SOUTH WIND WOMEN'S CENTER

9 March 2015

House Federal and State Affairs Committee
Representative Steve Brunk, Chairman
10th & Jackson
Topeka, KS 66612

Dear Mr. Chairman and Committee Members:

My name is Julie Burkhart and I am the CEO of Trust Women Foundation and South Wind Women's Center. We provide direct reproductive health care services, including abortion care, here in Kansas. I am here today to testify, as an opponent, to Senate Bill 95, which, if enacted, would restrict a woman's ability to access abortion services in Kansas.

I encourage the Committee to carefully consider this bill and the implications that it will have on Kansas women. There are a multitude of problems with the bill; three of which I'll touch on today.

1. **The bill dictates to *qualified physicians* the scope of their practice and implies that certain medical treatments that physicians may use would lead to criminalization.** I caution the committee against passing any law that would ban a particular procedure that a physician might need to utilize during a medical procedure. In medicine, each patient is unique and health care is not always delivered in the same absolute terms.

   Violating the physician-patient relationship will negatively impact the health of women in our state. Please find enclosed with my testimony documentation that addresses this very issue: In Kansas, researchers have found a correlation between the highly restrictive abortion laws and women's and, subsequently, children's health outcomes. I encourage you to review this study.

   Additionally, and perhaps most importantly, what happens if the standard of care calls for a D&E abortion? Medical practitioners across the state provide their patients with D&E abortions because they are a safe and effective medical procedure. Further, if the standard of care calls for a D&E and it's not done because of SB 95, may the physician hold up SB 95 as a defense to a Board of Healing Arts licensing action or medical malpractice action? This is a fundamental problem with SB 95. *It substitutes a legislative determination of the proper standard of care for a medically based standard of care.*

2. **Secondly, I urge you to consider the contradiction this bill raises to the decisions handed down by both the Kansas Supreme Court and the United States Supreme Court.**

   Section 3(a) excludes mental health considerations in direct violation to specific directives by the Kansas Supreme Court in *Alpha Medial Center v. Anderson*, 280 Kan. 903, 923-24,

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(2006) and *Doe v. Bolton* 410 U.S. 179, 191-192 (1973). Both say the mental health of a pregnant woman remains a necessary consideration to assure the constitutionality of the Kansas criminal abortion statute. SB 95 fails this constitutionality test.

For your further review, I have included a quote from the *Alpha* case:

> For example, the United States Supreme Court has long held, and continues to hold that, *in* order to be constitutional, state restrictions on abortions must include exceptions to preserve both the life and health of the pregnant woman. See *Casey,* 505 U.S. at 846 (emphasizing this rule as part of the "essential holding" of *Roe v. Wade,* 410 U.S. 113, 35 L. Ed. 2d 147, 93 S. Ct. 705, *reh. denied* 410 U.S. 959, 93 S. Ct. 1409, 35 L. Ed. 2d 694 [1973]); see also *Ayotte v. Planned Parenthood of Northern New England,* _ U.S. _, 126 S. Ct. 961, 163 L. Ed. 2d 812, 2006 WL 119149 (January 18, 2006). Moreover, "health" has been interpreted by the United States Supreme Court to include the mental or psychological health of the pregnant woman. See *Doe v. Bolton,* 410 U.S. 179, 191-92, 35 L. Ed. 2d 201, 93 S. Ct. 739 (1973); *United States v. Vuitch,* 402 U.S. 62, 71-72, 28 L. Ed. 2d 601, 91 S. Ct. 1294 (1971). The attorney general has said he disagrees with requiring an exception to preserve the pregnant woman's mental health. Until the United States Supreme Court or the federal Constitution says otherwise, however, the mental health of the pregnant woman remains **[924]** a consideration necessary to assure the constitutionality of the Kansas criminal abortion statute.
>
> *Alpha Med. Clinic v. Anderson,* 280 Kan. 903, 923-924, 128 P.3d 364, 378-379, 2006 Kan. LEXIS 18, 41-42 (Kan. 2006)

3. **Lastly, the state of Kansas is in a dire fiscal crisis and the job growth and economic stimulation has, quite clearly, been underwhelming.** Rather than focus on the crisis of the state's budget and economy, this bill serves as a distraction from the following:

    a. Kansas faces more than a $600 million State General Fund revenue shortfall for Fiscal Year 2016, which begins on July 1st of this year.
    b. Kansas ranks among the most-moved-out-of states in 2014 – the seventh most "moved-out-of" state in the country according to the 38th annual study by United Van Lines. In 2013, more than 4,200 people left Kansas than moved in.
    Job growth in surrounding states exceeds Kansas's and Kansas lags the national average. (Source: Wichita State's Center for Economic Development and Business Research (CEDER).

In closing, I would like to remind the Committee that Kansas, as reported by the Attorney General's office, has paid private law firms more than $1 million to defend anti-choice laws enacted during the past three years. Additionally, litigation costs include $179,000 in attorneys' fees and expenses associated with federal and state lawsuits filed over restrictions *enacted just last year.* This figure was disclosed to The Associated Press by the Attorney General's office. If this bill were to pass, the state would incur more cost for the defense of an unconstitutional and damaging bill. We have over 390,000 people living in poverty in Kansas – if poverty were a city, as this illustration shows (please see

attachment), poverty would be the largest city in Kansas. Citizens of this state would be better served if money to defend these lawsuits were utilized, instead, to help our fellow neighbors out of poverty and strife.

