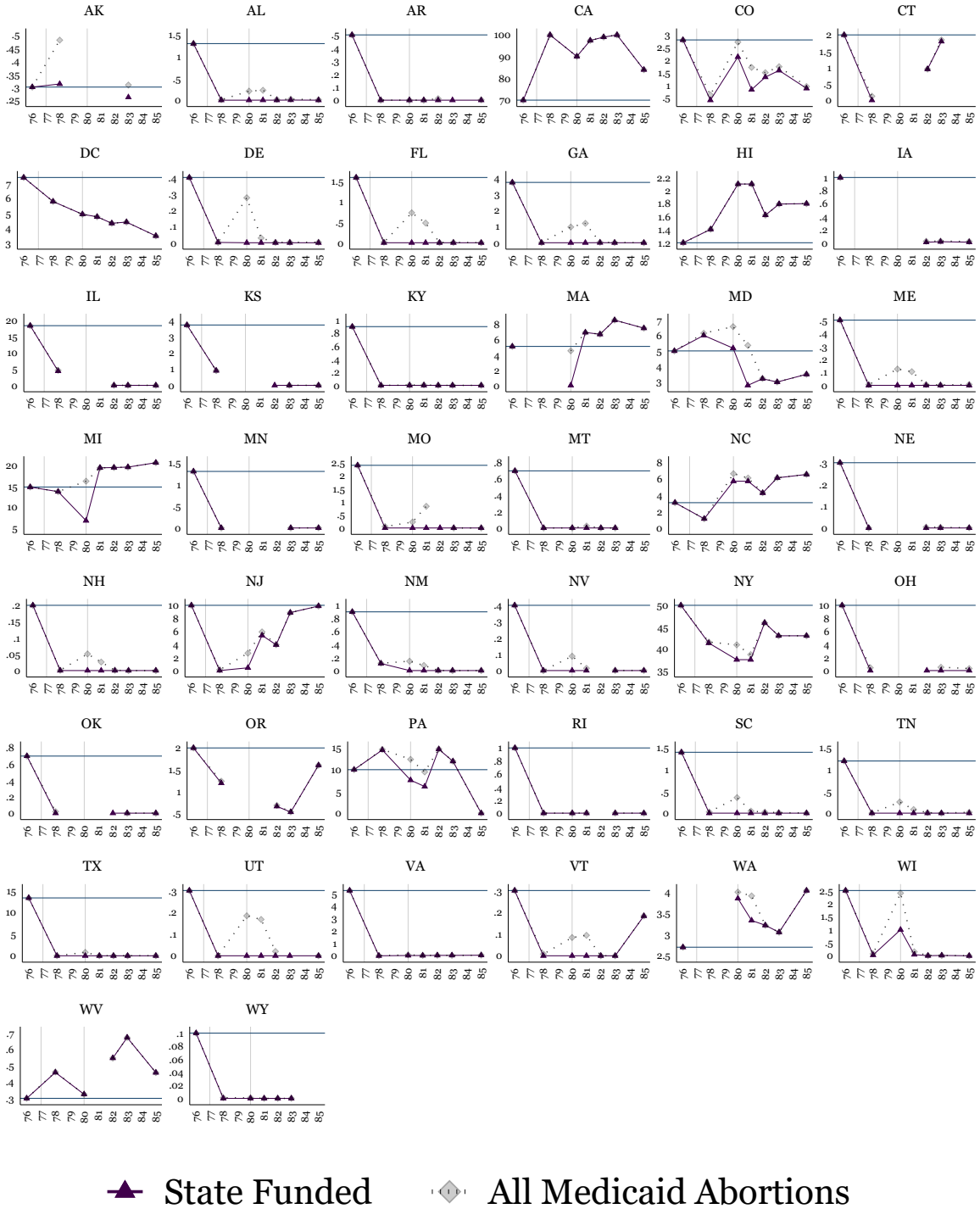
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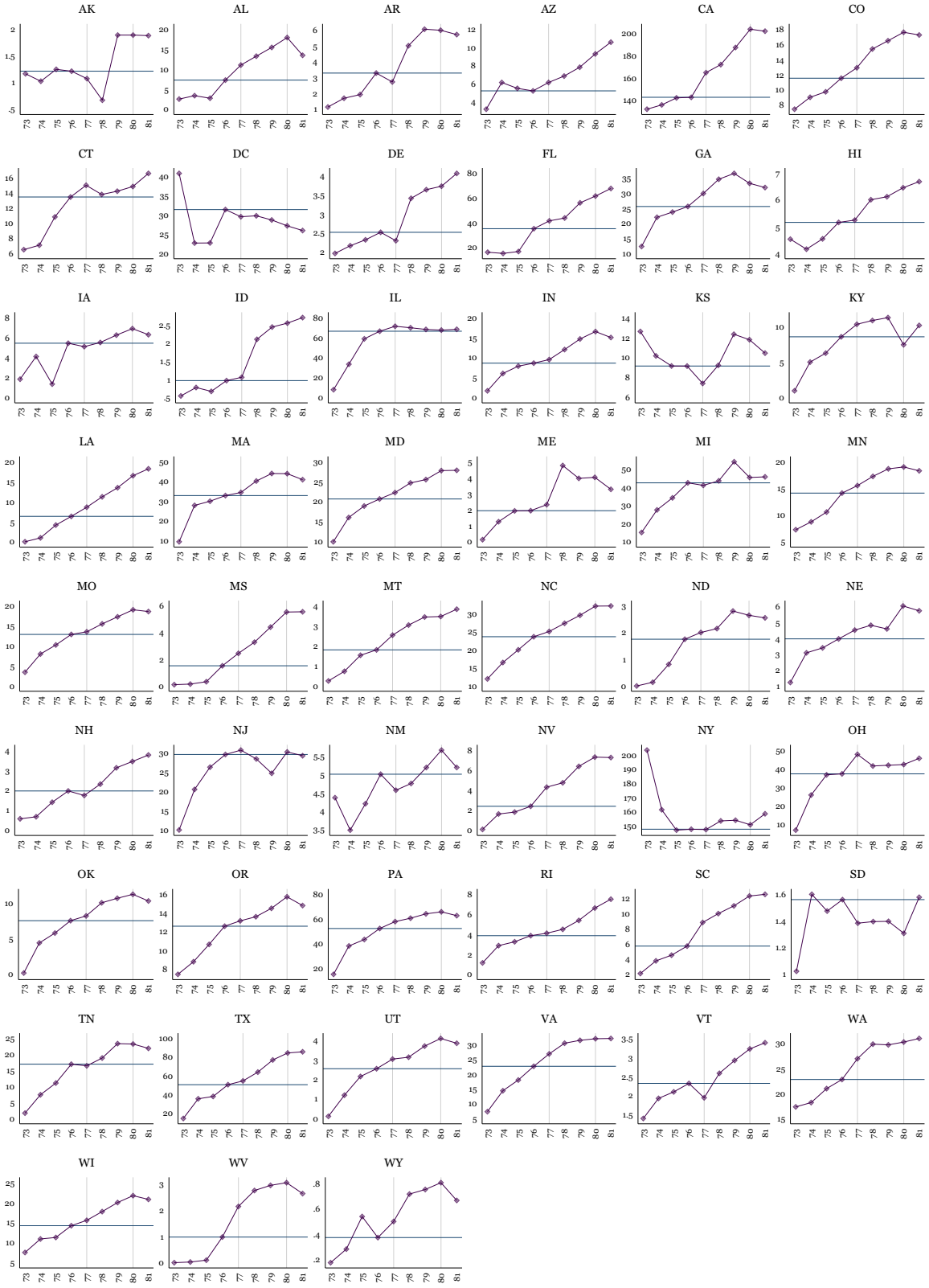
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Figure A.2: Medicaid Abortions in 1976 and Subsequent State-Funded Abortions, By State



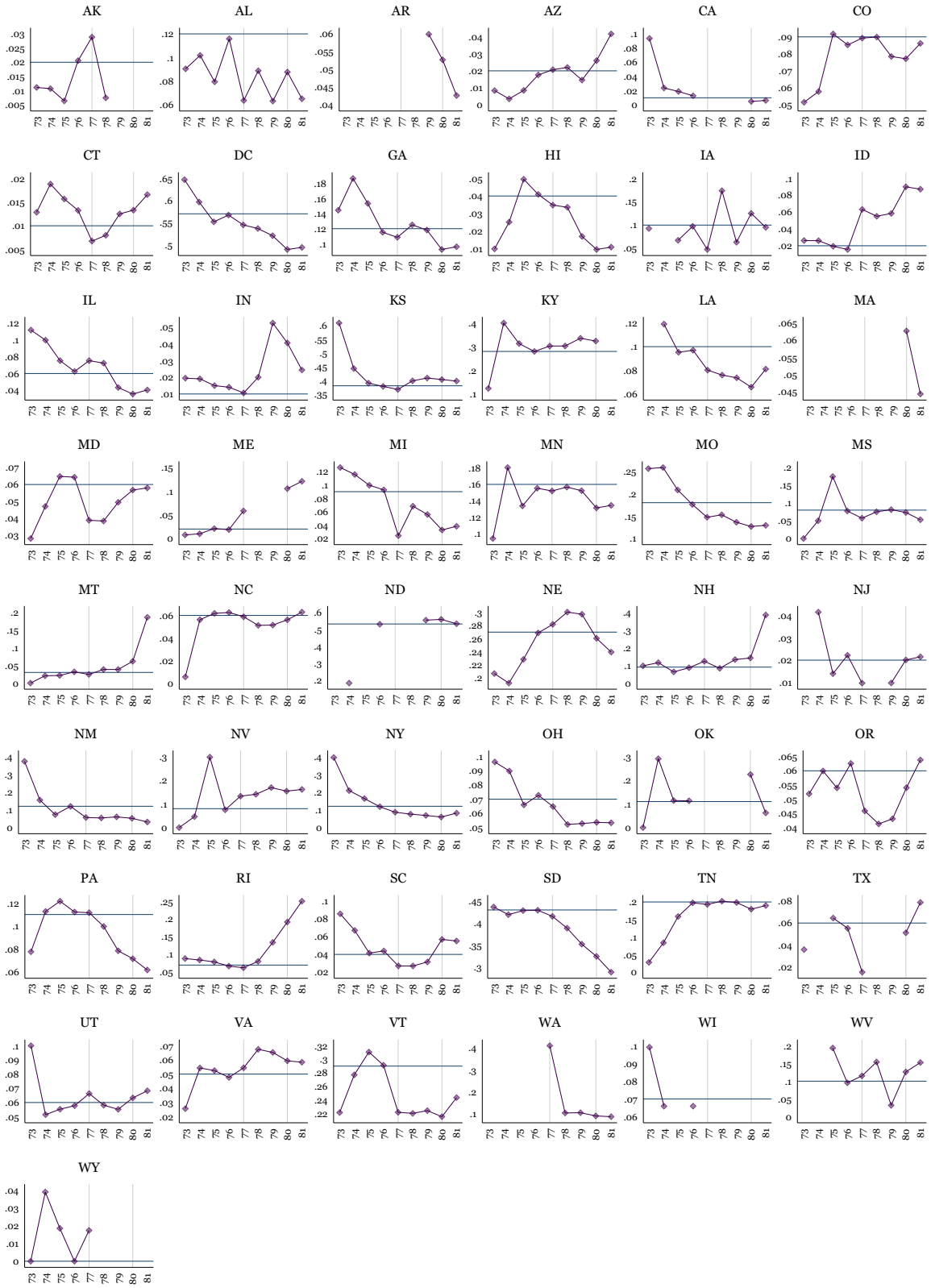
SOURCES: Lincoln et al. (1977), Gold (1980), Gold (1982), Nestor and Gold (1984), Gold and Nestor (1985), Gold and Macias (1986).
NOTES: Shows the number of Medicaid abortions in 1,000s, both the total Medicaid abortions (federal + state, gray diamonds) and state-funded abortions (colored triangle/solid line). y-axis represents the number of abortions in thousands, x-axis represents years.

Figure A.3: Abortions by State



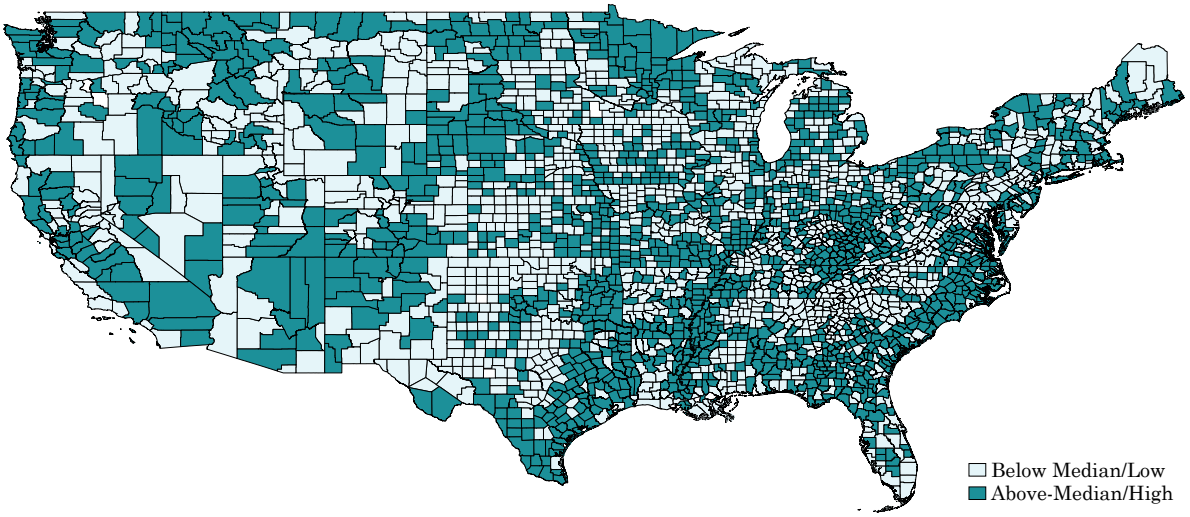
SOURCES: Abortion data from the CDC Abortion Surveillance Program. This data is only available by state.
NOTES: Shows the total of abortions in 1,000s in each state. y-axis represents the number of abortions in thousands, x-axis represents years.

Figure A.4: Abortions From Out-of-State Residents

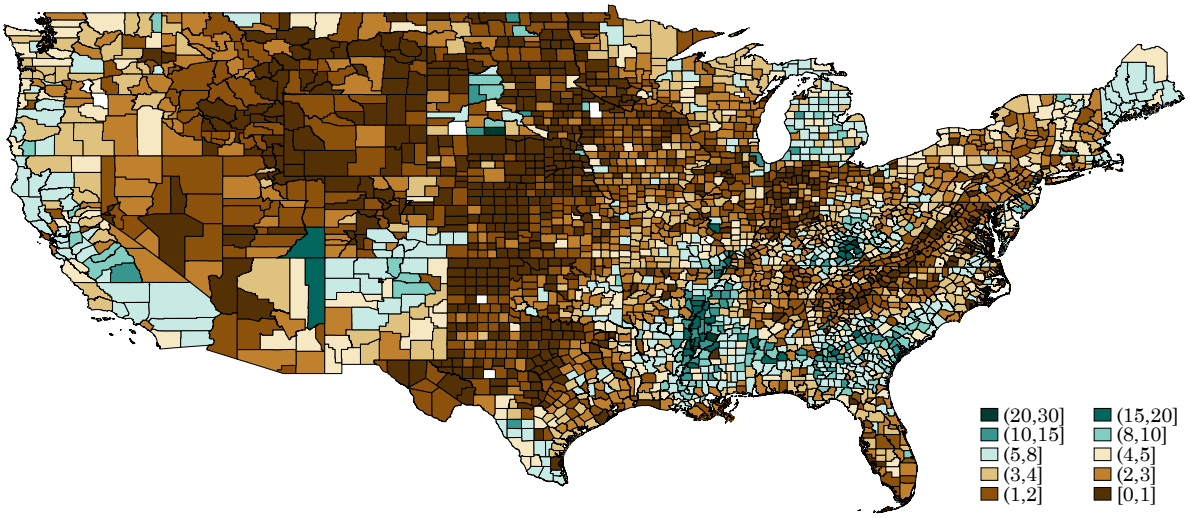


SOURCES: Abortion data from the CDC Abortion Surveillance Program. This data is only available by state. Data from the Table title *Reported Legal Abortions Obtained by Out-of-State Residents*. For 1980, this is Table 4 and 1979 Table A.1.
NOTES: Shows the share of abortions performed to out-of-state residents. Data missing in certain years for certain states. Lines are only connected when data is reported each year.

Figure A.5: County-level AFDC Receipt
Panel A: High and Low Eligibility within State

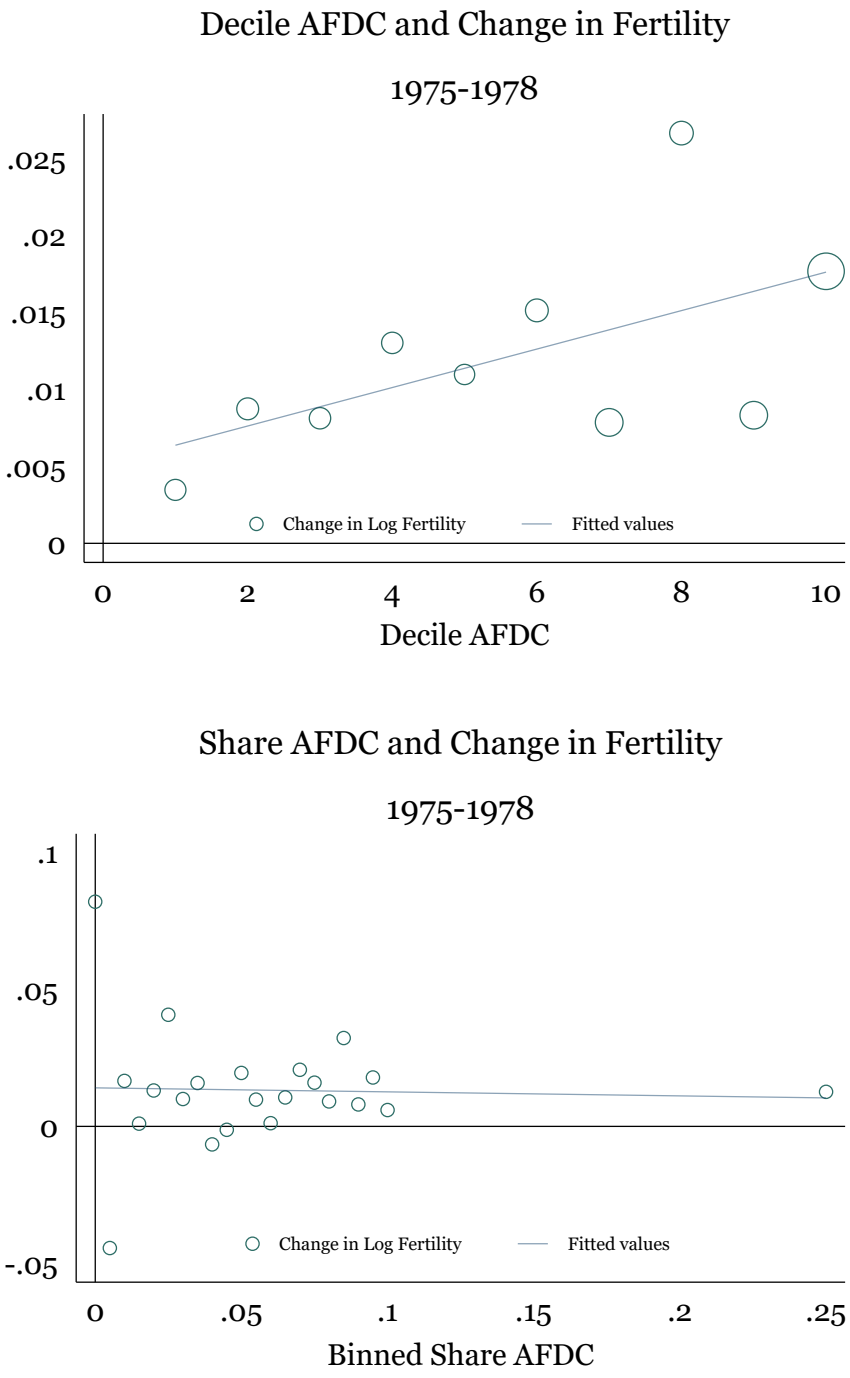


Panel B: Percent AFDC



SOURCE: Haines (2010).

