The Consequences of Abortion Funding Bans*

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Abstract: Do restrictions on public funding create unintended reliance on social assistance? In this paper, we study the 1976 Hyde Amendment, which barred federal funding for abortion. Using county-level data and an event-study design, we show that reduced federal funding for abortion increased fertility among young women by 2%. These effects were concentrated among non-white women, who subsequently experienced greater welfare participation in states with larger abortion funding declines. The consequences extend into the next generation: non-white girls born after Hyde were more likely to rely on public assistance in adulthood. Abortion funding restrictions reinforce long-run economic inequality across generations.

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1 Introduction

Public assistance programs are deeply interconnected, and eligibility criteria or structural changes to one program often influence participation in other programs (Remler and Glied, 2003; Currie and Grogger, 2002; Thompson and Garrett-Peltier, 2012; Kline and Walters, 2016). As a result, funding cuts or cost-containment measures in one area can lead to increased participation in other parts of the social safety net. Effects of such funding cuts are rarely distributed evenly; reductions in public spending disproportionately affect low-income and minority individuals, exacerbating existing disparities and reinforcing economic inequality (Currie and Grogger, 2002; Toffolutti and Suhrcke, 2019; Jackson et al., 2021). Conversely, expanding access to public programs can yield substantial, long-lasting benefits that span generations, acting as crucial investments in human capital and economic mobility (Sommers and Oellerich, 2013; Chetty et al., 2016; Hoynes et al., 2016; Aizer et al., 2016; Goodman-Bacon, 2018, 2021; Hoehn-Velasco, 2021; East et al., 2023).

A prime example of a long-standing and influential public funding restriction is the Hyde Amendment. The Hyde Amendment bars the use of federal Medicaid funds for abortion except in cases of rape, incest, or life endangerment, and has been in effect for nearly 50 years since 1976 (Trump, January 24, 2025; Gold, 1980). Prior to its passage, Medicaid financed roughly 300,000 abortions each year, about one quarter of all U.S. abortions (Cates, 1981). Over the 1977–2016 period, this proportion implies that 4.8–8.3 million abortions were directly affected by the withdrawal of public funding (Cates, 1981; Guttmacher Institute, 2025).

The Hyde Amendment funding restrictions remain relevant today, since one in five reproductive-age women, a total of 16 million women, rely on Medicaid for health coverage (Medicaid.gov, 2024; ACOG, 2024; KFF, 2022b,a, 2024). While some states use their tax dollars to fund abortion services for Medicaid enrollees, many do not, leaving substantial gaps in funding for abortion services (Gold, 1980). These restrictions continue to create major barriers to reproductive healthcare and shape the economic well-being of disadvantaged households. Although public debate over Hyde has centered on moral and ethical issues, the policy also has profound economic implications, particularly for low-income women receiving Medicaid.

In this paper, we analyze both the immediate and longer-term effects of the Hyde Amendment. We begin by investigating the initial impacts on fertility. We use a county-level event-study design that exploits variation in Medicaid eligibility as a measure of the Hyde Amendment's treatment intensity.[1] Our analysis draws on county-

[1]We examine the effects of the Hyde Amendment in counties with higher participation in the Aid to Families with Dependent

level fertility data from the Natality Detailed File, covering the years 1971 to 1982.[2]

We find that counties with higher Medicaid eligibility experience a clear increase in fertility following the Hyde Amendment. Our event-study estimates show a 2% increase in fertility among women under age 30, concentrated among those in their late teens and early twenties.[3] The increase is especially pronounced among unmarried women with children, the group most likely to be Medicaid-eligible. Complementary evidence from Georgia's county-level administrative records and the National Survey of Family Growth (NSFG) demonstrates that the Hyde Amendment reduced abortions among Medicaid-eligible women. In Georgia, counties with higher Medicaid eligibility display clear declines in abortions. In the NSFG, Medicaid recipients show a shift from abortion to live births after 1976. Together, these findings reinforce that restrictions on publicly funded abortion translate directly into higher fertility.

We then examine the downstream economic consequences of this fertility response, which has potential distributional effects. When unwanted births increase among low-income women, household resources are strained, and families may turn to public assistance. In this way, the fertility effects of abortion funding restrictions generate broader pressures on the social safety net. To test this hypothesis, we use the Current Population Survey to study economic outcomes in states that experienced larger declines in Medicaid-funded abortions before and after Hyde and a triple difference design where we additionally compare these outcomes for non-white and white women.[4] We find that non-white women in states with larger declines in Medicaid-funded abortions experienced a notable rise in welfare participation following Hyde. This increase in public assistance use is accompanied by a higher likelihood of having children in the household and a larger household size. These results show that the fertility effects of the Hyde Amendment were not merely demographic shifts but intensified reliance on welfare programs. Because young non-white women were especially likely to rely on Medicaid for healthcare, they bore the brunt of these restrictions.[5]

We then track children born around the time of the Hyde Amendment in the American Community Survey (ACS) from 2000 to 2019. We focus on women since they

Children (AFDC) program in 1976 (i.e., cash welfare; ASPE, 2024). AFDC participation was categorically linked to Medicaid coverage at the time of the Hyde Amendment. AFDC has been used in related research to identify Medicaid eligibility (Goodman-Bacon, 2018, 2021).

[2] While this time period overlaps with *Roe v. Wade*, in our main results, we incorporate state-by-year fixed effects to limit the influence of state policy.

[3] Young women account for most unintended pregnancies (KFF, 2021) and disproportionately rely on Medicaid to cover abortion costs (Authors' calculations from NHDS; see Figure A.4).

[4] Medicaid funding of abortions is from newly digitized publications of the number of Medicaid-funded abortions in each year.

[5] See Figure G.1. The focus on non-white women is motivated by state-level evidence showing that the fertility increase following the Hyde Amendment is concentrated among non-white women. Prior research has also shown that non-white women are especially affected by abortion restrictions (Joyce et al., 2013; Myers, 2017a; Farin et al., 2024; Gardner, 2024; Jones and Pineda-Torres, 2024). Historical evidence from the time also suggests that Black women were more affected by the Hyde Amendment than their white counterparts (Lincoln et al., 1977), with one source arguing that "proportionally more Black than white women will be forced to bear unwanted children" due to the reduction in Medicaid-funded abortions (Lincoln et al., 1977).

are more likely than men to receive public assistance. We expect the Hyde Amendment to have lasting effects as children born during this period grew up in larger households with greater reliance on public assistance. Our triple-difference event-study estimates indicate that, as adults, non-white girls exhibit significantly higher participation in public assistance, particularly public insurance.

These second-generation impacts highlight how the Hyde Amendment contributes to deeper economic inequality across generations. By limiting access to abortion, the funding restrictions increase fertility for women already facing structural disadvantages. These immediate changes then shape long-term reliance on public support. Although the Hyde Amendment's intent was to restrict federal funding for abortion, its broader, unintended consequences included increased demand for welfare and public insurance among families with fewer resources. These findings highlight the enduring impact of funding restrictions on the economic opportunities and well-being of disadvantaged women and their children. Fertility responses to abortion funding restrictions are not just demographic outcomes but central drivers of economic inequality. As a result, women who rely on Medicaid may require additional public investment and support as a direct result of Hyde.

Our study makes four key contributions to the literature. First, we show that abortion funding restrictions produced lasting economic consequences by altering fertility among low-income women. The Hyde Amendment increased births among Medicaid-eligible populations, and these additional births strained household resources and expanded reliance on welfare programs. In doing so, the policy shifted recipients of public support from a one-time Medicaid expense to other parts of the social safety net, thereby reinforcing cycles of inequality. Our findings complement a large body of literature showing that expansions of social programs yield long-term benefits (Sommers and Oellerich, 2013; Hoynes et al., 2016; Goodman-Bacon, 2018, 2021; East et al., 2023; Baker et al., 2023). However, our findings diverge from this prior work by highlighting the costs of restricting access to public support. Limiting one public program can increase dependence on others, with effects that persist across generations.

Second, we provide one of the first comprehensive analyses of the Hyde Amendment, linking the immediate fertility effects with economic outcomes. While prior research on Hyde has largely focused on whether fertility changed, we show the link between fertility and public assistance participation. By documenting the full chain of effects, our study moves beyond demographic outcomes to highlight how a targeted funding restriction can reshape the economic trajectories of disadvantaged families. This broader perspective is essential given Hyde's enduring reach: nearly fifty years after enactment, it continues to affect 16 million reproductive-age women annually

(KFF, 2025; Guttmacher Institute, 2021).

Third, we contribute to the literature on the economic consequences of restricted abortion access by leveraging plausibly exogenous variation from federal funding bans. Prior research has largely focused on the first generation of women directly affected by abortion restrictions, documenting impacts on outcomes such as educational attainment (Angrist and Evans, 1996; Pop-Eleches, 2006; Ananat et al., 2007; Mølland, 2016; González et al., 2018; Jones and Pineda-Torres, 2024), labor market outcomes (Angrist and Evans, 1996; Kalist, 2004; Mølland, 2016; Lindo et al., 2020b; Jones et al., 2021), and financial instability (Miller et al., 2023).[6] By contrast, the present study examines both the women whose ability to terminate a pregnancy was constrained by funding restrictions through the Hyde Amendment and the children born as a result. We add to this literature by showing that limiting abortion funding perpetuates reliance on the social safety net and the intergenerational transmission of economic inequality.[7]

Fourth, our paper is among the first to analyze the fertility effects of the Hyde Amendment using within-state, county-level variation, providing a more granular perspective than prior state-level studies. With the exception of Kane and Staiger (1996),[8] most research has relied on state-level responses to federal abortion funding restrictions (Garbacz, 1990; Haas-Wilson, 1993; Blank et al., 1996; Haas-Wilson, 1996; Levine et al., 1996; Haas-Wilson, 1997; Matthews et al., 1997; Cook et al., 1999). Several of these studies report little to no effect or reductions in fertility following Medicaid abortion funding restrictions. By contrast, our county-level approach leverages variation in Medicaid eligibility to identify local impacts that are masked in state-level aggregates. Incorporating state-by-year fixed effects further allows us to control for contemporaneous state policy responses. Our design reveals clear increases in fertility for young women.

[6] Another set of studies has shown that abortion access affect outcomes for children (Gruber et al., 1999; Bitler and Zavodny, 2001; Ananat et al., 2009; Mitrut and Wolff, 2011; Lahey and Wanamaker, 2025), as well as adolescents and adults (Ananat et al., 2009; Charles and Stephens, 2006; Pop-Eleches, 2006; Mølland, 2016; Myers, 2017a; Gutierrez, 2022). Studies have also examined the long-term effects of abortion access, including Lahey and Wanamaker (2025); Farin (2024, 2025).

[7] Our study also contributes to the broader literature on abortion restrictions (Haas-Wilson, 1996; Bitler and Zavodny, 2001; Pop-Eleches, 2006; Guldi, 2008; Jacobson and Royer, 2011; Lahey, 2014b,a; Miller et al., 2023), abortion legalization (Angrist and Evans, 1996; Levine et al., 1999; Donohue and Levitt, 2001; Ananat et al., 2004; Kalist, 2004; Levine and Staiger, 2004; Oreffice, 2007; Guldi, 2008; Foote and Goetz, 2008; Donohue and Levitt, 2008; Ananat et al., 2009; Mølland, 2016; Myers, 2017a; González et al., 2018; Clarke and Mühlrad, 2021; Hajdu and Hajdu, 2021; Jones et al., 2021; Abboud, 2025), parental consent and notification (Kane and Staiger, 1996; Joyce and Kaestner, 1996; Matthews et al., 1997; Bitler and Zavodny, 2001; Levine, 2003; Klick and Stratmann, 2008; Sabia and Rees, 2013; Sabia and Anderson, 2016; Joyce et al., 2020; Myers and Ladd, 2020), abortion provider restrictions (Quast et al., 2017; Fischer et al., 2018; Lindo et al., 2020a; Muratori, 2021; Jones and Pineda-Torres, 2024; Gardner, 2024), and mandatory waiting periods (Joyce et al., 1997; Joyce and Kaestner, 2000, 2001; Bitler and Zavodny, 2001; Lindo and Pineda-Torres, 2021; Myers, 2021b; Altındağ and Joyce, 2022; Durrance et al., 2024). Prior research has also shown the fertility effects of the pill (Goldin and Katz, 2000, 2002; Bailey, 2006; Ananat et al., 2007; Hock et al., 2007; Bailey, 2010; Bailey et al., 2012; Zuppann, 2012; Steingrimsdottir, 2016; Myers, 2017a).

[8] Our findings diverge from the earlier county-level study, Kane and Staiger (1996), in two key ways. First, we emphasize that many states did not fully replace the federal dollars lost due to the Hyde Amendment, even when states continued to fund Medicaid abortions. For example, Illinois and New Jersey continued Medicaid funding using state funds but reduced the scope of funded abortions. Second, we use AFDC participation instead of poverty rates. While the two are correlated, AFDC receipt is statutorily linked to Medicaid participation.

2 Background

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

In 1976, the U.S. Congress passed the Hyde Amendment, introduced by Illinois Representative Henry Hyde, as a rider to the Department of Labor, Health, Education, and Welfare Appropriations Bill (Gold, 1980; Copelon and Law, 2010; CRS, 2023). The Amendment prohibited the use of federal funds for abortion, initially allowing exceptions only when the mother's life was endangered (Copelon and Law, 2010; CRS, 2023). Since the 1990s, the Hyde Amendment has consistently allowed federal funds in cases of rape, incest, or when the mother's life is endangered (Foundation, 2021; CRS, 2023).[9]

Although enacted on September 30, 1976, the Amendment's enforcement was quickly halted. On October 22, a federal judge issued an injunction in *McRae v. Mathews* that blocked the Hyde Amendment's implementation (Copelon and Law, 2010; U.S. District Court for the Eastern District of New York, 1976). The injunction remained in effect until August 4, 1977, when it was lifted, allowing the Hyde Amendment to take full effect (Lincoln et al., 1977; CDC, 1977; Cates, 1981; Torres et al., 1986). As a result, abortions continued to receive federal funding in early 1977, but by the end of the year, those funds were barred. By 1978, federal support for abortion had fallen by 99% (Gold, 1980). The restrictions have remained in place ever since, except for a seven-month suspension in 1980 while the Supreme Court considered the law's constitutionality (Cates, 1981).

Despite delays in implementing the Hyde Amendment, the effects began as early as 1976. In that year, the Amendment received widespread publicity across the United States, which may have deterred women from seeking abortions funded by public programs (Trussell et al., 1980; Cates, 1981). As Cates (1981) explains, "The widespread publicity about the restriction of federal funds may have obscured the recognition of the continuing availability of state funds for abortion. This confusion may have deterred some low-income women from requesting abortions and some abortion providers from soliciting state reimbursement" (Cates, 1981, pg 1111).

In our own review, we found substantial coverage of the Hyde Amendment across both national and local media. Between 1976 and 1977, at least 110 news outlets in all 50 states reported on the Amendment. This widespread attention likely shaped public perception: many individuals may have been aware of the Amendment's existence

[9] Over time, Congress revised the Hyde Amendment multiple times: with exceptions for rape and incest intermittently included and removed (CRS, 2023)

but not fully informed about the legal status or the availability of alternative funding.[10] Media accounts at the time reflected strong reactions. For example, the Dayton Daily News described the Hyde Amendment as "an anti-poor amendment" and called it "blatantly unconstitutional on equal protection and privacy laws" (The Dayton Daily, 1976). The Anchorage Times noted, "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" (The Anchorage Times, 1976).

2.2 Who does the Hyde Amendment Affect?

The Hyde Amendment primarily affected reproductive-age women participating in the Medicaid program (Cates, 1981). Medicaid eligibility at the time was tied to AFDC receipt, which was categorically linked to Medicaid. For example, Medicaid/Medicare Management Institute (1978, 1979) states that "Medicaid eligibility is linked to the Federally assisted welfare programs of Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI) for the aged, blind, and disabled" (Medicaid/Medicare Management Institute, 1979, pg 24). To make this point clear, we show a breakdown of eligibility in Figures I, A.1, A.2, A.3. The categories of eligibility illustrate that, for able-bodied reproductive-age women, AFDC is the clearest pathway to Medicaid eligibility. AFDC participation has been used to identify Medicaid recipients in similar studies (Goodman-Bacon, 2018, 2021).

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 (10)-(12) 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*

[10] Low-income women may not have known about the availability of state funds for abortion. According to Cates (1981), "the same confusion over the availability of state funds for abortion that led some women to use other means to finance their pregnancy terminations may have led other women to continue their pregnancies to term" (Cates, 1981, pg 1111). Some providers may also have refrained from seeking reimbursement from available state funds (Cates, 1981, pg 1111).

aged 15-44, was about three times higher in FY 1976 than among the nonpoor" (Lincoln et al., 1977, pg 210). Table 1, Columns (7)-(9), 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 1976, for 44 reporting states, there were 260,800 state Medicaid-funded abortions and 962,314 total abortions, translating into 27% of all abortions.[11]

Historical evidence from the time also suggests that Black women were more affected by the Hyde Amendment than their white counterparts. An analysis at the time of the Hyde Amendment argued that "*proportionally more Black than white women will be forced to bear unwanted children*" due to the reduction in Medicaid-funded abortions (Lincoln et al., 1977, pg. 213). 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 should disproportionately affect 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 healthcare 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. The majority of subsidized abortions that still occurred were in states with funding available for medical necessity (Gold, 1980). However, the number of prevented abortions could be larger. Gold (1980) and Torres et al. (1986) estimate that in 1978, there were

[11] Based on author's calculations with data collected from Lincoln et al. (1977).

234,000 women in need of abortion who could not obtain one due to public funding restrictions. After the Hyde Amendment, Cates (1981) estimates that 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*.

We compile data on both Medicaid-funded abortions and total abortions across U.S. states. Figure II presents the aggregate estimates, where we group states by their decline in abortion funds. In Figure II, Medicaid-funded abortions are displayed on the left, while total abortions from the CDC Abortion Surveillance Program are in the middle, and the funding per abortion (a proxy for cost) is shown on the far right. We also provide the detailed state-level data in Table 1 Columns (8)-(11) as well as in the Appendix (Figure A.5, Figure A.6, Figure A.7, and Figure A.8).

Panel A of Figure II shows abortions in states with limited state funding after the Hyde Amendment, a 90%+ drop in funds. In these states, Medicaid abortions drop off almost completely, falling from 40,000 to less than 10,000. Despite the drop in funding, women in these states still continued to obtain abortions. 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 (by 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.

In Panel B, we show states with partial funding drops (1-89%). Panel B reveals that even in states with available public funds, abortions decline after the Hyde Amendment. Medicaid-funded abortions fell from over 80,000 to below 60,000 in 1978 (for the available states). For example, in Illinois, the state 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, abortion funding remained quite high. Figure II Panels C and D show states with 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 do not include them in the county-level analysis and only consider them as controls in the state-level analysis. However, we acknowledge

that these states may still have had hurdles to obtaining an abortion, even if purely informational hindrances. Thus, our state-level results will be biased downward if the informational effects are large.

2.4 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 III). 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 II). Although the abortion rate is higher for non-white women as compared to white women (right-top panel of Figure III), the non-white abortion rate falls after the Hyde Amendment, while the white abortion rate 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 under 15 only make up a small share of abortions (second panel of Figure III).

The third row of Figure III presents the proportion of abortions by each method. By 1974, abortions were primarily 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 III 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.

2.5 Aggregate Impacts of the Hyde Amendment Over Time

The Hyde Amendment's funding restrictions directly affected a large share of abortions over time. Estimates from the Guttmacher Institute suggest that about 30% of abortions are paid for by Medicaid (Guttmacher Institute, 2025), while contemporaneous estimates from the 1970s reported similar figures of 25–30% (Cates, 1981). Ap-

[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 for the national specification, only in Georgia. Second, the data reported in Figure III 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 III, 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 CDC totals are lower than the same reporting areas by The Alan Guttmacher Institute, which contacts abortion providers directly (Elam-Evans et al., 2002).

plying these rates implies that between 100,000 and 220,000 abortions were impacted each year in states with abortion funding restrictions (see Figure A.9). These annual totals amount to 4.8 million abortions affected by funding cuts over the 1977–2016 period. If we include states that replaced federal dollars with state funding, the number of abortions affected rises to 8.3 million. These tallies understate the true impact, as they do not account for women deterred from seeking abortions altogether after public funding declines.

3 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. But we also add health information from the *National Center for Health Statistics Multiple Cause of Death Files* and the *National Hospital Discharge Survey Series*. For the economic effects, we use the *Current Population Survey (CPS, Flood et al., 2024)* and the *American Community Survey (ACS, Ruggles et al., 2024)*. Here, we focus on the main data for the fertility results, and we describe the health and economic data where relevant.

3.1 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, 1970-1990) for county and state-level births. The Natality Detail File includes 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. When measuring the number of births, we base the timing on conception rather than birth. Since the risk of abortion is highest early in pregnancy, using the conception date provides a clearer picture of when abortions would have occurred. We calculate the conception year by subtracting the reported gestational age from the birth year. If gestation is missing from birth records, we assume a roughly average gestation of 38 weeks.

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]

[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

In our county and state-level analysis, we focus primarily on births to young women, specifically those under the age of 30. Women under the age of 30 make up 83% of births (see Table A.4) and have the most abortions (Figure III). This age group is also of particular interest because women in their teens and 20s are more likely to use public funds to pay for an abortion[14] and teenagers are the most likely to have out-of-wedlock births (Kane and Staiger, 1996).

3.2 Population: SEER Population Data

We combine the county-level births with SEER population data to construct fertility rates and controls (SEER, 2024). These data include 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 the SEER population data to calculate controls. Our main controls include the share female, the share white, and the unemployment rate (Haines, 2010).[15]

3.3 Medicaid Eligibility: AFDC Receipt

To measure Medicaid eligibility, we use the share of the population receiving Aid to Families with Dependent Children (AFDC), commonly referred to as "welfare." Specifically, we proxy Medicaid eligibility using the county-level share of the population receiving AFDC in 1976, based on data from Haines (2010) and United States Bureau of the Census (2012). This approach, using AFDC participation to approximate Medicaid eligibility, has been adopted in related studies (Goodman-Bacon, 2018, 2021). As Goodman-Bacon (2018) points out, there was a "federal requirement that states cover all cash welfare recipients" and a "statutory link between welfare receipt and Medicaid eligibility" (Goodman-Bacon, 2018, pg. 1). Based on these facts, AFDC participation provides a reliable indicator of Medicaid eligibility for reproductive-age women, as Medicaid access was statutorily tied to receipt of AFDC benefits and, beginning in 1972, Supplemental Security Income (SSI) (Provost and Hughes, 2000). Although Medicaid eligibility expanded in subsequent years, much of this growth occurred in the 1980s, after the time frame of our analysis (East et al., 2023).

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).
These data also include characteristics of the mother and newborn, although health information beyond birth weight and gestation is relatively limited during the study period. Unfortunately, many variables, even those included on the birth certificate, were not well reported before 1980. The variables we have include the mother's education level and marital status (for certain years).

[14] Author's calculations based on NHDS, see Figure A.4.

[15] Haines (2010) is not available in all years, and is linearly interpolated between years.

4 County-level Event Study for Fertility

To investigate the impact of the Hyde Amendment on county-level fertility rates, we employ an event-study design. While the Hyde Amendment had national effects, its impact varied significantly depending on the prevalence of Medicaid participation, especially among young women of reproductive age. We incorporate the differential effect of the Hyde Amendment using the share of county residents participating in the AFDC program (or cash welfare) in 1976. AFDC participation acts as a proxy for Medicaid, as AFDC receipt is categorically linked to Medicaid eligibility (see Figures I, A.1, A.2, A.3). In our empirical design, a county will receive a larger treatment if it has a higher level of AFDC participation, which represents local Medicaid eligibility.

Our central empirical strategy aims to determine whether the Hyde Amendment differentially increased fertility in counties with higher Medicaid eligibility (based on the proportion of AFDC recipients in 1976). Specifically, we estimate the following event-study model for county j in state s and conception year $t = 1971, ..., 1982$:

$$\begin{aligned} \ln(\text{Fertility})_{jst} = \alpha + \sum_{m=1971}^{1982} \beta_m \text{ Hyde Amendment}_m \times \text{Proportion AFDC}_j \\ + \mathbf{X}'_{jt}\gamma + a_j + \eta_{s(j)t} + \psi_{u(j)t} + \epsilon_{jst} \end{aligned} \tag{1}$$

where the outcome, $\ln(\text{Fertility})_{jst}$, is the natural log of the fertility rate, the number of conceptions to young women, 29 and under, per 1,000 young women 29 and under in the conception year.[16] In our main results, we show the overall fertility rate and the fertility rate to young women (<30). We focus on young women because they are most likely to be affected by funding restrictions. The majority of unwanted pregnancies occur among women in their 20s (KFF, 2021), and women in their teens and 20s are also the most reliant on public funding for abortion services (see Figure A.4).

The effect of restricted funding for abortion is captured by Hyde Amendment$_m$ $\times$ Proportion AFDC$_j$. Together, the interaction term will capture the effect of the Hyde Amendment based on the proportion of the Medicaid-eligible population in a county. The Hyde Amendment$_m$ represents a set of indicator variables that captures the effect of the Hyde Amendment, which passed in 1976. Though the Amendment passed in 1976, it was only effective briefly. A federal court placed an injunction on the Amendment until August 1977 (Lincoln et al., 1977; CDC, 1977; Cates, 1981; Torres et al., 1986). It then remained in effect until 1980, when it was temporarily lifted while a Supreme Court decision was pending (Lincoln et al., 1977; CDC, 1977; Cates, 1981; Torres et al., 1986). Thus, we anticipate that the Hyde Amendment will only be partially effective

[16] The results are similar if we use a Poisson model rather than OLS with the log of the fertility rate (see Figure VI).

in '76/'77 (U.S. District Court for the Eastern District of New York, 1976; Supreme Court of the United States, 1980). That said, however, there were also strong informational effects. Newspapers in every state across the U.S. publicized the Amendment in '76/'77.[17] Due to the complicated timing of the Hyde Amendment, we consider the post-period effects relative to the true pre-Hyde Amendment period, 1975 (the omitted period).

Proportion AFDC$_j$ measures the county-level AFDC recipients in 1976 from the United States Bureau of the Census (2012), relative to the county population. This variable will range from zero to one, with a zero indicating no AFDC recipients, and one indicating the entire county is receiving AFDC, with the full distribution across the U.S. shown in Panel A of Figure IV. The individual effect of Proportion AFDC$_j$ (not interacted with Hyde) is absorbed by the county fixed effects because it is not time varying.

a_j represents county fixed effects. η_{st} represent state-by-year (of-conception) fixed effects. These state-by-year fixed effects capture state-level changes, including state-level policies that could differentially affect fertility by state. State-by-year fixed effects allow us to interpret the effect, absent time-varying state-level changes that may affect fertility. Since our primary empirical strategy incorporates state-by-year fixed effects, state-level policy changes are effectively controlled for and do not pose a threat to identification. Only national policies that uniformly affect individuals eligible for AFDC/Medicaid could introduce potential bias.[18]

We also include fixed effects for population size by conception year and urbanicity by conception year, denoted as $\psi_{u(j)t}$. These fixed effects are constructed using time-invariant national quartiles of county-level urban share and population interacted with year-of-conception dummies.[19] We include these controls to account for any differential evolution of fertility across counties of varying population size and urbanization (Henshaw et al., 2009). For instance, urban areas might experience more rapid diffusion of social norms or fertility-related technologies, leading to distinct fertility patterns compared to rural areas. Similarly, counties with larger populations may follow different demographic trajectories than those with smaller populations. In the end, our main results remain virtually unchanged when these fixed effects are

[17] We found evidence of at least 110 national and local news outlets in all 50 states, covering the Hyde Amendment in 1976/1977.

[18] However, most major policies likely to influence fertility predate the Hyde Amendment, or occur during the 1980s. Expansions in contraceptive access largely occurred before our study period. Key legal milestones, including *Griswold v. Connecticut* (1965) and *Eisenstadt v. Baird* (1972), took place in the 1960s and early 1970s (Bailey, 2006, 2010; Myers, 2017b, 2021a). Title X clinics were also established during this earlier period, between 1964 and 1973 (Bailey, 2012). Abortion access expanded gradually in the late 1960s and early 1970s, culminating in *Roe v. Wade* in 1973 (Myers, 2021a). Likewise, major Great Society programs such as food stamps were introduced earlier, during the 1960s (Hoynes et al., 2016). Other potentially relevant policies, such as parental involvement laws and Medicaid expansions, were not implemented until the 1980s; therefore, we primarily focus our later state-level results on the late 1970s (East et al., 2023; Myers, 2021a) (see Section 8).

[19] Similar controls have been used in related empirical work (Bailey and Goodman-Bacon, 2015; Hoehn-Velasco, 2021).

included or excluded (shown in Figure V).

$\mathbf{X}_{jt}$ represents the county-year controls. Our main set of controls includes the share white, the share female, and the unemployment rate. We also include additional controls in Figure VI. Importantly, we add controls for programs such as the Title X clinics studied in Bailey (2012) and the average county-level distance to an abortion provider considered in Kane and Staiger (1996). In the main results, we avoid using controls like income, age shares, or birth characteristics, as they could be "bad controls" in this context (Angrist and Pischke, 2008), which we demonstrate in Section 6 and 8. Throughout the results, the regressions are weighted by the denominator of the fertility rate. Robust standard errors are clustered at the county level. We also exclusively rely on the canonical two-way fixed effects (TWFE) estimator because there is no staggered treatment timing in our analysis.

Overall, this identification strategy relies on the assumption that, absent the Hyde Amendment, fertility trends would have followed similar trajectories in counties with higher versus lower AFDC participation. Several features of the AFDC program, highlighted in Goodman-Bacon (2018), support the plausibility of this parallel trends assumption. First, AFDC participation rates were relatively stable over time during our period of analysis. Second, long-run variation in AFDC receipt is largely uncorrelated with state-level policies or demographic characteristics (Goodman-Bacon, 2018, 2021). Third, Medicaid eligibility rules remained unchanged during the 1970s, ensuring that our treatment effect is not conflated with contemporaneous eligibility expansions (Klemm, 2000). Finally, by incorporating state-by-year (of conception) fixed effects and leveraging within-state, county-level variation in AFDC participation, our design further mitigates the risk of bias from unobserved, time-varying state-level shocks.

In our baseline county-level analysis, we focus on within-state variation and exclude states that saw an increase in Medicaid-funded abortions following the Hyde Amendment (CA, HI, MI, NC, PA, WV, and WA). We omit these states because of both the strong information effects of the Hyde Amendment and the volatility in funding from year to year, shown in Figure II. However, in additional results, we also consider fertility effects across the average state-level funding declines. This alternative state-level strategy offers a more direct approach to measuring the effects of the Hyde Amendment and tests whether states with larger declines in Medicaid-funded abortions had larger increases in fertility. However, the state-level approach sacrifices variation within state by aggregating variation to the state level. In an ideal scenario, we would examine the decline in Medicaid-funded abortions at the county level. However, national county-level abortion data is unavailable, so we base our conclu-

sions on both state and county-level approaches. The state-level event study based on Medicaid-funded abortions is presented in Section 6.6.

5 Main Results

5.1 Fertility Rises in Counties with Higher Medicaid Eligibility

Figure V presents the county-level rise in fertility (based on AFDC participation) following the Hyde Amendment. Panel A plots the impact on births per reproductive-age woman (ages 15–44), while Panel B focuses on women under age 30, who are expected to be most directly affected by the abortion funding restrictions.

Panel A shows a modest overall increase in fertility following the Hyde Amendment, with births rising by 0.9%. The effect becomes more pronounced, beginning in 1978, the first year of full enforcement, and reaches a sustained 1–2% increase in fertility through 1982. The smaller effects in 1976–77 are consistent with partial enforcement during the federal injunction on the Hyde Amendment (Cates and Rochat, 1976; Cates, 1981). Figure V Panel B highlights a clearer rise in fertility among younger women, with an average post-period increase of 1.9%. This more pronounced increase in fertility is not surprising, given that women under 30 account for the majority of both births and abortions (see Table A.4 and KFF, 2021). Younger women are also more likely to use Medicaid to pay for abortion services (see Figure A.4).

These magnitudes in Figure V are consistent with evidence from the period. Cates (1981) estimated that roughly 5% of the 300,000 Medicaid-funded abortions performed annually prior to the Hyde Amendment were instead carried to term, implying about 15,000 additional births nationwide each year. A later study, Henshaw (1991), reported a larger effect, suggesting that as many as 20% of women denied Medicaid coverage carried pregnancies to term, or 60,000. Our estimates are between these two approximations. Counterfactual estimates based on Figure V show that births under age 30 rose by 45–216 per county annually (Figure A.10 Panel A), corresponding to a national increase of 9,000–38,000 additional births (Figure A.10 Panel B).

Our findings show key differences from prior work on the Hyde Amendment. The primary distinction lies in the use of within-state comparisons rather than state-level aggregates. Earlier studies found little or no impact (Levine et al., 1996; Haas-Wilson, 1997), but their designs compared states that did and did not fund abortions, often treating states with reduced funding as controls. As shown in Table A.3, the four states with the largest absolute declines in abortions continued to fund abortions but at reduced levels. Our county-level design overcomes this limitation by exploiting

differences in AFDC participation within-state, capturing variation in exposure that state-level analyses obscure. Combined with state-by-year fixed effects, our approach isolates the Hyde Amendment's impact from other contemporaneous state policies.[20]

Contextualizing our findings within a broader literature, recent studies offer relevant parallels. Kim et al. (2025) documents that the introduction of Medicaid abortion coverage in Illinois in 2018 led to an 18.2% increase in abortions and a 2.8% decline in births, magnitudes that mirror our historical estimates. Similarly, Dench et al. (2024) reports a 2.3% increase in fertility in states enacting abortion restrictions following the *Dobbs v. Jackson Women's Health Organization* decision. These contemporary estimates reinforce the central insight of our study: reductions in abortion access, particularly for low-income populations reliant on Medicaid, produce measurable increases in fertility. Together, the evidence underscores the continued relevance of the restrictions implemented through the Hyde Amendment fifty years later.

5.2 Births Shift Toward Unmarried Mothers with Children

We next examine whether the rise in fertility following the Hyde Amendment is concentrated among women most likely to be affected: unmarried mothers with existing children. Unmarried mothers were the primary recipients of AFDC and, therefore, disproportionately Medicaid-eligible. In Table 2, we analyze changes in birth order and marital status around the time of the funding change. The estimates point to a clear compositional shift in births. Table 2, Panel B, shows an increase in total birth order (Column (3)), along with a decline in the share of first births (Column (2)). At the same time, the share of births to unmarried women rises, while the share to married women falls (Column (1)). Column (4) also shows a compositional shift towards unmarried women with existing children. Event-study plots support the shift towards unmarried mothers with children. Figure B.1 shows a sustained increase in the share of births to unmarried women below age 30 with children.[21] Figure B.3 shows that the largest compositional shift is towards *non-white* unmarried women with children.

Appendix Figure B.5 further documents a parallel shift toward younger mothers, particularly those ages 18–27. Within this group, the largest increases again occur among non-white women (Panel iii). Together, these results indicate that the Hyde Amendment disproportionately increased births to younger, unmarried non-white women with existing children, a compositional change with important implications

[20] Our results also differ from the county-level study by Kane and Staiger (1996), which found little impact. A key distinction lies in our exposure measure: we use AFDC participation, a direct indicator of Medicaid eligibility, whereas Kane and Staiger (1996) relied on poverty rates. While correlated, the share in poverty does not yield the same fertility patterns (see Figure C.1).

[21] Figure B.2 shows the event studies for births by marital status and birth order for births of all women of reproductive age. Figure B.4 also drops states with large changes in births to married women due to changes in the definition over time on the birth certificate.

for family structure and welfare participation, which we explore in Section 8.

6 Robustness

6.1 Alternative Treatments

We test whether our findings are sensitive to alternative treatment definitions, focusing on fertility for women under 30. Figure VI Panels A.1–A.4 scale the baseline specification by state-level factors: the percent decline in state Medicaid abortions, the 1976 abortion cost-to-AFDC payment ratio, and the 1976 cost of an abortion. In all cases, the estimated post-Hyde increases in fertility closely mirror the baseline. Figure VI Panel B explores alternative groupings of Medicaid eligibility, retaining the dose-response approximation, except for Panel B.4, which applies a binary treatment. There is a consistent rise in fertility across specifications using percentiles, deciles, or quartiles of AFDC participation, and when collapsed to a binary treatment.[22]

We further test other measures of Medicaid eligibility in Figure C.1. Panels (1)-(3) confirm that the results are robust using earlier AFDC participation years (1970, 1972, and 1975). In Panels (4)-(5), we use an alternative proxy for Medicaid eligibility: the county-level share of deliveries to unmarried mothers with existing children in 1975 and 1971. Unmarried women with children at home are the most likely group to be receiving AFDC, and therefore Medicaid. The results appear robust to using unmarried women with children as an alternative proxy for Medicaid eligibility. In Panels (6) and (7), we split 1976 AFDC adults from children, and the results indicate that the rise in fertility is closely related to adult AFDC participation, rather than child participation, which is what we would expect.[23]

6.2 Additional Checks on the Baseline Specification

Next, Figure VI Panel C.1 presents Poisson estimates, testing an alternative functional form. Panel C.1 models the fertility rate as the number of births per unit of exposure. The Poisson model yields a clear increase in fertility, with a flatter pre-trend preceding the Hyde Amendment. Then, Figure VI Panel C.2 considers only fertility for those 18-29, omitting minors. Subsetting to adult women removes those affected

[22] Figure C.2 shows that the majority of the effect is concentrated in the top quartile of AFDC receipt. Panels (1)-(3) highlight a notable increase in fertility for the top quartile relative to the 3rd, 2nd, and 1st quartiles. These results are consistent with the descriptive changes in fertility by quartile and decile shown in Figure C.3 (following Callaway et al., 2024), where fertility changes are largest in counties with the highest eligibility.

