

116TH CONGRESS
2D SESSION

H. R. 8027

To improve the public health response to addressing maternal mortality and morbidity during the COVID–19 public health emergency.

IN THE HOUSE OF REPRESENTATIVES

AUGUST 11, 2020

Ms. UNDERWOOD (for herself, Ms. WILD, Mr. KHANNA, Ms. MOORE, Ms. NORTON, Ms. ROYBAL-ALLARD, Mr. CARSON of Indiana, Mr. FOSTER, Mr. TRONE, Mr. LAWSON of Florida, Mrs. MCBATH, Mr. BUTTERFIELD, Ms. OMAR, Ms. JUDY CHU of California, Mr. COHEN, and Mr. KENNEDY) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Education and Labor, and Natural Resources, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To improve the public health response to addressing maternal mortality and morbidity during the COVID–19 public health emergency.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Maternal Health Pan-
5 demic Response Act of 2020”.

1 **SEC. 2. FINDINGS.**

2 Congress finds as follows:

3 (1) The World Health Organization declared
4 COVID–19 a “Public Health Emergency of Inter-
5 national Concern” on January 30, 2020. By the be-
6 ginning of August 2020, there have been over
7 18,000,000 confirmed cases of, and over 700,000
8 deaths associated with, COVID–19 worldwide.

9 (2) In the United States, the number of cases
10 of COVID–19 has quickly surpassed the number of
11 such cases in every other nation, and as of August
12 5, 2020, over 4,000,000 cases and 156,000 deaths
13 have been reported by the United States alone.

14 (3) Long-standing systemic health and social
15 inequities have put communities of color at increased
16 risk of contracting COVID–19 or experiencing se-
17 vere illness; age-adjusted hospitalization rates from
18 COVID–19 are highest for American Indian and
19 Alaska Native, Black, and Latinx people.

20 (4) Prior to the start of the COVID–19 pan-
21 demic, the United States was facing a maternal mor-
22 tality and morbidity crisis, in which the United
23 States has the highest maternal mortality rate in the
24 developed world, and that rate is not improving.

25 (5) More than 50,000 women in the United
26 States annually experience severe maternal mor-

1 bidity, and much larger numbers experience more
2 common harmful challenges, such as prenatal and
3 postpartum anxiety and depression and lack of sup-
4 port for meeting breastfeeding goals.

5 (6) Compared to White women, Black and
6 American Indian and Alaska Native women in the
7 United States are significantly more likely to die
8 from pregnancy-related complications, and Black
9 and American Indian and Alaska Native women suf-
10 fer disproportionately high rates of maternal mor-
11 bidity.

12 (7) The causes of maternal mortality and mor-
13 bidity are complex and include racial, ethnic, and so-
14 cioeconomic inequities; racism, bias, and discrimina-
15 tion; comorbidities; and inadequate access to the
16 health care system, including behavioral health care,
17 which are factors that have similarly contributed to
18 the racial disparities seen in COVID–19 outcomes.

19 (8) The burden of morbidity and mortality in
20 the United States for both COVID–19 and maternal
21 health outcomes has also fallen disproportionately on
22 Black, Latinx, and American Indian and Alaska Na-
23 tive communities, who suffer the most from great
24 public health needs and are the most medically un-
25 derserved.

1 (9) According to the Centers for Disease Con-
2 trol and Prevention, “pregnant people have changes
3 in their bodies that may increase their risk of some
4 infections” and “pregnant people have had a higher
5 risk of severe illness when infected with viruses from
6 the same family as COVID–19 and other viral res-
7 piratory infections, such as influenza”.

8 (10) As of June 25, 2020, the latest informa-
9 tion from the Centers for Disease Control and Pre-
10 vention indicates that pregnant women are more
11 likely to be hospitalized and are at higher risk for
12 intensive care unit admissions than nonpregnant
13 women due to COVID–19, and Latinx and Black
14 pregnant people have been disproportionately in-
15 fected by COVID–19.

16 (11) Our understanding of the specific impact
17 of COVID–19 on pregnant people is limited, in part
18 due to a lack of robust data collection, but the
19 COVID–19 pandemic has further strained the health
20 care system and added another layer of fear and vul-
21 nerability for pregnant people, with disproportionate
22 effects on people of color.

