



# Linking Reproductive Health Care Access to Labor Market Opportunities for Women

By Kate Bahn, Adriana Kugler, Melissa Mahoney, Danielle Corley, and Annie McGrew

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# Introduction and summary

Economic opportunity is a central tenet of the American dream and a mainstay of American political discourse. But when embracing this core economic aspiration, the ways in which people’s complex lives affect their ability to fully engage in the economy are often overlooked. The Center for American Progress report, “The Pillars of Equity: A Vision for Economic Security and Reproductive Justice,”<sup>1</sup> explored the diverse factors that affect the ability of women to determine the level and nature of their participation in the labor force and the economy. The report concluded, “Women’s economic contributions often depend on having access to comprehensive reproductive health services, as well as to education, jobs with livable wages, and workplace supports.” Understanding the connections between these economic and health issues is particularly important when determining the mix of policies necessary to place women on firm economic ground, as well as to empower women to make the decisions that make sense for them. Such analysis also requires moving beyond the issue silos that often isolate discussions about the economy, health care, and employment, as well as digging deeper into the growing body of research that reveals how these issues mutually reinforce each other.

Far too often, any discussions about reproductive justice, reproductive rights, and reproductive health care access are considered special interest matters in political debates, separate from a broader policy agenda aimed at economic empowerment. The data findings in this report show that these issues are correlated, however, and that states with policies affording women more control over their bodies are also the states where women have more opportunity in the labor market. These findings help demonstrate that, in order to encourage a dynamic economy replete with opportunity across the country, it is critical to foster both access to reproductive choices as well as economic opportunities for all women and their families.

Gaining a more in-depth understanding of the multiple factors shaping women’s economic stability and overall health and well-being is particularly important in this current political climate. Phrases such as “women’s empowerment” are often deployed rhetorically by policymakers without any real commitment to concrete

actions that help move women forward. The Trump administration has touted first daughter Ivanka Trump as spearheading a women’s empowerment initiative—yet she has virtually no results to show.<sup>2</sup> At the same time, the administration has pursued a series of measures that erode women’s economic standing and access to health care, both of which are essential to women’s empowerment. For example, while claiming to be in support of equal pay for women, the Trump administration has done practically nothing to improve pay practices, bolster equal pay protections, or support more robust enforcement of anti-discrimination laws.<sup>3</sup> Quite the opposite—Ivanka Trump supported the administration’s decision to halt implementation of a critical pay data collection tool<sup>4</sup> that would have provided enforcement officials with much-needed information about employer pay practices.

## What is reproductive justice?

Reproductive justice extends beyond reproductive rights, which implies legal rights to reproductive health care services. It is based on women’s human right to control their reproductive destiny within the context and the conditions of their community. The term was coined by black women following the 1994 International Conference on Population and Development in Cairo.<sup>5</sup> Movement co-founder Loretta Ross writes, “Reproductive Justice addresses the social reality of inequality, specifically, the inequality of opportunities that we have to control our reproductive destiny.”<sup>6</sup>

The concept of reproductive justice was developed to address the needs of women who face greater structural barriers to exercising their bodily autonomy, particularly women of color and other marginalized women, including transgender people. Reproductive justice is not a topic that is discussed in economics, but it is clearly a concept that relates to economic opportunity.<sup>7</sup> It closely aligns with some economic thinking, such as the capabilities approach developed by economist Amartya Sen. This approach involves both the technical right to an opportunity or a choice, as well as ensuring that an individual’s needs are met and that they have the ability to equitably access those opportunities within a specific cultural context.<sup>8</sup>

Moreover, the administration has also initiated an all-out assault on women’s reproductive rights domestically and internationally—for example, the administration has reinstated the Global Gag Rule,<sup>9</sup> supported congressional efforts to main-

tain the Hyde Amendment,<sup>10</sup> endorsed restrictive measures as part of the effort to repeal the Affordable Care Act (ACA),<sup>11</sup> as well as issued guidance to expand religious and moral exemptions that restrict insurance from covering certain reproductive health costs.<sup>12</sup> Each of these efforts separately has negative consequences for women, but together—along with too many other examples—they comprise a regressive, anti-woman agenda wrapped in a cynical, false narrative about women’s empowerment. The administration’s shallow claims to support women’s equality coupled with attacks by congressional opponents of pro-women policies have shown a complete ignorance of the complex ways in which women’s economic opportunities are linked to their reproductive rights and health care access.

This report shows that women’s economic empowerment, as measured by women’s labor force participation, earnings, and mobility, is correlated with stronger measures of upholding reproductive rights and health care access. Specifically, states with the best conditions for women to exercise bodily autonomy—through laws that empower women to make their own reproductive health decisions without interference—are the same states where women have greater economic opportunity. When women have secure control over planning whether and how to have a family, they are also able to invest in their own careers and take risks in the labor market that lead to better economic outcomes.

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## Key findings

To understand the ways in which women’s reproductive autonomy and economic opportunity are linked, the authors analyzed economic outcomes for women who face varying degrees of reproductive health care access and found that:

- Women living in states with a better reproductive health care climate—including insurance coverage of contraceptive drugs and services; expanded Medicaid eligibility for family-planning services; insurance coverage of infertility treatments; and the availability of state-supported public funding for medically necessary abortions—have higher earnings and face less occupational segregation compared with women living in states that have more limited reproductive health care access.
- Women in states with robust reproductive health care climates also are less likely to work part time,<sup>13</sup> giving them more opportunity for higher earnings; nonwage benefits such as access to paid sick days and paid leave; and greater promotion opportunities.<sup>14</sup>

- Reproductive rights and health care access also reduce job lock, or the lack of labor mobility between jobs. Women who live in states with positive indicators of reproductive health care access, as measured by publicly available funding for abortion, are more likely to transition between occupations and from unemployment into employment. On the other hand, women in states with more limited abortion access, as measured by the presence of targeted regulation of abortion providers (TRAP) laws, are less likely to make these transitions.

Together, these findings start to paint a picture that shows how certain economic outcomes are connected to a woman's ability to access the full range of reproductive health care services. Furthermore, the findings help clarify that women cannot achieve economic progress without securing greater autonomy to direct their futures.

# Current reproductive health climate

In the last several months, reproductive health care access has come under increased threat under the Trump administration and a Republican-majority Congress. In March, President Donald Trump signed a bill spearheaded by anti-abortion rights members of Congress that rolls back Obama-era protections for Title X providers who offer family-planning services.<sup>15</sup> In May, President Trump signed an executive order that allows employers to deny women health insurance coverage for preventative care—including contraception—on the basis of religious or moral objection.<sup>16</sup> And in early October, the Trump administration issued rules that give insurers, employers, schools, or even individuals leeway to deny contraceptive coverage on the basis of religious or moral objection—essentially undermining the contraceptive coverage mandate under the ACA.<sup>17</sup> Trump has also appointed numerous anti-abortion rights individuals to positions within the executive branch and the federal courts, which will threaten reproductive health care access for years to come.<sup>18</sup> Most recently, the administration decided to stop making payments to insurance companies for cost-sharing reductions (CSR), which reduce low-income enrollees' out-of-pocket costs;<sup>19</sup> additionally, the administration's support for Congress' repeated failed attempts to repeal the ACA put health insurance coverage for millions of women at risk.<sup>20</sup>

While the Trump administration poses dramatic new threats, the onslaught on women's reproductive health access is by no means a new phenomenon. Since the U.S. Supreme Court granted women the legal right to an abortion in the landmark 1973 case *Roe v. Wade*, states have enacted 1,142 abortion restrictions.<sup>21</sup> This has led to differing degrees of access to abortion, specifically, and reproductive health care, generally, across the United States based on a woman's ZIP code.