[23] Panel (8) concludes by showing that the share in poverty does not produce the same rise in fertility as using the share AFDC, aligning with Kane and Staiger (1996). While these measures are correlated, AFDC participation will be more representative of Medicaid eligibility than poverty status, as AFDC receipt is categorically linked to Medicaid eligibility.

by the Supreme Court decision in 1979 that liberalized consent for minors.[24] After removing minors, the plotted points follow a similar pattern to the baseline

Panels C.3 and C.4 add additional controls. Importantly, Panel C.3 adds controls for programs that could directly affect county-level fertility, including the Title X clinics studied in Bailey (2012) and the average county-level distance to an abortion provider considered in Kane and Staiger (1996).[25] Then, Panel C.4 adds controls for age shares (18-19, 20-24, and 25-29), the share of nulliparous deliveries, the share with a high school degree, the share with a college degree, and the average birth order. These analyses show increases in fertility that are similar to our baseline results.

Panel D.1-D.2 shows that the results are robust to alternative methods of handling the standard errors. Panel D.1 clusters the standard errors at the state level to limit spatial correlation across counties. Panel D.2 adjusts the standard errors for spatial and serial correlation using the method described in Hsiang (2010). Then, in Figure VI Panel D.3, we also present pre-trends based on the methodology outlined by Roth (2022) and Caceres-Bravom (2024). While there is some evidence of pre-trends, they remain outside the confidence intervals of the main estimated treatment effect.

Another potential concern is migration across states. We view this as unlikely to bias our results. Historical evidence shows Medicaid recipients faced substantial financial and logistical barriers to traveling for abortion care (Cates, 1981; Henshaw, 1991). Residential moves are also rare among low-income households, particularly those tied to state-level benefits. If migration did occur, it would likely attenuate our estimates and reduce the observed fertility increases in high-eligibility counties. In Panel D.4, we consider only births occurring to mothers who still reside in their birth state, eliminating any state-level migration. The fertility response suggests a larger increase than the baseline, implying that any migration biases the effect downward. Next, Panel E restricts the sample to counties near states with different declines in abortion funding. Counties near other states should be similar in observable characteristics. Across counties in close proximity to states with different Medicaid abortion policies, high-AFDC counties show a post-Hyde fertility increase.

Finally, in Figures C.4-C.5, we drop each state individually from the sample to ensure the estimated effect is not driven by a single large state. Figures C.4-C.5 show a similar increase in fertility, even with each individual state removed.[26]

[24] 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, Bellotti v. Baird (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 increase in fertility.

[25] We gather this information from Bailey (2012) at the county level. Because the Title X clinic information from Bailey (2012) is not time-varying during our sample period, we interact the presence of a Title X program with year indicators.

[26] One state that is notable to drop is Virginia. Virginia experienced changes in geographic boundaries between independent cities

6.3 The Fertility Effects are Largest in States with Partial Cuts

Next, we examine whether fertility increased most in the states with 90-100% reductions in state Medicaid-funded abortions, or states where the funding declines are most likely to bind. Table 2, Panel C, Columns (6)-(7), shows that the rise in fertility is more pronounced in states with moderate declines in Medicaid funding (between 1% and 90%). These effects are visible both in the difference-in-differences estimates and in the event-study results shown in Figure B.7. The fertility increase in states with moderate funding declines is likely driven by the fact that the largest reduction in the number of abortions (in absolute terms) occurred in states with less-than-100% cuts to Medicaid abortions (Table A.3). The importance of states with partial funding reductions helps explain why our findings diverge from those of prior studies, such as Levine et al. (1996) and Haas-Wilson (1996). The most pronounced fertility effects are actually observed in states with partial reductions in Medicaid-funded abortions rather than in states that entirely eliminated Medicaid abortion funding.

6.4 Permutation Placebo Test

We then conduct a permutation placebo test by randomizing AFDC participation across counties. To generate this placebo test, we randomly assigned the assignment of AFDC participation across counties 2,000 times. 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. The plotted cumulative distribution function (CDF) from this exercise is shown in Figure C.6, with a non-parametric p-value. The non-parametric p-value suggests that our baseline estimate is highly statistically significant.

6.5 Other Outcomes

Controls as Outcomes. Next, Figure C.7 examines several potential controls as outcomes, as the Hyde Amendment may have changed the characteristics of births. In the top panel, we focus on whether the decline in funding for abortions leads to the closure of abortion providers. Since Medicaid funds approximately 25% of abortions (Cates, 1981), a reduction in funding could lower demand, potentially exerting pressure on existing clinics. However, the first two panels of Figures C.7 show little change in the number of abortion providers. There is no evidence of an increase in closures or a reduction in the number of providers after the federal funding cuts for abortion services. Then, in the third panel of Figure C.7, we assess whether the Hyde

and counties in 1980, which would change the reporting of Virginia's county-level data. Still, even when removing Virginia, the increase in fertility remains similar.

Amendment affects the share of mothers who currently reside outside of their birth state, a proxy for migration. Although there is a linear trend upward, the results do not suggest that the Hyde Amendment itself increased migration.

We then turn to additional characteristics of births, including education, parity, marital status, and race. As indicated in Table 2, we observe a shift away from births to married mothers and toward higher-order births. This shift aligns with expectations, as the increase in fertility is primarily driven by unmarried women with children, those most likely to be eligible for AFDC/Medicaid.

Mortality Outcomes. Figure D.1 examines mortality effects of the Hyde Amendment, plotting the log of mortality rates for infants, neonates, and children ages 1–4. Infant mortality rates show an increase, but this upward trend predates the Amendment. By contrast, there is little discernible change in neonatal or child mortality. We also investigate maternal outcomes; although the best measure of maternal health, maternal mortality, was relatively low during this period. More than 95% of county-level observations record zero deaths. Instead, aggregating maternal mortality to the state level yields more cases, but event-study estimates following Equation 2 show little change in maternal mortality (Figure D.2), consistent with the infant and child results.

For maternal morbidity, the best available source is the National Hospital Discharge Survey (NHDS). While NHDS provides discharge-level data, it lacks geographic identifiers for our study period. Restricted state-level information only appears in later waves. Using these data, we do find differences in abortion-related complications by marital status and race, but these individual-level comparisons are not geographically based and, therefore, should be interpreted as suggestive rather than definitive.[27]

6.6 State-level Changes in Fertility

Next, we consider an alternative empirical strategy by shifting the analysis to the state level. Specifically, we examine the fertility decline using the actual state-level treatment: the percentage decline in Medicaid-funded abortions (shown in Figure IV, Panel B). This measure provides a more direct proxy for the effect of the Hyde Amendment than AFDC participation, as it captures the reduction in publicly financed abortions. In the absence of substitution to funding sources or better prevention of pregnancy, the decline in Medicaid-funded abortions would map one-to-one into higher fertility. Because many women were still able to obtain abortions despite the funding restrictions, the correspondence between the decline in Medicaid-funded abortions and births will not be one-for-one.

[27] These results are available on request.

While ideally we would conduct this analysis at the county level, to our knowledge, no similar information on Medicaid abortion declines is available at that level of granularity. However, a limitation of the state-level approach is that if states with continued funding for abortion experience informational effects from funding restrictions, our estimates will be downward-biased, and the county-level results will be more accurately specified.

Formally, the event study for state s and conception year t appears as follows:

$$\ln(\text{Fertility})_{st} = \alpha + \sum_{m=1973}^{1982} \beta_m \, \text{Hyde}_m \times (\% \Downarrow \text{Medicaid Abortions}_s) + \mathbf{X}_{st}'\gamma + a_s + \eta_t + \epsilon_{st} \tag{2}$$

where the outcome variable $\ln(\text{Fertility})_{jst}$ reflects the natural log of the fertility rate. The effect of the Hyde Amendment is captured by Hyde_m. $\% \Downarrow \text{Medicaid Abortions}_s$ is the state-level average percent decline in Medicaid-funded abortions (Figure IV Panel B). The decline in Medicaid-funded abortions represents the decline in abortions paid for by Medicaid. Women still may have received an abortion through other means, including paying for an abortion directly.

We compare states with higher percent declines in Medicaid-funded abortions to states with lower declines, based on the average decline from 1976 to 1978-1982. States that increase their funding for Medicaid abortions will be treated as control states. Arizona is also an omitted control state because it did not have a Medicaid program until 1982 (Boudreaux et al., 2016). In addition to using the average decline, we also show the effect of the time-varying decline in Medicaid abortions in Figure VIII, the initial funding decline (1976-1978) in Figure E.3, and a binary specification capturing the decline in funding in Figure E.4. Further, Figures E.5 and E.6 show a specification where states with a rise in Medicaid-funded abortions are treated with a negative effect, rather than considering these states as control states with zero treatment.

We also include state and year fixed effects, a_s and η_t. We cluster the robust standard errors at the state level. Note that in the main text, Figure VII, we focus on young women, but we show all ages in Appendix Figure E.2. In the state-level specification, we consider the years following *Roe v. Wade* in 1973, and before the majority of parental involvement laws were enacted in the 1980s.

6.6.1 Results: State-Level Fertility Increases Among Young Non-White Women

The state-level results using the observed decline in Medicaid abortions as the treatment provide further evidence that the Hyde Amendment led to increases in fer-

tility. Fertility rises most clearly among populations most reliant on Medicaid for abortion access, younger non-white women. Figure VII shows that states experiencing larger reductions in Medicaid-funded abortions show significant increases in births among non-white women, especially those under age 25. Non-white births for those under 25 increase by 2-4%. By contrast, there is no consistent effect for white women.

There is also a clear relative rise in non-white fertility, compared to white fertility, after the Hyde Amendment (Figure E.1). The relative rise in fertility occurs most clearly for non-white women under the age of 25. This relative increase in fertility for non-white compared to white women helps to motivate our analysis in Section 8.

Figure VIII explores the time-varying relationship between changes in Medicaid-funded abortions and fertility. Table 1 shows wide year-to-year variation in Medicaid abortions in certain states like Michigan and Pennsylvania. We exploit the time-varying variation in funding in a difference-in-differences design that considers the effect of the percent change in Medicaid funding for each year relative to 1976.[28] Figure VIII shows an increase in fertility for those under age 25 using time-varying changes in Medicaid-funded abortions. The results with the time-varying declines mirror the findings using the average decline in Medicaid-funded abortions (Figure VII).[29]

Taken together, the state-level results reinforce the core findings from the county-level analysis presented in Section 5.1. While the county-level analysis leverages variation in Medicaid eligibility within state, the state-level analysis relies on observed declines in Medicaid-funded abortions. These state-level results highlight that the fertility effects were concentrated among young, non-white women. This demographic focus aligns with expectations, as younger non-white women are more likely to depend on Medicaid for abortion services (see Figures A.4 and G.1).

7 Mechanisms for the Rise in Fertility

7.1 Georgia's County-level Abortions Decline

To support the rise in fertility observed in high Medicaid-eligibility counties, we turn to county-level legal abortion data from the Vital Statistics of Georgia. Ideally, we would have county-level abortion data for the entire U.S. and produce a comprehensive "first stage." However, county-level abortion data is difficult to obtain, and (to our knowledge) national data is completely unavailable for the period of focus. Instead,

[28] If a state has higher Medicaid abortions than in 1976, the annual change will be marked as zero. We focus on the years up to 1980 because the main fertility decline appears before 1981.

[29] While Figure VIII shows a negative coefficient for older women, the event-study results in Appendix Figure E.2 indicate that fertility for older women is on a preexisting downward trend.

we benefit from the fact that Georgia published detailed administrative data on abortions by county and race in its annual vital statistics publications (Georgia Department of Public Health, 1975-1981). We digitize this abortion data and display the results in Figure IX using our baseline county-level specification.

Figure IX reveals a sharp decline in abortions in Georgia in counties with higher AFDC participation. Using the assumption that the average abortion-to-live-birth ratio in 1977 was approximately 300 abortions per 1,000 births, a reduction in abortions by 9.6% would translate into approximately 26 additional births per 1,000 live births (Center for Disease Control, 1979). This would correspond to a 2.5% increase in fertility, very similar to the point estimate in Figure IX Panel B, and slightly higher than the 1-2% increase in fertility observed in our main results. Georgia's decline in abortions in counties with higher AFDC participation supports the hypothesis that the Hyde Amendment's funding restrictions contributed to an increase in births in counties with higher Medicaid eligibility. The decline in abortions in counties with higher Medicaid eligibility in Georgia adds credibility to the fertility results and suggests that similar mechanisms are at play nationwide.

7.2 Medicaid Births Increase and Abortions Decline in the NSFG

We also verify the correspondence between the increase in births and decline in abortions using alternative survey data, the 1982 National Survey of Family Growth (NSFG, Cycle III) (NCHS, 2010). The NSFG is a nationally representative survey of the U.S. population of women ages 15–44. The survey collects fertility histories, including detailed contraceptive use, fertility intentions, demographic characteristics, and retrospective pregnancy histories.

The pregnancy histories allow us to estimate whether the share of abortion, live births, or miscarriage based on the pregnancy year, changes after the Hyde Amendment. Our identification strategy leverages variation across Medicaid coverage groups and time, comparing outcomes for women covered by Medicaid after the Hyde Amendment against pregnancy outcomes for women who were not covered by Medicaid. Formally, we estimate the following specification:

$$\text{Outcome}_{it} = \alpha + \beta\,(\text{Medicaid}_i \times \text{Post-Hyde}_t) + \mathbf{X}_i'\gamma + 1(\text{Medicaid})_i + \eta_t + \epsilon_{it}, \qquad (3)$$

where Outcome_{ijt} denotes the pregnancy outcome for woman i in the year the pregnancy ended t. Pregnancy outcomes can include birth, miscarriage, stillbirth, or abortion. The variable $1(\text{Medicaid})_i$ is an indicator for whether woman i reported Medicaid coverage. Post Hyde_t equals one for pregnancies that ended after 1976. The coefficient

of interest, β, captures the differential change in pregnancy outcomes for Medicaid recipients after the Hyde Amendment. The effect is relative to non-Medicaid women and relative to the pre-Hyde period.

$\mathbf{X}_i$ controls for individual characteristics, including age during pregnancy and the race of the mother (indicators for white and black). Specifications also include Medicaid indicators, $1(\text{Medicaid})_i$, to account for differences in baseline pregnancy outcomes between coverage groups, as well as pregnancy-year fixed effects, η_t. Regressions are weighted by the individual weight provided in the NFGS. Standard errors are clustered at the individual level.

7.3 Results: Live Births Increase and Abortions Decline

Table 3 presents the pregnancy outcomes before and after the Hyde Amendment for those receiving Medicaid. The estimates reveal a clear shift towards live births and away from abortions for those receiving Medicaid following the implementation of the Hyde Amendment, but no similar change in miscarriage or stillbirths after Hyde.

Beginning with abortions in Columns (1)-(4), the Hyde Amendment appears to reduce abortions as a pregnancy outcome for Medicaid recipients. The coefficients suggest a 7–8 percentage point reduction in abortions for Medicaid recipients after the Hyde Amendment. These declines are evident both when restricting the sample to women under age 30 and in the full sample. Consistent with the reduction in abortions, the estimates indicate a statistically significant increase in live births. The coefficients suggest an increase in live births as a pregnancy outcome by 9–11 percentage points. This pattern suggests that the reduction in abortions among Medicaid-eligible women translates directly into an increase in live births.

By contrast, the estimates for miscarriage are small, negative, and statistically insignificant. This serves as a falsification check, supporting the interpretation that the Hyde Amendment's impact was concentrated on abortion and live birth outcomes rather than reflecting spurious changes, reporting differences, or broader shifts in pregnancy outcomes. Overall, the results indicate that the Hyde Amendment's funding restrictions meaningfully reduced abortions and produced a corresponding rise in live births for Medicaid recipients.

8 Welfare Receipt Rises for Young Non-white Women

Next, we consider whether the Hyde Amendment forces more women to claim welfare using the *Current Population Survey* (CPS, Flood et al. (2024)). In this specifi-

cation, we use an event study that exploits two sources of variation. First, we capture the observed decline in Medicaid funding for abortion at the state level, using the percent decline in Medicaid-funded abortions (Figure IV, Panel B). States with higher percent reductions in Medicaid-funded abortions have larger increases in fertility, particularly non-white women (Figure VII). Second, because non-white fertility increases by more than white fertility at the state level, we also compare non-white women to white women within these states with higher percent declines in Medicaid-funded abortions.

Several factors motivate the comparison by race. Figure G.1 shows that non-white women are more likely to be eligible for Medicaid and more likely to pay for abortions through Medicaid as compared to white women. Almost 50% of non-white abortions to single women are paid for by Medicaid, even after the Hyde Amendment. Further, half of non-white women receive welfare before the Hyde Amendment (Figure G.1), which is categorically linked to Medicaid during the study timeframe. Similar studies have relied on the fact that Black women are more affected by abortion restrictions than white women and performed a comparable triple difference design by race (Gardner, 2024). Finally, states with larger reductions in Medicaid abortions show the clearest increases in fertility for non-white women (Figure VIII).

Formally, our revised event study for individual i in state s and year t appears as:

$$\begin{aligned} \text{Welfare}_{ist} = \alpha + &\sum_{m=1974}^{1980} \beta_m \, \text{Hyde}_m \times (\% \Downarrow \text{Medicaid Abortions}_s) \times 1(\text{Non-white})_i \\ &+ \delta_1 1(\text{Non-white})_i + \delta_2 (\% \Downarrow \text{Medicaid Abortions}_s) \times 1(\text{Post})_t \\ &+ \delta_3 (\% \Downarrow \text{Medicaid Abortions}_s) \times 1(\text{Non-white})_i \\ &+ \delta_4 \, \text{Non-white}_i \times 1(\text{Post})_t + \mathbf{X}_{it}' \gamma + a_s + \phi_t + \epsilon_{ist} \end{aligned} \tag{4}$$

where the outcome Welfare_{ist} represents whether or not an individual is receiving any welfare payment.[30] We focus primarily on welfare participation as our main outcome. In additional analyses, we also examine household income, employment, and the number of children in the household. Considering fertility allows us to validate our fertility results from the Natality Detail File with the CPS data.

The effect of the Hyde Amendment is captured by $\text{Hyde Amendment}_m \times (\% \Downarrow \text{Medicaid Abortions}_s) \times 1(\text{Non-white})_i$. To match the conception results, where we consider conceptions beginning in 1976, here we consider the effect on economic outcomes beginning in 1977, to correspond with the timing of the birth. In the present

[30] Welfare is based on a binary variable that captures any welfare receipt based on the CPS definition: "INCWELFR indicates how much pre-tax income (if any) the respondent received during the previous calendar year from various public assistance programs commonly referred to as 'welfare.'" See https://cps.ipums.org/cps-action/variables/INCWELFR#description_section.

specification, 1976 represents the omitted period. % Decline Medicaid Abortions$_s$ is the state-level average percent decline in Medicaid abortions, used in previous state-level analyses (Figure IV Panel B). 1(Non-white)$_i$ captures whether the individual is non-white.[31] Though we show the time-varying declines in Figure VIII.

$\mathbf{X}'_{it}$ includes controls, which include indicators for the age of the woman. a_s is the state fixed effects and ϕ_t is the time fixed effect. A limitation of the CPS data is that, at the beginning of the sample, only large states are available. During the study time-frame, smaller states are grouped together. While the groupings also change over time, we begin the analysis in 1974 to avoid changes in the grouping. For grouped states, we take the average decline in Medicaid abortions, and we regroup states consistently together over time. We also drop any grouped states as a robustness check.

ϵ_{ist} is the regression error term. Robust standard errors are clustered at the state level. As in the fertility results, we focus on women under 30 for the main results. We weight the regressions by the household weights provided in the CPS. But we show the unweighted and collapsed state-level results in the robustness checks. Similar to the state-level fertility results, we conclude the analysis in 1980. This avoids the beginning of a series of major welfare reforms in 1981 (Ferejohn, 1991), changes in parental involvement laws, and major Medicaid expansions (East et al., 2023).

8.1 Results: More Non-white Women Receive Welfare

Figure X shows the consequences of the Hyde Amendment on welfare receipt. The results reveal an increase in welfare participation among non-white women in states with larger declines in Medicaid-funded abortions. Specifically, Figure X shows that in states with a 100% decline in Medicaid abortions, there is a 3.0 percentage point increase in welfare receipt for non-white relative to white women. A state with a 50% decline would experience a 1.5 percentage point increase in welfare receipt.[32]

Robustness checks confirm the consistency of the increase in welfare participation in Panel B of Figure X. These include excluding grouped states, removing minors, focusing on those under 25, focusing on single non-white women (those most likely to be eligible for welfare), and removing weights. Figure X also shows a binary indicator for any reduction in abortion funding, subsamples of only non-white women under 25, and subsamples including only single women under 25. We also drop each state individually from the analysis in Figure G.2. We conclude by also exploring time-

[31] We also include the other terms necessary for a difference-in-difference-in-differences. 1(Non-white)$_i$ $\times$ 1(Post)$_t$ captures the effect of being non-white in the post period (1977 and onward). % Decline Medicaid Abortions$_s$ $\times$ 1(Post)$_t$ captures the effect of declines in Medicaid abortions in the post period (1977 and onward). % Decline Medicaid Abortions$_s$ $\times$ 1(Non-white)$_i$ captures the effect of declines in Medicaid abortions while being non-white.

[32] See Table G.1 for the descriptive statistics of welfare assistance, family and household structure, and employment of the CPS sample in the treated states.

varying changes in Medicaid abortions in Figure VIII.

8.2 Mechanisms for the Rise in Welfare Payments

Further, Figure XI Panel A shows a parallel decline in employment and working any hours in the past week. Figure XI Panel A also shows that while welfare receipt increases, there is no corresponding rise in other forms of government assistance, such as unemployment compensation or veterans' benefits.[33] This stability in other types of government assistance reinforces the conclusion that the rise in welfare receipt is a direct result of the Hyde Amendment rather than broader shifts in public program participation or changing social norms around public assistance.

Panel B of Figure XI further reveals that the rise in welfare receipt is mirrored by a rise in the number of children and having any child in the household. There is a 2-4 percentage point increase in the probability of having a child in the household. The similar magnitudes of the increase in the probability of having a child and the rise in welfare participation among non-white women may be driven by both a need to support additional children and the qualification for welfare payments due to the number of dependents.[34]

Taken together, these findings indicate that the Hyde Amendment exacerbated economic inequality, particularly among non-white women. Restrictions on abortion funding raised fertility rates, pushing many into welfare dependency and deepening reliance among those already on AFDC. Larger family sizes also reduced women's ability to participate in the labor force, whether through job loss or reduced hours due to caregiving responsibilities. Our findings mirror evidence from the Turnaway Study, which shows that women denied abortions were less likely to be employed and more likely to rely on welfare (Foster et al., 2022). Miller et al. (2020, 2023) also document increased financial hardship after abortion denial. These findings suggest that the Hyde Amendment reversed some of the economic gains achieved through abortion legalization. Whereas Gruber et al. (1999) found that abortion legalization improved economic outcomes and reduced welfare participation, we observe the opposite trend emerging just four years later.

[33] The CPS includes non-welfare/social security government assistance; see https://cps.ipums.org/cps-action/variables/INCGOV#description_section for more information.

[34] While it may appear counterintuitive that welfare receipt would increase for women who should have already received welfare in order to participate in Medicaid, many states had eligibility for welfare starting at the beginning of pregnancy (East et al., 2023). Thus, women could have potentially qualified for welfare during their pregnancy and then continued their support when they were not able to access abortion. Panel B of Figure X shows that most of the significant increase in welfare participation occurs where AFDC eligibility begins during pregnancy, including the first pregnancy (East et al., 2023).

9 Second Generation Effects: More Non-white Women Receive Public Assistance

Finally, we conclude by examining the long-term second-generation effects of the Hyde Amendment. In this specification, we focus on women born during the period 1974-1980 in the American Community Survey (ACS, Ruggles et al., 2024) in 2000-2019. We focus on girls born around the Hyde Amendment as adults because women are more likely to be eligible for public assistance through programs like welfare and Medicaid. Though we also show the effects for men in the appendix (see Figure H.4).[35]

The ACS has advantages over the CPS, including more observations and the fact that all states are documented separately. The ACS also includes information on Medicaid and public insurance participation (from 2008 onward). One disadvantage of the ACS is that we are unable to isolate children of young women or Medicaid recipients around the Hyde Amendment. So these results are more general than the CPS results.

To examine outcomes in the ACS, we follow a similar empirical strategy to Equation 4, except that we account for both the birth state and year, in addition to the contemporary state and year. Formally, our revised event study for individual i in year t and state s who was born in year y and state of birth b appears as follows:

$$\begin{aligned}\text{Welfare}_{itsyb} = \alpha + \sum_{m=1974}^{1980} \beta_m \text{Hyde}_m \times (\%\Downarrow \text{Medicaid Abortions}_b) \times 1(\text{Non-white})_i \\ + \delta_1\, 1(\text{Non-white})_i + \delta_2\, (\%\Downarrow \text{Medicaid Abortions}_b) \times 1(\text{Post})_y \\ + \delta_3\, (\%\Downarrow \text{Medicaid Abortions}_b) \times 1(\text{Non-white})_i \\ + \delta_4 1(\text{Non-white})_i \times 1(\text{Post})_y + \mathbf{X}'_{ist}\gamma + a_s + \eta_{st} + a_y + \pi_b + \epsilon_{itsyb}\end{aligned} \tag{5}$$

where the majority of Equation 5 reflects Equation 4, except the following modifications. First, the Hyde Amendment timing is based on the birth year y and birth state b rather than the current time and place. We thus include current state-by-year fixed effects, η_{st}, to absorb recent competing state-level policies that may affect public assistance. We also include fixed effects for the birth year a_y and birth state π_b. Robust standard errors are clustered at the birth state level. We also collapse the data to the current state, birth state, birth year, current year, and mother's birth state and birth year level for computational ease. But the individual-level point estimates are shown in Figure VIII, when we consider time-varying changes in Medicaid abortions. We

[35] An important outcome for men is incarceration, which we proxy using the IPUMS "group quarters" variable and captures individuals living in institutional settings (correctional facilities and mental institutions). We find no significant change in group quarters residency, our best available proxy for incarceration, suggesting that the Hyde Amendment did not have a clear effect on criminal involvement later in life (Donohue and Levitt, 2001). Across other outcomes, men show minimal changes, with the exception of a modest decline in college degree attainment.

consider birth years 1974 to 1980 and women under age 45.[36]

9.1 Second-Generation Effects: Public Assistance Rises

Figure XII demonstrates that, beyond its immediate impact on fertility and welfare receipt, the Hyde Amendment also generates second-generation consequences. Figure XII illustrates the long-run second-generation effects by examining the differential impact of the Hyde Amendment on public assistance among the children of women affected by Hyde. These girls are observed as adult women in the ACS from 2000 to 2019. The event studies reveal a notable increase in public assistance participation, particularly in the areas of public insurance and Medicaid enrollment. Public assistance participation grows by 2.0 percentage points, while public insurance participation grows by 1.8 percentage points.[37,38]

We also find consistent evidence of increased public program participation when focusing on non-white women alone, rather than comparing them to white women (Figures H.1 and H.2). The DiD event studies indicate a 1.5 percentage point rise in public insurance enrollment, driven largely by Medicaid, and some evidence of increased welfare participation among non-white women in states with larger declines in Medicaid-funded abortions. These figures also show a higher likelihood of non-white women being unmarried with children (Figure H.2). The remainder of Figure H.1 provides robustness checks across the public assistance outcomes, including considering the initial drop in funding, a binary indicator for any drop in funding, dropping movers, and alternative ways of collapsing the data.[39]

Finally, Figure VIII reports public assistance outcomes and DiD estimates using the time-varying decline in Medicaid-funded abortions. Panel C indicates that non-white women experienced significant increases in welfare receipt, public insurance coverage, and participation in the food stamp program. White women do not experience comparable changes in public assistance receipt.

These second-generation effects establish that the Hyde Amendment perpetuates economic disadvantage across generations. By restricting access to abortion, the Amendment increased the likelihood that children would be born into lower-income households already reliant on public assistance, conditions that frequently persist into

[36] In the ACS, "welfare" is defined slightly differently than in the CPS. The variable INCWELFR measures pre-tax income received in the past year from public assistance programs. See https://usa.ipums.org/usa-action/variables/incwelfr#description_section

[37] Insurance variables in the ACS are only available after 2007, losing observations in the bottom two panels of Figure XII.

[38] Table H.1 shows descriptive statistics for the ACS sample in the treated states.

[39] Figure H.3 shows event studies for other outcomes of the second generation, including food stamps receipt, family structure, educational attainment, and employment. Overall, we do not see evidence of any changes in these outcomes for the second generation as a result of Hyde.

adulthood. These long-term effects highlight that many of the children born in the years surrounding the Hyde Amendment restrictions now face the same economic vulnerabilities as adults, suggesting that the policy's costs extend beyond the original generation directly affected. Overall, non-white women and their children impacted by the Hyde Amendment ultimately require greater public support during their lifetime as a direct result of these funding restrictions.

10 Conclusion

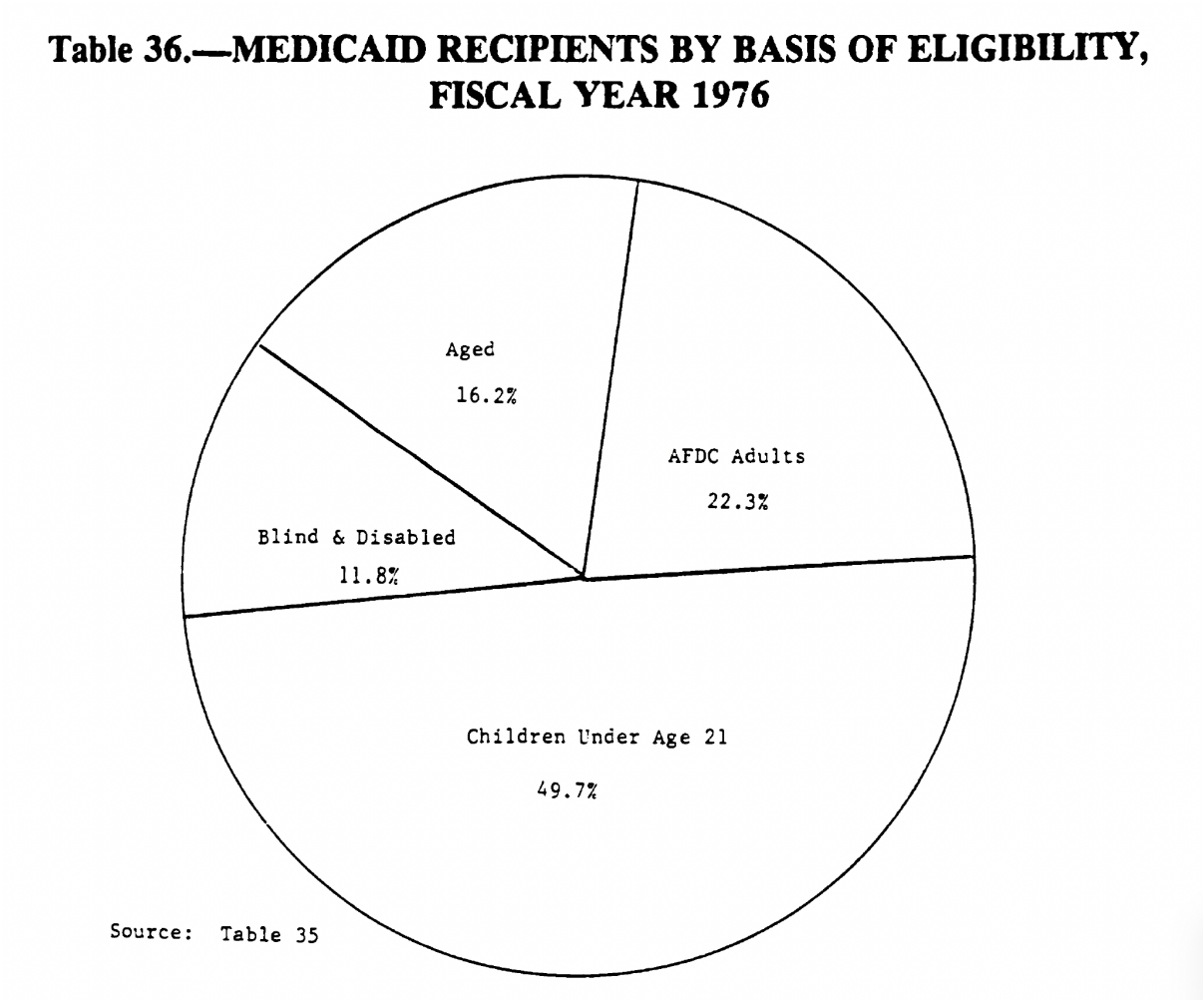
In this paper, we demonstrate that the Hyde Amendment raised fertility rates in counties with higher Medicaid eligibility. Our county-level analysis reveals that, on average, fertility increased by 2% for young adult women and 1% overall. Complementary evidence from survey data and administrative records confirms a corresponding decline in abortions, underscoring the direct link between reduced public funding for abortion and higher fertility.

These fertility responses were not merely demographic shifts; they carried economic consequences. We show that the additional births induced by Hyde translated into greater reliance on welfare programs, particularly among non-white women, who are more likely to depend on Medicaid. The rise in public assistance use was accompanied by larger household size and greater post-Hyde AFDC participation, illustrating how targeted funding cuts in one program can increase demand for others. Following affected cohorts into adulthood, we further demonstrate that daughters born as a result of Hyde's restrictions were more likely to rely on public assistance themselves, revealing an intergenerational transmission of disadvantage.

These findings point to the significant and unintended economic consequences of abortion funding restrictions. By limiting funding to abortion and, subsequently, its access to low-income women, the Hyde Amendment increased household size and, in turn, reliance on public assistance programs. This shift redirected costs from a one-time healthcare service to long-term welfare support, showing how targeted funding cuts can reshape the structure of public spending. The trade-off between restricting abortion access and rising demand for welfare highlights the potentially overlooked economic implications of such policies. More broadly, our results underscore a central lesson: the higher fertility as a result of abortion funding restrictions reshapes dependence on social assistance and perpetuates cycles of disadvantage. These seemingly narrow funding restrictions can have ripple effects across the safety net and reinforce inequality in ways policymakers may fail to anticipate.

