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Giving Birth under the ACA: Analyzing the Use of Law as a Tool to Improve Health Care

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Elizabeth Kukura*

Giving Birth Under the ACA: Analyzing the Use of Law as a Tool to Improve Health Care

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I. INTRODUCTION

Confronting a host of shortcomings in the health care system related to access, quality, and cost, Congress passed the landmark Patient Protection and Affordable Care Act (ACA) in 2010.¹ Contained within over 900 pages of legislation are numerous provisions that impact maternity care in beneficial ways. But although much ink has been spilled exploring the ACA's impact on reproductive health in the form of the contraceptive coverage mandate and the exclusion of coverage for abortion care, scholars have directed little attention to the Act's impact on maternity care either as an essential matter of reproductive health or a vital component of the country's health care delivery system. Childbirth is big business in the U.S., constituting the most common reason for hospitalization and the source of more hospital charges than any other condition. With 85% of women giving birth during their lives, the vast majority of people encounter the maternity care system and rely on maternity care providers to tend to the health of women and their babies. How maternity care is delivered matters tremendously, not only because childbirth is transformational, but also because the steep cost of having a baby makes high-quality maternity care an issue of financial security for American women and their families.

This Article helps fill a gap in the scholarly discussion of the ACA with a comprehensive analysis of how the Act impacts health care for childbearing women,² looking not only to provisions that have ex-

1. Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (codified as amended in scattered sections of the U.S.C.).

2. This Article refers to women as the primary beneficiaries of the ACA's maternity care reforms but acknowledges that some men also experience pregnancy and childbirth. Advocates have proposed changes to improve care for transgender men who become pregnant, as well as the cultural competency of maternity care providers who treat male-identified patients. See Robin Marantz Henig, *Transgender Men Who Become Pregnant Face Social, Health Challenges*, NPR (Nov. 7,

panded access to care but also to reforms and investments directed at long-term change. This analysis provides a springboard for considering further legal and structural reforms necessary to build a maternity care system that uses resources more efficiently and effectively. Researchers and advocates concerned with childbirth in the U.S. have identified a crisis in the maternity care system.³ With nearly one-third of babies born by cesarean,⁴ a maternal mortality rate in the U.S. that ranks sixtieth in the world,⁵ and an infant mortality rate higher than those of twenty-six other countries,⁶ there are various economic, legal, political, and social factors contributing to the inadequate performance of the nation's maternity care delivery system. While the ACA's expansion of maternity coverage to millions more women is a significant development in the quest for better outcomes, greater insurance coverage and access to medical care are not necessarily sufficient for improving health. The kind of care provided and who delivers it shape the course of pregnancy and birth. Furthermore, the way maternity care is paid for influences what care is available and the manner of its delivery by establishing background norms about the value of particular forms of care and creating incentives that privilege certain approaches over others.

2014), <http://www.npr.org/sections/health-shots/2014/11/07/362269036/transgender-men-who-become-pregnant-face-health-challenges>, archived at <http://perma.unl.edu/WC4M-WN77>.

3. See, e.g., Janet Weiner & Lauren Reed-Guy, *Philadelphia's Maternity Care Crisis*, LEONARD DAVIS INST. OF HEALTH ECON. (Nov. 25, 2013), <http://ldi.upenn.edu/voices/2013/11/25/philadelphia-s-maternity-care-crisis>, archived at <http://perma.unl.edu/KB3E-QD9F>; Ina May Gaskin, *Doctors Need Midwives: Ina May Gaskin on the U.S. Maternity Crisis*, THE DAILY BEAST (May 5, 2011), <http://www.the-dailybeast.com/articles/2011/05/05/doctors-need-midwives-ina-may-gaskin-on-us-maternity-care-crisis.html>, archived at <http://perma.unl.edu/65PY-FVZC>.
4. JOYCE A. MARTIN ET AL., NAT'L VITAL STATISTICS SYS., BIRTH: FINAL DATA FOR 2013, at 7 (2015) (reporting that 32.7% of babies born in the U.S. in 2013 were by cesarean).
5. 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, archived at <http://perma.unl.edu/XA4H-APM9>; see also Andis Robeznieks, *U.S. Has Highest Maternal Death Rate Among Developed Countries*, MODERN HEALTHCARE (May 6, 2015), <http://www.modernhealthcare.com/article/20150506/NEWS/150509941>, archived at <http://perma.unl.edu/2QXQ-J6PQ> (noting WHO's Center for Health Development ranks the U.S. sixty-first among all nations in maternal health, based on data from 2003–2011). Research suggests that current maternal mortality statistics undercount the actual number of deaths related to pregnancy or birth due to inconsistent and unreliable reporting practices. See Ina May Gaskin, *Maternal Death in the United States: A Problem Solved or a Problem Ignored?*, J. PERINATAL ED., Spring 2008, at 10, 10–11 (discussing a Massachusetts study that documented a 93% underreporting rate of maternal death).
6. Abby Goodnough, *U.S. Infant Mortality Rate Fell Steadily from '05 to '11*, N.Y. TIMES (Apr. 17, 2013), http://www.nytimes.com/2013/04/18/health/infant-mortality-rate-in-us-declines.html?_r=0, archived at <http://perma.unl.edu/CZ6U-NYA6>.

In identifying the need for systemic maternity care reform beyond the ACA, this Article argues that achieving optimal maternity care requires several related shifts in the culture surrounding childbirth—both within the medical community and in society at large. Typical twenty-first-century childbirth in the U.S. reflects a socially constructed understanding of birth as a medical event, fraught with risk and fear of complications, rather than a normal, physiologic process female bodies are well-constructed to perform. The notion of childbirth as pathological—understood as an illness or condition to be controlled—originated with physicians in the nineteenth and early-twentieth centuries who, in organizing as a professional class of obstetricians, sought to distinguish themselves from midwives, who traditionally served as birth attendants, and convince patients they needed physician care during childbirth.⁷ A medicalized conception of childbirth seeped into the larger culture and has become a self-reinforcing norm. Medical tinkering with the birthing process necessitates further technological intervention, and fewer people—whether physicians or pregnant women—are exposed to normal birth; unmediated, physiologic birth has become the exception, rather than the rule. Economic pressures associated with hospital management, the cost of malpractice insurance, and the time-intensive nature of attending births reinforce and exacerbate the medicalization of childbirth by incentivizing the use of labor and delivery practices that increase medical management and intervention.

Thus, while expanding access to maternity care at a reasonable cost will undoubtedly improve health outcomes, a truly health-affirming (and cost-effective) maternity care system requires a fundamental shift in how care is delivered. This Article identifies three areas where structural reform is imperative: (1) revamping payment systems to eliminate misaligned incentives; (2) adopting evidence-based medicine in maternity services; and (3) promoting the midwifery model of care—highlighting how the ACA makes modest commitments in each context, while leaving much work left undone. First, maternity care reimbursement policies should be reformed to reduce the risk that financial incentives will lead to unnecessary medical intervention in labor and delivery. Payment systems should also be adjusted to encourage collaboration between midwives and physicians. Second, health care providers, policymakers, and other stake-

7. See MAINSTREAMING MIDWIVES: THE POLITICS OF CHANGE 32–33 (Robbie Davis-Floyd & Christine Barbara Johnson eds., 2006) [hereinafter MAINSTREAMING MIDWIVES]; Suzanne Hope Suarez, *Midwifery Is Not the Practice of Medicine*, 5 YALE J.L. & FEMINISM 315, 327 (1993) (citing Frances E. Kobrin, *The American Midwife Controversy: A Crisis of Professionalization*, in WOMEN AND HEALTH IN AMERICA 318, 322 (Judith Walzer Leavitt ed., 1984)); JEAN DONNISON, MIDWIVES AND MEDICAL MEN: A HISTORY OF THE STRUGGLE FOR THE CONTROL OF CHILDBIRTH 40 (1988).

holders should prioritize the identification and adoption of evidence-based maternity care practices in order to eliminate the use of ineffective and harmful practices that increase costs and create unnecessary complications. Third, midwifery should be fully accepted as a safe, cost-effective option for women with low-risk pregnancies, and barriers to midwives' participation in mainstream maternity care should be eliminated through legal and policy reform. Though certainly not exhaustive, these initiatives suggest a roadmap for creating the cultural shifts required to achieve an optimally functioning maternity care system. Each area of focus requires the reshaping of norms through legal and non-legal methods, raising questions about the type of change law can effect in the way medicine is practiced and health care is delivered. With these questions in mind, the Article concludes by reflecting on law as a vehicle for influencing social and cultural norms in the health care context.

Part II provides an overview of maternity care in the U.S., highlighting the degree to which childbirth is a significant component of the health care economy, and illustrating where and how birth occurs in twenty-first-century America. Part III turns to the ACA, examining the major contributions the Act makes to improving maternity care through expanded access to coverage, improved insurance benefits, and various programmatic and policy investments. Part IV explores the limitations of the ACA in producing structural changes to maternity care and identifies three areas where advocacy has the potential to change the social norms and values that shape the childbirth experience, resulting in better care for women and babies and more cost-effective use of maternity care resources. The Article concludes by suggesting that maternity care presents a useful case study for theorizing the utility of law as a tool for producing cultural change in health care and improving health outcomes, offering some preliminary reflections for further engagement in future work.

II. OVERVIEW OF MATERNITY CARE IN THE UNITED STATES

A. High Costs and Poor Outcomes: Demonstrating the Urgent Need for Maternity Care Reform

Maternity care is one of the most widely consumed forms of specialized medical care; 85% of women carry a pregnancy to term and give birth before age 44.⁸ Unlike the patients of most medical specialists, however, the vast majority of people who use maternity care are

8. CTRS. FOR DISEASE CONTROL & PREVENTION, RECOMMENDATIONS TO IMPROVE PRECONCEPTION HEALTH AND HEALTH CARE—UNITED STATES: A REPORT OF THE CDC/ATSDR PRECONCEPTION CARE WORK GROUP AND THE SELECT PANEL ON PRECONCEPTION CARE 2 (2006), *archived at* <http://perma.unl.edu/C3UW-QYMQ>.

healthy and turn to the health care system for assistance in welcoming their babies into the world.⁹ Approximately four million babies are born annually in the U.S.¹⁰ Childbirth is the leading reason for hospitalization in the American health care system,¹¹ with new mothers and their babies constituting 23% of all people discharged from hospitals.¹² Hospital charges for childbirth exceed expenditures for any other condition, totaling \$111 billion each year.¹³ In 2009, birth-related costs represented 26% of hospital charges to Medicaid—or \$54 billion—and 13% of hospital charges to private insurers, or \$49 billion.¹⁴ In terms of the individual consumer, in 2011, the average hospital charge for an uncomplicated vaginal birth was \$10,657, while a complicated cesarean cost an average of \$23,923.¹⁵ The most recent data available on the cost of childbirth at out-of-hospital birth centers, from 2010, reflect an average charge for a vaginal birth of \$2,277.¹⁶ None of the average charges for hospitals or birth centers include the cost of newborn care, anesthesia, or compensation for the care provided by an obstetrician or midwife.¹⁷ Furthermore, hospital charges do not represent the full extent of the costs associated with childbirth,

9. CAROL SAKALA & MAUREEN P. CORRY, *CHILDBIRTH CONNECTION, EVIDENCE-BASED MATERNITY CARE: WHAT IT IS AND WHAT IT CAN ACHIEVE* 26 (2008), *archived at* <http://perma.unl.edu/S55L-23C5> (noting that 83% of women have low-risk pregnancies in the U.S.).

10. MARTIN ET AL., *supra* note 4, at 3.

11. SAKALA & CORRY, *supra* note 9, at 2.

12. *Id.*

13. CHILDBIRTH CONNECTION, NAT'L P'SHIP FOR WOMEN & FAMILIES, *UNITED STATES MATERNITY CARE FACTS AND FIGURES* (2012) [hereinafter *MATERNITY CARE FACTS AND FIGURES*], *archived at* <http://perma.unl.edu/W3ZT-WZMC>. Significantly, the U.S. spends almost twice as much per capita on health care as any other nation. See CARMEN DENAVAS-WALT ET AL., *U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2012*, at 22–25 (2013), *archived at* <http://perma.unl.edu/GR7Q-AH87>; see also ORG. FOR ECON. CO-OPERATION & DEV., *HEALTH AT A GLANCE 2013: OECD INDICATORS 24–25, 64–65, 88–89, 155–56* (2013), *archived at* <http://perma.unl.edu/XH47-HEU7> (noting that the United States has fewer doctors and hospital beds per person, and a shorter life expectancy at birth, than the OECD average, despite higher expenditures).

14. *MATERNITY CARE FACTS AND FIGURES*, *supra* note 13. In 2010, private insurance paid for 48% of maternal childbirth-related hospital stays; Medicaid paid for 45% of stays. *Id.*; see U.S. Agency for Healthcare Research & Quality, *Healthcare Cost and Utilization Project*, <http://hcupnet.ahrq.gov/> (last visited Jan. 27, 2016), *archived at* <http://perma.unl.edu/8GCJ-N9DK>.

15. CHILDBIRTH CONNECTION, NAT'L P'SHIP FOR WOMEN & FAMILIES, *AVERAGE U.S. FACILITY CHARGES FOR GIVING BIRTH: FACILITY LABOR AND BIRTH CHARGE BY SITE AND METHOD OF BIRTH, UNITED STATES, 2009–2011* (2013), *archived at* <http://perma.unl.edu/K3T3-TZK4>. Actual payments for medical services tend to be lower than hospital charges. SAKALA & CORRY, *supra* note 9, at 13–14 (discussing availability of payment data).

16. *MATERNITY CARE FACTS AND FIGURES*, *supra* note 13.

17. *Id.*

such as prenatal and postpartum care. In 2010, prenatal care was the seventh most common reason for an outpatient visit.¹⁸

Despite the hefty costs associated with maternity care, U.S. birth outcomes—measured by maternal and infant mortality, as well as maternal morbidity—are notably inferior to those of other industrialized nations. The U.S. lags behind fifty-nine other countries, including China, on a list of 180 nations ranked by maternal mortality, which represents a drop in the rankings of almost forty spots since 1990.¹⁹ In fact, the United States is one of only eight countries that reported an increase in maternal mortality over the last decade.²⁰ From 1990 to 2013, the maternal mortality ratio (MMR) jumped 136%, from 12 to 28 maternal deaths out of every 100,000 live births.²¹ Although changes in the reporting of maternal deaths may be a contributing factor, the last three decades have seen a marked increase in the number of women dying during childbirth.²² Some researchers have attempted to explain the nation's declining maternal health outcomes by referring to the worsening health of the general population—including high rates of obesity, diabetes, and heart disease—as well as the rising average age for first pregnancies, but neither provides adequate explanation for the U.S.' poor performance relative to the cost of maternity care.²³

The impact of adverse health outcomes associated with childbirth is not born equally across society. Women of color die in childbirth at a higher rate than white women, consistent with racial disparities in

18. CTRS. FOR DISEASE CONTROL & PREVENTION, NATIONAL AMBULATORY MEDICAL CARE SURVEY: 2010 SUMMARY TABLES, at 11 tbl.9, *archived at* <http://perma.unl.edu/5THP-JD92>.

19. Morello, *supra* note 5.

20. Nicholas J. Kassenbaum et al., *Global, Regional, and National Levels and Causes of Maternal Mortality During 1990–2013: A Systematic Analysis for the Global Burden of Disease Study 2013*, 384 *THE LANCET* 980, 998 (2014). The others were Afghanistan, Belize, El Salvador, Guinea-Bissau, Greece, Seychelles, and South Sudan. *Id.*

21. WORLD HEALTH ORGANIZATION (WHO) ET AL., *TRENDS IN MATERNAL MORTALITY: 1990 TO 2013*, at 43 (2014); *see also* Kassenbaum et al., *supra* note 20, at 998 (reporting the U.S. MMR to be 18.5 per 100,000 live births, relying on a different data set, but showing a similar level of increase as the WHO study on MMR trends).

22. Changes in population health—including an increase in conditions like hypertension and diabetes, as well as better medical care for women with heart or neurological diseases—contribute to more high-risk pregnancies. *See* Morello, *supra* note 5. Researchers note, however, that the number of maternal deaths is probably still underreported and mischaracterized on death certificates. *Id.*

23. *See* T.J. MATHEWS ET AL., NAT'L CTR. FOR HEALTH STATISTICS, *DELAYED CHILDBEARING: MORE WOMEN ARE HAVING THEIR FIRST CHILD LATER IN LIFE* 6 fig.5 (2009) (reporting higher average ages of mother at first birth in thirteen other developed nations, with comparable increases in age at first birth over time).

the U.S. health care system more broadly.²⁴ Non-Hispanic black women are between three and four times more likely to die from pregnancy-related causes than white women, with even greater disparities in high-risk pregnancies.²⁵ Regions with significant low-income and minority populations report some of the highest maternal mortality rates in the country. For example, Washington, D.C., where 50% of the population is black, has a rate of 41.6 deaths per 100,000 live births; the rate in Fulton County, Georgia, is 94 maternal deaths per 100,000 live births among black residents, while the rate of white women dying in the county is too insignificant to report.²⁶ Most shockingly, Chicksaw County, Mississippi, reports a rate of 595 deaths per 100,000 live births, which is higher than both Kenya (400 deaths) and Rwanda (320 deaths).²⁷

Public health data on infant mortality similarly reflect worse outcomes than other industrialized nations. Although the infant mortality rate in the U.S. declined 12% from 2005 through 2011, at 6.05 infant deaths per 1,000 live births, it remains higher than many of its peer countries.²⁸ In the most recent ranking of infant mortality rates among countries belonging to the Organization for Economic Cooperation and Development (OECD), issued in 2008, the U.S. ranked twenty-seventh.²⁹ The World Health Organization reports that infants born in the U.S. have a higher risk of dying during their first months of life than babies born in forty other countries.³⁰ As with

24. See CTR. FOR REPRODUCTIVE RIGHTS, REPRODUCTIVE INJUSTICE: RACIAL AND GENDER DISCRIMINATION IN U.S. HEALTH CARE—A SHADOW REPORT FOR THE UN COMMITTEE ON THE ELIMINATION OF RACIAL DISCRIMINATION 13 (2014), *archived at* <http://perma.unl.edu/P4FM-J3YU> (discussing issues that drive racial disparities in maternal mortality in the U.S., including socioeconomic factors, geography, and the quality of health care).

25. *Pregnancy Mortality Surveillance System*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/reproductivehealth/MaternalInfantHealth/PMSS.html>, *archived at* <http://perma.unl.edu/LKB4-M886> (noting that in 2011, the pregnancy-related mortality ratio for white women in the U.S. was 11.8 per 100,000 live births, compared to 41.1 deaths for black women); AMNESTY INT'L, DEADLY DELIVERY: THE MATERNAL HEALTH CARE CRISIS IN THE USA 19 (2010), *archived at* <http://perma.unl.edu/5AU4-TC3D>.

26. CTR. FOR REPRODUCTIVE RIGHTS, *supra* note 24, at 13.

27. *Id.*

28. See MARIAN F. MACDORMAN ET AL., NAT'L CTR. FOR HEALTH STATISTICS, RECENT DECLINES IN INFANT MORTALITY IN THE UNITED STATES, 2005–2011, at 1–2 (2013). Sweden, Japan, and Finland report fewer than three infant deaths per 1,000 live births. See Sarah Kliff, *Graph of the Day: The United States Has a Really High Infant Mortality Rate*, WASH. POST (Jan. 9, 2013), <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/01/09/graph-of-the-day-the-united-states-has-a-really-high-infant-mortality-rate/>, *archived at* <http://perma.unl.edu/SFY2-UDG8>.

29. Goodnough, *supra* note 6.

30. *U.S. Newborn Death Rate Trails Behind 40 Other Nations*, INT'L BUS. TIMES (Aug. 31, 2011, 10:27 AM), <http://www.ibtimes.com/us-newborn-death-rate-trails-behind-40-other-nations-307366>, *archived at* <http://perma.unl.edu/3V4E-LESF>.

maternal mortality, infants born to women of color—especially non-Hispanic black women—die at higher rates than their white counterparts and also experience higher rates of preterm birth (live births before thirty-seven completed weeks of gestation) and low birthweight.³¹ Notably, nations with higher life expectancy and lower infant mortality rates spend less per capita for health care than the United States.³²

In 2006, a mid-course review of the Department of Health and Human Services' *National Healthy People 2010* objectives concluded that the U.S. had lost ground in its efforts to achieve targets for various maternity care measures, including low birthweight and very low birthweight, preterm births, maternal labor and birth complications, primary and repeat cesareans in low-risk women, cerebral palsy, and mental retardation.³³ The review reflected worsening outcomes on a range of measures related to the health and well-being of women and their babies beginning in the final decades of the twentieth century. For example, from 1981 to 2006, the national rate of preterm birth increased by 36%.³⁴ Preterm babies suffer higher rates of complications due to the under-development of their lungs, hearts, and brains, among other organs.

Short of death, the United States' poor performance in maternity care also impacts ongoing health and quality of life. Researchers for Amnesty International have called attention to the increase in birth-related complications accompanying the rising maternal mortality rate, finding that “[s]evere complications that result in a woman nearly dying, known as a ‘near miss,’ increased by 25 per cent between 1998 and 2005.”³⁵ More than one-third of women who give birth each year—approximately 1.7 million women—experience one or more complications that have an adverse effect on their health.³⁶ This occurs despite the fact that an estimated 83% of women have low-risk pregnancies in the U.S.³⁷

31. See SAKALA & CORRY, *supra* note 9, at 17; MACDORMAN ET AL., *supra* note 28, at 1–2.

32. THE COMMONWEALTH FUND COMM'N ON A HIGH PERFORMANCE HEALTH SYSTEM, WHY NOT THE BEST? RESULTS FROM THE NATIONAL SCORECARD ON U.S. HEALTH SYSTEM PERFORMANCE, 2008, at 10 (2008). The U.S. also ranks last among nineteen developed nations in terms of “preventable mortality,” referring to deaths from conditions that can be cured. *Id.* at 18.

