Filling a Federal Void: Promises and Perils of State Law in Addressing Women's Health Disparities

Valarie K. Blake and Michelle L. McGowan

Introduction

As the nation contemplates another major national health reform effort with the upcoming 2020 presidential election, women's health disparities must be of central importance. The Patient Protection and Affordable Care Act of 2010 (ACA) included some measures to address women's health disparities, such as bans on preexisting condition discrimination and gender rating by health insurers, no-cost sharing for preventive healthcare including contraception and cancer screenings, and Medicaid expansion.[1] Yet, other important dimensions of women's health have been largely absent from federal law due both to neglect and political division. The absence of federal attention to improving access to comprehensive reproductive health care and women's health outcome disparities has left regulatory gaps for states to fill as they see fit.

Without baseline federal regulatory standards to promote women's health across the reproductive life cycle, this approach has had mixed results with some states promoting women's health while others ignore or harm it. Lawmakers sometimes even enact laws purportedly to protect women's health, when the evidence base suggests otherwise; for instance, restrictions on access to abortion are often passed in the name of health when the evidence shows they may contribute to maternal morbidity and mortality and limit reproductive autonomy.

In this commentary we tell a tale of two states and their impact on women's health in the absence of federal reforms to protect and promote reproductive health within the population. One state, California, has led the charge for reducing maternal morbidity and mortality, becoming a model nationwide for how to support women's health. The other state, Ohio, has slowly eroded access to abortion in the name of health, when the evidence suggests the opposite. We argue that state innovations can go a long way toward

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reducing women's health disparities but only in states that have the political will to focus on these issues. Absent this, federal reforms are necessary to require every state to uphold women's and maternal health. At minimum, states successfully studying and combating women's health disparities can set the course for evidence-based practices for other states and for federal reforms, as well as debunking draconian measures that are harmful to women's health.

The Promise of the States: California

The United States continues to rank worst in maternal mortality compared to other economically developed countries. The Centers for Disease Control and Prevention report that the maternal mortality rate in 2018 was 17.4 deaths per 100,000 live births; black women died in that year at a rate of 2.5 to 3.1 times higher than white and Hispanic women.[2] The problem offers no easy solution and will require legislative, clinical, and other reforms. The ACA offered only a partial solution; it expanded access to pre- and postnatal care for some vulnerable groups through limited Medicaid expansion, but it did little to improve the quality of obstetrics care. But in California, many years before the public turned its eye to this issue, experts spotted this trend and decided to act. The result is a promising example of what state law can do to improve women's health disparities when federal initiatives are absent.

In 2006, the California Department of Public Health was disturbed to find that maternal deaths were more than doubling based on the department's death certificate surveillance.[3] The state defined maternal death as death during pregnancy or within 42 days of the end of a pregnancy.[4] (California was also concerned with pregnancy-associated deaths, or deaths that occur within one year of a pregnancy).The California Department of Public Health allocated federal money from the Title V Maternal and Child Health Services block grant to establish the California Pregnancy-Associated Mortality Review (CA-PAMR), a collaboration between the state's public health agency, reproductive health experts at Stanford University School of Medicine, and the Public Health Institute (a nonprofit health organization in the state).[3] The public-private collaboration between medical experts and public health officials has since become a nationwide model for state-level maternal morbidity and mortality review committees.

The CA-PAMR reviews and reports in detail on maternal deaths occurring in the state. Other organizations in the cohort research the topic, develop quality improvement toolkits, and collect data from 200 different hospitals on maternal mortality and other perinatal performance measurements. The CA-PAMR did something unique; it modeled itself after morbidity and mortality committees (or M&Ms), regularly held meetings in hospitals where physicians gather to discuss adverse events and appropriate responses. With the CA-PAMR, however, the task was to study in-depth the problem of maternal mortality in the state. The task was not easy. There was no guarantee that information about maternal deaths were being properly collected for study since not all death certificates would make note of whether the woman was pregnant at the time of her death or the timing of the death in relation to the end of a pregnancy. The CA-PAMR used a collection of administrative data sets — maternal death certificates, patient discharge and emergency room data, coroner and autopsy reports, and fetal death data — to piece together the body of existing maternal deaths. A volunteer committee of experts then reviewed these cases for cause of death and timing, factors contributing to the death, whether it was pregnancy-related, whether the death could be prevented, and where there might be opportunities for quality improvement.

Out of this process, the CA-PAMR published these findings in the first in-depth medical record review to focus on maternal mortality, as a way to inform clinical practice in and outside of the state.[5] CA-PAMR and its cohort produced toolkits to prepare clinics for common causes of maternal death. One notable example is the meticulous toolkit for treating hemorrhage which even includes detailed instructions for items needed to create a hemorrhage crash cart to monitor and respond to life threatening bleeds.[6] Recent research demonstrates that the use of these toolkits could be scaled up to tackle maternal hemorrhage in hospitals all over the country.[7] The group also created a number of quality measures that are used by the Joint Commission, the nonprofit organization that serves as the primary accrediting body for many hospitals and other health care organizations.