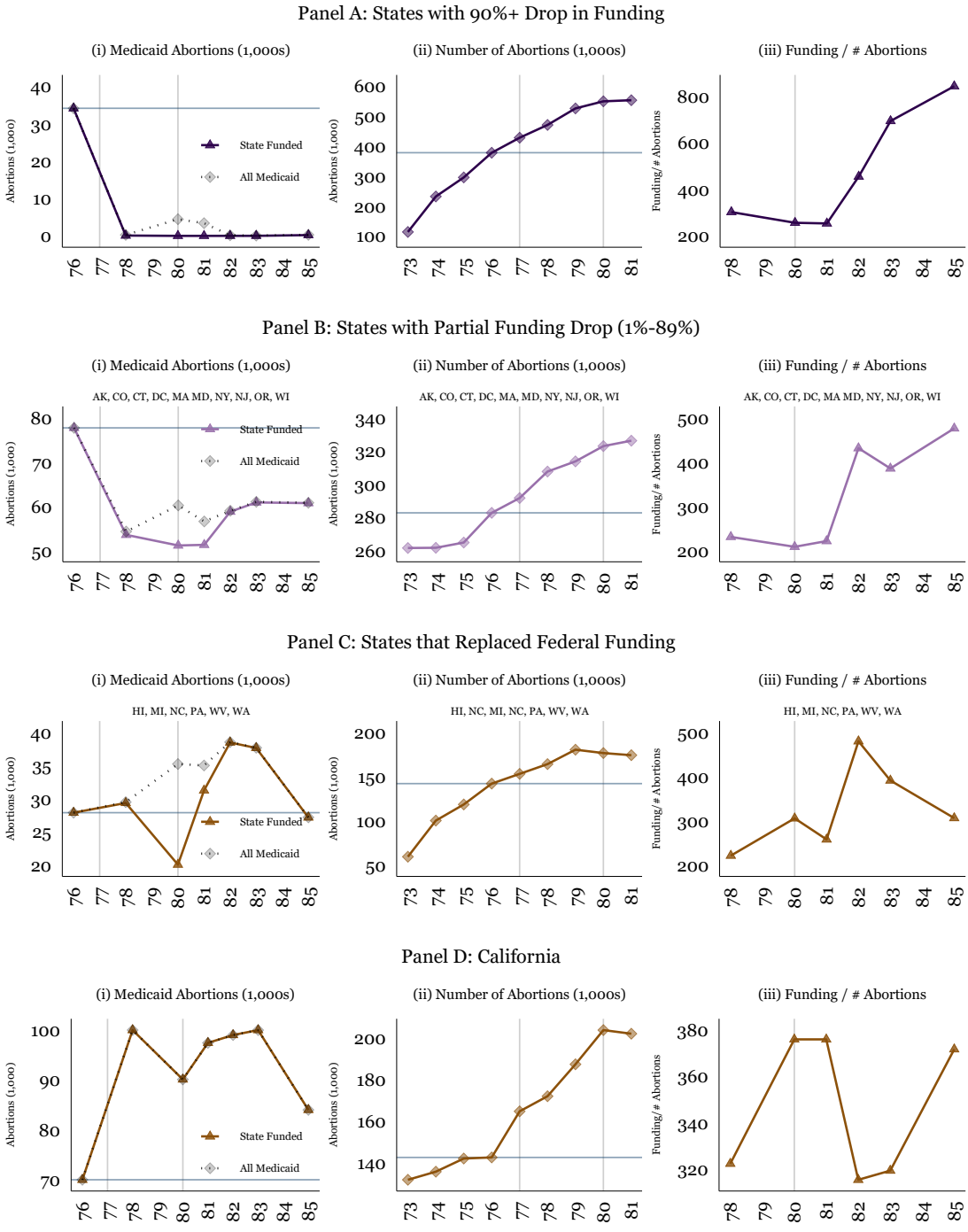
11 Figures

Figure I: Medicaid Eligibility



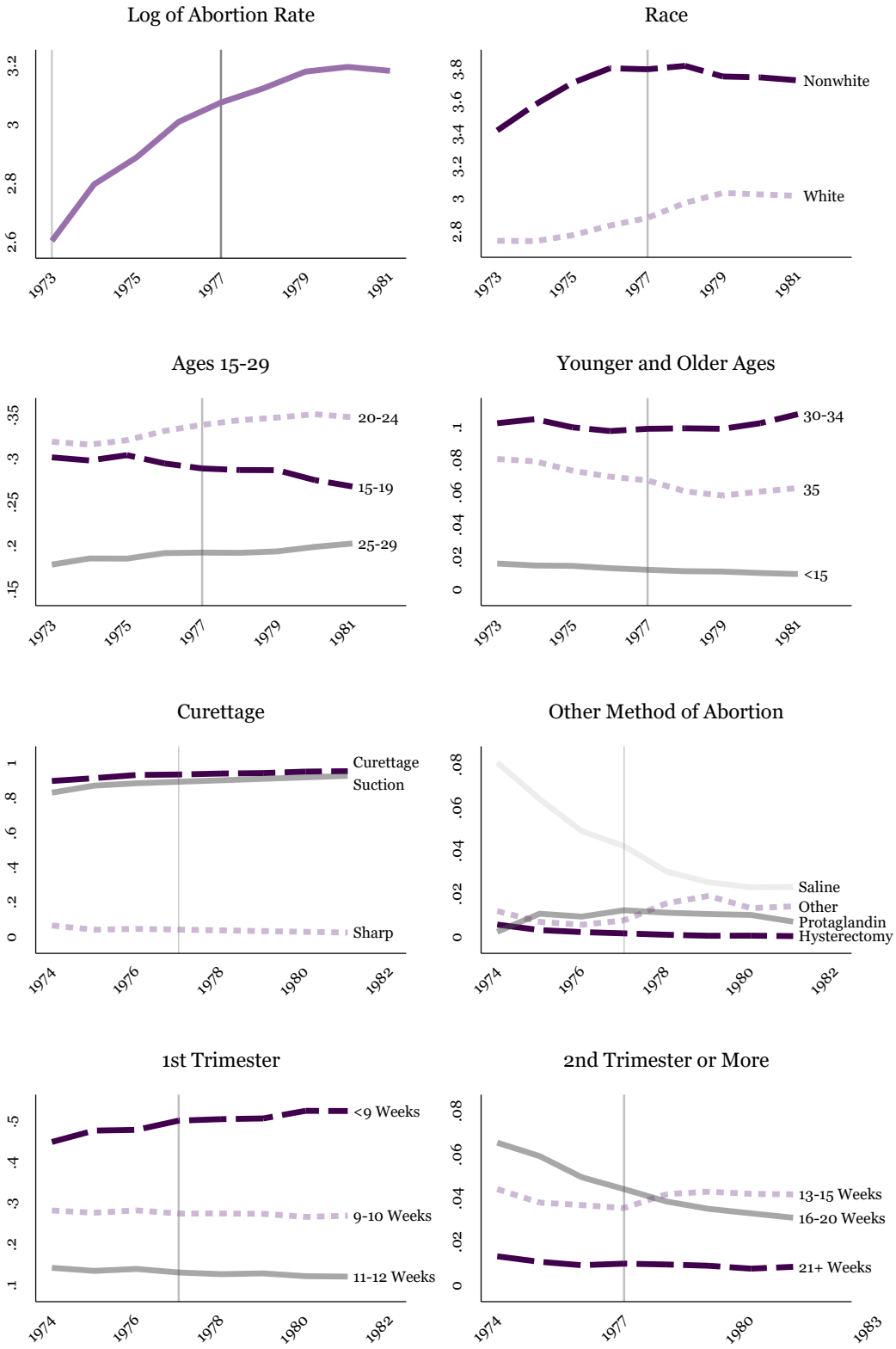
SOURCE: Medicaid/Medicare Management Institute (1979) Page 65.

Figure II: State Medicaid Abortions



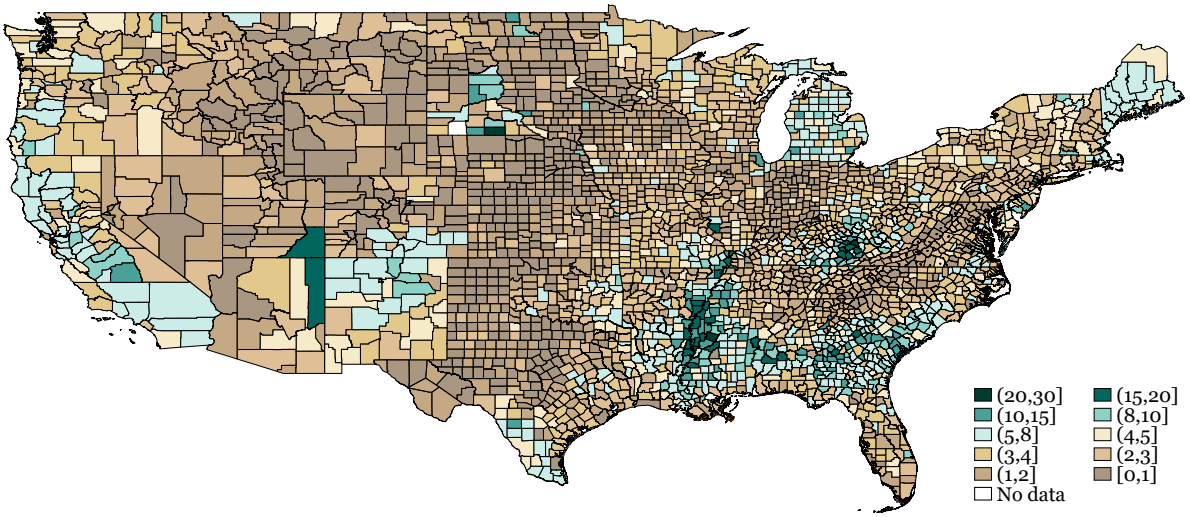
SOURCES: Lincoln et al. (1977), Gold (1980), Gold (1982), Nestor and Gold (1984), Gold and Nestor (1985), Gold and Macias (1986). Abortion data from the CDC Abortion Surveillance Program (CDC, 1977). This data is only available by state.
NOTES: The far left side of the graph shows the number of Medicaid abortions in 1,000s, both the total Medicaid abortions (federal + state-funded abortions, gray diamonds) and state-funded abortions (colored triangle/solid line). 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 middle graph, Panel (ii), shows all abortions in 1,000s. The right graph, Panel (iii), shows the Medicaid funding per abortion, which approximates the cost per abortion. Panel (iii) only includes states with at least seven years in the sample. Panel A shows states with very limited funding for Medicaid abortions, most states, or those not included in Panels B-D. 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.5). Panel B shows states with limited but available funding for Medicaid abortions. Panel C shows states with adequate funding for abortion (a similar or higher 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 horizontal blue line shows the starting number of Medicaid abortions. See Figure A.5, Figure A.6, and Figure A.8 for the individual state-level graphs.

Figure III: Abortion Rate and Share of Abortions by Characteristic

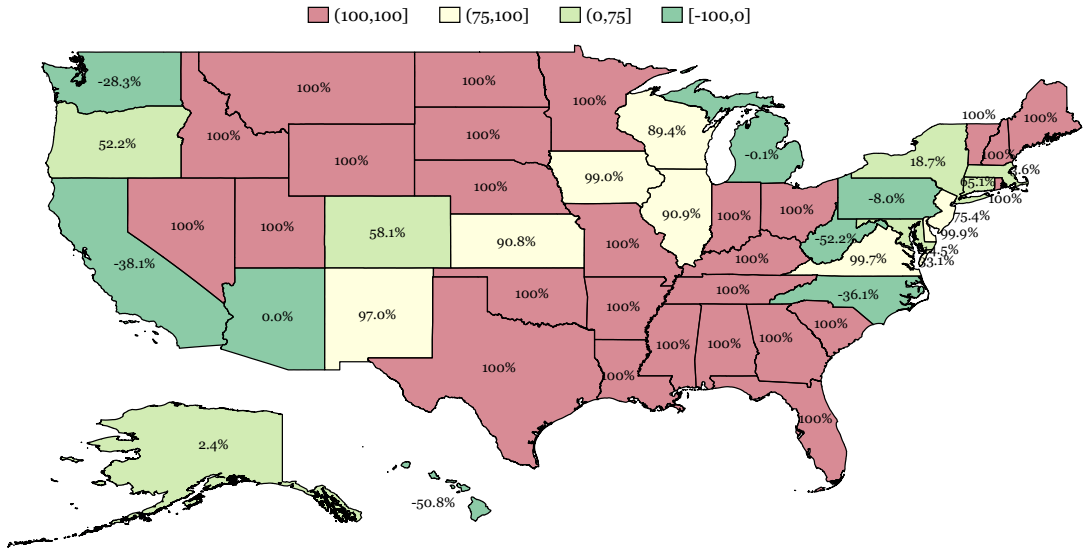


SOURCES: Abortion data from the CDC Abortion Surveillance Program (CDC, 1977). This data is only available by state.
NOTES: The top two graphs show the abortion rate. For the remaining panels, the graphs show the share of abortions by each characteristic for the balanced panel of states. Data for suction and sharp curettage is missing between 1977 and 1980; however, this data is available prior to 1977 and in 1981.

Figure IV: Map of Main Treatment Variables
Panel A: County-level Medicaid Eligibility: Percent AFDC

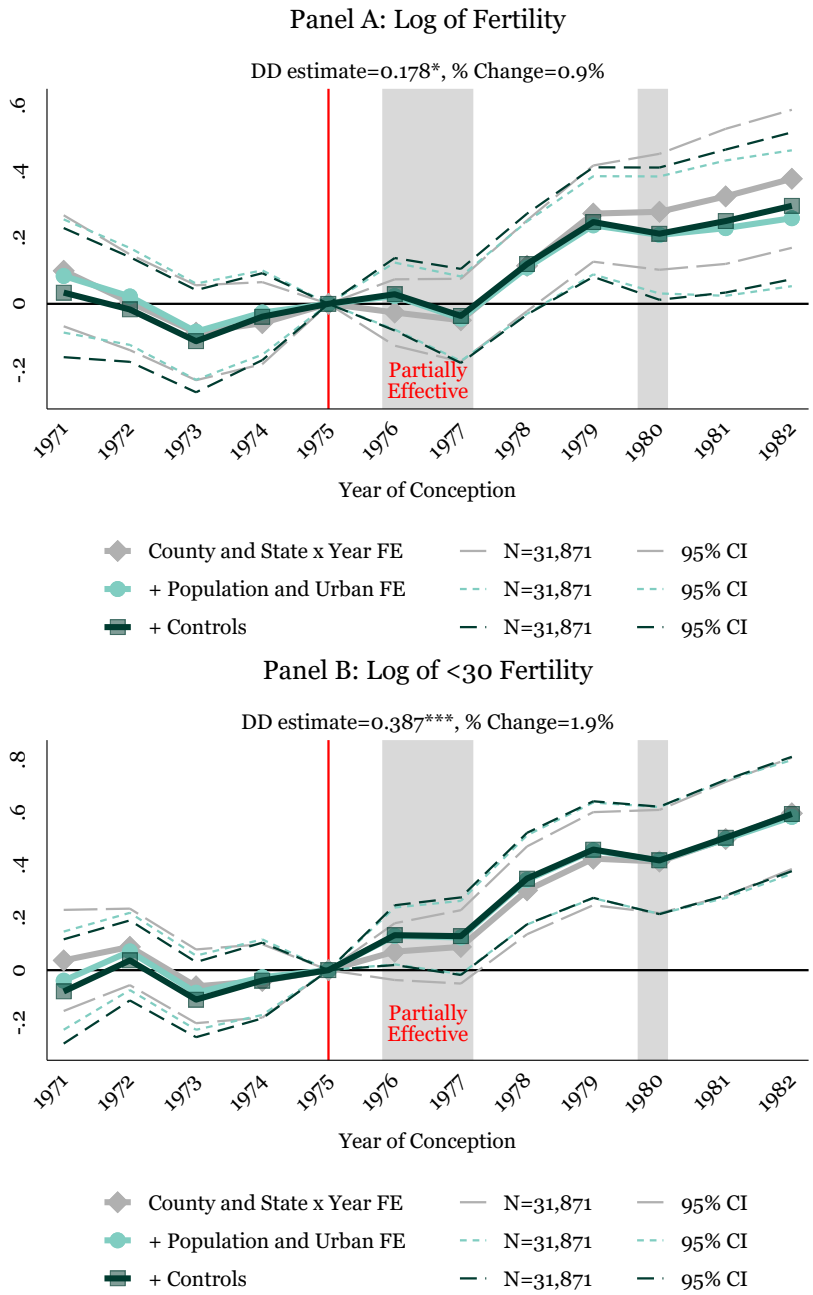


Panel B: State-Level Percent Decline in State Medicaid Abortions



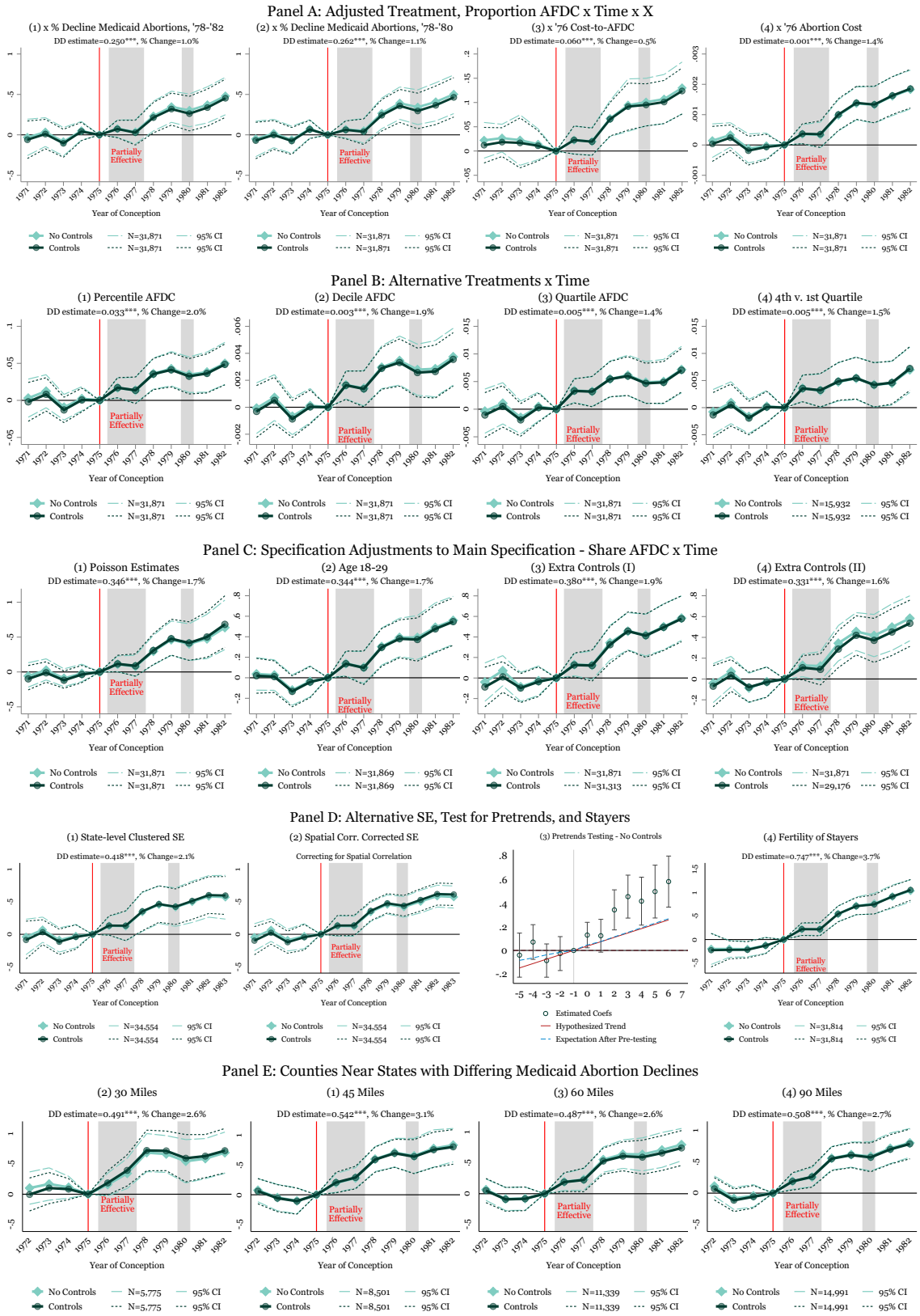
SOURCES: Lincoln et al. (1977), Gold (1980), Gold (1982), Nestor and Gold (1984), Gold and Nestor (1985), Gold and Macias (1986), Haines (2010), and United States Bureau of the Census (2012).
NOTES: The top map shows the percent of residents receiving AFDC at the county level, our main source of variation in the fertility results. In the event study, these percentages (0 to 100) are described as proportions (0 to 1). The bottom map shows the percentage decline in state Medicaid abortions, or the average decline from 1976 over 1978-1982. Panel B is our main source of variation in state-level specifications.

Figure V: The Hyde Amendment and County-level Fertility
Hyde Amendment x Time x Proportion Medicaid Eligibility



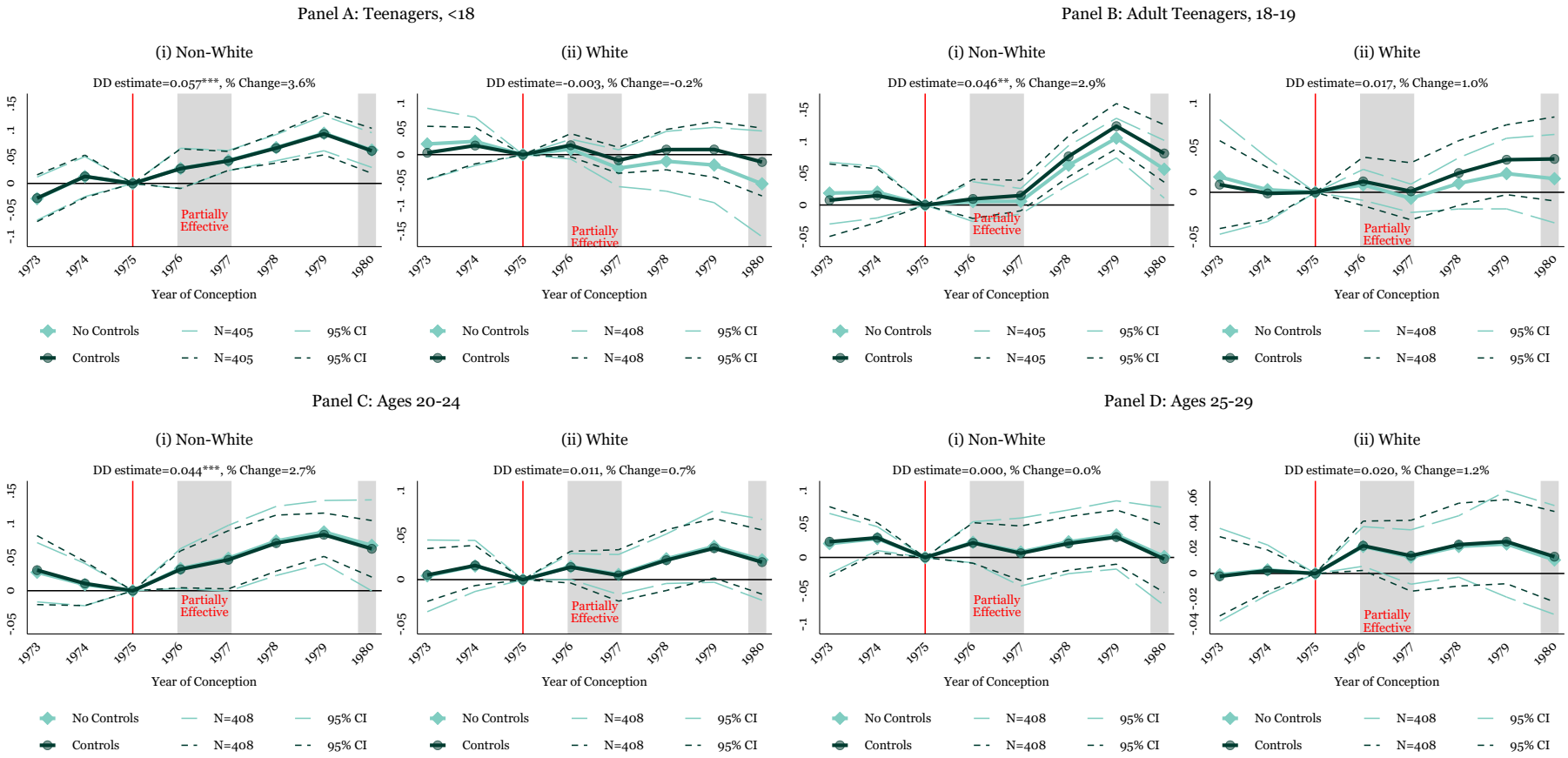
SOURCES: Vital Statistics Natality Birth Data (Birth Certificate Records) from the National Vital Statistics System of the National Center for Health Statistics. SEER Population data and Haines (2010) used for the controls and the population counts. Medicaid eligibility determined by the share of the population in the county receiving AFDC in 1976 (United States Bureau of the Census, 2012).
NOTES: Displays OLS coefficients. The outcome is the log of the fertility rate. In Panel A, the fertility rate is the number of births per 1,000 reproductive-age women 15-44. In Panel B, the fertility rate is the number of births to women under 30 per 1,000 women under 30. Regressions are weighted by the denominator of the rate. Baseline fixed effects include county fixed effects and state-by-year fixed effects (gray diamonds). Green (circles/squares) also include the 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, interacted with the share AFDC in a county (see Equation 1). The period just before the legal change is the excluded period–indicated by the vertical line. States that **increased** their funding for Medicaid abortions excluded from the county-level specification (CA, HI, MI, NC, PA, WV, WA). Arizona, which did not have a Medicaid program until 1982, is also excluded. Dashed and dotted lines reflect 95% confidence intervals. Robust standard errors clustered at the county level. The grouped post period, or DD estimate, represents the effect of funding restrictions on abortion from the Hyde Amendment interacted with the share of AFDC recipients in a county. Percentage effect calculated using the point estimate at the average county-level AFDC participation. Our main set of controls includes the share white, the share female, and the unemployment rate.

Figure VI: Robustness Checks on Figure V



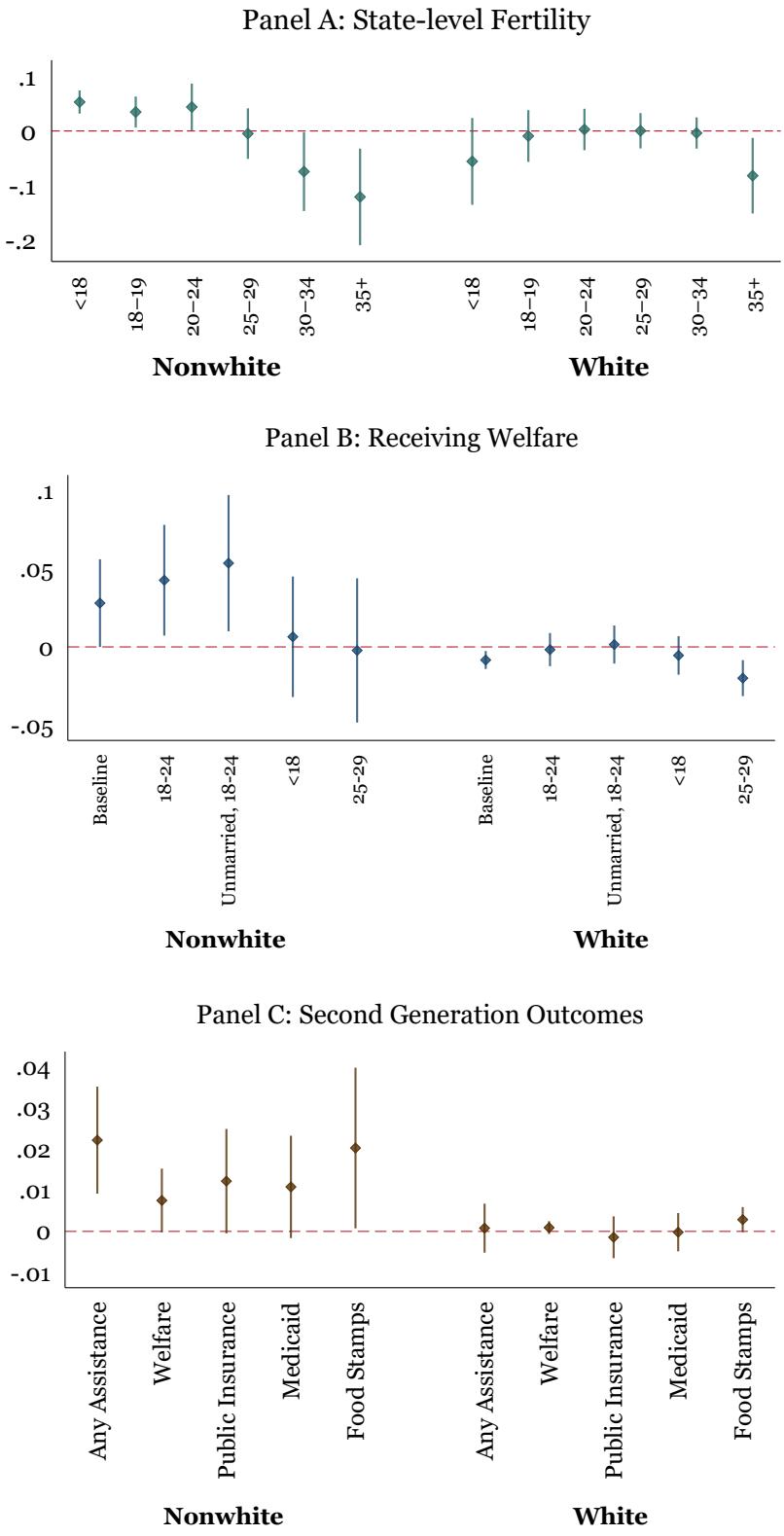
NOTES: Represents county-level specification from Figure V, except with the following modifications. Panels A.1-A.4 show the treatment (Hyde x share AFDC) also interacted with factors that may affect the strength of the fertility change. Panels A.1-A.4 show the share of AFDC with the % decline in Medicaid Abortions in 1978-1982 (A.1) and 1978-1980 (A.2), the cost-to-AFDC ratio in 1976 (A.3), and the 1976 abortion cost (A.4). Panel B uses alternative treatments rather than the share of AFDC recipients in a county. Panel B.1 uses the percentile of AFDC receipt, Panel B.2 shows the decile of AFDC receipt, and Panel B.3 interacts with the quartile of AFDC receipt. Panel B.4 shows the 4th versus the 1st quartile, a binary treatment rather than a dose-response treatment. Panel C.1 shows the Poisson estimates, where the outcome is the number of births to women less than 30, and the exposure is the number of young adult women less than 30 in each county. Panel C.2 considers young adults, 18-29. Panel C.3 controls for the inverse hyperbolic sine of the average distance to an abortion provider (based on county centroids) and controls for fertility programs through Title X (Bailey, 2012) at the county level. Because the Title X clinic information is not time-varying during our sample period, we interact the presence of a Title X program with year indicators. Then, Panel C.4 also adds controls for the share 18-19, the share 20-24, the share 25-29; the share of nulliparous deliveries, the share with a high school degree, the share with a college degree, and the average birth order. Panel D.1 clusters the standard errors at the state level. In Panel D.2, the standard errors are corrected for spatial correlation as described in Hsiang (2010). Panel D.3 tests for pretrends from Roth (2022); Caceres-Bravom (2024). Panel D.4 considers only mothers who still reside in their birth state. In other words, those who have not migrated out of their birth state. Panel E restricts the sample to counties within x (30, 45, 60, 90) miles of states with differing abortion declines.

Figure VII: State-level Analysis – % Decline in Medicaid Abortions x Hyde Amendment



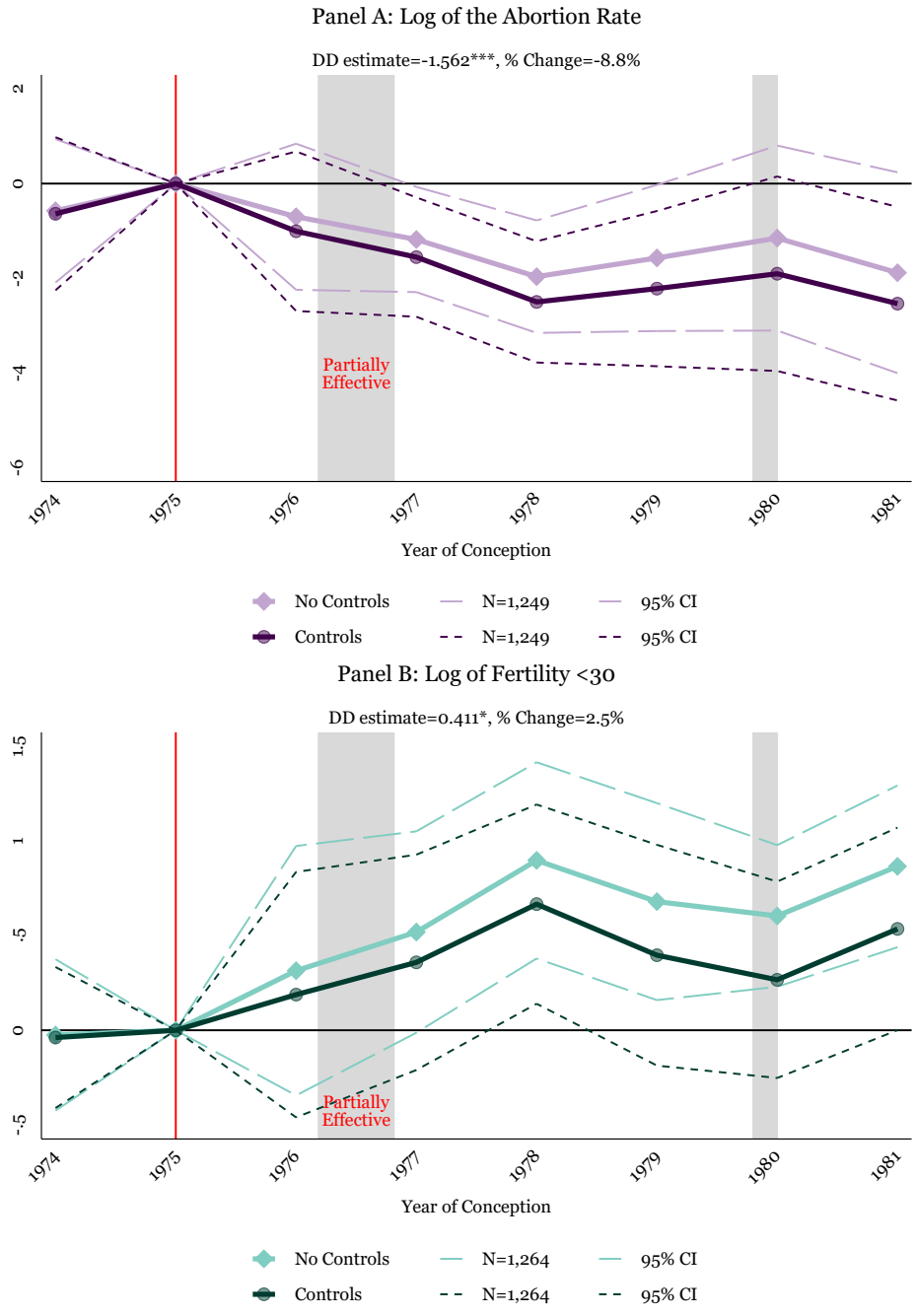
NOTES: Represents state-level event study specification based on Equation 2. Similar to the county-level specification in Figure V, except here the treatment is the average % decline in Medicaid abortions from 1976 to 1978-1982. States with increases in Medicaid funding for abortion before 1983 are included as control states (CA, HI, MI, NC, PA, WV, WA). Arizona is the only true zero because it did not have a state Medicaid program. State-fixed effects and year-fixed effects are included. Our main set of controls includes the share white, the share female, and the unemployment rate. Robust standard errors clustered at the state level. We also show the effect of the time-varying decline in Medicaid abortions in Figure VIII, the initial funding decline (1976-1978) in Figure E.3, and a binary specification capturing the decline in funding in Figure E.4. Further, Figure E.5 shows a specification where states with a rise in funding for Medicaid abortions are treated with a negative effect, rather than considering these states as control states with zero treatment.

Figure VIII: State-level Analysis – Time-Varying % Decline in Medicaid Abortions x Hyde Amendment



NOTES: Difference-in-difference results, considering the percent decline in Medicaid abortions. Represents the state-level version of the county-level specification in Figure V, except here the treatment is the annual % decline in Medicaid abortions from 1976 to each year 1977-1980. Unfortunately, data for 1977 and 1979 are unavailable, and we replace these missing years with 1978 and 1980, respectively. If a state has higher Medicaid abortions than in 1976, the annual change will be marked as zero. We also show that the results are similar if we treat increases in abortions as negative values in Figure E.6. We focus on the years up to 1980 because the main fertility decline appears before 1981, or 1977-1980, before the temporary pause on the Hyde Amendment and the major changes to AFDC/welfare and Medicaid expansions (East et al., 2023). The effects above are absolute effects on each group noted by the Medicaid abortion declines. Panel C is for children born from 1974-1980, around the time of the Hyde Amendment.

