Statement for the Record Submitted by
Stacey D. Stewart, President and CEO, March of Dimes
Hearing of the House Committee on Oversight and Reform
"Birthing While Black: Examining America's Black Maternal Health Crisis"
Thursday, May 6, 2021, 11 A.M.

On behalf of March of Dimes, the nonprofit organization leading the fight for the health of all moms and babies, we appreciate this opportunity to submit testimony for the record. We began that fight more than 80 years ago as an organization dedicated to eradicating polio in the U.S., a goal that we achieved. We continue that fight today as we work to address some of the biggest threats to moms and babies, such as premature birth and maternal mortality, through research, education, programs and advocacy.

March of Dimes' ongoing work to improve maternal and infant health is more important than ever as our nation is in the midst of a dire maternal and infant health crisis. Rates of preterm birth are increasing, the U.S. is one of the most dangerous places to give birth in the developed world, and there are unacceptable disparities in birth outcomes between women and infants of color and their White peers.

We know the pandemic has only worsened this crisis. According to CDC data, expectant mothers with the virus had a 50 percent higher chance of being admitted to intensive care and a 70 percent higher chance of being intubated than non-pregnant women in their childbearing years.[i] The data also shows pregnant Latina and Black women were infected at higher rates than White woman. As we know, COVID-19 strikes the respiratory and cardiovascular systems, which are the two systems already strained during pregnancy.

Pregnancy affects every system in a woman's body and the immune system changes so that it can protect not only the mother, but the baby. This can make pregnant women more susceptible to certain infections as different parts of the immune system are enhanced while others are suppressed. Therefore, it is crucial that pregnant and lactating women have access to COVID-19 vaccines. They must be included in vaccine trials so that there is data to allow them to make informed decisions with their medical providers about getting the vaccine and to ensure that the vaccine is safe and effective for them.

We also know, the health and well-being of mothers and infants are inextricably linked. By improving the health of women before, during and between pregnancies, we can improve outcomes for both them and their infants. But we have many challenges before us.

OUR NATION IS IN THE MIDST OF A MATERNAL AND INFANT HEALTH CRISIS

Nearly every measure of the health of pregnant women, new mothers, and infants living in the U.S. is going in the wrong direction. In many communities, infant mortality rates exceed those in developing nations.[ii] Approximately every 12 hours, a woman dies due to pregnancy-related complications.[iii]

Preterm Birth

Each year, March of Dimes releases its annual Report Card grading the U.S., each of the states, DC, and Puerto Rico, on their progress toward improving maternal and infant health.[iv] Our most recent 2020 report found the nation's preterm birth rate rose for the fifth year in a row in 2019 to 10.2 percent. This startling increase comes after nearly a decade of decline. As you might expect, the worsening national picture does not signal good news in individual states. Between 2018 and 2019, preterm birth rates worsened in 38 states. While we have four states, New Hampshire, Oregon, Vermont, and Washington, earning a B+, we have eight states and one territory earning a F. What do these statistics mean for the nation's families? They mean 1 in every 10 babies are born preterm, which can lead to life-long health problems and, in the most tragic cases, a baby's death.

These topline numbers tell only part of the story. Diving deeper into the data highlights an even starker reality for certain communities. With preterm birth rates as high as 14.6 percent (Mississippi), 13.1 percent (Louisiana), and 12.5 percent (Alabama), infants born in the southeastern U.S. are much more likely to be born early than in other parts of the country. Racial disparities exist across the U.S., Hispanic, American Indian/Alaska Native, and Black babies are born premature at a rate surpassing their White peers. In fact, the preterm birth rate among Black women is 50 percent higher than the rate among all other women-combined.