I encourage the Committee to vote no on SB 95. Thank you for hearing my testimony today.

Sincerely,

Julie A. Burkhart
CEO
Trust Women Foundation
South Wind Women's Center

If poverty were a city in Kansas...

Number of Kansans living below poverty—
391,734

...it would be the state's largest city

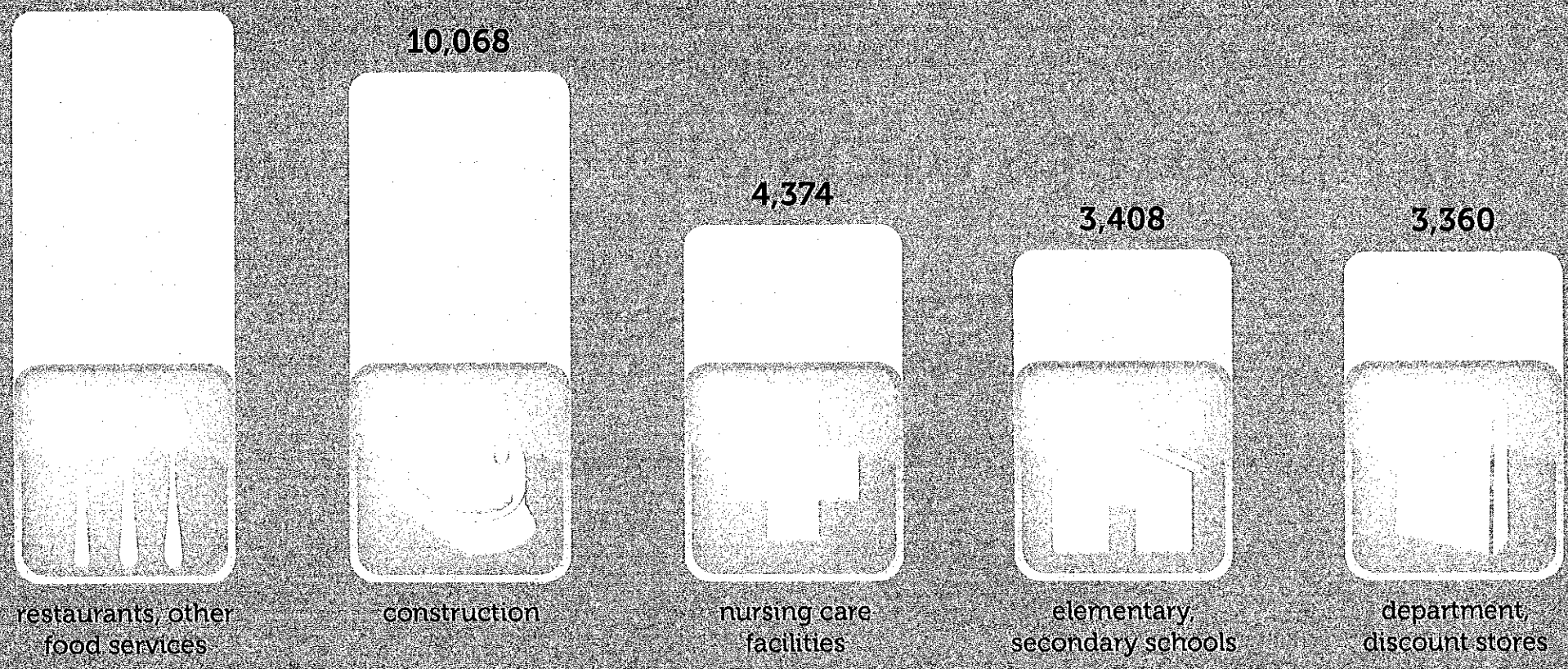
All figures are for 2012
Source: American Communities Survey Data

Kansas CENTER FOR ECONOMIC GROWTH

realprosperityks.com

Medicaid Expansion Benefits Hard-working Kansan

Workplaces with the most uninsured workers who could gain Medicaid coverage in 2014



he majority of Kansans who stand to benefit from Medicaid expansion are hard-working employees. These uninsured worke e critical to Kansas' economy. By providing access to regular health care, we can ensure they stay healthy and able to work.

ndustries with most uninsured workers under 138 percent of the federal poverty level in Kansas
ource: Working Kansans Need Medicaid Health Coverage Option
ansas Center for Economic Growth, March 2014
/ww.realprosperityks.com

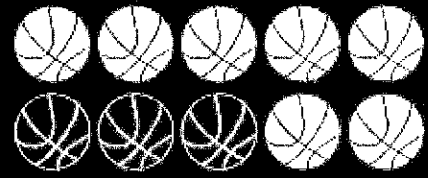
Kansas
CENTER FOR ECONOMIC
GROWTH

Education Cuts

The Kansas Center for Economic Growth recently analyzed data from the Kansas State Department of Education and surveyed school districts in Kansas and found that funding cuts are affecting educational outcomes and programs.

