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Increasing commercial coverage of doula services: perspectives from health plans and large employers in California

Ashley Nguyen[1], Mounika Parimi[1], Kendy Yaneth Mendoza[1], Anu Manchikanti Gómez[2], Cassondra Marshall[1,*]

[1]School of Public Health, University of California, Berkeley, 2121 Berkeley Way #5302, Berkeley, CA 94720, United States
[2]Sexual Health and Reproductive Equity Program, School of Social Welfare, University of California, Berkeley, 113b Haviland Hall, MC 7400, Berkeley, CA 94720-7400, United States

*Corresponding author: School of Public Health, University of California, Berkeley, 2121 Berkeley Way #5302, Berkeley, CA 94720, United States.
Email: cassiejm@berkeley.edu

Abstract

Although Medicaid coverage of doula services has expanded since 2014, commercial coverage remains nascent. Little is known about what motivates private payers to cover doula support. Through qualitative interviews with staff members ($n = 11$) from health plans and employers that operate in California, we aimed to identify factors that could influence commercial coverage of doula services. In our first theme, we describe how a health plan or employer's commitment to birth equity can serve as a catalyst for commercial coverage of doula services. Second, participants noted that when considering new benefits, payers would review evidence related to doula support and weigh cost. The third theme centers on how consumer demand could impact a health plan or employer's appetite for adding a commercial doula benefit. The final theme highlights the operational considerations health plans and employers are contemplating, such as how to prioritize populations that could most benefit from doula support. Our findings suggest that the decision to cover doula support largely hinges on payer priorities. However, we found that health plans and employers interested in advancing birth equity were compelled by evidence supporting doula care, suggesting there may be opportunities to increase commercial coverage of doula services.

Key words: doula; insurance benefits; health insurance; maternal health.

Introduction

In the United States, public insurance coverage of doula services has significantly expanded since 2014, when only 2 state Medicaid programs reimbursed doulas for providing physical, emotional, and informational support to pregnant and birthing people before, during, and after childbirth.[1] As of 2024, at least 15 states and the District of Columbia have implemented Medicaid doula benefits, and other states are expected to follow suit.[1,2] Commercial insurance coverage of doula support, however, remains nascent.

The push to expand access to doula support is largely rooted in the desire to improve maternal and infant health and address persistent racial and ethnic inequities in birth outcomes. Studies have demonstrated that doula support is associated with a range of clinical outcomes, including lower rates of cesarean delivery and preterm birth,[3] which can contribute to reduced costs, particularly for state Medicaid programs.[4-6] Doula support can also improve patient experience.[7] For example, one study found that doula support was associated with higher levels of respectful care, especially among Black women,[8] who have historically faced systemic racism and implicit bias within healthcare systems.[9]

Researchers have found there is an appetite for doula support in the United States, particularly among Black women.[10,11] However, access to doula services has mostly been reserved for individuals who can afford the out-of-pocket cost needed to hire a doula. Fees vary but can range from $600 to $2000 or more.[6,12] Although state Medicaid doula benefits are slowly shifting who can access doula support and how doulas are compensated for serving individuals with low incomes, a coverage gap is emerging for privately insured individuals who desire doula support but for whom cost is a barrier.[13,14]

Notably, a majority of those who are privately insured obtain health coverage through their employment,[15] and employers have major influence over the maternity benefits this population receives.[16] Some employers do cover doula services, but commercial doula benefits are not widespread.[17,18] However, state legislators have begun passing bills aimed at increasing commercial coverage of doula services.[2,13] In 2021, Rhode Island became the first state to require some private health plans to cover doula support, which Rhode Island doulas advocated for in addition to Medicaid coverage of doula services.[13,19] Louisiana, Utah, Illinois, and Virginia also have new laws that will require some private health plans to cover doula services.[2]

California's Department of Health Care Services began covering services through its Medicaid program, Medi-Cal, in

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2023 after 2 years of planning and stakeholder engagement.[20] The benefit covers full-spectrum doula services, which includes support before, during, and after abortion, miscarriage, stillbirth, or childbirth.[21] California also has 2 laws that encourage private health insurers to offer doula support.[22,23] Specifically, a bill signed into law in 2023 requires private health plans to develop maternal and infant health equity programs that address racial health disparities in maternal and infant health outcomes through the use of doulas.[23]

Other than legislative mandates, little is known about what motivates private payers, including health plans and employers who sponsor health coverage, to cover doula support. Research exploring payer perspectives largely focuses on expanding access to doula support for the Medicaid population.[24-26] The purpose of this study is to identify factors that could influence commercial coverage of doula services, from the perspective of health plans and large employers that operate in California. In this article, we use "commercial coverage" to encompass private insurance coverage of doula services and employer benefits that may be offered separately from health insurance.