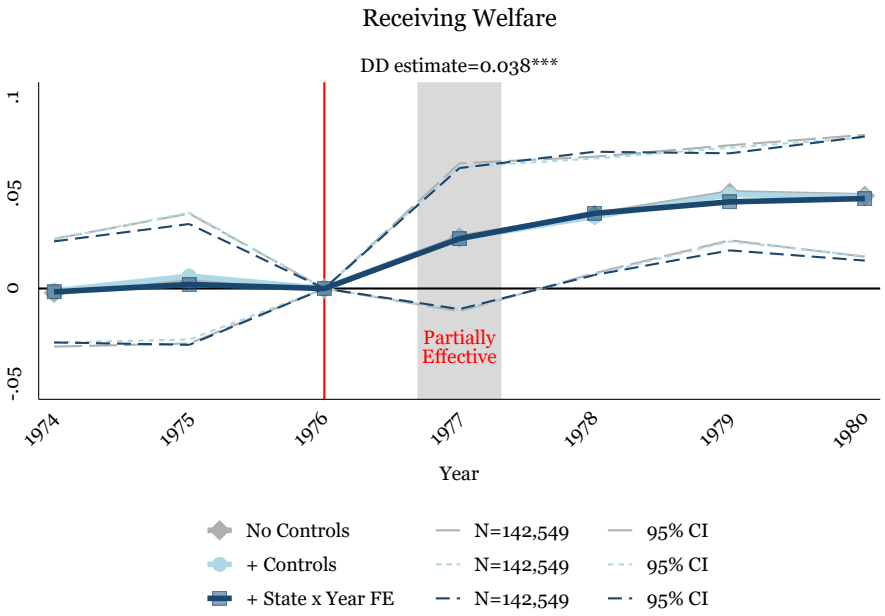
Figure IX: The Hyde Amendment and Abortions in Georgia
Hyde Amendment x Time x Proportion Medicaid Eligibility



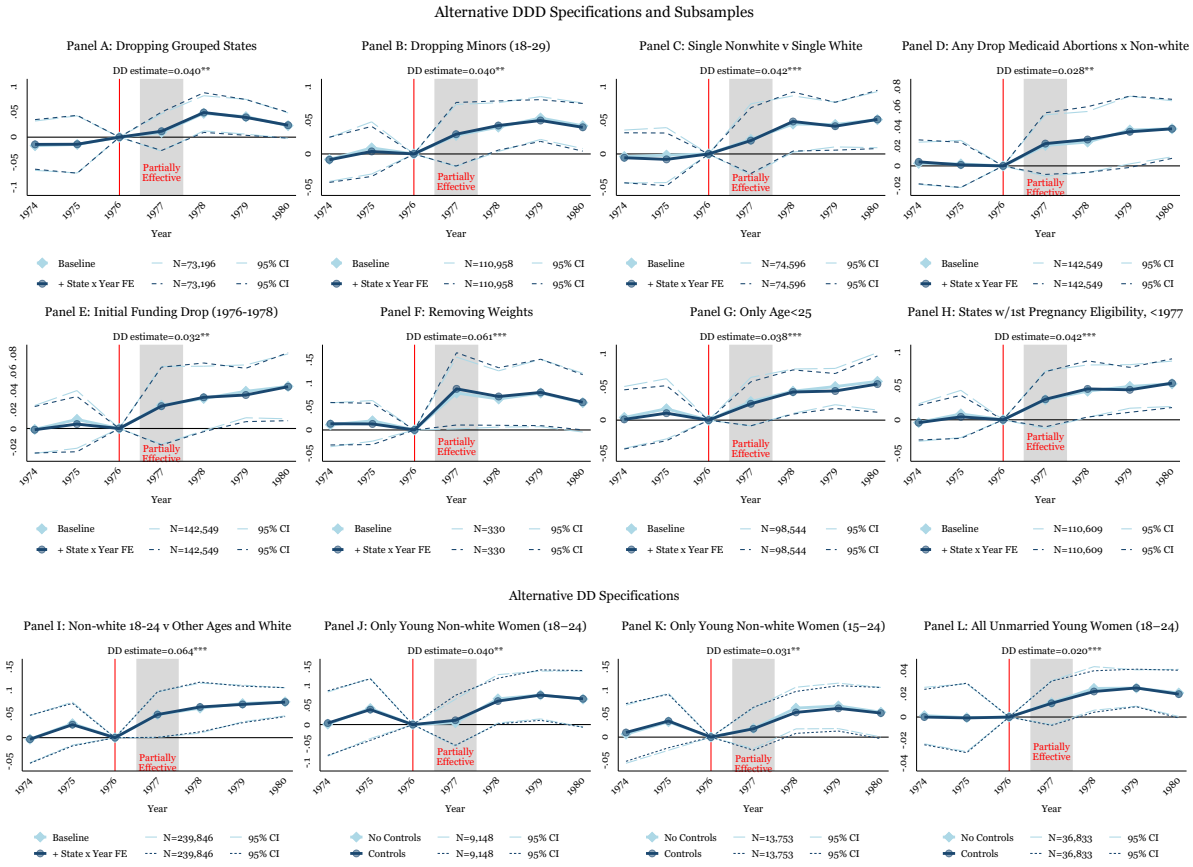
SOURCES: Georgia abortion data from annual vital statistics publications in Georgia Department of Public Health (1975-1981)
NOTES: Displays OLS coefficients. The outcome is the log of abortions per 1,000 reproductive-age women, with weights applied by the denominator of the rate. Results are only shown for Georgia, so they represent the declines in abortions by AFDC participation in a single state. Baseline fixed effects include the county and year (because we only have a single state). Dashed and dotted lines reflect 95% confidence intervals. Robust standard errors clustered at the county level. The grouped post period, or DD estimate, represents the effect of funding restrictions on abortion from the Hyde Amendment interacted with the share of AFDC recipients in a county. Percentage effect calculated using the point estimate at the average county-level AFDC participation. Our main set of controls includes the share white, the share female, and the unemployment rate. Percentage effect calculated using the point estimate at the average county-level AFDC participation.

Figure X: CPS Data–Decline in Medicaid Abortions x Non-white Women x Hyde

Panel A: Main Effect: Welfare Participation



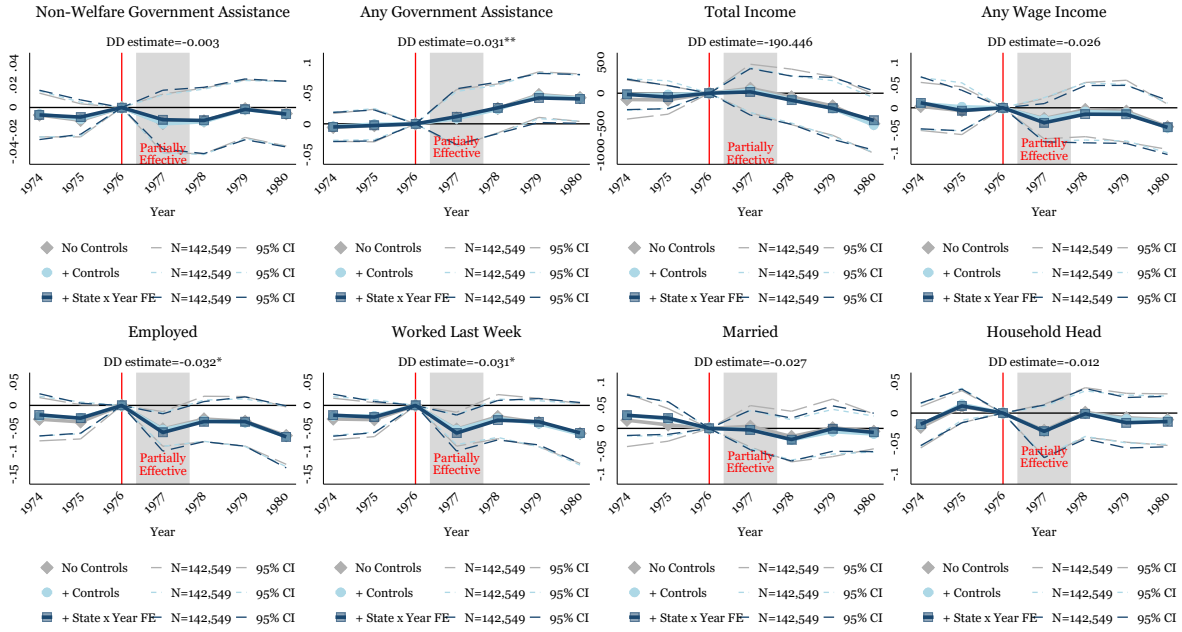
Panel B: Robustness Checks on Welfare Participation



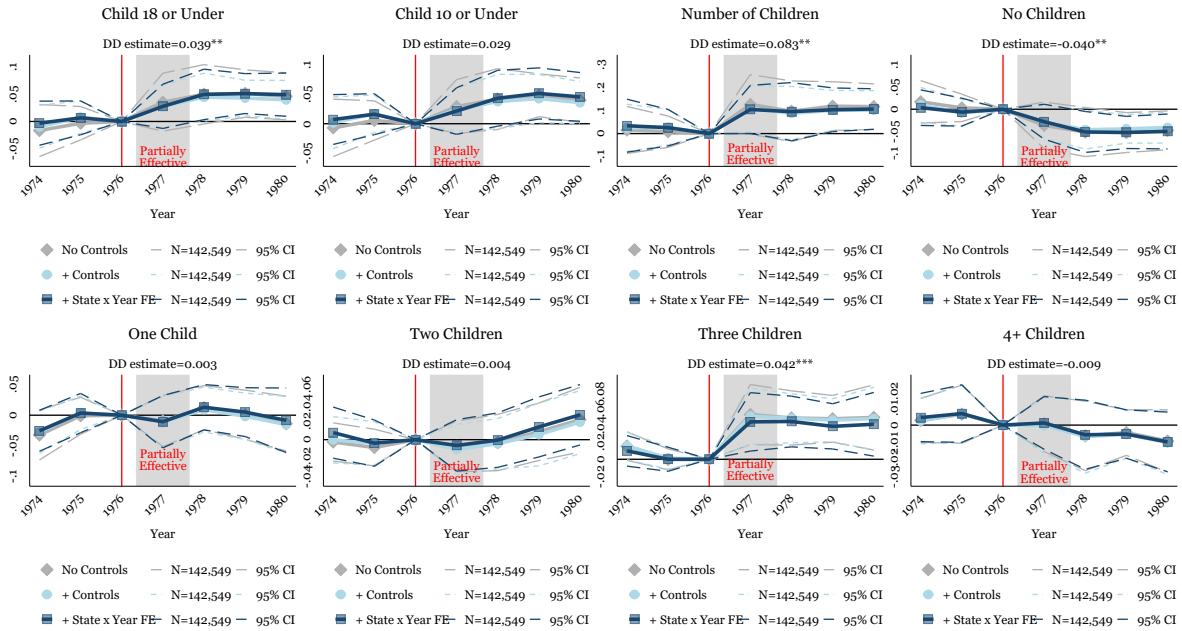
SOURCE: CPS data (Flood et al., 2024).
NOTES: OLS coefficients reported. Considers the impact of the Hyde Amendment, using the % decline in state-level Medicaid abortions interacted with year indicators and an indicator for non-white. Fixed effects include state, year, non-white, non-white-x-percent decline, non-white-x-post, and percent-decline-x-post fixed effects. The CPS data reports state groups at the beginning of the sample, so we take the average % decline in Medicaid abortions for grouped states (weighted by the reproductive age women). States also grouped similarly over time for consistency. Controls include indicators for age, most other controls, like education, would be "bad controls." Robust standard errors clustered at the state level. Only women 15-29 are included in the sample, unless otherwise noted. Regressions are weighted by the weight in the CPS.

Figure XI: CPS Data–Mechanisms for the Rise in Welfare Payments

Panel A: Employment and Income

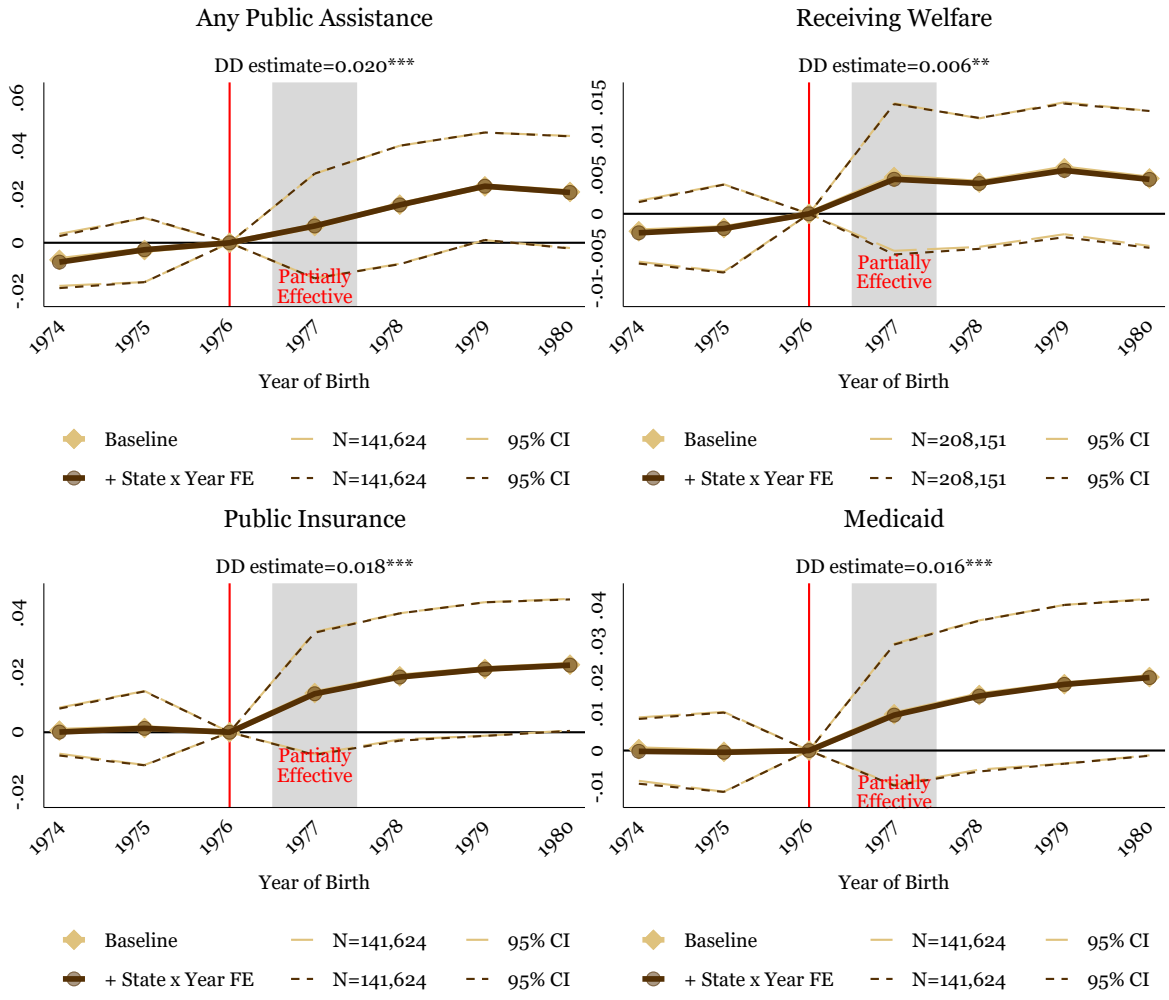


Panel B: Fertility-related Outcomes



NOTES: Reflects Panel A of Figure X except considering other outcomes.

Figure XII: ACS Data–Public Assistance of the Second Generation Women



SOURCE: ACS Data (Ruggles et al., 2024).
NOTES: ACS data collapsed to the race (non-white v white), state, state of birth, year, and birth year level. Considers the impact of the Hyde Amendment, using the % decline in Medicaid abortions interacted with year indicators and an indicator for non-white. Only includes adult women under 45 born between 1974 and 1980. Fixed effects include the current year of birth, birth state, non-white-x-percent decline, non-white-x-post, and percent-decline-x-post fixed effects. State-by-year fixed effects are included where noted, and in regressions without state-by-year FE, state and year fixed effects are included. No controls included, because age can be backed out of year of birth and year. Regressions are weighted by the sum of the weights in the ACS. Robust standard errors clustered at the state of birth level.

12 Tables

Table 1: State Medicaid Abortion Characteristics

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
State	Medicaid Abortions 1976	State Funded Abortions 1978	State Funded Abortions 1980	State Funded Abortions 1981	State Abortions 1982	Average % Decline Medicaid Abortions	Medicaid Abortion Rate 1976	Non-Medicaid Abortion Rate 1976	Ratio Medicaid to Non Medicaid Abortions 1976	Average Abortion Cost 1976	Average AFDC Payment 1976	Cost-to-AFDC payment 1976
CA	70000	100000	90108	97437	99000	-38.1	100	24	4.2	307	135	2.3
NY	50000	41326	37500	37500	46000	18.8	85	35	2.5	289	140	2.1
IL	18300	4400			0	91.0	60	19	3.1	400	256	1.6
MI	14800	13700	6750	19400	19470	-0.2	52	16	3.1	218	300	0.7
TX	13300	0	0	0	0	100.0	91	16	5.6	196	104	1.9
PA	10000	14535	7596	6125	14697	-7.4	39	17	2.2	415	260	1.6
NJ	10000	0	421	5399	3952	75.6	52	17	3.0	321	217	1.5
OH	10000	0			0	100.0	46	16	2.8	160	256	0.6
DC	7400	5782	4921	4753	4313	33.2	190	171	1.1	460	207	2.2
VA	5200	0	21	19	30	99.7	65	15	4.2	181	255	0.7
MA	5100		0	6934	6695	4.1	21	28	0.7	280	175	1.6
MD	5000	6009	5179	2766	3193	14.3	56	21	2.6	274	193	1.4
KS	3700	904			0	90.8	82	24	3.4	310	247	1.3
GA	3700	0	0	0	6	100.0	30	21	1.5	211	139	1.5
NC	3100	1123	5730	5730	4295	-36.1	29	15	2.0	309	363	0.9
CO	2800	404	2125	823	1319	58.3	77	20	3.8	379	297	1.3
WA	2700		3840	3326	3213	-28.4	37	27	1.4	253	191	1.3
WI	2500	29	997	45	3	89.3	34	11	3.2	460	196	2.3
MO	2400	0	0	0	0	100.0	25	10	2.5	460	48	9.6
OR	2000	1191			657	52.1	43	25	1.7	169	203	0.8
CT	2000	0			951	65.2	37	17	2.2	301	205	1.5
FL	1600	0	0	0	0	100.0	16	28	0.6	239	242	1.0
SC	1400	0	0	0	0	100.0	25	8	3.1	448	263	1.7
AL	1300	0	0	1	0	100.0	20	7	3.0	280	238	1.2
MN	1300	0				100.0	22	14	1.6	232	296	0.8
HI	1200	1406	2100	2100	1623	-50.6	56	27	2.1	214	97	2.2
TN	1200	0	0	0	0	100.0	15	22	0.7	160	205	0.8
RI	1000	0	0	0		100.0	30	16	1.9	298	283	1.1
IA	1000				8	99.0	25	10	2.7	244	168	1.5
NM	900	109	0	0	0	97.0	41	17	2.4	280	263	1.1
KY	900	0	0	0	0	100.0	7	12	0.6	379	229	1.7
MT	700	0	0	0	0	100.0	46	5	8.3	167	137	1.2
OK	700	0			0	100.0	14	12	1.2	202	195	1.0
AR	500	0	0	0	0	100.0	11	6	1.8	207	141	1.5
ME	500	0	0	0	0	100.0	17	7	2.3	160	119	1.3
DE	400	2	0	0	0	99.9	30	17	1.8	409	266	1.5
NV	400	0	0	0		100.0	60	25	2.4	202	210	1.0
WV	300	459	325		547	-52.0	13	1	15.9	223	252	0.9
AK	300	312				2.4	74	16	4.6	310	113	2.7
UT	300	0	0	0	0	100.0	18	8	2.4	208	104	2.0
VT	300	0	0	0	0	100.0	32	21	1.5	184	246	0.7
NE	300	0			0	100.0	16	14	1.2	383	173	2.2
NH	200	0	0	0	0	100.0	18	12	1.4	250	157	1.6
WY	100	0	0	0	0	100.0	28	5	5.4	241	296	0.8
ID		0	0	0	0	100.0		7		430	363	1.2
IN		0	0	0		100.0		7		225	269	0.8
LA		0	0	0	0	100.0		9		199	171	1.2
MS		0	0	0	0	100.0		1		278	266	1.0
ND		0	0	0	0	100.0		10		331	154	2.1
SD		0	0	0	0	100.0		11		226	85	2.6
AZ						0.0		16		293	297	0.8

SOURCE: Lincoln et al. (1977), Gold (1980), Gold (1982), Nestor and Gold (1984), Gold and Nestor (1985), Gold and Macias (1986).

Table 2: Heterogeneity–Difference-in-Differences, AFDC Participation x Hyde

Panel A: Log of Fertility Rate (<30)

Outcome: Log of Fertility Rate (<30)	Fertility Rate <30			Fertility Rate <30 2+ Births		Fertility Rate <30 1st Births	
	(1) All	(2) White	(3) Non-white	(4) White	(5) Non-white	(6) White	(7) Non-white
1(Hyde) x Share AFDC	0.3833***	0.4877***	0.4444***	0.6626***	0.6718***	0.2765*	0.0581
	(0.0878)	(0.1108)	(0.1064)	(0.1280)	(0.1516)	(0.1525)	(0.1176)
N	34,554	34,553	26,196	34,430	24,421	34,412	22,950
Adjusted R-squared	0.926	0.926	0.770	0.906	0.724	0.832	0.665

Panel B: Share of <30 Birth Characteristics

Outcome: Share of Births	Marital	Birth Order		Unmarried		Married	
	(1) Married	(2) 1st Births	(3) Total Birth Order	(4) 2+ Births	(5) 1st Births	(6) 2+ Births	(7) 1st Births
1(Hyde) x Share AFDC	-0.6233***	-0.2166***	0.4583***	0.5163***	0.0962	-0.3258***	-0.2866***
	(0.0963)	(0.0299)	(0.0754)	(0.0473)	(0.0649)	(0.0589)	(0.0742)
N	32,983	34,482	34,482	32,966	32,966	32,966	32,966
Adjusted R-squared	0.661	0.588	0.746	0.747	0.331	0.306	0.298

Panel C: Interactions

Outcome: Log of Fertility <30	Demand			Cost		Funding Decline	
	(1) High State Share AFDC	(2) High Medicaid Abortions	(3) High Rate Medicaid Abortions	(4) High Cost of Abortion	(5) High Ratio Cost to AFDC	(6) 100%	(7) 1-90%
1(Hyde) x Share AFDC	0.2040	0.2040	0.4780***	0.4370**	0.4890***	0.6192***	0.9025***
	(0.1437)	(0.1437)	(0.0877)	(0.1741)	(0.1558)	(0.1202)	(0.1352)
1(Above Median)	0.2892	0.2892	-0.0659	-0.0316	-0.0982		
	(0.1784)	(0.1784)	(0.1618)	(0.1947)	(0.1854)		
$1 \times$ 1(Hyde) x Share AFDC						-0.4891***	
						(0.1766)	
1(>90% Decline) $\times$ 1(Hyde) x Share AFDC							-0.6954***
							(0.1545)
N	29,341	29,341	29,341	34,554	34,554	34,554	34,554
Adjusted R-squared	0.940	0.940	0.940	0.937	0.937	0.937	0.938
F-stat from Joint F-test	10.393	10.393	17.028	12.619	10.738	7.673	20.251
P-value from Joint F-test	0.000	0.000	0.000	0.000	0.000	0.006	0.000
County FE and State x Year FE	X	X	X	X	X	X	X
Controls	X	X	X	X	X	X	X

NOTES: Reflects grouped post-period from Figure V. Panel A shows the fertility rate for women less than 30 for different groups, with the regressions weighted by the denominator. The fertility rates are per all women <30, per non-white women <30, per white women <30, respectively. Panel B shows the share of births to women younger than 30, with the regressions weighted by the number of births. Panel C shows the interactions of Medicaid eligibility with various factors, state-level demand, cost, and funding. These state-level policies are time-invariant. See also the event studies in Figures B.6 and B.7. For the specific state-level policies, see Table A.1.

Table 3: Effects of Hyde × Medicaid on Abortion, Live Birth, and Miscarriage from the NSFG

	Abortion				Live Birth				Miscarriage				Stillbirth			
	(1) <30	(2) <30	(3) All	(4) All	(5) <30	(6) <30	(7) All	(8) All	(9) <30	(10) <30	(11) All	(12) All	(13) <30	(14) <30	(15) All	(16) All
1(Hyde)=1 × 1(Medicaid)=1	-0.0748*	-0.0848**	-0.0672*	-0.0710*	0.0933*	0.1063**	0.1049**	0.0999**	-0.0261	-0.0275	-0.0461	-0.0354	0.0076	0.0061	0.0084	0.0065
	(0.0403)	(0.0406)	(0.0377)	(0.0375)	(0.0521)	(0.0508)	(0.0508)	(0.0490)	(0.0413)	(0.0403)	(0.0465)	(0.0417)	(0.0086)	(0.0083)	(0.0079)	(0.0078)
N	3,608	3,608	4,253	4,251	3,608	3,608	4,253	4,251	3,608	3,608	4,253	4,251	3,608	3,608	4,253	4,251
Adjusted R-squared	0.001	0.031	0.001	0.036	0.000	0.042	0.001	0.044	0.002	0.016	0.001	0.021	0.001	0.009	0.000	0.006
Medicaid FE and Pregnancy Year FE	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Controls		X		X		X		X		X		X		X		X

NOTES: Reports linear probability model difference-in-differences capturing the interaction of the Hyde Amendment (post-1976) with Medicaid receipt. Columns show the pregnancy outcomes, with the possible outcomes including abortion, live birth, stillbirth, and miscarriage. Columns (1)–(4) present estimates for the probability of abortion. Columns (5)–(8) show the probability of a live birth. Columns (9)–(12) display the probability of miscarriage. Columns (13)–(16) present the probability of stillbirth. The first two rows in each outcome are restricted to women younger than 30, and subsequent rows show the full sample. All regressions include Medicaid fixed effects and pregnancy-year fixed effects. Specifications with controls include race indicators (black and white) and controls for maternal age. Standard errors are clustered at the individual level and weighted by the survey weight. Data from the 1982 version of NCHS (2010). We keep only the years of pregnancy between 1974 and 1979. We do not include 1980 because of the pending Supreme Court Decision that paused the Hyde Amendment in 1980, and the fact that we only consider a grouped post period in the present analysis.

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Online Appendix

A Background

Figure A.1: Table of Medicaid Eligibility, 1975

TABLE 54.–UNDUPLICATED YEARLY NUMBER OF RECIPIENTS BY BASIS OF ELIGIBILITY, FISCAL YEAR 1975
(in thousands)[1]

State	Total recipients	Aged	Blind	Disabled	Children under 21	AFDC adults
Alabama	323	121	2	40	110	51
Alaska	10	1	.....	1	5	3
Arizona	([2])	([2])	([2])	([2])	([2])	([2])
Arkansas	184	72	1	22	60	28
California	3,344	637	24	481	1,507	695
Colorado	151	32	.5	25	62	32
Connecticut	192	24	.3	20	112	35
Delaware	49	4	.3	3	30	11
District of Columbia	147	12	.2	12	82	40
Florida	386	86	2	53	170	76
Georgia	516	113	2	58	240	102
Guam[4]	.....	.....	.....	.....	.....	.....
Hawaii	93	10	.2	5	56	22
Idaho	39	6	.1	5	19	9
Illinois	1,600	108	2	194	957	339
Indiana	242	34	1	21	128	58
Iowa	143	30	1	10	69	33
Kansas	139	22	.6	12	77	27
Kentucky	357	78	2	40	153	84
Louisiana	397	127	2	47	157	64
Maine	122	21	.4	16	56	29
Maryland	345	45	.4	33	188	78
Massachusetts	588	132	8	63	278	109
Michigan	955	107	2	86	528	232
Minnesota	245	45	.7	22	127	50
Mississippi	287	85	2	30	128	42
Missouri	342	90	3	29	156	64
Montana	45	8	.2	6	21	10
Nebraska	70	16	.3	9	31	14
Nevada	23	4	.1	2	12	6
New Hampshire	50	11	.5	4	23	11
New Jersey	623	57	1	55	363	148
New Mexico	76	10	.3	11	39	16
New York	2,696	412	6	317	1,295	667
North Carolina	329	91	7	72	103	56
North Dakota	27	7	.1	3	12	5
Ohio	764	131	.9	20	396	217
Oklahoma	214	59	1	26	102	27
Oregon	169	18	1	17	86	47
Pennsylvania	1,090	102	15	97	512	364
Puerto Rico	1,098	37	.4	21	784	255
Rhode Island	109	33	.3	11	40	25
South Carolina	264	85	3	31	103	43
South Dakota	42	12	.1	4	18	9
Tennessee	319	84	1	49	137	47
Texas	729	248	4	77	286	115
Utah	55	6	.2	6	29	15
Vermont	49	9	.1	5	25	10
Virgin Islands	19	1	.....	.1	14	3
Virginia	312	60	2	33	148	69
Washington	274	40	.7	41	133	61
West Virginia	124	21	.7	20	50	32
Wisconsin	419	96	2	44	202	75
Wyoming	11	2	.....	1	6	2
Total[3]	21,197	3,699	107.1	2,308	10,421	4,662

SOURCE: Medicaid/Medicare Management Institute (1978) Page 70.

Figure A.2: Medicaid Eligibility, 1976

TABLE 54.—UNDUPLICATED YEARLY NUMBER OF RECIPIENTS BY BASIS OF ELIGIBILITY, FISCAL YEAR 1976

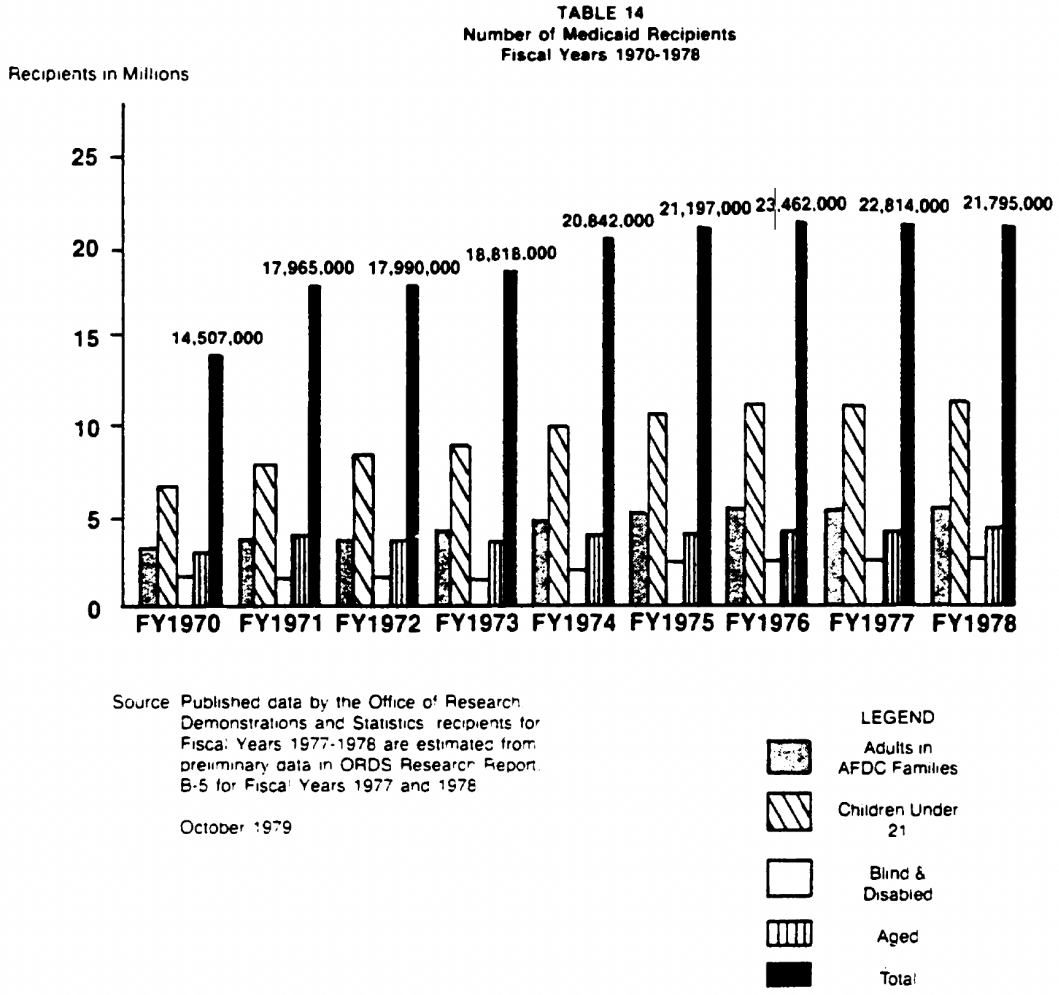
(in thousands) [1], [5], [6]

State	Total recipients [4]	Aged	Blind	Disabled	Children under 21	AFDC adults
Alabama	321.6	110.9	1.9	47.6	111.2	50.0
Alaska	9.6	1.0	(7)	1.4	5.3	1.9
Arizona	(2)	(2)	(2)	(2)	(2)	(2)
Arkansas	220.9	72.1	1.6	32.6	80.5	34.1
California	3,393.6	597.7	23.6	503.1	1,552.8	716.5
Colorado	180.3	38.2	0.4	20.4	91.0	30.4
Connecticut	211.0	24.9	0.3	19.4	124.6	41.7
Delaware	52.3	4.6	0.3	3.7	32.2	11.5
District of Columbia	152.7	12.9	0.2	13.3	85.0	41.2
Florida	398.2	92.8	2.2	65.5	164.3	73.3
Georgia	591.0	140.9	3.5	90.0	248.1	108.6
Guam	(3)	(3)	(3)	(3)	(3)	(3)
Hawaii	95.6	9.8	0.1	5.6	57.5	22.5
Idaho	41.7	6.6	0.1	5.4	19.9	9.8
Illinois	1461.1	98.8	2.1	188.2	804.2	367.8
Indiana	253.8	32.5	1.2	22.2	135.5	62.4
Iowa	154.6	31.9	1.1	13.6	69.3	38.8
Kansas	158.1	24.0	0.5	14.4	88.5	30.6
Kentucky	404.9	75.3	2.2	48.1	180.5	98.8
Louisiana	428.9	125.7	2.2	64.3	167.1	69.6
Maine	126.1	18.2	0.3	12.7	60.0	34.9
Maryland	355.6	46.4	0.5	35.7	191.8	81.3
Massachusetts	835.8	126.8	8.6	60.6	478.4	161.4
Michigan	979.0	99.3	1.6	89.0	547.8	241.2
Minnesota	269.1	52.1	0.8	31.1	133.4	51.6
Mississippi	299.9	87.1	1.7	31.5	136.0	43.7
Missouri	366.0	78.7	3.2	29.9	174.7	79.4
Montana	41.6	7.7	0.3	6.3	18.6	8.6
Nebraska	70.5	15.2	0.3	8.5	32.1	14.5
Nevada	26.3	4.7	0.2	2.4	12.5	6.5
New Hampshire	49.1	10.3	0.4	4.2	22.8	11.4
New Jersey	656.1	61.6	1.2	63.3	376.2	153.7
New Mexico	81.3	11.5	0.3	12.6	40.9	15.9
New York	2,884.0	463.3	5.4	331.1	1,383.7	700.4
North Carolina	345.8	76.1	4.5	58.6	112.7	93.9
North Dakota	26.1	6.5	0.1	2.9	11.6	5.1
Ohio	803.5	129.2	1.4	33.4	411.7	227.8
Oklahoma	205.6	55.5	0.8	24.7	99.4	25.2
Oregon	189.6	20.3	1.3	18.9	96.9	52.2
Pennsylvania	2,241.4	175.7	7.0	235.5	1,159.8	663.3
Puerto Rico	1,106.7	23.8	0.2	25.4	852.3	204.9
Rhode Island	116.1	32.1	0.3	11.9	43.3	28.6
South Carolina	292.2	98.9	3.2	45.0	97.3	47.9
South Dakota	40.5	10.1	0.1	3.8	18.2	8.1
Tennessee	358.6	90.9	1.4	60.0	152.8	53.5
Texas	722.5	251.1	4.6	94.0	269.4	103.4
Utah	59.5	5.7	0.1	5.7	32.7	15.3
Vermont	56.9	9.3	0.1	6.3	28.0	13.1
Virgin Islands	9.1	1.1	(7)	0.1	6.6	1.3
Virginia	320.4	61.0	1.7	36.4	151.0	70.4
Washington	274.2	39.4	0.7	38.5	136.1	59.5
West Virginia	192.7	30.4	0.8	32.3	83.8	45.4
Wisconsin	516.9	104.7	1.3	51.3	257.1	102.5
Wyoming	13.0	2.3	(4)	1.2	6.8	2.7
Totals [4]	23,461.7	3,807.7	98.3	2,663.7	11,653.6	5,238.3

[1] Numbers rounded to nearest hundred

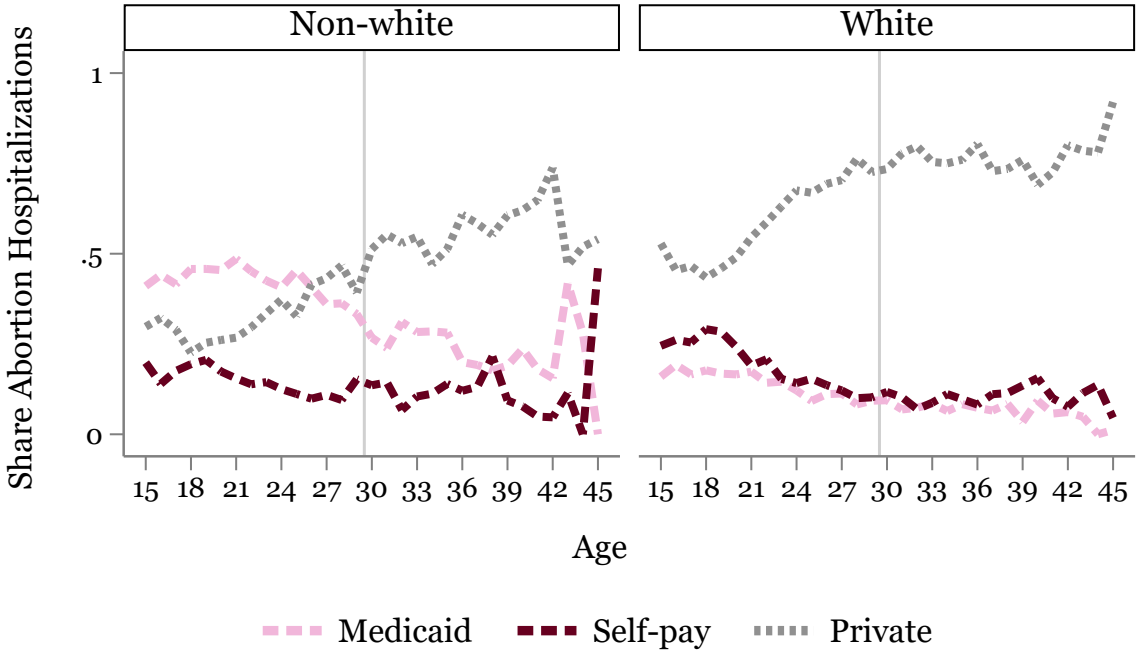
SOURCE: Medicaid/Medicare Management Institute (1979) Page 76.

