Rhia VENTURES

From Here to Maternity: The Business Case for Strong Maternal Health Care Coverage and Benefits in the Private Sector

About Rhia Ventures

Rhia Ventures is a women-led social investment organization that seeks to create a vibrant, equitable market for women's sexual, reproductive, and maternal health. Through impact investing, market research, and collaboration – with reproductive justice advocates, funders, investors, corporations, policy makers, and others – Rhia centers equity as it strives to transform the U.S. maternal and reproductive health market.

More information about Rhia Ventures can be found at www.rhiaventures.org, along with the companion piece to this report, Hidden Value: The Business Case for Reproductive Health.

Acknowledgments

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Foreword

It brings me great pleasure to share From Here to Maternity: The Business Case for Strong Maternal Healthcare Benefits in the Corporate Sector with you.

Like its companion piece, *Hidden Value: The Business Case for Reproductive Health*, *From Here to Maternity* was inspired by our observation of a gap in the existing literature that addresses the economics of reproductive and maternal healthcare. Most of this work, whether academic or aimed toward a general audience, focuses on the role of government action. Relatively little of it speaks to managers in the private sector, whose approach to reproductive and maternal health has a daily impact on millions of workers.

From Here to Maternity aims to help fill this gap. Through our Corporate Engagement program, we regularly connect with corporate leaders about reproductive and maternal health care. In our experience, few companies are taking a holistic view of the topic, and many are unfamiliar with a range of policy interventions that could yield significant benefit to themselves, their employees and their investors. As we detail within, these interventions can run from the relatively direct (such insuring midwife and doula care, or providing lactation counseling), to the more complex, which can involve partnering with insurers and provider networks to address the root causes of a range of avoidable and negative birth outcomes.

Maternal health care is a material expenditure. In 2018, private health insurance covered the costs for nearly one half of the 3.8 million births in the U.S. In 2016, maternal and newborn care made up 15% of all hospital charges billed to private insurers. *From Here to Maternity* addresses the costs of inaction on maternal health care, and the potential for benefit.

From Here to Maternity will also be of interest to investors, a rising number of whom are integrating ESG (environmental, social and governance) concerns into their investment decision making processes. (Global sustainable investment assets under management stood at **$35.3T** at the start of 2020 – over one-third of total assets under management.) ESG investors are hungry for companies to communicate policies, practices and metrics that demonstrate their commitment to human capital management. What better place to start with policies relevant to the wellbeing and retention of the more than 40 million women in the U.S. workforce today in their childbearing years?

Three of 2020's most prominent legacies include a national moment of racial reckoning, an outflow of women from the U.S. workforce, and devastating economic setbacks for many Americans. Although much ground has been lost, the call for corporations to help advance racial and gender equity is only growing louder and more influential. As we push the "reset" button to shift from shareholder to stakeholder primacy in decision-making, intentional corporate action to address maternal and reproductive healthcare can play a prominent role in the achievement of these goals. Negative pregnancy and birth experiences fall disproportionately on Black, Indigenous, women of color and women from low-income or communities marginalized by geography, policy or other factors. Developing policies that drive equitable outcomes for women experiencing the deepest disparities is a winning strategy for all, as every worker can benefit from more inclusive policies. (The recently released *Black Reproductive Justice Policy Agenda* explores these connections and policy implications brilliantly.)

In this spirit, we offer *From Here to Maternity* as a resource to all seeking to create a healthier, more inclusive, and more equitable workplace and world.

Erika Seth Davies
CEO
Rhia Ventures

Executive Summary

It's no secret that maternal health in the United States lags significantly behind that of other developed countries, and it has become increasingly well known, in this extended moment of national racial reckoning, that within this country, Black women suffer from much higher rates of maternal mortality and morbidity than women of other races. This tragic inequity has wide-ranging repercussions to all sectors of society.

Many corporate executives may not be aware of the ways that negative maternal health outcomes weigh heavily on their businesses and the economy. Women* who go through pregnancy and birth with minimal complications are more likely to have healthy children, use fewer costly health care services, and remain in the workforce. Conversely, negative pregnancy and birth outcomes place a toll on corporate aspirations toward greater diversity, equity, and inclusion (DEI) with respect to gender and race. Simply put, it is not possible for companies to succeed in building an inclusive workforce without policies that support women through their maternity journeys – from **preconception** care through post-delivery – particularly given the setbacks to women's workforce participation that have resulted from the Covid-19 pandemic. It is in the urgent interest of businesses to improve maternal health care and benefits.

In the most literal sense, private employers have a great deal invested in positive maternal health outcomes. Prior to the pandemic, pregnancy, childbirth, and newborn care accounted for nearly one fourth of all hospital stays, five times greater than the next leading cause. Private health insurance picked up much of the tab, covering the costs for *nearly one half* of all 3.8 million U.S. births in 2018.[1]

A large body of literature speaks to the causes of America's poor maternal health outcomes and how to improve them, but relatively few studies focus on the impact upon corporations, and the difference they can make in their role as providers of insurance and benefits. *From Here to Maternity: The Business Case for Strong Maternal Health Care Coverage in the Private Sector* is written for two primary audiences. It is for corporate leaders seeking to understand how strong

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* We note that not all those who can become pregnant identify as women, and urge employers, insurers and health care providers to implement policies and programs that are sensitive to the needs of anyone who can become pregnant. This report uses inclusive language where possible, but reverts to "women" predominantly to describe those in need of maternal health care, particularly in those instances where substituting fully gender-inclusive language would misrepresent source material.

maternal health care benefits can **improve employee health and wellbeing; help create a healthier, more stable, and more diverse talent pool; contribute to greater retention; and reduce both absenteeism and presenteeism**. It is also for the investment community, particularly the growing number of those integrating corporate ESG (environmental, social, and governance) performance into their investment decision making. These investors may use the information in this report to begin a dialogue with portfolio companies on the quality of their maternal health benefits and related policies.

KEY FINDINGS

- **Maternal health care is among the most significant health care costs borne by employers.** Contributing factors include the over-use of C-sections, and a rising incidence of pre-term births. In 2018, private health insurance covered the costs for nearly one half of the 3.8 million births in the U.S., forcing many female workers to choose between their jobs and their families.
- **Rising costs are driven by inequities in the U.S. health care system.** Fixing those inequities is a long-term challenge that requires the concerted efforts of the public and private sectors, but – even in the current belt-tightening environment – there are immediate steps that companies can take to improve employee maternal health.
- **Doula and midwife services can dramatically reduce negative pregnancy outcomes** such as preterm births, low birthweight, and C-sections, but insurance coverage for these services is rare.
- **Although required by law, counseling and support for on-site breastfeeding lags in many workplaces.** Fewer than half of American women had access to resources that would allow them to breastfeed at work as of 2016.
- **Adequate mental health benefits can help businesses avoid some of the costs of perinatal mood and anxiety disorders,** which cost the U.S. as much as $14.2B a year.
- **Generous paid family and medical leave is necessary to promote parent-child bonding in the first year following birth,** but fear of repercussions contributes greatly to employees' underutilization of available leave.