Nearly 50% of districts
have seen average class size GROW

Kansas schools have GAINED more than
19,000
students but have
665
FEWER teachers



About **30%** of districts have
REDUCED or ELIMINATED
extracurricular activities

Source: Quality at Risk: Impact of Education Cuts
Kansas Center for Economic Growth, September 2014

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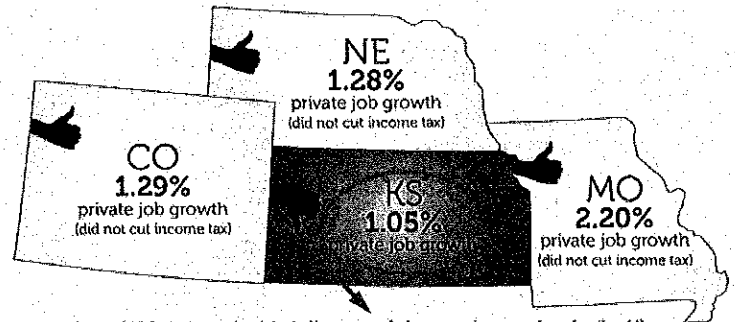
No jobs boom from Kansas tax cuts



6 out of 10 fastest-growing jobs in Kansas pay below poverty wages for a family of three

Source: Bureau of Labor Statistics, Seasonally Adjusted 2013 monthly average
Kansas Department of Labor, Labor Information Center Wage Data Survey

www.kansasprosperity.com

Kansas GROWTH

EVALUATING PRIORITIES

Measuring women's and children's health and well-being against abortion restrictions in the states

State Brief: Kansas

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of

Ibis Reproductive Health

Acknowledgements:

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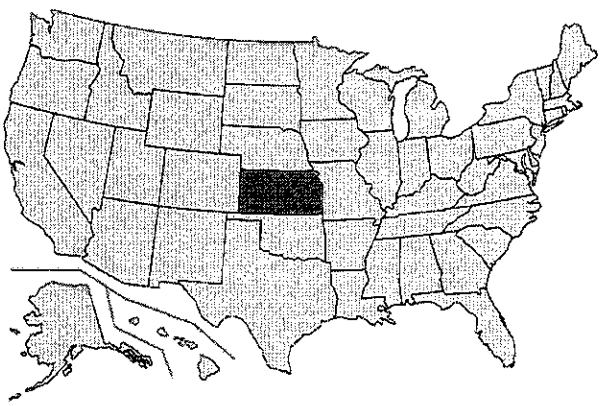
CONTEXT

Since abortion was legalized in the United States (US) in 1973, states have passed hundreds of laws limiting whether, when, and under what circumstances a woman may obtain an abortion.[1] Such attacks on abortion are on the rise; from 2011-2013 states enacted more restrictions than were enacted in the entire previous decade.[2] Anti-choice groups claim these restrictions are necessary to protect and support the health and well-being of women, their pregnancies, and their children, a claim that has become the foundation of many successful proposals to restrict abortion access further.[3]

To support an evidence-based effort to fight back against the onslaught of abortion restrictions, Ibis Reproductive Health and the Center for Reproductive Rights collaborated to evaluate the claims of anti-choice policymakers. We aimed to determine if the concern that anti-choice policymakers say they have for women, pregnancies, and children translates into the passage of state policies known to improve the health and well-being of women and children, or into improved state-level health outcomes for women and children. We also aimed to document how states with relatively few abortion restrictions fare in terms of women's and children's health policies and outcomes. This brief provides a snapshot of the findings detailed in our full report[4] and an in-depth look at our findings for Kansas.

Kansas overview

Kansas, located in the Midwest, is relatively rural,[5,6] and is the 21st poorest state in the country.[7] Compared to the US as a whole, Kansas has a higher proportion of White residents, a lower proportion of Black and Hispanic residents, and a similar proportion of residents who are other races.[6] Kansans tend to be more religious than other Americans.[8,9] Its state legislature is strongly anti-choice; the Kansas Senate, the Kansas House, and Governor Sam Brownback (R) are all anti-choice.[1]



Kansas is home to an estimated 596,340 women of reproductive age.[10] The proportion of Kansas women who have abortions each year is lower than the national average, as is the percentage of pregnancies ending in abortion.[11] In 2011, there were only three abortion providers in Kansas, leaving three-quarters of Kansas women living in a county with no abortion provider.[11] More detail about Kansas can be found in Table 1 below.

Table 1: Key facts about Kansas

	Kansas	US
Population, n[6]	2,840,600	313,395,400
Population density, people per square mile[5]	35	87
Metropolitan status, %[5]		
Metropolitan	65	85
Non metropolitan	35	15
Race/ethnicity, %[6]		
White	77	62
Black	6	12
Hispanic	8	17
Other	9	8
Median household income, $[7]	50,003	51,847
Religion, %[8,9]		
Very religious	45	40
Moderately religious	29	29
Nonreligious	26	31
Abortion rate, per 1,000 women of reproductive age[11]	13	17
Pregnancies ending in abortion, %[11]	13	18
Women living in county with no abortion provider, %[11]	74	38

METHODS

We examined state-level policies and outcomes related to the well-being of women and children; our definition of well-being is broad, encompassing health, social, and economic status. We then determined what, if any, relationship exists between those policies and outcomes and state-level restrictions on abortion. This involved: (1) selecting indicators[i] of abortion restrictions, outcomes related to women's and children's health and well-being, and policies that support women's and children's health and well-being; (2) scoring the selected state restrictions, outcomes, and policies; and (3) graphically exploring the relationship between abortion restrictions and women's and children's well-being.

