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S. 4769

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

IN THE SENATE OF THE UNITED STATES

SEPTEMBER 30 (legislative day, SEPTEMBER 29), 2020

Ms. WARREN (for herself, Mr. BOOKER, Ms. HARRIS, Mrs. GILLIBRAND, and Ms. SMITH) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

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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''.

6 **SEC. 2. FINDINGS.**

7 Congress finds as follows:

8 (1) The World Health Organization declared
9 COVID–19 a ''Public Health Emergency of Inter-

1 national Concern'' on January 30, 2020. By the be-
2 ginning of August 2020, there have been over
3 18,000,000 confirmed cases of, and over 700,000
4 deaths associated with, COVID–19 worldwide.
5 (2) In the United States, the number of cases
6 of COVID–19 has quickly surpassed the number of
7 such cases in every other nation, and as of August
8 5, 2020, over 4,000,000 cases and 156,000 deaths
9 have been reported by the United States alone.
10 (3) Longstanding systemic health and social in-
11 equities have put communities of color at increased
12 risk of contracting COVID–19 or experiencing se-
13 vere illness; age-adjusted hospitalization rates from
14 COVID–19 are highest for American Indian and
15 Alaska Native, Black, and Latinx people.
16 (4) Prior to the start of the COVID–19 pan-
17 demic, the United States was facing a maternal mor-
18 tality and morbidity crisis, in which the United
19 States has the highest maternal mortality rate in the
20 developed world, and that rate is not improving.
21 (5) More than 50,000 women in the United
22 States annually experience severe maternal mor-
23 bidity, and much larger numbers experience more
24 common harmful challenges, such as prenatal and

1 postpartum anxiety and depression and lack of sup-
2 port for meeting breastfeeding goals.
3 (6) Compared to White women, Black and
4 American Indian and Alaska Native women in the
5 United States are significantly more likely to die
6 from pregnancy-related complications, and Black
7 and American Indian and Alaska Native women suf-
8 fer disproportionately high rates of maternal mor-
9 bidity.
10 (7) The causes of maternal mortality and mor-
11 bidity are complex and include racial, ethnic, and so-
12 cioeconomic inequities; racism, bias, and discrimina-
13 tion; comorbidities; and inadequate access to the
14 health care system, including behavioral health care,
15 which are factors that have similarly contributed to
16 the racial disparities seen in COVID–19 outcomes.
17 (8) The burden of morbidity and mortality in
18 the United States for both COVID–19 and maternal
19 health outcomes has also fallen disproportionately on
20 Black, Latinx, and American Indian and Alaska Na-
21 tive communities, who suffer the most from great
22 public health needs and are the most medically un-
23 derserved.
24 (9) According to the Centers for Disease Con-
25 trol and Prevention, "pregnant people have changes

1 in their bodies that may increase their risk of some
2 infections'' and ''pregnant people have had a higher
3 risk of severe illness when infected with viruses from
4 the same family as COVID–19 and other viral res-
5 piratory infections, such as influenza''.

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

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

21 (12) As of July 30, 2020, over 14,000 pregnant
22 people in the United States have tested positive for
23 COVID–19 and 35 pregnant people have died as a
24 result of COVID–19.

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

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

16 **SEC. 3. DEFINITIONS.**

17 In this Act:

18 (1) COVID–19 PUBLIC HEALTH EMERGENCY.—
19 The term ''COVID–19 public health emergency''
20 means the period beginning on the date that the
21 public health emergency declared by the Secretary of
22 Health and Human Services under section 319 of
23 the Public Health Service Act (42 U.S.C. 247d) on
24 January 31, 2020, with respect to COVID–19 took

1 effect, and ending on the later of the end of such
2 public health emergency or January 1, 2023.
3 (2) CULTURALLY CONGRUENT.—The term ''cul-
4 turally congruent'', with respect to care or maternity
5 care, means care that is anti-racist and is in agree-
6 ment with the preferred cultural values, beliefs,
7 worldview, and practices of the health care consumer
8 and other stakeholders.
9 (3) INDIAN TRIBE, TRIBAL ORGANIZATION, AND
10 URBAN INDIAN ORGANIZATION.—The terms ''Indian
11 Tribe'' and ''Tribal organization'' have the meanings
12 given the terms ''Indian tribe'' and ''tribal organiza-
13 tion'', respectively, in section 4 of the Indian Self-
14 Determination and Education Assistance Act (25
15 U.S.C. 5304), and the term ''urban Indian organiza-
16 tion'' has the meaning given such term in section 4
17 of the Indian Health Care Improvement Act (25
18 U.S.C. 1603).
19 (4) MATERNAL MORTALITY.—The term ''mater-
20 nal mortality'' means a death occurring during preg-
21 nancy or within one year of the end of pregnancy,
22 from a pregnancy complication, a chain of events
23 initiated by pregnancy, or the aggravation of an un-
24 related condition by the physiologic effects of preg-
25 nancy.

