

2021

## All Aboard the Momnibus: Will Congress' Proposed Legislative Package Help Drive Down Black Maternal Mortality Rates?

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### Recommended Citation

Skyler Arbuckle, *All Aboard the Momnibus: Will Congress' Proposed Legislative Package Help Drive Down Black Maternal Mortality Rates?*, 24 SMU SCI. & TECH. L. REV. 413 (2021)  
<https://scholar.smu.edu/scitech/vol24/iss2/8>

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# All Aboard The Momnibus: Will Congress's Proposed Legislative Package Help Drive Down Black Maternal Mortality Rates?

*Skyler Arbuckle\**

## I. INTRODUCTION

Motherhood is one of life's most beautiful, inspiring, and for many women, rewarding, purposes. It is a sacred journey that marks a new chapter in every woman's story, and it should be one of the happiest moments in every woman's life. Many women will become mothers during their lifetime, and while pregnancy and childbirth can be life-altering events, they can even prove to be life-ending for some women. American women die in childbirth at a higher rate than in any other developed country.<sup>1</sup> Pregnancy-related complications account for approximately 700 deaths in the United States annually, according to the Centers for Disease Control and Prevention (CDC).<sup>2</sup> Further, research shows that roughly 60% of all pregnancy-related deaths are preventable.<sup>3</sup>

However, not all women face the same risks during pregnancy and childbirth: there are stark racial disparities amongst pregnancy-related deaths in the United States. Black women in the U.S. are more likely than any other racial group to die from pregnancy or childbirth.<sup>4</sup> Specifically, Black women are three to four times more likely to die from pregnancy-related causes than their white counterparts.<sup>5</sup> Black women are also more likely to experience preventable maternal death compared to white women, and Black women's increased risk of pregnancy-related mortality spans education and income levels.<sup>6</sup> If the United States eliminated the racial disparities in maternal mor-

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1. See Gianna Melillo, *Racial Disparities Persist in Maternal Morbidity, Mortality and Infant Health*, AJMC (June 13, 2020), <https://www.ajmc.com/view/racial-disparities-persist-in-maternal-morbidity-mortality-and-infant-health> [<https://perma.cc/Z5M6-EW4P>].

2. See *Pregnancy-Related Deaths*, CTRS. FOR DISEASE CONTROL & PREVENTION (May 7, 2019), <https://www.cdc.gov/vitalsigns/maternal-deaths/index.html> [<https://perma.cc/Y52U-NG84>].

3. *Id.*

4. *Black Women's Maternal Health: A Multifaceted Approach to Addressing Persistent and Dire Health Disparities*, NAT'L P'SHIP FOR WOMEN & FAMS., (Apr. 2018) <https://www.nationalpartnership.org/our-work/health/reports/black-womens-maternal-health.html> [<https://perma.cc/ZX4X-3HWT>].

5. *Id.*

6. *Id.*

tality, the U.S. maternal mortality rate would resemble the maternal mortality rates of other countries in the developed world.<sup>7</sup> Simply put, America must prioritize saving the lives of Black mothers if it wants to resolve its maternal mortality crisis.<sup>8</sup>

While some of the statistics help put this ongoing crisis in context, the stories of the lives lost and testimonies of Black mothers with near-death experiences illustrate how America fails its Black mothers. Kira Johnson was a successful entrepreneur who spoke five languages, flew planes, and enjoyed skydiving until she tragically lost her life in childbirth.<sup>9</sup> After what should have been a routine Cesarean section to deliver her son, Langston, Johnson's husband, Charles, began noticing issues.<sup>10</sup> As Kira's catheter turned pink with blood, Charles pleaded with the hospital to take action only to be told she "just isn't a priority."<sup>11</sup> Kira's condition continued to deteriorate as nurses and doctors ignored Charles.<sup>12</sup> When doctors took Kira to surgery, they discovered that her abdomen had filled with close to four liters of blood after bleeding internally for nearly ten hours, and her heart stopped immediately.<sup>13</sup> What was supposed to be one of the happiest days of Kira and Charles's life ended in an unspeakable and avoidable tragedy. Kira was in excellent health, had no pre-existing conditions, and gave birth at one of the top hospitals in the nation.<sup>14</sup> Unfortunately, however, the architect of her demise was her identity as a Black woman.

This crisis also impacts Black woman across America's educational and socioeconomic spectrum. Shalon Irving, a 36-year-old CDC epidemiologist with two master's degrees, a Ph.D., and excellent health insurance, died three weeks after delivering her daughter.<sup>15</sup> Shalon's journey to pregnancy presented several red flags, including fertility difficulties, a blood clotting

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7. See Khiara M. Bridges, *Racial Disparities in Maternal Mortality*, 95 N.Y.U. L. REV. 1229, 1294 (2020).

8. *See id.*

9. See Kristi Pahr, 'My Wife's Legacy Gives a Voice to the Voiceless': Charles Johnson's Loss Launched a Maternal Health Revolution, PARENTS.COM (Apr. 10, 2020), <https://www.parents.com/pregnancy/giving-birth/stories/my-wifes-legacy-gives-a-voice-to-the-voiceless-charles-johnsons-loss-launched-a-maternal-health-revolution/> [<https://perma.cc/B6D4-VLVF>].

10. *Id.*

11. *Id.*

12. *See id.*

13. *See id.*

14. *See id.*

15. See Nina Martin, *Black Mothers Keep Dying After Giving Birth. Shalon Irving's Story Explains Why*, NPR (Dec. 7, 2017, 7:51 PM), <https://www.npr.org/2017/12/07/568948782/black-mothers-keep-dying-after-giving-birth-shalon-irvings-story-explains-why> [<https://perma.cc/NX3H-RQTG>].

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disorder, and uterine fibroids, which Black women are two to three times more likely to develop than their white female counterparts.<sup>16</sup> After her cesarean section to deliver her daughter, Soleil, Shalon developed a tender lump along her incision that required draining, followed by dangerously high spikes in her blood pressure that caused chronic pain, persistent headaches, and nine pounds of weight gain in ten days.<sup>17</sup> After being sent home without treatment following a negative screening for postpartum pre-eclampsia, Irving returned to her doctor five days later reporting an unwell feeling and swelling in her right leg only to be sent home with a prescription to treat hypertension.<sup>18</sup> That same night, Irving collapsed in her home from cardiac arrest and was rushed to the hospital where she later died after being removed from life support.<sup>19</sup> Shalon's story demonstrates, yet again, that education and socioeconomic status will not insulate Black women from this insidious issue. World-famous women are just as vulnerable.

In a *Vogue* cover story, world renowned tennis star and superstar athlete, Serena Williams, opened up about her near fatal birthing experience.<sup>20</sup> Just a day after giving birth to her daughter Alexis Olympia via cesarean section, Williams began experiencing trouble breathing.<sup>21</sup> Due to her long history of blood clots, a condition that nearly killed her in 2011, Williams immediately suspected she was suffering from a pulmonary embolism or a blood clot in her lungs.<sup>22</sup> After alerting a nurse to describe what was happening in her body, Williams requested a CT scan and a blood thinner, only to have her concerns shrugged off by the nurse.<sup>23</sup> Still, Williams insisted on a

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16. Saralyn Cruickshank, *The Death of a Young Black Mother Brings Attention to the Issue of Racial Health Disparities*, HUB JOHNS HOPKINS UNIV. (Feb. 26, 2019), <https://hub.jhu.edu/2019/02/26/shalon-irving-maternal-mortality-symposium/> [<https://perma.cc/N2UM-7JCJ>] (discussing Shalon Irving's pregnancy journey and untimely death); Monica Ploetzke MD, *Fibroids: Greater in African-American Women than White. Why?*, MCLEOD HEALTH, <https://www.mcleodhealth.org/blog/fibroids-greater-in-african-american-women-than-white-but-why/> [<https://perma.cc/3V7C-4V79>] (last visited Feb. 18, 2022) (discussing statistics on Black women's rates of developing fibroids, which are non-cancerous growths in the uterus).
  17. Cruickshank, *supra* note 16.
  18. *Id.*
  19. *Id.*
  20. See P.R. Lockhart, *What Serena Williams's Scary Childbirth Story Says About Medical Treatment of Black Women*, Vox (Jan. 11, 2018, 4:40 PM), <https://www.vox.com/identities/2018/1/11/16879984/serena-williams-childbirth-scare-black-women> [<https://perma.cc/XG87-8WKE>].
  21. *See id.*
  22. *See id.*
  23. *See id.*

CT scan, but instead, her doctor performed an ultrasound of her legs.<sup>24</sup> Finally, after the ultrasound revealed nothing, Williams underwent a CT scan which showed several small blood clots in her lungs, and doctors immediately placed her on a heparin drip.<sup>25</sup> Thankfully, Williams survived this blatant example of racial prejudice and bias, but her story is a stark reminder that racism robs countless Black women in the United States of the precious experience of motherhood.

A breakdown of these shocking statistics helps put this alarming crisis in context. Racial and gender inequalities cause Black women to live on society's edges, exposing them to certain risk factors that contribute to the elevated number of Black maternal deaths.<sup>26</sup> Factors such as poverty, lack of access to healthcare, and exposure to institutional and systemic racism all work in concert to undermine healthy maternal outcomes for Black mothers.<sup>27</sup> For example, Black women represent 22.3% of women in poverty but make up only 12.8% of America's female population,<sup>28</sup> and higher poverty rates are associated with higher rates of maternal mortality for women of all races.<sup>29</sup> Additionally, Black women are twice as likely to be unemployed than white women,<sup>30</sup> with a total unemployment rate of 8.5% for Black women and 5.1% for White women in 2020.<sup>31</sup> Black women's poverty and unemployment rates also affect their access to care, as Black women are more likely than their white counterparts to be low income and enrolled in Medicaid, with 31% of Black women enrolled in Medicaid, compared to only 16%

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24. *See id.*

25. *See id.*

26. *See* CTR. FOR REPRODUCTIVE RTS., RESEARCH OVERVIEW OF MATERNAL MORTALITY AND MORBIDITY IN THE UNITED STATES, [https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/USPA\\_MH\\_TO\\_ResearchBrief\\_Final\\_5.16.pdf](https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/USPA_MH_TO_ResearchBrief_Final_5.16.pdf).

27. *See id.*

28. Robin Bleiweis et al., *The Basic Facts About Women in Poverty*, CTR. FOR AM. PROGRESS (Aug. 3, 2020, 9:03 AM), <https://www.americanprogress.org/issues/women/reports/2020/08/03/488536/basic-facts-women-poverty/> [https://perma.cc/BRU5-JZLV].

29. *See Research Overview of Maternal Mortality and Morbidity in the United States*, *supra* note 26.

