

STRATEGIES TO ADDRESS DISPARITIES IN RATES OF CESAREAN SECTIONS

Prepared by Catalyst for Payment Reform December 2025



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Introduction and Acknowledgements

About Catalyst for Payment Reform

Catalyst for Payment Reform (CPR) is an independent, nonprofit corporation with the mission to catalyze employers, public purchasers, policy makers, and others to implement strategies that produce affordable, high-quality health care and improve the functioning of the health care marketplace.

CPR has hosted various purchaser and multi-stakeholder collaboratives over the past seven years on a variety of topics, including [benefits design](#), [maternity health](#) and [accountable care](#). Through these collaboratives, in partnership with subject matter experts, CPR provided participants with hands-on, custom support, and published How-to-Guides, toolkits, and hosted virtual events to disseminate the collaboratives' learnings to a broader audience.

About the Project

CPR partnered with a large health plan to conduct a systematic review of patient journeys in two clinical areas and identify opportunities to increase access through benefits design, with the goal of reducing disparities across the targeted populations. The two clinical areas reviewed were:

- a. Pregnancy through delivery for pregnant women – examining the disparities in the rate of Cesarean sections between Black and White pregnant women.
- b. Colorectal cancer screening – examining the disparities in the rate of colorectal cancer screenings in marginalized Black, Indigenous, People of Color (BIPOC) communities.

Over a 12-month period, CPR hosted collaborative meetings, convening a diverse group of subject matter experts ranging from employer-purchasers, benefits consultants, policy experts, and consumer representatives. CPR also conducted individual interviews with consumer representatives for their insights and perspectives.

Most participants in the collaborative were based in California, which limited the perspectives to some degree.

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Executive Summary

The United States faces a profound maternal health crisis, characterized by the highest maternal mortality rates among high-income countries. This crisis disproportionately impacts Black pregnant women who experience significantly worse outcomes. This report examines the systemic factors driving these disparities and proposes actionable strategies for stakeholders across the healthcare ecosystem.

Although the scope of this report is limited to the disparities between Black and White pregnant women, it is important to acknowledge high C-section rates of other racial groups, like Asian American and Pacific Islander, Native American, and Indigenous pregnant women.ⁱ

An Alarming Reality: Disparities in Maternal Mortality and C-Section Rates for Black Women

The healthcare system has historically failed Black pregnant women due to racial discrimination and medical bias. Black women are 2.6 times more likely to die from pregnancy-related causes than White women; a key contributor to this disparity is the alarmingly high, and often unnecessary, rate of C-sections. Black pregnant women have significantly higher C-section rates (~36.6%) than White pregnant women (~30.9%), based on data from March of Dimes and the National Center for Health Statistics.ⁱⁱ Furthermore, C-section births lead to [greater complications](#) for both mothers and babies than vaginal births. Hospitals often meet C-section reduction targets for White patients, but fail to meet them for Black patients, highlighting systemic inequities and medical bias against Black patients.ⁱⁱⁱ

Strategies for Stakeholders, Including Patients

Addressing these disparities requires concerted action from various stakeholders, including employer-purchasers, health plans, providers, community-based organizations, and policy advocates. This report elucidates key research findings resulting from collaborative discussions, stakeholder interviews, and a literature review. To illustrate the experience of Black pregnant women, CPR created a scenario featuring a healthcare persona based on information gathered through research and consumer representative interviews. To improve outcomes for Black pregnant women, stakeholders can incorporate best-practice strategies in benefits design, policy recommendations, and/or community-based outreach. In addition, patients can be their own best advocates when equipped with proper tools and information, such as a Patient Question Checklist. Such resources can empower patients to engage effectively with employers, health plans, and providers regarding their care options, pregnancy risks, and rights.

What Does the Research Show?

U.S. maternal outcomes are poor, and they are worse for Black pregnant women.