Figure A.6: Change in Young Adult Fertility by AFDC Receipt



NOTES: Shows the descriptive change in fertility from 1975/76 to 1977/78 by two measures of Medicaid eligibility–the decile of AFDC receipt and the binned share of AFDC eligibility. Attempted depiction of Figure IV from Callaway et al. (2024).

Table A.1: State Factors

State	(1) Percent of National AFDC Population in State (1975)	(2) Percent Population Share AFDC (1975)	(3) Percent of National Non-white Population in State (1980)	(4) Percent Population Share Non-white (1980)	(5) Ratio Medicaid to Non Medicaid Abortions 1976	(6) Cost-to-AFDC payment 1976
CA	12.8	6.8	14.5	23.0	4.2	2.3
NY	10.9	6.8	9.4	20.1	2.5	2.1
MI	6.1	7.5	3.6	14.8	3.1	0.7
PA	5.7	5.4	3.2	10.1	2.2	1.6
MA	3.2	6.2	1.0	6.3	0.7	1.6
MD	1.9	5.3	2.8	24.9	2.6	1.4
DC	0.9	14.4	1.2	72.6	1.1	2.2
NC	1.7	3.5	3.8	24.2	2.0	0.9
NJ	4.0	6.2	3.2	16.4	3.0	1.5
IL	7.2	7.2	5.8	18.9	3.1	1.6
WA	1.3	4.3	0.9	8.3	1.4	1.3
CO	0.9	3.9	0.8	10.3	3.8	1.3
HI	0.5	6.3	1.7	65.6	2.1	2.2
OR	1.0	5.0	0.4	5.2	1.7	0.8
WI	1.7	4.2	0.7	5.5	3.2	2.3
KS	0.7	3.4	0.5	8.2	3.4	1.3
WV	0.7	4.1	0.2	3.8	15.9	0.9
AK	0.1	2.8	0.2	22.4	4.6	2.7
NM	0.5	5.2	0.8	24.0	2.4	1.1
VA	1.6	3.6	3.0	20.8	4.2	0.7
DE	0.3	5.4	0.3	17.9	1.8	1.5
AL	1.5	4.6	2.7	26.2	3.0	1.2
LA	2.1	6.1	3.4	30.7		1.2
KY	1.8	5.9	0.7	7.7	0.6	1.7
SD	0.2	3.7	0.1	7.4		2.6
NV	0.1	2.6	0.3	12.2	2.4	1.0
FL	2.2	3.0	4.2	16.0	0.6	1.0
OK	0.8	3.3	1.1	14.0	1.2	1.0
WY	0.1	1.8	0.1	4.9	5.4	0.8
RI	0.5	5.9	0.1	4.9	1.9	1.1
GA	2.7	6.1	4.0	27.7	1.5	1.5
NE	0.3	2.4	0.2	4.9	1.2	2.2
VT	0.2	5.3	0.0	0.9	1.5	0.7
ME	0.6	6.2	0.0	1.0	2.3	1.3
TX	3.1	2.9	7.8	20.6	5.6	1.9
ND	0.1	2.1	0.1	4.0		2.1
MT	0.2	2.5	0.1	5.8	8.3	1.2
MS	1.7	7.9	2.4	35.9		1.0
TN	1.9	5.1	2.0	16.4	0.7	0.8
AR	1.0	5.2	1.1	17.3	1.8	1.5
ID	0.2	2.4	0.1	4.2		1.2
MO	2.4	5.8	1.5	11.6	2.5	9.6
IN	1.6	3.4	1.3	8.8		0.8
OH	5.2	5.5	3.2	11.0	2.8	0.6
NH	0.2	3.3	0.0	1.1	1.4	1.6
UT	0.3	3.1	0.2	5.3	2.4	2.0
MN	1.2	3.4	0.4	3.3	1.6	0.8
CT	1.2	4.3	0.8	9.5	2.2	1.5
SC	1.2	5.0	2.6	31.2	3.1	1.7
AZ	0.6	3.0	1.2	16.8		0.8
IA	0.9	3.4	0.2	2.5	2.7	1.5

SOURCES: Haines (2010), Lincoln et al. (1977).

Table A.2: ICD Codes

8th Revision	9th Revision
1968-1978	1979-1998
Panel A: ICD Definition of Maternal Deaths (All-cause)	
Complications of pregnancy (630-634)	Ectopic and molar pregnancy (630-633)
Urinary infections and toxaemias of pregnancy and the puerperium (650-652)	Other pregnancy with abortive outcome (634-639)
Abortion (640-645)	Complications mainly related to pregnancy (640-648)
Delivery (650-662)	Normal delivery and other indications for care in pregnancy, labour and delivery (650-659)
Complications of the puerperium (670-678)	Complications occurring mainly in the course of labour and delivery (660-669)
	Complications of the puerperium (670-677)
	Other maternal and fetal complications (678–679)
Panel B: ICD Definition of Abortion-specific Deaths	
Abortion induced for medical indications (640)	Spontaneous abortion (634)
Abortion induced for other legal indications (641)	Legally induced abortion (635)
Abortion induced for other reasons (642)	Illegally induced abortion (636)
Spontaneous abortion (643)	Unspecified abortion (637)
Abortion not specified as induced or spontaneous (644)	Failed attempted abortion (638)
Other abortion (645)	Complications following abortion and ectopic and molar pregnancies (639)

Table A.3: Descriptive Statistics for Fertility

	Above Median AFDC Pre-Hyde Amendment		Below Median AFDC Pre-Hyde Amendment		Diff.	Above Median AFDC Post-Hyde Amendment		Below Median AFDC Post-Hyde Amendment		Diff.
	Mean	Std. Dev.	Mean	Std. Dev.	Est.	Mean	Std. Dev.	Mean	Std. Dev.	Est.
Fertility										
Births (1,000s)	1.010	2.610	0.609	1.330	0.401***	1.101	2.830	0.686	1.461	0.415***
Log of Fertility Rate	4.362	0.201	4.291	0.211	0.072***	4.354	0.202	4.297	0.226	0.056***
Women 15-44 (1,000s)	14.109	37.868	9.192	23.347	4.917***	15.675	41.443	10.654	26.138	5.021***
Population (1,000s)	64.751	168.469	42.570	106.499	22.181***	67.506	171.541	46.443	112.309	21.063***
By Age										
Log of <18 Fertility Rate	4.368	0.452	4.165	0.514	0.203***	4.295	0.451	4.039	0.539	0.256***
Log of 18-19 Fertility Rate	5.416	0.415	5.278	0.499	0.139***	5.360	0.383	5.175	0.487	0.185***
Log of 20-24 Fertility Rate	6.464	0.322	6.412	0.395	0.052***	6.484	0.322	6.394	0.409	0.090***
Log of 25-29 Fertility Rate	6.223	0.243	6.211	0.235	0.012**	6.290	0.208	6.275	0.212	0.015***
Log of 30-34 Fertility Rate	5.471	0.342	5.417	0.317	0.054***	5.526	0.298	5.495	0.278	0.031***
Log of 35+ Fertility Rate	4.226	0.492	4.066	0.436	0.160***	4.001	0.434	3.844	0.404	0.157***
By Race										
Log of White Fertility Rate	5.884	0.637	5.902	0.653	-0.018	5.916	0.648	5.967	0.741	-0.051***
Log of Non-white Fertility Rate	5.937	0.565	5.805	0.629	0.132***	5.910	0.570	5.827	0.647	0.083***
Poverty										
Share of Population on AFDC	0.055	0.035	0.023	0.014	0.032***	0.055	0.035	0.023	0.014	0.032***
Share Households in Poverty (1979)	0.150	0.074	0.111	0.046	0.038***	0.150	0.074	0.111	0.046	0.038***
Share Female Households in Poverty (1979)	0.046	0.029	0.026	0.014	0.021***	0.046	0.029	0.026	0.014	0.021***
Share Births by Age										
Age <18	0.096	0.045	0.076	0.042	0.020***	0.076	0.037	0.059	0.033	0.018***
Age 18-19	0.137	0.041	0.122	0.046	0.014***	0.119	0.035	0.105	0.038	0.015***
Age 20-24	0.369	0.053	0.374	0.066	-0.005***	0.365	0.045	0.365	0.056	-0.001
Age 25-29	0.249	0.059	0.270	0.068	-0.021***	0.278	0.053	0.299	0.059	-0.021***
Age 30-34	0.099	0.034	0.107	0.043	-0.008***	0.120	0.035	0.131	0.045	-0.011***
Age 35+	0.050	0.027	0.050	0.031	-0.000	0.042	0.019	0.042	0.022	0.000
Controls										
Share White	0.852	0.185	0.940	0.093	-0.089***	0.852	0.183	0.940	0.091	-0.088***
Share Female	0.509	0.015	0.505	0.018	0.004***	0.511	0.015	0.507	0.016	0.004***
Maternal										
Maternal Deaths, White	0.074	0.323	0.048	0.233	0.026***	0.052	0.261	0.041	0.246	0.011**
Maternal Deaths, Non-white	0.065	0.344	0.026	0.176	0.039***	0.048	0.302	0.018	0.175	0.030***
Log of Maternal Mortality	3.020	1.655	3.450	1.440	-0.431***	2.962	1.601	3.440	1.632	-0.478***
Log of Maternal Mortality	4.167	1.435	4.925	1.345	-0.758***	3.940	1.548	4.322	1.330	-0.382*
N	6,235		6,285		12,520	4,988		5,028		10,016

SOURCES: Vital Statistics Natality Birth Data (Birth Certificate Records) from the National Vital Statistics System of the National Center for Health Statistics. SEER Population data used for the controls and the population counts. Medicaid eligibility determined by the share of the population in the county receiving AFDC in 1976 (Haines, 2010).

Table A.4: Descriptive Statistics for NHDS Sample by Race

	Non-white Pre-Hyde Amendment		White Pre-Hyde Amendment		Diff.	Non-white Post-Hyde Amendment		White Post-Hyde Amendment		Diff.
	Mean	Std. Dev.	Mean	Std. Dev.	Est.	Mean	Std. Dev.	Mean	Std. Dev.	Est.
Complications										
Pregnancy Complications	0.279	0.449	0.189	0.392	0.090***	0.272	0.445	0.179	0.383	0.094***
Delivery Complications	0.096	0.295	0.095	0.294	0.000	0.119	0.324	0.127	0.333	-0.007***
Postpartum Complications	0.014	0.118	0.007	0.081	0.008***	0.010	0.100	0.006	0.075	0.004***
Abortion										
Abortion Complications	0.179	0.384	0.115	0.320	0.064***	0.161	0.367	0.091	0.288	0.069***
All Possible Abortion Complications	0.195	0.397	0.130	0.336	0.065***	0.181	0.385	0.109	0.312	0.073***
Abortions excluding Miscarriages	0.165	0.371	0.100	0.300	0.065***	0.144	0.351	0.075	0.264	0.068***
Hemorrhage										
Any Hemorrhage	0.027	0.161	0.032	0.176	-0.005***	0.037	0.189	0.040	0.195	-0.003**
Hemorrhage	0.020	0.139	0.025	0.156	-0.005***	0.025	0.156	0.027	0.162	-0.002*
PP Hemorrhage	0.007	0.082	0.007	0.083	-0.000	0.012	0.110	0.013	0.112	-0.001
Controls										
Age	23.426	5.888	24.958	5.494	-1.532***	24.020	5.764	25.293	5.334	-1.274***
Northeast	0.240	0.427	0.285	0.451	-0.045***	0.256	0.436	0.244	0.430	0.011***
Midwest	0.194	0.395	0.265	0.441	-0.071***	0.181	0.385	0.264	0.441	-0.083***
South	0.479	0.500	0.300	0.458	0.178***	0.465	0.499	0.316	0.465	0.149***
West	0.088	0.283	0.150	0.357	-0.062***	0.099	0.299	0.176	0.381	-0.078***
Age 15-17	0.139	0.346	0.063	0.243	0.076***	0.109	0.311	0.051	0.220	0.058***
Age 18-19	0.159	0.366	0.104	0.305	0.056***	0.135	0.342	0.092	0.289	0.043***
Age 20-24	0.339	0.473	0.336	0.473	0.003	0.346	0.476	0.329	0.470	0.017***
Age 25-29	0.206	0.404	0.308	0.461	-0.102***	0.238	0.426	0.317	0.465	-0.080***
Age 30-34	0.099	0.298	0.129	0.335	-0.030***	0.117	0.322	0.157	0.364	-0.040***
Age 35-39	0.043	0.203	0.046	0.209	-0.003*	0.042	0.201	0.043	0.203	-0.001
Age 40-45	0.015	0.120	0.015	0.120	-0.000	0.013	0.114	0.011	0.104	0.002***
1(Married)	0.442	0.497	0.863	0.344	-0.422***	0.407	0.491	0.828	0.378	-0.421***
1(Single)	0.434	0.496	0.090	0.286	0.344***	0.473	0.499	0.115	0.319	0.358***
1(Widowed)	0.006	0.080	0.002	0.048	0.004***	0.007	0.084	0.003	0.052	0.004***
1(Divorced)	0.024	0.155	0.017	0.129	0.007***	0.030	0.170	0.019	0.136	0.011***
1(Separated)	0.071	0.258	0.019	0.136	0.053***	0.042	0.200	0.015	0.120	0.027***
N	18,792		67,770		86,562	25,506		83,635		109,141

SOURCE: National Hospital Discharge Survey (NHDS) Files.
NOTES: Shows the sample of deliveries in the NHDS over 1973-1981. Only those who report race are included.

B Robustness checks for fertility analyses

B.1 Alternative Handling of the Standard Errors

In the main analysis, we cluster the standard errors at the county level–the level of the treatment and the fixed effects (Abadie et al., 2017). However, spatial correlation between counties may present an issue in our main estimates, and Figure IV Panels A and B present alternative methods of handling the standard errors. First, Panel A adjusts the standard errors for spatial and serial correlation using the method described in Hsiang (2010) and with the Stata wrapper from Forouzandeh (2024) (used in Baum-Snow and Han (2024)). The results in Figure IV display a similarly statistically significant increase in fertility as the baseline estimates.

Second, as an additional check, Panel B of Figure IV shows the standard errors clustered at the state level. With this alternative method of handling the standard errors, the rise in fertility is still apparent and significant.

B.2 Poisson Estimates and Linear Fertility with OLS Coefficients

As an alternative to the log of the fertility rate and OLS estimation, we show the Poisson estimates in Panel C of Figure IV, where the outcome is the number of births to women aged 18-29. We choose the exposure as the number of young adult women (18-29) in each county. In the Poisson model, the fertility rate is modeled as the number of observations in the outcome per the exposure. With the Poisson estimates of the fertility rate, there is a clear increase in fertility by 1.7%. The effect size is similar to the baseline effect of 1.8%.

Panel D then shows the effect of the Hyde Amendment on the linear fertility rate (the number of births per 1,000 reproductive-age women 18-29) in an OLS specification. Here, there is a clear increase in fertility, by six births per 1,000 women between the ages of 18 and 29. This effect size with the linear fertility rate is similar to the baseline Poisson estimates.

B.3 Continuous Measures of Eligibility

We switch to an event study that considers the dose-response of Medicaid eligibility, allowing counties with more Medicaid recipients to have a larger treatment weight than counties with fewer recipients. In other words, we use continuous eligibility measures interacted with event-study indicators. Formally, we revise Equation 1 by replacing the indicator variable, $1(\text{Above-Median Share AFDC})_{js}$, with a continuous measure of eligibility:

$$\ln(\text{Fertility})_{jst} = \alpha + \sum_{m=1972}^{1981} \beta_m \text{ Hyde Amendment}_m \times \text{Share AFDC Recipients}_{js} + \mathbf{X}'_{jt}\gamma + a_j + \eta_{s(j)t} + \psi_{u(j)t} + \epsilon_{jst} \tag{3}$$

where we replace the indicator variable for the above-median AFDC recipients with the share of AFDC recipients in a given county (a continuous variable). This specification will give a larger treatment weight to counties with more eligible individuals. Figure IV Panel E shows the results from Equation 3. The results appear similar to the baseline, where following the Hyde Amendment, counties with more Medicaid eligibility show a larger increase in fertility.

Then, in Panels F and G, we replace Share AFDC Recipients$_{js}$ with two other continuous measures of eligibility. In Panel F, we use the national percentile of AFDC receipt, and in Panel G, we interact the decile with the event study indicator. Both alternative measures of continuous eligibility, or dose-response models, show larger increases in fertility in high-eligibility counties.

B.4 Alternative Eligibility Comparisons

Next, in Figures B.1 and B.2, we also make alternative comparisons by eligibility. In Figure B.1, we use our original comparison by quartile from Figure III Panel B, but we compare the top quartile to the 2nd and 3rd quartile of eligibility.

Panel A shows a clear increase in fertility for the 4th/top quartile relative to the second quartile of eligibility. Though the increase in fertility is smaller than with the comparison of the top quartile to the bottom quartile. Fertility increases by 2.5% instead of 3% when comparing the top quartile of AFC receipt to the bottom quartile.

In Panel B, comparing the top quartile to the 3rd quartile reveals an even smaller increase in fertility (as expected). The 4th quartile shows an increase in fertility by 1.6% relative to the 3rd quartile. As expected, the highest quartile of eligibility shows the largest increase in fertility relative to the bottom quartile (3%), with the effect smaller when compared against the 2nd (2.5%) or 3rd quartile (1.6%).

Then, Figure B.2 again takes our original event-study from Equation 1 but splits counties out by decile. Figure B.2 displays the clearest increase in fertility in the top five deciles relative to the first decile. These results by decile reflect the descriptive change in fertility by decile shown in Figure A.6. Overall, the highest eligibility counties show the largest increases in fertility, both in an event study, Figure B.2, and descriptively, Figure A.6.

