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A Closer Look at States with Strict Abortion Laws and the Impact on Healthcare Coverage for Single,  
Low-Income Mothers

by

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Undergraduate honors thesis under the direction of

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## ABSTRACT

*Objective:* The so-called “War on Abortion” is political in nature and not only affects abortion access, but healthcare access as well. Research has examined healthcare consequences of abortion bans but none comparing states’ level of abortion access and the healthcare coverage in the United States. In this paper, I seek to begin a discussion on the wellbeing of the mother and her children that must be had if states, particularly southern, Republican states, insist on passing laws that set up barriers between women and the right to an abortion. *Methods:* In this paper, I use state-level data collected by the U.S. Census Bureau and implement a one-way analysis of variance (ANOVA) to study the rate of uninsurance for three strategic groups: single mothers; those with low-income ( $\leq \$25,000$ - $\$49,999$ ); and married couple households to see how they compare to single households in states with strict abortion laws. The ANOVA tests for differences across states with varying levels of strictness regarding abortion. *Results:* Single mothers and low-income families have statistically significant differences in the average rate of uninsurance such that it is lower in states with limited to no restrictions on abortion compared to states with strict and even partial restrictions. Critically, there is no such distinction for married couple households. *Conclusion:* I find that recent bans on abortion are part of a broader system limiting healthcare access and that the consequences are concentrated among disadvantaged households. Policymakers must consider the effects of abortion reform on women, especially single mothers and those with low-income.

## INTRODUCTION

States are now within their rights to ban access to abortion following the 2022 Supreme Court ruling in *Dobbs v. Jackson Women’s Health Organization* that the U.S. Constitution does not provide the right to an abortion. Republican states including Texas, Alabama, and Louisiana have already passed abortion reforms that restrict or outright ban a woman’s right to an abortion (Melhado, 2022). Another politically divided topic is healthcare, which also serves as an indicator for mother and child wellbeing after carrying a pregnancy to term. This paper moves to answer the question: *What is the experience of the United States healthcare system among low-income, single mothers in states with strict anti-abortion laws?* I hypothesize that healthcare coverage will be lower for single mothers and low-income families in states that also maintain restricted access to abortion services compared to states with few to no restrictions because bans

on abortion are a form of healthcare restriction, particularly for low-income populations (Warraich et. al, 2021).

To answer this supposition, I study trends in healthcare policy and utilization for single mothers and low-income families in order to estimate the relationship between healthcare provision and state political affiliation as related to states' abortion laws. An analysis of variance (ANOVA) is used to determine if there is a statistically significant difference between state abortion access levels and uninsurance rates for, single mothers, low-income families, and married couples which is followed by a pairwise test to highlight the significance between abortion levels. This analysis determines that there is no relationship for married couples and their uninsurance rates but finds a significant difference for single mothers and low-income families' uninsurance rates and between abortion access levels.

My research presents a unique perspective that has not been taken when examining single mothers and their children in states with strict abortion laws. The results of this study may work to guide policymakers when passing abortion and healthcare reform.

## **BACKGROUND**

### **Single Mothers and Welfare Reform**

Research on the wellbeing of single mothers and their children and their experience with welfare reform and healthcare coverage is worth reviewing because their interaction with the legal and political system differs from their counterparts. Single mothers and low-income households struggle financially, and research shows they contend with welfare and government assistance similar to obtaining and qualifying for healthcare insurance for themselves and their children.

In 1935, the passing of the Social Security Act put the Assistance for Families with Dependent Children (AFDC) program, known as “welfare,” into action. In the 1960s, members of AFDC were enrolled with Medicaid. In 1996, the Personal Responsibility Work Opportunity and Reconciliation Act (PRWORA) was meant to work to put families on government welfare into the work force as soon as possible and replaced AFDC with Temporary Assistance for Needy Families (TANF) (Narain, 2017). Economic struggle in 2007 “heightened discourse about how governments should respond to poverty” as many families suddenly found themselves unemployed with children to care for. The welfare reform put in place almost ten years before

