From Access to Wellness: Early Life Exposure to Abortion Legalization and the Next Generation's Health[*]

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Abstract

We examine the multigenerational impacts of legalized abortion in the United States by analyzing how early-life exposure to this policy shift affects birth outcomes in the next generation. Using event study and two-way fixed effects models, we link maternal early-life exposure to legal abortion with improved birth outcomes in the subsequent generation, including higher birth weights and reduced rates of low birth weight. Our analysis of the mechanisms shows that these improvements in birth outcomes are not driven by changes in maternal racial or age composition within the treated generation. Instead, enhanced educational attainment and increased prenatal care utilization among the treated generation appear to play a critical role. Our results highlight the far-reaching implications of reproductive health policies, especially relevant in the post-Dobbs era, where access may once again become constrained for many.

Keywords: Abortion, Roe v. Wade, Infant Health, Intergenerational Effects, Dobbs v. Jackson Women's Health Organization

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1. Introduction

Legal abortion has gained renewed attention following the Supreme Court's decision in Dobbs v. Jackson Women's Health Organization, which overturned Roe v. Wade. This ruling has profound implications for women's reproductive rights and access to abortion services, with potential long-term effects on maternal and infant health outcomes. Research suggests that access to safe, legal abortion provides women with greater control over their reproductive choices, reducing unwanted or mistimed pregnancies (Levine et al., 1999; Myers, 2017). This, in turn, may lead to better prenatal care and improved birth outcomes for future generations.

In this study, we investigate the multigenerational impacts of one of the most transformative public health interventions of the 20th century: the legalization of abortion in the United States during the early 1970s. By giving women greater autonomy over their reproductive choices, this policy shift had widespread social, economic, and health implications. We build on prior research that demonstrates the short-term benefits of legal abortion for the first generation to explore whether these positive effects carry forward to the next generation.

We use natality data from 1970 to 2020 and implement two-way fixed effects models to study how legal abortion access in early life affects birth outcomes across generations. Specifically, we examine children whose mothers were exposed to legal abortion during childhood, calling them the "second generation." To explore possible mechanisms, we also study these mothers, women born between 1960 and 1980 who directly exposed to abortion legalization in their early years, referring to them as the "first generation." Finally, we consider their mothers, who gave birth between 1960 and 1980, labeling them the "zeroth generation."

We find that the first generation's exposure to legal abortion leads to a statistically significant increase in the second generation's birth weight and reduces the incidence of very low birth weight and small-for-gestational-age. These outcomes are of particular interest for second-generation analysis, as birth weight strongly predicts health and economic outcomes later in life (Almond et al., 2018; Almond & Currie, 2011). Event study analyses rule out concerns that these effects reflect pre-existing trends in birth outcomes. Further, we show that the effects are robust to alternative specifications and new methods introduced by (Sun & Abraham, 2021), which address biases often encountered in traditional two-way fixed effects and event study models.

Our analysis of the mechanisms shows that the improvements in birth outcomes of the second generation are not driven by shifts in racial composition or maternal age in the first generation who were exposed to legal abortion in early life. Instead, enhanced first-generation education and increased prenatal care utilization appear to play a critical role. Exposure is linked to higher high school and college completion rates among the first generation, more frequent prenatal visits, and earlier initiation of care, all of which likely contribute to better outcomes for the second generation. Additionally, exposure to legal abortion is associated with improved birth outcomes among the first generation. Since mothers' low birth weight is linked to their child's low birth weight (Currie & Moretti, 2007), this improvement in first-generation birth outcomes could partly explain the better overall birth outcomes in the second generation.

This paper contributes to two strands of literature. First, it adds to the ongoing literature on the "fetal origins hypothesis." While most causal studies in this area focus exclusively on the treated cohorts (Almond et al., 2018), we extend this research by using a quasi-experimental design to document multigenerational effects that reach beyond the initially treated cohorts.

Second, this paper contributes to the literature on how early-life health experiences affect later offspring. Most studies in this area have focused on exposure to extreme events, such as famines or disease outbreaks, which may not fully capture the effects of more common and modifiable health exposures. Notable exceptions include East et al. (2023), who examined the intergenerational impact of Medicaid expansions, and Colmer & Voorheis (2020), who studied the 1970 Clean Air Act. Our study adds to this literature by documenting the multigenerational effects of one of the most transformative public health interventions of the 20th century. This evidence is particularly relevant in light of the recent Supreme Court decision in Dobbs v. Jackson Women's Health Organization. By demonstrating significant intergenerational effects, our findings suggest that changes in reproductive healthcare access may have lasting impacts, extending beyond those directly affected to future generations.

In addition to the aforementioned studies, our paper closely aligns with recent studies examining the effects of in utero exposure to abortion legalization in the United States during the early 1970s on later-life disability, mortality, and longevity. Farin (2024) reports a positive impact of in utero exposure to legal abortion on midlife survival probability, with an increase of roughly 3%. Noghanibehambari et al. (2024) focus on adult mortality and disability outcomes, finding that in utero exposure to legalized abortion is associated with a 3.8% reduction in adult cumulative mortality rates and an approximate 4.5% reduction in disability. Lutchen (2011) documents a reduction in mortality rates over the age range of 20–30 by approximately 3%. Building on this foundation, our paper provides evidence that the benefits extend beyond longevity: the first generation not only had higher survival rates during the first and fifth decades of life but also has healthier offspring, highlighting intergenerational health gains associated with early-life policy changes.

The remainder of our paper is organized as follows: Section 2 provides background on abortion legislation in the 1960s-1970s and reviews related literature. Section 3 outlines our empirical strategy, and Section 4 describes the data used in our analysis. Section 5 presents the results, followed by Section 6, which examines the underlying mechanisms. Finally, Section 7 concludes with a summary of findings and implications.

2. Background

2.1. Related literature

Previous research has demonstrated that the legalization of abortion in the late 1960s and early 1970s had far-reaching impacts on a variety of socioeconomic outcomes. These include improvements in educational attainment and female labor force participation, changes in family structure and fertility rates, and according to some studies, a reduction in crime rates (Ananat et al., 2009; Angrist et al., 2012; Donohue & Levitt, 2020, 2001, 2008; Foote & Goetz, 2008; Gruber et al., 1999; Kalist, 2004; Melanie, 2008; C. K. Myers, 2017). However, the relationship between abortion legalization to lower crime rates remains contested, with other research finding no clear evidence of a causal effect (Joyce, 2004, 2009). (Gruber et al., 1999) sought to explain the observed changes in socioeconomic outcomes following the legalization of abortion through what they called the "marginal child" hypothesis. They argued that the children who were not born because of increased access to legal abortion—referred to as "marginal children"—would have been more likely to experience adverse socioeconomic conditions had they been born.

The literature also underscores that legal abortion access significantly reduced maternal mortality, decreased infant mortality, and improved infant health (Farin et al., 2024; Gruber et al., 1999; Joyce, 1987). Of particular importance to our study, (Currie & Moretti, 2007) demonstrate that a mother born with low birth weight is significantly more likely to have a child with low birth weight. This raises the natural question of whether the impacts of legal abortion on the first generation persist into the next generation. Our study seeks to examine whether the socioeconomic and health effects of abortion access for mothers translate into long-term effects on their children's birth outcomes.

Research on the multigenerational impacts of early-life exposures is growing. (Almond et al., 2006) examine the significant drop in Black infant mortality following the Civil Rights Act and find that Black women born during this period were less likely to have low birth weight babies. Similarly, (Almond et al., 2012) show that higher infant mortality rates, serving as a proxy for disease exposure, are linked to worse long-term health outcomes and a higher likelihood of future offspring being born underweight. (Colmer & Voorheis, 2020) document improved educational outcomes for the grandchildren of those exposed to pollution reductions following the 1970 Clean Air Act amendments. (East et al., 2023) investigate the multigenerational impacts of prenatal Medicaid eligibility expansions, finding that the health benefits of early-life program exposure extend to the next generation.

International studies offer further evidence. (Painter et al., 2008) find that the offspring of individuals exposed to the Dutch Hunger Winter of 1944–1945 in utero experienced poorer health in later life. (Almond et al., 2010) similarly report increased low birth weight in the next generation following fetal exposure to the 1959–1961 Chinese famine. (Richter & Robling, 2013) show that in-utero exposure to the 1918–1919 influenza pandemic reduced educational attainment in the children of those affected in Sweden, while (Black et al., 2019) link in-utero exposure to radioactive fallout in Norway with lower cognitive ability in their offspring.

We build on this growing body of research by exploiting policy-driven changes in access to legal abortion, a key aspect of reproductive rights in the U.S. In doing so, we shed light on the intergenerational benefits of legal abortion, which have not been examined in previous studies.

2.2. Abortion Legislation in the 1960s and 1970s: The Road to Roe v. Wade

In the 1960s, abortion was illegal in nearly every U.S. state, with only a handful permitting it in cases where the mother's life was at risk (Droegemueller et al., 1969). By the mid-1960s, however, states began to address this stark landscape. The first wave of change came from "reform" states, which modified their criminal abortion laws to allow the procedure in specific cases. In 1967, Colorado became the first state to reform its abortion laws, marking the beginning of a broader movement across the United States (Myers, 2024). Colorado's law allowed abortion in cases of rape, incest, severe birth defects, or when there was a substantial risk to the mother's physical or mental health (Lamm, 1971). Following Colorado, other states began reforming their abortion laws, allowing limited access under specific conditions. By 1972, 13 states had enacted similar reforms (Myers, 2024).[5]

While these states allowed abortion under restricted conditions, they stopped short of full legalization. By the end of the 1960s, however, another group of states—referred to as "repeal" states—went further. Beginning with California in 1969, these states fully repealed their criminal abortion laws, permitting the procedure without the same strict limitations (Myers, 2024). In 1970, Alaska, Hawaii, New York, and Washington joined California in legalizing abortion (Myers, 2024). Washington, D.C., also allowed abortion from 1971 following a court ruling (Myers, 2024).

This gradual shift in state laws set the stage for the landmark 1973 Roe v. Wade decision, which effectively overturned state-level restrictions on abortion. The Supreme Court's ruling in Roe legalized abortion nationwide, establishing the constitutional right to access abortion and marking a significant turning point in reproductive rights across the United States.

[5] The "reform" states that enacted more limited changes to their abortion laws during the late 1960s and early 1970s include California, Colorado, and North Carolina in 1967; Maryland in 1968; Arkansas, Delaware, Georgia, New Mexico, and Oregon in 1969; Kansas, South Carolina, and Virginia in 1970; and Florida in 1972.

2.3. Mechanisms Through Which Legal Abortion Affects Subsequent Generations' Birth Outcomes

A key mechanism through which expanded access to reproductive rights and services, such as the legalization of abortion, can impact the health and well-being of subsequent generations is the *selection effect*. This effect can prevent the birth of "marginal children"—those more likely to be born into adverse circumstances (Gruber et al., 1999).

An emerging body of theoretical and empirical research suggests that expanded access to reproductive rights and services—including the legalization of abortion in the 1970s—could have significant, unintended impacts on the health and well-being of subsequent generations through selection effects. For instance, greater access to reproductive health services can impact the timing of parenthood, potentially reducing teenage pregnancies, which are associated with various short- and long-term health costs for both mothers and infants (Branson & Byker, 2018; Heiland et al., 2019; Hotz et al., 2005; Ribar, 1994, 1996; Schulkind & Sandler, 2019). Such policies may also shift demographic patterns by altering cohort characteristics, particularly through differential rates of teenage pregnancies across various sociodemographic groups (Geronimus, 2003; Kearney & Levine, 2015; Santelli & Melnikas, 2010). This selection mechanism has also been observed in recent policies restricting reproductive healthcare access. For example, (Caraher, 2024) examines Texas's 2021 six-week abortion ban and finds it reduced abortion rates by 40%, increased fertility by 4%, raised very low birth weight incidence by 7 percentage points, and led to a 6% rise in infant mortality, with the most severe effects on Black non-Hispanic women and those far from less restrictive states.

The legalization of abortion might improve health outcomes for children born to parents who actively choose to become parents (Bozzoli et al., 2009; Nobles & Hamoudi, 2019). Changes in fertility rates and family size may also play a critical role. Smaller family sizes allow for increased resource allocation per child, including time, nutrition, and investments in human capital (Blake, 1981a; Conley & Glauber, 2006; Fletcher & Kim, 2019; Frenette, 2011). Reduced fertility also lowers the cost associated with enhancing child quality, encouraging parental investments (Becker & Lewis, 1973). Delayed or fewer births among teenagers may also increase personal resources and time for human capital development and labor market entry (Angrist et al., 2012; Bailey et al., 2012; Goldin & Katz, 2002; Miller et al., 2023).

In turn, parent's higher educational attainment and work experience can lead to improved labor market outcomes, which in turn benefit children in both the short and long run (Aizer et al., 2016; D. Almond et al., 2018; Chen & Li, 2009; Lindo, 2011). Reduced teenage childbearing might also delay unplanned marriages and improve partner matching, leading to increased family income and marital stability, which further enhance children's outcomes (Choo & Siow, 2006; Forsstrom, 2021; Frimmel et al., 2024; Goldin & Katz, 2000; Gruber, 2004).

Additionally, legalization of abortion may affect cohort sizes by reducing overall fertility rates, with potential advantages for school resources (via smaller class sizes), educational attainment, and wage outcomes (due to reduced labor supply and competition) (Bound & Turner, 2007; Brunello, 2009; Connelly, 1986; Morin, 2015; Reiling, 2016).

Moreover, abortion legalization, and more generally, improvements in reproductive healthcare access, may also change the composition of the labor market with implications for child outcomes. (Herbst & Tekin, 2025) examine how the expansion of oral contraceptives and abortion access in the 1960s and 1970s reshaped the child care labor market. They find that these reproductive policies led to a decline in the share of highly educated women in the child care workforce, increasing the proportion of lower-skilled workers, which in turn reduced average wages and potentially impacted the quality of child care services.

A second potential channel through which abortion access can improve the health of subsequent generations is through *healing effects*. By reducing maternal stress and encouraging the utilization of prenatal care, abortion access may lead to healthier birth outcomes for children who are carried to term.

While theoretical insights suggest that in utero exposure to legalized abortion may yield long-term benefits, empirical evidence is still needed to confirm these effects on maternal and infant health outcomes. This paper aims to address this research gap.

3. Empirical Strategy

Our empirical strategy compares birth outcomes of mothers who were born in different years relative to the birth-state-specific year of abortion legalization. We operationalize these comparisons using event study specifications of the following forms:

$$y_{cbrstg} = \alpha + \sum_{i=\underline{T}}^{-5} \gamma_i I(c - T_b^* = i) + \sum_{j=0}^{\overline{T}} \lambda_j I(c - T_b^* = j) + \beta Z_{cbr} + \Theta_g + \Gamma_{\mathrm{rc}} + \Lambda_b + \Omega_s + \Psi_t + \varepsilon_{cbrstg} \quad (1)$$

Where y is the average birth outcome of mothers who belong to birth cohort c, born in state b in census region r, currently reside in state s, and are observed in year t, and categorized in a sociodemographic group g. The sociodemographic group is based on race (white, Black, other), maternal education (less than eight years, between 9–12 years, more than 12 years), maternal age (12-18, 19-39, 40-54), maternal pregnancy order (first-time mother, second-and-higher birth orders), and child gender (female, male). The function $I(.)$ is an indicator function that turns on if its inside argument is true. The parameter T_b^* represents the year abortion was legalized in each state. Therefore, the parameters γ and λ measure differences in birth outcomes of the second generation in states with early legalization compared to other states.

The matrix Z includes several maternal birth state-by-birth year covariates, including real per capita income, hospital beds per capita, hospitals per capita, average disease rate, and measures of state–cohort exposure to Aid to Families with Dependent Children (AFDC), Medicaid, and Fair Employment Practices Act (FEPA).[6]

The parameter Θ includes dummies for maternal race, maternal education, maternal age, birth order, and child gender. The parameter Γ represents birth cohort-by-birth region fixed effects, which accounts for the cross-cohort convergence of health outcomes across Census regions (Goodman-Bacon, 2021). Cohort fixed effects also account for the overall evolution of birth outcomes based on maternal cohort and all temporal changes in health technology, and relevant economic and social policies that affect cohorts within a census region. The parameter Λ contains birth state fixed effects to absorb time-invariant unobservable characteristics of states that affect individuals' long-term outcomes, including maternal birth outcomes. The parameters Ω and Ψ represent current state and current year fixed effects to account for time-invariant place-specific unobserved characteristics and place-invariant temporal features that affect birth outcomes. Standard errors are clustered on maternal birth state and birth year to account for both serial and spatial correlations in error terms. The regressions are weighted using the number of births in each collapsed cell.

[6] In Appendix Table B-13, we control for the potential influence of variations in contraception pill access across states and cohorts. Our results remain robust even after incorporating controls for pill policies.

To summarize the event study coefficients, we also estimate the effects on a dummy variable indicating maternal birth year being after the birth-state-specific year of abortion legalization (Exp), using the following formula:

$$y_{cbrstg} = \alpha + \eta Exp_{cbr} + \beta Z_{cbr} + \Theta_g + \Gamma_{\text{rc}} + \Lambda_b + \Omega_s + \Psi_t + \varepsilon_{cbrstg} \quad (2)$$

All parameters and covariates are similar to those of equation (1). All regressions are implemented using the difference-in-differences method developed by (Sun & Abraham, 2021).

4. Data

The primary source of data comes from natality detailed files of the National Center for Health Statistics (NCHS, 2020). The restricted-access version of the NCHS data provides mothers' state of birth, an important identifier in our setting. The data includes limited maternal sociodemographic information, including age, race, education, and marital status. It also reports several crucial infants' characteristics, including gender and birth order, as well as information on their health at birth, including birth weight and gestational age.

We remove observations with missing values for the primary variables in our empirical method, which accounts for less than 1% of the total sample. We also exclude mothers born outside of the US, eliminating 10.8% of observations. In addition, we restrict the sample to mothers born between 1960 and 1980 to capture multiple cohorts born before and after abortion legalization. These restrictions result in a sample of roughly 68 million births to these mothers. We collapse the sample at the following levels: mother's birth state, mother's birth year, current state, current year, maternal race (white, Black, other), maternal education (less than eight years, between 9 – 12 years, more than 12 years), maternal age (12-18, 19-39, 40-54), maternal pregnancy order (first-time mother, second-and-higher birth orders), and child gender (female, male).

We use data from several sources to construct state by year panel of covariates covering the years 1960 – 1980. First, we construct total reported disease per capita using the state-level disease inventory collected by the Tycho project (Tycho, 2021). Second, we extract the information on state-level Aid to Families with Dependent Children (AFDC) as well as measures of income per capita and hospital per capita from (Goodman-Bacon, 2018). We obtain state-level information on the Fair Employment Practices Act from (Farin et al., 2024).

Outcome Variables. We use birth weight and gestational age as the primary outcomes of interest, while constructing several derivative outcomes as follows. As an adverse outcome related to birth weight, we generate a dummy variable for low birth weight, indicating birth weight less than 2,500 g. This is a conventional threshold in the literature, and several studies document associations between low birth weight and adverse developmental outcomes throughout the life course (Bharadwaj et al., 2018; Currie & Moretti, 2007; Fletcher, 2011). As another standard adverse outcome related to gestational age, we define preterm birth as indicating gestational age under 37 weeks. Since birth weight and gestational age are mechanically linked, it is useful to disentangle the influences of birth weight from those of gestational age. To do so, we focus on fetal growth, which measures the intrauterine weekly weight gain of infants, i.e., birth weight divided by gestational age. In addition, we define a dummy variable to measure the birth weight rank of an infant within their gestational week of birth. The small-for-gestational-age (SGA) variable is defined as a dummy indicating that the infant's birth weight falls in the bottom decile of the birth weight distribution for their gestational week.

4.1. Defining Zeroth, First, and Second Generations and Their Outcomes

While our main analysis uses individual-level birth records from the restricted-access NCHS Natality Detail Files, our study examines outcomes across three distinct generational cohorts: zeroth generation (grandmothers), first generation (mothers), and second generation (children). This subsection defines these generational groups and explains how we construct and measure relevant outcomes for each, using a combination of individual-level and historical state-level aggregate data.

Zeroth Generation: Mothers of the First Generation. We define zeroth generation as women who gave birth between 1960 and 1980. These women are the grandmothers of the infants in our final analytic sample. To analyze fertility patterns and family structure among this group, we use state-level birth certificate data and public tabulations reported by the National Vital Statistics System (NVSS). Specifically, we calculate fertility rates for this group using annual state-level birth counts by maternal race for the years 1960 to 1980. In addition, we use publicly available natality records from the NCHS for the years 1968 to 1980 to compute the share of teenage mothers (aged 12–18) and the share of married mothers at the time of childbirth. These aggregate outcomes are explored later in the paper as part of our analysis of mechanisms, particularly to assess whether abortion legalization affected the composition of births among the previous generation.

First Generation: Mothers in the Main Sample. We define first generation as women born between 1960 and 1980, who later become mothers in our primary birth outcomes sample. Since individual-level birth data are not available for these cohorts prior to 1973, we use state-level vital statistics to construct key indicators of birth outcomes during their own infancy. Specifically, we explored the effects on state-level share of low birth weight, very low birth weight, and infant mortality, extracted from (Goodman-Bacon, 2018). These outcomes are used to characterize the early-life health environment experienced by generation one, which serves as a potential mechanism influencing second-generation health.

Second Generation: Children in the Final Sample. The second generation refers to the infants in our main analytic dataset—children born between 1970 and 2020 to mothers from the first generation (born 1960–1980). These observations are drawn from the restricted NCHS Natality Detail Files and serve as the primary unit of analysis throughout the paper.

4.2. Census-ACS Data

To explore children's longer-term outcomes, we use census 2000 and the American Community Survey 2001 – 2022 (hereafter Census – ACS data), extracted from the IPUMS project (Ruggles et al., 2024). We focus on several measures of disability. Since these measures are reported for post-childhood years, we restrict the sample to individuals at least 18 years old. Additionally, since we need to observe mothers in the household to extract birth state and birth year information, we further restrict the sample to individuals aged 26 or younger. Besides, we implement criteria consistent with the NCHS data, focusing on mothers born between 1960 and 1980.

4.3. Summary Statistics

Figure 1 shows the geographic distribution of abortion legalization across states. Figure 2 illustrates the time series evolution of preterm birth (top panel) and low birth weight (bottom panel) among mothers from the 1960–1980 birth cohorts who gave birth between 1970 and 2020. Visually, we observe a shift in these trends starting with the maternal cohorts of 1973. Additionally, early-adopting states show a sharper decline in these outcomes. While the data are aggregated, they suggest potential intergenerational effects of abortion legalization.

