

How the Lone Star State's Refusal to Expand Medicaid Is Leaving Pregnant Women More Alone Than Ever

by NAOMI STRAUSS*

Introduction

The maternal mortality rate in Texas has steadily increased in the last ten years, and doubled in 2011-2012.¹ These recent statistics make Texas one of the most dangerous places in the developed world to be pregnant and to deliver a child.² Across America, maternal health is in crisis.³ This alarming trend in maternal mortality is an issue of national importance, especially when compared to decreasing maternal mortality rates in every other developed country around the world—American women are five times more likely to die from childbirth than a British woman.⁴ Exactly why is still largely unknown.

The State of Texas has made a series of decisions that targets women's health and family planning services and limits access. Since 2011, at least eighty-two family planning clinics have closed throughout Texas.⁵ Most

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1. J. David McSwane & Terri Langford, *Reasons for Texas's Surge in Pregnancy-Related Deaths Cloaked in Secrecy, Bad Data*, DALLAS NEWS (Sept. 28, 2016), <http://www.dallasnews.com/news/texas-legislature/2016/09/28/secrecy-bad-data-cloak-reasons-texas-surge-pregnancy-related-deaths>.

2. Nina Martin, *Maternal Mortality in Texas is a National Embarrassment*, MOTHER JONES (Aug. 24, 2016), <http://www.motherjones.com/politics/2016/08/spike-rates-pregnancy-related-deaths-texas-national-embarrassment>.

3. *Pregnancy Mortality Surveillance System*, CTR. FOR DISEASE CONTROL AND PREVENTION (2017), <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html>.

4. See *OECD Health Data: Health Status: Maternal and Infant Mortality*, <http://stats.oecd.org/index.aspx?queryid=30116>.

5. See Amanda J. Stevenson et al., *Effect of Removal of Planned Parenthood from the Texas Women's Health Program*, 374 N. ENGL. J. MED., 853–860 (Mar. 2016).

recently, Texas' decision to exclude Planned Parenthood from state insurance coverage negatively impacts women across Texas, particularly women of color.⁶ This exclusion has exacerbated systematic societal issues and has erected new institutional barriers to affordable health care. In light of this, and despite states' historic police powers, the Texas government cannot disavow federally funded Medicaid services without providing an equally effective alternative. The Supreme Court has not yet held that access to health care is a fundamental right, however government health programs still must be administered consistent with due process and equal protection.

Reproductive health advocates point to the increasingly restrictive women's health legislation the Texas legislature passed in recent years. After high profile laws restricted abortion access, such as the notorious Texas law originally known as House Bill No. 2, Texas became the symbolic leader of the movement to defund family planning and women's health programs. The presence and combination of these circumstances have created the perfect storm in Texas, which has metastasized across America. This is a live issue, particularly given recent political developments such as President Donald Trump's repeated failure to dismantle the Affordable Care Act ("ACA"), various emboldened states' attempts to pass increasingly restrictive legislation in the wake of renewed efforts to overturn *Roe v. Wade*,⁷ and the upcoming potential "Democratic wave" in the 2018 midterm elections.⁸

In the face of a broken health care system, politicians and healthcare experts have proposed solutions and brainstormed what an ideal system could look like. But ideological lines regarding that reimagining have been drawn in the sand, making health care politically controversial across both state and federal levels. The Republican leadership prefers a block grant system between the federal government and the states, which would give states full autonomy to provision federal funds as they wish. The best example of this intent is the failed Cassidy-Graham Bill. On the other side

6. Stevenson et al., *supra* note 5.

7. Sabrina Tavernise & Sheryl G. Stolberg, *Abortion Foes, Emboldened by Trump, Promise Onslaught of Tough Restrictions*, N.Y. TIMES (Dec. 11, 2016), <http://www.nytimes.com/2016/12/11/us/abortion-foes-donald-trump-restrictions-politics.html>. See also Samantha Schmidt, *After Months of Controversy, Texas Will Require Aborted Fetuses to Be Cremated or Buried*, WASH. POST (Nov. 29, 2016), <https://www.washingtonpost.com/news/morning-mix/wp/2016/11/29/despite-months-of-outcry-texas-will-require-aborted-fetuses-to-be-cremated-or-buried/>; Sheryl G. Stolberg, *John Kasich Signs One Abortion Bill in Ohio But Vetoes a More Restrictive Measure*, N.Y. TIMES (Dec. 13, 2016), <http://www.nytimes.com/2016/12/13/us/kasich-ohio-heartbeat-abortion-bill.html>.

8. Harry Enten, *Special Elections So Far Point to A Democratic Wave in 2018*, FIVE THIRTY EIGHT (Dec. 13, 2017), <https://fivethirtyeight.com/features/special-elections-so-far-point-to-a-democratic-wave-in-2018/>.

of the aisle, more of the Democratic leadership is beginning to voice stronger support for Senator Bernie Sander's vision of a single-payer, Medicare for all system.⁹ The chasm between the two viewpoints seems unbridgeable; whichever prevails will establish a new healthcare landscape.

This Note argues for the expansion of Medicaid, and the direct correlation between access to Medicaid and positive outcomes regarding women's health issues. Part I will provide an overview to key maternal health and mortality concepts and definitions. It will also provide context for the crisis, by comparing national and global maternal health statistics. Part II will define the contours of the situation in Texas by highlighting what action has been taken to understand the crisis, as well as continuing limitations. Part III introduces the federalism tension inherent in women's health and family planning, and how it manifests, particularly in Texas. After detailing Texas's current health care landscape, this Note advocates for Texas to expand Medicaid coverage. This expansion will have a positive effect on maternal health outcomes, by ensuring access for more low-income women. Lastly, Part V will address recommendations that the government and policymakers should consider.

I. Overview of Maternal Health and Mortality

Improving maternal health and reducing maternal mortality rates are issues of national and international importance. However, there is currently no clear picture of maternal mortality trends in the United States.¹⁰ Despite decreasing global maternal mortality rates, the reported (unadjusted) U.S. maternal mortality rate more than doubled from 2000 to 2014 (300 deaths in 2000 and 856 in 2014).¹¹ While this seems alarming, most of the reported increase was the result of improved ascertainment of maternal deaths.¹² In other words, this statistic does not mean the number of *actual* U.S. maternal deaths doubled in that time period; rather, the number of *reported* maternal deaths doubled.

9. Pat Garofalo, *The Single-Payer Surge*, U.S. NEWS (Sept. 13, 2017), <https://www.usnews.com/opinion/thomas-jefferson-street/articles/2017-09-13/bernie-sanders-spurs-democrats-single-payer-health-care-surge>.

10. See Marian F. MacDorman et al., *Recent Increases in the US Maternal Mortality Rate: Disentangling Trends from Measurement Issues*, 128 *OBSTETRICS & GYNECOLOGY* 447–455 (2016).

11. *Id.*

12. *Id.*; see also MATERNAL MORTALITY AND MORBIDITY TASK FORCE AND DEPARTMENT OF STATE HEALTH SERVICES JOINT BIENNIAL REPORT (2016), <https://www.dshs.texas.gov/mch/pdf/2016BiennialReport.pdf> [hereinafter the TASK FORCE REPORT]. The report found that new methodologies of calculating severe maternal morbidity (“SMM”) revealed a higher prevalence than SMM than previously found by past studies.

In fact, most states were successful in reducing their maternal mortality rates over this time frame with one notable exception: Texas. Part A of this section provides comprehensive definitions for each important topic relating to maternal health as a starting point for understanding the situation in Texas. With these definitions in mind, Part B considers global perspectives on maternal health to provide context for the unprecedented maternal mortality spike in Texas.

A. Definitions and Important Maternal Health Concepts

Because these terms often sound similar to each other, it is helpful to first consider each concept separately. *Maternal health* is a broad term that refers to the health of women during pregnancy, childbirth, and the postpartum period.¹³ While motherhood is often socially portrayed as a positive and fulfilling experience, for too many women it is associated with suffering, ill health, and even death.¹⁴ A reduction in maternal deaths has traditionally been used as a critical measure of progress in improving maternal health. Thus, the *maternal mortality ratio* is considered one of the main indicators of a country's status regarding maternal health.¹⁵

National sources of maternal mortality information come from the Centers for Disease Control and Prevention (“CDC”)—through either the National Center for Health Statistics (“NCHS”) or the Pregnancy Mortality Surveillance System (“PMSS”).¹⁶ The CDC has not published the national maternal mortality rate since 2007.¹⁷ The NCHS's measure—the most commonly referenced—is referred to as the maternal mortality rate, or the number of maternal deaths per 100,000 live births.¹⁸ The NCHS is the nation's principal health statistics agency, compiling statistical information to guide public health decisions.¹⁹ The PMSS's measure is called the

13. *Maternal Health Fact Sheet*, WORLD HEALTH ORG. (2016), http://www.who.int/topics/maternal_health/en/.

14. *Id.*

15. Tabassum Firoz et al., *Measuring Maternal Health: Focus on Maternal Morbidity*, WORLD HEALTH ORG. (Aug. 6, 2013), <http://www.who.int/bulletin/volumes/91/10/13-117564/en/>.

16. *Report from Maternal Mortality Review Committees: A View into Their Critical Role*, CDC FOUND. 8 (2017).

17. *Vital and Health Statistics, Maternal Mortality and Related Concepts*, DEP'T OF HEALTH & HUMAN SERVS. (Feb. 2007), https://www.cdc.gov/nchs/data/series/sr_03/sr03_033.pdf.

18. *National Vital Statistics System*, NAT'L CTR. FOR HEALTH STATISTICS (Jan. 4, 2018), <https://www.cdc.gov/nchs/nvss/deaths.htm>.

19. *NCHS Fact Sheet: Overview*, NAT'L CTR. FOR HEALTH STATISTICS (Sept. 2017), https://www.cdc.gov/nchs/data/factsheets/factsheet_overview.htm.

pregnancy-related mortality ratio, as it also considers associated but not pregnancy-related deaths.²⁰

Yet, measuring maternal mortality only covers a small portion of what makes up *maternal morbidity*—the health problems borne by women during pregnancy and the postpartum period.²¹ In other words, maternal morbidity can be thought of as a spectrum, ranging from life threatening conditions to less serious, non-life threatening ones.²² In order to envision the relationship between these two terms, maternal deaths have been described as the tip of the iceberg and maternal morbidity as the base.²³ Starting at the base, maternal morbidity consists of many conditions such as cardiac events, infection, drug overdoses, high blood pressure or eclampsia, unsafe abortion, sepsis, hemorrhage, and obstructed labor.²⁴ These conditions are considered *severe* when, but for major medical and technological intervention, the mothers might have died.²⁵

The tip of the iceberg also includes various definitions of *maternal death*.²⁶ The CDC defines pregnancy-related death as the death of a woman while pregnant or within one year of termination of pregnancy, irrespective of the duration and site of the of the pregnancy, from any cause related to or aggravated by her pregnancy or its management, including from: (1) pregnancy complication; (2) a chain of events initiated by pregnancy; or (3) the aggravation of an unrelated condition by the psychological effects of pregnancy.²⁷

B. Providing Context—Maternal Mortality Trends

Texas's unprecedented spike in maternal mortality stands in stark contrast to the consistent reduction in maternal mortality both across America and worldwide. Maternal health has always been an international concern, particularly in developing countries with limited access to, and infrastructure for, health care. In 2000, the United Nations adopted the

20. *Pregnancy Mortality Surveillance System*, *supra* note 3.

21. *Id.*

22. *Id.*

23. *Id.*

24. *Id.*

25. Martin, *supra* note 2.

26. Identifying the temporal distance between a maternal death and her pregnancy is important in understanding how the pregnancy or related conditions may have contributed to the death. Therefore, it is critical to set standard benchmarks to record time of death in relation to a pregnancy to improve reporting going forward.

27. TASK FORCE REPORT, *supra* note 12.

Millennium Development Goals (“MDG”).²⁸ These goals highlighted global issues the U.N. would prioritize in the new millennium. To address the international maternal health problem head on, MDG 5a aimed to reduce the global maternal mortality rate by 75% from 1990 to 2015.²⁹ In 2015, the goal had not been met, but the number of maternal deaths worldwide dropped by 43%, with most of the reduction occurring after 2000.³⁰

Despite international efforts and overall improvements, maternal mortality is still unacceptably high.³¹ In 2015, over 303,000 women died during and following pregnancy and childbirth around the world.³² This number is likely significantly underreported, as just 51% of countries have data on maternal cause of death.³³ Additionally, almost all of these deaths occurred in low-resource settings and developing countries.³⁴ Most of these women could have survived with the proper combination of access, resources, and screening.

Specifically, the United States has the worst rate of maternal mortality in the developed world.³⁵ Despite the U.N. goal for a 75% reduction in maternal mortality by 2015, the estimated mortality rate for forty-eight states and Washington, D.C., increased between 2000 and 2014.³⁶ This makes the U.S. a rare country, where maternal deaths are becoming more prevalent in recent years.³⁷ More recent numbers indicate somewhere between 700 and 900 women died from pregnancy-related causes in 2016.³⁸

28. *Maternal Mortality Fact Sheet*, *supra* note 13.

29. *Id.*

30. *Id.*

31. *Id.*

32. *Id.*

33. UNITED NATIONS, THE 2015 MILLENNIUM DEVELOPMENT GOALS REPORT (2015) http://www.undp.org/content/dam/undp/library/MDG/english/UNDP_MDG_Report_2015.pdf. [hereinafter THE 2015 MILLENNIUM DEVELOPMENT GOALS REPORT].