Methods

Recruitment

As part of a larger study on payer investment in doula services in California,[20] we purposively sampled health plans that offer private insurance and large employers that operate in the state. With guidance from experts familiar with the health care purchaser landscape in California, we developed a list of potential health plans and employers to recruit from. Recruitment emails were sent to health plan and employer leaders. Recipients of the recruitment email, which included interview topics, could ask someone else at their organization to participate in an interview, and more than one person could participate in a joint interview. Participants were also asked to identify key stakeholders from other health plans and employers whose perspectives were important to include in our study.

Interviews

We developed 2 semistructured interview guides (one for health plans and one for employers) informed by a review of the literature and conversations with experts with knowledge of health plans, benefit design, and doula support. Experts included advocates familiar with the California policy landscape, a health plan advisor, and a health services researcher. Both interview guides focused on awareness of doulas, current coverage of doula services, new benefit considerations, and interest in implementing a commercial doula benefit and potential challenges to doing so. Given that we conducted interviews prior to the implementation of the Medi-Cal doula benefit, our interview guides included questions related to the potential impact of Medi-Cal coverage of doula services on the commercial space. California state lawmakers introduced bills related to private health plan coverage of doula support in 2022 and 2023 after data collection ended[22,23]; therefore, we did not ask interviewees about this legislation. If the plan or employer covered doula services, we probed on how the idea originated and the makeup of the benefit (eg, covered services, rates, eligibility, and doula requirements). If the plan or employer did not cover doula services, we asked questions related to whether there have been internal conversations about doing so in the future and whether consumers have requested a doula benefit. When time allowed, we asked participants to describe what factors into a plan or employer's decision-making process when considering new benefits and probed on the influence of consumers and cost.

We conducted interviews between September 2021 and February 2022. Participants provided verbal consent prior to each interview. All interviews were conducted via phone or videoconference. Interviews were audio-recorded and professionally transcribed. Two members of our research team reviewed each transcript to remove identifiers. Participants in 1 interview declined to be recorded. The interviewer took detailed notes during this interview, which we included in the analysis; however, we did not use any quotes. To protect participant confidentiality, we report limited descriptors of participants and their respective health plans and employers and refer to the organizations as plans/employers. Participants received a $45 gift card incentive if they were eligible to accept. The Committee for Protection of Human Subjects at the University of California, Berkeley approved the study protocol.

Researcher reflexivity

All members of our research team have academic training in public health, with a focus on maternal and child health, at the undergraduate, graduate, or doctoral level. Four members have prior qualitative research experience. Our research team includes faculty researchers with expertise in health equity, implementation science, and qualitative methods; a project coordinator with additional training in journalism; a doctoral candidate with research experience in community models of perinatal care; and an undergraduate student with community engagement experience. Three members of our research team have prior experience conducting research related to doula support. Notably, some of this research was conducted in partnership with doulas, advocates, public health professionals, and clinicians before or during data collection for this study. Additionally, 2 members of our research team have utilized doula support. No one on our research team is a doula.

Analysis

We conducted a thematic analysis to identify factors that could influence commercial coverage of doula services.[27] Using inductive and deductive approaches to create a codebook, MP developed initial codes based on the interview guides and reflections from listening to the audio recordings and reviewing the transcripts. CM and AN reviewed the initial codebook and made suggestions based on their familiarity with the data. After revising the codebook, MP and AN coded 2 transcripts individually using Dedoose coding software[28] while keeping notes in an ongoing memo. MP and AN then met to review the coded transcripts and discuss and resolve any discrepancies. With input from CM, MP and AN revised the codebook, which they utilized to code all transcripts independently. The coders met frequently to review each transcript, come to a consensus on the applied codes, and discuss observations noted in memos updated throughout the coding process. After coding was complete, MP and AN iteratively developed a thematic map with input from CM. AN then used the thematic map and coded data to draft theme abstracts. CM and AN discussed the theme abstracts, and AN

further refined the thematic map and abstracts before drafting preliminary findings. All members of the study team reviewed and approved the final results.

