Willful Disregard: How Ignoring Structural Racism in Maternal Mortality Has Led Black Women to Become Invisible in Their Own Crisis

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> *Indeed, in important respects, if the general discourse that surrounds racial disparities in maternal mortality is impoverished, then we should expect that the solutions that observers propose to this problem will be impoverished as well.*[1]

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1. Khiara M. Bridges, *Racial Disparities in Maternal Mortality*, 95 N.Y.U. L. REV. 1229, 1235 (2020).

INTRODUCTION

The tragedy of maternal mortality in the United States is not a novel issue. Efforts to collect data on pregnancy-related deaths started in the early twentieth century.[2] What was true then still holds today—maternal mortality rates in the United States are significantly worse than in similar countries in the developed world.[3] Today, approximately 700 women in the United States die annually from pregnancy-related causes.[4] Moreover, there are racial disparities in maternal mortality.[5] The maternal mortality rate for Black women[6] in the United States is

2. Eugene Declercq & Laurie Zephyrin, *Maternal Mortality in the United States: A Primer*, Commonwealth Fund, (Dec. 16, 2020), https://www.commonwealthfund.org/publications/issue-brief-report/2020/dec/maternal-mortality-united-states-primer [https://perma.cc/Y5HE-QP4D].
3. Jamila K. Taylor, Cristina Novoa, Katie Hamm, and Shilpa Phadke, *Eliminating Racial Disparities in Maternal and Infant Mortality*, Center for American Progress (May 2, 2019), https://www.americanprogress.org/article/eliminating-racial-disparities-maternal-infant-mortality/ [https://perma.cc/4KUT-62RD].
4. Centers for Disease Control and Prevention (CDC), Maternal Mortality (last updated Aug. 13, 2020), https://www.cdc.gov/reproductivehealth/maternal-mortality/index.html [https://perma.cc/9MTC-UGLJ].
5. Declercq et al., *supra* note 2, at 5 (reporting findings that "black mothers have been more likely to die than white mothers for the last 100 years."); *see also* Bridges, *supra* note 1, at 1231. ("Black women in the United States have *always* died during pregnancy, childbirth, or shortly thereafter at higher rates than white women.")
6. This article focuses on Black women and their unique experiences of racism in maternal health care and willful disregard by United States institutions and the mainstream Reproductive Rights movement. However, people other than women can become pregnant, including trans men and nonbinary people. Therefore, this article will use gendered language such as "women" or "mothers" when referring specifically to women's experiences or data about women in particular and will otherwise use gender-inclusive language such as "pregnant people."

significantly higher than rates for white and Hispanic women.[7] Strikingly, Black women are nearly three times more likely to suffer a pregnancy-related death compared to white women.[8] It is no secret that the issue of maternal mortality in the United States is a profoundly racial one.[9] So, why have some of the solutions to an issue of racial inequity ignored the impact of race?

As Professor Khiara M. Bridges has emphasized, the United States' maternal health crisis will never be fully resolved if the discourse surrounding the issue is not one of race. Although the United States government knows that Black women have disproportionately suffered poor maternal health outcomes for over a century, these disparities persist because of the willful disregard of structural racism in health care and its impact on Black women's reproductive health outcomes. This willful disregard has been on display throughout history: from the time of slavery, where enslavers exploited and diminished Black women's reproductive autonomy, up to the present day, when the United States government has the power to protect Black pregnant people's reproductive health but willfully fails to do so.[10]

This article begins with a brief introduction to the issue of racial disparities in maternal mortality in the United States. The remainder of the analysis proceeds in five parts. Part I discusses the historical legacy of slavery on Black women's reproductive health and autonomy. Part II then transitions into a critique of the mainstream Reproductive Rights framework in the United States, discussing how Black women and feminists of color birthed a framework that brought their reproductive health needs and freedoms to the forefront. Part III reviews maternal mortality rates in the United States, specifically for Black women, and surveys multiple factors contributing to racial disparities in maternal health outcomes in the United States. Of these factors, access to affordable, reliable, and quality health care is a significant determinant of Black maternal health outcomes.[11] Thus, we would expect that our legal institutions' responses and solutions to maternal mortality would include closing the gaps in access to such health care. However, this expectation is largely unmet. Part IV assesses how federal and state institutions' (in)action has impacted the United States' maternal health crisis, or,

7. CDC – National Center for Health Statistics, *Maternal Mortality Rates in the United States, 2020* (last updated Feb. 23, 2022), https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2020/maternal-mortality-rates-2020.htm#anchor_1559670094897 [https://perma.cc/2TSS-UPP6].
8. *Id.* ("In 2020, the maternal mortality rate for non-Hispanic Black women was . . . 2.9 times the rate for non-Hispanic White women.").
9. Bridges, *supra* note 1, at 1294. ("The United States is a deadly place for women to give birth in large part because it is a dangerous place for *black women* to give birth.")
10. Building U.S. Capacity to Review and Prevent Maternal Deaths, *Report From Nine Maternal Mortality Review Committees*, CDC Foundation, (2018), https://www.cdcfoundation.org/sites/default/files/files/ReportfromNineMMRCs.pdf [https://perma.cc/8LXU-ETAR].
11. Kaiser Family Foundation (KFF), *Racial Disparities in Maternal and Infant Health: An Overview* (November 10, 2020), https://www.kff.org/report-section/racial-disparities-in-maternal-and-infant-health-an-overview-issue-brief/ (Reporting findings that "[d]isparities in maternal and infant health, in part, reflect increased barriers to care for people of color.") [https://perma.cc/E2NP-SVVK].

rather, its Black maternal health crisis. Part V concludes the article with recommended solutions to the Black maternal health crisis—solutions that are not only attainable on an individual and institutional level, but also crucial to the survival of Black pregnant people in the United States.[12]

I. THE HISTORICAL LEGACY OF SLAVERY ON BLACK WOMEN'S REPRODUCTIVE HEALTH AND AUTONOMY

To fully understand how the United States has willfully disregarded race and thus the critical needs of Black pregnant people in its solutions to the maternal health crisis, a historical overview of the reproductive oppression of Black women in the United States is necessary.

A. The Black Woman's Role on the Plantation

Enslavers exploited and diminished Black women and their reproductive autonomy at the outset of slavery.[13] Black women's experiences on the plantation were distinct from those of enslaved men. U.S. law failed to recognize the rights of Black people as well as Black women's autonomy over their reproductive capacities, which resulted in Black enslaved women struggling to control their own bodies."[14] Black women were considered vital to the growth of the slave population. Congress abolished slave trade between the nations in 1808, which particularly devalued Black women's reproductive capacities.[15] Enslavers, concerned that the cotton-growing industry would suffer, were "forced to rely on natural reproduction as the surest method of replenishing and increasing the domestic slave population."[16] However, enslavers' need for Black enslaved women's reproduction did not affect the degree of respect these women received

12. The solutions to the Black maternal health crisis go beyond purely institutional responses, as discussed in further detail throughout this paper. However, the government's willful failure to protect Black pregnant people significantly contributes to this public health crisis.
13. ANGELA Y. DAVIS, WOMEN, RACE & CLASS 6 (Random House-New York 1981). ("Expediency governed the slaveholders' posture toward female slaves: when it was profitable to exploit them as if they were men, they were regarded, in effect, as genderless, but when they could be exploited, punished and repressed in ways suited only for women, they were locked into their exclusively female roles.")
14. Jamila K. Taylor, *Structural Racism and Maternal Health Among Black Women*, 48 JOURNAL OF LAW, MEDICINE & ETHICS 506, 507 (2020).
15. Act Prohibiting the Importation of Slaves, Pub. L. No. 9-22, 2 Stat. 426 (1808); Taylor, *supra* note 14. It is important to note that the ban did not abolish the internal slave trade or even slavery, but rather the very lucrative international slave trade for human rights concerns. The Act was promoted by then President of the United States, Thomas Jefferson. Ironically, many of those who opposed the slave trade were themselves plantation owners, like Jefferson. These people believed in the right to own property and thus legitimized slave ownership, but also believed that it was immoral to capture people from their native land and ship them across the seas; *see also* Michel Martin & Eric Foner, *End of Slave Trade Meant New Normal for America*, NPR (Jan. 10, 2008, 12:00 PM ET), https://www.npr.org/templates/story/story.php?storyId=17988106 [https://perma.cc/89VZ-JVDH].
16. Davis, *supra* note 13, at 7. "[S]he who was potentially the mother of ten, twelve, fourteen or more became a coveted treasure indeed.")

as mothers. Black enslaved women were not considered mothers but rather "'breeders'—animals, whose monetary value could be precisely calculated in terms of their ability to multiply their numbers."[17] Accordingly, just as Black enslaved women were classified as the property of their enslavers, so were their children.[18] Black enslaved women had no legal rights to their children, as "children could be sold away from their mothers at any age because 'the young slaves…stand on the same footing as other animals.'"[19]

