The Million-Dollar Blind Spot

What your maternity claims are trying to tell you — and how to act on it

A benefit leader's guide to avoiding a million dollar maternity bill.

Do you know if your organization has had a **$1 million maternity claim**? One in five HR and benefits leaders have — and **75% say maternity costs increased** in the past year. But far fewer can point to what's driving the rise, or what to do about it.

To understand how HR and benefits leaders are navigating rising maternity costs, Maven surveyed 536 HR and benefits professionals at organizations with 1,000 or more employees, focusing on how well employers can see their cost drivers, measure the impact of their investments, and communicate that data to finance leadership.

The findings were consistent: most organizations have more data than they're using. The majority can already identify C-sections and NICU admissions in their claims data — but fewer than 4 in 10 have presented a cost-driver breakdown to their CFO, and even fewer are measuring whether their maternity programs are actually improving outcomes.

To move the needle on maternal health and healthcare cost savings, HR and benefits leaders need a framework for turning claims data into decisions.

In this guide, we'll explore what steps you can take to map cost drivers to program gaps, measure what matters, and build the business case for smarter benefits investment.

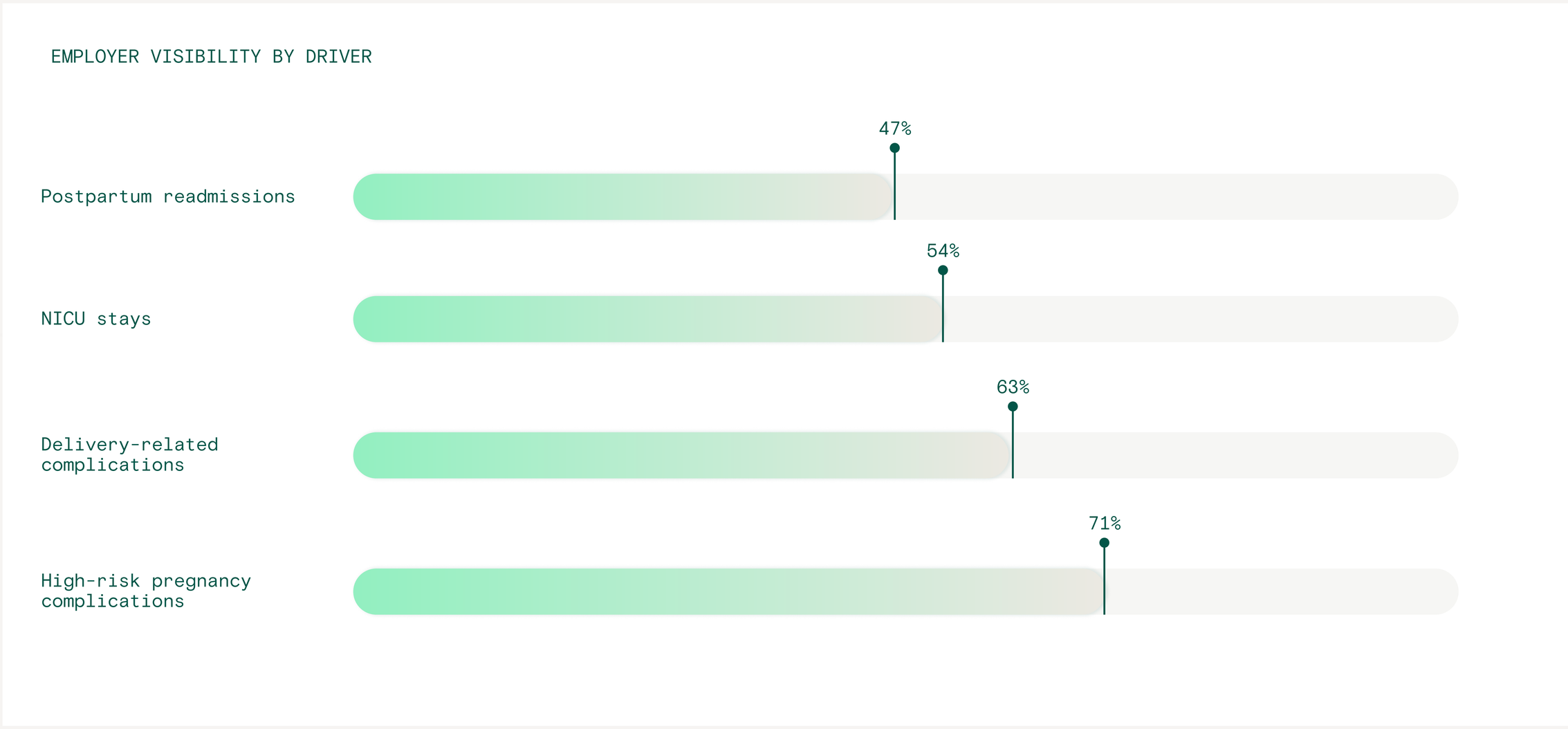
Understand the most common cost drivers

While total maternity spend can reveal whether costs are rising and how that is impacting your healthcare costs, it doesn't tell you what's driving the spend, where uncontrolled costs may be hiding, or where to intervene.