Table 1 reports summary statistics of the final sample for mothers born before and after abortion legalization in their state of birth, in the left and right panels, respectively. There is a slightly higher share of white mothers in the pre-legalization subsample versus the post-legalization subsample, 72.8% versus 68.5%. Both subsamples reveal quite comparable maternal education levels. The average birth weight is higher in the pre-legalization versus post-legalization subsample, 3306.8 g versus 3275.8 g. The Shares of low birth weight and preterm birth are also lower in the pre-legalization subsample compared to the post-legalization subsample, 8.2% (11.9%) versus 8.5% (12.3%). Both subsamples reveal quite similar prenatal healthcare utilization measures, including the total number of prenatal visits, whether any prenatal visits occurred, and the month prenatal care began.

The bottom panel of Table 1 reports summary statistics of the Census – ACS sample. Similar to the NCHS sample, we observe a higher share of whites in the pre-legalization subsample. We observe slightly higher incidences of cognitive disability and ambulatory disability in the post-legalization subsample versus the pre-legalization subsample. However, self-care disability is quite similar across both subsamples, at 1.2%. Vision–hearing disability is more prevalent in the post-legalization subsample than in the pre-legalization subsample, 2.2% versus 1.7%.

5. Results

5.1. Second Generation Infant Health

Figure 3, Figure 4, and Figure 5 display the event study estimates outlined in Equation (2). These figures illustrate the impact of mother's in utero exposure to legal abortion on their children's infant health, compared to children of mothers who were not exposed, across the five years preceding legalization and six years following the event. The year before the event ($t = -1$) corresponds to an omitted category and is thus normalized to zero by construction.

Figure 3 and Figure 4 demonstrate that in the five years before legalization, there is no significant difference in birth outcomes—such as birth weight, likelihood of low birth weight, gestational age, and likelihood of preterm birth—between the treatment and control groups. However, these outcomes begin to diverge a few years after legalization: infants of mothers exposed to abortion legalization exhibit improved birth outcomes compared to those of non-exposed mothers. By five years post-legalization, legal abortion is associated with an increase in birth weight of 7–8 grams, a gestational age increase of 0.07 weeks, and reductions in low birth weight by 0.4 percentage points and preterm birth by 0.6 percentage points. Although the impacts on fetal growth and small-for-gestational-age outcomes in Figure 5 are less precisely estimated, they indicate similarly positive effects.

Table 2 presents the overall difference-in-differences estimates based on Equation (1). Consistent with the event study results, we find that legal abortion led to statistically significant improvements in birth outcomes, including increases in average birth weight and fetal growth, as well as reductions in the likelihood of low birth weight and small-for-gestational-age births. The coefficient estimates indicate that legal abortion increases next generation's birth weight by 3.3 grams, or 0.1% relative to the mean (column 1), and decreases the likelihood of low birth weight by 1.6% (column 2). Additionally, exposure to legal abortion is associated with a 0.07-gram per week reduction in fetal growth, relative to a mean of 85 grams per week, corresponding to a 0.08% decrease. It is also linked to a 0.1 percentage point reduction in the likelihood of small-for-gestational-age births, or a 1.2% decrease relative to the mean.[7]

To better understand the magnitude of these effects, we can compare them to the documented intergenerational impacts of other early-life maternal exposures on second-generation

[7] We also examine whether early-life exposure to legalized abortion affects the upper tail of the birth-weight distribution, focusing on macrosomia-related outcomes. Appendix Table G-1 reports estimates using a series of thresholds from 4,000g to 4,900g. The results show no systematic effect on the likelihood of very high birth weight. Virtually all coefficients are small in magnitude and statistically insignificant across all thresholds.

birth outcomes. For instance, (East et al., 2023) employed a difference-in-difference and event study approach to explore how mothers' in-utero access to Medicaid affected second-generation birth outcomes. Their findings revealed that the 1980s Medicaid expansions resulted in a 4.7-gram increase in birth weight for the next generation. Thus, the effect of legal abortion exposure on birth weight is approximately 70% of the impact associated with Medicaid access.

Similarly, (D. Almond et al., 2012) found that higher exposure to disease increases the likelihood that future offspring are born below the low birth weight threshold. Specifically, an additional post-neonatal death in the year following birth is estimated to raise the probability of low birth weight by 0.6%. Therefore, the effect of in-utero exposure to legal abortion is comparable to an exposure reduction of approximately 2.7 fewer post-neonatal deaths.[8]

5.2. Heterogeneity Analysis

Previous research suggests that early-life exposure to legal abortion could impact maternal mortality differently by race (Farin et al., 2024). Further, male fetuses are more sensitive to negative health environments than female fetuses (Trivers & Willard, 1973). Therefore, one would expect that improvements in maternal health might disproportionately affect male fetuses. Based on this line of evidence, we examine heterogeneity in the effects of legal abortion and next-generation birth outcomes by maternal race and child gender. These results are reported in Table 3 and Table 4.

[8] It is worth noting that the magnitude of the health improvements documented in our study also complements and extends the findings of Farin (2024), Lutchen (2011), and Noghanibehambari et al. (2024). While these studies identify significant health gains in terms of mortality (2.9–3.2% reduction in adulthood cumulative mortality) and disability (4.5% reduction in adulthood disability), our study focuses on the intergenerational effects of legal abortion, demonstrating health benefits for the offspring of those exposed to legal abortion in utero. Specifically, we find that legal abortion policies are associated with modest but meaningful improvements in birth outcomes for the next generation, including a 3.3-gram increase in birth weight (0.1% of the mean), a 1.6% reduction in the likelihood of low birth weight, and a 1.2% decline in small-for-gestational-age births.

Comparing panels A and B of Table 3, we observe significant differences in the effects of early-life exposure to legal abortion based on maternal race. For white mothers (Panel A), exposure leads to a small but statistically significant increase in the second generation's birth weight (1.88 grams) and fetal growth (0.04 grams per gestational week). However, the effects on other outcomes, such as low birth weight, gestational age, preterm birth, and small-for-gestational-age (SGA), are not statistically significant.

In contrast, the impact on Black mothers (Panel B) is much more substantial and covers a broader range of outcomes. Exposure to legal abortion results in a 13.29-gram increase in birth weight and a 0.31-gram per week increase in fetal growth. Additionally, it significantly reduces the likelihood of low birth weight by 0.54 percentage points, preterm birth by 0.30 percentage points, and SGA by 0.30 percentage points. These results indicate that Black mothers experience stronger and more comprehensive benefits from early-life exposure to legal abortion compared to white mothers. This is consistent with the findings of (Farin et al., 2024), who reported that legal abortion led to a greater reduction in maternal deaths among non-white mothers compared to white mothers.

Appendix Table C-3 replicates our main analysis restricting the sample to Hispanic mothers. The effects are notably larger than in the full sample. Exposure to legal abortion increases birth weight by 15.6 grams (vs. 3.3 grams in the main sample), improves fetal growth by 0.32 grams/week (vs. 0.07), and reduces low birth weight by 0.34 percentage points (vs. 0.12). These substantially larger gains suggest that Hispanic populations, who may have faced greater structural barriers to healthcare and family planning, benefited disproportionately from expanded abortion access (Dehlendorf et al., 2010, 2013; Kim et al., 2016).

In Table 4, we examine heterogeneity in treatment effects by child gender. Panel A reports the results for female children, and Panel B presents the estimates for male children. We observe slightly larger improvements in birth weight and fetal growth among females: birth weight increases by 3.4 grams for females compared to 3.1 grams for males, and fetal growth improves by 0.08 versus 0.06 grams per week. However, when we turn to adverse birth outcomes, the relative improvements are slightly larger for male children. The effects on low birth weight, preterm birth, and small for gestational age among females are 1.4%, 0.6%, and 1.0% of the respective means, while for males these effects are 1.7%, 1.0%, and 1.3%. These patterns are broadly consistent with the "fragile male hypothesis," which suggests that male fetuses may be more susceptible to improvements or shocks to mothers (Kraemer, 2000).[9]

In Appendix Table C-1, we examine whether the effects of maternal exposure to legal abortion vary by birth order. We find that the effects are concentrated among higher-order births. For these children, birth weight increases by 4.58 grams (vs. 3.3 grams in the main sample), fetal growth improves by 0.11 grams per gestational week (vs. 0.07), and the likelihood of low birth weight falls by 0.19 percentage points (vs. 0.12). In contrast, estimates for first-borns are smaller and statistically insignificant. These stronger effects for higher-order births may reflect several mechanisms. Abortion access likely improved maternal education and health, with cumulative benefits more evident in later births. Additionally, better spacing and selective fertility may have enabled more favorable conditions for higher-parity births (Conde-Agudelo et al., 2006).

[9] In Appendix Figure C-1 through Appendix Figure C-6, we show the event studies for the heterogeneity analyses discussed in this section.

5.3. Correlates of Early Adoption

One interesting question is what factors affected early adopters to legalize abortion. Although this is an empirical question that deserves a deeper investigation beyond the scope of the current study, we can examine descriptive correlations between state characteristics and early adoption status. Specifically, we focus on the year 1968 and construct state-level data that includes several state characteristics such as income, hospital beds per capita, hospitals per capita, disease rates, an indicator of early Medicaid adoption, an indicator of early contraceptive pill legalization, and measures of the gender wage gap. To calculate the gender wage gap, we employ data from the Annual Social and Economic Supplements of the Current Population Survey (ASEC-CPS) extracted from (Flood et al., 2018). We use raw wages reported by individuals for the years 1962 – 1968 to calculate the state-level gender wage gap. Additionally, we partial out the effects of age, education, race, occupation type (272 codes), and industry (836 codes) to construct a residual gender wage gap measure.

Appendix Table A-1 shows the correlations between these characteristics and an indicator of early abortion legalization. Focusing on regressions that include region fixed effects (columns 2 and 4), we observe that income and gender wage gap are the primary factors associated with early abortion legalization. For instance, a $1,000 increase in the gender wage gap (in 2020 dollars) is correlated with a 9.6 percentage point higher probability of early adoption, based on a mean of 0.12. We should note that all regressions include these additional state covariates. In the main results of the paper, we do not include measures of the gender wage gap as the state-year panel extracted from the ASEC-CPS eliminates a significant portion of states. However, as reported in Appendix Table B-16, the results become even larger when we include this measure into our regressions.

5.4. Robustness Checks

In Appendix B, we show the robustness of the results across alternative specifications and sample selections. We document that the results are robust to the inclusion of second-generations' birth region-by-birth year fixed effects (Appendix Table B-1). The results are robust if we drop early reform states (Appendix Table B-2) and states with historically lower access to reproductive health services and more restrictive abortion culture (Appendix Table B-3).[10] Since early repeal states could serve as hubs for abortion services for neighboring states, spillovers could bias the estimates (Farin et al., 2024). In Appendix Table B-4, we find comparable and, in some cases, larger coefficients when we exclude states adjacent to early repeal states.

The results become smaller in size but remain comparable and significant for several outcomes when we include a state specific trend (Appendix Table B-5). The results are also quite comparable to the main estimates when we exclude all covariates and include only birth state and region – cohort fixed effects (Appendix Table B-6). The results are even slightly larger when we include additional maternal birth state covariates, including infant mortality rate, life expectancy, and measures of measles and polio rates interacted with birth year fixed effects (Appendix Table B-7).[11] Although standard errors are slightly inflated when we cluster them at the birth state level only, the primary coefficients remain statistically significant (Appendix Table B-8).

We observe larger effects when we weigh the regressions using a combination of birth counts and the proportion of women in the maternal birth state, as well as by interacting birth count with maternal birth state infant mortality rate (Appendix Table B-9 and Appendix Table B-10)

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[10] This sample list of states was frequently referenced in several studies (Freilich & Pridemore, 2007; Hoffmann & Johnson, 2005; Jones et al., 2008; Mouw & Sobel, 2001).

[11] Several studies point to the relevance of early life disease on long-term outcomes, including multigenerational effects on birth outcomes (Almond et al., 2012; Case et al., 2005; Case & Paxson, 2009; Noghanibehambari, 2023). Specifically, this is specification accounts for the influence of the polio vaccination campaign of 1955 and the measles vaccination campaign of 1963 (Atwood, 2022).

In Appendix Table B-11, we allow for fixed effects of states to flexibly vary across race groups and find comparable point estimates. As early-life shocks might change the propensity of individuals to migrate, we include interactions of birth state fixed effects with current state fixed effects. The results reported in Appendix Table B-12, are quite comparable to the main results. In Appendix Table B-13, we control for the potential influence of changes in contraception pill access across states and cohorts and observe comparable point estimates.

Further, the coefficient magnitudes are comparable to the main results when we utilize OLS, suggesting minimal influence of negative weighting of OLS (Appendix Table B-14). Finally, we show that the estimated effects are quite robust and even larger when we add a battery of additional maternal and paternal controls to our regressions (Appendix Table B-15).[12] Moreover, there is evidence that a large portion of the observed effects of abortion on marriage, divorce, and fertility was driven by California (Hoehn-Velasco et al., 2024). In Appendix Table B-17, we show that our results remain significant when we remove California-born mothers to mitigate the so-called *California Effect*.

Additionally, we conduct two balancing tests. First, we artificially shift the abortion years ten years earlier. The fact that the resulting point estimates become small and statistically insignificant lends credibility to the argument that our results capture the true effects of abortion (Appendix Table B-18). Second, since the effects are specific to the in utero period, we should not observe similar changes among foreign-born mothers. To test this, we assign a placebo abortion legalization exposure based on their current state of residence and replicate the analysis using these

[12] In Appendix Figure B-2 through Appendix Figure B-7, we show the event studies for the robustness analyses discussed in this section.

mothers. As expected, the estimated coefficients become small and statistically insignificant (Appendix Table B-19).

Both low birth weight and SGA are defined based on conventional but arbitrary threshold definitions. To examine the robustness of the results across alternative definitions of these variables, we generate additional dummy variables capturing alternative thresholds. For low birth weight, for example, we create dummy variables indicating whether birth weight is below values ranging from 2,000 to 3,000 grams. For SGA, we create dummy variables that capture whether a baby's birth weight falls below specific cutoffs based on deciles for each gestational week. These cutoffs range from the 1st to the 10th decile. We report these results in Figure 6. The top panels show the estimated coefficients across different thresholds and the bottom panels show the percentage change with respect to the mean of the outcomes. For low birth weight, we observe a relatively robust and constant effect across different thresholds. For birth weight rank, we observe reductions at the lower tail up to the third decile and increases in the top two deciles.

Another concern is that our estimates may be partially driven by changes in the age composition of mothers over the years. To address this issue, we begin by documenting in Appendix Figure B-1 the evolution of maternal age across birth years separately for early-adopting and late-adopting states. The figure shows that both groups exhibit nearly identical age trajectories over time. This visual evidence suggests that differential trends in maternal age are unlikely to confound our estimates. To further address this concern, we augment our baseline specification to include maternal age-by-child-birth-year fixed effects. These fixed effects flexibly absorb any secular shifts in the age distribution of mothers that may occur over time. Appendix Table B-24 reports the results of this specification.[13] The estimated effects of exposure remain extremely similar in magnitude and statistical significance to our baseline estimates.

An additional concern is that the Hyde Amendment of 1976, which restricted the use of federal funds for abortion, may have altered access to abortion services in ways that interact with our identification strategy (Adashi & Occhiogrosso, 2017). Recent evidence shows that Hyde led to increases in fertility among young women, particularly non-white women, and generated longer-run increases in reliance on public assistance that extended into the next generation (Hoehn-Velasco et al., 2025). To ensure that our findings are not driven by cohorts whose early-life exposure overlapped with the post-Hyde period, we re-estimate our main specification restricting the zeroth generation to those giving birth between 1960 and 1976. This restriction limits the analysis to cohorts whose in-utero exposure occurred fully within the pre-Hyde legal environment and correspondingly reduces the number of post-treatment years observed for these cohorts. These results, reported in Appendix Table B-21, Appendix Table B-22, and Appendix Table B-23 remain quite comparable to the main results.

A common feature of natality data is birth-weight heaping, in which medical staff round infants' weights to the nearest ounce values, creating spikes in the distribution (Blencowe et al., 2019). To ensure that such rounding does not bias our estimates, we re-estimate the main specification after removing all observations at common heaping points. As shown in Appendix Table B-20, the results are nearly identical to the baseline estimates.

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[13] The estimates from these regressions use data collapsed at all levels in the same way as the main analytic sample, but instead of creating three maternal age categories, we collapse the data by single maternal age.

5.5. Robustness to an Alternative Exposure Measure

In our main specification, which uses an indicator for whether a state had legalized abortion as the exposure measure, we implicitly assume that early-legalizing states had no effect on individuals in non-legalizing states. However, this may be unrealistic, as individuals could travel across state lines to obtain abortions. To address this, we next examine the effects of abortion legalization using an alternative exposure measure based on geographic proximity to legalized-abortion states. Specifically, instead of using our baseline exposure measure, we follow Ananat et al. (2007) and construct a *distance-based exposure* measure. This measure equals one for individuals whose birth state was geographically close to a state where abortion was already legal. Concretely, we calculate the distance between each state's population-weighted centroid and the centroid of its nearest legalized-abortion state. We then assign exposure = 1 if this distance falls in the bottom-tercile of all distances.

For example, consider a woman born in Nevada in 1971. Nevada had not yet legalized abortion, but its centroid is geographically close to California, which fully legalized abortion in 1969. Because Nevada is among the closest states to an early-legalizing state, it falls in the bottom tercile of distances, and therefore receives exposure = 1. By contrast, a woman born in Alabama in 1971 is much farther from any early-legalizing state (e.g., New York, Washington, California). Alabama does not fall in the closest tercile, so we assign exposure = 0. In addition, for women born directly in early-legalizing states (e.g., California, New York, Hawaii), exposure is automatically set to 1. For cohorts born before 1968, i.e., prior to the emergence of early reform laws, exposure is set to 0 for all states.

We then re-estimate the specification in equation (1) using this alternative measure and present the results in Appendix Table F-1. The findings broadly mirror our main specification:

exposure is associated with higher birth weight (+4.3 grams) and longer gestational age (+0.03 weeks), along with significant reductions in low birth weight (–0.19 percentage points) and preterm birth (–0.33 percentage points). The estimate for fetal growth is positive and marginally significant, while the coefficient for small-for-gestational-age is near zero and not statistically significant. Taken together, these results reinforce our main conclusion that access to legalized abortion had meaningful intergenerational benefits for child health.

5.6. Schwartz Test for Robust Significance in Large Samples

Given the very large size of our dataset (over 6.8 million observations), we follow a robustness check suggested by Deaton (1995) to address concerns about conventional significance testing in working with large sample sizes. When sample sizes are extremely large, the probability of a Type II error becomes negligible, meaning that even trivial differences may be detected as statistically significant. In such cases, Deaton (1995) proposes using a higher critical value for the t-statistic, specifically, the square root of the natural logarithm of the sample size ($\sqrt{LnN}$), as an adjusted threshold for statistical significance. This adjustment originates from a Gideon Schwartz-designed F-test and is transformed into a t-statistic via the square root. For our full sample, this yields a critical value of 3.97. As shown in Appendix Table D-1, the estimated effects on fetal growth and small-for-gestational-age in the full sample, as well as birth weight and fetal growth among Black infants, remain significant even under this more conservative test.

5.7. Second Generation Disability Outcomes

Low birth weight has been linked to a higher risk of physical disabilities, vision disability, hearing disability, and learning disorders later in life (Chaikind & Corman, 1991; Fletcher, 2011; Mccormick et al., 1992; Spracklen et al., 2017). Given this well-documented association, it is crucial to investigate whether improvements in birth conditions following maternal exposure to legalized abortion translate into better long-term health outcomes for children. To reassess this relationship in our context, we analyze U.S. Census data from 2000-2022,[14] with the results presented in Table 5, which explores the impact of maternal exposure to legalized abortion on children's later-life disability outcomes.

The findings reveal a meaningful reduction in several disability outcomes among children whose mothers were exposed to legalized abortion. Specifically, this exposure is associated with a 0.24 percentage point decrease in self-care disability (column 3) and a 0.30 percentage point decrease in vision-hearing disabilities (column 4). These results suggest that maternal in-utero exposure to legalized abortion is linked to improved health outcomes in the next generation, particularly in reducing self-care and sensory disabilities. This supports broader evidence that access to legal abortion may help avoid high-risk pregnancies and improve birth outcomes, ultimately leading to better long-term health outcomes for children.

6. Mechanisms

Improvements in birth outcomes for the second generation can occur through two potential channels. The first is the *selection effect*, which may prevent the birth of "marginal children"—those more likely to grow up in adverse circumstances (Gruber et al., 1999). This occurs due to compositional changes among those born in the first or second generation. The second channel involves *healing effects*, where legal abortion improves the overall health distribution of infants affected in utero. This shift could result from reduced maternal stress or positive behavioral changes, such as increased utilization of prenatal care, among those who proceed with childbirth.

[14] Extending the analysis to earlier years is not feasible, as this period is the earliest in which second-generation individuals reach 18 years of age.

To shed light on these pathways, we begin by examining changes in the composition of first-generation mothers and their patterns of prenatal care utilization.

We should note that improvements in health outcomes among first generations could reflect both selection and healing effects. For instance, abortion legalization could impose a compositional change by selecting healthier mothers into pregnancy and birth. On the other hand, reductions in fertility and family size could increase per child resources and parental investment with long-term implications for children's health outcomes intergenerational spillovers (Bailey, 2013; Bailey et al., 2012). Within the framework of the current study we cannot disentangle these two effects.

6.1. Composition of Women Giving Birth among the First Generation

We begin by examining how exposure to legal abortion impacts the sociodemographic characteristics of the first generation. Columns 1 and 2 of Table 6 present the effects of exposure on the racial composition of the first generation. The results show no significant changes in the likelihood of a mother being white or Black, with coefficients close to zero and statistically insignificant. This suggests that the observed improvements in birth outcomes are unlikely to be driven by changes in the racial composition of mothers. Additionally, we perform a robustness check that excludes controls for the mother's education and race. The results, presented in Appendix Table B-6, closely align with our main model estimates. This suggests that the observed health improvements in the second generation are not driven by changes in the racial composition of mothers giving birth.

Next, we explore the effect of exposure on maternal age at the time of childbirth. Columns 7–9 of Table 6 show that legal abortion has no significant effect on the likelihood of a mother being a teenager (12–18 years old) or over 40 years old at the time of birth, with small and insignificant coefficients in columns 7 and 9. The coefficient for mothers aged 19–39 (column 8) is also not statistically significant. Thus, the improvements in birth outcomes do not appear to be driven by shifts in the age at which women give birth.