34. *Maternal Mortality Fact Sheet*, *supra* note 13.

35. Nina Martin & Renee Montagne, *U.S. Has the Worst Rate of Maternal Deaths in the Developed World*, NPR (May 12, 2017), <https://www.npr.org/2017/05/12/528098789/u-s-has-the-worst-rate-of-maternal-deaths-in-the-developed-world>.

36. MacDorman et al., *supra* note 10; Carol Morello, *Maternal Deaths in Childbirth Rise in the U.S.*, WASH. POST (May 2, 2014), https://www.washingtonpost.com/local/maternal-deaths-in-childbirth-rise-in-the-us/2014/05/02/abf7df96-d229-11e3-9e25-188ebe1fa93b_story.html.

37. Nicholas Kristof, *If Americans Love Moms, Why Do We Let Them Die?*, N.Y. TIMES (July 29, 2017), <https://www.nytimes.com/2017/07/29/opinion/sunday/texas-childbirth-maternal-mortality.html>.

38. So far, NPR and ProPublica have identified 134 of these lost mothers. See Nina Martin et al., *Lost Mothers*, PROPUBLICA (July 17, 2017), <https://www.propublica.org/article/lost-mothers-maternal-health-died-childbirth-pregnancy>; see also Robin Fields & Joe Sexton, *How Many American Women Die from Causes Related to Pregnancy or Childbirth? No One Knows*,

II. The Perfect Storm in Texas

Although trends across the United States are disturbing, the situation for mothers in Texas is particularly disconcerting. Since 2010, the number of maternal deaths in Texas has remained higher than in previous decades. As mentioned, researchers observed a significant spike in maternal mortality—a doubling—over a two-year period from 2010 to 2012.³⁹ Since then, maternal mortality rates have remained high.⁴⁰

Moreover, after instigating—and losing—a Supreme Court battle over abortion provider restrictions, Texas has become the symbol of state resistance to the imposition of federal values. This tension has flared in the women's health and family planning contexts, not just because these are morally-laden issues, but also because the ACA restricted the state's ability to regulate their own health care landscapes. Southern states, like Texas, have traditionally rejected federal leadership regarding such state matters, setting up a battle that the Trump Administration continues to encourage. Moreover, Texas is secretive regarding their women's health efforts, demonstrated by the refusal to release public information that would shed light on the causes of the crisis.⁴¹

A. What We Know About the Current Situation in Texas

Two studies have been completed in an attempt to determine factors contributing to this spike in maternal death. The first is a study published by the American College of Obstetricians and Gynecologists ("ACOG"), which looks at the recent increases in the overall U.S. maternal mortality rate ("MacDorman study").⁴² The MacDorman study concludes, "absent war, natural disaster or severe economic upheaval, the doubling of a mortality rate within a 2-year period in a state with almost 400,000 annual births seems unlikely."⁴³ The second is a report ("task force report") compiled by a

PROPUBLICA (Oct. 23, 2017), <https://www.propublica.org/article/how-many-american-women-die-from-causes-related-to-pregnancy-or-childbirth>.

39. MacDorman et al., *supra* note 10.

40. TEX. DEP'T OF STATE HEALTH SERVS., MATERNAL MORTALITY IN TEXAS: USING PRECISION PUBLIC HEALTH TO IMPROVE MATERNAL OUTCOMES (2016), <https://www.dshs.texas.gov/mch/pdf/Maternal-Mortality-in-Texas---Using-Precision-Public-Health-to-Improve-Maternal-Outcomes.pdf>.

41. See Edgar Walters, *State Employee Steps Down After Controversial Women's Health Study*, TEXAS TRIBUNE (Feb. 18, 2016), <https://www.texastribune.org/2016/02/18/state-employee-resigning-after-unflattering-womens/>. There, a high-ranking state employee resigned after co-authoring an "unflattering" study that found fewer women accessed a Texas family planning program after the state's exclusion of Planned Parenthood in 2013.

42. MacDorman et al., *supra* note 10.

43. MacDorman et al., *supra* note 10.

special task force created by the Texas Legislature in conjunction with the Texas Department of State Health Services (“DSHS”).⁴⁴ This report explores the current crisis in Texas and provides recommendations to reduce maternal morbidity and mortality.

I. MacDorman Study: Attempting to Disentangle Trends from Measurements

MacDorman performed an observational study analyzing vital statistics from maternal mortality data from all U.S. states in relation to the format and year of their adoption of the standardized pregnancy question in their death certificates. The main goal of the study was to provide an overview of U.S. maternal mortality trends from 2000-2014.⁴⁵ According to MacDorman, the estimated maternal mortality rate for forty-eight states and Washington, D.C., increased during this period.⁴⁶ The international trend was in the opposite direction.⁴⁷ Realizing the increase in reported maternal deaths was connected with the implementation of standardized pregnancy questions in various parts of the country, MacDorman sought to disentangle and define that specific relationship.

In an attempt to standardize reporting, the CDC added a pregnancy question to the 2003 revision of the U.S. standard death certificate.⁴⁸ The purpose of including a pregnancy question is to determine if the death is related to pregnancy with better accuracy. The “question” includes checkboxes to represent each of the following options: (1) pregnant within the past year; (2) pregnant at the time of death; (3) not pregnant but pregnant within forty-two days of death; (4) not pregnant but pregnant between forty-three days to one year before death; and (5) unknown if pregnant within the last year.⁴⁹ This addition is necessary and helpful, but because states have adopted the question at different times and to various degrees, data is still inconsistent.

It is clear the CDC’s addition of the pregnancy question in 2003 has led to increases in reported maternal mortality rates at both state and federal levels.⁵⁰ Before this addition, eighteen states had a pregnancy question on

44. TASK FORCE REPORT, *supra* note 12.

45. MacDorman et al., *supra* note 10.

46. *Id.*

47. THE 2015 MILLENNIUM DEVELOPMENT GOALS REPORT, *supra* note 33.

48. *Revisions of the U.S. Standard Certificates and Reports*, NAT’L VITAL STATISTICS SYSTEM (Aug. 30, 2017), <https://www.cdc.gov/nchs/nvss/revisions-of-the-us-standard-certificates-and-reports.htm>.

49. MacDorman et al., *supra* note 10.

50. *Id.*

their death certificate.⁵¹ However, only three of those states collected information within the forty-two day standard timeframe.⁵² Fifteen states had pregnancy questions with timeframes ranging from three to eighteen months after pregnancy.⁵³ Finally, thirty-two states and Washington, D.C., did not have a pregnancy question on their unrevised death certificate.⁵⁴ In 2003—the year the question was added—only four states revised their death certificates.⁵⁵ By 2014, all states except California, Colorado, and West Virginia were supplying pregnancy data for the standard forty-two day timeframe.⁵⁶

The differing timeframes by states obfuscate efforts to accurately measure maternal mortality trends. For example, if California counts deaths within a forty-two-day timeframe, but Texas always counts deaths within a sixty-day period, it may seem as though more women are dying in Texas. Standardized timeframes are important for clear reporting purposes, but also because it is critical to narrow down a timeframe where the health outcome can be appropriately attributed to pregnancy.

Adding further uncertainty, the United States has not published an official maternal mortality rate since 2007.⁵⁷ As MacDorman posits, this is attributable in part to difficulties in disentangling the effects of inconsistent reporting.⁵⁸ First, the delay in states' adoption of the new pregnancy questions presents issues. Second, when combined with the use of nonstandard questions, a situation resulted in which some states used the U.S. standard, others used a question similar to that standard, and still others did not use any pregnancy questions whatsoever.

Because of the relatively rare occurrence of maternal death, MacDorman only individually analyzed the data from the country's two most populous states: California and Texas. California showed the expected declining trend in maternal death, whereas Texas had a sudden and significant increase during the same time period.⁵⁹ The maternal mortality

51. MacDorman et al., *supra* note 10.

52. *Id.*

53. *Id.*

54. *Id.*

55. *Id.*

56. MacDorman et al., *supra* note 10, at 1.

57. *Id.* The CDC's National Center for Health Statistics is the source of official United States maternal mortality statistics used for both subnational and international comparisons. All of this data is recorded in the National Vital Statistics System. This system's previous studies identified significant underreporting of maternal deaths.

58. *Id.*

59. MacDorman et al., *supra* note 10.

rate in California is a third of the American average, and this is all the more impressive considering more than half a million women give birth in the state each year, accounting for one-eighth of all U.S. births.⁶⁰ MacDorman argues this is in part because California took proactive steps to reduce the maternal mortality rates.⁶¹

For example, California initiated a statewide pregnancy-associated mortality review in 2006.⁶² The state then zeroed in on the complications that were most preventable. Further, the state contracted with the California Maternal Quality Care Collaborative (“CMQCC”) to investigate the primary causes of maternal death. The CMQCC is funded by the California Healthcare Foundation, the California Department of Public Health, and the CDC. This collaborative “developed and promulgated evidence-based tool kits” to address two of the more preventable contributors to maternal death: obstetric hemorrhage and preeclampsia.⁶³ A recent study showed a twenty-one percent reduction in severe health problems associated with hemorrhages in California hospitals participating in the CMQCC’s programs.⁶⁴ Hospitals that didn’t join the effort saw a non-significant one percent reduction.⁶⁵

By contrast, from 2011-2012, the maternal mortality rate doubled in Texas.⁶⁶ Before that, the data shows Texas saw a modest increase in maternal mortality rates from 2000 to 2010.⁶⁷ These results are “puzzling,” especially considering the doubling took place in a two-year period.⁶⁸ Of note, Texas revised its death certificate to meet the U.S. standard in 2006 and additionally, implemented an electronic death certificate. However, the 2006 changes did not appreciably affect the maternal mortality trend, and the doubling occurred in 2011 through 2012, several years later.⁶⁹ Additionally,

60. Julia Belluz, *California Decided It Was Tired of Women Bleeding to Death in Childbirth*, VOX (June 29, 2017), <https://www.vox.com/science-and-health/2017/6/29/15830970/women-health-care-maternal-mortality-rate>.

61. MacDorman et al., *supra* note 10.

62. *Id.*

63. *Id.*

64. Elliott K. Main et al., *Reduction of Severe Maternal Morbidity from Hemorrhage Using A State Perinatal Quality Collaborative*, 216 AM. J. OBSTET. & GYNECOL. 298 (Mar. 2017); Elliott K. Main et al., *Pregnancy-Related Mortality in California: Causes, Characteristics, and Improvement Opportunities*, 125 AM. J. OBSTET. & GYNECOL. 938 (Apr. 2005).

65. Elliott K. Main et al., *Reduction of Severe Maternal Morbidity from Hemorrhage Using A State Perinatal Quality Collaborative*, 216 AM. J. OBSTET. & GYNECOL. 298 (Mar. 2017).

66. Main et al., *supra* note 65.

67. *Id.* at 5.

68. MacDorman et al., *supra* note 10.

69. MacDorman et al., *supra* note 10.

updated research shows that these reporting inconsistencies cannot alone explain Texas's surge. Before comparing, MacDorman eliminated deaths attributed to unspecific causes or women over forty, as the data seemed especially inconsistent in these categories.⁷⁰ After comparing more reliable data from two five-year periods, 2006 to 2010 and 2011 to 2015, MacDorman found Texas's mortality rate still went up thirty-six percent.⁷¹ Moreover, unlike California, Texas has actively taken steps to reduce both funding and coverage for family planning programs, as well as access.

2. *Maternal Mortality and Morbidity Task Force and Department of State Health Services: Joint Biennial Report*

Overall, MacDorman's work highlights the difficulty in disentangling trends in maternal mortality by relying on vital statistics information alone. In response to the disturbing statistics, the Texas legislature determined that all cases of maternal death in Texas must be reviewed.⁷² To enable this review, Senate Bill 495 amended Chapter 34 of the Texas Health and Safety Code to establish the Maternal Mortality and Morbidity Task Force.⁷³ In December 2013, the DSHS Commissioner appointed a fifteen-member multidisciplinary task force to investigate pregnancy-related death in Texas.⁷⁴ This task force was created to study maternal mortality and morbidity in Texas and generate a Biennial Report in conjunction with the DSHS ("task force report" or "report.")⁷⁵ Most recently, Governor Greg Abbott signed Senate Bill 17, extending the task force's work until 2023.⁷⁶

One of the task force's primary findings was that severe data quality issues that make it difficult to identify a maternal or "obstetric" death.⁷⁷ The report found notable variation in how deaths are investigated, depending on

70. Marian F. MacDorman & Eugene Declercq, *The Failure of United States Maternal Mortality Reporting and Its Impact on Women's Lives*, BIRTH (Jan. 2018); see also Robin Fields, *Maternal Deaths Are Increasing in Texas, but Probably Not as Much as Officials Thought*, TEXAS TRIBUNE (Jan. 4, 2018), <https://www.texastribune.org/2018/01/04/maternal-deaths-are-increasing-texas-probably-not-much-officials-thou/>.

71. Fields, *supra* note 70.

72. All cases of maternal death, with the exception of motor accidents and non-pregnancy-related cancers. See TASK FORCE REPORT, *supra* note 12, at 3.

73. *Id.*

74. *Id.*

75. S.B. 495, 83d Legislature, Reg. Sess. (Tx. 2013).

76. Morgan Smith & Patrick Svitek, *Texas Legislature Ends Special Session Without Passing Property Measure*, TEXAS TRIBUNE (Aug. 15, 2017), <https://www.texastribune.org/2017/08/15/texas-house-adjourns-sine-die/>; Marissa Evans, *Gov. Abbott Signs Bill Giving Texas Maternal Mortality Task Force More Time*, TEXAS TRIBUNE, (Aug. 16, 2017), <https://www.texastribune.org/2017/08/16/abbotts-signature-gives-maternal-mortality-task-force-more-time/>.