30. *See id.*

31. Margaret Teresa Brower & Jamila Michener, *Latina and Black Women Lost Jobs in Record Numbers. Policies Designed for All Women Don't Necessarily Help*, WASH. POST (Feb. 9, 2021, 6:00 AM), <https://www.washingtonpost.com/politics/2021/02/09/latina-black-women-lost-jobs-record-numbers-policies-designed-all-women-dont-necessarily-help/> [https://perma.cc/CEQ3-TE88].

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of white women.<sup>32</sup> Black women's lack of access to necessary healthcare makes them less likely to receive recommended disease prevention and management, which further causes Black women to enter pregnancy without added benefits of preconception care.<sup>33</sup>

Yet, even when healthcare is accessible to Black women, issues regarding quality of care and implicit racial discrimination from healthcare providers and America at large can have drastic effects on the health of Black mothers. Studies have shown that implicit racial discrimination adversely affects Black patients as they are treated differently than white patients with the same symptoms.<sup>34</sup> For example, a 2016 study on racial bias in pain perception and treatment found that Black patients were undertreated by medical staff for pain compared to white patients.<sup>35</sup> Moreover, quality of care in Black-serving hospitals, in which 75% of Black women give birth, also negatively impacts Black mothers as these hospitals have drastically higher rates of maternal complications than other hospitals.<sup>36</sup> Finally, racism contributes to poor Black maternal health outcomes by acting as a stressor that compromises Black women's overall health.<sup>37</sup> Research suggests that racism operates as a psychological stressor that, over time, leads to physiological changes in the body that make Black women more susceptible to disease.<sup>38</sup>

State and federal leaders have begun to address America's maternal health crisis by drafting legislative proposals that directly address America's Black maternal health crisis.<sup>39</sup> This comment examines America's ongoing Black maternal health crisis and how Congress's proposed legislation, Black

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32. *Medicaid Coverage of Abortion*, GUTTMACHER INST., <https://www.guttmacher.org/evidence-you-can-use/medicaid-coverage-abortion> [https://perma.cc/5B4H-XVKJ] (last visited Jan. 24, 2022).

33. *See Research Overview of Maternal Mortality and Morbidity in the United States*, *supra* note 26.

34. *Id.*

35. Laura Joszt, *Implicit Biases Have an Explicit Impact on Healthcare Outcomes*, AJMC (Sept. 28, 2018), <https://www.ajmc.com/view/implicit-biases-have-an-explicit-impact-on-healthcare-outcomes> [https://perma.cc/DG9T-G9QW].

36. *See Black Women's Maternal Health: A Multifaceted Approach to Addressing Persistent and Dire Health Disparities*, *supra* note 4.

37. *Research Overview of Maternal Mortality and Morbidity in the United States*, *supra* note 26.

38. *Id.*

39. *See* Taylor Platt et al., *State Strategies to Address the Black Maternal Health Crisis*, NAT'L ACAD. FOR STATE HEALTH POL'Y (Oct. 12, 2020), <https://www.nashp.org/state-strategies-to-address-the-black-maternal-health-crisis/> [https://perma.cc/E9JC-2PDD]; *see* Booker, Underwood, Adams, *Senators Unveil Black Maternal Health Momnibus Act to Address America's Maternal Health Crisis*, COREY BOOKER (Feb. 8, 2021), <https://www.booker.senate.gov/news/press/booker-underwood-adams-senators-unveil-black-maternal-health->

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Maternal Health Momnibus Act 2021 (Momnibus), may fall short. The comment will begin by first examining the historical and legal background of America's Black maternal health crisis by exploring slavery as part of America's history, which will assist in contextualizing the present issue. Building on the historical foundation, the comment will then elaborate on some of America's previous initiatives aimed at confronting its maternal health crisis. The comment will then transition to a discussion of Congress's proposed legislation, Momnibus, by focusing on its strengths and shortcomings. Finally, the comment will provide an analysis of a hypothetical bill to be added to Momnibus' legislative package by examining some of its safeguards and pitfalls in addressing one of the root causes of the Black maternal health crisis, and then conclude with a big picture perspective of why the Black maternal health crisis demands our undivided attention and assistance.

## II. HISTORICAL ORIGINS OF AMERICA'S BLACK MATERNAL HEALTH CRISIS

The origins of America's Black maternal health crisis have profound and unconscionable roots dating back to one of America's greatest moral failures—slavery. American chattel slavery was a horrific, violent, and downright disgraceful institution that subjected African men, women, and children to violent and inhumane treatment that spanned countless aspects of their everyday lives. The justification made by white slaveowners keen on upholding the institution of slavery was simple—African slaves were not legally considered people, but property.<sup>40</sup> Accordingly, slave masters could do with their property what they wanted because the chattelized bodies of their slaves were legally subject to their master's "uncontrolled authority."<sup>41</sup> This authority granted uninhibited freedom to slave masters to inflict physical, psychological, and even sexual abuse on their slaves with no repercussions.<sup>42</sup> Further, slave owners were empowered and insulated to continue the practice of slavery due to the statutory and common law rules crafted to protect and proliferate this peculiar institution.<sup>43</sup>

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momnibus-act-to-address-americas-maternal-health-crisis [https://perma.cc/7XNG-VBZN].

40. See Paul Finkelman, *The Centrality of the Peculiar Institution in American Legal Development - Symposium on the Law of Slavery: Introduction*, 68 CHI.-KENT L. REV. 1009, 1032 (1992).
41. Seth F. Kreimer, *Rejecting "Uncontrolled Authority over the Body": The Decencies of Civilized Conduct, the Past and the Future of Unenumerated Rights*, 9 U. PA. J. CONST. L. 423, 424 (2007) (discussing the differences between slavery and other domestic labor during antebellum America).
42. *Id.*
43. See Finkelman, *supra* note 40 (Introductory discussion on how slavery was a juxtaposition for the American ideals of freedom and natural rights. Southerners frequently referred to slavery as their "peculiar institution" par-

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At its inception, American chattel slavery was not regulated under any jurisprudential system or by any methodical legal rules to shape the practice.<sup>44</sup> However, as slavery continued to grow as a widespread institution in the colonies, the need grew for slavery to be rooted in and safeguarded by law. Early American colonies were originally ruled not under Parliamentary or common law but as lands in the king's possession that were either annexed to the Crown or granted the lord's proprietary.<sup>45</sup> Under this framework, colonists legally constructed different insular practices with unbridled authority to create their local slave laws.<sup>46</sup> By piecing together components of English common law and jurisprudential traditions despite the common law's custom of anti-slavery rhetoric, white colonists were able to develop slavery with full legal fortification and minimal intervention.<sup>47</sup>

While some of America's first documented slave laws are conceivably traced back to Virginia in the 1600s, the evolution of American slave jurisprudence would continue well into the late 1800s with both federal and state laws regulating the practice.<sup>48</sup> At the federal level, the U.S. Constitution inertly consented to the practice of slavery.<sup>49</sup> While the word "slavery" was never expressly mentioned in the Constitution until the ratification of the 13th Amendment, which outlawed the institution, the Constitution nevertheless protected slavery with three key provisions.<sup>50</sup> The first provision, found in Article I, Section 2, Clause 3, the Three-Fifths Clause, granted slave-hold-

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tially because they themselves recognized how the slavery was in direct contrast to America's core ideals.)

44. See Jonathan A. Bush, *Free to Enslave: The Foundations of Colonial American Slave Law*, 5 *YALE J.L. & HUMANS*. 417, 419 (1993).
45. *Id.* at 420; see The Editors of Encyclopedia Britannica, *Proprietary Colony*, BRITANNICA, <https://www.britannica.com/topic/proprietary-colony> [<https://perma.cc/9CA2-FUAE>] (last visited Jan. 24, 2022) ("Proprietary colony, in British American colonial history, a type of settlement dominating the period 1660–90, in which favorites of the British crown were awarded huge tracts of land in the New World to supervise and develop. Before that time, most of the colonies had been financed and settled under the jurisdiction of joint-stock companies operating under charters granted by the crown.").
46. See Bush, *supra* note 44, at 420.
47. See *id.*
48. See PAUL FINKELMAN, *THE LEGAL UNDERSTANDING OF SLAVERY: FROM THE HISTORICAL TO THE CONTEMPORARY*, *SLAVERY IN THE UNITED STATES: PERSONS OR PROPERTY?* 107 (Jean Allain ed., 2012); see Ariela Gross & David R. Upham, *Article IV, Section 2: Movement of Persons Throughout the Union*, NAT'L CONST. CTR., <https://constitutioncenter.org/interactive-constitution/interpretation/article-iv/clauses/37> [<https://perma.cc/GCS8-3P4M>] (last visited Jan. 24, 2022).
49. See FINKELMAN, *supra* note 48, at 105.
50. *Id.*

ing states a vast windfall by permitting three-fifths of “all other persons” (slaves) to be counted for both taxation and representation purposes.<sup>51</sup> This highly significant clause profoundly shaped the representation of slave-holding states in national politics by increasing the size of the South’s congressional delegation.<sup>52</sup>

The next reference to slavery in the Constitution can be found in Article I, Section 9, Clause 1, which specifically prohibited Congress from legislating the importation of slaves before 1808.<sup>53</sup> Though this clause has been subject to great debate, it undoubtedly states Congress could not prohibit the importation of slaves, and implies further importation would be subject to the discretion of the states.<sup>54</sup> The third and final provision, the Fugitive Slave Clause, is found in Article IV, Section 2, Clause 3.<sup>55</sup> This clause stated that any person held in service or labor in one state could not escape to another state and be discharged of his services.<sup>56</sup> The clause, which the Supreme Court would later expound upon in the infamous case of *Dred Scott v. Sandford*, became the basis for federal intervention on behalf of state issues.<sup>57</sup> By requiring that slaves anywhere in the Union be returned to their rightful master, the Fugitive Slave Clause ostensibly makes clear that the Constitution was indeed pro-slavery and its drafters “consented to a document which laid the foundation for the tragic events which were to follow.”<sup>58</sup>

With the Constitution protecting slavery’s perpetuity, many states created common and statutory laws regulating slavery as a practice.<sup>59</sup> The laws were vast and included provisions regulating slave ownership, the rights (or

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51. U.S. CONST. art. I, § 2, cl. 3.

52. See David Waldstreicher, *How the Constitution Was Indeed Pro-Slavery*, ATLANTIC (Sept. 19, 2015), <https://www.theatlantic.com/politics/archive/2015/09/how-the-constitution-was-indeed-pro-slavery/406288/> [<https://perma.cc/U4F7-KQP5>].

