morganhealth

January 2025

Opportunities to drive high-value maternal health care in employer-sponsored insurance

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Maternal health outcomes are worse in the United States than in any other developed country, and yet **one in every six dollars** that an employer spends on inpatient health care goes towards maternity services. A single pregnancy episode (prenatal care, childbirth, and postpartum care) in the employer-sponsored insurance (ESI) population costs **nearly $25k per pregnancy on average, 14% of which individuals pay out-of-pocket (OOP).** Despite being a key cost driver for employers, maternal health care is riddled with **deeply-rooted inequities that result in poor health outcomes**, (even for low-risk pregnancies), and a negative patient experience. Birthing individuals often experience undiagnosed postpartum depression and face childbirth-related debt; for non-white birthing individuals, rates of adverse outcomes, including mortality, are **2-3 times higher**.

The silver lining is that innovation is occurring – from new companies offering innovative care models, to policies that encourage investment in workforce and training. Medicaid, which pays for 42% of births in the U.S. (and over 50% in some states), has led the way in scaling this type of innovation for maternal health care, exploring new payment models and workforce transformations. Perhaps as a result, Medicaid also tends to be a market entry point for many new maternal health care companies. Unfortunately, the commercial insurance sector sees much less innovation and experimentation in maternal health care, despite tremendous need. Commercial insurance covers half of women in the U.S. – it's time to ensure maternal health care innovation for this population is on par with Medicaid. To identify the most meaningful opportunities for maternal health care innovation in commercial populations, we must first understand the similarities and differences in the ESI maternal health population relative to Medicaid.

We analyzed 2021-2022 birth certificate data from the **Center for Disease Control and Prevention (CDC)'s National Vital Statistics System** and the 2019-2022 **National Health Interview Survey (NHIS)** data to shed light on the similarities and differences between the Medicaid and ESI populations, and to highlight areas of Medicaid innovation that could be applied to ESI. Below are three key challenges facing birthing individuals with ESI, some of which are unique to ESI while others map to what is seen in Medicaid populations.

51.7%

U.S. births covered by private insurance

$25k

Average cost of a single pregnancy in the employer-sponsored insurance population

Birthing individuals on ESI are financially strained: 26% of Black birthing individuals with employer-sponsored insurance also receive WIC