33. U.S. DEPT. HEALTH & HUMAN SERVS., HEALTHY PEOPLE 2010 MIDCOURSE REVIEW (2006), archived at <http://perma.unl.edu/2LBA-296R>.

34. SAKALA & CORRY, *supra* note 9, at 14.

35. AMNESTY INT'L, *supra* note 25, at 1.

36. *Id.*

37. SAKALA & CORRY, *supra* note 9, at 26.

B. Understanding the Landscape of Childbirth

In previous work, I have traced the evolution of dominant childbirth practices in the U.S. over time, mapping critical changes in who attends to birthing women, where women give birth, and how birth happens.³⁸ Other scholars have explored how childbirth in the U.S. reflects economic and social forces in the professionalization of medicine, and have argued that professional competition, reverence for medicine and technological innovation, patriarchal views about women's bodies, and race and class bias have produced a medicalized, physician-dominated, and costly approach to birth.³⁹ Shifts in the who, where, and how of birth resulted, in part, from broader developments in the health care system throughout the nineteenth and twentieth centuries;⁴⁰ they also highlight flaws in the delivery of maternity care and illuminate paths for improvement. This section describes several defining characteristics of the maternity care delivery system in order to contextualize the subsequent discussion of the ACA's impact on maternity care and the need for reform.

Modern-day childbirth is, to an unprecedented degree, a procedure-intensive medical event. Cesarean surgery is the most common operating room procedure in the U.S.,⁴¹ reflecting the near record-high rate of 32.7% of all babies born by cesarean in 2013.⁴² This widely reported statistic exceeds the World Health Organization's projection that medically necessary cesareans should represent only 10–15% of all births in an industrialized nation.⁴³ But medical intervention into birth extends far beyond cesareans. In 2005, 49% of all hospital procedures performed on individuals aged 18–44 were obstetric procedures.⁴⁴ Six of the fifteen most commonly performed hospital procedures for the entire population are associated with childbirth,⁴⁵

38. See Elizabeth Kukura, *Contested Care: The Limitations of Evidence-Based Maternity Care Reform*, 31 BERKELEY J. GENDER L. & JUST. (forthcoming June 2016) (mapping the transitions from home to hospital, from midwife to physician as the dominant birth attendant, and from birth as a social experience to a medical one).

39. See, e.g., BARBARA BRIDGMAN PERKINS, *THE MEDICAL DELIVERY BUSINESS: HEALTH REFORM, CHILDBIRTH, AND THE ECONOMIC ORDER* (2004); RICHARD W. WERTZ & DOROTHY C. WERTZ, *LYING IN: A HISTORY OF CHILDBIRTH IN AMERICA* 85 (1989); JUDITH WALZER LEAVITT, *BROUGHT TO BED: CHILD-REARING IN AMERICA, 1750–1950*, at 39 (1986).

40. See generally PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* (1982).

41. SAKALA & CORRY, *supra* note 9, at 2.

42. MARTIN ET AL., *supra* note 4, at 7. The rate peaked in 2009 at 32.9% after increasing every year since 1996. *Id.*

43. World Health Org., *Appropriate Technology for Birth*, 2 LANCET 403, 436–37 (1985).

44. SAKALA & CORRY, *supra* note 9, at 11.

45. *Id.* at 11–12. These childbirth-related procedures are medical induction (along with manually assisted delivery and other procedures to assist delivery), repair of

and six of the ten most common procedures billed to Medicaid and private insurers in 2005 were related to maternity care.⁴⁶ Although “more intensive and invasive care is appropriate for about one mother in six,” based on the definition of low-risk pregnancy identified in the federal *Healthy People 2010* initiative,⁴⁷ research suggests that rates of invasive medical procedures during childbirth significantly exceed this target; a landmark study of women’s birth experiences reported that 41% of women underwent an attempt by their health care provider to induce labor artificially,⁴⁸ 31% had their labors artificially accelerated with synthetic oxytocin,⁴⁹ and 36% had their water broken by their care provider to induce or augment labor.⁵⁰ Respondents reported widespread use of pain medications during childbirth, with 67% receiving an epidural or spinal analgesia and 16% receiving a narcotic analgesia.⁵¹ Further, 25% of women received an episiotomy, a surgical incision to widen the vaginal opening.⁵² Researchers have identified a phenomenon where procedures that interfere with the physiologic process of birth can also incur a “cascade of secondary interventions” that are used to monitor and treat side effects of the original interventions.⁵³ Cumulatively, such interventions may “create a distorted understanding of childbirth as a time when things are likely to go wrong and intensive medical management is required.”⁵⁴ Fur-

current obstetric laceration, cesarean, circumcision, fetal monitoring, and the artificial rupture of membranes. *Id.*

46. *Id.* at 12.

47. *Id.* at 26.

48. EUGENE R. DECLERCQ ET AL., *CHILDBIRTH CONNECTION, LISTENING TO MOTHERS III—PREGNANCY AND BIRTH: REPORT OF THE THIRD NATIONAL U.S. SURVEY OF WOMEN’S CHILDBEARING EXPERIENCES 14* (2013) [hereinafter *LISTENING TO MOTHERS III*].

49. *Id.*

50. *Id.* at 18. Significant proportions of women were limited in their mobility after well-established contractions (57%), including those with an intravenous drip (62%) or a bladder catheter (47%). *Id.*

51. *Id.* at 17.

52. *Id.* at 19.

53. SAKALA & CORRY, *supra* note 9, at 28 tbl.3. *LISTENING TO MOTHERS III* reported that of first-time mothers who labored, 47% experienced an induction, and of those having an induction, 78% had an epidural. Among women who had both an induction and an epidural, 31% ultimately had a cesarean. Women who experienced induction or an epidural—but not both—had cesarean rates of 19% to 20%. *LISTENING TO MOTHERS III, supra* note 48, at 24.

54. SAKALA & CORRY, *supra* note 9, at 28. Anthropologist Robbie Davis-Floyd has analyzed the relationship between obstetrical interventions and societal fear of birth. See Robbie E. Davis-Floyd, *The Role of Obstetrical Rituals in the Resolution of Cultural Anomaly*, 31 *SOC. SCI. MED.* 175 (1990). Paradoxically, such fear-assuaging interventions appear to increase the risk of complications in otherwise low-risk births, thus further ratcheting up the fear and anxiety associated with giving birth.

thermore, data on birth outcomes reveal that an intervention-heavy childbirth is not necessarily a safer childbirth.⁵⁵

Childbirth was not always a medical experience, nor does it need to be today. Obstetricians, who are trained in pathology and surgery, are the lead caregivers for almost 80% of U.S. women during pregnancy and labor. But midwives historically attended the vast majority of births, leaving physicians responsible for only the most complicated cases when the use of instruments was necessary.⁵⁶ As physicians began to professionalize in the nineteenth century, they cultivated a wider client base for childbirth services by “wag[ing] systematic and virulent propaganda campaigns” against midwives, many of whom were immigrants.⁵⁷ By 1900, physicians attended approximately half of all births, while midwives attended the rest.⁵⁸ After 1900, the availability of pain medications, such as opium, attracted more women to hospitals for physician-attended births,⁵⁹ and by 1930,

55. K.C. Johnson & B.A. Daviss, *Outcomes of Planned Home Births with Certified Professional Midwives: Large Prospective Study in North America*, *BMJ* 330(7505):1416 (2005) (finding the rates of intervention among low-risk women with usual care were two to sixteen times higher than the rates for women receiving midwifery care, with no increased risk associated with the infrequent use of interventions during midwife-attended births); Michelle Andrews, *The Real Price of Having a Baby*, *KAISER HEALTH NEWS* (July 17, 2015), <http://time.com/money/3962611/baby-childbirth-cost/>, archived at <http://perma.unl.edu/VH8B-DGMU> (reporting that hospitals with higher estimated costs were more likely to have serious complications among low-risk childbirths).

56. See Catherine M. Scholten, “On the Importance of the Obstetric Art:” *Changing Customs of Childbirth in America, 1760–1825*, in *WOMEN AND HEALTH IN AMERICA* 142, 142–47 (Judith Walzer Leavitt ed., 1984).

57. MAINSTREAMING MIDWIVES, *supra* note 7, at 32–33. Anti-midwife campaigning invoked racial superiority, describing midwives as “filthy and ignorant and not far removed from the jungles of Africa,” representing “a relic of barbarism.” Neal Devitt, *The Statistical Case for the Elimination of the Midwife: Fact Versus Prejudice, 1890–1935* (pt. I), 4 *WOMEN & HEALTH* 81, 89 (1979); see also LEAVITT, *supra* note 39, at 39 (noting that physicians “carried with them the status advantages of their gender and of the popular image of superior education”). Mid-century statistics reflect racial differences in who received physician or midwife care during childbirth. In 1935, only 5% of white women in childbirth were attended by midwives, compared to 54% of black pregnant women. George W. Lewis & Peter G. McCaffery, *Sociological Factors Affecting the Medicalization of Midwifery*, in *MIDWIFERY AND THE MEDICALIZATION OF CHILDBIRTH: COMPARATIVE PERSPECTIVES* 24 (Edwin Van Teijlingen et al. eds., 2000). By 1953, as midwives became even further marginalized, only 3% of white women were attended by midwives, while 20% of black women employed midwives at their births. *Id.*

58. LEAVITT, *supra* note 39, at 12.

59. *Id.* at 39.

midwives attended only 15% of births.⁶⁰ This trend continued, despite evidence that midwife-assisted births were safer.⁶¹

Midwives today attend births in one of three settings: the hospital, a freestanding birth center, or the woman's home. The Midwives Alliance of North America (MANA) categorizes certified midwives as certified nurse–midwives (CNM), certified professional midwives (CPM), and certified midwives (CM), with differences in where they practice and the scope of their independence.⁶² Modern midwifery rejects an approach to childbirth concerned with identifying pathology and managing illness, instead advancing a vision of “socially oriented preventive care, which incorporates prenatal care and a concern for the social and emotional aspects of pregnancy and birth.”⁶³ This philosophy generally makes midwives the birth attendants of choice in most countries; however, as of 2015, there were only about 11,000 practicing CNMs in the U.S. and far fewer CPMs or CMs.⁶⁴ In fact, among developed nations, only the U.S. and Canada rely predominantly on specialists, rather than midwives, to provide maternity care to healthy women.⁶⁵ Legal restrictions on midwifery persist—sometimes in the form of criminal prosecution—and many women cannot choose a mid-

60. Judy B. Litoff, *An Enduring Tradition: American Midwives in the Twentieth Century*, in *THE AMERICAN MIDWIFE DEBATE: A SOURCEBOOK ON ITS MODERN ORIGINS* 9 (Judy B. Litoff ed., 1986).

61. *Id.* at 5 (noting that early twentieth-century studies showed “maternal mortality rates were lowest in those localities reporting the highest percentage of midwife-attended births”). In 1925, a national conference at the White House announced, “the record of trained midwives . . . surpasses the record of physicians in normal deliveries.” Judith P. Rooks, *Nurse Midwifery: The Window Is Wide Open*, 90 *AM. J. NURSING* 30, 31 (1990).

62. *What Is a Midwife?*, MIDWIVES ALLIANCE OF N. AM. (MANA), <http://mana.org/about-midwives/what-is-a-midwife>, archived at <http://perma.unl.edu/AK3R-KQTL> (last visited Nov. 8, 2015). MANA also recognizes traditional midwives or community-based midwives, consisting of those midwives who choose not to become certified or licensed due to religious, personal, or philosophical reasons.

63. Suarez, *supra* note 7, at 346–47. The Midwives Model of Care includes: monitoring the physical, psychological and social wellbeing of the mother throughout the childbearing cycle; providing the mother with individualized education, counseling and prenatal care; continuous hands-on assistance during labor and delivery; minimizing technological interventions; and identifying and referring women who require obstetrical attention. *Midwifery Model*, MANA, <http://mana.org/about-midwives/midwifery-model>, archived at <http://perma.unl.edu/56FB-JLAC> (last visited Nov. 8, 2015).

64. *See Midwives & Birth in the United States*, AM. COLL. OF NURSE-MIDWIVES (ACNM), <http://www.midwife.org/Essential-Facts-about-Midwives>, archived at <http://perma.unl.edu/EN6A-Q224> (last updated Feb. 2015) (reporting the existence of 11,018 CNMs and 88 CMs, who together attend 92% of all midwife-assisted births).

65. SAKALA & CORRY, *supra* note 9, at 62. In addition to obstetricians and midwives, maternity care is also provided by some family physicians, who tend to practice with a primary care orientation that is more aligned with midwifery than with the specialist training of obstetricians. *See id.* at 63.

wife as their primary care provider during pregnancy due to geography or lack of insurance coverage.

The historical shift from midwife to obstetrician as the primary birth attendant for American women mirrors childbirth's move from home to hospital. Throughout the eighteenth and nineteenth centuries, most women gave birth at home; hospitals were considered the last resort for poor, homeless, or working-class women.⁶⁶ Beginning in the early twentieth century, middle- and upper-class women increasingly sought hospital births, influenced by new theories of germ transmission, desirous of pain medication, and convinced of the superior expertise of physicians in matters of childbirth.⁶⁷ Historian Judith Walzer Leavitt calls the shift from home to hospital the "single most important transition in childbirth history," reflecting how common hospital practices—such as the exclusion of friends and family from the birth, the separation of mother and child after delivery, and the confining of the woman to a hospital bed—transformed the birthing experience.⁶⁸

The vast majority of American women still choose to give birth in a hospital, accounting for over 98% of births in 2012,⁶⁹ but options for out-of-hospital births exist. Women who live near one of the approximately eighty freestanding birth centers across the country and are experiencing a low-risk pregnancy might choose this approach, which emerged in the last decades of the twentieth century as an alternative to hospital birth.⁷⁰ Birth centers are staffed by CNMs and CPMs and do not provide interventions typically available in hospitals.⁷¹ The average cost of childbirth in a freestanding birth center is approximately one-quarter the cost for an uncomplicated vaginal birth in a hospital.⁷² Other women choose to give birth at home with a midwife (or in a tiny number of cases, unassisted). Although they represent a small

66. See WERTZ & WERTZ, *supra* note 39, at 132.

67. See LEAVITT, *supra* note 39, at 39, 173–74 (“It was more the image of science’s potential, the lure of what science could offer, than any proven accomplishments that attracted women to the hospital.”).

68. *Id.* at 195.

69. MARIAN F. MACDORMAN ET AL., NAT’L CTR. FOR HEALTH STATISTICS, TRENDS IN OUT-OF-HOSPITAL BIRTHS IN THE UNITED STATES, 1990–2012, at 1 (2014) [hereinafter TRENDS IN OUT-OF-HOSPITAL BIRTHS].

70. Susan Rutledge Stapleton et al., *Outcomes of Care in Birth Centers: Demonstration of a Durable Model*, 58 J. MIDWIFERY & WOMEN’S HEALTH 1, 3–14 (Jan.-Feb. 2013) (studying maternity care at seventy-nine birth centers across the U.S. from 2007–2010).

71. Birth centers do not administer oxytocin to induce labor, monitor the fetal heart rate intermittently with a Doppler ultrasound, and offer no pharmacologic pain relief (other than local analgesia to suture tears in the perineum). See SHEILA KITZINGER, *HOMEBIRTH: THE ESSENTIAL GUIDE TO GIVING BIRTH OUTSIDE THE HOSPITAL* 58 (1991) (noting birth centers perform few episiotomies and no operative deliveries).

72. MATERNITY CARE FACTS AND FIGURES, *supra* note 13, at 1.

fraction of the annual U.S. birth rate, the number of out-of-hospital births has slowly been climbing—accounting for 1.36% of births in 2012.⁷³ Approximately two-thirds of out-of-hospital births are home births.⁷⁴ In 2012, the percentage of out-of-hospital births was higher for non-Hispanic white women than for any other group, representing one in forty-nine births to non-Hispanic white women.⁷⁵

The shift to physician-attended hospital births introduced a variety of medical interventions into the laboring process, reflecting both the availability of technological equipment and the orientation of physicians to birth as an adverse health condition requiring management. As historians Richard W. Wertz and Dorothy C. Wertz note, although physicians brought “more precise and effective manipulations and interventions, both to prevent and to cure disease,” they were also “on the lookout for trouble in birth.”⁷⁶ The language and practices of this medically oriented childbirth paradigm can be traced to the work of Dr. Joseph DeLee, the author of the most prominent obstetric textbook in the 1920s. Characterizing childbirth as a pathological process that demands a program of active control over labor and delivery, he introduced various interventions to save women from the “evils natural to labor,”⁷⁷ such as sedation, preventive episiotomies, regular use of forceps, and placental extraction. Although they were introduced without thorough investigation of their risks and benefits, many of DeLee’s interventions have persisted almost a century later. The model of twenty-first-century childbirth—characterized by high rates of intervention without improving outcomes—has been referred to as the “perinatal paradox: doing more and accomplishing less.”⁷⁸

73. TRENDS IN OUT-OF-HOSPITAL BIRTHS, *supra* note 69, at 1 (reporting an increase in the percentage of out-of-hospital births from 0.87% in 2004 to 1.36% in 2012). The National Center for Health Statistics defines “out-of-hospital” to include home, birth center, clinic or doctor’s office, or any other non-hospital location.

74. *Id.* Of the 53,635 out-of-hospital births in 2012, 66% occurred at home and 29% took place in freestanding birth centers (with the remaining 5% percent of babies arriving in a clinic, doctor’s office, or other location). *Id.*

75. *Id.* at 2. Non-Hispanic white women also account for about 89% of the total increase in out-of-hospital births from 2004–2012. *Id.* Because many insurers do not cover home births, many women pay out-of-pocket for their home births, an option that is unavailable to lower-income women, who are disproportionately women of color.

76. WERTZ & WERTZ, *supra* note 39, at 136.

77. JUDITH ROOKS, MIDWIFERY AND CHILDBIRTH IN AMERICA (1997) (noting how DeLee’s work “changed the focus of health care during labor and delivery from responding to problems as they arose to preventing problems through routine use of interventions,” which eventually were applied to all women in labor, regardless of whether they had any diagnosed complication).

78. Roger A. Rosenblatt, *The Perinatal Paradox: Doing More and Accomplishing Less*, 8 HEALTH AFFAIRS 158, 158–68 (1989).

III. THE ACA AND MATERNITY CARE

After vigorous public debate and a long, contentious legislative battle, President Obama signed the ACA into law on March 23, 2010.⁷⁹ The law's passage was particularly remarkable considering the decades of resistance to federal health care reform.⁸⁰ The ACA's drafters identified the high costs and the unavailability of affordable health insurance as barriers to health care access, and developed an interdependent set of reforms to expand coverage, decrease costs, and improve the quality of health care in the U.S. Among the ACA's innovations are the expansion of Medicaid eligibility, the requirement that previously uninsured individuals purchase insurance, the creation of federal subsidies to enable individuals to comply with the law, the requirement that large employers provide health insurance to employees, and a series of insurance market regulations aimed at eliminating previous barriers to coverage. The ACA also contains various measures to improve the quality of health care delivery, a necessary component of improving health outcomes. Among the ACA's many "environment-altering" reforms are the establishment of health care exchanges or marketplaces for the purchase of individual and small-group coverage, mandated appeals mechanisms by private insurers, initiatives to improve public health systems, and programs to enlarge the health care workforce.⁸¹

While the ACA expands coverage and regulates the health insurance industry to an unprecedented extent, the law preserves the system of private insurance that developed throughout the twentieth century, which maintains employer-sponsored plans and the individual market as two separate avenues for acquiring insurance if one is not covered by a government insurance program. Despite the perpetuation of existing fragmentation in health care,⁸² the ACA brings affordable coverage to a significant portion of the previously uninsured and underinsured population, including millions of women, and effects positive changes in health care delivery as a whole. At the time of the ACA's passage, there were approximately 52 million uninsured people

79. See Janet L. Dolgin and Katherine R. Dieterich, *Social and Legal Debate About the Affordable Care Act*, 80 U.M.K.C. L. REV. 45, 51 (2011) (describing the process of passing the ACA and the controversy surrounding use of the reconciliation process).

80. See *id.* at 48 n.23 (noting that at least seven presidents tried and failed to reform U.S. health care during the twentieth century).

81. Michael J. DeBoer, *Access Without Limits? Revisiting Barriers and Boundaries After the Affordable Care Act*, 44 CONN. L. REV. 1239, 1260–61 (2012).