Maternal Health

The state of maternal health mirrors that of infants born too soon. Outcomes are getting worse and those worsening outcomes are driven by disparities. Each year, about 700 women die from complications related to pregnancy.[v] For every maternal death, another 70 women suffer life-threating health challenges. That's over 50,000 women each year.[vi] While other countries have reduced their maternal mortality rates since the 1990s, the U.S. maternal mortality rate continues to rise.[vii]

The threat of maternal mortality and morbidity is especially acute for women of color. Black mothers of all ages are three times more likely to die from pregnancy-related complications than their White peers.[viii] The rates of pregnancy-related death for Black and American Indian/Alaska Native women over the age of thirty are 4 to 5 times higher than their White peers.[ix] Black women are 27 percent more likely to experience severe pregnancy complications than White women.[x] These disparities cannot be explained by differences in age or education. According to the latest CDC data, maternal mortality rates among Black women with a completed college education or higher was 1.6 times that of White women with less than a high school diploma.[xi]

Maternal mortality is also significantly higher in rural areas, where obstetric providers may not be available[xii] and delivery in rural hospitals is associated with higher rates of postpartum hemorrhage.[xiii] In September 2020, March of Dimes released an updated report showing that 2.2 million women of childbearing age live in "maternity care deserts," which are counties without a hospital, birth center or providers offering obstetric services.[xiv] An additional 4.8 million women of childbearing age live in counties with limited access to maternity care. Each year, 150,000 babies are born to mothers living in these maternity care deserts.[xv]

But it is not just access to quality prenatal care that makes the difference. Improving the health of a mom before she becomes pregnant and in the postpartum period are essential to maternal and infant health. Chronic conditions begin long before a woman becomes pregnant, such as high blood pressure, diabetes, heart disease and obesity, putting women at higher risk of pregnancy complications and must be appropriately managed. We know that more than one-third of pregnancy-related deaths from 2011 to 2016 were associated with cardiovascular conditions.[xvi]

We also know the "4th trimester," the 12-week period immediately after birth, is a vulnerable time for moms, babies and families and so it is imperative to ensure mothers are receiving adequate care during this postpartum period. About 1 in 8 women experience symptoms of postpartum depression.[xvii] These conditions are the most common complication of pregnancy and childbirth, impacting an estimated 800,000 women in the U.S. each year.[xviii]

Sadly, maternal mental health conditions often go undiagnosed and untreated, increasing the risk of multigenerational long-term negative impact on the mother's and child's physical, emotional, and developmental health, and the risk of poor health outcomes. **Furthermore, women of color and women who live in poverty are disproportionately impacted by both the pandemic and maternal mental health conditions, experiencing both at rates 2-3 times higher than White women.**[xix] [xx]

A MULTIFACETED RESPONSE IS NECESSARY

This has led to an urgent crisis that demands a comprehensive response by policymakers. The causes of our nation's maternal and infant health crisis are complex, and there is still much we do not know. That is why March of Dimes was pleased Congress passed the *Preventing Maternal Deaths Act* (P.L. 115-344) and the *PREEMIE Reauthorization Act* (P.L. 115-328) in late 2018. Both bills enable the continuation of vital programs to collect enhanced data on the causes of maternal mortality and premature birth, respectively, and translate that data into meaningful action to prevent future deaths. However, addressing the maternal and infant health crisis demands additional Congressional effort that can be taken immediately.

March of Dimes recommends Congress take action without further delay on the following policies as part of a comprehensive plan to address the maternal health crisis:

- Recently, Congress took a positive step in the right direction by passing the *American Rescue Plan Act of 2021* (P.L. 117-2), which includes an option for states to extend

postpartum coverage from 60 days to 12 months. While this is a significant improvement it is one we need to build on. Congress must take the next step and make one year of Medicaid and CHIP coverage after birth a permanent, mandatory policy across the nation.