53. U.S. CONST. art. I, § 9, cl. 1.

54. See Gordon Lloyd & Jenny S. Martinez, *The Slave Trade Clause*, NAT’L CONST. CTR., <https://constitutioncenter.org/interactive-constitution/interpretation/article-i/clauses/761> [<https://perma.cc/79ZR-RWY4>] (last visited Feb. 25, 2022).

55. U.S. CONST. art. IV, § 2, cl. 3.

56. See Gross & Upham, *supra* note 48.

57. See *Dred Scott v. Sandford*, 60 U.S. 393, 496 (1857).

58. See Steven Mintz, *Historical Context: The Constitution and Slavery*, GILDER LEHRMAN INST. AM. HIST., <https://www.gilderlehrman.org/history-resources/teaching-resource/historical-context-constitution-and-slavery> [<https://perma.cc/5RQN-KC8T>] (last visited Jan. 24, 2022).

59. See Andrew Cohen, *Constitution’s Biggest Flaw? Protecting Slavery*, BERKELEY NEWS (Sept. 17, 2019), <https://news.berkeley.edu/2019/09/17/constitutions-biggest-flaw-protecting-slavery/> [<https://perma.cc/3P8H-D68B>]; see WILLIAM GOODELL, *THE AMERICAN SLAVE CODE IN THEORY AND PRACTICE:*

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lack thereof) of slaves, the dominion of slave owners, and even the punishment and killing of slaves as was codified by what are referred to today as slave codes.<sup>60</sup> For example, Louisiana's civil code defined a slave as one "who is in the power of a master to whom he belongs" and who could "sell him, dispose of his person, his industry and his labor . . . [the slave] can do nothing, possess nothing, nor acquire any thing, but what must belong to his master."<sup>61</sup> In the view of the law, slaves were not people, and this feature of the slave system made the common law of property integral to the foundation of colonial slave law, as it justified the denial of a slave's personhood and thus legitimized their inhumane treatment.<sup>62</sup> Building upon that foundation, colonists classified slaves as either real property or personal (chattel) property.<sup>63</sup> As property instead of sentient beings with rights, slaves could not own property and were prohibited from making contracts—most notably contracts of marriage.<sup>64</sup> Slaves could be seized and sold to pay the debts of their owners, and could even be transmitted by inheritance or by will and testament in the distribution of estates.<sup>65</sup> Slaves could also be punished and killed at the will of their masters if their death resulted from "moderate correction."<sup>66</sup> By classifying slaves as property, slavers did not have to acknowledge or honor their slaves' humanity, and any treatment to the contrary would cause the entire legal institution of slavery to crumble. Ultimately, the culmination of these laws achieved one of slavery's chief objectives—it stripped slaves of their humanity and bodily autonomy.

As a result of the many infringements on their bodily autonomy, slaves were bound to the laws of the state and to the laws of their masters. With virtually complete legal support and fortification, slavery continued to grow into a comprehensive system "designed to create a permanent supply of human labor by regulating the transfer, sale, use, and regeneration of that labor," and Black women quickly emerged at the center of this dishonorable practice.<sup>67</sup> Thus, the expectation for Black women to be both efficient labor-

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ITS DISTINCTIVE FEATURES SHOWN BY ITS STATUTES, JUDICIAL DECISIONS, AND ILLUSTRATIVE FACTS 18 (2006).

60. See GOODELL, *supra* note 59, at iii–iv.
61. See *id.* at 23.
62. See Bradley J. Nicholson, *Legal Borrowing and the Origins of Slave Law in the British Colonies*, 38 AM. J.L. HIST., 53–54 (1994).
63. See Bush, *supra* note 44, at 427.
64. See GOODELL, *supra* note 59, at 105.
65. See *id.* at 63.
66. See THOMAS D. MORRIS, *SOUTHERN SLAVERY AND THE LAW, 1619–1860*, at 172 (1999).
67. See Jeffrey J. Pokorak, *Rape as a Badge of Slavery: The Legal History of, and Remedies for, Prosecutorial Race-of-Victim Charging Disparities*, 7 NEV. L.J. 1, 8–9 (2006).

ers and efficient breeders to ensure a steady supply of slave labor emerged, which ultimately had further devastating implications.<sup>68</sup> Consequently, the absence of bodily autonomy directly influenced the desecration and defiling of Black women's sexual and reproductive freedom.<sup>69</sup>

Black women's sexual and reproductive uniqueness during slavery made them especially vulnerable to particular modes of enslavement that would profoundly alter their experiences with labor and birthing for generations to come.<sup>70</sup> This vulnerability manifested in the unremitting cycle of rape and sexual abuse that enslaved Black women endured from their masters—including forced breeding with fellow enslaved men that was vindicated by white supremacist ideologies.<sup>71</sup> These ideologies included narrative myths that Black women were lascivious, lustful, and hypersexual beings who tempted white men and were thus not worthy of protection or justice.<sup>72</sup> The rape and sexual assault of Black women by white men was further undermined through the doctrine of *partus sequitur ventrum*, which statutorily classified the child born of an enslaved woman and a white man as a "slave."<sup>73</sup> This legal doctrine enabled white slave owners to enslave their children through maternal descent, providing yet another illustration of the unrestrained control masters exhibited over their female slaves through a strict white-supremacist-based caste system that subsequently birthed the American social construct of race.<sup>74</sup> White colonists weaponized the law to superficially remedy the glaring dichotomy between a country founded on the sweeping principles of liberty and natural human rights to construct a theory of racial superiority to answer for the blatant paradox between oppression and freedom.<sup>75</sup>

However, white men's dominion and authority over Black enslaved women did not stop at sexual and reproductive control; it also extended to control over their health. Due to continuous forced sexual acts, Black women experienced significantly higher childbirth rates, which resulted in higher rates of health defects after childbirth and diminished their value to planta-

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68. *Id.* at 9.

69. *Id.*

70. See Pamela D. Bridgewater, *Un/Re/Dis Covering Slave Breeding in Thirteenth Amendment Jurisprudence*, 7 WASH. & LEE RACE & ETHNIC ANC. L.J. 11, 14 (2001).

71. See *id.*

72. See *id.* at 18.

73. See Pokorak, *supra* note 67, at 9–10; see Bush, *supra* note 44, at 425.

74. See Pokorak, *supra* note 67, at 9.

75. See *id.*

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tion owners.<sup>76</sup> To combat this issue, many slave owners established “owner-physician pacts” that allowed slave owners to trade Black slaves to white physicians who would perform excruciating and sometimes life-threatening experiments on slaves—ones that were far too dangerous to attempt on whites.<sup>77</sup> In return, many slaveholders received money under health insurance policies for the slaves, unless enslaved women healed from their illnesses.<sup>78</sup> Through this type of agreement, Dr. James Marion Sims (Sims) began his unethical experimentation on Black women’s bodies and built his dishonorable legacy as the “Father of Modern Gynecology.”<sup>79</sup>

Sims began his work as a plantation doctor in Alabama.<sup>80</sup> He focused his work on Black mothers and their infant children when he noticed the high infant mortality rates of Black enslaved children.<sup>81</sup> After attempting and failing to treat Black children diagnosed with tetany (muscle spasms) due to their young age and underdeveloped bodies, Sims began to focus his work on Black women.<sup>82</sup> His first three subjects included three enslaved Black women named Anarcha, Lucy, and Betsy, who suffered from vesicovaginal fistula and would endure agonizing pain at the hands of Sims and his scalpel.<sup>83</sup> Sims used these three women to develop and perfect a series of techniques to repair vesicovaginal fistula, which afflicted both Black and white women who experienced intense childbirth.<sup>84</sup>

Sims routinely experimented on Black women without anesthesia, and Sims and historians documented the pain these women endured as he experimented on their bodies.<sup>85</sup> For example, Sims recounted, “Lucy’s agony was extreme. . . she was much prostrated, and I thought she was going to die. That was before the days of anesthetics, and the poor girl, on her knees, bore the operation with great heroism and bravery.”<sup>86</sup> Sims’ accounts of his experiments lie in stark contrast to the realities lived by his Black female subjects.<sup>87</sup> Where Sims depicted enslaved women as consenting and even the honored

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76. Maia A. Hill, *The Stain of Slavery on the Black Women’s Body and the Development of Gynecology: Historical Trauma of a Black Women’s Body*, JHU RICHARD MACKSEY NAT’L UNDERGRADUATE HUMANS. RSCH. SYMP., 3 (2020).

77. *Id.*

78. *Id.*

79. *Id.* at 4.

80. *Id.*

81. *Id.*

82. Hill, *supra* note 76, at 4.

83. *Id.*

84. *Id.*

85. *Id.*

86. *Id.*

87. *Id.*

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subjects of his depraved experiments, historical accounts detail that “. . . each surgical scene was a violent struggle between the slaves and physicians and each woman’s body was a bloodied battleground. Each naked, unanesthetized slave woman had to be forcibly restrained by the other physicians through her shrieks of agony as Sims determinedly sliced, then sutured her genitalia.”<sup>88</sup> The steadfast belief that Black women did not endure or feel pain as part of their racial endowment permitted physicians to experiment on Black enslaved women without anesthesia which invigorated the fable of the Black woman super body.<sup>89</sup> Sims perfected his techniques to later use on white women who routinely received complete anesthesia, and cemented his legacy as the Father of Modern Gynecology and a “champion” of women’s health.<sup>90</sup> However, Sims’ racist and dehumanizing misuse of enslaved Black women’s bodies is a testament to the iniquities of slavery and its shameful narratives that have propagated the fictitious differences between Black and white women’s bodies within medicine.<sup>91</sup>

While exposing enslaved Black women to torturous medical experiments that were painful and humiliating, Dr. Sims and other physicians during that period also deprived Black mothers of more peaceful birthing experiences—experiences almost always provided by midwives. During Antebellum America, midwives were older women that skillfully assisted mothers before, during, and after giving birth.<sup>92</sup> Midwives utilized holistic methods to assist mothers during their pregnancy and delivery, including the use of herbal medicine, knowledge of efficient birthing positions and fertility cycles, and even transitioning back into the community post-delivery.<sup>93</sup> The American origins of midwifery were profoundly shaped by slavery and enslaved African women,<sup>94</sup> who were some of America’s first midwives and were the primary birthing providers for enslaved women.<sup>95</sup>

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88. Sara Spettel, *The Portrayal of J. Marion Sims’ Controversial Surgical Legacy*, J. UROL., 2426 (2011).

89. Hill, *supra* note 76, at 5.

90. *Id.* at 7.

91. *Id.*

92. See Lucy Phelps Hamilton, “*If De Babies Cried*”: *Slave Motherhood in Antebellum Missouri*, PITTS. ST. UNIV. 16 (2015), [https://digitalcommons.pittstate.edu/etd/27/?utm\\_source=Digitalcommons.pittstate.edu%2Fetd%2F27&utm\\_medium=PDF&utm\\_campaign=PDFCoverPages](https://digitalcommons.pittstate.edu/etd/27/?utm_source=Digitalcommons.pittstate.edu%2Fetd%2F27&utm_medium=PDF&utm_campaign=PDFCoverPages).