82. See generally THE FRAGMENTATION OF U.S. HEALTH CARE: CAUSES AND SOLUTIONS (Einer Elhague ed., 2010).

in the U.S.⁸³ Although the individual mandate and subsidized marketplaces did not go into effect until 2014, approximately one million people were projected to gain coverage under ACA provisions implemented from 2010–2013, with millions more seeing improvements to their coverage under new regulations prohibiting lifetime or annual limits on coverage benefits and restricting insurers' ability to rescind coverage.⁸⁴ The Congressional Budget Office (CBO) estimated that the expansion of Medicaid and creation of the state exchanges would reduce the number of uninsured Americans by approximately 32 million, while nevertheless leaving undocumented immigrants, low-wage earners, and others who cannot afford even subsidized plans still without insurance.⁸⁵ After the U.S. Supreme Court upheld the constitutionality of the ACA's individual mandate in 2012, the CBO estimated that the ACA would reduce the number of non-elderly uninsured individuals by 14 million in 2014 and by 29 to 30 million later in the decade.⁸⁶

Although women and men were equally likely to be uninsured before the ACA, women's specific health care needs—especially during their childbearing years—“le[ft] them more exposed to the rapidly rising costs of care and to the problems resulting from loss of health coverage.”⁸⁷ Women faced more difficulty acquiring coverage through the individual market and were often charged higher premiums for the same benefits than men of the same age.⁸⁸ Further, the vast majority of policies sold on the pre-ACA individual market did not cover pregnancy-related costs.⁸⁹ A 2010 analysis predicted that up to 15 million uninsured women could gain subsidized coverage under the ACA, with an additional 14.5 million women benefiting from ACA provisions designed to expand coverage or reduce premiums.⁹⁰ Before implementation of the law, roughly half of uninsured women had incomes less than 138% of the federal poverty level (FPL) and would qualify for expanded Medicaid; another 37% of uninsured women had incomes between 139% and 399% of the FPL, making them eligible for subsi-

83. SARA R. COLLINS ET AL., THE COMMONWEALTH FUND, INSURING THE FUTURE: CURRENT TRENDS IN HEALTH COVERAGE AND THE EFFECTS OF IMPLEMENTING THE AFFORDABLE CARE ACT 3 (2013).

84. SARA R. COLLINS ET AL., THE COMMONWEALTH FUND, REALIZING HEALTH REFORM'S POTENTIAL: WOMEN AND THE AFFORDABLE CARE ACT OF 2010, at 3–4 (2010) [hereinafter REALIZING HEALTH REFORM'S POTENTIAL].

85. CONG. BUDGET OFFICE, ESTIMATES FOR THE INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT UPDATED FOR THE RECENT SUPREME COURT DECISION (2012), archived at <http://perma.unl.edu/LXM8-723W>.

86. *Id.*

87. REALIZING HEALTH REFORM'S POTENTIAL, *supra* note 84, at 1.

88. *Id.*

89. *Id.*

90. *Id.*

dized insurance purchased through a state or federal exchange.⁹¹ As of 2011, approximately 13% of pregnant women remained uninsured, with more facing under-insurance.⁹² Though the ACA touches all aspects of women's health, this Article focuses on the Act's impact on health care related to pregnancy and birth. The remainder of Part III examines how the ACA impacts maternity care by increasing insurance coverage, improving the benefits available to insured women, and investing in relevant programmatic and policy initiatives.

A. The ACA's Significant Expansion of Access to Maternity Coverage

Given that insurance is a gateway to health care in the U.S., the ACA's greatest contribution to maternity care is arguably the increased coverage for previously uninsured women. Americans access health coverage through one of several sources: some are covered by an employer-sponsored plan, with both employer and employee receiving tax benefits for contributing to the cost of insurance; others purchase individual coverage on the open market; and some access coverage through a government-sponsored insurance program. At the time of the ACA's passage, 56% of the insured population was covered by an employer-sponsored plan, 8% purchased individual coverage, and 31% accessed government-sponsored insurance.⁹³ The inclusion of maternity benefits in a woman's health insurance package would vary depending on the source of her insurance. For example, federal law requires that employers who make health insurance available to employees include maternity care in the coverage to avoid unlawful discrimination on the basis of sex.⁹⁴ But small businesses with fewer than fifteen employees are exempt from the law, leaving the matter of maternity care coverage to the employer's discretion.⁹⁵ In the individual market, most pre-ACA plans excluded maternity coverage altogether; where coverage was available, women often faced burdensome rules or benefits limits that effectively restricted access to care. Women eligible for government-sponsored health insurance had mater-

91. KAISER FAMILY FOUND., *HEALTH REFORM: IMPLICATIONS FOR WOMEN'S ACCESS TO COVERAGE AND CARE* 2 (2013).

92. Nicole Moody, Comment, *Health Reform and the Plight of the Uninsured Pregnant Woman*, 90 OR. L. REV. 643, 655 (2012).

93. CARMEN DENAVAS-WALT ET AL., U.S. CENSUS BUREAU, *INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2009*, at 24–25 fig.8 (2010).

94. 42 U.S.C. § 2000e(k) (2012) (requiring employers with more than fifteen employees to cover pregnancy-related expenses to the same extent it covers other medical conditions).

95. *But see* Adam Sonfield, *The Potential of Health Care Reform to Improve Pregnancy-Related Services and Outcomes*, 13 GUTTMACHER POL'Y REV. 13, 17 (2010) (discussing state law versions of the Pregnancy Discrimination Act that include small employers as well).

nity benefits included in their coverage; in fact, under pre-ACA Medicaid rules, pregnancy made a previously uninsured woman eligible for coverage, but only until sixty days after giving birth.

It is important to note that one significant gap in maternity coverage remains: undocumented immigrants cannot benefit from the ACA's reforms due to their exclusion from Medicaid and a rule prohibiting them from purchasing insurance on an exchange (even if paid entirely out of pocket).⁹⁶ Undocumented immigrants will continue to resort to emergency rooms for non-emergency health care needs, and many immigrant women will lack access to proper prenatal and postpartum care.⁹⁷ The CBO estimates that once the ACA is fully implemented, undocumented immigrants will comprise nearly one-third of the uninsured population.⁹⁸

The ACA increases access to maternity coverage through a variety of mechanisms. Some reforms impact all insurance, regardless of the source, while others are specific to the mode of coverage—government-sponsored, employer-sponsored, or through the individual market. In sections III.A and III.B, this Article first addresses reforms that universally apply to all types of coverage, and then considers provisions of the ACA that apply only in certain contexts.

1. *ACA Reforms that Apply Regardless of Coverage Source*

The ACA regulates insurance practices that previously acted as barriers to accessing or paying for maternity care. Significantly, the law prohibits insurers from using a preexisting condition to exclude a

96. ACA § 1312(f)(3), 42 U.S.C. § 18032(f)(3) (2012); see also Greg Siskind, *The Impact of Immigration Reform on the Healthcare Sector*, 26 HEALTH L. 9, 12 (2014); Vinita Andrapalliyal, "Healthcare for All?" *The Gap Between Rhetoric and Reality in the Affordable Care Act*, 61 UCLA L. REV. DISCOURSE 58, 62 (2013); Stephen Zuckerman et al., *Undocumented Immigrants, Left Out of Health Reform, Likely to Continue to Grow as Share of the Uninsured*, 30 HEALTH AFFAIRS 1997, 1999, 2002 (2011).

97. See Janet L. Dolgin & Katherine R. Dieterich, *When Others Get Too Close: Immigrants, Class, and the Health Care Debate*, 19 CORNELL J. L. & PUB. POL'Y 283, 286–87 (2010). Fifteen states provide prenatal care to undocumented immigrants under the Children's Health Insurance Program's (CHIP) unborn child option, using federal law's definition of a fetus as a child for the purposes of CHIP administration as a way to make maternity coverage available to pregnant immigrants; three other states offer prenatal care to undocumented immigrants using state funds only. *Medical Assistance Programs for Immigrants in Various States*, NAT'L IMMIGR. L. CTR., <http://www.nilc.org/document.html?id=159>, archived at <http://perma.unl.edu/79LK-DF36> (last updated Sept. 2015).

98. *CBO's Analysis of the Major Health Care Legislation Enacted in March 2010: Hearing on H.R. 3950 Before the Subcomm. on Health of the H. Comm. on Energy and Commerce*, 112th Cong. 1 (2011) (statement of Douglas W. Elmendorf, Director, CBO), archived at <http://perma.unl.edu/E5FT-NZ6F>.

woman from coverage.⁹⁹ This includes conditions such as a current pregnancy, a prior cesarean, or domestic violence victim status.¹⁰⁰ Over one-quarter of women in the U.S. have a diagnosed preexisting condition that would otherwise have led to the denial of coverage.¹⁰¹ Previously, some insurers would provide higher-priced coverage to women with a prior cesarean or would approve an application only with proof that the woman had been sterilized; it is unknown how many women were unable to acquire health insurance due to pregnancy or domestic violence-related concerns before the ACA was enacted.¹⁰² The ACA also limits an insurer's ability to rescind coverage upon a change in an insured's health status.¹⁰³ Although this provision applies to all employer-sponsored and individual plans, people who obtained coverage on the individual market before the ACA were much more likely to have their benefits cancelled retroactively to the time of enrollment.¹⁰⁴ Researchers estimate that approximately 5,350 women had their coverage rescinded each year before the ACA.¹⁰⁵

Starting in September 2010, the ACA requires that adult children up to age twenty-six be able to join or remain on a parent's health insurance plan.¹⁰⁶ Insurers are required to offer adult-dependent insurance regardless of the dependent's living situation, financial inde-

99. ACA § 2704, 42 U.S.C. § 300gg-4 (2012). The preexisting condition ban did not go into effect until 2014. However, from 2010–2013, the ACA made preexisting condition insurance plans (PCIPs) available to people who had been uninsured for at least six months and who suffered a health problem that impeded their ability to obtain coverage, with \$5 billion allocated to subsidize the gap between premiums collected for PCIPs and the cost of claims for those years. REALIZING HEALTH REFORM'S POTENTIAL, *supra* note 84, at 7. An estimated 200,000 people obtained coverage through PCIPs before the global preexisting condition exclusion ban came into effect. *Id.*

100. ACA § 2704, 42 U.S.C. § 300gg-4.

101. FAMILIES USA, BEING A WOMAN JUST GOT A LITTLE EASIER: HOW THE AFFORDABLE CARE ACT BENEFITS WOMEN 2 (July 2012), *archived at* <http://perma.unl.edu/MR5S-XKUC> (noting 28.4% of U.S. women have a diagnosed pre-existing condition that could lead to a denial of coverage without the ACA's protections).

102. See Denise Grady, *After Cesareans, Some See Higher Insurance Cost*, N.Y. TIMES (June 1, 2008), http://www.nytimes.com/2008/06/01/health/01insure.html?_r=0, *archived at* <http://perma.unl.edu/RKK8-RP7R>.

103. ACA § 2712, 29 C.F.R. § 2590.715-2712. Before this regulation came into effect, rescission was most common in situations where an insured was diagnosed with an expensive health condition and the insurer would initiate an investigation into the insured's enrollment paperwork and health history to find any discrepancies on which to rescind the policy entirely. See REALIZING HEALTH REFORM'S POTENTIAL, *supra* note 84, at 6.

104. REALIZING HEALTH REFORM'S POTENTIAL, *supra* note 84, at 2.

105. *Id.* A 2009 House Energy and Commerce Committee investigation found that between 2003 and 2007, three insurance companies alone rescinded nearly 20,000 policies. *Id.* at 6.

106. ACA § 2714, 29 C.F.R. § 2590.715-2714.

pendence, marital status, or student status.¹⁰⁷ By the end of 2011, approximately 2.5 million young adults had acquired coverage as a result of this provision.¹⁰⁸ The adult dependent mandate (ADM) is an important source of maternity coverage for young women. One study considering the impact of the ADM on spending and use of services based on the experience of one large national employer found that the ADM cohort was more likely to incur claims related to pregnancy, as well as mental health and substance abuse—which together comprised 60% of all inpatient claims.¹⁰⁹ The study found pregnancy-related claims accounted for 19% of inpatient claims in the ADM cohort, compared to 5% in the comparison group.¹¹⁰ However, the ACA does not require that maternity care benefits be included for adult dependents,¹¹¹ and one estimate suggests that approximately 70% of employer plans do not cover dependents' pregnancies.¹¹²

The ACA contains several provisions that expand effective access to health care for pregnant women or those planning to be pregnant by restricting the discretion of insurers over the costs shouldered by their insureds. The ACA bans lifetime coverage limits in all individual and group health plans for services that are classified as essential health benefits (EHBs).¹¹³ The law designates ten categories of health services as EHBs under the ACA: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental

107. *Id.*; see REALIZING HEALTH REFORM'S POTENTIAL, *supra* note 84, at 4. Although actual dependency is not a necessary condition for coverage, the ACA does not extend this coverage to the spouse or children of the adult dependent. See Paul Fronstin, Emp. Benefit Research Inst., *Mental Health, Substance Abuse, and Pregnancy: Health Spending Following the PPACA Adult-Dependent Mandate*, Employee Benefit Research Institute, ISSUE BRIEF, No. 385, at 4 (Apr. 2013).

108. BENJAMIN D. SOMMERS & KARYN SCHWARTZ, U.S. DEPT. HEALTH & HUMAN SERV., 2.5 MILLION YOUNG ADULTS GAIN HEALTH INSURANCE DUE TO THE AFFORDABLE CARE ACT (2011).

109. Fronstin, *supra* note 107, at 9.

110. *Id.*

111. See Amanda Marcotte, *Health Care Reform Leaves Out Young Pregnant Women*, SLATE (Aug. 8, 2012), http://www.slate.com/blogs/xx_factor/2012/08/08/aca_and_pregnancy_many_young_women_not_receiving_maternity_coverage.html, archived at <http://perma.unl.edu/manage/vest/V8BP-H3AZ> (explaining that the PDA requires maternity coverage for an employee's spouse, but not for dependents); Michelle Andrews, *Must Plans Cover Maternity Services for Adult Children?*, N.Y. TIMES (June 28, 2010), <http://prescriptions.blogs.nytimes.com/2010/06/28/must-plans-cover-maternity-services-for-adult-children/>, archived at <http://perma.unl.edu/54SZ-WS9S> (noting that if an employer offers maternity benefits to non-spouse dependents, then it must do so for all dependents up to age twenty-six).

112. *Dependents Often Excluded from Maternity Care Coverage Under Employer-Sponsored Health Plans*, NAT'L P'SHIP FOR WOMEN & FAMILIES (Aug. 7, 2012), http://go.nationalpartnership.org/site/News2?page=newsArticle&id=34794&news_iv_ctrl=0&abbr=daily2_, archived at <http://perma.unl.edu/R9RZ-7QE5>.

113. ACA § 2711, 42 U.S.C. § 300gg-11 (2012).

health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services (including chronic disease management), and pediatric services (including oral and vision care).¹¹⁴ Before the law went into effect, approximately 102 million people were covered by plans with lifetime coverage limits, and between 9,325 to 10,200 women surpassed the plan limit each year.¹¹⁵ The ACA also eliminates annual limits on benefits paid for EHBs, with an exception for grandfathered plans sold on the individual market.¹¹⁶ Before the ACA, an estimated 18 million people were covered under plans with annual benefit limits.¹¹⁷ Although the bans on lifetime and annual limits only apply to EHBs, meaning insurers can still put dollar limits on non-essential services, the designation of maternity care as an EHB means that no woman will lack coverage for pregnancy and birth-related costs because of spending limits. Finally, the ACA limits the total annual cost-sharing obligations for EHBs, including maternity care, offered under all types of plans.¹¹⁸ The maximum amount an individual could incur in cost-sharing in 2010 was \$5,950 for an individual and \$11,900 for a family, to be adjusted annually for cost-of-living. Although there is no requirement that employer-sponsored insurance cover all EHBs, where an employer plan does provide such coverage, it must adhere to the cost-sharing limits for EHBs.¹¹⁹ This would include those employers

114. ACA § 1302(b)(1), 42 U.S.C. § 18022(b)(1); *see also* Patient Protection and Affordable Care Act: Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. Vol. 12,834, 12,866 (Feb. 25, 2013) (to be codified at 45 C.F.R. pts. 147, 155–56) (listing required categories of EHBs). For more discussion of EHBs, *see infra* section III.B.

115. *See* REALIZING HEALTH REFORM'S POTENTIAL, *supra* note 84, at 4–5.

116. ACA § 1001(5), 42 U.S.C. § 300gg-11. The ACA phased in this restriction beginning in September 2010, raising the permissible annual limit for benefits each year until such limits were banned entirely in 2014. REALIZING HEALTH REFORM'S POTENTIAL, *supra* note 84, at 2, 5.

117. REALIZING HEALTH REFORM'S POTENTIAL, *supra* note 84, at 2. By 2013, an estimated 1,750 women gained coverage because of the ban on annual benefit limits. *Id.*

118. ACA § 1302(c), 42 U.S.C. § 18022(c); Patient Protection and Affordable Care Act: Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, Final Rule, 78 Fed. Reg. 12,834, 12,837 (Feb. 25, 2013) (interpreting the out-of-pocket maximums as applying to all non-grandfathered plans).

119. ACA §§ 1201, 1301, 42 U.S.C. §§ 300gg-6, 18022; *see also* Allison K. Hoffman, *Health Care Spending and Financial Security After the Affordable Care Act*, 92 N.C. L. REV. 1481, 1510 n.124 (2014) (noting that the ACA creates an incentive for employers not to cover those services that have been designated as EHBs because providing such coverage subjects them to restrictions on annual and lifetime caps, as well as the ACA's out-of-pocket spending limits). In the maternity care context, the concern Hoffman raises would only apply to those employers exempt from the Pregnancy Discrimination Act.

large enough to be covered by the Pregnancy Discrimination Act and other employers who provide maternity coverage voluntarily.

2. *ACA Reforms that Apply to Particular Modes of Coverage*

Some access-increasing provisions of the ACA only apply to certain types of insurance. Before the ACA, the market for individual insurance coverage had limited availability and restrictive pricing that put coverage out of reach for millions of people. Medicaid, too, restricted access for millions of uninsured people with strict eligibility rules based on income and status. This subsection considers the ACA's impact on each source of insurance in turn.

a. *Individual Market*

One of the ACA's most significant reforms is the requirement that all individuals (with certain exceptions) have health insurance that meets minimum essential coverage requirements.¹²⁰ Beginning in 2014, individuals who fail to purchase such insurance are subject to a tax,¹²¹ the constitutionality of which was upheld by the U.S. Supreme Court in 2012.¹²² In order to help individuals comply with the mandate, the ACA facilitates the creation of subsidized insurance exchanges or marketplaces, where consumers can compare available plans and choose the coverage that best fits their health and financial circumstances.¹²³ Insurers can still offer coverage in the non-exchange individual market, subject to other ACA rules, but only those plans purchased through the exchange are eligible for federal subsi-

120. ACA § 1302, 42 U.S.C. § 18022(c); *see also* Wendy K. Mariner, *The Affordable Health Care Act and Health Promotion: The Role of Insurance in Defining Responsibility for Health Care Risks and Costs*, 50 DUQ. L. REV. 271, 280 (2012) (discussing the principles of shared risk underlying the ACA). Exemptions are available for financial hardship, religious objections, American Indians, those without coverage for less than three months, undocumented immigrants, incarcerated individuals, those for whom the lowest cost option exceeds 8% of an individual's income, and those with incomes below the tax-filing threshold. *See* KAISER FAMILY FOUND., FOCUS ON HEALTH REFORM: SUMMARY OF THE AFFORDABLE CARE ACT 1 (2013) [hereinafter FOCUS ON HEALTH REFORM], *archived at* <http://perma.unl.edu/9LDT-DGEG> (explaining the formula for determining the tax penalty). Adults under age thirty who are ineligible for subsidized coverage, or who cannot find a plan with a premium that costs 8% or less of their income, may buy catastrophic insurance plans with a skeletal set of benefits. *See* REALIZING HEALTH REFORM'S POTENTIAL, *supra* note 84, at 10.

121. The tax amounts to the greater of either a flat rate or a share of household income. *See* FOCUS ON HEALTH REFORM, *supra* note 120, at 1.

122. Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012).

123. *See* KAISER FAMILY FOUND., EXPLAINING HEALTH CARE REFORM: WHAT ARE HEALTH INSURANCE EXCHANGES? 1 (2009), *archived at* <http://perma.unl.edu/FA3A-9N4V>. All exchanges must offer plans with coverage at four levels of cost-sharing based on actuarial estimates: bronze (covers an average of 60% of enrollee's medical costs), silver (70%), gold (80%), or platinum (90%). *Id.* at 3.

dies.¹²⁴ Although the statute contemplates each state creating its own exchange, the ACA authorizes HHS to operate an exchange for any state that did not create its own by 2014;¹²⁵ as of 2015, fourteen states had created their own exchange,¹²⁶ with citizens of the remaining states using the federal government's website to purchase individual coverage.¹²⁷

Low- and moderate-income consumers who purchase individual insurance through an exchange may be eligible for tax credits to pay for their insurance premiums. In 2015, the U.S. Supreme Court confirmed that individuals could receive federal subsidies regardless of whether they purchased insurance through an exchange maintained by a state or the federal government.¹²⁸ Such credits are only available to those who lack government-sponsored coverage or affordable employer-sponsored coverage.¹²⁹ Individuals who are enrolled in an employer-based plan, but spend more than 9.5% of their income on premiums or have cost-sharing obligations of more than 40%, may be eligible for subsidized coverage through the exchanges, where they will have access to better benefits and lower out-of-pocket spending.¹³⁰ Tied to silver-level plans, the credits cap premium contributions at approximately 3% of income for individuals and families earning just over 133% of the FPL and gradually increases to 9.5% of income for those earning 300–399% of the FPL.¹³¹ When the exchanges became operational in January 2014, approximately 7 million uninsured adult women under age sixty-five became eligible for subsidized coverage through the exchanges.¹³² An estimated 1.6 uninsured women (about 10% of all uninsured women) earned too much to receive premium credits but still benefited from the consumer protections that apply to all plans offered on the individual market, including the essential health benefits package.¹³³

124. REALIZING HEALTH REFORM'S POTENTIAL, *supra* note 84, at 10.

125. ACA § 1321, 42 U.S.C. § 18022(c).

126. *State Health Insurance Marketplace Types, 2016*, KAISER FAMILY FOUND., <http://kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/#note-3>, archived at perma.unl.edu/FDX3-ALV7 (last visited Jan. 23, 2016). On December 30, 2015, newly elected Republican Governor Matt Bevin notified CMS that Kentucky would dismantle its exchange and transition to the federally facilitated marketplace by 2017.