As a consequence of these efforts, California's maternal mortality dropped more than half from 2006 to 2013, making its death rate substantially lower than the remainder of the United States.[8] California's practices also informed an increasing trend towards the development of state-based Maternal Mortality Review Committees (MMRCs)[9] and, indirectly, has fueled federal legislation. The 2018 Preventing Maternal Deaths Act, passed unanimously in both chambers of Congress, dedicates funds to the states to develop or improve upon existing MMRCs.[10] The Act promotes a uniform way for MMRCs to collect and report on maternal deaths, to study causes of maternal mortality and disparities therein, and to develop policies, educational practices, and other solutions to the

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problem at the state level. Following the Act, at least thirteen states have passed some form of legislation to establish or build on an existing MMRC; for instance, Pennsylvania established its first MMRC by state statute in 2018.[11]

The Preventing Maternal Deaths Act, and indeed MMRCs, are not the cure-all for maternal mortality, but they are certainly an important step towards saving women's lives and enhancing equality in reproductive care. They are also an example of how state lawmakers can drive both state and national health reform in meaningful ways, as well as contribute to the body of evidence-based care on women's and maternal health.

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The Peril of the States: Ohio

At the national level, the Hyde Amendment (1977) bars the use of federal funds to cover abortion care except in cases of maternal life endangerment, rape, or incest.[12] Policy debates over the range of preventive women's health services to be covered under the ACA explicitly excluded abortion care, and ultimately included a provision that limited abortion coverage to ACA insurance plans sold through the marketplace.[13] In many ways federal legislation that restricts insurance coverage for abortion care is unsurprising considering the contentious public debate over abortion and the continual roiling in the court system since the Supreme Court of the United States' (SCOTUS) decision on *Roe v. Wade* established a negative right to abortion in the United States in 1973. While *Roe v. Wade*[14] established the individual's right to prevent birth in consultation with their healthcare provider, this right does not extend to a state or social obligation to ensure that individuals can exercise the right not to procreate.[15] In fact, the 1992 SCOTUS decision on *Planned Parenthood v. Casey*[16] opened the door for states to impose restrictions on access to abortion, which has resulted in extensive state-level variation in the regulation of abortion in the United States in the intervening years.

While the majority of states have imposed abortion restrictions in the years since the *Casey* decision, since 2000 only four states — Ohio, Mississippi, South Carolina, and Utah — have consistently been rated by the Guttmacher Institute as hostile to abortion rights.[17] Among these, Ohio was the only state to shift to a Republican state-government trifecta in the immediate wake of the passage of the ACA, which corresponded with an onslaught of new state legislative activity to restrict abortion in the decade following national health reform.[18] The state of Ohio has implemented sixteen abortion-restrictive regulations since 2011, which has coincided with the closure of more than half of the abortion clinics in the state.[19] Since 2010 abortion rates have decreased statewide - falling below national averages - and abortion ratios have especially declined in rural counties.[20] Further, the proportion of abortions completed after 10 weeks gestation has increased in Ohio as compared to the nation, which suggests delays in access to abortion care.[21]

Focus groups and interviews with obstetrician-gynecologists and genetic counselors in Ohio have revealed that specific types of state abortion regulations related to health reform impose hardships for their patients' access to abortion care.[22] These healthcare providers noted that health insurance reforms signed into law in Ohio in 2011 and 2012 have hindered patient access to abortion care beyond the restrictions posed by the Hyde Amendment by increasing the financial and logistical hurdles to obtain an abortion in Ohio. Specifically they noted legislation that banned public facilities from providing non-therapeutic abortions and extended the ban on state funding of insurance plans that cover abortion imposed through the 2011 biennial state budget bill,[23] and prohibitions on ACA insurance plans from covering non-therapeutic abortions in Ohio.[24] In 2019 the state legislature proposed banning all Ohio insurance companies from offering coverage for abortion under nearly all circumstances, which signals at least some legislators' determination to foreclose nearly all insurance coverage for abortion care in Ohio.[25] Physicians and genetic counselors who participated in focus groups and interviews focused on the detrimental

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impact of these regulations on their patients' ability to exercise reproductive autonomy. They were particularly distressed about their inability to 1) provide or refer their patients in-house for abortion care because of where they worked and 2) facilitate access to abortion at free-standing clinics because patients' insurance did not cover it or patients lacked the financial means to pay for abortion out-of-pocket.