Results

We conducted 8 interviews with staff members ($n = 11$) from 5 health plans that offer private insurance and 3 large employers that operate in California. Several participants' roles focused on delivering health insurance to members and employees in California. However, some participants oversaw broader geographic regions that included California, other states, and/or other countries. Participants had a range of job responsibilities, which included designing benefits, implementing benefits, improving quality and cost of health care, and providing subject matter expertise. About half of participants held leadership positions (eg, senior director or manager of their department, chief medical officer, or medical director). Five participants were physicians and one was a nurse.

Most participants were familiar with a doula's role and the benefits of doula services. There was a range of interest in covering doula support. Three plans/employers were early adopters. These plans/employers were either actively exploring coverage of doula services, currently piloting a doula benefit, or had already piloted a doula benefit. However, most plans/employers were not in the process of piloting, developing, or administering a doula benefit. Some of these participants reported engaging in high-level discussions about doula support within their plans/employers over the years, but these discussions did not result in any significant action. Overall, many participants reported an interest in observing implementation of the Medi-Cal doula benefit, which could factor into future decision-making around commercial coverage of doula services.

Below we describe factors that could influence commercial coverage of doula services through 4 themes identified in interviews with participants. Theme 1 is an organizational commitment to birth equity can be a catalyst for doula coverage. Theme 2 is evidence and cost effectiveness must be considered when adding a doula benefit. Theme 3 is consumer demand and competition will impact appetite for adding commercial doula coverage. Theme 4 is health plans and employers are contemplating key operational considerations related to commercial doula benefits. The latter theme focuses on 3 key issues: (1) prioritizing populations that could most benefit from doula support; (2) assessing a doula's qualifications; and (3) doula workforce capacity.

Theme 1: Organizational commitment to birth equity can be a catalyst for doula coverage

Early adopter participants described how the spotlight on nationwide trends related to inequities in maternal health motivated their plans/employers to explore adding doula coverage. During their discovery processes, participants described reviewing research related to doula support, engaging subject matter experts, and developing a rationale to present to leadership.

One participant described how after the murder of George Floyd in 2020, a plan/employer deepened its commitment to addressing health inequities that impact Black communities. One area of focus was maternal and infant health:

> Well, after the murder of George Floyd in 2020, our company really took a strong stance against disparities against Black and African American individuals. So we put out basically our commitment to improving it. … Health equity was one of those areas. And within that was Black and African American mothers and babies.

An internal taskforce focused on improving maternal and infant health discussed the possibility of covering doula support, which led to leadership approving the launch of a doula pilot program to "test the market." The participant reported that although doulas are not a "cure all" for adverse maternal and infant health outcomes, doulas can help advance health equity, which was important to the plan/employer.

Similarly, participants from another plan/employer described how internal conversations around health equity served as a catalyst for a small-scale doula pilot program:

> There's a lot of emphasis in the organization—there always has been and of course renewed in recent years—on equity. … Everybody's seeing the data that shows that Black women have much worse maternal outcomes than others in the state. And so there was a lot of desire to get at that.

Notably, most participants described health equity and improving maternal health outcomes as plan/employer priorities. Some participants described putting resources toward other initiatives aimed at improving maternal health that were not specific to doula support, such as working with providers to reduce cesarean delivery rates or providing members/employees access to digital health platforms related to fertility, pregnancy, and parenting.

Theme 2: Evidence and cost effectiveness must be considered when adding a doula benefit

Almost all participants reported the importance of considering the impact a benefit would have on health outcomes and costs. Before creating a new benefit, plans/employers conduct internal reviews of available research to make sure the proposed benefit is evidence-based. Among those familiar with doula-related research, a few participants were compelled by studies that found doula support is associated with improved maternal health outcomes and cost savings. However, one participant identified gaps in the literature, particularly around cost effectiveness and the impact of Medicaid doula benefits on birth outcomes. Another participant noted that research may not always convince leaders who are skeptical about doula support.