Among high income countries, the U.S. has the highest rate of maternal mortality rates, with the rate being highest for Black pregnant women.^{iv}

According to the Centers for Disease Control (CDC), Black women are 2.6 times more likely to die from a pregnancy-related cause than White women. Multiple factors contribute to these disparities, such as variation in quality healthcare, underlying chronic conditions, structural racism, and implicit bias. In 2022, the maternal mortality rate for Black women was 49.5 deaths per 100,000 live births vs. 19.0 per 100,000 live births for White women.^v

A study of over 1.2 million live births in California between 2018-2020 showed Black patients had a significantly higher C-section rate (28.4%). Among the 106 hospitals that did not meet the [Healthy People 2020](#)¹ C-section target of 23.9% for Black patients, 63 hospitals met it for White patients with a mean rate of 21.4%.^{vi} Higher C-section rates lead to higher risks, which includes infection, blood loss and/or clots, reactions to anesthesia, surgical injury, and increased risk for future pregnancies.^{vii}

Medical bias and misaligned incentives for C-sections negatively and disproportionately impact Black pregnant women.

According to the [CDC](#), the U.S. C-section delivery rate increased 60% from 1996 to 2009, from 20.7% to 32.9%, then slightly decreased from 2009 to 2019 down to 31.7%, and started to increase again in recent years including up to 32.1% in 2021.^{viii} From 2020 to 2022, according to March of Dimes, the C-section rate for Black pregnant women was 36.6% vs. 30.9% for White pregnant women.^{ix}

C-sections—especially unnecessary or coerced ones—contribute to maternal morbidity and mortality rates for Black pregnant women. A study found that financial incentives for hospitals to perform C-sections and risk aversion among obstetricians regarding vaginal births are significant systemic barriers to natural birth.^x Some studies suggest that C-section rates increase as the end of the workday approaches, indicating the influence of scheduling convenience on surgical decisions.^{xi}

Doulas, midwives, and birth centers are essential resources

Social support for birthing women is critical during the pre-labor, labor, and delivery process.^{xii} Along with family, a partner/spouse, or friends, professionals like doulas and midwives can offer personalized care to mothers.

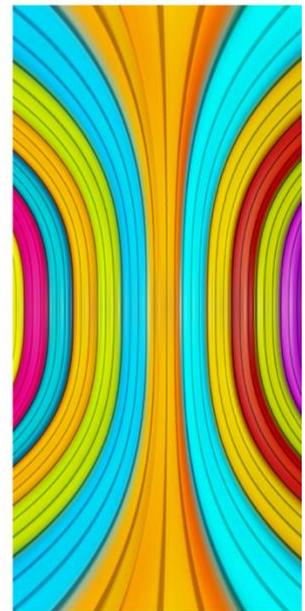
Doulas are non-medical professionals providing physical, emotional, and information support throughout pregnancy, childbirth, and postpartum. A 2023 [review](#) of 16 studies from 2000 to

¹ The Healthy People Initiative is a federal initiative started in the 1980s after Surgeon General Julius Richmond released a report called “Healthy People: The Surgeon General’s Report on Health Promotion and Disease Prevention.” Since 1980, the framework is updated every ten years with recommendations for improving health and wellbeing nationwide. Healthy People 2020 was the fourth iteration at the time of this study.

2021 found that perinatal doula care was significantly correlated with positive delivery outcomes including reduced C-section and premature deliveries.^{xiii} The same study found that the emotional support doulas provide reduces anxiety and stress during the labor period as well as the length of labor.^{xiv}

A midwife is a health care provider [specializing](#) in women's reproductive health and childbirth. Midwives can perform various tasks depending on certification level.^{xv} The use of midwives during childbirth is [associated](#) with fewer C-sections, lower preterm birth rates, lower episiotomy rates, higher breastfeeding rates, and a greater sense of respect and autonomy for the patient. Only [seven percent](#) of certified nurse-midwives and certified midwives identified as Black or African American, despite accounting for 14 percent of the population.^{xvi}

