Call the Midwife:

Improving Maternal Mortality in the United States

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ABSTRACT

Maternal mortality rates in the United States have been steadily rising over the past two decades, and it is imperative that coordinated federal action is taken to prevent further deaths. This policy brief analyzes several alternatives to address rising maternal mortality rates. Due to the urgent nature of the issue, this memorandum focuses primarily on solutions that can be implemented to reduce deaths immediately. This policy brief recommends that Congress fully incorporating midwives into the American healthcare system by requiring public and private insurers to cover midwife services, increasing reimbursement equity for midwife services, and reducing restrictions on where and how midwives can practice.

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PROBLEM

The United States is in the midst of a rising maternal mortality crisis and, without a concerted effort to reduce maternal deaths, will continue to worsen. In 2021, the United States' maternal mortality rate rose to 32.9 maternal deaths per 100,000 live births, nearly three times that of other developed nations. This figure has been steadily increasing over the past three decades despite an overall decline in other parts of the developed world (Katella 2023; UNICEF 2023; CDC 2021). The maternal mortality rate measures the number of maternal deaths per 100,000 live births during or within 42 days of the end of a pregnancy (Collier and Molina 2020).

The crisis worsened with the onset of the COVID-19 pandemic, during which maternal mortality rates jumped by 60% in just three years, with over 1,000 maternal deaths in 2021 alone (CDC 2023). Maternal mortality rates in the U.S. also differ widely based on race and ethnicity, and mortality rates are especially high among Black women. The maternal mortality rate for Black women reached a new high in 2021 of 69.9 deaths per 100,000 live births, over twice the national average (Katella 2023).

Mortality rates also vary widely by state, ranging from a low of 10.10 deaths per 100,000 live births in California to a high of 43.50 in Arkansas (World Population Review 2025). This range indicates that state-led solutions are inconsistent and a coordinated national response is necessary to ensure equitable outcomes across states. The vast majority of maternal deaths—over 80 percent—are preventable and are typically caused by factors including chronic health conditions, lack of adequate prenatal care, and age (Trost et al. 2022; Chakhtoura et al. 2019, 180).

Chronic Health Conditions and a Lack of Prenatal Care

Certain pre-existing health conditions like cardiovascular disease or asthma can increase the risk of pregnancy-related complications, especially if they have not previously been identified or are not adequately managed during a pregnancy. As such, access to quality primary care services as well as prenatal care is crucial to ensure that chronic health conditions are identified and managed for the duration of a pregnancy.

Complications related to pre-existing chronic health conditions are the fastest growing cause of maternal mortality, accounting for roughly half of all maternal deaths. According to a 2018 report from nine maternal mortality review committees (MMRCs), the most common underlying conditions include heart disease and mental health conditions (Collier and Molina 2020). The prevalence of chronic conditions among the U.S. childbearing population has also increased in recent years (Admon et al. 2018).

However, many women lack access to the kind of early prenatal care that would allow them to identify and treat chronic conditions that might cause complications. Prenatal care has been shown to result in better birth outcomes and lower mortality rates, but many women face significant barriers in accessing adequate care. In 2016, roughly a quarter of American women received prenatal care late in their pregnancies or received fewer prenatal visits than is medically recommended (Novoa 2020).

Significant barriers to accessing care include cost of care both with and without health insurance, and lack of access to adequate care. Many women delay prenatal care because of financial barriers, which are compounded by the shortage of maternity care providers. In 2017, the American College of Obstetricians and Gynecologists (ACOG) reported that roughly half of U.S. counties lack any obstetrician-gynecologists (OB-GYNs), with women in rural areas facing the most acute shortages (Marsa 2018).

Advanced maternal age (AMA) or so-called geriatric pregnancies in which the mother is 35 years of age or older are typically associated with greater risk, and the average maternal age in the United States has steadily increased over the past three decades. Many women are waiting longer to have children. As a result, birth rates for women in their 30s have increased significantly (Morse 2022). Since 1990, fertility rates from women ages 20-24 have decreased by 43%, while fertility rates for women ages 30-39 have increased 67%. In 2022, 19% of all pregnancies were among women over 35.

Women over 35 are more vulnerable to complications like preterm labor and preeclampsia and are more likely to have multiple chronic conditions that can cause complications during or after a pregnancy (Glick et al. 2021; Gantt et al. 2022).

CURRENT SOLUTIONS

States have taken some action in recent years to mitigate maternal deaths, but these efforts have largely fallen short in addressing the root causes of maternal deaths. In 2018, Congress passed the Preventing Maternal Deaths Act (H.R. 1318), which strengthened maternal mortality review committees (MMRCs). MMRCs are state committees tasked with reviewing reports of maternal deaths to develop a greater understanding of the root causes of maternal mortality. While these committees have proven to be a valuable source of data, they have resulted in few actionable policy changes to address a worsening maternal health crisis.