Generally, participants reported that benefits projected to be cost effective or cost saving will garner more internal support. Some participants described the importance of conducting an actuarial analysis when considering new benefits. For example, a plan/employer would estimate the impact of doula support on the plan/employer's population and estimate costs associated with adding a benefit.

To help decide whether a new benefit is worth pursuing, one participant described utilizing the Triple Aim, which focuses on improving the individual experience of care, improving the health of populations, and reducing costs.[29] The participant noted that a benefit does not always result in a financial return, but if it improves health outcomes, it may be worth the investment. For example, the participant said, if doula support lowers cesarean rates and the number of low birthweight infants, it could be the right "values play" for a plan/employer, even if it does not end up resulting in a return on investment.

When presenting potential benefits to leadership, the participant reported being honest about how the benefit may or may not result in cost savings: "So we'll usually make that argument more around some of those positive outcomes, and it doesn't always result in dollars and cents."

Theme 3: Consumer demand and competition will impact appetite for adding commercial doula coverage

Participants reported that consumer demand generally plays a crucial role in new benefit development. From the health plan perspective, large employers who purchase coverage for employees are a particularly influential group of consumers. If large employers express interest in offering doula coverage to employees, plans may be motivated to develop a benefit. However, as one participant pointed out, if adding a new benefit increases premiums, employers—and ultimately individual consumers (ie, members and employees)—must be willing to pay for it.

Overall, participants reported that employer and individual consumer requests for doula coverage have been minimal. However, a few participants anticipated increased consumer demand due to the Medi-Cal doula benefit. One participant said: "I mean, I will just assume that this is going to come to the commercial world very shortly as well. And we'll probably get our employer groups also coming to us."

Additionally, if more plans/employers offer doula benefits, competitors may follow suit. One participant described how the proliferation of Medicaid coverage of doulas nationwide and increased support from plans and employers will ultimately be "what changes the tide of things." If more plans/employers offer doula benefits, another participant said leadership may also be more receptive: "As covering doulas become more of the norm, I think it becomes easier, obviously, for us to make that case internally and for other employers to be able to also add that to their plan as well."

Theme 4: Health plans and employers are contemplating key operational considerations related to commercial doula benefits

Participants noted there were a lot of unanswered questions about how to incorporate doula support into commercial insurance coverage. In this theme, participants described 3 key issues to consider prior to developing and implementing a commercial doula benefit: (1) prioritizing populations that could most benefit from doula support; (2) assessing doulas' qualifications; and (3) doula workforce capacity.

Prioritizing populations that could most benefit from doula support

Rather than offering a commercial doula benefit to all members/employees, a few participants reported they would consider starting with a focal population. Given the benefits of doula care, most of these participants felt it was important to initially prioritize populations disproportionately impacted by adverse maternal and infant outcomes, including Black, American Indian, Alaska Native, Pacific Islander, and Native Hawaiian birthing people. One participant acknowledged there could be logistical challenges to creating a targeted benefit but described it as necessary to advance health equity:

> A lot of times, policies will be rolled out to a very broad audience or kind of an open rollout when, in fact, the area of concern doesn't get the attention it should. I think whoever works in this space should really focus on the women who are experiencing the worst disparities and make sure that they benefit from the benefit.

When choosing a focal population to pilot a commercial doula benefit, one participant described looking at geographic areas with the worst maternal and infant health outcomes, particularly among Black birthing people. However, any eligible employee/member could utilize the benefit in this geographic area, regardless of race/ethnicity.

Although participants primarily discussed prioritizing benefit users by racial/ethnic group, others shared different vantage points. First, a participant suggested commercial plans prioritize designing a doula benefit for individual and family health plans available through Covered California, the state's marketplace. The participant reported that members often go back and forth between Medicaid and marketplace plans; therefore, this approach would capture individuals who may be economically marginalized and could most benefit from doula support. Second, a participant from a health plan that offers both Medicaid and commercial coverage expressed concerns about prioritizing specific populations. The participant emphasized the importance of providing the same services to members, regardless of whether the payer is private or public. However, the participant did not know how their plan would approach commercial coverage of doula services after the Medi-Cal doula benefit went into effect, stating: "All I know is that we strive to ensure that the services available are equitable and are consistent as much as possible across our populations."

