



STATE REGULATION OF BIRTH CENTERS:

A 50-State Survey of Women's Birth Freedom

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THE UNITED STATES SPENDS MORE THAN ANY OTHER country on maternity care—more than \$111 billion annually. Despite those efforts, the nation ranks 60th globally in preventing maternal mortality. High costs and poor health outcomes can be attributed, in part, to the landscape of onerous state regulations that limit women's access to nonhospital birth settings, such as freestanding birth centers. These facilities are led by midwives and have been shown to lower costs and improve health outcomes for low-risk pregnancies.¹ Though the majority of women continue to choose hospital births over nonhospital settings,² many would choose nonhospital births if they were free to do so.

The experience of Pacific Legal Foundation client Katie Chubb illustrates these regulatory hurdles. In 2022, Chubb tried to open a birth center in Augusta, Georgia, but was denied a certificate of need (CON), a government-mandated permission slip that health-care providers must obtain before opening or expanding facilities. Georgia CON laws require birth centers to enter into a transfer agreement with a local hospital, despite the rarity of emergency transfers. All three Augusta hospitals refused to enter into transfer agreements with Chubb—predictably, given that Chubb was a prospective competitor—so Chubb challenged in court the ability of incumbent hospitals to effectively veto CON applications for birth centers.

Although Governor Brian Kemp signed a law repealing CON requirements for birth centers in April 2024, obviating a key part of Chubbs legal complaint, Georgia law still requires birth centers to secure hospital transfer agreements. As a result, Chubb's birth center remains unopened.

Chubb's experience is not unique. In most states, birth center entrepreneurs face regulations, such as licensing requirements, CON laws, and staffing directives, that slow or stop their enterprise. Amid this

regulatory landscape, 17 states had no birth centers as of 2025, according to the American Association of Birth Centers (AABC). Despite the dearth of birth options in these states, numerous studies support the safety and cost savings of birth centers.

This research in brief surveys regulations in the 50 states that govern birth centers. Such a survey enables further study of the relationship between state regulation and competition, entrepreneurship, the number of women's healthcare providers, and the extent of birth freedom.

THE BIRTH CENTER MODEL

BIRTH CENTERS AND NURSE MIDWIVES ARE increasingly common providers of maternity care, offering alternatives to hospital-based childbirth for women with low-risk pregnancies. In the United States, birth centers are most often freestanding facilities that offer prenatal, intrapartum, and postpartum care. As of 2022, there were 400 birth centers across 40 states.³ However, nearly 70 percent of birth centers are concentrated in only 10 states.⁴

Birth centers are an important tool to address declining rural maternity care access across the country. More than 28 million women of reproductive age live in rural areas, where obstetric services are often limited.⁵ In fact, more than one-third of US counties are considered maternity deserts—meaning there are no birth facilities or obstetric clinician services available to the 1 in 10 women of reproductive age who live there.⁶ Birth centers also play a crucial role in increasing access to

maternity care in underserved communities. Even if a mother chooses to deliver at a hospital, birth centers can still benefit these communities because they also offer prenatal care.

Since the establishment of the first rural birth center in South Texas in 1971, the birth center model has expanded significantly, reflecting rising interest in community-based, low-intervention care. A 2020 analysis of data from the AABC Perinatal Data Registry finds that the number of US birth centers increased by 97 percent over the past decade, reaching approximately 384 centers nationwide, with about 30 percent located in rural or small-town areas. Although fewer than 1 percent of US births occur in birth centers,⁷ that number continues to grow. Between 2004 and 2013 alone, the number of US births occurring in freestanding birth centers grew by more than 75 percent, from 9,620 to 16,913 births annually.⁸

EVIDENCE SUPPORTING THE BIRTH CENTER MODEL

A substantial and growing body of research shows that midwife-led birth centers offer a safe, high-value model of care for women with low-risk pregnancies.⁹ Evidence also shows that certified nurse midwives demonstrate high competence in managing low-risk pregnancies and use fewer costly and invasive interventions, such as labor augmentation, cesarean delivery, and instrumental births, than do physicians, thus contributing to lower overall healthcare costs without compromising quality.¹⁰