B.5 Alternative Measures of Eligibility

Next, in Figure IV Panel H, we show the increase in fertility with an alternative measure of Medicaid eligibility. We consider the share of households living in poverty rather than the share of the population receiving AFDC. We then take counties with above median levels of household heads in poverty (within state). The results with this measure of eligibility are similar to the baseline with AFDC recipients. Fertility rises by 1.7% after the Hyde Amendment in counties with an above-median share of households living in poverty. The increase in fertility is even stronger if we consider the top quartile of households in poverty (rather than above median) in Panel I of Figure IV.

Then, in Panel J, we use the above median share of AFDC recipients for the entire US rather than within the state. The increase in fertility is similar to our baseline estimates–a 1.7% increase in fertility. The increase is similar to the highest quartile of national AFDC receipt in Panel K. Using the measure of high eligibility by state or over the whole U.S. does not appear to change the main takeaways from the results. Fertility increases in counties with high AFDC recipients.

B.6 Placebo Test: Are the Results Driven by Large Cities?

Then, in Panel L, we change our measure of high and low-eligibility to above and below-median population counties. This robustness check tests whether large cities

completely drive the results. In Panel L, we take the treated group as counties in the above-median population group (within the state). In high population counties, there is no change in fertility after the Hyde Amendment. Overall, the results do not appear to be disproportionately driven by changes in fertility in the largest population cities and counties in the U.S.

B.7 Dropping Certain States

Next, in Figure IV Panel M, we remove MD and MI, two states left in our sample that had (arguably) the most funding for abortions under Medicaid following the Hyde Amendment. Without these two states, the increase in fertility is similar to the baseline in Figure III, a rise in fertility by 1.7%.

Then, we omit states that expanded Medicaid eligibility before 1982, based on East et al. (2023). These states showed sharp changes in eligibility based in East et al. (2023), and due to the expanded Medicaid access early in the sample, our measure of Medicaid eligibility, AFDC receipt, may be weaker in these states. However, even if these states with expanded eligibility are removed, the effect is similar, or slightly stronger (2.2%) in Panel N of Figure IV.

B.8 Extra Controls

In Figure IV Panels O-T, we add county-level controls to our estimates from Equation 1. In our main specification, we omit many of these controls from our baseline specification because they are "bad controls" that may change with the Hyde Amendment Angrist and Pischke (2008). For example, the composition of deliveries may shift after the Hyde Amendment, so we do not control for the characteristics of births. The number of abortion providers may also adjust in response to the Hyde Amendment, so we choose not to control for providers in our baseline specification. Still, the results are robust to adding these controls in Panel O-T of Figure IV.

First, Panel O adds controls for the share of married deliveries and the share of deliveries with a high school and college education. Second, Panel P adds controls for the share of first deliveries, the total birth order, and the share of deliveres to each age group, 20-24 and 25-29 (omitting 18-19). Panel Q adds controls for the quartile of median income interacted with year-fixed effects (across the US), and the quartile of average AFDC payment across the US interacted with year-fixed effects. Panel R controls for the number of abortion providers per reproductive age female at the county level from Bailey et al. (2012). Panel R also controls for whether the county had a Title X program interacted with year-fixed effects (from Bailey et al. (2012)). Panel S controls for the same Title X program and whether the county has any abortion provider. Panel T controls for all these controls together. With these extra controls, together and separately, the increase in fertility is larger (over 2%) as compared to the baseline (1.8% in Figure III).

B.9 Test for Pretrends

In Figure B.5, we also show pretrends calculated based on Roth (2022); Caceres-Bravom (2024). While there is evidence of pretrends, the pretrends are well below the estimated coefficient, and even outside of the estimated confidence interval over 1977-1980. The estimated pretends do catch up to the bottom of the confidence interval in 1981, the year we see a dip in births. We expect this dip in births because federal funding for abortion resumed in 1980, affecting deliveries occurring in the subsequent year. Still, in the initial years, the

estimated coefficient is far above the expected effect based on the simulated pretends.

B.10 Results By Age

In our main analysis, we consider the fertility effect for young adult women. These women aged 18-29 are more likely to be directly covered by Medicaid (rather than a parent), and those in their teens and 20s have the vast majority of unwanted pregnancies that end in abortion (KFF, 2021). Women in their teens and 20s are also more likely to use non-private funds to pay for an abortion (see Figure D.1).

We confirm that the age groups 18-29 are the most affected group in Figure B.6. As expected, the clearest increase in fertility occurs for those in their twenties, a 1.4-2% increase in fertility. Women in their late teens and 20s are also the highest fertility age group in the sample and represent the most unwanted pregnancies (KFF, 2024a). However, the top two panels also show an increase in fertility for teenagers. Teenagers (those under 20) show an increase in fertility by roughly 2-4%. Though, for young women under 18, the effect is slightly delayed. For women 30 and over, there is little change in fertility following the Hyde Amendment. These results align with the fact that women in their teens and 20s also compose the highest share of abortions (Figure II). While those in their 30s make up a small portion of abortions.

B.11 Permutation Test.

We then conduct a permutation placebo test by randomizing the counties in the above-median AFDC group. To generate this placebo test, we randomize the assignment of counties into above and below-median counties within each state. The treatment timing is the same as the baseline. Then, following Chetty et al. (2009), Buchmueller et al. (2011), Ohrn (2018) and Baron et al. (2020), we run the baseline regression from Equation 1 with a grouped post period. We execute the simulation 1,000 times and choose a distinct random assignment of counties in each simulation. The plotted cumulative distribution function (CDF) from this exercise is shown in Figure B.7. Based on the estimates, we also calculate a non-parametric p-value based on the CDF of the simulated coefficients compared against our point estimate. The non-parametric p-value suggests that our baseline estimate is highly statistically significant.

B.12 Dropping One State at a Time

Next, in Figures B.8-B.9 we drop each state individually from the sample. This ensures the estimated effect is not driven by a single large state. Figures B.8-B.9 show a similar increase in fertility even with each individual state removed from the national sample.

B.13 Controls as Outcomes

Finally, in Figures B.10, we consider various potential controls as outcomes. In the top panel, we are most interested in whether the abortion providers change as a result of the Hyde Amendment. The first two panels display little change in the number of abortion providers in high-eligibility counties after the Hyde Amendment.

Then, we show measures of education, parity, marital status, and race. Births shirt away from being college-educated and married births, which is expected because the increase in fertility should mainly occur for those unmarried and those with lower levels of education. We also see a temporary shift towards more non-white births and black births, and a decline in white

births. However, this effect is only temporary. But these results indicate that black/non-white births do increase more than white births initially after the Hyde Amendment. The fact that the shift in race of delivery is only temporary helps to explain why there is only a temporary change in non-white maternal mortality (in the next section of results, Section 4).

B.14 State-level Changes in Abortion and Fertility

Finally, we consider the fertility rate, abortion rate, and the gestation of abortion in states with high eligibility in Figure C.1. Here, we consider the log of the state-level fertility rate, with state-fixed effects, region-by-year fixed effects, and the standard errors clustered at the state level. High-eligibility states are compared against low-eligibility states in Panel A. Considering states with high eligibility aligns with our baseline results by county-level eligibility.

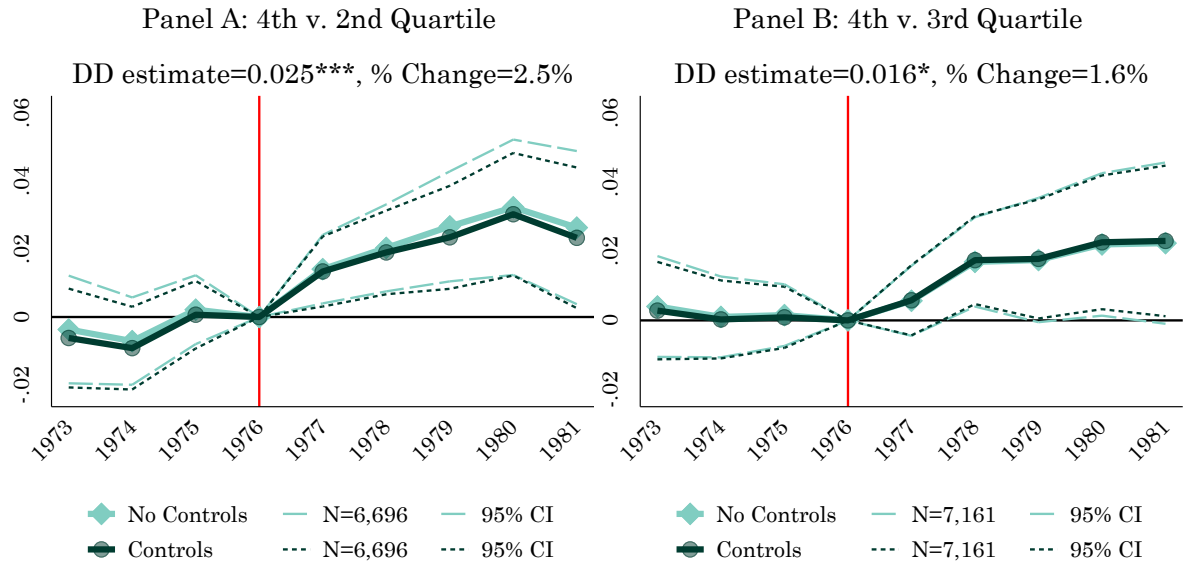
In Panel A.i, there is a small increase in fertility, by only 0.3%. This state-level comparison illustrates the limitation of aggregating effects to the state level. Based on our county-level results, there is a much clearer increase in fertility in high-eligibility counties relative to low-eligibility counties within the state. Because there is a small change in fertility, we also explore the abortion rate for young women in Panels A.ii and A.iii; while there is a decline in abortions, the effect is insignificant. Though, with the very small change in fertility, we would not expect to see large changes in abortions. Still, a limitation of this analysis is that we only have a subset of states reporting abortions by age, which may explain why the results are statistically insignificant.[31]

Next, in Figure C.2, we compare high-eligibility versus low-eligibility states but consider the gestation of abortions. Figure C.2 shows that abortions are shifting later in gestation in high-Medicaid eligibility states (or high AFDC states). Figure C.2 shows that in states with an above-median share of AFDC recipients, abortions shift towards 8 weeks and 13-20 weeks.

Overall, the state-level results show a small increase in state-level fertility in high-eligibility states and some evidence of a reduction in abortions. High-eligibility states also show more abortions earlier in gestation and later in gestation, even pushing abortions to the (early) second trimester. Unfortunately, we do not have information on county-level abortions during the period of focus, so these state-level changes in abortions are the best information available.

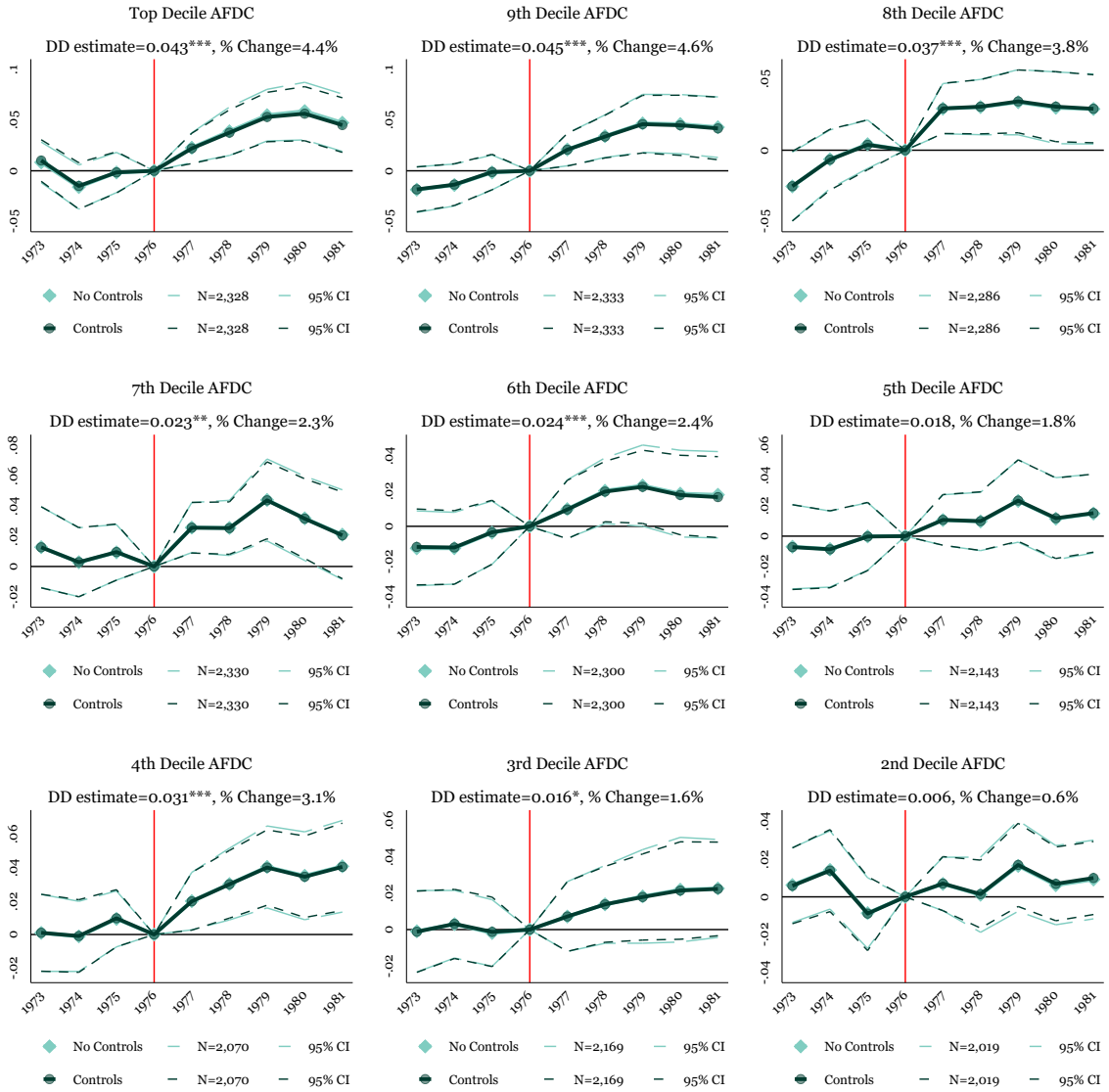
[31] In Panel B.i, we compare states with funding available against states without funding available. The plotted points in Panel B.i reflect the approach of other studies in the literature (Levine et al., 1996; Haas-Wilson, 1997), except that we focus on young adults, or those most likely to get an abortion. Here similar to prior work, we see an increase in fertility (prior work showed a small decline in fertility in states without funding, Levine et al. (1996)). Though, we see no clear change in abortions to young adult women. Our fertility effects are larger in Panel B.i as compared to Levine et al. (1996) because we focus on the age group most affected by abortion restrictions, 18-29.

Figure B.1: Alternative Quartiles of Comparison: Fertility for Young Adult Women (18-29)



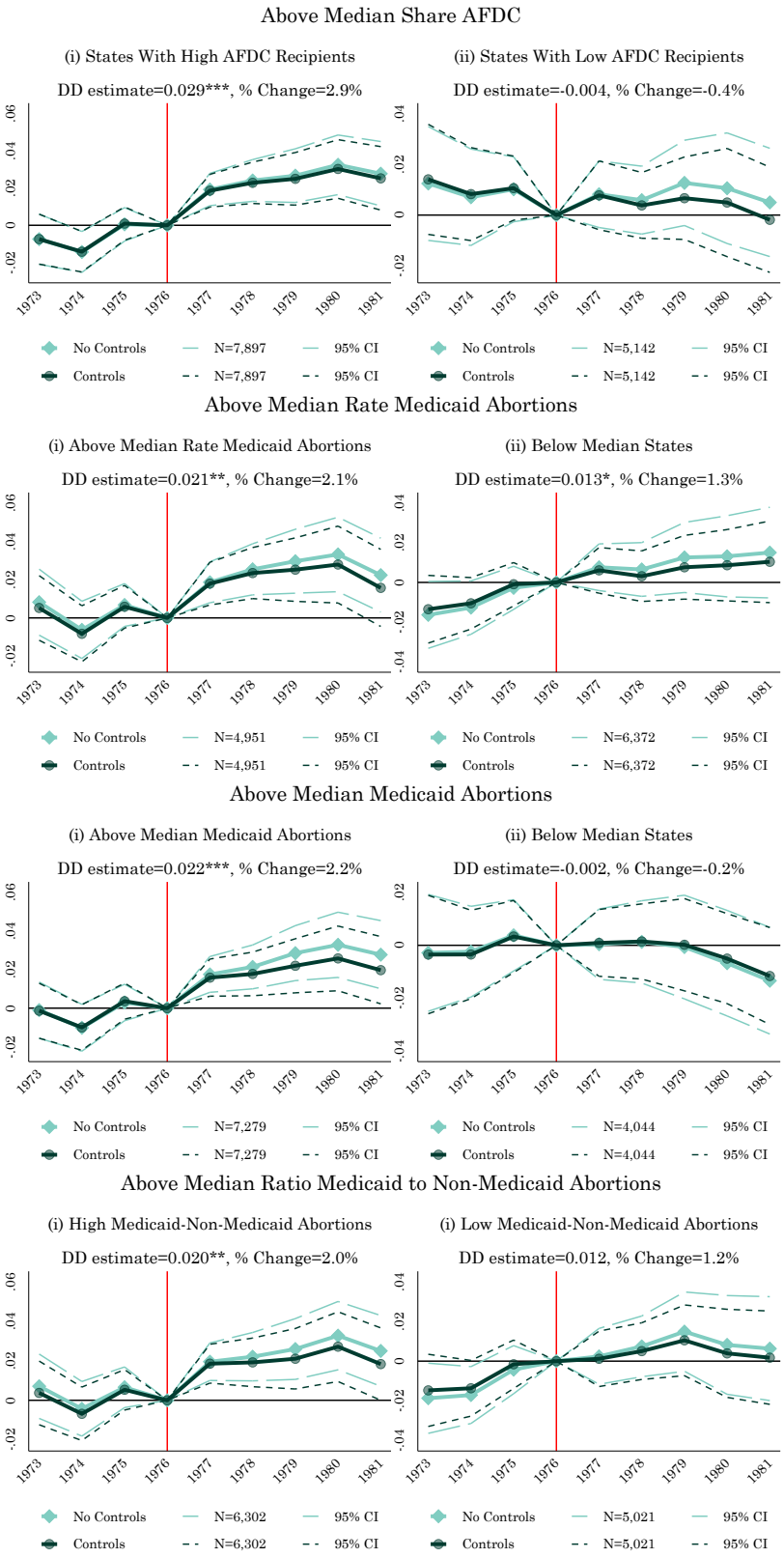
NOTES: Reflects the specification in Panel B of Figure III except comparing the top quartile to the second and third quartiles of eligibility.

Figure B.2: Deciles of Eligibility – The Hyde Amendment and Fertility for Young Adult Women (18-29)



NOTES: Reflects the specification in Figure III except comparing each decile of eligibility to the first decile of eligibility.