Clinical Research Institute
POWERED BY MAVEN

Population-level data on what pregnant women do during pregnancy — which medications they take, which recommendations they follow, how they manage risk — has never been systematically collected at scale. Rather than leveraging national benchmarks that rely on clinical trials or modeled estimates, the Maven Clinical Research Institute (MCRI) published the first-of-its-kind maternity benchmarks, giving employers and health systems a reference point grounded in real-world behavior among privately insured pregnant people. Throughout this guide, we reference MCRI findings alongside pulse survey data to show both where the gaps are and what closing them can look like in practice.

Maven's survey found that while most employers can identify at least one maternity cost driver in their claims data, visibility is uneven — the share of employers who can identify any given driver ranges from 47% (postpartum readmissions) to 71% (high-risk pregnancy complications). When pulling a maternity cost report from your health plan or TPA, make sure to request costs for both the mother and infant — NICU stays and delivery-related complications are often tracked separately but represent some of the largest line items in total maternity spend. There are three outcomes-based metrics that account for the majority of high-cost claims and have the clearest evidence-based interventions tied to them:



NICU admissions and length of stay

NICU admissions are often the single largest line item in an employer's maternity spend, and it can be influenced by what happens earlier in pregnancy. Length of stay matters as much as admission rate — even modest reductions in NICU days can represent significant cost savings. The key drivers of NICU admissions are preterm birth and high-risk pregnancy complications like preeclampsia and gestational diabetes — conditions that, when identified early, can be actively managed to reduce the likelihood of a NICU stay.

61% of employers can identify NICU admissions in their claims data. If your NICU admission rate or average length of stay is elevated relative to benchmarks, it's a downstream indicator that earlier intervention opportunities and opportunities for NICU-specific parenting support are being missed.

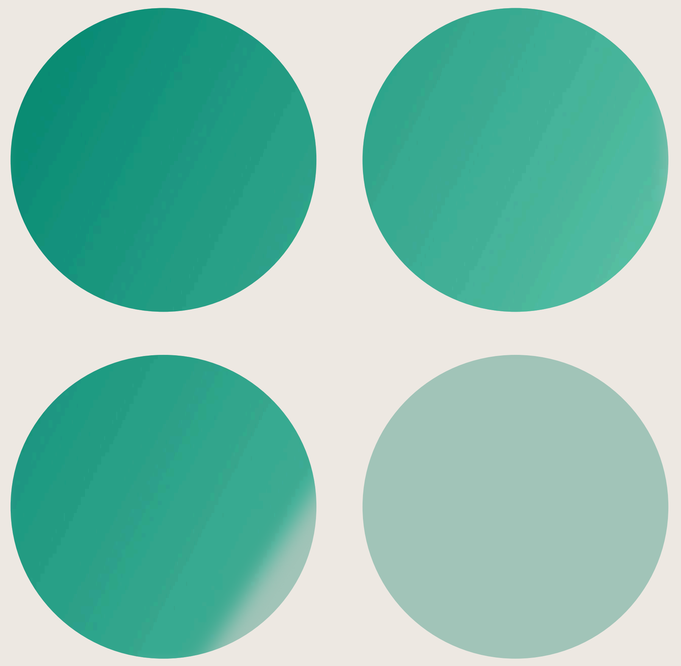
There are two clinical risk factors that can be a major driver of NICU admissions:

HIGH-RISK PREGNANCY COMPLICATIONS

Conditions like preeclampsia, gestational diabetes, and placenta previa significantly increase the likelihood of preterm birth and NICU admission. 71% of employers can identify high-risk complications in their claims data — meaning most already have what they need to engage at-risk employees earlier. Research shows that a daily low-dose aspirin between weeks 12 and 28 of pregnancy can reduce the risk of preeclampsia by 18% and preterm birth by 9% — but only if at-risk women are identified early enough to act on it. Among Maven members at risk of preeclampsia, 74% who received a targeted message before 28 weeks used LDA, compared to a national benchmark of 66%.

71%

of employers can identify high-risk complications in their claims data



PRE-TERM BIRTH RATE

Preterm births (delivery before 37 weeks) are the primary driver of NICU admissions and extended stays. The average NICU stay runs $3,000 to $5,000 per day, and preterm infants are more likely to require prolonged care. Tracking preterm birth rates in your population helps identify whether high-risk pregnancies are being identified and supported early enough.

C-section rate

C-sections cost roughly 85% more than vaginal deliveries, on average, and are associated with longer hospital stays, higher rates of postpartum complications, and increased risk in future pregnancies. A C-section rate above the national average of around 32% is a signal worth investigating, as it may reflect gaps in birth planning support, doula access, or high-risk care coordination. In fact, nearly 50% of employers don't currently offer doula support, despite evidence that it can improve outcomes.

Research shows that women who received doula care had reduced rates of C-sections and postpartum anxiety and depression. In addition, among members who had previous C-sections, having two or more doula appointments on Maven is associated with a reduction in risk of repeat c-sections by 60%, compared to members who did not use a doula, according to research published in Obstetrics and Gynecology.

