Mercer

Maternal mortality in America:

sobering reality and the employer's role

welcome to brighter

A brief introduction to maternal mortality in the United States

Today, the United States has the **highest maternal mortality rate** among high-income countries. It's also the only high-income country where this rate has been steadily *increasing*. Perhaps more shocking is that 80% of recorded pregnancy-related deaths are entirely preventable. The leading cause of hospitalization for women and birthing people is childbirth, which presents a unique opportunity for employers to intervene along the care journey, supporting expectant parents and their families throughout preconception care, pregnancy and postpartum.

A few notes on terminology:

- **Maternal morbidity** includes any short- or long-term health problems caused by pregnancy and giving birth
- **Maternal mortality** refers to the death of a birthing person from complications related to pregnancy or within the weeks and months following childbirth

As women and birthing people around the world gained access to improved living conditions, maternity care services, procedures and life-saving antibiotics throughout the 20th century, maternal morbidity and mortality rates began a slow but consistent decline. By the late '90s, however, this global downward trend in complications related to pregnancy, childbirth and postpartum care began to reverse in the United States.

At the heart of rising maternal morbidity and mortality rates lies the complex interplay between medical treatment bias, systemic racism and gender discrimination, and updated methods in maternal death surveillance[1]. In addition, recent and historical data tell us that maternal mortality is most prevalent after delivery (up to one year postpartum), when 52% of deaths occur. Almost a third of maternal deaths occur during pregnancy (31%), while the remainer (17%) occur around the time of delivery.

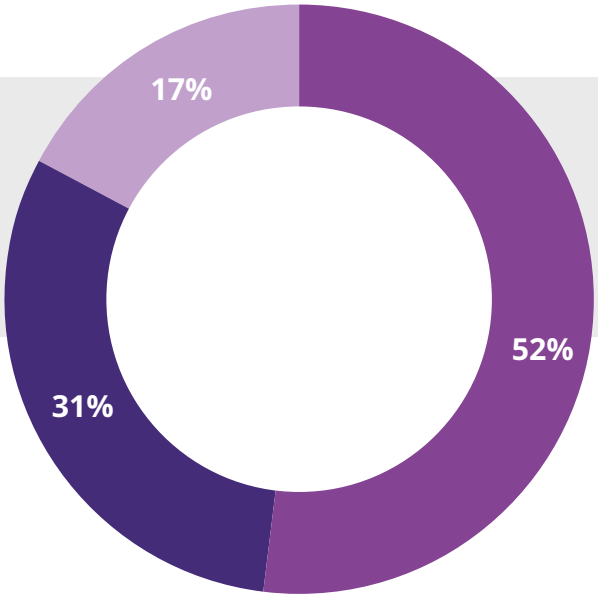
The most prevalent underlying causes of maternal mortality include: hemorrhage (13.6%), cardiovascular conditions (21.3%), hypertensive disorders of pregnancy (6.5%) and mental health conditions (22.7%). Chronic conditions such as hypertension and cardiovascular disease, which are more prevalent in certain racial and ethnic groups already, are exacerbated in pregnancy by unequal access to high-value care and limited availability of culturally sensitive and patient-centered maternal health care.

1 Data collection studies revealed that maternal mortality data was substantially undercounted until 2003, when the standard United States death certificate finally introduced a pregnancy checkbox.

As a result, pregnancy and childbirth are particularly devastating for Black women, Native women, and women and birthing people in rural communities, who experience maternal mortality and morbidity at significantly higher rates than their White and urban counterparts. For Black women, the maternal mortality rate is three times the rate for non-Hispanic White women. Another concern is the maternal mortality rate for Hispanic women, which rose disproportionately — almost doubling (increase of 44.4%) — between 2019 and 2020. These racial and ethnic disparities still hold after stratifying by other risk factors, such as socioeconomic status, educational attainment, and even expertise in racial disparities in health care.

52%

of deaths occur after delivery (up to one year postpartum)



The COVID-19 pandemic and the recent Supreme Court Dobbs ruling are exacerbating this public health emergency. The **UN Committee on the Elimination of Racial Discrimination (CERD)** has specifically issued a report on the human rights impacts of deteriorating access to comprehensive and non-discriminatory reproductive health care in the United States. Maintaining access to abortion (an essential component of women and birthing people's health care) and increasing access to culturally competent care (including doulas and midwives) is critical to reducing the high maternal mortality rate.

In addition, this crisis has been recognized by both the United Nations and the current Presidential Administration: established in 2015, the United Nations' Sustainable Development Goals 3 (Good Health and Well-Being) and 5 (Gender Equality) have called for major reductions in maternal, neonatal and child mortality and universal access to sexual and reproductive health services by 2030. More recently, in their Blueprint for Addressing the Maternal Health Crisis, the Biden-Harris Administration has urged immediate action. Maternal deaths are largely preventable, and we already know many of the key solutions. We must now make a concerted effort to meet this public health emergency head-on and reverse this trend once and for all.

The Employer's Responsibility

Maternal morbidity, which is much less discussed than maternal mortality and yet much more prevalent (estimated by the CDC to impact 50,000 women per year), has far-reaching and often long-term impacts to an individual's family and workplace. Any physical or mental health issue that hinders a member's ability to meet the needs of their family and/or job can cause significant disruption to that individual's family or work community — or both. Productivity and engagement can be lost when a member is unable to focus on the demands of their job, and can lead to a desire to leave the workforce. Retaining working parents, particularly women and women of color, is imperative, as these members provide significant value to the workforce.

