

Chapter 2:

# Advancing Maternal and Infant Health by Extending the Postpartum Coverage Period

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## Recommendations

- 2.1** Congress should extend the postpartum coverage period for individuals who were eligible and enrolled in Medicaid while pregnant to a full year of coverage, regardless of changes in income. Services provided to individuals during the extended postpartum coverage period will receive an enhanced 100 percent federal matching rate.
- 2.2** Congress should extend the postpartum coverage period for individuals who were eligible and enrolled in the State Children's Health Insurance Program while pregnant (if the state provides such coverage) to a full year of coverage, regardless of changes in income.
- 2.3** Congress should require states to provide full Medicaid benefits to individuals enrolled in all pregnancy-related pathways.

## Key Points

- Postpartum care is critical to monitoring health after pregnancy as well as to addressing other health care needs. However, under current law, coverage for those enrolled in Medicaid by virtue of their pregnancy ends after 60 days postpartum and many individuals are not otherwise eligible for Medicaid.
- The short postpartum period disrupts coverage and access to care. Among women whose births were paid for by Medicaid, nearly one in four report being uninsured postpartum.
- Inadequate postpartum care may contribute to persistent racial and ethnic disparities in maternal and infant health outcomes. Black, non-Hispanic women and Indigenous women have higher risks of maternal morbidity and mortality.
- Although a wide array of stakeholders support extending the postpartum period, federal and state efforts to date have been limited in scope, often focusing on individuals with substance use disorder.
- An extension of postpartum coverage would be a meaningful step to improve outcomes by helping to ensure that individuals receive ongoing medical care. Approximately 123,000 uninsured new mothers would become newly eligible if states were required to provide such coverage. It would also serve as a way to improve health equity.
- States, however, should not be expected to bear the cost of such a mandate, especially in light of current budget challenges due to COVID-19 and the accompanying economic downturn. To offset the costs, the Commission recommends 100 percent federal funding.
- Pregnancy-related services may be broad in scope, but the definitions differ across the states providing limited services, and the provision of certain benefits may depend on the provider or plan. To ensure the best possible outcomes, all pregnant and postpartum individuals should have comprehensive coverage.

## CHAPTER 2: Advancing Maternal and Infant Health by Extending the Postpartum Coverage Period

Postpartum care is critical to monitoring health after pregnancy as well as to addressing other health care needs. However, under current law, coverage for those enrolled in Medicaid by virtue of their pregnancy ends after 60 days postpartum.<sup>1</sup> Many of these women are not eligible under another Medicaid pathway. This disrupts coverage and access to care for postpartum women whose pregnancies were covered by Medicaid.<sup>2</sup>

It is important to note that the federal policy of covering postpartum care for only 60 days is not rooted in modern medical knowledge and does not reflect needs attendant to pregnancy that extend well beyond this period. Women may experience risks to their lives postpartum, with almost 12 percent of maternal deaths occurring in the late postpartum period, and a considerable share of these deaths are potentially preventable. In the year following a pregnancy, multiple health issues may arise. These go beyond the physical recovery from childbirth and include behavioral health needs such as postpartum depression and substance use disorder (SUD), family planning, and chronic conditions that predated the pregnancy or arose because of it. These all may require ongoing medical care. Moreover, racial and ethnic disparities in pregnancy-related mortality and morbidity have been well documented.

Although there has been great interest in extending the postpartum period from a wide array of stakeholders, federal and state efforts have been piecemeal, providing ongoing coverage in just a handful of states, and in many cases, only for individuals with SUD. In light of poor maternal and birth outcomes, unacceptable racial and ethnic

disparities, a rich body of evidence, and limited action to address these concerns, the Commission recommends three changes to federal statute to improve maternal health:

- Congress should extend the postpartum coverage period for individuals who were eligible and enrolled in Medicaid while pregnant to a full year of coverage, regardless of changes in income. Services provided to individuals during the extended postpartum coverage period will receive an enhanced 100 percent federal matching rate.
- Congress should extend the postpartum coverage period for individuals who were eligible and enrolled in the State Children's Health Insurance Program while pregnant (if the state provides such coverage) to a full year of coverage, regardless of changes in income.
- Congress should require states to provide full Medicaid benefits to individuals enrolled in all pregnancy-related pathways.

Given that Medicaid covers 43 percent of all births nationally, extending the postpartum coverage period is an important step in addressing poor maternal and infant health outcomes. A continuation of coverage during this period would help to ensure access to ongoing medical care to address the health and well-being of individuals during the postpartum period. Furthermore, an extension of the postpartum coverage period would improve health equity and help stem persistent and troubling racial and ethnic disparities in maternal outcomes. Finally, as the health of the child is inextricably linked with that of the mother, improving outcomes for the mother would also improve the health of the child.

Requiring states to provide such coverage in both Medicaid and the State Children's Health Insurance Program (CHIP) would ensure that all eligible postpartum individuals receive the same coverage period regardless of where they live or in which program they are enrolled. In the Commission's view, however, given the resource constraints

now facing states, they should not be expected to bear the cost of such a mandate and the federal government should provide full federal funding.

All pregnant and postpartum individuals should also be provided comprehensive coverage to ensure the best possible birth and maternal health outcomes. As such, states should not have the option to limit coverage to pregnancy-only services. Although these actions, if taken by Congress, would likely not by themselves eliminate severe maternal morbidity and mortality, they would represent meaningful steps to improve the lives of women and their families.

The chapter begins by describing Medicaid and CHIP coverage for pregnant women under current law, including eligibility and benefits. It then describes the changes in coverage that occur throughout and following an individual's pregnancy, before turning to the health issues facing postpartum individuals. The chapter then highlights recent state and federal action to extend the postpartum coverage period. It then describes the key areas the Commission discussed during its deliberations, including evidence on the effects on health equity, insurance coverage, and continuity of care, as well as issues related to state flexibility and financing. The chapter concludes with the Commission's recommendations and its rationale.

## Medicaid and CHIP Coverage for Pregnant Women

Medicaid has long played a key role in providing maternity-related services for pregnant women, financing more than two out of every five births in 2018 (MACPAC 2020a). Coverage for this population has evolved over time, and today there are dedicated Medicaid and CHIP eligibility pathways specifically for pregnant women.

### Historical context

Until the mid-1980s, Medicaid eligibility was closely linked to the receipt of cash payments under the Aid to Families with Dependent Children (AFDC) program. Between 1984 and 1990, Congress expanded Medicaid eligibility for low-income pregnant women, creating new mandatory and optional eligibility groups (Table 2A-1). These new eligibility groups were based on income relative to the federal poverty level (FPL), rather than receipt of cash payments under AFDC. This was a notable shift, because the FPL exceeded most state AFDC eligibility standards and generally increases annually to account for inflation (MACPAC 2020b).

In expanding eligibility, Congress sought to cover more low-income pregnant women in Medicaid, especially during the early stages of pregnancy. The rationale was that improved access to adequate prenatal care would have positive effects on birth outcomes, including reductions in infant mortality and morbidity rates (Ellwood and Kenney 1995).

In 1986, Congress required 60 days postpartum coverage for pregnant women (Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272).<sup>3</sup> Later that year, states were given the option to guarantee continuous Medicaid eligibility to a woman throughout her pregnancy and for 60 days following delivery regardless of changes in income or assets (Omnibus Budget Reconciliation Act of 1986, P.L. 99-509). Thirty-eight states adopted this option (GAO 1989). In 1990, Congress required all states to provide continuous coverage for pregnant and postpartum women for 60 days after pregnancy (Omnibus Reconciliation Act of 1990, P.L. 101-508).