the recession put barriers between families in need and government welfare. Life expectancy among low-income women in the late 1990s and early 2000s “suggest that conditions affecting the health of these women deteriorated substantially” (Basu, 2015:531). Research on married mothers has shown health benefits as the result of employment, which increased with welfare reform, but the same cannot be said for single, low-income mothers. A majority of single mothers are young, more likely to be Black, more likely to report Medicaid coverage, and less likely to report private health insurance coverage (Narain, 2017; Kneipp, 2002). Part of the goal for the PRWORA was that single, low-income mothers would obtain employment that offer private insurance to its employees; however, different types of employment moderate healthcare coverage. So, even though low-income mothers are finding employment, the jobs they are able to get that allow them to remain the primary caregiver for their children do not offer the private health insurance the PRWORA hoped for, leaving many of these women uninsured and with health problems (Narain, 2017; Kaestner, 2003).

Previous research has also referred to role strain as a unique experience for women and have reasoned that the woman’s role as a mother, employee, and perhaps a caretaker for another family member creates financial, emotional, and physical strain for this group. With these pressing roles, healthcare becomes a matter for the backburner. Almost 60% of women reported that the barrier in obtaining healthcare insurance was affordability; it is safe to assume that this may be due to the low paying jobs these mothers were obliged to pick up. Twelve percent of single mothers reported in the study that “they or one of their children had to go without healthcare because there were more urgent needs to be met” (Kneipp, 2002:23), such as obtaining shelter, food, or clothes (Basu, 2015; Spurl, 2012; Monheit, 2008). Welfare reform acts such as the PRWORA forced women to work to earn money after relying on government assistance, creating a multiple role strain, and because the jobs most of these women were taking did not pay enough to cover healthcare and preventative health measures, their health suffered (Kneipp, 2002).

### **Women’s health**

The implications of abortion reforms on women’s health have been investigated in previous research, finding that countries and states with abortion bans display rates of poor health and mortality for women, especially women with low- and middle-income. Abortion reform disproportionately affects women of color, single mothers, and women with low-income.

In other countries, abortion restrictions were found to lead to these groups having low healthcare coverage and high mortality rates (Ishola et. al 2021; Clarke et. al, 2020). Not to mention, research has shown that women with low-income are not only more likely to be uninsured, but they also exhibit high unintended pregnancy rates (112 per 1,000 for low-income women, vs. 20 per 1,000 for women at or above 200% the federal poverty line), resulting in a higher need for an abortion. The reasoning most abortion patients provide is the inability to afford another child, because most abortion-seekers are already mothers (about 60% as of 2016) (Boonstra, 2016).

Much research investigates the United States' Hyde Amendment (1977), which prohibits abortion procedures to be covered by Medicaid dollars. This Amendment specifically disproportionately affects low-income women and women of color, forcing them to carry a pregnancy to term, resulting in a child that is less likely to succeed when compared to their counterparts (Boonstra, 2016; Ishola et. al, 2021; Pabayo et. al, 2020). Because "restrictive laws on abortion do not translate to lower rates of induced abortions" (Clarke et. al, 2020), other research considers women who attempt an abortion resulting in maternal death. Research in Mexico finds that abortion legalization, even lightening of abortion restriction (from a six-week ban to twelve weeks), results in substantially lower maternal death rates, especially in more liberal states (Clarke et. al, 2020). This research infers that the same can be translated for U.S. states, postulating that the Mexican states with higher maternal mortality "exhibit some of the lowest levels of government expenditure on maternal health" (Clarke et. al, 2020), and because of some U.S. states' refusal to expand Medicaid, the same can be said for the U.S. (Douglas et. al, 2022; Hajdu et. al, 2021; Ishola et. al, 2021; Boonstra, 2016).

### **Children's health**

As reviewed above, the rate of unintended pregnancy is highest among women already below the federal poverty line (Boonstra, 2016); therefore, research has also been conducted for children who are born in U.S. states with strict abortion laws. A study in infant mortality rates and state abortion access find a significant correlation with infant mortality rates and the number of abortion restrictions. In other words, "infants born in states with three or more restrictive laws were significantly more likely to die before their first birthday" (Pabayo et. al, 2020) when compared to infants born in states with fewer or no restrictions. This also may have to do with the lack of healthcare coverage for these infants' mothers because they were more likely to be born to low-income, single, and non-White mothers (Pabayo et. al, 2020; Boonstra, 2016). As of

2020, 38.1% of single mothers were impoverished, versus 7.5% for married-couple families; and female-headed impoverished households were more likely to be women of color, with 35% of Black single mothers below the federal poverty line, 34% of Hispanic mothers, and an impressive 43% of Native American mothers living below the poverty line compared to 26% of White single mothers (Single Mothers Guide). Moreover, these mothers in these socioeconomic groups may not have been able to pay for preventative medicine and doctors' visits for their infant, resulting in infant death.