1 (5) POSTPARTUM.—The term ''postpartum''
2 means the 1-year period beginning on the last day
3 of a person's pregnancy.
4 (6) RESPECTFUL MATERNITY CARE.—The term
5 ''respectful maternity care'' refers to care organized
6 for, and provided to, all pregnant and postpartum
7 people in a manner that is culturally congruent,
8 maintains their dignity, privacy, and confidentiality,
9 ensures freedom from harm and mistreatment, and
10 enables informed choice and continuous support dur-
11 ing labor, childbirth, and postpartum.
12 (7) SECRETARY.—The term ''Secretary'' means
13 the Secretary of Health and Human Services.
14 (8) SEVERE MATERNAL MORBIDITY.—The term
15 ''severe maternal morbidity'' means an unexpected
16 outcome caused by labor and delivery that results in
17 significant short-term or long-term consequences to
18 the health of the pregnant person.

19 **SEC. 4. EMERGENCY FUNDING FOR FEDERAL DATA COL-**
20 **LECTION, SURVEILLANCE, AND RESEARCH**
21 **ON MATERNAL HEALTH OUTCOMES DURING**
22 **THE COVID–19 PUBLIC HEALTH EMERGENCY.**

23 To conduct or support data collection, surveillance,
24 and research on maternal health as a result of the
25 COVID–19 public health emergency, including support to

1 assist in the capacity building for State, Tribal, territorial,
2 and local public health departments to collect and trans-
3 mit racial, ethnic, and other demographic data related to
4 maternal health, there are authorized to be appro-
5 priated—

6 (1) $100,000,000 for the Surveillance for
7 Emerging Threats to Mothers and Babies program
8 of the Centers for Disease Control and Prevention,
9 to support the Centers for Disease Control and Pre-
10 vention in its efforts to—

11 (A) work with public health, clinical, and
12 community-based organizations to provide time-
13 ly, continually updated guidance to families and
14 health care providers on ways to reduce risk to
15 mothers and babies and tailor interventions to
16 improve their long-term health;

17 (B) partner with more State, Tribal, terri-
18 torial, and local public health programs in the
19 collection and analysis of clinical data on the
20 impact of COVID–19 on pregnant and
21 postpartum patients and their newborns, includ-
22 ing among pregnant people of color; and

23 (C) establish regionally based centers of
24 excellence to offer medical, public health, and
25 other knowledge to ensure communities, espe-

1 cially communities of color, can help pregnant
2 and postpartum patients and infants get the
3 care they need;
4 (2) $30,000,000 for the Enhancing Reviews
5 and Surveillance to Eliminate Maternal Mortality
6 program (commonly known as the ''ERASE MM
7 program'') of the Centers for Disease Control and
8 Prevention, to support the Centers for Disease Con-
9 trol and Prevention in expanding its partnerships
10 with States and Indian Tribes and provide technical
11 assistance to existing Maternal Mortality Review
12 Committees; and
13 (3) $45,000,000 for the Pregnancy Risk As-
14 sessment Monitoring System (commonly known as
15 the ''PRAMS'') of the Centers for Disease Control
16 and Prevention, to support the Centers for Disease
17 Control and Prevention in its efforts to—
18 (A) create a COVID–19 supplement to its
19 PRAMS questionnaire;
20 (B) add questions around experiences of
21 respectful maternity care in prenatal,
22 intrapartum, and postpartum care;
23 (C) conduct a rapid assessment of
24 COVID–19 awareness, impact on care and ex-
25 periences, and use of preventive measures

1 among pregnant, laboring and birthing, and
2 postpartum people during the COVID–19 pub-
3 lic health emergency; and
4 (D) work to transition the survey to an
5 electronic platform and expand the survey to a
6 larger population, with a special focus on reach-
7 ing underrepresented communities;
8 (4) $15,000,000 for the National Institute of
9 Child Health and Human Development, to conduct
10 or support research for interventions to mitigate the
11 effects of the COVID–19 public health emergency on
12 pregnant and postpartum people, including Black,
13 Latinx, Asian-American and Pacific Islander, and
14 American Indian and Alaska Native people.