77. TASK FORCE REPORT, *supra* note 12, at 1.

the reporting system involved, which varies from county to county throughout Texas.⁷⁸ Not only were there differences in how maternal death investigations were conducted, there were also inconsistencies in the quality of the investigations.⁷⁹ After analyzing these findings, the task force recommended further examination of the coding mechanism and in addition, a death certificate quality improvement initiative.⁸⁰

Based on these recommendations, recently Texas has taken positive steps to address reporting issues. Recent activity out of the Texas legislature charges the task force with updating its pregnancy-related death investigation protocol on its website, which must include guidelines regarding toxicology screenings, and correctly noting when death was related to pregnancy.⁸¹ House Bill 2466 also implemented new measures that allow low-income mothers to be screened for postpartum depression earlier, during their baby's initial doctor visits.⁸² This is an important measure, considering that the report found seventeen percent of Texas mothers experience postpartum depression.⁸³ Suicide is a real risk—it is among the five leading causes of death for American women ages 10-44 years, and the WHO has identified it as a leading cause of death in high-income countries both in pregnancy and within forty-two days postpartum.⁸⁴

Arguably, had there been consistent and reliable data recording, the shocking findings from Texas starting in 2011 would have been investigated sooner. Improving maternal health reporting systems would not only benefit the DSHS and Texas by clarifying the factors contributing to maternal mortality, it also benefits the nation as a whole by identifying systemic issues and improving overall medical reporting.

78. TASK FORCE REPORT, *supra* note 12, at 1.

79. For example, because of the lack of standardization, some deaths that should have been investigated by a medical examiner or a justice of the peace were not appropriately routed to the correct investigating agency. This “crossing of wires” directly resulted in missed opportunities to perform necessary laboratory tests. Moreover, the report found inconsistencies in the laboratory reporting itself, specifically toxicologic testing. Consequently, the appropriate tests were not always performed at the time of the investigation, which hindered the task force's ability to assess the death's relation to pregnancy. TASK FORCE REPORT, *supra* note 12, at 1, 8.

80. *Id.* at 7–8.

81. S.B. No. 1599, 85th Legislature, Reg. Sess. (Tx. 2017).

82. H.B. 2466, 85th Legislature, Reg. Sess. (Tx. 2017).

83. Marissa Evans, *Postpartum Depression Screening Bill Gets Abbott's Signature*, TEXAS TRIBUNE (June 15, 2017), <https://www.texastribune.org/2017/06/15/postpartum-depression-screening-bill-gets-abbotts-signature/>.

84. Melonie Heron, *Deaths: Leading Causes for 2013*, 65(5) NAT'L VITAL STATISTICS REPORTS 1, 2 (2016).

B. What We Don't Know

Due to limitations surrounding the collection of vital statistics, relying on them alone cannot illuminate the whole situation. Additionally, factors such as older women having children, or an increase in the number of pregnant women who have diseases and chronic conditions before pregnancy require additional data to extricate. This section explains how inconsistent recording of maternal deaths, as well as Texas's erosion of open privacy laws, have thwarted efforts to reduce maternal mortality.

1. *The Impact of Inconsistent Recording*

There is currently no holistic and comprehensive picture of maternal mortality trends in the United States. A major reason for this is inconsistent maternal mortality reporting methods. Both previously mentioned assessments of Texas's maternal health crisis—the task force report and MacDorman's study—took issue with the quality of death reporting in Texas and nationwide. In both studies, researchers were reliant on a small sample of records provided by the DSHS and those records were heavily redacted. To ensure privacy, a multistep process was used to prepare the records for disclosure. First, all provider-identifying information was redacted from case records by nonlicensed DSHS staff.⁸⁵ Second, a DSHS nurse abstracted, consolidated, synthesized, and summarized relevant medical information.⁸⁶

In short, the final product was a heavily edited, often by multiple individuals, and abridged version of the original records. These summaries contain no sensitive, confidential, or identifying information. While standardizing reporting protocol by updating the U.S. national death certificate to include questions about maternal mortality helped clarify new data, it does not retroactively fill in the gaps. In the meantime, Texas women continue to die at alarming rates, and the data accessible to the public does not provide enough insight as to why.

2. *An Impending Legal Battle: Privacy Interests Versus Public Necessity*

The direct connection between family planning cuts and the spike in maternal mortality has not been empirically established. Neither the task force nor MacDorman's study specifically analyze whether family planning cuts triggered the spike in mortality. To do so, in addition to mounting constitutional challenges, the public needs access to additional maternal

85. TASK FORCE REPORT, *supra* note 12, at 9.

86. *Id.*

mortality data that the DSHS will not release. The redacted, synthesized records simply do not allow in-depth analysis.

In its refusal, the DSHS cites an exception to the Texas Public Information Act (“TPIA”), which prohibits the disclosure of confidential information. Historically, Texas has maintained strong open access laws. Further, TPIA’s stated policy objectives are to provide accountability and transparency in government by establishing mechanisms to foster public access to government records.⁸⁷ As of late, however, the trend is moving in the opposite direction and transparency issues are increasingly frequent.⁸⁸

Regarding the nondisclosures relating to maternal mortality rates, the public does not necessarily need the confidential patient information. Rather, the public is entitled to the record layout, which is more akin to a table of contents—describing an inventory, not the sensitive patient identification information. Under the TPIA, the public is “entitled” to all information not otherwise subject to an exception⁸⁹, of which the record layout information is not. Therefore, especially given the seriousness of this issue, the DSHS should comply with the TPIA and release the inventory information relating to maternal mortality. Doing so will ensure academics and researchers have the most accurate information to better confront this ongoing crisis.

A fundamental premise of Texas law is that all government information is presumed to be available to the public. The underlying rationale is that “the government is the servant and not the master of the people.”⁹⁰ However, certain exceptions may apply to disclosure. The TPIA states governmental bodies shall promptly release requested information that is not confidential by law, either constitutionally, statutorily, or by judicial decision, or information for which an exception to disclosure has not been sought.⁹¹ Enumerated exceptions include information on personnel records, pending litigation, competitive bids, trade secrets, real estate deals, and certain legal matters involving attorney-client privilege.⁹²

The requested maternal health data could provide answers regarding the maternal mortality crisis, yet the DSHS is keeping this information secret. In fact, the DSHS has refused to disclose even an inventory of what data it

87. TASK FORCE REPORT, *supra* note 12; *see also* Greater Houston P’ship v. Paxton, 468 S.W.3d 51, 57 (Tex. 2015).

88. McSwane & Langford, *supra* note 1.

89. Tex. Gov’t Code §§ 552.001-.353.

90. *Id.*; *see also* Texas Public Information Act, FREEDOM OF INFO. FOUND. OF TEXAS (Dec. 15, 2016).

91. Tex. Gov’t Code §§ 552.001-.353.

92. *Id.*

keeps.⁹³ Specifically, the public needs this information to conduct studies determining whether the rise in maternal mortality correlates with cuts to women's health programs and lack of access to affordable health insurance. This impact data will shed light on crafting more effective policies to address the crisis. The requested information would also contribute to analyzing the intersectionality of race, class, mental health, substance use, and access to consistent health care throughout pregnancy and the postpartum period.

Regarding important issues of public interest, state agencies have made a summary index of confidential information available to the public. The information contained in these indices varies, but have included the names, locations, and cause of death of every mortality reported to the state department's Vital Statistics division.⁹⁴ In addition to historical precedent, there is a recent example where the DSHS granted a request such as the one at issue here. In 2010, the DSHS released Vital Statistics data that showed how many Texas suicides involved military veterans.⁹⁵ There, the state agreed that using this kind of data, when properly balanced with a public necessity, was appropriate, setting applicable precedent. Considering the seriousness and imminence of this health issue, the state should release the equivalent of a summary index of maternal mortality information to the public. A summary index does not contain qualitative, confidential data—it instead essentially collates data into a table of contents.

Texas Supreme Court Justice Jeffrey Boyd wrote: “Forty-two years ago, the Texas Legislature passed what has become widely regarded as the strongest and most successful open government law in the country.”⁹⁶ However, things have changed. Kelly Shannon, the Executive Director at Freedom of Information Foundation of Texas, recently explained that the Texas Supreme Court and lower courts have watered down the TPIA.⁹⁷ This legal battle originated because Texas Health and Safety Code Chapter 34 specifies that confidential information acquired by the department, including identifying information of an individual or a health care provider, is privileged and may not be disclosed to any person or to members of the task

93. McSwane & Langford, *supra* note 1.

94. *Id.*

95. Lindsay Wise & Yang Wang, *More Young Texans Serving in Military Commit Suicide*, HOUS. CHRON. (Oct. 4, 2010), <http://www.chron.com/news/houston-texas/article/More-young-Texans-serving-in-military-commit-1701598.php>.

96. *Greater Houston P' ship v. Paxton*, 468 S.W.3d 51, 67 (Tex. 2015); *see also* Kelley Shannon, *Court Rulings Taking a Toll on Texas Public Records Access*, DALLAS MORNING NEWS (Aug. 1, 2016), <http://www.dallasnews.com/opinion/commentary/2016/08/01/kelley-shannon-court-rulings-taking-toll-texas-public-records-access>.

97. Shannon, *supra* note 96.

force.⁹⁸ Therefore, government entities and private companies alike have been denying information based on this confidentiality exception.

Increased transparency could also lead to clearer solutions for Texas's recent spike in maternal mortality. Moreover, the public is entitled to access basic information about maternal mortality. Generally, the process of requesting information is straightforward,⁹⁹ and so far, some action has been taken. Primarily, the Dallas Morning News requested data related to maternal deaths through the TPIA.¹⁰⁰ The DSHS denied the request, citing a 2011 opinion by then-Attorney General Greg Abbott that made secret the cause of death, dates of birth, and last known address of the deceased.¹⁰¹ The DSHS also argued that keeping these records secret prevents fraud.¹⁰² Additionally, the DSHS cited a 1990 Attorney General's opinion, which determined that the open records law does not make programming information and source codes public.¹⁰³ However, record experts agree that this opinion does not extend to a record layout.¹⁰⁴

The DSHS is on weak legal footing, and a court might view this urgent public health matter as an opportunity to restore commitment to transparency, open government, and protecting free speech.

III. Federalism Tension: The States and Medicaid

Beyond reporting issues and privacy interests, the larger looming battle is between the states and the federal government. Both the federal and state

98. TASK FORCE REPORT, *supra* note 12, at 9.

99. A request begins by writing a formal request to the agency or entity that maintains the requested information. The TPIA provides that public information is to be released promptly, which is judged on a reasonableness standard. For example, a government body has a ten-day deadline, unless the contents are subject to an exception and require an attorney general's decision to be issued allowing the information to be withheld. After a ruling or an exception is sought, the attorney general must decide within forty-five days. During this review period, the original requester can offer written comments to the attorney general. There is a presumption that information is public—if a governmental body does not seek an attorney general decision in time, the information is presumed to be public and available. See *How to Request Public Information*, ATTORNEY GENERAL OF TEXAS, <https://www.texasattorneygeneral.gov/og/how-to-request-public-information> (Dec. 18, 2016).

100. *Id.*

101. Tex. Att'y Gen. Op. OR2011-04298 (2011).

102. *Id.*

103. Tex. Att'y Gen. Op. ORD 581 (1990).

104. Joe Larsen, a Texas open records expert, gave the following statement: "It's ridiculous. We have a clear public health problem, and the people need to know what in the world is going on here, and they're stymied by this." He continued, "[a] record layout is not software. It's not code. It's not source code. Period. I liken it to the key of a map. It's actually public information itself. It's like the Dewey decimal system, in a way." See McSwane & Langford, *supra* note 1.

governments have important interests in the provision of health care and how it is structured between them, which inherently leads to conflict. Medicaid illustrates this tension best. The issue is not whether Texas can refuse to expand Medicaid coverage under the ACA. After *National Federation of Independent Business v. Sebelius* and *King v. Burwell*, the Supreme Court was clear the federal government cannot force states to expand Medicaid, making the decision to expand coverage under the ACA an option, not a requirement.¹⁰⁵ Rather, the issue is to what extent states can create their own health care programs that contradict federal efforts. Federal public health financing through Medicare, Medicaid, and the ACA relies on an array of public and private entities to deliver health care services.¹⁰⁶ Under this combined public and private system, states use federal funds to manage health care, which they contract locally with private hospitals and providers. This allows states flexibility. States have historic police powers, promised through the Tenth Amendment, that enable them to regulate the public safety, health, and welfare of its citizens. However, when states deny federal cooperation and provide inadequate alternatives, an important question of which way to tip the scales emerges.

Traditionally, federal statutes or other rules have required that all medically qualified providers be eligible to provide care that is funded wholly or in part through federal programs.¹⁰⁷ This shared entitlement structure implicates federalism concerns and typically divides most along party lines. However, there has been an increase in legislation challenging this tradition, especially after the ACA was passed.¹⁰⁸ This legislation specifically attempts to exclude Planned Parenthood affiliates from participating in state-administered, federally funded family-planning programs.¹⁰⁹ Texas has led the way, but sixteen states and both houses of the U.S. Congress have passed similar legislation.¹¹⁰

In this way, conservatives are also set on dismantling Medicaid. Many lawmakers view it as an “unaffordable financial burden . . . as a font of federal rules constricting state creativity . . . and as a welfare program

105. Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 587 (2012); King v. Burwell, 135 S. Ct. 475 (2015).