In 2021, states were given the option to extend pregnancy-related Medicaid coverage to up to one year postpartum. Since then, 49 states have implemented a 12-month extension for postpartum Medicaid coverage , which has historically

been associated with lower postpartum hospitalization rates and increases in postpartum visits (KFF 2024). However, while increased postpartum coverage can help protect women against complications occurring after delivery, Medicaid expansions are insufficient to address the issues many women face in accessing adequate prenatal care. Complications resulting from chronic health conditions, one of the primary drivers of America's uncharacteristically high mortality rates, cannot be adequately managed with just postpartum coverage which does not allow physicians to manage chronic conditions proactively to prevent potentially life threatening complications. As such, high maternal mortality rates persist even in states that have enacted the Medicaid expansion, indicating the need for a more comprehensive solution.

POLICY ALTERNATIVES

This brief outlines five policy alternatives that could be implemented to reduce maternal mortality rates nationwide. Policy alternatives are evaluated against six criteria: efficacy, speed of implementation, short- and long-term costs, equity, and political feasibility. Alternatives receive an efficacy rating from "not effective" to "very effective" to reflect the degree to which they may reduce maternal mortality rates. Alternatives also receive a rating from "slow" to "fast" to reflect the speed of implementation and how quickly an alternative might begin reducing mortality rates to protect the lives of mothers and the well-being of their children. Alternatives are rated from "low cost" to "high cost" for both short and long-term costs. Given existing budgetary strain on public aid programs, any policy solutions must be financially sustainable in the long-term. Short-term costs associated with program implementation are to be expected, but they must be recouped by long-term savings. Existing racial and ethnic disparities in maternal health outcomes must also be addressed, making equity another important consideration in the evaluation of policy alternatives, with options rated on a scale from "not equitable" to "very equitable." Finally, a solution is useless if it cannot realistically be implemented; thus, alternatives are also scored from "not feasible" to "very feasible."

To ensure that alternatives are evaluated accurately, criteria have been weighted to reflect their relative value. Efficacy is weighted most strongly, as any alternative which does not meaningfully reduce maternal mortality rates is not a viable solution. This analysis also prioritizes equity to address the extreme racial disparities in maternal health outcomes. Given that the highest mortality rates are among marginalized communities and communities of color, meaningfully addressing maternal mortality rates requires prioritizing solutions that will address racial and ethnic disparities.

Speed of implementation, long-term costs, and political feasibility have all been weighted similarly. A program with higher long-term costs will be less feasible,

and an alternative that might need to be debated for an extended period of time is less valuable given the urgency of the issue. Short-term costs have received the lowest weight, as long-term savings from improved health outcomes can offset high short-term costs. In this context, "costs" refers specifically to financial costs to the federal government.

Table 1: Policy alternatives and evaluation criteria

	Alternative					
Criterion	***Status Quo***	***Integrate Midwives***	***Access to Prenatal Care***	***Bias Training***	***VBAC Reimbursement***	***Weight***
Efficacy	Not Effective (1)	Very Effective (3)	Very Effective (3)	Somewhat Effective (2)	Not Effective (1)	0.25
Speed of Implementa-	Fast (3)	Fast (3)	Mid-Speed (2)	Fast (3)	Fast (3)	0.15
Short-Term Cost	Low Cost (3)	Mid-Cost (2)	Mid-Cost (2)	Low Cost (3)	Mid-Cost (2)	0.10
Long-Term Cost	High Cost (1)	Low Cost (3)	Low Cost (3)	Low Cost (3)	Low Cost (3)	0.15
Equity	Not Equitable (1)	Very Equitable (3)	Somewhat Equitable (2)	Very Equitable (3)	Very Equitable (3)	0.20
Political Feasibility	Somewhat Feasible (2)	Somewhat Feasible (2)	Somewhat Feasible (2)	Not Feasible (1)	Somewhat Feasible (2)	0.15
Rating	**1.75**	**2.7**	**2.35**	**2.45**	**2.2**	

Maintaining the Status Quo

Maternal mortality rates have increased despite efforts by some states to combat the problem. Without a more coordinated approach, mortality rates will continue to rise. There are no short-term costs or time delays associated with maintaining the status quo, but it will result in high long-term costs in the form of increased healthcare costs as the problem worsens. Current policies do not address racial and ethnic disparities, which are likely toww grow worse without targeted intervention. As maternal health and reproductive justice continue to dominate federal and state agendas, lawmakers may experience increasing pressure from constituents to produce a more effective solution.