23 (12) As of July 30, 2020, over 14,000 pregnant
24 people in the United States have tested positive for

1 COVID–19 and 35 pregnant people have died as re-
2 sult of COVID–19.

3 (13) The World Health Organization states
4 that everyone “has the right to safe and positive
5 childbirth experience, whether or not they have a
6 confirmed COVID–19 infection, this includes the
7 right to respect and dignity, a companion of choice,
8 clear communication by maternity staff, pain relief
9 strategies, and mobility in labor when possible and
10 the position of choice”.

11 (14) A COVID–19 public health response with-
12 out concerted Federal action and focus on maternal
13 health care access and quality, research, data collec-
14 tion, mitigating negative socioeconomic consequences
15 of the pandemic, and safeguarding the right to safe
16 and positive childbirth experience will risk exacer-
17 bating the maternal mortality and morbidity crisis.

18 **SEC. 3. DEFINITIONS.**

19 In this Act:

20 (1) COVID–19 PUBLIC HEALTH EMERGENCY.—

21 The term “COVID–19 public health emergency”
22 means the period beginning on the date that the
23 public health emergency declared by the Secretary of
24 Health and Human Services under section 319 of
25 the Public Health Service Act (42 U.S.C. 247d) on

1 January 31, 2020, with respect to COVID–19 took
2 effect, and ending on the later of the end of such
3 public health emergency or January 1, 2023.

4 (2) CULTURALLY CONGRUENT.—The term “cul-
5 turally congruent”, with respect to care or maternity
6 care, means care that is anti-racist and is in agree-
7 ment with the preferred cultural values, beliefs,
8 worldview, and practices of the health care consumer
9 and other stakeholders.

10 (3) INDIAN TRIBE, TRIBAL ORGANIZATION, AND
11 URBAN INDIAN ORGANIZATION.—The terms “Indian
12 Tribe” and “Tribal organization” have the meanings
13 given the terms “Indian tribe” and “tribal organiza-
14 tion”, respectively, in section 4 of the Indian Self-
15 Determination and Education Assistance Act (25
16 U.S.C. 5304), and the term “urban Indian organiza-
17 tion” has the meaning given such term in section 4
18 of the Indian Health Care Improvement Act (25
19 U.S.C. 1603).

20 (4) MATERNAL MORTALITY.—The term “mater-
21 nal mortality” means a death occurring during preg-
22 nancy or within one year of the end of pregnancy,
23 from a pregnancy complication, a chain of events
24 initiated by pregnancy, or the aggravation of an un-

1 related condition by the physiologic effects of preg-
2 nancy.

3 (5) POSTPARTUM.—The term “postpartum”
4 means the 1-year period beginning on the last day
5 of a person’s pregnancy.

6 (6) RESPECTFUL MATERNITY CARE.—The term
7 “respectful maternity care” refers to care organized
8 for, and provided to, all pregnant and postpartum
9 people in a manner that is culturally congruent,
10 maintains their dignity, privacy, and confidentiality,
11 ensures freedom from harm and mistreatment, and
12 enables informed choice and continuous support dur-
13 ing labor, childbirth, and postpartum.

14 (7) SECRETARY.—The term “Secretary” means
15 the Secretary of Health and Human Services.

16 (8) SEVERE MATERNAL MORBIDITY.—The term
17 “severe maternal morbidity” means an unexpected
18 outcome caused by labor and delivery that results in
19 significant short-term or long-term consequences to
20 the health of the pregnant person.

1 **SEC. 4. EMERGENCY FUNDING FOR FEDERAL DATA COL-**
2 **LECTION, SURVEILLANCE AND RESEARCH ON**
3 **MATERNAL HEALTH OUTCOMES DURING THE**
4 **COVID-19 PUBLIC HEALTH EMERGENCY.**

5 To conduct or support data collection, surveillance,
6 and research on maternal health as a result of the
7 COVID-19 public health emergency, including support to
8 assist in the capacity building for State, Tribal, territorial,
9 and local public health departments to collect and trans-
10 mit racial, ethnic, and other demographic data related to
11 maternal health, there are authorized to be appro-
12 priated—

13 (1) \$100,000,000 for the Surveillance for
14 Emerging Threats to Mothers and Babies program
15 of the Centers for Disease Control and Prevention,
16 to support the Centers for Disease Control and Pre-
17 vention in its efforts to—

