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Addressing the High Costs of Childbirth: State Policy Approaches to Lowering Cesarean Section Rates

The World Health Organization's ideal acceptable rate of cesarean births is 10% to 15% — but the U.S. national average for these procedures is 32.1%. Although cesarean sections (C-sections) can be lifesaving in limited circumstances, unnecessary C-sections also brings serious risks for babies and birthing people. Babies born by C-section have higher rates of infection, respiratory complications, and neonatal intensive care unit stays, and lower breastfeeding rates. The C-section risks to birthing people include higher rates of hemorrhage, transfusions, infections, and blood clots. C-sections also increase the costs of childbirth because of the higher risks of these maternal and infant complications. The cascading health and financial burden of C-sections reveals that when the conditions exist to support vaginal deliveries, less birthing people will have C-sections and the cost of childbirth coverage will be more cost-effective.

BACKGROUND

The United States has a higher cost of childbirth than many other countries and the highest rate of infant and maternal deaths in the world – with the highest rate among Black women.[1] The costs associated with pregnancy, including prenatal, childbirth, and postpartum care, average a total of $18,865 with the average out-of-pocket payments totaling $2,854 for pregnant people enrolled in large group plans. For those whose births result in C-section the average cost is $26,280 with $3,214 paid out-of-pocket.[2] C-sections are abdominal surgeries that increase recovery time, extend hospital stays, and cost significantly more than vaginal births.

Most pregnancy-related health spending is for the delivery. Although C-sections can be lifesaving in limited circumstances, unnecessary C-sections increase costs of medical

[1] "Insights into the U.S. Maternal Mortality Crisis: An International Comparison." The Commonwealth Fund, 4 June 2024.

[2] Matthew Rae, Cynthia Cox, and Hanna Dingel. "Health costs associated with pregnancy, childbirth, and postpartum care." PETERSON-KFF Health System Tracker, 13 July 2022.

care and involve a higher risk of maternal complications, can be a contributor to the higher rates of maternal morbidity, and can complicate future pregnancies. C-sections increase the cost of patient care because the birthing person has higher rates of hemorrhage, transfusions, infections, and blood clots, and infants have higher rates of infection, respiratory complications, and neonatal intensive care unit stays. There are associated costs including hospital readmissions, home care, and subsequent C-sections. Once a birthing person has had a C-section, there is a greater than 90% chance of having the procedure for subsequent births. Thus, the birthing person has a higher risk of major complications, such as hysterectomy and uterine rupture.[3]

According to research from the World Health Organization (WHO) published in 2021, C-section use continues to rise globally, now accounting for more than 1 in 5 (21%) of all childbirths. This number is set to continue increasing over the coming decade, with nearly a third (29%) of all births likely to take place by C-section by 2030.[4] The World Health Organization's ideal acceptable rate of cesarean births is 10% to 15% — but the U.S. national average for these procedures is 32.1%.[5] [6] The World Health Organization recommends some non-clinical actions, such as patient educational interventions, audits of C-sections, and a requirement for a second opinion before a C- section, to reduce medically unnecessary C-sections.[7]

POLICY RECOMMENDATIONS

The example bills and initiatives below are a reference to be used within a collaborative governance model in order to secure and sustain meaningful racial, social, and economic justice outcomes. We invite values-aligned state legislators to partner with issue advocates and grassroots leaders. Together, they can commit to centering the people most impacted by systemic and structural oppression to transform the conditions of power at the state level.