Similar to studies focused on Mexican mothers (Clarke et. al, 2021), studies have also been conducted looking at child socioeconomic outcomes in Hungary following a Hungarian 1974 abortion reform, which resulted in decreased induced abortions, but did not result in successful children. In one such study, researchers followed the associated cohort of newborns to adulthood, finding that "restricted access to abortion had, on average, a negative impact on the socioeconomic outcomes of the affected cohort of children" (Hajdu et. al, 2021). Research emphasizes the negative mental and emotional impacts on mothers from carrying an unintended pregnancy to term, raising a child in poor economic conditions, and inability to keep up with pre-natal health due to low socioeconomic status (Pabayo et. al, 2020; Hajdu et. al, 2021).

This paper adds to previous research the aspect of single mothers and healthcare access, but also to the lack in research on married couples. Previous studies show that single mothers are disproportionately affected by abortion reform, but research on how they compare to married couples has not been done. As such, this paper is unique in that I use data on married couples to infer that single mothers have a very different experience with healthcare in states with strict abortion access. I hypothesize that abortion bans are just one part of changes in the healthcare system that disproportionately disadvantage low-income and single-mother households, which will result in significant differences in uninsurance rates for these groups across states with varying levels of abortion restrictions.

## **METHODS**

I obtain data from the U.S. Census Bureau (USCB) and five-year estimates from the American Community Survey (ACS) for the year 2020, for individual states' total number of married couples, single mothers, and low-income households and total number of uninsured individuals in each group. I then link these data with state abortion from the Center for

Reproductive Rights, assigning indicator variables for each in order to determine if there is a statistically significant difference between individual levels of access. I use the software Stata to run my rate summary, analysis of variance (ANOVA), pairwise test, and a regression analysis for single mothers and states' dominant political party.

The continuous dependent variable is the rate of uninsurance, which was calculated by dividing the total sample by the number of people without insurance. Data collection for the dependent variable was collected from table C27021 for single mothers and married households, and table B27015 was used to collect data on low-income households. For this paper, I consider "low-income" to be at or below 200% of the federal poverty line, which the Department of Health and Human Services considers to be, at the time of this paper, \$46,060 (Office of the Assistant Secretary for Planning and Evaluation, 2022). Therefore, I combined the total number of people with a yearly income under \$25,000 with the income bracket of \$25,000-\$49,999.

The independent variable is the level of abortion strictness for each state, and in order to decipher the level of strictness for state abortion laws, I use data from The Center for Reproductive Rights, a human rights legal organization, and assigned indicator variables for each level. *0* was assigned to states with a complete ban on abortion and those restricting abortion at or less than the six-week gestational period. *1* was given to states with restrictions between eight and twenty weeks. *2* indicated that state residents had complete access to an abortion up until viability (about twenty-two weeks).

The dependent variable is continuous, but the independent variable, state level of abortion access, is an indicator with three categories; therefore, I use a one-way analysis of variance (ANOVA) to determine if there is a statistical difference in the average value of the dependent variable across the levels of the independent variable. I use Stata for my analysis, starting with a descriptive analysis that examines mean differences across the different states. After, I implement an ANOVA to formally test for differences, I then determine which categories are different from one another using a pairwise comparison test. To test for political influence on uninsurance rates, I then use a regression analysis for single mothers and state partisan control (see Table 3a).