18 (A) work with public health, clinical, and
19 community-based organizations to provide time-
20 ly, continually updated guidance to families and
21 health care providers on ways to reduce risk to
22 mothers and babies and tailor interventions to
23 improve their long-term health;

24 (B) partner with more State, Tribal, terri-
25 torial, and local public health programs in the
26 collection and analysis of clinical data on the

1 impact of COVID–19 on pregnant and
2 postpartum patients and their newborns, includ-
3 ing among pregnant people of color; and

4 (C) establish regionally based centers of
5 excellence to offer medical, public health, and
6 other knowledge to ensure communities, espe-
7 cially communities of color, can help pregnant
8 and postpartum patients and infants get the
9 care they need;

10 (2) \$30,000,000 for the Enhancing Reviews
11 and Surveillance to Eliminate Maternal Mortality
12 program (commonly known as the “ERASE MM
13 program”) of the Centers for Disease Control and
14 Prevention, to support the Centers for Disease Con-
15 trol and Prevention in expanding its partnerships
16 with States and Indian Tribes and provide technical
17 assistance to existing Maternal Mortality Review
18 Committees;

19 (3) \$45,000,000 for the Pregnancy Risk As-
20 sessment Monitoring System (commonly known as
21 the “PRAMS”) of the Centers for Disease Control
22 and Prevention, to support the Centers for Disease
23 Control and Prevention in its efforts to—

24 (A) create a COVID–19 supplement to its
25 PRAMS questionnaire;

1 (B) add questions around experiences of
2 respectful maternity care in prenatal,
3 intrapartum, and postpartum care;

4 (C) conduct a rapid assessment of
5 COVID–19 awareness, impact on care and ex-
6 periences, and use of preventive measures
7 among pregnant, laboring and birthing, and
8 postpartum people during the COVID–19 pub-
9 lic health emergency; and

10 (D) work to transition the survey to an
11 electronic platform and expand the survey to a
12 larger population, with a special focus on reach-
13 ing underrepresented communities; and

14 (4) \$15,000,000 for the National Institute of
15 Child Health and Human Development, to conduct
16 or support research for interventions to mitigate the
17 effects of the COVID–19 public health emergency on
18 pregnant and postpartum people, including Black,
19 Latinx, Asian American and Pacific Islander, and
20 American Indian and Alaska Native people.

21 **SEC. 5. COVID–19 MATERNAL HEALTH DATA COLLECTION**
22 **AND DISCLOSURE.**

23 (a) DATA COLLECTION.—The Secretary, acting
24 through the Director of the Centers for Disease Control
25 and Prevention and the Administrator of the Centers for

1 Medicare & Medicaid Services, shall make publicly avail-
2 able, on the website of the Centers for Disease Control
3 and Prevention, pregnancy and postpartum data collected
4 across all surveillance systems relating to COVID–19,
5 disaggregated by race, ethnicity, State, and Tribal location
6 including the following:

7 (1) Data related to all COVID–19 diagnostic
8 testing, including the number of pregnant people
9 and postpartum people tested and the number of
10 positive cases.

11 (2) Data related to all suspected cases of
12 COVID–19 in pregnant, birthing, and postpartum
13 people who did not undergo testing.

14 (3) Data related to all COVID–19 serologic
15 testing, including the number of pregnant and
16 postpartum people tested and the number of such
17 serologic tests that were positive.

18 (4) Data related to treatment for COVID–19,
19 including hospitalizations, emergency room, and in-
20 tensive care unit admissions of pregnant, birthing,
21 and postpartum people related to COVID–19.

22 (5) Data related to COVID–19 outcomes, in-
23 cluding total fatalities and case fatality (expressed
24 as the proportion of people who were infected with

1 COVID–19 and died from the virus) of pregnant
2 and postpartum people.

3 (6) Data related to pregnancy and infant health
4 outcomes for pregnant people with confirmed or sus-
5 pected COVID–19, which may include stillbirths,
6 maternal mortality and morbidity, infant mortality,
7 preterm births, low-birth weight infants, and cesar-
8 ean section births.