Prenatal Care

When people receive early, comprehensive, and continuous prenatal care they are more likely to have healthy pregnancies and less likely to have complications. Complications

[3] "Reducing Unnecessary C-Sections in California." California Health Care Foundation, 22 June 2022.
[4] Betran AP, Ye J, Moller A, et al. Trends and projections of caesarean section rates: global and regional estimates. BMJ Global Health 2021;6:e005671.
[5] "WHO statement on caesarean section rates." World Health Organization, 14 April 2015.
[6] Osterman MJK, Hamilton BE, Martin JA, Driscoll AK, Valenzuela CP. Births: Final data for 2022. National Vital Statistics Reports; vol 73, no 2. Hyattsville, MD: National Center for Health Statistics. 2024.
[7] "New WHO guidance on non-clinical interventions specifically designed to reduce unnecessary caesarean sections." World Health Organization, 11 October 2018.

during childbirth cost more than uncomplicated deliveries. When birthing people are healthier entering the prenatal and perinatal period, the birthing person and child will be healthier during labor and delivery, and childbirth coverage will be more cost-effective.

State Initiatives to Lower C-section Rates

Some states, like California, have also implemented statewide initiatives to lower the state C-section rate. The California Maternal Quality Care Collaborative (CMQCC) and Smart Care California implemented multiple approaches to decrease the rates of cesarean delivery from 2016 to 2019. All California hospitals were exposed to statewide actions to reduce the rates of cesarean delivery, including the 149 hospitals that had baseline rates of cesarean delivery greater than 23.9%. This resulted in a decrease in the rate of cesarean delivery for nulliparous, term, singleton, vertex (NTSV) births in California from 26.0% in 2014 to 22.8% in 2019.[8] [9] Some of the statewide activities included clinician education, enhanced support for people in labor, and hospitals sharing unblinded physician-level cesarean delivery rates and allowing physicians to see their own rates and compare themselves with their peers.

A 2021 study found that people delivering at hospitals with higher profits per procedure were associated with an increased probability of undergoing cesarean delivery.[10] To reduce unnecessary C-sections states may want to establish a demonstration project to test payment models for maternity care, including postpartum care, using Smart Care California's Recommendations to Align Birth Payment to Reduce Unnecessary C-Section.[11] Some of the strategies include:

- Reimbursing physicians and hospitals, separately, the same flat rate regardless of cesarean or vaginal delivery.
- Including a NTSV C-section metric in existing hospital and physician quality incentive programs, which is based on low-risk first-time birthing people.

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[8] Rosenstein MG, Chang S, Sakowski C, et al. Hospital Quality Improvement Interventions, Statewide Policy Initiatives, and Rates of Cesarean Delivery for Nulliparous, Term, Singleton, Vertex Births in California. *JAMA.* 2021;325(16):1631–1639.

[9] The C-section rate among low-risk, first-time birthing people (also called Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate) is the proportion of live babies born at or beyond 37.0 weeks gestation to people in their first pregnancy, that are singleton (no twins or beyond), and in the vertex presentation (no breech or transverse positions) via C-section birth.

[10] Sakai-Bizmark R, Ross MG, Estevez D, Bedel LEM, Marr EH, Tsugawa Y. Evaluation of Hospital Cesarean Delivery-Related Profits and Rates in the United States. JAMA Network Open. 2021 Mar 1;4(3):e212235.

[11] "Aligning Birth Payment to Reduce Unnecessary C-Section: A Menu of Options." Smart Care California, October 2017.

- Having payers contract with a network of doctors and hospitals who are held accountable for the quality and cost of the entire continuum of care for a population of patients.
- Considering paying less for C-sections without a medical indication and for scheduled repeat C-sections
- Requiring or incentivizing hospital participation in a maternal data center.
- Implementing network quality improvement requirements with a deadline.

Community Birth Settings

Community birth settings is an increasingly used term for both birth centers and home birth care, and is almost exclusively led by midwives. Research shows that community birth settings provide multiple benefits including: lower rates of many interventions; more favorable assessments of experiences; better outcomes, such as lower rates of preterm birth and cesarean birth, and higher rates of breastfeeding; and lower overall costs. Expanding access to care in community birth settings is a cost-effective solution to providing higher quality care and better birth outcomes, and – with intentional focus – to advancing birth equity.[12] Additionally, Doula support is a well-researched and evidence-based pathway to improve pregnancy outcomes and experiences, reduce medical interventions related to birth, including C-sections, and provides cost savings from a public health standpoint.[13] Of note, interest for both community birth settings and doula care far exceeds access.

