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**An Analysis of How  
Medicaid Expansion in Kansas  
Will Affect Abortion Rates**

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## Executive Summary

This month, the Kansas state legislature will consider legislation that would expand Kansas' Medicaid program. Currently, the Kansas Medicaid program does not fund elective abortions. However, in April 2019 in *Hodes & Nauser v. Schmidt*, the Kansas Supreme Court ruled that access to abortion is a “fundamental right” under the state's Bill of Rights. As such, based on the precedent set in numerous other states, many legal analysts are concerned that the Kansas Supreme Court will likely require the state to fund elective abortions for Medicaid-eligible women in the future. Under this scenario, expanding the state Medicaid program allows more women to become eligible for publicly funded abortions, and would increase the number of abortions that occur.<sup>1</sup> Additionally, by guaranteeing Medicaid coverage to all low-income women – regardless of whether or not they are pregnant – the expansion would remove the incentive of many low-income women to carry their pregnancy to term. Finally, it would increase taxpayer funding for Planned Parenthood, the nation's largest abortion provider and the locus of a significant number of abortions in Kansas. Overall, expanding Medicaid eligibility in Kansas will likely increase the overall incidence of abortion in the state.

## Introduction

In the months leading up to the passage of the Affordable Care Act (commonly referred to as “ObamaCare”), or ACA, a number of pro-life policy analysts expressed concern that the legislation could increase the incidence of abortion.<sup>2</sup> One major concern was that the ACA would result in taxpayer subsidies of health insurance plans that cover abortion.<sup>3</sup> Others were concerned that the ACA would indirectly subsidize abortion by generating additional revenue for Planned Parenthood. Finally, some feared that the ACA would grant the U.S. Department of Health and Human Services the power to require that health insurance plans cover abortion-inducing drugs and devices.<sup>4</sup> However, the ACA could also increase the incidence of abortion in another way; specifically, it encourages states to expand Medicaid eligibility and, in many states, this amounts to increased access to abortion.

As originally written, the ACA required each state to expand its Medicaid program to cover all adults under age 65 whose household incomes are less than or equal to 138 percent of the federal poverty level. States that failed to expand Medicaid would risk losing all federal funding for their Medicaid programs.<sup>5</sup> However, in June 2012, the United States Supreme Court ruled in *National Federation of Independent Business v. Sebelius* that the federal government could not require individual states to expand their Medicaid programs.<sup>6</sup> As such, states can decide for themselves if they want to expand Medicaid, without compromising their current federal Medicaid funding. In addition, the ACA offered federal incentives for Medicaid expansion and it continues to pay 90 percent of the cost of enrollment increases, a more generous formula than previously applied to the states.

Since 2012, approximately 36 states have expanded their Medicaid program in this manner.<sup>7</sup> Kansas is not among them. Republican Sam Brownback, who served as Governor of Kansas between 2011 and 2018, consistently opposed Medicaid expansion. In 2017, Governor Brownback vetoed legislation that would have expanded the state Medicaid program and the Kansas state legislature was unable to override him. Governor Brownback said that the cost of expanding Medicare was “irresponsible and unsustainable” at a time when the state was dealing with an ongoing budget crisis. He also criticized the bill for facilitating an increase in Medicaid reimbursements to Planned Parenthood.<sup>8</sup>

However, Kansas’ new Governor, Democrat Laura Kelly, has made Medicaid expansion a high priority. She campaigned on expanding the state Medicaid program during her successful run for Governor in 2018.<sup>9</sup> In the fall of 2019, she said that Medicaid expansion would be her top priority in 2020.<sup>10</sup> She argued that Medicaid expansion will provide access to health care for 150,000 Kansans, strengthen rural hospitals, create thousands of jobs, and expand access to both prescription drugs and mental health care.<sup>11</sup> But Governor Kelly overlooks the various moral quandaries that expansion poses – not the least of which is the fact that the expansion of Medicaid is likely to result in a higher incidence of taxpayer-funded abortion in the state.