9 (b) TIMELINE.—The Secretary shall update the data
10 made available under this section not less frequently than
11 monthly, during the COVID–19 public health emergency
12 and for at least one month after the end of the COVID–
13 19 public health emergency.

14 (c) PRIVACY.—In publishing data under this section,
15 the Secretary shall take all necessary steps to protect the
16 privacy of people whose information is included in such
17 data, including by complying with—

18 (1) privacy protections under the regulations
19 promulgated under section 264(c) of the Health In-
20 surance Portability and Accountability Act of 1996
21 (42 U.S.C. 1320d–2 note); and

22 (2) protections from all inappropriate internal
23 use by an entity that collects, stores, or receives the
24 data, including use of such data in determinations of

1 eligibility (or continued eligibility) in health plans,
2 and from inappropriate uses.

3 (d) INDIAN HEALTH SERVICE.—The Director of the
4 Indian Health Service and Director of the Centers for Dis-
5 ease Control and Prevention shall consult with Indian
6 Tribes and confer with urban Indian organizations on data
7 collection and reporting for purposes of this section.

8 (e) DATA COLLECTION GUIDANCE.—The Secretary
9 shall issue guidance to States and local public health de-
10 partments to ensure that all relevant demographic data,
11 including pregnancy and postpartum status, are collected
12 and included when sending COVID–19 testing specimen
13 to laboratories, and State and local health departments
14 and Indian Tribes are disaggregating data on COVID–19
15 status in data on maternal and infant morbidity and mor-
16 tality. The Secretary shall ensure that the guidance is de-
17 veloped in consultation with Indian Tribes to ensure that
18 it includes tribally developed best practices on reducing
19 misclassification of American Indian and Alaska Native
20 people in Federal, State, and local public health surveil-
21 lance systems.

1 **SEC. 6. INCLUSION OF PREGNANT PEOPLE AND LACTATING**
2 **PEOPLE IN VACCINE AND THERAPEUTIC DE-**
3 **VELOPMENT FOR COVID-19.**

4 (a) IN GENERAL.—The Director of the National In-
5 stitutes of Health shall—

6 (1) support and advance the responsible inclu-
7 sion of pregnant and lactating people in COVID-19
8 therapeutic and vaccine clinical trials when safe and
9 appropriate;

10 (2) prioritize the implementation of final rec-
11 ommendations made by the Task Force on Research
12 Specific to Pregnant Women and Lactating Women
13 to improve the inclusion of pregnant and lactating
14 people in clinical research when safe and appro-
15 priate, particularly as these recommendations apply
16 to the development and issuance of safe and effective
17 COVID-19 therapeutics and vaccines; and

18 (3) ensure that at least one COVID-19 vaccine
19 developed and made available for use in the United
20 States is suitable for pregnant people and lactating
21 people.

22 (b) REQUIREMENTS.—

23 (1) REPORTING REQUIREMENTS.—The Director
24 of the National Institutes of Health shall collect in-
25 formation from every developer of a drug or biologi-
26 cal product for the treatment or prevention of

1 COVID–19 in the clinical stages of development that
2 received Federal funding from the Department of
3 Health and Human Services and its subagencies re-
4 garding—

5 (A) how evidence is being generated to
6 evaluate the safety, efficacy, and appropriate
7 dosing of the drug or biological product among
8 pregnant people and lactating people;

9 (B) plans for the systematic collection of
10 data from people who are inadvertently exposed
11 to the drug or biological product while pregnant
12 or lactating;

13 (C) plans for the inclusion of pregnant
14 people and lactating people, including racial and
15 ethnic minorities disproportionately affected by
16 COVID–19, in clinical trials or the rationale for
17 exclusion; and

18 (D) plans for performing Developmental
19 and Reproductive Toxicology studies, or the ra-
20 tionale for not performing such studies.