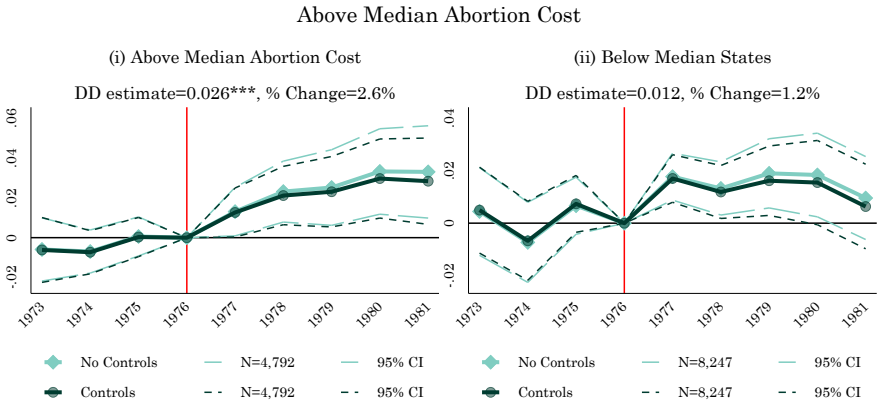
Figure B.3: Heterogeneity by State-level Demand

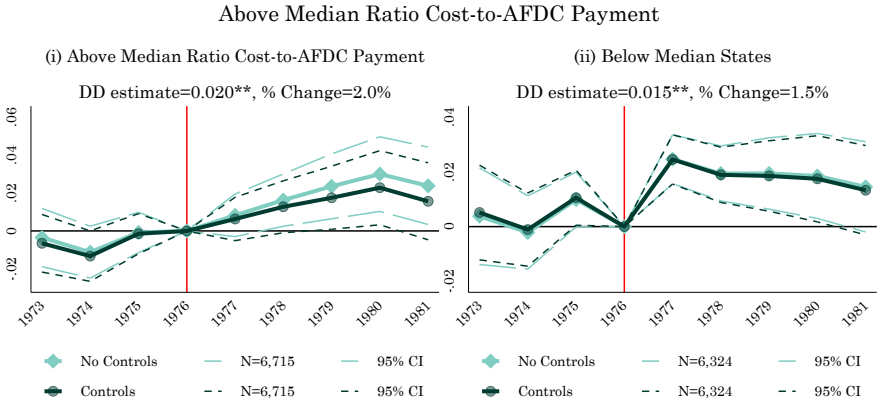


NOTES: Represents county-level specification from Panel A of Figure III, except breaking out fertility by state-level policies. The Medicaid and non-Medicaid abortion rates are from Lincoln et al. (1977). See Table 1 and A.1 for state-level policies.

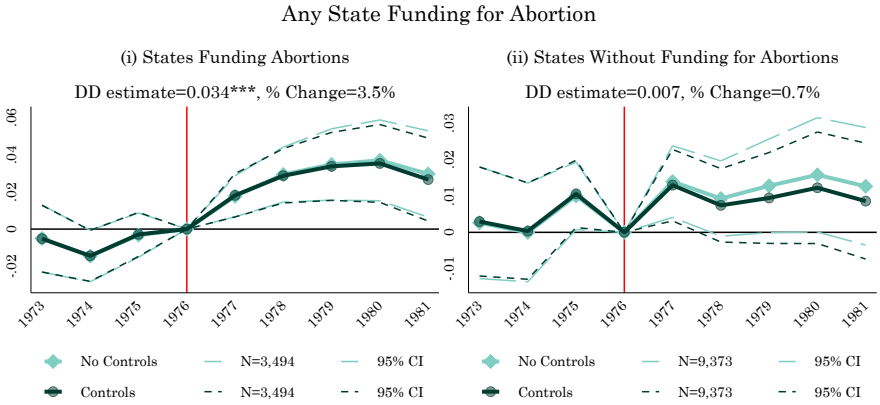
Figure B.4: Heterogeneity by State-level Cost and Funding

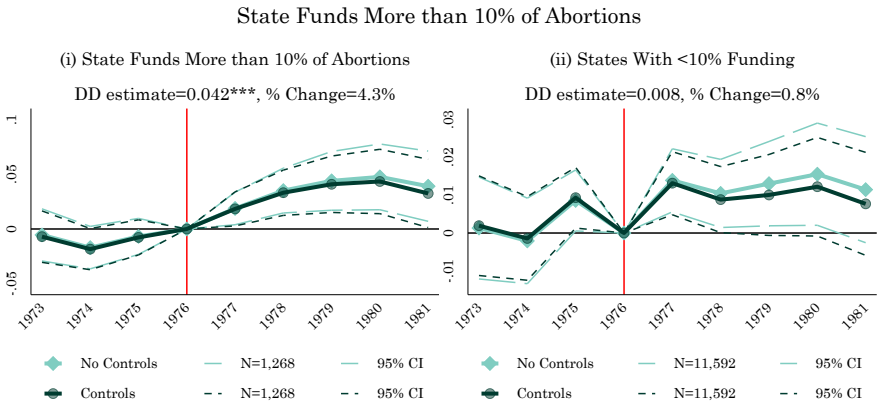
Panel A: Cost of an Abortion





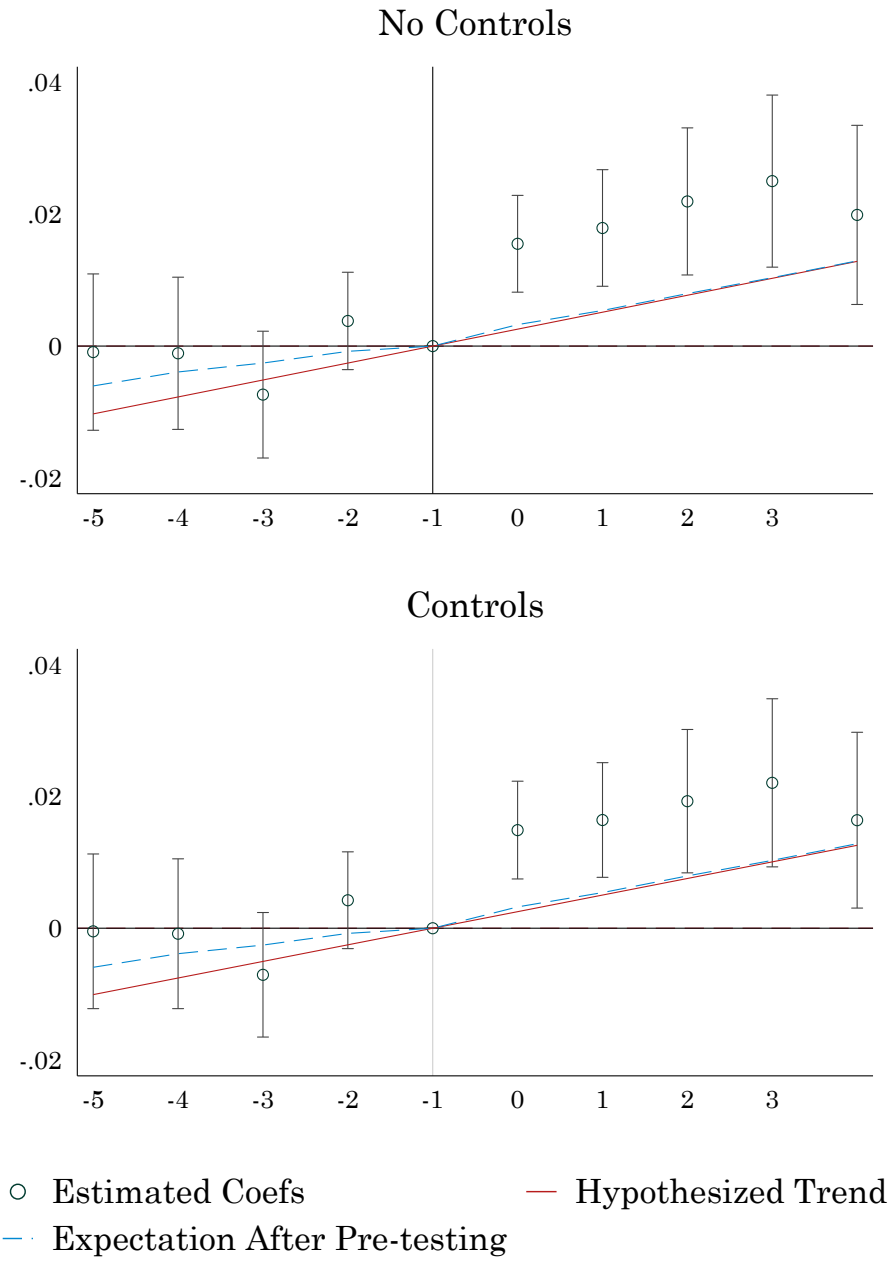
Panel B: State Funding





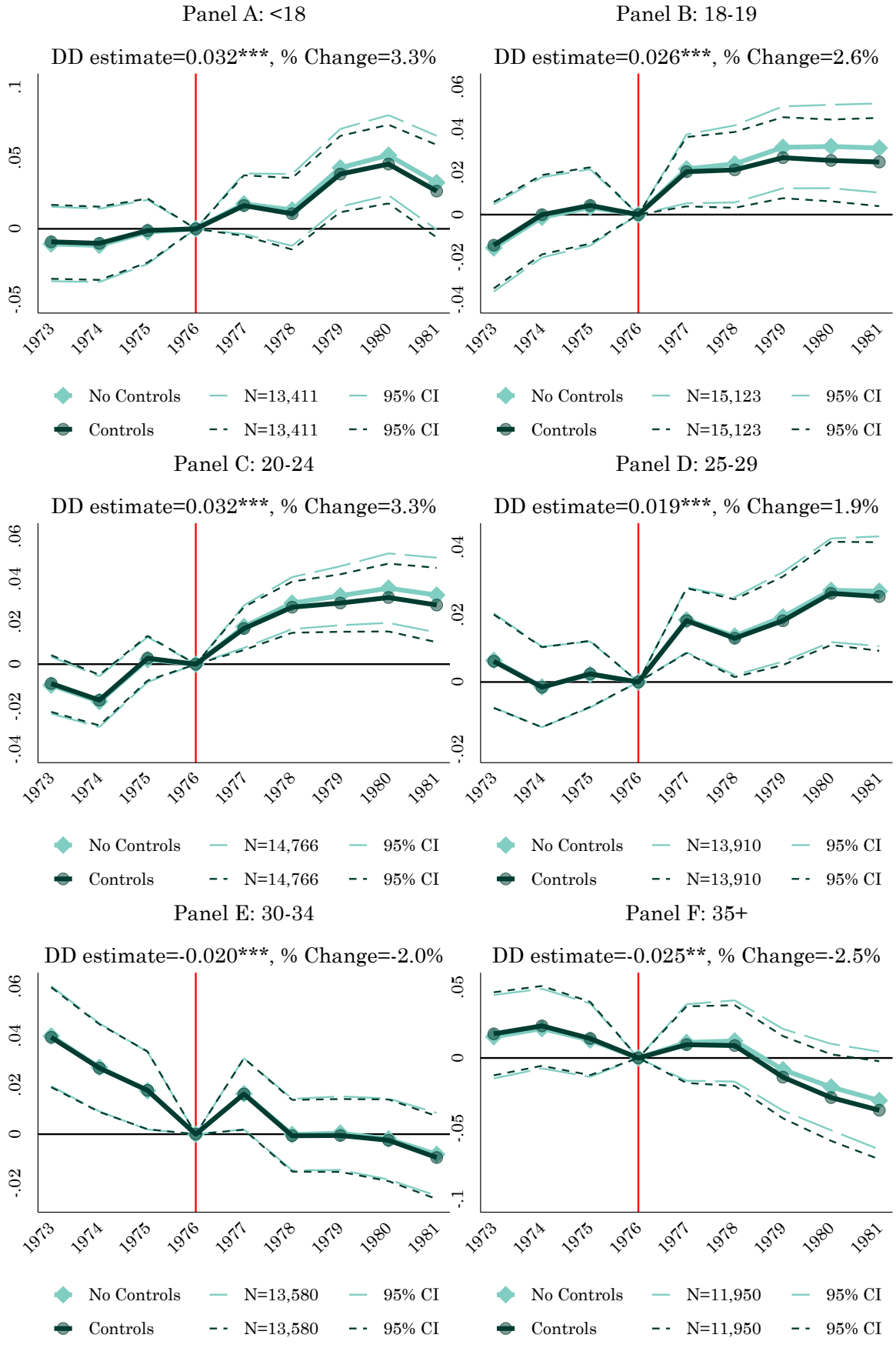
NOTES: Represents county-level specification from Panel A of Figure III, except breaking out fertility by state-level policies. Cost of an abortion per AFDC payment from Lincoln et al. (1977). State funding for an abortion from Gold (1980), Gold (1982). See Table 1 and A.1 for state-level policies.

Figure B.5: Overlaid Pretrends– The Hyde Amendment and Fertility for Young Adult Women (18-29)



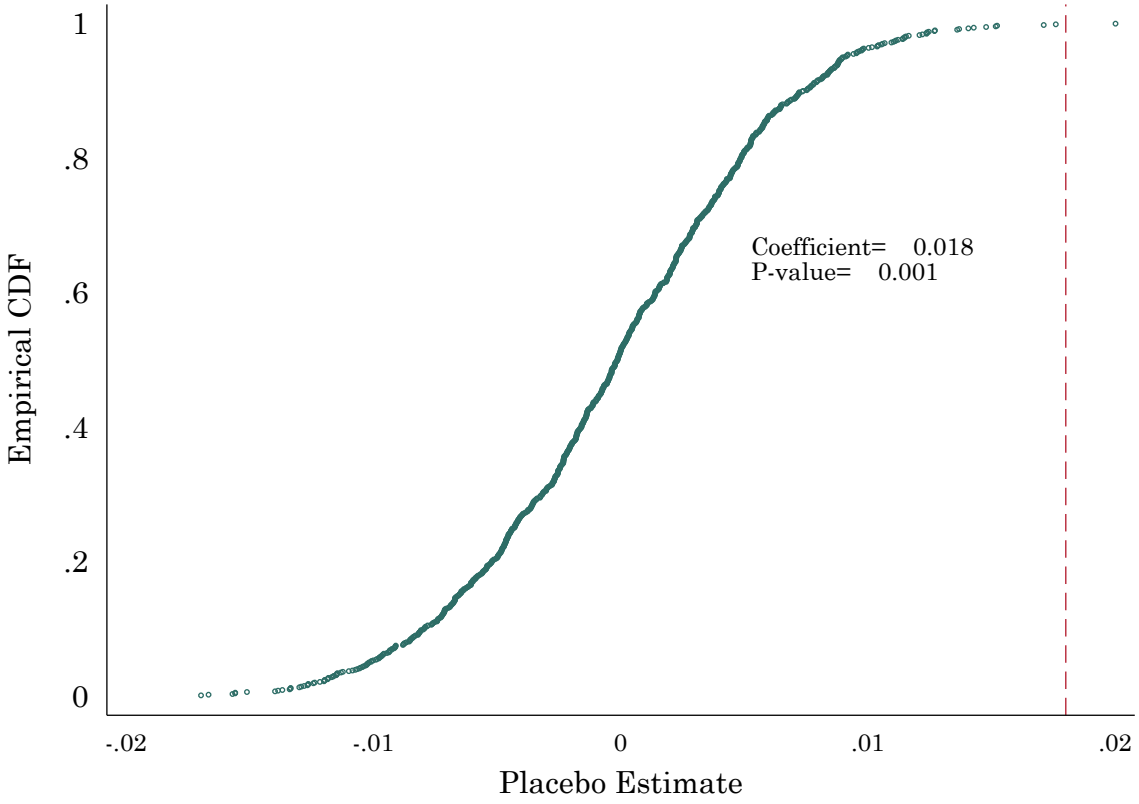
NOTES: Reflects the specification in Figure III considering the test for pretrends from Roth (2022); Caceres-Bravom (2024).

Figure B.6: Fertility by Age Group



NOTES: Reflects the specification in Panel A of Figure III except considering different age groups.

Figure B.7: Permutations on High Medicaid Eligibility Counties



NOTES: Represents county-level specification from Panel A of Figure III, except randomizing the treated counties. We randomly assign counties to above and below-median AFDC eligibility (within state) and run Equation 1 with a grouped post-period coefficient. Each plotted point represents a separate regression. The randomization is performed 1,000 times. The plotted CDF represents the distribution of estimates from these placebo simulations, with the estimated coefficient for our 'actual' difference-in-differences estimate indicated by the vertical line. The non-parametric p-value is calculated as the number of placebo observations that are greater than the estimated effect, divided by the sample size of all permutation estimates.

Figure B.8: Dropping Individual States (I): County-level Fertility Young Adult Women in Above-Median Medicaid Eligibility Counties



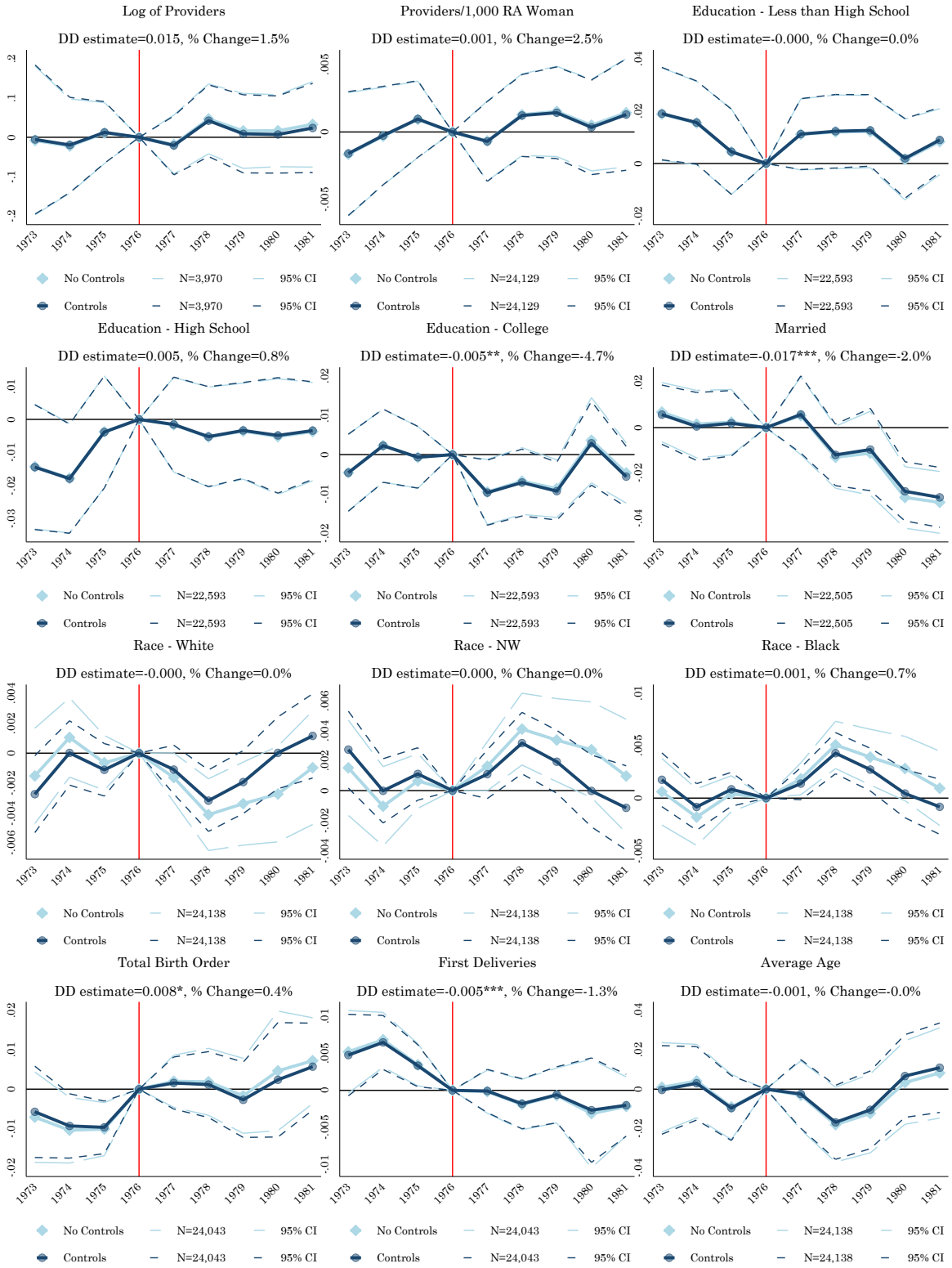
NOTES: Represents county-level specification from Figure III, except dropping one state at a time.