### Current eligibility

All states are required to cover pregnant women in Medicaid with incomes up to at least 133 percent FPL, although some states have higher mandatory minimum thresholds because they expanded coverage to higher-income pregnant women prior to this requirement.<sup>4,5</sup> All but four states have opted to extend Medicaid coverage to pregnant women

with incomes above the required minimum and, as of October 2020, the median eligibility threshold was 195 percent FPL and ranged from 133 percent FPL to 375 percent FPL (Table 2A-2). Eligibility for pregnant women in Medicaid extends through 60 days postpartum.<sup>6</sup> Women who are otherwise eligible for Medicaid (for example, as low-income parents) and become pregnant can retain their existing coverage and generally are not required to shift to a pregnancy-related eligibility pathway; as such, they do not face an end to their coverage at 60 days postpartum.<sup>7</sup>

States may also provide comprehensive health care coverage for uninsured, targeted low-income pregnant women through CHIP, either under a state plan option or through a demonstration program authorized under Section 1115 of the Social Security Act (the Act).<sup>8</sup> Currently, six states (Colorado, Missouri, New Jersey, Rhode Island, Virginia, and West Virginia) cover low-income pregnant women in CHIP, with a median income eligibility level of about 257 percent FPL (Table 2A-2). The 60-day postpartum period also applies to pregnant women covered in CHIP.<sup>9</sup>

At the end of a woman's 60-day postpartum period, states are required to screen her for continued eligibility through all other pathways or transfer her to the federal or state health care exchange if she is no longer eligible for any type of Medicaid.<sup>10</sup> Whether another Medicaid pathway is available depends upon the woman's household income, the state's eligibility threshold for parents, and if the state has adopted the Medicaid expansion for low-income adults as authorized under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended). Regardless of whether a state has expanded Medicaid, income eligibility for pregnant women is higher in the vast majority of states than it is for any alternative pathway (Table 2A-2).

In the 37 states that have expanded Medicaid to low-income adults, a woman may be eligible for ongoing Medicaid coverage if her income is at or below 133 percent FPL.<sup>11</sup> To retain Medicaid in a

non-expansion state, she would need to be eligible through another pathway, likely as a parent.<sup>12</sup> The median eligibility threshold for parents in non-expansion states is about 36 percent FPL (or \$6,271 annually for a family of two in 2021). Postpartum women who have income above this threshold, but at or below 100 percent FPL, are not eligible for Medicaid or subsidized coverage on the exchange. Subsidized exchange coverage may be available for women with incomes above 100 percent FPL.<sup>13</sup>

States take different approaches to coverage for pregnant women (Figure 2-1). The variation across the states is a function of the eligibility threshold for pregnant women in Medicaid, whether the state covers pregnant women in CHIP and at what incomes, the eligibility threshold for parents, and whether the state has adopted the Medicaid expansion. These differences dictate the coverage options available for women after the end of the postpartum period. (Some states have sought a Section 1115 demonstration to extend the postpartum period beyond 60 days. We discuss these approaches in greater detail later in the chapter.) The following examples illustrate the variation in state coverage policies:

- In Florida, pregnant women with incomes up to 191 percent FPL are eligible for Medicaid. At the end of the postpartum period, a woman with income at or below 27 percent FPL could remain on Medicaid as a low-income parent. Because the state has not adopted the Medicaid expansion, women with incomes above this level, but below 100 percent FPL, are not eligible for Medicaid or subsidized coverage on the exchange. Women with incomes above 100 percent FPL could be eligible for subsidized exchange coverage.
- In Illinois, pregnant women with incomes up to 208 percent FPL are eligible for Medicaid. Illinois has adopted the Medicaid expansion and covers parents up to 133 percent FPL; as such, at the end of her postpartum period, a woman with income at or below 133 percent FPL could remain eligible for Medicaid. Women

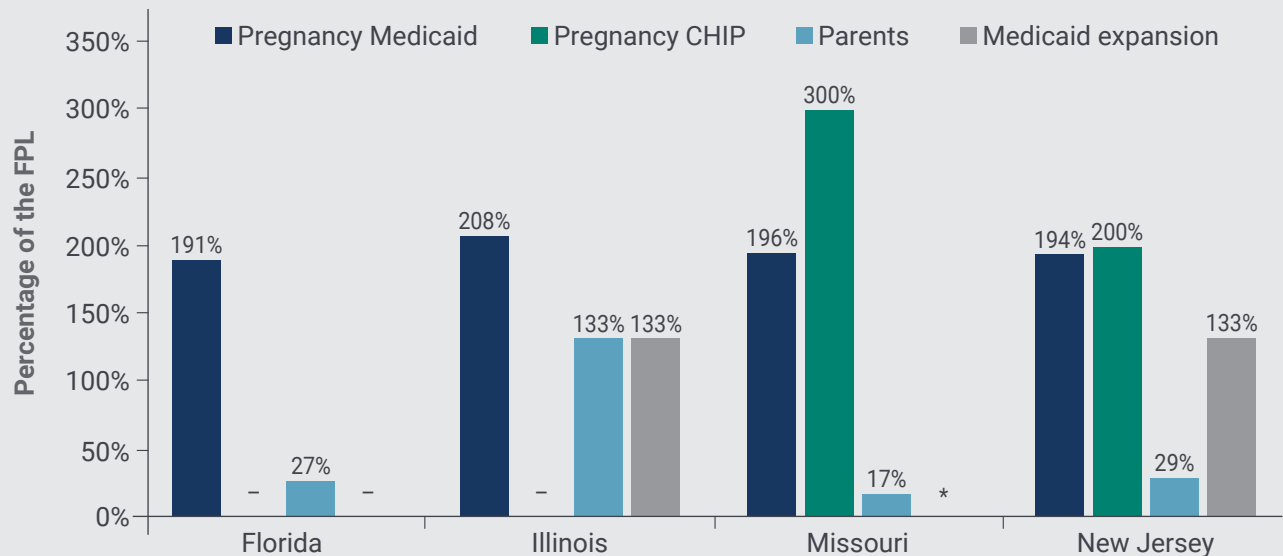
with incomes above 133 percent FPL could be eligible for subsidized exchange coverage.<sup>14</sup>

- In Missouri, pregnant women with incomes up to 196 percent FPL are covered in Medicaid, while uninsured pregnant women with incomes up to 300 percent FPL are covered in CHIP. Following the postpartum period, women with incomes below 17 percent FPL could remain in Medicaid as a low-income parent. (The state has adopted, but not yet implemented, the Medicaid expansion.) Women with incomes above this level but below 100 percent FPL are not eligible for Medicaid or subsidized coverage on the exchange. Women with

incomes above 100 percent FPL could be eligible for subsidized exchange coverage.

- In New Jersey, pregnant women with incomes up to 194 percent FPL are covered in Medicaid, while uninsured pregnant women with incomes up to 200 percent FPL are covered in CHIP. Because New Jersey expanded Medicaid, at the end of the postpartum period, a woman with income up to 133 percent FPL could remain eligible for Medicaid. Women with incomes above 133 percent FPL could be eligible for subsidized coverage on the exchange.

**FIGURE 2-1. Medicaid and CHIP Income Eligibility Thresholds in Selected States by Pathway as a Percentage of the FPL, October 2020**



**Notes:** CHIP is the State Children’s Health Insurance Program. FPL is federal poverty level.

– Dash indicates that the state does not provide coverage under this eligibility pathway.