Section I explores **three key drivers** pushing up maternal health care costs: unnecessary Caesarean deliveries (C-sections), rising numbers of **preterm births**, and the drain on productivity and retention that results from insufficient support for pregnant people and new parents. Understanding the biggest drivers of these costs and disparate outcomes can help businesses reduce avoidable adverse health complications for their employees, resulting in lower health care costs, better productivity, and higher retention.

Section II offers a number of specific recommendations tailored to corporate decision makers and investors.

Businesses can gain strategic benefits by investing in measures to improve maternal health outcomes, such as

- Enhancing company competitiveness in the labor market
- Increasing talent retention
- Meeting DEI goals and commitments

From Here to Maternity: The Business Case for Strong Maternal Health Care Coverage in the Private Sector illustrates the value to employees, companies, shareholders, and other stakeholders that is waiting to be tapped when employers understand what's possible and what's at stake.

Section I

Companies today face heightened pressure to control costs while also safeguarding the health of their employees, a state of affairs exacerbated by the Covid-19 pandemic. Improving maternal health policies is a smart and cost-effective way to do both. Although the long-term labor market implications of the pandemic are still unfolding, what is clear is that first-rate maternal health policies support employee wellbeing while benefiting the employer.

Maternal health care is among the most significant health care costs borne by employers. Much of this cost is related to poor maternal health outcomes that result from inequities in the U.S. health care system. Fixing those inequities is a long-term challenge that requires the concerted efforts of the public and private sectors, but – even in the current belt-tightening environment – there are immediate steps that companies can take to improve employee maternal health. These actions can reduce direct health care costs, improve loyalty and productivity, and enhance the ability of firms to recruit workers from a stronger and more diverse talent pool. These outcomes are of vital importance to managers, recruiters, and human resources professionals in any economic environment.

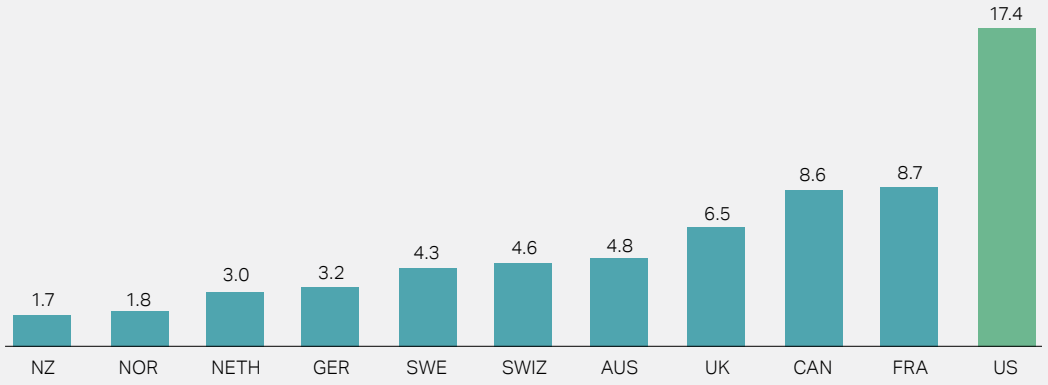
The impact of the Covid-19 crisis on women's position in the workplace and American society cannot be overstated. The *2020 Women in the Workplace* report by McKinsey and Lean In declares,

> *This is the first time we've seen signs of women leaving the workforce at higher rates than men; in the previous five years of this study, women and men left their companies at similar rates. If these women feel forced to leave the workforce, we'll end up with far fewer women in leadership – and far fewer women on track to be future leaders. All the progress we've seen over the past five years would be erased.*[2]

Labor Department statistics showed that nearly four times as many women left the workforce in 2020 as men.[3]

Comprehensive maternal health care benefits can help attract women back into the workplace or remove a reason for leaving in the first place.

Figure 1. 2018 Maternity mortality ratios: OECD nations



*Notes: The **maternal mortality ratio** is defined by the World Health Organization as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.*

Data: OECD Health Data 2020, showing data for 2018 except 2017 for Switzerland and the UK; 2016 for New Zealand; 2012 for France.

Source: Roosa Tikkanen et al., Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries (Commonwealth Fund, Nov. 2020). https://doi.org/10.26099/411v-9255

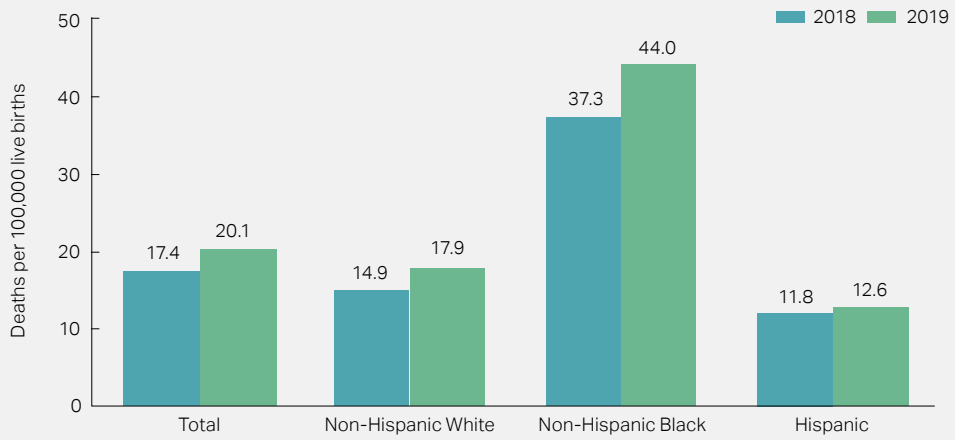
A 2020 study by the Commonwealth Fund revealed that the U.S. maternal mortality is the highest relative to 10 other wealthy nations.[4]

Maternal health in the U.S. lags significantly behind that of other developed countries (see figure 1).