93. See Julie Morel, *Black Birthing Mothers: The Historical Context and Potential Benefits of Midwifery-Based Care*, VASSAR COLL. 10 (2019), [https://digitalwindow.vassar.edu/senior\\_capstone/924/?utm\\_source=Digitalwindow.vassar.edu%2Fsenior\\_capstone%2F924&utm\\_medium=PDF&utm\\_campaign=PDFCoverPages](https://digitalwindow.vassar.edu/senior_capstone/924/?utm_source=Digitalwindow.vassar.edu%2Fsenior_capstone%2F924&utm_medium=PDF&utm_campaign=PDFCoverPages).

94. See *id.* at 4.

95. See *id.* at 9–10.

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By respecting motherhood and the birthing process as a sacred and hallowed journey, Black midwives refrained from invasive intervention during birth and instead encouraged and supported women during active labor until it was time for “catching babies.”<sup>96</sup> However, as slavery ended and the advent of modern gynecology surged, skilled Black midwives posed a threat to white male gynecologists.<sup>97</sup> To monopolize gynecology for their financial gain, white male gynecologists began engaging in heavily racist and misogynistic smear campaigns to eradicate Black midwives by falsely alleging that their practices were unhygienic, ineffective, and even barbarous.<sup>98</sup> Gynecologists would continue to oust midwives by lobbying state legislatures to prohibit midwifery which, in turn, drove Black women out of the practice of midwifery and also adversely affected women’s reproductive health.<sup>99</sup>

The historical origins of the Black maternal health crisis, as contextualized by American chattel slavery, provides a more robust understanding of the dehumanization that still haunts Black mothers today. African American women are unfortunately still enduring the same agony and death that has besmirched their bodies through the bloodline of their foremothers.<sup>100</sup> The racialization of Black women’s bodies as property to be used as a vessel that feels no pain has disastrously affected Black maternal health outcomes. Therefore, Black women’s relationship with motherhood is in desperate need of repair from a country that was the architect of their affliction.

### III. PREVIOUS INITIATIVES AND CONSIDERATIONS AIMED AT COMBATING AMERICA’S MATERNAL HEALTH CRISIS

America’s maternal health crisis has garnered the attention of doctors, legislatures, and other health professionals across the nation who are struggling to comprehend why the United States is the only developed country where maternal mortality rates are astonishingly increasing.<sup>101</sup> In response, U.S Representatives Diana DeGette and Jaime Herrera Beutler introduced

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96. *See id.* at 10.

97. *See* Michelle Goodwin, *The Racist History of Abortion and Midwifery Bans*, ACLU (July 1, 2020), <https://www.aclu.org/news/racial-justice/the-racist-history-of-abortion-and-midwifery-bans/> [https://perma.cc/3D3Z-2BTD].

98. *Id.*

99. *Id.*

100. Hill, *supra* note 76, at 8.

101. *See* Anna Kheyfets, *The Preventing Maternal Deaths Act of 2018 and Why it is Important*, Mt. SINAI (Aug. 9, 2019), <https://health.mountsinai.org/blog/the-preventing-maternal-deaths-act-of-2018-and-why-it-is-important/> [https://perma.cc/G73Q-QY5A].

the Preventing Maternal Deaths Act (PMDA).<sup>102</sup> The PMDA passed the U.S. House by unanimous vote and was officially signed into law on December 21, 2018.<sup>103</sup> The legislation provides \$60 million in federal funds over a five-year span to direct the U.S. Department of Health and Human Services to create a program addressing five critical tasks:<sup>104</sup> (1) reviewing all maternal deaths in the United States; (2) establishing and sustaining a Maternal Mortality Review Committee (MMRC) in every state; (3) developing a plan for ongoing healthcare provider education to improve the quality of maternal care, the dissemination of those findings, and the implementation of recommendations in each state; (4) distribution of Maternal Mortality Review Information Applications (MMRIA) to every state MMRC; and (5) providing public disclosure of information found in the review committees in the form of state reports.<sup>105</sup> One of the PMDA's chief objectives is to create uniformity in how each state handles maternal deaths (a tactic that has never been utilized before) to collect the best data available and establish recommendations and policies that drastically reduce the number of maternal deaths.<sup>106</sup>

While the PMDA has been praised by doctors and health care professionals as a crucial step in the right direction, the PMDA still has much room for improvement.<sup>107</sup> The law is focused on uniform data collection to better understand America's ongoing maternal health crisis, but it still does not directly address the blatant racial disparities amongst maternal mortality rates.<sup>108</sup> However, several members of Congress have taken steps toward tackling Black maternal mortality rates.<sup>109</sup> For example, in April 2019, Con-

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102. See Press Release, *Bipartisan Bill to Prevent Maternal Deaths Passes U.S. House*, DIANA DEGETTE (Dec. 11, 2018), <https://degette.house.gov/media-center/press-releases/bipartisan-bill-to-prevent-maternal-deaths-passes-us-house> [<https://perma.cc/4JQN-ZRXX>].

103. See Nina Martin, "Landmark" Maternal Health Legislation Clears Major Hurdle, PROPUBLICA (Dec. 12, 2018, 12:56 PM), <https://www.propublica.org/article/landmark-maternal-health-legislation-clears-major-hurdle> [<https://perma.cc/C4KS-E9C2>].

104. See Kheyfets, *supra* note 101; see Elizabeth Chuck, "An Amazing First Step": Advocates Hail Congress's Maternal Mortality Prevention Bill, U.S. NEWS (Dec. 19, 2018, 4:48 AM), <https://www.nbcnews.com/news/us-news/amazing-first-step-advocates-hail-congress-s-maternal-mortality-prevention-n948951> [<https://perma.cc/FV7J-ZMSH>].

105. See Kheyfets, *supra* note 101.

106. See Chuck, *supra* note 104.

107. See *id.*

108. See Martin, *supra* note 103.

109. See Alexa Richardson, *Policy Roundup: Improving Maternal Health Outcomes for Black Women*, PETRIE-FLOM CTR. HARV. L. SCH. (Nov. 14, 2019), <https://blog.petrieflom.law.harvard.edu/2019/11/14/policy-roundup-improving-maternal-health-outcomes-for-black-women/> [<https://perma.cc/FA8R-ZCJF>].

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gresswomen Lauren Underwood and Alma Adams formed the Black Maternal Health Caucus to make the issue of Black maternal health outcomes a national priority by exploring the best policy approaches to address the issue.<sup>110</sup> While the Caucus was able to achieve grand milestones such as the passage of an appropriations bill that funded millions of dollars into the research of maternal health disparities; the majority of the funding went to broad federal initiatives to combat maternal health disparities in general, not Black maternal health disparities specifically.<sup>111</sup> To more directly address Black maternal mortality, funding is specifically needed for organizations prioritizing issues concerning Black maternal health.<sup>112</sup>

Similarly, this issue gained national attention during the 2016 presidential election. Democratic primary candidate, Elizabeth Warren, took a very robust approach in an attempt to combat the Black maternal health crisis.<sup>113</sup> Warren's ambitious, outcome-oriented plan would have incentivized hospitals to lower their costs by providing them with "bonuses" for reducing racial disparities.<sup>114</sup> While Warren's plan was not completely foolproof in that it would have potentially penalized hospitals that already lack resources and serve disadvantaged communities, her proposal arguably had the potential to more closely target and improve outcomes for Black mothers.<sup>115</sup> Additionally, the Maternal Care Access and Reducing Emergencies (CARE) Act, introduced by Vice President Kamala Harris would have emphasized implicit bias training for health care providers and specifically targeted obstetric providers.<sup>116</sup> The bill, which died in the previous Congress,<sup>117</sup> would have also awarded grants to ten states to establish "pregnancy medical home programs" to integrate pregnancy care with care and services such as social workers, mental health professionals, doulas, and substance abuse treatment and support.<sup>118</sup> Although Vice President Harris's plan would have directly

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110. *See id.*

111. *See id.*

112. *See* Kim Krisberg, *Programs Work from Within to Prevent Black Maternal Deaths: Workers Targeting Root Cause—Racism*, NATS. HEALTH (Aug. 29, 2019), <https://www.thenationshealth.org/content/49/6/1.3-0> [<https://perma.cc/5RSY-XJWC>].

113. *See* Richardson, *supra* note 109.

114. *See id.*

115. *See id.*; Sarah Jones, *There's a Problem with Elizabeth Warren's Maternal Mortality Plan*, INTELLIGENCER (Apr. 25, 2019), <https://nymag.com/intelligencer/2019/04/the-problem-with-elizabeth-warrens-maternal-mortality-plan.html> [<https://perma.cc/8MHT-KQWP>].

116. *See* Richardson, *supra* note 109.

117. *See* Maternal Care Access and Reducing Emergencies Act, S. 1600, 116th Cong. (2019).

118. *See* Richardson, *supra* note 109.

targeted racism, one of the principal issues of the Black maternal health crisis, by engaging health professionals in implicit bias training, some studies tend to suggest that such training is not always effective.<sup>119</sup> Additionally, her plan posed several potential drawbacks, mainly the potential of the increased criminalization of Black mothers and their families by bringing them in greater contact with state agencies and increasing the risk of reports of substance, domestic, and even child abuse.<sup>120</sup> Still, Vice President Harris's proposal is unique in attacking the prevalent systemic racism within the medical profession.<sup>121</sup>

The Maximizing Outcomes for Moms through Medicaid Improvement and Enhancement of Services (MOMMIES) Act, introduced by Senator Corey Booker and Congresswoman Ayanna Pressley, emphasized the expansion of Medicaid coverage past 60 days post-partum to cover people through 365 days postpartum and expanding the services Medicaid will cover beyond pregnancy-related services.<sup>122</sup> Similar to Vice President Harris' CARE Act, the MOMMIES Act, which also died in the previous Congress, would have provided integrated care to ensure that mothers had access to services, and it would have also commissioned a multiyear study and legislative report on gaps in care for low-income women of color.<sup>123</sup> Senator Booker's proposal appears to take Vice President Harris's proposal a step further by expanding Medicaid, which will ensure an immediate increase in access and services for many low-income Black people during and after pregnancy.<sup>124</sup> However, like the CARE Act, the MOMMIES Act also poses the risk of extra state monitoring and surveillance of Black families, which could have potentially damaging effects.<sup>125</sup>

Despite these several legislative efforts to better understand and combat the increase in Black maternal deaths in the United States, one of the most latent components enabling the crisis is being left to fester—institutional racism.<sup>126</sup> The institutional and pervasive nature of racism in the United States

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119. *See id.*; Jason A. Cantone, *Federal and State Court Cooperation: Effectiveness of Implicit Bias Trainings*, FED. JUD. CTR., <https://www.fjc.gov/content/337738/effectiveness-implicit-bias-trainings> (last visited Feb. 24, 2022) [<https://perma.cc/N7LL-ZAJA>].