85%

C-sections cost roughly 85% more than vaginal deliveries

Postpartum readmission rate

Postpartum readmissions — hospitalizations within 60 days of delivery — are a marker of gaps in postpartum support and follow-up care. They're also a leading indicator of more serious maternal health issues, including postpartum depression, infection, and hemorrhage. A readmission rate above benchmark is rarely a postpartum problem in isolation; it usually signals something that wasn't caught or supported during pregnancy. Tracking this metric alongside postpartum benefit utilization can reveal whether your current postpartum programs are reaching members at the right time.

How to understand the cost drivers at your organization:

1. Request a cost report

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2. Spot the patterns that signal risk - before claims escalate

Getting the right data is the first step. The second is knowing what you're looking at and what it tells you about risk in your population — before it becomes a seven-figure claim.

Leaders can take a closer look at the top cost drivers within their maternity claims data, and how those costs have changed year-over-year, to better understand the patterns that are developing as a result of gaps in maternity support. The employers best positioned to manage maternity costs aren't just tracking C-section rates or NICU admissions in isolation — they're looking at risk factors and how they relate to those outcomes metrics, and what they predict about future spend.

Here are the most important patterns to look for.

ELEVATED C-SECTION RATE + HIGH NICU ADMISSIONS

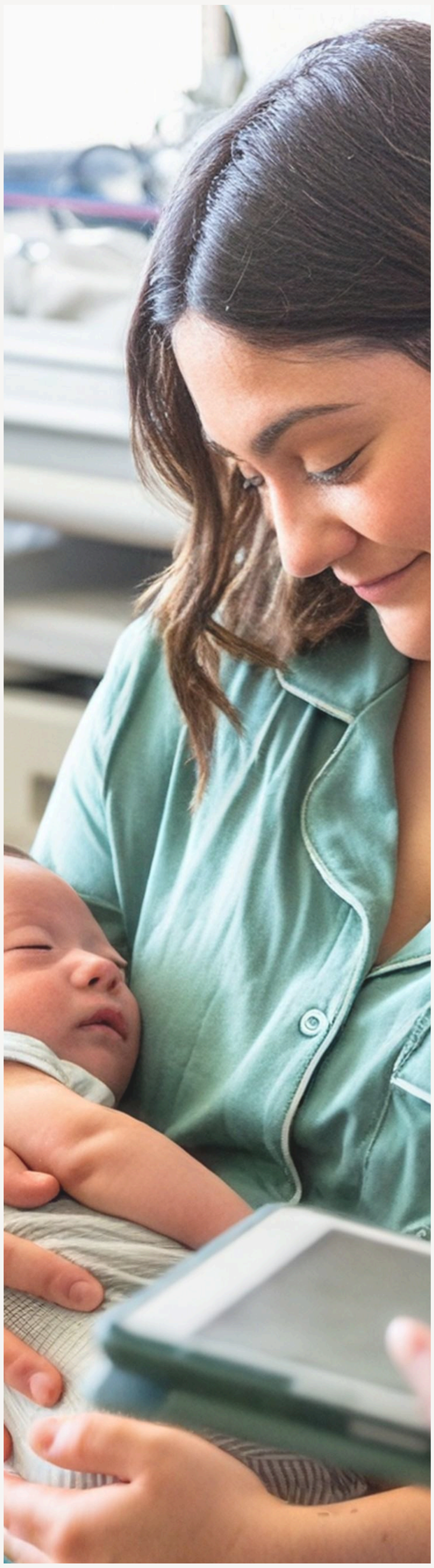
These two metrics tend to move together. A C-section rate above the national benchmark, paired with above-average NICU admissions, often points to a population with a higher-than-expected share of high-risk pregnancies — and a benefits program that isn't reaching them early enough.

THE FERTILITY-TO-HIGH-RISK CONNECTION

The connection between fertility care and high-risk pregnancies is the pattern many employers are missing entirely. Pregnancies following IVF or IUI carry a statistically higher likelihood of multiples, preterm birth, and high-risk complications — yet only 32% of employers actively track high-risk pregnancies among employees who used fertility treatment. An additional 20% say they have the data but don't analyze it this way For employers who offer fertility benefits — 44% of organizations surveyed — this is a significant blind spot. Funding fertility care without connecting it to downstream maternity support can open the door for uncontrolled maternity claims.