In terms of education, the results are more pronounced. Exposure to legal abortion is associated with a 4.1 percentage point increase in the likelihood of a mother having completed high school (column 5) and a 1.3 percentage point increase in the likelihood of completing college or more (column 6). Since higher maternal education is strongly linked to better child birth outcomes (Currie & Moretti, 2003), this educational improvement could partly explain the better overall birth outcomes in the next generation.[15]

We further do not observe any statistically significant or economically meaningful change in age at first birth or in a proxy for total fertility (measured by the birth order variable for women giving birth after age 40) (columns 10-11).

6.2. First-Generation Fertility Rates

A natural question is whether the cohorts exposed to abortion legalization in utero went on to display different fertility patterns once they reached adulthood. We examine this by aggregating birth counts at the birth state–birth year–state–year level and calculating the birth rate as the number of births divided by the total number of women in each birth state and birth year. We then regress this measure on exposure, conditioning on the fixed effects specified in Equation (1). The results, reported in Appendix Table E-1, show that exposed women had lower fertility in adulthood—about 0.4 fewer births per woman (off a mean of 3.1) in levels and roughly 3.7% lower

[15] Appendix Table C-4 shows that the positive effects of abortion legalization on infant health are concentrated among mothers with more than eight years of education. For this group, exposure is associated with higher birth weight, lower incidence of low birth weight, modest improvements in fetal growth, and reduced rates of small-for-gestational-age births. By contrast, the estimates for mothers with very low education (0–8 years) are small and statistically insignificant. These results are consistent with the argument that improvements in maternal education resulting from exposure to abortion legalization in utero represent one possible channel for the observed effects on infant health.

in the log specification. This fertility reduction is a plausible channel for the infant-health improvements we observe in the second generation. Fewer births per mother ease resource dilution and time constraints within households, allowing greater per-child investment during prenatal development, which is predictive of improved birth outcomes (Becker, 1960; Becker & Lewis, 1973; Blake, 1981b; Frenette, 2011).

6.3. First Generation Prenatal Healthcare Utilization

Second, we investigate prenatal healthcare utilization as a potential mechanism behind improved birth outcomes. The estimate in column 12 of Table 6 suggests that exposure to legal abortion is linked to a 0.28 increase in the number of prenatal visits. Furthermore, the likelihood of receiving no prenatal care (column 13) decreases by 0.15 percentage points, and the initiation of prenatal care is accelerated by 0.25 months (column 14). The event study results in Figure 7 reinforce these findings. This implies that the improvements in mothers' prenatal care utilization likely contribute to the enhanced birth outcomes observed in the second generation.

In Appendix Table C-5, we examine whether the effects on first-generation prenatal care utilization and maternal education differ by race. The results show that both non-white and white mothers exposed to legal abortion in early life substantially increased their use of prenatal care, with larger gains among non-white women (0.42 additional visits vs. 0.36 for whites) and a larger reduction in the likelihood of receiving no prenatal care. Non-white mothers also initiated prenatal care earlier by a larger margin. In terms of education, exposure led to increases in high school and college completion for both groups, though the gains in high school completion are larger for white mothers while the increases in college completion are similar across groups. Overall, these patterns suggest improvements in pathway outcomes for both racial groups, with especially pronounced gains among non-white mothers, consistent with the larger infant-health gains documented in the Table 3.

6.4. First Generation Infant Health

Third, we consider the immediate impact of legal abortion on births in 1960-1980. The findings are reported in Table 7 and Figure 8. The results suggest that legal abortion is associated with several positive birth outcomes for the first generations. In particular, legal abortion is associated with a significant reduction in low birth weight rates, very low birth weight rates, and infant mortality rates. The effects on low birth weight and infant mortality rates are primarily concentrated among whites while the effects on very low birth weight remains significant for both whites and Blacks. The coefficient in column 3 of Table 7 suggests a reduction of roughly 3.2% with respect to the mean among first generations. The coefficient of column 2 of Table 2 suggests a reduction of approximately 1.6% among second generations. Using these two numbers, we estimate the cross-generation elasticity and low birth weight of roughly 50%. (Currie & Moretti, 2007) employ grandmother fixed effects to estimate mother – child correlations in birth outcomes. They estimate a correlation coefficient of 0.029, of a mean of 0.06, a change of roughly 48%. This number is quite similar to what we observe in our comparisons of first and second generations' changes in low birth weight.[16]

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[16] An additional dimension along which first-generation birth outcomes may vary is birth order. Ideally, we would examine this heterogeneity using the same state-level birth outcome data employed in Table 7. However, the aggregate vital statistics for 1960–1980 do not report birth outcomes separately by birth order, preventing a direct decomposition at the state–cohort level. To explore this heterogeneity, we instead turn to the individual-level natality microdata, which contain birth-order information but begin only in 1968. This substantially reduces the number of pre-treatment cohorts and limits the size of the control group, making the resulting estimates less precise. Nonetheless, using the 1968–1980 natality data disaggregated by birth order and maternal race, we estimate the effects of early-life exposure to legalized abortion on first-generation birth outcomes. The results, reported in Appendix Table C-2, indicate modest improvements in birth outcomes among first-born children of white mothers, with less consistent patterns among non-white mothers and higher-parity births. These findings should be interpreted cautiously due to the truncated sample window but provide suggestive evidence that birth-order heterogeneity may play a role in shaping the intergenerational impacts of abortion legalization.

6.5. Effects on Zeroth Generation Outcomes

Finally, we examine the impact of legal abortion on fertility rates, the share of teenage mothers, and the proportion of married mothers among the zeroth generation—defined as cohorts directly exposed to legal abortion who had children between 1960 and 1980. The findings in columns 1 and 2 of Table 8 (and top two panels of Figure 9) indicate that exposure to legal abortion does not significantly alter fertility patterns among white mothers of the zeroth generation. In contrast, Black mothers show a significant reduction in fertility rates by 0.067 percentage points (1.4 percent relative to the mean). Given that white infants generally exhibit better health outcomes than Black infants and that maternal birth outcomes are linked to children's birth outcomes (Currie & Moretti, 2007), the selection effect—reflected in the reduction of Black births in the first generation—could contribute to the positive impact of legalization on the second generation's health.

The results of columns 3 and 4 (and bottom two panels of Figure 9) indicate that exposure to legal abortion is linked to a decrease in teenage motherhood and an increase in the share of married mothers. These selection effects in the zeroth generation—fewer teenage mothers and more married mothers—may help explain the observed results. These patterns suggest that access to legal abortion not only empowers women to make better reproductive choices but also positively influences their family dynamics and social outcomes. In this regard, legal abortion provides women with the means to prevent the birth of "marginal children"—those who might grow up in adverse circumstances (Gruber et al., 1999).

6.6. Birth Spacing Mechanism of First Generations

Appendix Table E-2 examines whether in utero exposure to legal abortion influenced the fertility behavior of first-generation women, focusing in particular on the timing of births.[17] Specifically, exposed mothers were significantly less likely to have closely spaced births within 1–2 years (column 2), and more likely to delay subsequent births to 2–3 years (column 3) or 3–4 years (column 4).[18] These adjustments in spacing suggest that early-life exposure to abortion legalization enabled women to exert greater control over their fertility and family planning decisions. Longer interbirth intervals are linked to improved maternal health, greater resource allocation per child, and healthier infant outcomes, providing a plausible channel through which the benefits of legal abortion exposure may have carried forward to the next generation (Buckles & Munnich, 2012; Conde-Agudelo et al., 2006; Maitra & Pal, 2008; Molitoris, 2017; Rosenzweig, 1986).

6.7. Summary of Evidence for Selection and Healing Mechanisms

To conclude this section, we summarize the empirical evidence supporting the two main mechanisms through which legal abortion may have improved second-generation birth outcomes: selection effects and healing effects. While the two are not mutually exclusive, each is supported by distinct patterns in the data.

The evidence for selection effects includes: (1) increased high school completion among first-generation women; (2) a reduction in fertility rates for Black mothers in zeroth generation; and (3) a decline in the share of teenage mothers in zeroth generation.

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[17] The birth spacing variable is only applicable to mothers with second or higher-order births (i.e., it does not apply to first-time mothers). In addition, the variable is not available for all years in the sample; it is only observed for the periods 1970–1993 and 2009–2017.

[18] In Appendix Table E-2, we use categorical indicators for different interbirth intervals rather than a single continuous measure to avoid imposing linearity or monotonicity on the relationship between exposure and birth spacing, allowing the data to flexibly capture non-linear patterns.

In terms of healing effects, we observe (1) increased prenatal care utilization by first-generation mothers (more visits, earlier initiation, and fewer with no care) and (2) improvements in first-generation infant health (lower low birth weight and infant mortality rates).

Together, these findings suggest that both selection and healing mechanisms contributed to the observed improvements in second-generation birth outcomes. While we do not formally quantify the relative importance of each channel, the evidence indicates that abortion access affected both the composition of mothers and the health environment under which children was born.

7. Conclusion

Our research provides evidence that access to legal abortion has far-reaching, intergenerational consequences for maternal and child health. We find that early-life exposure to legal abortion is associated with improved birth outcomes in the subsequent generation, including higher birth weight and reduced rates of low birth weight. These findings suggest that the positive impacts of abortion access extend beyond the immediate health benefits for women to their children.

We perform a back-of-the-envelope calculation to estimate the average social benefit of these positive effects. In 2000, approximately 307,000 births were classified as low birth weight. Based on the estimated impact in Table 2, this represents a reduction of 1.15% relative to the mean, or about 1,774 fewer cases of low birth weight in that year. Each instance of low birth weight incurs $82,106 (2000 USD) in health care costs (Beam et al., 2020).[19] Using this estimated cost, first-generation exposure to legal abortion eligibility results in about $146 million in medical cost

[19] We adjust (Beam et al., 2020) estimated healthcare spending of $114,437 (in 2016 USD) to $82,106 (in 2000 USD).

savings related to low birth weight in the second generation. Importantly, this estimate accounts only for benefits to the second generation, excluding potential improvements in the first generation's health, educational attainment, and labor market outcomes. Additionally, this calculation does not include potential medical cost savings from improved long-term health outcomes in the second generation linked to healthier birth weights.

Our findings underscore the importance of reproductive health policies in shaping the health and well-being of future generations. The recent Supreme Court decision in Dobbs v. Jackson Women's Health Organization has raised concerns about the potential erosion of abortion access in the United States. As policymakers and healthcare providers navigate this new landscape, it is crucial to consider the long-term implications of such changes for maternal and child health. Our research provides valuable insights into the potential costs of restricting access to abortion, highlighting the need for policies that support reproductive health and well-being.

As a final note, we highlight that the legalization of abortion not only expanded access to elective terminations but also improved the availability and quality of miscarriage management (Nobles et al., 2024; Rubin, 2022). Prior to legalization, miscarriages were often treated under restrictive legal and medical conditions, limiting access to timely and appropriate care. The expansion of abortion services likely enhanced clinical practices related to pregnancy loss. Therefore, while our estimates capture the overall impact of exposure to abortion legalization, part of the observed improvement in infant health outcomes may have stemmed from better miscarriage management, with important consequences for maternal and infant health.

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Tables

Table 1 - Summary Statistics

	Born Post-Legalization		Born Pre-Legalization	
	Mean	**SD**	**Mean**	**SD**
NCHS Sample:				
Birth Year of Child	2003.895	6.835	1994.396	8.027
Birth Year of Mother	1976.635	2.326	1966.331	3.962
White	.685	.464	.728	.445
Black	.216	.412	.212	.409
Mother's Education: 0-8 Years	.057	.231	.056	.229
Mother's Education: High School	.387	.487	.407	.491
Mother's Education: College-More	.478	.5	.466	.499
Mother's Age 12-18	.094	.292	.078	.269
Mother's Age 19-39	.881	.324	.857	.35
Mother's Age: 40-54	.025	.156	.065	.246
Firstborn Child	.397	.489	.387	.487
Birth Count	10.081	60.904	9.913	59.745
Child Female	.494	.5	.495	.5
Birth Weight	3275.789	494.674	3306.795	500.875
Low Birth Weight	.085	.223	.082	.221
Gestational Age	38.698	2.154	38.926	2.278
Preterm Birth	.123	.263	.119	.26
Fetal Growth	84.341	11.56	84.698	11.751
Small for Gestational Age	.106	.247	.103	.244
Total Prenatal Visits	11.382	3.446	11.287	3.513
No Prenatal Visits	.013	.092	.013	.094
Month Prenatal Care Began	2.765	1.253	2.521	1.325
Exposure to Abortion Legalization	1	0	0	0
Per-Capita Income (1967 1,000 Dollars)	7.328	1.816	3.163	.996
Hospital Beds Per Capita (Per 1,000)	5.202	.99	4.983	.842
Hospitals Per Capita (1,000)	.034	.015	.037	.017
Reported Disease Rate (Per 1,000)	212.953	230.884	273.86	293.095
Share of Black Women (20-64) on AFDC	20.138	7.222	12.799	6.996
Share of White Women (20-64) on AFDC	3.21	1.55	1.512	.994
Exposure to Medicaid	9.215	3.39	-1.154	4.673
Exposure to FEPA	4.817	6.369	.372	3.721
Observations	2,342,310		4,478,323	
Census-ACS sample:				
White	.648	.478	.772	.42
Female	.462	.499	.457	.498
Birth Year of Child	1997.674	3.766	1991.475	5.982
Birth Year of Mother	1975.588	2.546	1965.149	3.76
Exposure to Abortion Legalization	1	0	.055	.229
Cognitive Disability	.064	.245	.039	.194
Ambulatory Disability	.043	.204	.012	.11
Self-Care Disability	.012	.11	.017	.131
Vision Hearing Disability	.022	.148	.022	.148
Observations	244,287		1,248,685	

Notes. The NCHS sample is collapsed at the state, year, birth state, birth year, maternal race, child gender, birth order (first time/higher-order), maternal age (teenage, middle-age, old), and maternal education (less than high school, preschool, college). Number of pre-collapse observations is 68,006,570. The sample covers years 1970-2020 for cohorts born between 1960 – 1980. FEPA stands for Fair Employment Practices Act.

Table 2 – Effects on Second Generations' Birth Outcomes

	Outcomes:					
	Birth Weight	Low Birth Weight	Gestational Age	Preterm Birth	Fetal Growth	Small For Gestational Age
	(1)	(2)	(3)	(4)	(5)	(6)
Exposure	3.28449***	-.0012***	.0069	-.00095*	.06948***	-.00113***
	(.958)	(.00037)	(.00464)	(.00055)	(.01925)	(.00036)
Observations	6820633	6820633	6820633	6820633	6820633	6820633
R-squared	.3195	.10401	.2275	.11669	.31611	.14793
Mean DV	3317.625	0.077	38.902	0.116	85.047	0.098

Notes. Standard errors, clustered on maternal birth state and birth year, are in parentheses. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980.

Second generation: Children whose mothers, born between 1960 and 1980, were exposed to legal abortion in early life.

*** $p<0.01$, ** $p<0.05$, * $p<0.1$

Table 3 - Heterogeneity in the Effects on Birth Outcomes of Second Generation by Maternal Race

	Outcomes:					
	Birth Weight	Low Birth Weight	Gestational Age	Preterm Birth	Fetal Growth	Small For Gestational Age
	(1)	(2)	(3)	(4)	(5)	(6)
Panel A. White						
Exposure	1.88169**	-.00052	.00292	-.00062	.03999**	-.00051
	(.85473)	(.00032)	(.00378)	(.00049)	(.01885)	(.00036)
Observations	4865822	4865822	4865822	4865822	4865822	4865822
R-squared	.20372	.03568	.22402	.04721	.25114	.10464
Mean DV	3365.611	0.065	39.034	0.101	86.034	0.085
Panel B. Black						
Exposure	13.28736***	-.0054***	.02538	-.00297*	.31378***	-.00304**
	(3.03599)	(.00148)	(.01558)	(.00172)	(.06774)	(.00129)
Observations	1455694	1455694	1455694	1455694	1455694	1455694
R-squared	.09406	.03795	.06385	.04561	.10022	.07401
Mean DV	3087.881	0.135	38.280	0.187	80.294	0.158

Notes. Standard errors, clustered on maternal birth state and birth year, are in parentheses. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980.

Second generation: Children whose mothers, born between 1960 and 1980, were exposed to legal abortion in early life.

*** p<0.01, ** p<0.05, * p<0.1

Table 4 - Heterogeneity in the Effects on Birth Outcomes of Second Generation by Sex

	Outcomes:					
	Birth Weight	Low Birth Weight	Gestational Age	Preterm Birth	Fetal Growth	Small For Gestational Age
	(1)	(2)	(3)	(4)	(5)	(6)
Panel A. Female						
Exposure	3.43895***	-.00118***	.00586	-.00064	.0766***	-.00128***
	(1.0043)	(.00044)	(.00508)	(.00055)	(.02216)	(.00043)
Observations	3372867	3372867	3372867	3372867	3372867	3372867
R-squared	.27322	.11132	.23584	.12206	.24558	.125
Mean DV	3256.376	0.083	38.962	0.111	83.361	0.119
Panel B. Male						
Exposure	3.14079**	-.00121**	.00785	-.00125*	.06278**	-.00098*
	(1.27414)	(.00048)	(.00558)	(.00074)	(.02678)	(.00053)
Observations	3447766	3447766	3447766	3447766	3447766	3447766
R-squared	.27665	.09011	.21494	.10912	.25792	.10458
Mean DV	3376.050	0.071	38.845	0.121	86.655	0.078

Notes. Standard errors, clustered on maternal birth state and birth year, are in parentheses. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980.

Second generation: Children whose mothers, born between 1960 and 1980, were exposed to legal abortion in early life.

*** p<0.01, ** p<0.05, * p<0.1

Table 5 – Effects on Second-Generation Disability Outcomes

	Outcomes:			
	Cognitive disability	Ambulatory disability	Self-care disability	Vision-hearing disability
	(1)	(2)	(3)	(4)
Exposure	-.00484*	-.00221	-.00239**	-.00299**
	(.00275)	(.00189)	(.00113)	(.00146)
Observations	1492972	1492972	1492972	1492972
R-squared	.00423	.00313	.00145	.0017
Mean DV	0.057	0.037	0.012	0.019

Notes. Standard errors, clustered on mother birth state, are in parentheses. Regressions are weighted using IPUMS person weights. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, and child birth year fixed effects, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 2000-2022. The sample is restricted to individuals aged 18-25.

Second generation: Children whose mothers, born between 1960 and 1980, were exposed to legal abortion in early life.

*** p<0.01, ** p<0.05, * p<0.1

Table 6 - Exploring Mechanism Channels: Effects on First-Generation Sociodemographic Characteristics and Prenatal Care Utilization

	Outcomes:						
	Mother White	Mother Black	Child Gender	Mother Education 0-8 Years	Mother Education High School	Mother Education College – More	Mother Age 12-18 Years
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Exposure	.0017	-.00136	-.00014	-.00029	.04068***	.01253***	-.00052
	(.00192)	(.00182)	(.00058)	(.00046)	(.00754)	(.00318)	(.00091)
Observations	6820633	6820633	6820633	6820633	6820633	6820633	6820633
R-squared	.11233	.12686	.00001	.02328	.18967	.24215	.31305
Mean DV	0.809	0.168	0.488	0.020	0.465	0.451	0.082
	Mother Age 19-39 Years	Mother Age 40-54 Years	Age at First Birth	Child Birth Order Conditional on Mother Age > 40	Total Number of Prenatal Visits	No Prenatal Visits	Months Prenatal Care Began
	(8)	(9)	(10)	(11)	(12)	(13)	(14)
Exposure	.00039	.00013	-.03013	.00359	.2789***	-.00152***	-.02485**
	(.00125)	(.00061)	(.05092)	(.01998)	(.06782)	(.0005)	(.01023)
Observations	6820633	6820633	2683761	288413	6665792	6820633	6563596
R-squared	.19043	.13972	.04673	.07163	.39411	.09405	.41536
Mean DV	0.900	0.018	24.208	2.937	11.281	0.012	2.510

Notes. Standard errors, clustered on maternal birth state and birth year, are in parentheses. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980.

First generation: Women born between 1960 and 1980 who were directly exposed to legal abortion in early life.