One of the most comprehensive studies of the birth center model was conducted as part of the Strong Start

for Mothers and Newborns Initiative, a federally funded program led by the Center for Medicare and Medicaid Innovation from 2012 to 2016. This study evaluates three models of maternity care aimed at improving outcomes and lowering costs for Medicaid beneficiaries: centering or group prenatal care, maternity care home, and birth center care.¹¹ Roughly 21 percent of birth centers studied were located in rural areas. The birth center model—midwife-led prenatal care in community-based settings—achieved the most consistently favorable outcomes.¹² Birth centers participating in Strong Start reported improved outcomes compared with national benchmarks

across key indicators, including primary cesarean rates, preterm birth rates, and low birth weights. Breastfeeding rates were significantly higher, and patient satisfaction was higher than in other models studied.¹³

Other studies yield similar results to those of Strong Start, supporting the safety and effectiveness of the birth center model. The National Birth Center Study II, which analyzes outcomes for more than 15,000 women receiving birth center care from 2007 to 2010, reports high rates of spontaneous vaginal birth, low rates of assisted and cesarean delivery, and no maternal deaths. Two earlier studies, the first National Birth Center Study (1985–1987) and the San Diego Birth Center Study (1994–1996), conclude that birth centers could provide safe, resource-efficient care to the 85 percent of pregnant women considered low risk. Both studies observe high patient satisfaction and a significant reduction in the use of costly interventions, such as epidurals and inductions.¹⁴

International evidence further supports the safety and effectiveness of the birth center model. A Cochrane

systematic review of randomized trials from countries including Canada, Australia, and the United Kingdom concludes that midwife-led care—the foundation of the birth center model—was associated with fewer preterm births, episiotomies, and epidurals.¹⁵ Similarly, a Birthplace in England study finds that for low-risk individuals, birth centers offered outcomes on par with hospitals, with fewer interventions and no increase in adverse neonatal events.¹⁶

Neonatal outcomes in birth center settings have also proven comparable to hospital care. Multiple systematic reviews find no significant differences in perinatal mortality between birth centers and hospitals for low-risk women.¹⁷

The volume of national and international research on the birth center model supports the use of birth centers for safe, effective care for low-risk pregnancies. These centers can improve outcomes, reduce unnecessary interventions, increase patient satisfaction, and increase women's access to maternity care.

50-STATE SURVEY OF BIRTH CENTER REGULATION

DESPITE THE SAFETY AND EFFICACY OF THE BIRTH center model, state regulations have limited the growth of birth centers and restricted women's access to maternity care. When birth centers became more prevalent in the United States in the 1980s, state regulation followed. Many of these regulations, influenced by the American Public Health Association's 1982 model regulatory framework, remain largely unchanged and saddle birth centers with cumbersome requirements. For example, some construction regulations are based on standards for ambulatory surgery centers or other medical facilities, leading to impractical requirements—such as minimum hallway widths or birth rooms as large as operating rooms—that do not align with the home-like, noninstitutional nature of birth centers.¹⁸ These requirements are also unnecessary for the health or safety of mothers and newborns.

This 50-state survey of birth center regulations identifies state regulations of birth centers across five areas: licensure, accreditation, CON laws, physician involvement, and hospital affiliations (transfer agreements and proximity requirements),¹⁹ highlighting areas of reform for policymakers that support access to birth centers and women's birth freedom.

Five states—Idaho, Maine, North Carolina, North Dakota, and Wisconsin—have no regulations of birth centers in the five areas. The other 45 states and the District of Columbia have some level of regulation of birth centers.

Licensure

Forty-two states and the District of Columbia require birth center licensure through statute or regulation. Eight states—Alabama, Idaho, Maine, North Carolina, North Dakota, Oklahoma, Virginia, and Wisconsin—do not have licensing requirements (though some of them require licensure for Medicaid reimbursement). Birth centers are operational in six of those eight states (Alabama, Idaho, North Carolina, Oklahoma, Virginia, and Wisconsin). Licensure renewal periods vary but most commonly occur annually or biennially.