127. See U.S. Dept. Health & Human Servs., *Individuals & Families*, HEALTHCARE.GOV, <http://www.HealthCare.gov>, archived at <http://perma.unl.edu/7QZQ-EBZR> (last visited Nov. 8, 2015).

128. King v. Burwell, 135 S. Ct. 2480 (2015).

129. ACA §§ 1401–02 (codified as amended in scattered sections of 26 and 42 U.S.C.) (setting limits on cost sharing and making tax credits available to those earning between 133–400% of the FPL).

130. REALIZING HEALTH REFORM'S POTENTIAL, *supra* note 84, at 12.

131. *Id.* at 5 tbl.2, 10.

132. *Id.* at 10.

133. *Id.*

In addition to providing tax credits to subsidize premiums, the ACA also provides credits to reduce the burden of cost sharing for eligible individuals who purchase insurance through the exchange.¹³⁴ These credits reduce out-of-pocket costs under a silver plan bought on the exchange from 30% of total medical costs to 6% for people earning up to 150% of the FPL; the limit rises to 13% for those with incomes up to 200% of the FPL, and to 27% for those earning from 201–249% of the FPL.¹³⁵ Before the ACA, an estimated 14.5 million women were considered underinsured due to high out-of-pocket costs relative to income.¹³⁶

In addition to tackling the general affordability of insurance purchased on the individual market, the ACA also eliminates pricing discrimination against women in the individual market, known as “gender rating.”¹³⁷ The majority of insurers participating in the pre-ACA individual market engaged in gender rating, charging higher premiums of women than of men of the same age for the same coverage, though such practices were not supported by actuarial justification, as evidenced by the significant variation in rates charged across states and insurance companies.¹³⁸ Before the ACA, thirty-seven states permitted some form of gender rating in the individual market.¹³⁹ One study that examined insurance available in the capital cities of states that permitted gender rating found that 92% of the best-selling plans engaged in gender rating, and in thirty-one states,

134. ACA §§ 1401–02 (codified as amended in scattered sections of 26 and 42 U.S.C.). The House of Representatives sued the Administration to block the cost-sharing reductions for low-income enrollees, arguing that such reductions are illegal as unappropriated payments. See Timothy Jost, *Implementing Health Reform: House Can Sue Administration Over ACA Cost-Sharing Reduction Payments*, HEALTH AFFAIRS BLOG (Sept. 10, 2015), <http://healthaffairs.org/blog/2015/09/10/implementing-health-reform-house-can-sue-president-over-aca-cost-sharing-reduction-payments/>, archived at <http://perma.unl.edu/CA7D-G9LU>. In September 2015, a federal district court allowed the claim to proceed. *Id.*

135. REALIZING HEALTH REFORM’S POTENTIAL, *supra* note 84, at 10.

136. *Id.* at 2–3.

137. Though insurers can no longer take gender into account when setting rates, premiums may reflect age, tobacco use, family composition, geography, and participation in a health promotion program. *Id.* at 9.

138. NAT’L WOMEN’S LAW CTR. (NWLC), TURNING TO FAIRNESS: INSURANCE DISCRIMINATION AGAINST WOMEN TODAY AND THE AFFORDABLE CARE ACT 5, 8 (2012), archived at <http://perma.unl.edu/8K2L-B3VA>. In the large-group market for employer-sponsored insurance, Title VII prohibits employers from charging female employees higher premiums than men, though insurers may charge employers higher rates if there are more women than men in the workforce, with the cost of higher premiums spread across all members of the risk pool. Businesses that predominantly employ women experience the impact of gender rating the most. *Id.* at 9–11 (describing gender rating in the group-insurance market).

139. *Id.* at 8 (noting thirteen states had banned gender rating, and how Vermont instituted rate “bands” that set limits on the amount an insurer can vary premiums by sex).

all of the best-selling plans charged higher premiums of women.¹⁴⁰ Women spent approximately \$1 billion more for health insurance annually than did men, not including any additional costs for maternity coverage, which were excluded from the primary insurance plan.¹⁴¹ When combined with the elimination of preexisting condition exclusions, the ban on gender rating represents a significant improvement in effective access for millions of previously uninsured or underinsured women. According to one study, an estimated 7.3 million women who tried to buy insurance on the individual market over a three-year period before the ACA's implementation were denied coverage, charged more, or had a condition excluded from coverage entirely as a preexisting condition.¹⁴² As with the ACA's other regulatory reforms that restrict insurers' rate-setting discretion, the ban on gender rating ensures effective access to insurance for millions of women who previously found all available insurance priced out of their reach.

b. Medicaid

The ACA makes several changes to the Medicaid program that will enable easier access to maternity care for low-income women. Medicaid is the jointly financed state-federal health coverage program for poor and low-income people, which provided more than 22.4 million women with basic coverage in 2009 before passage of the ACA.¹⁴³ Even before the ACA, federal law required states to offer Medicaid coverage for pregnancy-related care to women with family incomes at or below 133% of the FPL; states had the option to receive matching federal funds to expand Medicaid to pregnant women with incomes up to 185% of the FPL.¹⁴⁴ Pregnancy-related coverage includes prenatal care, labor and delivery, and health care for sixty days postpartum. Prior to the ACA, non-pregnant, non-elderly adults without children were not eligible for Medicaid in most states regardless of income, though some states provided coverage for parents of dependent children at very low income levels.¹⁴⁵ One of the ACA's greatest contribu-

140. *Id.* at 7. Of the plans examined that engaged in gender rating in 2012, only 3% included maternity care, meaning maternity coverage did not account for the difference in premium costs between men and women. *Id.*

141. *Id.*

142. REALIZING HEALTH REFORM'S POTENTIAL, *supra* note 84, at 3, 6 tbl.3.

143. KAISER FAMILY FOUND., MEDICAID'S ROLE FOR WOMEN ACROSS THE LIFESPAN: CURRENT ISSUES AND THE IMPACT OF THE AFFORDABLE CARE ACT 1 (2012) [hereinafter LIFESPAN].

144. *Id.* Expanded Medicaid could provide full coverage or cover only pregnancy-related services, at the discretion of the individual state. NAT'L P'SHIP FOR WOMEN & FAMILIES, WHY THE AFFORDABLE CARE ACT MATTERS FOR WOMEN: HEALTH INSURANCE COVERAGE FOR LOWER- AND MODERATE-INCOME PREGNANT WOMEN 3 (2014) [hereinafter NPWF FACT SHEET]. Medicaid pays for 40–50% of all U.S. births. LIFESPAN, *supra* note 143, at 3.

145. REALIZING HEALTH REFORM'S POTENTIAL, *supra* note 84, at 9.

tions in terms of increasing access to health insurance is the expansion of Medicaid to all adults with incomes up to 138% of the FPL.¹⁴⁶ Although the ACA required states to expand coverage to all adults below the income threshold, the U.S. Supreme Court ruled in 2012 that mandated expansion was unconstitutional, leaving Medicaid expansion to state discretion.¹⁴⁷ As of January 2016, thirty-one states and the District of Columbia have opted to expand Medicaid coverage.¹⁴⁸

Medicaid expansion stood to have the greatest impact among women, as nearly half of all uninsured women before the ACA lived in households with incomes under 133% of the FPL,¹⁴⁹ which makes them eligible under the ACA, though the law's impact in this regard has been somewhat blunted by the continuing refusal of nineteen states to accept federal expansion funds. Approximately 7 million women were expected to be newly eligible for Medicaid coverage as a result of the ACA.¹⁵⁰ Although Medicaid for pregnancy-related care was already available before the ACA, coverage for all income-eligible women of childbearing age in expansion states ensures that more women will receive regular health care before getting pregnant and therefore be able to prepare for a healthy pregnancy. Medicaid expansion also eliminates the problem of delays in establishing coverage for newly covered pregnant women upon confirming a pregnancy, resulting in delayed access to prenatal care.

Other ACA reforms improve access to Medicaid for women of childbearing age. As of January 2014, state Medicaid programs and state exchanges were streamlined so that individuals attempting to enroll in coverage who are identified as Medicaid-eligible are automatically enrolled in Medicaid without a separate application, thereby capturing women who did not know they were eligible for Medicaid.¹⁵¹ The Act resolved problems related to complicated income eligibility

146. ACA § 2001 (codified as amended in scattered sections of 42 U.S.C. (2014)). The ACA extends Medicaid coverage to all individuals with incomes up to 133% of the FPL and includes a provision to disregard the first 5% of income, which means that Medicaid is effectively available to all individuals with incomes up to 138% of the FPL. In 2015, the FPL was \$11,770 for a single adult and \$24,250 for a family of four. *2015 HHS Poverty Guidelines*, U.S. DEPT. HEALTH & HUMAN SERVS., <http://aspe.hhs.gov/2015-poverty-guidelines>, archived at <http://perma.unl.edu/7R7G-AD88> (last visited Jan. 28, 2016).

147. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (2012).

148. *Current Status of State Medicaid Expansion Decisions*, KAISER FAMILY FOUND., <http://kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision/>, archived at <http://perma.unl.edu/5AFP-EFS3> (last visited Jan. 23, 2016). Virginia, South Dakota, and Wyoming are currently discussing expanding Medicaid. *Id.*

149. REALIZING HEALTH REFORM'S POTENTIAL, *supra* note 84, at 9.

150. LIFESPAN, *supra* note 143, at 6 (reflecting a post-*Sebelius* projection).

151. ACA § 2201(b)(1)(B), 42 U.S.C. § 1396w-3.

standards that varied across states, implementing the same uniform modified gross-income standard that determines eligibility for subsidies for coverage purchased through the exchanges.¹⁵² The ACA also extended Medicaid eligibility to adults under age twenty-six who were formerly in state foster care.¹⁵³ Finally, the Act mandated a temporary two-year increase in reimbursement rates for primary care providers who accept Medicaid, addressing concerns about a shortage of providers willing to accept new Medicaid patients.¹⁵⁴

Certain women will continue to lack insurance coverage, despite the ACA's Medicaid reforms. Women living in non-expansion states who are not eligible for Medicaid and are too poor to qualify for subsidized insurance through an exchange fall into the "Medicaid gap" and will remain uninsured—an unintended consequence of the Supreme Court's ruling that made Medicaid expansion optional for states.¹⁵⁵ Legal immigrants must wait five years before they are eligible for Medicaid; they can use the exchanges to buy subsidized insurance on the individual market, but legal immigrants with incomes at or below the FPL are not eligible for either subsidies or Medicaid, at least for the first five years.¹⁵⁶ Undocumented immigrants continue to be excluded from Medicaid coverage entirely.

B. The ACA's Improvement of Maternity Care Benefits

Affordable health insurance may be the initial gateway to accessing health care, but the matter of which benefits are covered under a particular insurance plan is also an important factor in determining what care people receive and whether they can pay for needed services. This section examines the ACA's contribution to improving maternity care benefits under different types of insurance. While it is possible to interpret quite broadly the question of what impacts ma-

152. 42 U.S.C. § 1396a(e) (2012).

153. *Id.* § 1396a(a)(10)(A)(i)(IX).

154. LIFESPAN, *supra* note 143, at 6. Historically, Medicaid payment rates have been approximately 66% of the rates Medicare providers receive (and even lower in some states). Although Congress did not extend the increase beyond the end of 2014, some states have decided to continue the fee increase using state funds. See Susan Sumrell, *Medicaid Fee Bump Expires in 2015: The Impact on Primary Care Provider Payments in States*, NAT'L ASS'N OF CMTY. HEALTH CTRS. (Jan. 6, 2015), <http://blogs.nachc.com/policyshop/medicaid-fee-bump-expires-in-2015-the-impact-on-primary-care-provider-payments-in-states/>, archived at <http://perma.unl.edu/XY8B-HUUP>.

155. RACHEL GARFIELD & ANTHONY DAMICO, KAISER FAMILY FOUND., *THE COVERAGE GAP: UNINSURED POOR ADULTS IN STATES THAT DO NOT EXPAND MEDICAID—AN UPDATE 1* (2016), archived at <http://perma.unl.edu/XZ4J-BVK7> (explaining how restrictive Medicaid rules in some states, combined with the decision not to expand the program under the ACA, has created a category of poor people without insurance options).

156. Moody, *supra* note 92, at 682.

ternity care, the focus here remains on provisions with a direct or closely connected impact on the care of pregnant, birthing, and post-partum women.

1. ACA Reforms that Apply Regardless of Coverage Source

The ACA includes a provision intended to make employment more compatible with breastfeeding. Though not a regulation that applies to benefits coverage, this is a significant intervention into the employment environment on behalf of lactating women; it applies to all non-exempt employees, regardless of their insurance status or source of coverage. Specifically, the ACA amends the Fair Labor Standards Act (FLSA) to require employers to provide reasonable breaks and a private, non-bathroom location for lactating women to express milk.¹⁵⁷ Employers with fewer than fifty employees can be exempted if compliance would impose an “undue hardship.”¹⁵⁸ Although the requirement only applies to employees classified as nonexempt under the FLSA, the ACA’s breastfeeding protections are estimated to cover approximately 19 million women.¹⁵⁹

In protecting employees’ right to express milk, the ACA targets two related concerns. First, the U.S. falls short of all breastfeeding targets recommended by public health authorities. The American Academy of Pediatrics recommends exclusive breastfeeding for six months for optimal infant health, with continued breastfeeding in conjunction with solid food until at least one year of age; the World Health Organization suggests that children should be breastfed for two years.¹⁶⁰ The federal government’s *Healthy People 2020* goal is that 60.6% of new mothers breastfeed through six months, up from a goal of 50% for 2010.¹⁶¹ By contrast, in 2006, 43.5% of infants were at least partially

157. 29 U.S.C. § 207(r)(1) (2010). Women are entitled to these accommodations until their nursing child is one year old.

158. *Id.* § 207(r)(3).

159. See ROBERT DRAGO ET AL., INST. FOR WOMEN’S POLICY RESEARCH, BETTER HEALTH FOR MOTHERS AND CHILDREN: BREASTFEEDING ACCOMMODATIONS UNDER THE AFFORDABLE CARE ACT iii (2010) (suggesting this figure is an underestimate, given the likelihood that many salaried women who are not formally covered by the ACA protections but work with covered hourly workers will nevertheless benefit from workplace changes to ensure compliance with the law, such as access to newly created lactation rooms).

160. Am. Acad. of Pediatrics, *AAP Reaffirms Breastfeeding Guidelines*, AAP.ORG (Feb. 27, 2012), <https://www.aap.org/en-us/about-the-aap/aap-press-room/pages/aap-reaffirms-breastfeeding-guidelines.aspx>, archived at <http://perma.unl.edu/YZS5-94PL>; *Health Topics: Breastfeeding*, WORLD HEALTH ORG., <http://www.who.int/topics/breastfeeding/en>, archived at <http://perma.unl.edu/2FQ8-3MVM> (last visited Jan. 28, 2016).

161. U.S. Dep’t of Health & Human Servs., Office of Disease Prevention & Health Promotion, *Healthy People 2020: Maternal and Infant Care Goals*, HEALTHYPEOPLE.GOV, <https://www.healthypeople.gov/2020/topics-objectives/topic/maternal-infant-and-child-health/objectives>, archived at <http://perma.unl.edu/Z3V7-86G8>

breastfed to six months, with only 22.7% partially or exclusively nursed for an entire year.¹⁶² Researchers estimate that if 80% of infants were exclusively breastfed for six months, health care expenditures would be reduced by \$10.5 billion and 741 infant deaths could be prevented annually.¹⁶³

The second concern addressed by the ACA is that returning to full-time work after the birth of a baby creates a significant barrier to continued breastfeeding. Research has shown that women with maternity leave of less than or equal to six months stop breastfeeding earlier than those with a leave greater than six months; similarly, women returning to work within one year weaned significantly earlier than those who did not return to work.¹⁶⁴ Breastfeeding is associated with higher socio-economic status; new mothers living in poverty are approximately two-thirds as likely to breastfeed compared to women in families with incomes at or above 350% of the poverty line.¹⁶⁵ The demands of hourly work—including highly regulated breaks and low levels of employee discretion—intensify existing barriers to breastfeeding. Evidence suggests that interventions such as breastfeeding education, the creation of a lactation room, and the provision of pumping equipment raise rates of breastfeeding and extend its duration.¹⁶⁶ Researchers estimate that these ACA protections mean an additional 165,000 women annually will breastfeed until at least six months, raising the rate of breastfeeding at six months from 44.5% to 47.5%, and affecting more than one million women and their children over the next six years.¹⁶⁷ Because the requirement applies

(scroll down and click on links under “MICH-21”); DRAGO ET AL., *supra* note 159, at 2.

162. DRAGO ET AL., *supra* note 159, at 2.

163. *Id.* at 1.

164. Chao-Hua Chuang et al., *Maternal Return to Work and Breastfeeding: A Population-Based Cohort Study*, 47 INT'L J. OF NURSING STUD. 461, 461 (Apr. 2010). Another study found that half of new mothers subject to TANF work requirements stopped breastfeeding by six months, resulting in approximately 25,000 infants not breastfed annually because their mothers are poor and subject to TANF work requirements. Steven J. Haider et al., *Welfare Work Requirements and Child Well-Being: Evidence from the Effects on Breastfeeding*, 40 DEMOGRAPHY 479, 479–97 (2003). In addition to producing milk to leave for another caregiver to feed the baby while the woman is working, expressing milk when apart from the baby is important for maintaining a sufficient supply of milk. When a woman is unable to express milk during the workday, her body responds by producing less milk, which means the baby has less milk available when nursing. INA MAY GASKIN, INA MAY'S GUIDE TO BREASTFEEDING (2009).

165. See DRAGO ET AL., *supra* note 159, at 5–7 & fig.5 (discussing the links between breastfeeding and race, income, age, and education).

166. *Id.* at 4–5. In 2008, only 53% of employers provided a private space or lactation room for employees to express milk. *Id.* at 1.

167. *Id.* at 12. The normalization of pumping breaks in the workplace may also have the long-term effect of reducing the stigma associated with breastfeeding and workplace pumping, thus raising breastfeeding rates even higher.

to nonexempt employees—a category that includes low-wage workers—women of lower socio-economic status are most likely to benefit from the ACA’s breastfeeding provisions.¹⁶⁸

2. ACA Reforms that Apply to Particular Modes of Coverage

a. Individual Market

The ACA makes a significant improvement in the availability of maternity coverage in the individual market by designating maternity and newborn care as one of ten essential health benefits (EHBs) that all qualified health plans (QHPs) participating in the exchanges, as well as all new individual plans sold outside the exchanges, must include.¹⁶⁹ Maternity care refers to prenatal care, labor and delivery, and all related diagnostic screenings, with some variation among states as to the services included in the required maternity care benefit.¹⁷⁰ In addition to maternity and newborn care, marketplace plans must include as EHBs hospitalization, mental health and substance use disorder services (including behavioral health treatment), and

168. *Id.* at 11 (“ACA protections for expressing breast milk in the workplace will serve to equalize opportunities for breastfeeding across lines of socioeconomic status. Employment and breastfeeding will be more complimentary for those who historically have faced the greatest challenges combining these activities.”). *But see* Nancy Ehrenreich, *Breastfeeding on a Nickel and a Dime: Why the Affordable Care Act’s Nursing Mothers Amendment Won’t Help Low-Wage Workers*, 20 MICH. J. RACE & L. 65, 67–69 (2014) (questioning the effectiveness and wisdom of the Reasonable Break Time for Nursing Mothers provision of the ACA). Ehrenreich expresses skepticism about the strength of the protections, given the law’s broad delegation to employers to tailor accommodations for their employees, the need for employees to negotiate break time in workplaces rife with power imbalances and insecurity, and the limited remedies for enforcement. *Id.* at 68, 95–96 (explaining how a wronged employee’s options are to petition the Department of Labor to seek an injunction or sue for retaliation, if adverse action was taken). Ehrenreich also expresses concern that the ACA increases the social pressure on low-income women to breastfeed “without meaningfully improving their ability to do so,” given other non-employment-related social constraints that preclude breastfeeding. *Id.* at 69–70 (“[T]he formal state embrace of breastfeeding represented by the statute risks becoming part of the already-extant disciplinary system under which low-income women are surveilled and regulated to determine whether they live up to governmental standards of good mothering . . .”).

169. To be designated a QHP and be sold through the exchange, a plan must include coverage for a set of minimum EHBs, comply with cost-sharing limits (including out-of-pocket costs), and meet various private-market reforms pursuant to the ACA. *Glossary: Qualified Health Plan*, HEALTHCARE.GOV, <https://www.healthcare.gov/glossary/qualified-health-plan>, archived at <http://perma.unl.edu/P356-J45H> (last visited Nov. 3, 2015); *see also* U.S. DEPT. HEALTH & HUMAN SERVS., ASPE ISSUE BRIEF, ESSENTIAL HEALTH BENEFITS: INDIVIDUAL MARKET COVERAGE 2 n.1 (2011), archived at <http://perma.unl.edu/U6NE-73JT> [hereinafter ASPE ISSUE BRIEF] (noting that EHBs apply to non-grandfathered plans in the individual and small group markets both inside and outside the exchanges).