21 (2) DRUG APPROVALS AND BIOLOGICAL PROD-
22 UCT LICENSING.—The Commissioner of Food and
23 Drugs shall require a drug or biological product de-
24 veloper submit, as part of an application for ap-
25 proval of a drug under section 505 of the Federal

1 Food, Drug, and Cosmetic Act (21 U.S.C. 355) or
2 licensing of a biological product under section 351 of
3 the Public Health Service Act (42 U.S.C. 262) for
4 the treatment or prevention of COVID-19—

5 (A) an adequate representation of the ef-
6 fect of the drug or biological product on preg-
7 nant people and lactating people, either through
8 the inclusion of pregnant people and lactating
9 people in clinical trials when safe and appro-
10 priate or other research, or through a scientific
11 and ethical justification as to why pregnant
12 people or lactating people were not included in
13 clinical trials; and

14 (B) a comprehensive plan for the collection
15 of additional evidence of safety and efficacy for
16 pregnant and lactating people after approval
17 under such section 505 or licensure under such
18 section 351, or after issuance of an emergency
19 use authorization under section 564 of the Fed-
20 eral Food, Drug, and Cosmetic Act (21 U.S.C.
21 360bbb-3).

22 **SEC. 7. PUBLIC HEALTH COMMUNICATION REGARDING MA-**
23 **TERNAL CARE DURING COVID-19.**

24 (a) PUBLIC HEALTH CAMPAIGN.—The Director of
25 the Centers for Disease Control and Prevention shall un-

1 dertake a robust public health education effort to enhance
2 access by pregnant people, their employers, and their pro-
3 viders to accurate, evidence-based health information
4 about COVID–19 and pregnancy, safety, and risk, with
5 a particular focus on reaching pregnant people in under-
6 served communities.

7 (b) EMERGENCY TEMPORARY STANDARD.—

8 (1) IN GENERAL.—In consideration of the grave
9 risk presented by COVID–19 and the need to
10 strengthen protections for employees, pursuant to
11 section 6(c)(1) of the Occupational Safety and
12 Health Act of 1970 (29 U.S.C. 655(c)(1)) and not-
13 withstanding the provisions of law and the Executive
14 order listed in paragraph (3), not later than 7 days
15 after the date of enactment of this Act, the Sec-
16 retary of Labor shall promulgate an emergency tem-
17 porary standard to protect all employees at occupa-
18 tional risk from occupational exposure to SARS-
19 CoV-2.

20 (2) PREGNANT AND POSTPARTUM EMPLOY-
21 EES.—The emergency temporary standard promul-
22 gated under this subsection shall include consider-
23 ation of the risks and needs specific to pregnant and
24 postpartum employees.

1 (3) INAPPLICABLE PROVISIONS OF LAW AND
2 EXECUTIVE ORDER.—The requirements of chapter 6
3 of title 5, United States Code (commonly referred to
4 as the “Regulatory Flexibility Act”), subchapter I of
5 chapter 35 of title 44, United States Code (com-
6 monly referred to as the “Paperwork Reduction
7 Act”), the Unfunded Mandates Reform Act of 1995
8 (2 U.S.C. 1501 et seq.), and Executive Order 12866
9 (58 Fed. Reg. 190; relating to regulatory planning
10 and review), as amended, shall not apply to the
11 standard promulgated under this subsection.

12 (c) TASK FORCE ON BIRTHING EXPERIENCE AND
13 SAFE, RESPECTFUL MATERNITY CARE IN RESPONSE TO
14 THE COVID–19 PUBLIC HEALTH EMERGENCY.—

15 (1) ESTABLISHMENT.—The Secretary, in con-
16 sultation with the Director of the Centers for Dis-
17 ease Control and Prevention and the Administrator
18 of the Health Resources and Services Administra-
19 tion, shall convene a task force to develop Federal
20 recommendations regarding respectful maternity
21 care, including safe birth care and postpartum care,
22 during the COVID–19 public health emergency.

23 (2) DUTIES.—The task force established under
24 paragraph (1) shall develop, publicly post, and up-
25 date Federal recommendations in multiple languages

1 to ensure quality, provide nondiscriminatory mater-
2 nity care, promote positive birthing experiences, and
3 improve maternal health outcomes during the
4 COVID–19 public health emergency, with a par-
5 ticular focus on outcomes for communities of color
6 and rural populations. Such guidelines and rec-
7 ommendations shall—

8 (A) address, with particular attention to
9 ensuring equitable treatment on the basis of
10 race and ethnicity—

11 (i) measures to facilitate respectful
12 maternity care;

13 (ii) strategies to increase access to
14 specialized care for those with high-risk
15 pregnancies or pregnant individuals with
16 elevated risk factors;