Between 2000 and 2017, the U.S. saw its maternal mortality rates rise dramatically, even as the global average declined by a dramatic 38%.[5] Within this grim trend, Black, American Indian and Alaska Native women are at far greater risk of dying during childbirth and experiencing pregnancy or childbirth complications.[6] According to the Centers for Disease Control and Prevention (CDC), in 2019, the maternal mortality rate for non-Hispanic Black women was 44 deaths per 100,000 live births, 2.5 times the rate for non-Hispanic white women (17.9) and 3.5 times the rate for Hispanic women (12.6). Rates for non-Hispanic Black women were significantly higher than rates for non-Hispanic white and Hispanic women.[7]

The incidence of maternal mortality rose for all groups between 2018 and 2019 (see figure 2).

Figure 2. Maternal mortality rates, by race and Hispanic origin: U.S., 2018 and 2019



Source: Centers for Disease Control.

"If we had a panic button, we'd be hitting it. Leaders must act fast or risk losing millions of women from the workforce and setting gender diversity back years."

– Sheryl Sandberg, Chief Operating Officer of Facebook and co-founder of LeanIn.org, September 2020

(Largest study of women in corporate America finds 1 in 4 women are considering leaving the workforce or downshifting their careers due to Covid-19, LeanIn.org, 30 September 2020)

SOCIAL DETERMINANTS OF HEALTH

Maternal health policies intended to benefit all employees may not achieve that goal if they are rolled out without regard to social determinants of health that disadvantage **BIPOC** women, and **transgender** and **nonbinary** people. Black and Latina women face higher preconception and maternal health risks, even those in higher income brackets[8], due to factors including geography, lack of access to adequate health coverage, communication difficulties between patient and provider, cultural barriers, provider stereotyping, and lack of access to providers.[9] These and other stressors associated with living in a racist society have been shown to be associated with heightened morbidity and mortality among Black Americans in a phenomenon known as "weathering."[10] The following are important disparities for corporate leaders to be aware of when evaluating how adequately health care provider networks serve all of their company's workforce, and as leaders explore corrective measures their companies might undertake in collaboration with other public and private institutions:

- Many Black and brown communities are geographically distant from health care facilities, and limited transportation options impede access to perinatal health care visits.[11] According to the March of Dimes, 4.8 million women of childbearing age live in counties with limited access to maternity care.[12]
- Three quarters of Black mothers give birth at hospitals that have higher rates of maternal complications than other hospitals and perform worse on numerous birth outcomes.[13]
- Toxic environmental hazards are more prevalent in communities of color, from proximity to toxic waste dumps to health hazards from living in inferior or older housing.[14]
- Supermarkets and other purveyors of healthy foods are scarcer in neighborhoods where people of color live.[15]
- Racial and ethnic bias among health care providers is well documented.[16]
- Transgender and nonbinary people are subject to bias in the provision of reproductive health care; for example, the majority of insurance providers rarely cover fertility treatment for transgender people.[17]

For a deeper look, we recommend *Black women's maternal health: A multifaceted approach to addressing persistent and dire health disparities* (National Partnership for Women and Families, Issue Brief, April 2018).

***Words set in green are defined in the Glossary.**

Between 1991 and 2014, the U.S. maternal mortality rate more than doubled.[18] The gap between the U.S. and other high-income countries is statistically attributable to dramatically higher rates of maternal mortality in the Black community,[19] driven by racism and its outcomes: inequitable access to health care, housing, education, healthy food, and good jobs. These "social determinants of health" (see sidebar) lead to high rates of chronic conditions that undermine the health and well-being of BIPOC and low-income workers. **Addressing these disparities is crucial to improving maternal health outcomes and creating more equitable employment.**

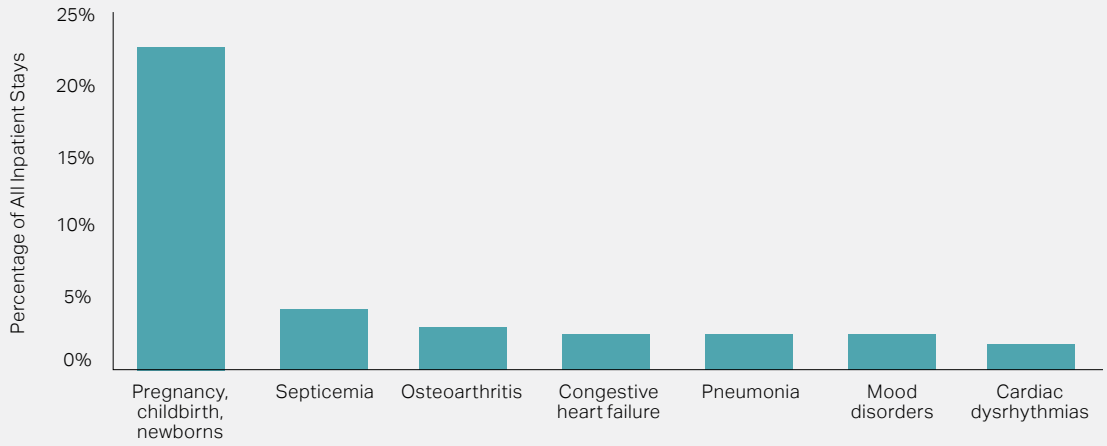
COVID-19 has exacerbated disparities in access to and outcomes of the U.S. health care system, including during pregnancy. Pregnant women face a raft of new challenges, among them: health care providers shifting **prenatal** and **postpartum** care to telemedicine platforms, a rising incidence of missed and delayed in-person appointments, the conversion of labor and delivery wards into Covid-19 wards, delivery without **midwives** or partners, and separation of newborns from mothers who test positive for the virus.[20] The pandemic also dramatically underscores the dependence of millions of American workers on their employers for health care insurance and hardships due to lack of paid family and medical leave.[21]

With all this in mind, **this is a good time for companies to review and strengthen their maternal health policies**. In 2016, the U.S. spent $98B on hospitalizations for pregnancy and childbirth.[22] Just prior to the pandemic, pregnancy, childbirth, and newborn care accounted for almost one in four (23%) of all hospital stays, far outpacing other causes of hospitalization.[23]

"Black birthing people are already more likely to die, regardless of their income or education," said Dr. Joia Crear-Perry, an obstetrician and president of the National Birth Equity Collaborative, a nonprofit dedicated to eliminating racial disparities in birth outcomes. "Now, with Covid, resources are scarce and hospitals don't have what they need. Who bears the brunt? The people least likely to be listened to."

("She Was Pregnant With Twins During Covid. Why Did Only One Survive?" The New York Times, 9 August 2020)

Figure 3. Leading Reasons for Hospital Stay, United States, 2014



Source: National Partnership for Women and Families, Maternity care in the United States: We can – and must – do better, Issue Brief, February 2020.