Birth centers are also an alternative for women who prefer a more home-like stay than a hospital. Birth centers are health care facilities that provide a home-like environment for low-risk pregnancies and births. According to the [National Partnership for Women & Families](#), between 2019 and 2020, there was a 30% increase in Black women opting to give birth in birth centers.^{xvii} Compared to larger hospital settings, birth centers offer clients longer appointments and more autonomy in their birth. According to the American Association of Birth Centers, state regulations prohibit birth centers from performing C-sections.^{xviii} Only 20 out of approximately 400 U.S. birth centers are led by Black, Indigenous, and People of Color; the lack of representation limits options for Black pregnant women that seek care from those with similar lived experiences.^{xix}



Risk Factors

Evidence shows the likelihood of a C-section increasing based on the following risk factors:

Risk Factor	How this impacts Black pregnant women
First-time live birth	In first-time live births, Black pregnant women are 21% more likely to deliver via C-section than White pregnant women, despite being low risk. (2022 study in Obstetrics & Gynecology)
Pre-pregnancy weight	2020 CDC data showed the C-section rate varied from ~20% for underweight women to >50% for the highest category of obese women. Data shows pre-pregnancy obesity to be much higher for Non-Hispanic Black women than White women.
Hypertensive disorders of pregnancy (HDP)	<p>CDC data published in 2022 indicates a higher prevalence of HDP in Black women (20.9%) than White women (14.7%).</p> <p>For example, pre-eclampsia, with or without severe features, is a disorder of pregnancy associated with new-onset hypertension, which occurs usually after 20 weeks of gestation and frequently near term (StatPearls). In the U.S., Black pregnant women currently experience the highest rate of pre-eclampsia.^{xx}</p>
Age	Although not specific to only Black pregnant women, during 2020-2022 in the United States, the average rate of Cesarean deliveries was highest for women ages 40 and older (47.5%), followed by women ages 30-39 (35.9%), ages 20-29 (28.0%) and under age 20 (19.2%). (March of Dimes)
Gestational weight gain	<p>According to a 2017 article in JAMA, gestational weight gain above recommendations is associated with a higher risk for C-section.</p> <p>20.5% of primary C-sections could be prevented if cardiometabolic factors were eliminated.^{xxi}</p> <p>Evidence suggests that women from ethnic minority groups are more likely to gain excessive weight during pregnancy.^{xxii}</p>
Gestational diabetes mellitus (GDM)	Although Black pregnant women have the lowest rate of gestational diabetes, those who do develop GDM during pregnancy face a 52% increased risk of developing diabetes in the future compared to White women who develop GDM during pregnancy, according to a Kaiser Permanente study .

To better paint a picture of the challenges that Black pregnant women face in their pregnancy journeys, CPR developed a scenario featuring a doula and patient persona created based on our collaborative interviews and a literature review of current published research. Patient personas are grounded in research but developed with hypothetical elements to offer detailed insights that can help stakeholders understand patients' needs.

Note: These are example personas and are meant to be illustrative and not representative of entire communities/populations. The information included in each description is based on peer-reviewed research, and/or interviews with community members. The images were generated with AI.

Let's follow Briana, a certified doula, as she works with a Black pregnant individual with different risk factors in her maternal care journey. ^{xxiii, xxiv}



Briana is a 38-year-old woman of Pacific Islander descent who offers both in-person and virtual doula services. She runs a private practice in California that serves clients who can pay out of pocket as well as California Medicaid (Medi-Cal) recipients. Trained as a doula at a birth center outside of a hospital setting, Briana incorporates her clinical training, certifications, and cultural heritage into her approach as a doula. When meeting with Medi-Cal families for the first time, Briana provides a birth plan template and encourages clients to complete it according to their preferences, involving family members or partners if they wish. She then reviews the plan with the family, answers any questions, and offers education to help them understand their options. The birth plan may cover topics such as the use of epidurals, different methods of labor induction, and preparations for a possible C-section.