Figure B.9: Dropping Individual States (II): County-level Fertility Young Adult Women in Above-Median Medicaid Eligibility Counties



NOTES: Represents county-level specification from Figure III, except dropping one state at a time.

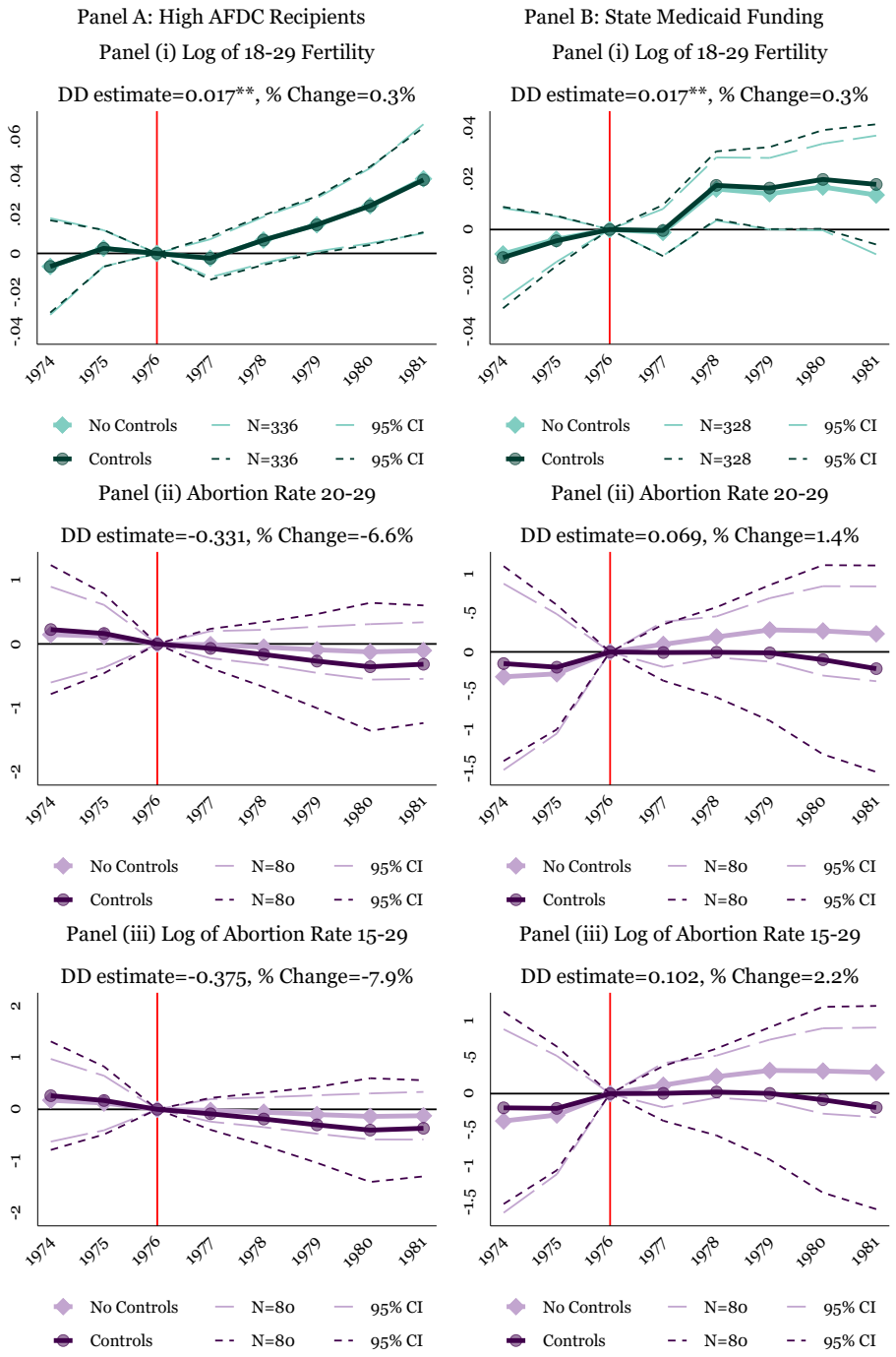
Figure B.10: Controls as Outcomes, High Medicaid Eligibility Counties



NOTES: Represents county-level specification from Panel A of Figure III, except considering the share of each characteristic from the birth certificates, as well as the county-level abortion providers (the first two panels).

C Abortion Surveillance Data

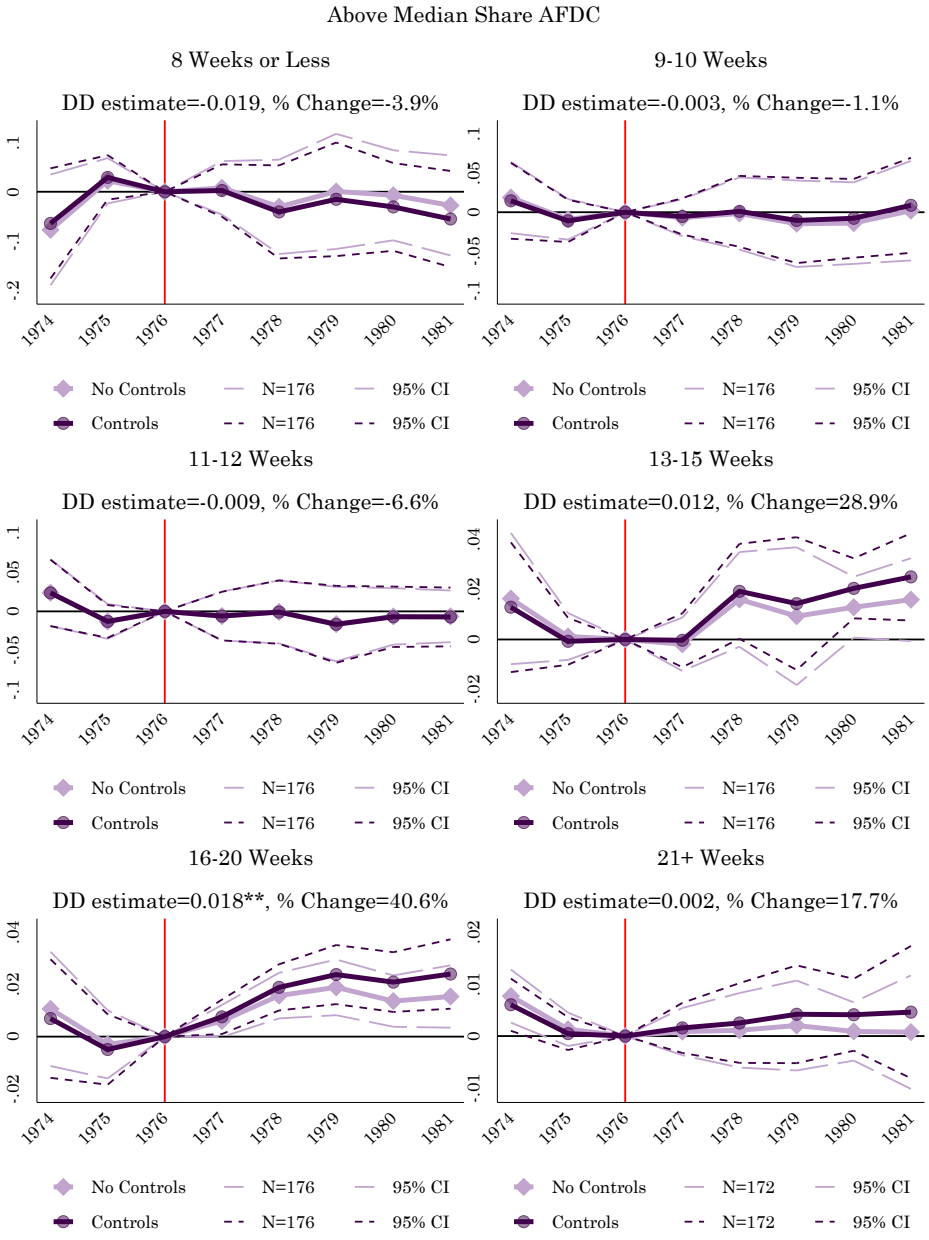
Figure C.1: State-level Fertility Rate and Age-Specific Abortions Rate



SOURCE: Vital Statistics Natality Birth Data (Birth Certificate Records) from the National Vital Statistics System of the National Center for Health Statistics. SEER Population data used for the controls and the population counts. CDC abortion Surveillance data.

NOTES: Considers the state-level abortion rate per relevant population and the fertility rate for 18-29 in state-level versions of Equation 1. The first panel compares states by high Medicaid eligibility and low eligibility (above and below-median AFDC recipients). The second panel compares states with funding for an abortion against states with no funding. Only includes the 42 states in our main sample. In the abortion results, the sample only includes states that reported at least 8 years of by-age abortion data to obtain a balanced panel. Specification includes state and year fixed effects and region-by-year fixed effects. Our main set of controls includes the share white, the share of other race, and the share female. Standard errors clustered at the state level.

Figure C.2: Share of Abortions by Gestation in High AFDC States Relative to Low AFDC States



SOURCE: CDC abortion Surveillance data.

NOTES: Considers the share of abortions by gestation. Estimates reflect state-level versions of Equation 1, comparing states by high Medicaid eligibility and low eligibility (above and below-median AFDC recipients). Only considers total abortions that report gestation. Only includes states that reported at least 8 years of data to obtain a balanced panel. Removes states that do not report all years of abortions by gestation and only includes the 42 states in our main sample. Specification includes state and year fixed effects and region-by-year fixed effects. Our main set of controls includes the share white, the share of other race, and the share female.

D National Hospital Discharge Survey

D.1 Robustness of Morbidity Results from the Hospital Discharge Survey

First, we show alternative measures of abortion-related morbidity, including extra complications (ectopic pregnancy and missed miscarriage), as well as removing spontaneous abortions. Figure D.4 shows the additional measures of abortion complications. The results for alternative measures of abortion complications in Figure D.4 are similar to the baseline increase in abortion complications in Figure VIII.

Second, we show the log of abortion complications in Figure D.5, where there again is a similar rise in abortion complications to Figure VIII. Third, in Figure D.6, we show variations of Figure VIII. In dark plotted points, we show the results per female, and in light plotted points, we show the results for only those 18-29. While the confidence intervals are slightly wider for the restricted age group, overall, the results appear similar to the baseline increase in abortion complications from Figure VIII.

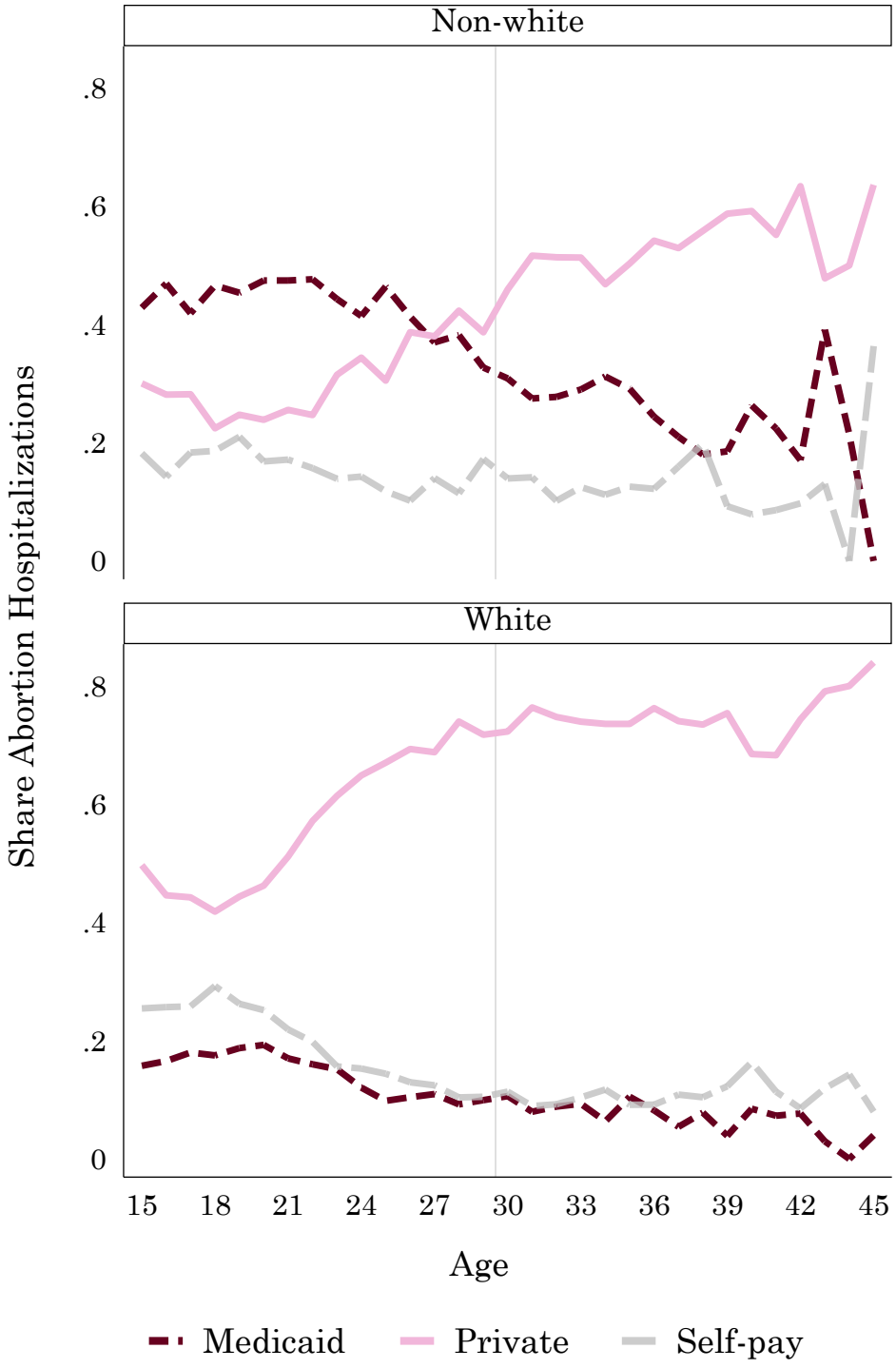
Fourth, Figure D.7 adds controls for marital status (rather than splitting into single women). Here we include indicators for married, single, and divorced, and collapse the data at this level of marital controls. The results with marital controls appear similar to the baseline, abortion complications rise for non-white women after the Hyde Amendment.

Fifth, in Figure D.8, we also directly compare public to private payer groups rather than non-white to white. Although, a limitation of this analysis is that payer status is only available beginning in 1977. Comparing public to private payment individuals, there is also a rise in abortion complications for the Medicaid/public group. Here, the effect is a rise in hospitalization for abortion complications by 16-36%. These results by payer confirm our results by race and indicate that the Hyde Amendment disproportionately affected the maternal health of those receiving Medicaid.

Then, we consider other complications in Figure D.9. Here, there is a clear increase in pregnancy complications, but most of that increase is coming from abortion complications. For the remainder of the grouped complications, there is little change in postpartum or delivery complications. The results are similar for public versus private payers in Panel C.

Finally, we show that the characteristics of abortions and deliveries changed little after the Hyde Amendment for the non-white versus the white sample. Figure D.10 shows the marriage rate and the length of stay for the sample of abortions and deliveries. While there is some decline in the marriage rate, the length of stay is similar before and after the Hyde Amendment. These results suggest that deliveries and abortion complications are not worsening in severity on average since the length of stay is similar. However, non-white women appear less likely to be married in the sample of deliveries and abortions after the Hyde Amendment, suggesting that marital controls are, in fact, "bad controls" (Angrist and Pischke, 2008).

Figure D.1: NHDS Abortion Complications – Share Payer by Age



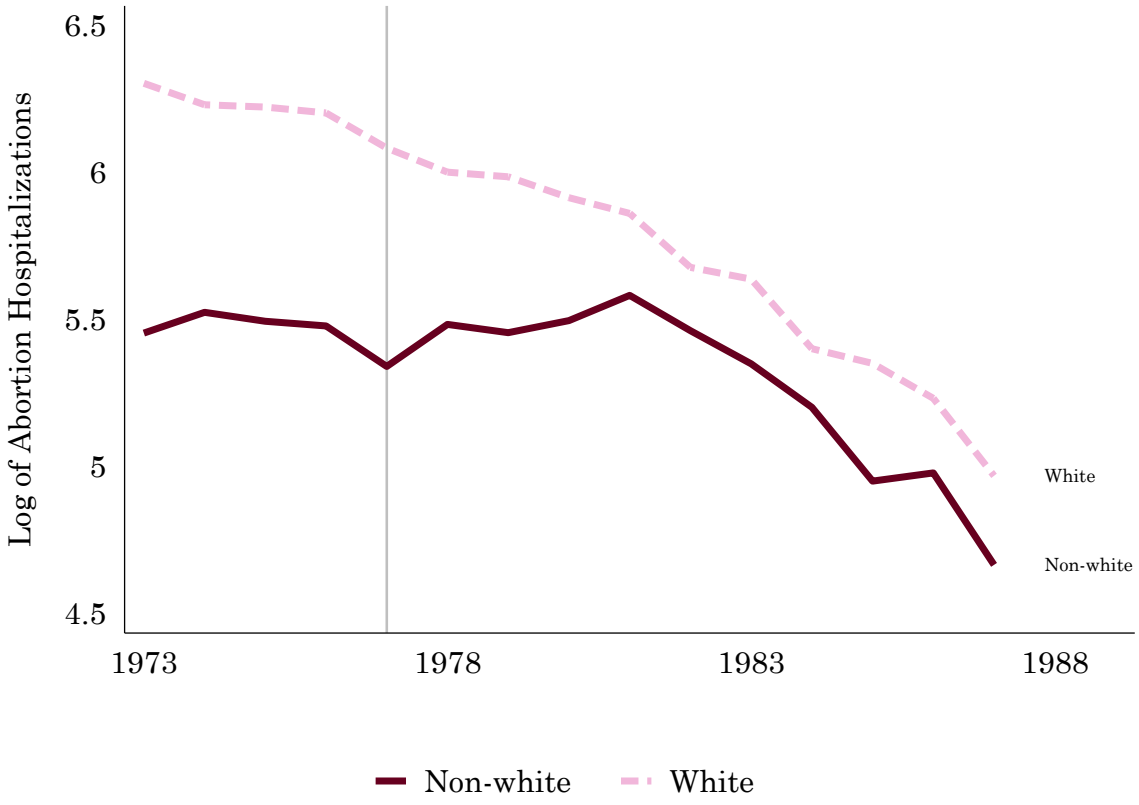
SOURCE: National Hospital Discharge Survey (NHDS) Files.
NOTE: We show the share of abortions paid by race and over age. Figure VI shows the same graph by race over time.