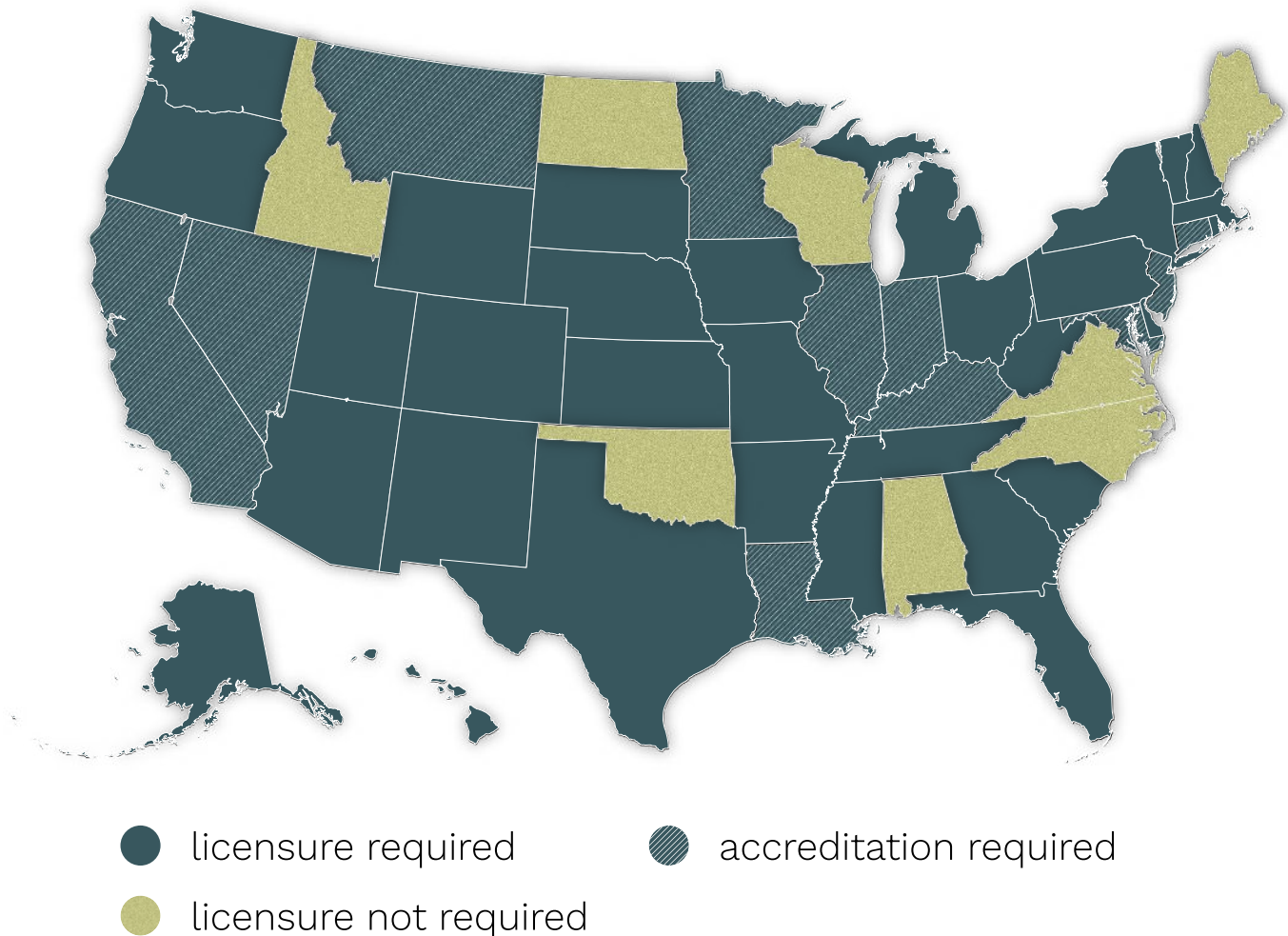
Accreditation

Accreditation plays a similar role to that of licensure in many states. The Commission for the Accreditation of Birth Centers is the primary accrediting body for birth centers in the country.²⁰ In total, 11 states—California, Connecticut, Illinois, Indiana, Kentucky, Louisiana,