17 (iii) COVID–19 diagnostic testing for
18 pregnant and laboring patients;

19 (iv) birthing without one’s chosen
20 companions, with one’s chosen companions,
21 and with smartphone or other telehealth
22 connection to one’s chosen companions;

23 (v) newborn separation after birth in
24 relation to maternal COVID–19 status;

1 (vi) breast milk feeding in relation to
2 maternal COVID–19 status;

3 (vii) licensure, training, scope of prac-
4 tice, and Medicaid and other insurance re-
5 imbursement for certified midwives, cer-
6 tified nurse-midwives, certified professional
7 midwives, in a manner that facilitates in-
8 clusion of midwives of color and midwives
9 from underserved communities;

10 (viii) financial support for perinatal
11 health workers who provide non-clinical
12 support to people from pregnancy through
13 the postpartum period, such as a doula,
14 community health worker, peer supporter,
15 lactation consultant, nutritionist or dieti-
16 tian, social worker, home visitor, or a pa-
17 tient navigator in a manner that facilitates
18 inclusion from underserved communities;

19 (ix) how to identify, address, and
20 treat prenatal and postpartum mental and
21 behavioral health conditions, such as anx-
22 iety, substance use disorder, and depres-
23 sion, which may have arisen or increased
24 during the COVID–19 public health emer-
25 gency;

1 (x) strategies to address hospital ca-
2 pacity concerns in communities with a
3 surge in COVID–19 cases and to provide
4 childbearing people with options that re-
5 duce potential for cross-contamination and
6 increase the ability to implement their care
7 preferences while maintaining safety and
8 quality, such as the use of auxiliary mater-
9 nity units and freestanding birth centers;

10 (xi) how to identify and address rac-
11 ism, bias, and discrimination in the deliv-
12 ery treatment and support to pregnant and
13 postpartum people, including evaluating
14 the value of training for hospital staff on
15 implicit bias and racism, respectful mater-
16 nity care, and demographic data collection;
17 and

18 (xii) such other matters as the task
19 force determines appropriate;

20 (B) identify barriers to the implementation
21 of the guidelines and recommendations;

22 (C) take into consideration existing State
23 and other programs that have demonstrated ef-
24 fectiveness in addressing pregnancy, birth, and

1 postpartum care during the COVID–19 public
2 health emergency; and

3 (D) identify policies specific to COVID–19
4 that should be discontinued when safely possible
5 and those that should be continued as the pub-
6 lic health emergency abates.

7 (3) MEMBERSHIP.—The task force established
8 under paragraph (1) shall be comprised of—

9 (A) representatives of the Department of
10 Health and Human Services, including rep-
11 resentatives of—

12 (i) the Secretary;

13 (ii) the Director of the Centers for
14 Disease Control and Prevention;

15 (iii) the Administrator of the Health
16 Resources and Services Administration;

17 (iv) the Administrator of the Centers
18 for Medicare & Medicaid Services;

19 (v) the Director of the Agency for
20 Healthcare Research and Quality; and

21 (vi) the Director of the Indian Health
22 Service;

23 (B) at least 3 State, local, or territorial
24 public health officials representing departments
25 of public health, who shall represent jurisdic-

tions from different regions of the United States with relatively high concentrations of historically marginalized populations, to be appointed by the Secretary;

(C) at least 1 Tribal public health official representing departments of public health;

(D) 1 or more representatives of a community-based organization that addresses adverse maternal health outcomes with a specific focus on racial and ethnic inequities in maternal health outcomes, appointed by the Secretary, with special consideration given to organizations led by a person of color or from communities with significant minority populations;

(E) 1 or more obstetrician-gynecologist or other physician who provides obstetric care, with special consideration for physicians who are from, or work in, communities experiencing the highest rates of COVID–19 mortality and morbidity;

(F) 1 or more nurse, such as a certified nurse-midwife, women’s health nurse practitioner, or other nurse who provides obstetric care, with special consideration for nurses who are from, or work in, communities experiencing

1 the highest rates of COVID–19 mortality and
2 morbidity;

3 (G) 1 or more perinatal health workers
4 who provide non-clinical support to people from
5 pregnancy through postpartum period, such as
6 a doula, community health worker, peer sup-
7 porter, lactation consultant, nutritionist or die-
8 titian, social worker, home visitor, or patient
9 navigator;

