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# Expanding Postpartum Medicaid Coverage

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The postpartum period is an important, but often neglected element of maternity care. New mothers may be dealing with a host of medical conditions, such as complications from childbirth, pain, depression or anxiety, all while caring for a newborn. While Medicaid pays for nearly half of all births and must cover pregnant women through 60 days postpartum, after that period, states can and have made very different choices regarding whether eligibility for Medicaid coverage is continued. In states that haven't expanded Medicaid, in particular, many women are left without a pathway to coverage and become uninsured during a medically vulnerable phase of their lives. This brief discusses Medicaid's eligibility for pregnancy and postpartum care, describes gaps in coverage particularly for low-income women who live in states that have not expanded Medicaid under the ACA, and highlights several state and federal efforts to extend postpartum coverage to more women for a longer period of time.

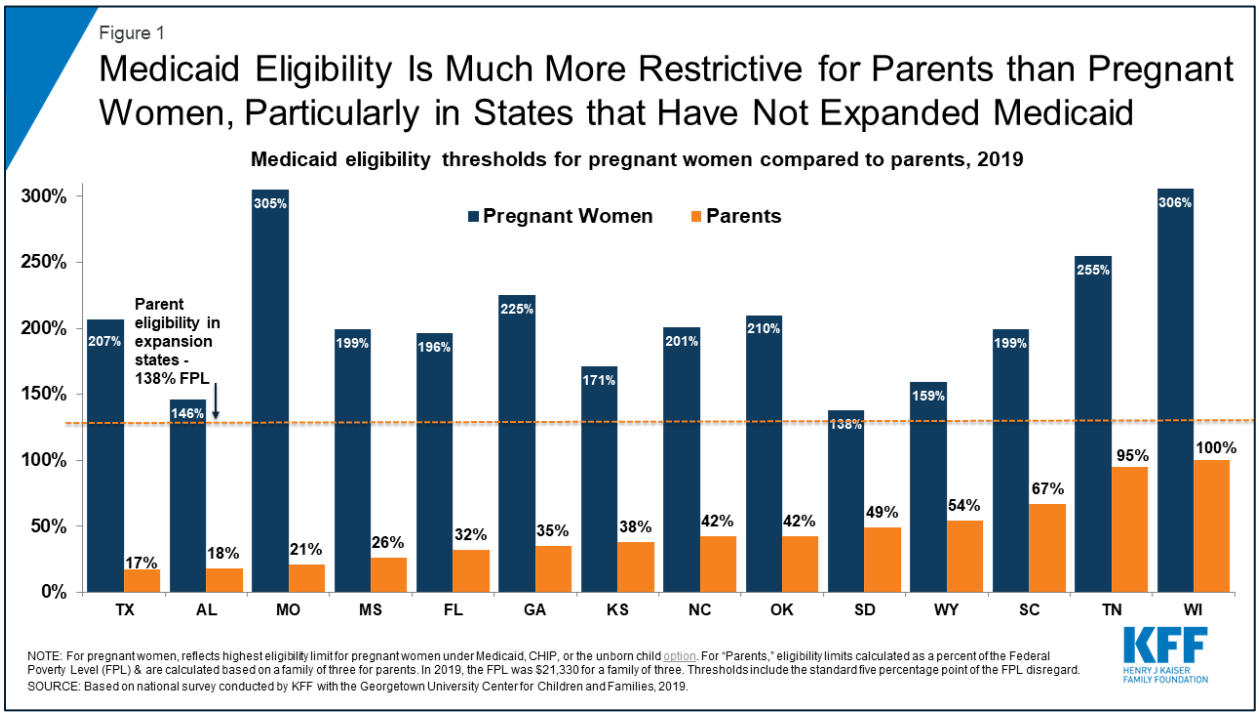
## What is Medicaid's role for pregnancy and postpartum care?

Medicaid has long prioritized coverage of pregnant women and now finances nearly half of all births in the United States. Federal law requires that all states extend eligibility for pregnant women with incomes up to 138% of the federal poverty level (FPL); however, most states go beyond this minimum threshold, ranging from 138% to 380% FPL. Pregnancy-related coverage for the mother must last through 60 days postpartum and the infant is eligible for Medicaid for the first year after birth. Following the 60 days postpartum period, the decision about coverage for women is up to the states. In the states that have expanded Medicaid under the ACA, most women are typically eligible to remain covered because eligibility is extended to all qualifying individuals with incomes up to 138% FPL, or they may qualify for subsidized coverage through the Marketplace. In the states that have not adopted the ACA's Medicaid expansion, many new mothers again become uninsured because they do not meet the state's Medicaid income eligibility requirements for parents. The postpartum period can be a medically vulnerable period for many women. In fact, many cases of maternal mortality and pregnancy-related depression occur in the postpartum period. All states provide pregnant women with the full range of Medicaid benefits that include prenatal care, childbirth and delivery services, but not all states extend eligibility to moms beyond 60 days after delivery Assuring that low-income women have continuous coverage after pregnancy would support improvements in infant and maternal outcomes.