Nevada, Maryland, Minnesota, Montana, and New Jersey—require accreditation for birth centers, as indicated in Figure 1. Some states, such as Alaska, Florida,

and Louisiana, allow accreditation site visits to substitute for state facility inspections, reducing duplicative regulatory burdens on birth centers.²¹

FIGURE 1. States Requiring Licensure and Accreditation for Birth Centers



Source: Authors' calculations.

CON Laws

CON laws, originally enacted with the goal of curbing healthcare spending by controlling the expansion of medical facilities, have become a barrier to the establishment of freestanding birth centers. Although these laws were once federally mandated under the Health Planning Resources Development Act of 1974, the federal government repealed the requirement in 1987, and some states subsequently abandoned their CON programs. However, in other states, CON laws continue to allow competing hospitals to veto new birth centers from entering the market.

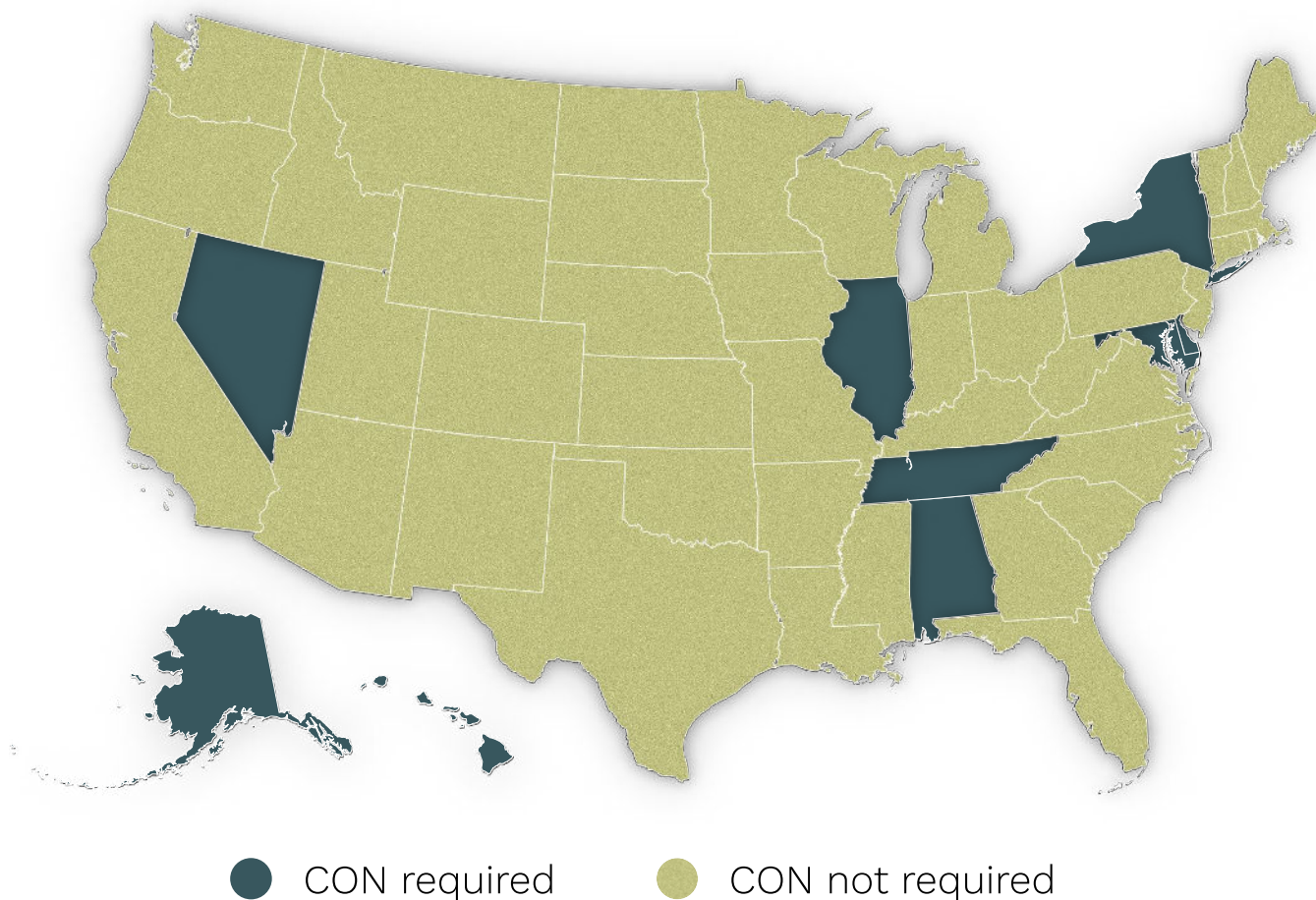
The AABC cites CON laws as one of the most significant regulatory obstacles to meeting demand for community-based, midwife-led maternity care. Excessive costs and lengthy regulatory timelines to gain a CON in some states can be prohibitive for birth centers. For example, 2021 research into New York's CON review for new birth centers finds that the process takes up to two years and requires up to \$250,000 in up-front costs.²² Such laws can delay or block birth center licensure entirely, especially when CON applications face opposition from existing hospital systems that may view birth centers as competitors.²³