170. NPWF FACT SHEET, *supra* note 144, at 2.

prescription drugs—services that are commonly used by women during pregnancy and childbirth.¹⁷¹ Plans sold through the exchange must carry cost-sharing protections for EHBs, meaning that deductibles and co-pays may not surpass predetermined levels derived as a percentage of income.¹⁷²

It would be hard to overstate the extent to which the inclusion of maternity care as an EHB changes the landscape of the individual marketplace for women who are pregnant or planning to become pregnant. Before the ACA, whether pregnancy-related care was included in plans sold on the individual market was left to the discretion of insurers. No federal anti-discrimination law ensured that women buying individual insurance had maternity coverage, as they were guaranteed in government and employer-sponsored plans.¹⁷³ As of March 2012, only nine states required all insurers on the individual market to cover maternity care, and three additional states required at least some plans to include maternity coverage.¹⁷⁴ A 2009 study found that only 12% of health plans sold in the pre-ACA individual market included maternity coverage; when the states that mandated coverage were excluded, the percentage dropped to 6% of plans offering maternity benefits.¹⁷⁵ The study, which examined 3,300 individual policies available to a thirty-year-old woman in capital cities around the country, discovered that in twenty-five of those cities, there was not a single plan available that covered maternity care.¹⁷⁶ An HHS analysis of 2011 data submitted by health insurance companies revealed that 62% of enrollees who purchased insurance on the individual market lacked coverage for maternity services.¹⁷⁷ In nearly half of states, maternity riders were available to supplement plans that lacked coverage, but such riders typically had high premiums, waiting periods, and restrictive benefits, making them cost-effective only when the woman experienced complications during childbirth—which is generally impossible to predict.¹⁷⁸

171. ACA § 1302(b)(1), 42 U.S.C. § 18022(b)(1) (2012); *see also supra* note 119 (discussing EHBs). There is some overlap between EHBs and the preventive services required under all plans, but only preventive services must be covered without cost-sharing.

172. *See supra* notes 118–21.

173. *See generally* BRIGETTE COURTOT & JULIA KAYE, NAT'L WOMEN'S LAW CTR., STILL NOWHERE TO TURN: INSURANCE COMPANIES TREAT WOMEN LIKE A PRE-EXISTING CONDITION 3 (2009).

174. NWLC, *supra* note 138, at 13.

175. *Id.* at 11.

176. *Id.*

177. ASPE ISSUE BRIEF, *supra* note 169, at 1.

178. NWLC, *supra* note 138, at 11 (reporting that maternity riders were available to supplement plans in the capital cities of twenty-one states, providing the only form of maternity coverage in fourteen of those states). The NWLC report cited a rider available in Kansas that cost over \$1,600 per month, while the most expen-

Furthermore, when individual plans did cover maternity benefits, the plan often capped the amount of benefits or included long waiting periods before beginning coverage.¹⁷⁹ Some plans included a separate maternity deductible as high as \$10,000 and waiting periods of up to a year before maternity benefits could be claimed.¹⁸⁰ As discussed above, insurers were also allowed to exclude pregnant women and those with a prior cesarean from coverage for having a preexisting condition—practices no longer allowed under the ACA.¹⁸¹ This left millions of women without insurance coverage for pregnancy and childbirth-related care.

Significantly (and controversially), the ACA excludes abortion from the list of required benefits that insurers participating in the exchanges must provide¹⁸² and leaves intact state laws that prohibit abortion coverage.¹⁸³ In fact, one unintended consequence of the ACA's passage is that in the wake of public debate that highlighted the issue of insurance coverage for abortion, twenty-five states passed laws restricting abortion coverage in plans offered on the exchange.¹⁸⁴ Ten states now have laws in effect restricting insurance coverage for abortion in all private insurance plans written in the state.¹⁸⁵ The ACA also prohibits the use of federal subsidies to pay for abortion coverage, which means insurers offering such coverage through the exchange must collect two payments from consumers and separate the funds used to pay for abortion—a burdensome requirement for insur-

sive plan on the market for the remaining health coverage cost \$222.76 per month. *Id.*

179. See REALIZING HEALTH REFORM'S POTENTIAL, *supra* note 84, at 9. A 2012 study found that more than half of plans offered in the individual market in 2010 did not meet the baseline "bronze level" standards of the ACA. *Id.*
180. NWLC, *supra* note 138, at 11. *But see* Moody, *supra* note 92, at 678 (questioning whether, factoring in the typical deductible, the out-of-pocket costs for an uncomplicated vaginal delivery under an exchange plan will differ from the costs incurred under pre-ACA coverage).
181. See *supra* section III.A.
182. ACA § 1303(a)(1)(A), 42 U.S.C. § 18023(a)(1) (2012) (stating that insurance plans may voluntarily cover abortion services). Abortion proved to be one of the most highly contested health services in the public debate over the ACA. See, e.g., Lisa C. Ikemoto, *Abortion, Contraception and the ACA: The Realignment of Women's Health*, 55 *How. L.J.* 731, 732 (2012).
183. ACA § 1303(c)(1), 42 U.S.C. § 18022(c)(1) (stating that the ACA does not preempt state laws regarding abortion coverage).
184. GUTTMACHER INST., STATE POLICIES IN BRIEF: RESTRICTING INSURANCE COVERAGE OF ABORTION 1 (2015), archived at <http://perma.unl.edu/CGD4-T7XE>.
185. *Id.* Federal law already prohibits coverage for abortion in government-sponsored insurance under the Hyde Amendment, except when the pregnancy resulted from rape or incest, or threatens the life of the woman. Department of Justice Appropriations Act, 2014, Pub. L. No. 113-76, 128 Stat. 409. Seventeen states use state Medicaid funds to provide all or most medically necessary abortions. GUTTMACHER INST., STATE POLICIES IN BRIEF: STATE FUNDING OF ABORTION UNDER MEDICAID 1 (2015), archived at <http://perma.unl.edu/QQ7P-GMY4>.

ers and consumers that disincentivizes the provision of abortion coverage on the exchange.¹⁸⁶ Given that nearly half of pregnancies in the U.S. are unintended, abortion is a health care service regularly sought by pregnant women who do not wish to become parents.¹⁸⁷ Access to safe and affordable abortion is necessary for women to maintain their reproductive health and the ability to become pregnant in the future. By further restricting access to abortion, the ACA narrows the scope of women's health, while expanding women's access to health care in so many other ways.¹⁸⁸

b. Private Insurance (Individual and Employer-Sponsored)

The ACA significantly expands the coverage of preventive women's health services by mandating that insurers cover specific preventive services without cost-sharing.¹⁸⁹ The required preventive services were identified by four expert medical and scientific bodies: the U.S. Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP), the Health Resources and Services Administration's (HRSA) Bright Futures Project, and the HRSA and Institute of Medicine (IOM) committee on women's clinical preventive services.¹⁹⁰ Under the women's health guidelines developed by the IOM and HRSA, plans must cover well-woman preventive care visits, including preconception care, screening for gestational diabetes, folic acid supplements, iron deficiency anemia screening, HPV screening, annual screening and counseling for HIV and other STIs, all FDA-approved contraceptive methods and contraceptive counseling for all women with reproductive capacity, and screening and counseling for

186. ACA § 1303(a)(2)(B), 42 U.S.C. § 18023(a)(2)(B) (requiring segregation of federal funds from other funds providing abortion coverage).

187. *See Fact Sheet: Unintended Pregnancy in the United States*, GUTTMACHER INST. (July 2015), <http://www.guttmacher.org/pubs/FB-Unintended-Pregnancy-US.html>, archived at <http://perma.unl.edu/8PYF-6YYP> (reporting that 51% of pregnancies each year are unintended).

188. *See Ikemoto, supra* note at 182, at 762–63 (observing that women's health as defined by federal policy “now omits a procedure that an estimated three in ten women will have by the age of 45”).

189. ACA § 1001, 42 U.S.C. § 300gg-13. This requirement does not apply to grandfathered plans, meaning those in existence before March 23, 2010. *See* U.S. Dept. Health & Human Servs., Health Res. & Servs. Admin., *Women's Preventive Services Guidelines*, HRSA, <http://www.hrsa.gov/womensguidelines/>, archived at <http://perma.unl.edu/PPL8-8BUK> (last visited Jan. 28, 2016) [hereinafter *Women's Preventive Services Guidelines*].

190. KAISER FAMILY FOUND., PREVENTIVE SERVICES COVERED BY PRIVATE HEALTH PLANS UNDER THE AFFORDABLE CARE ACT 1 (2015), archived at <http://perma.unl.edu/GJ6F-Z38K> (noting that new or updated recommendations issued by any of these panels must be covered without cost-sharing in the plan year that begins on or after exactly one year from the new recommendation's issue date) [hereinafter *KFF PREVENTIVE SERVICES*].

interpersonal and domestic violence.¹⁹¹ Insurance must also cover alcohol misuse screening and counseling for all adults, as well as tobacco counseling and cessation intervention, with expanded counseling for pregnant women.¹⁹² A 2013 study reported that 20% of women aged 18–64 postponed preventive services in the prior year due to cost—a figure that rises to 35% of women earning less than 200% of the FPL.¹⁹³ The preventive services coverage mandate is a significant step in ensuring women can access the care they need to maintain their health during pregnancy, identifying and addressing risk factors that lead to complications during birth and other adverse health outcomes.¹⁹⁴

Also included in the mandatory preventive services coverage is comprehensive lactation support and counseling by a trained provider during pregnancy and after the birth, as well as the cost of a breast pump and related accessories.¹⁹⁵ Finally, the ACA requires that all new plans allow patients to see an OB/GYN without referral, guaranteeing direct access to obstetric and gynecological care without the delay or co-pay associated with obtaining a referral.¹⁹⁶

c. Medicaid (and Medicare)

Poor and low-income pregnant women were already eligible for Medicaid coverage for prenatal, childbirth, and postpartum care before the ACA, but the Act eliminated cost-sharing for pregnancy-related services, including co-pays, coinsurance, and deductibles.¹⁹⁷ It provides a 1% increase in federal matching funds to state Medicaid programs that cover without cost-sharing all preventive services that receive an A or B rating by the U.S. Preventive Service Task Force and all immunizations recommended by the federal Advisory Commit-

191. *Women's Preventive Services Guidelines*, *supra* note 189. Beyond those services identified here, the ACA mandates coverage for all services that receive an A or B rating from the USPSTF, which includes a variety of other important health services for women. It also requires coverage for all immunizations recommended by the Advisory Committee on Immunization Practices of the CDC. *See* KFF PREVENTIVE SERVICES, *supra* note 190, at 2.

192. KFF PREVENTIVE SERVICES, *supra* note 190, at 6 tbl.1.

193. *Id.* at fig.1.

194. *See* John Aloysius Cogan, Jr., *The Affordable Care Act's Preventive Services Mandate: Breaking Down the Barriers to Nationwide Access to Preventive Services*, 39 J.L. MED. & ETHICS 355, 355 (2011) (noting how the ACA's preventive services mandate “transforms the U.S.'s public and private health care financing systems into vehicles for promoting public health”).

195. KFF PREVENTIVE SERVICES, *supra* note 190, at 6 tbl.1.

196. ACA § 2719A, 42 U.S.C. § 300gg-19a (2012).

197. *Id.* § 2702, 42 U.S.C. § 18023(b)(2). For non-pregnancy-related care, Medicaid limits out-of-pocket spending to 5% of family income. NPWF FACT SHEET, *supra* note 144, at 2.

tee on Immunization Practices.¹⁹⁸ The ACA also requires Medicaid coverage of comprehensive tobacco cessation programs for pregnant women.¹⁹⁹

The ACA makes two important changes to Medicaid reimbursement rules that give pregnant women more options regarding the kind of care they receive during pregnancy and childbirth. First, the ACA mandates state and federal Medicaid coverage of freestanding birth centers,²⁰⁰ as well as separate reimbursement for the services of the providers who staff the centers.²⁰¹ Medicaid has covered CNMs since the early 1980s, which led some states to approve funding for reimbursement to those freestanding birth centers staffed by CNMs.²⁰² But after a technical regulatory amendment created ambiguity about whether birth centers were meant to be Medicaid-reimbursable facilities under the law, the Centers for Medicare & Medicaid Services (CMS) took action in 2009 to reverse a twenty-year history of funding birth centers in Texas and rejected reimbursement to all birth centers for facility fees.²⁰³ The ACA's extension of Medicaid funding to all freestanding birth centers makes reimbursement possible for birth centers staffed by CPMs—where approved by the state in which they practice—and eliminates any doubt about other centers' eligibility for reimbursement.²⁰⁴

198. ACA § 2702, 42 U.S.C. § 18051.

199. LIFESPAN, *supra* note 143, at 6.

200. ACA § 2301, 42 U.S.C. § 1396d(1)(3)(A) (defining “birth centers” as health facilities where women give birth that are not hospitals or patient residences). Birth centers are required to be licensed or “otherwise approved” by the state in order to be reimbursed.

201. See Deborah Fisch, Note, *The Long Gestation of the Law: How Texas Birth Centers Lost Their Medicaid Funding*, 12 J.L. Soc'y 194, 228 (2010–2011) (noting that extension of the definition of birth attendant to “nurse-midwives and other providers of services such as birth attendants recognized under State law, as determined appropriate by the Secretary,” enables Medicaid reimbursement for birth centers staffed by CPMs and CNMs).

202. Omnibus Reconciliation Act of 1980, Pub. L. 96-499, § 965, 94 Stat. 2599 (1980) (amending the Social Security Act to authorize reimbursement to nurse-midwives under Medicaid); see also Medicare and Medicaid Program; Nurse-Midwife Services, 47 Fed. Reg. 21046, 21049 (May 17, 1982) (“We believe that it is in the public's best interest to increase the availability and accessibility of nurse-midwife services to women eligible for Medicaid.”).

203. See Fisch, *supra* note 201, at 195, 210–13.

204. *But see* Letter from Linda Cole, President, Am. Ass'n of Birth Ctrs., to Hon. Kathleen Sebelius, Sec'y of Health and Human Servs. (Mar. 15, 2013), archived at <http://perma.unl.edu/DK4D-AYKQ> (follow “Read AABC's letter to Kathleen Sebelius” hyperlink to the letter) (the ACA's mandate for Medicaid reimbursement of birth centers and birth attendants “has been implemented correctly in fewer than half the states”).

The second midwifery-related reform is that CNMs are now reimbursed by Medicare at a rate equal to that of physicians.²⁰⁵ Previously, CNMs billed 65% of what physicians billed, despite performing identical services. Medicare equalization increases midwifery access for women enrolled in the program—specifically, disabled women of childbearing age and senior women obtaining well-woman care from midwives. Significantly, it signals the value of midwifery care and provides advocates a tool with which to pursue equitable reimbursement under Medicaid in the twenty-two states where midwives receive less than 100% of the rates reimbursed for physicians; Medicare equalization may also enable advocates to pursue increased private insurance coverage of midwifery.²⁰⁶

C. The ACA's Investments in Better Care Through Programmatic and Policy Initiatives

In addition to expanding access and improving coverage for women of childbearing age, the ACA makes investments in research, outreach programs, and policy initiatives designed to improve the delivery and effectiveness of prenatal, childbirth, and postpartum care. The Act provided states with \$1.5 billion over the course of five years to operate the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, which funds voluntary home visits by social workers and nurses to at-risk parents in counties with high rates of teenage births, poverty, infant mortality, and low birthweight.²⁰⁷ Operated by the HRSA in partnership with the Administration for Children and Families, MIECHV funds evidence-based models to improve prenatal health, information about the stages of pregnancy, breastfeeding, and infant care, and education about child development and effective parenting techniques.²⁰⁸ Research links home visiting programs with the development of language, cognitive function, and socioemotional skills in children, as well as increased maternal

205. Am. Coll. of Nurse-Midwives, *Midwives and Medicare after Health Care Reform*, <http://www.midwife.org/Midwives-and-Medicare-after-Health-Care-Reform>, archived at <http://perma.unl.edu/K34J-VH4S> (last visited Nov. 3, 2015).

206. *Id.* (noting that Medicare “serves as the gold standard of reimbursement rates and sets a precedent”).

207. ACA § 2951, 42 U.S.C. § 711 (2012); see also CHARLES MICHALOPOULOS ET AL., HHS OFFICE OF PLANNING, RESEARCH & EVALUATION, REVISED DESIGN FOR THE MOTHER AND INFANT HOME VISITING PROGRAM EVALUATION (2013). MIECHV’s funding was set to expire at the end of the 2015 fiscal year. The President’s budget requests \$500 million for fiscal year 2016 and \$15 billion over the next ten years to continue expanding the program.

208. U.S. Dept. Health & Human Servs., *Maternal, Infant, and Early Childhood Home Visiting*, HRSA, <http://mchb.hrsa.gov/programs/homevisiting/>, archived at <http://perma.unl.edu/3UCS-S4QW> (last visited Jan. 28, 2016).

health, a decrease in child maltreatment, and less parental stress.²⁰⁹ In 2014, State Home Visiting Programs served approximately 115,500 parents and children, nearly 80% of whom had household incomes at or below 100% of the FPL.²¹⁰

The ACA created the Pregnancy Assistance Fund, which provides grants to states to assist pregnant and parenting teens, mothers, and fathers complete high school and continue on to higher education, assisting with access to health care, child care, family housing, and other critical social supports.²¹¹ Administered by HHS' Office of Adolescent Health, the Pregnancy Assistance Fund provides \$25 million in competitive grants to states and tribal entities for this work, and also provides funds to improve services for pregnant women who are victims of domestic violence, sexual violence, and stalking.²¹² The ACA also expands research on postpartum depression, authorizes grants for clinical services provided to women with (or at risk for) postpartum depression, and appropriates money to study the benefits of screening.²¹³

Further, the ACA invests in efforts to improve delivery systems, quality of care, and value. While not focused specifically on pregnancy and childbirth, such efforts target problems that manifest within the maternity care arena and, thus, merit consideration of their potential for long-term improvements to the provision of maternity care. To enhance the quality of health care while reducing costs, the ACA established the Center for Medicare & Medicaid Innovation (CMI) within CMS.²¹⁴ CMI tests new service delivery and payment models to determine their effect on quality and expenditures. The ACA identifies possible models for testing by the CMI, such as the use of patient-centered medical homes, the introduction of comprehensive or salary-based compensation for providers (rather than traditional fee-for-ser-

209. ZERO TO THREE: NAT'L CTR. FOR INFANTS, TODDLERS, & FAMILIES, THE RESEARCH CASE FOR HOME VISITING 1 (2014), archived at <http://perma.unl.edu/YUM7-VXB2>; Edward Rodrigue & Richard V. Reeves, *Home Visiting Programs: An Early Test for the 114th Congress*, BROOKINGS INST. (Feb. 5, 2015, 11:45 AM), <http://www.brookings.edu/blogs/social-mobility-memos/posts/2015/02/05-home-visiting-funding-reeves>, archived at <http://perma.unl.edu/QKX2-P27K> (reviewing research on the positive effects of home visiting programs and arguing for establishment of MIECHV as a permanent federal program).

210. *Maternal, Infant, and Early Childhood Home Visiting*, supra note 208.

211. See U.S. Dept. Health & Human Servs., *What Is the Pregnancy Assistance Fund?*, OFFICE OF ADOLESCENT HEALTH, <http://www.hhs.gov/ash/oah/oah-initiatives/paf/home.html>, archived at <http://perma.unl.edu/679J-VJ3G> (last visited Jan. 28, 2016).

212. *Id.*

213. ACA § 2952(a)–(c), 42 U.S.C. § 712 (2012).

214. *Id.* § 3021(a), 42 U.S.C. § 1315a (establishing the CMI to “test innovative payment and service delivery models to reduce program expenditures . . . while preserving or enhancing the quality of care furnished to individuals”).

vice arrangements), and direct contracting with groups of providers to promote care coordination and the adoption of salary-based payment.²¹⁵ The HHS Secretary evaluates each model, including changes in spending, patient-level outcomes, and patient-centeredness criteria.²¹⁶ As discussed in section IV.A, the provision of maternity care in the U.S. is plagued by misaligned incentives created by the current structure of provider payments and hospital reimbursements. Fee-for-service payment encourages a procedure-intensive approach to childbirth and undermines collaboration between midwives and obstetricians in providing coordinated care. CMI's efforts could benefit maternity care greatly if sufficient resources are dedicated to testing relevant models and disseminating constructive results.

As to health care quality, the ACA created the Center for Quality Improvement and Patient Safety (CQuIPS), housed within the Agency for Healthcare Research and Quality (AHRQ).²¹⁷ The ACA authorized \$20 million to CQuIPS to support research on improving health care delivery and promote best practices in the delivery of health care services.²¹⁸ CQuIPS uses research from a wide range of disciplines, including epidemiology, health services, sociology, psychology, human factors engineering, biostatistics, health economics, clinical research, and health informatics.²¹⁹ Among its tasks is to create strategies to improve quality by reducing variations in health care delivery²²⁰ and coordinate its activities with those of the CMI.²²¹ In the maternity care context, variation in the rates of cesareans and the use of other medical interventions during childbirth suggest that factors other than medical necessity drive clinical practice, highlighting the need for reform of maternity care services delivery models.²²²

The ACA also invests in the expansion and dissemination of comparative effectiveness research (CER). An outgrowth of evidence-based medicine, CER is “designed to inform health-care decisions by providing evidence on the effectiveness, benefits, and harms of differ-

215. *Id.*

216. *Id.*

217. *Id.* § 3501, 42 U.S.C. § 299b-33.

218. *Id.* § 3501(933)(c)(1), 42 U.S.C. § 299b-33(c)(1).

219. *Id.* § 3501(933)(b)(1), 42 U.S.C. § 299b-33(b)(1).

220. *Id.* § 3501(933)(b)(6), 42 U.S.C. § 299b-33(b)(6).

221. *Id.* § 3501(933)(f), 42 U.S.C. § 299b-33(f).