[i]"Indicator" refers to the presence or absence of a policy (either an abortion restriction or a policy to support women's or children's well-being) or a health outcome statistic (e.g., infant mortality rate, prevalence of asthma, etc.).

We selected indicators based on evidence of their importance to the well-being of women and children and the availability of up-to-date, state-level data. We ultimately included 76 indicators in five topic areas: abortion restrictions (14), women's health outcomes (15), children's health outcomes (15), social determinants of health (10), and policies supportive of women's and children's health and well-being (22).[ii] The data were collected from a variety of government and nonprofit organizations with expertise in women's and children's health, well-being, and policy.

For each state, we calculated two primary scores: one score for abortion restrictions and one score for overall women's and children's well-being.

- For abortion restrictions, each state was scored 0-14 to reflect the total number of 14 possible abortion restrictions. Any legislation signed into law was counted, including those unenforced due to court challenges. Higher scores indicate more abortion restrictions.
- For overall women's and children's well-being, we calculated scores for each of the four topic areas within women's and children's well-being, then summed the four sub-scores to calculate an overall well-being score. Each state was scored 0 or 1 for each of the selected indicators, for a total possible score of 0-62 (see below for details on how we determined 0 or 1 for indicators in each sub-topic). Higher scores indicate better performance on women's and children's well-being.
- For each indicator in the three health outcome sub-topics (women's health, children's health, and social determinants of health), we determined whether states met a pre-determined benchmark, which was set to be moderately but meaningfully better than the national average. Because the national average for selected indicators is often poor relative to other developed countries, the pre-determined benchmarks do not necessarily reflect an "ideal," but rather are meant to be attainable goals for states.[iii] A state received a score of 1 if it met or exceeded the benchmark and a 0 if it did not. The score for each subtopic is the number of indicators for which a state met or exceeded the benchmark. Total possible

[ii] For a complete list of indicators and data sources, please see our full report, *Evaluating priorities: Measuring women's and children's health and well-being against abortion restrictions in the states. Research report.*
[iii] For more information on how the benchmarks were calculated, please see our full report, *Evaluating priorities: Measuring women's and children's health and well-being against abortion restrictions in the states. Research report.*

scores were 0-15 for women's health, 0-15 for children's health, and 0-10 for social determinants of health. Higher scores indicate better performance in that sub-topic.

- For indicators of policies to support women's and children's well-being, each state was scored 0-22 to reflect the total number of 22 possible supportive policies. Higher scores indicate more policies supporting women's and children's well-being.

To examine the relationship between abortion restrictions and women's and children's health and well-being, we created a series of scatter plots, comparing states' abortion restriction scores against their total scores on overall women's and children's well-being, as well as against their scores on each of the sub-topics (women's health, children's health, social determinants of health, and supportive policies).

RESULTS

We obtained data on all 76 indicators for all 50 states and the District of Columbia.

Abortion restrictions

Kansas tied with Oklahoma and Mississippi for being the state with the most abortion restrictions in the country. Of the 14 restrictions included in this analysis, Kansas had all 14.

Table 1: Abortion restrictions

Abortion restrictions	Yes	No
Parental involvement before a minor obtains an abortion	✓	
Mandatory waiting periods between time of first appointment and abortion	✓	
Mandatory counseling prior to abortion	✓	
Requirement to have or be offered an ultrasound	✓	
Restrictions on abortion coverage in private health insurance plans	✓	
Restrictions on abortion coverage in public employee health insurance plans	✓	
Restrictions on abortion coverage in Medicaid	✓	
Only licensed physicians may perform abortions	✓	
Ambulatory surgical center standards imposed on facilities providing abortion	✓	
Hospital privileges or alternative arrangement required for abortion providers	✓	
Refusal to provide abortion services allowed	✓	
Gestational age limit for abortion set by law	✓	
Restrictions on provision of medication abortion	✓	
Below average number of providers (per 100,000 women aged 15-44)	✓	
Total number of restrictions	14	

Women's and children's well-being

Kansas performed above average on indicators of women's and children's health and socioeconomic well-being. With a total score of 25, Kansas ranked 21st for overall women's and children's well-being, tied with the District of Columbia and Pennsylvania.

Women's health

Compared to other states, Kansas performed well on indicators of women's health. The state met the benchmark for eight of the 15 women's health indicators evaluated. This was the third-highest score and ranked Kansas eighth out of 51, tied with Maine and Vermont.

