January 28, 2021

To: Chairman Hansen and Members of the Business and Labor Committee

From: Aubrey Mancuso, Executive Director

**RE: Support for LB 416 - Provide for implicit bias training, coverage under the medical assistance program for doula services and postpartum women, instruction to health professionals, and a pilot program**

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Nebraska’s children deserve every opportunity to grow up to be happy, healthy, and productive adults. Access to affordable and quality health care ensures that children get the best start in life, and public health insurance programs are an essential investment in the health of Nebraska kids. Voices for Children in Nebraska supports LB 416 because it invests in healthier pregnancies for more Nebraska mothers.

Together, Medicaid and the Children’s Health Insurance Program (CHIP), provide health insurance coverage to nearly 30% of Nebraska children.[[1]](#endnote-1) Pregnant women can also receive coverage through CHIP at a higher income level than other adults, at 194% of the federal poverty level (FPL), and are currently eligible for a 60-day postpartum period after delivery as is currently required by federal law.[[2]](#endnote-2) Nearly a third of all Nebraska births were covered by Medicaid in 2016.[[3]](#endnote-3)

The maternal mortality rate in the United States is an extreme aberration among industrialized nations and has consistently increased over time.[[4]](#endnote-4) Black women and American Indian or Alaska Native women are significantly more likely to die from a pregnancy-related complication: 3.3 and 2.5 times as high, respectively, as their White counterparts.[[5]](#endnote-5) Though the risk for and prevalence of childbirth complications are much the same by race, these disparities persist even after controlling for income and education level, indicating that there are systemic barriers to quality care for Black and Native mothers.[[6]](#endnote-6)

Similarly, infant death rates in the United States were 76 percent higher than infants in other wealthy nations.[[7]](#endnote-7) Though infant deaths rates have largely declined in the country over time, disparities by race have widened, with Black and American Indian or Alaska Native infants experiencing worse outcomes, at 11.2 and 8.5 deaths per 1,000 live births.[[8]](#endnote-8) In Nebraska, the infant mortality rate has been on the rise since 2013. In 2018, there were 150 infant deaths, at a rate of 5.9 deaths per 1,000 live births.[[9]](#endnote-9) Black and American Indian or Alaska Native infants in Nebraska experienced significantly higher mortality rates at 10.4 and 9.0 deaths per 1,000 live births.[[10]](#endnote-10)

Health disparities for women of color are the result of a range of systemic barriers to healthy pregnancies that include access to reproductive health care, exposure to chronic stress, and even the availability of quality hospitals located in communities of color.[[11]](#endnote-11) LB 416 addresses one aspect of health equity for women of color—discrimination and implicit bias in health care institutions. Study after study has shown that Black patients are treated differently by health care providers than White patients with the same symptoms.[[12]](#endnote-12) A recent national survey of nearly 1,600 American women found that 22 percent of Black women and 29 percent of native women reported being discriminated against during a doctor or health clinic visit.[[13]](#endnote-13)

LB 416 further invests in doula care for Medicaid-eligible women, who are significantly less likely to utilize the benefits of doula care due to cost. Doulas are trained to provide support to women from pregnancy through birth, by providing information and offering support to women in communicating effectively with clinical professionals. A systematic review of 22 studies involving more than 15,000 women found that that this form of continuous support through childbirth results in positive outcomes, including lower rates of caesarean births, lower utilization of pain medications, shorter labor periods, increased breastfeeding, higher levels of satisfaction, and decreased likelihood of postpartum depression.[[14]](#endnote-14) Currently, at least two other states have expanded such coverage through a State Plan Amendment in their Medicaid programs.[[15]](#endnote-15)

Finally, the expansion of postpartum Medicaid coverage for Nebraska mothers in LB 416 fills a critical and overlooked gap in maternal and infant health in our state. Postpartum health conditions can require treatment well beyond the first two months after birth, and this provision ensures that lower-income mothers can continue to receive the care they need to address childbirth complications, lactation difficulties, pain, depression, reproductive needs, and anxiety, during an already-stressful time in their family’s lives.[[16]](#endnote-16)

We thank Senator Cavanaugh for her leadership on this issue and this committee for their time and consideration. We would urge the committee to advance LB 416. Thank you.