Since beginning her work as a doula in 2013, Briana has noticed improvements in the relationship between doulas and healthcare providers, but she still encounters some resistance and anxiety from providers. Many providers worry that doulas like Briana will advise clients to go against medical advice or encourage the use of traditional or “new age” birthing methods that are not widely accepted. Briana, on the other hand, is concerned about providers' lack of understanding regarding the mistrust many low-income BIPOC pregnant women feel toward the healthcare system, as well as the limited time providers spend discussing the potential side effects of interventions, especially medications used to induce labor. She believes that the increased willingness of providers to work with doulas is due to data showing improved birth outcomes for patients, particularly those from marginalized communities.

One of Briana's clients is Imani, a 26-year-old Black woman and first-time parent living in Oakland, California. Imani is a Medi-Cal recipient. During her prenatal visit, Imani shared she

was experiencing severe headaches and swollen feet, but her doctor initially dismissed her concerns. With support from Briana and her mother, Imani persisted and requested to be tested for preeclampsia, which was eventually diagnosed. Although relieved to have an explanation for her symptoms, Imani felt disheartened by her doctor's initial response, which reminded her of previous experiences where her pain was not taken seriously.

Throughout her pregnancy, Imani felt more confident navigating the healthcare system with Briana by her side. Having Briana's support made Imani feel more comfortable advocating for her needs in a system that had often felt intimidating and traumatic to her and her family. Briana also prepared Imani's boyfriend, Gregory, as well as her mother and sister, for the delivery, helping them understand what to expect and how to best support Imani during labor. Imani gave birth to a baby girl named Nia, with Briana—who is also a lactation specialist—providing immediate postpartum support.



What can You Do? Strategies to Address C-Section Disparities

As we have seen from the scenario above, Black pregnant women face unique challenges in terms of maternity care. There is no one-size-fits-all solution, but there are ways that stakeholders in the healthcare system can address these disparities. Together, stakeholders can alleviate the burden through benefits design, policy, and community-based work.

Stakeholders

Employer-purchasers - Many people get their health coverage from their employer; in 2023, [178 million people](#), or 68% of working-age adults, had employer-sponsored insurance. Employers and other healthcare purchasers can utilize benefits design, data, and advocacy to address disparities in C-section rates and the maternity care journey.

Health Plans - Whether covered by an employer or through private individual insurance, people depend on their health plans for access to benefits.

Providers - Health care providers offer one-on-one, human interaction with and direct care to patients. By building trust and recognizing the barriers that Black pregnant patients face, providers can help them on their maternity journey.

Community-based Organizations (CBOs) - CBOs play an essential role in the respective communities they serve through direct services, community education and outreach, and policy advocacy.

Strategies

Expand Doula Benefits

This strategy is targeted towards employer-purchasers, health plans, and providers.

Stakeholders can expand the coverage of maternity care through benefits design. Benefits design determines how much the health plan (or self-funded purchaser) and the patients will pay for covered health services, from which providers the patient can seek care, and under what circumstances or medical necessity requirements the services are covered. Benefits design can close care gaps through the following mechanisms:

- Reducing or eliminating financial barriers to health services.
- Providing coverage for additional services.
- Signaling to patients which services are valuable and important to fostering good outcomes.

Employer-purchasers can use benefits design to offer and optimize doula benefits to provide support for pregnant women, particularly in underserved communities. A Business Group on Health (BGH) survey in 2023 found that 12% of employers offered birth doula services to expectant parents in 2022, with an additional 5% adding them as a benefit in 2023, and 27% considering doing so for 2024/2025.^{xxv}

CPR interviewed [Lauleva Lua'iufi Aiono](#), a certified doula and traditional birth attendant based

in the Bay Area, who provided first-hand experience and recommendations for improving outcomes. As the founder of [M.A.N.A. Pasefika](#), Lauleva and her team provide reproductive health services for the Native Hawaiian and Pacific Islander communities in San Francisco such as family planning, pregnancy testing, abortion care, contraception, and more. She explained that a "band-aid" approach will not fully address the root causes of C-section disparities. In the Pacific Islander community, which Lauleva notes has much lived experience with hypertension and diabetes, there is a low understanding of body literacy and the implications of this on pregnant women, on the type of birth they may have, and the future health of the baby. With that in mind, Lauleva and her organization have shifted from 1-on-1 doula services to a community education model.