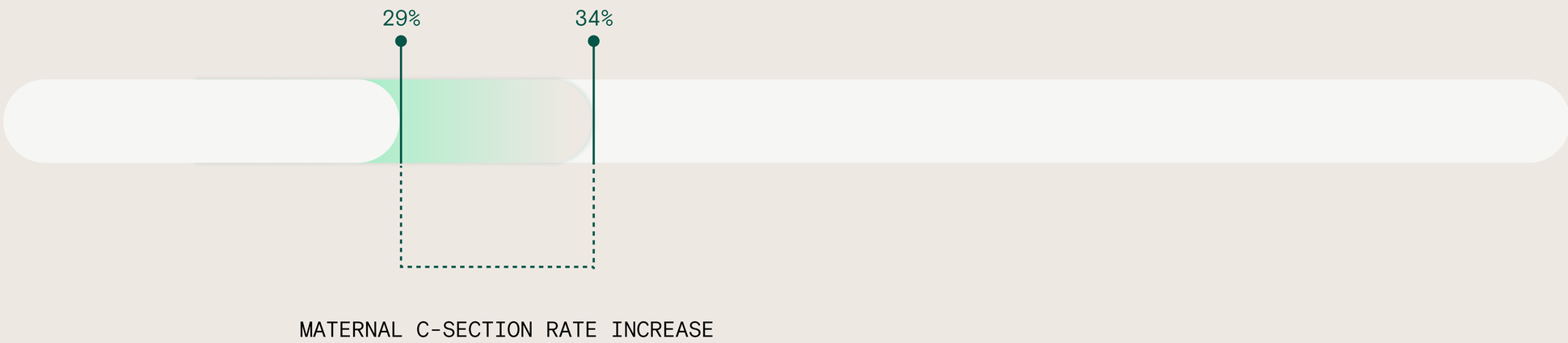
POSTPARTUM READMISSIONS AS A LAGGING INDICATOR

A postpartum readmission rate that's above benchmark is usually a signal of a gap during pregnancy care, rather than an isolated postpartum incident. Readmissions are most commonly driven by postpartum depression, infection, and hypertensive complications, all of which have earlier clinical warning signs.



Year-over-year trends matters as much as the snapshot

A C-section rate that's climbed from 29% to 34% over two years is worth acting on. Single-year benchmarking tells you where you stand relative to peers, but year-over-year trending tells you whether your population's risk profile is changing and whether your current benefits are keeping up. Request at least two to three years of data when looking at maternity costs and outcomes, and establish a baseline before your next benefits review cycle.



Your next steps:

- **UNDERSTAND ENGAGEMENT RATES.**

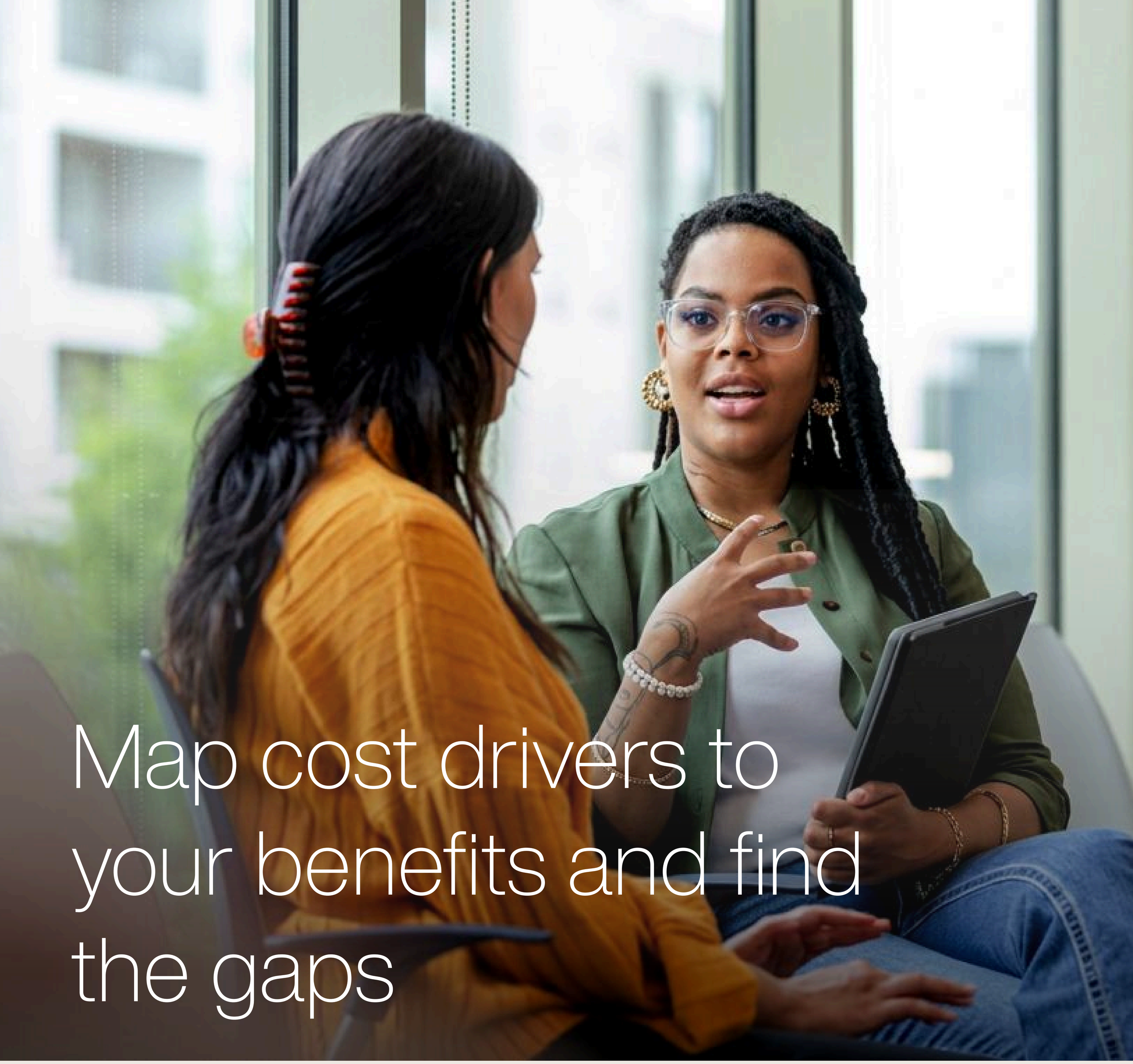
  57% of employers reach out as soon as pregnancy is identified, but 20% have no proactive outreach program at all. In a high-risk population, that gap is where expensive claims may originate.