## Where are the gaps in coverage for women who are postpartum?

To date, 36 states and DC have adopted expanded eligibility for Medicaid under the ACA and offer low-income women the opportunity to continue their pregnancy related Medicaid coverage after the 60 days postpartum period. In the 14 states that have not adopted the ACA's Medicaid expansion, postpartum

women need to requalify for Medicaid as parents to stay on the program. While the eligibility thresholds for pregnant women typically go higher than the minimum federal requirement of 138% FPL, Medicaid income eligibility levels for parents are much lower than for pregnant women in all of the states, as low as 17% FPL ($3,636 for a family of three) in Texas (**Figure 1**). As a result, many women in non-expansion states become uninsured after pregnancy-related coverage ends 60 days postpartum because, even though they are poor, their income is still too high to qualify for Medicaid as parents, even though their infant is eligible for their first year of life.




Prior to ACA implementation, many women with Medicaid during pregnancy would become uninsured after the 60 days postpartum coverage period ended. A national study of women's insurance coverage during the perinatal period in the pre-ACA era found that more than half of women covered by Medicaid or CHIP at the time of delivery were uninsured at least one of the six months following delivery, far higher than the rate for women who had private insurance at the time of delivery (55% Medicaid compared to 35% private). This reflects, in part, the greater volatility of income levels and coverage access among low-income women.

Research shows that since the ACA was implemented, uninsured rates among postpartum women have decreased nationally, with a larger drop in expansion states compared to non-expansion states. In a state-level analysis of 40 states, as of 2015-2016, Texas, Georgia, and Oklahoma had uninsured rates among postpartum women above 20%, with Florida close behind at 18%. All ten of the states with the highest uninsured rates among postpartum women were non-expansion states. Furthermore, women in non-expansion states who are dropped from Medicaid after 60 days postpartum may not even qualify for subsidies to assist with the purchase of private insurance in state Marketplaces because they have

incomes between the income limit for parents and 100% FPL, placing them in the "coverage gap" and making private insurance unaffordable.

## Why is coverage for postpartum care important?

Health characteristics and outcomes vary between pregnant women by socioeconomic status. Compared to pregnant women who are privately insured, those with Medicaid are more likely to be overweight or obese, have higher rates of smoking before or during pregnancy, and are at greater risk for poor infant outcomes, including low birthweight and preterm births. However, a recent study examining the impact of Medicaid expansion on infant outcomes did not find any effect on the overall rates of low birth weight or preterm birth, but did detect some decline in racial disparities.

One of the most common complications for pregnant and postpartum women is depression. The American College of Obstetricians and Gynecologists (ACOG) estimates that 14-23% of pregnant women and as much as a quarter of postpartum women experience depression. Several studies have found higher rates among women of color, low-income women, as well as variation between states. ACOG recommends screening during the postpartum visit and initiation of treatment or referral to a mental health provider when a woman is identified with depression.

States have discretion to determine the specific scope of maternity care benefits under Medicaid. However, states that have expanded Medicaid eligibility under the ACA must cover all preventive services recommended by the United States Preventive Services Task Force (USPSTF) for beneficiaries that qualify as a result of the ACA expansion. These include many pregnancy-related services, such as prenatal screening tests and folic acid supplements. It also includes coverage for breastfeeding supports that extend to the postpartum period, with coverage for lactation consultation and breast pumps. Many states cover substance use treatment and home visiting services. Fewer cover other maternity services such as doula care and home births. Pregnancy-related services under Medicaid are exempt from cost-sharing, and after the postpartum period, Medicaid typically charges beneficiaries very little cost sharing for other services. A large body of evidence shows that even nominal cost sharing impedes access to care for low-income women and families. For low-income people in particular, the lower cost sharing and absence of deductibles under Medicaid can be a major advantage over private insurance.