Figure D.2: NHDS: Annual Number of Abortion Complications per Year



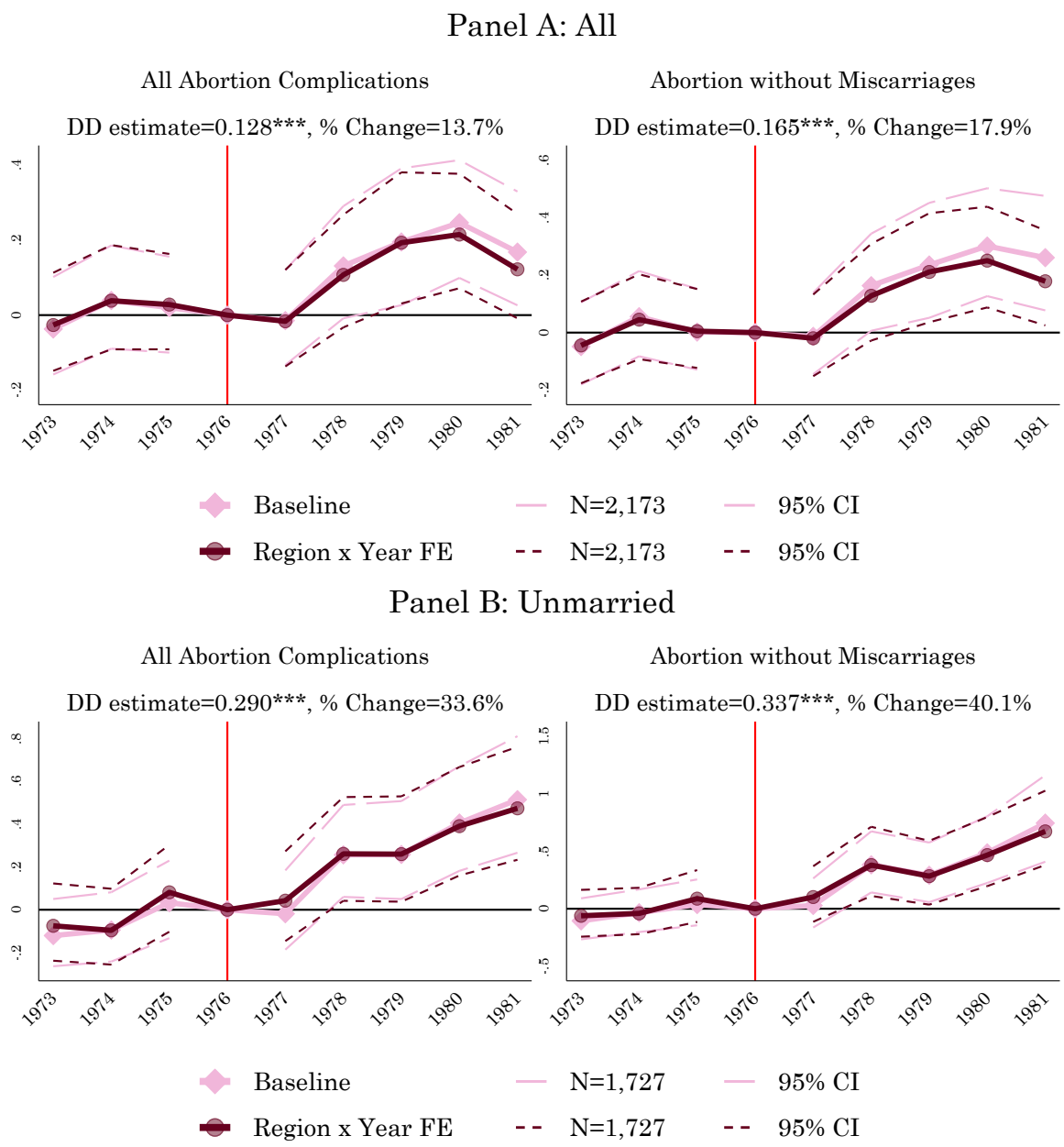
SOURCE: National Hospital Discharge Survey (NHDS) Files.
NOTES: Shows the number of (standard) abortion complications over time by race and by region.

Figure D.3: NHDS Log of Abortion Complications – By Race



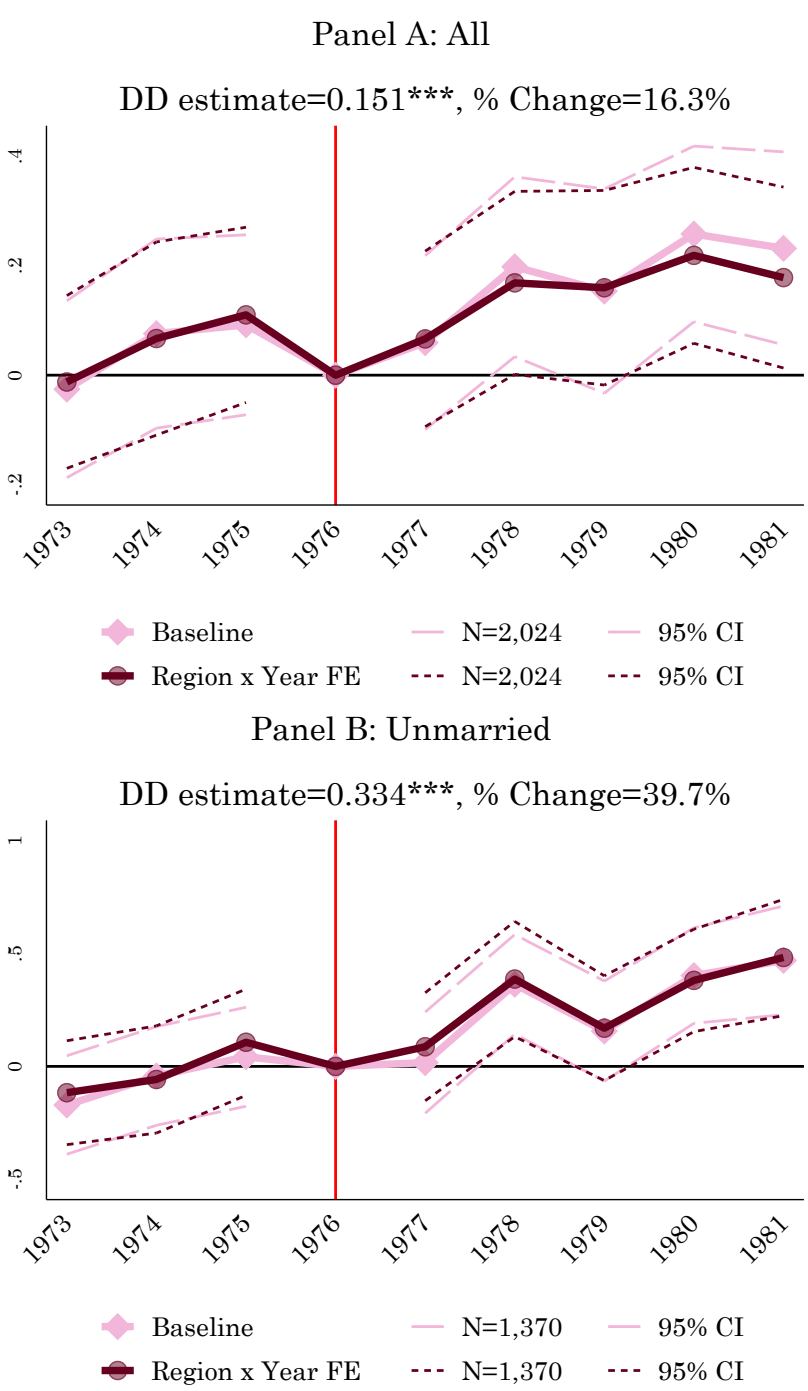
SOURCE: National Hospital Discharge Survey (NHDS) Files.
NOTES: Shows the log of abortion complications by race over time.

Figure D.4: Hospitalizations for Alternative Measures of Abortion Complications, Non-white versus White



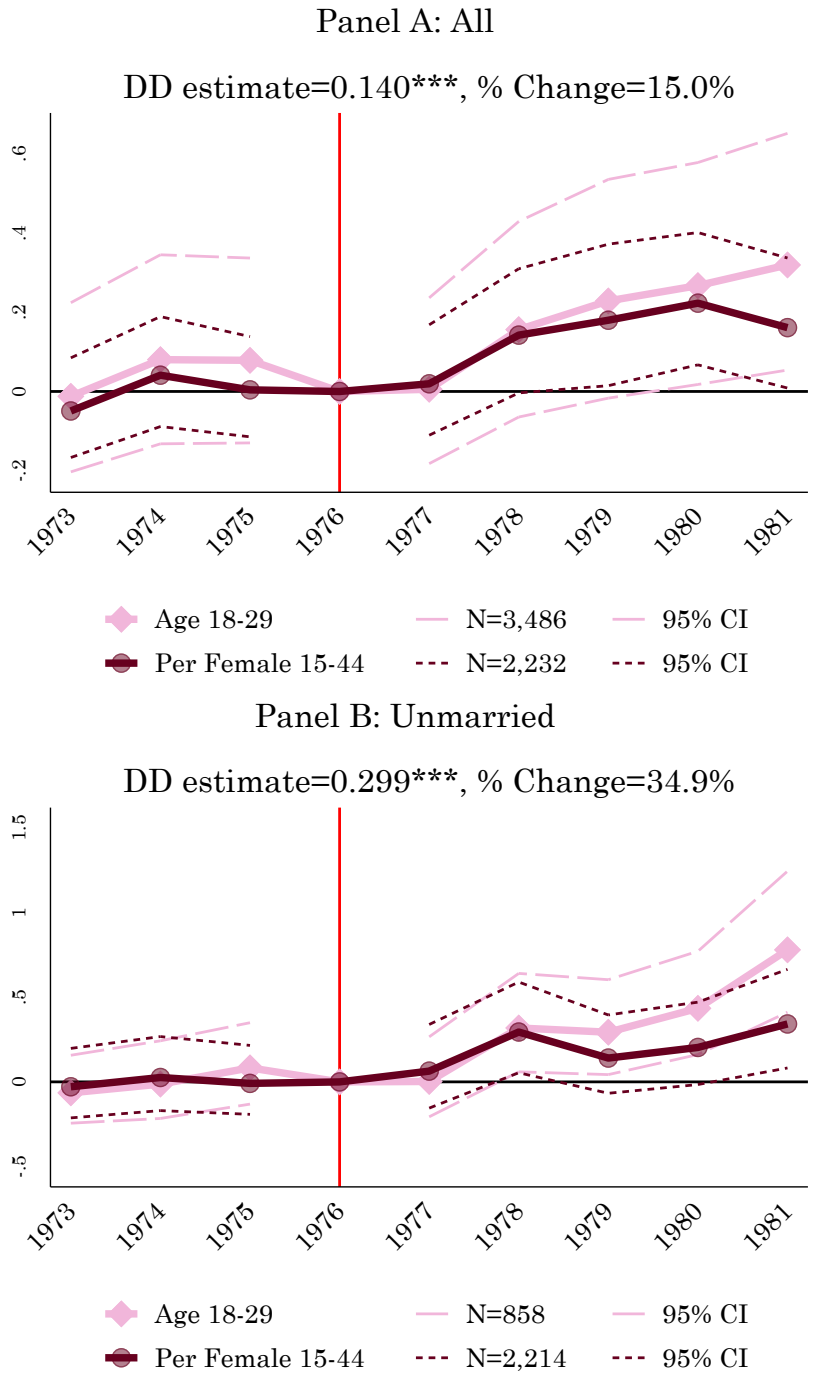
NOTES: Represents Figure VIII except considering different measures of abortion complications. *All abortion complications* include the standard abortion complications plus miscarriages (spontaneous abortions), ectopic pregnancies, and missed abortions. *Abortion without miscarriages* includes abortion complications without spontaneous abortions. Induced abortions include only those specified as induced on the ICD code (635/636 on ICD-9 and 640/641/642 on ICD-8).

Figure D.5: NHDS Event Study: Log of Abortion Complications (OLS)



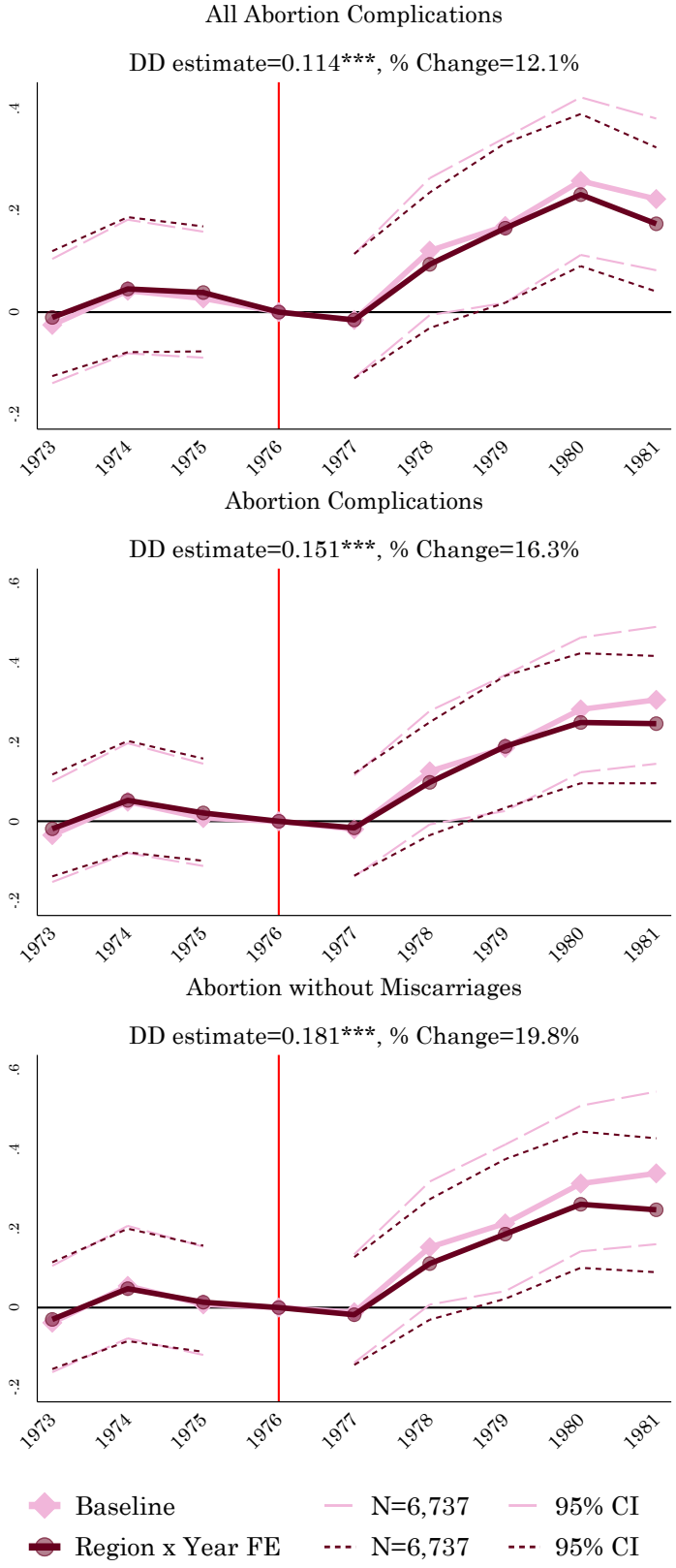
NOTES: Reflects Figure VIII except considering the log of the rate of abortion complications (per 1,000 deliveries). Estimates reflect OLS point estimates. Regressions are weighted by the sum of the individual weights in the collapsed data. The weights are reported in the NHDS.

Figure D.6: NHDS Event Study: *Robustness Checks* on Cases of Abortion Complications



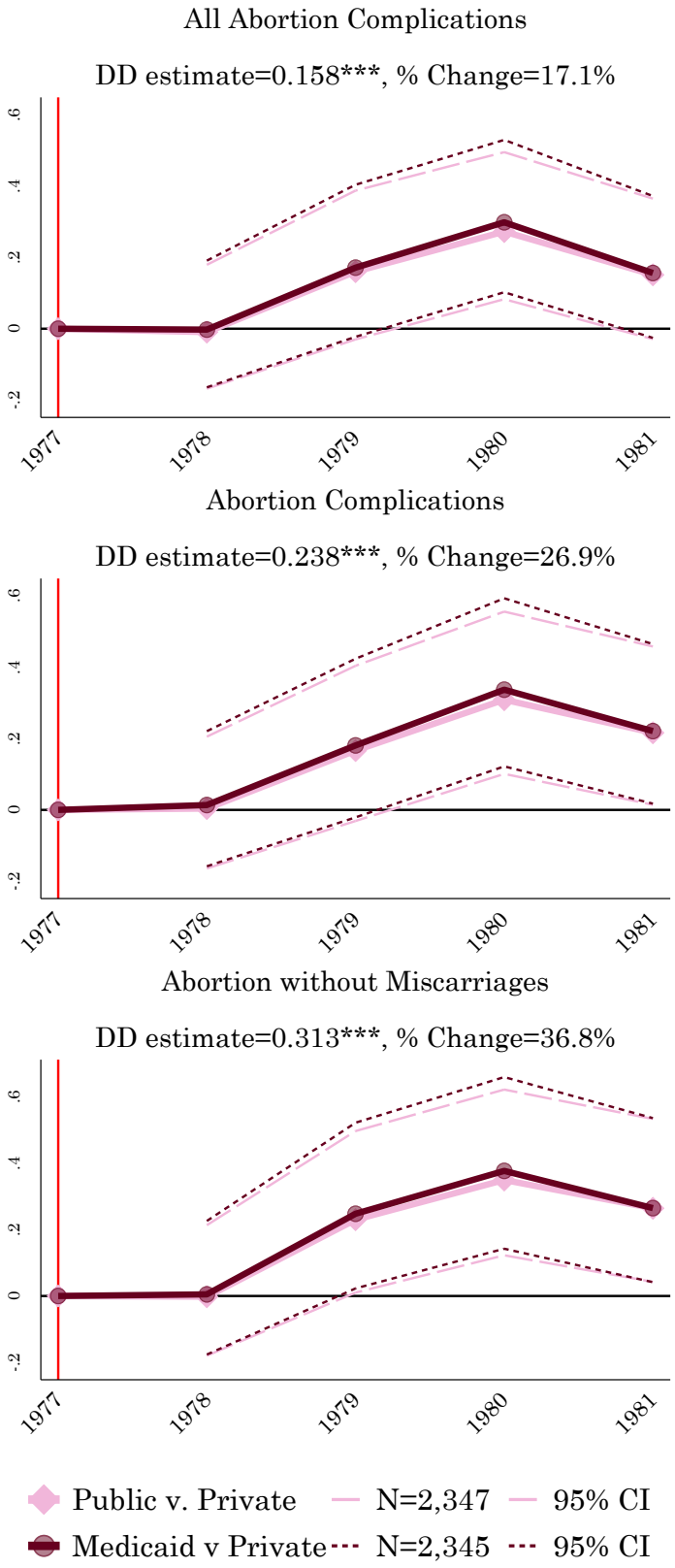
NOTES: Reflects Figure VIII except considering robustness checks. Here, the results show the sample of 18-29 to reflect our main fertility results, which are shown in light diamond. The dark circles show the abortion complications per reproductive-age hospitalization rather than per delivery.