15 **SEC. 5. COVID–19 MATERNAL HEALTH DATA COLLECTION**
16 **AND DISCLOSURE.**

17 (a) DATA COLLECTION.—The Secretary, acting
18 through the Director of the Centers for Disease Control
19 and Prevention and the Administrator of the Centers for
20 Medicare & Medicaid Services, shall make publicly avail-
21 able, on the website of the Centers for Disease Control
22 and Prevention, pregnancy and postpartum data collected
23 across all surveillance systems relating to COVID–19,
24 disaggregated by race, ethnicity, State, and Tribal location
25 including the following:

1 (1) Data related to all COVID–19 diagnostic
2 testing, including the number of pregnant people
3 and postpartum people tested and the number of
4 positive cases.

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

8 (3) Data related to all COVID–19 serologic
9 testing, including the number of pregnant and
10 postpartum people tested and the number of such
11 serologic tests that were positive.

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

16 (5) Data related to COVID–19 outcomes, in-
17 cluding total fatalities and case fatality (expressed
18 as the proportion of people who were infected with
19 COVID–19 and died from the virus) of pregnant
20 and postpartum people.

21 (6) Data related to pregnancy and infant health
22 outcomes for pregnant people with confirmed or sus-
23 pected COVID–19, which may include stillbirths,
24 maternal mortality and morbidity, infant mortality,

1 preterm births, low-birth weight infants, and cesar-
2 ean section births.
3 (b) TIMELINE.—The Secretary shall update the data
4 made available under this section not less frequently than
5 monthly, during the COVID–19 public health emergency
6 and for at least one month after the end of the COVID–
7 19 public health emergency.
8 (c) PRIVACY.—In publishing data under this section,
9 the Secretary shall take all necessary steps to protect the
10 privacy of people whose information is included in such
11 data, including by complying with—
12 (1) privacy protections under the regulations
13 promulgated under section 264(c) of the Health In-
14 surance Portability and Accountability Act of 1996
15 (42 U.S.C. 1320d–2 note); and
16 (2) protections from all inappropriate internal
17 use by an entity that collects, stores, or receives the
18 data, including use of such data in determinations of
19 eligibility (or continued eligibility) in health plans,
20 and from inappropriate uses.
21 (d) INDIAN HEALTH SERVICE.—The Director of the
22 Indian Health Service and Director of the Centers for Dis-
23 ease Control and Prevention shall consult with Indian
24 Tribes and confer with urban Indian organizations on data
25 collection and reporting for purposes of this section.

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

15 **SEC. 6. INCLUSION OF PREGNANT PEOPLE AND LACTATING**
16 **PEOPLE IN VACCINE AND THERAPEUTIC DE-**
17 **VELOPMENT FOR COVID–19.**

18 (a) IN GENERAL.—The Director of the National In-
19 stitutes of Health shall—
20 (1) support and advance the responsible inclu-
21 sion of pregnant and lactating people in COVID–19
22 therapeutic and vaccine clinical trials when safe and
23 appropriate;
24 (2) prioritize the implementation of final rec-
25 ommendations made by the Task Force on Research

1 Specific to Pregnant Women and Lactating Women
2 to improve the inclusion of pregnant and lactating
3 people in clinical research when safe and appro-
4 priate, particularly as these recommendations apply
5 to the development and issuance of safe and effective
6 COVID–19 therapeutics and vaccines; and
7 (3) ensure that at least one COVID–19 vaccine
8 developed and made available for use in the United
9 States is suitable for pregnant people and lactating
10 people.
11 (b) REQUIREMENTS.—
12 (1) REPORTING REQUIREMENTS.—The Director
13 of the National Institutes of Health shall collect in-
14 formation from every developer of a drug or biologi-
15 cal product for the treatment or prevention of
16 COVID–19 in the clinical stages of development that
17 received Federal funding from the Department of
18 Health and Human Services and its subagencies re-
19 garding—
20 (A) how evidence is being generated to
21 evaluate the safety, efficacy, and appropriate
22 dosing of the drug or biological product among
23 pregnant people and lactating people;
24 (B) plans for the systematic collection of
25 data from people who are inadvertently exposed