Integrating Midwives into Healthcare Systems

Midwife-led care has consistently been linked to better maternal health outcomes, including lower mortality rates, fewer C-sections, and lower preterm birth rates (Niles and Zephyrin 2023). Midwife-led care monitors the mother's well-being throughout her pregnancy, making it easier to identify chronic conditions that may cause complications (NACPM 2023). Midwives also minimize the use of interventions like C-sections that are associated with

greater risks (NACPM 2023). States that place more restrictions on midwives were shown to have poorer maternal health outcomes (Niles and Zephyrin 2023). Despite this evidence, only 12% of births were attended by midwives in 2021 (GAO 2023).

Fully incorporating midwives into the U.S. healthcare system would entail ensuring that midwife services are covered by public and private insurers, increasing reimbursement equity, and reducing restrictions on where and how midwives are allowed to practice. Many private insurers do not cover midwife services, and when covered, midwives are paid less than physicians for the same services (Niles and Zephyrin 2023). Many states also place restrictions on midwives, often requiring that they be supervised by a physician, severely limiting their scope and effectiveness (Niles and Zephyrin 2023).

However, midwives are not trained physicians and are therefore unable to perform certain emergency procedures. For instance, in the event that an emergency C-section is necessary, a midwife is not able to perform the procedure. As such, allowing midwives to practice without the supervision of a licensed physician outside of a hospital setting could result in delayed emergency care during labor that may put some women at greater risk. Nevertheless, midwives would be better equipped to identify high-risk pregnancies given their more holistic approach that follows a woman throughout the entirety of her pregnancy from prenatal to postpartum care, and can ensure that those women deliver in a hospital setting where emergency care is readily available if needed. In addition, few maternal deaths actually occur during labor and delivery (about 11%), with most resulting from complications after birth (CDC 2024).

Implementation would require minimal short-term costs. Midwife services would replace existing care options at no additional cost to the insurer, and, is likely to reduce overall Medicaid reimbursements due to the decreased number of complications and costly interventions associated with midwife-attended births. However, incorporating midwives may be less politically feasible than some solutions. As part of the Momnibus Act, House Democrats introduced a bill to diversify and grow the perinatal workforce, which does not include provisions for insurance coverage, reimbursement equity, or lessening restrictions on midwifery practice. The bill was introduced first in 2021 and again in 2023 but has made no progress through the House. There are also many common misconceptions about midwives, like the idea that they only attend home births, which may make some lawmakers wary of supporting this alternative.

Increasing Access to Prenatal Care

Prenatal care helps ensure that risk factors and chronic health conditions are identified early and managed effectively throughout a pregnancy (Howell 2018, 387-99). Given that financial constraints pose the greatest barrier to accessing

prenatal care, expanding Medicaid coverage to reduce cost-related barriers would reduce mortality rates. California's expansion of its state Medicaid program (Medi-Cal) to cover more low-income women in the 1960s and 1970s provides a promising case study. By the end of the program's expansion period in 1978, the proportion of women receiving early prenatal care increased, and pregnant women covered by Medi-Cal, especially low-income women, showed improved pregnancy outcomes (Howell 2018, 387-99). The program was also shown to be very cost-effective; for every dollar Medi-Cal reimbursed for prenatal care, the state saved $1.70 in reimbursement for newborn intensive care (Howell 2018, 387-99).

In addition to its cost-effectiveness, this alternative is simple and relatively easy to implement, so it may begin reducing deaths relatively quickly. Additionally, the expanded access for lower-income women can address some existing disparities. Widespread adoption of the postpartum Medicaid expansion also suggests that a similar Medicaid expansion will be politically feasible.

Mandating Bias Training for Medical Staff

Roughly one in three women experience discrimination while receiving maternity care because of factors like age, weight, income, and race or ethnicity (Yousra et al. 2023, 961-67). Women of color report discrimination at even greater frequency. Common complaints include providers ignoring patients or failing to respond to requests for help in a timely manner, shouting at or scolding patients, violating patients' physical privacy, and threatening to withhold treatment or forcing patients to accept unwanted interventions (Yousra et al. 2023, 961-67). Providers are also less likely to recognize acute pain in Black patients or believe patients' reports of their own symptoms, making it more difficult to diagnose and treat potentially life-threatening pregnancy complications in a timely manner (Yousra et al. 2023, 961-67).

The Center for Medicare and Medicaid Services (CMS) could require hospitals providing prenatal care to administer implicit bias training to doctors and nurses through an incentive program similar to existing value-based programs that reduce providers' Medicare reimbursements if certain requirements are not met. Requiring hospitals to administer bias training may help reduce maternal deaths, particularly among women of color. Though bias training in healthcare settings is relatively new and its impacts have not been studied in depth, bias training in other areas has proven to produce positive results (Lai, 2014). Still, there is some uncertainty regarding long-term efficacy of these programs. Various training courses already exist, making adoption for hospitals and clinics fast and relatively simple. Short-term costs will largely be borne by hospitals and providers, and improved health outcomes are also likely to produce long-term savings for Medicaid, though any savings will be notably less than those from other alternatives. Bias training is a simple solution that

has already been implemented in some form by most workplaces and does not involve significant cost to the government, making it politically appealing for many politicians. However, given the federal government's current negative stance on programs supporting diversity, equity, and inclusion (The White House 2025), this program may remain politically infeasible despite its cost efficiency.