Businesses pick up much of these costs as providers of health insurance:

- In 2016, maternal and newborn care made up 15% of all hospital charges billed to private insurers.[24]
- In 2018, private health insurance covered the costs for nearly one half of the 3.8 million births in the U.S.[25]

Understanding the biggest drivers of these costs and disparate outcomes can help businesses reduce avoidable adverse health complications for their employees, resulting in reduced health care costs, better productivity and higher retention.

Good preconception health care reduces pregnancy complications, birth defects, and long-term developmental issues, and speeds postpartum recovery. For every dollar spent on preconception care, $1.60 is saved in maternal and fetal care cost, according to a recent prospective analysis. The return on investment is even more dramatic for investing in prenatal care: for every dollar spent on prenatal care, employers can expect savings of $3.33 ***postnatal*** *care and $4.63 in long-term morbidity costs.*

(The business case for promoting healthy pregnancy, pg. 3, in National Business Group on Health, Investing in Maternal and Child Health: An Employer's Toolkit, Part 4: Healthy Pregnancy and Healthy Children: Opportunities and Challenges for Employers)

FERTILITY BENEFITS

According to the CDC, 13% of women in the United States have difficulty getting or staying pregnant.[26] While expensive relative to other reproductive health care benefits, fertility benefits are highly desired by employees and linked to greater loyalty and commitment:

- FertilityIQ reported that among employees whose **in vitro fertilization** (IVF) treatments were fully covered, more than 70% said that they felt more grateful to their employers, 60% felt more loyal to their employers, and over half stayed at their jobs longer.[27]
- In a FairyGodboss survey, women said egg-freezing benefits would make them four times more likely to apply for a job at a company and three times more likely to stay at the company; 48% said the same of IVF benefits.[28]
- In the same survey, twice as many Black respondents and three times as many Latina respondents said that egg-freezing benefits would make them likelier to apply for a job, compared with white respondents.[29]

Most insurance companies don't cover fertility treatments, or if they do, require a diagnosis of infertility that can discriminate against **LGBTQ** and single people.[30] There is great variation in employer-provided fertility coverage, and that coverage is changing rapidly. According to the fertility benefits provider Carrot, companies offer lifetime caps on the use of the benefit that range between $5,000 and $75,000. Costs vary greatly, depending on the type of treatment sought (e.g., egg freezing, IVF, surrogacy), and exemptions from coverage are common.[31]

Between 2017 and 2018, the benefits consulting firm Mercer charted an increase in the provision of IVF benefits from 37% to 44% among big employers. FertilityIQ also tracked a strong uptick (by 23%) in new or "dramatically improved" fertility treatment offerings during 2018, driven by certain sectors (consumer product and retail, insurance, health care, and industrial manufacturing) catching up with others that already offered fertility benefits (technology, consulting, and finance).[32]

Employers should be wary of plan designs that over-rely on multiple embryo transfers, which can result in a higher incidence of high-risk and expensive multiple births. "Fertility treatment is one of the unique areas that require outcomes data to be reported to the CDC each year," according to *Employee Benefits News*. "Because of this, a managed fertility benefit should be data-driven with accurate real-time clinical outcomes that exceed the national averages. These superior clinical outcomes are a critical driver of overall savings."[33]

Section II: Drivers of High Maternal Health Care Costs for Employers

Three key drivers of poor outcomes and high costs associated with pregnancy and birth are:

- Unnecessary C-sections
- Rising numbers of **preterm** births
- Low productivity and high turnover associated with insufficient workplace support

Over-reliance on C-sections

Although often unnecessary, C-sections are the most common major surgery performed in the U.S. In 2014, *Consumer Reports* published a special report on the topic that concluded, "Experts say that the main problem is a health care system that no longer values normal birth and focuses on scheduling labor, in part for patient and doctor convenience."[34] Doctors may also fear that labor is moving too slowly and may lead to complications, an assumption based on outdated information.[35] Unfortunately, mothers whose first birth is by C-section are more likely to have C-sections for subsequent births, compounding the costs and physical repercussions.[36]

The World Health Organization says C-sections are necessary in only 10–15% of births, yet roughly 1 in 3 women in the United States delivers by C-section. The rate rose steadily from fewer than 1 in 20 in the 1960s[37] to 1 in 5 in the mid-1990s.[38] The procedure is performed more frequently for Black and Latina women, a situation that the pandemic may be exacerbating. In 2020, hospitals across New York City reported higher rates of labor inductions and C-sections, as well as an uptick in premature babies born to Black and Latina mothers.[39]

> *The biggest risk factor for having a C-section in the U.S. is "the hospital a mother walks into to deliver her baby, and how busy it is."*
>
> *– Dr. Neel Shah, Harvard Medical School*
>
> *("Your biggest C-section risk may be your hospital," ConsumerReports.org, 10 May 2018)*

The Blue Cross Blue Shield Association has adopted a new national health equity strategy aimed at reducing racial health disparities in maternal and three other areas (behavioral health, diabetes, and cardiovascular conditions). It has set a goal to reduce disparities in maternal health outcomes by 50% within 5 years.

(Blue Cross Blue Shield Association press release, 20 April 2021)

Businesses pay a high price for unnecessary C-sections. Private insurers paid, on average, 34% more for C-sections in 2017 than for vaginal births ($15K versus $11.2K).[40] Costs vary significantly by geography, which may indicate opportunities for savings.[41] Employers should also be aware that the for-profit status of a hospital doubles the likelihood that its patients may be steered toward C-sections.[42]

But more expensive does not mean safer – one study found that an unnecessary C-section increases **morbidity** five times over that of a vaginal birth.[43] In addition, C-sections increase the risk of mortality, result in more long-term health complications, and require a longer recovery time,[44] thus lengthening maternity leaves. **Businesses are subsidizing a practice that raises costs and results in poor outcomes.**

Preterm Births

Rates of preterm birth have been rising steadily. In 2018, the fourth straight year of increase, 1 in 10 babies in the United States were born preterm.[45] Preterm births and care for low-birthweight infants are the most expensive pregnancy-related costs. One recent study found that infants born before 37 weeks of gestation incurred average health care costs of more than $75K during the first 6 months of life (with costs soaring over $600K for those born at 24 weeks). Average spending for low birthweight infants reached nearly $115K.[46]

Social determinants of health have an outsize influence on pregnancy outcomes (see *page 12*). Cardiovascular illnesses and strokes have eclipsed delivery complications as the leading cause of **maternal morbidity** and mortality, accounting for one third of all pregnancy-related deaths from 2011 to 2015.[47] Compared with white mothers, Black and Latina mothers are more likely to be exposed to environmental hazards and suffer from preexisting conditions that can compromise their pregnancies.