Figure A.3: Medicaid Eligibility by Category Over Time



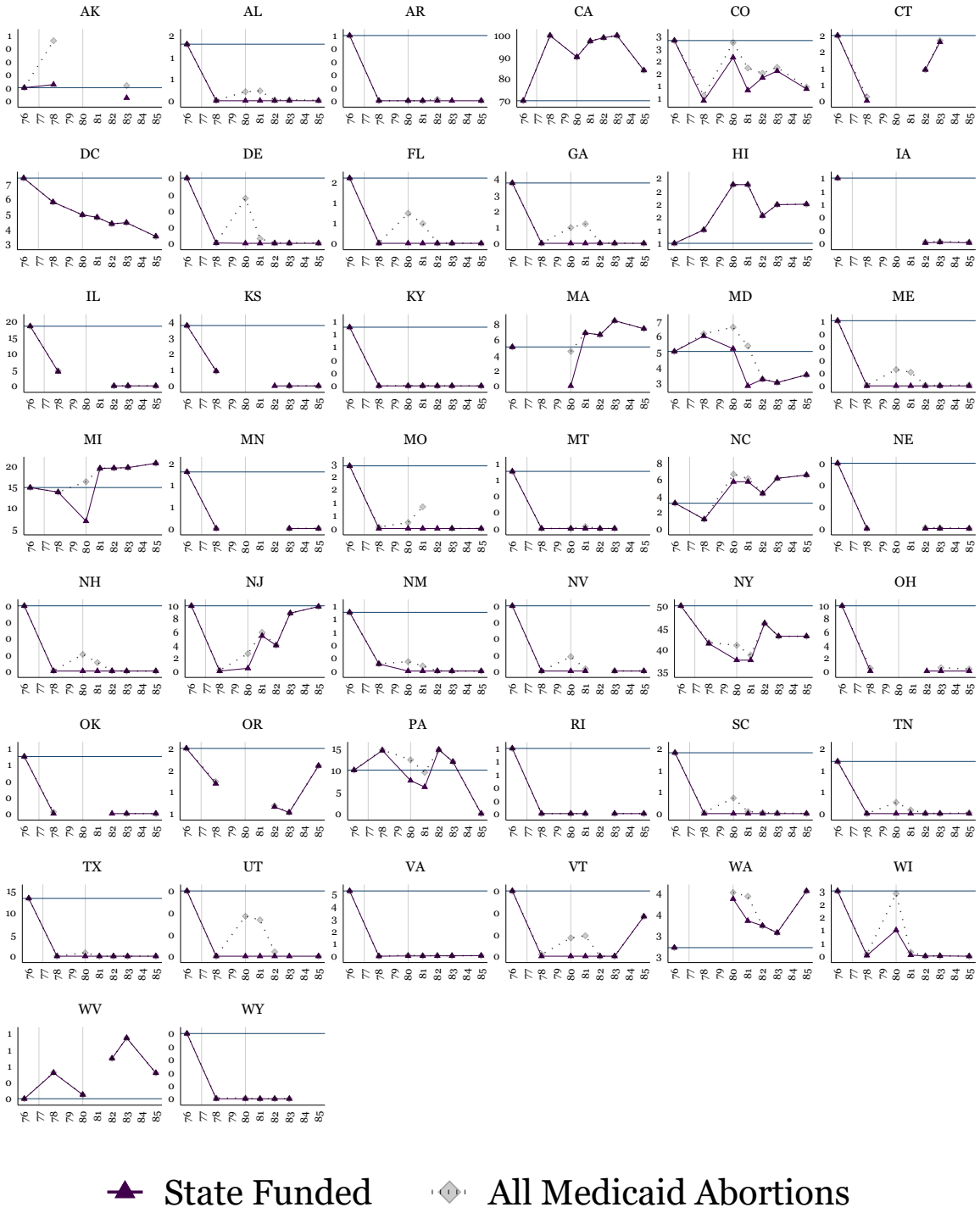
SOURCE: Medicaid/Medicare Management Institute (1979) Page 14.

Figure A.4: NHDS Abortion Complications – Share Payer by Age and Race



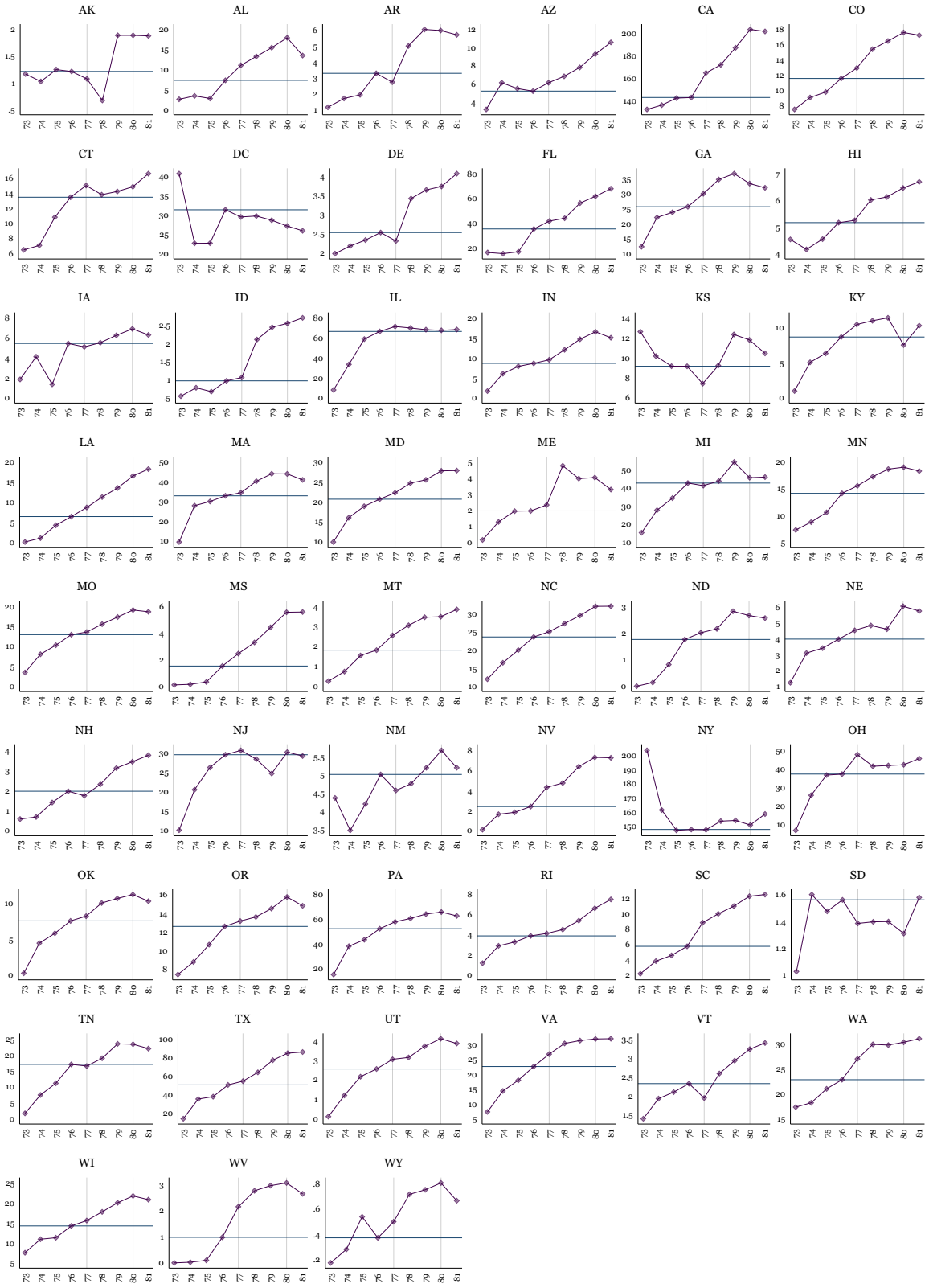
SOURCE: National Hospital Discharge Survey (NHDS) Files.
NOTE: Shows the share of abortions by each payer by race and over age.

Figure A.5: Medicaid Abortions in 1976 and Subsequent State-Funded Abortions



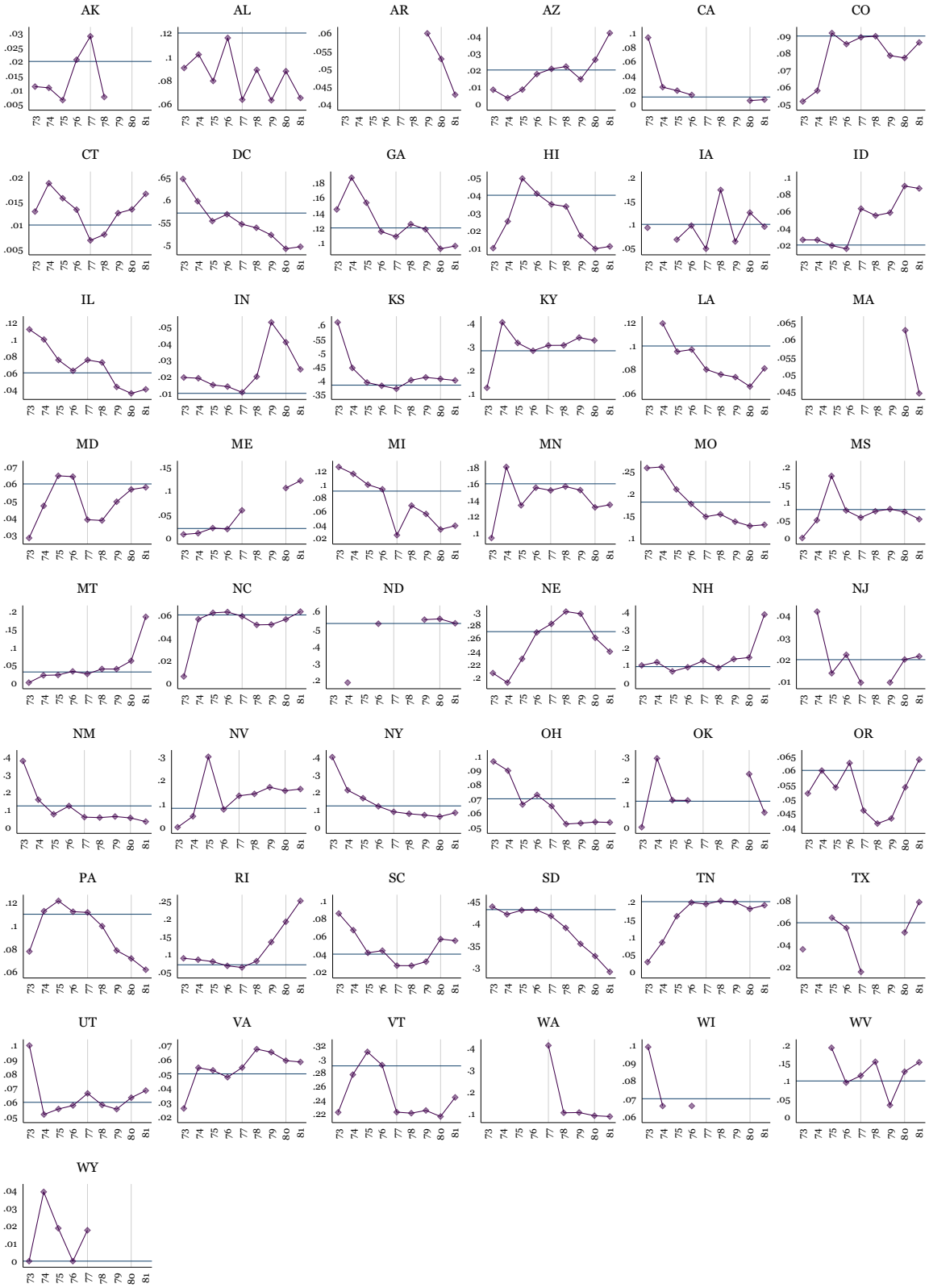
SOURCES: Lincoln et al. (1977), Gold (1980), Gold (1982), Nestor and Gold (1984), Gold and Nestor (1985), Gold and Macias (1986).
NOTES: Shows the number of Medicaid abortions in 1,000s, both the total Medicaid abortions (federal + state, gray diamonds) and state-funded abortions (colored triangle/solid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

Figure A.6: All Abortions by State



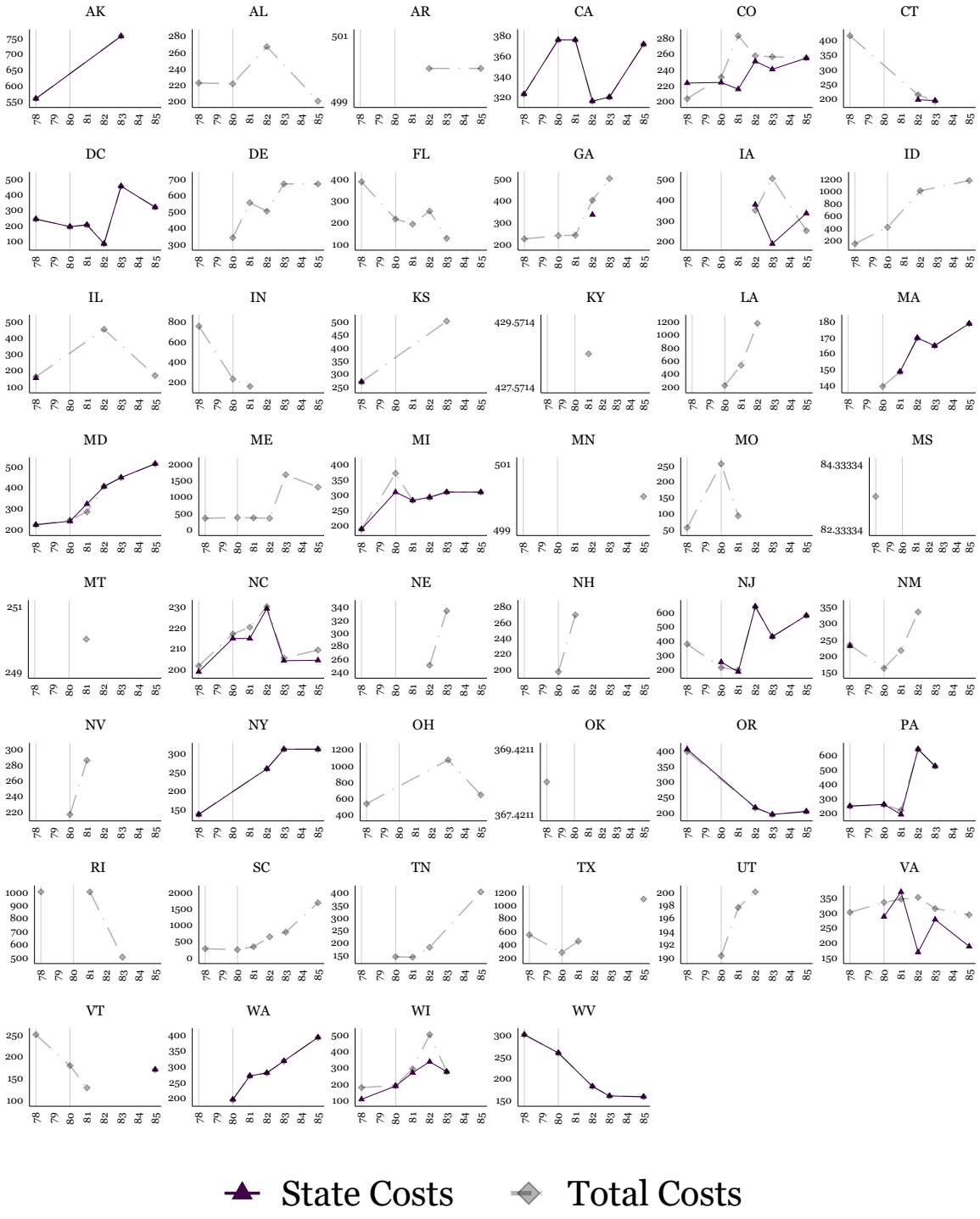
SOURCES: Abortion data from the CDC Abortion Surveillance Program (CDC, 1977). This data is only available by state.
NOTES: Shows the total abortions in 1,000s in each state. The y-axis represents the number of abortions in thousands, and the x-axis represents years.

Figure A.7: Abortions From Out-of-State Residents



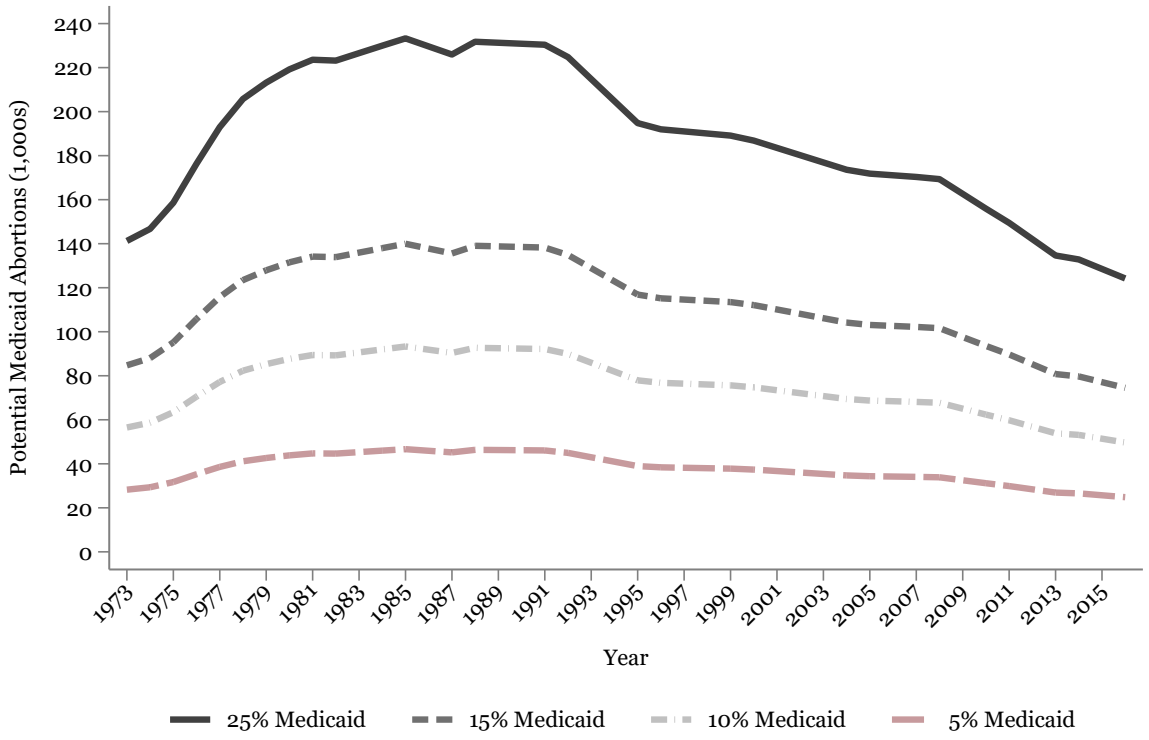
SOURCES: Abortion data from the CDC Abortion Surveillance Program (CDC, 1977). This data is only available by state.
NOTES: Shows the share of abortions from out-of-state residents.

Figure A.8: Costs–Funding / # Abortions

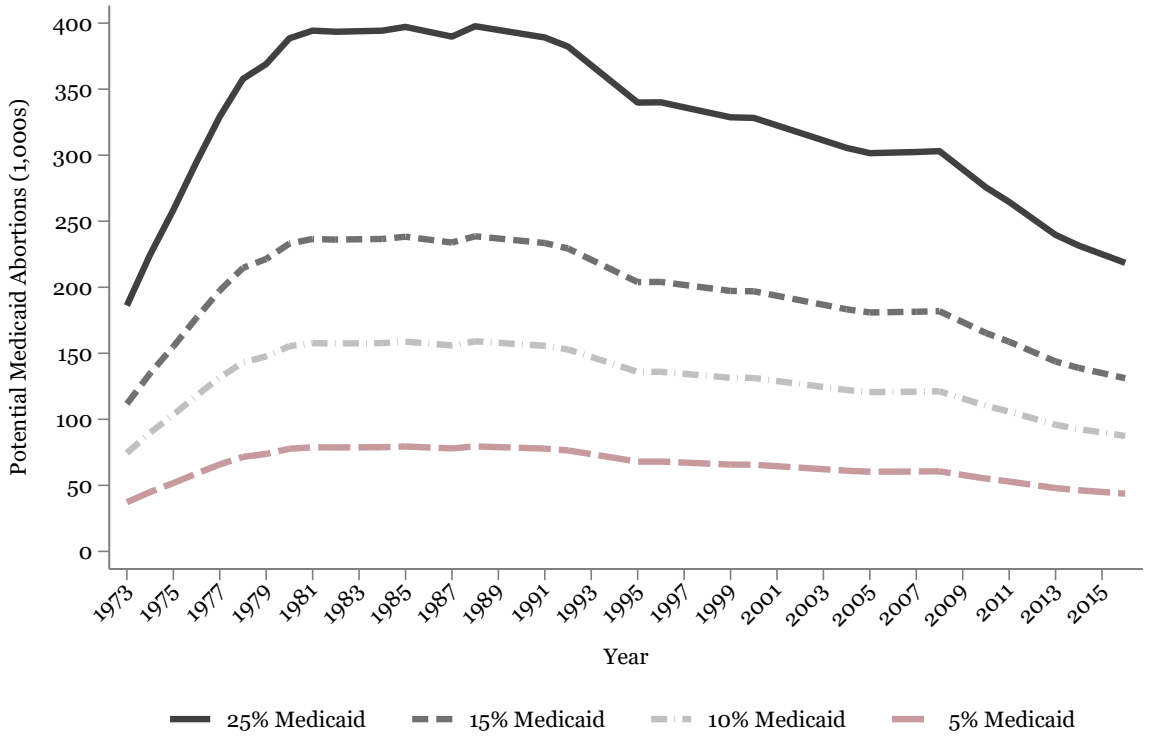


SOURCES: Lincoln et al. (1977), Gold (1980), Gold (1982), Nestor and Gold (1984), Gold and Nestor (1985), Gold and Macias (1986).
NOTES: Shows the Medicaid abortion funding divided by the number of abortions.

Figure A.9: Estimates of Medicaid Abortions over Time
Panel A: Medicaid Funding Restricted States

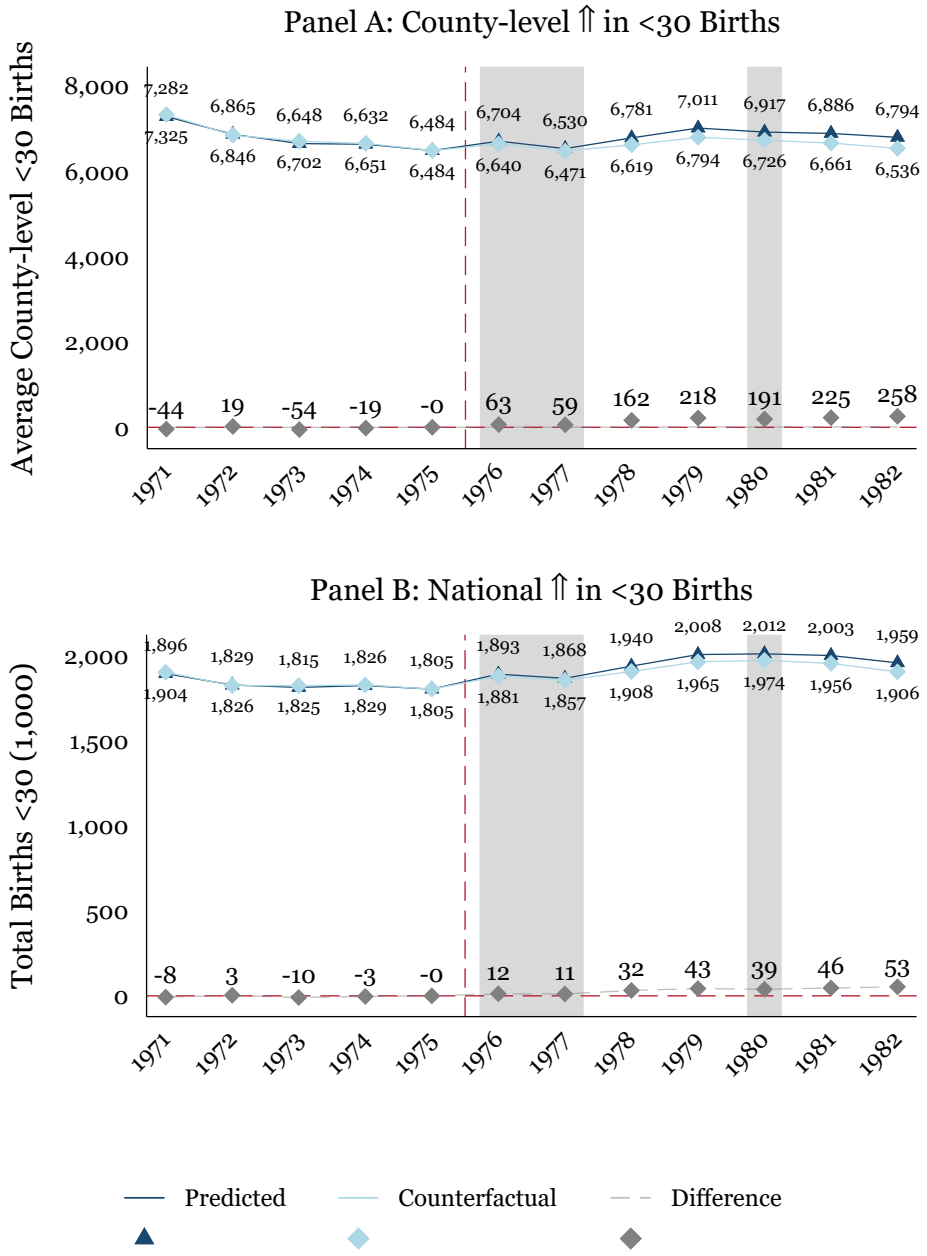


Panel B: All Potential Medicaid Abortions in All States



NOTES: Data on abortions from Guttmacher Institute, covering the years 1973–2016. The lines represent estimates of the number of abortions that Medicaid could have funded at varying funding levels. Each line represents the percentage of total abortions by state. So 25% will represent 25% of total abortions. Panel A shows only abortions in Medicaid-funding restricted states. Panel B shows all potential Medicaid abortions. According to Guttmacher Institute (2025), approximately 30% of abortions are paid for by Medicaid. Similarly, Cates (1981) found that 25–30% of abortions were funded through Medicaid. As such, the 25% line aligns most closely with these estimates, though we also display lower levels to account for varying funding scenarios.

Figure A.10: The Hyde Amendment and Change in Fertility



NOTES: In Panel A, for the counterfactual trends, the plotted series represents the average county-level increase in <30 births (states with funding declines only). Panel B illustrates the increase in <30 births at the national level, which encompasses births across all counties in the main sample. Each panel shows three series. (i) The dark blue line shows the predicted values, which are fitted values from the main event-study regression computed using *predict, xbd*. (ii) The light blue counterfactual lines remove Hyde's contribution at each event time. The counterfactual is constructed by subtracting, for each event time, the estimated coefficients on the event-time indicators. (iii) The gray lines show the difference between the predicted and counterfactual values. For the counterfactual and predicted values, all estimates are exponentiated and multiplied by the number of women to reverse the rates. The vertical line marks the year before the Hyde Amendment.

Table A.1: State Factors

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

SOURCES: Haines (2010).

Table A.2: State Abortions and Funding by Year

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
State	Medicaid Abortions 1976	State Funded Abortions 1978	State Funded Abortions 1980	State Funded Abortions 1981	State Abortions 1982	State Abortions 1983	State Abortions 1985	State Funds 1976	State Funds 1978	State Funds 1980	State Funds 1981	State Funds 1982	State Funds 1983	State Funds 1985
CA	70000	100000	90108	97437	99000	100000	84000	24412	32237	33880	36636	31229	31939	31224
NY	50000	41326	37500	37500	46000	43000	43000	7875	5600	5300	5300	11900	13400	13400
MI	14800	13700	6750	19400	19470	19570	20620	2432	2568	2079	5452	5669	6031	6351
PA	10000	14535	7596	6125	14697	11925	0	1913	3566	1949	1142	9431	6243	0
MA	5100		0	6934	6695	8546	7497	1105	1680	0	1029	1135	1407	1338
MD	5000	6009	5179	2766	3193	2983	3484	1675	1326	1231	885	1287	1330	1780
DC	7400	5782	4921	4753	4313	4393	3464	1420	1382	935	959	345	1980	1092
NC	3100	1123	5730	5730	4295	6149	6564	1110	223	1230	1230	984	1254	1340
NJ	10000	0	421	5399	3952	8886	9891	3500	0	105	979	2521	3796	5688
IL	18300	4400			0	1	0	2667	666			0		0
WA	2700		3840	3326	3213	3049	4025	640		749	896	896	965	1574
CO	2800	404	2125	823	1319	1587	873	110	90	475	177	330	381	222
HI	1200	1406	2100	2100	1623	1793	1800	212	605	1	1	973	1191	928
OR	2000	1191			657	525	1602	547	481			141	101	324
WI	2500	29	997	45	3	11	0	250	3	184	12	1	3	0
KS	3700	904			0	0	0	300	242			0	0	0
WV	300	459	325		547	673	458	92	138	84		99	107	72
AK	300	312				261		18	174				197	
NM	900	109	0	0	0	0	0	165	25	0	0	0	0	0
VA	5200	0	21	19	30	29	43	463	0	6	7	5	8	8
DE	400	2	0	0	0	0	0	44		0	0	0	0	0
AL	1300	0	0	1	0	3	0	339	0	0		0		0
CT	2000	0			951	1800		428	0			186	347	484
NH	200	0	0	0	0	0	0	31	0	0	0	0	0	0
AR	500	0	0	0	0	0	0	61	0	0	0	0	0	0
SC	1400	0	0	0	0	0	0	249	0	0	0	0	0	0
MN	1300	0				0	0	216	0				0	0
MT	700	0	0	0	0	0		210	0	0	0	0	0	
MS		0	0	0	0	0			0	0	0	0	0	
NE	300	0			0	0	0	12	0			0	0	0
RI	1000	0	0	0		0	0	96	0	0	0		0	0
UT	300	0	0	0	0	0	0	25	0	0	0	0	0	0
KY	900	0	0	0	0	0	0	197	0	0	0	0	0	0
NV	400	0	0	0		0	0	200	0	0	0		0	0
SD		0	0	0	0	0	0		0	0	0	0	0	0
FL	1600	0	0	0	0	0	0	229	0	0	0	0	0	0
OH	10000	0			0	0	0	2000	0			0	0	0
ID		0	0	0	0	0	0		0	0	0	0	0	0
ME	500	0	0	0	0	0	0	212	0	0	0	0	0	0
OK	700	0			0	0	0	59	0			0	0	0
LA		0	0	0	0	0	0		0	0	0	0	0	0
IN		0	0	0			0		0	0	0			0
GA	3700	0	0	0	6	0	0	949	0	0	0	2	0	0
WY	100	0	0	0	0	0		13	0	0	0	0	0	
TX	13300	0	0	0	0	0	0	3500	0	0	0	0	0	0
TN	1200	0	0	0	0	0	0	275	0	0	0	0	0	0
MO	2400	0	0	0	0	0	0	180	0	0	0	0	0	0
VT	300	0	0	0	0	0	183	180	0	0	0	0	0	31
ND		0	0	0	0	0	0		0	0	0	0	0	0
AZ							0							0
IA	1000				8	16	9	297	185		14	3	3	3

SOURCES: Lincoln et al. (1977), Gold (1980), Gold (1982), Nestor and Gold (1984), Gold and Nestor (1985), Gold and Macias (1986).

Table A.3: State Decline in Medicaid Abortions

State	(1) % Change in Medicaid Abortions	(2) Change in Medicaid Abortions per 1,000 Women	(3) Average Decline in # Abortions
DC	-33.2	-59.3	2458
KS	-90.8	-25.6	3361
IL	-91.0	-25.5	16650
NJ	-75.6	-18.3	7557
RI	-100.0	-18.2	1000
OH	-100.0	-16.2	10000
VA	-99.7	-16.0	5183
TX	-100.0	-15.7	13300
MT	-100.0	-15.6	700
GA	-100.0	-11.2	3699
NM	-97.0	-11.2	873
DE	-99.9	-11.1	400
VT	-100.0	-9.7	300
NY	-18.8	-9.4	9419
CO	-58.3	-9.2	1632
MO	-100.0	-8.7	2400
NV	-100.0	-8.5	400
WI	-89.3	-8.2	2232
ME	-100.0	-7.9	500
SC	-100.0	-7.4	1400
CT	-65.2	-7.4	1304
OR	-52.1	-7.0	1041
IA	-99.0	-6.1	990
AL	-100.0	-5.8	1300
MN	-100.0	-5.4	1300
TN	-100.0	-4.5	1200
KY	-100.0	-4.3	900
OK	-100.0	-4.1	700
AR	-100.0	-4.0	500
WY	-100.0	-3.7	100
NH	-100.0	-3.7	200
UT	-100.0	-3.5	300
NE	-100.0	-3.4	300
FL	-100.0	-3.1	1600
MD	-14.3	-2.7	713
MA	-4.1	-0.7	209
AK	-2.4	-0.3	7
AZ	0.0	0.0	0
MI	0.2	0.1	-30
PA	7.4	1.0	-738
WV	52.0	1.5	-156
NC	36.1	3.2	-1119
WA	28.4	3.2	-767
HI	50.6	10.9	-607
CA	38.1	19.0	-26636
SD	-100.0		
ID	-100.0		
ND	-100.0		
IN	-100.0		
LA	-100.0		
MS	-100.0		

Notes and Sources: Average change from 1976 to 1978-1982. States missing information replaced with 100% decline if no state abortions in post-Hyde years. Data from Lincoln et al. (1977), Gold (1980), Gold (1982), Nestor and Gold (1984), Gold and Nestor (1985), Gold and Macias (1986).