VBAC Reimbursement

C-sections are uncharacteristically common in the United States, and unnecessary C-sections are associated with a myriad of additional risks. In the United States, the C-section rate is 32% (compared to roughly 19% in France and Denmark), and this higher rate has not been associated with an improvement in maternal health outcomes (Ledbetter 2023; Son and Lai 2023, 535-41). Black and Hispanic women in particular are more likely to deliver by C-section. This is especially concerning given that the risk of death after a C-section is 3.6 times higher than after a vaginal birth (Ledbetter 2023).

One reason for high C-section rates is that doctors who attend C-sections are paid about 15% more than doctors who attend vaginal births (Oster, McClelland 2019). Studies have shown that the more physicians are paid for C-sections, the higher C-section rates become, and vice versa (Oster and McClelland 2019). Requiring insurers to raise reimbursement rates for vaginal births could reduce maternal mortality by eliminating financial incentives to perform C-sections.

A pilot program in Minnesota in 2009 introduced a blended payment rate for births regardless of delivery mode, which lowered the state's C-section rate by 3 percentage points (Kozhimannil et al. 2018, 658-64). The program also produced greater decreases in C-section rates among Black women, suggesting it can reduce at least some racial disparities in maternal outcomes. As a result of the program, the state also saw a decrease in the cost of childbirth hospitalizations, which would offset Medicaid cost increases associated with raising reimbursement rates. One analysis estimated that for a federal program, the overall cost increase is about $480 million a year, or 0.8% (Oster and McClelland 2019). As health outcomes continue to improve, C-section rates and overall costs can be expected to decrease in the long term. However, one study of Minnesota's pilot program found no significant impacts on maternal morbidity, casting some doubt on the program's effectiveness as a solution for America's maternal mortality crisis (Kozhimannil et al. 2018, 658-64).

Ultimately, this alternative would be relatively simple and quick to implement. It is also likely to produce equitable results and is cost-effective because long-term savings would significantly offset short-term cost increases. This alternative's simplicity, low visibility, and cost-effectiveness should also make it very politically appealing. However, given that Minnesota's program has little

observable impact on maternal morbidity specifically, there is doubt as to how effectively this alternative could address maternal mortality rates.

POLICY RECOMMENDATION

This brief recommends fully incorporating midwives into American healthcare systems by ensuring that midwife services are covered by both public and private insurers, increasing reimbursement equity when midwife services are covered, and reducing restrictions on where and how midwives are allowed to practice. Compared to other alternatives, incorporating midwives will require minimal short-term costs to implement, and incorporation has the capacity to reduce mortality rates relatively significantly and quickly. Incorporating midwives will also be highly cost effective in the long-term, and midwife services have been shown to produce more equitable maternal health outcomes than traditional care models. In addition, incorporating midwives will address more than one issue related to maternal mortality: midwives can help reduce workforce shortages and expand access to maternity care by empowering more providers, and an emphasis on midwife services will reduce the U.S.'s abnormally high C-section rates.

While other alternatives like expanding Medicaid and increasing access to prenatal care may also rapidly reduce maternal mortality, the midwife alternative is unique in its holistic nature. Midwives are able to address a wide range of issues through comprehensive pre- and antenatal care, and they therefore have the best chance of producing significant, lasting reductions in mortality rates.

Given that the Momnibus Act has stalled in the House, careful steps should be taken to safeguard this alternative's political feasibility. This brief recommends creating an informational campaign to dispel common misconceptions about midwifery. The framing of this alternative is also vital and should emphasize the large demand among women, especially women of color, for midwife-led care. Roughly two-thirds of Black women indicated that they would definitely want or would consider a midwife for future births (Niles and Zephyrin 2023). However, due to current restrictions on midwives, demand for midwife services currently outstrips supply. Emphasizing this alternative's favorability among constituents would help to improve its feasibility.

This alternative can be implemented either through agency rulemaking or legislation. Given Republican control of Congress, feasibility considerations are similar for both avenues. Either avenue will also likely require the U.S. Department of Health and Human Services (HHS) to promulgate a rule governing coverage and reimbursement requirements for midwife services.

Despite potential concerns about feasibility, incorporating midwives will be the most effective method for lowering maternal mortality quickly and improving

long-term outcomes for mothers and their children.

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