- **COMPARE HIGH-RISK COMPLICATION RATES AND NICU ADMISSIONS AMONG EMPLOYEES WHO USED FERTILITY BENEFITS AGAINST THOSE WHO DIDN'T.**

  If the rates are meaningfully higher in the fertility cohort, that's a signal that your maternity support program needs an earlier, more targeted touchpoint for that population.

- **WORK BACKWARDS.**

  What is your high-risk complication rate? What's your postpartum benefit utilization rate? Low utilization of a maternity benefit paired with high readmission rates is an indicator that your postpartum support exists on paper but isn't reaching members at the right moment.



Map cost drivers to your benefits and find the gaps

Knowing your cost drivers is only useful if it leads somewhere. The next step is mapping what you're seeing in the data to what your current benefits are — and aren't — covering. While many benefits appear to provide comprehensive support on paper, it’s important to take a closer look at how your benefits offerings are aligned to the risk factors for your population and whether the employees who need those benefits are actually being reached. A mapping exercise can help surface both. Your maternity benefits provider should be able to partner with you on this exercise to help you understand what resources and support are most needed for your particular population.

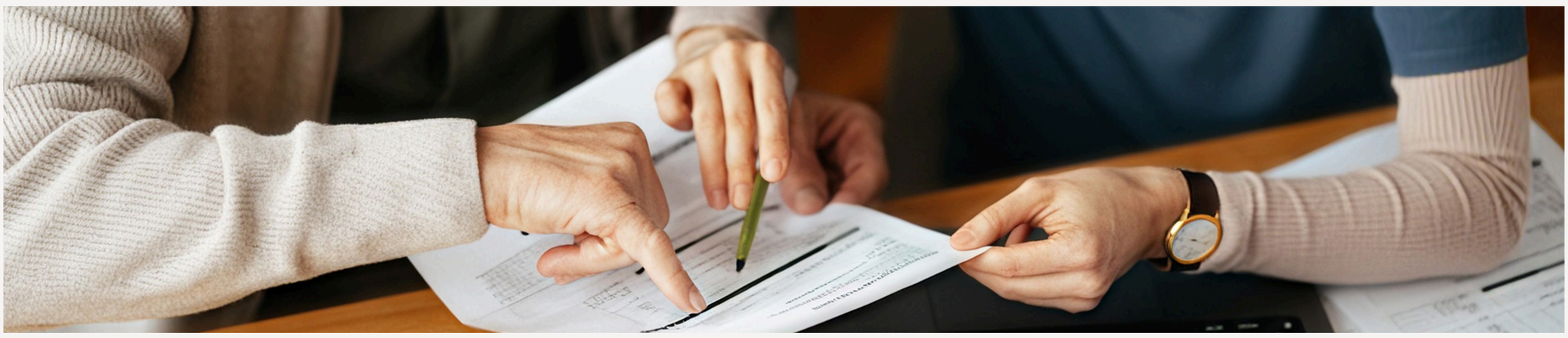
The mapping framework

Start with the three cost drivers from Section 1. For each one, ask two questions:

Do we have a benefit designed to address this risk factor?

Is there evidence that eligible employees are using it?

A benefit that exists but isn't being utilized is ultimately an extra line item. The goal is to identify both structural gaps (no benefit exists) and engagement gaps (the benefit exists but isn't reaching the right people at the right time).