**Table 1a:**

Data for individual states' level abortion access, total number of single mothers and uninsured single mothers in each state

State	indicator variable	Total Single Mothers	Uninsured Single Mothers	Uninsurance Rate
Alabama	0	917,935	126,069	0.13733979
Alaska	2	96,334	16,431	0.170562833
Arizona	1	1,185,943	171,396	0.144522966
Arkansas	0	511,055	53,823	0.105317432
California	2	6,357,434	569,655	0.089604548
Colorado	2	692,968	70,466	0.101687235
Connecticut	2	562,058	34,956	0.06219287
Delaware	2	166,374	11,372	0.068352026
Florida	1	3,787,443	653,110	0.172440879
Georgia	1	2,034,912	350,457	0.172222189
Hawaii	2	218,359	9,691	0.044381042
Idaho	0	194,131	31,006	0.159716892
Illinois	2	2,001,888	174,025	0.086930438
Indiana	0	990,849	101,197	0.102131606
Iowa	1	371,634	24,466	0.065833589
Kansas	2	361,620	51,388	0.142104972
Kentucky	0	692,452	43,656	0.063045525
Louisiana	0	1,001,200	97,645	0.097527966
Maine	2	152,718	15,827	0.103635459
Maryland	2	1,059,131	78,232	0.073864328
Massachusetts	2	1,014,338	38,944	0.038393514
Michigan	2	1,535,444	114,867	0.074810283
Minnesota	2	657,103	50,004	0.076097659
Mississippi	0	673,146	110,776	0.164564597
Montana	2	110,480	12,512	0.113251267
Missouri	0	896,000	128,146	0.143020089
Nebraska	1	228,463	31,421	0.137532117
Nevada	2	527,720	73,252	0.138808459
New Hampshire	2	147,566	13,678	0.092690728
New Jersey	2	1,383,103	153,961	0.111315643
New Mexico	2	397,627	42,346	0.106496792
New York	2	3,420,401	217,240	0.063513021
North Carolina	1	1,724,811	255,003	0.147844025
North Dakota	0	73,383	10,064	0.13714348
Oklahoma	0	626,251	122,904	0.196253579
Oregon	2	536,583	45,928	0.085593468
Ohio	1	1,862,387	143,347	0.076969502
Pennsylvania	1	1,937,181	137,775	0.071121387
Rhode Island	2	175,763	10,481	0.059631436
South Carolina	1	961,277	135,092	0.140533894
South Dakota	0	110,592	21,054	0.190375434
Tennessee	0	1,115,173	138,662	0.124341246
Texas	0	4,992,042	1,103,164	0.220984519
Utah	1	327,692	48,041	0.146604128
Vermont	2	69,448	4,117	0.059281765
Virginia	2	1,235,825	157,167	0.127175773
Washington	2	922,780	78,624	0.085203407
West Virginia	0	257,074	20,517	0.079809705
Wisconsin	2	720,395	55,244	0.076685707
Wyoming	0	59,640	11,612	0.194701543

**Table 1b:**

Data for individual states' level abortion access, total number of low-income families (yearly income at or less than \$25,000-\$49,999) and uninsured low-income families in each state