A significant body of academic and policy research shows that expanding eligibility for Medicaid dramatically increases Medicaid enrollment. Specifically, a recent analysis published by the Kansas Health Institute indicates that the current legislative proposal would increase Kansas’ Medicaid rolls by approximately 132,000 people.<sup>12</sup> Much of the subsequent policy

debate has centered around the cost to the taxpayers and how expanded Medicaid coverage would impact the quality of health care coverage for individuals already on Medicaid.

However, pro-lifers have expressed concerns that Medicaid expansion would result in more abortions in Kansas. While the Kansas Medicaid program does not currently cover abortions,<sup>13</sup> many are concerned that, in the future, the Kansas Supreme Court will likely require the state Medicaid program to fund elective abortions based on its April 2019 holding in *Hodes & Nauser v. Schmidt* in which the court declared access to abortion to be a “fundamental right” under the state's Bill of Rights.<sup>14</sup> Legal analysts have demonstrated that, with one exception, every state court that has both recognized a state constitutional right to abortion and adopted the strict scrutiny standard of judicial review (as the Kansas Supreme Court did), has struck down restrictions on public funding of abortion when those restrictions have been challenged.<sup>15</sup> Indeed, currently 16 state Medicaid programs cover elective abortions. In nine states, this policy was enacted not through the democratic process, but through a court order.<sup>16</sup>

If the existing funding restrictions are invalidated under *Hodes*, there are several ways that Medicaid expansion would likely increase the incidence of abortion in Kansas. First, the expansion would make 43,000 Kansas women of childbearing age eligible to enroll in the Kansas Medicaid program.<sup>17</sup> Second, Medicaid expansion would result in women leaving non-abortion providing exchange plans to enroll in a Medicaid program that will likely cover abortion. Third, by guaranteeing Medicaid coverage to all low-income women – regardless of whether they are pregnant – low-income women would lose the incentive to carry their pregnancy to term. Finally, Medicaid expansion could indirectly subsidize abortion by increasing the amount of taxpayer funding for Planned Parenthood, the nation’s largest abortion provider.

#### *Background: Federal and State Policies Regarding Public Funding for Abortion*

As legal access to abortion was expanded in the late 1960s and early 1970s, questions were raised about the extent to which state Medicaid programs should subsidize abortions for low-income women. Evidence from that time indicates that state Medicaid programs did provide reimbursement for eligible women obtaining abortions in states where it was legalized. After the *Roe v. Wade* decision legalized abortion in all 50 states,<sup>18</sup> a number of states took action to limit the extent to which their state Medicaid programs would pay for elective abortions.<sup>19</sup>

This resulted in a series of court cases culminating in the *Beal v. Doe*,<sup>20</sup> *Maher v. Roe*,<sup>21</sup> and *Poelker v. Doe*<sup>22</sup> decisions in 1977 in which the U.S. Supreme Court held that the government is not required to fund elective abortions either under federal statute or the U.S. Constitution. Meanwhile, in 1976 Congress passed an appropriations limitation known as the Hyde Amendment which restricted federal Medicaid funds for abortions. This resulted in another round of litigation. In 1980, the Supreme Court ruled in *Harris v. McRae*<sup>23</sup> that the federal Hyde Amendment was constitutional.<sup>24</sup>

Since that time, the federal funding of abortions has been largely limited to situations where either the abortion was performed to save the life of the woman or when the pregnancy resulted from rape or incest.<sup>25</sup> However, states have always been free to use their own tax

dollars to fund abortions through their respective state Medicaid programs. As noted, currently 16 states fund elective abortions through their state Medicaid programs.<sup>26</sup>

### *The History of Taxpayer-Funded Abortion in Kansas*

In 1969, Kansas adopted the Model Penal Code legislation on abortion that was drafted by the American Law Institute. This liberalized the abortion laws in Kansas. Abortion became legal in Kansas if the pregnancy posed a substantial risk to the physical or mental health or the life of the mother. Abortion was also legal in cases where a child would be born with a physical or mental defect and in cases where the pregnancy resulted from rape, incest, or statutory rape. The legislation took effect July 1, 1970.<sup>27</sup> Kansas thus became one of 13 states to enact legislation prior to 1973 embodying provisions of the Model Penal Code.<sup>28</sup>