Nearly one-third, or 30 percent, of these restrictions have been enacted since 2010, when abortion opponents gained seats in state legislatures and governors' mansions after the midterm elections that year.<sup>22</sup> In 2016 alone, 50 new abortion restrictions were enacted in 18 states.<sup>23</sup> Restrictions—most of which lack rigorous scientific basis<sup>24</sup>—include banning all abortions 20 weeks post-fertilization; impos-

ing medically unnecessary restrictions on abortion facilities and providers; and requiring women to receive counseling or to undergo waiting periods before having an abortion.<sup>25</sup> The final result of all these restrictions is the same, however. In states that impose restrictions, it is significantly more difficult for women to make choices in terms of when and under what circumstances to proceed with a pregnancy.

These laws have had a significant impact on abortion providers. At least 162 abortion clinics have closed or stopped offering the procedure since 2011, while just 21 clinics opened during the same time period.<sup>26</sup> As a result, access to abortion services has been limited in many parts of the country. For example, the Guttmacher Institute estimates that 93 percent of reproductive-age women in the South and 68 percent in the Midwest live in a state that is hostile or extremely hostile to abortion.<sup>27</sup>

Barriers to accessing reproductive health services extend beyond abortion. Approximately one-half of U.S. counties do not have an OB-GYN. These are mostly rural counties, where more than 10 million women, or 8.2 percent of all U.S. women, live.<sup>28</sup> As a result, women in rural areas often have to travel longer distances—with the associated higher costs that entails—to access health care services.<sup>29</sup> For example, one-half of reproductive-age rural women live within a 30-minute drive of a hospital offering perinatal services.<sup>30</sup> For many women, geographic location is the primary determinant of ability to plan for their family.

The growing number of religiously affiliated hospitals further limits women's reproductive health care access.<sup>31</sup> These institutions may use religious guidance—known as Ethical and Religious Directives<sup>32</sup>—rather than medical standards when determining care, meaning that in areas with already-limited access to medical services, women may have no choice but to see a provider who does not offer contraception, sterilization, infertility treatments, or abortion services.<sup>33</sup> In five states—Alaska, Iowa, Washington, Wisconsin, and South Dakota—more than 40 percent of acute care hospital beds are in hospitals operating under Catholic health care directives. In another five states—Nebraska, Colorado, Missouri, Oregon, and Kentucky—between 30 percent and 39 percent of acute care hospital beds are in facilities operating under these directives.<sup>34</sup>

Due to structural inequality based on race, gender, and sexuality, barriers to comprehensive health care persist, particularly for women of color and LGBTQ individuals. These communities are more likely to experience additional barriers to accessing reproductive health care.<sup>35</sup> Women of color may experience disparate

access to health information; lack of reliable transportation or insurance; communication barriers for nonnative English speakers with medical professionals; and a historical distrust of the health care system.<sup>36</sup> Communities of color face worse health outcomes on average, and for women of color, this includes higher rates of mortality from cancer,<sup>37</sup> of maternal mortality,<sup>38</sup> and of pre-existing conditions such as asthma,<sup>39</sup> hepatitis,<sup>40</sup> diabetes, HIV, and AIDS.<sup>41</sup> While overall rates of unintended pregnancy have declined, they remain significantly higher for Latinas and black women.<sup>42</sup> For immigrant women, language barriers and concern about immigration policies can be a deterrent to seeking care.<sup>43</sup> Teens and LGBTQ individuals may face barriers in accessing health care, with both groups more likely to face stigma, discrimination related to stigma, and even denial of care.<sup>44</sup> LGBTQ communities are also among those who significantly benefited from the ACA—since they are more likely to live in poverty—and have benefited from both the expansion of Medicaid as well as the health insurance marketplace.<sup>45</sup>

# Access and affordability of family-planning services

While the legal right to abortion is one aspect of autonomy over reproduction choices, affordability of all reproductive health care services is necessary to ensuring that women have the ability to control their own bodies and plan for their families if they so choose. The ACA has been instrumental in increasing access to reproductive health services for women by making these services more affordable. In addition to increasing access to health insurance through establishing the health insurance exchanges, which include financial help, and through providing increased funding for states to expand Medicaid, the ACA also includes no-cost preventive services, allowing millions of women to access several preventative reproductive health services. These services include contraception; well-woman visits; breastfeeding counseling and supplies; and screening and treatment for sexually transmitted infections (STIs). Women can also no longer be charged higher premiums due to their gender.<sup>46</sup>

As a result of the ACA, approximately 9.5 million women who were previously uninsured now have coverage.<sup>47</sup> From 2013 through 2015, the uninsured rate for women ages 19 through 64 fell from 17 percent to 11 percent,<sup>48</sup> and since the passage of the ACA, the number of women who report that they delayed or went without care due to cost has also fallen.<sup>49</sup> Insurance coverage for women of color ages 18 through 64 increased at nearly twice the rate of women overall between 2013 and 2015, demonstrating both the importance of the ACA for these women—including the law’s Medicaid expansion—and the risks associated with Congress’ threats to repeal.<sup>50</sup> In addition, 62.4 million women now have access to contraception at no cost.<sup>51</sup> Due to the ACA’s contraceptive mandate, women and families saved \$1.4 billion in out-of-pocket costs for contraceptive pills in 2013 alone.<sup>52</sup>

These gains, however, were not distributed evenly across the country. Uninsured rates generally dropped more in states that expanded Medicaid.<sup>53</sup> In fact, one analysis found that the strongest indicator in determining whether an individual who did not have insurance in 2013 gained coverage under the ACA was whether they lived in a state that expanded its Medicaid program in 2014.<sup>54</sup>

Access to family-planning services and other reproductive health care services also remains uneven. Prior to the passage of the ACA, 28 states already required insurers to cover prescription contraceptive drugs and devices.<sup>55</sup> Some of these states expanded or amended their policies to match the federal standard, while others went beyond the federal mandate by requiring coverage of more types of contraceptives. Of these 28 states, 20 now allow certain employers and insurers to refuse to comply with the ACA's contraception coverage mandate, while eight states do not allow any employers or insurers to refuse compliance.<sup>56</sup> Title X of the Public Service Health Act focuses on providing critical family-planning health services, including physical exams; prescriptions; contraceptive coverage; referrals; and educational and counseling services.<sup>57</sup> Title X providers, such as Planned Parenthood, serve about 4 million clients every year, helping fill the gap in services for low-income families.<sup>58</sup> Additionally, 28 states have Medicaid family-planning programs, and 17 of these states also expanded Medicaid under the ACA—meaning that women in these states have access to a full range of services compared with women in states without Medicaid family planning or Medicaid expansion.<sup>59</sup> Additionally, Medicaid expansion increased eligibility for Medicaid to all individuals with incomes up to 138 percent of the federal poverty level; thus, more people qualified for the program, expanding coverage for women.