\* Missouri has opted to expand Medicaid to include adults under age 65 with incomes up to 133 percent of the federal poverty level, but has not yet implemented the expansion.

Parent eligibility thresholds reflect Medicaid state plan coverage of the eligibility group for parents and other caretaker relatives. In expansion states, parents and caretaker relatives with incomes above the standard shown here may be eligible for coverage in the new adult group.

**Sources:** MACPAC, 2020, analysis of CMS 2020b.

## Benefits

Pregnant women are typically entitled to the full Medicaid benefit package; however, for women covered by Medicaid through poverty-level pregnancy pathways (i.e., women with incomes above the state's income threshold for the former AFDC program), states may limit services to those related to pregnancy.<sup>15</sup> Pregnancy-related services are defined as those that are necessary for the health of the pregnant woman and fetus, including prenatal care, delivery, postpartum care, family planning services, and services for other conditions that might complicate the pregnancy or threaten carrying the fetus to full term or the safe delivery of the fetus (42 CFR 440.210). If a state proposes not covering certain services or items for pregnant women that it covers for other adults, the state must describe the basis for determining that such services are not pregnancy-related in its state plan (CMS 2012a).

In CHIP, states can model their benefits for pregnant women based on specific private insurance plans, a package equivalent to one of those benchmarks, or coverage approved by the Secretary of the U.S. Department of Health and Human Services (the Secretary) (§ 2112(b)(4) of the Act). (These are the same options available to states for low-income children in CHIP.) The majority of states have elected to provide Secretary-approved coverage that is the same as coverage for pregnant women under Medicaid (Edwards 2021). Therefore, changes to coverage under the state plan for pregnant women covered in Medicaid would also affect pregnant women in CHIP.

Although the vast majority of states provide the full Medicaid package to all pregnant women, five states limit benefits for some pregnant women to only pregnancy-related services. Four states (Arkansas, New Mexico, North Carolina, and South Dakota) provide only pregnancy-related services to pregnant women in their programs with a wide range of incomes; California provides only pregnancy-related services to women with incomes above 133 percent FPL (Brooks et al. 2020, CA DHCS 2020a).<sup>16</sup>

- In Arkansas, pregnancy-related services are provided to women with incomes between 15 percent FPL and 209 percent FPL. The services consist of prenatal care, delivery, postpartum care, and family planning. All services must be pregnancy-related and services that lack a pregnancy code are not covered (AR DHS 2021, Brooks et al. 2020, Gallaher 2020, Golden 2020, CMS 2013a).
- In California, pregnancy-related services are provided to women with incomes between 133 percent FPL and 208 percent FPL. These women receive all medically necessary services related to their pregnancy or for any conditions that may complicate the pregnancy. The treating clinician attests to the need for the covered benefits for these women on the basis of their pregnancy (Mollow 2021; CA DHCS 2020a, 2015; CMS 2020c).
- In New Mexico, coverage for women with incomes between 42 percent FPL and 250 percent FPL is limited to pregnancy-related services (Lovato 2020; NM HSD 2020a, 2019a, 2019b; CMS 2014). However, pregnant women are enrolled in managed care and, in addition to the standard benefit package, each managed care organization offers full Medicaid benefits to pregnant women as a value-added service (NM HSD 2020b).<sup>17</sup>
- In North Carolina, pregnancy-related services are provided to women with incomes between 37 percent FPL and 196 percent FPL. These services must be related to the pregnancy or be for the treatment of illness or injury that in the physician's judgment may complicate the pregnancy. This can include conditions related to the pregnancy, preexisting conditions, and new conditions that may adversely affect the best possible outcome of the pregnancy. Covered services comprise prenatal care, labor and delivery, family planning, pharmacy, physician services, behavioral health, and routine dental care. Other services, such as podiatry, chiropractic, and optical services, may be covered with prior approval (Dowler 2020; NC DHHS 2020, 2011; CMS 2013b).

- In South Dakota, the coverage for women with incomes between 47 percent FPL and 133 percent FPL is limited to services that are directly tied to their pregnancy and delivery, based primarily on the diagnosis on the claim. Coverage also includes 60 days of postpartum care and family planning services (Brooks et al. 2020, Hynes 2020, SD DSS 2020, CMS 2013c).

Given the minimal information defining pregnancy-related services in some states, as well as the discretion left to the provider or plan to determine whether something is pregnancy-related, it is not clear the extent to which states actually limit benefits and the practical effect of those limitations on pregnant individuals. It is also not clear from the state plans or other documentation how postpartum visits are treated or what conditions are considered pregnancy-related following a pregnancy. For example, services that are considered pregnancy-related while a woman is pregnant, such as a flu vaccine, may not be considered pregnancy-related once the pregnancy ends.

In March 2014, the Commission recommended that Congress change the statute to require full Medicaid coverage for women who are eligible through mandatory or optional pregnancy-related pathways. This recommendation sought to align coverage for pregnant women across eligibility pathways and ensure the best possible outcomes for the woman and newborn (MACPAC 2014). Nothing in this recommendation would have prohibited states from providing enhanced pregnancy benefits that are designed to improve maternal and birth outcomes to all pregnant women covered under the state plan.<sup>18</sup> This recommendation has not yet been adopted by Congress.

## Transitions following the postpartum period

The experience at the end of the postpartum coverage period (regardless of whether it occurs following the current 60 days or after one year, as recommended by the Commission) differs depending on whether an individual shifts to another Medicaid

eligibility pathway, secures coverage on the exchange or through another source, or becomes uninsured.<sup>19</sup>

Women who remain eligible for Medicaid at the end of the postpartum period generally face minimal changes in terms of out-of-pocket costs because the rules on premiums and other cost sharing are fairly consistent across Medicaid eligibility groups. For example, premiums can be imposed on adults, parents, and pregnant women whose incomes exceed 150 percent FPL, and pregnant women may be charged cost sharing for services not related to the pregnancy. Overall expenses for premiums and cost sharing cannot exceed 5 percent of monthly or quarterly household income (MACPAC 2017b). Similar to those covered by Medicaid, pregnant women covered by CHIP cannot be subject to any cost sharing for pregnancy-related assistance, and only one state (West Virginia) requires premiums for this group (§ 2112(b)(6) of the Act, Edwards 2021). For young women (under age 19) who remain eligible for CHIP under the statutory definition of a targeted low-income child after the postpartum period, any applicable cost sharing would resume.

Benefits differ depending on the Medicaid eligibility pathway, especially in states that offer enhanced benefits to pregnant women. For example, 11 states provide additional dental benefits, such as allowing more frequent services to pregnant women (MACPAC 2021). In Virginia, pregnant women are the only adult Medicaid population in the state with access to comprehensive dental coverage (Mathematica 2020). Individuals may lose coverage for these services when transferring to a new eligibility pathway after their postpartum coverage period ends.

Women who become eligible under the Medicaid expansion following the postpartum period would receive the same alternative benefit plan (ABP) offered to anyone in the expansion group.<sup>20</sup> The benefit requirements differ in some key ways. For example, many behavioral health services that are optional under traditional Medicaid are mandatory under the ABP. States have considerable flexibility in determining the scope of coverage under the



state plan and the ABP; as such, it is not possible to generalize about the differences. However, as of August 2018, 25 of 31 expansion states had aligned ABP benefits with traditional Medicaid benefits under the state plan, so women transitioning to the new adult group following the postpartum coverage period in these states would see few, if any, changes to their benefits (CRS 2018).