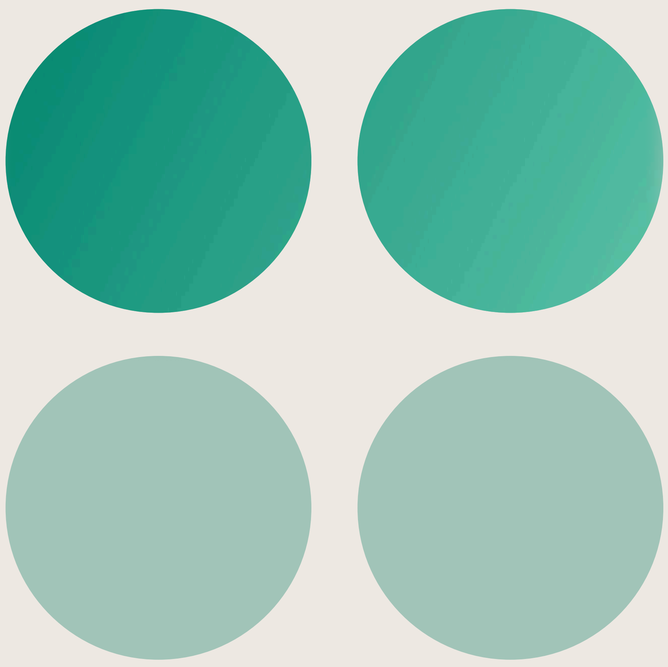


Cost driver	What to look for	Benefits	Utilization Rate	Gap
NICU stays	• NICU admission rates • NICU length of stay • Pre-term birth rate • Rates of preeclampsia and gestational diabetes	• High-risk pregnancy care coordination • Birth planning	Unknown	Data gap
High C-section rate	• High-risk pregnancy rate • Prior C-section and VBAC rates	• Doula support • Birth planning	Low/ None	Structural or engagement
Postpartum readmissions	• Pregnancy and postpartum-related ER visits	• Prenatal/ Postpartum mental health screening & support • Follow-up care	Moderate	Possible engagement

The most common gaps, and what they signal

From our survey of more than 500 HR and benefits leaders, a few patterns emerged consistently:

Doula support is the largest structural gap in the market. Nearly 50% of employers don't currently offer it — despite the scientific evidence demonstrating it reduces C-sections and improves postpartum outcomes. If your C-section rate is elevated and doula support isn't in your program, that's the first gap worth closing.



50%

of employers don't currently offer doula support

Early outreach is the most common engagement gap. 20% of employers have no proactive outreach program for pregnant employees, and another 16% only reach out when a complication arises. Without early identification of high-risk pregnancies, the conditions most likely to drive NICU admissions — preterm birth, preeclampsia, gestational diabetes — go unmanaged until they show up in claims.

Fertility-to-maternity continuity is a commonly overlooked structural gap. If your fertility and maternity benefits are managed by separate vendors with no shared data, there's no mechanism to flag the employees most likely to have a high-risk pregnancy. 21% of employers are in this position.

Maven streamlines fertility and maternity benefits — including high-risk care coordination, doula support, mental health, and lactation support — into a single program with shared data across the full journey, closing the vendor fragmentation gap that leaves most employers unable to connect fertility utilization to downstream maternity risk.

60%

Maven is associated with a reductions in risk of repeat c-sections by 60%

Your next step: How to prioritize the gaps you find

Not every gap carries equal cost risk. Prioritize by two factors: the per-member cost associated with the outcome, and the strength of evidence for the available intervention. NICU admissions sit at the top of both lists: they're the highest-cost outcome and are directly influenced by earlier interventions like high-risk care coordination, birth planning support, and early outreach. C-section reduction and postpartum readmission prevention follow.

Close structural gaps first — then focus on engagement — to ensure the right benefits are in place and the employees who need support are using them.

Build the CFO narrative: Turn claims data into a business case

Benefits leaders are often the most informed person in the room when it comes to maternity program design. But in a conversation with your finance team, program design isn't as much a priority as cost, risk, and return on investment are.

The employers who are most effective at securing budget and buy-in for maternity benefits can translate what their programs do into terms finance leadership can act on. That starts with how the data is framed:

What we spent:

Total maternity cost, broken down by driver

Why we spent it:

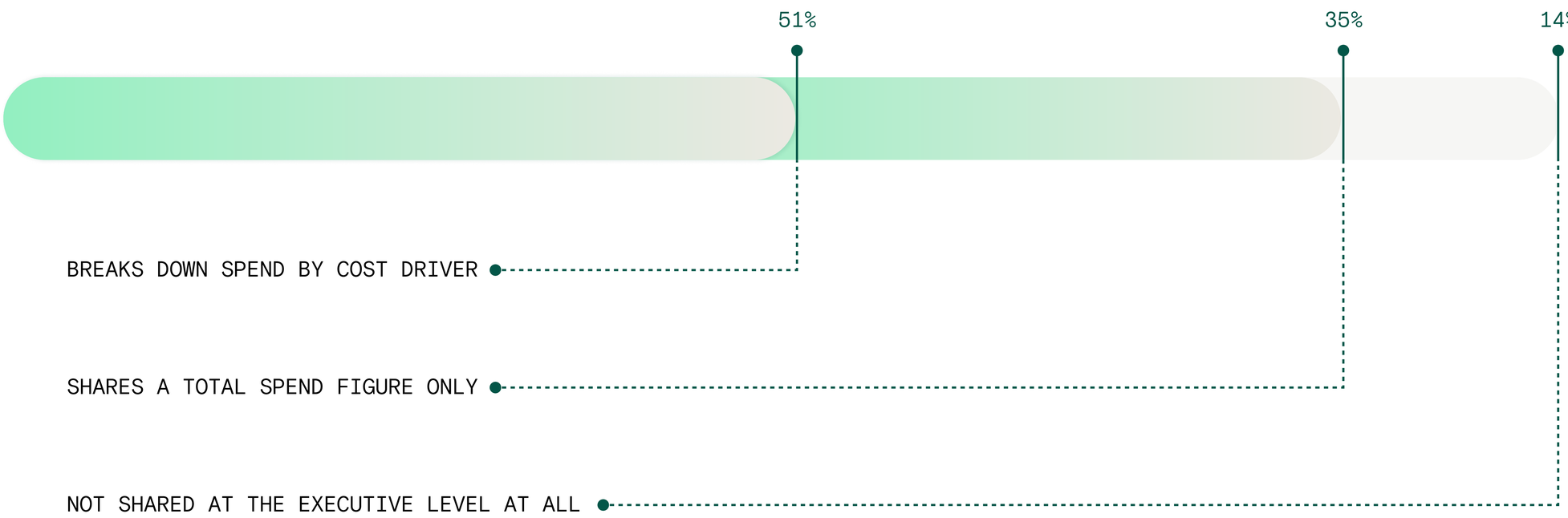
Which cost drivers are elevated, and what's contributing to them