Subsequent to the *Roe v. Wade* decision, the state funded elective abortions for women enrolled in the state Medicaid program.<sup>29</sup> However, when the federal Hyde Amendment was implemented on December 1, 1977, the Kansas Medicaid program adopted a policy of only paying for abortions that were necessary to save the life of the mother. Except for a brief period of time in the 1970s when the federal Hyde Amendment was temporarily struck down by a court ruling, Kansas has continued to fund abortions for women on Medicaid in only very limited circumstances.<sup>30</sup>

There is a good chance that this policy may change in the near future. In 2019 in *Hodes & Nauser, MDs, P.A. v. Schmidt*,<sup>31</sup> the Kansas Supreme Court found an independent right to abortion in the state constitution. Declaring abortion to be a “fundamental right,” the Kansas Supreme Court adopted the strict scrutiny test as the standard of judicial review for all laws involving abortion. With the exception of the Florida Supreme Court,<sup>32</sup> every state court that has both recognized an independent state constitutional right to abortion and adopted the strict scrutiny standard of judicial review (as the Kansas Supreme Court did) has struck down restrictions on public funding of abortion when those restrictions have been challenged.

Limits on public funding of abortion through state Medicaid programs have been struck down by the state supreme courts of Alaska, California, Massachusetts, Minnesota, and New Jersey.<sup>33</sup> Additionally, limits on taxpayer funding of abortion have been struck down by trial courts in both Connecticut and Montana.<sup>34</sup> Also, applying the equivalent of a “strict scrutiny” analysis under the state’s equal rights provision, the New Mexico Supreme Court invalidated restrictions on public funding of abortion in 1998.<sup>35</sup> Restrictions on public funding of abortion have been struck down on state constitutional grounds even under a standard of review that is less exacting than strict scrutiny in both Arizona and West Virginia.<sup>36</sup> Given these numerous precedents, it is a virtual certainty that the current restrictions on public funding of abortion in Kansas would be struck down, if challenged on the basis of the opinion in *Hodes*.

In 2016, I authored a comprehensive analysis of the Hyde Amendment that was published by the Charlotte Lozier Institute. It found that Kansas’ limits on taxpayer funding of abortion save approximately 500 lives a year. Furthermore, these limits have saved the lives of 32,000 Kansans since 1976.<sup>37</sup> In the likely scenario where courts require the Kansas Medicaid program to cover elective abortions, the number of abortions would increase. If Medicaid is expanded to

cover more women of childbearing age, the abortion rates would increase by an even larger margin.

### *The Impact of Medicaid Funding on the Incidence of Abortion*

Additional existing studies support this analysis. For example, a 2009 Guttmacher Institute literature review identified 18 peer-reviewed studies that analyzed the impact of state Medicaid funding on the incidence of abortion.<sup>38</sup> These methodologically diverse studies utilized abortion data from a variety of sources. Overall, of the 18 studies they considered, 15 found statistically significant evidence that abortion rates went up after Medicaid funding was increased.<sup>39</sup> Two additional studies not included in the Guttmacher analysis also provide strong evidence that Medicaid funding of abortion increases the incidence of abortion.<sup>40</sup>

These findings held for studies using time series cross-sectional data to analyze overall abortion rates.<sup>41</sup> They also held for studies using time series cross-sectional data to specifically analyze teen abortion rates.<sup>42</sup> They held as well for studies that analyzed abortion rates in smaller groups of states<sup>43</sup> and for two studies that specifically analyzed the impact of public funding restrictions on pregnancy outcomes in North Carolina.<sup>44</sup>

The studies that analyzed data from North Carolina were especially interesting. From 1980 to 1995 North Carolina taxpayers funded abortion for low-income women – not through Medicaid, but through a state abortion fund that periodically ran out of money. Whenever funds were depleted, the researchers found there were statistically significant decreases in the abortion rate and, months later, statistically significant increases in the birth rate.<sup>45</sup> These findings were statistically stronger when the pregnancy outcomes for African-American women were considered. Overall, the authors concluded that 37 percent of the women who would have otherwise had an abortion carried their child to term when funding was not available.<sup>46</sup>