As a result of differing state policies, an individual's access to care varies significantly depending on the state where she resides. Continuing gaps in coverage mean that more than 1 in 10 women remains uninsured.<sup>60</sup> The recent decision to stop CSR payments to insurance providers,<sup>61</sup> as well as congressional proposals to repeal the ACA, further threaten women's health coverage. Recently, proposed bills in the House of Representatives and Senate range from causing an estimated 16 million to 32 million people to lose their health insurance.<sup>62</sup> Congressional Republican leaders have also attempted to further limit abortion access by proposing restrictions on private insurance coverage of the procedure,<sup>63</sup> and congressional proposals have included prohibiting federal Medicaid payments to Planned Parenthood for one year, which would harm the approximately two-thirds of Planned Parenthood patients that rely on federal funding for health care coverage.<sup>64</sup>

Access to contraception is one type of reproductive health care access that has been integral to women's increased economic opportunity. An estimated 62 percent of women of reproductive age use contraception.<sup>65</sup> While abortion is less common—an estimated 30 percent of women will have had an abortion by age 45<sup>66</sup>—it is another economically important aspect of reproductive health care since it has both direct costs, including paying for services out of pocket, and long-term costs for women. Furthermore, like contraceptive services, abortion access

constitutes an aspect of bodily autonomy. Being able to guarantee and expect control over one's body, including reproductive decisions, is a necessary condition of the ability to fully engage in the labor market and face a lower likelihood of financial precarity.<sup>67</sup>

Unfortunately, abortion is not accessible for many women. According to research from the Guttmacher Institute, in 2008, one-third of the women who obtained an abortion had no insurance and another 31 percent were covered by state Medicaid.<sup>68</sup> Seventeen states have a policy that directs state Medicaid to provide funding for medically necessary abortions.<sup>69</sup> But because of the Hyde Amendment—which prevents federal funds from paying for abortion care except for in cases of rape, incest, or to save the mother's life—without additional state funding, women covered by Medicaid seeking abortions must cover the direct costs of the procedure without insurance coverage.<sup>70</sup> The median cost of a surgical abortion at 10 weeks gestation without insurance was \$470 in 2009,<sup>71</sup> which is already more money than many Americans would be able to come up with in the case of an emergency.<sup>72</sup>

In addition to direct costs of the medical procedure, these women must bear the practical costs imposed by state restrictions, such as multiple doctor's office visits and unnecessary waiting periods. A low-income single mother who needs to pay for travel to the nearest clinic; a night at a hotel while she completes a mandatory waiting period; child care; and lost earnings from missing work, could end up paying an additional \$1,380, according to one estimate by ThinkProgress for a typical woman in Wisconsin, a state with mandatory waiting periods.<sup>73</sup> The same estimates found that a middle-income woman living in a city would pay less, at \$593. This means that state restrictions affect those who already have the least resources and face the most barriers to receiving medical care, exacerbating economic inequality.

Women who want an abortion but cannot afford the out-of-pocket costs inflicted by the Hyde Amendment face major consequences during the course of their careers. The most thorough study of how women's lives have been affected by restricted access to abortion is the Turnaway Study, which followed women who wanted to have an abortion but did not obtain one.<sup>74</sup> Research done with the findings of the Turnaway Study found that cost was the primary reason for not obtaining the procedure for 85 percent of the women who considered an abortion.<sup>75</sup> Subsequently, these women faced worse economic outcomes, were more likely to live in poverty, and often carried unwanted pregnancies to term.<sup>76</sup>

# Previous evidence demonstrates that access to reproductive health care and rights affects economic opportunities

Equitable access to reproductive health care is not only important to help all women have bodily autonomy; it is also vital to allowing women to fully engage in the economy. Research has shown that access to contraception and abortion has serious economic consequences for women, in both immediate costs as well as long-term effects on economic stability and progress. Deciding if, when, and how to raise a family is closely connected with labor force attachment and career development, determining both what kind of and how much work a woman will be able to do.

This research has shown that the practical ability of women to access reproductive health care has economic effects beyond the immediate costs of care. The capabilities approach developed by Nobel laureate economist Amartya Sen<sup>77</sup> describes the underlying economic processes that connect women's bodily autonomy to economic opportunity. Further developing this approach, the philosopher Martha Nussbaum has written on capabilities applied to gender equality.<sup>78</sup> She describes capabilities as what people are able both to do and to be.

Nussbaum outlines what she calls “central human capabilities,” which include bodily integrity. She defines this as: “Being able to move freely from place to place; to be secure against violent assault, including sexual assault and domestic violence; having opportunities for sexual satisfaction and for choice in matters of reproduction.”<sup>79</sup> Under this concept, the right to abortion is not merely the absence of a legal ban on the procedure; it also pertains to the accessibility and affordability of abortion and whether women have the means—financial and otherwise—to have the procedure done if they so choose. This emphasizes the role of resources in ensuring that women have access to these services.

The capabilities approach applied to bodily integrity, including reproductive choice, is similar to the reproductive justice framework that correlates legal rights with the ability to exercise those rights equitably. In the CAP report, “The Pillars of Equity,” reproductive justice is defined as “the economic, social, and political

power and resources for women to make healthy decisions about their bodies; sexuality and reproduction; families; and communities.”<sup>80</sup> (see text box on page 2) The concept of reproductive justice incorporates how systemic inequality, which includes economic inequality, affects the ability of women to have freedom to exercise their rights and have access to the services that they need to ensure self-determination.

“The Pillars of Equity” discusses the resources, including cultural norms of respect, that women need in order to have access to reproductive health services and notes that “some people need supports beyond policy change and legal services.”<sup>81</sup> Nussbaum uses the example of people with varying physical ability who may need different resources to be mobile, and society has decided that there should be devoted resources to ensuring that people with physical limitations are able to be mobile. Likewise, due to their biological reproductive abilities, women have different resource needs in order to have capabilities equal to men. Not only does a pregnant woman need more resources such as nutrition and health care to sustain herself, but a woman of reproductive age needs different resources than a man in order to ensure that she has agency in terms of determining her reproduction choices. This determination, in turn, affects her ability to have equitable access to opportunity in the labor market.

Legal access to contraception has been an important development in women’s access to more opportunities in the labor market. Birth control pills became widely available to women in the late 1960s and early 1970s as state-level laws determined who could gain access to a prescription and under what circumstances.<sup>82</sup> As states expanded coverage for women during their coinciding child-bearing and human capital development years, women were able to better control their autonomy and plan for their careers. For example, in their paper, “Power of the Pill,” economists Claudia Goldin and Lawrence Katz are able to link access to the pill to increased applications of women into medical school.<sup>83</sup> The ability to obtain higher education degrees was crucial for women’s ability to enter a wider variety of occupations and realize higher earnings during this time period.<sup>84</sup>

In a subsequent study—“More Power to the Pill”—economist Martha Bailey found that labor force participation rates are higher among women ages 26 through 30 who live in states that have longer histories of legal access to the pill.<sup>85</sup> The ability to plan when and how to have a family through access to contraception enabled women to remain in the labor force during these crucial years for career-building. These years are important for job experience and career development

and affect lifetime earnings trajectories. Previous research by CAP found that parents who leave the workforce to provide child care face a long-term financial penalty in the form of lost wages, lost wage growth, and lost retirement savings.<sup>86</sup> In “Calculating the Hidden Cost of Interrupting a Career for Child Care,” CAP found that “workers can expect to lose up to three or four times their annual salary for each year out of the workforce” precisely because most parents have children when they are young, and lost earnings early in a career translate into significant losses over a long-term trajectory. This is because skills beget skills, and early loss in skills-building results in depreciation of skills later on.