What we're doing about it:

How current benefits address those drivers, what gaps exist, and the projected impact of closing them

35% of HR and benefits leaders in our pulse survey presented maternity costs to their CFO as a total spend figure only, without a breakdown by cost driver. 14% aren't sharing maternity costs at the executive level at all. That makes it nearly impossible to build a case for targeted investment, or to demonstrate that existing programs are working.

HOW MATERNITY COSTS GET REPORTED TO THE CFO



Maternity and newborn care cost summary

Fill out this template to help guide a conversation with your finance team about maternity costs at your organization. This single-page cost summary moves from problem to program to projection to help you define areas of opportunity in your maternity benefits.

1. Population snapshot

Total covered lives, number of maternity claims in the past year, total maternity spend. This establishes scale and sets the context.

TOTAL COVERED LIVES

MATERNITY CLAIMS, PAST 12 MO.

TOTAL MATERNITY SPEND

2. Cost driver breakdown

Your key metrics from Section 1 – costs broken down by mother vs. infant and time window, paired with C-section rate, NICU admissions, postpartum readmissions – benchmarked against national averages where available.

MOTHER VS. INFANT SPLIT

C-SECTION RATE VS. NATL. AVG

NICU ADMISSIONS VS. NATL. AVG

POSTPARTUM READMISSION RATE

TIME WINDOW COVERED

3. Risk indicators

Any population-specific signals worth flagging, such as fertility treatment utilization rate, high-risk pregnancy rate, gaps in early outreach. This is where the fertility-to-high-risk blind spot becomes a CFO-level conversation, not just a benefits design question.

FERTILITY TREATMENT UTILIZATION

HIGH-RISK PREGNANCY RATE

EARLY OUTREACH GAPS

4. Current program investments

A brief summary of what's in place, mapped to the cost drivers it's designed to address. This helps you build a clear cost mitigation framework.

5. Gaps and proposed action

What's missing, what it's likely costing, and what closing the gap would require. Where possible, anchor this to a cost-per-outcome figure: a single prevented NICU admission, for example, can offset a significant share of a maternity program's annual cost.

To learn more about how Maven can help you understand your maternity costs and how to reduce them, contact us.

Making the ROI case

Where possible, translate program gaps into projected cost exposure rather than clinical risk.

These figures are the math behind the “million-dollar baby” claim. When a CFO sees that a single prevented preterm birth or NICU admission can offset the cost of a full maternity support program, the conversation shifts from whether to make the investment to how to close the gap.

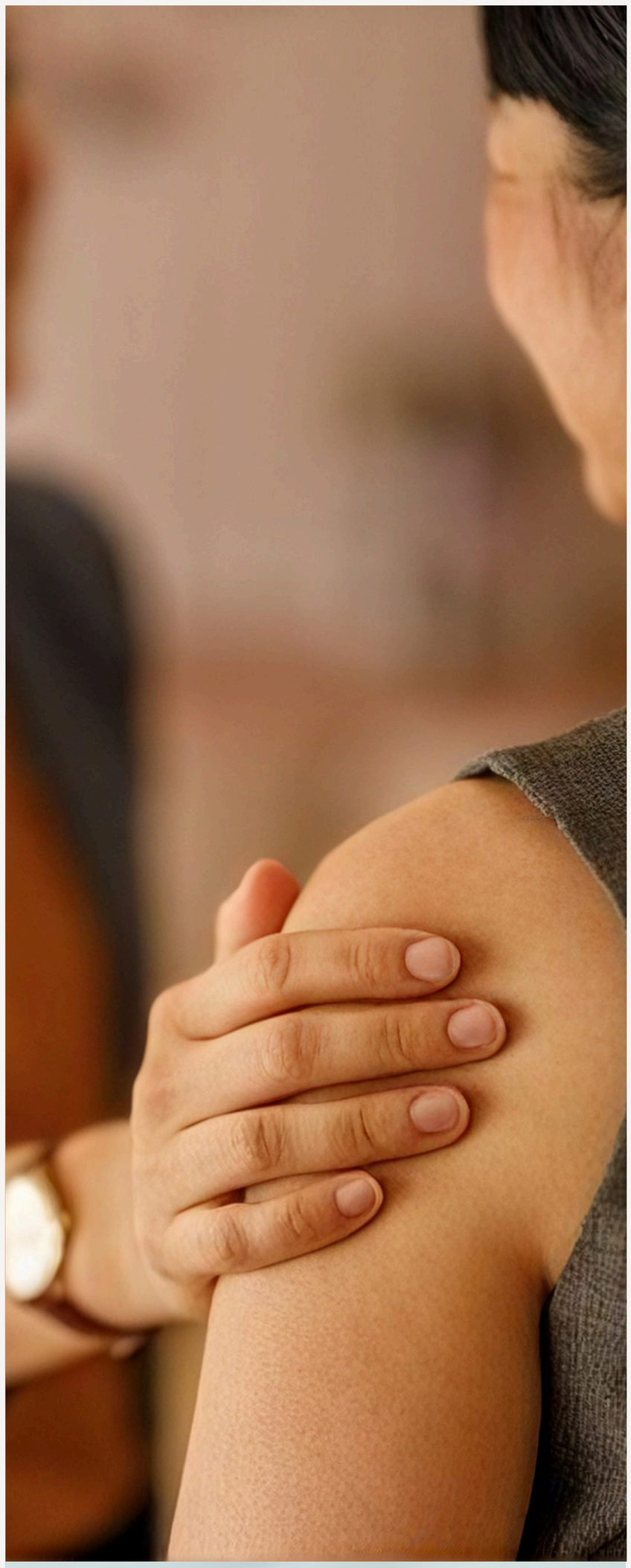
MCRI research found that high-risk Maven members who attended a birth planning appointment had 40% lower risk of a NICU admission — at an average cost of $58,100 for a weeklong NICU stay, even modest reductions in admissions across a covered population represent significant avoided claims.

