**Internship Research**

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**Chapter One: Fetal Heartbeat Bill**

**Introduction:** The Fetal Heartbeat bill has been proposed on several occasions by South Carolina legislators. After several failed attempts, the bill has been proposed again by anti-abortion politicians. We know that this bill would be detrimental to women’s rights. In my research of this subject, I have come across several points as to why this bill would not be successful. Before I discuss my findings, here is a brief background on this subject.

**Background:** The Fetal Heartbeat Protection From Abortion Act was first introduced in January of 2019 in the SC House of Representatives. This bill seeks to amend several sections of the Code of Laws of South Carolina regarding abortion. This is the current stance on abortion as written in South Carolina Law:

Abortions defined as using an instrument or medication with the intent to terminate a pregnancy (other than birth, to preserve a baby’s life or remove dead fetus) are [legal in South Carolina](http://www.prochoiceamerica.org/government-and-you/state-governments/state-profiles/south-carolina.html) only under the following three circumstances:

1. In the first trimester with the pregnant woman’s consent.
2. In the second trimester with the pregnant woman’s consent in a [certified hospital or clinic](http://www.prochoiceamerica.org/government-and-you/state-governments/state-profiles/south-carolina.html?templateName=template-161602701&issueID=8&ssumID=2822).
3. In the third trimester when necessary, to preserve the life or health of the pregnant woman on the written recommendation of two doctors, and if the basis is mental health then both the two doctors and a consulting psychiatrist must agree in writing the abortion is necessary.
* The pregnant woman’s written consent is required for an abortion to be performed in South Carolina. However, if she’s under 17 years and unmarried, the consent of at least one parent, grandparent, or guardian is required, except in medical emergencies or if the pregnancy is the result of [incest](https://criminal.findlaw.com/criminal-charges/child-abuse-overview.html).
* South Carolina has a judicial bypass where the minor can [petition the court](http://www.judicial.state.sc.us/forms/pdf/SCCA461.pdf) for the right to an abortion without parental notification. She has the right to court-appointed counsel for this hearing and guardian ad litem will be appointed. The abortion is to be [granted](http://www.judicial.state.sc.us/forms/pdf/SCCA463.pdf) if it’s in the best interest of the child. If the court finds the minor is too immature and the abortion wouldn’t be in her best interest, it’ll be denied. She has a right to appeal in this case.
* If denied, the father is identified, he will be ordered to share in the costs of delivery and raising the child. The state may pay for counseling, prenatal care, delivery, and post-natal care.
* Either a spouse, parent, or legal guardian will have to consent to abortion for a woman found mentally incompetent.

The Fetal Heartbeat Act seeks to amend sections in Chapter 41 of Title 44 in regard to abortions in the Code of Laws of South Carolina. been proposed in the South Carolina House of Representatives multiple times to no success. The question is why do supporters of this bill continue to propose this bill, despite there being more pressing matters that need attention. I believe it is because these individuals feel that passage of this bill could be possible in 2021. While I don't believe this bill has the chances of passage if the following conditions were to occur passage could be possible. The Fetal Heartbeat bill has always passed in the House of Representatives because the Republican party holds majority control. In the Senate, supporters of the bill have not been able to secure the necessary number of votes. Here is where the passage of this bill could be possible. In the 2020 elections, the Democratic party lost three seats in the South Carolina Senate. The Republican Party also gained seats in the House of Representatives. The Republican party now holds a supermajority, which may allow for the passage of the Fetal Heartbeat bill. Currently, the bill has been approved by the Senate's Medical Affairs Subcommittee. If the bill is approved by the Medical Affairs committee, then it will be sent to the Senate floor for voting. Despite the state still suffering from COVID-19, this issue is being discussed again because the Republican party feels that they now have the control needed to pass this bill in the Senate.

**Research:** In researching this issue, I determined that this bill would ultimately remove a woman's right to continue the pregnancy or not. This bill would seek to prohibit all abortions after six weeks of pregnancy. The issue with this clause is that many women do not know that they are pregnant until after eight- weeks of pregnancy. After interviewing some friends and family members, I determined that the actual identification of pregnancy depends on the individual. My mother discovered she was pregnant at two weeks as she became very ill. For both of my grandmother’s pregnancies, she did not find out until she was seven weeks pregnant. After viewing various pregnancy blogs, some did not find out they were pregnant until they were nine weeks. The implementation of this bill would inhibit women that discover they are pregnant after six weeks from obtaining an abortion.

In my research, I discovered that fetal heartbeat detection is actually a very controversial topic. Do some say a heartbeat can be detected as early as four weeks but is that truly a heartbeat? According to MedlinePlus, the fetal heartbeat cannot be detected until the sixth week of pregnancy. According to The American Heart Association, the fetal heart is not developed until eight weeks gestation. Keeping this information in mind, a medical expert could say that this bill is not medically sound, given that the actual fetal heart is not developed until after six weeks.

Maternal health services in South Carolina are already limited to some individuals. Enacting this bill would force some women to continue a path that they do not want. Maternal health services are already limited in various rural and urban communities. With continuous physician shortages in these areas, women who were forced to remain pregnant due to the limitations of this bill, may not be able to receive proper prenatal or postpartum care. A research article published by the South Carolina Center for Rural and Primary Healthcare stated that "The ratio of OB/GYN to 1,000 residents, at the county level, ranges from 0.043 in Berkeley County to 1.218 in Charleston County (Table 1). The median ratio among counties with a provider was 0.24 (mean 0.31). Ten counties (Abbeville, Allendale, Bamberg, Barnwell, Calhoun, Edgefield, Hampton, Lee, McCormick, and Saluda) have zero providers in their county," (Bennett, Purser, Carter, &amp; Stanek, 2019).