The increasing rates of maternal mortality (typically defined as death within one year of pregnancy) with stark racial and ethnic disparities have again highlighted the need for improving access to care for all women of reproductive age. Identifying the causes of maternal mortality and morbidity is complex, but research strongly indicates that access to health care throughout a woman's reproductive years, particularly before a pregnancy, is essential for prevention, early detection, and treatment of some of the conditions that place women at higher risk for pregnancy-related complications, including cardiovascular disease, diabetes, and chronic hypertension. Furthermore, a wider array of conditions, including mental health challenges, domestic violence, and substance use all play a role in maternal mortality and broader maternal health outcomes.

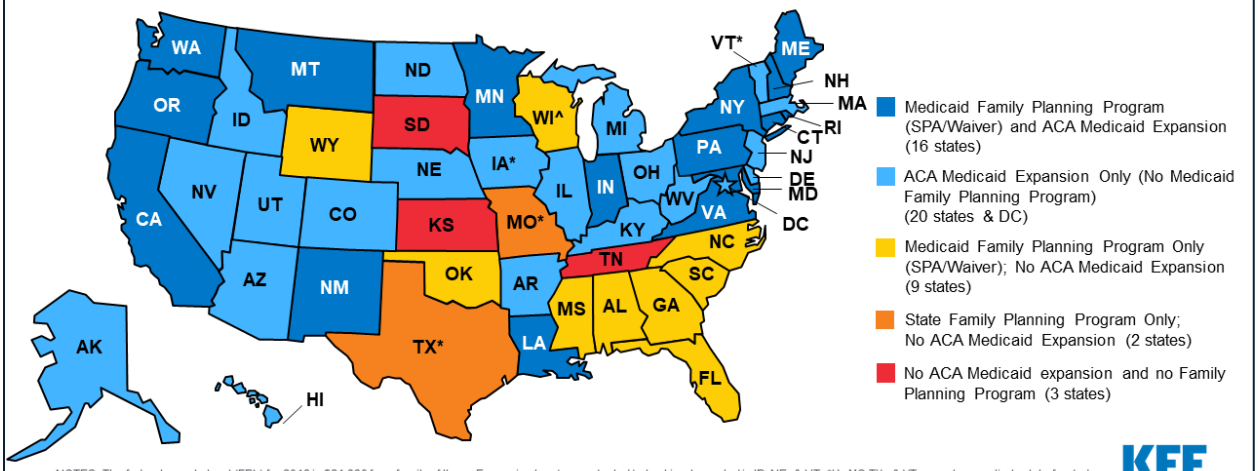
## What efforts have states made to provide more benefits to postpartum women?

There have been some efforts to broaden Medicaid coverage for women of reproductive age to address some of their particular health needs. For example, half of all states extend Medicaid coverage for just family planning services to individuals who do not qualify for full Medicaid coverage. While these family planning-specific programs do not provide comprehensive coverage as Medicaid does, they provide access to postpartum and intrapartum contraceptive services, which are essential for pregnancy planning and healthy birth spacing. Intended pregnancies are associated with positive maternal and infant outcomes, including earlier receipt of prenatal care, while women with births resulting from unwanted pregnancies are at higher risk of having low birthweight infants. Of the 14 ACA non-expansion states, eight offer women limited scope Medicaid family planning coverage, and a few operate state-funded family planning programs, providing access to contraception, a critical service for many during the postpartum period (**Figure 2**). However, in three states – Tennessee, Kansas, and South Dakota – postpartum women who were covered by Medicaid for pregnancy likely become uninsured after 60 days because the state has not expanded Medicaid under the ACA, and may not even have access to contraceptive services because the state does not have a Medicaid-funded family planning program.

Figure 2

### State Decisions on Medicaid Expansion and Family Planning Programs Affect Women's Access to Postpartum Care

**State Decisions on ACA Medicaid Expansion and Medicaid Family Planning Programs, May 2019**




NOTES: The federal poverty level (FPL) for 2019 is $21,330 for a family of three. Expansion has been adopted but not implemented in ID, NE, & UT. *IA, MO,TX, & VT operate an entirely state-funded programs to provide family planning services ^WI did not adopt Medicaid expansion under the ACA, but extends coverage to adults up to 100% FPL.
SOURCE: Kaiser Family Foundation, Status of State Action on the Medicaid Expansion Decision, As of April 2019.
Guttmacher Institute, State Policies in Brief, Medicaid Family Planning Eligibility Expansions, As of May 1, 2019.