Furthermore, Black enslaved women were expected to maintain their role as both field workers and caregivers, enduring long hours of physical labor.[20] Black enslaved women were considered to be "robust," a racist conception embodied in enslavers' exploitation of Black women's labor and subjugation of Black women to medical experimentation. The idea of "robustness" is the false belief that Black people are biologically stronger than and more capable of enduring pain than their white counterparts.[21] This belief developed primarily during the time of slavery, when advancements in medicine were made through dehumanizing experimentation on enslaved Black people. The belief in Black people's robustness persists in the quality of health care Black people receive today. The notion that Black women are robust has resulted in Black women receiving misdiagnoses and lower-quality health care, contributing to the public health crisis Black women endure to this day.[22]

B. The Medical Exploitation of Enslaved Black Women

For the most part, enslavers exploited and controlled Black enslaved women's physical and reproductive capabilities. However, the desire to sustain the fertility of Black enslaved women also compelled enslavers to seek out the assistance of physicians, whose contributions to the medical profession left an

17. *Id*. at 7; *see also* DOROTHY ROBERTS, KILLING THE BLACK BODY: RACE, REPRODUCTION, AND THE MEANING OF LIBERTY 24 (Vintage Books-New York 1997) ("With owners expecting natural multiplication to generate as much as 5 to 6 percent of their profit, they had a strong incentive to maximize their slaves' fertility. An anonymous planter's calculations made the point: I own a woman who cost me $400 . . . Admit she made me nothing—only worth her victuals and clothing. She now has three children, worth over $3000.").

18. *Id.* ("One year after the importation of Africans was halted, a South Carolina court ruled that female slaves had no legal claims whatever on their children.")

19. *Id.,* citing Barbara Wertheimer, *We Were There: The Story of Working Women in America* 109 (Pantheon Books-New York 1977).

20. Taylor, *supra* note 14, at 508. It is also important to note that although they were expected to be caregivers to both their own children and the children of their enslavers, Black enslaved women had no legal rights to their children. "In fact, the law granted to whites a devisable, *in futuro* interest in the potential children of their slaves." ROBERTS, *supra* note 17, at 33. Black enslaved women's motherhood was thus both lucrative and exploited, as enslaved women were systemically denied the right to be mothers at all.

21. *See* Kelly M. Hoffman et al., *Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs About Biological Differences Between Blacks and Whites*, 113 Proc. Nat'l Acad. Sci. U.S. 4296 (2016) (discussing a study that examines the disproportionate quality of care Black people receive due to the racially biased belief that Black people have "thicker skin" and thus feel less pain).

22. *Id.*

oppressive legacy that continues to impact Black women's reproductive care and autonomy.[23]

James Marion Sims was a nineteenth-century physician known as the "Father of Gynecology" for his pioneering work in the field.[24] Sims perfected the surgical repair of vesicovaginal fistula, a tearing between the bladder and the wall of the vagina that women may suffer during childbirth.[25] However, Sims improved his technique on enslaved Black women whose enslavers brought them to Sims.[26] Sims and his surgeons never asked these enslaved Black women suffering from vesicovaginal fistula "if they would agree to [Sims' operation], as they were totally without any claims to decision-making about their bodies or any other aspect of their lives."[27] Sims conducted his experiments on a total of seven enslaved Black women, including three women named Betsey, Lucy, and Anarcha.[28] Sims used no form of anesthesia when operating on these women, even when anesthesia was standard practice.[29] The procedures were extremely painful, details of which Sims recounted in his autobiography. After Sims performed his inaugural operation on Lucy, Sims recounted: 'I thought she was going to die…it took Lucy two or three months to recover entirely from the effects of the operation.'[30] Sims reported that it was not until after he performed twenty-nine unsuccessful surgeries on Anarcha that he performed his first successful one.[31] This procedure was not performed on white women until it was mastered, and even then, "none of them, due to the pain, were able to endure a single operation."[32] Sims' experimentations humiliated and further debilitated enslaved Black women.[33] Nevertheless, Sims and other physicians during the era of slavery "had specific orders to ensure that reproductive conditions did not negatively impact an enslaved woman's ability to bear children on the plantation."[34]

The historical legacies of coercion, oppression, and exploitation have laid a foundation for racial inequalities in reproductive health care today. Even after Black people obtained legal rights, the legacy of slavery left a lasting impression in every facet of their lives. Passing a law alone could not change perceptions of

23. Taylor, *supra* note 14, at 508. ("The use of a 'scientific approach' to plantation management ushered in a new era of slave breeding, coercion, medical experimentation, and the neglect for reproductive freedom.")
24. Dineo Khabele, Kevin Holcomb, Ngina K. Connors, and Linda Bradley, *A Perspective on James Marion Sims, MD, and Antiblack Racism in Obstetrics and Gynecology*, 28 J. MINIMALLY INVASIVE GYNECOLOGY 153 (Feb. 2021).
25. Durrenda Ojanuga, *The Medical Ethics of the 'Father of Gynaecology,' Dr. J Marion Sims*, 19 J. MED. ETHICS 28, 29 (1993).
26. *Id.*
27. *Id.*
28. *Id.*; Khabele, *supra* note 24, at 153.
29. Ojanuga, *supra* note 25; Khabele, *supra* note 24, at 153.
30. Ojanuga, *supra* note 25, at 29.
31. Khabele, *supra* note 24, at 153.
32. Ojanuga, *supra* note 25, at 30.
33. *Id.* at 29.
34. Taylor, *supra* note 14, at 508.

Black women as "robust"[35] with superhuman bodies that could withstand any pain. Enslavers continued to exploit Black as "breeders"[36] but denied them rights as mothers. This racist reproductive oppression[37] persists in the substandard health care that Black women receive today. The exploitation and devaluation of Black women's reproduction also carried into government policy and activism around reproductive rights, where Black women were denied a seat at the table. Therefore, both society at large and the mainstream Reproductive Rights movement decentered and devalued Black women's reproductive health and rights.

II. A CRITIQUE OF THE REPRODUCTIVE RIGHTS FRAMEWORK—AND WHY BLACK WOMEN NEEDED THE REPRODUCTIVE JUSTICE FRAMEWORK

A. A Critique of the Reproductive Rights Framework

Just as Black women struggled to maintain their reproductive freedom during slavery, Black women face that same struggle in the mainstream feminist movement, which has failed to center Black women's unique experiences of structural racism. The Supreme Court failed to acknowledge Black women's experiences and further excluded Black women from the conversation on reproductive rights. Prior to *Roe v. Wade*, a landmark Supreme Court case in reproductive rights which recognized a constitutional right to abortion, "the discourse surrounding abortion rights was diverse and multifaceted, reflecting concerns about the environment, the breadth of criminal regulation, sex equality, racial and class injustice, and intersectional claims that implicated both race and sex discrimination."[38] Yet, the Court's decision in *Roe* reflected none of these intersectional approaches to reproductive rights. Rather, the Court's reasoning reflected a much narrower interpretation, rooted in the constitutional right to "privacy."[39]

The constitutional right to "privacy" discussed in *Roe*, where people with the capacity for pregnancy were now afforded the "choice" to make decisions regarding their reproductive health with their physicians, disregarded the fact that Black women have been systemically robbed of that "privacy" and the "choice"

35. Hoffman, *supra* note 21.

36. Davis, *supra* note 13, at 7.

37. Women's Leadership and Resource Center, *Reproductive Oppression Against Black Women*, UNIVERSITY OF ILLINOIS CHICAGO, https://wlrc.uic.edu/reproductive-oppression-against-black-women/ [https://perma.cc/98LR-U944] (last visited Apr. 8, 2022). ("Reproductive oppression refers to the regulation and exploitation of individuals' bodies, sexuality, labor, and procreative capacities as a strategy to control individuals and entire communities. Reproductive oppression against Black women is rooted in the US history of commodification of Black women's bodies, sexuality, and reproductive lives.")

38. *Roe v. Wade*, 410 U.S. 113 (1973); Melissa Murray, *Race-ing Roe: Reproductive Justice, Racial Justice, and the Battle for Roe v. Wade*, 134 HARV. L. REV. 2025, 2048 (2021) (explaining that it was acknowledged in the movement that Black women "experienced motherhood differently based on their race and class…").