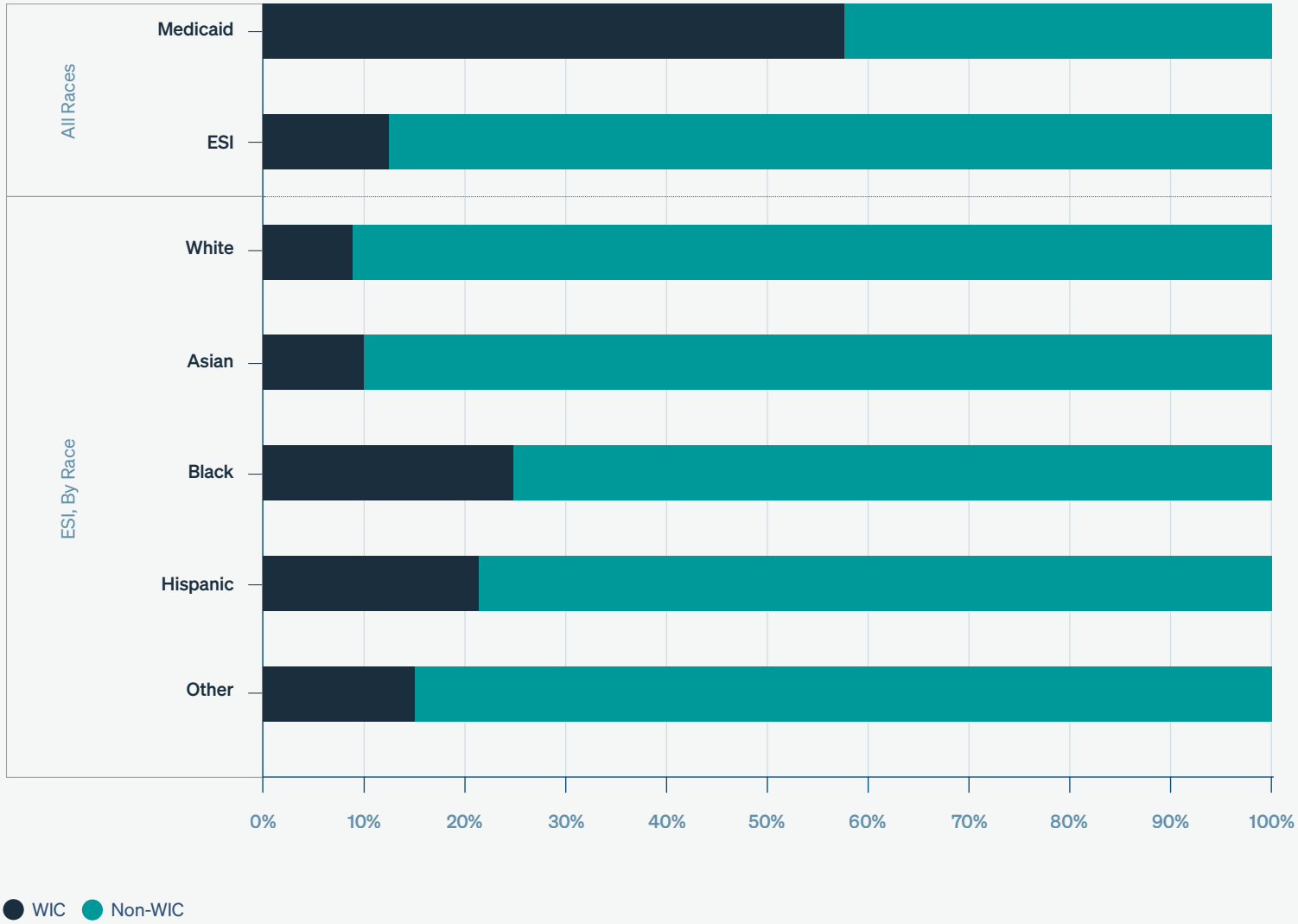
Socioeconomic status is often inferred by whether an individual is covered under Medicaid. For pregnant individuals, Medicaid is an imperfect determinant of socioeconomic status because income thresholds are low enough that individuals who don't qualify can still face significant economic hardship. Coupling this with Medicaid's significantly more generous coverage of pregnancy than most ESI plans, there is a group of pregnant individuals with ESI who are at elevated risk of an adverse financial event. To understand the financial stress a birthing individual with ESI might be facing, we assessed the prevalence of Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) enrollment – another type of federal financial assistance linked to pregnancy status and income level – across all births in 2022. Our findings demonstrate that nearly 13% of all birthing individuals on ESI are receiving WIC. When stratifying by race, we found that 26% of Black birthing individuals on ESI are receiving WIC, followed by 21% of Hispanic birthing individuals on ESI. Black and Hispanic birthing individuals on ESI are much closer in prevalence of WIC coverage to their Medicaid counterparts than other races.

The prevalence of WIC receipt in the ESI population becomes even more meaningful when considering that **roughly one-third of young women with medical debt cite childbirth as the primary contributor.** Within ESI, **birthing individuals incur $3,000 more in OOP spend** within the year of giving birth compared to matched ESI individuals who did not give birth, primarily due to high deductibles and poor coverage of childbirth events in commercial plans. For ESI individuals who meet criteria for WIC (and likely many more who do not), an additional $3,000 cost is a major adverse financial event. While financial challenges are inherent in the Medicaid population, **Medicaid coverage of childbirth events generally exceeds coverage in ESI**, exacerbating financial hardship for pregnant individuals with low socioeconomic status who do not qualify for Medicaid.

Our findings demonstrate that nearly 13% of all birthing individuals on ESI are receiving WIC, despite the long-held belief that it is designed for the Medicaid population.