Assessing a doula's qualifications

There are multiple pathways to becoming a doula, and the content of doula training and certificate processes can vary.[30,31] This level of variation is at odds with how health plans typically operate. We observed that participants wrestled with how doulas and the services they provide would fit into existing structures associated with health plans if covered by private insurance. For example, participants noted that clinical providers, such as physicians, midwives, and nurses, are licensed. In contrast, doulas provide nonclinical support and are not subject to licensure.

For the reasons described above, a participant reported that covering doula services may make some people "uncomfortable":

> When there is a lot of variation in what a doula does and there's different definitions, people are going to point that out and say, well, we're not really sure … who we're getting, and that makes people uncomfortable. So I think that's the controversy around it. That's how it is a lot of times in health care. I mean, we are interested in licensure. There's lots of people who can do what a nurse can do, but we want the nurse to do it. She's licensed to do it. And I think that lack of licensure or accreditation of any sort … that didn't feel you know quite—I mean, even midwives doing deliveries is something that has been controversial for health plans and not all of them will cover it and it has to be in certain situations. And so I think that's really the issue. [A doula is] not a licensed health care person.

Participants reported a need to create standardized processes to determine whether a doula is qualified to provide services to members and be reimbursed through a commercial doula benefit. Several participants described a preference for working with doulas who have completed the same training and certification processes. However, one of these participants expressed concern about whether a certifying body is "actively managing" doulas' certifications with the same rigor as a state medical board, which reviews complaints and can suspend or terminate a provider's license. A couple participants noted that health plans are responsible for monitoring the quality of providers. One participant described this sentiment:

> If we are providing [doula services] as a covered benefit, there's a certain accountability for quality and quality assurance and consistency to a set of standards that we would be accountable for in that situation.

A participant managing a commercial doula pilot program reported "there is no source of truth" on the best doula training and certifying organizations. Still, for the pilot, the participant stated that members/employees could only work with a doula "credentialed" through one of 2 organizations selected by the plan/employer. (Notably, doulas typically are certified through an organization, not credentialed.) The plan/employer selected the doula organizations based on reputation and the number of doulas available in the geographic region where members/employees lived.

Doula workforce capacity

Several participants reported that plans/employers would need to consider the size, diversity, and capacity of the doula workforce. If there are not enough doulas to create adequate provider networks, offering a commercial doula benefit would not be worthwhile, participants reported. A participant said:

> We need doulas to be able to offer doulas because you can say all day that you're adding a benefit for a doula. But then if … you can't find one unless you travel 3 or 4 hours away, that benefit really wasn't offered to you even though it was.

Some participants emphasized the importance of monitoring how the doula workforce responds to demand generated from Medi-Cal coverage of doula services. One participant noted that plans/employers should be mindful of potential labor shortages and the "unintended consequences" of offering commercial coverage of doula services:

> It's not clear there are enough certified qualified people to care for the potential demand, not just of the Medi-Cal [doula benefit] but expanding into private payer benefits. And it could be just difficult to predict labor forces. So there could be waves of doulas moving away from that new Medi-Cal benefit altogether because a certain private payer reimburses them a lot more.

Discussion

This study identified several factors that could influence commercial coverage of doula services, from the perspective of health plans and employers that operate in California. Health plans and employers in our study were interested in advancing maternal health equity; however, only some participants reported an interest in doing so by covering doula support. Factors that could help move the needle toward increased commercial coverage of doula services include a strong evidence base that demonstrates the positive impact of doula support on outcomes and costs and consumer demand for doula coverage, specifically from large employers. Participants also described several operational considerations that health plans and employers would need to address if they chose to cover doula support, including how to prioritize populations that could most benefit from doula support.

Our findings suggest that the implementation of California's Medi-Cal doula benefit will impact how health plans and employers approach commercial coverage of doula services. Some participants anticipated that the proliferation of Medicaid coverage of doula services may contribute to increased demand in the commercial space. At the same time, most participants described a desire to monitor Medi-Cal doula benefit implementation before pursuing commercial coverage. As such, lessons learned from the Medi-Cal doula benefit should be shared with private payers, including health plans and employers, in California.