120. *See* Richardson, *supra* note 109.

121. *See id.*

122. *See* MOMMIES Act, S. 1343, 116th Cong. (2019); MOMMIES Act, H.R. 2602, 116th Cong. (2019).

123. *See* Richardson, *supra* note 109.

124. *See id.*

125. *See id.*

126. *See* Annie Waldman, *How Hospitals Are Failing Black Mothers*, PROPUBLICA (Dec. 27, 2017, 8:00 AM), <https://www.propublica.org/article/how-hospitals-are-failing-black-mothers> [<https://perma.cc/8LLA-P77E>].

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has made it especially burdensome for African Americans and other minorities to fully participate in America's society and economy.<sup>127</sup> This same structural racism is ever-present in America's healthcare system—an industry that is believed to be committed to ensuring that every patient receives just and equitable care.<sup>128</sup> On July 2, 1964, to combat the persistent and unrelenting issue of systemic racism, President Lyndon Johnson signed into federal law the Civil Rights Act of 1964 (CRA).<sup>129</sup> Congress enacted the sweeping and comprehensive federal legislation to prohibit discrimination in several venues, including employment, housing, education, voting, and public accommodations.<sup>130</sup> Most notably for the context of healthcare, Title VI of the CRA prohibits discrimination of individuals on the basis of race, color, and national origin by institutions that receive federal funding, which includes healthcare institutions that receive federal assistance.<sup>131</sup> Therefore, medical providers who serve patients who receive federally funded healthcare, such as Medicaid and Medicare, are bound by Title VI.<sup>132</sup>

Title VI's implementation in the healthcare field was supposed to desegregate America's highly racialized healthcare system by prohibiting covered health care facilities from blatantly discriminating against individuals on the basis of race, national origin, or color.<sup>133</sup> Essentially, federally funded health care facilities could no longer deliberately deny services to citizens based on race, color, or national origin without legal consequences. However, medical

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127. See Randall Akee, *The Race Problem in Economics*, BROOKINGS (Jan. 22, 2020), <https://www.brookings.edu/blog/up-front/2020/01/22/the-race-problem-in-economics/> [<https://perma.cc/2KFT-GAMA>].

128. See Monique Tello, *Racism and Discrimination in Health Care: Providers and Patients*, HARV. HEALTH PUB. (July 9, 2020, 12:34 PM), <https://www.health.harvard.edu/blog/racism-discrimination-health-care-providers-patients-2017011611015> [<https://perma.cc/7LQN-N7T2>].

129. Civil Rights Act of 1964 (1964).

130. *Id.*

131. See *Civil Rights Requirements – A. Title VI of the Civil Rights Act of 1964*, 42 U.S.C. 2000d et seq. (Title VI), HEALTH & HUM. SERV. (July 26, 2013), <https://www.hhs.gov/civil-rights/for-individuals/special-topics/needy-families/civil-rights-requirements/index.html> [<https://perma.cc/742D-LYS9>].

132. See *id.*; *Financial Management*, MEDICAID.GOV, <https://www.medicaid.gov/medicaid/financial-management/index.html> (last visited Feb. 18, 2022) [<https://perma.cc/KE3E-5YYS>]; see *How Is Medicare Funded?*, MEDICARE.GOV, <https://www.medicare.gov/about-us/how-is-medicare-funded> (last visited Feb. 18, 2022) [<https://perma.cc/9P5U-V6UM>].

133. See Kay Van Wey, *Unequal Access to Healthcare: The More Things Change, The More Things Stay the Same*, NAT'L L. REV. (Aug. 11, 2020), <https://www.natlawreview.com/article/unequal-access-to-healthcare-more-things-change-more-things-stay-same> [<https://perma.cc/G88M-C5XQ>].

racism still plagues much of America's healthcare system.<sup>134</sup> One proposed approach to curtail the persistent and enduring issue of racial discrimination in America's healthcare system is a restructuring of Title VI.<sup>135</sup> Professor Dayna Bowen Matthew's proposal focuses on restructuring Title VI by addressing America's long-standing issue with racism by eradicating its most insidious form—implicit bias.<sup>136</sup>

Implicit bias is a term used to describe instances where people's prejudices and stereotypes lead to unintended discrimination on the basis of race, ethnic origin, socioeconomic status, and other inequalities.<sup>137</sup> Implicit bias manifest in many ways within America's healthcare system.<sup>138</sup> Generally, most Americans do not view their own behavior as racially biased, and physicians, in particular, tend to strongly believe that they are not biased or racist in caring for their patients.<sup>139</sup> Fueling this conviction is the touted belief that physicians and other health care professionals belong to professional bodies that espouse egalitarian values that require their members to treat all patients alike, regardless of their race or ethnicity.<sup>140</sup> However, physicians, like many Americans, are equally capable of making automatic unintentional judgments about race and ethnicity that arise from their subconscious.<sup>141</sup>

These exact sorting mechanisms can be destructive within a racial and ethnic framework, especially when they are subconsciously employed against racial and ethnic minorities who are forced to live on the edges of society due to America's white supremacist power structures, as previously explained above.<sup>142</sup> Within this context, physicians are especially susceptible to allowing implicit biases to affect their daily practice by virtue of what their medical education has taught them to do—perform “sorting patterns” to help identify and eventually solve a patient's medical issue.<sup>143</sup> For African American patients in particular, these unintentional judgments can very easily creep into a physician's “sorting patterns” and are especially harmful due to the

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134. *See id.*

135. *See* DAYNA BOWEN MATTHEW, JUST MEDICINE: A CURE FOR RACIAL EQUITY IN AMERICAN HEALTH CARE 209–13 (2015).

136. *See id.*

137. *See* Betsy Mason, *Making People Aware of Their Implicit Biases Doesn't Usually Change Minds. But Here's What Does Work*, PBS (June 10, 2020, 7:00 PM), <https://www.pbs.org/newshour/nation/making-people-aware-of-their-implicit-biases-doesnt-usually-change-minds-but-heres-what-does-work> [https://perma.cc/G6UU-V28E].

138. *See* Van Wey, *supra* note 133.

139. *See* MATTHEW, *supra* note 135, at 34.

140. *Id.*

141. *Id.* at 38.

142. *Id.*; *see* Van Wey, *supra* note 133.

143. *See* MATHEW, *supra* note 135, at 38–39.

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narratives and negative stereotypes that were first introduced, perpetuated, and bolstered during American chattel slavery.<sup>144</sup>

To curb the issue of implicit racial and ethnic bias in America's health care system, Matthew suggests a radical and fundamental transformation of the system to ensure that minority patients receive equitable and ethical healthcare outcomes.<sup>145</sup> She proposes that making unconscious bias illegal will address treatment and outcomes in health care disparities for minority populations.<sup>146</sup> First, Matthew proposes legislative reforms that will incentivize health care providers to adopt nondiscriminatory policies and procedures within their institutions or face consequences that would impact the institution's financial and reputational standing.<sup>147</sup> The ultimate objective of Matthew's proposed anti-discrimination law is to use the law as a tool to combat implicit bias by reshaping and influencing America's social norms that create health care disparities amongst racial and ethnic minority patients.<sup>148</sup> By making implicit bias and unconscious racism a costly and potentially latent consequence for health care providers, the hope is that these providers take the necessary precautions to help mitigate their propensity to perpetuate racial bias in their facilities.<sup>149</sup>

However, if health care providers fail to invest in internal reforms to address implicit bias, Matthew proposes reforming Title VI of the Civil Rights Act of 1964.<sup>150</sup> Her proposed reforms to Title VI include: (1) prohibiting policies and practices that have a disparate impact on the basis of race, color, or national origin; (2) restoring disparate impact claims read out of Title VI by Supreme Court precedent; and (3) introducing a new disparate impact cause of action based on a negligence standard of care.<sup>151</sup> First, Matthew proposes revisions to Section 601 of Title VI to include language that expressly and specifically prohibits unintentional discrimination.<sup>152</sup> As previously discussed, while Title VI's original purpose was to outlaw racism and discrimination in America, the collective attitudes proliferated during its enactment made it socially unacceptable for Americans to practice overt racism, which in turn allowed implicit bias to fester and further develop.<sup>153</sup>

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144. *Id.*; see Bush, *supra* note 44, at 418–22.

145. See MATTHEW, *supra* note 135, at 190–93.

146. *Id.* at 190.

147. *Id.* at 191–92.

148. *Id.* at 190.

149. *Id.* at 191–92.

150. *Id.* at 195.

151. See MATTHEW, *supra* note 135, at 195–96.

152. *Id.* at 209–11.

153. See Van Wey, *supra* note 133.

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Matthew ostensibly suggests a better remedy for implicit bias by expressly adding unconscious or unintentional biases to Section 601 of Title VI.<sup>154</sup>

In using this language as a starting point, Matthew next suggests creating a new cause of action to prohibit discrimination due to implicit bias by expressly adding “rights-creating language” to Section 601 based on a negligence standard of care.<sup>155</sup> Matthew purports that a negligence cause of action will not only empower private victims directly impacted by unconscious racism to challenge a health care institution’s policies and programs, but it will also allow institutions to assert an affirmative defense to protect their federal funding by showing they took reasonable steps to effectively combat unconscious or implicit biases.<sup>156</sup> Finally, Matthew proposes amending Section 602 of Title VI to restore the public-private enforcement model for Title VI causes of action authorized under Section 601 by allowing aggrieved individuals to sue in federal or state court.<sup>157</sup>

Matthew’s plan to attack and eradicate unconscious bias and racism in health care through large-scale federal policy intervention has the potential to considerably benefit racial and ethnic minorities in need of unbiased medical care—especially Black mothers.<sup>158</sup> Implicit bias is at the very core of America’s Black maternal health crisis, and a policy intervention like Matthew’s could help mitigate the loss of America’s Black mothers.<sup>159</sup>

#### IV. MOMNIBUS ACT OF 2020

On March 9, 2020, members of the Black Maternal Health Caucus introduced a historic legislative package in hopes of curing America’s urgent Black maternal health crisis.<sup>160</sup> Spearheaded by Representatives Lauren Underwood and Alma Adams, and current Vice President Kamala Harris, the Black Maternal Health Momnibus Act of 2020 (Momnibus) was introduced as a bipartisan legislative bundle of nine bills that will supplement existing maternal health legislation.<sup>161</sup> The 117th Congress reintroduced the

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154. See MATTHEW, *supra* note 135, at 203.

