

Written Testimony

Of

The American College of Obstetricians and Gynecologists

Before the

House Committee on Education and Labor

Regarding the Hearing

Expecting More: Addressing America's Maternal and Infant Health Crisis

January 28, 2020

Chairman Scott, Ranking Member Foxx, and distinguished members of the Education and Labor Committee, thank you for the opportunity to submit this statement for the Committee's record of its hearing entitled "Expecting More: Addressing America's Maternal and Infant Health Crisis". The American College of Obstetricians and Gynecologists (ACOG), with a membership of more than 60,000, is the leading physician organization dedicated to advancing women's health. Key to that mission is our core value that all women should have access to affordable, high-quality, safe health care.

As members of the Committee know, and the title of this hearing reinforces, the United States is in crisis. More than 700 women die each year in the United States from pregnancy-related or pregnancy-associated complications.¹ The U.S. has a higher maternal mortality rate than any other industrialized country. At a time when 157 of 183 countries in the world report decreases in rates of maternal mortality, ours is rising.²

According to the Centers for Disease Control and Prevention (CDC), over 60 percent of maternal deaths are preventable.³ Common causes include hemorrhage, cardiovascular and coronary conditions, cardiomyopathy, and infection. Overdose and suicide, driven primarily by the opioid epidemic, are also emerging as leading causes of maternal mortality in a growing number of states.⁴

Non-Hispanic Black women experience three to four times the rate of maternal mortality than non-Hispanic White women and disparities persist even when controlling for socioeconomic status.⁵ Native American/Alaska Native women are two to three times more likely to experience a pregnancy-related mortality.⁶ For every maternal death in the United States, there are 100 women who experience severe maternal morbidity, or a "near miss". These numbers are unacceptable. ACOG is committed to our goal of eliminating preventable maternal deaths and to eliminating the unacceptable racial disparities in maternal health outcomes. We are eager to continue our strong partnership with this Committee and other valuable partners to achieve this important goal.

We applaud you and your colleagues in the US Congress for taking an important first step last Congress in passing the Preventing Maternal Deaths Act, P.L. 115-344, to encourage states to create and expand maternal mortality review committees (MMRCs). MMRCs are multidisciplinary groups of state experts in maternal and public health, as well as community advocates, that review individual maternal deaths and identify actionable recommendations to reduce preventable maternal deaths. While traditional public health surveillance using vital

¹ *Building U.S. Capacity to Review and Prevent Maternal Deaths*. (2018). Report from nine maternal mortality review committees. Retrieved from http://reviewtoaction.org/Report_from_Nine_MMRCs

² *Reducing Maternal Mortality in the United States*. Lu MC. JAMA. Published online September 10, 2018. doi:10.1001/jama.2018.11652

³ *Building U.S. Capacity to Review and Prevent Maternal Deaths*. (2018). Report from nine maternal mortality review committees. Retrieved from http://reviewtoaction.org/Report_from_Nine_MMRCs

⁴ Ibid.

⁵ *Pregnancy Mortality Surveillance System*. Centers for Disease Control and Prevention. Available at: <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html>

⁶ *Vital Signs: Pregnancy-Related Deaths, United States, 2011–2015, and Strategies for Prevention, 13 States, 2013–2017*. Petersen EE, Davis NL, Goodman D, et al. MMWR Morb Mortal Wkly Rep 2019;68:423–429. DOI: <http://dx.doi.org/10.15585/mmwr.mm6818e1>

statistics can tell us about trends and disparities, MMRCs are best positioned to comprehensively assess and characterize maternal deaths, to understand the causes and contributing factors and identify opportunities for prevention.

Eliminating racial disparities in maternal health outcomes

We need action and policies that work to eliminate preventable maternal mortality and that seek to eliminate unacceptable racial disparities in maternal health outcomes.