Women who are ineligible for Medicaid following the postpartum period may be eligible for subsidized exchange coverage if their incomes are above 100 percent FPL. It is important to note, however, that exchange coverage could require considerable premiums and cost sharing. For example, in 2020, individuals with incomes between 133 percent and 150 percent FPL received subsidies that limited the amount they would pay for an exchange plan to between roughly 3 percent and 4 percent of income. Additionally, those with incomes below 250 percent FPL are eligible for cost-sharing reductions. Despite these subsidies, out-of-pocket costs in exchange plans are typically higher than in Medicaid, especially for individuals with extensive health needs (Haley et al. 2021). Studies have shown reduced Medicaid enrollment when premiums are instituted, which suggests that exchange premiums may be a barrier to enrollment for individuals shifting from Medicaid (Dague 2014). Furthermore, as noted above, exchange plans have considerable out-of-pocket costs; research has shown that individuals may forgo care, including necessary care, due to costs (Artiga et al. 2017, MACPAC 2015a, Snyder and Rudowitz 2013).

Shifting to exchange coverage after the postpartum period has additional consequences. First, available benefits may differ when postpartum women shift from Medicaid to an exchange plan.<sup>21</sup> Second, women may have to navigate the special enrollment process and then select a plan to secure coverage on the exchange. Available data suggests that postpartum women are not always successful in transferring to the exchange. About 43,000 uninsured new mothers nationwide had incomes between 138 percent and 200 percent of poverty in 2017 and could likely have qualified for subsidized exchange coverage.<sup>22</sup> There may be several reasons they remained uninsured: they

were unaware that such coverage is available, they struggled with the enrollment process, or they could not afford the premiums (McMorrow et al. 2020a).

If postpartum individuals are unable to secure another source of coverage, they may pay out of pocket for services or forgo care completely. As discussed in greater detail below, uninsured new mothers report problems with access to care; about one in five report at least one unmet need due to cost and almost half report not having a usual source of care (McMorrow et al. 2020b).

## Coverage Disruptions

Research shows that insurance coverage facilitates access to prenatal and postpartum care; receipt of these services improves birth outcomes and supports the long-term health of women and newborns. For example, coverage during the prenatal period might allow for services, such as smoking cessation, to address conditions that would otherwise contribute to adverse maternal and birth outcomes. Postpartum care offers the opportunity to monitor recovery from pregnancy and childbirth and to address other ongoing health care needs, including family planning and behavioral health.

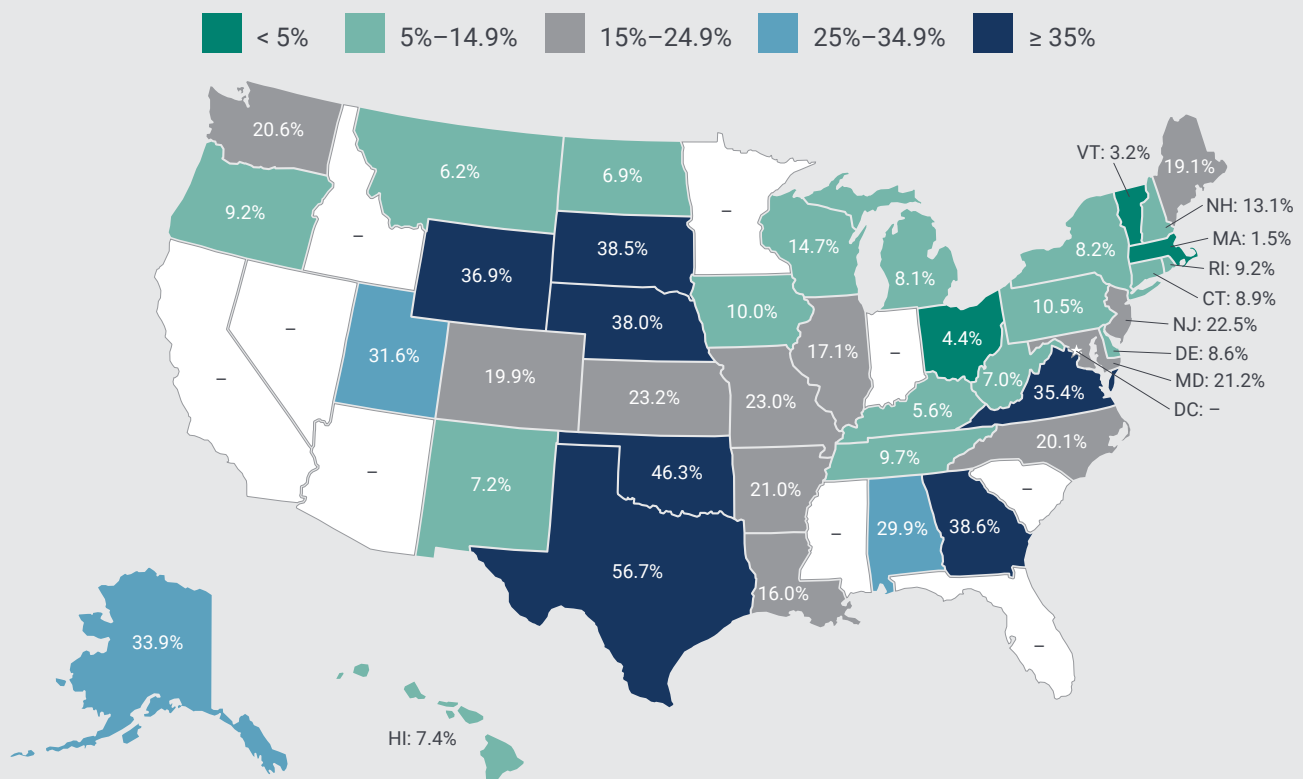
However, pregnant women may experience coverage disruptions due to changes in employment, income, and Medicaid eligibility that often accompany birth. A study examining data from 2005–2013 found that nearly 60 percent of pregnant women experienced a change in the type of insurance coverage they had in the nine months before delivery. Half of the women who were uninsured had acquired Medicaid or CHIP coverage by the month of delivery, but 55 percent of these women were uninsured at some point during the six months after birth. The risk factors associated with a loss of insurance after delivery included not speaking English at home, being unmarried, having Medicaid or CHIP coverage at delivery, living in the South, and having a family income between 100 percent and 185 percent FPL (Daw et al. 2017).

Between 2015 and 2017, following implementation of the ACA, the rate of coverage changes during the perinatal period declined. However, one-third of women still experienced a change in health insurance from pre-pregnancy to postpartum. The disruptions occurred across the pregnancy—25 percent of women experienced a change from pre-pregnancy to delivery, and almost 29 percent experienced a change from delivery to postpartum. In states that chose not to expand Medicaid, the pre-pregnancy rate of uninsurance was nearly double and the postpartum uninsurance rate was nearly triple that of expansion states. Overall, in states that expanded Medicaid, a higher proportion of women were continuously insured and the churning rate on and off Medicaid was less pronounced (Box 2-1). The proportion of women who experienced a period of uninsurance from pre-pregnancy to delivery varied

widely among states, with several states reporting uninsurance above 30 percent, including Texas at 46.5 percent, Oklahoma at 38.1 percent, and Georgia at 32.4 percent (Daw et al. 2019).

Among women whose births were paid for by Medicaid between 2015 and 2017, more than half (55.7 percent) were insured by Medicaid three or more months postpartum. Nearly one in four (23.1 percent) reported postpartum uninsurance. The postpartum uninsurance rates were three times higher in states that had not implemented the Medicaid expansion than in states that had (38.2 percent and 12.8 percent, respectively). The postpartum uninsurance rate for women with births paid for by Medicaid varied considerably across states, ranging from 1.5 percent in Massachusetts to 56.7 percent in Texas (Figure 2) (Daw et al. 2021).