Table 2: Women's health

Women's health indicators	KS	US	Benchmark	KS meets benchmark Yes	KS meets benchmark No
Cervical cancer screening rate, % of women (range)	82.7	80.9 *(73.2-88.9)*	82.5 or ↑	✓	
Women without health insurance, % of women (range)	18.0	21.0 *(5.0-33.0)*	17.9 or ↓		X
Women with no personal health care provider, % of women (range)	13.0	17.3 *(8.0-26.8)*	14.7 or ↓	✓	
Maternal mortality ratio, deaths per 100,000 live births (range)	7.1	12.1 *(1.2-38.2)*	9.0 or ↓	✓	
Women reporting poor mental health, % of women (range)	34.9	40.1 *(30.1-46.1)*	38.4 or ↓	✓	
Suicide deaths, per 100,000 women (range)	5.9	6.1 *(2.6-12.5)*	5.0 or ↓		X
Prevalence of overweight or obesity, % of women (range)	57.7	56.6 *(47.0-66.4)*	54.5 or ↓		X
Smoking prevalence, % of women (range)	17.8	16.4 *(9.2-27.6)*	14.6 or ↓		X
Prevalence of sexual violence, % of women (range)	39.4	44.6 *(28.9-58.0)*	41.5 or ↓	✓	
Asthma prevalence, % of women (range)	10.3	10.7 *(7.3-14.1)*	9.9 or ↓		X
Proportion of pregnancies unintended, % of pregnancies (range)	47.0	49.0 *(37.0-70.0)*	45.9 or ↓		X
Preterm birth rate, % of live births (range)	10.6	12.0 *(8.4-17.6)*	11.1 or ↓	✓	
Prevalence of low birth weight, % of live births (range)	7.1	8.1 *(5.7-12.1)*	7.5 or ↓	✓	
Chlamydia incidence, per 100,000 women (range)	583.9	643.3 *(322.2-1,358.6)*	546.2 or ↓		X
HIV incidence, per 100,000 women (range)	6.2	19.0 *(2.3-177.9)*	6.6 or ↓	✓	
Number of indicators meeting benchmark				8	

Children's health

Kansas performed slightly above average on indicators of children's health, meeting the benchmark for five of the 15 indicators evaluated. This score ranked Kansas in 20th place for indicators of children's health, tied with Colorado, Maryland, Montana, North Dakota, Virginia, and Wyoming.

Table 3: Children's health

Children's health indicators	KS	US	Benchmark	KS meets benchmark Yes	No
Children with health insurance, percent of children (range)	93.9	91.1 *(81.7-97.9)*	92.9 or ↑	✓	
Children with a medical home, percent of children (range)	61.3	57.5 *(45.4-69.3)*	60.3 or ↑	✓	
Children who had both medical and dental preventive visits in the past 12 months, percent of children (range)	70.1	68.1 *(56.0-81.4)*	71.2 or ↑		X
Infants exclusively breastfed for six months, percent of children (range)	15.1	16.4 *(4.1-27.4)*	19.3 or ↑		X
Children receiving complete vaccination, percent of children (range)	65.0	68.4 *(59.5-80.2)*	70.9 or ↑		X
Children with emotional, developmental, or behavioral problems that received needed care, percent of children (range)	72.2	61.0 *(40.4-86.3)*	65.1 or ↑	✓	
Infant mortality rate, per 100,000 infants (range)	689.0	638.7 *(423.6-989.5)*	573.5 or ↓		X
Child mortality rate, per 100,000 children (range)	22.0	17.0 *(9.0-30.0)*	14.6 or ↓		X
Teen mortality rate, per 100,000 teens (range)	62.0	49.0 *(29.0-85.0)*	41.8 or ↓		X
Children overweight or obese, percent of children (range)	30.2	31.3 *(22.1-39.8)*	29.2 or ↓		X
Children living with someone who smokes, percent of children (range)	25.3	24.1 *(12.4-41.0)*	21.3 or ↓		X
Confirmed cases of child maltreatment, per 1,000 children (range)	2.0	9.0 *(1.0-23.0)*	6.7 or ↓	✓	
Children with asthma problems, percent of children (range)	8.0	9.0 *(4.0-16.0)*	7.9 or ↓		X
Teen alcohol or drug abuse, percent of teens (range)	5.9	6.5 *(4.7-9.2)*	6.1 or ↓	✓	
Teen birth rate, per 1,000 female teens (range)	34.0	29.0 *(14.0-47.0)*	24.7 or ↓		X
Number of indicators meeting benchmark				5	

Social determinants of health

Kansas performed well on indicators of social determinants of health. The state met the benchmark for six of the ten indicators. This score ranked Kansas 11th in the nation, tied with Nebraska and Wisconsin.