The authors of the Guttmacher literature review acknowledge that the best research indicates that Medicaid funding increases the incidence of abortion: they state that “the best studies...used detailed data from individual states and compared the ratio of abortions to births both before and after the Medicaid restrictions took effect.<sup>47</sup> These found that 18-37 percent of pregnancies that would have ended in Medicaid funded abortions were carried to term when funding was no longer available.”<sup>48</sup> Looking at this another way, according to Guttmacher, the methodologically strongest studies found that Medicaid funding of abortion increases the abortion rate for women on Medicaid by anywhere from 22 percent to 58 percent.<sup>49</sup>

### **Impact of Medicaid Expansion on the Incidence of Abortion in Kansas**

As the four points below demonstrate, in Kansas, Medicaid Expansion will increase the incidence of abortion, will increase the taxpayer funding of abortions, and will increase the amount of taxpayer funds going to Planned Parenthood.

## **1) Medicaid Expansion Would Make 43,000 Additional Women of Childbearing Age Eligible for a Medicaid Health Insurance Plan That Will Likely Cover Abortion in the Future**

An impressive body of policy and academic research shows that increasing eligibility for Medicaid increases state Medicaid rolls.<sup>50</sup> In particular, a 2013 analysis published by the Kansas Health Institute indicates that increasing Medicaid eligibility to 138 percent of the poverty line would increase Kansas Medicaid rolls by approximately 132,000 people.<sup>51</sup> An Urban Institute study found that the proposed state Medicaid expansion would make 43,000 additional women of childbearing age (19-44) eligible for the state Medicaid program.<sup>52</sup>

As was mentioned earlier, if the current limits on state funding of abortion are challenged and stricken in court, past precedent strongly suggests that the courts will strike down these limits and require the Kansas Medicaid program to cover elective abortions. Again, other states where courts have found that abortion is a fundamental right have required their state Medicaid program to fund elective abortions. A significant body of evidence shows that the incidence of abortion is sensitive to its cost. As such, placing more women of childbearing age on an insurance program that covers abortion will certainly increase the incidence of abortion in Kansas.

Currently, pregnant women in Kansas whose income is less than 171 percent of the poverty line are already eligible for the state Medicaid program. Because of this, some have argued that if the Kansas Medicaid program covers elective abortions in the future, women in this income category will be eligible for publicly funded abortions regardless of whether or not Medicaid is expanded.

However, if Medicaid is not expanded, a pregnant woman seeking a publicly funded abortion still has to apply to enroll in Medicaid. A woman might have to wait ten days to two weeks for the application to be processed.<sup>53</sup> Consequently, it is possible that the application process and the delay may dissuade some Kansas women from seeking abortions. However, if Medicaid is expanded, many of those women of childbearing age will already be enrolled in Medicaid. They will not have to apply to enroll in Medicaid and they will not face a delay. Overall, if the state Medicaid program is required to fund elective abortions, Medicaid expansion will give thousands of Kansas women faster and easier access to taxpayer-funded abortions.

Furthermore, the example of Alaska is instructive. Alaska legalized abortion in 1970 and has been paying for elective abortions through its state Medicaid program since the 1970s.<sup>54</sup> When the Alaska state legislature considered expanding the state Medicaid program in 2015, pro-lifers and other opponents of Medicaid expansion argued that Medicaid expansion would increase the number of publicly funded abortions performed in Alaska.<sup>55</sup>

The predictions of pro-lifers turned out to be correct. After Alaska expanded its state Medicaid program in 2015 there has been a significant increase in the number of publicly funded abortions in Alaska. As Table 1 indicates, after Medicaid expansion, the average annual number of abortions paid for by the state Medicaid program increased from 473 to 590. Furthermore, the percentage of abortions performed in the state that were covered by the Alaska Medicaid program significantly increased from approximately 34 percent to over 47 percent. Overall,



Medicaid expansion in Alaska resulted in Alaska taxpayers paying for 100 more abortions every year. The same thing could well happen in Kansas.