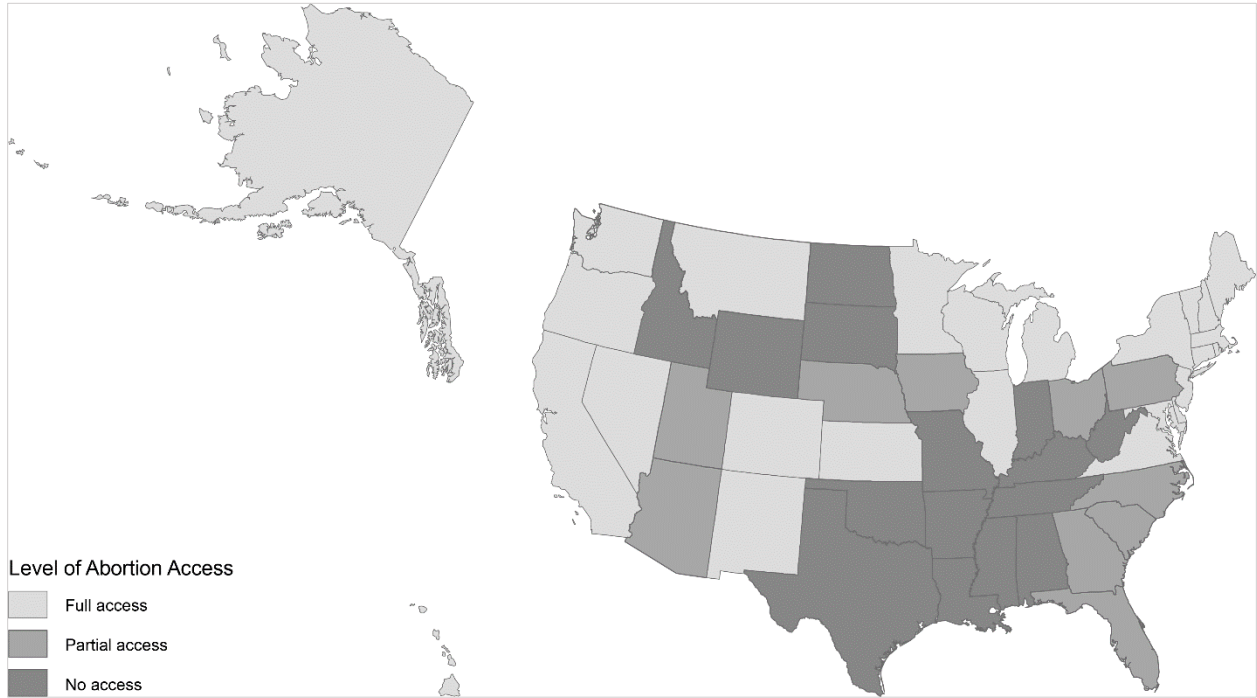
State	indicator variable	Total Single Mothers	Low Income Households (<\$25,000-\$49,999)	Uninsurance Rate
Alabama	0	917,935	271,805	0.142888535
Alaska	2	96,334	25,655	0.080870393
Arizona	1	1,185,943	332,739	0.308038045
Arkansas	0	511,055	133,800	0.10950527
California	2	6,357,434	1,058,716	0.104461938
Colorado	2	692,968	162,619	0.117707221
Connecticut	2	562,058	68,953	0.082659321
Delaware	2	166,374	22,019	0.08223839
Florida	1	3,787,443	1,244,595	0.170077058
Georgia	1	2,034,912	698,185	0.198869762
Hawaii	2	218,359	15,827	0.058730977
Idaho	0	194,131	81,822	0.145289827
Illinois	2	2,001,888	385,538	0.106533258
Indiana	0	990,849	256,244	0.116467928
Iowa	1	371,634	70,664	0.075225686
Kansas	2	361,620	136,553	0.152291573
Kentucky	0	692,452	126,811	0.074219027
Louisiana	0	1,001,200	218,007	0.116756606
Maine	2	152,718	45,851	0.108445561
Maryland	2	1,059,131	114,694	0.091103772
Massachusetts	2	1,014,338	62,361	0.041008088
Michigan	2	1,535,444	258,713	0.078277782
Minnesota	2	657,103	102,130	0.075430533
Mississippi	0	673,146	218,442	0.169160478
Montana	2	110,480	40,460	0.111621491
Missouri	0	896,000	305,974	0.148350095
Nebraska	1	228,463	77,353	0.139335861
Nevada	2	527,720	153,641	0.159923765
New Hampshire	2	147,566	28,064	0.098324931
New Jersey	2	1,383,103	266,057	0.133915287
New Mexico	2	397,627	97,860	0.115913533
New York	2	3,420,401	393,403	0.071168083
North Carolina	1	1,724,811	597,134	0.162112649
North Dakota	0	73,383	24,761	0.121834929
Oklahoma	0	626,251	293,141	0.200055279
Oregon	2	536,583	116,085	0.09499241
Ohio	1	1,862,387	344,131	0.088442249
Pennsylvania	1	1,937,181	308,937	0.080960731
Rhode Island	2	175,763	18,809	0.065342834
South Carolina	1	961,277	285,424	0.152560057
South Dakota	0	110,592	42,827	0.155458677
Tennessee	0	1,115,173	352,074	0.142668136
Texas	0	4,992,042	2,365,530	0.255736318
Utah	1	327,692	111,709	0.155266329
Vermont	2	69,448	9,368	0.053065062
Virginia	2	1,235,825	291,005	0.138742745
Washington	2	922,780	170,238	0.095747499
West Virginia	0	257,074	56,215	0.075007539
Wisconsin	2	720,395	143,477	0.084143232
Wyoming	0	59,640	27,564	0.168951927