Kentucky and South Carolina are both similar in regard to population, healthcare, and politics. Former Kentucky Governor Matt Bevin actually signed several anti-abortion bills into law, including a fetal heartbeat bill. However, all of these laws have either been temporarily or permanently banned by a federal judge. Considering that Kentucky is also a Republican state, I am not surprised that they would have a similar stance on abortion. Both states equally lack certain maternal and child health services. The main issue is access to maternal health services. If this bill were to be instituted, the state has to make sure that the women who are forced to continue their pregnancy have access to prenatal care. Many individuals do not have transportation, therefore traveling 30 minutes to an hour for prenatal care is not an option. What both of these states should be focusing on improving their maternal and child health services. This bill is a distraction from the real issues our state and the entire country are facing. The state's efforts should be focused on reducing the number of individuals contracting COVID-19, issuing vaccines, and fixing our current economic situation.

**Fetal Heartbeat Bill Update/Medicaid**

As of January 28, 2021, The South Carolina Senate passed the Fetal Heartbeat bill after three days of deliberation. To recap, this bill would ban all abortions after a fetal heartbeat is detected. A heartbeat is usually detected around six weeks gestation. The only exceptions added to this bill are in the case of rape, incest, fetal anomaly, or possible harm to the mother. The implementation of this bill significantly limits women’s rights, in regards to their bodies.

The problem with this bill is some individuals already have limited access to maternal health services. Rural communities are already experiencing limited access to maternal health services. In 2015, The South Carolina Department of Health and Environmental Control conducted an analysis of maternal healthcare needs in South Carolina. This analysis examined possible risk factors for pregnancy, as well as factors for a positive pregnancy. Influential risk factors for pregnancy include education, income, insurance type, access to care, and racial norms. All of these factors are important, but in light of the recent passage of the fetal heartbeat bill, three of these factors have increased in importance. Income, insurance type, and access to care are factors that influence an individual's ability to seek care. Transportation was listed as a significant barrier to healthcare access.

Many smaller communities do not have maternal health services. Individuals who do not qualify for Medicaid, as well as individuals who do not receive insurance through their employer, are limited in their ability to seek healthcare. Under Medicaid, expectant mothers can receive health care coverage if they fall within the qualifications guidelines. The problem with these guidelines is that many women still do not qualify to receive Medicaid. For example, let's say we have a twenty-year-old woman experiencing her first pregnancy. She has no familial support, no health insurance, the father of the child does not want to be involved, and she only makes about $1,200 dollars a month. Under the guidelines established by the state of South Carolina, she would not qualify for this program. In South Carolina, the state is required to cover ineligible expectant mothers for 60 days after giving birth, but what if the mother is experiencing birth complications past the 60 day period. Advocates for Medicaid expansion have suggested that the coverage period be extended to one year postpartum. This extension would allow the mother to receive the appropriate post-partum for a new mother. Most lawmakers do not understand how important these services are for some individuals. According to the Kaiser Family Foundation, “ For pregnant women who are eligible for Medicaid under the ACA’s Medicaid expansion pathway, states must cover all preventive services recommended by the United States Preventive Services Task Force (USPSTF) including many pregnancy-related services, such as prenatal screening tests and folic acid supplements as well as services in the postpartum period, such as lactation consultants and breastfeeding supplies,” ( Ranji & Gomez, 2020). Problems with lactation and breastfeeding can last well beyond 60 days. If the Biden administration expands Medicaid coverage, this will allow women (who would otherwise not receive care), to receive the proper prenatal and postpartum care.

The passage of this bill is likely to increase the maternal and infant mortality rate in South Carolina, as many women will be unable to seek prenatal care and postpartum care. As of April 2019, The current maternal mortality rate in South Carolina is 24 per 100,000 live births. African- American women the rate is 41.9 per 100,000 live births. A study published in the American Journal of Public Health examined the effects of Medicaid on infant mortality rates. According to the study, “We examined data from 2010 to 2016 and 2014 to 2016 to compare infant mortality rates in states and Washington, DC, that accepted the Affordable Care Act Medicaid expansion (Medicaid expansion states) and states that did not (non–Medicaid expansion states), stratifying data by race/ethnicity,” (Bhatt & Beck-Sagué, 2018). The results of the study concluded that the infant mortality rate rose in states that did not expand Medicaid. In states with Medicaid expansion, the infant mortality rate declined. The results of this study show how necessary Medicaid coverage is for expectant mothers. It is likely that women will either travel out of state to seek an abortion or attempt ulterior methods to relieve themselves of their pregnancy. I expect that South Carolina will also see a spike in both maternal and infant mortality rates, as we have not expanded Medicaid services.

**Fetal Heartbeat Bill Summary:** The Fetal Heartbeat Protection From Abortion Act was first introduced in January of 2019 in the SC House of Representatives. This bill seeks to amend several sections of the Code of Laws of South Carolina regarding abortion. This act seeks to ban all abortions after a fetal heartbeat is detected. Supporters of this act state that a fetal heartbeat can be detected at six weeks gestation, but this is not accurate for every expectant mother. For individuals who find out they are expecting after six weeks, they have no choice but to continue with the pregnancy. This bill eliminates a woman's right to choose in regards to her reproductive health. For individuals who live in areas lacking maternal health services, many women have to travel over an hour to seek prenatal care and to give birth. Kentucky has a similar stance on this issue, but they have a wide variety of maternal health services. As of January 28, 2021, The South Carolina Senate passed the Fetal Heartbeat bill after three days of deliberation. This bill poses significant risks for expectant mothers. Expectant mothers are covered under Medicaid for 60 days after giving birth, but many women do not qualify for Medicaid due to new regulations.