These conditions also result in preterm births and delivery of low-birthweight infants. In 2018, the rate of preterm birth among Black mothers was 50% higher than the rate of preterm birth among non-Hispanic white mothers,[48] and Black infants were 3.2 times more likely than non-Hispanic white infants to die from complications related to low birthweight.[49]

Preterm births can negatively affect the health of mother and child over the long term as well. Babies born preterm are more likely to suffer from costly physical and mental health conditions that require special care.[50] In addition, employers incur related costs from parents' absenteeism, lower productivity, and higher levels of stress.[51]

In addition to chronic conditions, preterm births result from lack of access to quality **preconception** and **prenatal care**. **The intervention shown to most significantly improve outcomes is the care of doulas and midwives** throughout the cycle of pregnancy and birth.

Doula care consists of evidence-based, non-medical support grounded in unconditional and continuous emotional assistance throughout a pregnancy. By supporting pregnant people in making positive, informed decisions regarding their health care, doulas facilitate well-being during the pregnancy and the physical and psychological healing process after birth. Midwives provide similar support and also deliver babies, in homes or hospitals.

Studies show that doula care correlates with lower rates of preterm and low birthweight babies, reductions in **postpartum (sometimes called perinatal) depression**, and increases in both rates of initiation and duration of breastfeeding.[52] The National Partnership for Women and Families reports that doula care also lowers health care spending; doula care correlates to decreased use of epidurals, and reduced incidence of pregnancy complications. It estimates that the consequent reduction in C-sections would save private insurers more than $2.25B each year. Doulas improve outcomes for low-income women (in particular, Indigenous and Black women) by advocating for their needs within institutions that exhibit racism and class bias.[53]

Many studies attest to the beneficial outcomes of midwife-assisted births, including a lower risk of C-section, fewer preterm births, a greater likelihood of vaginal births after C-sections, higher birthweight, higher rates of breastfeeding, and lower rates of neonatal death.[54]

Despite the clear benefits of doula and **midwifery** care, however, they attend relatively few births: only about 8% of all births in the U.S. are attended by midwives. The likely reason is that **doula services are not typically covered by insurance**.[55] The March of Dimes recommends that all payers provide such coverage to supplement medical care from the prenatal through postpartum periods, in accordance with the birthing parent's preference.[56]

BENEFITS OF DOULA CARE DURING LABOR

A 2017 review of 26 studies involving more than 15,000 women found that continuous labor support by doulas resulted in

- A 39% reduction in the likelihood of C-sections
- A 15% greater likelihood of vaginal delivery
- Shorter labor, by an average of 41 minutes
- A nearly one-third reduction in reported negative birth experiences

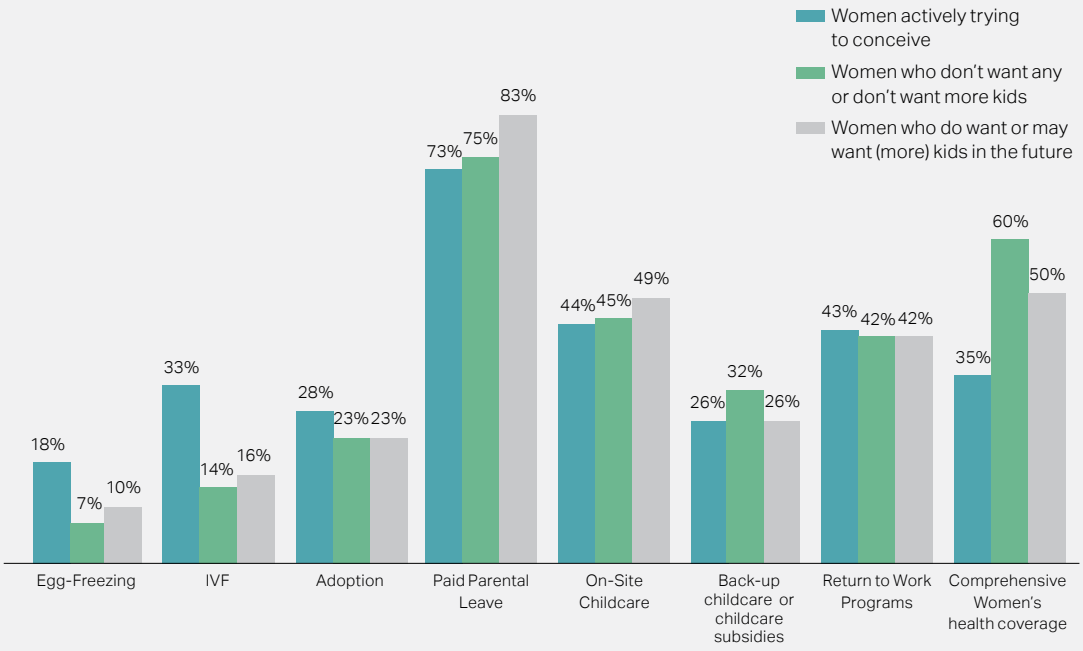
(Bey A, et al., *Advancing Birth Justice: Community-Based Doula Models as a Standard of Care for Ending Racial Disparities*, Ancient Song Doula Services, Village Birth International, Every Mother Counts, March 2019)

Lost Productivity and High Turnover Associated with Insufficient Workplace Support

Balancing work and family needs is one of the greatest challenges for American workers. The effects of insufficient support for pregnancy and parenting fall disproportionately on women, who risk significant losses in lifetime income when they take time out of the workforce.[57] The closure of daycare centers and schools during the pandemic exacerbates the pressures on women, who are the vast majority of parents who drop out of the workforce to attend to family needs.

Both the productivity and the retention of employees who are parents can be negatively affected by the specifics of an employer's insurance coverage, especially insufficient paid leave and flextime, lack of support for breastfeeding, and insufficient mental health support.[58]

Figure 4. Women who say these benefits would make them likelier to view a company as positive and supportive of women



(Report: The Benefits Today's Top Female Talent Won't Compromise On, Fairygodboss and Extend Fertility, May 2019.)

Paid parental leave. Unlike other advanced economies, the U.S. does not require employers to provide paid leave or flextime to employees who are pregnant or have recently given birth.[59] According to the U.S. Department of Labor, only 20% of private industry workers had access to paid family leave in 2020.[60] As of February 2021, at least 75 businesses are on record as supporting a federal paid leave policy, including Airbnb, Levi Strauss & Co., Patagonia, and Adobe.[61]

Other companies with standout paid leave policies include Hewlett-Packard, American Express, Estée Lauder Companies, Netflix, Airbnb, Amazon Goldman Sachs, and Twitter. All provide 20 weeks or more paid leave to primary and secondary caregivers.[62]

Yet according to the National Partnership for Women and Families, **in 2020 only 19% of the private sector workforce in the U.S. had access to employer-provided paid family leave**.[63]

When Google increased paid maternity leave from 12 to 16 weeks, it saw a 50% drop in the rate of new mothers leaving the firm.