**FIGURE 2-2. Postpartum Uninsurance Rates among Women Whose Births Were Paid for by Medicaid, 2015–2017**



**Notes:** Dash indicates data are not available. Data are not available in Arizona, California, the District of Columbia, Florida, Idaho, Indiana, Minnesota, Mississippi, Nevada, and South Carolina.

**Source:** Daw et al. 2021.

## Racial and ethnic disparities in continuity of coverage

Women of color are more likely to experience discontinuity in coverage. One study found that 75 percent of white, non-Hispanic women were continuously insured, compared to 55 percent of Black, non-Hispanic women, 50 percent of Indigenous women, and about 20 percent of Hispanic Spanish-speaking women (Daw et al. 2020a).

Another study examining changes in uninsurance following implementation of the ACA found declines in uninsurance among white, non-Hispanic, Black, non-Hispanic, and Hispanic new mothers. However, disparities in coverage remained: nearly 25 percent of Hispanic new mothers were uninsured and 12 percent of Black, non-Hispanic new mothers were uninsured, compared to 7 percent of white, non-Hispanic new mothers (Johnston et al. 2019).<sup>23</sup>

Racial and ethnic disparities in postpartum insurance exist among women whose births were paid for by Medicaid. Between 2015 and 2017, Black, non-Hispanic women had a lower rate of uninsurance (12.6 percent) and a higher rate of Medicaid coverage (65.5 percent) compared to white, non-Hispanic women (15.7 percent and 62.7 percent, respectively). More than half (56.3 percent) of Spanish-speaking Hispanic women were uninsured postpartum.<sup>24</sup>

English-speaking Hispanic women had lower rates of uninsurance (29.7 percent), but were still significantly more likely to be uninsured in the postpartum period in comparison to white, non-Hispanic women.

Indigenous women were also more likely to report postpartum uninsurance (25.6 percent). For all race and ethnicity groups, postpartum uninsurance rates were significantly higher in non-expansion states (Daw et al. 2021).<sup>25</sup>

Earlier work looking at disparities in insurance status across the perinatal period found the widest racial disparities in uninsurance in the prepregnancy and postpartum period for the lowest-income women. Specifically, when controlling for income, the likelihood of uninsurance was lower or similar for Black, non-Hispanic women compared with white, non-Hispanic women. These data suggest that the overall Black-white disparity in coverage can be largely explained by the lower average household incomes among Black, non-Hispanic women and the corresponding higher rates of Medicaid coverage. The high rates of uninsurance among Spanish-speaking Hispanic women reflects, in part, the more limited coverage options available to immigrant women (Daw et al. 2020a).<sup>26</sup>

## BOX 2-1. Effects of the Medicaid Expansion for Pregnant and Postpartum Women

Although not targeted to pregnant women, the Medicaid expansion under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) has affected coverage, utilization, and disparities.

For example, one study found that Medicaid expansion was associated with an increase in Medicaid coverage and a decrease in uninsurance among new mothers with incomes below 100 percent FPL (Johnston et al. 2020). Another study found that Medicaid expansion resulted in a 10-percentage-point decrease in churning between insurance and uninsurance; the study also found a 7.8-percentage-point increase in continuous Medicaid coverage in expansion states relative to non-expansion states (Daw et al. 2020b).

Other studies have connected Medicaid expansion to a change in utilization. For example, following expansion in one state, postpartum outpatient utilization increased—particularly among women who experienced severe maternal morbidity at delivery—compared to a neighboring non-expansion state (Gordon et al. 2020). Another study found that Medicaid expansion was associated with increased receipt of prepregnancy health counseling, reported daily folic acid intake, and increased postpartum use of the most effective birth control methods (Myerson et al. 2020). A recent study examining the effects of the Medicaid expansion in Oregon found increased enrollment in Medicaid prior to pregnancy, which subsequently increased receipt of timely and adequate prenatal care (Harvey et al. 2021).

Furthermore, some studies suggest that Medicaid expansion may reduce health disparities among new mothers and their infants. A comprehensive review of the literature suggests expansion narrowed disparities in infant and maternal health outcomes for Black and Hispanic individuals (Guth et al. 2020). Another study found that although expansion was not associated with changes in rates of preterm or low birthweight infants overall, there were greater reductions in rates of low birthweight and preterm births among Black infants in states that expanded Medicaid than in states that did not (Brown et al. 2019).<sup>27</sup> Medicaid expansion is also associated with lower maternal mortality, particularly among Black, non-Hispanic mothers (Eliason 2020).

## Postpartum Health Issues

A weakness in current Medicaid coverage for pregnant women is that it neglects the clinical importance of the full postpartum period. Clinical standards for postpartum care have evolved since the 1980s, acknowledging that individuals require care well beyond the period during which the body may physically recover from childbirth. What has been termed the fourth trimester—the 12-week period after pregnancy—is marked by considerable biological, psychological, and social changes for the mother. Multiple issues may arise during this

time, including stresses on maternal emotional well-being and fatigue; challenges with infant care and feeding; need for family planning; and risks related to substance use (Verbiest et al. 2017). Additionally, chronic conditions that predated the pregnancy or arose because of it may require ongoing medical care, both to improve the woman's health and to reduce the chances of complications during subsequent pregnancies. Many of these concerns continue past the fourth trimester and through one year postpartum. Although these conditions and challenges are not limited to women covered by Medicaid, they are more likely to have

certain risk factors that make them susceptible to poor outcomes in comparison to privately insured women (MACPAC 2020a).

The American College of Obstetricians and Gynecologists (ACOG), along with a coalition of other maternal health providers, recommends that all women have contact with their provider within the first three weeks postpartum. This initial assessment should be followed by ongoing care as needed and a comprehensive postpartum visit no later than 12 weeks after birth to assess the multiple issues that may arise. Women with chronic medical conditions, such as hypertensive disorders, diabetes, and mood disorders, should be advised on the importance of timely follow-up (ACOG 2018). Furthermore, provider groups stress that the interpregnancy period is an opportunity to address complications or medical issues that developed during pregnancy, to assess a woman's mental and physical well-being, and to improve her long-term health (ACOG and SMFM 2019).<sup>28, 29</sup>

Women may experience considerable risks to their health and life during the postpartum period. One-third of pregnancy-related deaths occur postpartum, including almost 12 percent that occur in the late postpartum period (between 43 and 365 days postpartum).<sup>30</sup> Nationally, cardiomyopathy was the leading cause of death in the postpartum period (Petersen et al. 2019a). Drug overdose, suicide, and homicide are also leading causes of death during or within a year of pregnancy (IL HFS 2020, TX DHHS 2018).<sup>31</sup> A considerable share of these deaths may be potentially preventable (Davis et al. 2019).<sup>32</sup> For example, the Illinois Maternal Mortality Review Committee found 71 percent of pregnancy-related deaths that occurred between 61 and 364 days postpartum to be potentially preventable. Moreover, women covered by Medicaid were two and one-half times as likely to die within one year of pregnancy as women with private insurance (IL HFS 2020).<sup>33</sup>

Racial and ethnic disparities in pregnancy-related mortality have been well documented. Black, non-Hispanic women and American Indian and Alaska Native women have two to three times higher

pregnancy-related death rates compared to white, non-Hispanic women (40.8 per 100,000, 29.7 per 100,000, 12.7 per 100,000, respectively) (Petersen et al. 2019b). The causes and timing of deaths also differ by race: cardiomyopathy, embolism, and hypertensive disorders contribute to a significantly higher proportion of deaths among Black women in comparison to white women; hemorrhage and hypertensive disorders contribute to a significantly higher proportion of deaths among American Indian and Alaska Native women in comparison to white women (Petersen et al. 2019b). A greater proportion of deaths among Black women occurs in the late postpartum period in comparison to white women (Petersen et al. 2019a).