1 to the drug or biological product while pregnant
2 or lactating;
3 (C) plans for the inclusion of pregnant
4 people and lactating people, including racial and
5 ethnic minorities disproportionately affected by
6 COVID–19, in clinical trials or the rationale for
7 exclusion; and
8 (D) plans for performing Developmental
9 and Reproductive Toxicology studies, or the ra-
10 tionale for not performing such studies.
11 (2) DRUG APPROVALS AND BIOLOGICAL PROD-
12 UCT LICENSING.—The Commissioner of Food and
13 Drugs shall require a drug or biological product de-
14 veloper submit, as part of an application for ap-
15 proval of a drug under section 505 of the Federal
16 Food, Drug, and Cosmetic Act (21 U.S.C. 355) or
17 licensing of a biological product under section 351 of
18 the Public Health Service Act (42 U.S.C. 262) for
19 the treatment or prevention of COVID–19—
20 (A) an adequate representation of the ef-
21 fect of the drug or biological product on preg-
22 nant people and lactating people, either through
23 the inclusion of pregnant people and lactating
24 people in clinical trials when safe and appro-
25 priate or other research, or through a scientific

1 and ethical justification as to why pregnant
2 people or lactating people were not included in
3 clinical trials; and
4 (B) a comprehensive plan for the collection
5 of additional evidence of safety and efficacy for
6 pregnant and lactating people after approval
7 under such section 505 or licensure under such
8 section 351, or after issuance of an emergency
9 use authorization under section 564 of the Fed-
10 eral Food, Drug, and Cosmetic Act (21 U.S.C.
11 360bbb–3).

12 **SEC. 7. PUBLIC HEALTH COMMUNICATION REGARDING MA-**
13 **TERNAL CARE DURING COVID–19.**

14 (a) PUBLIC HEALTH CAMPAIGN.—The Director of
15 the Centers for Disease Control and Prevention shall un-
16 dertake a robust public health education effort to enhance
17 access by pregnant people, their employers, and their pro-
18 viders to accurate, evidence-based health information
19 about COVID–19 and pregnancy, safety, and risk, with
20 a particular focus on reaching pregnant people in under-
21 served communities.
22 (b) EMERGENCY TEMPORARY STANDARD.—
23 (1) IN GENERAL.—In consideration of the grave
24 risk presented by COVID–19 and the need to
25 strengthen protections for employees, pursuant to

1 section 6(c)(1) of the Occupational Safety and
2 Health Act of 1970 (29 U.S.C. 655(c)(1)) and not-
3 withstanding the provisions of law and the Executive
4 order listed in paragraph (3), not later than 7 days
5 after the date of enactment of this Act, the Sec-
6 retary of Labor shall promulgate an emergency tem-
7 porary standard to protect all employees at occupa-
8 tional risk from occupational exposure to SARS–
9 CoV–2.
10 (2) PREGNANT AND POSTPARTUM EMPLOY-
11 EES.—The emergency temporary standard promul-
12 gated under this subsection shall include consider-
13 ation of the risks and needs specific to pregnant and
14 postpartum employees.
15 (3) INAPPLICABLE PROVISIONS OF LAW AND
16 EXECUTIVE ORDER.—The requirements of chapter 6
17 of title 5, United States Code (commonly referred to
18 as the ''Regulatory Flexibility Act''), subchapter I of
19 chapter 35 of title 44, United States Code (com-
20 monly referred to as the ''Paperwork Reduction
21 Act''), the Unfunded Mandates Reform Act of 1995
22 (2 U.S.C. 1501 et seq.), and Executive Order 12866
23 (58 Fed. Reg. 190; relating to regulatory planning
24 and review), as amended, shall not apply to the
25 standard promulgated under this subsection.

1 (c) TASK FORCE ON BIRTHING EXPERIENCE AND
2 SAFE, RESPECTFUL MATERNITY CARE IN RESPONSE TO
3 THE COVID–19 PUBLIC HEALTH EMERGENCY.—
4 (1) ESTABLISHMENT.—The Secretary, in con-
5 sultation with the Director of the Centers for Dis-
6 ease Control and Prevention and the Administrator
7 of the Health Resources and Services Administra-
8 tion, shall convene a task force to develop Federal
9 recommendations regarding respectful maternity
10 care, including safe birth care and postpartum care,
11 during the COVID–19 public health emergency.
12 (2) DUTIES.—The task force established under
13 paragraph (1) shall develop, publicly post, and up-
14 date Federal recommendations in multiple languages
15 to ensure quality, provide nondiscriminatory mater-
16 nity care, promote positive birthing experiences, and
17 improve maternal health outcomes during the
18 COVID–19 public health emergency, with a par-
19 ticular focus on outcomes for communities of color
20 and rural populations. Such guidelines and rec-
21 ommendations shall—
22 (A) address, with particular attention to
23 ensuring equitable treatment on the basis of
24 race and ethnicity—