**Table 1c:**

Data for individual states' level abortion access, total number of married couples and uninsured married couples in each state

<u>State</u>	<u>indicator variable</u>	<u>Total Married Couple Families</u>	<u>Uninsured Married Couples</u>	<u>Uninsurance Rate</u>
Alabama	0	2,798,763	184,119	0.0658
Alaska	2	432,053	41,670	0.0964
Arizona	1	4,081,779	357,467	0.0876
Arkansas	0	1,754,739	115,719	0.0876
California	2	23,468,181	1,405,303	0.0599
Colorado	2	3,425,266	216,320	0.0632
Connecticut	2	2,091,312	80,731	0.0386
Delaware	2	549,043	26,045	0.0474
Florida	1	11,849,225	1,186,887	0.1002
Georgia	1	5,955,495	598,322	0.1005
Hawaii	2	842,874	25,020	0.0297
Idaho	0	1,157,153	95,240	0.0823
Illinois	2	7,466,922	402,811	0.0539
Indiana	0	3,936,318	254,041	0.0645
Iowa	1	1,906,865	66,960	0.0351
Kansas	2	1,797,894	114,108	0.0635
Kentucky	0	2,600,602	118,178	0.0454
Louisiana	0	2,439,471	157,935	0.0647
Maine	2	794,524	44,558	0.0561
Maryland	2	3,505,371	160,783	0.0459
Massachusetts	2	3,955,716	72,312	0.0183
Michigan	2	5,781,091	215,592	0.0373
Minnesota	2	3,455,126	107,956	0.0312
Mississippi	0	1,586,728	136,127	0.0858
Montana	2	645,073	42,794	0.0663
Missouri	0	3,594,679	256,478	0.0713
Nebraska	1	1,188,897	67,129	0.0565
Nevada	2	1,656,542	147,017	0.0887
New Hampshire	2	844,481	34,195	0.0405
New Jersey	2	5,542,203	314,250	0.0567
New Mexico	2	1,110,652	91,538	0.0824
New York	2	10,829,013	452,552	0.0418
North Carolina	1	5,964,894	483,595	0.0811
North Dakota	0	457,582	23,420	0.0512
Oklahoma	0	2,300,463	261,896	0.1138
Oregon	2	2,466,982	126,179	0.0511
Ohio	1	6,598,522	311,325	0.0472
Pennsylvania	1	7,418,659	345,547	0.0466
Rhode Island	2	581,072	17,868	0.0308
South Carolina	1	2,848,771	215,208	0.0755
South Dakota	0	520,237	31,253	0.0601
Tennessee	0	3,944,036	281,986	0.0715
Texas	0	17,289,594	2,598,985	0.1503
Utah	1	2,248,155	162,358	0.0722
Vermont	2	357,449	9,576	0.0268
Virginia	2	5,094,164	316,831	0.0622
Washington	2	457,993	219,478	0.4792
West Virginia	0	1,064,369	48,159	0.0452
Wisconsin	2	3,453,353	139,093	0.0403
Wyoming	0	368,068	32,220	0.0875

**Abortion Access Map:**



**RESULTS**

To determine whether the average uninsurance rate differs overall for state abortion access, an ANOVA model is appropriate to signify if the mean is statistically different on each level of access. The null hypothesis is as follows:

ANOVA H(null): There is no statistical difference in uninsurance rate between state abortion access.

In the case of single mothers, the rate summary shows that the uninsurance rate is lower for states with greater abortion access (14% for states with complete restrictions, 13% for states with a partial ban, 9% for states with complete abortion access). Not to mention, the rate of uninsurance almost doubles for states with no access (i.e., states with restrictions before six weeks) and partial access (i.e., restrictions between eight and twenty weeks of pregnancy) at 14% and 13%, respectively, compared to married couples as shown in Table 2a. However, unlike for married couples, the ANOVA test reveals that there is a variation within the sample of single mothers, meaning the null hypothesis is rejected – there *is* a difference in means for single mothers and the rate of uninsurance (F-statistic= 9.17, p-value= 0.0004), depicted in Table 2b.