Proactive Legislation

Black Mamas Matter: In Policy and Practice 2023

Beyond initiatives for lowering the C-section rates there are sample legislation on policies that can be implemented by state legislatures to enhance quality of care for all pregnant people. In 2023, the Black Mamas Matter Alliance (BMMA), a group of Black women-led organizations and multidisciplinary professionals, published a comprehensive, issues and values-based policy agenda. In centering one of the most vulnerable populations of birthing people, the needs of all birthing people will be addressed and uplifted. BMMA's policy recommendations are bulleted below with examples of state legislation beneath.

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[12] "Improving Our Maternity Care Now Through Community Birth Settings." National Partnership for Women & Families, April 2022.
[13] "A Cost-Benefit Analysis of Doula Care from a Public Health Framework." National Health Law Program, 23 January 2024.

- Cover the full range of maternal, sexual, and reproductive health services by every public and private health plan and coverage program at no or low cost. These services include:
    - Preconception, prenatal, labor and delivery, interconception, and postpartum care.
        - IA House File 334- proposes that the Iowa Medicaid program cover the CenteringPregnancy model of group prenatal care. Referred to committee 2/2023.
        - IL SB 0967- "Improving Health Care for Pregnant and Postpartum Individuals Act" was enacted 1/2023. Multiple initiatives, including that the department must develop best practices for timely identification and assessment of pregnancy-related complications and support a statewide perinatal quality improvement initiative. The Act further includes coverage for dental services for pregnant individuals, comprehensive tobacco use cessation programs, and reproductive health care.
        - MI SB 190- creates a prenatal cash allowance pilot program. Referred to committee 5/2023.
    - Full spectrum, including community-based, doula, midwifery, lactation support, and other perinatal care.
        - LA HB 272- mandates private health insurance to reimburse doula services up to $1,500. Effective 8/2023.
        - RI H 5929A- makes doula services eligible for reimbursement through private insurance plans. Effective 7/2022.
        - VA HB 935- requires private health insurance to cover doula services for at least 8 visits. Effective 1/2025.
        - WA SB 5581- mandates the Office of the Insurance Commissioner to analyze and report on the extent of cost-sharing, and the impact of eliminating such costs. Effective 7/2023.
- Increase access to birth centers by expanding midwifery licensure and access, establishing Medicaid reimbursement at living wages, and eliminating barriers, such as certificate of need, physician supervision, and collaborative agreement requirements.
    - CA SB 159- increases the Medicaid reimbursement rate for doula care from $1500 to $3100 following broader state increases to Medicaid provider rates. Effective 1/2024.

    - WA SB 5950- approves a Medicaid reimbursement rate that will allow birth doulas to claim up to $3,500. Effective 7/2024.
- Develop home birth infrastructure, including public education, health system integration, and the expanding of midwifery licensure and access.
    - IL HB 5142- Provides that insurers shall cover all services for pregnancy, postpartum, and newborn care that are rendered by perinatal doulas or licensed certified professional midwives, including home births, home visits, and support during labor, abortion, or miscarriage. Effective 1/2025 and 1/2026.
- Expand telehealth access through public and private insurance coverage, increased broadband access, and public education.
    - CA AB 2339- would have provided equal access to asynchronous telehealth services and give Medi-Cal beneficiaries the same convenient care as their peers with private insurance, but the governor vetoed the bill 9/2024 citing, “I believe that there are consumer protections provided through a live interaction between a patient and provider.”

RESOURCES

- Black Mama’s Matter Alliance (BMMA)
- California Maternal Quality Care Collaborative
- National Center for Health Statistics: Cesarean Delivery Rate by State
- WHO Guidance on Non-clinical Interventions

CONTACT INFORMATION:

Please contact the State Innovation Exchange (SIX) Reproductive Rights team at reproductiverights@stateinnovation.org with questions or requests for more information.