106. Stevenson et al., *supra* note 5.

107. *Id.*

108. *Id.*

109. *Id.*

110. *Id.*

stoking dependency and joblessness.”¹¹¹ But without Medicaid, millions of women would be left without the care they need to protect their health.¹¹² Specifically, eliminating expansion, barring new enrollment or cutting federal reimbursement will impact young, low-income adults—the exact population in greatest need of coverage for reproductive health.¹¹³

Studies show Medicaid has a large and positive impact on access to care and health outcomes.¹¹⁴ The Department of Health and Human Services comprehensively reviewed Medicaid expansion and found that it has increased access to primary care, expanded use of prescription medications, and increased rates of diagnosis of chronic conditions for new enrollees.¹¹⁵ Moreover, the Kaiser Foundation reviewed 153 studies summarizing the effects of Medicaid expansion and found that expansion results in “significant coverage gains and reductions in uninsured rates, both among the low-income population broadly and within specific vulnerable populations.”¹¹⁶ Beyond an increase in coverage, expansion positively affects utilization of services, affordability of care, and financial security among the low-income population.¹¹⁷ Despite Medicaid enrollment growth initially exceeding projections in many states, analyses find positive effects on multiple economic outcomes, including budget savings, revenue gains, and overall growth.¹¹⁸ Expansion also causes reductions in uncompensated care costs for hospitals and clinics.¹¹⁹

While the states are free to reject the ACA’s Medicaid expansion, they are not free to reject federal funds without providing an adequate alternative.

111. Adam Sonfield, *Why Protecting Medicaid Means Protecting Sexual and Reproductive Health*, GUTTMACHER INST. (Mar. 9, 2017), <https://www.guttmacher.org/gpr/2017/03/why-protecting-medicaid-means-protecting-sexual-and-reproductive-health>.

112. *Id.*

113. Sonfield, *supra* note 111.

114. Julia Paradise & Rachel Garfield, *What Is Medicaid’s Impact on Access to Care, Health Outcomes, and Quality of Care? Setting the Record Straight on the Evidence*, KAISER FAM. FOUND. (Aug. 2, 2013), <https://www.kff.org/medicaid/issue-brief/what-is-medicaids-impact-on-access-to-care-health-outcomes-and-quality-of-care-setting-the-record-straight-on-the-evidence/>.

115. *Medicaid Expansion Impacts on Insurance Coverage and Access to Care*, OFFICE OF THE ASSISTANT SEC’Y FOR PLANNING AND EVALUATION: DEP’T OF HEALTH AND HUMAN SERV. (Jan. 18, 2017), <https://aspe.hhs.gov/pdf-report/medicaid-expansion-impacts-insurance-coverage-and-access-care>.

116. Larisa Antonisse et al., *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review*, KAISER FAM. FOUND. (Sept. 25, 2017), <https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-september-2017/>.

117. *Id.*

118. *Id.*

119. *Id.*

Texas should expand Medicaid coverage under the ACA and, aspirationally, increase family planning budgets to compensate for aggressive cuts. These actions would help ameliorate ongoing potential constitutional violations regarding how care is provisioned and to whom. Increasing access to Medicaid will significantly help lower-income Texans who currently do not have access to pregnancy-related medical care because they cannot qualify under the wholly state-owned programs. Texas's commitment to opting out of the ACA's Medicaid expansion is compounded by the State Legislature's repeated cuts to family planning programs, specifically those involving Planned Parenthood affiliates. For example, the Legislature's special session in late 2017 produced additional restrictive women's health laws, and all three measures passed.¹²⁰ Moreover, Texas alone accounts for a quarter of adults in the coverage gap nationally, with 684,000 adults stuck without an affordable healthcare option.¹²¹

A. Overview of Medicaid

By way of background, Medicaid is a health insurance program for low-income families, the elderly, and people with disabilities.¹²² Medicaid is the nation's largest insurer, covering more than seventy million Americans (approximately one in five), and providing critical financing for hospitals and health centers.¹²³ Medicaid is structured as a federal-state partnership and though participation is optional, all fifty states participate.¹²⁴ This means states are subject to federal standards but design and administer their own Medicaid programs.¹²⁵ States may also apply for waivers from federal

120. Most controversial was an abortion coverage ban that requires women to buy supplemental insurance that would only cover abortion under a rape exception. Critics called this "rape insurance," where women would be required to anticipate needing an abortion via rape, but after intense debate the bill passed both houses in the legislature and Governor Abbott signed it in August 2017. See Gaby Galvin, *New Texas Law Bans Health Insurers from Covering Abortion in General Plans*, U.S. NEWS (Aug. 15, 2017), <https://www.usnews.com/news/national-news/articles/2017-08-15/texas-gov-greg-abbott-signs-abortion-coverage-ban-into-law>. Interestingly, another measure that passed was the requirement that doctors and facilities report more information about women who have abortions, including birth year, race, marital status, and the date of her last menstrual cycle—and fine those that do not comply. Curiously, the Texas government requires additional sensitive and confidential patient information to be released—only regarding women who have abortions—yet is uncomfortable releasing *any* information regarding maternal mortality.

121. *Id.*

122. *Medicaid Pocket Primer*, KAISER FAM. FOUND. (June 9, 2017), <https://www.kff.org/medicaid/fact-sheet/medicaid-pocket-primer/>.

123. *Id.*

124. *Id.*

125. *Medicaid Pocket Primer*, KAISER FAM. FOUND. (June 9, 2017), <https://www.kff.org/medicaid/fact-sheet/medicaid-pocket-primer/>.

participation to experiment with programs that promote the objectives of the Medicaid program.¹²⁶ These are called section 1115 demonstration waivers and, through them, the U.S. Secretary of Health and Human Services has the authority to allow states the flexibility to improve their programs with state-specific policy approaches that may deviate from federal standards.¹²⁷ For example, waivers are common when states face specific or unique public health emergencies, such as the opioid crisis.

The Centers for Medicare and Medicaid Services (“CMS”) is the federal agency within the Department of Health and Human Services (“HHS”) responsible for Medicaid.¹²⁸ Seema Verma was sworn in as the Administrator in March of 2017.¹²⁹ In her first joint action with Secretary Price, CMS sent a letter to state governors affirming the federal government’s partnership with states to improve the integrity and effectiveness of the Medicaid program.¹³⁰ Specifically, the letter mentions how the “[r]igid and outdated implementation and interpretation of federal rules . . . hinder states” and the federal government “has not kept pace.” It further calls the expansion of Medicaid a “clear departure from the core, historical mission of the program.”¹³¹ On June 28, 2017, Texas submitted an updated version of their Texas Healthy Women plan for a section 1115 waiver.¹³² A week later on July 5, 2017, CMS sent the Texas Health and Human Services Commission a letter indicating Texas’ application was submitted pursuant to federal regulations, such as transparency and notice and comment requirements.¹³³ CMS’s approval of Texas’ waiver is pending as of this writing.¹³⁴

B. Relationship with the Affordable Care Act in Constant Flu

In 2010, President Barack Obama signed the ACA into law. The law’s health insurance marketplaces have made sexual and reproductive health

126. *About 1115 Demonstrations*, MEDICAID.GOV, <https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html>.

127. *Id.*

128. Press Release, Dep’t of Health and Hum. Serv., Secretary Price and CMS Administrator Verma Take First Joint Action: Affirm Partnership of HHS, CMS, and States to Improve Medicaid Program (Mar. 14, 2017), <https://www.hhs.gov/about/news/2017/03/14/secretary-price-and-cms-administrator-verma-take-first-joint-action.html>.

129. *Id.*

130. *Id.*

131. *Id.*

132. Letter from Greg Abbott, Governor of the State of Texas, to CMS (June 28, 2017).

133. *Id.*

134. *State Waivers List*, MEDICAID.GOV, <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=43174>.

care accessible for millions of Americans by making comprehensive coverage affordable and helping to ensure enrollees have access to nearby providers.¹³⁵ Marketplace plans are required to cover ten essential health benefits, including maternity and newborn care.¹³⁶ As a result, considerably fewer women of reproductive age (15–44) lacked coverage following the first two years of ACA implementation.¹³⁷ This reduction of uninsured women was driven by substantial gains in both Medicaid and private insurance coverage.¹³⁸ By recent counts, Medicaid covers nearly thirteen million women of reproductive age.¹³⁹

Despite being controversial, the U.S. Supreme Court upheld the major provisions of the ACA in 2012.¹⁴⁰ However, the Supreme Court also held that states could opt out of the ACA's Medicaid eligibility expansions.¹⁴¹ Specifically, the ACA allows states to expand Medicaid eligibility to individuals with incomes up to 138% of the federal poverty level.¹⁴² So far, thirty-one states and the District of Columbia have done so.¹⁴³ Before, most low-income adults did not qualify for Medicaid because eligibility was exceedingly limited.¹⁴⁴ Successfully, the expansion has contributed to a decline in the uninsured rate among nonelderly individuals, “falling from 16.6% in 2013 to an historic low of 10% in early 2016.”¹⁴⁵ Further, Medicaid expansion is associated with lower general mortality rates, when compared to non-expansion states.¹⁴⁶

135. Kinsey Hasstedt, *How Dismantling the ACA's Marketplace Coverage Would Impact Sexual and Reproductive Health*, GUTTMACHER INST. (Apr. 6, 2017), <https://www.guttmacher.org/gpr/2017/04/how-dismantling-acas-marketplace-coverage-would-impact-sexual-and-reproductive-health>.

136. Abortion is not one of them. Congress explicitly allowed states to ban abortion coverage in marketplace plans, and twenty-five states have done so. Hasstedt, *supra* note 135. Moreover, for decades, the Hyde Amendment has banned federal dollars covering abortions for Medicaid recipients, except in cases of life endangerment, rape, or incest.

137. Hasstedt, *supra* note 135.

138. *Id.*

139. Sonfield, *supra* note 111.

140. Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519 (2012).

141. *Id.*

142. *Status of State Action on the Medicaid Expansion Decision: State Health Facts*, KAISER FAMILY FOUND., <https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act> (Jan. 16, 2018).

143. *Id.*

144. *Medicaid Pocket Primer*, KAISER FAMILY FOUND., <https://www.kff.org/medicaid/fact-sheet/medicaid-pocket-primer/> (June 9, 2017).

145. *Id.*

146. Benjamin D. Sommers, *State Medicaid Expansions and Mortality, Revisited: A Cost-Benefit Analysis*, 3 AM. J. OF HEALTH ECON. 392–421 (2017).

Since President Trump has taken office, he has sworn to repeal the ACA. While unable to do so outright, the President crafted other policies aimed at turning the law into a defunct program. First, the administration cut cost sharing reduction payments (“CSRs”). This denies reimbursements to health insurers to compensate them for out-of-pocket payments health discounts given to over six million ACA customers.¹⁴⁷ These customers make between \$12,000 and \$29,700 annually, so they pay less for co-payments, coinsurance, and deductibles when they obtain medical services as a result of CSRs.¹⁴⁸ States have already sued over this decision, calling it illegal under the ACA.¹⁴⁹

Cutting these reimbursements will cause premiums to go up.¹⁵⁰ Premiums serve as a barrier to obtaining and maintaining Medicaid coverage among low-income individuals.¹⁵¹ As a result, any money that states save from premiums and cost sharing will be offset by disenrollment, increased use of more expensive services (e.g., emergency room) and other costs, such as resources for the uninsured and administrative expenses.¹⁵² Moreover, cost sharing has negative effects on health outcomes and increases financial burdens for families.¹⁵³

Interestingly, cutting CSRs is having a different effect than some expected—it is “shifting” the population of those covered on the marketplace.¹⁵⁴ Because insurers are still required to cover anyone—regardless of pre-existing conditions—they must therefore shift the cost of new premiums elsewhere. This cost is usually attached to “silver” or middle-of-the-road plans, making healthy people less incentivized to pay more for insurance they likely do not need. Additionally, federal subsidies are continuing under the ACA, so in combination this has the effect of making bronze plans more attractive, as these cheapest plans entitle customers to

147. Dan Magan, *States to Sue to Block Trump Cutoff of Obamacare Money, As Higher-Income Customers Facing Biggest Hit*, CNBC (Oct. 13, 2017), <https://www.cnbc.com/2017/10/13/states-to-sue-to-block-trump-cutoff-of-obamacare-money.html>.

148. *Id.*

149. *Id.*; Press Release, California Attorney General Xavier Becerra, Attorney General Lawsuit Today to Defend Americans’ Health Care Against Trump’s Sabotage (Oct. 13, 2017), <https://oag.ca.gov/news/press-releases/attorney-general-becerra-file-lawsuit-today-defend-americans-health-care-against>.

150. Susan Milligan, *The Zombie Health Care Law*, U.S. NEWS (Jan. 5, 2018), <https://www.usnews.com/news/the-report/articles/2018-01-05/republicans-cant-kill-obamacare>.

151. Antonisse et al., *supra* note 116.

152. *Id.*

153. Deliana Kostova & Jared Fox, *Chronic Health Outcomes and Prescription Drug Copayments in Medicaid*, 55 MEDICAL CARE 520–27 (May 2017).