Most importantly, the pairwise test reveals that there is a significant difference between levels of state abortion access, with the difference between complete abortion restriction and complete abortion access having the most statistical difference (0.000 when comparing complete restriction and complete access; 0.012 when comparing partial ban and complete access). As indicated in Table 2c, evidence against the null hypothesis in the case of single mothers is extremely confident ( $p < 0.001$ ).

The rate summaries for low-income and single-mother households are similar as the rate of uninsurance almost doubles for states with no access and partial access for low-income households at 14% and 15% respectively compared to married couples (see Table 2a). ANOVA results for low-income families are the same with there being a greater variation within low-income households; therefore, the null hypothesis is rejected – there *is* a statistical significance for low-income families and uninsurance rates (F-statistic= 8.30, p-value= 0.0008) as outlined in Table 2b. As with single mothers, the pairwise test for low-income families in Table 2c likewise show that there is a significant difference between state abortion access (0.002 between complete restriction and complete access; 0.001 between partial restriction and complete access). Further, the evidence against the null hypothesis is also very high ( $p < 0.001$ ).

For married couples, the rate summary (see Table 2a) indicates that the uninsurance rate is relatively low at each level of abortion access (8% for couples living in highly restricted states, 7% in states with partial restriction and no restrictions). According to the analysis of variance (see Table 2b), married couples have a significance level of 0.9286, meaning the null hypothesis is accepted – there is no statistical significance for married couples and the rate of uninsurance (F-statistic= 0.07, p-value= 0.9286). Indeed, uninsurance rates for married couple families are uniformly low regardless of states’ abortion policy.

**Table 2a:**  
Average percentage of uninsurance by household type and levels of abortion access

Level of Abortion Access (indicator variable)	Average Uninsurance Rate (%)		
	<i>Single Mothers</i>	<i>Low-Income Households</i>	<i>Married Couples</i>
No access	14	14	8
Partial access	13	15	7
Full access	9	10	7

**Table 2b:**  
Analysis of variance (ANOVA results)

	F-statistic	p-value
<i>Single mothers</i>	9.17	0.0004**
<i>Low-income families</i>	8.3	0.0008**
<i>Married couples</i>	0.07	0.9286

\*p<0.05, \*\*p<0.001

**Table 2c:**  
Pairwise test

Level of Abortion Access (indicator variable) comparative test groups	p-value (p> t )		
	<i>Single Mothers</i>	<i>Low-Income Households</i>	<i>Married Couples</i>
1 vs. 0	0.393	0.575	0.816
2 vs. 0	0.000**	0.002*	0.704
2 vs. 1	0.012*	0.001**	0.938

\*p<0.05, \*\*p<0.001

**Political Polarization of abortion and healthcare**

The political environment is worth mentioning because “Republican states tend to have higher uninsurance rates, in part because many elected to not expand Medicaid over the past decade” (Warraich et. al, 2021). The close relationship between abortion bans and partisanship begs the question, *is the relationship between abortion bans and uninsurance really solely a reflection of the political context?* I run a regression analysis to determine the extent to which the relationship between uninsurance among single mothers and abortion access remains after controlling for state partisan control.

The ANOVA found that abortion access and healthcare insurance have a statistical relationship, but the regression analysis tests whether this difference remains when the political context is added. Here the dependent variable is continuous, which is why I use an ordinary least squares regression model. The focal independent variable is categorical, so the analysis tests the difference between the categories (level of abortion access) against the reference category. I measure political context using a binary variable based on state abortion access and rate of uninsurance where state partisan control is the reference category. Data on state partisanship was obtained from an online political encyclopedia, Ballotpedia.

**Table 3a:**

Data for individual state partisan control (0= Republican party control, 1= Democratic party control)

<u>State</u>	<u>indicator variable</u>
Alabama	0
Alaska	0
Arizona	0
Arkansas	0
California	1
Colorado	1
Connecticut	1
Delaware	1
Florida	0
Georgia	0
Hawaii	1
Idaho	0
Illinois	1
Indiana	0
Iowa	0
Kansas	0
Kentucky	0
Louisiana	0
Maine	1
Maryland	1
Massachusetts	1
Michigan	0
Minnesota	0
Mississippi	0
Montana	0
Missouri	0
Nebraska	0
Nevada	1
New Hampshire	0
New Jersey	1
New Mexico	1
New York	1
North Carolina	0
North Dakota	0
Oklahoma	0
Oregon	1
Ohio	0
Pennsylvania	0
Rhode Island	1
South Carolina	0
South Dakota	0
Tennessee	0
Texas	0
Utah	0
Vermont	1
Virginia	1
Washington	1
West Virginia	0
Wisconsin	0
Wyoming	0