(The real "family values" party: On paid sick leave, Dems lead U.S. to 21st century, Walsh J, Salon, 15 January 2015.)

Nestle's U.S. employees who are primary caregivers are eligible for 18 weeks of paid leave plus an additional 8 weeks unpaid. Usage of the benefit grew 30% between 2016 and 2019. Nestlé reports that early results indicate that newborns who benefited from the policy are less likely to need a sick visit and are more likely to have at least one immunization, and have 12% lower health care costs (excluding those with extensive needs, such as those born prematurely). Mothers who took paid leave reported lower rates of anxiety and filed fewer mental health claims.

(Nestlé, *Putting People First: Paid Parental Leave Helps Families Thrive*)

Strong evidence from California, which mandated paid family leave in 2004, suggests that paid family leave does not burden employers. A recent survey of more than 250 California employers revealed several positive findings[64]:

- The state's paid family leave program had either a positive or "not noticeable" effect on productivity, profitability, or performance (9 in 10 respondents).
- Employees did not abuse paid family leave (9 in 10 respondents). The same ratio reported they were unaware of any instances of employee abuse of the program at their business.
- Employment of new mothers rose following the introduction of paid family leave.
- Use of paid family leave by co-parents rose 10.6% from 2013 to 2018.

A 2011 study of the California law's effects found that the business community's fears that paid family leave would impose extensive new costs and overly burden small businesses were not borne out.[65]

Even when parental leave is available, company culture often inhibits parents from availing themselves of the benefit. A 2018 survey of 1,000 working parents in the U.S. found that only 52% of women and 32% of men took advantage of the leave available to them. Both reported "begrudging" attitudes among supervisors when they requested time off. Men reported this far more frequently than women (65% and 48% respectively), and 63% of men believed taking extended parental leave would damage their careers. Strong majorities say they would have taken a longer parental leave if they had seen coworkers do so (72% of men versus 56% of women).[66]

Paid sick leave. As the pandemic brought home, paid sick leave is also essential. Paid sick days enable workers to take brief periods of time away from work to attend to their and their family's health; paid "safe days" enable them to take time off for issues related to domestic

violence, sexual assault, or stalking. A decade ago, nearly 40% of private sector workers could not earn a single paid sick day, but with the passage of laws in 13 states and 23 other jurisdictions, that number had risen to 73% before the pandemic.[67]

A 2019 survey of more than 1,000 college-educated women conducted by the website Fairy Godboss found "remarkable" the extent to which the availability of paid leave "positively influences a woman's perception of a company, her likelihood to apply to a job there, and her likelihood of staying with that company. This held true regardless of respondents' age, ethnicity, family status, and desire (or not) to have children." (See Figure 4.)

"The most common American 'maternity leave' is actually a kind of Franken-leave mothers create out of sick days, vacation days, disability, and unpaid family medical leave."

"Why Women Really Quit Breastfeeding," Harper's Bazaar, *July 17, 2018.*

A study conducted by KPMG in 2015 estimated that worldwide, corporations would save $19B per year if parental leave was globally mandated. The consultancy also estimated that companies spend roughly $47B every year recruiting and training new employees to replace women who leave the workforce after giving birth.

(Company offers moms 16 weeks off in full pay, even in U.S., CNN Money, 6 March 2015)

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Work schedules. Pandemic-era pressures on working parents make flextime a must-have and a coveted benefit. At any given time throughout the pandemic, more than 60% of children in the U.S. have been remote-schooling.[69] Businesses need to ensure that workers can take advantage of flextime without fear of termination, reduction in hours, or other retaliation.

Part-time workers can also suffer from unpredictable, "just-in-time" work schedules. Research shows, however, that employees who can work their preferred hours are less distracted, have a better attitude, and perform better; those with unpredictable hours have low morale, receive less training, and make more mistakes. Those with more predictable schedules are more likely to be cross-trained on various job duties, are more knowledgeable, and provide faster customer service.[70]

Mental health. According to the CDC, in 2018 13% of new mothers suffered from postpartum depression.[71] Destigmatizing mental health care and making it accessible to all could significantly improve health and work outcomes for those trying to conceive, for pregnant employees and for new parents.

Suffering from perinatal depression and anxiety can play a serious role in a woman's ability to succeed at work – or go back at all – after having a child. Because of their impact on health and wellness, untreated mental health conditions can lead to missed days at work, decreased productivity, and increased turnover. Employees with depression may be less productive or engaged in their work, take more frequent sick or personal days, and be more distracted and disengaged while at work. Mental health conditions can also lead to greater attrition for employers, sometimes because the company culture lacks social or workplace support.[72]

The more flexibility pregnant employees have to attend to self-care, the more likely they will continue to perform well and return to work fully engaged. For example, research has shown a correlation between longer maternity leave and lower risks of postpartum depression.[73]

A 2019 study estimated that perinatal mood and anxiety disorders cost the U.S. as much as $14.2B a year, factoring in productivity loss, unemployment, elevated risk of preterm births, and other maternal health expenditures.[74]

Breastfeeding. The benefits of breastfeeding to both mother and child are so profound that the American Academy of Pediatrics and the World Health Organization recommend that all infants breastfeed exclusively for their first 6 months. Yet the need to return to work is the top reason new mothers cite for ending breastfeeding.[75] At the same time, women who know that their work environment is compatible with their breastfeeding goals are substantially less likely to be absent from work and less likely to quit.[76,77]

LACTATION SUPPORT PROGRAMS OFFER SIGNIFICANT COST SAVINGS

When Mutual of Omaha rolled out its lactation support program in the early 2000s, it measured $2,146 in health care cost savings for each woman who enrolled. Hospital costs for newborns reflected yearly savings of $115,881.

When CIGNA conducted a two-year study of 343 employees who participated in the insurer's lactation support program, it measured annual savings of $240K in health care expenses, 62% fewer prescription claims, and savings of $60K from reduced absenteeism.