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In 2016, CMS approved coverage of postpartum depression screening for women during well child visits. Postpartum depression can occur anytime in the first year after delivery, making the frequency of well child visits during that year an opportunity for identifying and screening for maternal depression. Under the CMS initiative, if the woman is covered by Medicaid, treatment services can be covered under Medicaid. If a woman is uninsured, for example in a non-expansion state, in order for Medicaid to cover

the treatment under the child, the treatment must involve the child, such as family therapy. California is currently considering legislation that would extend Medicaid coverage for a year for any individual who was pregnant and diagnosed with a maternal mental health condition.

Some states have attempted to extend Medicaid coverage to postpartum women for other conditions. For example, policymakers and advocates in Missouri have proposed a Medicaid extension for postpartum women in need of opioid treatment services. The prevalence of opioid abuse or dependence during pregnancy more than doubled between 1998 and 2011. ACOG recommends that postpartum women with substance use disorders should have access to and continue use of treatment services, including pharmacotherapy. The postpartum period can be a particularly susceptible time for relapse, with loss of insurance and access to care considered a potential trigger for relapse. CMS currently has a funding opportunity for up to 12 states to develop programs to care for pregnant and postpartum women with opioid use disorder. In North Carolina, a new pilot program allows the state to use Medicaid funds to pay for non-medical interventions, such as food or housing assistance for some beneficiaries, including high risk pregnant women.

At this point in time, no states (other than Medicaid expansion states) currently extend postpartum coverage beyond the federal requirement of 60 days, but it is under consideration in at least three states. A bill proposed in the Texas legislature would amend the state's Human Resources code to require that any woman who is eligible for medical assistance for pregnancy would remain eligible for coverage for at least 12 months following delivery or involuntary miscarriage. The bill recently passed the state's House and will move on the Senate for consideration. The New Jersey state legislature is also considering legislation to extend Medicaid to 12 months postpartum, and the bill was recently voted out of committee. The proposal is part a larger package to address maternal mortality, with other bills that would add coverage of doula services under Medicaid, change the program's payment policies for maternity care, and require the state to enhance data collection on maternal outcomes and quality of care. An Illinois bill under consideration would extend postpartum Medicaid coverage to one year and also add more benefits to pregnancy-related coverage, including for doula services.

## What proposals are currently being considered at the federal level to broaden coverage for postpartum women?

At the end of the 2017-2018 Congressional session, the President signed the Preventing Maternal Deaths Act of 2018, which allocates five years of funding for HHS to make grants to states for activities aimed at curbing pregnancy-associated deaths, including maternal mortality review committees, provider education, and enhanced data collection efforts.

In the current Congressional session, H.R. 1897, the federal MOMMA Act (sponsored by Rep. Robin Kelly) as well as an identical Senate bill, S. 916 introduced by Senator Durbin (D-IL), also aim to improve federal efforts with respect to the prevention of maternal mortality. The bill would amend the Social Security Act and extend Medicaid coverage for pregnant and postpartum women to one year, which would be federally-funded for the first 20 calendar quarters, and then lowered to 90% of the costs

thereafter. The bill has a Maintenance of Effort requirement that eligibility standards for pregnant and postpartum women shall not be more restrictive than those in place at the time of legislative enactment.

A group of U.S. Senators, including Presidential candidates Booker, Gillibrand, Harris, and Warren introduced another bill in May 2019 that would extend postpartum Medicaid coverage for up to one year. Their proposal includes a number of other changes, such as increasing Medicaid reimbursement rates for obstetric services, encouraging greater use of doula care and telemedicine for pregnancy, and ensuring that pregnant women are covered for the full range of Medicaid benefits in their state and not limited to pregnancy-related care.

## Conclusion

It has long been a national priority to extend coverage to low-income pregnant women and children, as evidenced by the higher Medicaid eligibility levels for pregnant women and children. The ACA offers states the option to extend Medicaid eligibility to low-income parents with incomes up to 138% of the federal poverty level. However, in the 14 states that have not adopted full scope Medicaid expansion, postpartum women lack a pathway to coverage and are at greater risk of becoming uninsured and losing access to critical health services in the postpartum and intrapartum periods. Some federal and state-level initiatives are in place to provide coverage for family planning or other more limited services to women reproductive age women, but they do not provide the same level of coverage afforded by full scope Medicaid. Given Medicaid's large role in maternity financing, an extension of postpartum coverage for the full year after a Medicaid birth could fill some of the gap that women in non-expansion states particularly face.