Employers are in a unique position to hold health insurers and vendors accountable for the work they do and how equitable access to quality care is achieved. Without pressure from employers, insurers and vendors are unlikely to change current practice, which is missing the mark in terms of adequately supporting birthing people of color. In addition, employers can use existing benefits infrastructure to inform at-risk employees and members about their unique risks, provide them with services to help them advocate for themselves, and support them in seeking out high quality, culturally sensitive care.

Actionable Steps for Employers in Supporting Favorable Birth Outcomes

As with many areas of health, employers can look to public health initiatives and follow Medicaid's focus on trying to address the complex factors that contribute to maternal mortality and morbidity in the United States.

As childbirth remains the leading cause of hospitalization in women, primary efforts should focus on **ensuring access to quality providers of choice and reducing barriers to true and informed choice during pregnancy, birth, and early postpartum.** It is widely documented and recognized that provider characteristics impact birth outcomes. Implicit biases can cause providers to knowingly or unknowingly provide differential support, for example: dismissing a Black woman expressing discomfort or pain, providing reduced support for breastfeeding in populations where breastfeeding initiation rates are historically lower (or higher, assuming they will "just catch on") than other groups, or initiating medical intervention (such as an epidural, Pitocin induction, or Cesarean section) without receiving true informed consent from the patient. Access to both Certified Nurse Midwives and Certified Professional Midwives, whose model of care focuses on holistic, patient-centered care, and operates with the assumption that birth is a unique life event vs. a strictly medical event, is associated with significantly lower rates of intervention compared to obstetric care and a positive birth experience, should be prioritized as a solution to reducing maternal morbidity and mortality, particularly among low-risk individuals.

Midwives operate in hospital, birth center and home settings, offering birthing individuals a greater level of choice about where and how they seek prenatal care and delivery of their babies as compared to a traditional hospital setting with an OB/GYN. Midwives are trained and qualified to respond to some emergent situations, recognize risk signs throughout pregnancy (referring out to an OB/GYN or higher level facility when needed) and early in the delivery process, maintaining relationships with nearby emergency medical services and local hospitals. While the risk of home delivery comes with a slightly elevated risk of perinatal death (in the infant), outcomes for birthing women are *improved* with out-of-hospital care, even controlling for risk level.

In addition, midwives often provide a higher level of care in the postpartum period — some offering up to 3-5 visits standardly in the first 6 weeks postpartum, compared to one single visit at 6 weeks (standard of care with OB/GYN). This increased level of interaction in the early postpartum phase allows midwives to identify both physical and mental health concerns more rapidly, and avert a number of possible negative physical and mental health outcomes.

Lastly, continuous labor support from doulas is associated with lower rates of medical intervention and better birth outcomes — particularly for women of color. As doulas most standardly practice in-person support (often coupled with on-demand virtual or phone support as needed), they are often community-based, and selected by members based on "fit." Doulas are becoming more commonplace in places where birth occurs and, barring emergencies, are welcomed into any birthing situation or location. The relatively low cost of doula support can still be a barrier for members, however, for an employer wishing to avoid high maternity costs, it would represent a minimal investment with a probability for far-reaching positive impacts, both short- and long-term, for a member's physical and emotional health.

Key actions for employers include the following:

1. **Provide expectant families with financial reimbursement to cover doula support.** Ensure that members have access to a network of community-based providers who can support them in-person if desired, and that members can select doulas based on racial, ethnic, religious, gender, or sexual identity, as well as lived experience. Doula support can vary from $600-1,500 per birth depending on geography, and can be reimbursed as a tax-favored expense to the member via an HSA or FSA.

2. **Review plan language and limitations surrounding out-of-hospital birth** (at-home birth and birth centers). Ensure that the plan has realistic and practical limitations regarding facility coverage, and consider offering an out-of-network benefit to provide some level of financial benefit where health plan networks may be insufficient.

3. **Review network access and discuss network inclusion requirements with the health plan administrator for freestanding birth centers and midwives** (both Certified Nurse Midwives and Certified Professional Midwives/Licensed Midwives) using state regulations and evidence-based recommendations from leading regulatory bodies such as the CDC, ACOG, and ACNM as a guide.

4. **Hold your carrier partners and vendors accountable for provider matching capabilities,** ensuring that members can search for and select providers who self-identify with a particular race or ethnicity, sexual and/or gender orientation, lived experience, or training/expertise. Consider requesting that your health benefit consultant perform a vendor or carrier diversity, equity and inclusion audit.

5. **Collect race and ethnicity data from your members,** send it on eligibility files to your vendors, hold your vendors accountable for health outcomes stratified by race and ethnicity.

6. **Review your health plan's maternity coverage.** Ensure that members have access to on-demand (virtual) health support and in-person coverage for various types of providers and practitioners, including alternative providers such as chiropractors, pelvic floor physical therapists, midwives, IBCLCs and doulas.

In addition to increasing access to providers, employers should ensure that their culture and policies support pregnant, birthing and newly postpartum individuals through the below actions:

7. **Provide strong support to members in the first 12 months postpartum and beyond,** through generous paid parental leave, 24/7 access to virtual lactation consultants (IBCLC designation) and infant nutritionists, virtual behavioral health options, and phased return to work programs. Consider how an individual's physical and cultural work environment may impact their post-return-to-work experience, like ergonomic comfort or a comfortable lactation space.

8. **Provide managers with specific training on how to support expectant and new parents of all genders and family makeups** to reduce stigma associated with talking about pregnancy and birth, as well as lactation.

9. **Reset the standards for benefits communications within your organization.** Use inclusive images and language. Package communications for expectant and new families to navigate them to all relevant services, policies and benefits they may need during their journey into parenthood.