39. *Id.* at 2049 (noting that the attorneys in *Roe* chose to "root their claims in the privacy logic that had undergirded the Court's earlier contraception decisions.").

to birth and raise a child.[40] *Roe* did not consider that, for Black women, "what happened to [their] bodies derived from their circumstances, whether poverty, racism, [or] injustice."[41] Although *Roe* purported to preclude the government from interfering with the right to abortion, the Court upheld many restrictions on abortion access that disproportionately harmed people of color, especially Black women. [42] The Court's decision in *Dobbs v. Jackson Women's Health Organization,* and the fallout from the end of *Roe*, further demonstrated Roe's shortcomings and the disproportionate harm that restrictions on access to reproductive health care have on Black women.[43]

The government has impeded Black women's access to reproductive health beyond abortion and contraceptives. [44] While barriers to abortion and contraception access disproportionately impact Black women, these rights are not the only issues concerning reproductive health. In fact, "access to abortion services, forced and coercive sterilization, reproductive tract infections (RTIs) and infant and maternal mortality and morbidity" are all issues concerning reproductive rights and "impact women of color, especially Black women, most severely."[45] However, Black women have often felt silenced, ignored, and further oppressed in the mainstream Reproductive Rights framework. This framework has emphasized "choice" and focused narrowly on the legal right to abortion and contraceptives rather than recognizing the full spectrum of Black women's reproductive health needs and the impact of structural racism on Black women's health and rights.[46]

B. The Birth of the Reproductive Justice Framework

Within the mainstream Reproductive Rights movement, which should have been a space where all women could find liberation, "Black women have been and

40. *See id.* at 2050; *see also* Taylor, *supra* note 14, at 510. ("The narrow focus on abortion effectively neglected the intersecting oppressions of race, class, and gender. Touting this focus as 'choice' implied that all women had the right to make determinations about their bodies, hence deeming their bodies legally protected. 'Choice' in these terms ignored the fact that economic and institutional barriers restricted the 'choices' of Black women.")

41. Mamie E. Locke, *Encyclopedia of Race & Racism—Reproductive Rights* 495 (John Hartwell Moore ed., 2008). ("For women of color, economic and institutional constraints restricted their choices.")

42. Jamila Taylor, "Women of Color Will Lose the Most if *Roe v. Wade* Is Overturned," *Center for American Progress* (Aug. 23, 2018), https://www.americanprogress.org/article/women-color-will-lose-roe-v-wade-overturned/ [https://perma.cc/GQT3-XXSA].

43. *Dobbs v. Jackson Women's Health Org.*, 597 U.S. ___ (2022); Samantha Artiga, Latoya Hill, Usha Ranji, and Ivette Gomez, What are the Implications of the Overturning of Roe v. Wade for Racial Disparities?*"*, KAISER FAMILY FOUNDATION (July 15, 2022), https://www.kff.org/racial-equity-and-health-policy/issue-brief/what-are-the-implications-of-the-overturning-of-roe-v-wade-for-racial-disparities/ [https://perma.cc/7WY6-BTHE].

44. Toni M. Bond, *Barriers Between Black Women & the Reproductive Rights Movement*, 8 POL. ENV'TS 2, 3 (2001).

45. *Id.*

46. *Id.* at 4. ("The voice of women color in the mainstream "pro-choice movement are drowned out by other seemingly more important aspects of the fight for reproductive rights, leaving them with the arduous challenge of trying to be activists operating on the fringes of the movement.")

still are treated as 'invited guests.'"[47] Realizing that the mainstream Reproductive Rights framework could no longer sustain and adequately address the unique needs of Black and brown women, "feminists of color began to articulate a new, intersectional approach to reproductive rights that explicitly centered concerns about race, class, and discrimination."[48] This need enabled the birth of the Reproductive Justice framework.[49] According to Loretta Ross, co-founder of SisterSong Women of Color and Reproductive Health Collective and "founding mother of Reproductive Justice,"[50]

> Reproductive Justice is the complete physical, mental, spiritual, political, social, and economic well-being of women and girls, based on the full achievement and protection of women's human rights…[t]he Reproductive Justice framework analyzes how the ability of any woman to determine her own reproductive destiny is linked directly to the conditions in her community—and these conditions are not just a matter of individual choice and access. Reproductive Justice addresses the social reality of inequality, specifically, the inequality of opportunities that we have to control our reproductive destiny.[51]

The Reproductive Justice framework situates abortion within broader "social justice issues that concern communities of color" that "directly affect an individual woman's decision-making process."[52] This framework acknowledges that "a narrow focus on protecting the legal right to abortion" fails to account for the legacy of reproductive oppression that has hindered the reproductive freedoms of marginalized groups in our society, encompassing not only the right to not have children, but also to have children and to parent with dignity in safe, sustainable communities.[53] Instead of focusing on the sole legal right to abortion and contraceptives, Reproductive Justice advocates combat reproductive oppression using three frameworks: (1) Reproductive Health, which promotes greater access to health care for historically disadvantaged communities;[54] (2) Reproductive Rights, which addresses the legal right to abortion and contraceptives;[55] and (3) Reproductive Justice, which raises awareness "to the social, political, and economic systemic inequalities that impact women's reproductive health and their ability to control their reproductive lives."[56]

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47. Bond, *supra* note 44, at 3.
48. Murray, *supra* note 38, at 2053.
49. *Id.* (explaining that "reproductive justice" is the combination of the terms "reproductive rights" and "social justice.").
50. Taylor, *supra* note 14, at 509.
51. Loretta Ross, *What is Reproductive Justice?,* Reproductive Justice Briefing Book, 4 (2007).
52. *Id.*; *What is Reproductive Justice?*, SISTERSONG (last visited Dec. 22, 2022), https://www.sistersong.net/reproductive-justice [https://perma.cc/BPE4-JPAN].
53. Ross, *supra* note 51, at 4.
54. Murray, *supra* note 38, at 2053; *see also* Ross, *supra* note 51, at 4.
55. Murray, *supra* note 38, at 2053.
56. *Id.*

Organizations like SisterSong have since organized to use the Reproductive Justice framework to specifically address the intersectional and unique reproductive concerns of Black, brown, and other women that have been excluded from the mainstream Reproductive Rights movement.[57] These organizations not only strive to empower people to advocate for reproductive freedoms, but also work to dismantle the systemic barriers that contribute to historical inequalities in reproductive health.[58] However, dismantling structural inequalities in health care will require more than just the efforts of grassroots organizations; it will also require the will of our legal institutions, which have always had the power to provide Black women with the resources they need to obtain their reproductive freedom in the United States.

III. MATERNAL MORTALITY RATES AND FACTORS MOTIVATING RACIAL DISPARITIES IN MATERNAL HEALTH OUTCOMES IN THE UNITED STATES

A. Maternal Mortality in the United States

Experts define maternal health as "the health of women during pregnancy, childbirth and the postnatal period."[59] Countries with failing maternal health generally have high maternal mortality ratios. According to the World Health Organization (WHO), "[t]he maternal mortality ratio (MMR) is defined as the number of maternal deaths during a given time period per 100,000 live births."[60] Reported in February 2022, the most recent U.S. MMR was 23.8 deaths per 100,000 live births, representing approximately 861 maternal deaths in 2020.[61] These figures are "remarkable," considering the significant amount of money spent on pregnancy and childbirth every year.[62] Moreover, these figures are even more astonishing considering that "[m]ost of these deaths are preventable."[63]

57. *See* Ross, *supra* note 51, at 5.
58. *Id.*
59. WORLD HEALTH ORG. (WHO), *Maternal health*, https://www.who.int/health-topics/maternal-health [https://perma.cc/7E8J-QCCQ] (last visited Apr. 10, 2022).
60. WORLD HEALTH ORG, (WHO), *Maternal mortality ratio (per 100 000 live births*), https://www.who.int/data/gho/indicator-metadata-registry/imr-details/26 [https://perma.cc/L9VE-9MUD] (last visited Apr. 10, 2022). Experts have measured and defined maternal mortality in various ways. The CDC defines a "pregnancy-related death" as a "death of a woman during pregnancy or within one year of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy." CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC), *Reproductive Health—Preventing Pregnancy-Related Deaths* (Apr. 13, 2022), https://www.cdc.gov/reproductivehealth/maternal-mortality/preventing-pregnancy-related-deaths.html [https://perma.cc/A3LV-9JPA]. Some experts define a "pregnancy-associated mortality" as a "[d]eath while pregnant or within one year of the end of the pregnancy, irrespective of cause." Declercq & Zephyrin, *supra* note 2, at 2. The WHO limits that time frame to "within 42 days of the end of pregnancy," or six weeks. *Id.*
61. CDC – MMRs in the U.S., 2020, *supra* note 7.
62. Bridges, *supra* note 1, at 1240.
63. Taylor, *supra* note 14, at 510.

Severe maternal morbidity (SMM)—which is also preventable—occurs when "a pregnant or recently postpartum woman faces a life-threatening diagnosis or must undergo a life-saving medical procedure."[64] SMM affects nearly 60,000 women in the United States every year, and the numbers are on the rise.[65] For every woman who suffers a maternal death, approximately one-hundred women experience SMM during their labor and delivery hospitalization.[66]

Multiple factors contribute to the United States' high MMR. A maternal death can "vary considerably and depend on when mothers die."[67] Looking narrowly, maternal deaths could result from the preexisting medical conditions an individual brings into pregnancy.[68] On a broad scale, maternal deaths could be attributed to the quality of the United States' healthcare system or the lack of access to healthcare, such as postpartum care.[69] Although the causes of the United States' high MMR are difficult to isolate, the fact that "[b]oth maternal mortality and morbidity disproportionately impact Black women" is not.[70]

B. Factors Motivating Racial Disparities in Maternal Health Outcomes

In 2020, the National Center for Health Statistics reported that the MMR for Black women was 55.3 deaths per 100,000 live births, while the MMR for white women was 19.1 deaths.[71] While maternal mortality in the United States is of serious concern across all racial groups, we cannot disregard that "the path to motherhood is significantly deadlier for [B]lack women than it is for their white counterparts,"[72] and that structural racism plays a central role in the disparities for

64. Bridges, *supra* note 1, at 1242-43. ("For every maternal death in the country, there are close to one hundred cases of severe maternal morbidity.")