1 (i) measures to facilitate respectful
2 maternity care;
3 (ii) strategies to increase access to
4 specialized care for those with high-risk
5 pregnancies or pregnant individuals with
6 elevated risk factors;
7 (iii) COVID–19 diagnostic testing for
8 pregnant and laboring patients;
9 (iv) birthing without one's chosen
10 companions, with one's chosen companions,
11 and with smartphone or other telehealth
12 connection to one's chosen companions;
13 (v) newborn separation after birth in
14 relation to maternal COVID–19 status;
15 (vi) breast milk feeding in relation to
16 maternal COVID–19 status;
17 (vii) licensure, training, scope of prac-
18 tice, and Medicaid and other insurance re-
19 imbursement for certified midwives, cer-
20 tified nurse-midwives, certified professional
21 midwives, in a manner that facilitates in-
22 clusion of midwives of color and midwives
23 from underserved communities;
24 (viii) financial support for perinatal
25 health workers who provide non-clinical

1 support to people from pregnancy through
2 the postpartum period, such as a doula,
3 community health worker, peer supporter,
4 lactation consultant, nutritionist or dieti-
5 tian, social worker, home visitor, or a pa-
6 tient navigator in a manner that facilitates
7 inclusion from underserved communities;
8 (ix) how to identify, address, and
9 treat prenatal and postpartum mental and
10 behavioral health conditions, such as anx-
11 iety, substance use disorder, and depres-
12 sion, which may have arisen or increased
13 during the COVID–19 public health emer-
14 gency;
15 (x) strategies to address hospital ca-
16 pacity concerns in communities with a
17 surge in COVID–19 cases and to provide
18 childbearing people with options that re-
19 duce potential for cross-contamination and
20 increase the ability to implement their care
21 preferences while maintaining safety and
22 quality, such as the use of auxiliary mater-
23 nity units and freestanding birth centers;
24 (xi) how to identify and address rac-
25 ism, bias, and discrimination in the deliv-

1 ery treatment and support to pregnant and
2 postpartum people, including evaluating
3 the value of training for hospital staff on
4 implicit bias and racism, respectful mater-
5 nity care, and demographic data collection;
6 and
7 (xii) such other matters as the task
8 force determines appropriate;
9 (B) identify barriers to the implementation
10 of the guidelines and recommendations;
11 (C) take into consideration existing State
12 and other programs that have demonstrated ef-
13 fectiveness in addressing pregnancy, birth, and
14 postpartum care during the COVID–19 public
15 health emergency; and
16 (D) identify policies specific to COVID–19
17 that should be discontinued when safely possible
18 and those that should be continued as the pub-
19 lic health emergency abates.
20 (3) MEMBERSHIP.—The task force established
21 under paragraph (1) shall be comprised of—
22 (A) representatives of the Department of
23 Health and Human Services, including rep-
24 resentatives of—
25 (i) the Secretary;

1 (ii) the Director of the Centers for
2 Disease Control and Prevention;
3 (iii) the Administrator of the Health
4 Resources and Services Administration;
5 (iv) the Administrator of the Centers
6 for Medicare & Medicaid Services;
7 (v) the Director of the Agency for
8 Healthcare Research and Quality; and
9 (vi) the Director of the Indian Health
10 Service;
11 (B) at least 3 State, local, or territorial
12 public health officials representing departments
13 of public health, who shall represent jurisdic-
14 tions from different regions of the United
15 States with relatively high concentrations of
16 historically marginalized populations, to be ap-
17 pointed by the Secretary;
18 (C) at least 1 Tribal public health official
19 representing departments of public health;
20 (D) 1 or more representatives of a commu-
21 nity-based organization that addresses adverse
22 maternal health outcomes with a specific focus
23 on racial and ethnic inequities in maternal
24 health outcomes, appointed by the Secretary,
25 with special consideration given to organizations