222. *See* SAKALA & CORRY, *supra* note 9, at 9 (finding the “use of specific maternity practices varies broadly across facilities, providers, and geographic areas . . . primarily due to differences in practice style and other extrinsic factors”); S.L. Clark et al, *Variation in the Rates of Operative Delivery in the United States*, 196 AM. J. OBSTETRICS & GYNECOLOGY 526.e1–526.e5 (2007) (finding a variation of 200–300% in primary cesarean rates within regions, and concluding that “a pattern of almost random decision making” exists for the use of cesarean surgery).

ent treatment options.”²²³ The ACA established the Patient-Centered Outcomes Research Institute (PCORI), a non-profit, non-governmental organization, to develop and fund CER that evaluates the health outcomes and clinical effectiveness of two or more medical treatments or services.²²⁴ PCORI is responsible for identifying and adopting national research priorities, establishing a standing methodology committee to maintain CER standards, performing CER, and disseminating research in a timely fashion to clinicians, patients, and the general public.²²⁵ PCORI is the “largest single research funder that has CER as its main focus.”²²⁶ Since DeLee’s introduction of medical interventions in the 1920s, many procedures have been used during childbirth without sufficient evidence supporting their safety and effectiveness. The work of PCORI in establishing methodological standards and promoting CER holds great promise for ensuring better maternity care.²²⁷

Finally, the ACA created Offices on Women’s Health within federal agencies such as the Department of Health and Human Services (HHS), the Centers for Disease Control (CDC), the Food and Drug Administration (FDA), and the Health Resources and Services Administration (HRSA).²²⁸ It created the Office of Women’s Health and Gender-Based Research under the Agency for Healthcare Research and Quality and established the Coordinating Committee on Women’s Health under HHS.²²⁹ These new offices will help ensure that women’s health—including maternity care—is included in future research and policy initiatives.

IV. ASSESSING THE ACA’S IMPACT ON MATERNITY CARE: ENHANCING COVERAGE WITHOUT SHIFTING CULTURE

The ACA’s significant expansion of insurance coverage and improvement of maternity benefits will make a dramatic—life-altering, in some cases—difference for millions of women who previously lacked insurance entirely, were underinsured, or whose plans excluded maternity coverage. Greater access to prenatal and postpartum care at an affordable cost will undoubtedly chip away at high maternal and

223. U.S. Dept. Health & Human Servs., *What Is Comparative Effectiveness Research*, AGENCY FOR HEALTHCARE RESEARCH & QUALITY, <http://effectivehealthcare.ahrq.gov/index.cfm/what-is-comparative-effectiveness-research1/>, archived at <http://perma.unl.edu/24NG-4H8H> (last visited Nov. 8, 2015); see *infra* section IV.B.

224. ACA § 6301(a), 42 U.S.C. § 1320e(b).

225. *Id.*

226. *About Us*, PATIENT-CENTERED OUTCOMES RESEARCH INST. (Oct. 6, 2014), <http://www.pcori.org/about-us>, archived at <http://perma.unl.edu/X7SE-YRA9>.

227. See *infra* section IV.B for further discussion of the promotion of evidence-based maternity care.

228. ACA § 3509 (codified as amended in scattered sections of 26 and 42 U.S.C.).

229. *Id.*

infant mortality rates and improve overall health outcomes. Though long overdue, the ACA's maternity care enhancements should be celebrated for bringing financial security to American families, especially those with low to moderate incomes. But just as insurance market reform is not the same as health services delivery reform, addressing maternity care's ills requires much more than increasing access to and the scope of insurance coverage.²³⁰ Structurally and politically, the ACA is constrained in its ability to effect the change in maternity care that women and their babies deserve—high-quality, patient-centered, empowering care with birth outcomes for both mother and child that reflect society's high social and economic investment in childbirth. To achieve this goal requires a more massive shift in medical culture and the ways in which social values inform the provision of maternity care and the childbirth experience.

Virtually all women who seek health care from mainstream medical institutions during pregnancy and childbirth confront a socially constructed and professionally reinforced understanding of birth as a medical event.²³¹ The historical shifts in where, how, and with whom women give birth have led to a deeply entrenched idea of birth as an illness or condition to be managed—inherently risky and, therefore, something to be feared. This paradigm of pathology originated within the medical community and can be traced to physicians' efforts to promote their professional interests, suppressing competition from midwives and convincing the public that their services were indispensable because childbirth was fraught with danger.²³² Such notions have long since seeped into the larger culture, regularly reinforced by cultural representations of childbirth in popular media as a source of fear and panic, with clenched knuckles and screaming women. At the same time, a range of economic issues—including financial pressure on hospitals, professional competition, rising costs of obstetrics malpractice insurance, and the compensation structure for childbirth services—have encouraged certain policies and practices that foster tension between financial concerns and the well-being of women and babies.

230. See William M. Sage, *Putting Insurance Reform in the ACA's Rear-View Mirror*, 51 Hous. L. Rev. 1081, 1082–83 (2014) (discussing structural distinctions in the ACA between insurance reform and health delivery system reform and noting that the “link between health insurance and health care is substantial, but the two are not coterminous”); see also Barak D. Richman, *Behavioral Economics and Health Policy: Understanding Medicaid's Failure*, 90 CORNELL L. Rev. 705, 709–10 (2005) (“Public debates and legislative efforts have fretted over insurance when instead they should have focused on health.”).

231. See MARSDEN WAGNER, *BORN IN THE USA: HOW A BROKEN MATERNITY SYSTEM MUST BE FIXED TO PUT WOMEN AND CHILDREN FIRST* 108 (2006).

232. See Suarez, *supra* note 7, at 327 (citing Kobrin, *supra* note 7, at 318, 322); DONNISON, *supra* note 7, at 40.

In the maternity care context, improving outcomes and reducing costs require addressing this deeply rooted paradigm of pathology and achieving structural and systemic change in the provision of care. An alternative model exists—where birth is a normal, physiologic process allowed to unfold free of outside pressure or mediation with specialized medical care available when necessary—but under current conditions, this model runs contrary to the dominant values of medicalized childbirth.²³³ The ACA is inadequate to alter this status quo, but it contains seeds for potential change. This Part identifies three aspects of maternity care where reform is not only needed but where there is potential to effect a deeper transformation in the values informing that care: (1) redesigning payment structures to eliminate misaligned incentives;²³⁴ (2) developing and promoting evidence-based medicine in the maternity context; and (3) elevating the midwifery model of care to enable midwives to take their proper place as first-line maternity care providers for the majority of low-risk women, with obstetricians handling specialized medical needs, as they are trained to do.²³⁵ These areas of reform are interdependent, but each is important in its own right. The ACA undertakes this work to varying degrees, but improving birth requires a greater commitment to reform.

A. The Need for Payment Reform in Maternity Care

Current methods of reimbursement for maternity care services promote various incentives for providers and hospitals that are poorly aligned with the goals of improving birth outcomes and reducing the

233. See B. Jessie Hill, *What Is the Meaning of Health? Constitutional Implications of Defining “Medical Necessity” and “Essential Health Benefits” Under the Affordable Care Act*, 38 AM. J.L. & MED. 445, 458 (2012) (reflecting on social construction in the health context and observing that it is “impossible to judge whether a symptom is unusual or pathological without some reference to what is normal, and it is impossible to determine normalcy without some reference to social, cultural, and moral values”).

234. Because this Article uses maternity care as a case study, the following discussion of payment reform focuses on incentives and disincentives in the maternity care context, though the larger structural problems identified here are found elsewhere in the health care system and are, by no means, specific to maternity care.

235. This list is not meant to be an exhaustive agenda for the achievement of cultural change in maternity care. For example, some advocates might consider the pursuit of health care delivery reforms aimed at enhancing “patient-centered care” to be an important component of such structural reform. See JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* 23–25 (1984) (discussing the philosophical shift to patient-centered care principles). Certainly, changes to health care delivery that enable greater patient engagement increase patient agency and may disrupt power relations between patients, providers, and insurers. However, the three issues addressed herein are directly attuned to the most problematic aspects of the maternity care system.

high costs of childbirth in the U.S.²³⁶ Insurers' standard payment practices encourage a procedure-intensive approach to maternity care and further entrench the medical model of childbirth, perpetuating widely held beliefs that medical management of childbirth is the optimal—or even only—way to have a baby. As discussed in Part II, maternity care is big business in the U.S. Obstetric procedures constitute nearly half of all hospital procedures performed on individuals aged 18–44.²³⁷ It is therefore unsurprising that the cost of childbirth has increased dramatically in recent years. From 2004 to 2010, the prices insurers paid for childbirth rose 49% for vaginal births and 41% for cesareans.²³⁸ By 2010, the average charges for maternal-newborn care for those covered by employer-provided insurance amounted to \$32,093 for vaginal birth and \$51,125 for cesarean birth, though the average total payment was \$18,329 and \$27,866, respectively.²³⁹ The average charge to Medicaid for the same care was \$29,800 for vaginal birth and \$50,373 for cesarean birth, with average payments of \$9,131 and \$13,590, respectively.²⁴⁰ Both commercial and Medicaid payers paid approximately 50% more for cesareans than vaginal deliveries, and commercial payers paid approximately 100% more than Medicaid, regardless of type of delivery.²⁴¹ Average out-of-pocket costs for childbirth rose fourfold during 2004–2010,²⁴² with insured women paying over \$3,400 for maternity care.²⁴³

Medical procedures are fee-generating mechanisms, and the ability to levy additional charges for procedures reinforces existing norms

236. See NICHOLE PERELMAN ET AL., CATALYST FOR PAYMENT REFORM, USING EDUCATION, COLLABORATION, AND PAYMENT REFORM TO REDUCE EARLY ELECTIVE DELIVERIES: A CASE STUDY OF SOUTH CAROLINA'S BIRTH OUTCOMES INITIATIVE 1 (2013) ("How we pay for health care can influence how providers deliver care and the health outcomes of patients. Paying for a health care service that does not follow clinical guidelines can encourage providers—even unwittingly—to provide that service to patients."), archived at <http://perma.unl.edu/ALM8-7PRG>.

237. SAKALA & CORRY, *supra* note 9, at 26.

238. See TRUVEN HEALTH ANALYTICS, THE COST OF HAVING A BABY IN THE UNITED STATES 8 (2013) [hereinafter COST OF HAVING A BABY], archived at <http://perma.unl.edu/3MZJ-AA5Y>.

239. *Id.* at 6. Actual payments made for medical services tend to be lower than the charges issued by hospitals. See SAKALA & CORRY, *supra* note 9, at 13–14. Studies have found significant geographic variation in maternity care costs. See, e.g., COST OF HAVING A BABY, *supra* note 238, at 7 (reporting childbirth payments ranging from \$10,318 (vaginal) and \$13,943 (cesarean) in Louisiana to \$16,888 (vaginal) and \$20,620 (cesarean) in Massachusetts).

240. COST OF HAVING A BABY, *supra* note 238, at 6.

241. *Id.*

242. *Id.* at 8.

243. See Elizabeth Rosenthal, *American Way of Birth, Costliest in the World*, N.Y. TIMES (June 30, 2013), <http://www.nytimes.com/2013/07/01/health/american-way-of-birth-costliest-in-the-world.html?pagewanted=all>, archived at <http://perma.unl.edu/YB6C-WMHZ> ("Two decades ago, women paid nothing other than a small fee for a private hospital room or television.").

about medicalized childbirth.²⁴⁴ Artificial induction and acceleration of labor with synthetic oxytocin has become routine,²⁴⁵ and elective inductions are rising in frequency.²⁴⁶ Reasons for elective, medically unnecessary inductions include patient discomfort, scheduling preferences, or physicians' economic benefit.²⁴⁷ Higher reimbursement rates for cesareans, along with longer hospitalization and higher hospital charges, provide incentives to recommend cesareans even when not medically necessary. Although scheduled elective cesareans are lower quality care,²⁴⁸ they are easier for hospitals to plan for, with predictable scheduling of staff and facility space.²⁴⁹ Importantly, obstetric procedures include interventions beyond induction and cesarean, such as administration of IV fluids, bladder catheterization, rupture of membranes to release amniotic fluid, fetal monitoring, episiotomy, shaving pubic hair, epidural anesthesia, and forceps- or vacuum-assisted delivery.

The payment systems currently used to reimburse most maternity care services contribute to the high cost of childbirth care by creating perverse incentives for provider decision-making and failing to link payment with quality and value.²⁵⁰ Fee-for-service payment mecha-

244. See *supra* section II.B.

245. See LISTENING TO MOTHERS III, *supra* note 48, at 14–15 (reporting that 41% of women underwent an attempt by a health provider to induce labor artificially, 63% had their labors artificially accelerated with synthetic oxytocin, and 39% had their water broken by their care provider in order to induce or speed up labor). Research shows that the average gestation has become shorter over time, raising concerns about the under-development of fetuses' brains and lungs. See SAKALA & CORRY, *supra* note 9, at 36 (discussing study concluding that the most common gestational age at birth for single babies had declined from forty to thirty-nine weeks during the period 1992–2002). Wide variation in the rates of induced labor suggests that this practice is not always related to the needs of women or babies. Compare Johnson & Daviss, *supra* note 55 (reporting 9.6% of women experienced induction attempt), with LISTENING TO MOTHERS III, *supra* note 48, at 14 (reporting 41% rate of induction by provider).

246. Aaron B. Caughey et al., *Systematic Review: Elective Induction of Labor Versus Expectant Management of Pregnancy*, 151 ANNALS OF INTERNAL MED. 252, 252–56 (2009).

247. *Id.*

248. See SAKALA & CORRY, *supra* note 9, at 43 (discussing risks associated with elective cesarean, including increased risk of respiratory morbidity and inadvertent iatrogenic prematurity).

249. CATALYST FOR PAYMENT REFORM, ACTION BRIEF: MATERNITY CARE PAYMENT 2 (2012) [hereinafter MATERNITY CARE PAYMENT], archived at <http://perma.unl.edu/24QH-TSPW> (“Improved reimbursement and decreased opportunity costs help drive the increase in cesarean deliveries.”).

250. See NETWORK FOR REG'L HEALTHCARE IMPROVEMENT, FROM VOLUME TO VALUE: TRANSFORMING HEALTH CARE PAYMENT AND DELIVERY SYSTEMS TO IMPROVE QUALITY AND REDUCE COSTS 1 (2008) [hereinafter FROM VOLUME TO VALUE] (explaining that a “major cause of the quality and cost problems in health care today is that payment systems encourage *volume-driven* health care rather than *value-driven* health care”).

nisms²⁵¹ used to reimburse hospitals create incentives for the overuse of complex and costly procedures.²⁵² Between 70–86% of maternity care payments cover care delivered during the intrapartum hospital stay; the remainder goes to prenatal and postpartum care.²⁵³ Insurers generally use a global fee payment system to reimburse the care provider—an obstetrician or midwife—for prenatal care and delivery, which discourages service coordination²⁵⁴ and encourages providers to recommend services that can be charged outside the global fee.²⁵⁵ It also disincentivizes the use of services that do not accrue reimbursement or are reimbursed at low rates, including effective, low-cost interventions such as smoking cessation for pregnant women and breastfeeding support.²⁵⁶ Anesthesiology, radiology, and lab services are billed separately.

Alternative models for maternity care reimbursement exist, offering the potential to “align incentives for providers and hospitals to adhere to evidence-based practices that improve outcomes . . . and decrease the growth in health care spending for maternity care services.”²⁵⁷ Insurers can set a single price for all services delivered by

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251. Under fee-for-service reimbursement, payers reimburse providers for each service they provide to consumers with no limit on the quantity of services for which a provider may bill. See AM. PUB. HEALTH ASS'N, MAJOR AFFORDABLE CARE ACT DELIVERY AND PAYMENT REFORMS 1 (2013) (noting that fee-for-service payment arrangements are widely believed to incentivize overtreatment and overbilling).
252. MATERNITY CARE PAYMENT, *supra* note 249, at 1. Hospitals are generally paid a case rate for either vaginal or cesarean delivery with additional payments for services related to complications that arise during birth. *Id.* at 1–2. Breaking down the average total payments by private insurers for maternal-newborn care with vaginal delivery, 59% of the payments went to facilities and 25% to the maternity care providers (obstetricians or midwives), followed by payments for anesthesiology, radiology/imaging, laboratory, and pharmacy services (in descending order). COST OF HAVING A BABY, *supra* note 238, at 6. For cesareans reimbursed by private insurers, 66% of payments went to facilities and 21% to maternity care providers, with the remainder going to anesthesiology, radiology/imaging, pharmacy, and laboratory services (in descending order). *Id.* The percentage breakdown of payments was similar for vaginal and cesarean births reimbursed by Medicaid. *Id.*
253. MATERNITY CARE PAYMENT, *supra* note 249, at 7.
254. Generally, payment accrues to the provider who is present and responsible for “delivering” the baby; researchers have noted the not uncommon situation where an obstetrician who has been seeing patients for office visits—while nurses attend to a laboring woman—rushes in at the last minute to “catch” the baby. See WAGNER, *supra* note 231, at 8. Without a mechanisms for fee-sharing, this payment model also disincentivizes collaborative teams of midwives and obstetricians.
255. See Peter B. Angood et al., *Blueprint for Action: Steps Toward a High-Quality, High-Value Maternity Care System*, 20 WOMEN'S HEALTH ISSUES S18, S24 (2010); MATERNITY CARE PAYMENT, *supra* note 249, at 1.
256. See Angood et al., *supra* note 255, at S24.
257. MATERNITY CARE PAYMENT, *supra* note 249, at 2.

all providers of a patient's care—a system known as bundling.²⁵⁸ Different approaches to bundling create different incentives. For example, bundling payment for a hospital birth with professional fees encourages hospitals and providers to coordinate to reduce cesarean rates and improve the quality of care.²⁵⁹ Reimbursement could also be bundled for comprehensive maternity care, with one risk-adjusted price for all prenatal care, ultrasounds, lab work, and delivery; performing fewer cesareans and minimizing complications “will lead to higher margins for providers.”²⁶⁰ Research suggests up to one-third of all costs associated with pregnancy are avoidable complications.²⁶¹ Bundled payments can be used to encourage evidence-based decisions about maternity care and reduce complications.

Other models incentivize different types of medical decision-making and provider behavior. A blended facility payment for delivery—a single rate for childbirth reimbursement regardless of delivery method—increases the reimbursement rate for vaginal deliveries and eliminates the incentive to perform more cesareans to collect more fees.²⁶² Insurers can reward high quality care, create “do not pay” policies for errors, or require prior authorization for overused procedures, such as elective, preterm deliveries.²⁶³ Reimbursement strategies might target hospitals and providers who safely offer vaginal birth after cesarean (VBAC) by paying an additional increment for enhanced surveillance during the labor of a woman with a previous cesarean.²⁶⁴ Insurers might also promote the Maternity Care Home model to foster continuity of care, promote accountability, and prioritize prevention.²⁶⁵

The ACA invests in the development and testing of alternative payment and service delivery models with the creation of the Center

258. See FROM VOLUME TO VALUE, *supra* note 250, at 2 (discussing requirements for effective bundling).

259. MATERNITY CARE PAYMENT, *supra* note 249, at 6 (discussing how bundled payment creates a “financial lever to use with providers toward reducing unnecessary intervention in labor and delivery”).

260. *Id.* at 7. This approach allows the facility and providers to decide how best to achieve good health outcomes while managing costs. See also Angood et al., *supra* note 255, at S25 (advocating comprehensive payment reform with full episode-of-care bundling but noting the need to exclude outliers with very high costs to minimize the need for caps and enable the participation of small hospitals, clinician groups, and birth centers).

261. MATERNITY CARE PAYMENT, *supra* note 249, at 7.

262. See *id.* at 5 (discussing methods of blended payment); Angood et al., *supra* note 255, at S26 (discussing the need to remove potential economic incentives for cesarean deliveries).

263. MATERNITY CARE PAYMENT, *supra* note 249, at 4 (noting examples of states where versions of positive and negative payment models have been tested or implemented); Angood et al., *supra* note 255, at S26.

264. Angood et al., *supra* note 255, at S26.

265. *Id.* at S36.

for Medicare and Medicaid Innovation (CMI), discussed in section III.C.²⁶⁶ The statute includes a list of possible models, including those that transition primary care practices away from free-for-service reimbursement and promote care coordination through risk-based comprehensive or salary-based payment.²⁶⁷ Congress appropriated \$5 million for 2010 and \$10 billion for 2011–2019 to implement CMI’s mission.²⁶⁸ CMI is currently testing new payment and service delivery models, evaluating results, and engaging experts to develop additional models to test.²⁶⁹

CMI currently funds one initiative aimed at improving birth outcomes: the Strong Start for Mothers and Newborns Initiative, which pursues two strategies. The first is a public-private partnership and awareness campaign to reduce early elective deliveries before thirty-nine weeks.²⁷⁰ With premature births estimated to cost at least \$26 billion annually and a prematurity rate that has grown by 36% over the last twenty years, this is certainly an important issue within maternity care and the research may illuminate useful approaches to shifting provider behavior.²⁷¹ But it is also a relatively easy issue for stakeholders to agree on as a priority and does not necessarily implicate issues involving care provision and coordination that are perceived to pose greater challenges to physician expertise and autonomy.

The second part of the initiative, Strong Start II, is a four-year project to test the effectiveness of enhanced prenatal care designed to reduce the frequency of premature births among Medicaid and CHIP beneficiaries and reduce the cost of maternity care for individuals enrolled in those programs.²⁷² Strong Start II tests the effectiveness of

266. ACA § 3021(a)(1), 42 U.S.C. § 300jj–51(a)(1) (2012). Successful models must either reduce spending without reducing quality of care or improve quality of care without increasing spending, and they must not deny or limit coverage or provision of any benefits.