At this point the extent to which these specific pieces of legislation that limit use of public facilities and federal, ACA marketplace, and state-funded insurance plans for abortion care contribute to the decline in abortion rates overall and the uptick of abortions at later gestational ages in Ohio is unknown. However, extrapolating from national data, one in ten women of reproductive age has Medicaid coverage, and in 2018 half of all women below the federal poverty level had Medicaid coverage.[26] At the same time, low-income women have higher rates of unintended pregnancy than higher-income women, thus women who experience more financial vulnerability also seek the highest levels of abortion in the United States.[27] National studies indicate that the majority of abortion seekers pay for their abortions themselves,[28] and that when financial assistance is available for abortion it comes in the form of private insurance, state-based Medicaid funds (from one of the 16 states that provides Medicaid coverage beyond Hyde Amendment restrictions),[28] or from other organizations such as the National Network of Abortion Funds.[30] Patients with public insurance are more likely to qualify for such insurance due to their low income status, hence low-income pregnant people are most likely to bear the brunt of legislative restrictions on public facilities and bans on public insurance coverage for abortion care. Closing off federal and state-based public funding streams and ACA exchange plans from covering abortion care costs in Ohio further limits the care pathways to patients who are more likely to face hardship in securing the financial resources both for seeking to terminate a pregnancy and for continuing a pregnancy. Hence it is very likely that uneven insurance coverage for abortion services perpetuates women's health care disparities in Ohio in terms of both accessibility and affordability of abortion care — which is primarily provided at free-standing abortion clinics — as the costs of abortion care are largely borne by patients themselves. Patients with readily available means are better positioned to procure the abortions they seek. Though some members of Congress have advocated for eliminating the Hyde Amendment[31] and the Equal Access to Abortion Coverage in Health Insurance Act proposed in Congress in 2015 would restore federal funding for abortion coverage if signed into law,[32] uncertainty prevails as to whether this provision in federal funding bans on abortion would ultimately reform health insurance coverage if states continue to restrict use of public funds for abortion care.

Implications for Women's Health

These two states represent two sides of the same coin: the perils and promises of the states acting as policy laboratories in the absence of a federal regulatory floor for promoting women's health.

As demonstrated by the achievements of the CA-PAMR, sometimes state solutions are the exact remedy needed. States may be more nimble than the federal government and may be able to quickly respond to a looming health crisis as evidenced by California's response when maternal deaths started to skyrocket. To the extent that a health crisis is driven partly by features unique to the state or locality, a strong state response may be even more important.

The CA-PAMR and the resulting federal 2018 Preventing Maternal Deaths Act are examples of high functioning federalism translated into health reform. When California responded to its maternal mortality crisis in the state, it acted only for itself. Using federal block grant money, it designed a fix that then happened to be useful for other states as well. The 2018 Preventing Maternal Deaths Act places a seal of approval on California's practices and provides federal backing for other states to develop their own committees which are best placed to identify unique contributors to maternal mortality in their borders. The law encourages states to develop their own unique solutions to the problem while also obligating states to meet certain best practices, informed by the successes of earlier state innovations, in exchange for federal money. All the while, the law acts as a feedback loop, requiring states to send data and information on best practices back up to the federal government, who may use this ideally to inform future federal reforms.

Ohio is the other side of the coin. Lawmakers there have exploited women's health and reproductive rights, the politically sensitive issues that they are, to restrict access to abortion. The slow-moving crisis in access to abortion in Ohio is no less important to women's health than the crisis in maternal morbidity and mortality. Indeed, if reducing maternal and infant morbidity and mortality is a bipartisan aim of the federal government — as evidenced by the overwhelming passage of the Preventing Maternal Deaths Act — then Ohio's restrictions on abortion threaten that laudable goal. Evidence consistently demonstrates an inverse relationships between good women's and infant health outcomes and restrictions on access to safe abortions.[33]

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Ohio's approach to regulating women's health in the decade following the ACA suggest a need for federal standards that recognize and safeguard women's health however pregnancies end; measure reproductive health access and outcomes across the states; and tie access to federal funding to efforts to ameliorate women's health disparities. Otherwise, we will continue to see an untenable patchwork of state policies where the difference between a state border can truly mean accessibility or inaccessibility of safe health care procedures that can dramatically alter the course of one's life, reproductive health, and financial wellness.[34] Additionally, we will fail to see the progress towards improved women's and maternal health outcomes that the federal government seeks in the Preventing Maternal Deaths Act.

Of course, political will to tackle harmful state policies may be lacking at the federal level at present and for some time in the future, especially surrounding abortion. At a minimum, though, states that innovate around women's health disparities are building an important body of evidence for how law interfaces with women's health outcomes. This can be used to inform other states' practices, as well as federal initiatives. It can also be used to challenge states, in the courts and otherwise, when they put forward laws in bad faith that harm women's health, under the guise of protecting their health.

There are lessons to be learned in California and Ohio. The next stages of health reform must consider the promises and perils of state innovation carefully, both in terms of successful policies that promote women's health that should be borrowed and replicated nationwide, as well as what the federal legislative and regulatory floor should be to ensure better reproductive health access and outcomes for women across the United States. Such a regulatory floor could be especially important for ameliorating gendered health disparities in the future in states that are currently hostile to comprehensive reproductive rights and fail to view women's health holistically.

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