155. *Id.* at 209.

156. *Id.*

157. *Id.*

158. See *id.* at 196.

159. See *id.* at 200–01.

160. See Press Release, *Representatives Underwood and Adams, Senator Harris, Members of the Black Maternal Health Caucus Unveil Historic Legislative Package to Address America’s Black Maternal Health Crisis*, U.S. HOUSE REP. BLACK MATERNAL HEALTH CAUCUS (Mar. 9, 2020), <https://blackmaternalhealthcaucus-underwood.house.gov/media/press-releases/representatives-underwood-and-adams-senator-harris-members-black-maternal> [https://perma.cc/QDG7-MCFJ].

161. See *id.*

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Momnibus after the proposed legislation died in the 116th Congress.<sup>162</sup> Collectively, the Momnibus Act proposes to: (1) make investments to improve social determinants of health such as housing, transportation, and nutrition; (2) fund community-based organizations that are focused on improving health outcomes for Black women; (3) support Veterans' Affairs health care for pregnant and postpartum Black women; (4) increase diversity within health care professions; (5) fund research to learn about the underlying source of disparate maternal and neonatal mortality among Black women and children; (6) fund efforts that help address and cure maternal mental health and substance abuse issues; (7) improve maternal health care for incarcerated women; (8) increase the use of telehealth to improve access to care in under-resourced areas; and (9) create funding models that provide incentives to offer much needed high-quality health care to women during pregnancy, birth, and postpartum.<sup>163</sup>

Momnibus's multifaceted approach to dealing with America's Black maternal health crisis provides a thorough and deliberate attack against the systemic barriers preventing Black mothers from accessing the healthcare they so desperately need during their pregnancy.<sup>164</sup> This detailed legislative package takes a systematic approach to dismantling the way racism heavily influences Black mothers' access to healthcare at all stages of their pregnancies.<sup>165</sup> This approach has the potential to adequately distribute resources that will safeguard the lives of Black mothers and their children—and for that Congress should be celebrated.

However, there is room for improvement to ensure that Black mothers are receiving the adequate care required at the physician-patient level. While Momnibus offers some fantastic initiatives that may help lower Black maternal mortality rates, it fails to overtly propose solutions that will assist in eradicating the implicit bias that afflicts Black mothers at the doctor-patient level.<sup>166</sup> Although two of its bill's, Title II and Title IV, offer various grants and programs that will attempt to diversify the perinatal force and further accountability measures to track instances of disrespect or bias on the basis

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162. See Black Maternal Health Momnibus Act of 2020, H.R. 6142, 116th Cong. (2020); see Black Maternal Health Momnibus Act of 2021, H.R. 959, 117th Cong. (2021).

163. Ellen Olshansky, *Help Reverse Devastating Health Disparities by Supporting the Black Maternal Health Momnibus Act*, HILL (June 24, 2020, 9:00 PM), <https://thehill.com/blogs/congress-blog/healthcare/504425-help-reverse-devastating-health-disparities-by-supporting-the?rl=1> [https://perma.cc/7ZHC-VTVA].

164. See *id.*

165. See *id.*

166. See Tori DeAngelis, *How Does Implicit Bias by Physicians Affect Patients' Health Care?*, AM. PSYCH. ASS'N (Mar. 20, 2019), <https://www.apa.org/monitor/2019/03/ce-corner> [https://perma.cc/XL35-4DVU].

of race, or other protected classes, a much more persuasive and express approach is necessary to hold hospitals and other maternity care clinics accountable.<sup>167</sup>

## V. HOW MOMNIBUS MAY FALL SHORT

While Momnibus provides a fulsome and detailed approach to potentially curing America's Black Maternal Health Crisis, it is discounting a very critical component of the crisis—implicit bias at the physician-patient level.<sup>168</sup> As previously discussed, implicit bias can influence the behaviors and attitudes of health care providers, and is one of many factors that contribute to health disparities.<sup>169</sup> This same implicit bias plagues many maternity care and obstetrics units across America which creates a culture of institutional incompetence when it comes to providing care and treatment for Black mothers that can be life threatening for some mothers like Serena Williams, or even deadly for other mothers, like Kira Johnson.<sup>170</sup> There are several proposals in Momnibus's Title II bill, Honoring Kira Johnson, that will seek to resolve implicit bias in maternity care settings,<sup>171</sup> I believe a more robust approach is needed.

To better combat the issue of implicit bias in maternity care settings, I am proposing an additional bill to be added to Momnibus's legislative package. My proposed bill, Title X Superior Care Standard for Moms, would employ a "carrots and sticks" legislative approach directed and overseen by the U.S. Department of Health & Human Services to target implicit bias nationwide in maternity care settings by utilizing a pay for performance model that will target hospitals and maternity care clinic's Medicaid reimbursements. Hospitals and maternity care clinics will be given a choice to opt into Title X, and hospitals that do will receive federal grants to use at their disposal. Hospitals and maternity care clinics that choose to opt out would be subject to a 0.5% reduction in Medicaid over 12 months each year by the Secretary of the U.S. Department of Health and Human Services.<sup>172</sup> Penalties

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167. See *Black Maternal Health Momnibus Overview*, <https://underwood.house.gov/sites/underwood.house.gov/files/Black%20Maternal%20Health%20Momnibus%20Section%20by%20Section.pdf> (last visited Feb. 18, 2022) [<https://perma.cc/8VJ7-6L6P>].

168. See DeAngelis, *supra* note 166.

169. See *id.*; See William J. Hall et al., *Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review*, NCBI (Dec. 2015), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4638275/> [<https://perma.cc/2TBF-XX6R>].

170. See Lockhart, *supra* note 20; see Pahr, *supra* note 9.

171. See Pahr, *supra* note 9; see *Black Maternal Health Momnibus Overview*, *supra* note 167.

172. See *Understanding the Hospital-Acquired Condition (HAC) Reduction Program*, COOK MED. (Aug. 27, 2019), <https://www.cookmedical.com/interven->

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assessed from hospitals that choose to opt-out of Title X's implementation will generate a pool of incentive funds as a reward for hospitals that improve Black maternal health outcomes. Under this approach, Title X would promote a national goal of improving America's maternal health outcomes with a particular focus on saving the lives of Black mothers by linking payment to the quality of hospital care.

In Section 1 of my proposed legislation, I recommend that the Department of Health and Human Services create a Maternal Implicit Bias Tracking and Reporting System (MIBTRS). Similar to the data collection measures executed by MMRCs, MIBTRS would go a step further to implement robust data collection and reporting measures to track the hospital's maternal health outcomes, the presence of implicit bias in patient interactions by tracking physician and other medical staff performance, equity outcomes in the delivery of maternal care to each patient, and quality improvement assessments.<sup>173</sup> The MIBTRS would include a detailed racial and ethnic breakdown of the total number of maternal deaths at each hospital or maternal care facility, the number of preventable maternal deaths, the cause of death, and the doctors and other medical staff involved in treating the mother.

Hospitals and other care facilities would implement patient satisfaction surveys that allow mothers and families to report the quality of care they received and report incidences of perceived bias based on race or ethnicity.<sup>174</sup> Hospitals and other maternity care facilities would be required to submit data collected from MIBTRS to the Centers for Medicare and Medicaid Services (CMS) to review and assess each hospital's performance over 12 months. After review and assessment, CMS would report and publish MIBTRS data on CMS.gov.<sup>175</sup>

Section 2 of my proposed legislation would require the implementation of implicit bias screenings on current and future staff that work directly with patients. By establishing a grant program to support a task force that specializes in the understanding and implementation of bias testing such as the Implicit Association Test (IAT),<sup>176</sup> hospitals and other maternity care clinics must conduct bias screenings to identify the members of their staff who pose greater risks to certain patient populations. The benefits of conducting implicit bias screenings of current and future staff are potentially two-fold in that screenings could be critical in identifying medical staff who pose unac-

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tional-radiology/understanding-the-hospital-acquired-condition-hac-reduction-program/ [https://perma.cc/A6DB-PKLM] (Much like HAC, this hypothetical bill would mimic the ACA's HAC program that reduced federal funding).

173. *See id.*

174. *See Black Maternal Health Momnibus Overview, supra* note 167.

175. *See Understanding the Hospital-Acquired Condition (HAC) Reduction Program, supra* note 172.

176. *See About the IAT, PROJECT IMPLICIT*, <https://implicit.harvard.edu/implicit/iatdetails.html> (last visited Jan. 24, 2022) [https://perma.cc/EL9J-J5EK].

ceptable safety risks to vulnerable patient populations and serve as a risk management tool.<sup>177</sup> Based on the results of implicit bias screenings and the data collected from MIBTRS, hospitals would be required to host implicit bias trainings for medical staff whose data and scores heavily correlated with discriminatory patterns.

Section 3 would require hospitals to implement patient safety mechanisms to treat the two most common and preventable causes of death for all mothers, obstetric hemorrhage and preeclampsia,<sup>178</sup> and support vaginal births among low-risk first time mothers. Founded in 2006, the California Maternal Quality Care Collaborative (CMQCC) is an organization leading the charge in reducing America's rising maternal mortality rates.<sup>179</sup> Since its inception, CMQCC has dramatically helped California reduce its maternal mortality rate by 55% through data collection on maternal mortality rates, targeting the complications that can be prevented, and creating "toolkits" that contain evidence based methods on effectively treating deadly complications when they arise.<sup>180</sup> Section 3 would establish a task force under HHS that will work with hospitals to implement CMQCC's toolkits for treating preeclampsia, obstetric hemorrhage, and supporting vaginal births to reduce the use of nonmedically warranted cesarean sections.<sup>181</sup>

Section 4 would require hospitals to hire a Chief Equity Officer to ensure health equity at their facilities remains a priority. These Chief Equity officers would focus their leadership on the oversight of the delivery system's performance in serving the needs of patients by addressing internal

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177. See Philip E. Tetlock et al., *Detecting and Punishing Unconscious Bias*, UNIV. PENN. 85 (2013), [https://repository.upenn.edu/mgmt\\_papers/233/](https://repository.upenn.edu/mgmt_papers/233/).

178. See *Maternal Mortality*, WORLD HEALTH ORG. (Sept. 19, 2019), <https://www.who.int/news-room/fact-sheets/detail/maternal-mortality> [<https://perma.cc/QBW6-2NUA>].

179. See *Who We Are*, CAL. MATERNAL QUALITY CARE COLLABORATIVE, <https://www.cmqcc.org/who-we-are> (last visited Feb. 24, 2022) [<https://perma.cc/W4SC-G853>].