Below are her suggestions for employer-purchasers and health plans:

- Adjust doula reimbursement based on geography and/or cost of living. Reimbursement rates for doulas are low in Medi-Cal, which may not be sustainable for those who want to become a doula but cannot afford to due to the cost of living.
- Build community connections, understanding it will take time. Learning and considering a community's specific needs allows the stakeholder to tailor programming to directly address those needs.
- "You can't serve people that you don't know. Otherwise, you're going to be serving statistics, you're going to be serving two-dimensional information, and our people aren't going to engage those services." – Lauleva
- Allow employees to use their Flexible Spending Account (FSA) funds for doula benefits, including home births.
- When designing doula benefits, employers and health plans should identify and partner with community-based organizations that provide culturally appropriate, community-led doula education programs.

Employer-purchasers have begun to implement new doula benefits. Below are some examples from collaborative participants.

The California Public Employees' Retirement System (CalPERS) coordinated with Medi-Cal to implement its doula benefit. By aligning with Medi-Cal's payment rates, CalPERS sought to avoid payment inequities to doulas and increase access for its members. Medi-Cal increased its doula payment maximum, which led to some health plans adjusting payment rates for CalPERS to align with Medi-Cal.

[Medi-Cal](#) (effective 1/1/2023) and [CalPERS](#) (effective 1/1/2025) doula coverage:

- One initial visit (in-person or virtual, as appropriate).
- Up to 8 additional visits that can be provided in any combination of prenatal and postpartum visits (in-person or virtual).
- Support during labor and delivery, including abortions, miscarriages, or labor and delivery resulting in a stillbirth.
- Up to two extended, three-hour postpartum visits (in-person or virtual).

Source: [NASHP](#)

Self-Insured Schools of California (SISC) implemented a virtual doula program through [Maven Clinic](#), to reduce unnecessary C-sections and improve health outcomes. Maven's platform provides education, telehealth support, and access to doulas and specialists via mobile or web access. Studies conducted by Maven show that virtual doulas help close care gaps between Black and White pregnant women. From a data pool of almost 9,000 Maven users, Black clients who attended two or more doula appointments had a nearly 60% decreased odds of having a C-section.²

[Walmart](#), who was not a participant in the collaborative, piloted a doula benefit in Georgia, Indiana, Illinois, and Louisiana starting in 2022 before expanding the program nationwide in October 2023.³ The benefit covers up to \$1,000 for doula services during pregnancy and is part of Walmart's Life with Baby program, which provides resources at no cost, such as resources from leading experts, baby gifts, and more. To be eligible for the benefit, the doula must be credentialed through either [DONA International](#) or the [National Black Doulas Association \(NBDA\)](#).^{xxvi}

The Appendix offers a **sample doula benefit template** that employers can consider incorporating into their benefits guide.

Address Whole Person Health Through Other Benefits

This strategy is targeted towards health plans.

Growing research and collaborative conversations revealed that addressing C-section disparities is not only a maternal health issue but is a holistic approach to one's well-being. "Whole person health" considers the full spectrum of physical, emotional, social, and spiritual factors that contribute to a person's overall well-being.^{xxvii} This can involve micro issues, such as an individual's diet, and macro issues, such as the environment in which one grows up.^{xxviii}

To address whole person health, health plans can offer benefits including virtual doulas and remote monitoring. Health plans can explore different approaches to doula benefits, such as stipends and coordination with Flexible Spending Accounts (FSAs). Furthermore, providing access to technology, like continuous glucose monitoring (CGM) and remote blood pressure monitoring (RBPM), can improve outcomes associated with diabetes and hypertension.

² Maven collaborative presentation, May 2025.

³ Walmart notes this excludes Hawaii, and those not enrolled in Walmart's Premier, Contribution, Saver or Local medical plans.