**Chapter Two: African-American Maternal Health**

Our country's history of racial discrimination has led to an increase in preventable death among African-American Women. Currently, African-American women are three times more likely to die from pregnancy-related causes than Caucasian women. As the woman ages, the risk of dying from these complications increases. The question is, why is this still happening. Considering the advancements the American healthcare system has been able to make, you would think the health of this population would be improving, not diminishing. Today’s topic focuses on uncovering the factors that are increasing this mortality rate as well as, identifying potential improvements that may be made by expanding Medicaid services.

One factor we have to consider is the African-American communities’ hesitation to receive healthcare services, due to previous discrimination and deception experienced in the past. I believe that a majority of the mistrust between the African-American community and the American healthcare system stems from the Tuskegee Syphilis Study. Here is a brief background on the subject. According to the Center for Disease Control and Prevention, “The study initially involved 600 black men – 399 with syphilis, 201 who did not have the disease. The study was conducted without the benefit of patients’ informed consent. Researchers told the men they were being treated for “bad blood,” a local term used to describe several ailments, including syphilis, anemia, and fatigue. In truth, they did not receive the proper treatment needed to cure their illness. In exchange for taking part in the study, the men received free medical exams, free meals, and burial insurance. Although originally projected to last 6 months, the study actually went on for 40 years,” (2020). The unethical components of this study would solidify some of the mistrust between the African-American community and the healthcare system. In 1945, penicillin was accepted as the appropriate treatment for syphilis. All of the healthcare professionals involved in this study knew that penicillin was the appropriate course of treatment, yet none of the participants were treated for syphilis. The study would not officially end until 1972 after an article is published condemning the study. While the Tuskegee experiment may have initiated the apprehension, it is not the sole reason.

I believe that discrimination would be the primary factor. The history of African-Americans in the United States is a story filled with entrapment, violence, and discrimination. Although today’s African-American individual has more rights then their grandparents and great-grandparents, there is still implicit bias and discrimination in the healthcare system towards African-Americans. The attitudes of the healthcare provider have been cited as a deterrent to receiving care. A study published in *The American Journal of Public Health* examined implicit racial and ethnic bias of healthcare providers’ effects on healthcare outcomes. The subsection entitled, *Health Disparities and Provider Attitudes,* stated that “Although overt discriminatory behavior in the United States may have declined in recent decades, covert discrimination and institutional bias are sustained by subtle, implicit attitudes that may influence provider behavior and treatment choices. As a result, patients of color may be kept waiting longer for assessment or treatment than their White counterparts, or providers may spend more time with White patients than with patients of color. In addition, providers may vary in the extent to which they collaborate with patients in systematic though non deliberate ways, in considering treatment options based on patients’ characteristics,” (Hall et al., 2015). Subtle biases, such as engaging the patient in a condescending or dominant tone, were cited as a tacit to decrease the patient’s control over the situation. From personal experience, I can say I see this form of bias extended more from older white males. I have seen this form of bias exhibited by an African-American male provider, but it is mostly exhibited by older white males. The article also cited that many patients felt like their opinions were not considered and that subtle bias prevented some patients from receiving the best care.

These subtle biases become evident in many cases of pregnancy-related deaths with African-American Women. Some of the cases I have studied mentioned that the physicians did not acknowledge the patient’s concerns, specifically regarding pain. Despite the patient educational background and income level, many of their concerns were disregarded by physicians. Here are some cases identified in an NPR article published in 2017. “There was the new mother in Nebraska with a history of hypertension who couldn't get her doctors to believe she was having a heart attack until she had another one. The young Florida mother-to-be whose breathing problems were blamed on obesity when in fact her lungs were filling with fluid and her heart was failing. The Arizona mother whose anesthesiologist assumed she smoked marijuana because of the way she did her hair. The Chicago-area businesswoman with a high-risk pregnancy who was so upset at her doctor's attitude that she changed OB/GYNs in her seventh month, only to suffer a fatal postpartum stroke,” ( Martin & Montagne, 2017). Tennis pro-Serena Williams had a similar experience after delivering her first child. Mrs. Williams has a history of blood clots. When she informed the medical staff that she was experiencing trouble breathing (a symptom she recognizes as her having a blood clot), and that she needed a CT scan and a blood thinner. Her concerns were initially ignored and the physician performed an ultrasound, which revealed nothing. The physician finally performed a CT scan, which revealed several blood clots in her leg. Had that CT scan not been performed, Serena Williams would probably have died from an embolism. I believe that these subtle biases may have a larger effect on black maternal mortality rates than access to care. African-American women who are well off and extremely educated are still experiencing the same lack of care that individuals from impoverished areas experience.

Access to maternal health services is still a barrier that many individuals are facing. We know the problem, but what is the solution? The issue is that the current Medicaid program is preventing women from addressing those postpartum complications with a physician. Current Medicaid policy allows for a woman to receive healthcare coverage up to 60 days after giving birth. The problem is that many women can develop postpartum complications after this 60 day period. “An increasing number of maternal deaths, which are defined as deaths during pregnancy and up to 365 days after, are occurring in the postpartum period. CDC data confirm that one-third of all pregnancy-related deaths occur one week to one year after pregnancy ends. In some states, the number is much higher. In Illinois, for example, 56 percent of pregnancy-associated deaths occurred between 43 and 364 days postpartum,” (Muller, 2020). For the women who do not have any other form of healthcare coverage, post 60 days could mean death.