1. Kids Count in Nebraska 2019 Report, Voices for Children in Nebraska, <https://kidscountnebraska.com/health/>. [↑](#endnote-ref-1)
2. 477 Neb. Admin. Code 19-001. [↑](#endnote-ref-2)
3. “Births Financed by Medicaid,” Kaiser Family Foundation, *State Health Facts*, <https://www.kff.org/statedata/>. [↑](#endnote-ref-3)
4. Marian F. MacDorman et al. “Is the United States Maternal Mortality Rate Increasing? Disentangling Trends from Measurement Issues,” *Obstetrics and Gynecology* 128, no. 3 (2016):447-455, doi:10.1097/AOG.0000000000001556. [↑](#endnote-ref-4)
5. Emily E. Petersen, et al., “Vital Signs: Pregnancy-Related Deaths, United States, 2011–2015, and Strategies for Prevention, 13 States, 2013–2017,” *Morbidity and Mortality Weekly Report* 68, no. 18 (2019):423-429, <http://dx.doi.org/10.15585/mmwr.mm6818e1>. [↑](#endnote-ref-5)
6. Gopal K. Singh, “Maternal Mortality in the United States, 1935-2007: Substantial Racial/Ethnic, Socioeconomic, and Geographic Disparities Persist,” U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, 2010, <https://www.hrsa.gov/sites/default/files/ourstories/mchb75th/mchb75maternalmortality.pdf>. [↑](#endnote-ref-6)
7. Ashish P. Thakrar et al., “Child Mortality in The US And 19 OECD Comparator Nations: A 50-Year Time-Trend Analysis,” *Health Affairs* 37, no. 1 (2018):140-149, <https://doi.org/10.1377/hlthaff.2017.0767>. [↑](#endnote-ref-7)
8. Gopal K. Singh and Stella M. Yu, “Infant Mortality in the United States, 1915-2017: Large Social Inequalities Have Persisted for Over a Century,” *International Journal of Maternal and Child Health and AIDS* 8, no. 1 (2019):19-31, doi: 10.21106/ijma.271. [↑](#endnote-ref-8)
9. Child and Maternal Death Review Team Report,” Nebraska Department of Health and Human Services, Division of Public Health, January 2019, <https://nebraskalegislature.gov/FloorDocs/106/PDF/Agencies/Health_and_Human_Services__Department_of/430_20190215-090844.pdf>. [↑](#endnote-ref-9)
10. *Ibid.* [↑](#endnote-ref-10)
11. “Black Women’s Maternal Health: A Multifaceted Approach to Addressing Persistent and Dire Health Disparities,” National Partnership for Women and Families, April 2018, <https://www.nationalpartnership.org/our-work/resources/health-care/maternity/black-womens-maternal-health-issue-brief.pdf>. [↑](#endnote-ref-11)
12. Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Washington, DC: The National Academies Press, 2003), <https://doi.org/10.17226/10260>. [↑](#endnote-ref-12)
13. National Public Radio, the Robert Wood Johnson Foundation, and the Harvard T.H. Chan School of Public Health, “Discrimination in America: Experiences and Views of American Women,” December 2017,

    <https://www.rwjf.org/content/dam/farm/reports/surveys_and_polls/2017/rwjf441994>. [↑](#endnote-ref-13)
14. Ellen D. Hodnett et al., “Continuous Support for Women During Childbirth,” *Cochrane Database of Systematic Reviews* 2013, no. 7, doi: 10.1002/14651858.CD003766.pub5. [↑](#endnote-ref-14)
15. Minnesota and Oregon. Amy Chen, “Routes to Success for Medicaid Coverage of Doula Care,” National Health Law Program and the Preterm Birth Initiative at the University of California San Francisco, December 2018, <https://healthlaw.org/resource/routes-to-success-for-medicaid-coverage-of-doula-care/>. [↑](#endnote-ref-15)
16. American College of Obstetricians and Gynecologists Committee on Obstetric Practice, “Optimizing Postpartum Care,” *Obstetrics and Gynecology* 131, no. 5 (2018):e140-e150, <https://www.acog.org/-/media/Committee-Opinions/Committee-on-Obstetric-Practice/co736.pdf?dmc=1&ts=20190222T1814547421>. [↑](#endnote-ref-16)