At ACOG, we are committed to addressing implicit bias, structural racism, and increasing the provision of culturally competent care. Our Committee Opinion No. 649 *Racial and Ethnic Disparities in Obstetrics and Gynecology* calls upon obstetrician–gynecologists and other health care practitioners to “acknowledge the role they play in perpetuating health care disparities” and to “advocate for a system of more culturally and linguistically appropriate care for all.”⁷

ACOG is working with our partners at the National Birth Equity Collaborative and the California Maternal Quality Care Collaborative to eliminate preventable maternal mortality by raising up the voices and experiences of Black women through Mother’s Voices Driving Birth Equity, a project funded by the Robert Wood Johnson Foundation. This work is being led by Black scholars to better understand Black women’s birth experiences in different geographic regions. Through this project, we will be able to incorporate patient voices and lived experiences in our patient safety work. If we hope to change how care is delivered, we must ensure that the methods hospitals and clinicians use to address implicit bias and racism align with Black women’s needs, values, and preferences.

In partnership with the U.S. Health Resources and Services Administration (HRSA), ACOG is also working to reduce maternal mortality and eliminate disparities in outcomes through the Alliance for Innovation on Maternal Health (AIM). AIM is a national, cross-sector, data-driven maternal safety and quality improvement initiative focused on increasing and supporting the adoption of evidence-based maternal safety best practices to promote safe maternal healthcare for every U.S. birth. AIM assists state-based teams and health systems with the implementation of maternal safety bundles. These bundles seek to improve the quality and safety of maternity care with the goal of reducing maternal deaths and severe maternal morbidity, including the stark racial and ethnic disparities in maternal health outcomes, by engaging health care organizations, state-based public health systems, consumer and patient advocacy groups, and other stakeholders within a national partnership to assist state-based teams in implementing evidence-based maternal safety best practices. The Reduction in Peripartum Disparities Bundle outlines best practices for physicians and health professionals to implement to address disparities in outcomes.

At ACOG, we are committed to addressing implicit bias, structural racism, and increasing the provision of culturally competent care to our patients and we urge Congress to support legislation to help combat this crisis.

⁷ *Racial and ethnic disparities in obstetrics and gynecology*. Committee Opinion No. 649. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2015;126:e130–4.

Support for workplace accommodations for breastfeeding mothers

ACOG strongly supports breastfeeding as the preferred method of feeding for newborns and infants and recommends exclusive breastfeeding until the infant is approximately six months of age, with continued breastfeeding as complementary foods are introduced during the infant's first year of life, or longer, as mutually desired by the woman and her infant.⁸ Enabling women to breastfeed is a public health priority. Interruption of lactation is associated with adverse health outcomes for infants, including greater infant risk of infectious disease, sudden infant death syndrome, and metabolic disease. Equally important, there are long term adverse health implications for maternal health, including higher maternal risks of breast cancer, ovarian cancer, diabetes, hypertension, and heart disease. Maintaining milk supply depends largely on frequency of milk removal through breastfeeding and through expressing milk (breast pumping or manual expression) when the woman and her infant are separated. Policies that protect the right of a woman and her child to breastfeed in public and that accommodate milk expression, such as insurance coverage for breast pumps, paid maternity leave, on-site childcare, break time for expressing milk, and a clean, private location for expressing milk, are essential to sustaining breastfeeding.⁹

While the Patient Protection and Affordable Care Act (ACA) amended the Fair Labor Standards Act to require employers to provide a nursing mother reasonable break time and a place that is shielded from view and free from intrusion to express milk for one year after childbirth, a gap in the law allows for the exclusion of 9 million employees from these workplace accommodations, including salaried employees, such as teachers. ACOG supports H.R. 5592, the Providing Urgent Maternal Protections for Nursing Mothers Act, which would close this gap by extending the ACA's workplace protections to cover salaried employees and others currently exempt from protections. We urge swift passage of this bill to ensure that nursing mothers have adequate protections in the workplace.

Importance of coverage for prenatal and maternity care

ACOG strongly believes that essential maternity care benefits, including prenatal care, should be guaranteed for all women, regardless of where they get their coverage; maternity coverage should be uniform and affordable under all insurance; and pregnancy and preventative care should be offered without cost-sharing.¹⁰ ACOG supports a core package of benefits for all women, regardless of their health, age, employment status, or where they live. All coverage sources, including employer-sponsored, individually purchased insurance, insurance obtained as a dependent, and public programs, should comply with this essential benefit standard. Out-of-pocket expenses should be minimized, and women should not be charged higher premiums than men for equivalent services.