1 led by a person of color or from communities
2 with significant minority populations;
3 (E) 1 or more obstetrician-gynecologist or
4 other physician who provides obstetric care,
5 with special consideration for physicians who
6 are from, or work in, communities experiencing
7 the highest rates of COVID–19 mortality and
8 morbidity;
9 (F) 1 or more nurse, such as a certified
10 nurse-midwife, women's health nurse practi-
11 tioner, or other nurse who provides obstetric
12 care, with special consideration for nurses who
13 are from, or work in, communities experiencing
14 the highest rates of COVID–19 mortality and
15 morbidity;
16 (G) 1 or more perinatal health workers
17 who provide non-clinical support to people from
18 pregnancy through postpartum period, such as
19 a doula, community health worker, peer sup-
20 porter, lactation consultant, nutritionist or die-
21 titian, social worker, home visitor, or patient
22 navigator;
23 (H) 1 or more patients who were pregnant
24 or gave birth during the COVID–19 public
25 health emergency;

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

(J) 1 or more patients who have received support from a perinatal health worker who provides prenatal and postpartum support, such as a doula, community health worker, peer supporter, lactation consultant, nutritionist or dietitian, social worker, home visitor, or a patient navigator, or a spouse or family member of such patient; and

(K) racially and ethnically diverse representation from at least 3 independent experts with knowledge or field experience with racial and ethnic disparities in public health, women's health, or maternal mortality and severe maternal morbidity.

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

Not later than 1 year after the end of the public health emergency declared by the Secretary of Health and Human Services under section 319 of the Public Health Service Act (42 U.S.C. 247d) on January 31, 2020, with respect to COVID–19, the Comptroller General of the United States shall submit to the appropriate committees of Congress a report on maternal health and public health

1 emergency preparedness, including prenatal, labor and de-
2 livery, and postpartum care during the COVID–19 public
3 health emergency, including the following:
4 (1) A review of the prenatal, labor and delivery,
5 and postpartum experiences of people during the
6 COVID–19 public health emergency, which shall—
7 (A) identify barriers to accessing preg-
8 nancy, birth, and postpartum care during a
9 pandemic;
10 (B) assess the extent to which public and
11 private insurers were providing coverage for
12 maternal health care during the public health
13 emergency, including for telehealth services;
14 (C) to the extent practicable, analyze ma-
15 ternal and infant health outcomes by race and
16 ethnicity (including quality of care, mortality,
17 morbidity, cesarean section rates, preterm birth,
18 prevalence of prenatal and postpartum anxiety
19 and depression) during the COVID–19 public
20 health emergency and the impact of Federal
21 and State policy changes made in response to
22 the COVID–19 pandemic on such outcomes;
23 (D) identify contributors to population-
24 based disparities seen in COVID–19 outcomes,
25 such as racial profiling of, and bias and dis-

1 crimination against Black, American Indian
2 and Alaska Native, Latinx, and Asian-American
3 and Pacific Islander people; and
4 (E) review the impact of increased unem-
5 ployment, paid family leave, changes in health
6 care coverage, and other social determinants of
7 health for pregnant and postpartum people dur-
8 ing the public health emergency.
9 (2) Consultation with maternity care providers,
10 maternal mental and behavioral health care special-
11 ists, researchers who specialize in women's health or
12 maternal mortality and severe maternal morbidity,
13 people who experienced pregnancy or childbirth dur-
14 ing the COVID–19 public health emergency, rep-
15 resentatives from community-based organizations
16 that address maternal health, and perinatal health
17 workers who provide nonclinical support to pregnant
18 and postpartum people (such as a doula, community
19 health worker, peer support, certified lactation con-
20 sultant, nutritionist or dietician, social worker, home
21 visitor, or navigator).
22 (3) Recommendations to improve the public
23 health emergency response and preparedness efforts
24 of the Federal Government specific to maternal

1 health, with a particular focus on outcomes for mi-
2 nority women, including—
3 (A) ways to improve research, surveillance,
4 and data collection of the Federal Government
5 related to maternal health;
6 (B) ways for the Federal Government to
7 factor maternal health outcomes and disparities
8 into decisions regarding distribution of re-
9 sources, including COVID–19 tests, personal
10 protective equipment, and emergency funding;
11 (C) the extent to which guidelines and rec-
12 ommendations of the Federal Government re-
13 lated to maternal health care during the
14 COVID–19 public health emergency were cul-
15 turally congruent and linguistically competent
16 for minority women; and
17 (D) ways to improve the distribution of
18 public health funds, data, and information to
19 Indian Tribes and Tribal organizations with re-
20 gard to maternal health during the COVID–19
21 public health emergency.

○