*** p<0.01, ** p<0.05, * p<0.1

Table 7 - Exploring Mechanism Channels: Effects on First-Generation Infant Health

	Outcomes:		
	Share Low Birth Weight Whites	Share Low Birth Weight Blacks	Share Low Birth Weight Total
	(1)	(2)	(3)
Exposure	-.00212***	-.00003	-.00185*
	(.00049)	(.00168)	(.00106)
Observations	1071	1071	1071
R-squared	.93014	.87713	.89948
Mean DV	0.066	0.126	0.101
	Share Very Low Birth Weight Whites	Share Very Low Birth Weight Blacks	Share Very Low Birth Weight Total
	(4)	(5)	(6)
Exposure	-.00037**	-.00126*	-.00108**
	(.00017)	(.00072)	(.00046)
Observations	1071	1071	1071
R-squared	.56073	.64075	.69839
Mean DV	0.010	0.022	0.017
	Infant Mortality Rate Whites (per 1,000 Births)	Infant Mortality Rate Blacks (per 1,000 Births)	Infant Mortality Rate Total (per 1,000 Births)
	(7)	(8)	(9)
Exposure	-.61026***	-.39994	-.56013***
	(.19058)	(.65177)	(.18674)
Observations	1071	1071	1071
R-squared	.96788	.89177	.9704
Mean DV	17.193	29.385	19.463

Notes. Standard errors, clustered on state, are in parentheses. Regressions are weighted using state population. All regressions include state fixed effects and region by year fixed effects. Regressions also contain state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1960 – 1980.
First generation: Women born between 1960 and 1980 who were directly exposed to legal abortion in early life.
*** p<0.01, ** p<0.05, * p<0.1

Table 8 - Exploring Mechanism Channels: Effects on Zeroth-Generation Outcomes

	Outcomes:			
	Birth Rate Whites (per 1,000 Women)	Birth Rate Blacks (per 1,000 Women)	Share Teenage Mothers	Share Married Mothers
	(1)	(2)	(3)	(4)
Exposure	-2.17053***	-7.61891***	-.002	.02524***
	(.73392)	(1.23013)	(.00186)	(.00591)
Observations	1071	1071	650	650
R-squared	.97467	.94895	.98713	.88046
Mean DV	79.274	110.940	0.175	0.872

Notes. Standard errors, clustered on state, are in parentheses. Regressions are weighted using state population. All regressions include state fixed effects and region by year fixed effects. Regressions also contain state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1960 – 1980.
Zeroth generation: Women who had children between 1960 and 1980.
*** $p<0.01$, ** $p<0.05$, * $p<0.1$

Figures

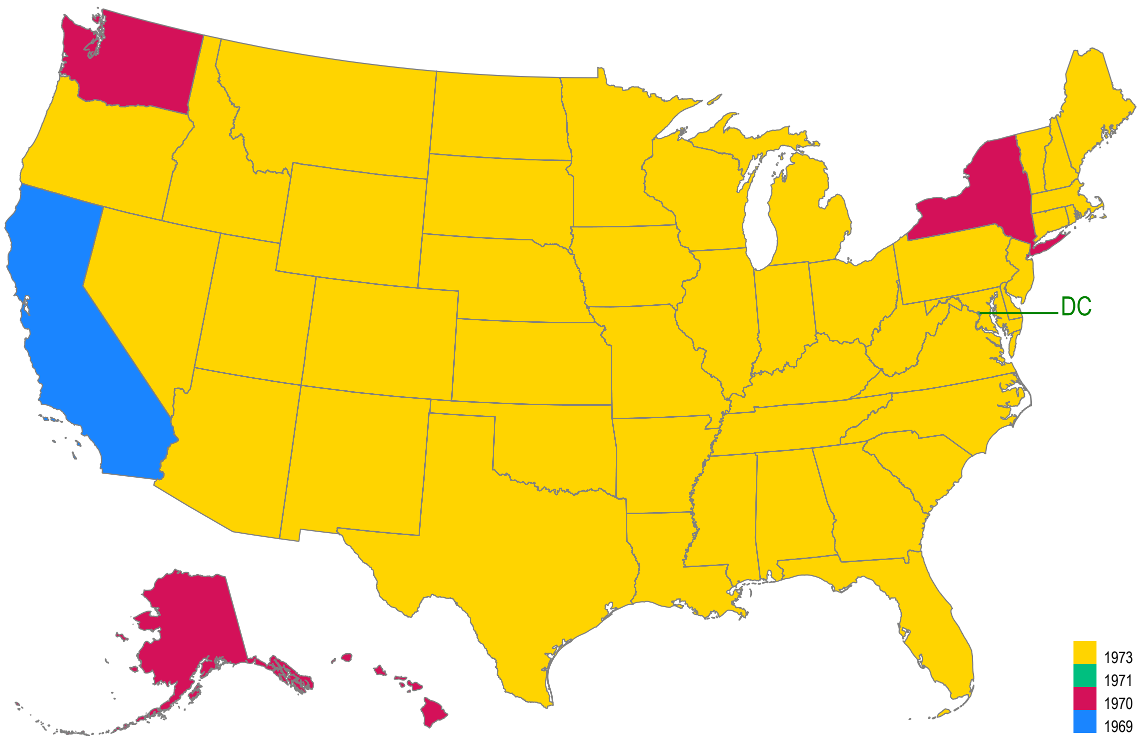
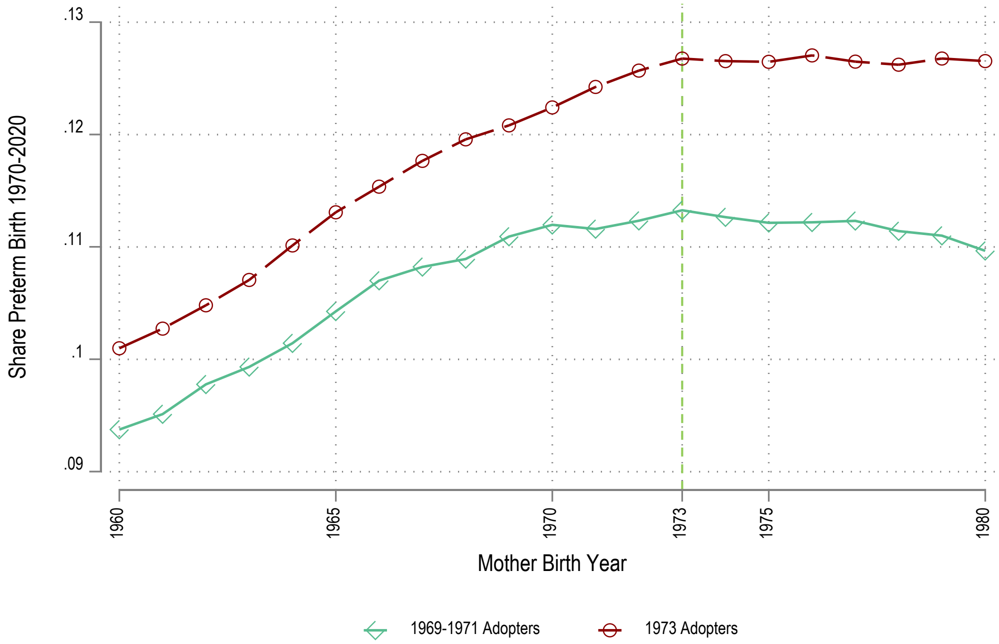


Figure 1 - Abortion Legalization across States



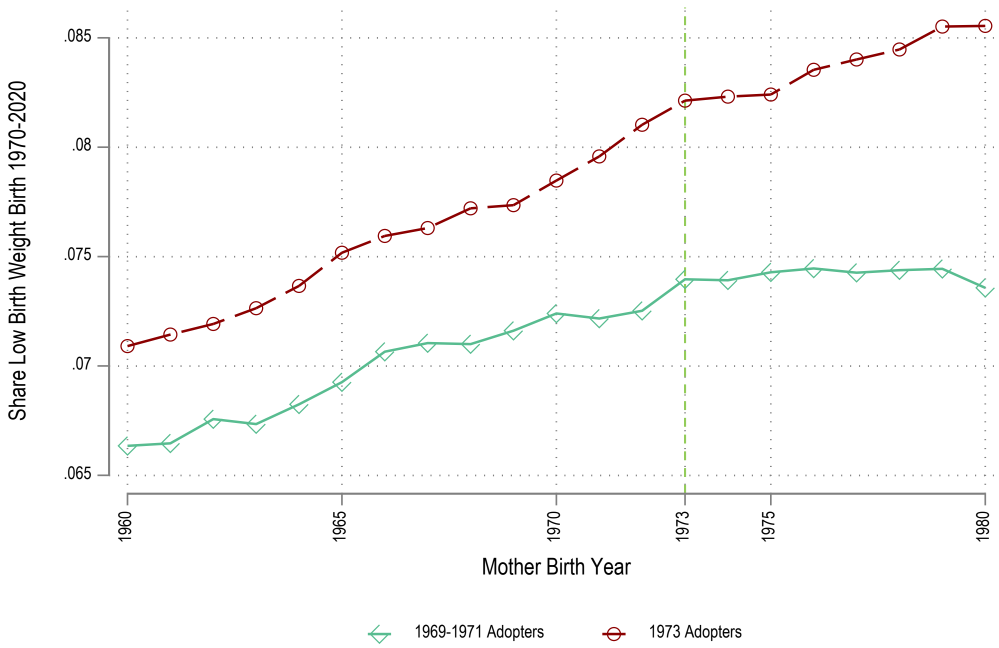
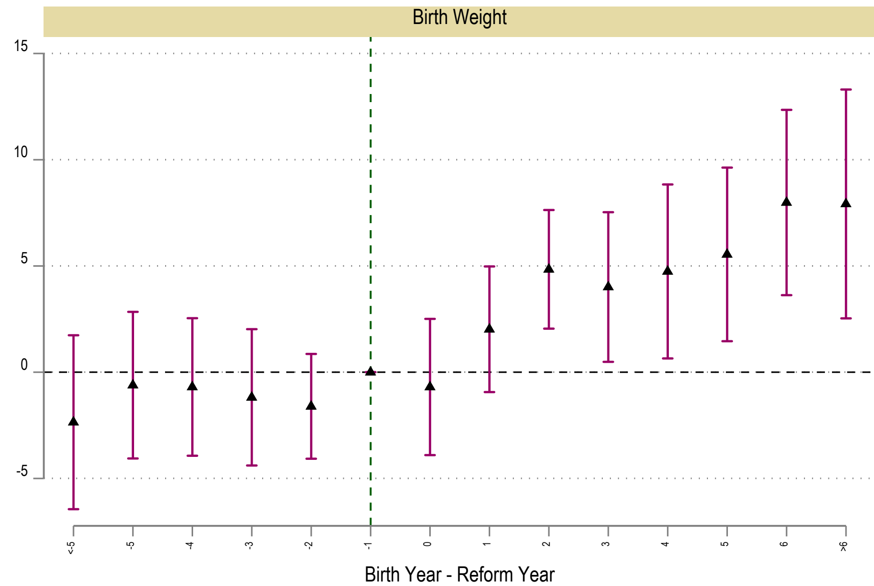


Figure 2 – Time series Evolution of Preterm Birth Share and Low Birth Weight Share by Maternal Birth Cohort



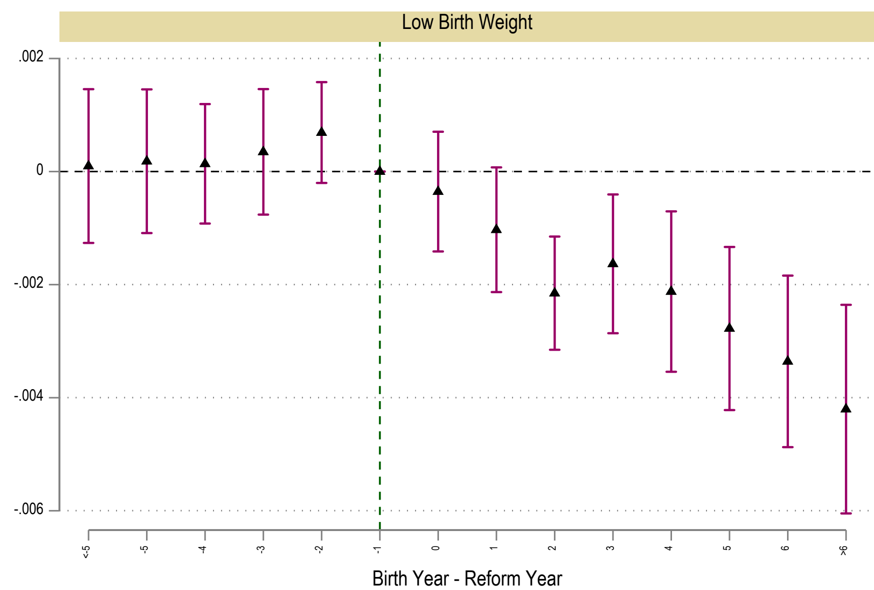


Figure 3 - Event Study Analysis to Show the Evolution of Second-Generation Birth Outcomes in Different Years Relative to the State-Specific Abortion Legalization Year

Notes. The horizontal axis displays the difference between the mother's birth year and the year abortion was legalized in their state, with negative values indicating birth years prior to legalization and positive values indicating birth years after legalization. Point estimates and 95% confidence intervals are illustrated. Standard errors are clustered on maternal birth state. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980. Second generation: Children whose mothers, born between 1960 and 1980, were exposed to legal abortion in early life.

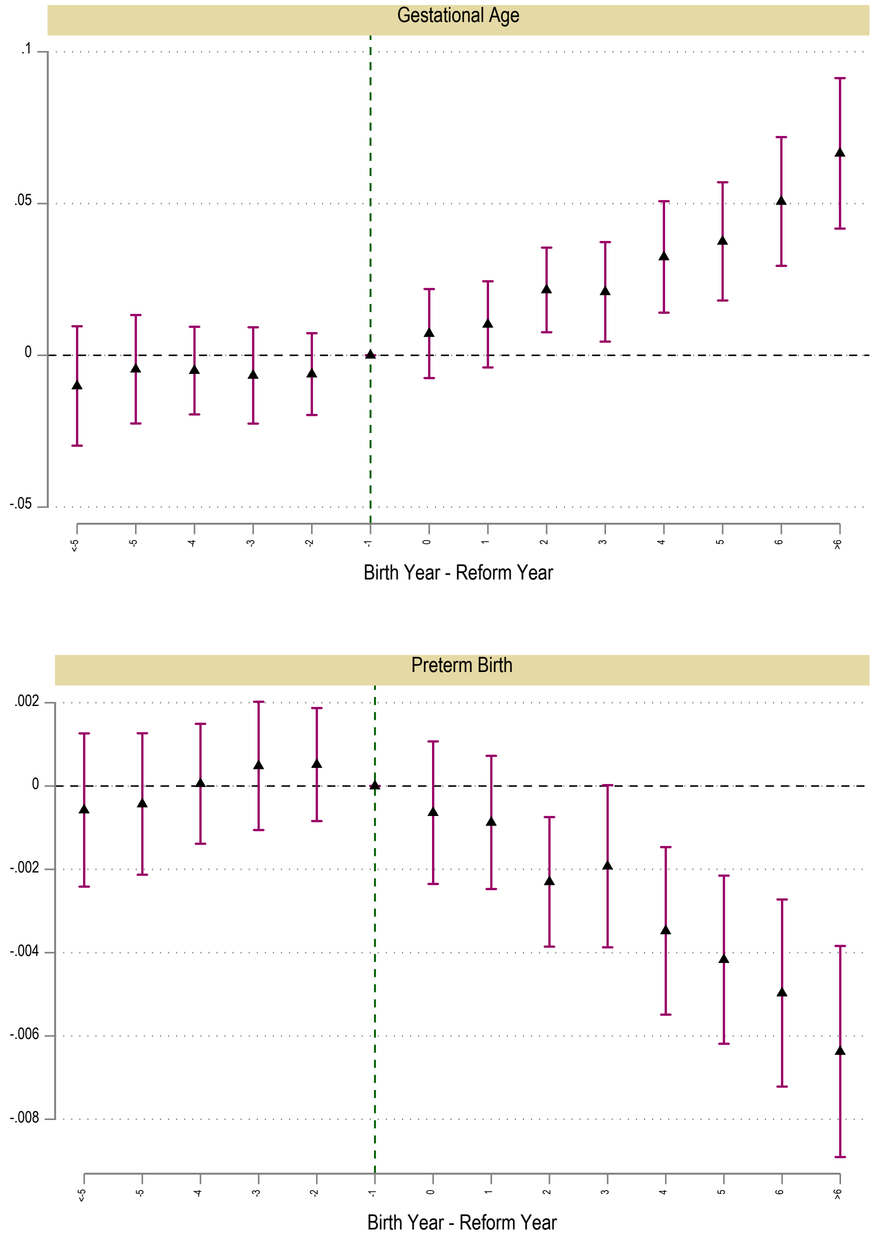


Figure 4 - Event Study Analysis to Show the Evolution of Second-Generation Birth Outcomes in Different Years Relative to the State-Specific Abortion Legalization Year

Notes. The horizontal axis displays the difference between the mother's birth year and the year abortion was legalized in their state, with negative values indicating birth years prior to legalization and positive values indicating birth years after legalization. Point estimates and 95% confidence intervals are illustrated. Standard errors are clustered on maternal birth state. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980. Second generation: Children whose mothers, born between 1960 and 1980, were exposed to legal abortion in early life.

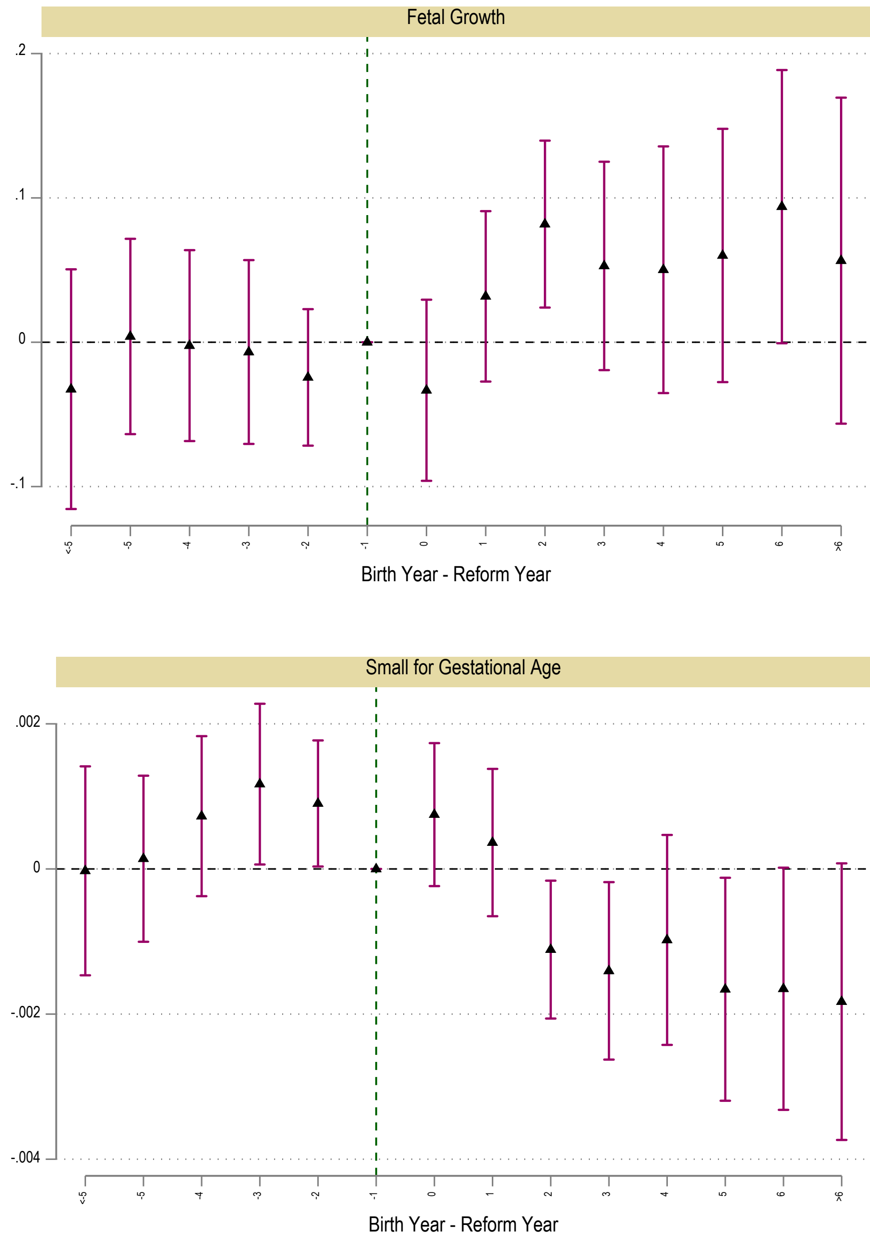


Figure 5 - Event Study Analysis to Show the Evolution of Second-Generation Birth Outcomes in Different Years Relative to the State-Specific Abortion Legalization Year

Notes. The horizontal axis displays the difference between the mother's birth year and the year abortion was legalized in their state, with negative values indicating birth years prior to legalization and positive values indicating birth years after legalization. Point estimates and 95% confidence intervals are illustrated. Standard errors are clustered on maternal birth state. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980. Second generation: Children whose mothers, born between 1960 and 1980, were exposed to legal abortion in early life.

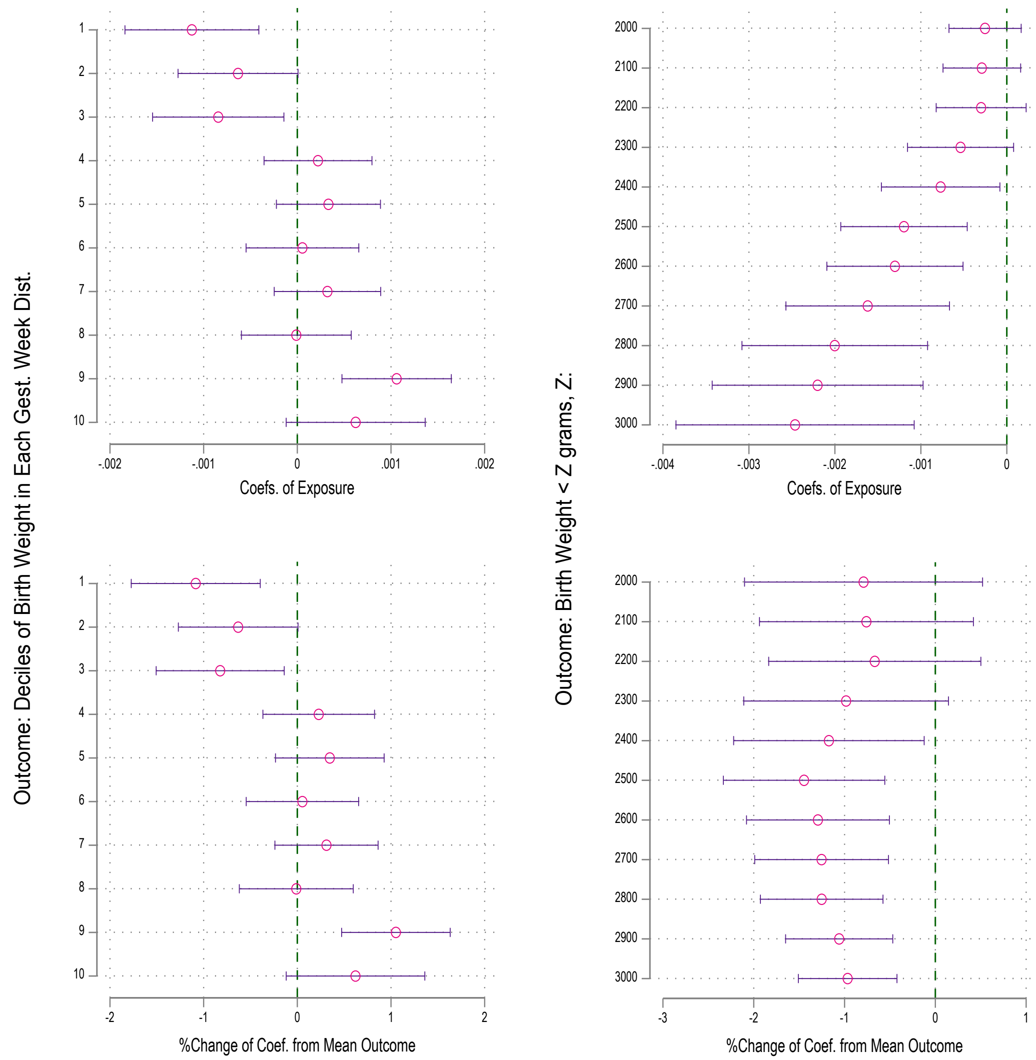


Figure 6 - Estimated Coefficients across the Birthweight Ranks Within Gestational Age Distribution (Left Panel) and Across the Thresholds of Low Birth Weight (Right Panel)

Notes. Point estimates and 95% confidence intervals are illustrated. Standard errors are clustered on maternal birth state. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980.