| Table 1: Medicaid Income Eligibility Limits for Pregnant Women, Parents, and Family Planning Expansions, by State | | | | | |
|---|---|---|---|---|---|
| State | Pregnant Women | | | Parents (in a family of three) | Family Planning Programs |
| | Medicaid | CHIP | Unborn-Child Options | | |
| Alabama | 146% | — | — | 18% | 146%*† |
| Alaska | 205% | — | — | 138% | — |
| Arizona | 161% | — | — | 138% | — |
| Arkansas | 214% | — | 214% | 138% | — |
| California | 213% | — | 322% | 138% | 200% |
| Colorado | 200% | 265% | — | 138% | — |
| Connecticut | 263% | — | — | 155% | 263%† |
| Delaware | 217% | — | — | 138% | — |
| DC | 324% | — | — | 221% | — |
| Florida | 196% | — | — | 32% | Losing coverage for any reason |
| Georgia | 225% | — | — | 35% | 200%* |
| Hawaii | 196% | — | — | 138% | — |
| Idaho# | 138% | — | — | 138% | — |
| Illinois | 213% | — | 213% | 138% | — |
| Indiana | 218% | — | — | 139% | 146%† |
| Iowa | 380% | — | — | 138% | ‡300% |
| Kansas | 171% | — | — | 38% | — |
| Kentucky | 200% | — | — | 138% | — |
| Louisiana | 138% | — | 214% | 138% | 138%† |
| Maine | 214% | — | — | 105% | 214%† |
| Maryland | 264% | — | — | 138% | 200%* |
| Massachusetts | 205% | — | 205% | 138% | — |
| Michigan | 200% | — | 200% | 138% | — |
| Minnesota | 283% | — | 283% | 138% | 200%† |
| Mississippi | 199% | — | — | 26% | 199%*† |
| Missouri‡ | 201% | 305% | 305% | 21% | ‡185% |
| Montana | 162% | — | — | 138% | 216%*† |
| Nebraska# | 199% | — | 202% | 138% | — |
| Nevada | 165% | — | — | 138% | — |
| New Hampshire | 201% | — | — | 138% | 201%† |
| New Jersey | 199% | 205% | — | 138% | — |
| New Mexico | 255% | — | — | 138% | 255%† |
| New York | 223% | — | — | 138% | 223%*† |
| North Carolina | 201% | — | — | 42% | 200%† |
| North Dakota | 152% | — | — | 138% | — |
| Ohio | 205% | — | — | 138% | — |
| Oklahoma | 138% | — | 210% | 42% | 138%*† |
| Oregon | 190% | — | 190% | 138% | 250% |
| Pennsylvania | 220% | — | — | 138% | 220%† |
| Rhode Island | 195% | 258% | 258% | 138% | Losing coverage postpartum |
| South Carolina | 199% | — | — | 67% | 199%† |
| South Dakota | 138% | — | — | 49% | — |
| Tennessee | 200% | — | 255% | 95% | — |
| Texas | 203% | — | 207% | 17% | ‡185% |
| Utah# | 144% | — | — | 138% | — |
| Vermont | 213% | — | — | 138% | ‡200% |
| Virginia | 148% | 205% | — | 38% | 205%*† |

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| | Medicaid | CHIP | Unborn-Child Options | | |
| **Washington** | 198% | — | 198% | 138% | 260%* |
| **West Virginia** | 163% | — | — | 138% | — |
| **Wisconsin** | 306% | — | 306% | 100% | 306%† |
| **Wyoming** | 159% | — | — | 54% | Losing coverage postpartum |

NOTES: "—" means not applicable. Eligibility levels are reported as percentage of the federal poverty level (FPL), and reflect Modified Adjusted Gross Income (MAGI)-converted income standards. All eligibility levels include a disregard equal to five percentage points of FPL for the highest income level for Medicaid or CHIP coverage. The 2019 FPL for a family of three was $21,330. In some states, eligibility limits for Section 1931 parents are based on a dollar threshold. The values listed represent the truncated FPL equivalents calculated from these dollar limits. #ID, NE, UT have all adopted Medicaid expansion under the ACA, but have not yet implemented it, so parent eligibility thresholds based on future implementation. ‡ IA, MO, TX, and VT have entirely state funded programs to provide family planning services. *State also extends Medicaid eligibility for family planning services to people losing full-benefit coverage after the end of the postpartum period. † FP expansion eligibility ceilings include 5% FPL "disregard" to applicant's income

SOURCES: Eligibility limits based on a national survey conducted by the Kaiser Program on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2019.

Guttmacher Institute. State Laws and Policies, Medicaid Family Planning Eligibility Expansions. As of May 2019.