154. Milligan, *supra* note 150.

qualify for subsidies.¹⁵⁵ Those subsidies are expected to remain the same or increase, despite the increased price in premiums, and could even render bronze plans free.¹⁵⁶ Thus, there is no reason for lower-income, higher-risk Americans not to sign up.¹⁵⁷ Ironically, this environment is creating what the Republicans fear most—a government health care program that is primarily catering to low-income, high-risk individuals.¹⁵⁸

Second, the federal government did not actively promote enrollment in the marketplace. A few points make this intention clear. The government moved the enrollment date up by at least two weeks to December 15, 2017.¹⁵⁹ Previously, enrollment stayed open through the new year, giving people more time to sign up.¹⁶⁰ Additionally, the government cut funding for “navigators” or people who help Americans make sense of the marketplace and what their best options are.¹⁶¹ It even shut down the website for twelve hours on Sundays, a day when many working people would research plans.¹⁶² These combined efforts obfuscated the enrollment process for many Americans, in an attempt to help the law “collapse from non-participation.”¹⁶³

Third, President Trump eliminated the individual mandate, touting it as a repeal of the ACA.¹⁶⁴ Practically, this elimination means that healthier people with less need for insurance are less likely to buy it, increasing premiums for those remaining in the pool.¹⁶⁵ As a result, this move has caused some to characterize the ACA as a “zombie law”¹⁶⁶ or “doomed.”¹⁶⁷ However, the law is still very much “alive,”¹⁶⁸ and some argue that it’s

155. Milligan, *supra* note 150.

156. *Id.*

157. *Id.*; Robert Pear, *Years of Attack Leave Obamacare a More Government-focused Health Law*, N.Y. TIMES (Dec. 26, 2017), <https://www.nytimes.com/2017/12/26/us/politics/republicans-trump-affordable-care-act-obamacare.html>.

158. Pear, *supra* note 157.

159. Matthew Choi, *Open Enrollment for Health Insurance Brings New Challenges in Texas*, TEXAS TRIBUNE (Oct. 31, 2017) <http://www.star-telegram.com/news/state/texas/article182000316.html>.

160. *Id.*

161. Milligan, *supra* note 150.

162. *Id.*

163. *Id.*

164. *Id.*

165. Pear, *supra* note 158.

166. Milligan, *supra* note 150.

167. Pat Garofalo, *Obamacare Is Alive*, U.S. NEWS (Dec. 27, 2017), <https://www.usnews.com/opinion/thomas-jefferson-street/articles/2017-12-27/obamacare-survived-2017-despite-donald-trump>.

168. *Id.*

stronger than ever.¹⁶⁹ Enrollment remained relatively steady at nine million people for 2018.¹⁷⁰ Moreover, a study showed that 60% of the increase in coverage the ACA achieved by 2016 was due to Medicaid expansion.¹⁷¹ Further, researchers did not find that the mandate, on its own, was responsible for driving enrollment.¹⁷² These findings suggest that the elimination of the mandate may not be as consequential as feared. Fundamental components of the law—the expansion of Medicaid, subsidies, and regulations that prevent insurers from excluding those with pre-existing conditions—remain intact.¹⁷³ As the private market and premiums fluctuate, the public-end (Medicaid and subsidies) “soldiers on,” making “government-run health care look competent and preferable.”¹⁷⁴

Additionally, the Trump Administration has remained committed to expand religious freedom and employer rights, specifically with regard to denying women coverage for a range of services, ranging from contraception to abortion.¹⁷⁵ In October 2017, the administration issued “sweeping guidance” on religious freedom, and promised that it would not allow “people of faith to be targeted, bullied or silenced anymore.”¹⁷⁶ The HHS issued two rules rolling back a federal requirement that an employer must include birth control coverage in their plans, offering an exemption on the basis of “sincerely held religious beliefs or moral convictions.”¹⁷⁷ States have also sued over this decision, arguing that the government is barred from respecting an establishment of religion under the First Amendment.¹⁷⁸ In January of 2018, following up on the promise to protect “religious freedom,” the HHS announced a new “Conscience and Religious Freedom Division” in the Office of Civil Rights.¹⁷⁹ These recent decisions implicate women’s

169. Molly Frean et al., *Disentangling the ACA’s Coverage Effects—Lessons for Policymakers*, 375 NEW ENG. J. MED. 1605, 1605–1608 (Oct. 27, 2016).

170. Milligan, *supra* note 150.

171. Molly Frean et al., *Premium Subsidies, the Mandate, and Medicaid Expansion: Coverage Effects of the Affordable Care Act*, NAT’L BUREAU OF ECON. RESEARCH (Apr. 2016), <http://www.nber.org/papers/w22213>.

172. *Id.*

173. Garofalo, *supra* note 167.

174. *Id.*

175. Robert Pear et al., *Trump Administration Rolls Back Birth Control Mandate*, N.Y. TIMES (Oct. 6, 2017), <https://www.nytimes.com/2017/10/06/us/politics/trump-contraception-birth-control.html>.

176. *Id.*

177. Pear et al., *supra* note 175.

178. *Id.*

179. Press Release, Dep’t of Health & Human Servs., HHS Announces New Conscience and Religious Freedom Division (Jan. 18, 2018), <https://www.hhs.gov/about/news/2018/01/18/hhs-ocr-announces-new-conscience-and-religious-freedom-division.html>.

health and family planning, as they indicate the current Administration's moral posturing.

C. Texas and Medicaid

Texas has the largest number of uninsured people in the country, at approximately five million (roughly one in five Texans).¹⁸⁰ Yet, the state has opted out and refuses to implement the ACA's Medicaid eligibility extension to more low-income adults and health insurance exchanges.¹⁸¹ This effectively means that uninsured Texans are left without an option for affordable health insurance. Indigent Texans' cannot afford their medical bills, pay for necessary prescription drugs, or obtain regular care for chronic conditions.¹⁸²

Texas made the decision to cut off federal funding and provide a wholly state-owned alternative. Overall these cuts have totaled \$73 billion.¹⁸³ In 2011, Texas began directing state-operated programs to exclude Planned Parenthood affiliates from its fee-for-service family planning program.¹⁸⁴ The targeting of Planned Parenthood is based on the argument that any dollar spent on the organization's services helps underwrite an abortion—directly or indirectly. However, the organization's latest report shows only three percent of all health services are for abortions.¹⁸⁵ This had the effect of denying family planning clinics funding, even if they didn't provide abortion.

One such example is the Medicaid waiver program, which received ninety percent of its funding from the federal government.¹⁸⁶ During the Obama Administration, CMS informed Texas that their waiver would not be renewed because these new exclusions violated federal law.¹⁸⁷ Instead of

180. Benjamin D. Sommers, *Medicaid Expansion in Texas: What's at Stake?*, COMMONWEALTH FUND (Apr. 7, 2016), <http://www.commonwealthfund.org/publications/issue-briefs/2016/apr/medicaid-expansion-texas>.

181. *Id.*

182. *Id.*

183. Analisa Packham, *Family Planning Funding Cuts and Teen Childbearing*, 55 J. OF HEALTH ECON. 168 (Aug. 2017).

184. Stevenson et al., *supra* note 5.

185. Marissa Evans, *Texas Wants to Renew Federal Women's Health Funding It Lost Over Planned Parenthood*, TEXAS TRIBUNE (May 16, 2017), <https://www.texastribune.org/2017/05/16/womens-health-programs-saw-sharp-decline-clients/>.

186. Usha Ranji et al., *Financing Family Planning Services for Low-income Women: The Role of Public Programs*, KAISER FAMILY FOUND. (May 11, 2017), <https://www.kff.org/womens-health-policy/issue-brief/financing-family-planning-services-for-low-income-women-the-role-of-public-programs/>.

187. *Id.*

complying, once the funding for these programs expired, Texas replaced the federally funded option with a wholly state-funded one—Healthy Texas Women (originally “Texas Women’s Health Program.”)¹⁸⁸ This new program excluded clinics affiliated with an abortion provider, effective January 1, 2013.¹⁸⁹ Texas’s refusal to accept the terms upon which they are eligible to receive federal funding created a Hobson’s choice for each Texan—they had no federal option and were forced to use the state-owned option, which is far narrower and covers less people. Under this program, and a “patchwork” of others, Healthy Texas Women served just half of the women previously covered.¹⁹⁰

Now that President Barack Obama has left office, Republicans in Texas re-applied for CMS funding in 2017.¹⁹¹ Texas’s section 1115 waiver is pending, and Governor Abbott recently sent a request for President Trump to approve it.¹⁹² That plan, Healthy Texas Women, includes a complete exclusion of Planned Parenthood from its plan.¹⁹³ Under current federal law, however, Medicaid patients are allowed to choose between “any willing provider.”¹⁹⁴ Essentially, if the federal government grants the waiver, they will have sanctioned state action that violates federal law. This particular political backdrop leaves Texans in an even worse position, where the Trump administration has paved the way for states to assert more control over the provision of government related services.

In addition to exclusion from fee-for-service programs, also in 2011, Texas cut family planning grants by 66%.¹⁹⁵ This included a redistribution effort aimed at turning all remaining grant funding away from dedicated family planning providers, such as Planned Parenthood. The reduction in funding was followed by the closure of eight-two family-planning clinics,

188. Ranji et al., *supra* note 186.

189. *Id.*

190. Evans, *supra* note 185.

191. *Id.*

192. Letter from Greg Abbott, Governor of Texas, to Donald Trump, President of the United States (Jan. 23, 2018).

193. See *Draft: Healthy Texas Women: Section 1115 Demonstration Waiver Application*, TEXAS HEALTH AND HUMAN SERVS. COMM’N (June 30, 2017), <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/1115-waiver/HTW/htw-1115-waiver-application-draft.pdf>. For example, Texas Human Resources Code §32.024(c-1) directs HHSC to ensure no money spent for the purpose of HTW is used to perform or promote elective abortions or to contract with entities that perform or promote elective abortions or affiliate with entities that perform or promote elective abortions.

194. Evans, *supra* note 185.

195. As the Stevenson study points out, this is a separate funding stream.

about a third of which were affiliated with Planned Parenthood.¹⁹⁶ Additionally in 2013, the Texas Legislature passed the infamous House Bill No. 2, which implemented various restrictions on abortion providers.¹⁹⁷ This law had immediate effects, leading to the closure of many additional clinics that once provided abortion related services.¹⁹⁸ Although this law was successfully challenged in the U.S. Supreme Court—where it was held unconstitutional—the restrictions had been in effect for a number of years and clinics remain closed.¹⁹⁹

In the non-expansion states, 2.6 million adults with incomes above the Medicaid eligibility limit, but below poverty, fall into a coverage gap; they are ineligible for Medicaid and do not qualify for the federal poverty line (“FPL”). In Texas, parents are covered up to 18% FPL.²⁰⁰ This is among the most restrictive eligibility policies in the country. By contrast, in states that have opted in, any citizen or qualifying legal immigrant with an income under 138% of poverty (about \$33,500 for a family of four) is eligible for Medicaid coverage.²⁰¹ Pregnant women are covered through a patchwork of programs, including Medicaid for Pregnant Women, the Children’s Health Insurance Program (“CHIP”), and Healthy Texas Women.²⁰² These programs cover Texas women based on family size.²⁰³ Overall, eligibility continues to vary significantly by group, with coverage available to children and pregnant women at higher levels relative to parents and other adults.

One study compared the effects of Texas’s highly restrictive eligibility policy to two other southern states that expanded Medicaid coverage—

196. Stevenson, *supra* note 5.

197. The ambulatory center restriction required abortion providers to meet hospital-like standards—such as minimum sizes for rooms and doorways, and pipelines for anesthesia. Further, the admitting privileges restriction required doctors to have admitting privileges at hospital within thirty miles of an abortion clinic.

198. During the time period in which House Bill No. 2’s restrictions were in effect, more than half of Texas’s abortion providers have had to close their doors. See Alexa Ura, *U.S. Supreme Court Overturns Abortion Restrictions*, TEXAS TRIBUNE (June 27, 2016), <https://www.texas-tribune.org/2016/06/27/us-supreme-court-rules-texas-abortion-case/>.

199. *Whole Women’s Health v. Hellerstedt*, 136 S. Ct. 2292 (2016).

200. M.Z. Gunja et al., *Insurance Coverage, Access to Care, and Medical Debt Since the ACA: A Look at California, Florida, New York and Texas*, COMMONWEALTH FUND (Mar. 22, 2017), <http://www.commonwealthfund.org/publications/issue-briefs/2017/mar/coverage-access-medical-debt-aca-california-florida-new-york-texas>.

201. *Id.*

202. *Medicaid for Low-income Pregnant Women*, TEXAS HEALTH AND HUMAN SERV. (2018), <https://yourtexasbenefits.hhsc.texas.gov/programs/health/women/pregnant>.

203. *Healthy Texas Women*, TEXAS HEALTH AND HUMAN SERV. (2018), <https://yourtexasbenefits.hhsc.texas.gov/programs/health/women/healthy-texas-women>.

Arkansas and Kentucky.²⁰⁴ The results were conclusive: “within 12 months, the uninsured rate among low-income adults in the two expansion states had dropped by more than half—from 41 percent to 16 percent.” In comparison, Texas’s uninsured rate only dropped from 39 percent to 27 percent.”²⁰⁵ Thus, Texas’s uninsured rate among low-income adults remains significantly higher.²⁰⁶ Ultimately, Texas’s decision not to expand has left millions of poor Texans “worse off than in comparison states in terms of coverage, household finances, and ability to obtain necessary medical care.”²⁰⁷ More modest gains in coverage and access to care among low-income people were found across Republican states that refused to expand Medicaid.²⁰⁸

D. The Stevenson Study: Effect of Excluding Planned Parenthood from the Texas Women’s Health Program

With an unnecessarily high rate of uninsured citizens, Texas leaves pregnant women (especially poor pregnant women) with particularly few adequate healthcare options by also failing to fund Planned Parenthood. Amanda J. Stevenson conducted a study published in the *New England Journal of Medicine* that considered the effect of the removal of Planned Parenthood (and its affiliates) from Texas’s fee-for-service family planning program, the Texas Women’s Health Program.²⁰⁹ Although this study does not specifically analyze how these cuts likely contributed to the spike in maternal mortality, it does provide insight into the consequences of cutting funds for family planning. Further, Stevenson establishes a connection between Texas’s exclusion of Planned Parenthood and the resulting disparate effects on women throughout Texas.