Table 4: Social determinants of health

Social determinants of health	KS	US	Benchmark	KS meets benchmark Yes	No
Women participating in the labor force, percent of women (range)	61.5	58.8 *(49.6-66.9)*	60.7 or ↑	✓	
Women's earnings, % of men's earning (range)	73.6	78.6 *(64.0-92.3)*	81.2 or ↑		X
On-time high school graduation, percent of students (range)	84.5	78.2 *(57.8-91.4)*	81.8 or ↑	✓	
Women in poverty, percent of women (range)	17.0	20.0 *(10.0-27.0)*	18.1 or ↓	✓	
Children in poverty, percent of children (range)	19.0	23.0 *(13.0-35.0)*	20.4 or ↓	✓	
Household food insecurity, percent of households (range)	14.4	14.7 *(8.7-20.9)*	13.5 or ↓		X
Children aged 3-5 not enrolled in preschool or kindergarten, percent of children (range)	40.0	40.0 *(17.0-54.0)*	36.5 or ↓		X
Homelessness rate, per 10,000 population (range)	9.3	20.3 *(8.1-112.5)*	12.2 or ↓	✓	
Unemployment rate, percent of labor force (range)	4.8	6.3 *(2.6-8.3)*	5.6 or ↓	✓	
Violent crime rate, per 100,000 population (range)	354.6	386.9 *(122.7-1243.7)*	297.5 or ↓		X
Number of indicators meeting benchmark				6	

Supportive policies

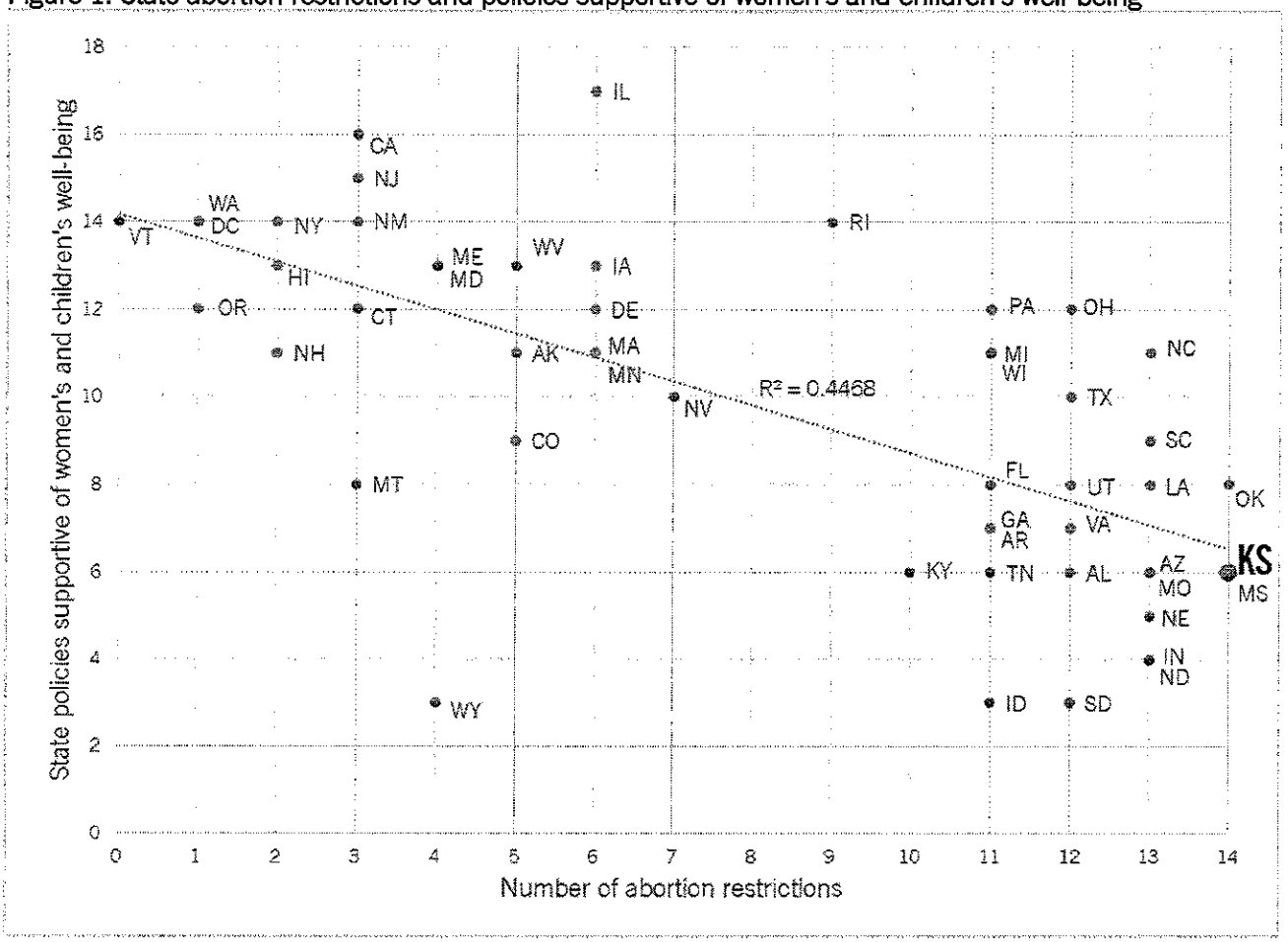
Kansas performed poorly on policies that support women's and children's well-being. Of the 22 policies included in this analysis, Kansas had six. This score placed the state 39th out of 51, tied with Alabama, Arizona, Kentucky, Mississippi, Missouri, and Tennessee.