Currently, South Carolina has not expanded Medicaid services, but there may be a chance to reverse this decision. Democrats are currently trying to urge states to expand Medicaid services for expectant mothers. *The Washington Post* presented an article on the subject. The article stated that “This morning, the House Energy and Commerce Committee will hold a hearing on its piece of the $1.9 trillion relief bill moving through the House. The legislation includes a short provision (it’s only a sentence long) saying states, for a length of five years, can extend Medicaid eligibility to women for 12 months after giving birth,”(Cunningham, 2021). Implementation of this policy would allow low-income women the opportunity to receive quality prenatal and postpartum care. African-American women in low-income areas would have healthcare coverage, but that doesn’t solve the other barriers to accessing care. Individuals without transportation may still have trouble accessing maternal health services due to location. There is still the issue of implicit bias. While there is no quick way to resolve this issue. Some healthcare institutions are taking measures to reduce implicit bias, but only time will tell if the methods are effective.

Overall, simply addressing the concerns of African-American women will not be enough. In order to truly improve health services for African-American women, we must be willing to accept the fact that racial bias and discrimination still exist in our current society. Once this issue is addressed, we will be able to improve our entire healthcare system.

**African-American Maternal Health:** In the American healthcare system, African-American women are at an increased disadvantage. A long-standing history of discrimination and racial bias has caused many African-American women to forgo seeking prenatal care. Bias on the part of the healthcare provider has been cited as the primary reason for the hesitation in receiving care. “A study published in *The American Journal of Public Health* examined implicit racial and ethnic bias of healthcare providers effects on healthcare outcomes. The subsection entitled, *Health Disparities and Provider Attitudes,* stated that “Although overt discriminatory behavior in the United States may have declined in recent decades, covert discrimination and institutional bias are sustained by subtle, implicit attitudes that may influence provider behavior and treatment choices. As a result, patients of color may be kept waiting longer for assessment or treatment than their White counterparts, or providers may spend more time with White patients than with patients of color,”(Hall et al., 2015). This bias can be connected to some incidences of pregnancy-related death in African-American women. Many African-American women feel as if their medical concerns are being ignored by their physicians. African-American women who cannot afford or do not live near any maternal health services are unable to address any postpartum medical concerns. Medicaid does provide healthcare coverage up to 60 days after birth, but women who experience complications after this period will be unable to afford care. “An increasing number of maternal deaths, which are defined as deaths during pregnancy and up to 365 days after, are occurring in the postpartum period. CDC data confirm that one-third of all pregnancy-related deaths occur one week to one year after pregnancy ends. In some states, the number is much higher. In Illinois, for example, 56 percent of pregnancy-associated deaths occurred between 43 and 364 days postpartum,” (Muller, 2020). Extending Medicaid services to a year would allow women to receive care for any postpartum complications they may develop.

**Chapter 3: Medicaid Expansion**

This week I was reminded of why Medicaid expansion is necessary for our country. I saw something that made me remember why we need expanded Medicaid services. Certain populations of individuals in our country are more vulnerable in regards to health. This vulnerability means that they require extra health services. I realized that the largest users of Medicaid services fall under the category of a vulnerable population. Those populations are the elderly, disabled individuals, children, and pregnant women.

When you break down the benefits of Medicaid for each population, you realize that Medicaid may be the only way they can receive any healthcare treatment. Let’s use elderly individuals as an example. For elderly individuals who cannot afford to retire or retirees who do not have a lot of income, medicare provides them with routine and specialized care. For individuals who are already covered under Medicare, Medicaid provides additional coverage for various services. According to Medicaid.gov, “Medicare enrollees who have limited income and resources may get help paying for their premiums and out-of-pocket medical expenses from Medicaid (e.g. MSPs, QMBs, SLBs, and QIs). Medicaid also covers additional services beyond those provided under Medicare, including nursing facility care beyond the 100-day limit or skilled nursing facility care that Medicare covers, prescription drugs, eyeglasses, and hearing aids. Services covered by both programs are first paid by Medicare with Medicaid filling in the difference up to the state's payment limit,”(2020). Many individuals with disabilities rely on the services provided through Medicare. “Medicaid is the primary payer for essential long-term services and supports. In addition to nursing home care, Medicaid supports home- and community-based services, such as personal and attendant care services that help people with disabilities live in their homes and communities. Medicaid also covers wheelchairs, lifts, and supportive housing services. This care is typically unavailable through private insurance and is too costly for all but the wealthiest people to fund out of pocket,”(2017).

For the disabled, Medicaid provides employment opportunities. For disabled children, provides services for the child while they are attending school. Ultimately, the major beneficiaries of Medicaid services are women and children. For women, Medicaid provides access to a variety of health services. Routine checkups, reproductive care, and long-term care services are covered under Medicaid. Many of the women who use Medicaid services are balancing work and family life. “Over half of nonelderly women on Medicaid work outside the home (56%). Many others are not employed for pay but are caring for family members (19%), have a serious illness or disability (13%), or attend school (6%). Approximately six in ten mothers on Medicaid (62%) are working and another quarter are caring for family members. Among women without children, half (53%) are working and another 19% have an illness or disability,”(*Medicaid's role for women,* 2019). On average, women live longer than men and develop chronic conditions that require long-term services (*Medicaid's role for women,* 2019). Under the Children’s Health Insurance Program (CHIP), are provided a variety of services, including well visits, dental care, and vaccines. Extra coverage varies from state to state.