Researchers have also documented racial differences in severe maternal mortality and morbidity (SMMM), during delivery hospitalizations. Black, non-Hispanic, and American Indian and Alaska Native women have heightened risk of morbidity compared with white, non-Hispanic women (Admon et al. 2018a). Medicaid beneficiaries are almost twice as likely as those with private insurance to experience SMMM. However, there appears to be little variability across payers in racial and geographic disparities in SMMM—the risk for people of color is similar when comparing Medicaid beneficiaries, women with private insurance, and women with other types of coverage (Kozhimannil et al. 2019).

An increasing number of pregnant women have chronic conditions that may require continued medical care in the postpartum period (Brown et al. 2020; CDC 2020; Admon et al. 2018b, 2017; Tyer-Viola and Palan Lopez 2014). Estimates suggest that one-quarter of pregnancies are affected by chronic illness, disproportionately occurring among women with low-incomes and women of color, including women covered by Medicaid (Admon et al. 2017, Tyer-Viola 2014). One recent study identified that at least one chronic condition occurred in nearly 10 percent of all delivery hospitalizations in 2013 and 2014, with increases seen in the prevalence of asthma, chronic hypertension, SUDs, and preexisting diabetes. The study also indicated

higher prevalence and larger increases in the prevalence of chronic conditions among women covered by Medicaid during pregnancy (Admon et al. 2017).

Women also face behavioral health issues in the postpartum period. Perinatal mood and anxiety disorders affect one in seven pregnant and postpartum women, and may be diagnosed well into the year after the end of a pregnancy. Such conditions often go undiagnosed and untreated, with about half of women with a diagnosis of depression receiving any treatment (Luca et al. 2019). Postpartum depression, which is estimated to occur in 5 percent to 25 percent of all pregnant, postpartum, and parenting women, can have adverse effects for both the mother and the child (Earls et al. 2019; USPSTF 2019). Low-income mothers are more likely to experience depression, with rates as high as 40 percent to 60 percent (CMS 2016). Women with a prepregnancy serious mental illness face a high risk of relapse during the postpartum period (Taylor et al. 2019). For women who have a history of tobacco and other substance use, the stresses of pregnancy, childbirth, and parenting are major risk factors for relapse during the postpartum period. For example, after successfully quitting smoking during pregnancy, approximately half of all women resume smoking during the 6 months after delivery (Verbiest et al. 2017). Similarly, although substance use decreases in pregnancy, one study found postpartum relapse among women who used alcohol, marijuana, and cocaine to be common (Forray et al. 2015). Another study found that the highest rate of overdose occurred in the late postpartum period, between 7 and 12 months after delivery (Schiff et al. 2018).

Oral health care is also important for pregnant and postpartum women, both for the positive effect it can have on other health conditions and because of the association between periodontal infections and preterm birth (MACPAC 2015b, ACOG 2013). Overall, relatively few pregnant women receive dental care; and those covered by Medicaid were 24 percent to 53 percent less likely to receive dental care than pregnant women covered by private insurance.

There are several possible reasons for this. One is that women may not understand the importance of dental care; a second is that it is not uncommon for both dental and medical professionals to suggest delaying treatment until after delivery. However, by the time a woman obtains an appointment, there may be limited time during the postpartum period for preventive care and treatment, especially if a series of visits is required (Kloetzel et al. 2011).

Lack of coverage can create a barrier to postpartum care. This was a key finding from the Strong Start for Mothers and Newborns Initiative (Strong Start), a four-year federal initiative to test and evaluate alternative enhanced prenatal care for women enrolled in Medicaid or CHIP who were at risk for having a preterm birth (CMS 2015). The evaluation of the initiative identified participant concerns regarding their loss of coverage in the postpartum period and the perceived difficulty of securing Medicaid coverage outside of pregnancy. Participants noted that the lack of coverage affected their access to care (Rodin et al. 2019). In another study, women with continuous Medicaid eligibility had higher postpartum visit rates than women with pregnancy-only Medicaid that ended after 60 days postpartum (DeSisto et al. 2020).

Other factors may also affect receipt of care. About 61 percent of women covered by Medicaid had a postpartum visit within eight weeks of delivery (CMS 2020d).<sup>34</sup> Fewer postpartum visits among Medicaid-enrolled women have been associated with being Black and in some cases Hispanic, being younger; having SUD, depression, a disability, or other children at home; and low attendance at prenatal care visits. Lack of information related to when their coverage would end, the importance of postpartum visits, as well as available programs or services hindered postpartum visit attendance among Strong Start participants. Logistical barriers, such as transportation and child care, also inhibited receipt of postpartum care (Rodin et al. 2019).

## State and Federal Action

Both state and federal officials are taking action to extend Medicaid postpartum coverage for a longer period of time.

### State action

As of January 2021, 12 states have extended or passed legislation to extend coverage beyond the 60-day postpartum period permitted under federal statute, although they may target a particular population, such as women with a mental health condition or SUD (Table 2-1).<sup>35</sup>

The majority of these states have not yet implemented the extension. To receive federal

matching funds for this coverage, states need approval of a demonstration waiver under Section 1115 from the Centers for Medicare & Medicaid Services (CMS), and many states have pending applications.<sup>36</sup> Some of the states are using state-only funds to extend the postpartum period.

Legislation to extend the postpartum period has been introduced in other states (Haley et al. 2021, Eckert 2020, ACOG 2020a, NASHP 2020). In at least three of these states (Tennessee, Virginia, and Washington), legislation was either vetoed or paused in response to COVID-19-related budget constraints, although Virginia has since moved forward (Cirruzzo 2020a, Kelman 2020).

**TABLE 2-1.** Features of State Postpartum Coverage Policies, January 2021

State	Authority	Implemented	Awaiting CMS approval	Length of extension	Upper income eligibility limit (FPL)	Limitations
California	State only funds	Yes	–	12 months	322%	Women with a mental health condition
Colorado	§ 1915(b) waiver	Yes	No	12 months	195	Women with an alcohol or SUD receive SUD treatment services
District of Columbia	§ 1115 demonstration	No	Not yet submitted	12 months	319	–
Georgia	§ 1115 demonstration	Yes	No	2 years	211	Women who deliver a very low birthweight baby receive family planning and targeted interpregnancy services
	§ 1115 demonstration	No	Yes	6 months	220	–
Illinois	§ 1115 demonstration	No	Yes	12 months	208	–
Indiana	§ 1115 demonstration	No	Yes	12 months	213	Women with an OUD
Michigan	§ 1115 demonstration	No	Not yet submitted	12 months	195	–

**TABLE 2-1.** (continued)

State	Authority	Implemented	Awaiting CMS approval	Length of extension	Upper income eligibility limit (FPL)	Limitations
Missouri	§ 1115 demonstration	No	Yes	12 months	196	Women with a SUD receive mental health and SUD treatment services
	§ 1115 demonstration	No	Not yet submitted	12 months	196	Women with postpartum depression or another mental health condition receive mental health treatment services
New Jersey	§ 1115 demonstration	No	Yes	6 months	200	Women who are not otherwise eligible for Medicaid
South Carolina	§ 1115 demonstration	Yes	No	12 months	194	Up to 500 women with a SUD or SMI
Texas	State-only funds; § 1115 demonstration	Yes	Yes	at least 12 months	200	Family planning and targeted postpartum care services only
Virginia	§ 1115 demonstration	No	Not yet submitted	12 months	200	Women with income between 133% and 200% FPL