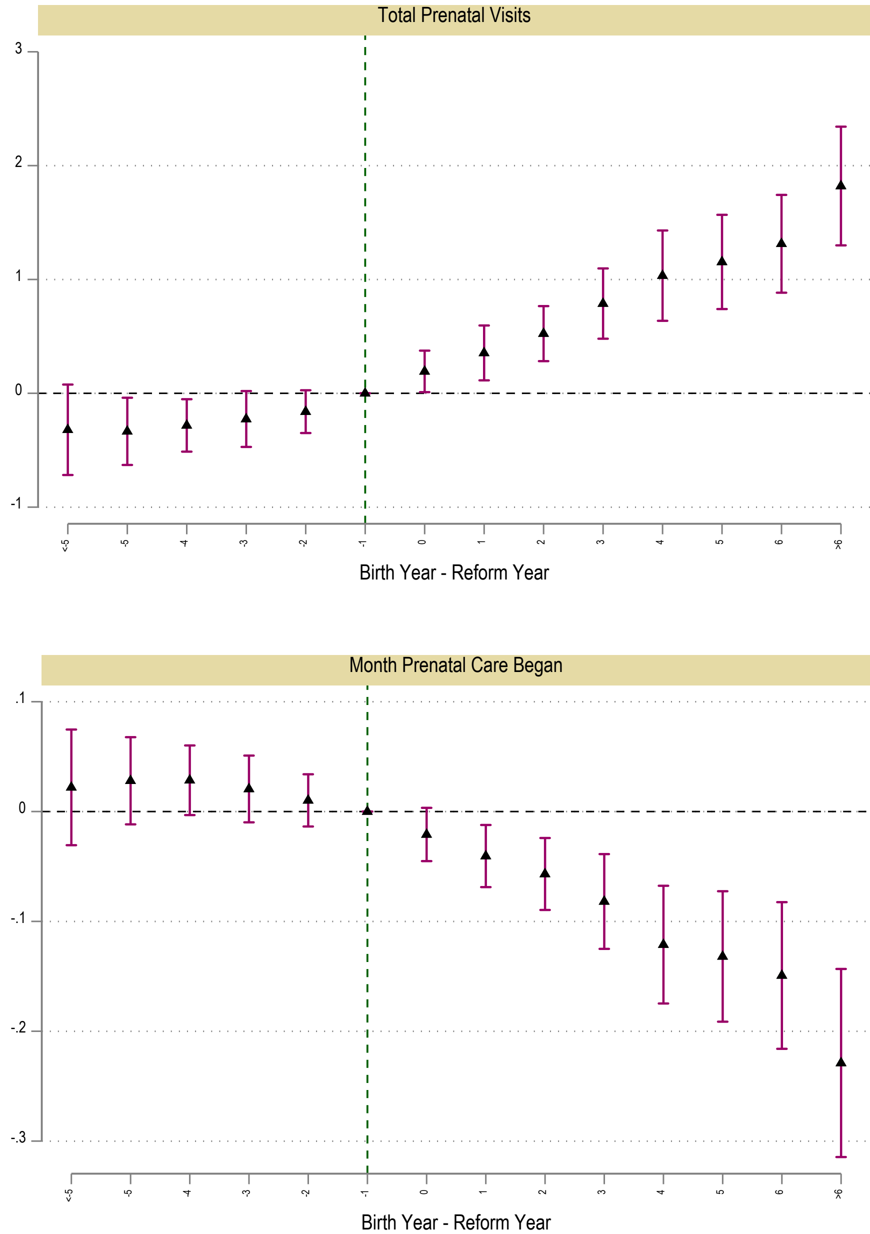


Figure 7 - Event Study Analysis to Show the Evolution of First-Generation Prenatal Care Utilization in Different Years Relative to the State-Specific Abortion Legalization Year

Notes. The horizontal axis displays the difference between the mother's birth year and the year abortion was legalized in their state. Point estimates and 95% confidence intervals are illustrated. Standard errors are clustered on maternal birth state. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980. First generation: Women born between 1960 and 1980 who were directly exposed to legal abortion in early life.

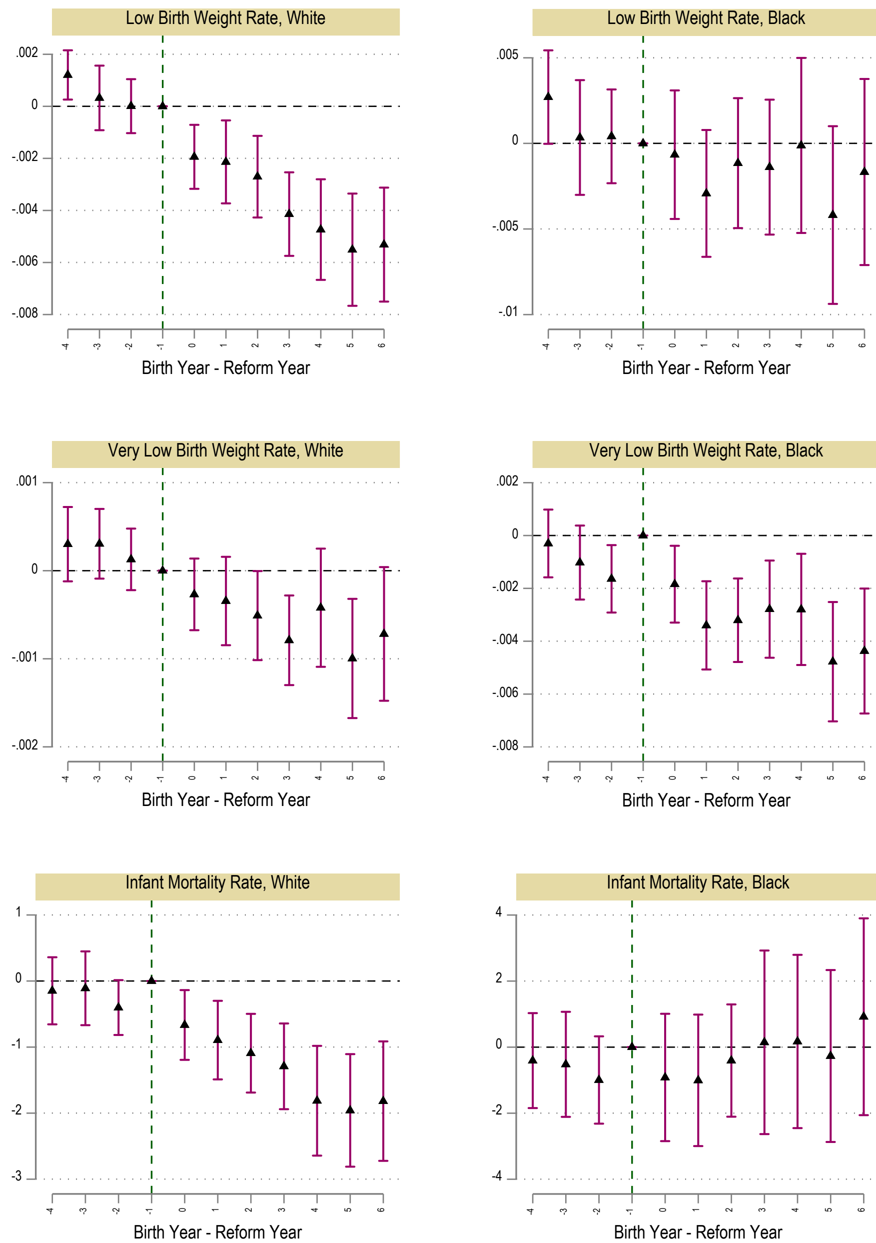


Figure 8 - Event Study Analysis to Show the Effects on First-Generation Infant Health

Notes. The horizontal axis displays the difference between the mother's birth year and the year abortion was legalized in their state. Point estimates and 95% confidence intervals are illustrated. Standard errors are clustered on maternal birth state. Regressions are weighted using state population. All regressions include state fixed effects and region by year fixed effects. Regressions also contain state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1960 – 1980.
First generation: Women born between 1960 and 1980 who were directly exposed to legal abortion in early life.

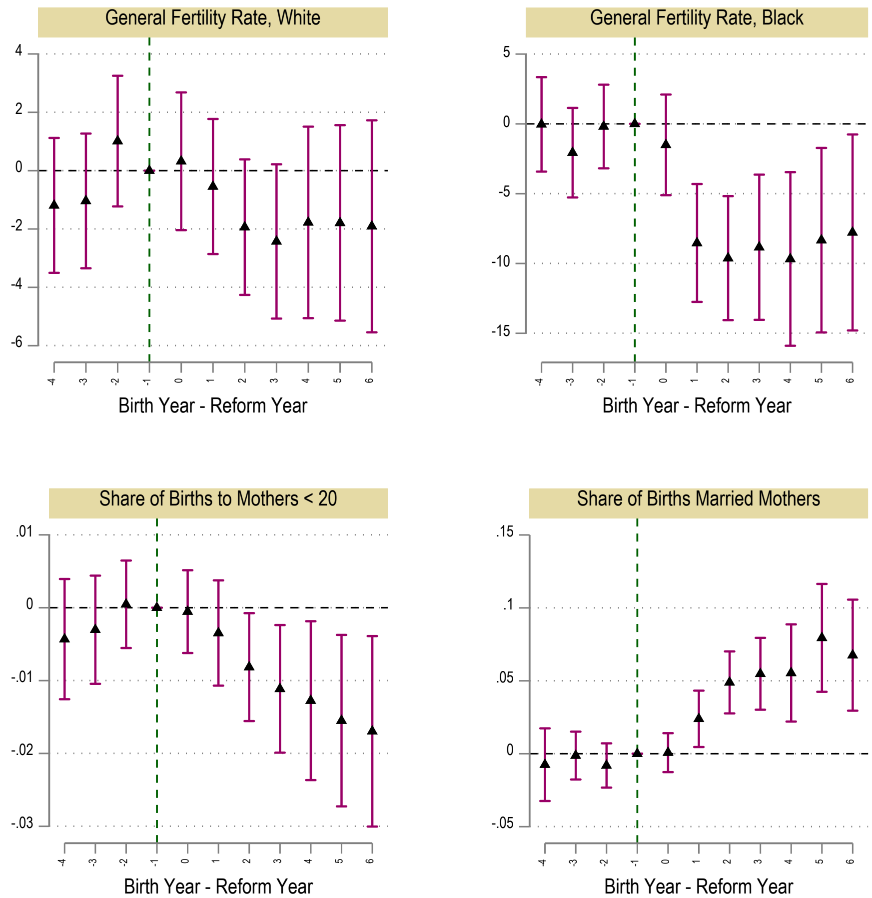


Figure 9 - Event Study Analysis to Show the Effects on Zeroth-Generation Infant Health

Notes. The horizontal axis displays the difference between the mother's birth year and the year abortion was legalized in their state. Point estimates and 95% confidence intervals are illustrated. Standard errors are clustered on maternal birth state. Regressions are weighted using state population. All regressions include state fixed effects and region by year fixed effects. Regressions also contain state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1960 – 1980.
Zeroth generation: Women who had children between 1960 and 1980.

Appendix A

Appendix Table A-1 - Correlation Between Early Abortion and State Characteristics

	Outcome: Early abortion			
	(1)	(2)	(3)	(4)
Gender Wage Gap 1962-1968 ($1,000 in 2020 dollars)	.07066***	.09611***		
	(.02332)	(.02526)		
Residual Gender Wage Gap 1962-1968 ($1,000 in 2020 dollars)			.075***	.10267***
			(.02772)	(.03202)
Log Per-Capita Income	1.75238***	1.7039***	1.66693***	1.5911***
	(.35956)	(.30042)	(.36389)	(.31893)
Hospital Beds per Capita (1,000)	-.03814	.00563	-.03644	.00665
	(.04537)	(.02771)	(.04482)	(.02946)
Hospitals per Capita (1,000)	3.3618**	-.05718	4.19713**	1.19158
	(1.5923)	(2.18892)	(1.62136)	(2.17744)
Disease Rate	.02245	.00791	.03124	.01971
	(.03242)	(.02991)	(.03058)	(.03023)
Early Medicaid Adopter	-.11176	-.01305	-.14164*	-.05595
	(.07358)	(.08166)	(.07412)	(.08201)
Early Contraceptive Pill Legalization	.1482	.0918	.15706*	.10427
	(.09012)	(.09642)	(.09103)	(.09281)
Observations	51	51	51	51
R-squared	.45553	.57488	.44321	.55626
Mean DV	0.118	0.118	0.118	0.118
Region FE	No	Yes	No	Yes

Standard errors are in parentheses. The data is for the year 1968. In calculating residual gender wage gap (columns 3-4), we partial out the effects of age, education, race, occupation type (272 codes), and industry (836 codes) from raw state-level gender wage gap.
*** p<0.01, ** p<0.05, * p<0.1

Appendix B

Appendix Table B-1 - Adding Current Region by Current Year Fixed Effects

	Outcomes:					
	Birth Weight	Low Birth Weight	Gestational Age	Preterm Birth	Fetal Growth	Small For Gestational Age
	(1)	(2)	(3)	(4)	(5)	(6)
Exposure	3.29452***	-.0012***	.00588	-.00093*	.07187***	-.00116***
	(.96727)	(.00037)	(.00473)	(.00056)	(.01935)	(.00036)
Observations	6820631	6820631	6820631	6820631	6820631	6820631
R-squared	.32015	.10423	.22845	.11702	.31667	.14813
Mean DV	3317.625	0.077	38.902	0.116	85.047	0.098

Standard errors, clustered on maternal birth state and birth year, are in parentheses. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980.
The regressions also include current region by current year fixed effects.
*** p<0.01, ** p<0.05, * p<0.1

Appendix Table B-2 - Dropping Early Reform States

	Outcomes:					
	Birth Weight	Low Birth Weight	Gestational Age	Preterm Birth	Fetal Growth	Small For Gestational Age
	(1)	(2)	(3)	(4)	(5)	(6)
Exposure	3.31831***	-.00131***	.00767	-.00073	.06552***	-.00107**
	(1.22822)	(.00035)	(.00528)	(.00062)	(.02532)	(.00047)
Observations	4505635	4505635	4505635	4505635	4505635	4505635
R-squared	.31106	.0995	.22993	.11149	.31365	.14659
Mean DV	3324.710	0.075	38.918	0.114	85.197	0.096

Standard errors, clustered on maternal birth state and birth year, are in parentheses. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980.

Early reform states: Colorado, California, North Carolina, Georgia, Maryland, New Mexico, Arkansas, Kansas, Oregon, South Carolina, and Virginia.

*** p<0.01, ** p<0.05, * p<0.1

Appendix Table B-3 - Dropping Alabama, Louisiana, Mississippi, Missouri, Georgia, and Texas

	Outcomes:					
	Birth Weight	Low Birth Weight	Gestational Age	Preterm Birth	Fetal Growth	Small For Gestational Age
	(1)	(2)	(3)	(4)	(5)	(6)
Exposure	3.33432***	-.00122***	.00655	-.00092*	.07147***	-.00125***
	(.96084)	(.00038)	(.00473)	(.00056)	(.01889)	(.00037)
Observations	5808784	5808784	5808784	5808784	5808784	5808784
R-squared	.30109	.09548	.21431	.10333	.30346	.13886
Mean DV	3328.560	0.075	38.940	0.112	85.246	0.095

Standard errors, clustered on maternal birth state and birth year, are in parentheses. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980.
*** p<0.01, ** p<0.05, * p<0.1

Appendix Table B-4 - Dropping Spillover States

	Outcomes:					
	Birth Weight	Low Birth Weight	Gestational Age	Preterm Birth	Fetal Growth	Small For Gestational Age
	(1)	(2)	(3)	(4)	(5)	(6)
Exposure	3.58336***	-.00124***	.01034**	-.00121**	.06963***	-.00114***
	(1.03102)	(.0004)	(.00507)	(.0006)	(.02025)	(.00035)
Observations	6124741	6124741	6124741	6124741	6124741	6124741
R-squared	.32359	.10538	.23027	.11823	.31951	.15041
Mean DV	3315.704	0.077	38.894	0.117	85.016	0.098

Standard errors, clustered on maternal birth state and birth year, are in parentheses. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980.
The sample drops states in the neighboring of early repeal states.
Spillover states: Arizona, Nevada, Oregon, Idaho, New Jersey, Pennsylvania, Connecticut, Massachusetts, Vermont, Maryland, and Virginia.
*** p<0.01, ** p<0.05, * p<0.1

Appendix Table B-5 - Adding State-Specific Linear Time Trend for Pretreatment Years

	Outcomes:					
	Birth Weight	Low Birth Weight	Gestational Age	Preterm Birth	Fetal Growth	Small For Gestational Age
	(1)	(2)	(3)	(4)	(5)	(6)
Exposure	2.71193***	-.00055	.00292	-.00007	.06616***	-.00074**
	(.91263)	(.00035)	(.00426)	(.00051)	(.01934)	(.00036)
Observations	6820633	6820633	6820633	6820633	6820633	6820633
R-squared	.31961	.10407	.22767	.1168	.31619	.14798
Mean DV	3317.625	0.077	38.902	0.116	85.047	0.098

Standard errors, clustered on maternal birth state and birth year, are in parentheses. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980.

The regressions include a birth state linear trend for the years prior to abortion legalization.

*** p<0.01, ** p<0.05, * p<0.1

Appendix Table B-6 - Only Birth State and Region – Cohort Fixed Effects

	Outcomes:					
	Birth Weight	Low Birth Weight	Gestational Age	Preterm Birth	Fetal Growth	Small For Gestational Age
	(1)	(2)	(3)	(4)	(5)	(6)
Exposure	3.31527***	-.00131***	.01562***	-.00112*	.05596**	-.00097***
	(1.22763)	(.00042)	(.00529)	(.00058)	(.02849)	(.00037)
Observations	6820633	6820633	6820633	6820633	6820633	6820633
R-squared	.04849	.01561	.05799	.0236	.0311	.0144
Mean DV	3317.625	0.077	38.902	0.116	85.047	0.098

Standard errors, clustered on maternal birth state and birth year, are in parentheses. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects and maternal birth year by birth region fixed effects. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980.
*** p<0.01, ** p<0.05, * p<0.1

Appendix Table B-7 - Adding Birth State Infant Mortality Rate, Life Expectancy, and Continuous Measures of Measles Rate (1950-1965) and Polio Rate (1950-1955) Interacted by Birth Year Fixed Effects

	Outcomes:					
	Birth Weight	Low Birth Weight	Gestational Age	Preterm Birth	Fetal Growth	Small For Gestational Age
	(1)	(2)	(3)	(4)	(5)	(6)
Exposure	3.33048***	-.00113***	.00889*	-.00127**	.06561***	-.00098***
	(.98586)	(.00037)	(.00482)	(.00057)	(.02009)	(.00036)
Observations	6673268	6673268	6673268	6673268	6673268	6673268
R-squared	.32291	.10545	.23032	.1185	.31933	.14975
Mean DV	3317.541	0.077	38.902	0.116	85.044	0.098

Standard errors, clustered on maternal birth state and birth year, are in parentheses. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980.

The regressions also include maternal birth state by birth year infant mortality rate and life expectancy. Additionally, regressions include continuous measures of measles and polio rates at maternal birth state level interacted with birth year fixed effects.

*** p<0.01, ** p<0.05, * p<0.1

Appendix Table B-8 - Birth State Level Clustering

	Outcomes:					
	Birth Weight	Low Birth Weight	Gestational Age	Preterm Birth	Fetal Growth	Small For Gestational Age
	(1)	(2)	(3)	(4)	(5)	(6)
Exposure	3.28449**	-.0012**	.0069	-.00095	.06948**	-.00113***
	(1.35429)	(.00054)	(.00662)	(.00061)	(.02605)	(.00037)
Observations	6820633	6820633	6820633	6820633	6820633	6820633
R-squared	.3195	.10401	.2275	.11669	.31611	.14793
Mean DV	3317.625	0.077	38.902	0.116	85.047	0.098

Standard errors, clustered on maternal birth state, are in parentheses. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980.
*** p<0.01, ** p<0.05, * p<0.1

Appendix Table B-9 - Weighting by Birth Count and Share of Females in Maternal Birth State Population

	Outcomes:					
	Birth Weight	Low Birth Weight	Gestational Age	Preterm Birth	Fetal Growth	Small For Gestational Age
	(1)	(2)	(3)	(4)	(5)	(6)
Exposure	5.04903***	-.00148***	.00737	-.00097	.11673***	-.00146***
	(1.0394)	(.00041)	(.00563)	(.00063)	(.0201)	(.0004)
Observations	6702480	6702480	6702480	6702480	6702480	6702480
R-squared	.37288	.12802	.2697	.13791	.37315	.18058
Mean DV	3320.764	0.076	38.899	0.115	85.131	0.096

Standard errors, clustered on maternal birth state and birth year, are in parentheses. Regressions are weighted using birth counts in each cell multiplied by the share of women in mothers' birth state. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980.

*** p<0.01, ** p<0.05, * p<0.1

Appendix Table B-10 - Weighting by Birth Count and Infant Mortality Rate in Maternal Birth State Population

	Outcomes:					
	Birth Weight	Low Birth Weight	Gestational Age	Preterm Birth	Fetal Growth	Small For Gestational Age
	(1)	(2)	(3)	(4)	(5)	(6)
Exposure	5.75446***	-.00204***	.00864	-.00139**	.13675***	-.00167***
	(1.34329)	(.00051)	(.00724)	(.00069)	(.02596)	(.00046)
Observations	6820633	6820633	6820633	6820633	6820633	6820633
R-squared	.38393	.13575	.27098	.15003	.37672	.18562
Mean DV	3308.966	0.079	38.873	0.119	84.879	0.100

Standard errors, clustered on maternal birth state and birth year, are in parentheses. Regressions are weighted using birth counts in each cell multiplied by the infant mortality rate in mothers' birth state. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980.
*** p<0.01, ** p<0.05, * p<0.1

Appendix Table B-11 - Adding Birth State by Maternal Race Fixed Effects

	Outcomes:					
	Birth Weight	Low Birth Weight	Gestational Age	Preterm Birth	Fetal Growth	Small For Gestational Age
	(1)	(2)	(3)	(4)	(5)	(6)
Exposure	3.13801***	-.00117***	.00622	-.00086	.06684***	-.00114***
	(.982)	(.00038)	(.0047)	(.00055)	(.0196)	(.00037)
Observations	6820633	6820633	6820633	6820633	6820633	6820633
R-squared	.32179	.10456	.2285	.11736	.31857	.1489
Mean DV	3317.625	0.077	38.902	0.116	85.047	0.098

Standard errors, clustered on maternal birth state and birth year, are in parentheses. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980.

The regressions include the interaction of maternal birth state by race dummies.

*** p<0.01, ** p<0.05, * p<0.1

Appendix Table B-12 - Adding Birth State by Current State Fixed Effects

	Outcomes:					
	Birth Weight	Low Birth Weight	Gestational Age	Preterm Birth	Fetal Growth	Small For Gestational Age
	(1)	(2)	(3)	(4)	(5)	(6)
Exposure	3.22321***	-.0012***	.00676	-.00094*	.06823***	-.00112***
	(.96584)	(.00038)	(.00468)	(.00056)	(.0194)	(.00037)
Observations	6820633	6820633	6820633	6820633	6820633	6820633
R-squared	.32128	.1049	.22931	.11792	.31743	.14875
Mean DV	3317.625	0.077	38.902	0.116	85.047	0.098

Standard errors, clustered on maternal birth state and birth year, are in parentheses. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980.