Figure D.7: NHDS Event Study: Adding *Marital Controls* with Cases of Abortion Complications



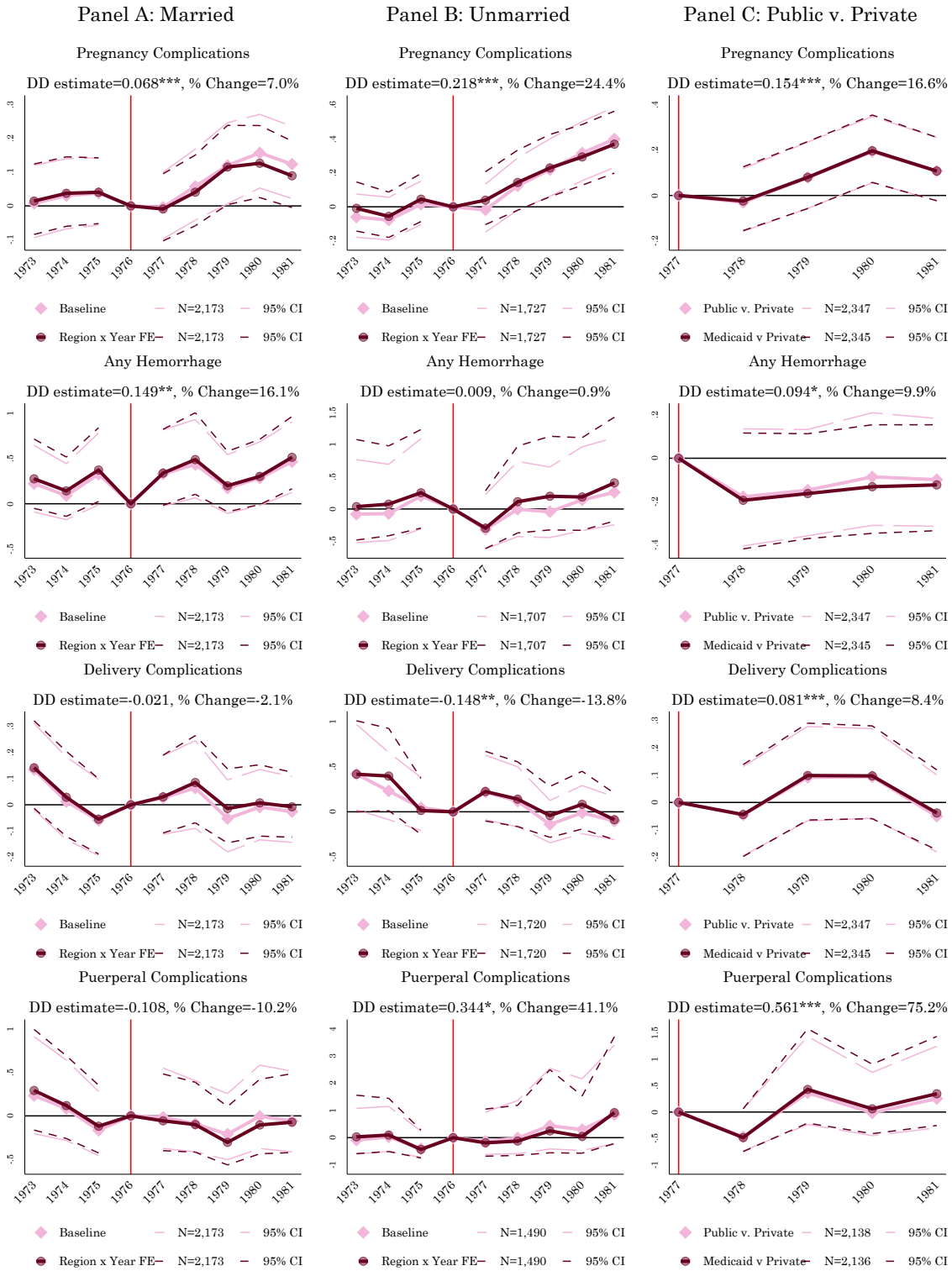
NOTES: Reflects Figure VIII except considering the effect with controls for marital status (indicators for married, single, and divorced). Here the data are collapsed to the level of the marital controls in addition to our baseline collapsed data.

Figure D.8: NHDS Event Study: Cases of Abortion Complications, *Public versus Private Insurance*



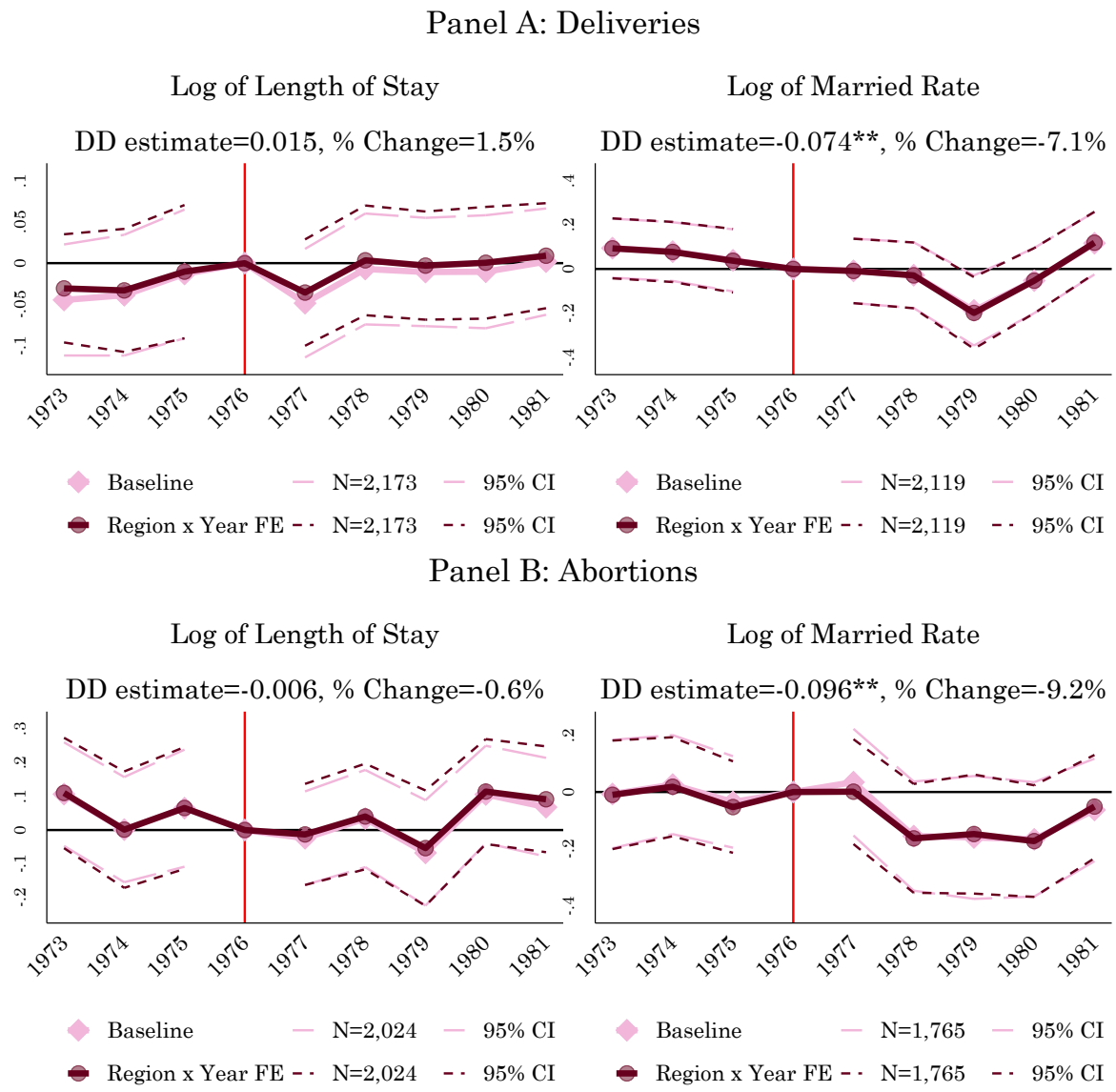
NOTES: Reflects Figure VIII, except considering Public versus Private insurance status. Unfortunately, insurance information is only available beginning in 1977, so these results are speculative rather than definitive. We include fixed effects for insurance type rather than race in the above specification.

Figure D.9: NHDS Event Study: Cases of Pregnancy and Abortion Complications



NOTES: Reflects Figure VIII and Figure D.8 except considering different complications. For pregnancy complications, delivery complications, and postpartum complications, we only include complications that are similar before and after the change to the ICD codes. Pregnancy complications only take unified complications, including all abortion/miscarriage/ectopic pregnancy complications, preeclampsia, infections of the genital tract, and antepartum hemorrhages. Delivery complications include postpartum hemorrhage, delivery trauma, and laceration. Postpartum complications include pulmonary embolism, mastitis, and sepsis.

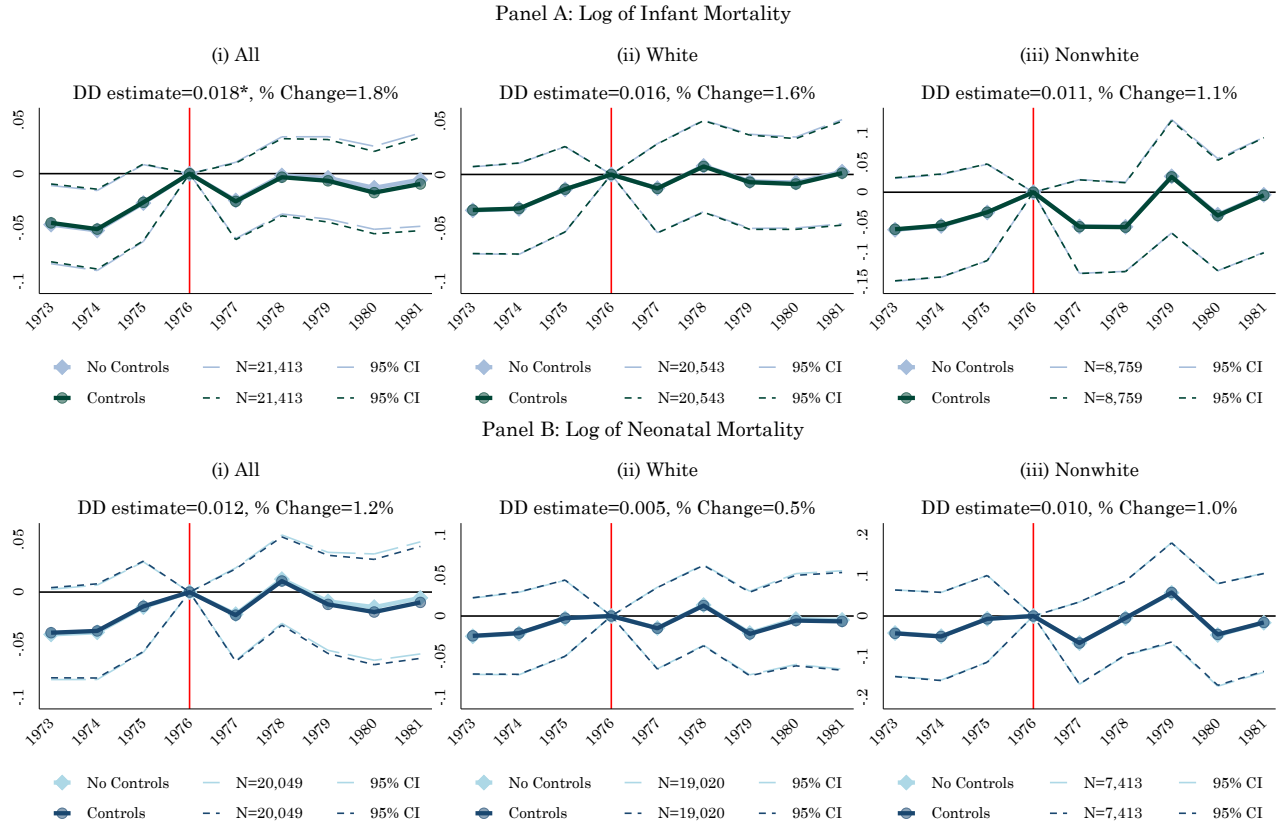
Figure D.10: NHDS Event Study: Characteristics of Abortion and Delivery Complications



NOTES: Reflects Figure VIII and Figure D.8 except considering whether complications change in the sample of deliveries and abortions. The plotted points show the OLS coefficients from the log of the length of stay and the log of the married rate (per 1,000) in the sample of abortions and deliveries. Results are weighted by the sample weight summed over the sample (deliveries in Panel A and abortions in Panel B).

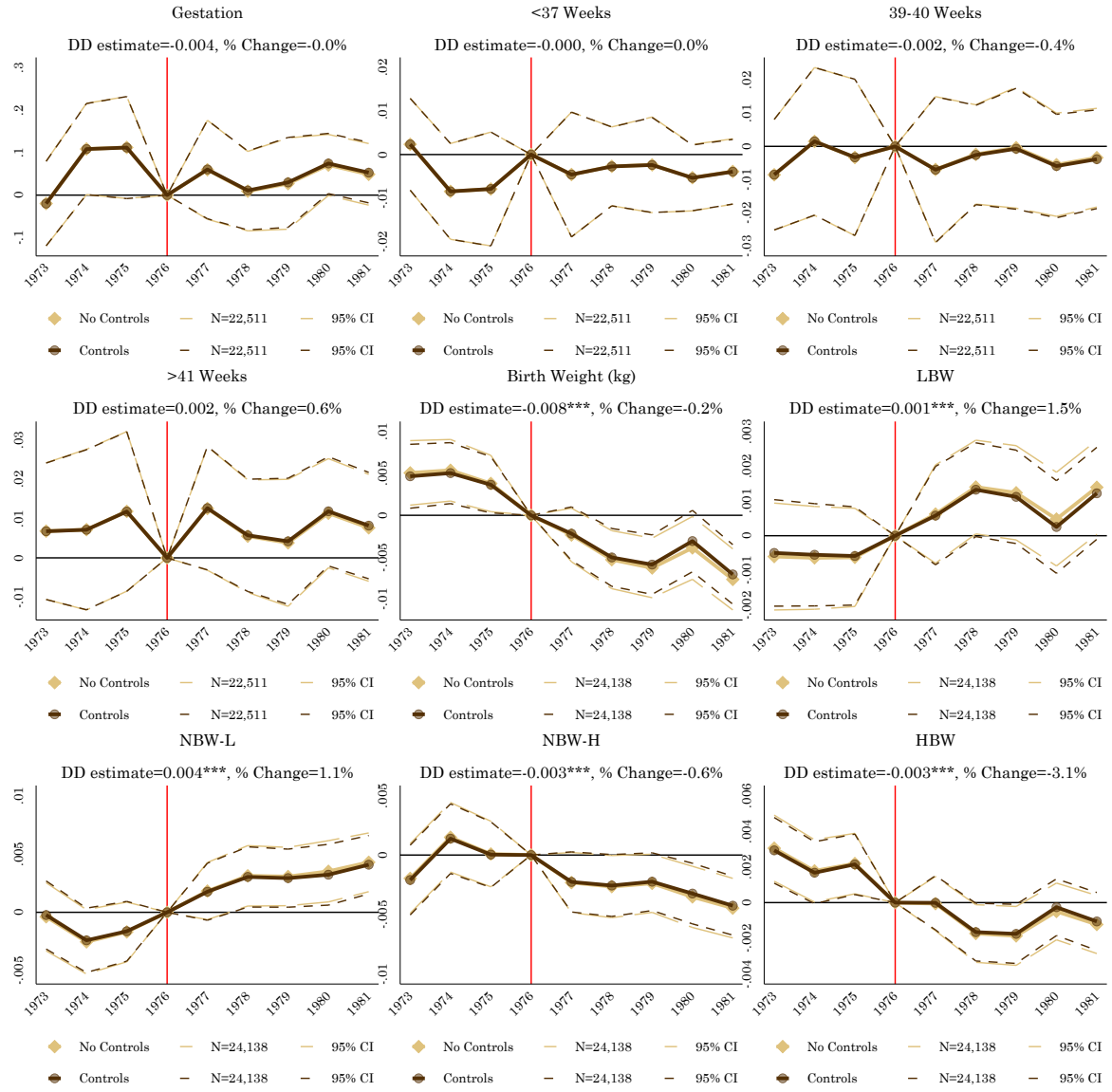
E Other Outcomes

Figure E.1: County-level Infant Mortality – High Medicaid Eligibility Counties



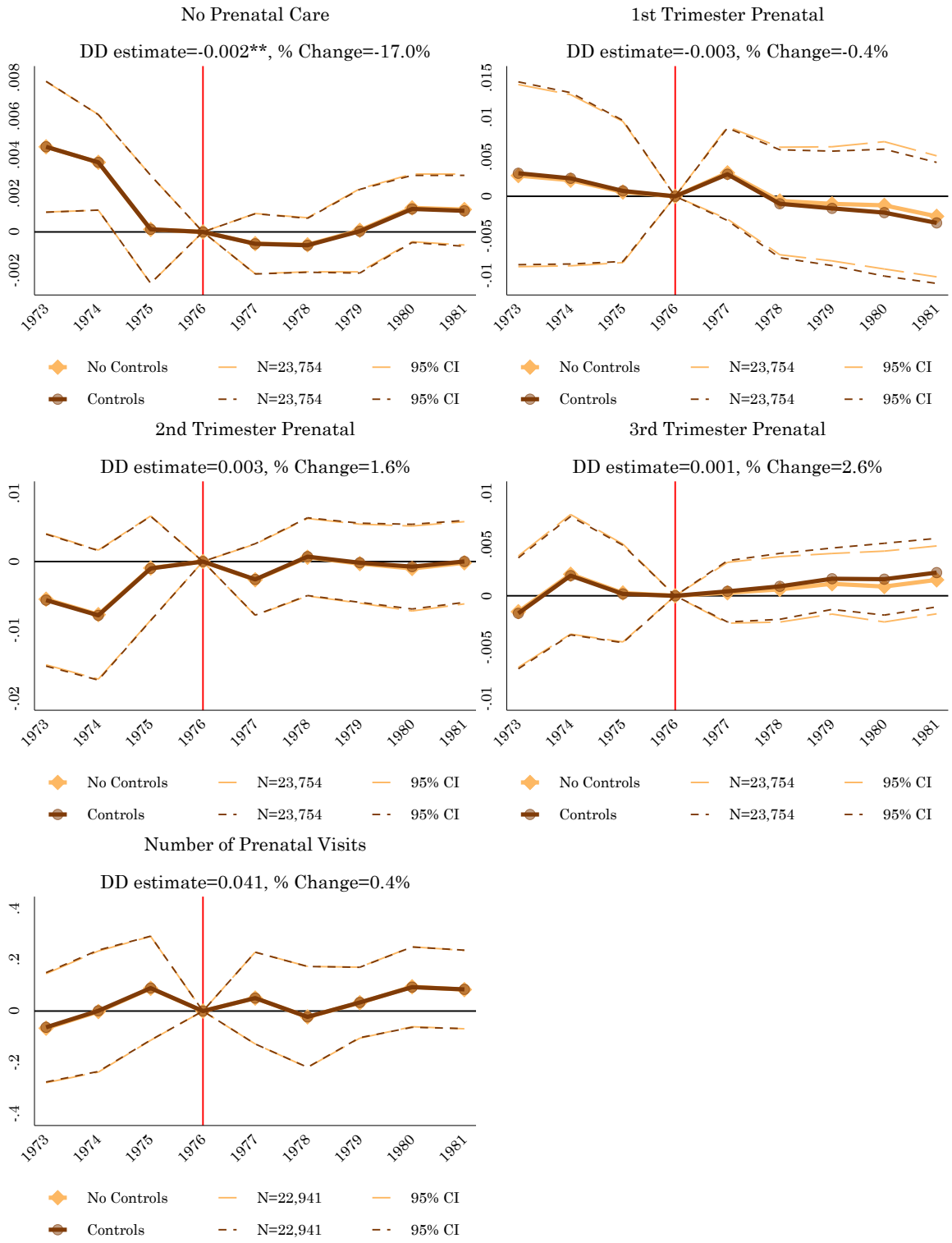
NOTES: Represents county-level specification from Figure III, except considering the log of the county-level infant/neonatal mortality. Here the exposure is the number of births (all, white, non-white).