**Notes:** § 1915(b) is Section 1915(b) of the Social Security Act (the Act). § 1115 is Section 1115 of the Act. FPL is federal poverty level. SUD is substance use disorder. OUD is opioid use disorder. SMI is serious mental illness. The upper income eligibility limit shown here is the level to which the state is applying or will apply the postpartum extension; additional coverage may be available to women under another pathway (e.g., CHIP). In most states, the extension of coverage applies to women in Medicaid. The state-only funded postpartum coverage in California also applies to women covered through the unborn child option; New Jersey and Virginia are proposing to extend the period for women in both Medicaid and CHIP. Texas received approval for a Section 1115 family planning waiver in January 2020; additional services under the program are currently state-funded, but the state has submitted a waiver to receive federal matching funds. Eligibility for the program will be redetermined every 12 months.

– Dash indicates that the category is not applicable.

**Sources:** MACPAC, 2021, analysis of ACOG 2020a; CA DHCS 2020b; CMS 2020e, 2020f, 2020g, 2019b; GA DCH 2020; IL HFS 2020; IN FSSA 2020; Haley et al. 2021; Mathematica 2020; MI HFA 2020; MO DSS 2020; NJ DHS 2020; TX HHSC 2020a, 2020b; and state legislative materials (District of Columbia, Georgia, Missouri, and Virginia).



The following states have extended or have passed legislation to extend the postpartum period as of January 2021:

- California provides an additional 10 months of postpartum care for women in Medicaid as well as those covered under the CHIP unborn child option who are diagnosed with a maternal mental health condition, using state-only funds (CA DHCS 2020b, Mathematica 2020). The program may be suspended on December 31, 2021, unless further legislative action is taken.
- Colorado extends coverage for substance use treatment for pregnant women in Medicaid who have an alcohol use disorder or SUD for up to one year after delivery under a Section 1915(b) waiver (CMS 2020e, Mathematica 2020).
- The District of Columbia passed legislation to extend coverage for one year for postpartum beneficiaries, directing the mayor to seek CMS approval through a Section 1115 demonstration.<sup>37</sup> The demonstration is not yet funded by the city (DC OB 2021).
- Georgia approved legislation to extend the postpartum period to six months. The state submitted a Section 1115 demonstration application to CMS in December 2020 (GA DCH 2020).<sup>38</sup> Under the state's family planning demonstration, women who had a very low birthweight baby are provided a limited package of interpregnancy care services for two years before being shifted back to the traditional family planning-only group (CMS 2020f).
- Illinois legislation extended coverage for pregnant women to 12 months postpartum. The state submitted a Section 1115 demonstration in January 2020; it is awaiting CMS approval (IL HFS 2020, Mathematica 2020).<sup>39</sup>
- Indiana submitted a Section 1115 demonstration application in October 2020 to extend the postpartum period for one year for mothers with an opioid use disorder as part of the state's Maternal Opioid Misuse initiative; it is awaiting CMS approval (IN FSSA 2020).
- Michigan's fiscal year 2021 budget included funding for an extension of the postpartum period to 12 months (MI HFA 2020). The state has not yet submitted a demonstration application to CMS.
- Missouri is seeking to provide ongoing SUD and mental health treatment for 12 months after the end of pregnancy for women with SUD. The state submitted a Section 1115 demonstration request in February 2020, and is awaiting CMS approval (MO DSS 2020). Subsequent legislation passed by the state would extend the postpartum period for 12 months for mental health treatment services for women with postpartum depression or other mental health issues.<sup>40</sup>
- New Jersey submitted an amendment to its existing Section 1115 demonstration to extend the postpartum coverage period to six months in Medicaid and CHIP for women who do not otherwise qualify for Medicaid (NJ DHS 2020).<sup>41</sup> The amendment was submitted in March 2020 and is awaiting CMS approval.
- South Carolina received approval in December 2019 to extend coverage to as many as 500 postpartum women with SUD or serious mental illness under a Section 1115 demonstration waiver (Mathematica 2020, CMS 2019b). The state originally proposed extending postpartum coverage for all pregnant women earning up to 194 percent FPL to one year postpartum (SC DHHS 2019).
- Texas provides family planning services to women using a Section 1115 demonstration (CMS 2020g). Additional services, including mental health and SUD services, as well as services to address asthma, diabetes, hypertension, and certain cardiovascular conditions, are provided using state-only funds. The state has submitted a Section 1115 demonstration to receive federal

matching funds for these additional services for postpartum women; it is awaiting CMS approval (Cirruzzo 2020b; TX HHSC 2020a, 2020b).

- Virginia’s 2020–2022 biennial budget directs the Department of Medical Assistance Services to seek authority to extend the postpartum coverage period to one year for women in Medicaid and CHIP with incomes between 133 percent and 205 percent FPL.<sup>42</sup> The state has not yet submitted a demonstration application to CMS.

## Federal action

On September 29, 2020, the U.S. House of Representatives passed H.R. 4996, which would give states the option of extending the Medicaid postpartum coverage period from 60 days to a full year at the state’s regular matching rate. Individuals would be entitled to the full Medicaid benefits package and services could not be limited to pregnancy-related services. If states choose to adopt the extension in their Medicaid program, they must also extend the postpartum period to pregnant women covered in CHIP.<sup>43</sup> The Senate did not act on the legislation before the 116th Congress concluded.

As this report went to press, the Biden Administration had not yet announced any plans related to postpartum coverage. The Trump Administration called for a relatively narrow postpartum coverage extension, proposing to allow states to extend Medicaid coverage for pregnant women with SUD to one year postpartum (OMB 2020). Under Secretary Alex Azar, the U.S. Department of Health and Human Services (HHS) also released an action plan describing the steps that HHS would take to address maternal health issues, including setting broader goals, such as reducing maternal mortality by 50 percent. The plan specifically noted support for policies to allow states to extend Medicaid coverage for postpartum women with SUD from 60 days to 365 days after birth (HHS 2020).

In 2019 and 2020, CMS convened an expert workgroup composed of new and returning members of the original expert panel to take stock of the progress of the Maternal and Infant Health Initiative and chart the trajectory of the initiative for the next five years. As one area of focus, the workgroup recommended increasing the use and quality of postpartum care, including expanding and ensuring continuity of coverage in the postpartum period (Bigby et al. 2020). CMS also launched a targeted technical assistance initiative to aid state agencies and their partners through a Postpartum Care Learning Collaborative open to all states that includes a series of informational webinars that began in early 2021. This will be followed by an action-oriented group for states interested in pursuing or continuing a quality improvement project (CMS 2020h).

## Considerations in Extending the Postpartum Coverage Period

In considering an extension of the postpartum coverage period, the Commission drew from its analysis of the literature in discussing the effects of such a policy on health equity, insurance coverage, and continuity of care. The Commission also discussed state flexibility and the financial implications.

### Improving health equity

Given Medicaid’s role in covering births for women of color, extending the postpartum coverage period would be a step toward improving health equity. An extension would increase postpartum coverage among individuals of color who disproportionately experience poor maternal and infant health outcomes.