The regressions also add birth state by current state fixed effects.

*** p<0.01, ** p<0.05, * p<0.1

Appendix Table B-13 - Adding Dummies to Capture Cohort-State-Specific Exposure to Contraception Pill Access

	Outcomes:					
	Birth Weight	Low Birth Weight	Gestational Age	Preterm Birth	Fetal Growth	Small For Gestational Age
	(1)	(2)	(3)	(4)	(5)	(6)
Exposure	2.99318***	-.00118***	.00577	-.00091*	.06524***	-.00107***
	(.9669)	(.00036)	(.00449)	(.00055)	(.02008)	(.00037)
Observations	6820633	6820633	6820633	6820633	6820633	6820633
R-squared	.31953	.10402	.22753	.11669	.31613	.14794
Mean DV	3317.625	0.077	38.902	0.116	85.047	0.098

Standard errors, clustered on maternal birth state and birth year, are in parentheses. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980.

The regressions add a series of dummy variables indicating the distance of mothers' cohorts relative to the state specific year of oral contraception pill access.

*** $p<0.01$, ** $p<0.05$, * $p<0.1$

Appendix Table B-14 - Utilizing Ordinary Least Squares Method

	Outcomes:					
	Birth Weight	Low Birth Weight	Gestational Age	Preterm Birth	Fetal Growth	Small For Gestational Age
	(1)	(2)	(3)	(4)	(5)	(6)
Exposure	3.28449***	-.0012***	.0069	-.00095*	.06948***	-.00113***
	(.95798)	(.00037)	(.00464)	(.00055)	(.01925)	(.00036)
Observations	68006574	68006574	68006574	68006574	68006574	68006574
R-squared	.3195	.10401	.2275	.11669	.31611	.14793
Mean DV	3317.625	0.077	38.902	0.116	85.047	0.098

Standard errors, clustered on maternal birth state and birth year, are in parentheses. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980.

*** p<0.01, ** p<0.05, * p<0.1

Appendix Table B-15 - Additional Maternal and Paternal Controls

	Outcomes:					
	Birth Weight	Low Birth Weight	Gestational Age	Preterm Birth	Fetal Growth	Small For Gestational Age
	(1)	(2)	(3)	(4)	(5)	(6)
Exposure	3.58336***	-.00124***	.01034**	-.00121**	.06963***	-.00114***
	(1.03102)	(.0004)	(.00507)	(.0006)	(.02025)	(.00035)
Observations	6124741	6124741	6124741	6124741	6124741	6124741
R-squared	.32359	.10538	.23027	.11823	.31951	.15041
Mean DV	3315.704	0.077	38.894	0.117	85.016	0.098

Standard errors, clustered on maternal birth state and birth year, are in parentheses. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980.

Additional controls include father race, father age group, maternal marital status at the time of birth, and missing variables for the missing values of these controls.

*** p<0.01, ** p<0.05, * p<0.1

Appendix Table B-16 – Adding Birth-State Gender Wage Gap

	Outcomes:					
	Birth Weight	Low Birth Weight	Gestational Age	Preterm Birth	Fetal Growth	Small For Gestational Age
	(1)	(2)	(3)	(4)	(5)	(6)
Exposure	7.02215***	-.00331***	.01644**	-.00117	.15648***	-.00213***
	(1.64145)	(.00062)	(.00811)	(.00079)	(.03489)	(.00064)
Observations	4189566	4189566	4189566	4189566	4189566	4189566
R-squared	.34133	.11465	.23474	.12643	.33817	.16046
Mean DV	3311.343	0.078	38.858	0.118	84.973	0.098

Standard errors, clustered on maternal birth state and birth year, are in parentheses. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980.

Additional regressors are raw state-level gender wage gap as well as residual gender wage gap. To calculate residual gender wage gap, we partial out the effects of age, education, race, occupation type (272 codes), and industry (836 codes) from raw state-level gender wage gap. These measures are calculated from ASEC-CPS data for the years 1962-1980.

*** p<0.01, ** p<0.05, * p<0.1

Appendix Table B-17 – Removing California

	Outcomes:					
	Birth Weight	Low Birth Weight	Gestational Age	Preterm Birth	Fetal Growth	Small For Gestational Age
	(1)	(2)	(3)	(4)	(5)	(6)
Exposure	3.33012***	-.00163***	.00868	-.001	.06807**	-.00116**
	(1.29001)	(.0004)	(.00549)	(.00062)	(.02652)	(.00045)
Observations	6503380	6503380	6503380	6503380	6503380	6503380
R-squared	.31502	.1022	.22265	.11597	.31089	.1458
Mean DV	3313.472	0.078	38.891	0.117	84.961	0.099

Standard errors, clustered on maternal birth state and birth year, are in parentheses. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980.
*** p<0.01, ** p<0.05, * p<0.1

Appendix Table B-18 – Placebo Test: Shifting Abortion Years Ten Years Earlier

	Outcomes:					
	Birth Weight	Low Birth Weight	Gestational Age	Preterm Birth	Fetal Growth	Small For Gestational Age
	(1)	(2)	(3)	(4)	(5)	(6)
Exposure	.59772	.0003	-.00667*	.00138***	.02916	-.00031
	(1.08596)	(.00031)	(.0039)	(.0004)	(.02329)	(.00037)
Observations	6220756	6220756	6220756	6220756	6220756	6220756
R-squared	.33413	.11355	.24284	.13831	.32649	.15524
Mean DV	3351.234	0.070	39.192	0.102	85.328	0.096

Standard errors, clustered on maternal birth state and birth year, are in parentheses. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980.
*** p<0.01, ** p<0.05, * p<0.1

Appendix Table B-19 – Placebo Test: Using Foreign-Born Mothers and Their State of Residence

	Outcomes:					
	Birth Weight	Low Birth Weight	Gestational Age	Preterm Birth	Fetal Growth	Small For Gestational Age
	(1)	(2)	(3)	(4)	(5)	(6)
Exposure	-1.67925	.00028	.00382	-.00097	-.06024*	.00084
	(1.52268)	(.00058)	(.0073)	(.00076)	(.03293)	(.00059)
Observations	753760	753760	753760	753760	753760	753760
R-squared	.35343	.09096	.22691	.09774	.39729	.1972
Mean DV	3303.010	0.068	38.818	0.110	84.893	0.098

Standard errors, clustered on maternal birth state and birth year, are in parentheses. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980.

*** p<0.01, ** p<0.05, * p<0.1

Appendix Table B-20 – Removing Birth Weight Heaping Points

	Outcomes:					
	Birth Weight	Low Birth Weight	Gestational Age	Preterm Birth	Fetal Growth	Small For Gestational Age
	(1)	(2)	(3)	(4)	(5)	(6)
Exposure	4.26925***	-.00101***	.00861**	-.00102*	.09062***	-.00136***
	(1.01846)	(.00037)	(.00435)	(.00056)	(.02171)	(.00039)
Observations	6778819	6778819	6778819	6778819	6778819	6778819
R-squared	.32	.08676	.23514	.10332	.31673	.1399
Mean DV	3357.561	0.054	39.033	0.101	85.902	0.088

Birth-weight heaping, rounding weights to common ounce values, can create spikes in the distribution (Blencowe et al., 2019). This table re-estimates the main specification after removing all observations that fall on common heaping points. Standard errors, clustered on maternal birth state and birth year, are in parentheses. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980.

*** $p<0.01$, ** $p<0.05$, * $p<0.1$

Appendix Table B-21 – Restricting Maternal Cohorts to 1960-1976

	Outcomes:					
	Birth Weight	Low Birth Weight	Gestational Age	Preterm Birth	Fetal Growth	Small For Gestational Age
	(1)	(2)	(3)	(4)	(5)	(6)
Exposure	2.8271***	-.00135***	.01018**	-.00113**	.05049***	-.00093**
	(.96199)	(.00038)	(.00462)	(.00055)	(.01939)	(.00037)
Observations	5604587	5604587	5604587	5604587	5604587	5604587
R-squared	.32128	.10625	.23349	.12354	.31653	.15099
Mean DV	3325.970	0.076	38.954	0.115	85.159	0.098

Standard errors, clustered on maternal birth state and birth year, are in parentheses. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980.
*** p<0.01, ** p<0.05, * p<0.1

Appendix Table B-22 - Effects on First-Generation Infant Health Restricting to Cohorts of 1960-1976

	Outcomes:		
	Share Low Birth Weight Whites	Share Low Birth Weight Blacks	Share Low Birth Weight Total
	(1)	(2)	(3)
Exposure	-.00209***	.00035	-.0015
	(.00057)	(.00188)	(.00119)
Observations	867	867	867
R-squared	.9187	.8651	.88425
Mean DV	0.068	0.129	0.103
	Share Very Low Birth Weight Whites	Share Very Low Birth Weight Blacks	Share Very Low Birth Weight Total
	(4)	(5)	(6)
Exposure	-.00027	-.00121	-.00098*
	(.00018)	(.00082)	(.00051)
Observations	867	867	867
R-squared	.58106	.62989	.69387
Mean DV	0.010	0.022	0.017
	Infant Mortality Rate Whites (per 1,000 Births)	Infant Mortality Rate Blacks (per 1,000 Births)	Infant Mortality Rate Total (per 1,000 Births)
	(7)	(8)	(9)
Exposure	-.64861***	.37382	-.6695***
	(.216)	(.80545)	(.21586)
Observations	867	867	867
R-squared	.95394	.85708	.96382
Mean DV	18.644	31.986	21.068

Notes. Standard errors, clustered on state, are in parentheses. Regressions are weighted using state population. All regressions include state fixed effects and region by year fixed effects. Regressions also contain state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1960 – 1976.
First generation: Women born between 1960 and 1976 who were directly exposed to legal abortion in early life.
*** p<0.01, ** p<0.05, * p<0.1

Appendix Table B-23 - Effects on Zeroth-Generation Outcomes Restricting to Cohorts of 1960-1976

	Outcomes:			
	Birth Rate Whites (per 1,000 Women)	Birth Rate Blacks (per 1,000 Women)	Share Teenage Mothers	Share Married Mothers
	(1)	(2)	(3)	(4)
Exposure	-2.1719***	-7.15048***	-.00369**	.02528***
	(.77912)	(1.46129)	(.00148)	(.00557)
Observations	867	867	450	450
R-squared	.97635	.9483	.99232	.87498
Mean DV	83.594	116.587	0.181	0.885

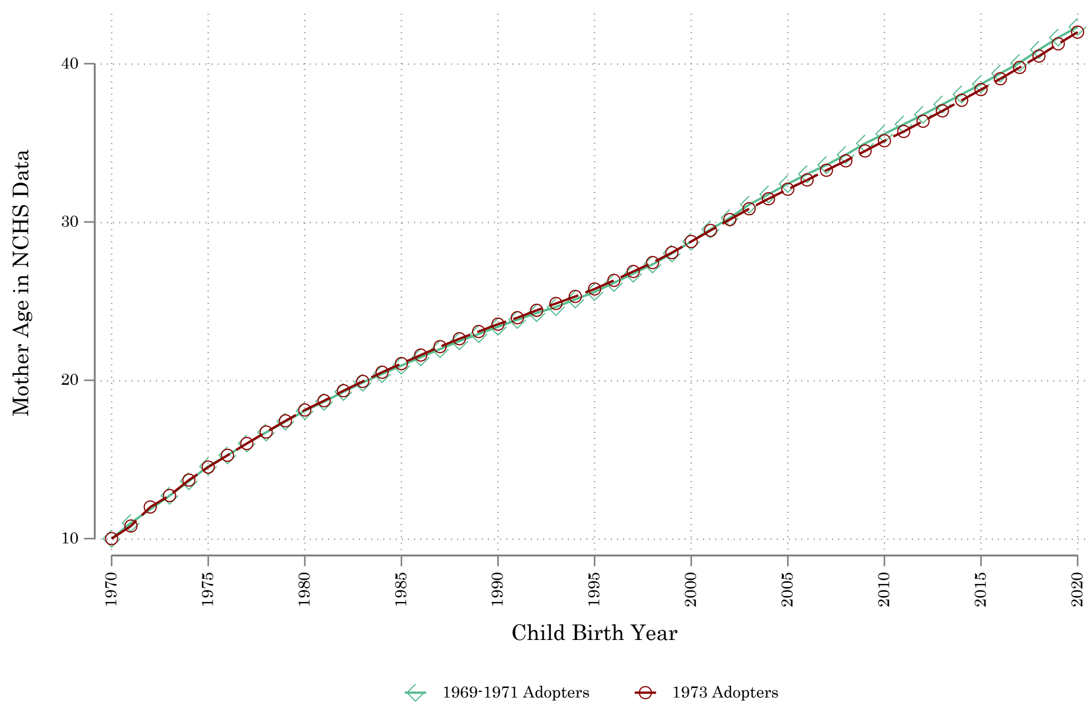
Notes. Standard errors, clustered on state, are in parentheses. Regressions are weighted using state population. All regressions include state fixed effects and region by year fixed effects. Regressions also contain state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1960 – 1976.
Zeroth generation: Women who had children between 1960 and 1976.
*** p<0.01, ** p<0.05, * p<0.1

Appendix Table B-24 – Adding Maternal Age by Year Fixed Effects

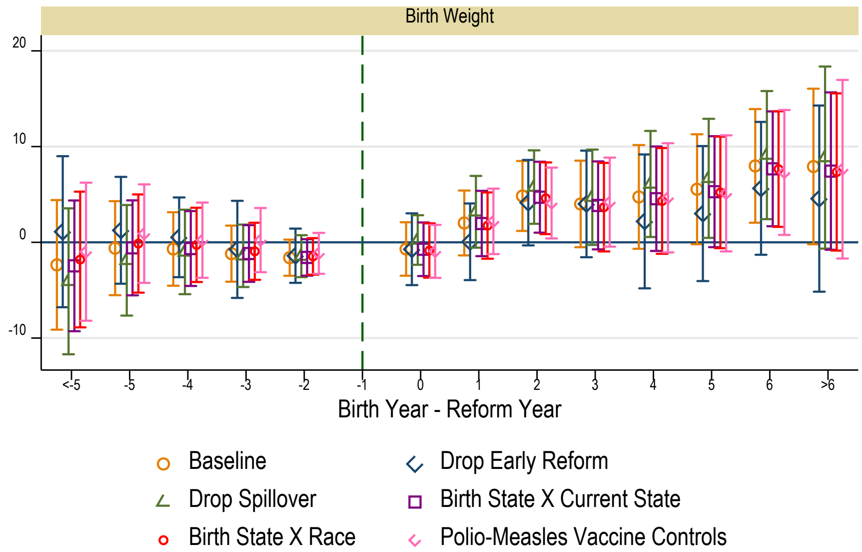
	Outcomes:					
	Birth Weight	Low Birth Weight	Gestational Age	Preterm Birth	Fetal Growth	Small For Gestational Age
	(1)	(2)	(3)	(4)	(5)	(6)
Exposure	3.42211***	-.00114***	.0066	-.00084	.074***	-.00113***
	(.94761)	(.00037)	(.00464)	(.00055)	(.01899)	(.00037)
Observations	6913252	6913252	6913252	6913252	6913252	6913252
R-squared	.32171	.10621	.23406	.12168	.31751	.15116
Mean DV	3317.173	0.077	38.898	0.116	85.043	0.099

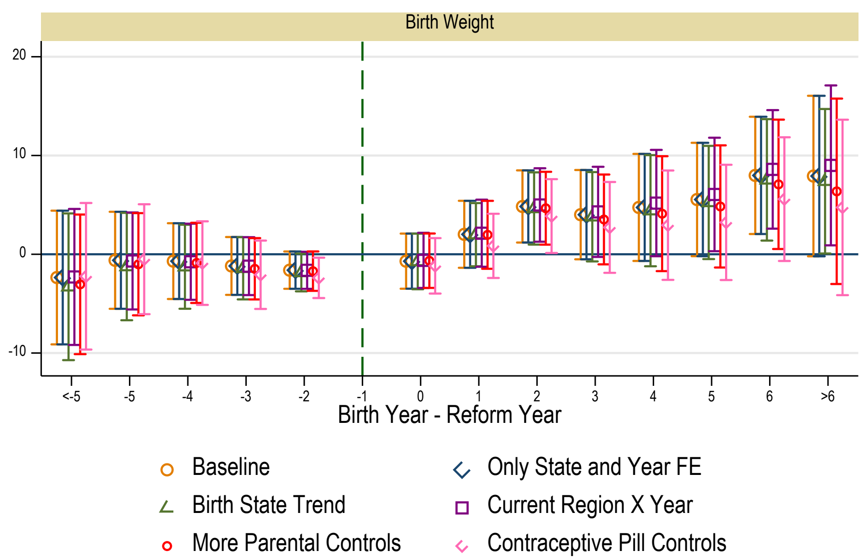
Standard errors, clustered on maternal birth state and birth year, are in parentheses. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980.

*** p<0.01, ** p<0.05, * p<0.1



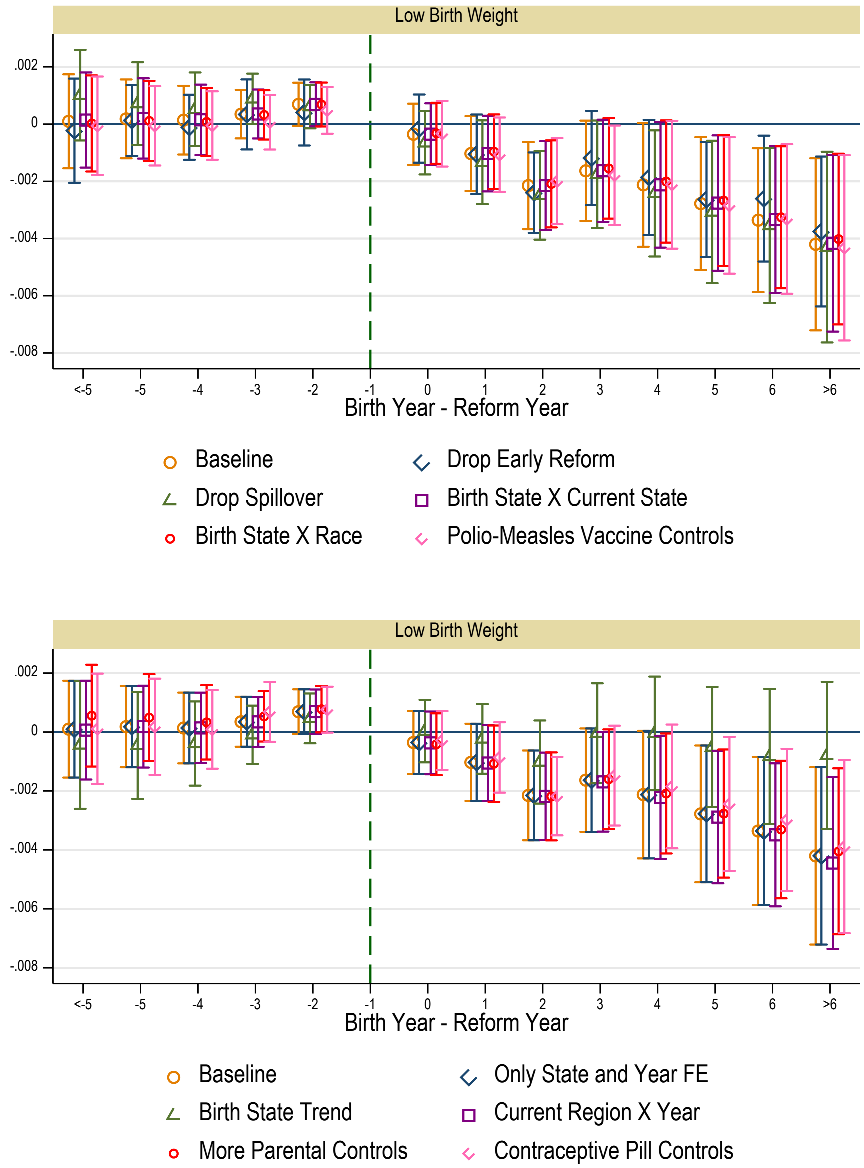
Appendix Figure B-1 - Evolution of Maternal Age across Years





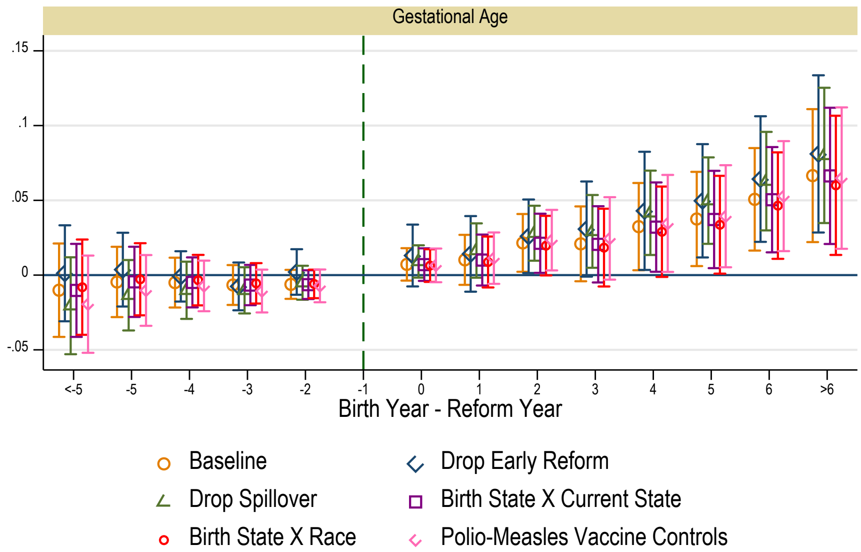
Appendix Figure B-2 - Event Study Analysis to Show the Robustness of the Results

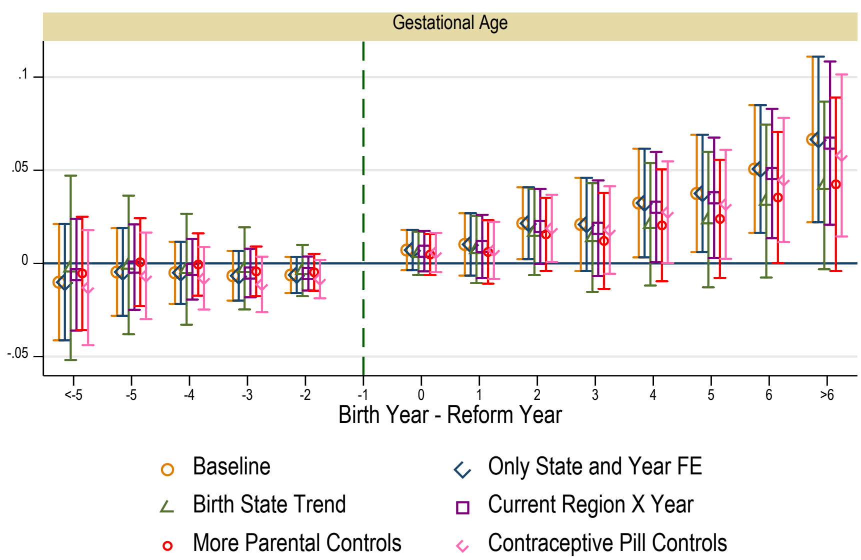
Notes. Point estimates and 95% confidence intervals are illustrated. Standard errors are clustered on maternal birth state. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980.