65. BLACK MAMAS MATTER ALLIANCE AND CENTER FOR REPRODUCTIVE RIGHTS, BLACK MAMAS MATTER: ADVANCING THE HUMAN RIGHT TO SAFE AND RESPECTFUL MATERNAL CARE, 20 (2018), http://blackmamasmatter.org/wp-content/uploads/2018/05/USPA_BMMA_Toolkit_Booklet-Final-Update_Web-Pages-1.pdf [https://perma.cc/77ES-YWA7].

66. *Id.*

67. Declercq & Zephyrin, *supra* note 2, at 9.

68. Bridges, *supra* note 1, at 1243.

69. *Id.* at 1246. (As I discuss later in the article, "[m]any maternal deaths—especially those that are caused by infection, blood clots, and hemorrhage—occur some period of time after the woman has delivered her baby. In order to avoid these deaths, recently postpartum women must be monitored, and they must have access to healthcare after their infant has been born." *Id.* However, many low-income and women of color are unable to afford health insurance that provides coverage beyond a single visit after the end of their pregnancy.)

70. Taylor, *supra* note 14, at 511.

71. CDC – MMRs in the U.S., 2020, *supra* note 7.

72. Bridges, *supra* note 1, at 1248.

Black women.[73] Six factors "acting in concert"[74] help explain the alarming disparities in maternal health outcomes for Black women: structural racism in health care, a lack of culturally competent healthcare providers, socioeconomic status and poverty, underlying chronic conditions, chronic stress and weathering, and a lack of access to quality and affordable health care.

1. Structural Racism in Health Care

We cannot adequately address the maternal health crisis in the United States "without taking account of how racism and bias manifest in the health care system, and in turn contribute to the high rates of maternal mortality and morbidity among Black women."[75] The Aspen Institute defines structural racism as a system where public policies, institutional practices, and cultural representations work to reinforce and perpetuate racism and racial inequities.[76] Said differently, structural racism is the concept that racism is so embedded into the laws, regulations, and very fabric of society that it seems like the natural order. Applied to maternal mortality, Black women are more likely to suffer poor maternal health outcomes because "harmful institutional practices and negative cultural representations of Black women" have infiltrated the healthcare system.[77] These practices are rooted in the historical reproductive oppression of Black women during slavery and now manifest as structural racism.

Structural racism in health care perpetuates disparities in the quality of care Black women receive compared to white women on their pathway to motherhood. According to the 2021 National Healthcare Disparities Report, Black people received worse quality of care than white people on 43 percent of quality measures.[78] Although standards of care and best practices exist in handling obstetric emergencies, discretion in how healthcare providers treat certain people has caused "some women [to] receive appropriate, high quality care while others

73. While not the central focus of this article, it is important to note that Native American women also have some of the highest rates of maternal mortality in the country, driven by their unique experiences of structural racism and reproductive oppression in the United States. *See* CENTERS FOR DISEASE CONTROL AND PREVENTION, *Infographic: Racial/Ethnic Disparities in Pregnancy-Related Deaths – United States, 2007-2016*, https://www.cdc.gov/reproductivehealth/maternal-mortality/disparities-pregnancy-related-deaths/infographic.html [https://perma.cc/J9ZV-TTBC] (last accessed Dec. 22, 2022).

74. Bridges, *supra* note 1, at 1253.

75. Taylor, *supra* note 14, at 511.

76. THE ASPEN INSTITUTE, *11 Terms You Should Know to Better Understand Structural Racism* (Jul. 11, 2016), https://www.aspeninstitute.org/blog-posts/structural-racism-definition/ [https://perma.cc/KDN9-GP68].

77. Taylor, *supra* note 14, at 511.

78. AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ), 2021 NATIONAL HEALTHCARE QUALITY AND DISPARITIES REPORT 1, D-24 (Dec. 2021), https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/2021qdr.pdf [https://perma.cc/KK6U-RGHQ]. Notably, the measures with the largest disparities for Black people included new cases of HIV, deaths as a result of HIV infection, and admissions to the hospital due to hypertension. *Id.* HIV/AIDs and hypertension are just some of the many chronic conditions and diseases Black people have historically suffered from at heightened rates.

do not."[79] The location where a pregnant person delivers their baby can have a significant impact on the quality of care they receive.[80] Markedly, 75 percent of Black women in the United States deliver their babies in only one-quarter of the nation's hospitals.[81] A recent study examining these "high [B]lack-serving hospitals" found that their MMR was higher than the MMR in "low [B]lack-serving hospitals."[82] Even more disturbing was that the high-Black serving hospitals provided low-quality care to all women, regardless of race, and the women served at these hospitals had an increased risk of suffering poor maternal health outcomes.[83] These findings suggest that improving the quality of care at hospitals that serve primarily Black and brown women may reduce racial disparities in maternal health outcomes.[84]

Addressing structural racism can remedy the United States' maternal health crisis. Structural racism lies at the foundation of each of the remaining factors contributing to racial disparities in maternal mortality.

2. Lack of Culturally Competent Healthcare Providers

Although access to care during pregnancy and postpartum improves maternal health outcomes, the ways that pregnant people interact with the healthcare system and healthcare providers are also significant.[85] Historically, people of color have had poor interactions with their healthcare providers, often reporting racial discrimination and disrespect.[86] In *Listening to Mothers*, a 2018 research survey studying women's birthing experiences in California hospitals, Black women and women of color reported that they were spoken to disrespectfully, handled roughly, and felt as if their healthcare providers ignored their concerns more often than white women.[87] Notably, among the women that indicated that they had experienced unfair treatment because of their race, the majority of women were Black.[88] In comparison, less than 1 percent of white women reported that they felt as if they were being treated unfairly because of their race or ethnicity.[89] The survey also asked women of various races and ethnicities questions about differences in treatment practices, specifically the use

79. BLACK MAMAS MATTER ALLIANCE, *supra* note 65, at 25.
80. *Id.*
81. Bridges, *supra* note 1, at 1265 (citing Elizabeth A. Howell, Natalia Egorova, Amy Balbierz, Jennifer Zeitlin & Paul L. Hebert, *Black-White Differences in Severe Maternal Morbidity and Site of Care,* 214 Am. J. Obstet. Gynecol. 122.e1, 122.e1 (2016)) [hereinafter Howell].
82. *Id*. (citing Howell, *supra* note 81, at 122.e3.).
83. *Id.*
84. BLACK MAMAS MATTER ALLIANCE, *supra* note 65, at 25.
85. Taylor, *supra* note 14, at 511.
86. *See* BLACK MAMAS MATTER ALLIANCE, *supra* note 65, at 26.
87. Taylor, *supra* note 14, at 511 (citing CAROL Sakala, EUGENE R. Declercq, JESSICA M. TURON & MAUREEN P. CORRY, *Listening to Mothers in California, A Population-Based Survey of Women's Childbearing Experiences* (National Partnership for Women's Families, 2019) [https://perma.cc/TZ8N-MBR9]).
88. *Id.* at 64.
89. *Id.* It is also significant to note that among this 1 percent, "[w]hite women had a clear advantage with none reporting that they were treated unfairly 'usually' or 'always.'"

of caesarean sections as a mode of birth.[90] Among all racial and ethnic groups, Black women exceedingly received cesarean sections, at a rate of 42 percent whereas white women received the procedure at a rate of 29 percent.[91] According to WHO, healthcare providers perform caesarean sections excessively, and in the absence of a medical necessity, they can put pregnant people and their babies at risk of suffering short- and long-term complications.[92] WHO emphasizes the importance of doctors focusing on each person's individual needs, rather than needlessly performing caesarean sections that could result in disabilities or even death.[93]

The needless use of dangerous procedures on Black women's bodies echoes the practices of James Marion Sims and other physicians during the era of slavery. Some healthcare providers exhibit little to no respect for the reproductive autonomy of Black women due to implicit biases they hold about Black women.[94] Implicit biases occur when we unconsciously associate people with attitudes or stereotypes, and these stereotypes influence our decision making.[95] Healthcare providers invoke implicit biases when caring for Black women when they see their race first and provide substandard care compared to their white patients. Health care providers justify their differential treatment of Black women with racial stereotypes; for example, Khiara M. Bridges suggested that health care providers often view Black women under a lens of "obstetrical and gynecological hardiness," a racist and explicitly false belief that Black women do not feel pain.[96] From the most painful experiences like childbirth, to mentions of discomfort during a routine visit, the belief that Black people have "robust" bodies has led healthcare providers to inadequately treat Black women in the healthcare system. This erasure of Black women causes healthcare providers to ignore their expressions of pain and overlook their treatment preferences, contributing to maternal mortalities and morbidities.[97]

90. *Id.* at 54.
91. *Id.* at 56.
92. World Health Organization (WHO), *Caesarean sections should only be performed when medically necessary*, (Apr. 10, 2015), https://apps.who.int/mediacentre/news/releases/2015/caesarean-sections/en/index.html [https://perma.cc/XJ5Q-BGV6].
93. *Id.*; *see also* Taylor, *supra* note 14, at 512 (citing Taylor et al., *supra* note 3). ("The rates for maternal mortality and severe maternal morbidity are about three times higher for women who had C-sections versus vaginal deliveries.")
94. *See* Taylor, *supra* note 14, at 512.
95. *See Understanding Implicit Bias*, Kirwan Inst., (May 29, 2012), https://kirwaninstitute.osu.edu/article/understanding-implicit-bias [https://perma.cc/664E-UG5N].
96. Taylor, *supra* note 14, at 512 (citing Khiara M. Bridges, *Reproducing Race: An Ethnography of Pregnancy as a Site of Racialization* 16-17 (Berkeley: University of California Press, 2011)).
97. Taylor, *supra* note 14, at 512.