Maven gives employers the strategic support and the outcomes data — C-section rates, NICU utilization, and postpartum readmission rates among enrolled members — needed to walk into a finance conversation with a cost-driver story, benchmarked and ready to present.

What this looks like when it's working

By using this framework, you can create a closed loop when it comes to maternity support — where claims data informs program design, program design is measured against clinical outcomes, and outcomes are reported back to finance leadership in a language they can act on.

Many employers are somewhere in the middle of building that loop. To understand where you stand, use these as a starting point for your own assessment:



1. Can I explain what's driving my maternity costs?

Understanding the core cost drivers impacting overall maternity costs is the most foundational step towards reducing those costs.

2. Do my current maternity benefits map directly to my highest-risk cost drivers?

If there are cost drivers with no corresponding benefit — or benefits with no measurable utilization — those are your highest-priority gaps.

3. Am I measuring the right things?

Employee satisfaction and return-to-work rates are useful signals. But if clinical outcomes — C-section rates, NICU admissions, post-partum readmissions — aren't in your measurement framework, you're evaluating your program's performance without the metrics that matter most to finance leadership.

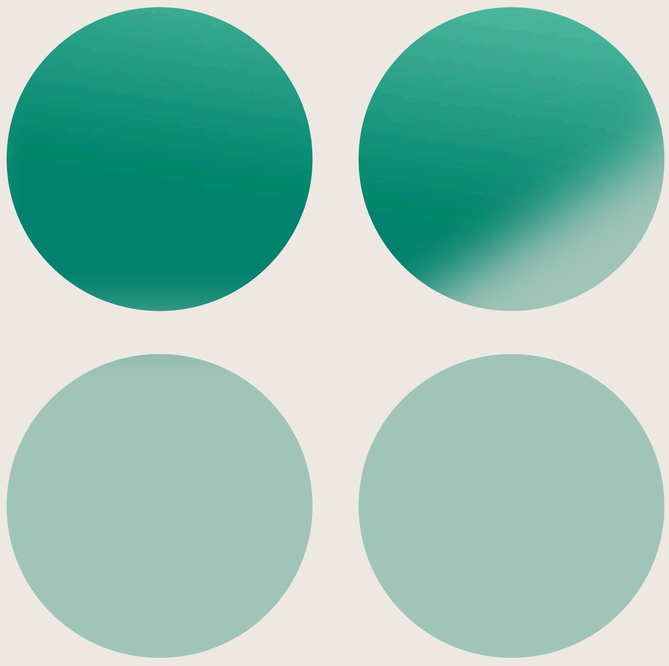
What the data tells us about where the industry is heading

44% of HR and benefits leaders in our pulse survey say they're very confident in their ability to manage and reduce maternity costs over the next two years. The ones most likely to get there share a few things in common: they're reaching pregnant employees in the first trimester, they're connecting fertility benefit utilization to downstream maternity risk, and they're walking into CFO conversations with cost-driver data, rather than a figure of total spend.

These are indicators of a more connected benefits system, where the data, the benefits, the measurement, and the business case are all speaking the same language.

44%

Confident in their abiility to reduce maternity costs



Maven works with employers to close the loop between claims data, program performance, and outcomes reporting. From early identification of high-risk pregnancies — including those following fertility treatment — to consolidated reporting across the full maternity journey, Maven gives benefits leaders the visibility they need to manage costs proactively and present results with confidence.

Maven is proven to improve outcomes and reduce costs associated with maternity care, including an average savings of $9,600 per birth across our fertility and maternity care. If you're ready to understand what your maternity cost profile looks like and take the steps toward addressing it, contact us here.

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