267. *Id.* § 3021(b)(2)(B)(i)–(xviii), 42 U.S.C. § 300jj–51(b)(2)(B)(i)–(xviii).

268. *Id.* § 3021(f), 42 U.S.C. § 300jj–51(f).

269. *About the CMS Innovation Center*, CTRS. FOR MEDICARE & MEDICAID SERVICES (Sept. 23, 2015), <http://innovation.cms.gov/about/index.html>, archived at <http://perma.unl.edu/AZ5N-NHPE>.

270. *Strong Start for Mothers and Newborns Initiative: General Information*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Oct. 6, 2015) [hereinafter *Start Strong for Mothers*], <http://innovation.cms.gov/initiatives/Strong-Start/>, archived at <http://perma.unl.edu/ZCB8-6LUZ>.

271. *Id.* (noting that the 500,000 babies born premature each year are at higher risk for health and other developmental problems, as well as death); see also MATERNITY CARE PAYMENT, *supra* note 249, at 4–5 (discussing costs and impacts associated with prematurity).

272. *Strong Start for Mothers*, *supra* note 270. This initiative includes twenty-seven awardees and 213 individual sites across thirty states, the District of Columbia, and Puerto Rico; it proposes to serve up to 80,000 women when fully implemented. See IAN HILL ET AL., CTRS. FOR MEDICARE & MEDICAID SERVS., STRONG

three models: maternity care homes, centering/group prenatal care, and birth centers. Each uses evidence-based approaches to reduce preterm birth and decrease the rate of low birthweight.²⁷³ Participants also increase outreach to Medicaid and CHIP recipients to inform them of available services.²⁷⁴ A preliminary evaluation of Strong Start found below-average cesarean rates, higher rates of breastfeeding, and fewer preterm deliveries in birth centers and group prenatal care sites. However, questions remain about the extent to which Strong Start interventions are responsible for those changes.²⁷⁵

Strong Start projects contribute to the development of effective, lower-cost maternity care delivery models, but it remains to be seen how much of CMI's work will be translatable to maternity care, given that the models proposed in the ACA cover a wide array of health care challenges—many of which are particular to Medicare beneficiaries.²⁷⁶ Also, even if testing payment system reform in Medicaid and Medicare programs yields promising and relevant results, there is no guarantee private actors will adopt those models.²⁷⁷ The ACA's creation of CMI is therefore a promising development for medium- to long-term reform of reimbursement mechanisms—especially to the extent that CMI's results provide support for transitioning from fee-for-service payment to comprehensive or salary-based payment models. But more aggressive payment reform is necessary to shift the norms of procedure-intensive, medicalized birth, which shape maternity care in the U.S. today.

B. Improving Outcomes Requires Practicing Evidence-Based Maternity Care

The failure of many maternity care providers to practice evidence-based medicine (EBM) also contributes to the medicalized culture of childbirth and impedes efforts to improve health outcomes and lower costs. As in many medical specialties, most obstetricians adhere to the traditional approach to medical practice, which refers to the study of disease mechanisms coupled with clinical experience—often without referencing subsequent research about the safety and efficacy of

START FOR MOTHERS AND NEWBORNS EVALUATION: YEAR 1 ANNUAL REPORT, at I (2014).

273. *Id.* at 3.

274. *Id.* at II.

275. *Id.* at VI.

276. See also Margot Sanger-Katz, *Health Spending Forecast: No Drastic Rise, but Slowdown Seems Over*, N.Y. TIMES, July 29, 2015, at B2 (observing that actuaries did not consider the impact of CMI's demonstration projects when projecting future health spending due to the "small and unproved" nature of the programs).

277. See Sage, *supra* note 230, at 1099 (discussing the difficulty of using payment policy to regulate private insurers in decentralized exchanges).

care, or newer approaches with better outcomes.²⁷⁸ In fact, it can take up to twenty years for original research to be incorporated into routine clinical practice.²⁷⁹ EBM addresses the best available scientific research in clinical practice; EBM refers to “the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients.”²⁸⁰

Although a growing body of research literature is available to clarify the effects of various maternity practices, such resources are “grossly underutilized in policy, practice, education, and research.”²⁸¹ Research on maternity care has identified a “widespread and continuing underuse of beneficial practices, overuse of harmful or ineffective practices, and uncertainty about the effects of inadequately assessed practices.”²⁸² Specifically, research does not support the use of common maternity care practices, including various prenatal tests and treatments, continuous electronic fetal monitoring, rupturing membranes during labor, and episiotomy.²⁸³ High cesarean rates and low VBAC rates suggest that providers frequently perform medically unnecessary cesareans and fail to support low-risk women who want to deliver vaginally after a previous cesarean, as research suggests they should.²⁸⁴ The ulcer drug cytotec has been used regularly since the 1990s to induce labor without sufficient study of its safety and continues to be used in hospitals despite evidence of risks of uterine rupture.²⁸⁵ Conversely, beneficial practices are underused in maternity care, despite support in the research literature for techniques such as continuous non-medical labor support (often provided by doulas), non-

278. HENCI GOER & AMY ROMANO, OPTIMAL CARE IN CHILDBIRTH: THE CASE FOR A PHYSIOLOGIC APPROACH 11 (2012).

279. Agency for Healthcare Research & Quality, *Translating Research into Practice (TRIP)-II*, U.S. DEPT. HEALTH & HUMAN SERVS. (2001), <http://archive.ahrq.gov/research/findings/factsheets/translating/tripfac/trip2fac.html>, archived at <http://perma.unl.edu/T9RV-TYPL>.

280. DAVID L. SACKETT ET AL., EVIDENCE BASED MEDICINE: WHAT IT IS AND WHAT IT ISN'T 71–72 (1996).

281. SAKALA & CORRY, *supra* note 9, at 43.

282. *Id.* at v.

283. See Kukura, *supra* note 38; SAKALA & CORRY, *supra* note 9; GOER & ROMANO, *supra* note 278.

284. See CAROL SAKALA, CHILDBIRTH CONNECTION, VAGINAL OR CESAREAN BIRTH?: A SYSTEMATIC REVIEW TO DETERMINE WHAT IS AT STAKE FOR MOTHERS AND BABIES 3–7 (2006), archived at <http://perma.unl.edu/9PSA-CFX3> (concluding that a large inventory of differences strongly favored vaginal birth over cesareans for both women and babies); see also Kukura, *supra* note 38 (manuscript at 32–35) (discussing how ACOG's non-evidence-based guidelines on the provision of VBAC restricted the availability of VBAC and subjected more women to unwanted repeat cesareans with higher risks of complications for them and their babies).

285. See WAGNER, *supra* note 231, at 74–84 (discussing consequences of using cytotec to induce labor without study of its risks or efficacy); Madeline Oden, *The Freedom to Birth—The Use of Cytotec to Induce Labor: A Non-Evidence-Based Intervention*, J. PERINATAL EDUC., Spring 2009, at 48, 48–51.

supine positions for laboring, delayed cord clamping, and early mother-baby skin-to-skin contact.²⁸⁶

That geographic variations in costs and cesarean rates are not correlated with better outcomes suggests that more rigorous adherence to EBM would reduce costs without adverse health consequences and, in fact, improve health outcomes.²⁸⁷ Deviation from EBM is not simply a failure of individual physicians but rather a problem throughout the profession. For example, an analysis of obstetrical practice bulletins issued by the American College of Obstetricians and Gynecologists from 1998–2004 found that a small portion satisfied high standards of evidence; only 23% were Level A (“based on good and consistent scientific evidence”), 35% were Level B (“based on limited or inconsistent scientific evidence”), and 42% were Level C (“based primarily on consensus and expert opinion”).²⁸⁸

As discussed in section III.C, the ACA invests in comparative effectiveness research (CER)—an outgrowth of EBM—to reduce variation in medical practice by developing guidelines and best practices for physicians.²⁸⁹ Generally, CER is a “rigorous evaluation of the impact of different options that are available for treating a medical condition for a particular set of patients”;²⁹⁰ it can improve quality of care by shaping decisions regarding insurance design, influencing physician behavior, and impacting consumer demand. The ACA’s biggest contribution to CER is the establishment of PCORI to oversee agenda-setting and allocate federal funds for research that evaluates the outcomes and clinical effectiveness of medical treatments or services.²⁹¹ PCORI’s work could improve the quality of health care by

286. Kukura, *supra* note 38, at pt. II.B.2.b; SAKALA & CORRY, *supra* note 9; GOER & ROMANO, *supra* note 278.

287. *See generally* CONG. BUDGET OFFICE, RESEARCH ON THE COMPARATIVE EFFECTIVENESS OF MEDICAL TREATMENTS: ISSUES AND OPTIONS FOR AN EXPANDED FEDERAL ROLE 1–2, 29 (2007) [hereinafter RESEARCH ON CER], *archived at* <http://perma.unl.edu/46NT-GJB2> (“[T]he current health system tends to adopt more-expensive treatments even in the absence of rigorous assessments of their impact.”).

288. *See* SAKALA & CORRY, *supra* note 9, at 63.

289. *See* David Eddy, *Evidence-Based Medicine: A Unified Approach*, 24 HEALTH AFFAIRS 9 (2005); Alan M. Garber, *Evidence-Based Guidelines as a Foundation for Performance Incentives*, 24 HEALTH AFFAIRS 174 (2005); Milton C. Weinstein & Jonathan A. Skinner, *Comparative Effectiveness and Health Care Spending—Implications for Reform*, 326 NEW ENG. J. MED. 460 (2010).

290. RESEARCH ON CER, *supra* note 287, at 3. Although information about the effectiveness of new drugs and medical devices is required before they can be certified by the FDA, the regulatory process generally does not evaluate such products relative to alternatives. *Id.* at 4. Access to comprehensive information about the effectiveness of different modes of treatment—such as surgery compared to the administration of drugs—is also often quite limited or non-existent.

291. ACA §§ 6301, 6302, 42 U.S.C. §§ 1320e, 299b-8; *see also* Eleanor D. Kinney, *Comparative Effectiveness Research Under the Patient Protection and Affordable Care*

identifying the most effective clinical practices and making research accessible to a wider audience of care providers.

In order for CER to make a positive impact on health care quality, well-designed studies that clearly show the relative benefits and costs of treatments must be produced,²⁹² and physicians and patients must be willing to consider scientific research that may conflict with their beliefs about what treatment is appropriate and preferable—particularly when considering data on cost-effectiveness and not simply safety and efficacy. Restrictions on PCORI's mandate and activities will limit its reach. For example, PCORI lacks authority to mandate health insurance coverage or reimbursement policy based on its research and must ensure that its findings “do not include practice guidelines, coverage recommendations, payment, or policy recommendations.”²⁹³

PCORI is also precluded from developing or using a dollars-per-quality-adjusted life year to determine what care is cost-effective or recommended.²⁹⁴ Such limitations suggest a deep uneasiness that medical care will be denied on cost-effectiveness grounds to those who need it, inspiring exaggerated claims by the ACA's opponents that the Act mandates “death panels” to ration health care and amounts to socialized medicine.²⁹⁵ To keep concerns about rationing from sinking

Act: Can New Bottles Accommodate Old Wine?, 37 AM. J.L. & MED. 522 (2011) (discussing the history of comparative effectiveness research and the creation of the Patient-Centered Outcomes Research Institute). Prior to the ACA, the American Recovery and Reinvestment Act of 2009 (ARRA) allocated \$1.1 billion to HHS for CER, including \$700 million for health care research and quality programs through NIH and AHRQ and \$400 million to be distributed by the HHS Secretary. American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, 123 Stat. 115. ARRA also established the Federal Coordinating Council for Comparative Effectiveness Research.

292. See Kukura, *supra* note 38, at pt. III (discussing the importance of research design and quality to pursuing the adoption of EBM).

293. ACA § 6301(a), 42 U.S.C. § 1320e(d)(8).

294. *Id.*

295. See John K. Iglehart, *The Political Fight over Comparative Effectiveness Research*, 29 HEALTH AFFAIRS 1757, 1757–59 (2010) (explaining how CER sent “conservative pundits . . . into rhetorical overdrive”). A gentler, more nuanced critique of federal investment in CER concerns encroachment on physician autonomy in health care decision-making. See, e.g., DeBoer, *supra* note 81, at 1264, 1268 (predicting PCORI's work “will add to and likely accelerate the decades-long trend to shift the decisional locus in medical necessity, effectiveness, and appropriateness determinations away from physicians treating particular patients and to organizations and agencies making effectiveness determinations based on generalized knowledge”). While concerns about the impact of profit-maximizing by third-party payers should not be dismissed, the physician-autonomy objection may be less relevant in the maternity care context, given providers' discretion in identifying medical necessity to justify clinical action and the fact that most maternity care decision-making takes place in emotional and time-sensitive conditions. This wild west of maternity care decision-making supports greater

the whole Act, the ACA includes explicit provisions to blunt the impact of CER on health care delivery, such as prohibiting Medicare from using CER with cost data in coverage decisions.²⁹⁶ It also does not require insurers to use CER to determine their benefits packages.

One barrier to realizing the benefits of CER in the childbirth context is the uneven collection of data about maternity care practices. The U.S. lacks comprehensive data on maternal mortality or obstetrics, which inhibits efforts to improve maternal health outcomes by improving quality of care.²⁹⁷ It was not until the federal revision of birth certificates in 2003 that planned home births were tracked and certified midwives were listed as birth attendants—information that is necessary to study the safety and efficacy of midwifery and home births.²⁹⁸ Revision of maternity-related billing codes would facilitate the collection of more meaningful data about the quality of prenatal care and the use of various medical interventions during childbirth.²⁹⁹

adherence to EBM in maternity care. See LISTENING TO MOTHERS III, *supra* note 48 (reporting data on physician-directed childbirth interventions).

296. ACA § 6301(a), 42 U.S.C. § 1320e(d); see also Allison K. Hoffman, *Three Models of Health Insurance: The Conceptual Pluralism of the Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1873, 1907 (2011) (noting that the ACA “sets the stage for more precisely designed Health Promotion insurance through CER, but it does not preordain that the results of such research will shape future health care financing and delivery”).
297. See AMNESTY INT’L, *supra* note 25, at 86–88 (noting the U.S.’ lack of consistent reporting on maternal mortality and other childbirth outcomes); SAKALA & CORRY, *supra* note 9, at 68–70 (calling for development of national standardized maternity performance measurement and reporting mechanisms to identify and address “current patterns of overuse, underuse, and unjustified practice variation”). The U.N. Special Rapporteur on the Right to Health has called on states to establish a comprehensive, effective system to track and analyze maternal deaths and their causes, including non-medical, socio-economic factors. See *Practices in Adopting a Human Rights-Based Approach to Eliminate Preventable Maternal Mortality and Human Rights*, Rep. of the Office of the U.N. High Comm’r for Human Rights, 18th Sess., Sept. 12–30, 2011, at 4, U.N. Doc. A/HRC/18/27 (July 8, 2011).
298. See Indra Lusero, *Making the Midwife Impossible: How the Structure of Maternity Care Harms the Practice of Home Birth Midwifery*, 35 WOMEN’S RTS L. REP. 406, 412–13 (2014) (observing how the administrative function of data collection can hamper efforts to improve maternity care by limiting the amount of information available to inform how resources are distributed and research agendas are determined).
299. See Angood et al., *supra* note 255, at S26 (calling for separate billing codes for scheduled cesareans, emergency cesareans, post-induction cesareans, and codes to distinguish spontaneous from induced vaginal births and indicate the newborn’s gestational age at delivery). Such specific data would foster more robust research on maternity care decision-making and improve health policy interventions. Beginning in October 2015, the tenth revision of the International Classification of Diseases introduced thousands of new diagnostic codes across various medical specialties, which will enable the collection of more detailed information about the services patients receive. See Robert Pear, *One Symptom in New Medical Codes: Doctor Anxiety*, N.Y. TIMES (Sept. 13, 2015), <http://www.nytimes.com/>

Although the ACA expanded health care data collection in national health surveys, the law does not tackle flaws in the collection and reporting of maternity care data, including childbirth-related mortality and morbidity.

Although practical and political impediments may hinder CER's ability to improve maternity care practices, the promotion of CER and incorporation of EBM into clinical practice are important prerequisites for changing delivery of care and improving health outcomes. Maternity care suffers from an overuse of harmful or ineffective practices and an underuse of beneficial practices, which makes the clarity that CER can provide more urgent. CER should be employed to shift from a culture of childbirth that prioritizes medical intervention—regardless of the strength of scientific evidence regarding conventional practice—to one that treats childbirth as a normal, physiologic process. Ensuring that maternity care-related research receives appropriate attention will be important, as will investment in the development of strategies to promote adoption of evidence-based research by the providers caring for women and their babies.

C. Transforming Birth by Elevating Midwives as Primary Maternity Care Providers

A third concern central to the goal of creating a more health-affirming (and cost-effective) maternity care system is the promotion of midwifery. Modern midwifery promotes socially oriented, preventive care for pregnant women—in contrast to the disease and risk-management orientation of traditional maternity care. Midwifery is an appropriate form of care for women with low-risk pregnancies—roughly 83% of pregnant women.³⁰⁰ Under optimal conditions, midwives and obstetricians would collaborate as autonomous providers (along with other specialists for high-risk situations), thereby easing the transition from a low-intervention birth to one requiring more medical involvement when warranted.³⁰¹ In fact, this is the situation in most other developed nations (with the exception of Canada) where midwives are the first-line providers for healthy pregnant women, yielding better health outcomes and lower maternity care costs.³⁰²

2015/09/14/us/politics/one-symptom-in-new-medical-codes-doctor-anxiety.html?_r=0, archived at <http://perma.unl.edu/KM2D-WJNR>.

300. See SAKALA & CORRY, *supra* note 9, at 26.

301. See *Midwifery: An Executive Summary*, LANCET, June 2014, at 5 (discussing research that supports midwives working as part of multidisciplinary teams to provide care for women and infants during childbirth); Mary J. Renfrew et al., *Midwifery and Quality Care: Findings from a New Evidence-Informed Framework for Maternal and Newborn Care*, 384 LANCET 1129 (Sept. 20, 2014), archived at <http://perma.unl.edu/3KM9-CVFU>.

302. See SAKALA & CORRY, *supra* note 9 at 62.

Research shows that midwifery care is safe; the practice is associated with a reduced likelihood of episiotomy, cesarean, and pregnancy-induced hypertension or preeclampsia.³⁰³ Women who experience midwifery care are less likely to experience labor induction, labor augmentation, electronic fetal monitoring, pain medications, assisted vaginal birth (vacuum/forceps), artificial rupture of membranes, and the administration of IV fluids.³⁰⁴ Midwifery care is also linked to a greater likelihood of spontaneous vaginal birth, reduced low birthweight, and greater satisfaction.³⁰⁵ Attacks on midwifery often focus on the safety of home birth in particular. However, a recent study using data on nearly 17,000 midwife-led births collected by MANA—the largest analysis of planned home births in the U.S. ever published—confirmed the safety of home births, with low rates of interventions and high rates of positive health outcomes.³⁰⁶ As highlighted in Part II, midwife-assisted births are less expensive than physician-attended births, even when comparing only uncomplicated vaginal deliveries.³⁰⁷ The fact that certified nurse midwives are licensed in all fifty states and covered by federal health insurance programs further demonstrates the safety and cost-effectiveness of midwifery care.

Despite the well-documented benefits of midwifery, midwives continue to face structural barriers, including a patchwork of state laws restricting or regulating their practice, which marginalizes midwives in the maternity care arena.³⁰⁸ CPMs, who work outside the hospital as “autonomous health professionals working within a network of re-

303. See Dennis Walsh & Soo M. Downe, *Outcomes of Free-Standing, Midwife-Led Birth Centers: A Structured Review*, 31 BIRTH 222, 222–29 (2004) (discussing the impact of midwifery care on episiotomy and cesarean rates).

304. See Ulla Waldenström & Deborah Turnbull, *A Systematic Review Comparing Continuity of Midwifery Care with Standard Maternity Services*, BRIT. J. OBSTETRICS & GYNAECOLOGY, Nov. 1998, at 1160, 1160–70; Sharon A. Brown & Deanna E. Grimes, *A Meta-Analysis of Nurse Practitioners and Nurse Midwives in Primary Care*, NURSING RESEARCH, Nov.–Dec. 1995, at 332, 332–39.

305. See Brown & Grimes, *supra* note 304.

306. Specifically, the study reported a cesarean rate of 5.2% (after transfer to a hospital) and fewer interventions than hospital births, with only 1% of babies requiring a transfer to the hospital after birth, mostly for non-urgent conditions. Melissa Cheyney et al., *Outcomes of Care for 16,924 Planned Home Births in the United States: The Midwives Alliance of North America Statistics Project, 2004 to 2009*, 59 J. OF MIDWIFERY & WOMEN'S HEALTH 17, 20 (2014). Ninety-seven percent of babies were born full-term, weighing an average of 8 pounds at birth; nearly 98% were being breastfed at the six-week postpartum visit. *Id.* at 21, 23; see also Kukura, *supra* note 38 (manuscript at 31–46) (discussing methodological flaws in research commonly cited to attack the safety of home births and summarizing additional recent research on the safety of out-of-hospital births).

307. See *supra* Part II.

308. See Lusero, *supra* note 298, at 406 (analyzing “how the maternity care system eliminates home birth midwives from its pool of viable care providers”).

lationships with other maternity care providers,”³⁰⁹ are authorized to practice in only twenty-eight states; they have waged state-by-state legalization and licensure campaigns to protect and expand their ability to practice without criminal penalty.