3. Socioeconomic Status and Poverty

Poverty has a negative impact on Black women's maternal health outcomes.[98] Although the rising rates of poverty and economic inequalities in the United States may cause higher rates of maternal mortality for all birthing people in the country, "Black women are more than twice as likely to live in poverty as [w]hite women are."[99] Moreover, the ramifications that poverty has on health are well-established.[100] Those who live in poverty are often exposed to unhealthy living conditions, live in food deserts where they cannot access affordable and healthy food options, and are unable to access quality health care.[101] All of these challenges contribute to those in poverty suffering poorer health outcomes and shorter life expectancies. For Black people, who "disproportionately bear the burdens of poverty in the United States, greater proportions of them have the poor health that is the known and expected consequence of poverty."[102]

While the income, education, and class inequalities that Black people have historically endured are contributors to racial disparities in maternal mortality,[103] these health disparities "cannot and should not be understood as a problem primarily of socioeconomic status."[104] In reality, Black women across varying socioeconomic statuses suffer poor maternal health outcomes.[105] Indeed, having a higher degree of income and education does not protect Black women from disproportionately suffering maternal deaths.[106] A college-educated Black woman is still more likely to suffer a pregnancy-related death than a white woman with less than a high school education.[107] Structural racism shapes poverty rates, but the impact of racism on maternal health outcomes reaches beyond socioeconomic status.

4. Underlying Chronic Conditions

Black women enter pregnancy with "poverty-related chronic conditions," such as hypertension, cardiovascular disease, diabetes, and obesity.[108] Specifically, "[h]eart disease is the number-one killer of Black women,"[109] and

98. Bridges, *supra* note 1, at 1258.
99. BLACK MAMAS MATTER ALLIANCE, *supra* note 65, at 22. ("Unemployment is twice as high for Black women compared to White women, and fully employed Black women earn an average of 63 cents for every dollar paid to White men. . .").
100. Bridges, *supra* note 1, at 1258.
101. *Id.*
102. *Id.* at 1259.
103. *Id*. at 1251.
104. *Id*. at 1258.
105. *Id*. 1257-58.
106. *Id*. at 1251.
107. *Id*.; *see also* Taylor, *supra* note 14, at 511 ("Black women, regardless of social or economic status, are more likely to die of pregnancy-related causes. This is even true when compared with white women who never finished high school.").
108. *Id.* at 1259*; see also* Black Women's Health Imperative, *Black Women Vote: National Health Policy Agenda 2020-2021*, 6 (2020) [https://perma.cc/JW98-88SZ].
109. Black Women's Health Imperative, *supra* note 1058, at 29.

Black women "are two to four times more likely than white women" to have type 2 diabetes.[110] These conditions go unmanaged in Black women because they lack access to quality health care, which causes them to suffer poor maternal health outcomes.[111] Preventative care would properly treat these health issues well in advance,[112] but they instead have persisted as chronic conditions.

Before continuing with the analysis, it is necessary to make a distinction regarding chronic conditions among Black women. Although Black women suffer poorer maternal health outcomes than their white counterparts, biology and genetics do not explain these health disparities.[113] To say that Black people are genetically unhealthier and thus are to blame for their poor health outcomes is inherently racist. Statements like this disregard that race is a social construct and not biologically predisposed.[114] Despite this, some scholars have still maintained that race is a biological construct and may be used to explain racial disparities in health, such as maternal mortality rates.[115] However, to allow the myth of biological race to persist would be to allow "society to throw up its hands at the problem of racial disparities in maternal mortality and claim that" the healthcare system cannot improve these racial disparities because they exist due to differences in Black women's genes.[116]

Furthermore, it also is problematic to outright blame Black women for entering their pregnancies with these chronic conditions and causing the United States' high MMR. The narrative that Black women are not taking care of themselves well enough to prevent these chronic conditions shifts the responsibility for their deaths back onto them.[117] This narrative ignores that there are a host of structural forces contributing to the disparities in health that Black women suffer.[118] "If preexisting conditions are not situated within structural and

110. *Id.* at 30.

111. Bridges, *supra* note 1, at 1259.

112. Black Women's Health Imperative, *supra* note 108, at 6.

113. Bridges, *supra* note 1, at 1255. ("It bears repeating, time and again, that no credible theory of population genetics can support the idea that black people's genes are responsible for the poor states of health that they disproportionately inhabit.").

114. *Id.* at 1256 (citing Alexis Gadson, Eloho Akpovi & Pooja K. Mehta, *Exploring the Social Determinants of Racial/Ethnic Disparities in Prenatal Care Utilization and Maternal Outcome,* 41(5) SEMINARS PERINATOLOGY 308, 308-09 (2017)). In their study on racial disparities in maternal health, these researchers began by clearly asserting that "categories of race and ethnicity do not represent individual behaviors or biology, but rather acknowledge historic inequities implicated in health outcomes…we assume race and ethnicity to be social constructs closely related to the social determinants of health, rather than biological or genetic categories, as well as constructs that may intersect with health care utilization, social determinants, and medical risk to generate observable differences in maternal health outcome." *Id.*

115. *Id*. at 1255-56. ("Unfortunately, even the American College of Obstetricians and Gynecologists has failed to clearly and definitively reject the idea that race has a biological or genetic essence.").

116. *Id.* at 1257.

117. *Id.* at 1279.

118. *Id.* at 1280. For Black women, social and environmental factors have not been conducive to leading healthy lives. In the context of maternal mortality, "Black women are

historical context, it may function to absolve society of responsibility for the poor state of health that Black women disproportionately inhabit."[119]

5. Chronic Stress and Weathering

Dealing with stress is a part of life. However, chronic stress may be one of the reasons Black women experience worse maternal health outcomes. That is what public health researcher Dr. Arline Geronimus was determined to uncover in 1992 when she began investigating why, as Black mothers aged, their maternal health declined.[120] Geronimus found that Black mothers had better maternal health outcomes in their late teens, while white mothers had better maternal health outcomes between their twenties and thirties.[121] Before her study, Geronimus was a student at Princeton University, where she worked with Black teen mothers as a research assistant.[122] Geronimus witnessed these young Black mothers experience life circumstances that her white classmates seldom experienced, which manifested as chronic conditions.[123] Geronimus coupled her 1992 findings with the observations she made as a research assistant to conclude "that the health of African-American women may begin to deteriorate in early adulthood as a physical consequence" of the constant stresses of racism, sexism, and classism.[124] This finding is known as the "weathering hypothesis"— Geronimus' theory that bodies prematurely age due to repeated exposure to social and economic inequity.[125]

As Black public health journalist Patia Braithwaite recognized, "[t]he term is meant to capture the positive connotation of weathering (making it through a difficult experience) along with the negative implication (being damaged in the process)."[126] Our bodies are naturally equipped to respond to stress, but in small doses.[127] According to the American Psychological Association, our body's response to persistent or chronic stress can have serious consequences.[128] In this

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disproportionately impacted by risk factors related to pregnancy, such as hypertension or gestational diabetes, but these factors are made worse by the compounded stress of racial discrimination, lower quality health care, climate change, and COVID-19." Black Women's Health Imperative, *supra* note 108, at 12.

119. Bridges, *supra* note 1, at 1280.

120. Arline T. Geronimus, *The Weathering Hypothesis and the Health of African-American Women and Infants: Evidence and Speculations,* 2 Ethnicity & Disease 207 (1992).

121. *Id.*

122. Patia Braithwaite, *Biological Weathering and Its Deadly Effect on Black Mothers,* SELF, (Sept. 30, 2019), https://www.self.com/story/weathering-and-its-deadly-effect-on-black-mothers [https://perma.cc/4RXW-QR9Q].