Prescription food programs are another avenue to tackle food insecurity, which disproportionately impacts Black pregnant women. [UnitedHealthcare](#) worked with digital health platform [Attane Health](#) to deliver food to high-risk mothers in the state of Kansas, during their third trimester. Attane Health focuses on personalized food access and health coaching for people living with chronic conditions, including expecting mothers.

Health plans can evaluate facilities in their network and their C-section rates and have discussions with in-network providers on performance, and consider imposing financial incentives and/or consequences on performance metrics. For Black pregnant women, health plans should highlight Black providers in provider directories, as research has shown higher satisfaction for Black pregnant women when they work with Black doctors.^{xxix}

Given conclusive evidence of improved outcomes provided by doulas and midwives, **health plans should expand the network of providers** to include more doulas, midwives, and birth centers.

Invest In Education

This strategy is targeted towards employer-purchasers, health plans, and CBOs.

Multiple stakeholders have a responsibility to keep patients informed of their care options.

Employers can share informational resources with employees regarding maternity care benefits and contact information for assistance. **For employer-purchasers** who offer a preferred provider product (PPO), employers should ensure employees are informed of their in-network options and work with their Third-Party Administrators (TPA)⁴ or health plan to identify high-value, in-network outpatient facilities and providers, and have these providers clearly identified in the health plan network directory.^{xxx}

The recommendations to purchasers in the previous section also apply to health plans. **Health plans can support and contribute to community efforts** aimed at improving outcomes and addressing provider bias. For example, health plans can partner with community-based organizations to conduct outreach and education in their respective communities.

CBOs help consumers navigate the healthcare system, whether it is to understand covered benefits or to understand out-of-network care. With enough resources and staffing, CBOs are also able to develop and implement culturally appropriate education and outreach programs to support Black women and pregnant women during their pregnancy journey. In Los Angeles County, the [Black Maternal Health Center of Excellence](#) connects Black families with services such as prenatal and postpartum care, certified doulas and midwives, and birth planning.

Utilize Data

This strategy is targeted towards employer-purchasers, health plans, and CBOs.

Employer-purchasers can promote data-driven accountability and hold plans accountable for reducing C-section disparities by requiring health plans to report C-section data stratified by race and ethnicity and linking them to plan performance. Through the contracting process, purchasers can enforce race/ethnicity stratification in quality reporting. Contractual language can include financial accountability tied to improvement in reducing

⁴ In the health care industry, a third-party administrator (TPA) is an administrative services provider that delivers support for self-insured health plans.

disparities. Collaborative participants recommended analyzing data elements like hospital performance, stratification by health plan, and utilization of benefits like doulas, midwives, and birth centers.

In order to address the long-term effects of racism in the maternity care journeys of Black pregnant women, **it must be measured**. For example, Birthing Cultural Rigor, an organization founded by obstetrician Dr. Karen Scott, developed a survey to measure racism during childbirth.^{xxx} The [Patient Reported Experience Measure of Obstetric Racism® \(The PREM OB Scale® Suite\)](#) asks patients about mistreatment and specific questions on their experiences, like whether they felt that their providers were empathetic and how their partners or family were treated at the hospital.^{xxxii} As a survey tool that is created by and for Black mothers and pregnant women, the PREM OB Scale® can be used by [stakeholders](#) who have an interest in addressing the structural obstetric racism affecting Black pregnant women.

As discussed above in relation to health plans, **employers can utilize data and evaluate key facilities**, and their C-section rates, and have discussions with providers on performance before adding them to their network. This is particularly important if the employer has a direct contracting relationship with facilities.

What Can Patients Do?

All the stakeholders listed previously can do their part to improve the patient journey, but with the proper tools and information, the patient can serve as their own best advocate. Many entities, including health plans, facilities, and states, have a [Patient Bill of Rights](#) that outlines what patients can expect when getting care and help them make informed decisions. Below is a checklist of questions that patients can ask their employer, health plan, or provider during their maternity care journey. We also considered any questions that Black pregnant women would specifically be interested in, based on the research, published patient stories, and collaborative discussions.