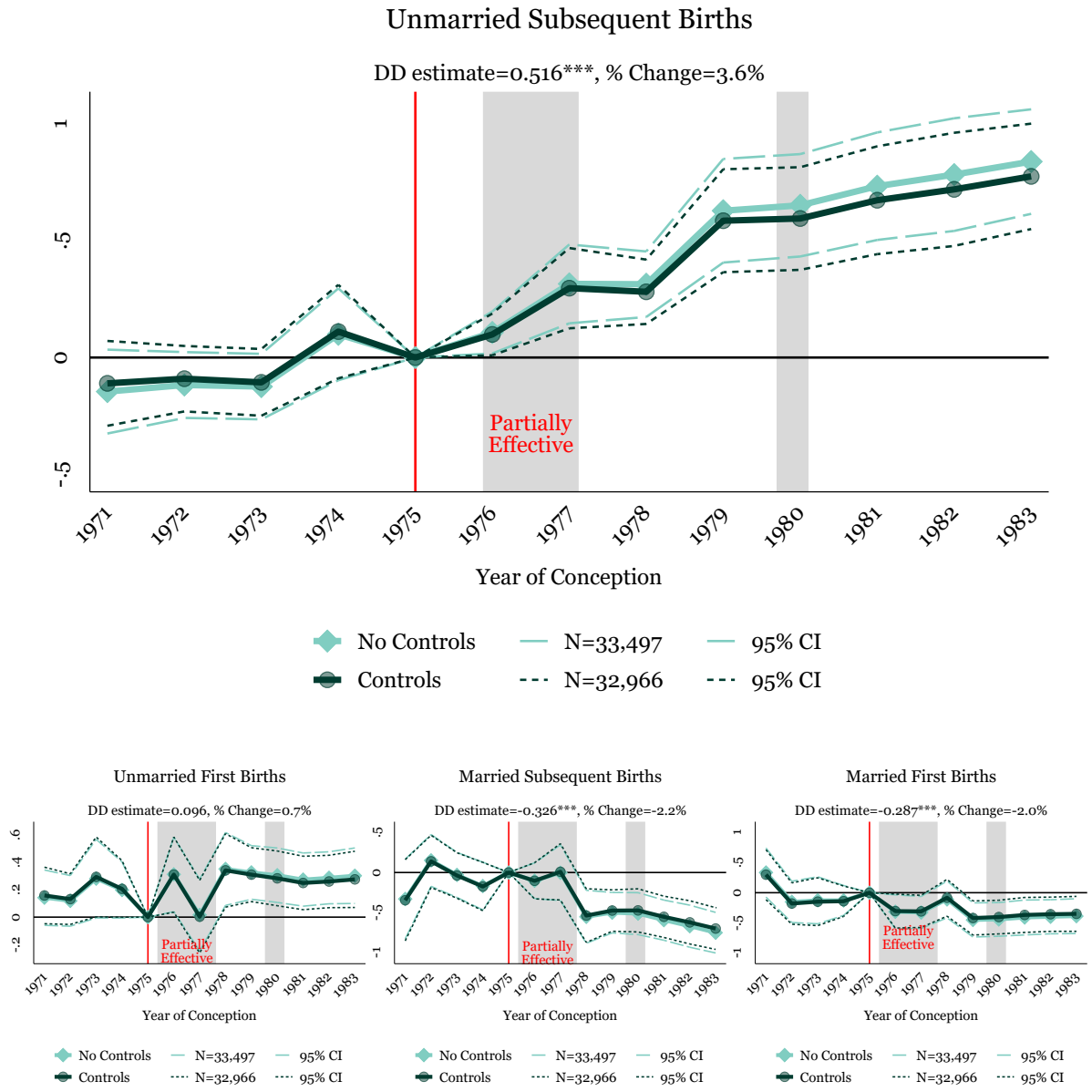
Table A.4: Descriptive Statistics for Fertility by Quartile of AFDC

	Q1 Pre-Hyde Amendment		Q2 Pre-Hyde Amendment		Q3 Pre-Hyde Amendment		Q4 Pre-Hyde Amendment		Q1 Post-Hyde Amendment		Q2 Post-Hyde Amendment		Q3 Post-Hyde Amendment		Q4 Post-Hyde Amendment	
	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.
Fertility																
Births (1,000s)	0.673	1.663	0.766	1.803	0.917	2.337	1.624	6.402	0.771	1.934	0.886	2.259	1.061	2.930	1.756	7.004
Log of Fertility Rate	4.291	0.243	4.317	0.200	4.348	0.194	4.408	0.217	4.268	0.252	4.280	0.218	4.304	0.196	4.360	0.218
Women 15-44 (1,000s)	9.962	27.541	10.959	28.135	12.829	33.646	20.562	73.842	12.092	32.338	13.243	34.796	15.325	41.679	23.181	83.089
Population (1,000s)	46.215	124.504	51.285	128.388	59.378	147.073	95.344	335.181	52.101	135.926	57.439	146.565	65.597	167.185	99.332	346.181
By Age																
Log of <18 Fertility Rate	4.585	0.620	4.701	0.564	4.794	0.543	4.969	0.488	4.398	0.631	4.533	0.566	4.655	0.530	4.860	0.486
Log of 18-29 Fertility Rate	4.869	0.302	4.878	0.255	4.901	0.241	4.933	0.244	4.817	0.317	4.817	0.268	4.836	0.238	4.867	0.244
Log of 30+ Fertility Rate	4.893	0.411	4.885	0.355	4.903	0.341	4.979	0.373	4.929	0.380	4.907	0.336	4.911	0.317	4.959	0.340
By Race																
Log of White Fertility Rate	4.276	0.249	4.286	0.206	4.299	0.201	4.311	0.226	4.254	0.259	4.254	0.228	4.264	0.210	4.277	0.226
Log of Non-white Fertility Rate	4.555	0.703	4.517	0.624	4.563	0.519	4.603	0.489	4.377	0.624	4.369	0.550	4.401	0.509	4.483	0.495
Poverty																
Proportion AFDC (1976)	0.018	0.012	0.029	0.015	0.040	0.020	0.071	0.043	0.018	0.012	0.029	0.015	0.040	0.020	0.071	0.043
Share Births by Age																
Age <18	0.072	0.042	0.081	0.040	0.088	0.041	0.102	0.046	0.051	0.032	0.059	0.031	0.065	0.033	0.078	0.037
Age 18-29	0.765	0.065	0.765	0.052	0.761	0.051	0.748	0.053	0.759	0.061	0.763	0.046	0.761	0.045	0.753	0.043
Age 30+	0.163	0.062	0.154	0.048	0.151	0.044	0.150	0.042	0.190	0.067	0.178	0.050	0.174	0.048	0.169	0.043
Controls																
Share White	0.956	0.074	0.922	0.111	0.883	0.148	0.813	0.211	0.955	0.072	0.923	0.107	0.884	0.143	0.811	0.210
Share Female	0.503	0.021	0.507	0.016	0.508	0.015	0.511	0.013	0.505	0.018	0.508	0.015	0.510	0.015	0.513	0.014
Unemployment Rate	4.455	2.467	4.821	2.249	5.316	2.355	6.286	2.733	5.544	2.963	6.068	2.778	6.635	2.840	7.986	3.501
N	3,801		3,670		3,620		3,600		5,333		5,138		5,071		5,037	

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 and Haines (2010) used for the controls and the population counts. Medicaid eligibility determined by the share of the population in the county receiving AFDC in 1976 (United States Bureau of the Census, 2012).

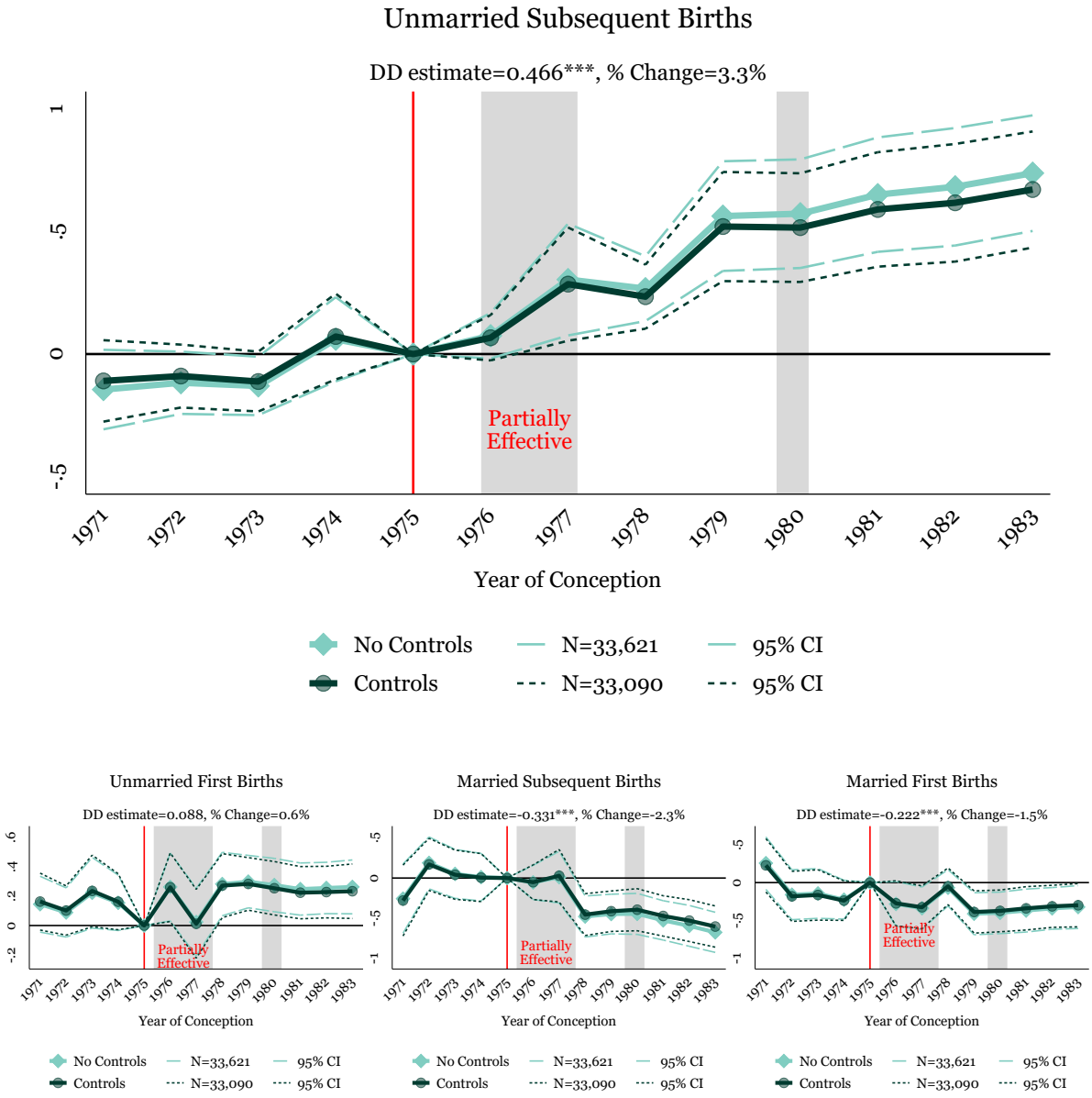
B Compositional Changes in Births

Figure B.1: The Hyde Amendment and Births by Marital Status and Birth Order for Women <30 Years



NOTES: Reflects the specification in Panel B of Figure V except considering the share of births of each type–unmarried/subsequent, unmarried first, married/subsequent, married/first. The regressions are weighted by the number of births. Sample from births to women less than 30, see Figure B.2 for all births and Figure B.3 for births by race.

Figure B.2: The Hyde Amendment and Births by Marital Status and Birth Order for All Births



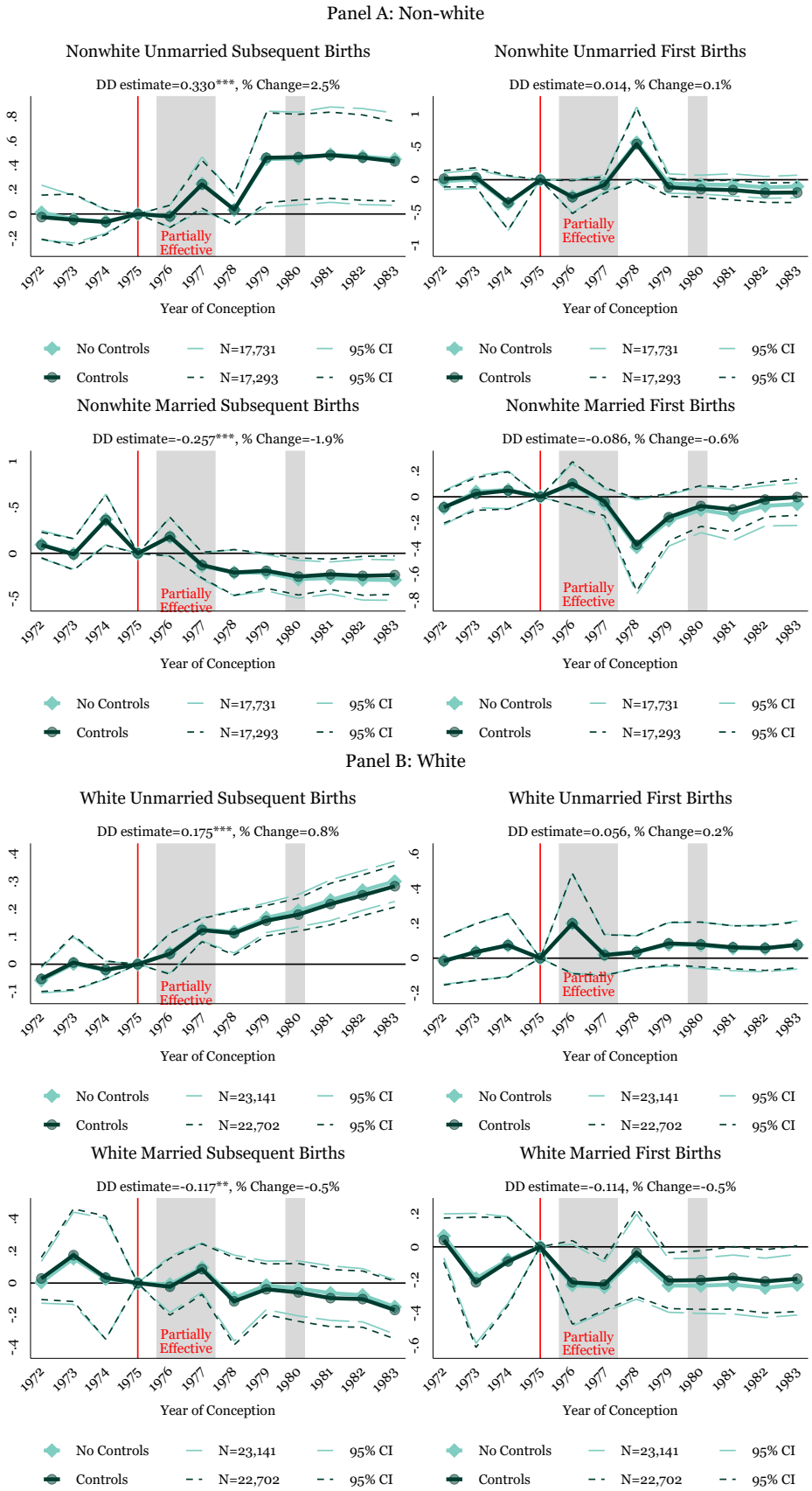
NOTES: Reflects the specification in Panel B of Figure V except considering the share of births of each type–unmarried/subsequent, unmarried first, married/subsequent, married/first. The regressions are weighted by the number of births. Sample from births to women less than 30.

Figure B.3: The Hyde Amendment and County-level Births by Maternal Characteristics and Race



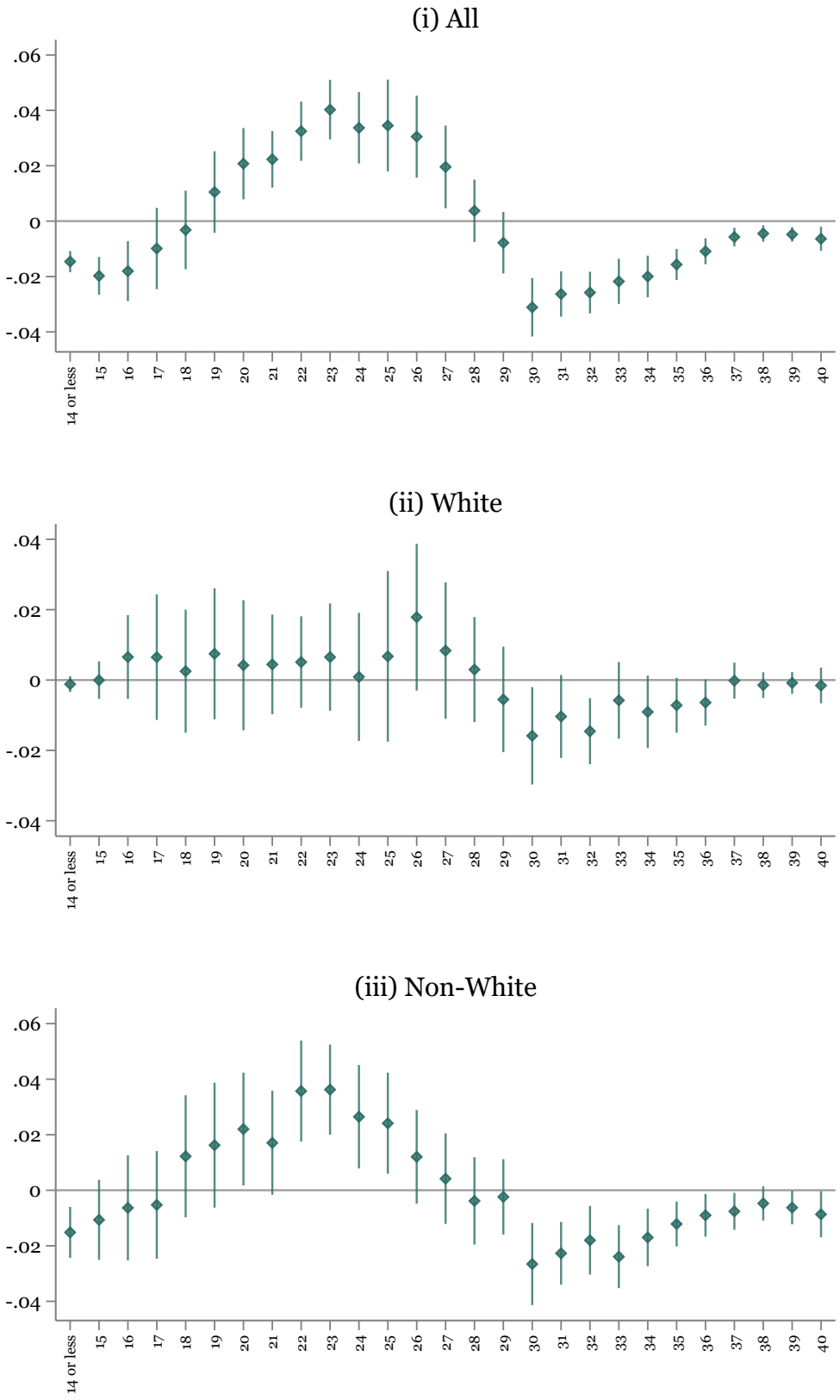
NOTES: Reflects the specification in Figure B.1 except breaking out the shares by race. The regressions are weighted by the number of births for each racial group. Sample from births to women less than 30.

Figure B.4: The Hyde Amendment and County-level Births by Type and Race, Omitting States with Jumps in Marriage



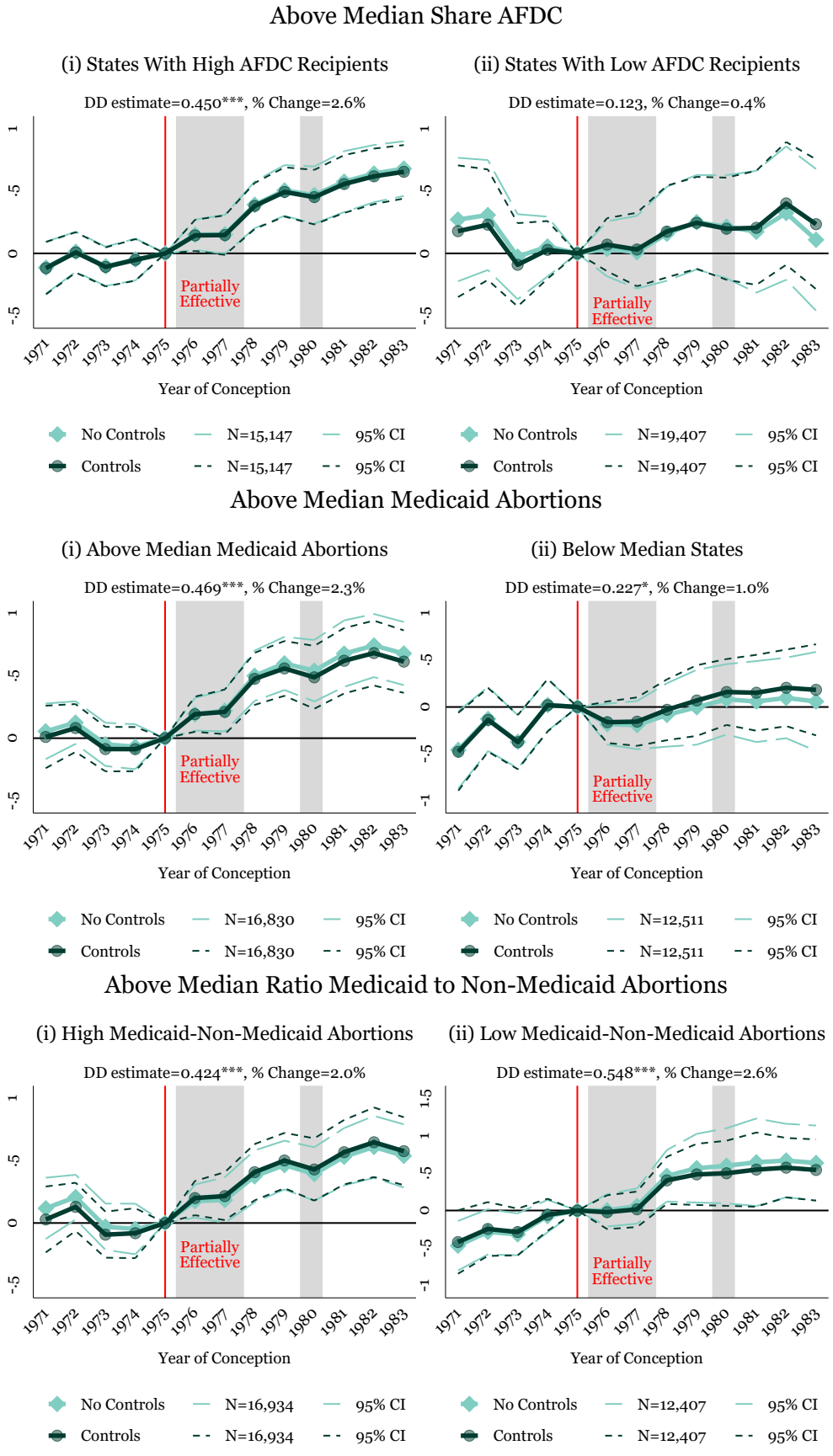
NOTES: Reflects the specification in Figure B.3 except considering states without a jump in births in 1978–"OH", "NY", "NV", "CT", "GA", "TX." And omitting counties with more than a 5% jump in any category in one year.

Figure B.5: The Hyde Amendment and Births by Age and Race



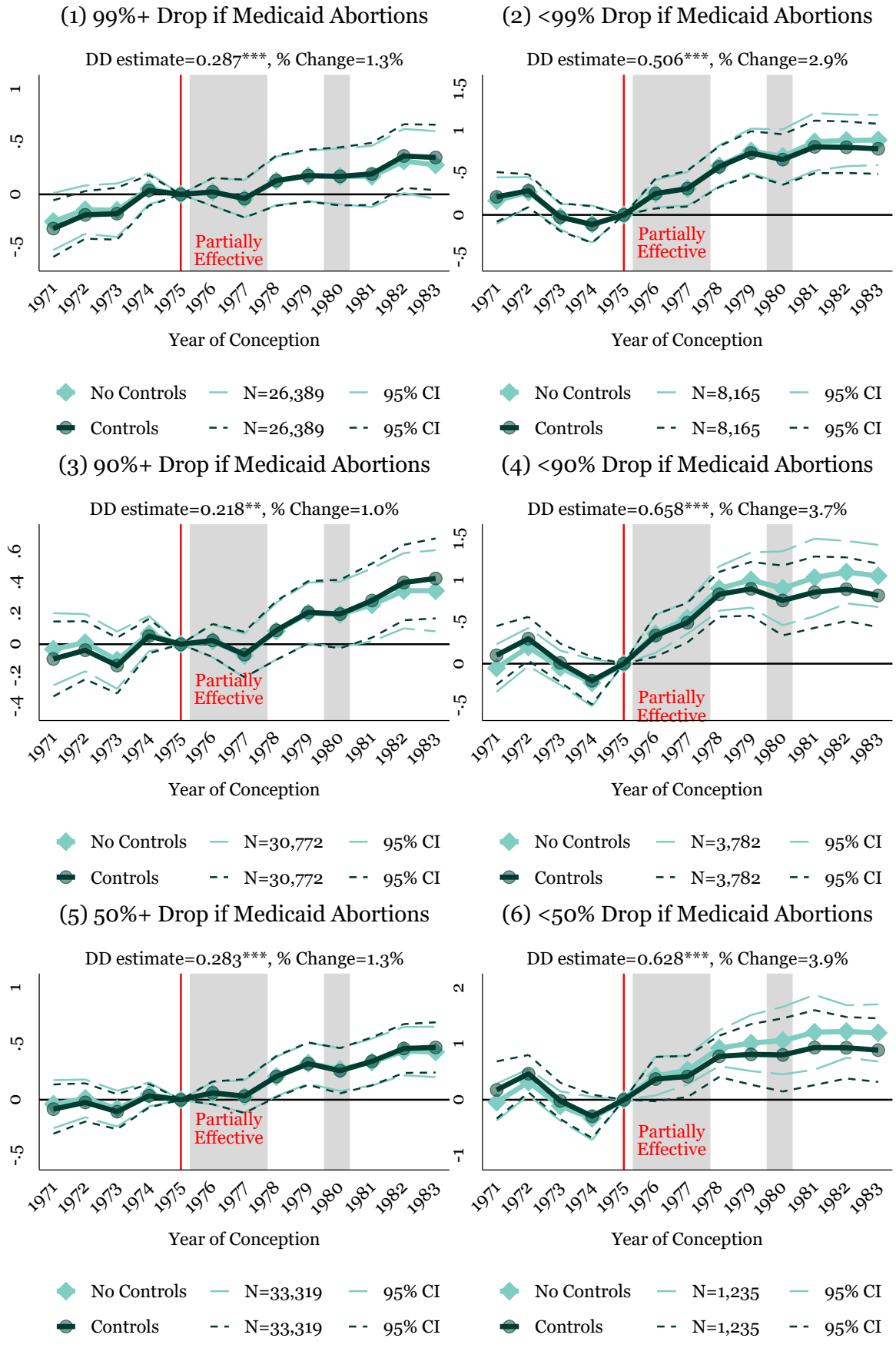
NOTES: Reflects the grouped post period specification in Figure V except breaking out the effect by share of each age in the top panel, and the share of age by race in the bottom two panels. Regressions weighted by the number of births, all, white, and non-white.

Figure B.6: Heterogeneity by State-level Demand



NOTES: Represents county-level specification from Panel B of Figure V, except breaking out fertility by state-level policies from Table 2. See Table 1 and A.1 for state-level policies.

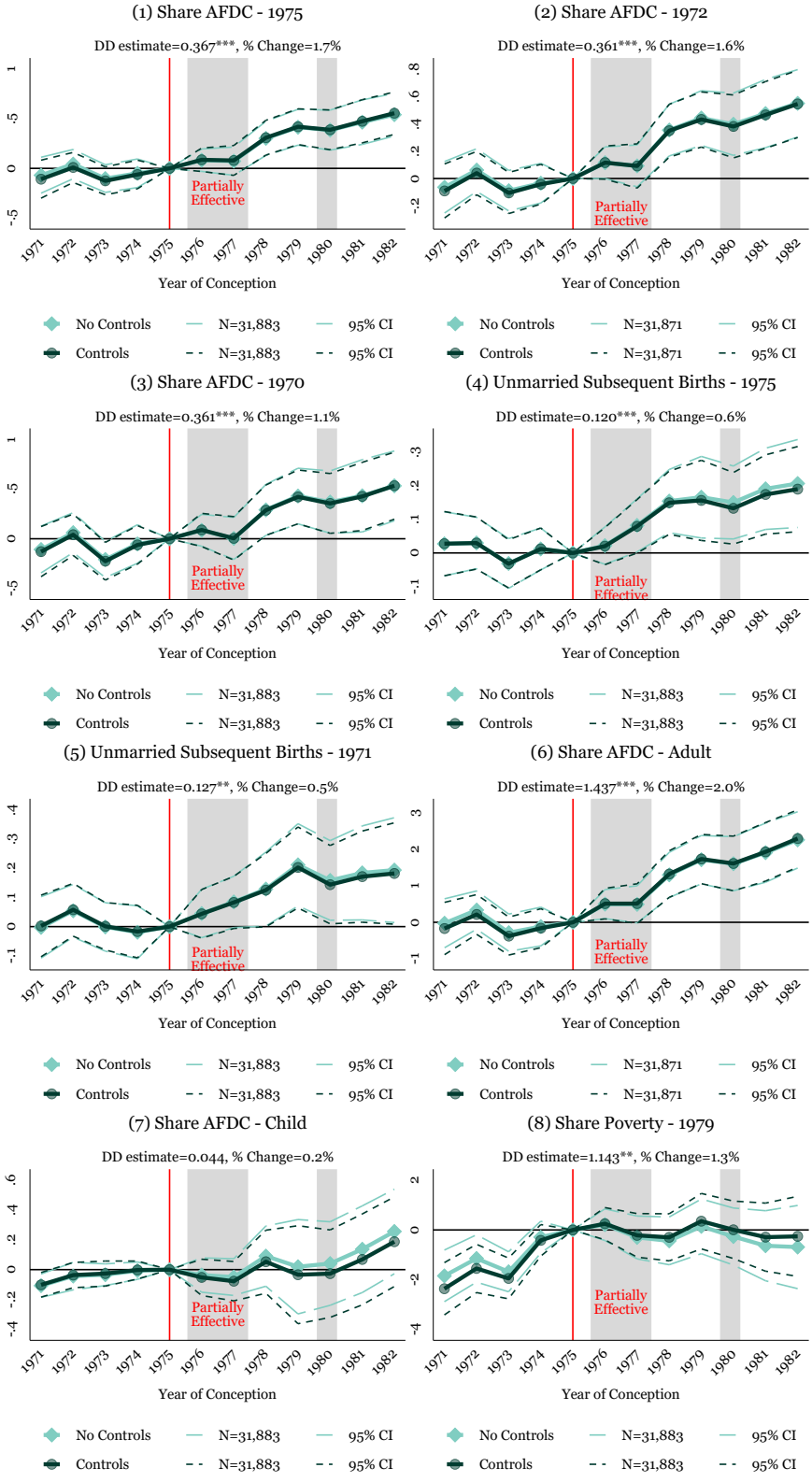
Figure B.7: Main Event Study by Grouped Decline in Medicaid Funded Abortions



NOTES: Reflects the specification in Figure V except considering subsamples by noted sample.

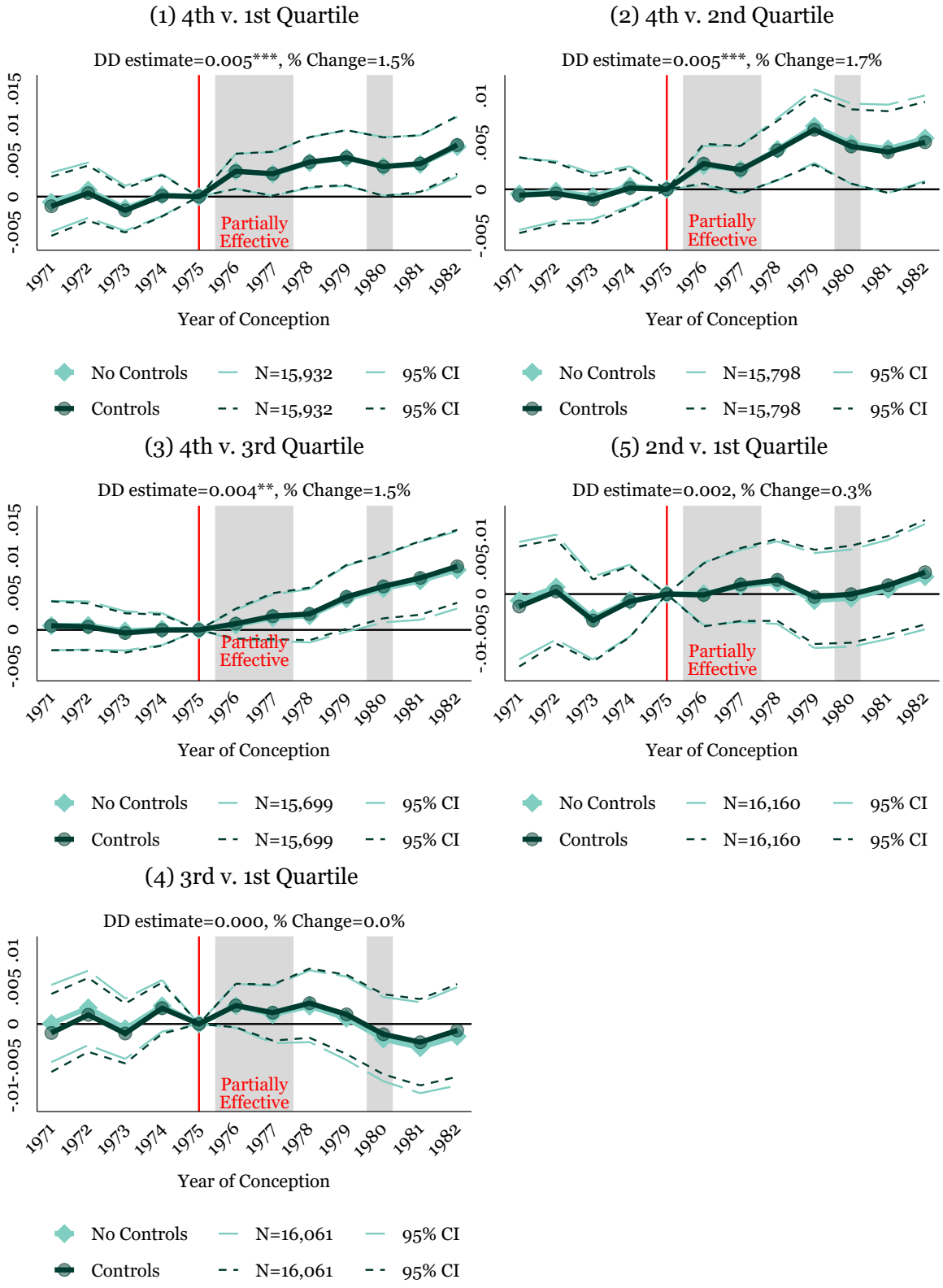
C Robustness Checks for Fertility Analyses

Figure C.1: Main Results Using Alternative Measures of Medicaid Eligibility



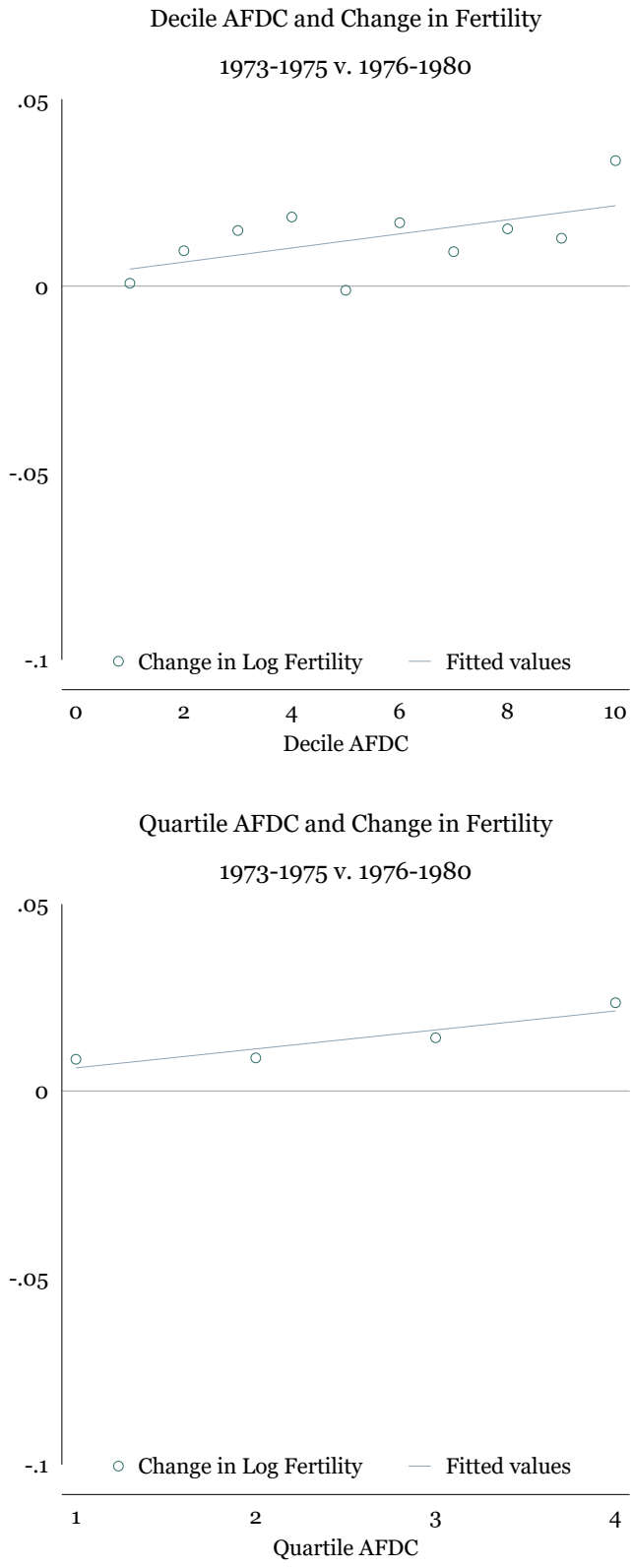
NOTES: Reflects the specification in Figure V, except considering alternative measures of Medicaid eligibility. Certain AFDC measures from Cunningham and Goodman-Bacon (2025).