⁸ *Optimizing support for breastfeeding as part of obstetric practice*. ACOG Committee Opinion No. 756. American College of Obstetricians and Gynecologists. Obstet Gynecol 2018;132:e187–96.

⁹ Ibid.

¹⁰ *Women's Health in Health Care Reform: Essential Insurance Reforms*. ACOG Department of Government Relations and Outreach. April 2009. Retrieved from: <https://www.acog.org/-/media/Departments/Members-Only/Government-Relations-and-Outreach/2017-Health-Care-Reform/2010EssentialInsuranceReforms.pdf?dmc=1>

With the standardized cost of maternity care being \$29,314,¹¹ it is clear the only way women can afford maternity care is with health insurance. Uninsured women face even greater costs without access to free prenatal care. However, even for women who are insured, coverage may not be sufficient to cover the cost of maternity care. According to a Kaiser Family Foundation analysis, many middle class families do not have the resources to meet the deductibles in private health plans.¹² A recent study showed that between 2008 and 2015, average out-of-pocket spending for maternity care rose among women with employer-based coverage even though the overall cost of maternity care remained stable.¹³ The authors concluded that women with deductibles were paying for a higher proportion of maternity care services over time. Unfortunately, with more than half of births in the U.S. being unplanned,¹⁴ what a woman needs in a health plan mid-year can suddenly be very different from what it was during open enrollment if she wasn't planning on getting pregnant. Switching health plans can provide the financial protection pregnant women and their families need during this life-changing period.

Although the ACA has added many protections for pregnant women, including making maternity care an Essential Health Benefit and requiring plans to cover prenatal care with no cost-sharing, it should go further by allowing women to pick and switch plans with lower out-of-pocket costs when they become pregnant.

As our testimony outlines, the United States is in crisis and swift policy solutions are needed to help combat a rising maternal mortality rate, and eliminate unacceptable racial disparities. As Congress considers actions to take in the 116th Congress, ACOG urges you to prioritize passage of H.R. 4995, the Maternal Health Quality Improvement Act, and H.R. 4996, the Helping Medicaid Offer Maternity Services Act. These bills are critically important eliminating preventable maternal deaths.

H.R. 4995 would accelerate evidence-based patient safety changes and move the needle in maternal mortality by:

- **Authorizing the Alliance for Innovation on Maternal Health (AIM) program, to help ensure implementation of best practices and eliminate preventable maternal mortality and severe maternal morbidity for every U.S. birth.** The *Maternal Health Quality Improvement Act* would authorize the AIM program, an initiative of the Health Resources Services Administration (HRSA), and provide support to advance evidence-

¹¹ *Out-Of-Pocket Spending For Maternity Care Among Women With Employer-Based Insurance, 2008–2015*. Moniz, MH, Fendrick, AM, Kolenic, GE, et al., Health Affairs Blog. Vol. 39, No. 1. Retrieved from: <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.00296>

¹² *Consumer Assets and Patient Cost Sharing*. Claxton, G, Rae, M, Panchal, Nirmita. Kaiser Family Foundation. February 2015. Retrieved from: <http://files.kff.org/attachment/issue-brief-consumer-assets-and-patient-cost-sharing>

¹³ *Out-Of-Pocket Spending For Maternity Care Among Women With Employer-Based Insurance, 2008–2015*. Moniz, MH, Fendrick, AM, Kolenic, GE, et al., Health Affairs Blog. Vol. 39, No. 1. Available at: <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.00296>

¹⁴ *Unintended Pregnancy in the United States*. Guttmacher Institute. January 2019. Available at: <https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states>

based practices to improve the quality and safety of maternity care throughout the care continuum.