According to the Kaiser Family Foundation, “A large body of research shows that Medicaid beneficiaries have far better access to care than the uninsured and are [less likely to postpone or go without needed care due to cost](https://www.macpac.gov/wp-content/uploads/2015/01/Contractor-Report-No_2.pdf). Moreover, rates of access to care and satisfaction with care among Medicaid enrollees are comparable to rates for people with private insurance. Medicaid coverage of low-income pregnant women and children has contributed to dramatic [declines in infant and child mortality](http://www-personal.umich.edu/~ajgb/medicaid_ajgb.pdf) in the U.S,”(Garfield & Rudowitz, 2020). Knowing the benefits that Medicaid can provide, some states have still opted out of expanding services. In our state of South Carolina, we have 27.5% of the population enrolled in Medicaid but refuse to expand coverage. The question is why?

Many South Carolina officials cite the high cost of expansion as the reason for opting out, but the cost of expanding services is not high at all. According to the Center on Budget and Policy Properties, “South Carolina will spend $372 million more on Medicaid to cover additional enrollment of currently eligible children and parents through 2022 with or without the expansion. The expansion would increase state spending by $1.2 billion. Altogether, this additional spending is just 7.0 percent more than what South Carolina would have spent on Medicaid in the absence of the ACA,”(How Would the Medicaid Expansion Affect South Carolina, 2013). After opting out of Medicaid expansion, the state of South Carolina imposed work requirements to qualify for Medicaid. The issue with this requirement is that many low-income individuals who are unable to work no longer qualify for Medicaid. “In December 2019, when CMS approved South Carolina’s Medicaid work requirement (“community engagement”) proposal, it was the first such approval for a state that hasn’t expanded Medicaid. Because South Carolina hasn’t expanded Medicaid, the state’s Medicaid population consists of low-income people who are children, elderly, disabled, pregnant, or parents of minor children. Adults who don’t fit into one of these categories are not eligible for coverage, no matter how low their income is,”(Norris, 2020). Many of the individuals who are a part of the vulnerable population I mentioned earlier, no longer qualify for Medicaid. So, what happened to these individuals? They are now included in the number of uninsured individuals in South Carolina. The number of uninsured individuals in South Carolina is currently 514,772, but that number continues to grow every day.

Now, that we have identified the issue, what is the solution? Where do we go from here? Healthcare is a right that should be provided to all individuals, despite their ability to pay. How do we incite change in this country? We do it by fighting back. We must challenge our senate and house representatives to make the decisions that we move our country forward and not backward. Having numerous advocates for a particular cause can incite change. Medicaid expansion isn’t a simple task that can be done overnight. Making this happen will take dedicated coordination and cooperation from state officials.

**Medicaid Expansion:** Medicaid services offer a variety of individuals access to healthcare services. Women, children, the disabled, and the elderly all benefit from Medicaid services. The services provided under Medicare allow these individuals to seek routine and specialized care. According to the Kaiser Family Foundation, “A large body of research shows that Medicaid beneficiaries have far better access to care than the uninsured and are [less likely to postpone or go without needed care due to cost](https://www.macpac.gov/wp-content/uploads/2015/01/Contractor-Report-No_2.pdf). Moreover, rates of access to care and satisfaction with care among Medicaid enrollees are comparable to rates for people with private insurance. Medicaid coverage of low-income pregnant women and children has contributed to dramatic [declines in infant and child mortality](http://www-personal.umich.edu/~ajgb/medicaid_ajgb.pdf) in the U.S,”(Garfield & Rudowitz, 2020). In states that have expanded Medicaid services, their citizens are receiving extra coverage for healthcare services. Unfortunately, South Carolina opted out of expanding its Medicaid services. South Carolina officials cited high costs as the reason for denying expansion, but expanding Medicaid services would not be a costly expenditure. “South Carolina will spend $372 million more on Medicaid to cover additional enrollment of currently eligible children and parents through 2022 with or without the expansion. The expansion would increase state spending by $1.2 billion. Altogether, this additional spending is just 7.0 percent more than what South Carolina would have spent on Medicaid in the absence of the ACA,”(How Would the Medicaid Expansion Affect South Carolina, 2013) (How Would the Medicaid Expansion Affect South Carolina, 2013). After refusing to expand Medicaid services, South Carolina officials then imposed work requirements to qualify for Medicaid. This addition disqualified thousands of South Carolinians from receiving Medicaid.

Special Note: A distinction should be made between individuals on Medicaid due to poverty and individuals on Medicaid due to disability. Individuals who are impoverished and may also be disabled, would be considered dual eligibles. Individuals with dual eligibility qualify for both Medicaid and Medicare. My research focuses mainly on impoverished individuals facing maternal health with or without Medicaid coverage.

**Chapter 4: Maternal and Child Mortality**

Today’s women face a crisis. Their healthcare needs are not being addressed and their current healthcare rights are being revoked. In South Carolina, women are at the mercy of state officials. Women in South Carolina have been denied extra health coverage that has been granted to residents in Medicaid expanded states. Also, women in South Carolina have been denied the right to an abortion after six weeks of conception. Expectant mothers are especially vulnerable, as South Carolina officials have been neglecting the needs of both pregnant women and their children. This is not a new issue, as this has been occurring for decades. The question is are South Carolina officials actively addressing the needs of women? Also, are we serving those populations that are most at risk?

South Carolina has several systems in place to monitor maternal health and child health issues. The Pregnancy Risk Assessment Monitoring System, also known as PRAMS, collects information on a women’s behaviors before, during, and after pregnancy. “The South Carolina Pregnancy Risk Assessment Monitoring System (SC PRAMS) Project plays a significant role in SC DHEC's public health surveillance activities. The SC PRAMS Project monitors and disseminates information on maternal behavioral risk factors occurring during pregnancy and on a child's early infancy period related to birth outcomes. Thus, the SC PRAMS Project provides sound and reliable maternal and infant health data, which can be used by health professionals for the planning and evaluation of perinatal health programs and for making policy decisions affecting the health of mothers and babies in South Carolina,” (*About PRAMS,* 2003). The PRAMS is an ongoing project that provides a variety of data on maternal and child health issues, but are those issues being addressed by South Carolina officials? Let’s go over the current status of maternal and child health in South Carolina.