Furthermore, women’s ability to ensure control over their reproduction affected their investments in human capital that increased their earnings, as well as how they participated in the labor force. In another paper by Martha Bailey, “The Opt-In Revolution? Contraception and the Gender Gap in Wages,” she finds that states where younger women had access during the time period when laws were changing led to an 8 percent wage premium for those women by age 50.<sup>87</sup> Her findings imply that access to the pill accounts for 10 percent of the convergence, or closing, of the gender wage gap by 1980 and 30 percent by the 1990s. Ultimately, these factors influenced the convergence of the gender wage gap<sup>88</sup> in the 20 years following increased accessibility of the contraceptive pill, during the prime working years of the young women who first gained access.

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## The reproductive health care access and economic opportunity link between states

The variation in reproductive health care access between states occurs alongside states’ very different labor markets. This reflects a variety of cultural norms and economic conditions across America. The authors of this report find that women perform better in the labor market in states with greater access to reproductive health care. This correlation suggests that women’s economic empowerment is integrated into an overall climate of women’s equality, including accessible reproductive health care that better enables women to exercise self-determination over their reproduction.

In order to understand the relation between reproductive health care access and labor market opportunities, the authors linked data from the Current Population Survey’s (CPS) Outgoing Rotation Group (ORG), which provides individual-level information on employment, earnings, and other labor market characteris-

tics, with state-level reproductive health care access information compiled by the Guttmacher Institute and the National Conference of State Legislatures. When differentiating between greater reproductive health care access and more limited reproductive health care access, the data show that women living in states with greater access also have higher earnings, higher rates of full-time employment, and better job opportunities.

In order to understand the connection between reproductive health care and economic outcomes, the authors examined correlations between positive or negative indicators for access by state and the economic conditions facing women and men in those states. Positive indicators for access to reproductive health care services include insurance coverage of contraceptive drugs and devices; expanded Medicaid eligibility for family-planning services; insurance coverage of infertility treatments; and the availability of state-supported public funding for abortion. Negative indicators for reproductive health care access include targeted regulation of abortion providers (TRAP) laws, whether one-quarter of women live in counties without an abortion provider, mandatory waiting periods, mandatory ultrasounds,<sup>89</sup> and restrictions of “late-term” abortions, since each of these factors make it more difficult to access abortion medical services. Three states have all four positive indicators for reproductive health care access and are referred to as positive indicator (PI) reproductive states—Connecticut, New York, and Maryland. Eleven states have all four indicators of limited reproductive health care access, known as negative indicator (NI) reproductive states—Ohio, Wisconsin, Kansas, Virginia, North Carolina, Kentucky, Alabama, Mississippi, Louisiana, Oklahoma, and Texas. While there are limits to an analysis looking at only a portion of the states, this provides a clear differentiation of summary statistics that reveal important insights. Of all reproductive-age women in the United States, 9.5 percent live in states with all four positive indicators and 27 percent live in states with all four negative indicators.

Based on the findings of this report, women do relatively better economically compared with men in states where they have greater access to reproductive health services. Table 1a shows that, while women still earn less than men across the country, they are doing relatively better in PI states. The table also shows that hourly wages are higher for both men and women of reproductive age in states with greater reproductive rights—PI states—than in states with limited reproductive rights—NI states. Not only are the wages higher for both women and men, but women also are doing relatively better in these states. Table 1b indicates that women’s wages in PI states are relatively higher than women’s national median

wage compared with men’s, when compared with their respective national median wages. Women’s incomes are 15.9 percent higher in PI states than women’s national median wage, while men’s wages are only 7.7 percent higher in PI states than men’s national median wage. Additionally, in NI states, women and men both make 4 percent less than their respective national median incomes. In other words, there is more divergence of women’s wages between PI and NI states compared with men’s.

**TABLE 1A**  
**Women and men have higher median wages in states with greater reproductive health care access**

Median hourly income for reproductive-age men and women

	Women	Men
National	\$15.8	\$19.0
States with greater reproductive health care access	\$18.4*	\$20.5*
States with limited reproductive health care access	\$15.2*	\$18.2*

\* The difference in median wage between states with greater reproductive health care access and those with more limited reproductive health care access is significant at the 1 percent level.

Note: Data are for 2014 through 2016 and for employed men and women of reproductive age—18 through 50 years old. Wage data is in 2016 dollars and is usual hourly earnings including overtime for hourly and nonhourly workers.

Sources: Center for Economic and Policy Research, “CPS ORG DATA,” available at <http://ceprdata.org/cps-uniform-data-extracts/cps-outgoing-rotation-group/cps-org-data/> (last accessed October 2017). State-level data on indicators of reproductive health care access are from the Guttmacher Institute and the National Conference of State Legislatures. See Methodological Appendix for more detail.

**TABLE 1B**  
**Women’s wages increase more than men’s in relation to the national median in states with greater reproductive health care access**

Median hourly income as a percentage of national median income

	Women	Men
States with greater reproductive health care access	115.9%	107.7%
States with limited reproductive health care access	96.0%	96.0%

Note: Data are for 2014 through 2016 and for employed men and women of reproductive age—18 through 50 years old. The data in the table present the median hourly income of women and men in states with greater reproductive health care access and in states with more limited reproductive health care access as a percentage of women’s and men’s national median hourly income.

Sources: Center for Economic and Policy Research, “CPS ORG DATA,” available at <http://ceprdata.org/cps-uniform-data-extracts/cps-outgoing-rotation-group/cps-org-data/> (last accessed October 2017). State-level data on indicators of reproductive health care access are from the Guttmacher Institute and the National Conference of State Legislatures. See Methodological Appendix for more detail.

In addition to relatively higher earnings, women work part time at a lower rate in states that provide relatively better access to reproductive health care services, although results are not statistically significant. While part-time work may afford workers the ability to balance labor force participation and family responsibili-

ties,<sup>90</sup> these jobs also often pay less, offer fewer nonmonetary benefits, are less stable, and offer less opportunities for advancement.<sup>91</sup> Part-time employment often leaves women in more precarious economic circumstances. Analysis by the National Women’s Law Center found that two-thirds of part-time workers in the United States are women.<sup>92</sup> However, Table 2 shows that there is more gender parity in the incidence of part-time work between women and men in states with more reproductive health care access—although the results for women are not statistically significant. The results in Table 2 show that both PI and NI states have lower overall rates of part-time work for both women and men compared with the national rate. But when comparing PI states to NI states, more men work part time in PI states than NI states, while more women work part time in NI states than PI, so the gap between women and men working part time is lower in PI states.

**TABLE 2**  
**Women with more access to reproductive health care work part-time at a lower rate than women with less access to reproductive health care**

Share of reproductive-age women and men with part-time jobs

	Women	Men
National	25.5%	12.3%
States with greater reproductive health care access	22.9%	12.0%*
States with limited reproductive health care access	24.0%	11.0%*

\* The difference in rates of part-time work between states with greater reproductive health care access and those with limited reproductive health care access is significant at the 5 percent level.

Note: Data are for 2014 through 2016 and for employed men and women of reproductive age—18 through 50 years old.

Sources: Center for Economic and Policy Research, “CPS ORG DATA,” available at <http://ceprdata.org/cps-uniform-data-extracts/cps-outgoing-rotation-group/cps-org-data/> (last accessed October 2017). State-level data on indicators of reproductive health care access are from the Guttmacher Institute and the National Conference of State Legislatures. See Methodological Appendix for more detail.

There is also evidence that women have higher-quality job opportunities in states where they also have more reproductive health care access. Tables 3a and 3b show that there are higher shares of both women and men who are managers in the workforce in PI states compared with both NI states and the national average. Like the other metrics above, women are also doing relatively better economically in PI states. Men in PI states have a 2 percent higher rate of being managers compared with the national average for men, while women have a 6.2 percent higher rate than the national average for women. More striking is that in NI states, men are managers at 2.9 percent less than their national rate, while women are managers at 4.7 percent less of their national rate. This indicates that women have less opportunity for higher-quality managerial work in these states.