123. Gene Demby, *Making the Case that Discrimination Is Bad for Your Health*, NPR: Code Switch, (Jan. 14, 2018, 7:00 AM), https://www.npr.org/sections/codeswitch/2018/01/14/577664626/making-the-case-that-discrimination-is-bad-for-your-health [https://perma.cc/Y5EA-DZY2].

124. Geronimus, *supra* note 120.

125. Braithwaite, *supra note* 122.

126. *Id.*

127. American Psychological Association, *Stress Effects on the Body,* (Nov. 01, 2018), https://www.apa.org/topics/stress/body [https://perma.cc/A5NY-XZVL].

128. *Id.*

sense, "if racism is a source of chronic stress for [B]lack people, and if chronic stress has negative physiological impacts, then racism could explain the higher rates of morbidity and mortality among [B]lack women."[129]

6. Lack of Access to Quality and Affordable Health Care

Lack of access to health care for people of color, especially Black women, perpetuates racial disparities in maternal health outcomes in the United States. Here, we begin to see how structural racism permeates not only our health care institutions but also our legal institutions. Legal institutions can enact policy change to provide everyone with the capacity for pregnancy equitable care and to ensure successful maternal health outcomes. However, these institutions have made it difficult for marginalized communities to access such necessary care.

People with low incomes are often unable to afford private health insurance, a significant barrier to accessing health care. The Patient Protection and Affordable Care Act (ACA), enacted under the administration of President Barack Obama on March 23, 2010, is a United States health reform law.[130] One of the primary goals of the ACA was to eliminate racial disparities in the number of uninsured individuals in the country.[131] "Before the passage of the ACA, people of color accounted for 54 percent of those uninsured in the United States."[132] Black women and other women of color, already burdened by the numerous structural barriers to accessing health care, suffered greatly from this lack of coverage.[133] After the passage of the ACA, racial and ethnic gaps in access to health care narrowed, with the uninsured rate for Black people dropping from 24.4 percent in 2013 to 14.4 percent in 2018.[134] The ACA has played a significant role in improving access to health care for Black women, but has not been a cure-all, in part due to some states' failure to adopt the law's Medicaid expansion provisions.

Structural racism is the connecting thread at the heart of the aforementioned factors that contribute to racial disparities in maternal mortality. Moreover, Black pregnant people often contend with multiple barriers to quality reproductive care at a time, compounding the impacts of structural racism. Thus, to ignore structural racism in maternal mortality is to ignore Black birthing people as a whole. Systemic racism has had a harrowing impact on Black people's health for centuries, pervading their experiences of pregnancy and childbirth. Structural racism exists in the fabric of the United States' institutions, and legal institutions have the power and responsibility to address these issues through policy reform.

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129. Bridges, *supra* note 1, at 1261.
130. Patient Protection and Affordable Care Act, 42 U.S.C. §18001 (2010).
131. BLACK MAMAS MATTER ALLIANCE, *supra* note 65, at 22.
132. Black Women's Health Imperative, *supra* note 108, at 9.
133. *Id.*
134. *Id*., citing J. Baumgartner, *How the Affordable Care Act Has Narrowed Racial and Ethnic Disparities in Access to Health Care*, Commonwealth Fund, (Jan. 16, 2020), https://www.commonwealthfund.org/press-release/2020/new-report-affordable-care-act-has-narrowed-racial-and-ethnic-gaps-access-health [https://perma.cc/7Q8V-TFB8].

However, by failing to center Black women and racism in its attempts to respond to the maternal health crisis, the government has willingly failed to do so.

IV. INSTITUTIONAL RESPONSES TO RACIAL DISPARITIES IN MATERNAL HEALTH OUTCOMES

Federal and state institutions have failed to adequately center Black women and address structural racism in their responses to the maternal health crisis. Although the passage of the ACA has made way for great progress in addressing racial disparities in maternal health outcomes and health care overall, public policy initiatives have created even more barriers to Black women's access to care. The following are examples of how our federal and state institutions have impacted the United States' maternal health crisis, or rather its Black maternal health crisis, by way of action or inaction.

A. The Affordable Care Act, Medicaid Expansion, and the Biden-Harris Administration

The passage of the ACA has been essential in ensuring access to care for Black women of reproductive age (fifteen to forty-four), who face the greatest disparities in health care coverage.[135] People of reproductive age must have health care coverage to participate in routine exams and other medical procedures to maintain their reproductive health.[136] The Essential Health Benefits requirement is a feature of the ACA that guarantees that people of reproductive age will receive this care.[137] This requirement comprises ten categories of services that health insurance plans must cover under the ACA, including prenatal, childbirth, and newborn care, which protects the health and safety of Black mothers and their babies.[138]

Pursuant to the ACA, this coverage is provided through Medicaid, a government program that provides health coverage to eligible low-income individuals who cannot afford or do not have access to quality health care.[139] When enacted, the ACA required states to expand Medicaid eligibility to individuals with incomes below 138 percent of the federal poverty level.[140] This

135. *Id.*
136. *Id.*
137. *Id.*; *see also* U.S. Centers for Medicare and Medicaid Services, *Essential Health Benefits,* (last visited April 14, 2022)., https://www.healthcare.gov/glossary/essential-health-benefits/ [https://perma.cc/TE4A-TYJ2].
138. Black Women's Health Imperative, *supra* note 108, at 9.
139. *See* U.S. Centers for Medicare and Medicaid Services, *Medicaid*, (last visited April 14, 2022), https://www.healthcare.gov/glossary/medicaid/ [https://perma.cc/5LGF-LYCM].
140. Judith Solomon, *Closing the Coverage Gap Would Improve Black Maternal Health,* Center on Budget and Policy Priorities, (Jul. 26, 2021). https://www.cbpp.org/research/health/closing-the-coverage-gap-would-improve-black-maternal-health [https://perma.cc/FR3Q-2K5D]. 138 percent below the federal poverty line is about $17,800 annually for a single adult with two children.

change was remarkable, considering that "Medicaid [now] pays for more than 40% of U.S. births and 65% of births to Black mothers."[141] Moreover, "nearly one-third (31 percent) of Black women of reproductive age are enrolled in the Medicaid program." [142] Medicaid is essential to improving Black women's reproductive health outcomes, as the program covers "family planning; sexually transmitted infection testing and treatment; and pregnancy-related care, including prenatal services, childbirth, and [limited] postpartum care."[143] The expansion of Medicaid under the ACA has improved the accessibility of comprehensive care to Black women, bettering their pathway to motherhood.[144]

Many of the ACA's opponents campaigned for it to be repealed.[145] The Supreme Court ruled on the ACA for the first time in *National Federation of Independent Business v. Sebelius*.[146] In *Sebelius*, the Court held that "Medicaid expansion is unduly coercive on the states," effectively rendering Medicaid expansion optional in each state.[147] Since that ruling, all but twelve states have adopted the Medicaid expansion.[148] In the average non-expansion state, Medicaid eligibility is capped at about 40 percent of the federal poverty level, "or just $8,800 in annual income for a single parent with two children."[149] In 2019, over 800,000 women of reproductive age were uninsured because they fell into what has become known as the "coverage gap"— where low-income individuals who live in one of the twelve non-expansion states have no access to affordable health care coverage because they make "too much" above the income threshold.[150] Of the 800,000 women of reproductive age in the coverage gap, two-thirds were women of color.[151] Moreover, many of the twelve non-expansion states are concentrated in the South, where Black women face some of the highest risks for poor maternal health outcomes and access to care.[152] Although these women could become

141. *Id.*
142. Black Women's Health Imperative, *supra* note 108, at 10.
143. *Id.*
144. Solomon, *supra* note 140.
145. Jane Perkins, *Fact Sheet: The Supreme Court's ACA Decision and Its Implications for Medicaid*, (April 15, 2013)., https://healthlaw.org/resource/fact-sheet-the-supreme-courts-aca-decision-its-implications-for-medicaid/ [https://perma.cc/PT5M-Q4VH] (stating that "[s]ince it was signed into law in March 2010, the ACA has been subjected to relentless litigation…").
146. *National Federal of Independent Business v. Sebelius*, 567 U.S. 519 (2012).
147. Perkins, *supra* note 145.
148. Kaiser Family Foundation (KFF), *Status of State Medicaid Expansion Decisions: Interactive Map,* (last updated Apr. 26, 2022), https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/ [https://perma.cc/3NB6-6ZCZ]. Notably, the 12 non-expansion states are Alabama, Florida, Georgia, Kansas, Mississippi, North Carolina, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming.
149. Perkins, *supra* note 145. Perkins notes that "[t]he exception is Wisconsin, which extends Medicaid eligibility to adults with incomes up to 100 percent of the poverty line."
150. *Id.*
151. *Id.* (29 percent were Black; 33 percent were Latina; 1 percent were American Indian/Alaska Native; 1 percent were Asian; 2 percent were Other)..
152. *Id.*; *see also* BLACK MAMAS MATTER ALLIANCE, *supra* note 65, at 6. ("Nine out of ten people who fall into the coverage gap live in the South, and Black adults are more likely than any other racial group to be affected by it." *Id.* at 24.).

eligible for Medicaid once they become pregnant, that does not ensure adequate maternal health. Preconception and prenatal care are vital to successful maternal health outcomes; without them, Black women are left "without access to care that could identify and address their health risks before pregnancy."[153] Lack of access to perinatal and comprehensive reproductive care causes issues like chronic stress and weathering, chronic health conditions, and other factors contributing to racial disparities in maternal mortality to persist unchecked. Access to necessary health care should not be conditioned on pregnancy; health care should not be a privilege, but a right to which every person is entitled regardless of their background.