Figure E.2: Birth Weight and Gestation in Above-Median Medicaid Eligibility Counties



NOTES: Represents county-level specification from Figure III, except considering the average characteristics of deliveries. The outcome is the average or share across all county-level deliveries. Regressions are weighted by the number of births. Birth weight groups include low birth weight (<2,500 grams), low-normal birth weight (2,500-3,249 grams), higher-normal deliveries (3,250-4,000 grams), and high birth weight (<4,000 grams). Regressions are weighted by the number of births.

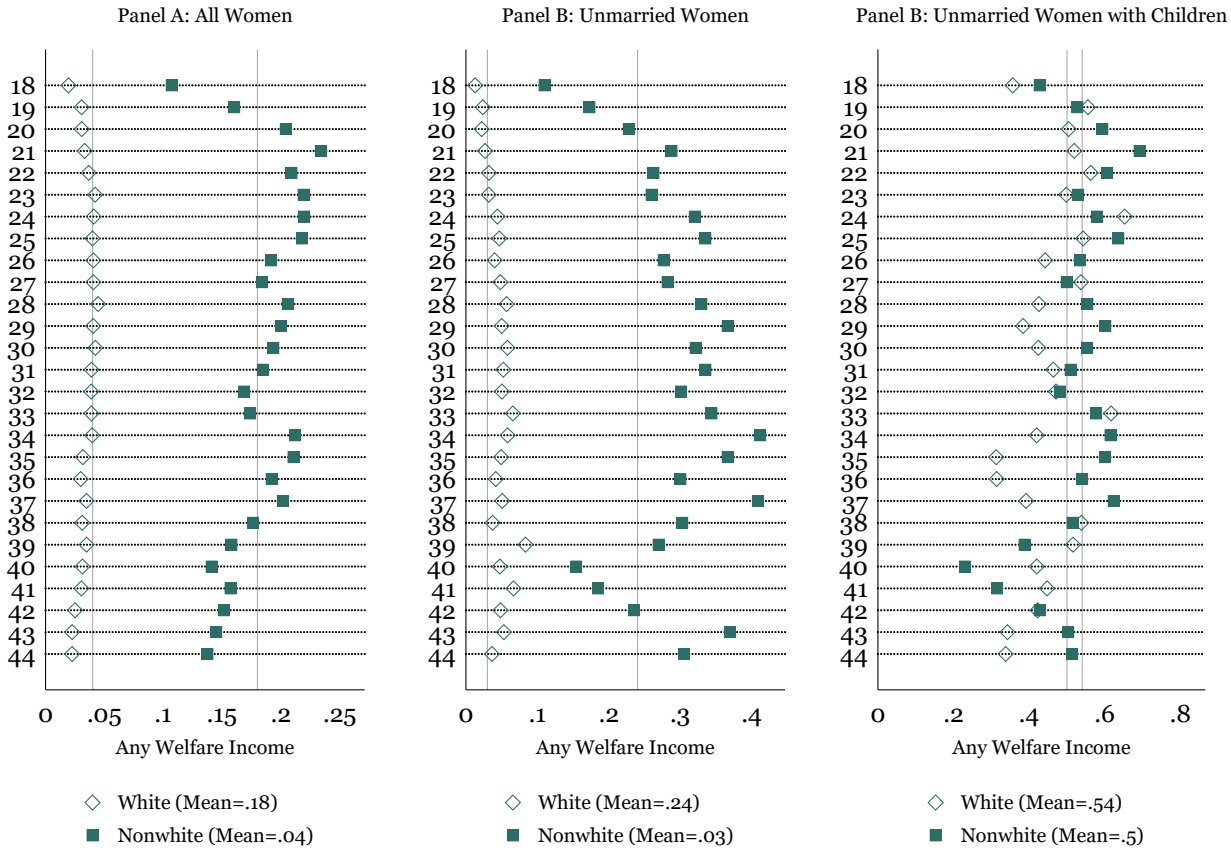
Figure E.3: Prenatal Care in Above-Median Medicaid Eligibility Counties



NOTES: Represents county-level specification from Figure III, except considering the average characteristics of deliveries. The outcome is the average or share across all county-level deliveries. Regressions are weighted by the number of births.

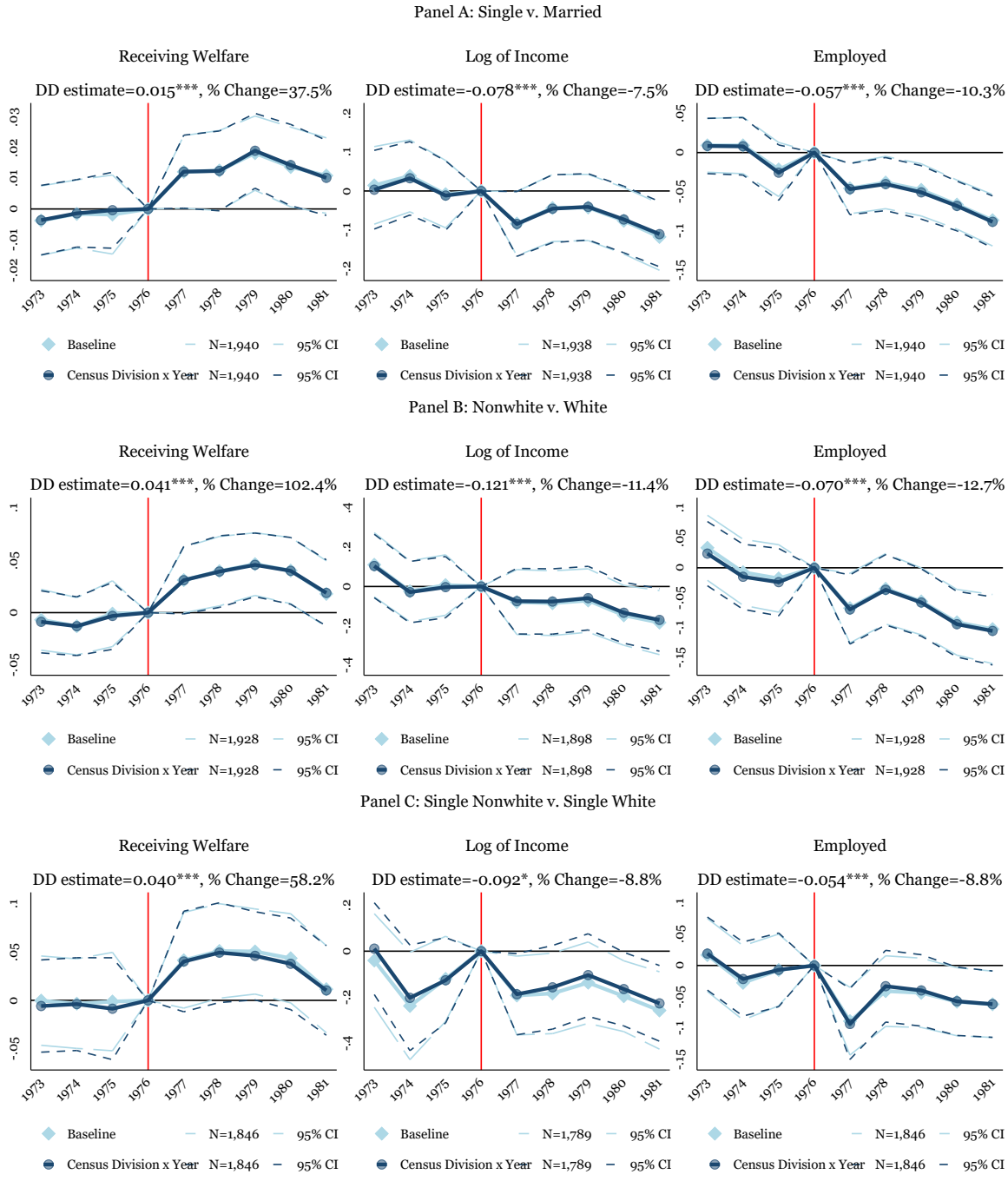
F Current Population Survey

Figure F.1: Welfare Payments by Race, Marital Status, and Children



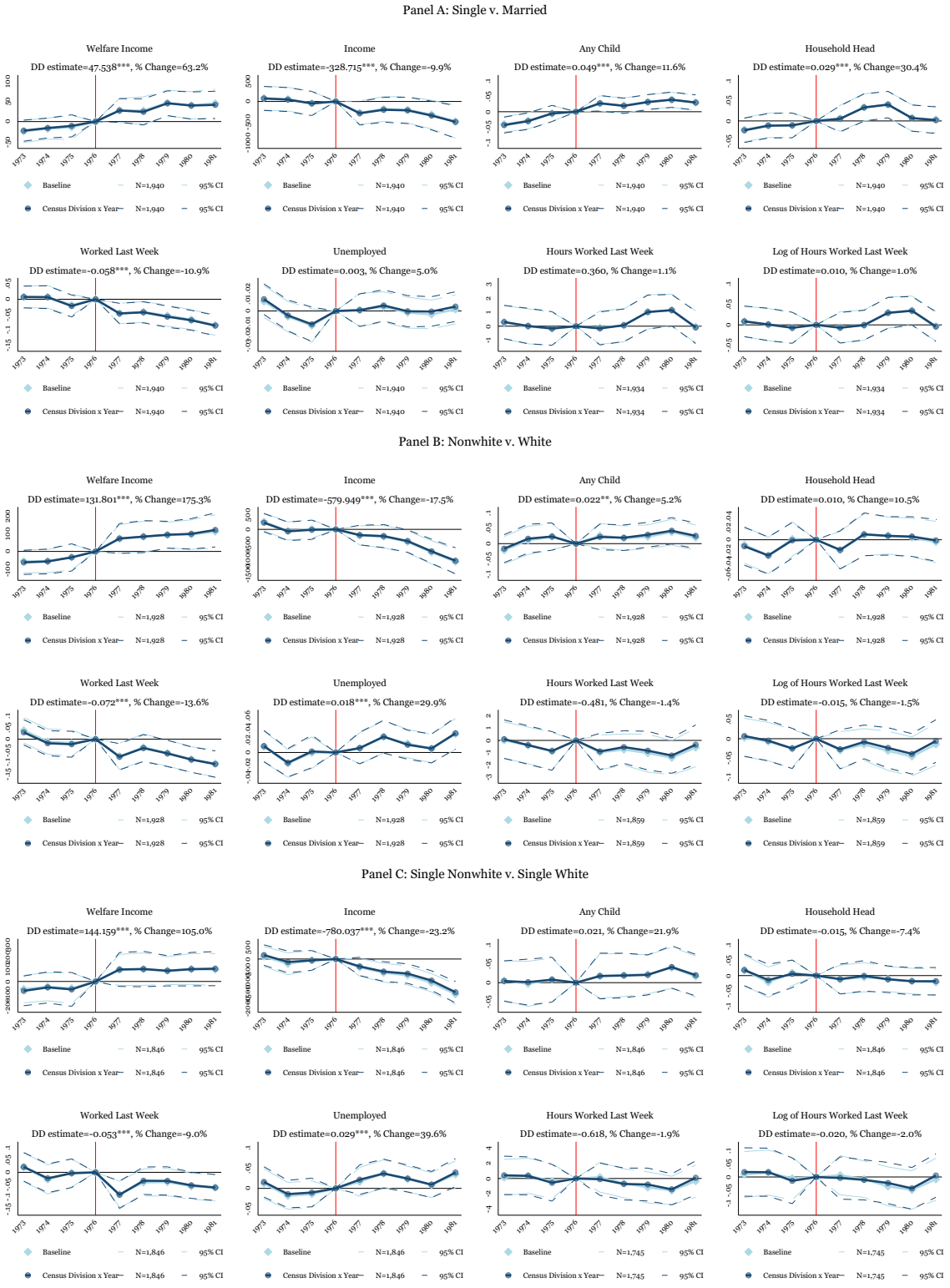
SOURCE: *IPUMS CPS* (1973-1981)
NOTES: Shows the share of each noted group receiving any welfare income in the CPS data over each age. The vertical lines show the mean welfare receipt by race, with the means noted in the legend.

Figure F.2: Income and Labor Supply–Nonwhite, Unmarried Women, and Non-white Unmarried Women, 18-29



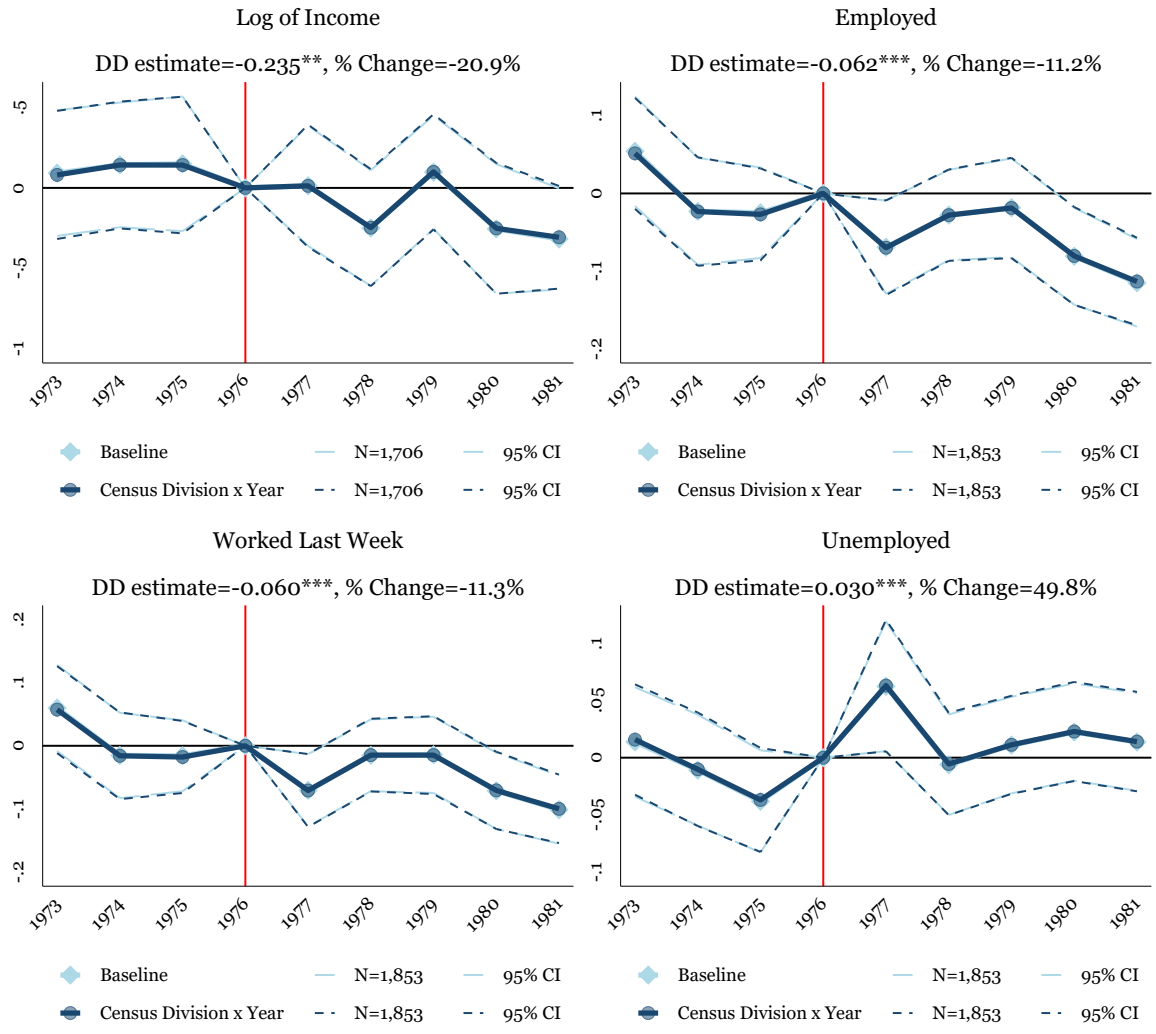
SOURCE: *IPUMS CPS* (1973-1981)
NOTES: CPS data collapsed to the region, age, race (or married depending on panel), and year level. Only includes women ages 18-29 to correspond with fertility results. Fixed effects for the region, year, age, and race (or married, depending on panel) level included. Census division-by-year fixed effects included where noted. Robust standard errors reported. In Panel A, only single and married women are included. In Panel C, only single women are included.

Figure F.3: Economic Outcomes in the CPS Data



NOTES: Reflects Figure F.2, except considering different outcomes.

Figure F.4: Income and Labor Supply–Welfare Recipients versus Non-Welfare Population, Women 18-29



NOTES: Reflects Figure F.2, except considering different outcomes.