Despite being designed to prevent unnecessary duplication of services and control costs, these regulations have concentrated healthcare in hospital settings and stifled the growth of the birth center model and other alternative settings that increase access to care. Encouragingly for the birth center model, between 2023 and 2025, Connecticut,²⁴ Georgia,²⁵ Kentucky,²⁶

Michigan,²⁷ Vermont,²⁸ and West Virginia all repealed CON laws for birth centers.²⁹

Nine states and the District of Columbia, as indicated in Figure 2, have some version of CON law affecting freestanding birth centers: Alabama, Alaska, Delaware, Hawaii, Illinois, Maryland, Nevada, New York, and Tennessee.

FIGURE 2. States with CON Laws for Birth Centers



Source: Authors' calculations.

Physician Involvement

Studies find that midwife-led care is associated with similar or better perinatal outcomes compared with physician-led care, including reduced preterm birth rates, lower incidences of low birth weight, and higher mean birth weights.³⁰ Despite these findings and despite laws in 35 states allowing certified nurse midwives to practice independently,³¹ some states mandate physician involvement in birth centers through supervisory agreements or staffing requirements, such as requiring a birth center to have a physician medical director.

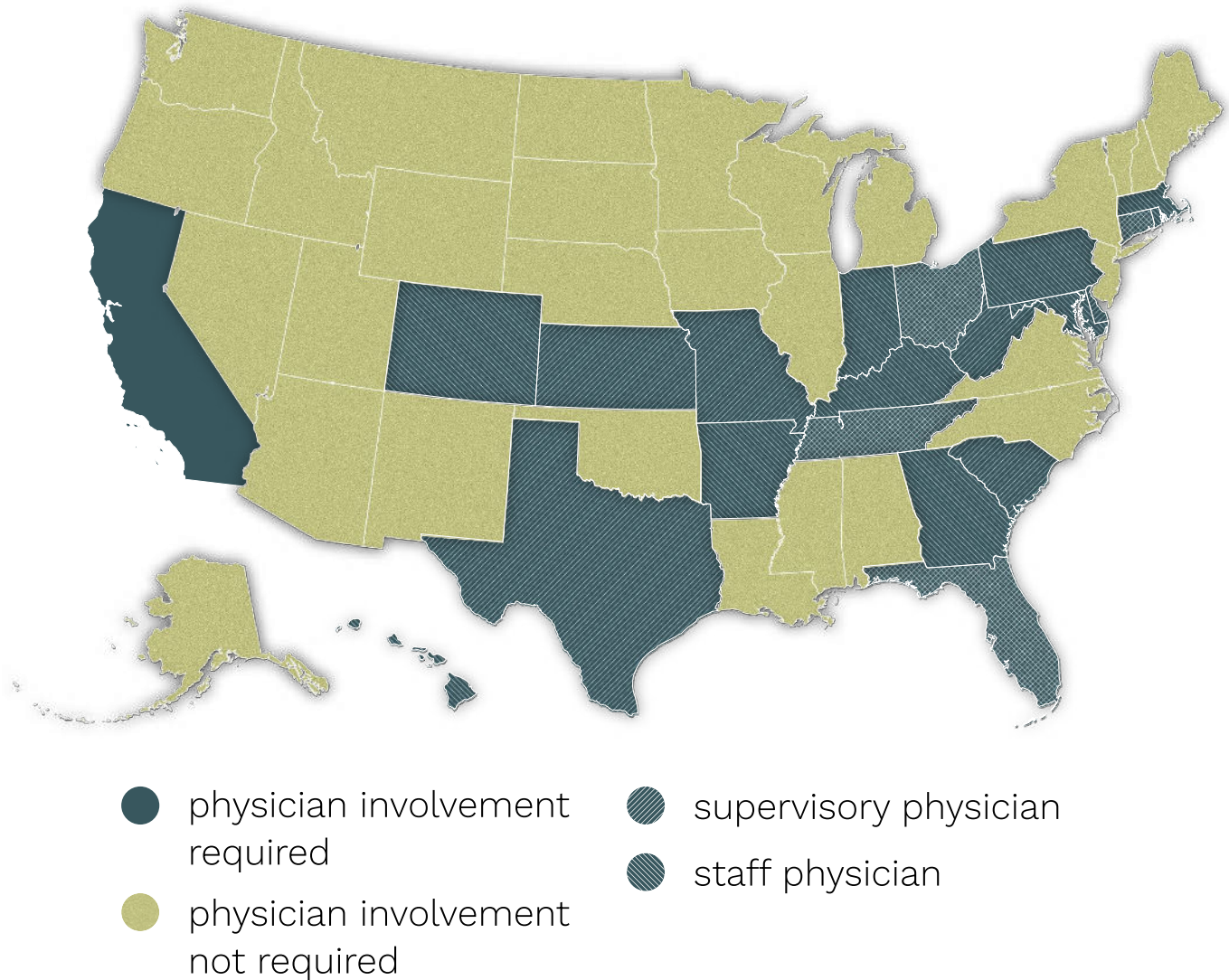
These requirements can add a significant financial burden to many birth center business models. In rural birth centers, which often function on tight margins, physician costs can be prohibitively expensive.³²

Requiring birth centers to retain physicians poses another significant challenge: Unexpected loss of a physician due to illness, relocation, or other reasons can force the immediate closure of a birth center.³³ This challenge disproportionately affects rural or underserved areas where physician availability is limited, potentially forcing pregnant women to seek hospital care.

Twenty-one states and the District of Columbia require physicians to serve in a supervisory role or as a staff member of a birth center. Ten states require a physician on staff,

seven states and the District of Columbia require physician supervision, and four states allow for either physician staff or supervision agreements, as indicated in Figure 3.

FIGURE 3. States with Physician Mandates



Source: Authors' calculations.

Hospital Transfer Agreements and Proximity Requirements

Mandating written hospital transfer agreements or requiring birth centers to locate close to existing hospitals can become a significant barrier to access for birth center care.³⁴ For example, some hospitals, often owing to competitive dynamics, refuse to enter into formal transfer agreements with birth centers.³⁵ However, the National Birth Center Study finds that only 2.4 percent

of pregnant women admitted to birth centers required an emergency transfer to a hospital.³⁶ Despite the low incidence of emergency transfers, many states continue to require hospital transfer agreements, restricting the availability of birth center care.