Patient Question Checklist

Questions to ask your employer:
<ul style="list-style-type: none">• What are my maternity care benefits for the different stages of my pregnancy, including pre-delivery, delivery, and postpartum care? Am I entitled to maternity care leave? How much PTO am I allowed?• Am I able to use my FSA or HRA/HSA benefit for doula care?
Questions to ask your health plan:
<ul style="list-style-type: none">• Do I have a Patient Bill of Rights or list of rights and responsibilities? If yes, where can I access it?• Do I have access to a doula, whether in-person or virtual? Am I responsible for cost sharing for this benefit?• Are birth centers or midwives covered? Can I find them easily in the provider directory?• Do you have a provider directory that can filter by provider or facility category? For example, can I look specifically for a provider that has worked with patients like me?

Question to ask your provider:

- Do I have a Patient Bill of Rights or list of rights and responsibilities? If yes, where can I access it?
- What are my delivery options?
- What risk factors do I have and how can we address them so I can lower my risk of needing a C-section?
- What are the risks of a C-section? What if I am of a certain age range?
- How will you address my concerns? What kind of communication channels will we have?
- What are my options for pain relief during labor?
- How will I be involved in making decisions about my care plan?
- How can I get screened for and manage conditions like preeclampsia or gestational diabetes?
- What are warning signs I should look for during pregnancy or postpartum, and what should I do if I experience them?
- Can I have a doula or midwife with me along my journey, including in the delivery room, if I choose?
- If a C-section is recommended:
 - Why is a C-section being recommended? What alternatives do I have?
 - Is this C-section medically necessary, or is there time to consider other options?
 - If I need a C-section, can I have skin-to-skin contact with my baby right away?
 - What are your hospital's C-section and vaginal birth after Cesarean (VBAC) rates, especially for Black patients?
 - Will you be the one performing my C-section delivery? If not, how can I meet the doctor who will?
 - Can I request a second opinion if I'm unsure about needing a C-section?

Policy Landscape

Policy can have a positive impact on addressing disparities in C-section rates for Black pregnant women. There has been significant legislation in various states regarding doula benefits and reimbursement. Yet, there are ongoing challenges regarding access to essential maternal benefits.

Kennedy v. Braidwood (which was formerly named Braidwood v. Becerra) challenged the ACA's coverage mandate of preventive services.^{xxxiii}

On January 10, 2025, the Supreme Court agreed to hear an appeal in this case. On February 18, 2025, the Trump Administration agreed to take over the case, arguing that the HHS Secretary has ultimate oversight of the United States Preventative Services Task Force members and its recommendations.^{xxxiv} [On June 27, 2025](#), the Supreme Court preserved coverage of preventive health care. While coverage remains intact, the court decision also raises the question of whether [Secretary of Health and Human Services Robert F. Kennedy Jr. plans to alter the USPSTF membership](#).

Currently there is no federal law requiring doula benefits, though CMS allows doula services as a covered benefit under Medicaid. Thirteen state Medicaid agencies [actively](#) reimburse for doula services, 12 states are in the process of implementing reimbursement strategies, and 19 states have taken [various actions](#) related to expanding doula access, which involves legislative action and doula pilot programs by Medicaid plans. Reimbursement rates by state vary from \$450-\$3,000+ per delivery.^{xxxv}

Certain state Medicaid agencies have implemented blended payment for maternity, in which case a single payment is given to a healthcare provider for an entire birthing episode, regardless of whether the delivery is vaginal or Cesarean. This would eliminate the financial incentive to perform a more expensive C-section procedure when not medically necessary. In [Minnesota](#), blended payment policies reduced C-sections by three percentage points and the cost of childbirth hospitalizations within three years also decreased. However, internal analyses found conflicting results; thus, the state rescinded the policy in 2015.