Maternal mortality rates have improved in states that have participated in Medicaid expansion.[154] "This is largely due to increased access to preventive care and the continuum of comprehensive health care and support . . . in turn reducing" poor maternal health outcomes.[155] However, there are caveats to this improvement. Postpartum care under Medicaid lasts for only sixty days after the end of a pregnancy.[156] The lack of care after these sixty days results in "churning": a disruption of health care during a high-risk time, which contributes to Black women's lack of access to health care.[157] In response to churning during the COVID-19 global pandemic, President Joseph Biden enacted the American Rescue Plan Act of 2021 to address some of the pandemic's harms.[158] Among other features, the law gives states the option of expanding postpartum coverage under Medicaid to a full year, commencing on April 1, 2022.[159] As of December 2022, twenty-seven states have implemented the twelve-month-extension of Medicaid postpartum coverage, with seven states planning to implement the extension in the future.[160]

President Biden and Vice President Kamala Harris, the first Black female Vice President of the United States, have also made efforts to address racial disparities in maternal health outcomes outside the realm of Medicaid.[161] On April

153. Perkins, *supra* note 145.
154. *See* Taylor, *supra* note 14, at 513.
155. *Id.*
156. Perkins, *supra* note 145.
157. Jamie R. Daw et al., *Women in the United States Experience High Rates of Coverage "Churn" In Months Before and After Childbirth*, Harvard School of Public Health: Health Affairs, (April 2017), https://www.hsph.harvard.edu/news/press-releases/women-childbirth-health-coverage/ [https://perma.cc/E537-7CBW].
158. American Rescue Plan Act, H.R. 1319, 117th Cong. (2021); *see also The American Rescue Plan*, The White House (last visited February 8, 2022), https://www.whitehouse.gov/american-rescue-plan/ [https://perma.cc/B3FV-QDYR]. This law is also called the "COVID-19 Stimulus Package."
159. Perkins, *supra* note 145.
160. Medicaid Postpartum Coverage Extension Tracker, Kaiser Family Foundation (KFF), (Last updated December 8, 2022), https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/ [https://perma.cc/C2HA-YLXD].
161. *FACT SHEET: Biden-Harris Administration Announces Initial Actions to Address the Black Maternal Health Crisis*, The White House (April 13, 2021), https://www.whitehouse.gov/briefing-room/statements-releases/2021/04/13/fact-sheet-biden-harris-administration-announces-initial-actions-to-address-the-black-maternal-health-crisis/ [https://perma.cc/SX7Q-USB3].

13, 2021, the Biden-Harris Administration announced initial actions it would take to address the United States' maternal mortality crisis, emphasizing that

> Quality, equitable health care is a right, not a privilege. The actions announced today are initial steps in the critical work this Administration will do to address our maternal mortality crisis, close disparities in maternal care and outcomes for all birthing people and address the systemic racism that has allowed these inequities to exist.[162]

These initial actions included increasing investment in implicit bias training for health care providers, investing in necessary reproductive and preventative health services to promote gender and health equity, and prioritizing investments in programs that protect access to health care in rural areas of the country.[163] In committing to address the maternal health crisis, the Biden-Harris Administration did not willfully disregard the fact that the problem of maternal mortality in the United States is one of race, and that the only way to alleviate the disturbing rates of maternal deaths is to bring the realities of structural racism to the forefront of our conversations. While the actions of the Biden-Harris Administration were significant first steps towards addressing the maternal health crisis, the government must make greater strides to fully implement the Administration's stated goals. More specifically, Congress and other legal institutions must take action to remedy this public health crisis.

B. HR 1318: The Preventing Maternal Deaths Act of 2018

On December 21, 2018, former President Donald Trump signed into law the Preventing Maternal Deaths Act.[164] Viewed by experts as a landmark policy in addressing maternal mortality in the United States, the Act authorized federal funding dedicated to eliminating disparities in maternal health outcomes and maternal mortality.[165] Specifically, the Act sustained maternal mortality review committees (MMRCs), "multidisciplinary committees that convene at the state or local level to comprehensively review deaths of women during or within a year of pregnancy."[166] Prior to the passage of the Act, the U.S. surveilled maternal deaths by reviewing death certificates that listed the clinically-defined cause of death.[167]

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162. *Id.*
163. *Id.*
164. Preventing Maternal Deaths Act of 2018, Pub. L. No. 115-344, 132 Stat. 5047 (2018).
165. The American College of Obstetricians and Gynecologists (ACOG), U.S. House Passes Landmark Legislation to Prevent Maternal Deaths, (Dec. 11, 2018), https://www.acog.org/news/news-releases/2018/12/us-house-passes-landmark-legislation-to-prevent-maternal-deaths [https://perma.cc/TWS8-DKE8].
166. Centers for Disease Control and Prevention (CDC), Pregnancy-Related Deaths: Data from 14 U.S. Maternal Mortality Review Committees, 2008-2017, (last reviewed Apr. 13, 2022), https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/mmr-data-brief.html [https://perma.cc/4HDP-D5RG].
167. *Building U.S. Capacity to Review and Prevent Maternal Deaths: Report from Nine Maternal*

By contrast, MMRCs broadly review factors that may have led to a pregnant person's death to develop strategies for preventing such deaths in the future.[168] MMRCs collect both clinical and non-clinical data, such as a person's age, how many days postpartum they were at the time of death, their geographic location, their race and ethnicity, the manner of their death, and other social factors significant to determining the cause of death.[169]

The idea behind implementing MMRCs across the U.S. was that comprehensive, quality data on maternal mortality may enable us to better address and reduce deaths.[170] However, that has not been the case. This may in part be because the text of the Act itself makes no mention of race, racial disparities, or structural racism as the predominant cause of worsening maternal health outcomes in the United States. As Dr. Joia Crear-Perry, Founder and President of the National Birth Equity Collaborative, testified during the congressional hearings on H.R. 1318,

> Throughout the bill, there is no mention of race, racism, or racial disparities. The inability to name this as a key focus to reduce RACIAL disparities in maternal mortality and morbidity will continue to exacerbate the problem.[171]

How can solutions to an issue primarily of racial inequity ignore race? By failing to mention structural racism, the Act functions as a purported solution that willfully ignores the history of racism, which plays a pivotal role in one of the United States' greatest public health and social crises. Thus, the Act cannot serve as an adequate remedy to maternal health disparities.

The Act is also problematic because it merely funds the collection of data, not the implementation of concrete actions to resolve maternal mortality. Prior to the Act's passage, collected data on maternal mortality rates was deemed unreliable by critics.[172] Compiling reliable and comprehensive information

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Mortality Review Committees, 8, (2018), https://cdn1.sph.harvard.edu/wp-content/uploads/sites/2413/2018/02/Report-from-Nine-MMRCs_1.pdf#:~:text=Report%20from%20Nine%20Maternal%20Mortality%20Review%20Committees5%20Executive,as%20a%20result%20of%20pregnancy%20or%20pregnancy-related%20complications [https://perma.cc/B6U6-9JQ6].

168. Data from 14 U.S. Maternal Mortality Review Committees, *supra* note 166.

169. Centers for Disease Control and Prevention (CDC), Pregnancy-Related Deaths: Data from 36 U.S. Maternal Mortality Review Committees, 2017-2019, (last reviewed Sep. 19, 2022), https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/data-mmrc.html#table1 [https://perma.cc/GD4Q-KJ8B].

170. Amnesty Int'l, *Deadly Delivery: The Maternal Health Care Crisis in the USA,* 85 (2010) [https://perma.cc/JEY5-E7L5] ("A lack of comprehensive data collection…is masking the full extent of maternal mortality and morbidity in the USA and is hampering efforts to analyze and address the problems...").

171. Better Data and Better Outcomes: Reducing Maternal Mortality In the U.S.: *Hearing Before the Subcomm. on Health of the Comm. on Energy & Commerce*, 115 Cong. 65 (2018) (Statement of Joia Crear-Perry, M.D., Founder and President of the National Birth Equity Collaborative).

172. Amnesty Int'l, *Deadly Delivery*, *supra* note 170.

regarding maternal deaths is an important component of addressing the issue. However, by creating and passing an Act dedicated only to data collection, with no further steps toward remedying maternal mortality rates and protecting Black people with the capacity for pregnancy, Congress has failed to implement solutions that advocates have long presented as crucial steps to effectively address maternal mortality.