- **Addressing racial and ethnic health disparities through implicit bias training and increasing the provision of culturally competent care.** Research suggests that stereotyping and implicit bias on the part of health care providers can contribute to racial and ethnic disparities in health outcomes.¹⁵ Providing support for training programs to eliminate and prevent discrimination in the provision of health care services can combat implicit biases and improve cultural competency in provider-patient communications and the provision of care.
- **Supporting state-based perinatal quality collaboratives working with providers, hospitals, and public health officials to implement best practices.** With the *Preventing Maternal Deaths Act*, Congress made a significant commitment to discovering the drivers of maternal mortality and identifying opportunities to prevent future tragedies. However, the investment in state Maternal Mortality Review Committees (MMRCs) is only beneficial if the data gathered leads to meaningful and timely action. Perinatal quality collaboratives (PQCs) – networks of health care providers, systems, public health professionals and other stakeholders – translate MMRC recommendations into policy and health care practice changes that will save women’s lives. For years, state-based PQCs have improved health outcomes for women and infants and lowered health care costs. For example, from September 2008 to March 2015, Ohio’s PQC achieved an estimated cost savings of over \$27,789,000 associated with a shift of 48,400 births to 39 weeks gestation or greater and a 68% decline in the rate of deliveries at less than 39 weeks gestation without a medical indication.¹⁶ Appropriately resourced, PQCs can provide the network and infrastructure to facilitate system-wide implementation of MMRC recommendations.
- **Improving access to obstetric care in rural areas through the creation of rural obstetric network grants, enhanced data collection, and telehealth programs.** Women living in rural areas have less health care access and experience poorer health outcomes than women living in urban areas,¹⁷ a trend exacerbated by the rapid rate of rural hospital closures and shuttering of obstetric units. Establishing rural obstetric networks, training providers in rural communities, and expanding access to telehealth services will help close the access gap for the approximately 500,000 women who give birth each year in rural hospitals.¹⁸

H.R. 4996 is also critical to eliminating preventable maternal deaths by allowing states the option to extend continuous Medicaid or CHIP eligibility for women for one year postpartum. Medicaid is the largest single payer of maternity care in the U.S., covering 42.6%

¹⁵ *Racial and ethnic disparities in obstetrics and gynecology*. Committee Opinion No. 649. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2015;126:e130–4. <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Racial-and-Ethnic-Disparities-in-Obstetrics-and-Gynecology>

¹⁶ *About Perinatal Quality Collaboratives*. Centers for Disease Control and Prevention. Available at:

<https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pqc.htm#success>

¹⁷ *Health disparities in rural women*. Committee Opinion No. 586. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2014;123:384–8.

¹⁸ *As Rural Hospitals Struggle, Some Opt To Close Labor And Delivery Units*. Andrews, M. Kaiser Health News (2016, February 23). Retrieved from <https://khn.org/news/as-rural-hospitals-struggle-some-opt-to-close-labor-and-delivery-units/>

of births.¹⁹ However, Medicaid pregnancy coverage ends roughly 60-days postpartum. As many MMRCs have found, and the CDC has confirmed, about 33% of pregnancy-related deaths occur during the time between 7 days to one year following childbirth, and greater than one third of those deaths occurred 43-365 days postpartum.²⁰ Deaths from preventable causes, including overdose and suicide, occur more frequently during this 12-month postpartum period.²¹ Closing this critical gap in coverage during this vulnerable time can mean the difference between life and death for many mothers. The *Helping Medicaid Offer Maternity Services Act* represents a positive step forward, and we urge its swift passage.

Thank you for the opportunity to provide testimony. With the help of this Committee, we can continue to make significant and meaningful progress on the path to better maternal outcomes. We look forward to working together with you to eliminate preventable maternal mortality and the unacceptable racial disparities in maternal health outcomes. Through this work, we can improve the lives of women, families, and communities.

¹⁹ *Births: Final Data for 2016*. National vital statistics reports; Martin JA, Hamilton BE, Osterman MJK, Driscoll AK, and Drake P. (2018, January 31) vol 67 no 1. Hyattsville, MD: National Center for Health Statistics. Retrieved from https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_01.pdf.

²⁰ *Vital Signs: Pregnancy-Related Deaths, United States*. Petersen EE, Davis NL, Goodman D, et al., 2011–2015, and Strategies for Prevention, 13 States, 2013–2017. MMWR Morb Mortal Wkly Rep 2019;68:423–429. DOI: <http://dx.doi.org/10.15585/mmwr.mm6818e1>.

²¹ *For Addicted Women, the Year After Childbirth Is the Deadliest*. Vestal, Christine. (2018, August 14) Pew Stateline. Retrieved from <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2018/08/14/for-addicted-women-the-year-after-childbirth-is-the-deadliest>.