Currently, South Carolina’s maternal mortality rate is 27.1 (per 100,000 live deaths). The national maternal mortality rate is 17.4. With the maternal mortality rate being higher than the national average, there must be an issue that is going unaddressed among expectant mothers in South Carolina. The 2020 South Carolina Morbidity and Mortality Review Committee identified possible factors that could be contributing to the high mortality rate. The committee reviewed 27 maternal deaths between 2016 and 2019. After reviewing all data collected, the committee determined that 74% of the cases were pregnancy-related. The findings also determined that hemorrhage and infection were majors contributors to pregnancy-related death. The committee also determined that 55% of the pregnancy-related deaths were preventable. “The largest proportion of factors identified by the SC MMMR Committee as contributing to pregnancy-related deaths were patient/family factors followed by provider and systems of care factors. On average, five contributing factors were identified for every pregnancy-related death,” (*South Carolina Maternal Morbidity and Mortality Review Committee Legislative Brief March 2020*, 2020). In previous reports, cardiovascular, coronary, and embolisms were also cited as contributors to pregnancy-related death. “From 2011–2013, 15.1 percent of U.S. pregnancy-related deaths were caused by cardiovascular disease, 14.5 percent by non-cardiovascular diseases, 12.7 percent by infection and sepsis, and 11.4 percent by hemorrhage. A legislative brief from the SC Maternal Mortality and Morbidity Review Committee finds that the most common causes of maternal death in SC are cardiovascular and coronary conditions, hemorrhage, infection, and embolism,”(*Maternal safety comes in threes,* 2019). These causes have been cited at the national level as a recurring cause for pregnancy-related death. As I stated earlier, many of these causes are preventable. Health officials know that these causes can be prevented, yet they keep occurring. Two environmental factors are associated with increasing the risk for pregnancy-related death. Those factors are provider factors and patient/family factors. Provider factors include, ignore patient concerns or misdiagnosing a health issue. Patient/family factors include not recognizing warning signs or not seeking care.

The healthcare needs of children are also going unaddressed. The infant mortality rate for South Carolina is 6.8 (per 1,000 live births), while the national rate is 5.7. For child mortality (individuals between the ages of 1-19), the rate for South Carolina is 33.2 (per 100,000 children). For the US, the rate is 25.7. A report published by the South Carolina Department of Health and Environmental Control acknowledged the top five causes for infant mortality between 2017 and 2018. “The top five leading causes of infant death overall in 2018 were birth defects, disorders related to short gestation and low birthweight, accidents, maternal complications of pregnancy, and bacterial sepsis. From 2017 to 2018, there was a 28.1% increase in the number of infant deaths from birth defects (from 64 deaths in 2017 to 82 deaths in 2018). The number of deaths due to preterm birth/low birth weight and accidents increased from 2017 to 2018 by 11.5% and 11.8%, respectively,”(*Infant Mortality and Selected Birth Characteristics 2018: South Carolina Residence Data*, 2019). If the mother’s needs are not being, then it is likely that the child’s needs are being neglected as well.

We know the problem and we know there are systems in place to monitor them, but the question remains; are they being addressed. I believe the answer to this question is both yes and no. We know that in more metropolitan areas of our state these needs are being addressed more rapidly than in rural communities. We also have to remember that even if the individual has access to health services provider issues could still cause the individual to develop pregnancy-related complications. We also have to acknowledge that individuals of certain races experience maternal, infant, and child mortality at a higher rate, and thus need access to various medical services. It is apparent that the women and children in our state need expanded Medicaid services. Women need access to postpartum services and children need access to multiple health services. Expanding Medicaid services would ensure that the needs of both mother and child are being met. The priority of South Carolina officials should be ensuring that their residents are healthy and able to access health services should their health status change.

**Maternal and Child Mortality:** The women and children of South Carolina are not having their healthcare needs met. The maternal mortality rate for South Carolina is 27.1, which is higher than the national average. When seeking to address why the rate was so high, I was again presented with the issue of pregnancy-related death. The 2020 South Carolina Maternal Morbidity and Mortality review revealed that hemorrhage and infection were major contributors to pregnancy-related death. This review also determined that 55% of the deaths surveyed were preventable. Cardiovascular issues have also been cited as a contributor to pregnancy-related death. Patient/family factors have been noted as the largest contributor to pregnancy-related death. Factors, such as home environment and proper nutrition may be part of the issue. The infant mortality rate for South Carolina is 6.8 (per 1,000 live births), while the national rate is 5.7. For child mortality (individuals between the ages of 1-19), the rate for South Carolina is 33.2 (per 100,000 children). For the US, the rate is 25.7. If the needs of the mother are not being met, then we can assume that the child’s needs are being neglected as well. Birth defects and low birth weight are contributors to this issue.

**Chapter 5: American Rescue Plan**

Since the beginning of the Coronavirus pandemic, the federal government has been providing economic stimulus packages to restimulate the economy. Previous aid packages provided only emergency relief to individual Americans, small businesses, state and local governments, and various other sectors (education, big corporations, public health…). As of March 11, 2021, The Biden Administration implemented a new stimulus bill that provides benefits that were not previously included in other stimulus bills. The American Rescue Plan provides states that have not expanded Medicaid services with possible incentives if the state expands its services. This bill would also provide new coverage for pregnant and postpartum women. For a state that has not expanded Medicaid services, like South Carolina, could this be the motivation needed to expand coverage in unexpanded states?