Even in states where CPMs are legally recognized, they continue to face confusing legal standards, struggle to find professional insurance coverage, and face uneven insurance coverage for their clients—many of whom must pay out of pocket for their midwife’s services.³¹⁰ By contrast, CNMs, who earn a nursing degree before pursuing further study in gynecology and obstetrics, are permitted to work in all fifty states (generally in institutional settings under physician control),³¹¹ and their services are covered by many insurance programs, including the federal health insurance programs for low-income people and service members.³¹² However, hospital-based midwives are subject to protocols that may impede their ability to follow the midwifery model of care; practicing under the physician supervision, they often confront a lack of professional respect and are marginalized.³¹³ In addition to the barriers midwives encounter, operators of freestanding birth centers find structural impediments to opening more facilities, including regulatory hurdles, legal restrictions on midwives, and a lack of cooperation from local physicians in providing backup support.

The ACA’s two pro-midwifery reforms are modest but important steps toward promoting access to and acceptance of midwifery. Their potential to effect broader change arises from the significant impact of CMS’ reimbursement regulations on setting health care policy and promoting particular forms of health care, even in private insurance, which often adopts Medicare reimbursement rates in private policies.³¹⁴ First, Medicaid reimbursement for freestanding birth centers makes midwifery care a meaningful option for low-income women.³¹⁵

309. *Who are CPMs*, NAT’L ASS’N CERTIFIED PROF. MIDWIVES (2014), <http://nacpm.org/about-cpms/who-are-cpms/>, archived at <http://perma.unl.edu/HW9K-NFNY>.

310. Lusero, *supra* note 298, at 433–34 (discussing legal, regulatory, and professional constraints on midwifery).

311. *Id.* at 407. Although some CNMs work in freestanding birth centers or maintain home-birth practices, in 2013, 94.6% of CNM-assisted births occurred in hospitals. *Essential Facts About Midwives*, AM. C. NURSE-MIDWIVES, <http://www.midwife.org/Essential-Facts-about-Midwives> (last updated Sept. 2015), archived at <http://perma.unl.edu/XYE3-M68Q>.

312. See 42 U.S.C. § 1396d (2012) (Medicaid); 10 U.S.C. § 1079 (2012) (Civilian Health and Medical Program for the Uniformed Services (“CHAMPUS”).

313. See WAGNER, *supra* note 231, at 249.

314. See John D. Blum, *Beyond the Bylaws: Hospital-Physician Relationships, Economics, and Conflicting Agendas*, 53 BUFF. L. REV. 459, 461 (2005) (“[Federal] reimbursement policies [] have acted both to promote, alter and end operational practices, touching on all matters of the institution’s business.”).

315. See Fisch, *supra* note 201, at 195 (identifying access to Spanish-speaking midwives and VBAC as two other factors that might make low-income women dependent on a freestanding birth center).

Midwifery care at freestanding birth centers is safe, cost-effective, and health-affirming. The availability of Medicaid reimbursement may encourage the growth of the birth center model, particularly where women lack sufficient access to prenatal care. Medicaid reimbursement may also spur insurers to provide the same coverage under private plans, which are currently uneven in their coverage of midwife-attended birth-center births.³¹⁶

Second, equal reimbursement for CNMs under Medicare means that midwife services will be billed at the same rate as physicians, rather than 65% of the physician rate, as they have been since Medicare first recognized CNMs under Part B in 1988.³¹⁷ This is an important step to ending the marginalization of midwives in maternity care. Twenty-nine states provide Medicaid reimbursement for CNMs' services at 100% of the physician rate; the ACA's equalization of Medicare reimbursement may prompt policymakers in the remaining states to equalize Medicaid rates.³¹⁸ Equalization of reimbursement may also enable independent nurse-midwifery practices to grow and make CNMs more visible in group practices and health plans.

But CPM reimbursement is still uneven, thereby maintaining a significant barrier to midwifery care for women who rely on government insurance and signaling through public policy disfavor for those midwives who work autonomously.³¹⁹ Nor does the law guarantee access to midwifery care for women using private insurance, despite the ACA's prohibition on discrimination by insurers against licensed medical providers.³²⁰ So, while the ACA's changes in birth center reimbursement and CNM rates are important developments in increasing midwifery access, they are modest, incremental steps to achieving a maternity care system in which midwives play a primary role in caring for healthy women with low-risk pregnancies.

316. Michelle Andrews, *Health Law Provides No Guarantees of Access to Midwives, Birthing Centers*, KAISER HEALTH NEWS (Mar. 4, 2014), <http://www.kaiserhealthnews.org/Stories/2014/march/04/michelle-andrews-health-law-provides-no-guarantees-of-access-to-midwives.aspx?referrer=search>, archived at <http://perma.unl.edu/5DA2-WH2P>.

317. *See Midwives and Medicare After Health Care Reform*, AM. C. NURSE-MIDWIVES, <http://www.midwife.org/Midwives-and-Medicare-after-Health-Care-Reform>, archived at <http://perma.unl.edu/B4LX-ZPK2> (last visited Nov. 8, 2015).

318. AM. C. NURSE-MIDWIVES, CERTIFIED NURSE-MIDWIFE AND CERTIFIED MIDWIFE MEDICAID REIMBURSEMENT RATES 3 (Sept. 2013), archived at <http://perma.unl.edu/DP9Q-WEVF>.

319. *See Andrews, supra* note 316; *see also SAKALA & CORRY, supra* note 9, at 68–70 (calling for adequate Medicaid/Medicare reimbursement rates for CPMs, CMs, and CNMs).

320. Andrews, *supra* note 316; Elisabeth Rosenthal, *Getting Insurance to Pay for Midwives*, N.Y. TIMES (July 3, 2013, 12:51 PM), <http://well.blogs.nytimes.com/2013/07/03/getting-insurance-to-pay-for-midwives/>, archived at <http://perma.unl.edu/KP8D-8BEX> (discussing the difficulty of getting private insurers to cover midwives).

The elevation of midwifery represents one of the most significant forms of cultural change possible with maternity care—and perhaps also one of the stickiest. Promoting midwifery requires overcoming physician resistance and neutralizing the effects of more than a century of rhetoric characterizing midwives as untrained, unskilled, and providers of inferior care. Midwives face professional hierarchies that have excluded them from hospitals and denied them the necessary support to practice legally in out-of-hospital settings.³²¹ A cost-effective model of maternity care—and one that prioritizes patient safety—requires physicians to enter truly collaborative relationships with midwives, cede some professional turf, and relinquish their monopoly on purported childbirth expertise.³²² Such a shift in power would also impact the doctor-patient relationship; the midwifery model of care treats the woman as an expert in her own body and, thus, an active agent in the birthing process. To the extent that many physicians practice medicine as “medical expert[s] sharing knowledge with an idyllic ‘compliant patient’ passively accepting medical decisions,” midwifery disrupts the traditional power dynamic between physician and patient.³²³ In light of these complex matters of authority, expertise, and power, it seems that elevating midwifery would produce tremendous cultural change in the maternity care system. The ACA takes only a modest step in this direction; the law stops short of achieving full CPM acceptance via state-level legalization and licensure campaigns, and incorporating midwives into maternity care as autonomous participants collaborating with physicians.

321. See Katherine Beckett & Bruce Hoffman, *Challenging Medicine: Law, Resistance, and the Cultural Politics of Childbirth*, 39 *LAW & SOC'Y REV.* 125, 131–39 (2005).

322. E.g., Neel Shah, *I'm an OB-GYN. I'm Not Sure Every Baby Needs to Be Born in the Hospital*, *WASH. POST* (June 5, 2015), <https://www.washingtonpost.com/posteverything/wp/2015/06/05/im-an-ob-gyn-i-dont-think-most-babies-should-be-born-in-the-hospital/>, archived at <http://perma.unl.edu/L7HV-FURQ>; Carla C. Keirns, *I Didn't Realize the Pressure to Have a C-Section Until I Was About to Deliver*, *WASH. POST* (Jan. 5, 2015), http://www.washingtonpost.com/national/health-science/pregnant-doctor-finds-intense-pressure-to-have-a-caesarean-delivery/2015/01/05/949ed918-7bd3-11e4-84d4-7c896b90abdc_story.html, archived at <http://perma.unl.edu/97LV-6SYG>.

323. Jasmine E. Harris, *Cultural Collisions and the Limits of the Affordable Care Act*, 22 *AM. U. J. GENDER SOC. POL'Y & L.* 387, 435 (2014) (critiquing the doctor-patient relationship model that provides for unilateral decision-making by the physician expert on patients' behalf). Harris argues privileging professional expertise can result in excluding the patient's voice, which “sends her a clear message about her autonomy, dignity, and role in addressing her own challenges.” *Id.* at 435–37. Though Harris' examples come from a discussion of the cultural barriers that interfere with the provision of mental health care to Latinas, her discussion of power in the physician-patient relationship is relevant to the childbirth context. See also WAGNER, *supra* note 231 (discussing the role of power dynamics between physicians and their patients in shaping clinical decision-making).

The three approaches to maternity care reform addressed in this Part—restructuring fee payment to eliminate misaligned incentives, adopting EBM within maternity care, and promoting midwifery—work in tandem to improve health outcomes, reduce costs, and change the cultural values that shape modern-day childbirth in the U.S. The problems these approaches address are interconnected. For instance, the perverse incentives created by the current payment system constitute a “pervasive barrier[] to evidence-based care” in the maternity context.³²⁴ Accepting EBM requires acknowledgment of the safety and cost-effectiveness of midwife-attended births, and making room for midwives in mainstream care means adjusting clinical practices and the methods of charging for maternity services. These efforts pick up where the ACA leaves off, building on the law’s important access-expanding and coverage-enhancing provisions to transform maternity care into the truly health-affirming system that women and their babies deserve.

V. CONCLUSION: REFLECTIONS ON LAW AS A TOOL TO IMPROVE HEALTH CARE

Although no recent legislation rivals the reach or significance of the ACA, laws are routinely passed to regulate, incentivize, and fund health care in the U.S. Examining how various types of laws impact the delivery of health care services is crucial to understanding how to craft laws that will improve outcomes and reduce costs. Maternity care provides a useful case study in the broader interrogation of law as a tool to improve health outcomes, and as a vehicle for change within health care culture. As discussed previously, maternity care in the U.S. is shaped by a health care culture that views childbirth as a medical event in need of management and control, rather than a normal, physiologic process.³²⁵ This understanding is informed by the work of sociologists, anthropologists, historians, and public health experts who have examined how physicians claimed authority over midwives to care for birthing women, how medical interventions have been promoted in an unqualified way, and how economic, legal, and reputational concerns in the medical profession prioritized risk management over holistic, socially oriented preventive care.³²⁶

324. MATERNITY CARE PAYMENT, *supra* note 249, at 1.

325. For a broader discussion of the concept of health care culture, see Tim Scott et al., *Implementing Culture Change in Health Care: Theory and Practice*, 15 INT’L J. FOR QUALITY IN HEALTH CARE 111, 111–18 (2003). For an example of legal reform aimed at changing health care culture, see Ansley Boyd Barton, *Recent Remedies for Health Care Ills*, 21 GA. ST. U.L. REV. 831, 854 (2005) (discussing state and federal legislation and addressing a culture of health care that inhibits reporting adverse events).

326. See WAGNER, *supra* note 231; MAINSTREAMING MIDWIVES, *supra* note 7.

Indeed, the firm entrenchment of medicalized childbirth in the U.S. health care system reflects the power of these social and cultural forces, which have constructed birth as something inherently dangerous, something to be feared.³²⁷ The norms and values that have dominated maternity care strongly influence the type of care provided and its delivery. The fact that decision-making about labor and birth often occurs in a time-sensitive and emotionally heightened context enhances the ability of medical professionals to determine the course of care, degrading informed consent and patient autonomy, and marginalizing women's voices and innate instincts in the process.

Part IV identified issues in the financing and delivery of maternity care services that are important steps to improving health outcomes, arguing that a meaningful change in maternity care requires a shift in the culture of childbirth. Though not a comprehensive account of all reforms that could contribute to the reconceptualization of childbirth, the initiatives discussed therein target various problems in how maternity care decisions are made and the type of care most valued. With proper investment and sustained political will, the restructuring of payment mechanisms, adoption of EBM practices, and elevation of midwifery will transform the culture of maternity care. As analyzed above, the ACA's contribution on each of these fronts is modest, and the law could (and should) have been more ambitious regarding maternity care-specific reforms. Its moderation in this regard is not a failure of law reform itself, however, and opportunities for further legislative efforts to improve maternity care should be pursued at the state and federal levels. Given that some of maternity care's more endemic problems are embedded in a medical culture where paternalism, reverence for technology, and the pursuit of efficiency influence the provision of care, it is worth asking how effective law can be as a tool to alter underlying social norms and values in the maternity care context. The remainder of this Part sets the stage for future inquiry into legal reform as a mechanism to improve health outcomes by changing health care culture.³²⁸

327. Cf. Bradley A. Areheart, *Disability Trouble*, 29 YALE L. & POL'Y REV. 347, 363 (2011) (discussing diagnoses in the disability context as a social concept; "acceptable categories of diagnoses are created by a variety of non-medical factors and take form as interested parties interact"); Lars Noah, *Pigeonholing Illness: Medical Diagnosis as a Legal Construct*, 50 HASTINGS L.J. 241, 243 (1999) ("[S]cholars and physicians alike have recognized that diseases are socially constructed and mutable.").

328. For a related perspective on the relationship between law, culture, and health, consider the work of Public Health Law Research (PHLR), a national program of the Robert Wood Johnson Foundation dedicated to collecting evidence for laws that improve public health. See *About Us*, PUB. HEALTH L. RES, <http://publichealthlawresearch.org/about>, archived at <http://perma.unl.edu/MU8L-4G4S> (last visited Nov. 8, 2015); *The Role of Law in Advancing a Culture of Health*, PUB. HEALTH L. RES, <http://publichealthlawresearch.org/role-law-advancing-culture>.

Historically, federal legislation has produced positive changes in norms governing discrimination in health care and the expectations society places on health care providers not to deny life-saving care.³²⁹ Beginning in the 1990s, HIPAA's enhanced privacy protections impacted how stakeholders in the health care industry understood ownership and use of an individual's medical history.³³⁰ From malpractice rules to disclosure requirements, law has provided a framework for the norms and values that shape health care. As a site of inquiry, maternity care bears two characteristics that make it fertile terrain for exploring law's potential to effect social change. First, there is wide latitude for maternity care providers to exercise discretion regarding what care to recommend and when to intervene in the birthing process; the exercise of discretion is shaped by the cultural context in which the provider operates. From the onset of contractions to the crowning of the newborn, there are numerous points at which more or less medical intervention may be recommended and pursued. Variation in clinical practice across physicians, hospitals, and regions supports the notion that something beyond medical necessity or advisability drives many decisions in the provision of maternity care.³³¹ Exploring how legal interventions can improve the quality of decision-making at those critical moments without unduly infringing on physician autonomy is important to understanding how law might impact the culture of health care and thereby improve outcomes.

Second, maternity care is a rich example of how paternalism operates in medical culture, raising questions about how law can shape individual behavior and professional norms. The perceived superiority of medical experts impacts social interactions and the provision of care throughout the profession, but maternity care has two attributes that heighten the degree of paternalism present in provider-patient

health, *archived at* <http://perma.unl.edu/QR73-X952> (last visited Nov. 8, 2015) (noting how the ACA introduced a "shift in the social norms of the health professions, [brought] a team-based approach and increase[ed] the emphasis on prevention and health management rather than treatment alone").

329. Title VI of the Civil Rights Act of 1964, 42 U.S.C. §§ 2000d–2000d7 (2012) (prohibiting discrimination on the basis of race, color, or national origin by any program or facility that receives federal funding); Rehabilitation Act of 1973 § 504, 29 U.S.C. § 701 (2012); Americans with Disabilities Act of 1990, Pub. L. No. 101-336, 104 Stat. 328 (codified as amended in scattered sections of 42 U.S.C.) (prohibiting discrimination in health care on the basis of disability); Emergency Medical Treatment & Labor Act (EMTALA), 42 U.S.C. § 1395dd (2012) (requiring hospitals to stabilize and treat anyone presenting at an emergency department, regardless of insurance status or ability to pay).
330. Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, 110 Stat. 1936 (1996).
331. *See, e.g.*, Jessica Mantel, *The Myth of the Independent Physician: Implications for Health Law, Policy, and Ethics*, 64 CASE W. RES. L. REV. 455 (2013) (discussing how health care culture prejudices clinical decision-making in ways that lead to poor quality or inefficient care).

interactions. First, maternity care involves women's bodies and reproductive capacities, which have long been subject to misunderstanding, misdiagnosis, contestation, and denigration. Second, maternity care requires maximizing the health and wellbeing of both the woman and the fetus, which can raise ethical and moral challenges or the false perception of maternal-fetal conflict in health care decision-making.³³² These factors may enhance the paternalistic quality of interactions between care providers and patients, reinforcing a culture of childbirth that privileges physician expertise. Studying legal interventions to the provider-patient relationship in order to improve the quality of care may therefore yield insight on the organizational and professional cultures more generally.

Law creates background norms that enable and encourage certain values to flourish, while discouraging others. Law helps create the conditions under which people interact. Legal reform oriented toward improving maternity care through "environment-altering" initiatives could take a variety of forms.³³³ One way to conceptualize different legal interventions is to categorize them according to the interests they target. Legal initiatives that seek to change provider behavior might focus on practices that promote self-interest or inspire fear of litigation. For example, a law mandating restructured payment models for maternity care might eliminate financial incentives for physicians to perform medically unnecessary procedures, or facilitate more collaborative relationships with midwives. In the malpractice context, legislation to modify the traditional custom-based standard of care applied by most jurisdictions would encourage physicians to update their clinical practices based on the best available evidence by lessening their fear of malpractice liability.³³⁴

In contrast, legal initiatives that seek to empower women and improve their birth experiences might remove barriers that keep them from accessing the health care they want. Disclosure laws requiring the publication of critical maternity care data—such as rates of cesareans, VBACs, breastfeeding, or maternal mortality—inform women about which hospitals and providers are likely to support their

332. Jamie R. Abrams, *The Illusion of Autonomy in Women's Medical Decision-Making*, 42 FLA. ST. U. L. REV. 17 (2015).

333. DeBoer, *supra* note 81, at 1252–54 (discussing how laws promoting access to insurance, increasing the availability of medical facilities, and prohibiting discrimination "have had an environment-altering impact" that reaches "physician-patient relationships, hospital-patient relationships, and insurer-insured relationships").

334. Carter L. Williams, Note, *Evidence-Based Medicine in the Law Beyond Clinical Practice Guidelines: What Effect Will EBM Have on the Standard of Care?*, 61 WASH. & LEE L. REV. 479, 519–32 (2004) (discussing frameworks for altering the medical malpractice standard of care in light of evidence-based medicine); Kukura, *supra* note 38 (manuscript at 52–65) (describing the standard of care for malpractice as a barrier to EBM adoption).

needs and preferences. Mandated disclosure also allows the market in maternity care services to respond to patient demand, as women who want a VBAC or for whom breastfeeding-supportive hospital policies are important can vote with their swollen feet and choose not to birth at hospitals reporting low rates of VBAC or breastfeeding.³³⁵ Laws that allow for CPM licensure provide women greater opportunities for midwife-attended birth; in areas without a freestanding birth center or hospital-based nurse-midwifery, CPMs may be the only option for women interested in a non-medicalized birth or VBAC. Licensure laws signal that midwifery care is valued and that women's agency in shaping their childbirth should be encouraged and promoted.

Other typologies may also prove useful for understanding what kinds of legal intervention are effective. Whether a law is mandatory or permissive—for example, requiring private health insurance to include reimbursement for midwifery services or making tax credits available for the construction of new birth centers—might be a useful indicator of the resulting impact on maternity care. The difference between legal intervention at the federal and state levels may also prove illustrative, especially since much federal innovation in health care policy is implemented through Medicare and Medicaid, or through federal funds for research, whereas regulation of the practice of medicine is within states' police powers. Another possible approach would compare laws that promote structural reforms to laws with a signaling function. Future research on legal interventions to improve maternity care should yield useful insight into whether, how, and under what conditions law can be an effective tool for changing the social norms and values that inform health care culture.

The ACA introduced a series of unprecedented reforms that expanded access to insurance and improved the scope of that coverage for millions of women who are pregnant or will become pregnant. The ACA's innovations touch various aspects of the delivery and financing of maternity care. The ACA also invested in a range of programmatic and policy initiatives that hold promise for long-term improvements in the provision of quality care. But expanded coverage and increased access to medical care are not enough to heal the ills of the U.S. maternity care system—deep structural flaws that have led to record-high rates of cesarean surgeries, shameful rates of maternal and infant mortality, and staggering financial costs.

335. Of course, this point is less salient for women who live in a region with only one hospital or where all available hospitals restrict access to VBAC. See Elizabeth R. Kukura, *Choice in Birth: Preserving Access to VBAC*, 114 PENN ST. L. REV. 955, 965–66 (2010) (discussing limitations on the availability of VBAC).

Using the ACA's reforms as a springboard, this Article identified three aspects of maternity care in need of structural reform: reworking payment models to eliminate misaligned incentives, promoting evidence-based maternity care practices, and elevating midwives as first-line maternity care providers for low-risk women. Achieving systemic change and improving health outcomes requires engagement with the social construction of birth as a medical event and a shift away from the procedure-intensive provision of maternity care. Reforming these aspects of maternity care will produce a more health-affirming, cost-effective maternity care system for all. These reforms are complex and interconnected, requiring the strategic use of law and advocacy to effect such structural and cultural change. Given this, studying maternity care reform—particularly the use of law to improve health outcomes—will contribute not only to the betterment of maternity care but also to crafting more effective legal interventions into the health care system more broadly.