180. See *id.*; Julia Belluz, *California Decided It Was Tired of Women Bleeding to Death in Childbirth*, VOX (Dec. 4, 2017, 11:23 AM), <https://www.vox.com/science-and-health/2017/6/29/15830970/women-health-care-maternal-mortality-rate> [<https://perma.cc/H2KL-S99U>].

181. See *OB Hemorrhage Toolkit V 2.0*, CAL. MATERNAL QUALITY CARE COLLABORATIVE, <https://www.cmqcc.org/resources-tool-kits/toolkits/ob-hemorrhage-toolkit> (last visited Feb. 24, 2022) [<https://perma.cc/36BN-Z77M>]; see *Preeclampsia Toolkit*, CAL. MATERNAL QUALITY CARE COLLABORATIVE, <https://www.cmqcc.org/resources-tool-kits/toolkits/preeclampsia-toolkit> (last visited Feb. 24, 2022) [<https://perma.cc/79CN-VX4L>]; see *Toolkit to Support Vaginal Birth and Reduce Primary Cesareans*, CAL. MATERNAL QUALITY CARE COLLABORATIVE, <https://www.cmqcc.org/VBirthToolkit> (last visited Feb. 24, 2022) [<https://perma.cc/6EJ8-E45L>].

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staff performance in the quality of care they provide.<sup>182</sup> The Chief Equity officers would monitor and oversee their hospital's maternal care department's implementation of the initiatives outlined in Sections 1, 2, and 3. Additionally, these Chief Equity Officers would have an external focus of community outreach to understand social determinants of health that impact minority communities and implement solutions to address medical and non-medical threats to health outcomes.<sup>183</sup>

By employing two significant constitutional provisions, Congress would have the authority to enact my proposed legislation. The first constitutional provision is Congress' authority under the spending clause.<sup>184</sup> The spending clause grants Congress the power to lay and collect "Taxes, Duties, Imposts, and Excises, to pay the Debts and provide for the common Defense and general Welfare of the United States."<sup>185</sup> Generally, legislation enacted under the spending clause grants Congress the authority to prescribe the terms and conditions on the receipt of the federal funds,<sup>186</sup> and is one of the key means Congress can utilize to influence state behavior without "commandeering" state officials in violation of the Tenth Amendment.<sup>187</sup> My proposed legislation would utilize Congress's spending power to withhold Medicaid, a joint state and federal funded program, for hospitals who do not opt-in to Title X.<sup>188</sup>

While my proposed legislation will use Congress's spending clause as the primary source of Congressional authority in enacting the legislation, Congress can also utilize its authority under Section Five of the Fourteenth Amendment to further fortify its enactment.<sup>189</sup> Section Five grants Congress "the power to enforce this article [of the Fourteenth Amendment] by appropriate legislation."<sup>190</sup> This significant constitutional provision allows Con-

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182. See Shantanu Agrawal & Adaeze Enekeuchi, *It's Time to Address the Role of Implicit Bias Within Health Care Delivery*, HEALTH AFFAIRS (Jan. 15, 2020), <https://www.healthaffairs.org/doi/10.1377/hblog20200108.34515/full/> [<https://perma.cc/4T4X-ZYY3>].

183. *See id.*

184. U.S. CONST. art. I, § 8, cl. 1.

185. *Id.*

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187. See Brian T. Yeh, *The Federal Government's Authority to Impose Conditions on Grant Funds*, CONG. RSCH. SERV. (Mar. 23, 2017), <https://fas.org/sgp/crs/misc/R44797.pdf> [<https://perma.cc/Q3JZ-S82Z>] (citing *Fullilove v. Klutznick*, 448 U.S. 448, 474 (1980); *Lau v. Nichols*, 414 U.S. 563 (1974); *Oklahoma v. Civil Serv. Comm'n*, 330 U.S. 127 (1947); *Helvering v. Davis*, 301 U.S. 619 (1937); *Steward Mach. Co. v. Davis*, 301 U.S. 548 (1937)).

188. See *Financial Management*, *supra* note 132.

189. U.S. CONST. amend XIV, § 5.

190. *Id.*

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gress to enact legislation to protect individuals from state action that violates the Equal Protection Clause<sup>191</sup> or the Due Process Clause<sup>192</sup> of the Fourteenth Amendment. Although the Supreme Court initially gave broad interpretation to Congress's authority under Section Five, more recent opinions have construed Section Five's power more narrowly.<sup>193</sup> As a result, there are two key limits on Congressional authority under Section Five.<sup>194</sup> First, Congress does not have the authority to regulate private conduct, and Congress may regulate only the actions of the state and local government.<sup>195</sup> Second, Congress does not have the power to create new rights or expand existing rights, and it may only prevent or remedy violations of rights already recognized by the Supreme Court.<sup>196</sup>

Although both of the limitations place conceivable constraints on the reach of Section Five's power, Congress may still be able to overcome these roadblocks.<sup>197</sup> Congress could first utilize the holdings in a few seminal cases that define the contours of the state action doctrine in relation to private conduct of state actors.<sup>198</sup> In *Smith v. Allright* and *Terry v. Adams*, the Supreme Court held that private organizations that have been delegated part of a state's public function are bound by the same constitutional restrictions as the state government.<sup>199</sup> In analyzing the nature of the task performed by private entities, which in these cases centered private entities conducting state elections, the Court found that the duty performed was governmental in nature.<sup>200</sup>

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191. *Id.* § 1.

192. *Id.*

193. See *Ex parte Virginia*, 100 U.S. 339, 345 (1879) (holding that Congress has broad latitude in its exercise of Section Five power); *City of Boerne v. Flores*, 521 U.S. 507, 519 (1997) (holding that Section Five does not authorize Congress to create new rights or expand the scope of the rights recognized by the court); *Shelby County v. Holder*, 570 U.S. 529, 557 (2013) (holding that Section Five of the Voter Rights Act under the constraints of Section 4(b) exceeded Congress's authority resulting in an unconstitutional violation of power to regulate elections).

194. See Erwin Chemerinsky & Earl M. Maltz, *The Fourteenth Amendment Enforcement Clause*, NAT'L CONST. CTR., <https://constitutioncenter.org/interactive-constitution/interpretation/amendment-xiv/clauses/703> (last visited Jan. 24, 2022) [<https://perma.cc/JA2P-4FJZ>].

195. See *id.*

196. *Id.*

197. See *id.*

198. See *State Action Requirement*, LEGAL INFO. INST., [https://www.law.cornell.edu/wex/state\\_action\\_requirement](https://www.law.cornell.edu/wex/state_action_requirement) (last visited Jan. 24, 2022) [<https://perma.cc/T4VL-NWSZ>].

199. See *Smith v. Allwright*, 321 U.S. 649, 664 (1944); *Terry v. Adams*, 345 U.S. 461, 484 (1953).

200. See *Allright*, 321 U.S. at 664; *Terry*, 345 U.S. at 477.

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In *Burton v. Wilmington Parking Authority*, the Court analyzed the various contacts between the government and a private entity, rather than analyzing the tasks performed.<sup>201</sup> *Burton*'s holding established that the Fourteenth Amendment's Equal Protection Clause applies to private entities upon the determination that the state is significantly participating in assisting or supporting those entities through numerous contacts.<sup>202</sup> Further, such "significant" participation is determined by sifting through the "facts and weighing the circumstances" of each case.<sup>203</sup>

In advancing their argument for Section Five's authority to overcome the limitation on regulating private conduct, Congress could first argue that public and private hospitals are performing a governmental task by providing healthcare to its citizens.<sup>204</sup> Each state has its own set of professional or occupational laws and healthcare laws that set the requirements for practicing professionals and guide the delivery and scope of healthcare within the state.<sup>205</sup> By looking to the licensing requirements and regulations that apply to hospitals operating within a state's jurisdiction, Congress could argue that hospitals are indeed performing a governmental task that would bring them within the grasp of state action.<sup>206</sup>

Additionally, Congress could argue that the contact established between states and hospitals through each states' Medicaid programs creates significant involvement between states and hospitals.<sup>207</sup> As previously mentioned, each state's Medicaid program is jointly funded by the federal government and the state through a program called the Federal Medical Assistance Percentage (FMAP) where the federal government pays states for a specified

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201. See *Burton v. Wilmington Parking Auth.*, 365 U.S. 715, 724 (1961).

202. See *id.*

203. See *id.* at 722.

204. See *id.*; *Allwright*, 321 U.S. at 664; *Terry*, 345 U.S. at 477.

205. See *Business - State Laws*, LEGAL INFO. INST., [https://www.law.cornell.edu/wex/table\\_business/](https://www.law.cornell.edu/wex/table_business/) [<https://perma.cc/F4CG-JEQY>] (last visited Feb. 18, 2022); *Health - State Laws*, CORNELL, [https://www.law.cornell.edu/wex/table\\_health](https://www.law.cornell.edu/wex/table_health) [<https://perma.cc/5NQ3-4QCB>] (last visited Jan. 22, 2022); *Health Law Statutes & Court Rules*, THOMSON REUTERS WESTLAW EDGE, [https://1.next.westlaw.com/Browse/Home/StatutesCourtRules/HealthLawStatutesCourtRules?transitionType=Default&contextData=\(Sc.Default\)](https://1.next.westlaw.com/Browse/Home/StatutesCourtRules/HealthLawStatutesCourtRules?transitionType=Default&contextData=(Sc.Default)) (last visited Jan. 22, 2022).

206. See *State Specific Requirements for Initial Medical Licensure*, FED'N ST. MED. BDS., <https://www.fsmb.org/step-3/state-licensure> [<https://perma.cc/7VN6-T8VB>] (last visited Jan. 22, 2022).

207. See *What Is the Difference Between Medicare and Medicaid?*, U.S. DEP'T HEALTH & HUM. SERVS. (Oct. 2, 2015), <https://www.hhs.gov/answers/medicare-and-medicare/what-is-the-difference-between-medicare-medicare/index.html> [<https://perma.cc/P8M4-YS67>].

percentage of Medicaid program expenditures.<sup>208</sup> As a result, Medicaid operates as an expenditure and one of largest sources of federal revenue in state budgets.<sup>209</sup> In this context, Congress could argue that all hospitals are state actors due to the funding they receive through each states' Medicaid FMAP program.<sup>210</sup> In arguing that hospitals have significant contact with the state via each state's Medicaid program and perform a state task by delivering healthcare to patients, Congress could work around Section Five's limitation on regulating the conduct of private actors.<sup>211</sup>

Regarding Section Five's second limitation prohibiting the creation or expansion of rights, Congress could argue Black mothers' Equal Protection rights are violated by facially neutral laws and policies that have discriminatory purposes and effects.<sup>212</sup> In the landmark case of *Washington v. Davis*, the Supreme Court established that a facially neutral law or policy violates the Equal Protection clause if its effects have a discriminatory purpose and discriminatory effect.<sup>213</sup> Under this precedent, to establish discriminatory purposes and effects, Congress may contend that hospitals are failing to follow their own regulations, policies and procedures when treating Black mothers, resulting in the disproportionate death rates for Black mothers under their care.<sup>214</sup> Additionally, Congress may also look to each states' healthcare statutory statements of purpose in addition to their overall statutory schemes, to argue that hospitals are not following state healthcare laws by failing to adequately deliver equitable healthcare to Black mothers.<sup>215</sup>

Building on a potential showing of discriminatory purpose, Congress could use statistical data regarding Black maternal health rates in each state

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208. See *Financial Management*, *supra* note 132.