TABLE 3A

### Men and women in states with greater reproductive health care access are more likely to be managers than in states with limited access

Share of reproductive-age men and women who are managers

	Women	Men
National	8.7%	11.3%
States with greater reproductive health care access	9.3%*	11.5%*
States with limited reproductive health care access	8.3%*	10.9%*

\* The difference in manager rates between states with greater reproductive health care access and those with limited reproductive health care access is significant at the 1 percent level.

Note: Data are for 2014 through 2016 and for employed men and women of reproductive age—18 through 50 years old.

Sources: Center for Economic and Policy Research, "CPS ORG DATA," available at <http://ceprdata.org/cps-uniform-data-extracts/cps-outgoing-rotation-group/cps-org-data/> (last accessed October 2017). State-level data on indicators of reproductive health care access are from the Guttmacher Institute and the National Conference of State Legislatures. See Methodological Appendix for more detail.

TABLE 3B

### States with greater reproductive health care access have higher shares of women managers than men compared with the national rate

Manager rates as share of national rates for women and men

	Women	Men
States with greater reproductive health care access	106.2%	102.0%
States with limited reproductive health care access	95.3%	97.1%

Note: Data are for 2014 through 2016 and for employed men and women of reproductive age—18 through 50 years old. Data show share of employed women and men who are managers in states with greater reproductive health care access and in states with limited reproductive health care access as a share of the national average of women and men who are managers.

Sources: Center for Economic and Policy Research, "CPS ORG DATA," available at <http://ceprdata.org/cps-uniform-data-extracts/cps-outgoing-rotation-group/cps-org-data/> (last accessed October 2017). State-level data on indicators of reproductive health care access are from the Guttmacher Institute and the National Conference of State Legislatures. See Methodological Appendix for more detail.

The authors of this report also calculated employment in two major gender segregated industries—the service industry and the manufacturing industry. Women are overrepresented in the service industry, while men are overrepresented in manufacturing.<sup>93</sup> Tables 4a and 4b show that the gap in the shares of men and women who work in different industries is much higher in NI states. This is most obvious in the service sector. In PI states, there is a 3.6 percentage-point difference in the shares of men and women who work in the service sector, while in NI states, this difference is slightly more than 12 percentage points with higher shares of women in the service industry in both PI and NI states. By contrast, the share of women in manufacturing is 3.4 percentage points lower than the share of men in manufacturing in PI states, but 11 percentage points lower in NI states.

TABLE 4A

## States with greater reproductive health care access have a smaller gap between the share of women and men working in services

Share of reproductive-age men and women who work in services

	Women	Men
National	93.1%	83.8%
States with greater reproductive health care access	95.6%*	92.0%*
States with limited reproductive health care access	92.7%*	80.5%*

\* The difference between states with greater reproductive health care access and those with limited reproductive health care access is significant at the 1 percent level.

Note: Data are for 2014 through 2016 and for employed men and women of reproductive age—18 through 50 years old.

Sources: Center for Economic and Policy Research, "CPS ORG DATA," available at <http://ceprdata.org/cps-uniform-data-extracts/cps-outgoing-rotation-group/cps-org-data/> (last accessed October 2017). State-level data on indicators of reproductive health care access are from the Guttmacher Institute and the National Conference of State Legislatures. See Methodological Appendix for more detail.

TABLE 4B

## States with greater reproductive health care access have a smaller gap between the share of women and men working in manufacturing

Share of reproductive-age men and women who work in manufacturing

	Women	Men
National	6.3%	14.3%
States with greater reproductive health care access	4.1%*	7.5%*
States with limited reproductive health care access	6.8%*	17.8%*

\* The difference between states with greater reproductive health care access and those with limited reproductive health care access is significant at the 1 percent level.

Note: Data are for 2014 through 2016 and for employed men and women of reproductive age—18 through 50 years old.

Sources: Center for Economic and Policy Research, "CPS ORG DATA," available at <http://ceprdata.org/cps-uniform-data-extracts/cps-outgoing-rotation-group/cps-org-data/> (last accessed October 2017). State-level data on indicators of reproductive health care access are from the Guttmacher Institute and the National Conference of State Legislatures. See Methodological Appendix for more detail.

The findings above indicate that women in states with better access to reproductive health care experience better overall economic conditions compared with those with poor access. But across all states, the evidence shows that certain measures of reproductive health care access in states are an indicator of overall labor market opportunity, including better wages and less occupational segregation, for women. The study also finds that there is evidence of less job lock—lack of labor mobility between jobs—for women in states with better reproductive health care access, indicating a correlation between the climate of women's reproductive rights and economic opportunity.

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## Reproductive health care access and job lock

Job lock is when a person is locked into a job or occupation because they lack the labor mobility or employment opportunities that would allow them to transition to another job that would be a better fit given their skills. Declining labor mobility has become a cause for concern in the U.S. labor market since 2000.<sup>94</sup> Mike Konczal and Marshall Steinbaum at the Roosevelt Institute have hypothesized that declining labor market dynamism is due to declining labor demand as evidenced by sluggish wage growth. In “Declining Entrepreneurship, Labor Mobility, and Business Dynamism: A Demand-Side Approach,” the authors write, “When it is hard to find another job, employed workers stay at the jobs they have, impairing their ascent up the job ladder and the accompanying wage growth over careers that historically led to the middle class.”<sup>95</sup>

The relationship between health care access and job lock has been well-researched by economists, finding overall that health insurance access is an important factor in job mobility.<sup>96</sup> Recent research by economists Ammar Farooq and Adriana Kugler found that variations in the Medicaid threshold between states affected occupational and industrial mobility for workers and that living in a state with more generous health care access—ranging from the least generous at 10th percentile to the most generous at the 90th percentile of Medicaid income thresholds—increased the likelihood of transitioning, or moving, occupations and industries by 7.6 percent and 7.8 percent, respectively. This effect was even stronger for women, who had an increase in industrial mobility of 10.2 percent in more generous Medicaid states.<sup>97</sup>

In the analysis for this report, the authors looked at the effect of indicators of reproductive health care access on occupational mobility as well as whether a worker is more likely to transition into employment from either unemployment or from outside of the labor force. The most consistent finding across regressions is the statistically significant impact of abortion rights and access, as measured by state funding for abortion under Medicaid and TRAP laws (output tables available in the Appendix).

When looking at each measure of reproductive health care access, the authors found that the likelihood of transitioning to new occupations increased by 1.5 percent for women in states with public insurance funding for abortion through state Medicaid laws, with no similar significant effect on men in those states. On

the other hand, the likelihood of transitioning to new occupations decreased by 1.9 percent for women in states with TRAP laws, which limit the ability of doctors to provide abortion services.

The authors also analyzed the likelihood of transitioning from unemployment to employment for each variable separately as well as the full specification. Public funding for abortion had a significant positive effect of a 1.6 percent increased likelihood of transition from unemployment to employment for both women and men. TRAP laws also have a significant, negative effect for both women and men, with a decreased likelihood of transition to employment of 1.5 percent for women and of 0.8 percent for men. States with low numbers of abortion providers also had a significant, negative effect—as expected—on transition from unemployment to employment for both women and men, with a decreased likelihood of transition to employment of 1.5 percent for women and of 0.9 percent for men.