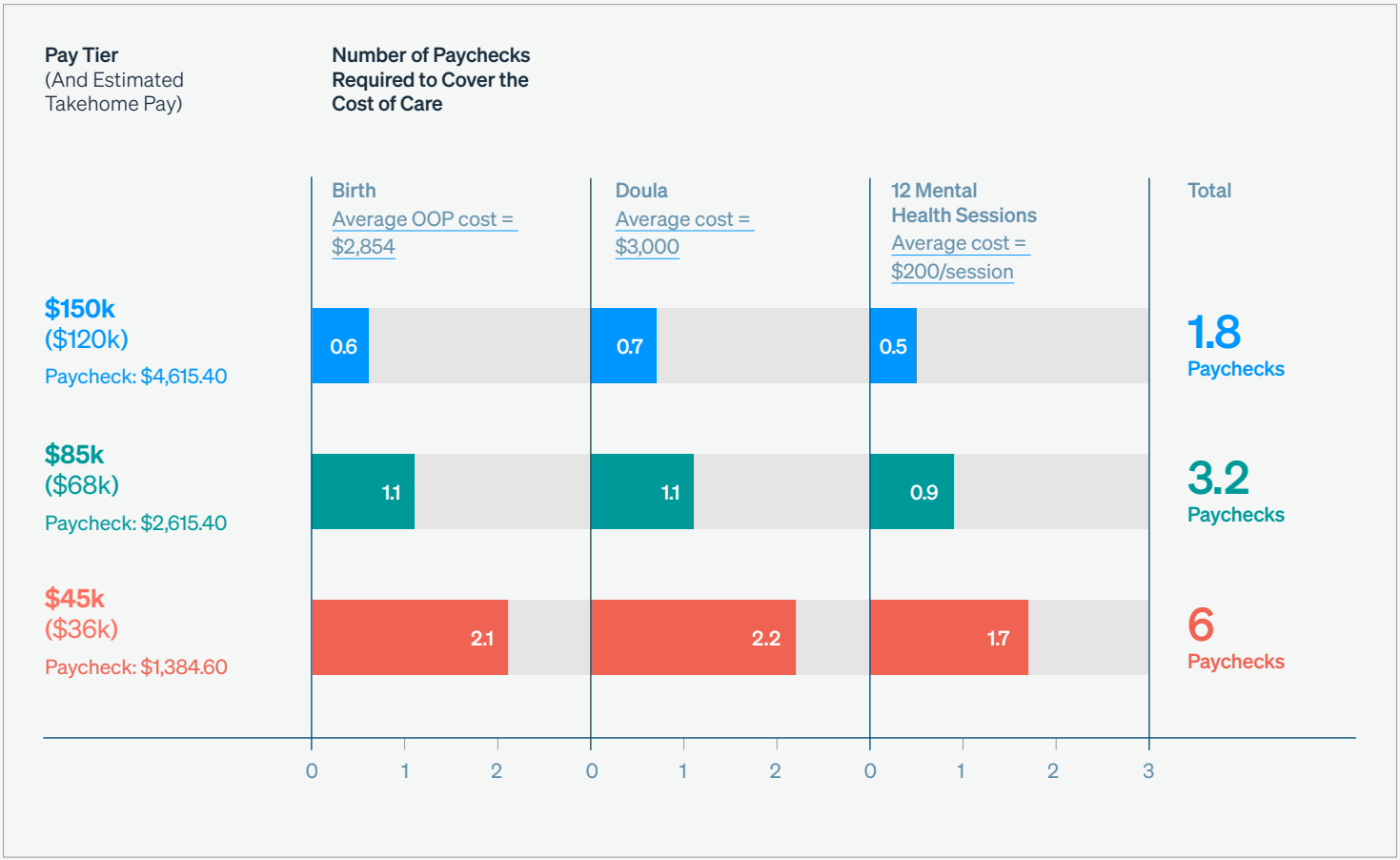
Using NHIS data, we were able to assess self-reported affordability challenges, and found that rates of difficulty paying medical bills within a year after childbirth in ESI approached the level of hardship those with Medicaid experienced (12.4% and 17% respectively). Affordability challenges were nearly identical for young birthing individuals (ages 18-29) regardless of insurance status: 16.2% for ESI vs 16.5% for Medicaid – fueling poor health outcomes. Additionally, 5.4% of birthing individuals with ESI reported delaying or not receiving medical care due to cost, and 6.9% of Medicaid birthing individuals reported the same, within a year of giving birth.