- That is why we have long supported the *Mothers and Offspring Mortality and Morbidity Awareness (MOMMA) Act* that would require all states to extend Medicaid postpartum coverage to one year. In addition, this legislation includes other key provisions to enhance Maternal Mortality Review Committees (MMRCs), standardize data collection and reporting, improve access to culturally competent care, and incentivize doula support services.
- March of Dimes is also a supporter of the *MOMMIES Act* that would mandate postpartum coverage for women served by Medicaid and CHIP, create a maternity care home demonstration project, and require important reports on access to doula care and how states are using telehealth to increase access to maternity care.
- In another step forward in improving care for women in rural areas, the House of Representatives voted last year to approve on a bipartisan basis the *Maternal Health Quality Improvement Act of 2019*, a bill we have supported since its introduction. But this legislation was left unfinished at the end of last session. Now, Congress must work to move this legislation across the finish line. This legislation would:
    - Address racial and ethnic disparities in maternal and infant health outcomes by providing support for training programs to address provider implicit and explicit bias, an important first step to eliminate systemic barriers in health care that perpetuate inequities in maternal health outcomes.
    - Authorize important public health initiatives to implement evidence-based practices and systems change. Both the Alliance for Innovation on Maternal Health (AIM) program and state-based perinatal quality collaboratives (PQCs) are initiatives with a record of success in advancing evidence-based or evidence-informed practices to improve the quality of maternity and newborn care. These programs are positioned to facilitate implementation of recommendations from state MMRCs and other expert bodies. Authorizing AIM and PQCs will ensure that the promise of new data and evidence to improve maternity care is quickly realized.
    - Improve care for women in underserved areas by establishing rural obstetric networks, training providers in rural communities and expanding access to telehealth services will help close the access gap for the 150,000 mothers living in maternity care deserts that give birth each year.

- We strongly support the Black Maternal Health Caucus and efforts to advance *The Black Maternal Health Momnibus Act of 2021*, legislation that is critical to filling the gaps in existing policies to improve health outcomes for Black moms. This legislation is composed of twelve individuals bills that would:

- Make critical investments in social determinants of health that influence maternal health outcomes, like housing, transportation, and nutrition. *(Social Determinants for Moms Act)*
- Provide funding to community-based organizations that are working to improve maternal health outcomes and promote equity. *(Kira Johnson Act)*
- Comprehensively study the unique maternal health risks facing pregnant and postpartum veterans and support VA maternity care coordination programs. *(Protecting Moms Who Served Act)*
- Grow and diversify the perinatal workforce to ensure that every mom in America receives culturally congruent maternity care and support. *(Perinatal Workforce Act)*
- Improve data collection processes and quality measures to better understand the causes of the maternal health crisis in the United States and inform solutions to address it. *(Data to Save Moms Act)*
- Support moms with maternal mental health conditions and substance use disorders. *(Moms Matter Act)*
- Improve maternal health care and support for incarcerated moms. *(Justice for Incarcerated Moms Act)*
- Invest in digital tools like telehealth to improve maternal health outcomes in underserved areas. *(Tech to Save Moms Act)*
- Promote innovative payment models to incentivize high-quality maternity care and continuity of insurance coverage from pregnancy through labor and delivery and up to 1 year postpartum. *(IMPACT to Save Moms Act)*
- Invest in federal programs to address the unique risks for and effects of COVID-19 during and after pregnancy and to advance respectful maternity care in future public health emergencies. *(Maternal Health Pandemic Response Act)*
- Invest in community-based initiatives to reduce levels of and exposure to climate change-related risks for moms and babies. *(Protecting Moms and Babies Against Climate Change Act)*
- Promote maternal vaccinations to protect the health and safety of moms and babies. *(Maternal Vaccination Act)*

- We also strongly support other family support policies like the *Family and Medical Insurance Leave (FAMILY) Act and Healthy Families Act.* Access to paid family leave and sick day benefits supports parent-infant attachment, establishing an essential foundation for safe, stable, nurturing relationships and parenting practices that promote optimal infant health and development. These benefits include improved establishment and maintenance of breastfeeding and on-time routine childhood vaccinations. Paid leave also generates important maternal health outcomes, including association with reduced depressive symptoms.