(The business case for breastfeeding: steps for creating a breastfeeding friendly worksite, U.S. Department of Health and Human Services, Office on Women's Health, 2008)

Despite labor laws that require support for breastfeeding mothers, a 2017 survey of employers conducted by the Society for Human Resource Management found that only half of respondents provided private rooms for breast-pumping, and a mere 13% offered **lactation counseling** services.[78] Another study found that **only 40% of new mothers have access to a private space for pumping and the break time in which to do it**. The racial disparity in such access was dramatic: only 14% of Black and Hispanic mothers had both.[79] In 2018, the Economic Policy Institute estimated that altogether, more than one third of working women of childbearing age in the U.S. (12.7 million women) were either legally exempt (excluded) from the break time for nursing mothers provisions in the Fair Labor Standards Act or vulnerable to being misclassified as exempt. This is because workers who are exempt from the overtime protections of the Act are also exempt from the provisions for break times for nursing mothers.[80]

These statistics make clear that breastfeeding often is incompatible with a return to full-time work, leaving women to weigh financial and career considerations against the health of their newborn babies. Not surprisingly, more than two thirds of American women (70%) want better support for breastfeeding at work.[81]

The American Academy of Pediatrics estimates employers can expect a 200–300% return for every dollar invested in lactation support programs.

(Policy statement: Breastfeeding and the use of human milk, American Academy of Pediatrics, Pediatrics: 2012, 129(3): e827–841)

Section III. Recommendations

For Companies

There are numerous ways for companies to support employees through pregnancy and childbirth while reducing the physical and mental health risks attached to negative pregnancy outcomes. We recommend the following actions.

1. **Identify areas of employee need** where stronger maternal health policies may be warranted. Examine maternity-related insurance claims in the aggregate to determine if the data reveal unhealthy trends such as a high incidence of C-sections, induced labor, or preterm births; high maternal or **infant mortality**; or high rates of perinatal depression. Investigate for underutilization of benefits and services, as it may indicate lack of employee awareness. Examine disparities in health, utilization, and outcomes to see if race or other social determinants of health are affecting the workforce or talent pool.
2. Where the data reveal areas in need of improvement, work with insurance and provider networks and community institutions to **understand and address the root causes** of any observed unhealthy trends. For example, your company may be able to play a role in mitigating financial and other barriers to access to care, by subsidizing transportation to doctor's visits, reducing out-of-pocket costs for insurance,[82] or initiating participation in programs to improve perinatal and infant health.
3. Consider extending maternal health care benefits to **part-time employees** as well.[83]
4. Promote (and if necessary, strengthen) the **mental health services** available to employees. *Investing in Maternal and Child Health* offers extensive guidance for communicating and incentivizing this and other benefit offerings.[84]
5. **Promote employee awareness** of maternal health insurance and benefits by making information available in multiple languages and through multiple communication channels. Develop specific, online resources for expecting employees and new parents, and ensure these resources speak to the diversity of your workforce.
6. **Support efforts to extend access to telemedicine.** Pregnancy-related health care services that can be delivered through telemedicine include virtual prenatal and postpartum visits, mental health care, lactation support, consultation with specialists, and even at-home monitoring of weight, fetal heart rate, and other measures of health.[85] Telehealth services accelerated dramatically during the pandemic due to swift action by policy makers

to remove regulatory obstacles and clear a path for reimbursement, but many of these changes have been instituted only for the duration of the public health emergency. We recommend that businesses lobby for such changes to be made permanent.[86]

7. Work with insurance payers and health care providers to **integrate the services of doulas and midwives into your health plans.**
8. **Reduce over-reliance on C-sections.** The Purchaser Value Network, a program of the Business Group on Health, recommends working in coalition with other local businesses to:
    - Meet with local hospitals to express concerns about high C-section rates
    - Eliminate financial incentives for inappropriate C-sections in hospital contracts
    - Review benefit coverage to encourage access to high value services such as midwives and doulas
    - Drive beneficiaries to high value services and providers.[87]
9. Review parental leave utilization rates, and consider surveying employees who have started or extended families during their tenure at the company. Extend paid parental leave to at least 12 paid weeks and encourage flextime. For part-time workers, **publish work schedules at least 2 weeks in advance.** Pay workers for their on-call hours and for cancelled shifts. Allow workers to decline extra shifts added at short notice, and provide a guarantee of estimated weekly hours.[88]
10. Align **pregnancy accommodations with those in the Pregnant Worker Fairness Act,** considered the gold standard for supporting and protecting the rights of pregnant employees. Enacted in 30 states, this law builds on the federal Pregnancy Discrimination Act of 1978. Educate employees about pregnancy accommodations and their right to request them.
11. Ensure that **lactation policies** comply with federal and state regulations.[89] Monitor compliance, clarify roles and responsibilities, and ensure that all employees have access to the same level of support.
12. **Provide fertility benefits.** Plan designs should be flexible to accommodate the needs of single people and LGBTQ employees, for whom a requirement to "try naturally" or undergo certain treatments may be inappropriate.
13. **Advocate for public policies** that support good-quality maternal health care and family support systems.
    - Excellent resource for policy specifics include *Improving Our Maternity Care Now: Four Care Models Decisionmakers Must Implement for Healthier Moms and Babies* and *Black Reproductive Justice Agenda*.[90]
    - Encourage lawmakers to expand access to quality, affordable health care to all workers.
    - Consider ways to publicly affirm the company's support for these policies, such as releasing a statement or signing on to business *amicus* briefs to defend against attempts to weaken public support for healthy families.
    - Review political contributions to assess whether they are inadvertently funding those working to undermine or limit access to quality maternal and reproductive health care.

Merck for Mothers' *Safer Childbirth Cities Initiative* supports community-based organizations in U.S. cities with high maternal mortality and morbidity in implementing evidence-based interventions and innovative approaches to reverse the country's maternal health trends and directly tackle racial inequities in maternal health outcomes.

In 2019, as a co-funder in the initiative, Rhia Ventures committed $300,000 in multi-year grants, to be distributed to community-based organizations focused on high-need cities to address social determinants of maternal health. The initiative now works in 19 cities, supporting local efforts to improve maternal health equity such as the *Black Mamas Matter Alliance* (Atlanta, GA), *ROOTT* (Columbus, OH), and the *Mississippi Public Health Institute* (Jackson, MS).

For Investors

Shareholders have a direct interest in the quality, competitiveness and cost-effectiveness of investee companies' benefits packages. We encourage shareholders to consider the following actions.

1. Discuss maternal health care policies with portfolio companies. Using this report as a conversation starter, encourage them to review their policies, strengthen them as necessary, and be transparent about their benefits so as to enhance their competitiveness in the labor market.
2. Incorporate assessment of a company's maternal health care benefits into your ESG evaluation of the company.
3. Collaborate with other investors to promote greater corporate awareness and responsibility in this area, at both the management and the board levels.
4. Encourage ESG research firms and other organizations that benchmark corporate policies to include maternal health care in their assessments of companies' approaches to managing human capital.
5. Vote proxies in support of shareholder proposals that seek greater transparency or stronger policies in the area of human capital management.