Looking Ahead

C-sections can be a life-saving and necessary procedure in some circumstances but can also lead to complications for both the pregnant woman and the baby. This report documents the higher C-section rate for Black pregnant women compared to White pregnant women, a disparity that likely leads to preventable deaths. There is a maternal mortality crisis in the U.S., and Black pregnant women are disproportionately impacted.

Black mothers and pregnant women continue to face barriers in their maternity care rooted in structural racism. One of the keys to addressing these disparities is to listen to Black pregnant woman and offer empathetic, coordinated support throughout the pregnancy, labor and delivery, as well as postpartum care. This support can take shape with maternity benefits expanding to include doulas, midwives, or birth centers. Also consider whole person health initiatives, such as programs that address food insecurity, which negatively impacts Black pregnant women who may lack access to [healthy whole foods](#).

Doulas, whether visits are virtual or in-person, have been shown to reduce C-section rates in Black pregnant women and improve maternal outcomes. Stakeholders can pilot benefits in a few states, like Walmart has, before implementing a strategy nationwide. Employers can administer these benefits through a TPA or point solution vendor and offer employees the option to pay through a FSA or Health Savings Account.

Collaborative discussions exposed some challenges, too. Participants discussed the limitations of benefit design as a tool for addressing deeply rooted systemic issues. Purchasers expressed the need to balance the implementation of localized strategies with the development of broader benefit designs. Other challenges include collecting comprehensive and reliable data, particularly regarding race and ethnicity, and workforce shortages, including a lack of diverse healthcare providers and limited availability of non-traditional healthcare workers, such as doulas and community health workers.

The strategies in this report are tailored to different stakeholders with a common goal: to reduce disparities in C-section rates between Black and White pregnant women. With collective, focused action, we can address the Black maternal health crisis and work towards healthier outcomes for Black pregnant women.

Appendix

Disclaimer: Please note that the information provided here by CPR is for informational purposes only and is provided as guidance for consideration. It is always recommended to consult with a qualified benefits consultant tailored to your situation. Any of these provisions can be modified to fit your benefit design needs.

Sample Employer Benefit Guide Section

Virtual Doula Support Benefit: Maternity & Postpartum Care

Purpose

To promote healthy births and reduce disparities in maternal outcomes, this benefit provides access to virtual doula support for employees and their families throughout pregnancy, childbirth, and the postpartum period.

What Is a Doula?

A doula is a trained professional who provides physical, emotional, and informational support before, during, and after childbirth. Research shows doulas can help reduce the likelihood of Cesarean sections, increase satisfaction with birth experiences, and improve outcomes—especially among Black, Indigenous, and other historically underserved pregnant women.

Covered Services

Members have 24/7 access to virtual maternity support through a designated platform (e.g., Maven), including:

- Prenatal coaching and birth planning
- Live chat or video visits with certified doulas
- Emotional and mental health support
- Lactation consulting
- Postpartum check-ins and recovery guidance

Eligibility

This benefit is available to:

- Employees
- Spouses or domestic partners
- Dependents enrolled in the health plan

When You Can Use It

Members may begin using the service:

- As early as pregnancy confirmation
- Through labor and delivery
- Up to 12 weeks postpartum (or longer depending on plan)

Accessing the Benefit

1. Log in to [Virtual Care Platform] via app or web browser
2. Register using your employer-sponsored health plan credentials
3. Schedule visits or message doulas at your convenience

Cost to Member

There is no cost to use the virtual doula service. All sessions and support features are covered by the employer plan.

Language and Cultural Support

- Support is available in multiple languages
- Doulas with culturally aligned backgrounds can be requested

Commitment to Remove Barriers

This benefit reflects our commitment to improving maternal health access and outcomes by expanding access to trusted, culturally responsive care for all families. We aim to:

- Reduce unnecessary C-section rates
- Address maternal mental health disparities
- Support pregnant women in underserved communities

Additional Benefits

This program complements our maternity leave policy, lactation support, and parental wellness programs. For more on available resources, contact [HR contact or Benefits Coordinator.]

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