Figure C.2: Alternative Quartiles of Comparison: Fertility for Young Adult Women



NOTES: Reflects the binary specification in Panel B.4 of Figure VI except comparing the top quartile to the second and third quartiles of eligibility.

Figure C.3: Change in Young Adult Fertility by AFDC Receipt



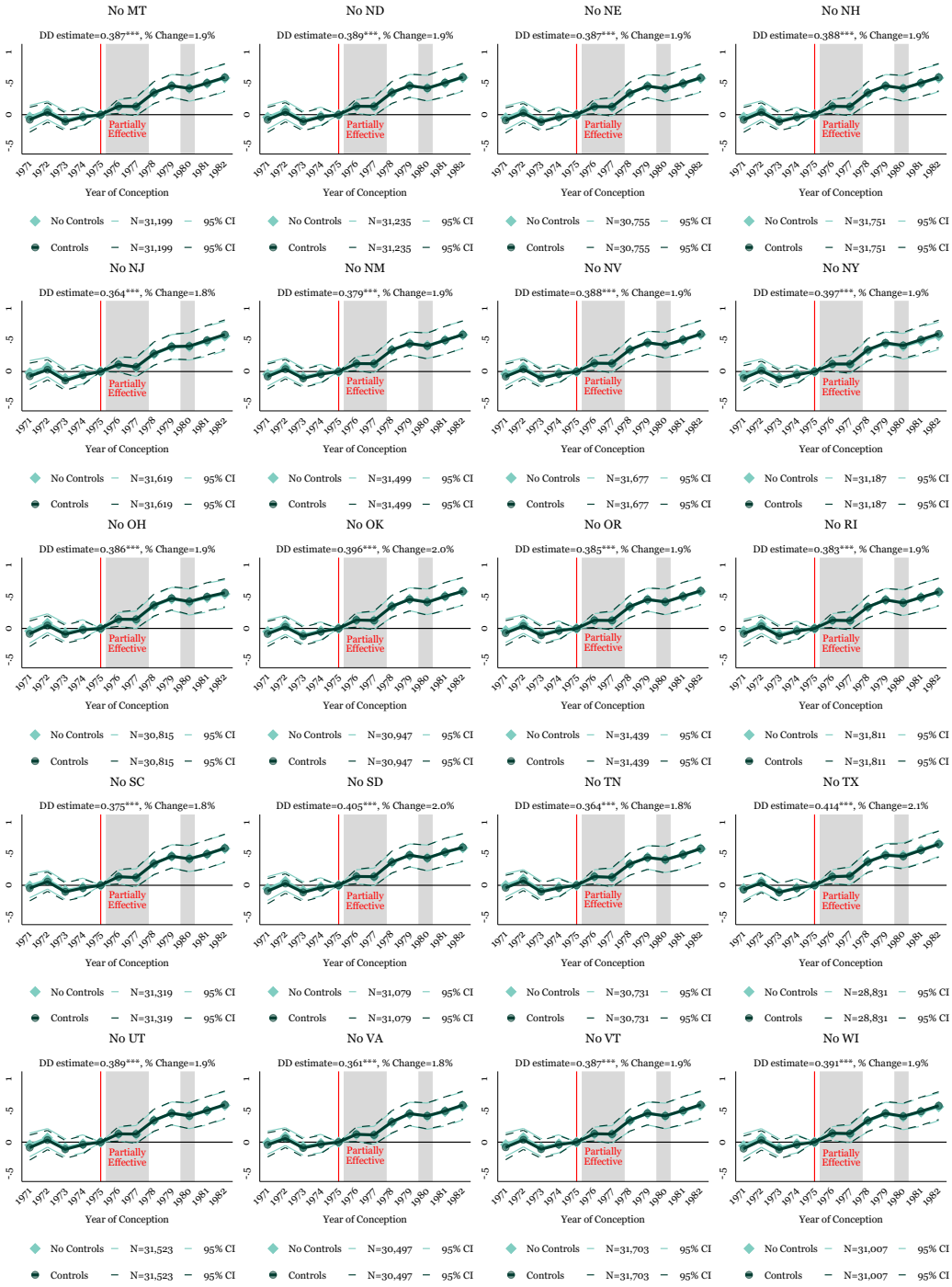
NOTES: Shows the descriptive change in fertility from 1973-75 to 1978-80 by two measures of Medicaid eligibility–the decile of AFDC receipt and the quartile of AFDC eligibility. Attempted depiction of Figure IV from Callaway et al. (2024).

Figure C.4: Dropping Individual States (I): County-level Fertility Young Adult Women



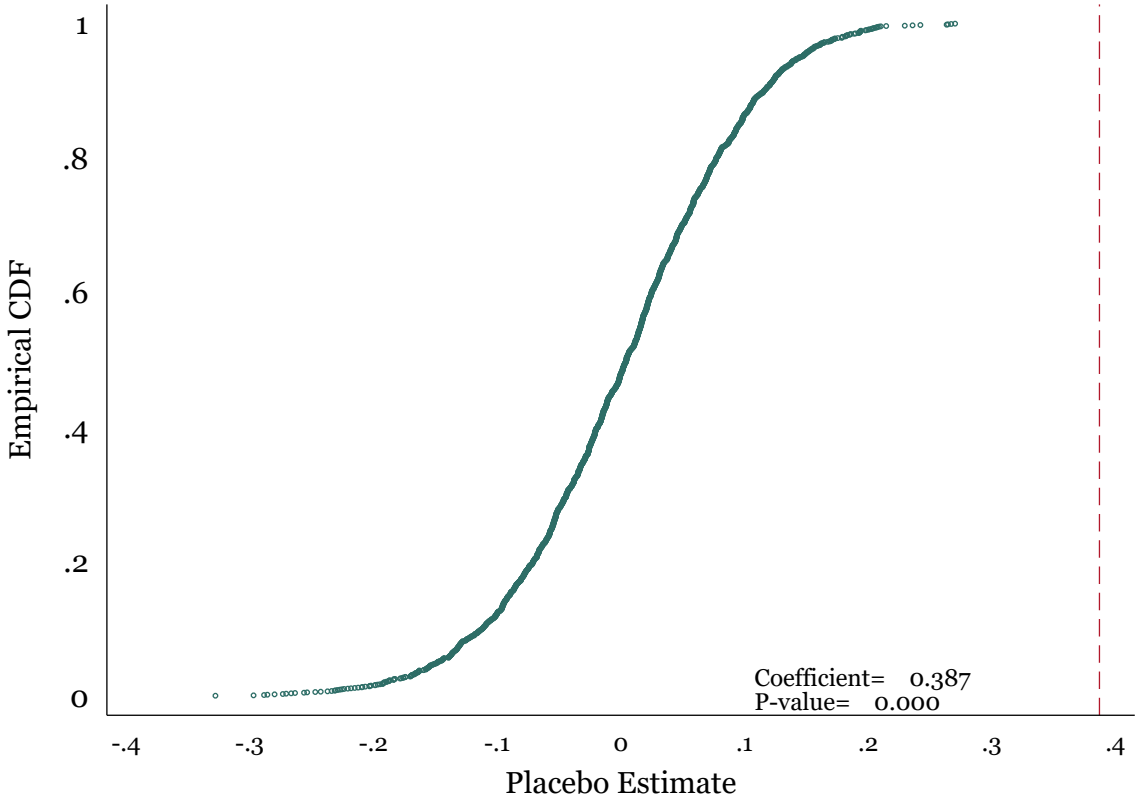
NOTES: Represents county-level specification from Figure V, except dropping one state at a time.

Figure C.5: Dropping Individual States (II): County-level Fertility Young Adult Women



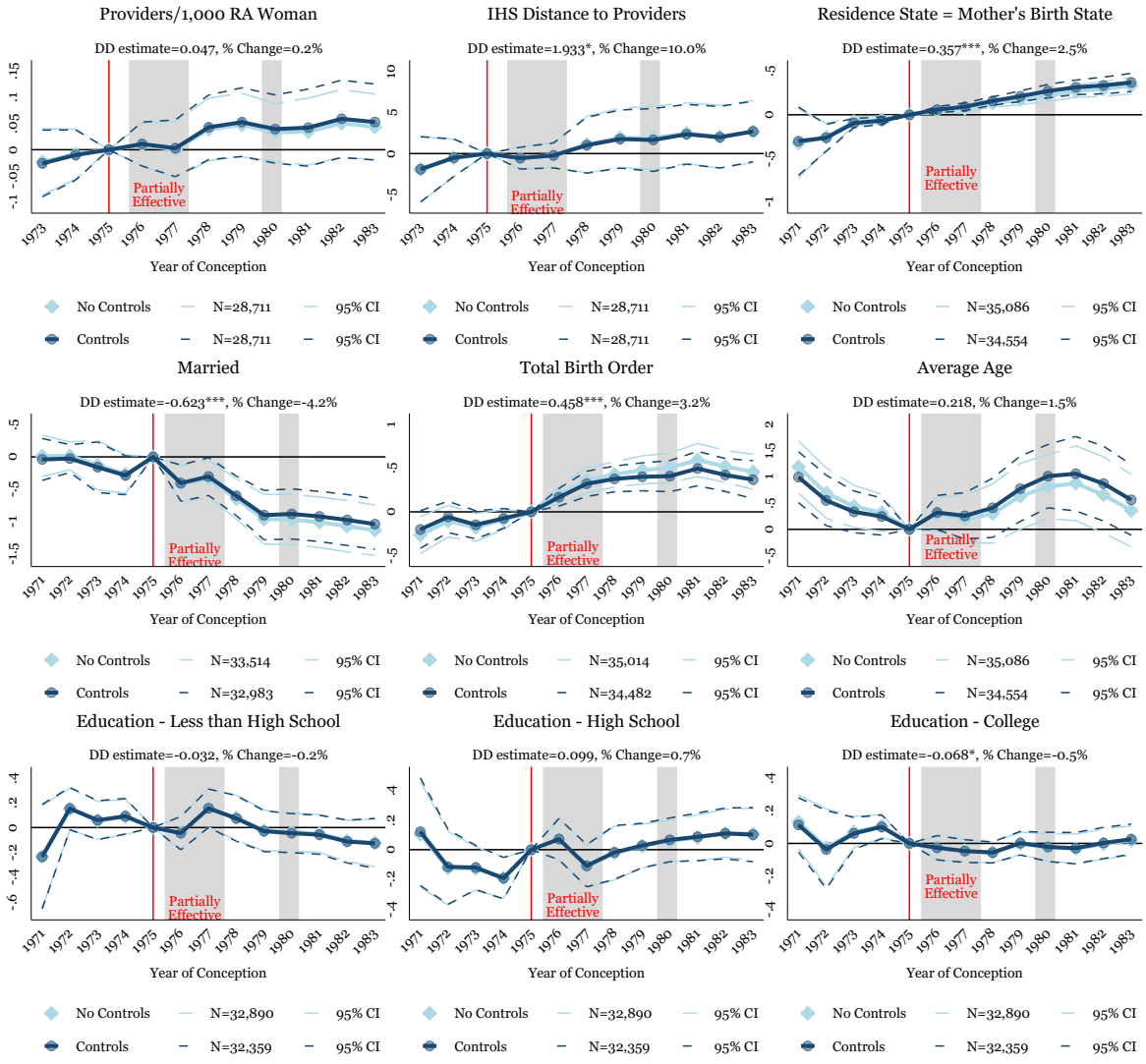
NOTES: Represents county-level specification from Figure V, except dropping one state at a time.

Figure C.6: Permutations on High Medicaid Eligibility Counties



NOTES: Represents county-level specification from Panel B of Figure V, except randomizing the treated counties. We randomly assign counties to 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 2,000 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 C.7: Controls as Outcomes



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

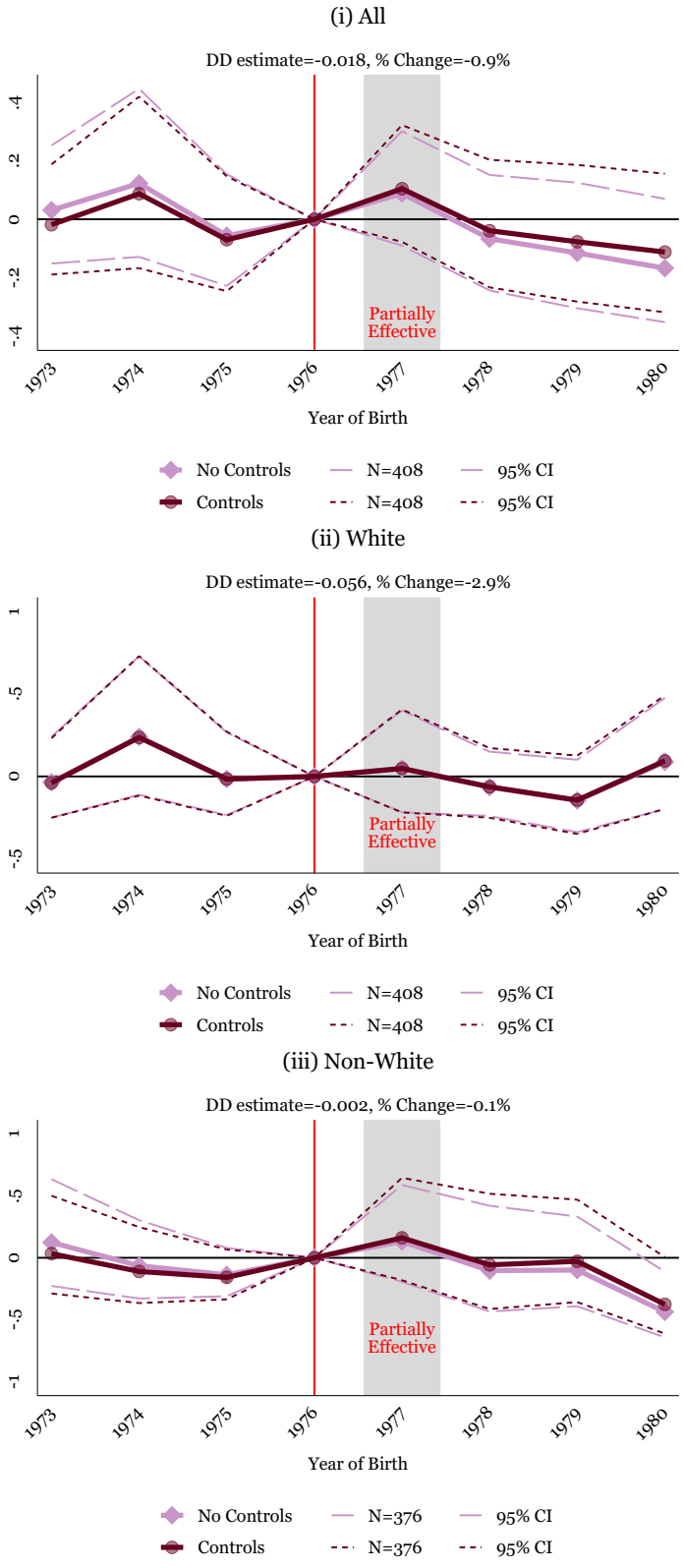
D Mortality Outcomes

Figure D.1: County-level Infant Mortality, Neonatal Mortality, 1-4 Mortality



NOTES: Represents county-level specification from Figure V, except considering the log of the county-level infant/neonatal/child mortality. Here, the denominator is the number of births (all, white, non-white), except in Panel C, where the denominator is ages 1-4 and is derived from the SEER population data.

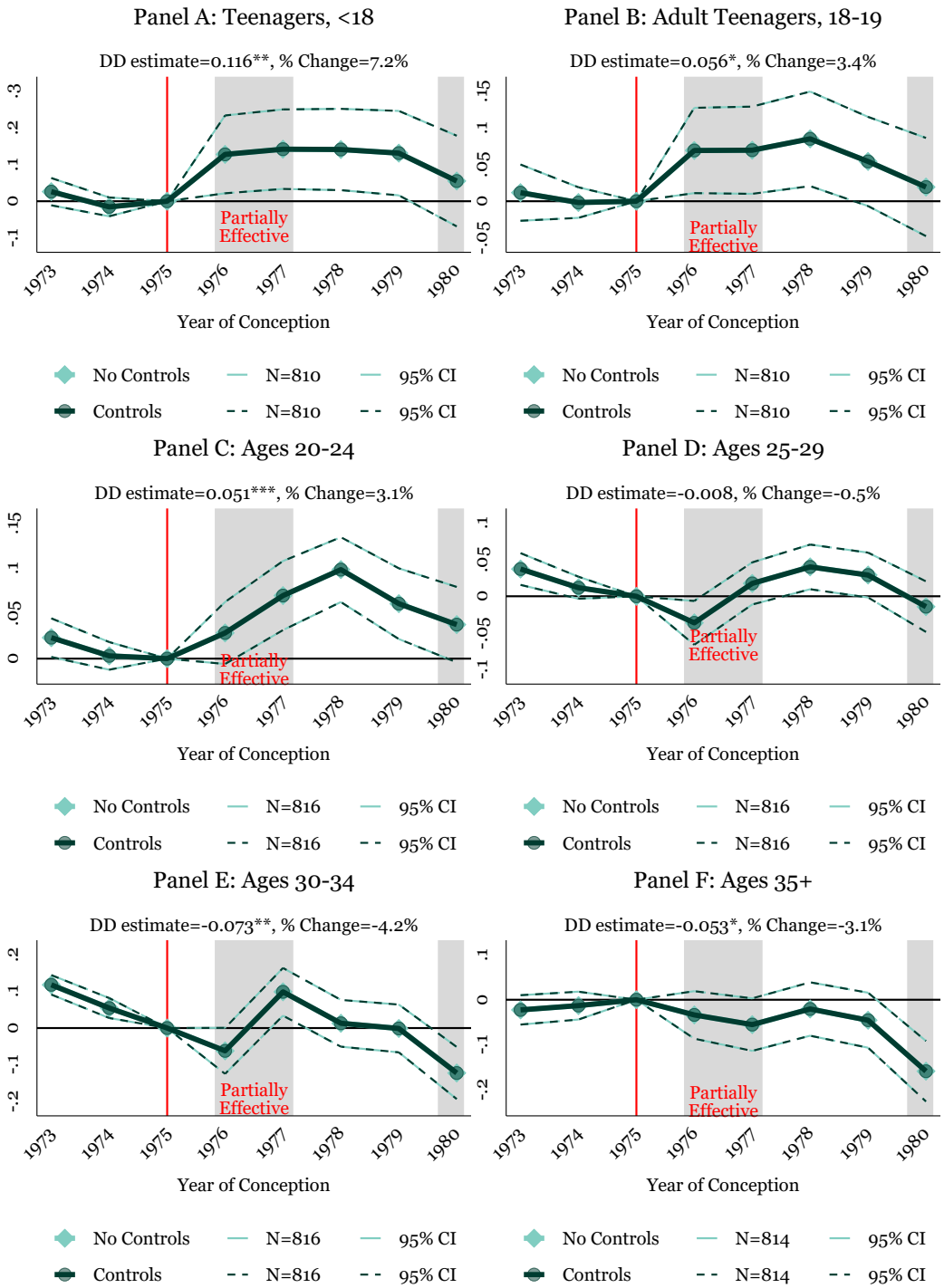
Figure D.2: State-level Maternal Mortality: Hyde Amendment x % Decline in Medicaid Abortions



NOTES: Represents specification in Figure VII, except showing maternal mortality. Here, the maternal mortality is per reproductive-age woman, but the results are similar if we consider maternal mortality per the number of births.

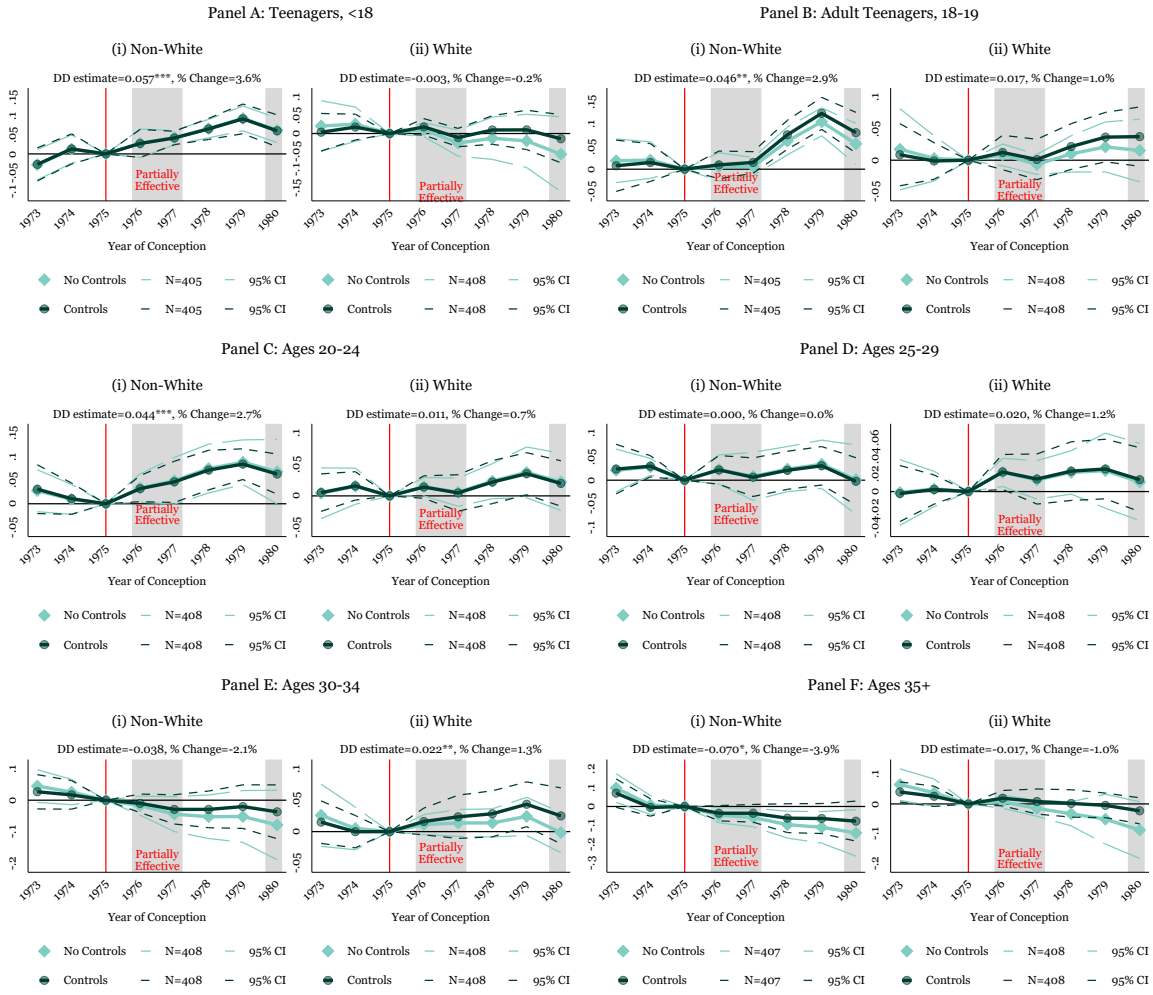
E State-level Analysis

Figure E.1: Hyde Amendment x State-level Decline in Medicaid Abortions
Non-white v. White Fertility



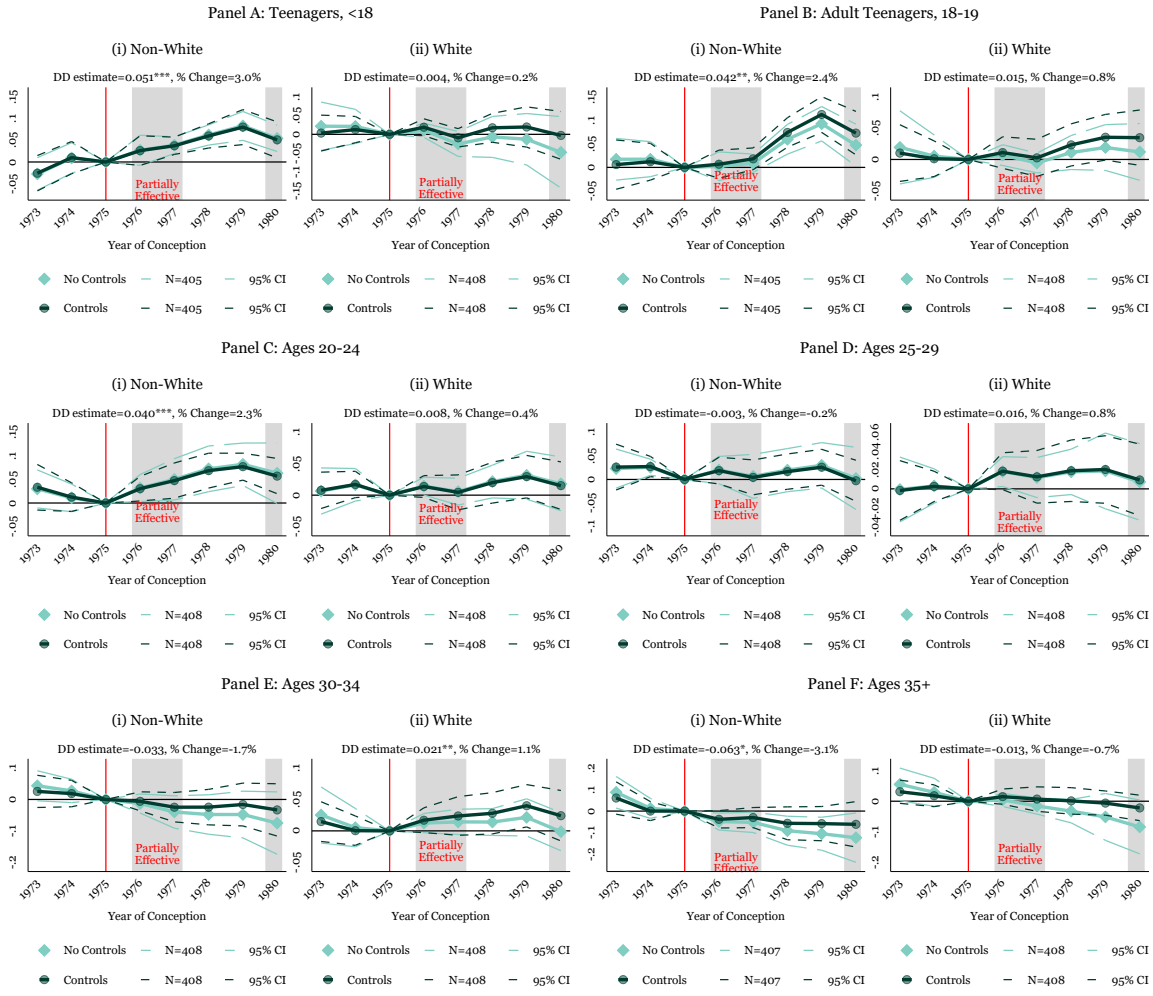
NOTES: Represents specification in Figure VII, except comparing non-white to white fertility after the Hyde Amendment. Similar to the specification in Equation 4.

Figure E.2: Hyde Amendment x State-level Decline in Medicaid Abortions, All Ages



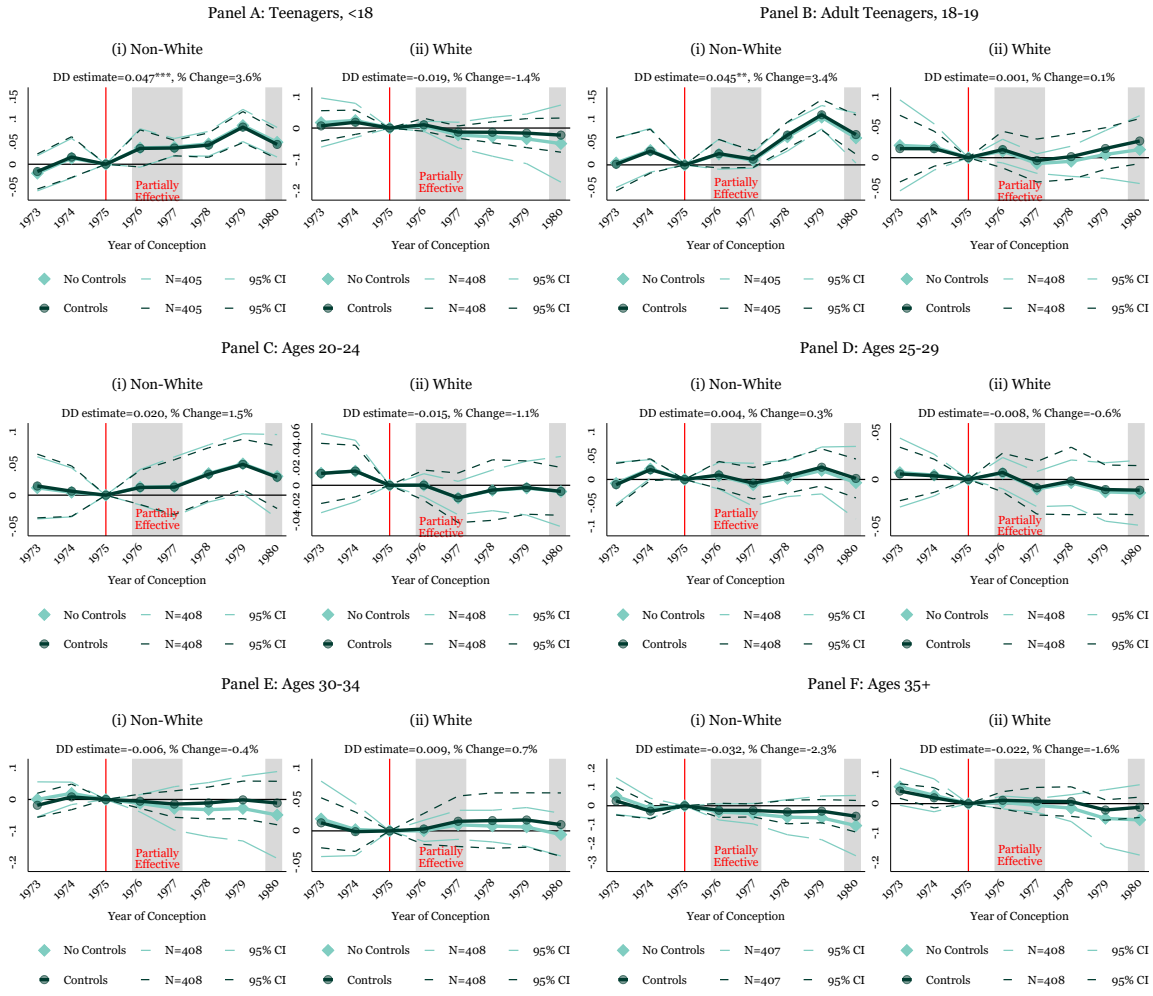
NOTES: Represents specification in Figure VII, except showing all ages.

Figure E.3: Hyde Amendment x 1976 to 1978 Decline in Abortions



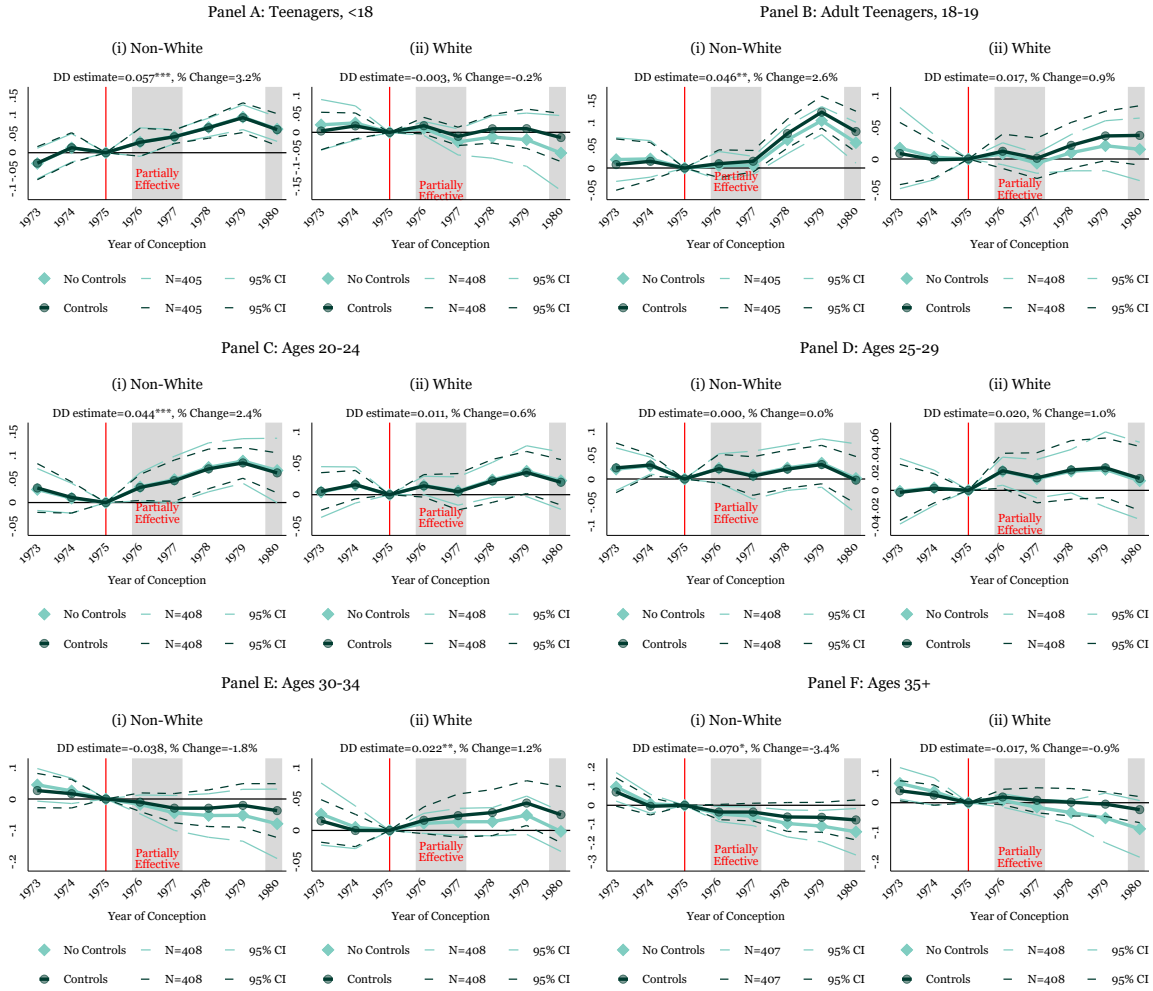
NOTES: Represents specification in Figure VII, except using the decline in funding from 1976 to 1978.

Figure E.4: Hyde Amendment x Binary Decline in Abortions



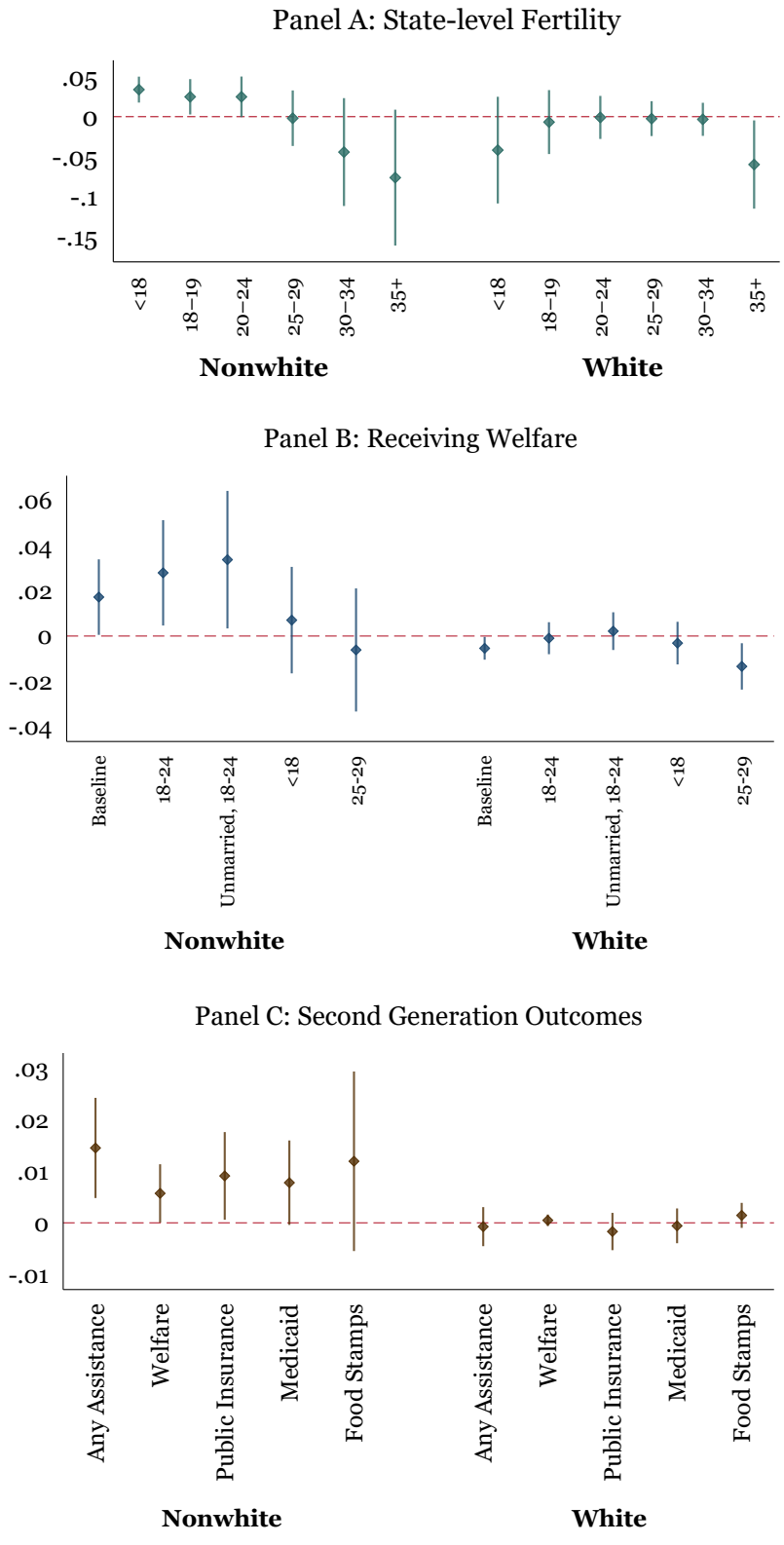
NOTES: Represents specification in Figure VII, except using a binary variable for any decline in Medicaid abortions rather than the percent decline.