And finally, the authors analyzed the likelihood of transition from out of the labor force into employment for each variable. A low numbers of abortion providers in a state had a significant, negative effect on the likelihood of re-entering the labor force of 1 percent for women and 0.7 percent for men. Public funding for abortion and TRAP laws continued to be significant for both men and women, with abortion funding increasing the likelihood of re-entering employment from being out of the labor force and TRAP laws decreasing the likelihood. Public funding for abortion increased the likelihood of moving out of the labor force into employment by 1.1 percent for women and 1.2 percent for men. TRAP laws decreased the likelihood by 0.9 percent for women and 0.7 percent for men.

These results suggest that women in states with more reproductive health care access and freedom have better economic outcomes on many metrics. Indicators for the availability of funding for abortion and the existence of TRAP laws had the strongest and most consistent effect on job lock. But abortion is a less common procedure compared with contraceptive usage or the need for family-planning services, both of which have been found in previous research to change the ways in which women plan for their careers. Abortion access itself may not be the factor that underlies the process by which women workers make choices about whether to change occupations or re-enter employment, but it is a metric of women's rights overall and how norms of gender equality influence economic outcomes.

# Conclusion

Reproductive health care access is intertwined with economic opportunity due to both the direct costs affecting women when they lack affordable access to reproductive health care services, and because reproductive rights and access to family-planning services afford women greater choice over their careers, which affects their long-term economic well-being.

Previous research has shown that early access to the contraceptive pill and family-planning programs allowed women to have greater participation in the workforce, invest in their careers, and reap the benefits of the converging gender wage gap.<sup>98</sup> The findings of this report suggest that the overall climate of women’s empowerment as measured by positive or negative indicators of access to reproductive health care services, particularly abortion, is related to women’s economic outcomes as measured by earnings, part-time work, occupational segregation, and job lock. This suggests the mutually reinforcing ways in which women’s autonomy over their bodies is related to their self-determination and to greater opportunities in the labor market.

As outlined in “The Pillars of Equity,” a comprehensive agenda for women’s empowerment must recognize the overall climate in which women engage in the labor force as workers and raise their families if and as they choose. The states where women workers have better access to reproductive health care services are also the states that create better conditions for women to have more opportunities in the labor market—albeit not yet achieving parity with men. Across the states and nationally, women must continue to have access to comprehensive reproductive health care through the following measures:

- Protecting and defending the ACA, which includes provisions to extend coverage of affordable contraception; testing and treatment of STIs; maternity care; fertility treatment; and a host of other women’s health care services. Furthermore, the Medicaid expansion that increased health insurance coverage for people in those states must be implemented by all states so that more women and their families can receive the health care that they need.

- Congress must support Title X, ensuring that low-income people, the uninsured, young people, and communities of color have access to comprehensive family-planning services.
- States and the federal government should not roll back abortion rights, and many states need to reverse the course of limiting women’s access to abortion care. This should include Congress passing the Equal Access to Abortion Coverage in Health Insurance Act<sup>99</sup>—which would require the federal government to ensure coverage of abortion in public and private health insurance programs—and the Women’s Health Protection Act,<sup>100</sup> which would prohibit states from enacting dangerous restrictions on abortions and unnecessary regulations such as those in TRAP laws.

Ensuring that women can exercise their reproductive rights and access affordable reproductive health care services will reflect a society that values women and provides them the opportunity to fully engage in the labor market.

In addition, the importance of ensuring that women have control over their bodies and their health—the economic conditions that foster positive economic outcomes for all—must be promoted so that women can take full advantage of new labor market opportunities with their increased autonomy. In order to expand women’s opportunities in the labor market, states and the federal government should establish the following measures:

- Raise the minimum wage within states as well as federally.
- Address the persistent and stagnant gender wage gap through encouraging pay equity and addressing discrimination.
- Guarantee all workers paid sick leave and paid family and medical leave. Women have a disproportionate responsibility over family caregiving, so a lack of access to supportive policies such as paid sick leave and paid family and medical leave can limit their labor market opportunities. Recent analysis by CAP shows that access to paid family and medical leave in California led to increased labor force participation for women as well as men.<sup>101</sup> Expanding paid family and medical leave through the Family and Medical Insurance Leave Act<sup>102</sup> would extend the benefits across the country so that workers are better able to balance family caregiving responsibilities with labor market opportunities.

- Affordable access to child care is also crucial, since increased autonomy over family planning and access to job opportunities is not sustainable if growing a family is not supported by access to child care while at the workplace.

Just as reproductive rights and health care access should not be siloed as a separate women's issue and an afterthought in this country's political debate, Americans must also recognize that a comprehensive agenda for women's equality must include reinforcing the link between reproductive justice and economic opportunity. These measures in tandem comprise a comprehensive agenda for women's empowerment and economic equality.

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## About the authors

**Kate Bahn** is an economist at the Center for American Progress. Her work has focused on labor markets, entrepreneurship, the role of gender in the economy, as well as inequality. In addition to her work on the Economic Policy and Women's Initiative teams, Bahn has written about gender and economics for a variety of publications, including *The Nation*, *The Guardian*, Salon, and *The Chronicle of Higher Education*. She also serves as the executive vice president and secretary for the International Association for Feminist Economics and as moderator of the organization's blog, "Feminist Economics Posts." Bahn received both her doctorate and master of science in economics from The New School for Social Research, where she also worked as a researcher for the Schwartz Center for Economic Policy Analysis.

**Adriana Kugler** is a professor at the McCourt School of Public Policy at Georgetown University. She is a research associate of the National Bureau of Economic Research and a research fellow at the Center for American Progress, the Center Economic Policy Research, the Institute of Advanced Studies, and the Stanford Center of Poverty and Inequality. She served as chief economist of the U.S. Department of Labor in 2011 and 2012, where she worked on developing policies on unemployment insurance, worker-training programs, retirement benefits, and occupational safety regulations, among others. Her academic work includes contributions on the impact of labor market policies (including payroll taxes, unemployment insurance, employment protection legislation, and occupational licensing) on employment. She currently serves on the Technical Advisory Committee of the U.S. Bureau of Labor Statistics and was on the Committee of Visitors of the National Science Foundation's Division of Social and Economic Science. She earned her doctorate from the University of California at Berkeley.

**Melissa Holly Mahoney** is an assistant professor of economics at the University of North Carolina at Asheville. Her work focuses on the economics of well-being, gender, and public K-12 education. She has conducted research in these areas in wide detail, from Amartya Sen's capability approach to economic development to the assessment of measured economic well-being of American households. She has also worked at the Levy Economics Institute of Bard College on their extended-income measure, and on policy issues related to gender equality, economic vulnerability, human resilience, and human development while working at the United Nations in New York. Mahoney received her doctorate in economics from The New School for Social Research.

**Danielle Corley** is a research assistant for Women's Economic Policy at the Center for American Progress. She contributes to research on work-family policy; women's and family economic security; and women's leadership. Prior to joining the Center, she worked in the Disability Policy and Oversight Office of the U.S. Senate Health, Education, Labor, and Pensions Committee and interned in the Texas Senate.

**Annie McGrew** is a special assistant for Economic Policy at the Center for American Progress. Prior to joining the Center, she interned at the Federal Reserve Bank of Atlanta in their community and economic development department. McGrew graduated from Emory University with a dual degree in economics and Latin American studies in May 2016.