Specifically, the Stevenson study concludes that this targeted exclusion was associated with adverse changes in the rates of provision and

204. Sommers, *supra* note 180. Of note, Kentucky and Arkansas expanded differently, and this has resulted in disparate results in the long term. Kentucky followed a more traditional expansion, whereas Arkansas chose to buy private coverage for poor people through the new federal insurance marketplace using federal Medicaid funds. This option enticed Republicans who opposed expanding a federal entitlement program. However, this “private option” has resulted in higher medical costs for its citizens. Compared to Kentucky’s 14.3% drop, the number of people who had trouble paying medical bills only dropped 7.6% in Arkansas. Benjamin Sommers posits the difference comes down to co-payments—in 2014, they were negligible in Kentucky but could total up to 5% of an Arkansas citizen’s income. See also Abby Goodnough, *Better Health Care Access in Kentucky and Arkansas, Study Says*, N.Y. TIMES (Jan. 5, 2016), <https://www.nytimes.com/2016/01/06/us/in-kentucky-and-arkansas-access-to-health-care-improves-study-says.html>.

205. Sommers, *supra* note 180.

206. *Id.*

207. *Id.*

208. Goodnough, *supra* note 204.

209. Stevenson, *supra* note 5.

continuation of contraception and with increases in the rate of childbirth covered by Medicaid.²¹⁰ First, the number of claims for long-acting reversible contraceptive (“LARC”) methods, such as contraceptive implants and intrauterine devices, declined.²¹¹ This finding is troublesome because it represents a deviation from the national trend toward an increased number of claims for LARC methods in counties with Planned Parenthood affiliates preceding the exclusion.²¹² It is also alarming because increased access to LARC methods is a priority of the American College of Obstetricians and Gynecologists (“ACOG”). This helps reduce unintended pregnancy and any associated health outcomes.²¹³ Additionally, a recent study identified a substantial unmet demand for LARC methods in Texas specifically.²¹⁴ This means access to reliable, long-term contraception is increasingly unobtainable for many women in Texas.

Next, the study found the number of claims for contraceptive injections also declined. Furthermore, among women using injections, fewer continued to receive them.²¹⁵ These findings do not establish causality, but they reasonably suggest diminished access to contraception leads to an increase in unintended pregnancies. While the study did not measure the rate of intended-versus-unintended pregnancy, Stevenson points out, “[i]t is likely that many of these pregnancies were unintended, since the rates of childbirth among these women increased in the counties that were affected by the exclusion and decreased in the rest of the state.”²¹⁶ Other research shows up to half of all pregnancies in America are unintended.²¹⁷ In short, restricted access to LARC methods led to a shift toward methods that have lower rates of efficacy and continuation.²¹⁸

An additional factor to consider with shorter-acting contraceptives is that they are more subject to human error.²¹⁹ For example, neglecting to take

210. Stevenson, *supra* note 5.

211. The study split contraceptives up into three groups: (1) long-acting reversible contraceptives (“LARC”), which include contraceptive implants and intrauterine devices; (2) injectable contraceptives (depot medroxyprogesterone acetate); and (3) short-acting hormonal methods, such as oral contraceptive pills, transdermal contraceptive patches, and contraceptive rings. Stevenson, *supra* note 5.

212. *Id.*

213. *Id.*

214. Joseph E. Potter et al., *Unmet Demand for Highly Effective Postpartum Contraception in Texas*, 90 *CONTRACEPTION* 488–495. (Nov. 2014).

215. Stevenson, *supra* note 5.

216. *Id.*

217. Kristof, *supra* note 37.

218. Stevenson, *supra* note 5.

219. *Id.*

oral contraceptives or incorrect administration are not issues with LARC methods because medical professionals implant these devices.²²⁰ This cyclically affects more low-income women, as they are less able to pay for pregnancy related services, let alone an unexpected pregnancy or one with complications. As Dr. Lisa Hollier, president of ACOG and leader of the task force, put it frankly, “[y]ou can’t die from a pregnancy when you’re not pregnant.”²²¹

This vicious cycle directly relates to Stevenson’s third and final finding: There was a disproportionate increase in the rate of childbirth covered by Medicaid, especially in the case of women who used injectable contraceptives.²²² This means that greater lower-income women—those covered by Medicaid—are giving birth. Overall, the conclusion was clear: The exclusion of Planned Parenthood affiliates has restricted access to highly effective methods of contraception, including both LARC and injectable methods. Additional data is required to identify all factors involved in diminished access to contraceptives, but preliminary inquiries have uncovered new obstacles that women returning to clinics post-exclusion are facing. For example, returning clients were required to pay \$60 or more for a contraceptive injection, and new clients were required to undergo additional examinations, office visits, or were charged a copayment before receiving the injection.²²³ These additional barriers constitute the dividing line between affordable and unaffordable health care for many low-income Texans, leaving them without care.²²⁴

To understand the lasting impact targeted laws such as these have, consider that more than one-third of Texas women do not have a single prenatal visit in their first trimester.²²⁵ Studies have repeatedly shown a connection between late or little to no prenatal care, and maternal mortality or neonatal death.²²⁶ And despite the wishes of antiabortion advocates,

220. Stevenson, *supra* note 5.

221. Kristof, *supra* note 37.

222. Stevenson, *supra* note 5.

223. *Id.*

224. Stevenson acknowledges that a limitation of her study is that it did not include contraceptive services that women paid for out of pocket or received through other subsidized programs. However, “since the fee-for-service family-planning program was the payer of first resort and since funding for subsidized family planning was severely limited in Texas during the study period, it is unlikely that women were pulled away from the Texas Women’s Health Program to be served through other programs. *See id.*”

225. Kristof, *supra* note 37.

226. Kyla Nguyen, *A Health Care Bill That’s Bad for Moms and Babies*, N.Y. TIMES (May 9, 2017), <https://www.nytimes.com/2017/05/09/opinion/a-health-care-bill-thats-bad-for-moms-and-babies.html>; Christian Meghea et al., *Statewide Medicaid Enhanced Prenatal Care Programs and*

abortions have increased in recent years. New research shows the loss of access to clinics and family planning services has led to increased unintended pregnancies and teenage abortions.²²⁷

Despite actually increasing abortion, social conservatives continue to advocate the exclusion of Planned Parenthood health centers from receiving any type of public funding—whether in the form of grants under Title X or in the form of reimbursements under Medicaid.²²⁸ The Guttmacher Institute's analysis shows that safety-net family planning centers will not be able to fill in these massive gaps (they would have to increase their caseloads by 47% on average to accommodate these exclusions).²²⁹ Federally Qualified Health Centers ("FQHCs") also could not serve all the women who rely on Planned Parenthood.²³⁰ The Obama Administration issued regulations that clarified states may not exclude otherwise qualified abortion providers from Title X, but President Donald Trump has since overturned them.²³¹

Given this context and the study's findings, it is in Texas' best interest to expand Medicaid coverage to more low-income Texan adults. Not only will additional coverage potentially save lives, but also the burden that taxpayers bear in light of this refusal is greater than the benefits of non-expansion. Economists agree. Expanding Medicaid coverage saves states money, as they will start to receive federal funding and reimbursements.²³² Specifically, Texas could receive up to \$100 billion dollars. This amount of

Infant Mortality, 136 PEDIATRICS 2 (Aug. 2015), <http://pediatrics.aappublications.org/content/pediatrics/136/2/334.full.pdf>.

227. Ally Baird, *Texas Slashed Funding for Planned Parenthood and Ended up With More Teen Abortions*, THINKPROGRESS (July 17, 2017), <https://thinkprogress.org/texas-family-plannin-g-cuts-3ed9f259c98e/>; Packham, *supra* note 182.

228. Title X is the backbone of the nation's publicly funded family planning effort. Through the Hyde Amendment, Title X funds cannot be used to fund abortion services. But antiabortion policymakers continue to target the program as indirectly supporting abortion.

229. Kinsey Hasstedt, *Beyond the Rhetoric: The Real-World Impact of Attacks on Planned Parenthood and Title X*, GUTTMACHER INST. (Aug. 3, 2017), <https://www.guttmacher.org/gpr/2017/08/beyond-rhetoric-real-world-impact-attacks-planned-parenthood-and-title-x>.

230. *Id.*

231. *Id.*; see also Kinsey Hasstedt, *Understanding Planned Parenthood's Critical Role in the Nation's Family Planning Safety Net*, GUTTMACHER INST. (Jan. 12, 2017), <https://www.guttmacher.org/gpr/2017/01/understanding-planned-parenthoods-critical-role-nations-family-plan-ning-safety-net>.

232. *See Only One Rational Choice: Texas Should Participate in Medicaid Expansion Under the Affordable Care Act*, PERRYMAN GRP. STUDY, https://www.perrymangroup.com/wp-content/uploads/Medicaid_Expansion.pdf (Mar. 1, 2018).

money could insure more than one million working poor.²³³ However, any provision in the ACA is controversial in Texas,²³⁴ and the leadership remains committed to rejecting it for the time being. As the study cautions, these findings have even larger implications regarding the likely consequences of proposals to exclude Planned Parenthood affiliates from public funding in other states or at the national level.²³⁵

IV. Medicaid Policy Arguments

Some have argued that immigration has put a strain on the health care system in Texas, but research found no such connection.²³⁶ In fact, the maternal mortality rate is lower for Hispanic women who compose the majority of recent immigrants.²³⁷ The population that consistently correlates with higher maternal mortality rates is black women, who are most acutely impacted by structural barriers to access.²³⁸ Additionally, other social factors such as unintended pregnancy and being unmarried contribute more to maternal mortality than geographic or medical factors.²³⁹ These social factors provide evidence for a “strong contribution of racial disparity to maternal mortality ratio in the United States.”²⁴⁰

A. Issues of Race, Class, Mental Health, Substance Use, and Geography Permeate Maternal Mortality

State decisions not to expand their Medicaid programs disproportionately affect poor women and women of color.²⁴¹ Black women

233. Wade Goodwyn, *Texas Politicians and Businesses Feud Over Medicaid Expansions*, NPR (May 29, 2015), <https://www.npr.org/sections/health-shots/2015/05/29/410520561/texas-politicians-and-businesses-feud-over-medicaid-expansion>.

234. In 2013, for example, Rick Perry spoke to the Texas Legislature and clarified Texas’s opinion on complying with the ACA. He began, “Thank you all for being here. The first day of April. Seems to me an appropriate April Fool’s Day—makes it perfect to discuss something as foolish as Medicaid expansion and to remind everyone that Texas will not be held hostage by the Obama administration’s attempt to force us into this fool’s errand of adding more than a million Texans to a broken system.” *See id.*

235. Stevenson, *supra* note 5.

236. *See* Moaddab et al., *Trends in Maternal Mortality: 2005 to 2014*, 128 *OBSTETRICS & GYNECOLOGISTS*. 869–875 (Nov. 2016).

237. *Id.*

238. *Id.*

239. *Id.*

240. *Id.*

241. Thus, state decisions about whether to expand Medicaid have implications for efforts to address disparities in health coverage, access, and outcomes among people of color. Rachel Garfield & Anthony Damico, *The Coverage Gap: Uninsured Poor Adults in States That Do Not*

and Latina women are more likely to be insured by Medicaid than white women.²⁴² When states do not expand, many adults fall into coverage gaps where they have incomes above Medicaid eligibility limits but below the lower limit for marketplace premium tax credits under the ACA.²⁴³ These same adults would have been eligible for Medicaid had their state expanded coverage.²⁴⁴ Thus, state action regarding Medicaid implicates how each state will be able to address disparities in health coverage, access, and outcomes among people of color.²⁴⁵

Another of the task force's findings focuses on women suffering from mental illness and demonstrates that the combination of poor resources and access to medical care make certain communities of women in Texas particularly vulnerable. Spikes in Texas's mortality and morbidity suggest that these conditions are contributing to mental health outcomes. Despite this, at the federal level, the CDC does not currently include psychosocial factors such as mental illness and substance use in its measure of severe maternal morbidity. Since the available maternal mortality data is largely based on the CDC's vitality statistics, this exclusion has an impact on how widespread the public, including the Texas government, understands the problem to be.

Race, class, geography, substance use, and mental health are social determinants of health.²⁴⁶ Understanding these underlying structural issues—and their cumulative effects—is important to solving the current maternal health crisis in Texas, as it is clear these issues permeate the findings of the task force, and maternal mortality in general across America.²⁴⁷ Thus, a future study will need to examine additional Texas data for race-ethnicity correlations and detailed causes of deaths to better capture the dynamics at play.

1. Intersection with Race and Class

From the research available, it is clear that low-income women, particularly those of color, are disproportionately impacted by certain causes

Expand Medicaid, KAISER FAMILY FOUND. (Nov. 1, 2017), <http://kff.org/uninsured/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/>.