Figure E.5: Hyde Amendment x % State Decline in Abortions, States with Increases in Abortions included as Negative Treatment



NOTES: Represents specification in Figure VII, except for specifying the percent decline in Medicaid abortions as negative when there is an increase in Medicaid abortions (rather than control states).

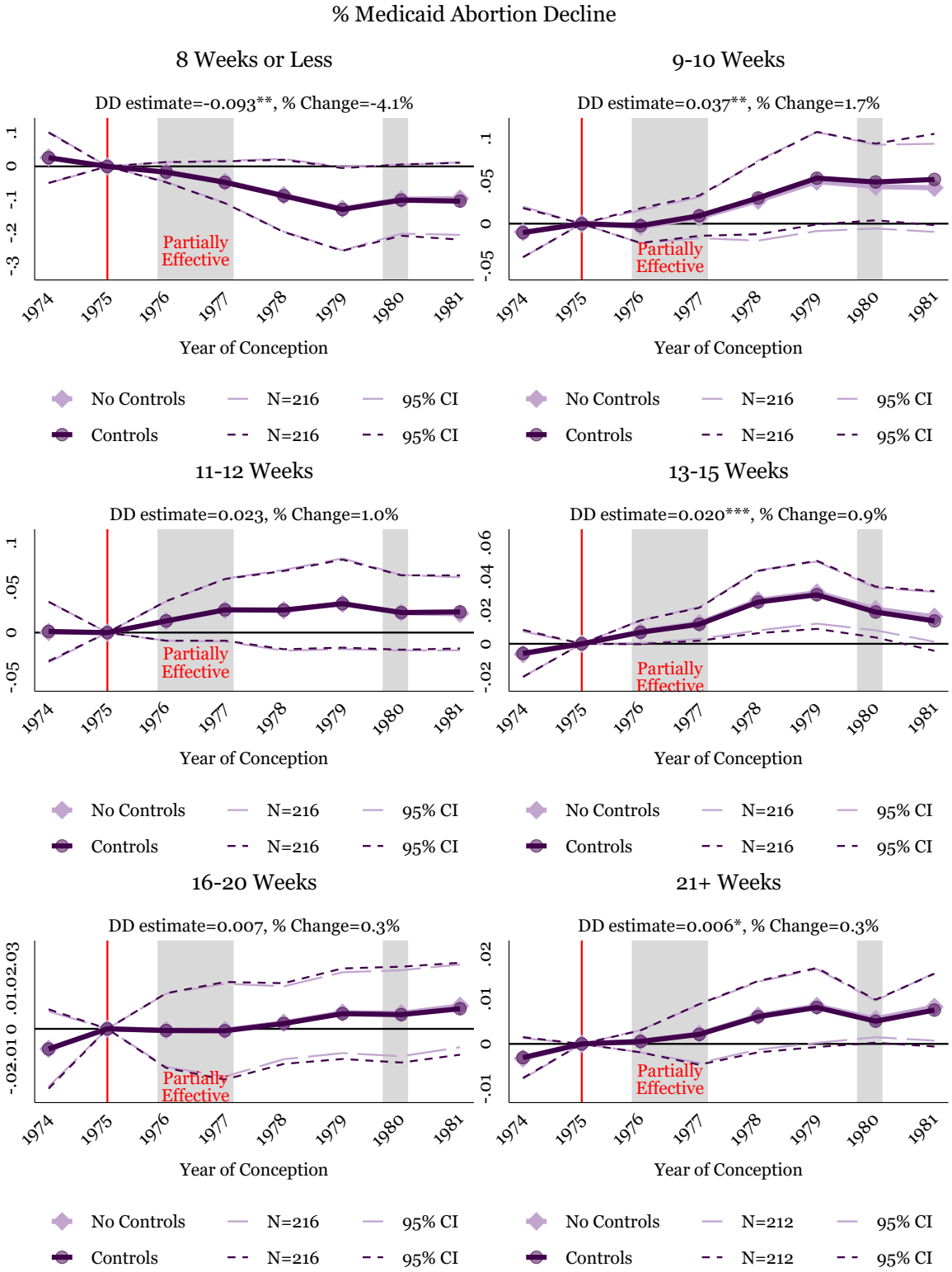
Figure E.6: Time-Varying % Decline in Medicaid Abortions x Hyde Amendment, States with Increases in Abortions included as Negative Treatment



NOTES: Reflects Figure VIII except including states with increases in Medicaid abortions as a negative treatment rather than zero.

F Abortion Surveillance Data

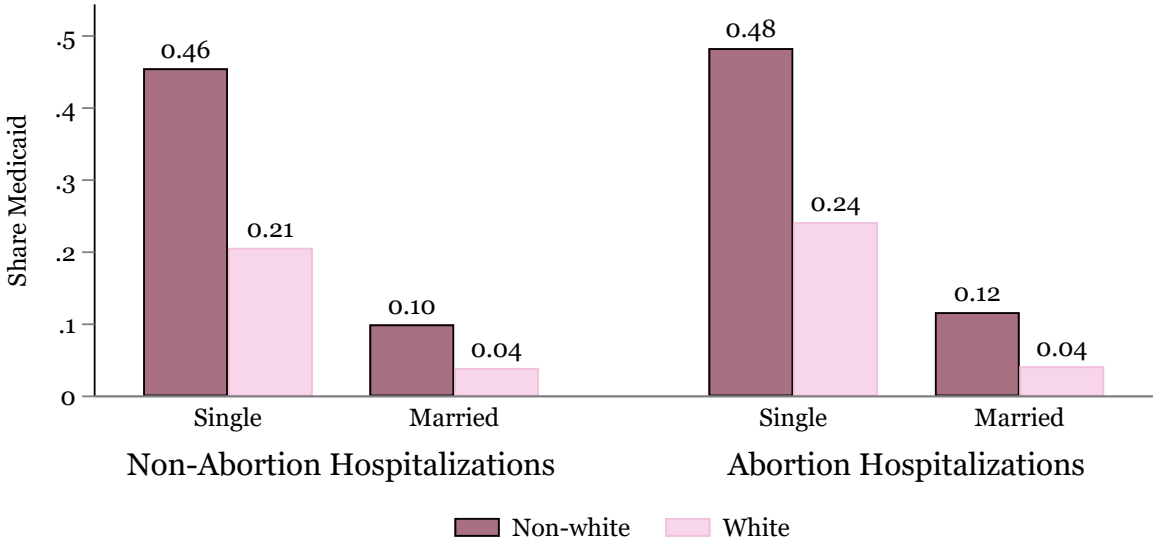
Figure F.1: Share of Abortions by Gestation



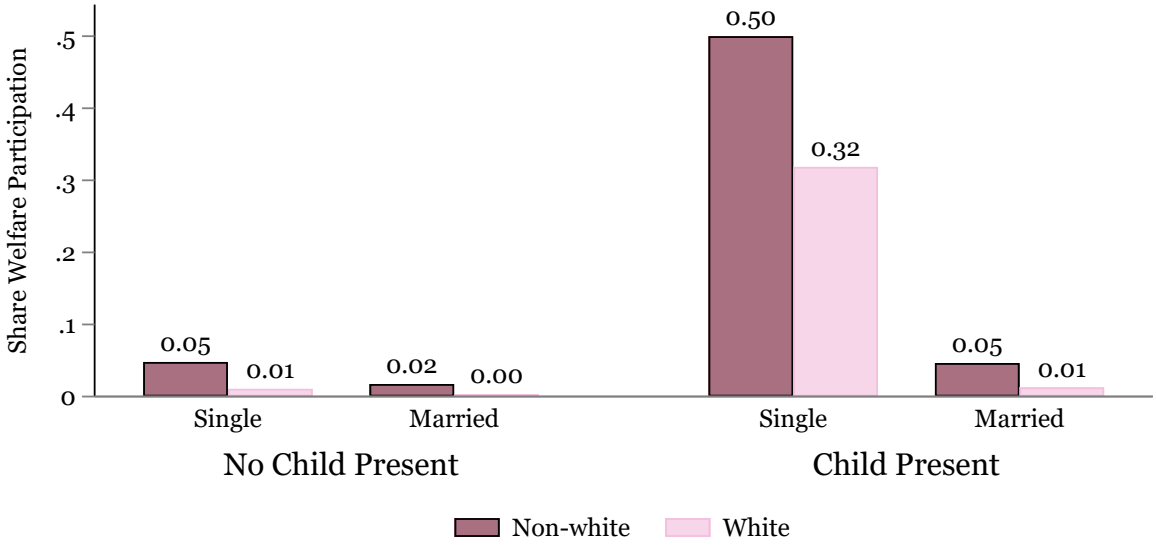
SOURCE: Abortion data from the CDC Abortion Surveillance Program (CDC, 1977). This data is only available by state.
NOTES: Represents specification in Figure VII, except considering the share of abortions at each gestation. The regressions are weighted by the number of abortions.

G Current Population Survey

Figure G.1: Who Receives Medicaid and Welfare? Women 15-44
Panel A: Medicaid-Funded Hospitalizations



Panel B: Welfare Receipt



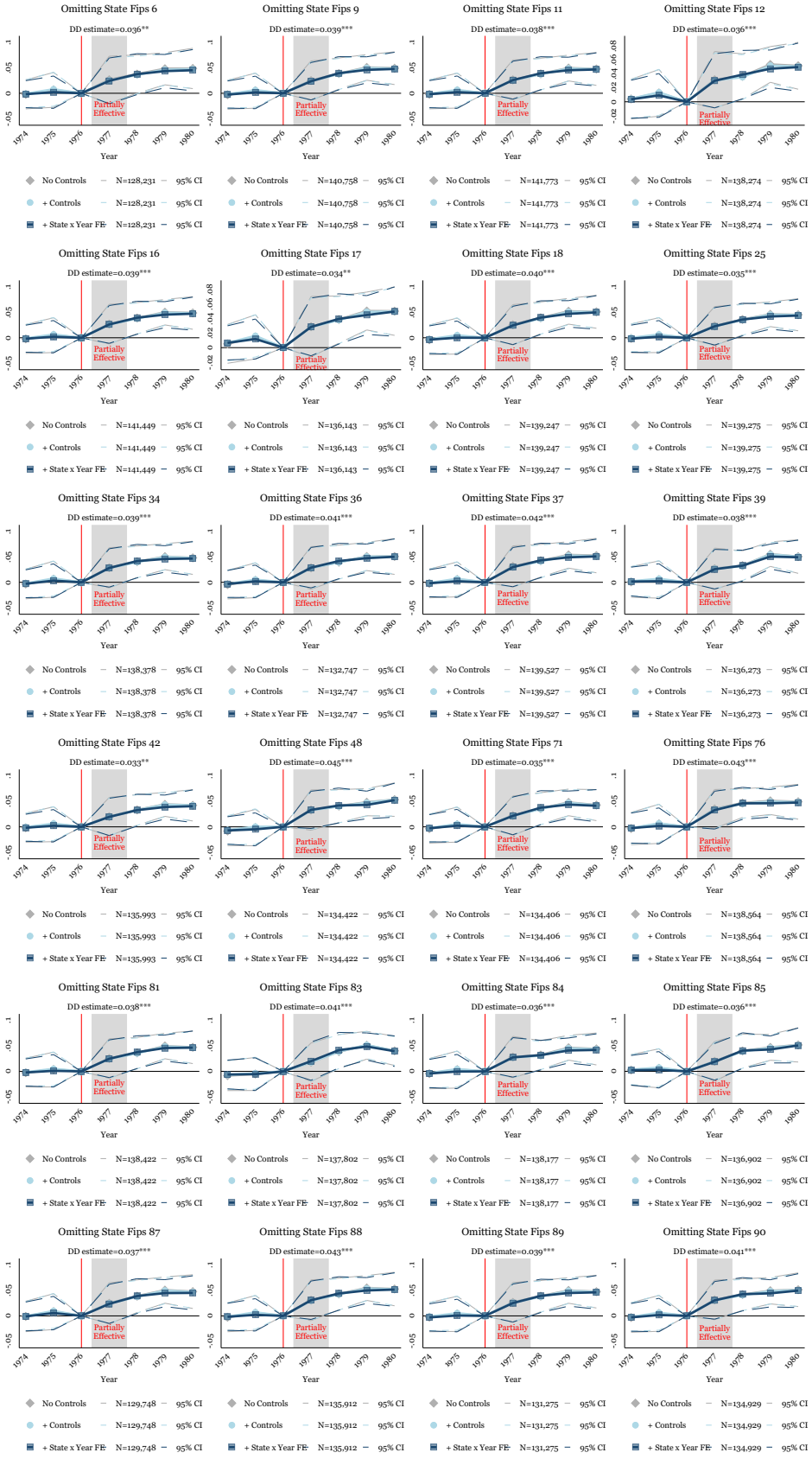
SOURCE: National Hospital Discharge Survey (NHDS) Files. In Panel A, the NHDS payer data are only available beginning in 1977; the data reflect 1977-1980. In Panel B, the CPS data from Flood et al. (2024) span the years 1974 to 1976.

Table G.1: Descriptive Statistics for CPS Sample, Treated States

	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.
Assistance										
Receiving Welfare	0.144	0.351	0.027	0.163	0.116***	0.171	0.377	0.032	0.176	0.139***
Non-Welfare Government Assistance	0.032	0.175	0.031	0.173	0.001	0.033	0.178	0.036	0.187	-0.004*
Any Government Assistance	0.172	0.378	0.058	0.233	0.115***	0.200	0.400	0.067	0.251	0.132***
Children										
Number of Children	0.853	1.232	0.601	0.976	0.253***	0.812	1.169	0.563	0.936	0.249***
Any Child	0.442	0.497	0.343	0.475	0.099***	0.431	0.495	0.331	0.470	0.101***
Age of Own Child Under 18	2.627	2.520	2.434	2.361	0.194***	2.846	2.752	2.400	2.487	0.446***
Child 18 or Under	0.441	0.497	0.342	0.474	0.099***	0.430	0.495	0.330	0.470	0.101***
Child 10 or Under	0.411	0.492	0.328	0.469	0.083***	0.397	0.489	0.316	0.465	0.080***
No Children	0.558	0.497	0.657	0.475	-0.099***	0.569	0.495	0.669	0.470	-0.101***
One Child	0.204	0.403	0.159	0.366	0.044***	0.199	0.399	0.162	0.368	0.037***
Two Children	0.137	0.344	0.128	0.335	0.009*	0.136	0.343	0.121	0.327	0.015***
Three Children	0.058	0.234	0.041	0.199	0.017***	0.062	0.242	0.036	0.186	0.026***
4+ Children	0.043	0.203	0.014	0.118	0.029***	0.033	0.180	0.012	0.107	0.022***
Employment										
Employed	0.369	0.482	0.473	0.499	-0.104***	0.380	0.485	0.526	0.499	-0.146***
Worked Last Week	0.355	0.478	0.458	0.498	-0.103***	0.362	0.481	0.509	0.500	-0.148***
Any Wage Income	0.517	0.500	0.637	0.481	-0.120***	0.528	0.499	0.681	0.466	-0.154***
Wage Income	1,767.162	2,851.919	2,114.035	3,021.820	-346.873***	2,380.993	3,856.660	3,048.717	4,056.052	-667.724***
Total Income	2,156.026	2,895.255	2,317.414	3,124.805	-161.388***	2,947.557	3,876.546	3,407.586	4,286.681	-460.029***
Household										
Household Head	0.175	0.380	0.076	0.265	0.099***	0.198	0.398	0.106	0.308	0.092***
Married	0.295	0.456	0.453	0.498	-0.158***	0.250	0.433	0.430	0.495	-0.180***
Age	21.361	4.302	21.546	4.338	-0.185***	21.551	4.338	21.748	4.306	-0.197***
N	5,608		35,786		41,394	9,559		61,069		70,628

SOURCES: CPS data from Flood et al. (2024).

Figure G.2: CPS Data–Dropping One State at a Time



NOTES: Reflects Figure X except dropping each state from the sample individually. State numbers correspond to CPS grouped state FIPS, https://cps.ipums.org/cps-action/variables/STATEFIP#codes_section.

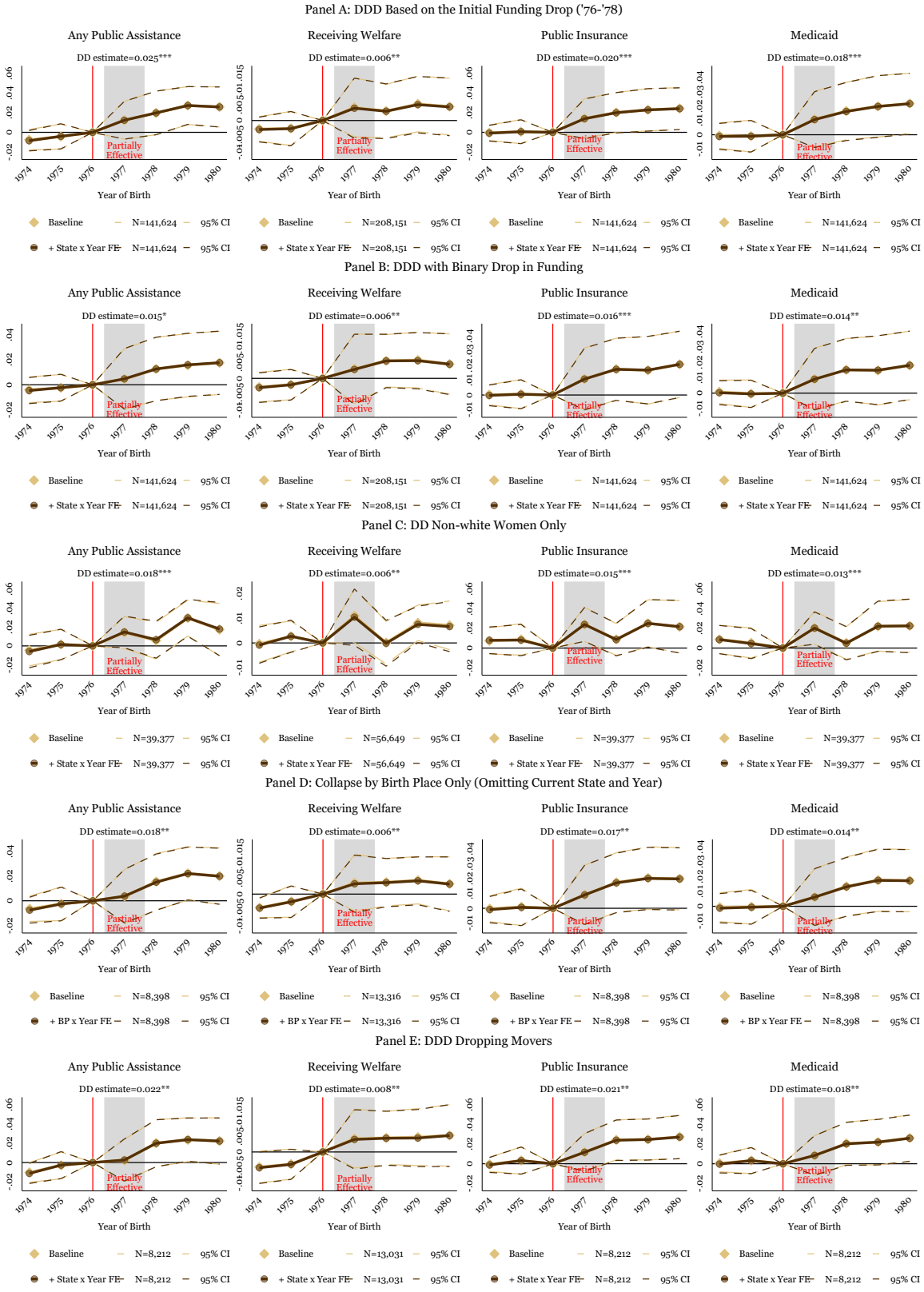
H American Community Survey

Table H.1: Descriptive Statistics for ACS Sample, Treated States

	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.
Assistance										
Any Public Assistance	0.379	0.485	0.171	0.376	0.208***	0.408	0.492	0.188	0.391	0.220***
Receiving Welfare	0.052	0.221	0.019	0.137	0.032***	0.058	0.233	0.022	0.148	0.035***
Public Insurance	0.250	0.433	0.122	0.328	0.127***	0.272	0.445	0.134	0.341	0.138***
Medicaid	0.230	0.421	0.110	0.313	0.120***	0.255	0.436	0.124	0.330	0.131***
Receiving Foodstamps	0.284	0.451	0.104	0.305	0.180***	0.313	0.464	0.119	0.324	0.194***
Children										
Number of Children	1.478	1.373	1.481	1.271	-0.003	1.384	1.382	1.317	1.289	0.067***
Any Child	0.685	0.464	0.710	0.454	-0.025***	0.640	0.480	0.636	0.481	0.004**
Children Under 5	0.274	0.561	0.374	0.648	-0.100***	0.364	0.639	0.439	0.691	-0.075***
Unmarried w/Children	0.247	0.431	0.049	0.215	0.198***	0.281	0.449	0.068	0.251	0.213***
Employment										
Employed	0.711	0.453	0.742	0.437	-0.032***	0.696	0.460	0.743	0.437	-0.047***
Unemployed	0.082	0.274	0.036	0.186	0.046***	0.092	0.289	0.041	0.198	0.051***
Hours Worked Last Week	30.832	17.948	30.507	18.013	0.325***	30.294	17.858	30.689	17.673	-0.395***
Log of Wage Income	10.030	1.094	10.167	1.100	-0.137***	9.908	1.143	10.083	1.113	-0.175***
Log of Total Income	9.928	1.153	10.082	1.198	-0.154***	9.818	1.188	10.008	1.199	-0.190***
Worked Last Week	0.801	0.399	0.812	0.391	-0.011***	0.800	0.400	0.820	0.384	-0.020***
Institution	0.010	0.101	0.004	0.067	0.006***	0.012	0.108	0.005	0.071	0.007***
Disability	0.107	0.309	0.073	0.261	0.034***	0.093	0.291	0.067	0.250	0.026***
Controls										
Age	35.868	4.893	35.910	4.972	-0.042**	32.487	5.063	32.626	5.139	-0.139***
Married	0.379	0.485	0.676	0.468	-0.297***	0.328	0.470	0.614	0.487	-0.286***
HS Degree or Higher	0.913	0.282	0.958	0.199	-0.046***	0.906	0.291	0.955	0.207	-0.049***
College Degree	0.280	0.449	0.421	0.494	-0.141***	0.274	0.446	0.422	0.494	-0.148***
Graduate Degree	0.114	0.318	0.153	0.360	-0.040***	0.104	0.305	0.146	0.353	-0.042***
N	90,142		405,955		496,097	133,228		572,228		705,456

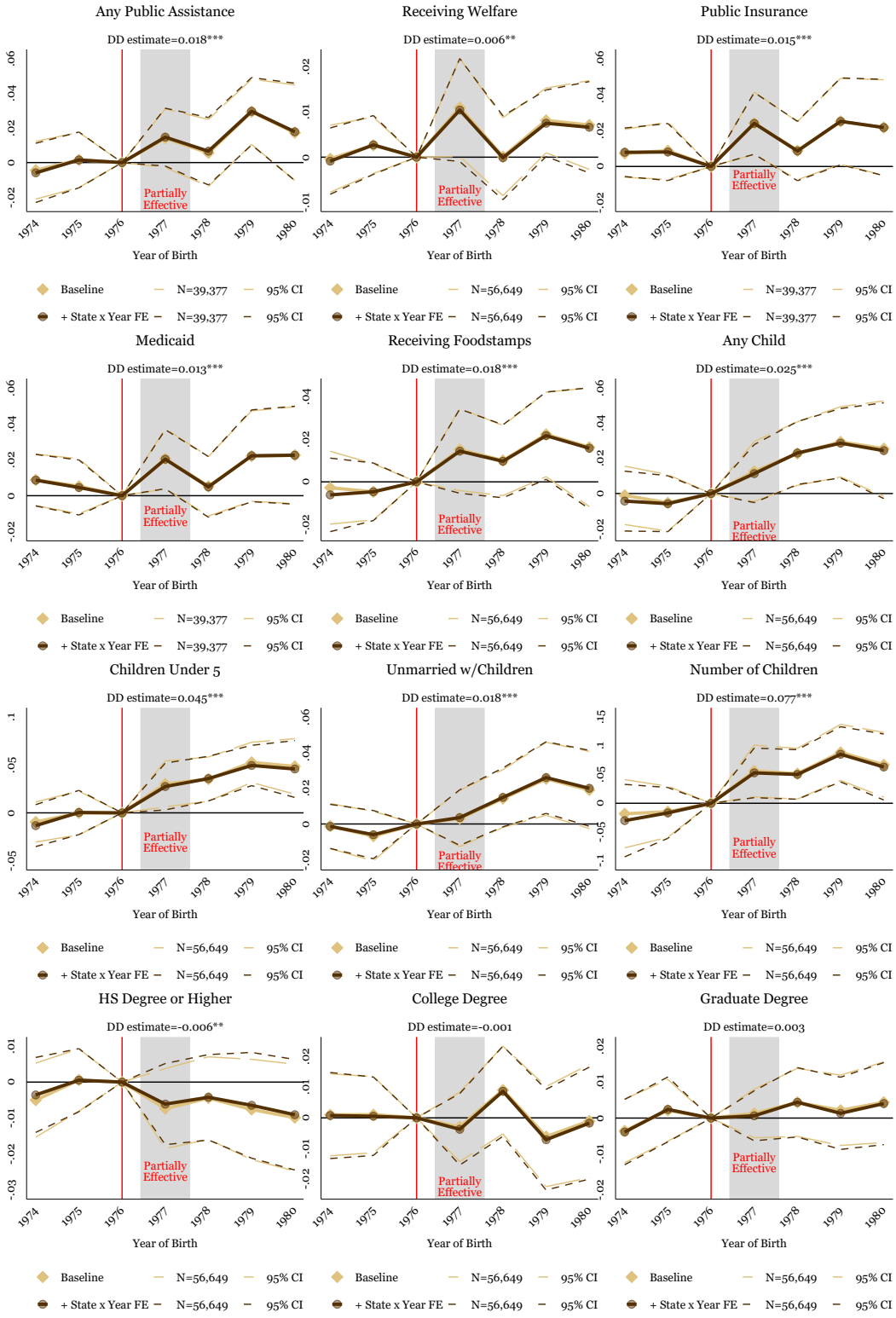
SOURCE: ACS data from Ruggles et al. (2024)

Figure H.1: ACS Data–Robustness of Public Assistance in the 2nd Generation



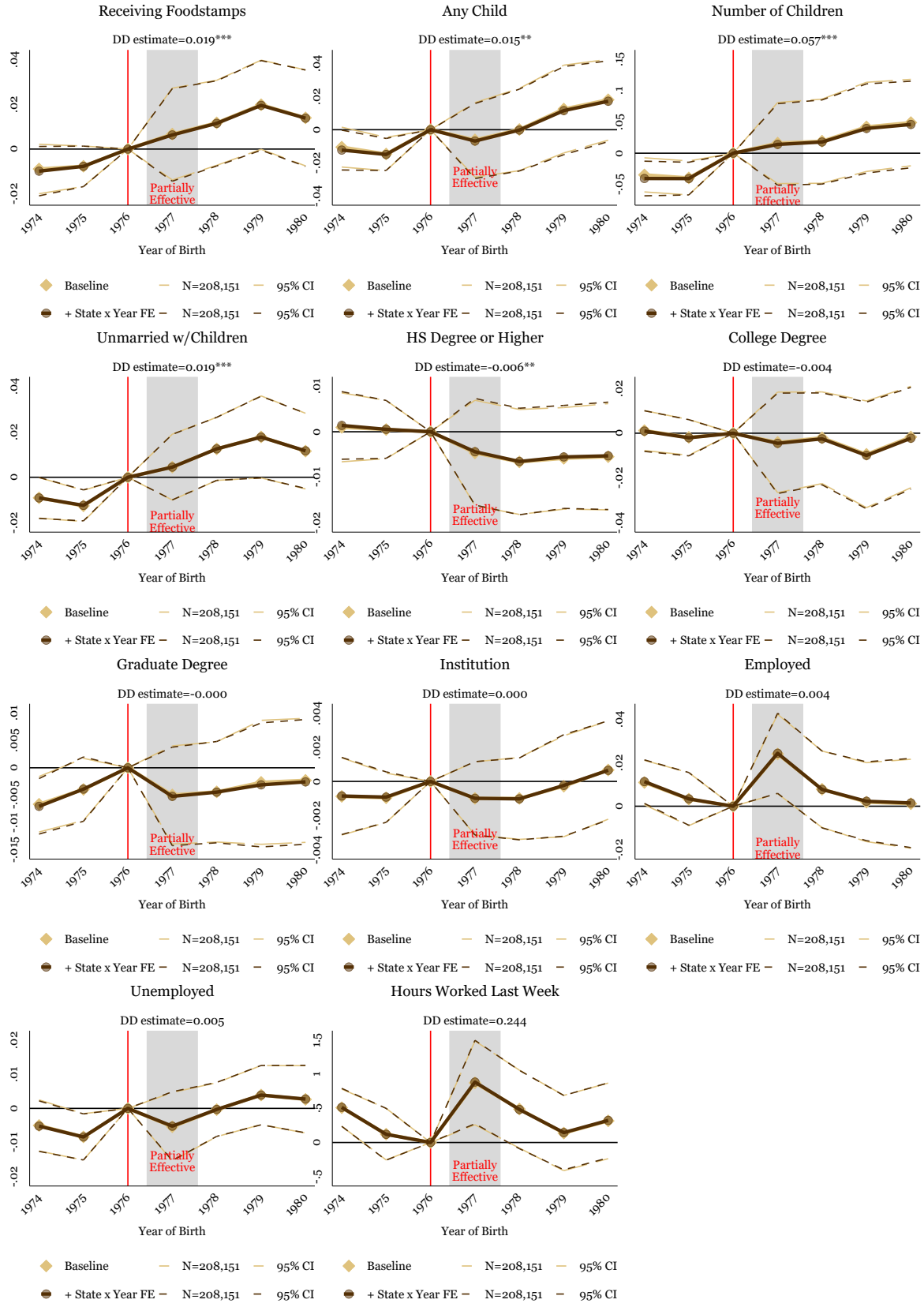
SOURCE: ACS data from Ruggles et al. (2024)
NOTES: Reflects Figure XII except considering robustness checks. Panel A considers only the initial funding drop. Panel B considers a binary drop in funding. Panel C considers a difference-in-differences with non-white women only. Panel D considers the effect collapsed to the birthplace and year of birth only, and omits the current state-level fixed effects. BP x year FE stands for birth place by birth year fixed effects. Panel E drops those who move out of their birth state.

Figure H.2: ACS Data–Public Assistance of 2nd Generation, Non-white Women Only



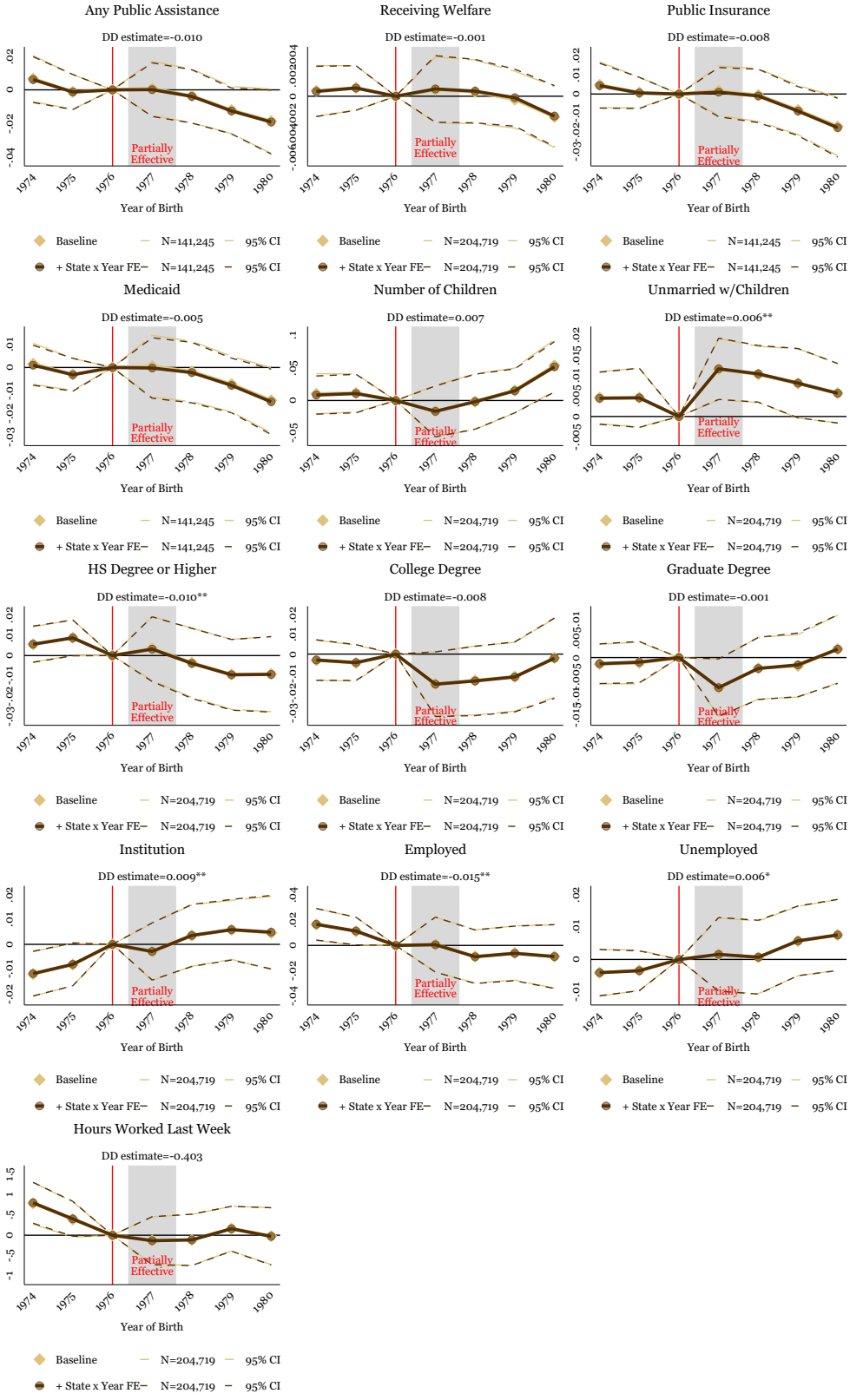
SOURCE: ACS data from Ruggles et al. (2024)
NOTES: Reflects Figure XII except considering subsamples of non-white women born around the Hyde Amendment in states with larger declines in abortion funding. Effectively, a difference-in-differences rather than a difference-in-differences-in-differences. ACS data collapsed to the race, state, state of birth, year, and birth year levels. Fixed effects include the birth state and year of birth, and state/year fixed effects or state-by-year fixed effects.. Regressions weighted by the sum of the weights in the ACS. Robust standard errors clustered at the birth state level.

Figure H.3: ACS Data–Public Assistance of 2nd Generation, Additional Outcomes



SOURCE: ACS data from Ruggles et al. (2024)
NOTES: Reflects Figure XII except considering subsamples of non-white women born around the Hyde Amendment in states with larger declines in abortion funding. ACS data collapsed to the race, state, state of birth, year, and birth year levels. Fixed effects include the birth state and year of birth. State-by-year fixed effects included where noted. Regressions weighted by the sum of the weights in the ACS. Robust standard errors clustered at the state level.

Figure H.4: ACS Data–Public Assistance of 2nd Generation, Non-white v. White Men



SOURCE: ACS data from Ruggles et al. (2024)
NOTES: Reflects Figures XII and H.3 except considering men.