Glossary

BIPOC stands for Black, Indigenous, and People of Color.

A **doula** is a trained professional who provides continuous physical, emotional, and informational support to a mother before, during, and shortly after childbirth to help her achieve a healthy and satisfying delivery (DONA International).

Fertility services encompass a number of methods to diagnose and treat infertility including hormonal medications, surgical procedures, intrauterine insemination, in vitro fertilization, and cryopreservation (freezing eggs, sperm, or embryos).

The **infant mortality rate** represents the risk of a baby dying before the age of 1 year. It is typically measured as the number of infant deaths for every 1,000 live births.

In vitro fertilization (IVF). IVF combines medicines and surgical procedures to help sperm fertilize an egg outside the body, after which the egg is implanted in the uterus.

Lactation counseling consists of education regarding feeding patterns, proper latch-on, basic positioning, infant arousal techniques, breast care, and breast conditions that a woman should report to her health care provider.

LGBTQ stands for lesbian, gay, bisexual, transgender, and queer/questioning.

Maternal morbidity is an overarching term that refers to any physical or mental illness or disability directly related to pregnancy and/or childbirth. These illnesses or disabilities are not necessarily life-threatening but can have a significant impact on quality of life.

The **maternal mortality ratio** is the number of maternal deaths during a given time period per 100,000 live births during the same time period.

Midwifery encompasses a full range of primary health care services for women from adolescence beyond menopause, including independent provision of primary care, gynecologic and family planning services; preconception care; care during pregnancy, childbirth and the postpartum period; care of the normal newborn during the first 28 days of life; and treatment of partners for sexually transmitted infections.

Nonbinary is a term used by those who feel their gender is neither exclusively female nor exclusively male.

Perinatal refers to the period immediately before and after birth. Definitions vary. The World Health Organization defining the perinatal period as beginning at 22 completed weeks of pregnancy and ending at 7 days after birth.

Postnatal and **postpartum** are often used interchangeably, although postpartum refers to issues pertaining to the mother and postnatal refers to those concerning the newborn. The postnatal period begins immediately after the birth of the baby and extends for up to 6 weeks (42 days).

Postpartum or **perinatal depression** is a mood disorder that can affect pregnant persons during pregnancy and after childbirth, with symptoms ranging from mild to severe.

Preconception or **pre-pregnancy care** focuses on identifying factors that can affect the health of a pregnancy before conception, such as diet and lifestyle, medical and family history, medications, and previous pregnancies.

Prenatal means occurring or existing before birth, referring to both the care of the pregnant person during pregnancy and the growth and development of the fetus.

Preterm birth is delivery that takes place prior to 37 weeks of gestation.

Transgender is a term used to describe those whose gender identity differs from their birth sex.

Resources

Beyond Birth: Continuing Care for Moms When They Need it Most, Ovia Health

Black Mamas Matter Toolkit: Advancing the Human Right to Safe and Respectful Maternal Health Care, Center for Reproductive Rights and the Black Mamas Matter Alliance, June 2016

Black Maternal Health Caucus of the U.S. House of Representatives

Black Reproductive Justice Agenda, June 2021

The Business Case for Breastfeeding, U.S. Department of Health and Human Services, Office on Women's Health, 2008

Businesses Advancing National Paid Leave

Employer Strategies to Promote High-Value Equitable Maternity Care, Purchaser Business Group on Health, 2021

Family benefits checklist: 5 benefits every employer needs to support women and families in the workplace, Ovia Health, 2018

"Improving Access to Paid Family Leave to Achieve Health Equity," Robert Wood Johnson Foundation, May 2021

Investing in Maternal and Child Health: An Employer's Toolkit, Campbell KP (ed.), Center for Prevention and Health Services and National Business Group on Health, 2010.

National Partnership for Women & Families (highly recommended):

- *Improving our maternity care now* makes specific recommendations for private sector decision makers on improving access to midwifery care, community birth, doula support, and support for community-led and community-based perinatal health worker groups.
- *Maternal health and abortion restrictions: How lack of access to quality care Is harming Black women* Issue Brief, October 2019
- *Maternity care in the United States: We can – and must – do better*, Issue Brief, February 2020
- *Black women's maternal health: A multifaceted approach to addressing persistent and dire health disparities*, Issue Brief, April 2018

- *Overdue: Medicaid and private insurance coverage of doula care to strengthen maternal and infant health*, Issue Brief, January 2016
- *Paid family and medical leave: Good for business*, Fact sheet, September 2018
- *Tackling maternal health disparities: A look at four local organizations with innovative approaches*
- *Why is the US Cesarean section rate so high?* Fact sheet, August 2016

Managing Flexible Work Arrangements, Society for Human Resource Management

Novel coronavirus "COVID-19": Special considerations for pregnant women, Kaiser Family Foundation, 17 March 2020

Ovia Health Resources - a collection of white papers, articles, webinars and research related to women's, maternal and family health.

Paid Leave and the Pandemic: Effective Workplace Policies and Practices for a Time of Crisis and Beyond, PL+US (Paid Leave US), Promundo and Parental Leave Corporate Task Force, January 2021

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86. For more specific information, see AHIP, Beyond COVID-19: Policy recommendations to strengthen and improve telehealth services, Issue Brief, 23 July 2020, and Janos E and Paolillo C, Telehealth Update: Extension of the public health emergency, OIG work plan updates, and the Protecting Access to Post-COVID 19 Telehealth Act, Mintz-Healthcare Viewpoints blog, 4 February 2021.

87. Purchaser Value Network Maternity Toolkit: Reducing Unnecessary C-Sections, Purchaser Business Group on Health, April 2016. Three specific strategies are recommended for eliminating financial incentives in contracts: deny payment for medically inappropriate care; reimburse C-sections and vaginal births at the same case rate; and pay one bundled fee for prenatal, delivery and postpartum care.

88. For additional recommendations on creating a culture that supports paid leave, see Paid Leave and the Pandemic: Effective Workplace Policies and Practices For a Time of Crisis and Beyond.

89. U.S. Department of Health and Human Services, Office on Women's Health, What employers need to know, 22 August 2018; How to accommodate breast-feeding employees in the workplace, Society for Human Resource Management blog, 5 September 2019. State laws can include the following: requiring lactation accommodations for employees who are not covered by the federal law; providing for paid lactation break time; extending the time during which an employee is permitted to take lactation breaks beyond 1 year after the birth of a child; providing specific requirements about the space made available for employees to express breast milk; and prohibiting discrimination against employees who choose to express breast milk in the workplace.

90. See Resources.