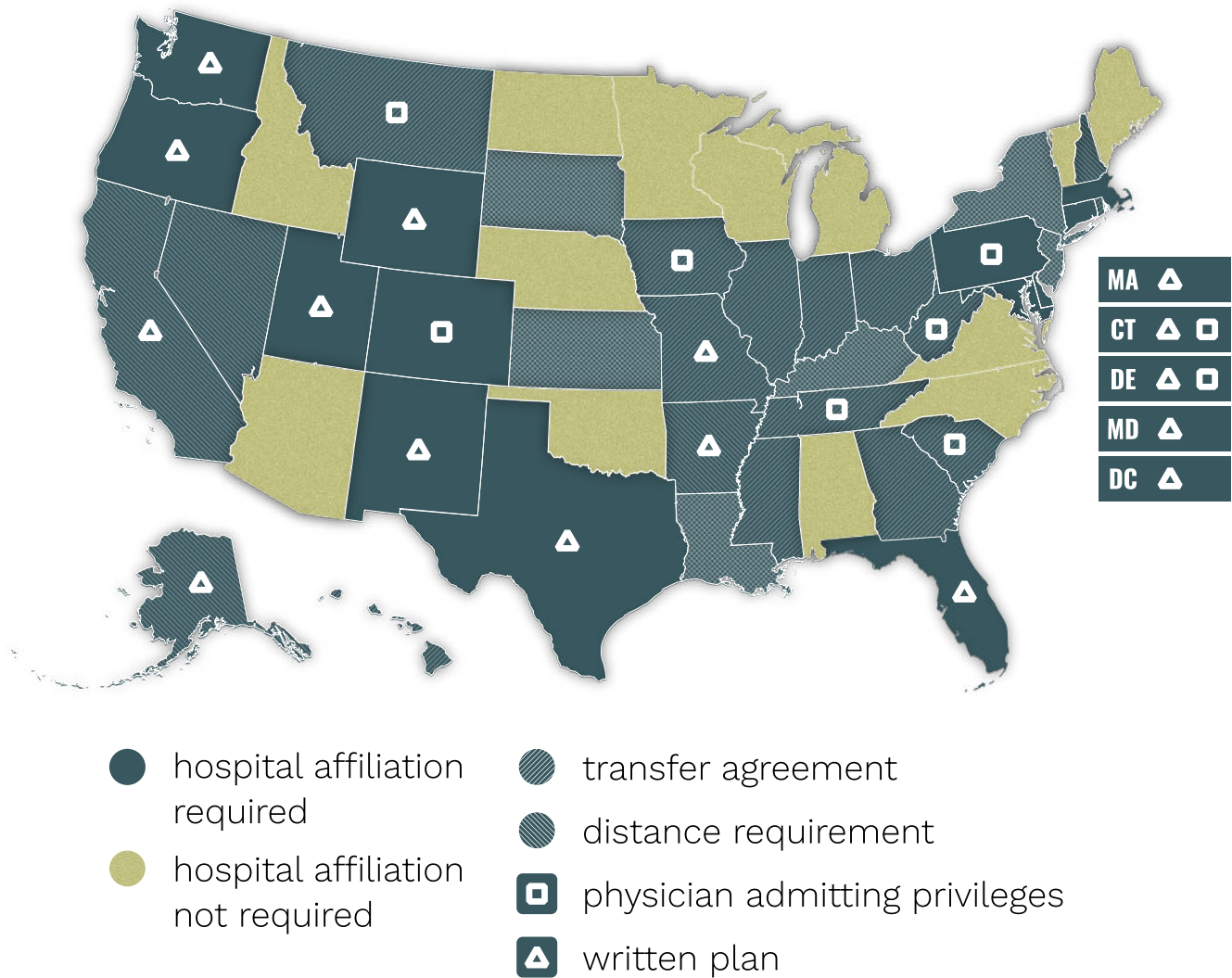
Rather than requiring transfer agreements, some states impose restrictive distance limitations on birth centers, specifying how close a birth center must be to a hospital, usually defined by minutes of travel time or miles. Though intended to ensure rapid access to

higher levels of care if complications arise, these distance mandates can reduce access to birth center care, excluding rural areas where hospitals may be sparse or distant.³⁷