**Table 1: Number of Abortions Funded by Alaska’s Medicaid Programs<sup>56</sup>**

Year	Medicaid Funded Abortions	Percent of Total Funded by Medicaid
2013	547	40.2%
2014	434	29.2%
2015	438	33.1%
2016*	556	44.7%
2017*	635	51.3%
2018*	579	45.9%
Average before Medicaid expansion	473	34.2%
Average after Medicaid expansion	590	47.3%
Difference	117	13.1%

\*indicates a year after Medicaid was expanded

Note: The percent funded by Medicaid reflects the percentage of abortions performed on Alaska residents that were funded by the state Medicaid program (total Medicaid-funded abortions/abortions performed on Alaska residents).

## **2) Medicaid Expansion Would Result in Women Leaving Non-Abortion-Providing Insurance Plans to Enroll in Abortion-Covering Medicaid**

In Kansas and other states that have not expanded Medicaid, individuals whose income exceeds 100 percent of the poverty line are currently eligible to purchase subsidized insurance plans through a federally-facilitated health care exchange.<sup>57</sup> However, if Medicaid were expanded to 138 percent of the poverty line, some individuals who are currently in exchange plans would become eligible for Medicaid. A recent analysis by the Urban Institute indicates that if Medicaid expands in Kansas, 11,000 women of childbearing age who are currently eligible for exchange plans would then become eligible for Medicaid.<sup>58</sup> Furthermore, a significant percentage of these people would likely enroll in Medicaid since it would be significantly less costly.

This phenomenon has played out in other states that have expanded Medicaid eligibility. In the mid-1990s, Delaware began to expand its Medicaid eligibility to include childless adults earning up to 100 percent of the federal poverty level. Between 2002 and 2011 the rate of private insurance in Delaware dropped by 10 percentage points, while Medicaid enrollment increased by 7 percentage points. Arizona and Maine have seen similar results after they expanded eligibility for their state Medicaid programs.<sup>59</sup>

Furthermore, a Lozier Institute analysis found that the insurance plans on Kansas’ federally facilitated health insurance exchange do not cover abortion. As of 2019, three insurers offered plans on the Kansas exchange, Blue Cross and Blue Shield of Kansas, Medicina, and Sunflower/Ambetter. Oscar and Cigna have announced that they will join the exchange in

2020.<sup>60</sup> Kansas has enacted a life-affirming law to ensure that elective abortion is not included in any of the plans sold on the exchange.<sup>61</sup> As such, the Medicaid expansion would likely result in a significant number of women choosing to leave exchange-based plans that do not cover abortion in favor of a state Medicaid program that does cover abortion.

Overall, the experience from other states is instructive. If Medicaid is expanded in Kansas, many women of childbearing age will leave exchange plans that do not currently cover abortion and enroll in a Medicaid plan which will very likely cover elective abortions in the future. A significant body of academic research shows that for some women, the decision of whether or not to obtain an abortion depends on its price. The cost of elective abortions will likely be lower for those Kansas women who leave exchange plans and enroll in the state Medicaid program. As a result, these women will be more likely to obtain abortions, thereby increasing the incidence of abortion in Kansas.

### **3) Medicaid Expansion Would Remove the Incentive for Low-Income Kansas Women to Carry Their Pregnancies to Term**

In Kansas, if a pregnant woman with no children (who is below 171 percent of the Federal Poverty Level) obtains an abortion, she also loses her eligibility for Medicaid. Medicaid has traditionally not covered able-bodied, non-pregnant, and childless adults. And so after a childless woman is no longer pregnant in Kansas, she is no longer eligible to receive Medicaid benefits. As such, the Medicaid coverage that is limited to pregnant women and mothers creates an incentive for some women to carry their pregnancy to term. However, if Medicaid is expanded, a childless woman at or below 138 percent of the Federal Poverty Line will retain Medicaid coverage whether she carries her pregnancy to term or not. The incentive for women to carry their pregnancy to term vanishes and, as a result, the incidence of abortion is likely to increase.

### **4) Medicaid Expansion Could Result in More Taxpayer Funding for Planned Parenthood**

Planned Parenthood operates two centers in Kansas; one in Overland Park and one in Wichita.<sup>62</sup> According to their website, both of these facilities perform abortions.<sup>63</sup> A 2019 Guttmacher report indicates that as of 2017 there were four facilities providing abortions in Kansas.<sup>64</sup> Therefore, a significant percentage of the abortion facilities in Kansas are Planned Parenthood affiliates.