 Here is a brief background on the current coverage under Medicaid expansion. “Individuals enrolled as part of the new adult group receive an alternative benefit plan (ABP), which is a [benchmark plan](https://www.macpac.gov/medicaid-101/benefits/) modeled on commercial insurance coverage, rather than the traditional Medicaid benefit plan. Individuals with special medical needs are exempt from the ABP and states have flexibility to include additional benefits. In addition, these benefit packages must cover the 10 essential health benefits specified in the ACA. Essential health benefits are defined as ambulatory services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, chronic disease management, and pediatric services, including oral and vision care. While states are allowed to offer ABPs to the new adult group that are less comprehensive than benefits offered to other Medicaid beneficiaries, most states have chosen to align their ABPs with traditional Medicaid benefits,” (*Medicaid expansion to the new adult group,* 2021).

The initial expansion under the Affordable Care Act provided many women with coverage who would otherwise have none. In states that have expanded Medicaid services, many expectant mothers have had their coverage increased from 60 days postpartum to 12 months. This inclusion of this prevented many women from experiencing many postpartum complications. The expansion of Medicaid services has been linked to lower cases of maternal-mortality and lower incidences of pregnancy-related death. A study presented at the Academy Health 2019 National Health Policy Conference determined that Medicaid expansion is linked to lower incidences of maternal mortality. “Confirming the hypothesis, the researchers observed that Medicaid expansion was significantly associated with lower rates of maternal mortality by 0.16 relative to states that did not expand, reflecting 1.6 fewer maternal deaths per 100,000 women. Looking at racial and ethnic subgroups, the biggest differences were seen among Hispanic mothers, with 0.22 fewer maternal deaths per 100,000 women in expansion states. However, this effect was not significant among non-Hispanic white or non-Hispanic black or African American mothers,”(*Medicaid expansion linked to lower maternal mortality rates,* 2019).

The American Rescue Plan offers amenities that were not offered in previous stimulus packages. This new act stands to address long-standing coverage gaps among pregnant and postpartum women.” Currently, Medicaid covers [almost](https://www.cdc.gov/nchs/products/databriefs/db387.htm#section_3) half of births nationally, with eligibility levels [ranging](https://www.kff.org/report-section/medicaid-and-chip-eligibility-and-enrollment-policies-as-of-january-2021-findings-from-a-50-state-survey-report/) from 138% to 380% of poverty across states. States must cover pregnant women with incomes up to 138% of the federal poverty level (FPL) through 60 days postpartum (the end of the month of the 60th postpartum day). The American Rescue Plan Act allows states to extend the postpartum period to a year by filing a State Plan Amendment (SPA) to their Medicaid program,” (*Postpartum coverage extension,* 2021).

This new addendum would also include the Children’s Health Insurance Program (CHIP). A new incentive proposed in the American Rescue Plan may be able to encourage South Carolina officials to expand Medicaid coverage. This new incentive would provide a 5 percent increase to the state’s Federal Medical Assistance Program for two years. “The FMAP increase is immediately available to states and would begin in the first calendar quarter when a new expansion state incurs spending for people in the Medicaid adult expansion groups. If a state expands during the public health emergency (PHE), that state will receive both the COVID-19-related 6.2 percentage point FMAP and the new 5-percentage-point increase,” (*Summary of American Rescue Plan,* 2021). The federal government currently provides 90 percent FMAP for states that have already expanded. If South Carolina decides to expand, that would raise the federal government’s FMAP contribution to 100 percent. Funding has consistently been cited as one of the reasons why South Carolina officials continue to deny Medicaid expansion, but this new provision would allow for an additional increase in funding. Thus, reducing expansion costs. The current percentage of uninsured individuals is 10.8%, with a majority of individuals living below the poverty line. If South Carolina chooses to expand Medicaid coverage under this new plan, the number of uninsured individuals will decrease. Previously uninsured individuals would be able to obtain health coverage through Medicaid.

Hypothetically, if South Carolina did expand Medicaid services, many South Carolinians would be able to receive needed medical treatments, as well as financial rewards. The rates of the uninsured, maternal mortality, pregnancy-related death, and various other conditions are likely to decrease due to the influx of individuals seeking preventive services. If funding is no longer an issue, what’s stopping SC officials from helping their citizens.

**American Rescue Plan Continued**

On March 12th, 2021, President Biden signed into action a new COVID-19 relief package, that provides various incentives for states that have not expanded Medicaid services. States that expand their Medicaid coverage can receive 100 percent federal coverage for Medicaid. This new act also increases postpartum coverage from 60 days after birth to a full year. While these two provisions have been highly publicized, several other provisions are just as important. The Federal government is providing several incentives to entice state officials into expanding their Medicaid coverage but will state officials compromise their beliefs to better serve their citizens?

An important provision provided in this legislation is 100 percent coverage for COVID-19 vaccines and administration for Medicaid members. “The new law clarifies that COVID-19 vaccines and administration are covered without cost-sharing for Medicaid enrollees and provides 100% federal matching funds for this coverage. CMS previously had [interpreted](https://www.govinfo.gov/content/pkg/FR-2020-11-06/pdf/2020-24332.pdf) the Families First Coronavirus Response Act (FFCRA) vaccine coverage requirement to exclude certain enrollees receiving limited benefit packages. The coverage provision applies to all enrollees, except those eligible only for Medicare cost-sharing assistance (partial duals) or COBRA premium assistance, from March 11, 2021 through the last day of the 1st calendar quarter that begins at least 1 year after the COVID-19 PHE ends,” (Musumeci, 2021). This new provision would provide Medicaid enrollees and potential enrollees the opportunity to be vaccinated for COVID-19 without having to make a full or partial payment o receive it.