Mandating transfer agreements or restricting birth center locations on the basis of distance can limit birth center availability without demonstrated safety benefits. Eighteen states require formal written transfer agreements with hospitals. Another 11 states have

distance requirements that dictate the location of birth centers in relation to a major hospital, whereas 8 states require a formal agreement or relationship with a physician who has hospital admitting privileges. In lieu of a formal transfer agreement, 15 states and the District of Columbia require birth centers to have a written plan or protocols in place for emergency transfers. Many states have a combination of these requirements, as indicated in Figure 4.

FIGURE 4. States with Hospital Affiliation Requirements



Source: Authors' calculations.

REGULATION RESTRICTS ACCESS TO EFFECTIVE MODELS OF MATERNAL HEALTHCARE

DESPITE EVIDENCE OF IMPROVED OUTCOMES, reduced costs, and high levels of patient satisfaction, regulations remain a significant barrier to expanding access to birth centers. These regulations do not enhance safety but instead limit the availability of safe, cost-effective maternity services, reducing women's birth options, especially in underserved or rural communities.

The experience of Katie Chubb exemplifies how regulation can restrict access to birth centers, particularly in areas with the greatest need for maternity care. Georgia has regulations in three of the five areas examined in our study: licensure, physician involvement, and hospital affiliations. These policies limit care options that may improve the state's poor maternal and infant health outcomes.

In 2024, nearly half of Georgia's counties (42 percent) were considered maternity care deserts, while another 12.4 percent had low to moderate access to maternity care services.³⁸ Between 2018 and 2022, Georgia had the eighth-highest maternal mortality rate in the nation, at 32.1 deaths per 100,000 births.³⁹ In 2022, the state had the ninth-highest infant mortality rate, at 7.08 deaths per 1,000 births.⁴⁰ Despite limited access to maternity care and poor health outcomes, Georgia continues to limit access to birth centers. Though the state eliminated CON requirements for birth centers in

2024, it continues to require transfer agreements that effectively grant hospitals a competitor's veto to block new birth centers.

Data show a correlation between the state regulatory burden and the number of operational birth centers: states with fewer regulations tend to have more birth centers, whereas those with more regulations, especially licensure or operational requirements, tend to have few birth centers or none. For example, the AABC finds that of the states that require a CON to establish a freestanding birth center, 60 percent have only one birth center or none. However, only 20 percent of states without CON requirements have similarly limited access.⁴¹

Although state regulations such as CON laws may be intended to protect patient safety, the power to restrict healthcare market entry tends to attract the political influence of industry incumbents, such as hospitals, which have an incentive to prevent competition from birth centers. That influence can cause the delay or denial of licensure or CONs for birth centers or otherwise disrupt birth center operations.

The surveyed regulations of birth centers ultimately limit women's healthcare choices and delay or deny access to some models of maternity care, thus failing to support the health of pregnant women. This is a curtailment of women's freedom to direct their own healthcare.

CONCLUSION

EVIDENCE FROM FREESTANDING BIRTH CENTERS demonstrates that the birth center model of care can lead to improved maternal and infant outcomes, highlighting the value of birth centers as a safe, effective, and patient-centered option in maternity care. Policymakers should consider reducing state regulatory barriers that unnecessarily restrict birth centers and limit women's maternity care choices.

Overregulation not only stifles access to high-quality, low-cost maternity care options but also undermines women's ability to select the birth care that best meets their needs and preferences. To improve outcomes and promote birth freedom, policymakers can reduce regulations that limit the growth of midwife-led birth centers, helping ensure that women have access to safe and evidence-based birth options.

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