10 (H) 1 or more patients who were pregnant
11 or gave birth during the COVID–19 public
12 health emergency;

13 (I) 1 or more patients who contracted
14 COVID–19 and later gave birth;

15 (J) 1 or more patients who have received
16 support from a perinatal health worker who
17 provides prenatal and postpartum support, such
18 as a doula, community health worker, peer sup-
19 porter, lactation consultant, nutritionist or die-
20 titian, social worker, home visitor, or a patient
21 navigator, or a spouse or family member of
22 such patient; and

23 (K) racially and ethnically diverse rep-
24 resentation from at least 3 independent experts
25 with knowledge or field experience with racial

1 and ethnic disparities in public health, women’s
2 health, or maternal mortality and severe mater-
3 nal morbidity.

4 **SEC. 8. GAO REPORT ON MATERNAL HEALTH AND PUBLIC**
5 **HEALTH EMERGENCY PREPAREDNESS.**

6 Not later than 1 year after the end of the public
7 health emergency declared by the Secretary of Health and
8 Human Services under section 319 of the Public Health
9 Service Act (42 U.S.C. 247d) on January 31, 2020, with
10 respect to COVID–19, the Comptroller General of the
11 United States shall submit to the appropriate committees
12 of Congress a report on maternal health and public health
13 emergency preparedness, including prenatal, labor and de-
14 livery, and postpartum care during the COVID–19 public
15 health emergency, including the following:

16 (1) A review of the prenatal, labor and delivery,
17 and postpartum experiences of people during the
18 COVID–19 public health emergency, which shall—

19 (A) identify barriers to accessing preg-
20 nancy, birth, and postpartum care during a
21 pandemic;

22 (B) assess the extent to which public and
23 private insurers were providing coverage for
24 maternal health care during the public health
25 emergency, including for telehealth services;

1 (C) to the extent practicable, analyze ma-
2 ternal and infant health outcomes by race and
3 ethnicity (including quality of care, mortality,
4 morbidity, cesarean section rates, preterm birth,
5 prevalence of prenatal and postpartum anxiety
6 and depression) during the COVID–19 public
7 health emergency and the impact of Federal
8 and State policy changes made in response to
9 the COVID–19 pandemic on such outcomes;

10 (D) identify contributors to population-
11 based disparities seen in COVID–19 outcomes,
12 such as racial profiling of, and bias and dis-
13 crimination against Black, American Indian
14 and Alaska Native, Latinx, and Asian American
15 and Pacific Islander people; and

16 (E) review the impact of increased unem-
17 ployment, paid family leave, changes in health
18 care coverage, and other social determinants of
19 health for pregnant and postpartum people dur-
20 ing the public health emergency.

21 (2) Consultation with maternity care providers,
22 maternal mental and behavioral health care special-
23 ists, researchers who specialize in women’s health or
24 maternal mortality and severe maternal morbidity,
25 people who experienced pregnancy or childbirth dur-

1 ing the COVID–19 public health emergency, rep-
2 resentatives from community-based organizations
3 that address maternal health, and perinatal health
4 workers who provide nonclinical support to pregnant
5 and postpartum people (such as a doula, community
6 health worker, peer support, certified lactation con-
7 sultant, nutritionist or dietician, social worker, home
8 visitor, or navigator).

9 (3) Recommendations to improve the public
10 health emergency response and preparedness efforts
11 of the Federal Government specific to maternal
12 health, with a particular focus on outcomes for mi-
13 nority women, including—

14 (A) ways to improve research, surveillance,
15 and data collection of the Federal Government
16 related to maternal health;

17 (B) ways for the Federal Government to
18 factor maternal health outcomes and disparities
19 into decisions regarding distribution of re-
20 sources, including COVID–19 tests, personal
21 protective equipment, and emergency funding;

22 (C) the extent to which guidelines and rec-
23 ommendations of the Federal Government re-
24 lated to maternal health care during the
25 COVID–19 public health emergency were cul-

1 turally congruent and linguistically competent
2 for minority women; and

3 (D) ways to improve the distribution of
4 public health funds, data, and information to
5 Indian Tribes and Tribal organizations with re-
6 gard to maternal health during the COVID-19
7 public health emergency.

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