March of Dimes thanks the Committee for focusing attention on the nation's urgent maternal and infant health crisis, and in particular the poor health outcome faced by black and brown women. As we work on advancing aggressive new policies like the *Black Maternal Health Momnibus Act*, Congress must also invest more in and sustain the HHS programs already in our

toolbox to fight this crisis. With your help, we can make strides to prevent preterm birth, end preventable maternal deaths, and address the maternal health disparities that impact black mothers, infants and their families. March of Dimes stands ready to work with you to achieve that change.

---

[i] https://www.cdc.gov/mmwr/volumes/69/wr/mm6925a1.htm

[ii] Ingraham, C. Our infant mortality rate is a national embarrassment. *Washington Post*. September 29, 2014. Available at https://www.washingtonpost.com/news/wonk/wp/2014/09/29/our-infant-mortality-rate-is-a-national-embarrassment/

[iii] March of Dimes. Nowhere to Go: Maternity Care Deserts Across the U.S. October 2018. Available at: https://www.marchofdimes.org/materials/Nowhere_to_Go_Final.pdf.

[iv] 2020 March of Dimes Report Card. March of Dimes. November 2020. Available at: https://www.marchofdimes.org/mission/reportcard.aspx.

[v] Centers for Disease Control and Prevention. Maternal Mortality. September 4, 2019. Available at: https://www.cdc.gov/reproductivehealth/maternal-mortality/index.html.

[vi] Ibid.

[vii] Centers for Disease Control and Prevention. Severe Maternal Morbidity in the United States. November 27, 2017. Available at: https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html.

[viii]Petersen EE, Davis NL, Goodman D, et al. Vital Signs: Pregnancy-Related Deaths, United States, 2011–2015, and Strategies for Prevention, 13 States, 2013–2017. *Morbidity and Mortality Weekly Report*. May 10, 2019. Available at: http://dx.doi.org/10.15585/mmwr.mm6818e1.

[ix] Petersen EE, Davis NL, Goodman D, et al. Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016. *Morbidity and Mortality Weekly Report*. September 6, 2019. Available at: http://dx.doi.org/10.15585/mmwr.mm6835a3.

[x] Leonard SA, Main EK, Scott KA, et al. Racial and ethnic disparities in severe maternal morbidity prevalence and trends. Annals of Epidemiology 2019:33:30-36. Available at https://www.sciencedirect.com/science/article/pii/S1047279718308998.

[xi] Ibid.

[xii] Faron, Dina. Maternal Health Care is disappearing in rural America. *Scientific American*, February 15, 2017. Available at: https://www.scientificamerican.com/article/maternal-health-care-is-disappearing-in-rural-america/.

[xiii] Kozhimannil KB, Thao V, Hung P, Tilden E, Caughey AB, Snowden JM. Association between hospital birth volume and maternal morbidity among low-risk pregnancies in rural, urban, and teaching hospitals in the United States. *American Journal of Perinatology*. 2016 May;33(6):590-9.

[xiv] March of Dimes. Nowhere to Go: Maternity Care Deserts Across the U.S. September 2020. Available at: https://www.marchofdimes.org/materials/2020-Maternity-Care-Report.pdf

[xv] ibid.

[xvi] Centers for Disease Control and Prevention. Pregnancy Mortality Surveillance System. October 10, 2019. Available at https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm.

[xvii] https://www.cdc.gov/reproductivehealth/depression/index.htm

[xviii] Maternal Mental Health Leadership Alliance. Maternal Mental Health Advocacy Day Fact Sheet. Available at: https://www.mmhla.org/mmhresources/.

[xix] Howell, E., et al. (2005). Racial and Ethnic Differences in Factors Associated With Early Postpartum Depressive Symptoms. Obstet Gynecol.

[xx] https://swhr.org/the-disproportionate-impact-of-covid-19-on-women-of-color/