Appendix Figure B-3 - Event Study Analysis to Show the Robustness of the Results

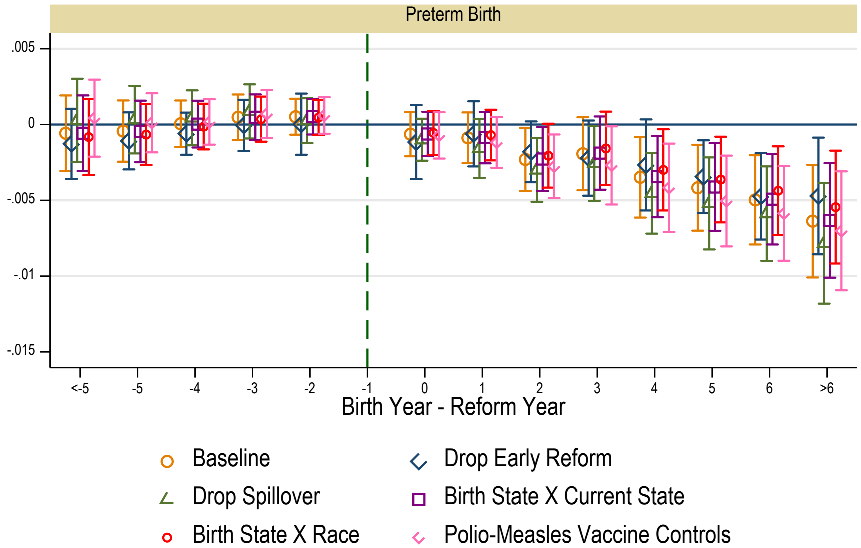
Notes. Point estimates and 95% confidence intervals are illustrated. Standard errors are clustered on maternal birth state. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980.

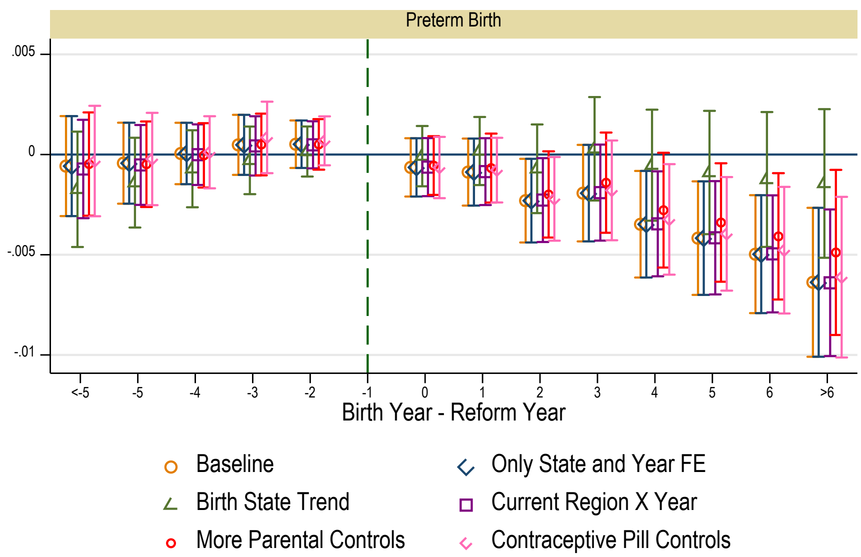




Appendix Figure B-4 - Event Study Analysis to Show the Robustness of the Results

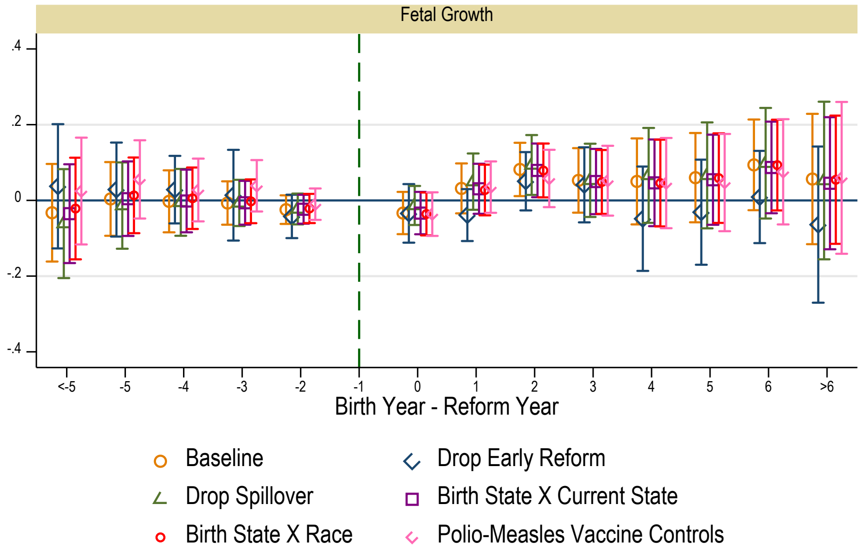
Notes. Point estimates and 95% confidence intervals are illustrated. Standard errors are clustered on maternal birth state. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980.

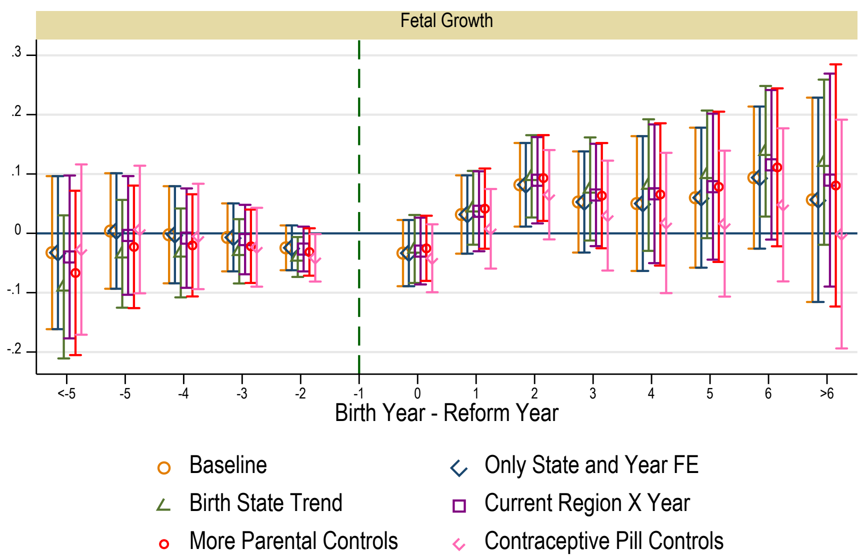




Appendix Figure B-5 - Event Study Analysis to Show the Robustness of the Results

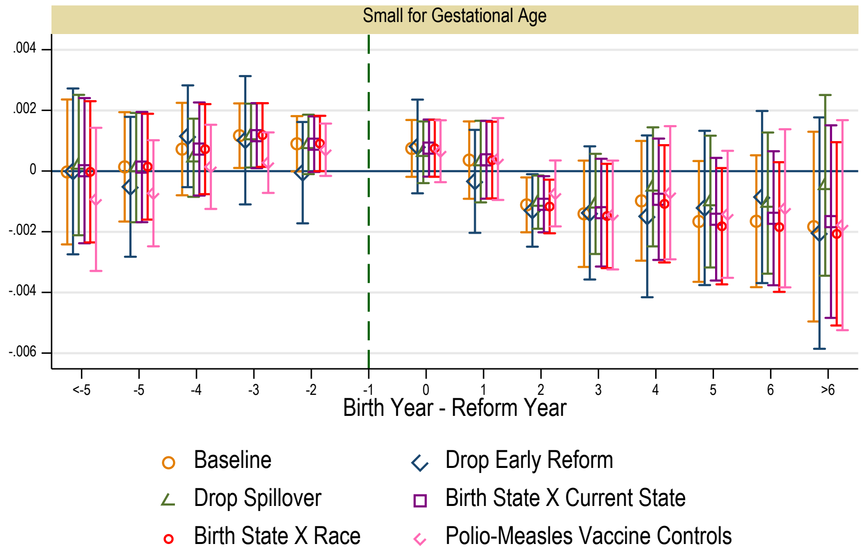
Notes. Point estimates and 95% confidence intervals are illustrated. Standard errors are clustered on maternal birth state. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980.

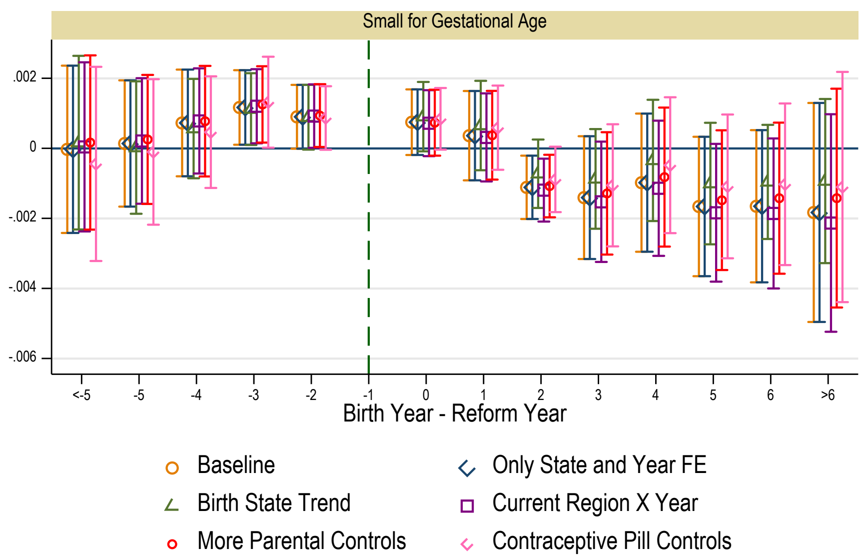




Appendix Figure B-6 - Event Study Analysis to Show the Robustness of the Results

Notes. Point estimates and 95% confidence intervals are illustrated. Standard errors are clustered on maternal birth state. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980.

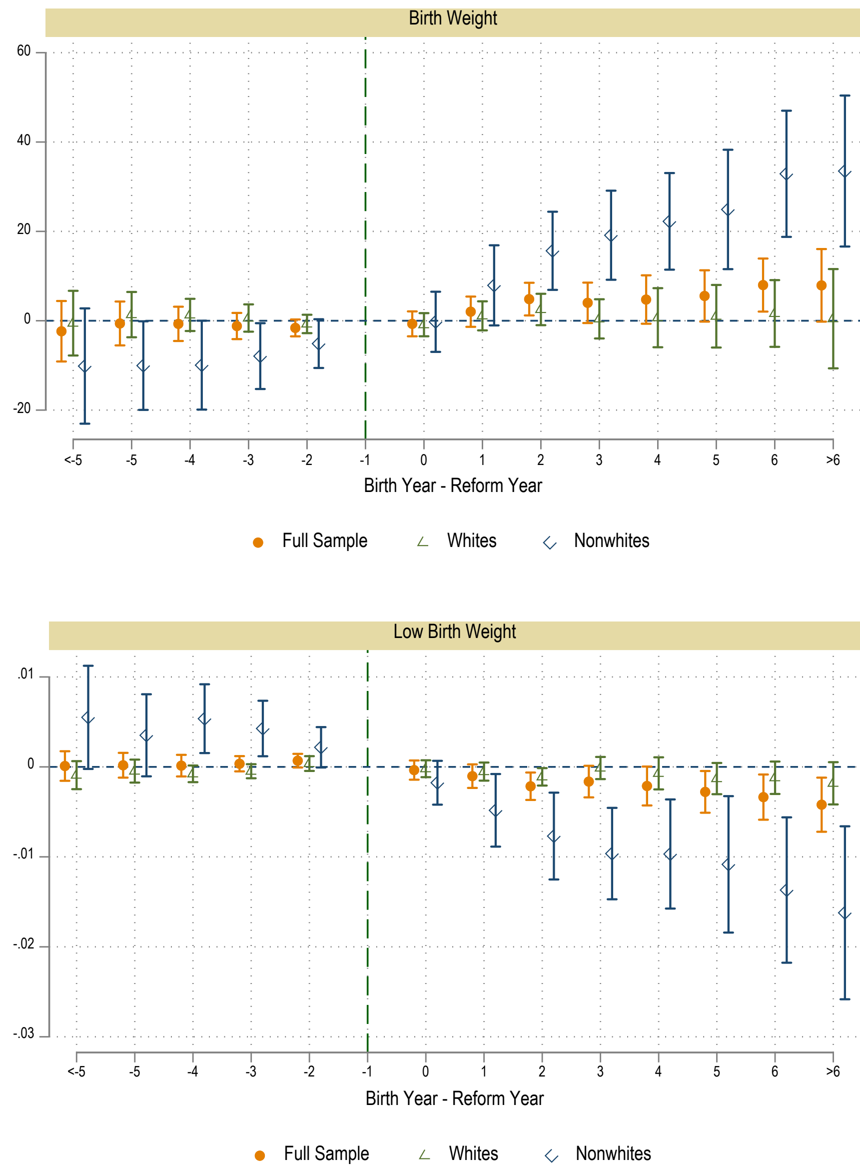




Appendix Figure B-7 - Event Study Analysis to Show the Robustness of the Results

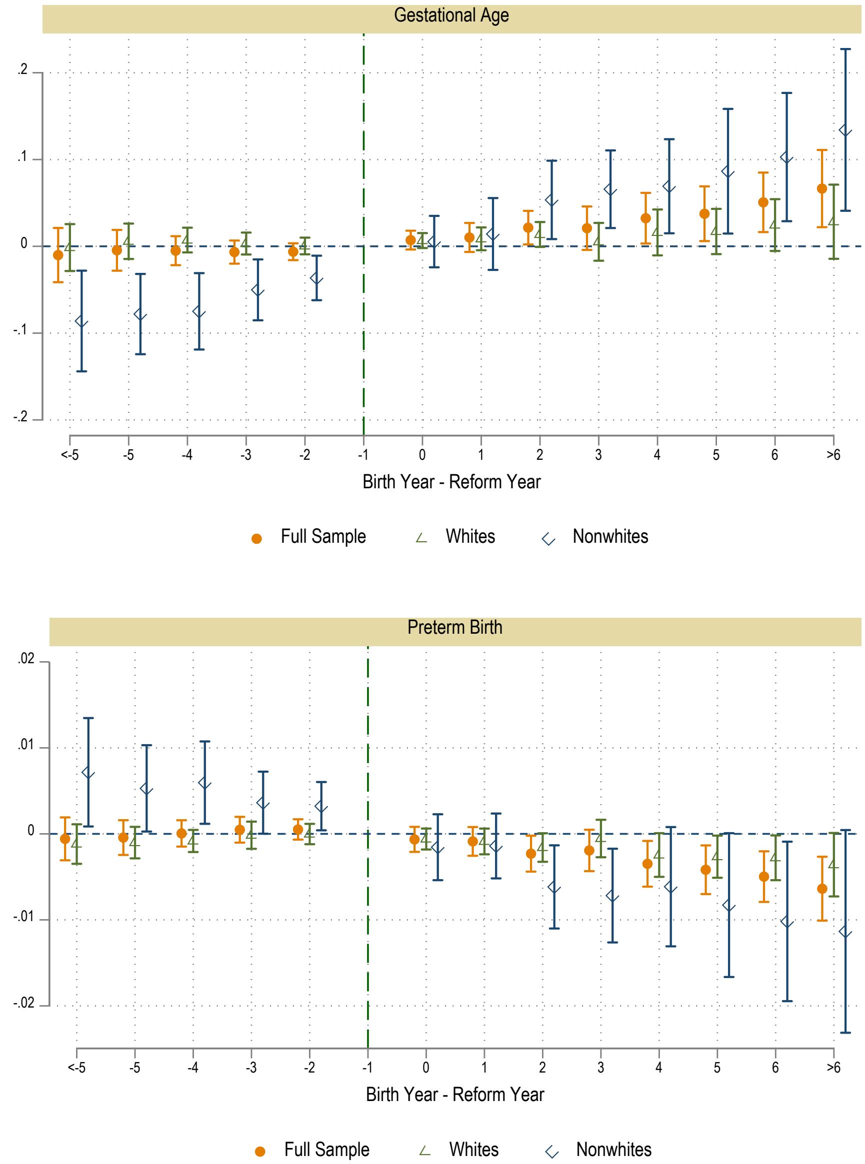
Notes. Point estimates and 95% confidence intervals are illustrated. Standard errors are clustered on maternal birth state. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980.

Appendix C



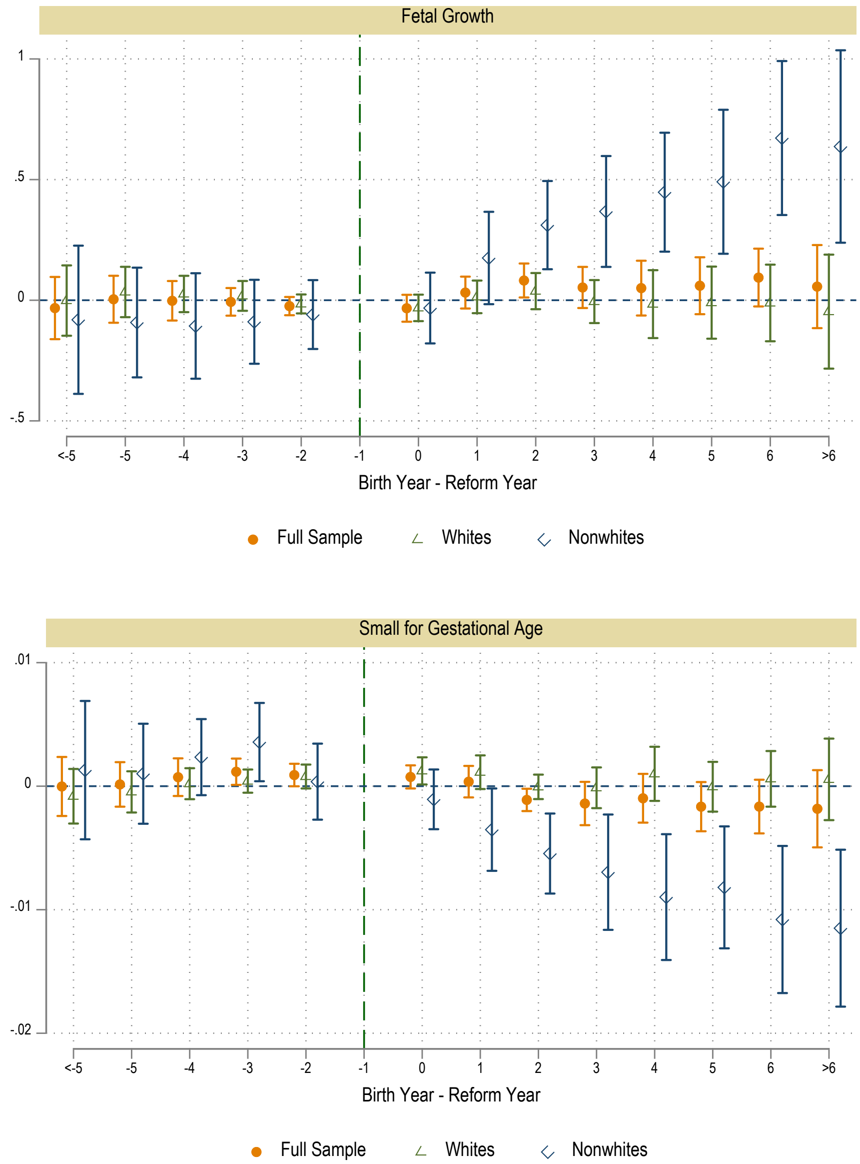
Appendix Figure C-1 - Event Study Analysis to Show the Heterogeneity by Race

Notes. The horizontal axis displays the difference between the mother's birth year and the year abortion was legalized in their state, with negative values indicating birth years prior to legalization and positive values indicating birth years after legalization. Point estimates and 95% confidence intervals are illustrated. Standard errors are clustered on maternal birth state. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980.



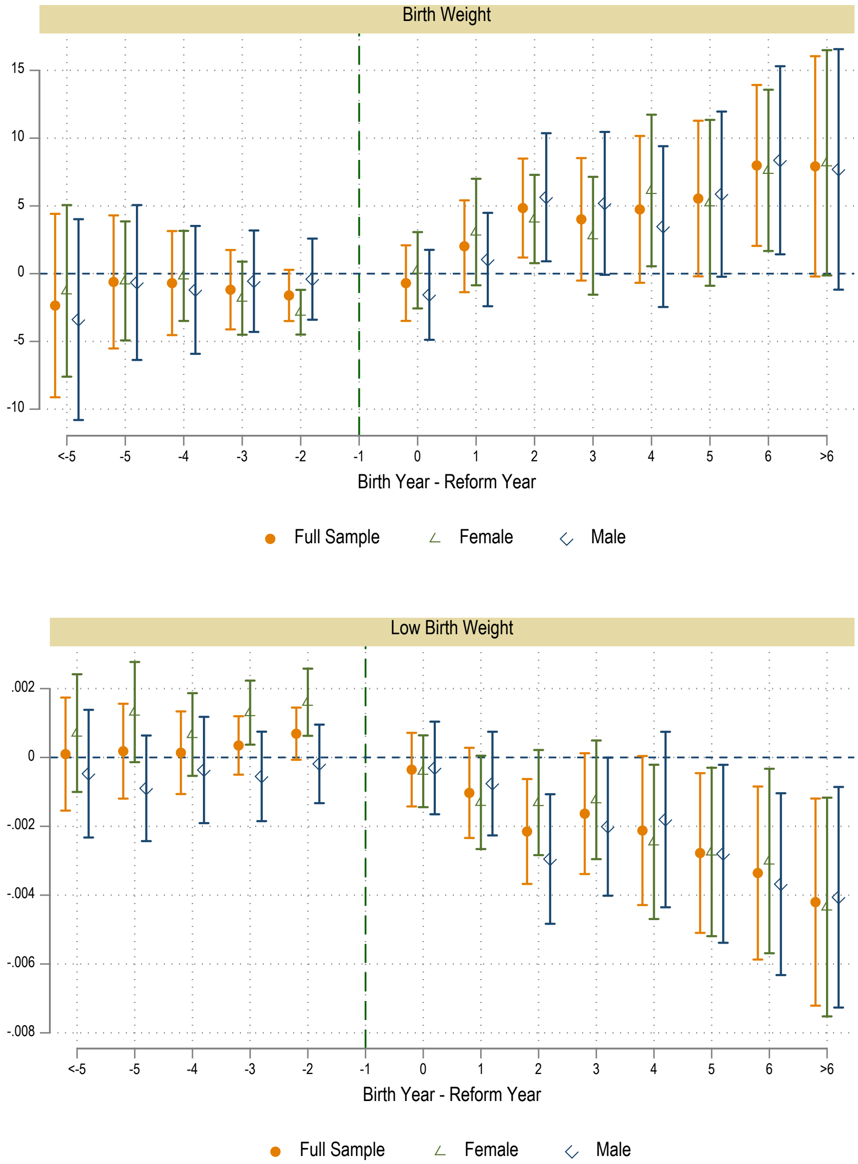
Appendix Figure C-2 - Event Study Analysis to Show the Heterogeneity by Race

Notes. The horizontal axis displays the difference between the mother's birth year and the year abortion was legalized in their state, with negative values indicating birth years prior to legalization and positive values indicating birth years after legalization. Point estimates and 95% confidence intervals are illustrated. Standard errors are clustered on maternal birth state. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980.