Figure 1. Age-Adjusted Prevalence of WIC Use among Birthing Individuals by Insurance Status and Race/Ethnicity: National Vital Statistics System, 2021-2022



Notes: Age adjusted from linear regression models with an indicator for insurance status and continuous years of individual's age, centered at 27yo. Age adjusted estimates reflect prevalence for a 27yo birthing individual.

Figure 2. Paychecks Required to Cover the Cost of Care, by Pay Tier

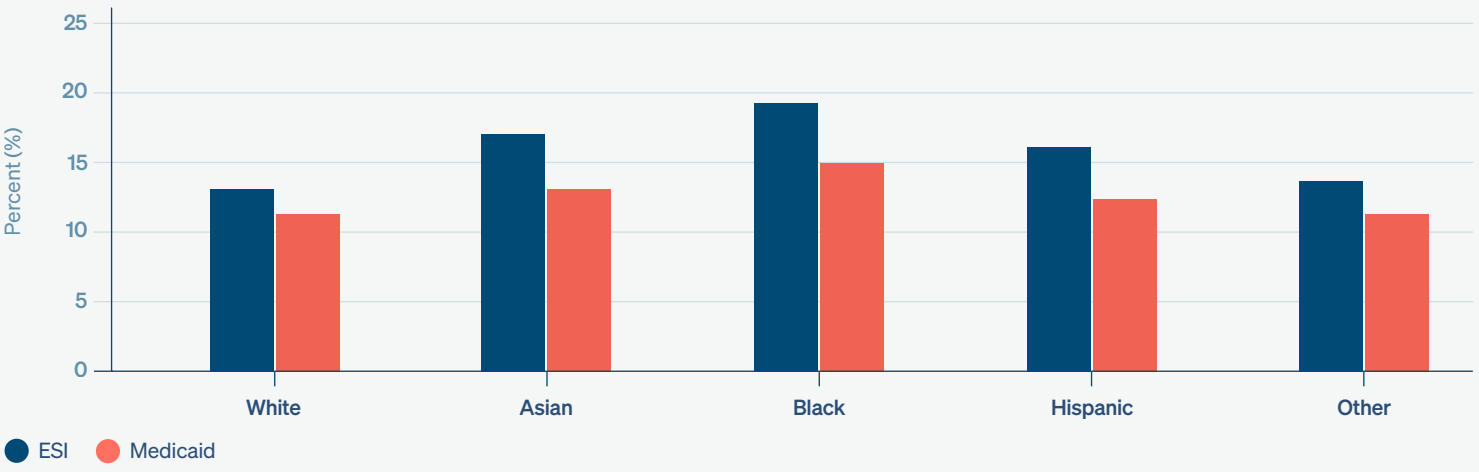


Birthing individuals receiving ESI are more likely to undergo c-sections for low-risk pregnancies than Medicaid recipients

When c-sections are not medically necessary, they can lead to poor clinical outcomes for both birthing individuals and babies. In addition, **c-sections raise the cost of childbirth significantly**. Given c-sections' effects on both cost and quality, the evidence supports using them only when medically necessary. For our analyses, we considered deliveries in low-risk pregnancies, defined as singletons presenting head-first, at full term, to birthing individuals younger than 40 without diabetes, hypertension, eclampsia, or pre-pregnancy obesity, and no previous births or c-sections. By this definition, 42.14% of ESI pregnancies and 38.12% of Medicaid pregnancies in 2022 were considered low-risk. Of all low-risk pregnancies in 2022, 14.2% of birthing individuals receiving ESI received a c-section vs. 12.8% of those receiving Medicaid. These differences became even more apparent when comparing ESI vs. Medicaid within races. Most notably, one in five low-risk Black birthing individuals receiving ESI underwent a c-section, compared to one in seven low-risk Black birthing individuals on Medicaid.