# Methodological appendix

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## Data

All analysis was done with state-by-state differences in reproductive health care access compiled with data from the Guttmacher Institute and the National Conference of State Legislatures linked with the CPS ORG. Positive indicators of access to reproductive health care include insurance coverage of Food and Drug Administration-approved prescription contraceptive drugs and devices;<sup>103</sup> expanded eligibility for Medicaid coverage of family-planning services;<sup>104</sup> insurance coverage of infertility treatments;<sup>105</sup> and the availability of public funding for all or most medically necessary abortions.<sup>106</sup> Indicators of more limited reproductive rights access include targeted regulations of abortion providers (TRAP) laws,<sup>107</sup> whether more than one-quarter of women ages 15 through 44 live in counties without an abortion provider,<sup>108</sup> mandatory waiting periods,<sup>109</sup> mandatory ultrasounds,<sup>110</sup> and restrictions of “late-term” abortions.<sup>111</sup> The indicators used were the same for summary statistics and regressions, with the exception of mandatory ultrasounds, which were excluded from the negative indicators used in the summary statistics due to the fact that mandatory ultrasounds are very common.

All indicators were compiled from Guttmacher Institute data except for state laws making infertility treatment more accessible, which was compiled from National Conference of State Legislatures data. Additionally, all indicators use 2017 data except for state laws governing infertility treatments and data on whether more than one-quarter of women live in states without an abortion provider—these two data points use the earliest available data, which is from 2014.

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## Summary statistics

All summary statistics are from the years 2014 through 2016 and are for individuals of reproductive age—18 through 50 years old. Of all reproductive-age women, 9.5 percent—6.5 million women—live in states with greater reproductive health care access and 27 percent—18.8 million—live in states with more limited reproductive health care access.

The authors of this report also ran summary statistics for unemployment rates, employment-to-population ratios (EPOP), and labor force participation rates (LFP) for the reproductive-age population, millennials, and low-income people. All the results were the same: Unemployment rates are slightly higher, and EPOP and LFP are lower, in states with greater reproductive rights—positive indicator states. It is unclear why unemployment would be higher and EPOP and LFP be lower in PI states, but perhaps because these are higher-income states overall, there is an income effect.

**TABLE A1**  
**Unemployment rates for reproductive-age men and women**

	Women	Men
National	5.8%	5.9%
States with greater reproductive health care access	5.8%	6.3%*
States with limited reproductive health care access	5.6%	5.5%*

\* The difference between states with greater reproductive health care access and those with limited reproductive health care access is significant at the 5 percent level.

Note: Data are for 2014 through 2016 and for men and women of reproductive age—18 through 50 years old.

Sources: Center for Economic and Policy Research, "CPS ORG DATA," available at <http://ceprdata.org/cps-uniform-data-extracts/cps-outgoing-rotation-group/cps-org-data/> (last accessed October 2017). State-level data on indicators of reproductive health care access are from the Guttmacher Institute and the National Conference of State Legislatures. See Methodological Appendix for more detail.

**TABLE A2**  
**Employment-to-population ratios for reproductive-age men and women**

	Women	Men
National	67.6%	79.1%
States with greater reproductive health care access	67.2%*	76.1%**
States with limited reproductive health care access	67.4%*	80.0%**

\* The difference between states with greater reproductive health care access and those with limited reproductive health care access is significant at the 5 percent level.

\*\* The difference between states with greater reproductive health care access and those with limited reproductive health care access is significant at the 1 percent level.

Note: Data are for 2014 through 2016 and for men and women of reproductive age—18 through 50 years old.

Sources: Center for Economic and Policy Research, "CPS ORG DATA," available at <http://ceprdata.org/cps-uniform-data-extracts/cps-outgoing-rotation-group/cps-org-data/> (last accessed October 2017). State-level data on indicators of reproductive health care access are from the Guttmacher Institute and the National Conference of State Legislatures. See Methodological Appendix for more detail.

**TABLE A3**  
**Labor force participation rates for reproductive-age men and women**

	Women	Men
National	71.8%	84.1%
States with greater reproductive health care access	71.4%*	81.2%*
States with limited reproductive health care access	71.4%*	84.7%*

\* The difference between states with greater reproductive health care access and those with limited reproductive health care access is significant at the 1 percent level.

Note: Data are for 2014 through 2016 and for men and women of reproductive age—18 through 50 years old.

Sources: Center for Economic and Policy Research, "CPS ORG DATA," available at <http://ceprdata.org/cps-uniform-data-extracts/cps-outgoing-rotation-group/cps-org-data/> (last accessed October 2017). State-level data on indicators of reproductive health care access are from the Guttmacher Institute and the National Conference of State Legislatures. See Methodological Appendix for more detail.

One thing to note from the tables above is that the difference in unemployment rate, EPOP, and LFP between states with positive indicators and those with negative indicators is smaller for women than for men. The variation in women's unemployment, EPOP, and LFP appears to be smaller across states than it is for men's.

## Regression analysis

To understand how variations affect women's labor market outcomes, the authors ran regressions on job lock and employment opportunity using CPS ORG transitions, by merging identical individuals from 2015 through 2016, merged with the indicators from the Guttmacher Institute and the National Conference of State Legislatures. Regressions were on a binary transition—between occupations, from unemployment to employment, and from not in the labor force to employment—for all women of reproductive age and for men of the same age as control group, depending on reproductive health care access metrics and common economic indicators that could affect transition, including a control for race, age, marital status, union status, and education level. Linear probability models were used because of their appropriateness in measuring binary dependent outcomes for binary independent indicators.

The most consistent finding across regressions has been the statistically significant impact of abortion rights and access, as measured by state funding for abortion under Medicaid and TRAP laws. These findings were limited to the likelihood for occupational change for women, with no significance for occupational change to a higher median wage occupation for public funding for abortion, and the likelihood of transition from unemployment to employment for both women and men.

Living in a state with funding for abortion through Medicaid increased the likelihood of transitioning to another occupation by 1.5 percent for women, with no significant impact on men, as expected. There was not a statistically significant effect for either women or men in the likelihood of transitioning to a higher paid occupation in those states.

**TABLE A4**  
**Likelihood of occupational transition, public funding for abortion**

Effect of public funding for abortion

Variables	Effect on female occupational mobility	Effect on male occupational mobility	Effect on female occupational mobility to higher-paying occupation	Effect on male occupational mobility to higher-paying occupation
Public abortion funding	0.0151*	-0.014	0.010	-0.003
	(0.009)	(0.009)	(0.008)	(0.008)
Race control	0.001	0.002	-0.000	-0.004
	(0.004)	(0.004)	(0.004)	(0.004)
Age	-0.00339***	-0.00473***	-0.00303***	-0.00422***
	(0.001)	(0.001)	(0.000)	(0.000)
Marital status	-0.0353***	-0.0231**	-0.003	-0.005
	(0.009)	(0.009)	(0.008)	(0.008)
Union	-0.144***	-0.0856***	-0.0604***	-0.0373***
	(0.013)	(0.013)	(0.011)	(0.011)
Education level	-0.0176***	-0.002	0.000	0.00814**
	(0.004)	(0.004)	(0.004)	(0.003)
Constant	0.720***	0.744***	0.372***	0.414***
	(0.024)	(0.022)	(0.021)	(0.020)
Observations	16,937	18,275	16,937	18,275
R-squared	0.02	0.014	0.007	0.009

Note: Robust standard errors in parentheses: \*\*\* p<0.01, \*\* p<0.05, \* p<0.1. Data are for 2014 through 2016 and for men and women of reproductive age—18 through 50 years old.