242. Sonfield, *supra* note 111.

243. Garfield & Damico, *supra* note 241.

244. *Id.*

245. *Id.*

246. CDC FOUND., REPORT FROM MATERNAL MORTALITY REVIEW COMMITTEES: A VIEW INTO THEIR CRITICAL ROLE 36–37 (2017).

247. TASK FORCE REPORT, *supra* note 12, at 20.

of maternal mortality, such as hemorrhage and blood transfusion.²⁴⁸ There are large disparities between countries, but also within countries, and between women with high and low income.²⁴⁹ Generally, maternal mortality is higher in women living in rural areas and among poorer communities.²⁵⁰ As the Stevenson study emphasized, there is an adverse effect on low-income women because of the reduction of the provision of highly effective methods of contraception, interruption contraceptive continuation, and increasing the rate of childbirth covered by Medicaid.²⁵¹

Additionally, as the task force report found, black women bear the greatest risk for maternal death.²⁵² Tragically, though only 11.4% of Texas births were to black women, they accounted for 28.8% of all maternal deaths.²⁵³ The report also found that black women were more likely to experience severe maternal morbidity during a pregnancy-related hospitalization as compared to women of other races.²⁵⁴ Further, the risk of mortality at discharge from a pregnancy-related hospital stay was almost twice as high for black women as it was for women of all other races.²⁵⁵ There were also geographic and racial/ethnic disparities regarding occurrences of hemorrhage and blood transfusions; in 2012, black women had the highest rate of being hospitalized for hemorrhage and blood transfusion.²⁵⁶ Recognizing this disparate impact, and the real toll it is taking on individual lives, is critical to creating sustainable solutions to the increasing frequency of maternal mortality in Texas.²⁵⁷

Texas Representative and attorney Shawn Thierry almost became one of the 189 Texas women who died from pregnancy-related causes in 2012 after

248. TASK FORCE REPORT, *supra* note 12, at 12.

249. *Maternal Mortality Fact Sheet*, WORLD HEALTH ORG. (Nov. 2016), <http://www.who.int/mediacentre/factsheets/fs348/en/>.

250. *Id.*

251. Stevenson, *supra* note 5.

252. TASK FORCE REPORT, *supra* note 12, at 4; *see also Why Are So Many Women Dying From Pregnancy in D.C.?*, THE ATLANTIC (Mar. 26, 2018), <https://www.theatlantic.com/video/index/556499/maternity-desert-dc/>.

253. *Id.* at 5.

254. *Id.* at 10. Severe maternal morbidity (“SMM”) includes unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman’s health. SMM affected at least 50,000 women in 2014, and rates are increasing. *See also Severe Maternal Morbidity in the United States*, CTR. FOR DISEASE CONTROL AND PREVENTION (Nov. 27, 2017), <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html>.

255. TASK FORCE REPORT, *supra* note 12, at 10.

256. *Id.* at 12.

257. Leah Samuel, *After Her Own Complicated Delivery, Lawmaker Aims to Address Texas’s Alarming Maternal Death Rate*, STAT NEWS (Aug. 9, 2017), <https://www.statnews.com/2017/08/09/texas-maternal-death-shawn-thierry/>.

suffering complications from an epidural.²⁵⁸ After becoming a state legislator, Thierry sponsored House Bill 11, the Texas Moms Matter Act, which called for special research into why black women are uniquely vulnerable to maternal mortality.²⁵⁹ After passing the House, the bill died in chamber after “tea-party backed lawmakers used a House procedural maneuver to kill every bill on the legislative calendar that was not supposed to generate debate.”²⁶⁰ However, she has continued to shine the light on maternal mortality; before the legislature’s special session, Thierry helped to convince Governor Abbott to add maternal mortality to the agenda.²⁶¹

A new report from the Center for American Progress analyzed multiple studies to better understand why black women are at “the forefront of America’s maternal mortality crisis.”²⁶² Controlling for poverty, mental and physical health, and prenatal care did not entirely explain why black women die at such higher rates.²⁶³ One study found that even when controlling for income, maternal age, and health status, black women are three times as likely to face pregnancy-related complications than white women.²⁶⁴ This comports with two UCLA doctors’—Dr. Michael Lu and Dr. Neal Halfon— theory that “the social and economic forces of institutional racism set African American and non-Hispanic white women on distinct life tracks, with long-term consequences for their health and the health of their future children.”²⁶⁵ Specifically, systemic and institutional gender and racial bias increases stress and leads to inadequate access to healthcare or disparities in housing, environment, education, and more. Inadequate access to healthcare, including reproductive services, contributes to “racial disparities in pregnancy-related

258. Elizabeth Chuck, *Texas Has the Highest Maternal Mortality Rate in the Developed World. Why?* NBC NEWS (Aug. 12, 2017), <https://www.nbcnews.com/news/us-news/texas-has-highest-maternal-mortality-rate-developed-world-why-n791671>.

259. Samuel, *supra* note 257.

260. H.B. 11, 85th Legislature, Reg. Sess. (Tx 2017); *see also* Meredith Hoffman, *Texas Lawmakers Make Few Moves to Address Pregnancy Related Deaths*, MY STATESMEN (June 4, 2017), <http://www.mystatesman.com/news/state—regional-govt—politics/texas-lawmakers-make-few-moves-address-pregnancy-deaths/P6psVBzaSa0mmnPbqTyfUK/>.

261. W. Gardner Selby, *Shawn Thierry Says Texas Leads Nation in Rate of Mothers Dying in Childbirth*, POLITIFACT (June 29, 2017), <http://www.politifact.com/texas/statements/2017/jun/29/shawn-thierry/shawn-thierry-says-texas-leads-nation-mothers-dyin/>; *see also* Letter to Greg Abbott, Governor of Texas, from Shawn Thierry Texas State Representative (June 5, 2017).

262. Prachi Gupta, *Systemic Racism Might Help Explain Why Black Women Are More Likely to Die from Pregnancy Than White Women*, JEZEBEL (Feb. 1, 2018), <https://jezebel.com/systemic-racism-might-help-explain-why-black-women-are-1822642557>.

263. *Id.*

264. *Id.*

265. M.C. Lu & N. Halfon, *Racial and Ethnic Disparities in Birth Outcomes*, 7 MATERN. CHILD HEALTH J. 1, 23–30 (Mar. 2003).

risk factors” like “hypertension, anemia, gestational diabetes, and obesity—and other conditions such as heart disease, HIV, AIDS, and cancer.”²⁶⁶ Additional research confirms there is something unique about the U.S.—black immigrant women from African and Caribbean countries who did not grow up in America experience lower mortality rates than African-American women.²⁶⁷

Moreover, black women are taken less seriously than white women when they are receiving medical attention.²⁶⁸ One analysis shows that women who deliver at hospitals that disproportionately serve black mothers are at a higher risk of harm.²⁶⁹ These so-called “black-serving” hospitals are more likely to have serious pregnancy-related complications than mothers who deliver at institutions that serve fewer black women.²⁷⁰ Dr. Elizabeth Howell, a professor of obstetrics and gynecology at the Icahn School of Medicine at Mount Sinai Hospital, estimated that the rate of harm for black women would fall by nearly 50% if black women gave birth at the same hospitals as white women.²⁷¹ As the Center for American Progress report emphasized, “[i]t is racism, not race itself, that threatens the lives of African American women.”

2. *Intersection with Mental Health and Substance Use*

The task force report also found that overdose by licit or illicit prescription drugs emerged as a leading cause of maternal death.²⁷² In fact, overdose remains the second largest cause of death among white women, and the third leading cause of death overall.²⁷³ Further, the report observed recurrent missed opportunities to screen for and refer women to treatment for mental health and substance use disorders, which contribute to maternal

266. Gupta, *supra* note 262.

267. Tiffany L. Green, *Black and Immigrant: Exploring the Effects of Ethnicity and Foreign-Born Status on Infant Health*, MIGRATION POL’Y INST. (Sept. 2012), <https://www.migrationpolice.org/research/CBI-infant-health>.

268. Annie Waldman, *How Hospitals Are Failing Black Mothers*, PROPUBLICA (Dec. 27, 2017), <https://www.propublica.org/article/how-hospitals-are-failing-black-mothers>.

269. *Id.*

270. *Id.*

271. E.A. Howard et al., *Site of Delivery Contribution to Black-White Severe Maternal Morbidity Disparity*, 215 AM. J. OBSTET. GYNECOL. 143–52 (Aug. 2016).

272. TASK FORCE REPORT, *supra* note 12, at 5.

273. *Maternal Mortality in Texas: Using Precision Public Health to Improve Maternal Outcomes*, TEXAS DEP’T OF STATE HEALTH SERV. (Nov. 15, 2016), <https://www.dshs.texas.gov/mch/pdf/Maternal-Mortality-in-Texas---Using-Precision-Public-Health-to-Improve-Maternal-Outcomes.pdf>.

morbidity and mortality.²⁷⁴ For example, depression and chronic disease frequently co-occur,²⁷⁵ and whether treated or untreated, mental illness can also contribute to, or be exacerbated by, substance use.²⁷⁶ Unfortunately, the frequency of these chronic conditions is on the rise in Texas.²⁷⁷ Thus, the ability to screen for these conditions can result in healthier, safer care.

Moreover, the available data on psychosocial factors is incomplete. This is largely because the available data considers only diagnosed mental illness *during* pregnancy.²⁷⁸ Thus, the current statistics do not reflect the *actual* prevalence of mental illness.²⁷⁹ To complicate things further, there are many variables at play that determine who is diagnosed with mental illness and how. As the task force explained, “[f]actors effecting likelihood of diagnosis, such as access to care, access to medical home, provider or health care system factors, care seeking behaviors among others contribute to lower prevalence of diagnosis among non-whites.”²⁸⁰

Substance use can be especially difficult to diagnose during delivery.²⁸¹ Typically, women with substance use issues will not be diagnosed unless they have a history of substance use treatment or if they are hospitalized for extreme cases, such as overdose.²⁸² Underdiagnosis of substance use issues also results from the lack of comprehensive care, and the failure to identify environmental factors that are associated with substance use. For example, women with opioid use disorder are frequently raised in family environments

274. TASK FORCE REPORT, *supra* note 12, at 12.

275. According to the National Institute of Mental Health, people with depression have an increased risk of developing many chronic illnesses—including diabetes, cardiovascular disease and stroke. Moreover, perinatal mood and anxiety disorders are frequently underdiagnosed, which leads to missed opportunities for treatment and increased risk of morbidity and mortality. *See, e.g.*, CDC FOUND., REPORT FROM MATERNAL MORTALITY REVIEW COMMITTEES: A VIEW INTO THEIR CRITICAL ROLE 32 (2017) [hereinafter CDC FOUNDATION REPORT].

276. The CDC does not currently include psychological factors such as mental illness or substance use in their measure of severe maternal morbidity. TASK FORCE REPORT, *supra* note 12, at 12. Additional environmental risk factors are chronic stressors, such as racism and poverty, unplanned pregnancy, lack of social support, childcare-associated stress, homelessness, and exposure to violence and trauma. CDC FOUNDATION REPORT, *supra* note 273, at 33. These environmental risk factors are positively associated with maternal mortality, and therefore should be included in the CDC’s national vitality information.

277. Chuck, *supra* note 258.

278. *Id.* at 13.

279. *Id.*

280. *Id.*

281. *Id.*

282. Chuck, *supra* note 258.

complicated by substance use, and often have been victims of physical and sexual violence.²⁸³

In light of recent findings that substance use is now a leading cause of maternal death, the task force recommended an examination of peripheral data to infer rates of drug use. One such way to identify substance use is tracking the prevalence of Neonatal Abstinence Syndrome (“NAS”) in newborns. A limitation of this focus is that NAS is only a result of prenatal opioid use. However, opioids are the most commonly abused substances both in Texas and across the nation, so tracking NAS is a helpful piece to the puzzle.²⁸⁴

The task force found that rates of NAS have steadily increased from 2008 to 2012, which suggests that more pregnant women are using opioids.²⁸⁵ Significantly, most of these NAS cases were found among patients on Medicaid, whereas Medicaid only paid for half of all births in Texas.²⁸⁶ The task force also observed postpartum substance use in several maternal deaths in 2011-2012, the same years in which the mortality rate spiked. Among nineteen women who were covered by Medicaid *at the time of pregnancy*, fourteen died after the sixty-day post-delivery mark, *after* Medicaid coverage typically expires.²⁸⁷

3. Geography

When hospital budgets are constrained, often obstetrical wards are the “first to go.”²⁸⁸ The disappearance of maternal care networks is common across rural America, forcing women to spend hours traveling to the nearest clinic.²⁸⁹ In fact, fewer than half of rural women live within a thirty-minute drive of the nearest hospital offering obstetric services.²⁹⁰ This lack of access reduces prenatal care initiation, which is a critical factor in preventing

283. CDC FOUNDATION REPORT, *supra* note 275, at 35.

284. TASK FORCE REPORT, *supra* note 12, at 13.

285. *Id.* at 14.

286. *Id.* at 14–15.

287. This is after Medicaid coverage typically expires and highlights the need to implement Medicaid coverage expansions so indigent women do not suffer without support.

288. Dina Fine Maron, *Maternal Health Care Is Disappearing in Rural America*, SCIENTIFIC AMERICAN (Feb. 15, 2017), www.scientificamerican.com/article/maternal-health-care-is-disappearing-in-rural-america/.