This bill also includes coverage of COVID-19 treatment services. The new law adds coverage of COVID-19 treatment services, without cost-sharing, for enrollees in the COVID-19 uninsured testing group and enrollees who receive alternative benefit plans (ABPs). This coverage includes specialized equipment and preventive therapies and treatment (if otherwise covered under Medicaid) of a condition that may seriously complicate the treatment of COVID-19 for those presumed to have or diagnosed with COVID-19. The [COVID-19 uninsured testing group](https://www.kff.org/coronavirus-covid-19/issue-brief/key-questions-about-the-new-medicaid-eligibility-pathway-for-uninsured-coronavirus-testing/) was created by the FFCRA and is available at state option, with 100% federal matching funds, during the PHE. The benefit package for this group previously was limited to COVID-19 testing and testing-related services,” Musumeci, 2021). For states that have expanded their Medicaid coverage, they will receive a 90% federal enhanced matching rate for individuals with alternative benefit plans (ABP). If South Carolina decides to expand their Medicaid services, the state of South Carolina would receive the 90% federal matching rate, as opposed to 6.2 percentage points being added on to their current rate. States can also receive funding for Medicaid home and community-based services. “States can receive a 10 percentage point increase in federal matching funds for [Medicaid home and community-based services](https://www.kff.org/medicaid/issue-brief/potential-impact-of-additional-federal-funds-for-medicaid-hcbs-for-seniors-and-people-with-disabilities/) (HCBS) from April 1, 2021 through March 30, 2022. The new funds must supplement, not supplant, the level of state HCBS spending as of April 1, 2021, and states must implement or expand one or more activities to enhance HCBS. HCBS help seniors and people with disabilities live independently in the community by assisting with daily self-care and household activities,”(Musumeci, 2021). Services covered under this initiative would include home-based services, such as assistance with activities of daily living (ADL’s).

The American Rescue Plan act also provides states with the option of providing community mobile crisis intervention services. These services would be provided by Medicaid enrollees who suffer from mental health issues and substance abuse disorders. “According to the Kaiser Family Foundation, “States have a new option to provide community-based mobile crisis intervention services with 85% federal matching funds for the first 3 years. The additional funds must supplement, not supplant, the level of state spending for these services in the fiscal year before the 1st quarter that a state elects this option. Services must be otherwise covered by Medicaid and provided by a multidisciplinary team to enrollees experiencing a mental health or substance use disorder crisis outside a hospital or other facility setting,” (Musumeci, 2021). The only issue with this provision is states have the option to impose restrictions on qualifications for these services. “These services generally do not have to be offered statewide, do not have to be comparable for all enrollees, and can restrict enrollees’ free choice of provider,”(Musumeci, 2021). While this particular provision would be a great way to address two current healthcare concerns, state officials could use this as a way to offset costs by restricting certain enrollees from using these services.

The incentives I discussed in this paper, as well as the incentives I previously discussed, should be the push South Carolina officials need to expand Medicaid services in our state. We need to expand our Medicaid services to eliminate the coverage gap in our state. “South Carolina’s governor and legislature have strongly rejected Medicaid expansion under the Affordable Care Act (ACA). As a result, there are about [121,000](http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/) people in the state who are in the “coverage gap” with no realistic access to health insurance. They are the state’s poorest residents, with incomes under the poverty level. They do not qualify for subsidies in the exchange and they also do not qualify for Medicaid,”(Norris, 2020). The state of South Carolina could receive up to $790 million dollars in increased funding if they expand Medicaid coverage. Our state officials are being presented with an opportunity to change the lives of thousands of its citizens, yet they continue to disregard the issue. We that expanding Medicaid would be beneficial for the entire state, but how do we make our elected officials understand this?

**American Rescue Plan:** On March 11, 2021, The Biden Administration implemented a new stimulus bill that provides benefits that were not previously included in other stimulus bills. The American Rescue Plan provides states that have not expanded Medicaid services with possible incentives if the state expands its services. This bill would also provide new coverage for pregnant and postpartum women. Many hope that these new incentives will entice South Carolina officials into expanding Medicaid services. South Carolina officials have stated that the costly expense is the reason for the denial of expanded services, but this new act provides the funding that South Carolina officials say is lacking. For states that have expanded their Medicaid coverage, they will receive a 90% federal enhanced matching rate for individuals with alternative benefit plans (ABP). If South Carolina decides to expand their Medicaid services, the state of South Carolina would receive the 90% federal matching rate, as opposed to 6.2 percentage points being added on to their current rate. The state of South Carolina could receive up to 790 million dollars in increased funding if they expand Medicaid coverage. This would help address the ongoing coverage gap for South Carolina citizens.

**Chapter 6: Conclusion**

In conclusion, all of my topics share a commonality and that is expanded Medicaid services. Our state is experiencing a profound health coverage gap. Over 500,000 South Carolinians are uninsured, but this can be changed. The American Rescue Plan act is a chance for officials to provide their citizens with the healthcare coverage they rightly deserve. Women deserve access to reproductive and postpartum services. Our elderly and disabled have earned the right to receive routine and specialized care. Finally, children should always have the right to seek healthcare. Medicaid expansion is a chance to prolong the lives of everyday people. It’s a chance for people to live a healthier life without worrying about the financial aspect of seeking healthcare. Expanding Medicaid services would help reduce the burden of chronic diseases for many individuals. To promote health is to promote life, and expanding Medicaid would do both.

**Appendix**

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