**Table 3b:**  
Regression analysis for single mothers and state political affiliation

Source	SS (sum of squares)	df	MS (mean of squares)	F (3,46) = 6.83 Prob > F = 0.0007	
Model	0.029722474	3	0.009907491		
Residual	0.066759572	46	0.001451295		
Total	0.096482046	49	0.001969021		

Uninsurance Rate	Coefficient	Std. err.	t	p> t
Level of Abortion Access				
1	-0.0135224	0.0155526	-0.87	0.389
2	-0.0344844	0.0174379	-1.98	0.054
State Partisan Control	-0.0229304	0.0169692	-1.35	0.183
Constant	0.1410849	0.0098363	14.34	0.000

The indication of difference in uninsurance across states with differing abortion access is weaker in the regression model than in the binary ANOVA. However, what is most telling is that the political context does *not* play a statistically significant role in determining healthcare insurance rates. Therefore, this research finds that abortion access is a greater determiner for healthcare coverage than the state partisan control.

Based on these results, the question of *the experience of the United States healthcare system among low-income families and single mothers in states with strict anti-abortion laws* may be answered in this paper. The rate of uninsurance is statistically significant in states with partial and highly restrictive abortion access for single mothers and low-income families but not in states with no abortion restrictions; additionally, the rate of uninsurance is statistically *insignificant* for married couples in all states, regardless of state abortion access. Thus, it can be deduced that single mothers and low-income families experience a significantly more onerous interaction with the U.S. healthcare system in states with abortion bans. This relationship is more than just a reflection of political divisions, making states’ level of abortion access a valuable marker of broader changes in state healthcare systems.

**DISCUSSION**

This paper finds that there is evidence of high uninsurance rates in states with limited abortion access for single mothers and low-income families, but there is no relationship for married couples, effectively describing the experience for single mothers and low-income families. The results infer that the experience for single mothers and low-income families is



drastically different from their counterparts. Evidently, the regression analysis found no relationship between healthcare uninsurance rates and political context of states; thus, the relationship identified for abortion access is about more than just the state partisan control.

The evidence presented here is substantial and suggests a relationship between abortion access and healthcare coverage for disadvantaged groups. However, there are some limitations that may advise future research. First, I use five-year estimates from the ACS from 2020, but a study using one-year estimates from 2021, once the data comes available will offer more comprehensive and relevant statistics for these groups. In this case, a difference-in-difference study would point to changes over time following the passing of *Dobbs v. JWHO* in states with strict abortion laws. This paper begins to ask the questions relevant to this recent passing, and future research would begin to further this questioning to how *Dobbs* will change healthcare coverage for single mothers and low-income families.

## **CONCLUSION**

With the passing of *Dobbs v. Jackson Women's Health Organization*, states across the U.S. have passed or attempted to pass abortion restrictions and/or complete bans. Previous research show that single mothers have had a tumultuous relationship with welfare reform and access to healthcare. As single mothers and low-income families attribute financial strain as a reason for opting out of healthcare coverage, the negative impact on mothers and their children is substantial (Hajdu et. al, 2021; Ishola et. al, 2021; Pabayao et. al, 2020; Narain et. al, 2017; Boonstra, 2016). Research has already shown that single mothers and those with low-income are more likely to become unintentionally pregnant, and without access to an abortion, they would be forced to carry the unplanned pregnancy to term, making them more likely to fall into poverty (Clarke et. al, 2020). Single mothers and low-income households are groups that would be at high financial strain and risk without access to an abortion. Yet regardless of political/personal opinions on abortion, with the passing of *Dobbs*, more and more women, especially women with low-income, will be without healthcare for themselves and their subsequent children. This paper moves to show that without extended access to abortion, more women and low-income families will be uninsured and impoverished. The chief purpose of this paper is to display the importance of healthcare policy if states continue to pass abortion restrictions.

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