209. See Laura Snyder & Robin Rudowitz, *Medicaid Financing: How Does it Work and What are the Implications?*, KAISER FAM. FOUND. (May 20, 2015), <https://www.kff.org/medicaid/issue-brief/medicaid-financing-how-does-it-work-and-what-are-the-implications/> [<https://perma.cc/2BW4-3D2A>].

210. See *id.*

211. See *id.*

212. See *Washington v. Davis*, 426 U.S. 229, 242, 247–48 (1976) (“[A] law, neutral on its face and serving ends otherwise within the power of government to pursue, is not invalid under the Equal Protection Clause simply because it may affect a greater proportion of one race than of another.”).

213. *Id.* at 246.

214. See *id.*; *Vill. of Arlington Heights v. Metro. Hous. Dev. Corp.*, 429 U.S. 252, 266 (1977) (“Determining whether invidious discriminatory purpose was a motivating factor demands a sensitive inquiry into such circumstantial and direct evidence of intent as may be available. The impact of the official action whether it ‘bears more heavily on one race than another,’ *Washington*, 426 U.S. at 242, 96 S. Ct. at 2049 may provide an important starting point.”).

215. See Sarah C. Carey, *A Constitutional Right to Health Care: An Unlikely Development*, 23 *CATH. U.L. REV.* 492, 511–13 (1974).

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to help prove the discriminatory effects of a failure in adhering to laws and policies to show “a clear pattern,” of implicit bias resulting in higher maternal mortality rates for Black women that is “unexplainable on grounds other than race.”<sup>216</sup> To remedy this deprivation, Congress could argue that the enactment of Title X under Section Five would be a congruent and proportional remedy to ensure the preservation of Black mothers’ Equal Protection rights in light of the stark racial contrasts so blatantly evident in America’s maternal health crisis.<sup>217</sup> In utilizing the previous arguments to overcome the two limitations on Congress’s use of Section Five Power, enactment of Title X is possible.<sup>218</sup>

Title X’s proposal is a sweeping and forceful approach to combatting the issue of implicit bias in maternity care settings but could be vulnerable to a latent constitutional challenge. A spending clause challenge could arise regarding Title X’s proposed Medicare reimbursement reductions for hospitals that chose to opt-out. The Supreme Court’s four-part test to determine whether Congress has exceeded its spending power, as established in *South Dakota v. Dole*, requires: (1) that the spending power be in pursuit of the general welfare; (2) the federal statutes provisions must unambiguously state the terms of the legislation so the states can make a choice to accept or decline participation; (3) there must be a relationship between the condition imposed and the purpose of the federal spending; and (4) the condition imposed must not induce states to violate other constitutional provisions.<sup>219</sup> Additionally, and notably, Congress’s financial incentive must not be so coercive as to go beyond pressure and result in compulsion.<sup>220</sup>

There are likely no inconsistencies contested to the first three prongs of the *Dole* test regarding Title X’s constitutionality.<sup>221</sup> The provision of Title X would be designed to serve the general welfare, given the Court’s reasoning that “the concept of welfare or the opposite is shaped by Congress.”<sup>222</sup> Here, the means Congress will take to ensure the Black mothers receive equitable healthcare is to address and eradicate implicit bias. Moreover, Congress can clearly articulate the conditions upon which states receive funds to ensure states have a choice to accept or decline participation. The conditions imposed by Congress through Title X would be related to one of the primary purposes of Medicaid disbursement—to ensure that low-income adults, chil-

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216. *See Vill of Arlington Heights*, 429 U.S. at 266.

217. *See City of Boerne v. Flores*, 521 U.S. 507, 520 (1997).

218. *See id.*

219. *S. Dakota v. Dole*, 483 U.S. 203, 204 (1987).

220. *Id.*

221. *See id.* at 203.

222. *Id.* at 208.

dren, elderly adults, and pregnant women have medical coverage.<sup>223</sup> Further, none of the provisions imposed by Title X would induce states to violate other constitutional provisions.

However, similar to the spending clause challenge presented in *National Federation of Independent Business v. Sebelius* regarding whether the Patient Protection and Affordable Care Act's (ACA) Medicaid expansion program was unconstitutionally coercive of states, Title X will likely face the same challenge.<sup>224</sup> The Court in *Dole* found that the government's financial inducement threatening states with the loss of five percent of its highway funds was not impermissibly coercive because Congress was offering only "relatively mild encouragement to the States," because the federal funds at stake constituted less than half of one percent of South Dakota's budget.<sup>225</sup> In contrast, the Court in *Sebelius* found the financial inducement Congress chose in threatening to take away all of a state's existing Medicaid funding if they opted out of the Affordable Care Act's Medicaid expansion program was unconstitutionally coercive.<sup>226</sup>

With regard to whether Title X's financial inducement is unconstitutionally coercive, Congress may contend that its threat to withhold 0.5% of FMAP spending is "mild encouragement" and thus not unconstitutionally coercive.<sup>227</sup> In 2020, total state Medicaid spending amounted to 28.6% of the average state's total budget, with federal funds covering 62.7% of those costs.<sup>228</sup> While the Court in *Dole* did not specify what percentage or amounts might rise to the level of coercion, the Court ostensibly defines the contours of this coercion based on the amounts at issue.<sup>229</sup> In this vein, Congress could argue that Title X's threat of withholding 0.5% of FMAP is a "relatively small percentage" of Medicaid funding.<sup>230</sup> Unlike the ACA's mandate requir-

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223. *Medicaid*, MEDICAID.GOV, <https://www.medicaid.gov/medicaid/index.html> (last visited Feb. 18, 2022) [<https://perma.cc/G8YF-E4EU>].

224. Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 580–81 (2012).

225. *Id.* at 580 (citing *S. Dakota v. Dole*, 483 U.S. 203, 208 (1987)).

226. *Id.* at 582.

227. *See id.*

228. *Summary: 2020 State Expenditure Report*, NAT'L ASS'N ST. BUDGET OFF. (Nov. 20, 2020), [https://higherlogicdownload.s3.amazonaws.com/NASBO/9d2d2db1-c943-4f1b-b750-0fca152d64c2/UploadedImages/Issue%20Briefs%20/Summary\\_of\\_2020\\_State\\_Expenditure\\_Report.pdf](https://higherlogicdownload.s3.amazonaws.com/NASBO/9d2d2db1-c943-4f1b-b750-0fca152d64c2/UploadedImages/Issue%20Briefs%20/Summary_of_2020_State_Expenditure_Report.pdf) [<https://perma.cc/YPG8-QB9B>].

229. *See Sebelius*, 567 U.S. at 581. ("A State that opts out of the Affordable Care Act's expansion in health care coverage thus stands to lose not merely 'a relatively small percentage' of its existing Medicaid funding, but all of it"); *Dole*, 483 U.S. at 211 ("Here, however, Congress has directed only that a State desiring to establish a minimum drinking age lower than 21 lose a relatively small percentage of certain federal highway funds.").

230. *See Dole*, 483 U.S. at 211.

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ing the Secretary of Health and Human Services to withhold *all* Medicaid payments to states deemed out of compliance with the ACA's requirements, Title X would only withhold 0.5%.<sup>231</sup> Although the Court in *Dole* noted that the funds at issue were "otherwise obtainable," which seemingly influenced its ultimate holding, the 0.5% reduction in FMAP would likely still be small enough to compel states to enact Title X without forcing states to substitute state alternatives to make up for the reduction.<sup>232</sup> Focusing on the reduction amount at issue, Congress can assert that Title X's 0.5% reduction in Medicaid FMAP more closely resembles the reduction presented in *Dole* and is thus, not constitutionally coercive.<sup>233</sup>

## VI. CONCLUSION

This Comment aims to raise awareness and further discussions about how America can adequately address the issue of maternal mortality that overtly and disproportionately affects Black women, including trans and gender-nonconforming or gender variant birthing people. Our nation's history has proven that the abuse and mistreatment of Black women and their bodies is no new occurrence, and this history has subsequently influenced the narratives cemented in America's conscious that inform how doctors, nurses, and other medical staff view and treat Black women and Black birthing people.<sup>234</sup> Implicit bias is one of the irrefutable threads woven into the stories of Black mothers who die.<sup>235</sup>

My objective in enacting Title X Superior Care Standard for Moms is to provide a potential legislative solution to confront implicit bias directly and urgently in hospitals and maternity care facilities across the nation. While legislation can be a critical first step in providing solutions to issues that plague our society, legislation often fails to go far enough due to the constitu-

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231. *See Sebelius*, 567 U.S. at 633.

232. *See id.* at 679–80 (dissent noting the effects "When a heavy federal tax is levied to support a federal program that offers large grants to the States, States may, as a practical matter, be unable to refuse to participate in the federal program and to substitute a state alternative. Even if a State believes that the federal program is ineffective and inefficient, withdrawal would likely force the State to impose a huge tax increase on its residents, and this new state tax would come on top of the federal taxes already paid by residents to support subsidies to participating States."); *Dole*, 483 U.S. at 211.

233. *See Dole*, 483 U.S. at 204.

234. *See Amy Roeder, America Is Failing Its Black Mothers*, HARV. PUB. HEALTH (Winter 2019), [https://www.hsph.harvard.edu/magazine/magazine\\_article/america-is-failing-its-black-mothers/](https://www.hsph.harvard.edu/magazine/magazine_article/america-is-failing-its-black-mothers/) [<https://perma.cc/L8C7-5CK8>].

235. *See id.*

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tional constraints on Congress.<sup>236</sup> Potential legislative efforts designed to combat the implicit bias that Black mothers face will undoubtedly be met with challenges and criticism to its practicality and implementation. Addressing Black maternal health disparities will likely be a collaborative effort at the state and federal level in offering solutions that will ensure that Black mothers receive the equitable healthcare they so rightfully deserve.

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236. See *Constitutional Authority Statements and the Powers of Congress: An Overview*, CONG. RSCH. SERV. 5 (Mar. 11, 2019), <https://fas.org/sgp/crs/misc/R44729.pdf> [<https://perma.cc/G6XC-XLV6>].