Table 6: Supportive policies

Supportive policies	Yes	No
Improving access to health care		
Moving forward with the Affordable Care Act's Medicaid Expansion		X
Allows telephone, online, and/or administrative renewal of Medicaid/CHIP	✓	
Requires domestic violence protocols, training, or screening for health care providers		X
Supporting pregnant women		
Medicaid income limit for pregnant women is at least 200% of the federal poverty line		X
Has expanded family/medical leave beyond the FMLA		X
Provides temporary disability insurance		X
Maternal mortality review board in place		X
Requires reasonable accommodations for pregnant workers		X
Prohibits or restricts shackling pregnant prisoners		X
Promoting children's and adolescents' health, education, and safety		
Allows children to enroll in CHIP with no waiting period		X
Requires physical education for elementary, middle, and high school		X
Mandates sex education		X
Mandates HIV education		X
Has broad eligibility criteria for Early Intervention services for children at risk of developmental delay	✓	
Initiative(s) to expand Early Head Start in place	✓	
Requires districts to provide full-day kindergarten without tuition		X
Has firearm safety law(s) designed to protect children		X
Supporting families' financial health		
Allows families receiving TANF to keep child support collected on their behalf		X
State minimum wage is above the federal minimum		X
Income limit for child care assistance is greater than 55% of state median income	✓	
Does not have a family cap policy or flat cash assistance grant	✓	
Promoting a healthy environment		
Requires worksites, restaurants, and bars to be smoke free	✓	
Total number of supportive policies	6	

Kansas's lack of supportive policies is consistent with the overall trend we observed of states with more abortion restrictions having fewer evidence-based policies that support women and children (see Figure 1).

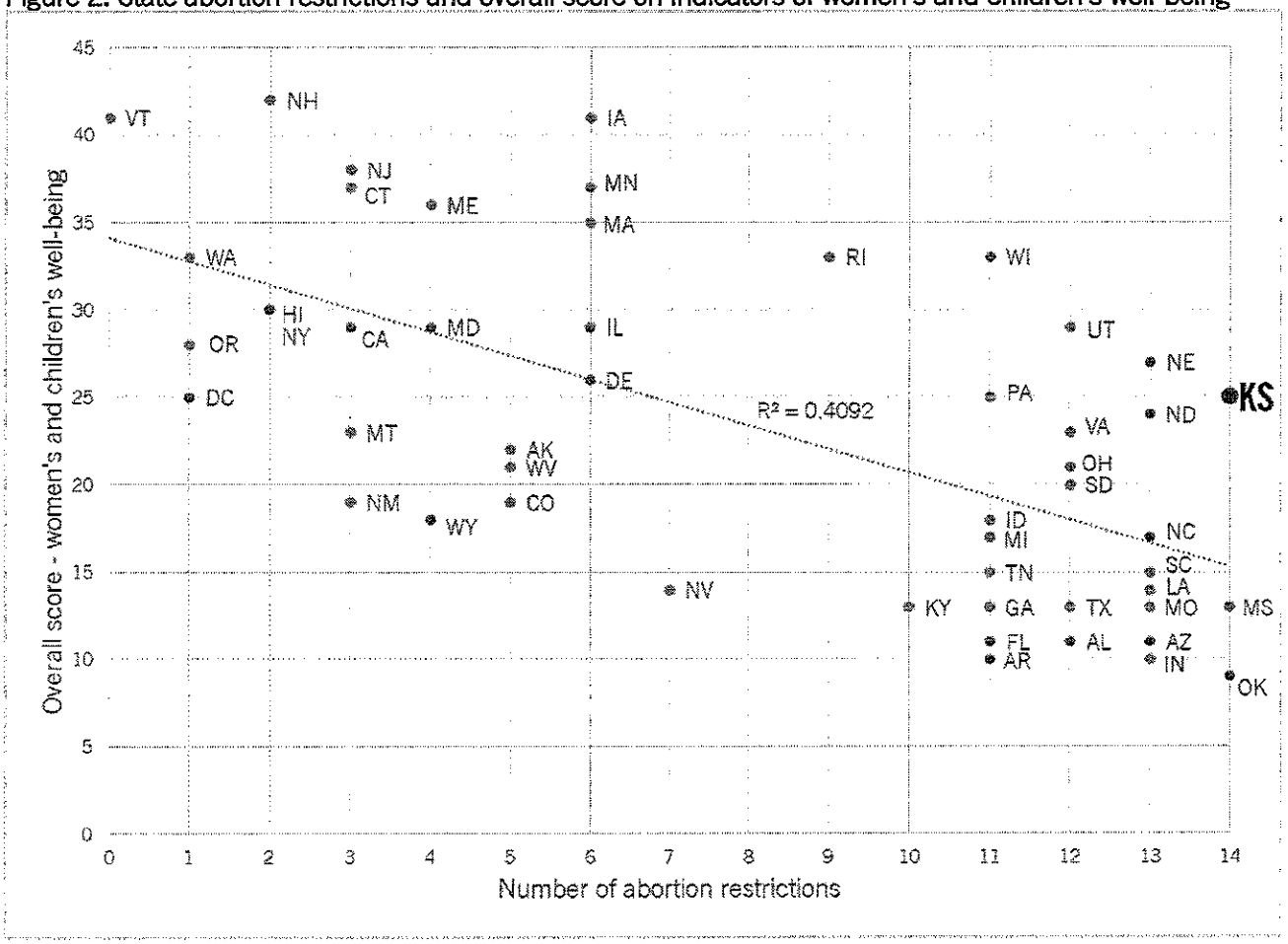
Figure 1. State abortion restrictions and policies supportive of women's and children's well-being



Relationship between abortion restrictions and well-being

Kansas, one of the most restrictive states in the country for abortion, performed above average across indicators of women's health, children's health, and social determinants of health. This is inconsistent with the overall trend we observed that the more abortion restrictions present, the worse a state scored overall on indicators of women and children's well-being (see Figure 2). However, while Kansas scored better than most other states with many abortion restrictions, its overall score is relatively low when compared to states with few abortion restrictions.