C. HB 1381: Maternal Health Outcomes (2021)

Florida is one of the states in the Southern region of the United States that has chosen not to expand Medicaid eligibility. Although Florida policymakers have annually proposed bills to expand Medicaid coverage to close the gap, the state's Republican-dominated House and Senate have consistently blocked their passage. This leaves many people, including a significant number of Black mothers, without affordable and continuous access to proper health care to aid in safe pregnancies. Considering the degree of success expansion states have seen, one clear remedy to address the Black maternal crisis in non-expansion states is to reform state policy to fill coverage gaps and implement tailored solutions to maternal health disparities.

In 2021, Florida Democratic legislators successfully proposed House Bill 1381: "Maternal Health Outcomes."[173] Notably, nearly all of the bill's sponsors were Black women policymakers and consistent supporters of racial justice legislation in Florida.[174] The bill established pilot programs in predominantly Black and brown communities in Florida to improve maternal health outcomes for women of color.[175] Specifically, the bill adds maternal health care initiatives like telehealth home visits, education for pregnant people, and training for health care professionals to the state funded "Closing the Gap" grant.[176] Administered by the Department of Health, the grant supports community organizations that strive to reduce racial and ethnic health care disparities.[177] Further legislation codified that proposals for Closing the Gap grants must address priority areas such as "decreasing racial and ethnic disparities in maternal and infant mortality rates" and "decreasing racial and ethnic disparities in severe maternal morbidity rates

173. Fla. H.B. 1381 (2021) (codified as Fla. Stat. §381.7353 (2021)).

174. *See* Legiscan, *Florida House Bill 1381*, https://legiscan.com/FL/bill/H1381/2021 [https://perma.cc/ZH88-MUB6] (listing the names of each of the bill's sponsors in addition to the bill text).

175. News Service of Florida, *Florida Lawmakers Target Minority Maternal Health in Duval* County, News4Jax, (Apr. 21, 2021, 8:00PM), https://www.news4jax.com/news/local/2021/04/22/florida-lawmakers-target-minority-maternal-health-in-duval-county/ [https://perma.cc/7UBR-QHSV].

176. *See* Legiscan, *Florida House Bill 1381*, *supra* note 174.

177. Office of Minority Health and Health Equity, *Closing the Gap Grant,* Florida Health (last reviewed Feb. 1, 2022 4:28PM), https://www.floridahealth.gov/programs-and-services/minority-health/GrantFundingResources/closing-the-gap.html. [https://perma.cc/RX8M-DNRL]; *see also* Fla Stat. §381.7356 (2021).

and other maternal health outcomes."[178]

Although Florida successfully passed H.B. 1381, the fight for reproductive justice and access to care for Black women in Florida, the other eleven non-expansion states, and the United States more broadly is far from over. Until the Black maternal health crisis is resolved, our policymakers, healthcare providers, and advocates must stand up for reproductive justice, dismantle structural racism in health care, and make efforts to provide accessible and effective preconception, prenatal, and long-term postpartum care.

V. EFFECTIVE SOLUTIONS TO THE UNITED STATES' BLACK MATERNAL HEALTH CRISIS

To address racial disparities in maternal mortality in the United States, we must engage in more honest conversations about race, racism, and the impact of structural racism on our medical and legal institutions. Twelve states that have willingly chosen not to participate in Medicaid expansion are states in which Black pregnant people predominantly reside. For state governments to leave hundreds of thousands of Black women uninsured is to treat Black women as if they are invisible. Medicaid is an important source of health coverage for people of reproductive age and has been proven to remedy maternal mortality rates.[179] Information on the success of Medicaid is public knowledge. The twelve non-expansion states are fully aware of the benefits of Medicaid expansion and have still chosen not to afford this level of care to Black women. It is critical that all states fully expand Medicaid coverage to provide comprehensive care for all people.

Another solution for legal and policymaking institutions to implement is enacting legislation that contains concrete, attainable goals to remedy maternal mortality. Measures like the Preventing Maternal Deaths Act of 2018 were an acceptable first step but nowhere near a comprehensive solution. Our government has sufficient data on maternal mortality, structural racism in health care, and effective solutions backed by experts to enact laws that could mitigate centuries of health inequities for Black pregnant people. These solutions must directly address the many factors that contribute to racial disparities in maternal health outcomes and develop ways to protect Black pregnant people from further reproductive injustices.

If our institutions continue to willfully disregard solutions that address the root of the issue, we risk wasting time in saving the lives of Black pregnant people across the nation. By failing to take measures known to remedy racial disparities in maternal mortality, the United States government perpetuates the erosion of Black people's reproductive autonomy. However, given the current composition of the Supreme Court and Congress, it seems unlikely that the federal government

178. Fla. Stat. §§381.7355(2)(a)1, 381.7355(2)(a)2 (2022). There are several additional priority areas concerning maternal morbidity and mortality rates that grant proposals may satisfy.

179. *See* Taylor, *supra* note 14, at 515.

will address racial inequities in reproductive care in the immediate future. If the Court is willing to revoke the constitutional right to abortion, and Congress has failed to safeguard this right, will federal government institutions effectively address racial inequities in maternal mortality? Even in light of the efforts of the Biden-Harris Administration, they likely will not.

With direct policy change through our highest legal institutions being unlikely, it seems that more realistic approach to policy change, particularly in non-expansion states, will have to occur through activism. "As seen throughout history, activism is essential in sparking policy change and holding our systems and institutions accountable."[180] For instance, organizations like SisterSong have continued to advocate for the reproductive needs, justice, and social concerns of Black women. The concerns of Black women must be at the forefront of policy change regarding maternal health care, as demonstrated by the fact that they were the sponsors of H.B. 1381. Policymakers can give Black women the voice and platform that they are seldom given, especially when it comes to the quality of care they deserve and need.

"Interventions to combat bias and racism within the health care system can be effective, but it will take commitment and concerted effort at both the institutional and individual levels."[181] On an individual level, we need more culturally competent healthcare providers. We can achieve this in several ways. One way is requiring health care providers to receive "training on implicit bias, class and gender bias, anti-racism, and human rights in the practice of health care."[182] These should be part of healthcare providers' required curriculum or educational development.[183] Implicit bias training is necessary because implicit negative stereotypes prevent providers from building positive relationships with their Black patients, which can impact the quality of care provided.[184] We also need to diversify the healthcare workforce.[185] Although Black physicians have been found to provide a better quality of and access to care in marginalized communities, "only 4% of U.S. physicians are Black."[186] We should encourage more Black people, especially Black women, to pursue careers in obstetrics and gynecology. States could encourage and promote the diversification of the healthcare workforce through "recruitment, scholarships and grants, housing or childcare assistance during training, mentoring programs, and state loan forgiveness programs."[187]

Most importantly, Black women need to regain control over their bodily and reproductive autonomy.[188] When Roe recognized a right to abortion under the

180. *Id.*
181. *Id.*
182. BLACK MAMAS MATTER ALLIANCE, *supra* note 65, at 49.
183. *Id.*
184. *See id.* at 26.
185. *See id.*
186. *Id.*
187. *Id.* at 49.
188. *Id.*

constitutional concept of privacy, Black women felt left out of the conversation due to historical racism tracing back to slavery.[189] Enslavers deprived Black women of bodily and reproductive autonomy, and we witness that same oppression now with the excessive and disproportionate use of cesarean sections on Black women. However,

> The right to safe and respectful maternal care encompasses a woman's right to actively participate and make informed decisions about her care. To make an informed decision, a woman must be provided with information about her condition, her health care options, and the risks and benefits associated with each one. *Maternal health care providers can empower their patients to become engaged decision-makers by centering them, educating them, and listening to them*.[190]

For Black women to regain their reproductive autonomy, they must beat the center of their own healthcare plans. Additionally, healthcare providers must put issues affecting Black women at the core of their care. Policymakers and other decisionmakers in legal institutions at all levels must address Black women's concerns. To continue to make Black women feel voiceless, overlooked, and dismissed is one of the United States' greatest public health failures. Adopting a Reproductive Justice framework and placing Black people with the capacity for pregnancy at the core of reproductive care reform not only has the power to eliminate racial disparities in maternal mortality rates, but also can foster equity in care for all people with the capacity for pregnancy.

CONCLUSION

Although it may seem as if the Biden-Harris Administration has made significant progress towards rectifying the United States' maternal health crisis, there is still much progress to be made. Given the composition of the Supreme Court, it is more than likely that further challenges to the ACA will arise. The Court may decide to diminish or completely remove necessary healthcare coverage for many at-risk individuals, including Black birthing people. However, there are many other avenues to protect Black people with the capacity for pregnancy, their reproductive justice, and bodily autonomy. These efforts include educating those who directly provide reproductive care to Black people, ensuring that Black people are well-represented in the health care profession, and listening to Black pregnant people and their needs. However, every solution must begin with addressing the reality of structural racism and its impact on Black women's maternal health outcomes. Only then will the United States begin to see transformative results in protecting its most endangered pregnant people.

189. And with the *Dobbs* decision, even the inadequate protections of *Roe* have been stripped away, leaving Black women disproportionately harmed.

190. *Id.* (emphasis added).