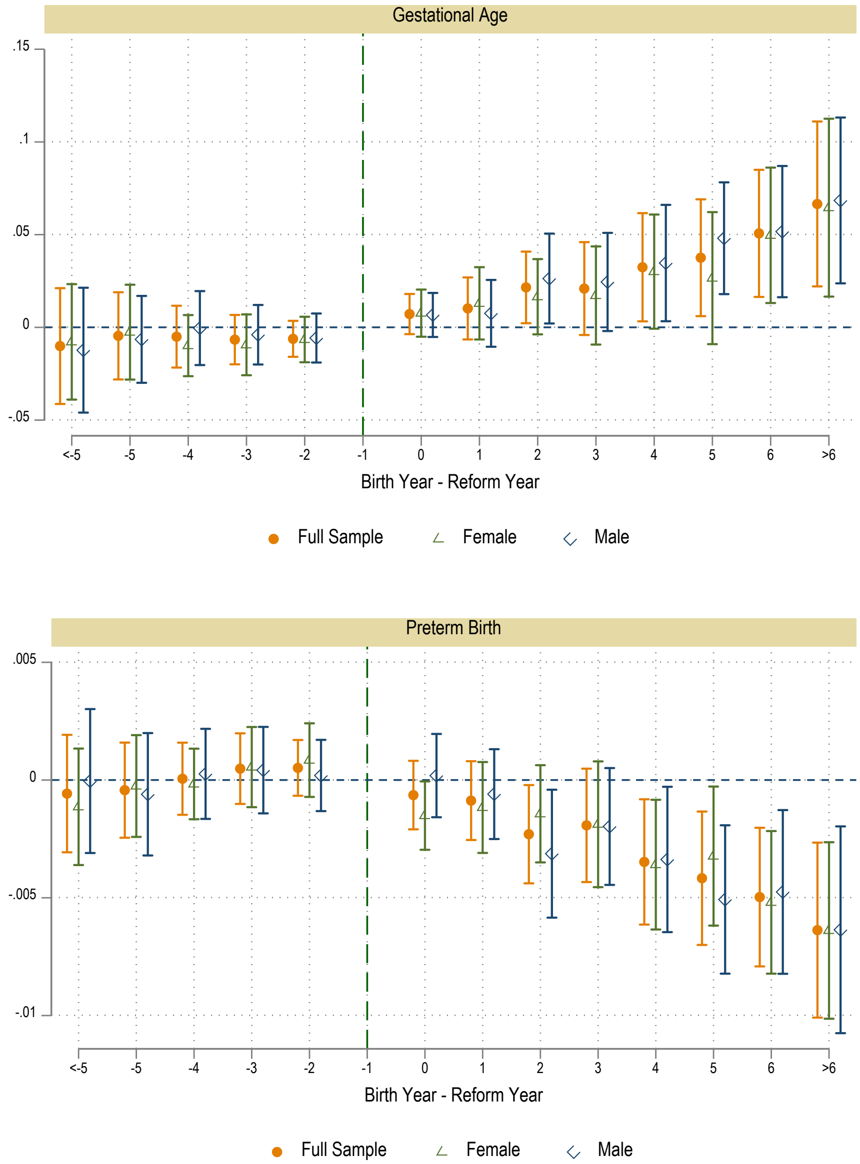
Appendix Figure C-3 - Event Study Analysis to Show the Heterogeneity by Race

Notes. The horizontal axis displays the difference between the mother's birth year and the year abortion was legalized in their state, with negative values indicating birth years prior to legalization and positive values indicating birth years after legalization. Point estimates and 95% confidence intervals are illustrated. Standard errors are clustered on maternal birth state. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980.



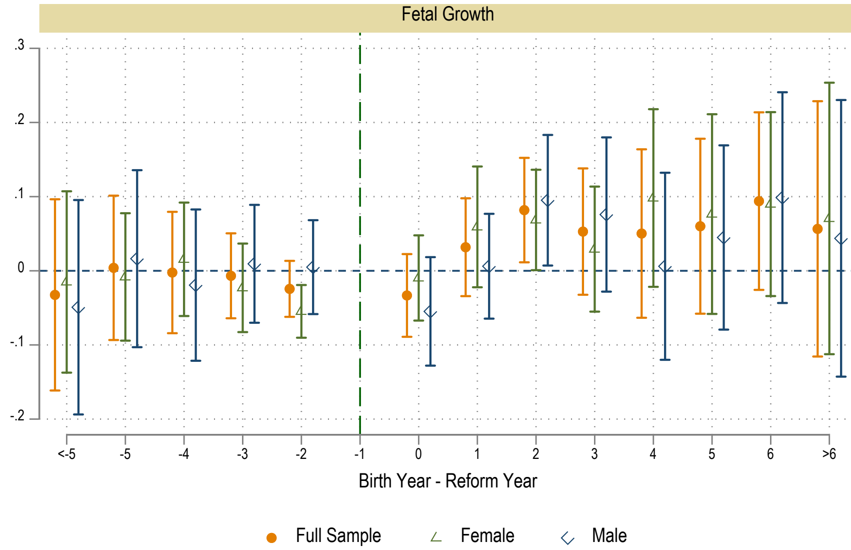
Appendix Figure C-4 - Event Study Analysis to Show the Heterogeneity by Gender

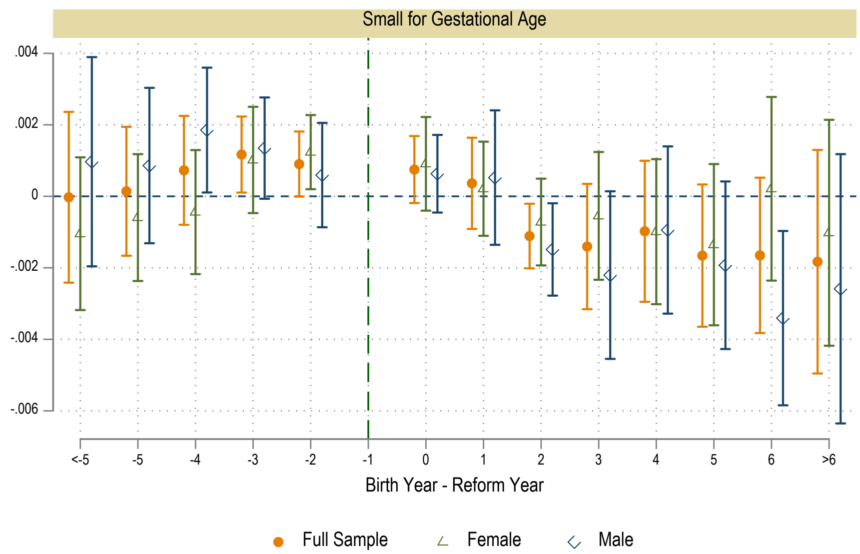
Notes. The horizontal axis displays the difference between the mother's birth year and the year abortion was legalized in their state, with negative values indicating birth years prior to legalization and positive values indicating birth years after legalization. Point estimates and 95% confidence intervals are illustrated. Standard errors are clustered on maternal birth state. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980.



Appendix Figure C-5 - Event Study Analysis to Show the Heterogeneity by Gender

Notes. The horizontal axis displays the difference between the mother's birth year and the year abortion was legalized in their state, with negative values indicating birth years prior to legalization and positive values indicating birth years after legalization. Point estimates and 95% confidence intervals are illustrated. Standard errors are clustered on maternal birth state. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980.





Appendix Figure C-6 - Event Study Analysis to Show the Heterogeneity by Gender

Notes. The horizontal axis displays the difference between the mother's birth year and the year abortion was legalized in their state, with negative values indicating birth years prior to legalization and positive values indicating birth years after legalization. Point estimates and 95% confidence intervals are illustrated. Standard errors are clustered on maternal birth state. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980.

Appendix Table C-1 - Heterogeneity Based on Birth Order of Second Generations

	Outcomes:					
	Birth Weight	Low Birth Weight	Gestational Age	Preterm Birth	Fetal Growth	Small For Gestational Age
	(1)	(2)	(3)	(4)	(5)	(6)
Panel A. First-Born						
Exposure	.96579	.0001	.00699	-.00023	.00699	.00023
	(1.28767)	(.00042)	(.00485)	(.00061)	(.03046)	(.00064)
Observations	2662289	2662289	2662289	2662289	2662289	2662289
R-squared	.25993	.07705	.17565	.09176	.23358	.11801
Mean DV	3297.534	0.075	39.141	0.107	84.044	0.108
Panel B. Second-Higher Birth Order						
Exposure	4.57817***	-.00187***	.00609	-.00133**	.10638***	-.00178***
	(1.21324)	(.0005)	(.00555)	(.00065)	(.02475)	(.00044)
Observations	4158344	4158344	4158344	4158344	4158344	4158344
R-squared	.35614	.12506	.22455	.13044	.35191	.16534
Mean DV	3327.736	0.078	38.782	0.120	85.552	0.093

Standard errors, clustered on maternal birth state and birth year, are in parentheses. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980.

*** p<0.01, ** p<0.05, * p<0.1

Appendix Table C-2 - Heterogeneity in the Effects on Birth Outcomes Among First Generations, by Birth Order and Race (Natality Data 1968–1980)

	Outcomes:					
	Birth Weight	Low Birth Weight	Gestational Age	Preterm Birth	Fetal Growth	Small For Gestational Age
	(1)	(2)	(3)	(4)	(5)	(6)
Panel A. Full Sample						
Exposure	5.04565**	-.00163***	-1.1754	.00138	1.19758	-.00063
	(2.22841)	(.00056)	(1.03275)	(.0022)	(.98161)	(.00148)
Observations	2499	2499	2499	2499	2499	2499
R-squared	.9609	.93807	.47136	.91623	.7076	.92935
Mean DV	3325.911	0.069	39.653	0.089	83.903	0.115
Panel B. First-Born, Mother White						
Exposure	8.91717***	-.00268***	.06086***	-.00369***	.10162*	-.00197
	(2.70713)	(.00084)	(.01287)	(.00108)	(.05736)	(.00121)
Observations	600	600	600	600	600	600
R-squared	.97485	.85018	.92065	.79031	.97438	.95617
Mean DV	3327.752	0.058	39.805	0.076	83.530	0.112
Panel C. First-Born, Mother Non-White						
Exposure	-3.01839	-.00056	.03492	.0007	-.13972	.00584*
	(5.73957)	(.00268)	(.03398)	(.0033)	(.12061)	(.00324)
Observations	599	599	599	599	599	599
R-squared	.92877	.84032	.91177	.9057	.89587	.83102
Mean DV	3088.274	0.114	38.824	0.155	79.497	0.184
Panel D. Second-Higher-Born, Mother White						
Exposure	4.02369	-.00188***	-1.66341	.00213	1.64904	-.00173
	(2.98861)	(.00069)	(1.47285)	(.00259)	(1.40074)	(.00169)
Observations	650	650	650	650	650	650
R-squared	.98449	.9362	.5772	.71515	.67539	.94863
Mean DV	3385.751	0.059	39.822	0.075	85.160	0.099
Panel E. Second-Higher-Born, Mother Non-White						
Exposure	-2.28143	-.00094	-.93168	.00647	.80583	.00069
	(5.08943)	(.00256)	(.91336)	(.00485)	(.85272)	(.00435)
Observations	650	650	650	650	650	650
R-squared	.94571	.88595	.3832	.78905	.61765	.85708
Mean DV	3142.592	0.119	38.826	0.160	80.851	0.163

Standard errors, clustered on maternal birth state and birth year, are in parentheses. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980.

First generation: Women born between 1960 and 1980 who were directly exposed to legal abortion in early life.

*** p<0.01, ** p<0.05, * p<0.1

Appendix Table C-3 - Replicating the Main Results among Hispanic Mothers

	Outcomes:					
	Birth Weight	Low Birth Weight	Gestational Age	Preterm Birth	Fetal Growth	Small For Gestational Age
	(1)	(2)	(3)	(4)	(5)	(6)
Exposure	15.56279***	-.00342**	.05081***	-.00604***	.31944***	-.00312**
	(2.97663)	(.00135)	(.01262)	(.00148)	(.06674)	(.0014)
Observations	955049	955049	955049	955049	955049	955049
R-squared	.13806	.04268	.11119	.03983	.15913	.0679
Mean DV	3288.760	0.079	38.680	0.126	84.794	0.099

Standard errors, clustered on maternal birth state and birth year, are in parentheses. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980.

*** p<0.01, ** p<0.05, * p<0.1

Appendix Table C-4 - Heterogeneity Based on Maternal Education

	Outcomes:					
	Birth Weight	Low Birth Weight	Gestational Age	Preterm Birth	Fetal Growth	Small For Gestational Age
	(1)	(2)	(3)	(4)	(5)	(6)
Panel A. Mother Education 0-8 Years						
Exposure	1.81439	-.0016	-.03854	.00719**	.11424	-.00152
	(6.8395)	(.0032)	(.02957)	(.00311)	(.16023)	(.00319)
Observations	384110	384110	384110	384110	384110	384110
R-squared	.15006	.03753	.08668	.07662	.12677	.05061
Mean DV	3206.970	0.102	38.876	0.147	82.330	0.143
Panel B. Mother Education > 8 Years						
Exposure	3.36609***	-.00116***	.00759	-.001*	.07053***	-.00108***
	(.94124)	(.00038)	(.00465)	(.00056)	(.01896)	(.00037)
Observations	6529142	6529142	6529142	6529142	6529142	6529142
R-squared	.32459	.10726	.23865	.11826	.3215	.1541
Mean DV	3319.430	0.077	38.898	0.116	85.099	0.098

Standard errors, clustered on maternal birth state and birth year, are in parentheses. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980.
*** p<0.01, ** p<0.05, * p<0.1

Appendix Table C-5 - Heterogeneity in the Effects on Prenatal Healthcare Utilization and Maternal Education by Race

	Outcomes:					
	Number of Prenatal Visits	No Prenatal Visits	Month Prenatal Care Began	Mother's Education: 0-8 Years	Mother's Education 9-12 Years	Mother's Education: College
	(1)	(2)	(3)	(4)	(5)	(6)
Panel A. Non-Whites						
Exposure	.41584***	-.00644***	-.0834***	-.0005	.0185*	.01363***
	(.07217)	(.00126)	(.01911)	(.00076)	(.01099)	(.0039)
Observations	1911474	1981667	1886401	1981667	1981667	1981667
R-squared	.30055	.06576	.25166	.03988	.18058	.21133
Mean DV	10.163	0.029	2.930	0.023	0.596	0.320
Panel B. Whites						
Exposure	.35755***	-.00053*	-.01502*	.00018	.04328***	.01232***
	(.08534)	(.00029)	(.0082)	(.00053)	(.00698)	(.00335)
Observations	4845328	4931585	4768374	4931585	4931585	4931585
R-squared	.2937	.03889	.30025	.02261	.20263	.26216
Mean DV	11.547	0.008	2.412	0.019	0.432	0.485

Notes. Standard errors, clustered on maternal birth state and birth year, are in parentheses. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980.

Second generation: Children whose mothers, born between 1960 and 1980, were exposed to legal abortion in early life.

*** p<0.01, ** p<0.05, * p<0.1

Appendix D

Appendix Table D-1 - Reporting t-Statistics of Main Results in Comparison with Schwartz Critical t-Statistics

	Outcomes:					
	Birth Weight	Low Birth Weight	Gestational Age	Preterm Birth	Fetal Growth	Small For Gestational Age
	(1)	(2)	(3)	(4)	(5)	(6)
Panel A. Full Sample						
t-Statistics (Table 2)	3.43	3.19	1.49	1.72	3.61	3.09
Critical t-Statistics based on Schwartz Test			**3.97**			
Panel B. Whites						
t-Statistics (Table 3)	2.2	1.62	0.77	1.26	2.12	1.4
Critical t-Statistics based on Schwartz Test			**3.92**			
Panel C. Blacks						
t-Statistics (Table 3)	4.38	3.65	1.63	1.73	4.63	2.36
Critical t-Statistics based on Schwartz Test			**3.76**			

Notes. All t-statistics are in absolute value.

Appendix E

Appendix Table E-1 - Exploring Mechanisms: The Effects on First-Generation Fertility

	Outcomes:	
	Birth Rate (per 1,000)	Log Birth Rate
	(1)	(2)
Exposure	-.00401***	-.0371***
	(.00083)	(.00723)
Observations	724704	724704
R-squared	.65105	.59122
Mean DV	0.031	-3.864

Standard errors, clustered on birth state and birth year, are in parentheses. Regressions are weighted using birth counts in each cell. All regressions include birth state fixed effects, birth year by birth region fixed effects, current state fixed effects, and current year fixed effects. Regressions also contain birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for cohorts of 1960 – 1980.
*** p<0.01, ** p<0.05, * p<0.1

Appendix Table E-2 - Exploring Mechanism the Effects on Birth Spacing

	Outcomes:				
	Birth Spacing between 0-1 Years	Birth Spacing between 1-2 Years	Birth Spacing between 2-3 Years	Birth Spacing between 3-4 Years	Birth Spacing between 4-5 Years
	(1)	(2)	(3)	(4)	(5)
Exposure	.00152	-.0065***	.00817***	.00404**	.00045
	(.00117)	(.00227)	(.00192)	(.00183)	(.00124)
Observations	1644524	1644524	1644524	1644524	1644524
R-squared	.14508	.39168	.09566	.06352	.07547
Mean DV	0.054	0.297	0.239	0.144	0.086
	Birth Spacing between 5-6 Years	Birth Spacing between 6-7 Years	Birth Spacing between 7-8 Years	Birth Spacing between 8-9 Years	Birth Spacing between 9-10 Years
	(6)	(7)	(8)	(9)	(10)
Exposure	-.00171	-.00032	-.00146**	-.00051	-.0013**
	(.0011)	(.00069)	(.00059)	(.00046)	(.00057)
Observations	1644524	1644524	1644524	1644524	1644524
R-squared	.09442	.10662	.11307	.10888	.0981
Mean DV	0.054	0.035	0.024	0.017	0.013

Notes. Standard errors, clustered on maternal birth state and birth year, are in parentheses. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980.

First generation: Women born between 1960 and 1980 who were directly exposed to legal abortion in early life.

*** p<0.01, ** p<0.05, * p<0.1

Appendix F

Appendix Table F-1 - Alternative Exposure Measure Based on Distance to Nearest Legalized Abortion State

	Outcomes:					
	Birth Weight	Low Birth Weight	Gestational Age	Preterm Birth	Fetal Growth	Small For Gestational Age
	(1)	(2)	(3)	(4)	(5)	(6)
Distance-Exposure Dummy	4.33421***	-.00191***	.02859***	-.00332***	.05443*	-.00046
	(1.60295)	(.00055)	(.00708)	(.00086)	(.03123)	(.00032)
Observations	52203242	52203242	52203242	52203242	52203242	52203242
R-squared	.07783	.02254	.12852	.03583	.09009	.04154
Mean DV	3328.006	0.075	38.969	0.114	85.181	0.098

Standard errors, clustered on maternal birth state and birth year, are in parentheses. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980.

The distance exposure dummy is an indicator variable that equals one if the minimum distance between the centroid of the mother's birth state and the population-weighted centroid of the nearest legalized-abortion state falls in the bottom tercile of the distribution. For mothers born in states that had already legalized abortion, this indicator is set to one, while for all states prior to 1968 it is set to zero.

*** p<0.01, ** p<0.05, * p<0.1

Appendix G

Appendix Table G-1 - Estimated Effects on Macrosomia-Related Birth Outcomes

	Outcomes:				
	Birth Weight > 4,000 g	Birth Weight > 4,100 g	Birth Weight > 4,200 g	Birth Weight > 4,300 g	Birth Weight > 4,400 g
	(1)	(2)	(3)	(4)	(5)
Exposure	.00074*	.00041	.00024	-.00015	-.00017
	(.00038)	(.0003)	(.00028)	(.00022)	(.00017)
Observations	6913253	6913253	6913253	6913253	6913253
R-squared	.16598	.13797	.10541	.08222	.05828
Mean DV	0.100	0.074	0.049	0.035	0.022
	Birth Weight > 4,500 g	Birth Weight > 4,600 g	Birth Weight > 4,700 g	Birth Weight > 4,800 g	Birth Weight > 4,900 g
	(6)	(7)	(8)	(9)	(10)
Exposure	-.00011	-.00016	-.0001	-.00008	-.00001
	(.00014)	(.0001)	(.00008)	(.00006)	(.00005)
Observations	6913253	6913253	6913253	6913253	6913253
R-squared	.04307	.02846	.01982	.0125	.00832
Mean DV	0.015	0.009	0.006	0.004	0.003

Notes. Standard errors, clustered on maternal birth state and birth year, are in parentheses. Regressions are weighted using birth counts in each cell. All regressions include maternal birth state fixed effects, maternal birth year by birth region fixed effects, child birth state fixed effects, child birth year fixed effects, maternal race, maternal education, maternal age, birth order, and child gender. Regressions also contain maternal birth state controls, including per capita income, per capita hospitals, per capita hospital beds, reported disease rates, share of women receiving AFDC, and dummies for exposure to Medicaid and FEPA. The data covers the years 1970-2020 for maternal cohorts of 1960 – 1980.
*** p<0.01, ** p<0.05, * p<0.1