The midwifery model of care has been shown to reduce unnecessary c-sections, reduce costs of childbirth, and improve overall outcomes; c-sections rates are lower when a midwife is present, regardless of insurance, race, or pregnancy risk level. Despite this, adoption of midwifery care in the U.S. lags that of other countries. Across all race and insurance type subgroups, we found the highest utilization of midwifery in Hispanic women receiving ESI (12.5%). This was nearly 3% higher than midwifery utilization in the Hispanic Medicaid population. Disparities by insurance status were not observed within other race groups. Importantly, within all subgroups stratified by race and insurance type, c-section rates were <1% for low-risk pregnancies when a midwife was present.

Figure 3. Age Adjusted Prevalence of Low-Risk C-Section by Insurance Status and Race/Ethnicity: National Vital Statistics System 2021-2022



Notes: Age adjusted from linear regression models with an indicator for insurance status and continuous years of individual's age, centered at 27yo. Age adjusted estimates reflect prevalence for a 27yo birthing individual.

Self reported depression and anxiety are equally prevalent in the ESI and Medicaid birthing populations

The postpartum period is the most neglected of the maternal health episode. Care in the Medicaid population varies widely on a state-by-state basis, with some states covering birthing individuals for only six weeks postpartum, while others have extended this coverage period to an entire year after childbirth. While this coverage limitation does not exist in ESI, it is still the case that standard OB care consists of only a single postpartum visit six weeks after birth. Prevalence rates of postpartum depression vary by study, and these variances are often attributed to differences in data capture. Some studies estimate that up to one-third of new birthing individuals have some form of postpartum depression or anxiety, and that only a small percentage of these individuals receive the care they need. We analyzed self-reported data from NHIS 2019-2022 and found that 36.2% of Medicaid birthing individuals and 31.2% of those receiving ESI reported feeling weekly depression or anxiety symptoms within a year of giving birth. While not a postpartum diagnosis, this helps validate **other findings that up to one-third of birthing individuals** experience mental health challenges.

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What do these findings mean for the future of maternal health innovation?

Unlike Medicaid, in which states heavily dictate budget, network and coverage, and provider payments, ESI plans have several stakeholders informing their structure, including carriers, brokers, employers (including self-insured employers), third-party administrators and the many providers and other vendors included in a plan design or network. Every ESI stakeholder has a role to play in effecting change. Below are some areas our research highlights as ripe for innovation, with **specific recommendations for key stakeholders to consider:**

Affordability challenges with childbirth and maternal care are significant in ESI and are likely to rise with the rising costs of health care and deductibles.	– Payors and employers should find ways to reduce unnecessary costs of care for their maternal health population and out of pocket spend – Payors and employers should follow Medicaid innovation in coverage of doulas, who **improve outcomes but are currently unattainable** by many birthing individuals on ESI due to high OOP cost
The uniquely high rate of low-risk c-sections in the ESI population is indicative of variation in the quality of care being provided.	– Employers can provide transparent data to their employees that enables them to find the best quality provider for delivery whether OB or midwife – Payors and employers should follow Medicaid innovations around blended and bundled payment methods for maternal health care and childbirth to incentivize providers to not perform c-sections when not medically necessary – Employers can put pressure on payors to reimburse midwifery at rates that enable midwives to accept commercial insurance, increasing their accessibility by the ESI birthing population
Postpartum mental health is ripe for disruption given the high prevalence in both ESI and Medicaid.	– Employers and payors should offer postpartum mental health support through channels that are convenient and affordable – Employers are well-positioned to offer much-needed mental health support as a standard benefit to birthing individuals when returning to work, and can leverage scalable technology-enabled solutions where the current medical system has gaps
Racial inequalities are stark in maternal health across the U.S. and are prevalent and nuanced in the ESI population.	– When considering maternal health benefits and programming, employers should be cognizant of the disproportionate financial challenges and overall birthing outcomes experienced by certain races and use selection criteria for new innovations that ensure health equity