We observed that participants in our study and payers involved in developing and implementing state Medicaid benefits seem to grapple with similar issues. These issues are often rooted in payers' limited understanding of how doulas operate and/or the initial assumption that doulas will conform to health system expectations rather than payers changing their processes to accommodate doulas. For example, participants described a desire to create standardized processes to assess whether a doula is qualified to serve health plan members, such as requiring doulas to complete specific doula trainings or obtain their certification. However, training and certification can be cost prohibitive.[32] Therefore, health plans that choose this approach would be limiting the potential provider pool of doulas to those who can afford to meet the plan's requirements, which could exclude a number of experienced doulas, including those who are Black, Indigenous, people of color and reflect the populations some participants reported wanting to prioritize with a commercial doula benefit. Additionally, utilizing a narrow list of approved trainings and certifications may preclude doulas who have attended lesser-known community-based trainings that are more likely to focus on structural racism in maternal health.[31,32] State Medicaid programs have also struggled to create accessible training and certification requirements for doulas.[33] To avoid creating unnecessary barriers, many state Medicaid officials have found that collaborating with doulas when designing such requirements is critical.[33] In Rhode Island and California, doulas worked with state officials to develop requirements that do not rely on a list of approved trainings.[34]

Some of our findings are consistent with 3 qualitative studies that explored payer perspectives on doula support more broadly through interviews with payers who facilitate access to public insurance coverage and other stakeholders, such as clinical leadership.[24-26] In these studies, stakeholders emphasized the importance of having evidence that demonstrates the impact of doula support on health outcomes and costs,[24-26] which is reflected in our study. In interviews with payer and provider decision-makers in Massachusetts, researchers found that a desire to improve health equity was an incentive for payer investment in doula services.[25] Similarly, we found that for some participants, an organizational commitment to birth equity was a catalyst for pursuing commercial doula coverage.

Several findings from this analysis have policy implications. First, one participant emphasized the importance of providing

the same services to both publicly and privately insured individuals. As doula coverage increases nationwide, organizations that administer private and public insurance coverage may need to consider whether only offering doula services to certain members based on payer is in line with their organizational values. Second, another participant noted the importance of monitoring how the California doula workforce responds to demand generated from the Medi-Cal doula benefit before expanding commercial coverage of doula services. Health plans should engage local doulas to better understand how the workforce might react to commercial coverage. Notably, in a review of the literature, we found that almost no studies have explored doulas' perspectives on commercial coverage of doula services or experiences with private health plans.

Lastly, participants in our study highlighted the importance of consumer demand but reported receiving few requests for doula coverage from individual consumers. Putting the burden on individual consumers to inquire about doula coverage would likely be a barrier to widespread commercial coverage of doula services. Additionally, several studies have found there is a desire for doula support among publicly and privately insured US women.[10,11,14]

Limitations

To our knowledge, this study is the first to explore factors that could influence commercial coverage of doula services from the perspective of payers. However, this study has some limitations. First, it is not possible to generalize our findings across all health plans that offer private insurance and large employers that operate in California. Next, our small sample size limits our ability to report differences between the health plan and employer perspective. Additionally, although our study recruitment email included interview topics and encouraged recipients to determine if they were the best person to participate in an interview, some participants had more direct involvement with designing and implementing new benefits than others. Finally, this study does not include other vital stakeholder perspectives, such as privately insured people of reproductive age or doulas.

Conclusion

In the absence of policies mandating private insurance companies cover doula services, the expansion of doula coverage may largely hinge on payer priorities. However, we found that some plans/employers interested in advancing birth equity were compelled by evidence supporting doula care. Participants identified increased consumer demand, particularly from large employers, and outcomes from the Medi-Cal doula benefit as influential factors that may impact expanded commercial coverage of doula services. Potential barriers to designing and implementing commercial doula benefits include doula workforce capacity and a mismatch between the health system's desire for standardization and the doula profession's varied approach to training and certification. Although our study focus is on California, our findings offer important insights for policy makers, health plans, and employers nationwide to consider when developing or adding commercial doula benefits. Given that many people, including those who are privately insured, cannot afford doula services, commercial doula benefits may help increase access to critical support that can improve pregnancy and birth experiences.

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Supplementary material

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Conflicts of interest

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Please see ICMJE form(s) for author conflicts of interest. These have been provided as supplementary materials.

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