Sources: Center for Economic and Policy Research, "CPS ORG DATA," available at <http://ceprdata.org/cps-uniform-data-extracts/cps-outgoing-rotation-group/cps-org-data/> (last accessed October 2017). State-level data on indicators of reproductive health care access are from the Guttmacher Institute and the National Conference of State Legislatures. See Methodological Appendix for more detail.

States' TRAP laws have a negative effect on the occupational mobility of women, both in transition to any occupation as well as transition to an occupation with higher pay. Women living in these states are 1.9 percent less likely to transition to another occupation and 1.6 percent less likely to transition to an occupation with a higher median wage. There was no statistically significant effect on men.

TABLE A5

### Likelihood of occupational transition, TRAP laws

Effect of TRAP laws

Variables	Effect on female occupational mobility	Effect on male occupational mobility	Effect on female occupational mobility to higher-paying occupation	Effect on male occupational mobility to higher-paying occupation
TRAP laws	-0.0185** (0.009)	-0.002 (0.008)	-0.0161** (0.008)	-0.003 (0.008)
Race control	0.001 (0.004)	0.001 (0.004)	-0.000 (0.004)	-0.004 (0.004)
Age	-0.00339*** (0.001)	-0.00474*** (0.001)	-0.00304*** (0.000)	-0.00423*** (0.000)
Marital status	-0.0356*** (0.009)	-0.0226** (0.009)	-0.003 (0.008)	-0.005 (0.008)
Union	-0.144*** (0.013)	-0.0884*** (0.013)	-0.0613*** (0.011)	-0.0382*** (0.011)
Education level	-0.0175*** (0.004)	-0.002 (0.004)	0.000 (0.004)	0.00800** (0.003)
Constant	0.736*** (0.024)	0.744*** (0.022)	0.385*** (0.022)	0.416*** (0.021)
Observations	16,937	18,275	16,937	18,275
R-squared	0.02	0.014	0.007	0.009

Notes: Robust standard errors in parentheses: \*\*\* p<0.01, \*\* p<0.05, \* p<0.1. Data are for 2014 through 2016 and for men and women of reproductive age—18 through 50 years old.

Sources: Center for Economic and Policy Research, "CPS ORG DATA," available at <http://ceprdata.org/cps-uniform-data-extracts/cps-outgoing-rotation-group/cps-org-data/> (last accessed October 2017). State-level data on indicators of reproductive health care access are from the Guttmacher Institute and the National Conference of State Legislatures. See Methodological Appendix for more detail.

TABLE A6

## Likelihood of occupational transition, full specification

Variables	Full specification on female occupational mobility	Full specification on male occupational mobility	Full specification on female occupational mobility to higher-paying occupation	Full specification on male occupational mobility to higher-paying occupation
Contraceptive coverage	-0.011 (0.010)	-0.008 (0.009)	-0.002 (0.009)	-0.003 (0.008)
Family planning	-0.008 (0.010)	-0.007 (0.009)	0.003 (0.008)	-0.006 (0.008)
Public abortion funding	0.015 (0.014)	-0.014 (0.013)	0.008 (0.012)	0.004 (0.012)
TRAP laws	-0.0292** (0.013)	-0.0218* (0.013)	-0.0272** (0.011)	-0.0209* (0.011)
Provider density	0.012 (0.013)	0.007 (0.013)	0.012 (0.012)	0.001 (0.011)
Mandatory ultrasound	0.0224* (0.013)	0.006 (0.012)	0.0233** (0.011)	0.0240** (0.011)
Mandatory waiting period	-0.008 (0.017)	0.004 (0.016)	-0.007 (0.015)	0.005 (0.014)
Race control	-5.83E-5 (0.004)	0.002 (0.004)	-0.001 (0.004)	-0.004 (0.004)
Age control	-0.00338*** (0.001)	-0.00474*** (0.001)	-0.00304*** (0.000)	-0.00424*** (0.000)
Marital status	-0.0361*** (0.009)	-0.0233** (0.009)	-0.003 (0.008)	-0.005 (0.008)
Union	-0.145*** (0.013)	-0.0862*** (0.013)	-0.0609*** (0.011)	-0.0369*** (0.011)
Education level	-0.0175*** (0.004)	-0.002 (0.004)	0.001 (0.004)	0.00815** (0.003)
Constant	0.737*** (0.029)	0.756*** (0.028)	0.377*** (0.026)	0.419*** (0.025)
Observations	16,937	18,275	16,937	18,275
R-squared	0.021	0.014	0.007	0.009

Notes: Robust standard errors in parentheses: \*\*\* p<0.01, \*\* p<0.05, \* p<0.1. Data are for 2014 through 2016 and for men and women of reproductive age—18 through 50 years old.

Sources: Center for Economic and Policy Research, "CPS ORG DATA," available at <http://ceprdata.org/cps-uniform-data-extracts/cps-outgoing-rotation-group/cps-org-data/> (last accessed October 2017). State-level data on indicators of reproductive health care access are from the Guttmacher Institute and the National Conference of State Legislatures. See Methodological Appendix for more detail.

The full specification on occupational mobility showed no statistically significant effect of almost all the variables measuring reproductive health care access, and frequently, there were signs in the opposite direction, with the exception of the significant, negative effect of TRAP laws, as expected. However, the effect was statistically significant for both women and men, although with a marginally stronger effect for women.

Regressions on the full specification were also run separately for each racial/ethnic demographic in the data set—white, black, Hispanic, and other, primarily Asian—with little explanatory power of the metrics for reproductive health care access. The one exception was insurance coverage of contraceptives having a negative effect of a 4.6 percent decreased likelihood of occupational mobility for Hispanic women and no effect on Hispanic men.

Linear probability models were also run for likelihood of transition from unemployment to employment for each variable separately as well as the full specification. Public funding for abortion had a significant positive effect of a 1.6 percent increased likelihood of transition from unemployment to employment for both women and men. TRAP laws also have a significant and negative effect for both women and men, with a decreased likelihood of transition to employment from unemployment of 1.5 percent for women and of 0.8 percent for men. States with low abortion provider density also had a significant and negative (as expected) effect on transition from unemployment to employment for both women and men, with a decreased likelihood of transition to employment of 1.5 percent for women and of 0.9 percent for men.

Linear probability models were also run for the likelihood of transition from being out of the labor force (not working and actively seeking work) into employment for each variable and the full specification. There a significant and negative effect of low abortion provider density within a state of 1 percent for women and 0.7 percent for men. Public funding for abortion and TRAP laws continued to be significant for both men and women, and signs were in the expected direction. Public funding for abortion increased the likelihood 1.1 percent for women and 1.2 percent for men. TRAP laws decreased the likelihood 0.9 percent for women and 0.7 percent for men.

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## Endnotes

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The Center for American Progress is an independent, nonpartisan policy institute that is dedicated to improving the lives of all Americans, through bold, progressive ideas, as well as strong leadership and concerted action. Our aim is not just to change the conversation, but to change the country.

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As progressives, we believe America should be a land of boundless opportunity, where people can climb the ladder of economic mobility. We believe we owe it to future generations to protect the planet and promote peace and shared global prosperity.

And we believe an effective government can earn the trust of the American people, champion the common good over narrow self-interest, and harness the strength of our diversity.

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We develop new policy ideas, challenge the media to cover the issues that truly matter, and shape the national debate. With policy teams in major issue areas, American Progress can think creatively at the cross-section of traditional boundaries to develop ideas for policymakers that lead to real change. By employing an extensive communications and outreach effort that we adapt to a rapidly changing media landscape, we move our ideas aggressively in the national policy debate.