Figure 2. State abortion restrictions and overall score on indicators of women's and children's well-being



DISCUSSION

This analysis shows that, compared to other states, Kansas has a large number of abortion restrictions, few policies in place to support women's and children's well-being, and above average outcomes for women's and children's health and social determinants of health.

Indeed, Kansas has all 14 abortion restrictions included in the analysis. Moreover, the state has recently attempted to increase the severity of existing restrictions around abortion counseling. In 2013, Kansas passed new legislation that requires abortion providers to provide women with inaccurate medical information, including that a woman's risk for breast cancer increases as a result of having had an abortion,[12] when no scientific link exists.[13] The trend of increasing restrictions on abortion is troubling as a large body of scientific evidence documents that restricting abortion is not beneficial to women and can interfere with women's reproductive decision-making, increase the risks of the abortion procedure by forcing women to delay desired health care, and lead to a number of emotional and financial harms.[14-20] Despite the existing evidence base, Kansas policymakers have continued to pass legislation limiting abortion access, making it one the most restrictive states in the country.

While passing numerous restrictions on abortion, policymakers have simultaneously passed very few evidence-based policies known to support women's and children's well-being. Of note, Kansas has implemented none of the policies we evaluated that are designed to support pregnant women and few of the policies aimed at improving access to health care or promoting children's and adolescents' health, education, and safety.

How do women's and children's health outcomes fare in this concerning policy environment? We found that Kansas met 13 of the 30 benchmarks on women's and children's health, and six of the ten benchmarks on indicators of social determinants of health, suggesting Kansas residents are healthier and experiencing more positive well-being than many other US residents. However, there are some important health outcomes where Kansas did not meet the benchmarks (such as infant, child, and teen mortality; smoking prevalence among women; and prevalence of overweight/obesity among women). Efforts are needed to address these critical health outcomes. Additionally, while Kansas performed relatively well in this analysis on access to health insurance and medical providers, its performance on these indicators will likely decrease in the coming years as other

states move ahead with expanding access to Medicaid under the Affordable Care Act; in Kansas, the decision not to expand Medicaid will leave nearly 50,000 women without access to affordable health care coverage.[21]

Our findings help dismantle the claim that anti-choice policymakers are working to protect and support the health and lives of women, their pregnancies, and their children, as there is little evidence of this in Kansas's state policies. This highlights the need for Kansas policymakers to focus their attention on evidence-based policies that have been shown to improve women's and children's well-being instead of on restricting abortion. Doing so would enable policymakers to send a clear and consistent message that they are invested in the well-being of their state residents.

Our analysis has some limitations. While we made every effort to select the most meaningful, evidence-based indicators, any attempt to analyze a concept as broad as women's and children's well-being is a simplification. Specifically, we did not adjust for poverty, which has been shown to play a major role in women's and children's well-being,[22] and is associated with other social issues that may play a role in our findings, such as racism[23] and sexism.[24] However, as detailed in our full report,[4] the data suggest that while household income (an incomplete, but important indicator of poverty[25]) does play a role in our findings, it cannot explain all of the differences observed between states. Some of the lowest well-being scores were among middle-income states with many abortion restrictions, such as Texas and Arizona.

Additionally, our simple yes/no scoring methodology is limited in its ability to detect the degree of variation in states' health outcomes and does not account for differences in specific policies across states (e.g., 24-hour vs. 72-hour waiting periods prior to an abortion). Nevertheless, we feel this simple approach is also a strength because it facilitates understanding and replicability of our analysis, and makes the information accessible to policymakers and advocates.[26]

There are a number of other strengths to our analysis. First, we selected indicators well-supported by public health bodies and scientific literature. The indicators of women's health, children's health, and social determinants of health included in this analysis are widely accepted indicators of health status.[27-29] Also, there is considerable evidence of the benefits to women and children of putting in place the supportive policies we evaluated.[30-32] Such benefits include improved health and safety, lower poverty rates, decreased reliance on public assistance, and better developmental

and educational outcomes for children.[4] In addition, the fact that Kansas fares similarly in other state profiles[1,33,34] boosts our confidence in the results.

Ultimately, we used a straightforward approach to evaluate lawmakers' stated aims to improve the well-being of women, their pregnancies, and their children. Our results show a disconnect between these aims and the policies implemented, emphasizing the need to ensure policies designed to affect well-being are founded on evidence. To ensure better population outcomes, Kansas policymakers must focus on implementing policies shown to improve the well-being of women and children, and not on restricting access to needed health care services such as abortion.

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