289. *Id.*

290. Committee Opinion, *Health Disparities in America*, AM. COLL. OF OBSTETRICS & GYNECOLOGISTS (Feb. 2014), <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Health-Disparities-in-Rural-Women>.

maternal death.²⁹¹ Studies have also found higher links between rural communities and rates of unintended pregnancy, as compared to in urban areas.²⁹² Not only is there a shortage of clinics in more rural areas, there also exists a shortage of medical professionals. Only 6% of obstetric gynecologists practice in rural areas, whereas 15% of the population, or forty-five million Americans, live in rural areas.²⁹³

Importantly, rural residents are more likely to be poor, lack private health insurance, or rely substantially on Medicaid or Medicare.²⁹⁴ This makes rural women uniquely vulnerable to the combination of socioeconomic and lack of access problems. Moreover, premiums tend to be higher in rural areas—exacerbating financial barriers to access.²⁹⁵ Despite premiums, multiple recent studies show that Medicaid expansion still has had a disproportionately positive impact in rural health outcomes.²⁹⁶ But like other psychosocial factors, geography cannot alone explain America's maternal mortality problem. Although the United States has a higher rural population than many European nations, such factors are present to an even greater degree in Canada, which is even more rural, yet has a maternal mortality of 10 per 100,000 live births (compared to the U.S. rate of 21–22 per 100,000 live births).²⁹⁷

B. Refusing to Expand Medicaid Is Costing Texas

The problems created by Texas's refusal to expand Medicaid coverage are “compounded by the state's opposition to outreach and enrollment assistance for many Texans who are eligible for coverage under the ACA.”²⁹⁸ This hurts more than just the low-income individuals affected; this also impacts Texas taxpayers and the state as a whole.²⁹⁹ After the ACA passed, federal funding provided to hospitals for uncompensated care was significantly reduced.³⁰⁰ This change primarily affected the non-expansion

291. Committee Opinion, *supra* note 290.

292. *Id.*

293. Maron, *supra* note 288.

294. Committee Opinion, *supra* note 290.

295. Dan Magan, *States to Sue to Block Trump Cutoff of Obamacare Money, As Higher-income Customers Facing Biggest Hit*, CNBC (Oct. 13, 2017), <https://www.cnbc.com/2017/10/13/states-to-sue-to-block-trump-cutoff-of-obamacare-money.html>.

296. Antonisse et al., *supra* note 116.

297. Moaddab et al., *supra* note 236.

298. *Id.*

299. There is also evidence that lack of information about the ACA's coverage options is a particular challenge among Latinos, relative to other racial and ethnic groups. To put this in context, Latinos comprise nearly half of Texas's low-income population. *See id.*

300. Sommers, *supra* note 180.

states, such as Texas. Fewer taxpayer dollars are spent reimbursing hospital emergency rooms in states that have expanded Medicaid.³⁰¹ Studies also show that in expansion states, the influx of newly insured patients has helped hospitals reverse trends such as declining admissions and a rise in uncompensated care.³⁰² For example, one study suggested that Medicaid expansion cut every dollar that a hospital in an expansion state spent on uncompensated care by forty-one cents between 2013 and 2015, corresponding to a reduction in uncompensated care costs across all expansion states of \$6.2 billion.³⁰³ These reimbursements primarily cover treating indigent people with preventable conditions that are managed more cost-effectively through regular access to affordable healthcare.³⁰⁴

Unsurprisingly, hospitals cannot absorb these losses, resulting in shifting costs to insured patients. John Hawkins, a vice president with the Texas Hospital Association, suggests \$1,800 of the family premium each year can be attributed to the cost of the uninsured to the state.³⁰⁵ Significantly, Texas hospitals had to cover at least \$5.5 billion in uncompensated care in 2015.³⁰⁶ To use just one hospital as an example, Dallas's Parkland Hospital reported spending \$765 million to provide uncompensated care.³⁰⁷ Dallas County Judge Clay Jenkins, who oversees the Dallas county hospital, explained the \$765 million in expenses could be offset by approximately \$580 million a year in Medicaid expansion money.³⁰⁸ Yet there is another critical way Texas citizens are paying for these losses: more than half of Dallas property owners' county property tax bill goes to reimburse the Parkland Hospital for the uncompensated care it statutorily has to provide.³⁰⁹

Because of the decision to opt out, Texans pay for this uncompensated care at multiple levels. As Bill Hammond, CEO of the Texas Association of Business, explained, "we pay for it with corporate income tax, we pay for it

301. Sommers, *supra* note 180.

302. PWC, *THE HEALTH SYSTEM HAVES AND HAVE NOTS OF ACA EXPANSION* (2014).

303. David Dranove et al., *The Impact of the ACA's Medicaid Expansion on Hospitals' Uncompensated Care Burden and the Potential Effects of Repeal*, COMMONWEALTH FUND (May 3, 2017), <http://www.commonwealthfund.org/publications/issue-briefs/2017/may/aca-medi-caid-expansion-hospital-uncompensated-care>.

304. Chris Tomlinson, *Texans Suffer When the Poor Don't Have Health Insurance*, HOUSTON CHRON. (Jan. 6, 2016), <http://www.chron.com/business/outside-the-boardroom/article/Texans-suffer-when-the-poor-don-t-have-insurance-6738792.php>.

305. Goodwyn, *supra* note 233.

306. Uncompensated care typically refers to treating patients that do not have health insurance.

307. Goodwyn, *supra* note 233.

308. *Id.*

309. *Id.*

with our personal income tax and we pay it in the fact that our premiums are higher than they would be if everyone was insured.”³¹⁰ If the Texas legislature expanded Medicaid, it could significantly improve access to health care for lower-income Texans seeking all services, including women’s health programs. As a bonus, according to economists, expanding Medicaid could save Texas businesses billions of dollars, through which Texas says it will invest in “upgrading equipment, hiring new employees, providing raises, and rewarding shareholders.”³¹¹ More low-income Texans will have affordable insurance if Medicaid is expanded, and this kind of stimulus would greatly improve the overall health care infrastructure in Texas.

VI. Next Steps/Recommendations

Beyond considering the Medicaid expansion, the state should consider better outreach efforts to educate its residents about current health care options. Increased outreach, combined with recognizing the impact that psychosocial factors have on health issues, will lead to better outcomes for women in Texas. Another goal should be to increase provider and community awareness of health disparities and implement programs that increase the ability of women to self-advocate.³¹² This is especially important in the face of “pervasive racial and ethnic disparities” that exist across maternal mortality trends.³¹³ This crisis presents an overdue opportunity for Texas to increase community outreach and engagement to educate women—and their families—about self-advocacy within a health system riddled with inequalities.

A. Health Care Recommendations

Texas must focus on increasing access to health services during the year after delivery and throughout the interconception period (the time between pregnancies) to improve continuity of care, enable effective care transitions, promote safe birth spacing, reduce maternal mortality, and reduce the cost of care in the Medicaid program.³¹⁴ However, this goal seems contrary to Texas’s dedicated efforts to restrict family planning budgets and access. As the task force explains, “increasing access to care throughout the first

310. Hammond is correct about premiums—Texas has the second-highest health insurance premiums in the country. See Goodwyn, *supra* note 233.

311. *Id.*

312. TASK FORCE REPORT, *supra* note 12, at 17.

313. *Id.*

314. *Id.* at 16.

postpartum year would improve interconception health while also reducing cost in the Medicaid program by decreasing the rate of unintended pregnancy, and by preventing, detecting and managing chronic conditions and other risk factors.”³¹⁵

Relatedly, Texas needs to continue to increase screening for, and referral to, behavioral health services.³¹⁶ Moreover, steps are being taken to view addiction as a brain disease, which necessitates the evidence-based approach that is applied to other chronic illnesses.³¹⁷ This shift in treatment strategy will ensure greater patient access to health services and highlights the responsibility of health care providers to treat all patients with dignity and respect. To cover additional bases, the report recommends performing non-invasive periodic screenings, such as simply having a conversation, to detect underlying mood disorders.³¹⁸

The task force mentions the need for a centralized database that tracks this maternal health information but does not directly mention the obstacles present regarding this information and Texas’s public access laws. Similarly, as discussed throughout, promoting best practices for improving the quality of maternal death reporting and investigation will have a large impact.³¹⁹ One specific improvement would be guidelines for comprehensive toxicology screening when indicated. This was a significant problem when analyzing the available data, as many toxicology screens were not conducted when indicated. This resulted in lack of clarity regarding any possible interplay with substance use and ultimately, the cause of death itself.

The last concrete thing Texas can do is to follow California’s lead and implement toolkits to address the most common—and preventable—causes of maternal death. In one study, almost 60% of maternal deaths were classified as preventable.³²⁰ After Texas lawmakers extended the group’s mission, the task force met in September 2017 and identified the most common death risk factors for new moms. New data from 2012 through 2015 showed 382 Texas women died from pregnancy-related and pregnancy-associated causes.³²¹ The most common causes of death shortly

315. TASK FORCE REPORT, *supra* note 12, at 16.

316. *Id.*

317. *Id.*

318. *Id.* at 17–18.

319. *Id.* at 18–19.

320. *Report from Maternal Mortality Review Committees: A View into Their Critical Role*, CDC FOUND., <https://www.cdcfoundation.org/sites/default/files/upload/pdf/MMRIAReport.pdf>.

321. Jackie Wang, *In Effort to Save Lives, Texas Maternal Mortality Task Force Identifies Death Risk Factors for New Moms*, DALLAS NEWS (Sept. 29, 2017), <https://www.dallasnews>

after giving birth were heart failure and hemorrhage.³²² This data allowed the task force to create a risk profile, consisting of factors such as lack of education, lack of health insurance, hypertension, smoking while pregnant, and diabetes.³²³

B. “Medicare for All or State Control”³²⁴

Leadership is required at the federal level. The partisan nature of health care reform will be an obstacle to efficient change, but with the midterm election in 2018, the health landscape could dramatically change. One faction of Congress, led by Bernie Sanders and supported by sixteen Democratic Senators, advocates for a Medicare-for-all, single-payer health care option.³²⁵ Under this system, the federal government would establish a budget for covered health care services and slowly expand Medicare to cover every American.³²⁶ This would effectively separate health insurance from employment, “shrinking the role of employers and insurance companies.”³²⁷

The opposition believes that government-controlled health care will never work because it will “eliminate choice, undermine quality, put a chill on medical innovation and place an even heavier burden on hard-working taxpayers.”³²⁸ Senator Lindsey Graham (R-SC) stepped into the health care policy arena after former Senator Rick Santorum (R-Pa.) passed on the idea of block granting health care dollars to states at the Senate barbershop.³²⁹ Conservatives in Congress have vowed this would be the basis of any ACA repeal plan in the future.³³⁰ Under this proposal, money would be distributed to the states based on a complex formula. This set ratio would no longer be based on how much states spend on care and would not be increased based

.com/business/health-care/2017/09/29/effort-save-lives-texas-maternal-mortality-task-force-identifies-death-risk-factors-new-moms.

322. *Id.*

323. *Id.*

324. Robert Pear, *Medicare for All or State Control: Health Care Plans Go to Extremes*, N.Y. TIMES (Sept. 13, 2017), <https://www.nytimes.com/2017/09/13/us/politics/health-care-obamacare-single-payer-graham-cassidy.html>.

325. *Id.*

326. *Id.*

327. *Id.*

328. *Id.*

329. Jennifer Haberkorn et al., *Inside the Life and Death of Graham Cassidy*, POLITICO (Sept. 27, 2017), <https://www.politico.com/story/2017/09/27/obamacare-repeal-graham-cassidy-243178>.

330. *Id.*

on new enrollments.³³¹ Depending on the state or specific legislation, policymakers will likely gain new authority to target reproductive health services and providers.

This block grant option would allow states to completely circumvent federal directives and control access. In politically conservative states, where women's rights are constantly under attack, this would lead to a significant ability to restrict what type of services to which women access. The Medicare-for-all option, rather, is closer to the ideal—where everyone is insured, giving women across the country more opportunities to interact with clinics. This will only lead to positive health outcomes, where women have more control to choose their future.

Conclusion

Understanding how to meet Texas's current needs requires determining the relationship between cuts to family planning programs and the closure of clinics to the increased mortality rates. As Texas continues to deal with this maternal health crisis, the public has the right to access public information that could help solve the problem. This does not compromise an individual's right to privacy, and therefore Texas should balance competing interests by committing to strong open access laws and requiring disclosure. In addition to fighting for increased access to maternal health information, other changes are necessary, such as a massive overhaul of maternal death reporting. As all parties who have studied this issue agree, inconsistent reporting has an indelible and negative impact on the ability to diagnose and solve maternal health problems.

Beyond reporting and privacy, Texas owes its citizens compliance with due process and equal protection. The choices in Texas right now are few and far between, foreshadowing an impending constitutional crisis. The spike in maternal mortality rates in Texas is a public health crisis, affecting the most vulnerable women on a level incomparable to any other developed country in the world. This is especially troublesome considering the current political climate, where Texas politicians are committed to reducing the role that women's health providers play in assuring affordable health care. While Texas may reject Medicaid expansion under the ACA until the Supreme Court rules otherwise, it is in Texas' best interest to expand Medicaid coverage to address systemic maternal health issues from multiple angles. Studies show expansion will save money and allow more low-income and

331. Adam Sonfield, *Why Protecting Medicaid Means Protecting Sexual and Reproductive Health*, GUTTMACHER INST. (Mar. 9, 2017), <https://www.guttmacher.org/gpr/2017/03/why-protecting-medicaid-means-protecting-sexual-and-reproductive-health>.

minority Texans to afford health insurance. Medicaid coverage greatly improves outcomes for women, and Texas's restriction of coverage is both cruel and costly. Ultimately, systematic denial of equal access of healthcare and the disparate impact of these state policies, necessitate federal leadership.