Planned Parenthood publicly advocates for Medicaid expansion.<sup>65</sup> On its website, Planned Parenthood states that 36 percent of women receiving publicly funded family planning receive their care at Planned Parenthood centers.<sup>66</sup> As such, an expansion of Medicaid could increase the amount of funding Planned Parenthood would receive for contraception and a range of other services. While this money would not be directly funding abortion, it would still be indirectly subsidizing abortion by funding a healthcare provider that performs a significant number of abortions in Kansas.

During his time in office, Kansas Governor Sam Brownback attempted to prevent Planned Parenthood from receiving funding from the state Medicaid program.<sup>67</sup> However, in 2018, the 10<sup>th</sup> Circuit Court of Appeals ruled that the state does not have the authority to prevent

Medicaid recipients from obtaining health services from Planned Parenthood.<sup>68</sup> As such, it is likely that future policy efforts to limit taxpayer dollars from going to Planned Parenthood will also be struck down by the judiciary. As a result, Medicaid expansion will likely result in more taxpayer dollars going to Planned Parenthood for years to come.

## Conclusion

Pro-lifers have good reason to oppose the current proposal to expand Medicaid coverage in Kansas. It would place approximately 33,000 women of childbearing age directly onto a Medicaid program<sup>69</sup> that will likely cover elective abortions in the future. Additionally, by guaranteeing Medicaid coverage to all low-income women – and not just pregnant, low-income women – it removes an important incentive for many women to carry their pregnancy to term. It would also indirectly subsidize abortion by providing taxpayer funding for Planned Parenthood. A broad body of academic research shows that subsidizing abortions through Medicaid increases state abortion rates. Pro-lifers would do well to oppose Governor Kelly’s Medicaid expansion proposal.

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<sup>1</sup> In this paper, references to the state Medicaid program funding elective abortion refers to the state using its own funds to provide elective abortions to Medicaid-eligible women. Because Medicaid is a federal-state partnership and the Hyde Amendment prohibits Medicaid funds from paying for elective abortions, states may not use federal or state Medicaid matching funds to pay for elective abortions.

<sup>2</sup> Susan B. Anthony List. “Taxpayer Abortion Funding in Obamacare.” <http://www.sba-list.org/taxpayer-funding-aca> (May 10, 2015).

<sup>3</sup> Susan B. Anthony List.

<sup>4</sup> Susan B. Anthony List.

<sup>5</sup> Prokop A. The Battle Over Medicaid Expansion in 2013 and 2014, Explained. *Vox.com*, May 12, 2015 <https://www.vox.com/2015/1/27/18088994/medicaid-expansion-explained> (February 18, 2020).

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- <sup>16</sup> Guttmacher Institute. State Funding of Abortion Under Medicaid.” 2020.
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- <sup>21</sup> *Maher v. Roe*, 432 U.S. 464 (1977).
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- <sup>24</sup> Merz, Jackson, and Klerman, 1995.
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- <sup>31</sup> *Hodes & Nauser, MDs, P.A. v. Schmidt*, 440 P.3d 461 (Kan. 2019) (*per curiam*).
- <sup>32</sup> *See Renee B. v. Florida Agency for Health Care Administration*, 790 So.2d 1036 (Fla. 2001).
- <sup>33</sup> Linton and Kirk, 2020.
- <sup>34</sup> Linton and Kirk, 2020.
- <sup>35</sup> *See New Mexico Right to Choose/NARAL v. Johnson*, 975 P.2d 841 (N.M. 1998).
- <sup>36</sup> *See Simat Corp. v. Arizona Health Care Cost Containment System*, 56 P.3d 28 (Ariz. 2002); *Humphreys v. Clinic for Women, Inc.*, 796 N.E.2d 247 (Ind. 2003) (limited partial invalidity); *Women’s Health Center of West Virginia, Inc. v. Panepinto*, 446 S.E.2d 658 (W. Va. 1993) (overturned by a state constitutional amendment in 2018).
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