As discussed above, considerable racial and ethnic disparities exist in maternal and infant health outcomes (Artiga et al. 2020a). Black, non-Hispanic

women and American Indian and Alaska Native women have higher pregnancy-related death rates than white, non-Hispanic women. The causes and timing of deaths also differ by race, with a greater proportion of deaths among Black women occurring in the late postpartum period (Petersen et al. 2019a, 2019b). There are also documented disparities in maternal morbidity, with Black, non-Hispanic and American Indian and Alaska Native women at greater risk (Admon et al. 2018a, Kozhimannil et al. 2019). Women of color are also at greater risk of giving birth to a preterm or low birthweight infant (Martin et al. 2019). Studies have also shown racial and ethnic disparities in access to postpartum care, contraception, and treatment for postpartum depression (Thiel de Bocanegra et al. 2017, Kozhimannil et al. 2011).

Although a number of factors, such as higher prevalence of comorbidities and pregnancy complications, lower socioeconomic status, and less access to prenatal care contribute to these disparities, they do not fully explain the differences in outcomes (Howell 2018). The disparities reflect barriers to care, including coverage and lack of access to culturally and linguistically appropriate care, as well as ongoing discrimination. Even after controlling for insurance status, income, age, and severity of health conditions, people of color are less likely to receive routine medical procedures and they experience a lower quality of care (Artiga et al. 2020a).

Gaps in coverage contribute to the poor maternal and infant health outcomes. Racial and ethnic disparities in insurance status and continuity of coverage for women spanning the prepregnancy to postpartum period exist, including among women whose births were paid for by Medicaid (Daw et al. 2021, 2020a). These coverage disparities are evident in the broader population and, despite gains in coverage following implementation of the ACA, they have persisted. Individuals who are Black, Hispanic, American Indian and Alaska Native, and Native Hawaiian or other Pacific Islander are more likely to be uninsured in comparison to whites (Artiga et al. 2020b, Buchmueller et al. 2016). Uninsured

Blacks are more likely than whites to be ineligible for both Medicaid and exchange coverage because a greater share of Black people live in states that have not adopted the Medicaid expansion, including many southern states (Artiga et al. 2020b).

An extension of the postpartum coverage period would increase coverage among individuals of color. Thirty-seven percent of Black, non-Hispanic, uninsured new mothers, 36 percent of uninsured white, non-Hispanic new mothers, and 24 percent of Hispanic uninsured new mothers would become eligible under an extension of the postpartum coverage period (Johnston et al. 2021). More limited, targeted extensions, such as those that focus on SUD, would not address many of the conditions that disproportionately impact people of color. For example, as noted above, cardiomyopathy contributes to a significantly higher proportion of deaths among Black women in comparison to white women. Yet, the condition can manifest up to five months postpartum.

## Increasing coverage options

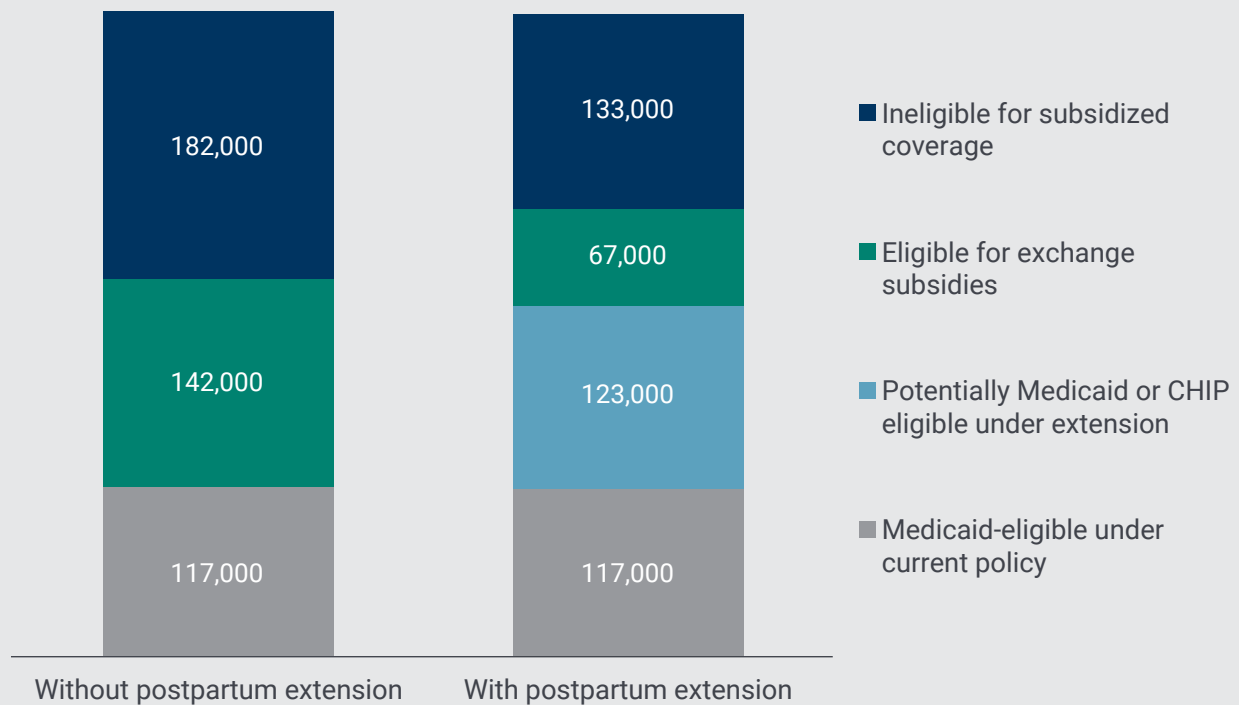
Extending the postpartum coverage period would provide women, including many who may otherwise become uninsured, with new coverage options. As discussed above, the availability of Medicaid coverage for such women depends on household income, the state's eligibility threshold for parents, and whether the state has adopted the Medicaid expansion. Subsidized exchange coverage may be available for women with incomes above 100 percent FPL, but unlike Medicaid for pregnant women, would require premiums and cost sharing. Subsidized exchange coverage is not available for women with incomes below 100 percent FPL. As such, in states that have not adopted the Medicaid expansion, coverage options are extremely limited for women whose incomes fall above Medicaid's upper income eligibility limit for parents and below the eligibility threshold for exchange coverage.

An extension of the postpartum period would address some of the disruptions in coverage, because about half of all uninsured new mothers

reported that losing Medicaid or other coverage following pregnancy was the reason they were uninsured (McMorrow et al. 2020b). A recent study finds, using 2016–2018 data, that of 440,000 uninsured new mothers, approximately 28 percent (123,000) would become newly eligible for Medicaid or CHIP through an extension of the postpartum coverage period; another 27 percent (117,000) were likely already eligible for Medicaid but not enrolled; and 15 percent (67,000) were in the income range for subsidized exchange coverage (Figure 2-3) (Johnston et al. 2021).

Most (83 percent) uninsured new mothers likely to become eligible for Medicaid or CHIP following an extension of the postpartum coverage period live in non-expansion states. Nearly two-thirds of new mothers likely to benefit from a postpartum coverage extension live in five states—Florida, Georgia, Missouri, North Carolina, and Texas. These states have high rates of uninsurance among new mothers, have low eligibility thresholds for parents, and have chosen not to expand Medicaid (Missouri has adopted, but not yet implemented the expansion) (Figure 3) (Johnston et al. 2021).<sup>44</sup>

**FIGURE 2-3.** Number of New Mothers Uninsured Postpartum and Estimated to be Eligible for Subsidized Coverage under Current Eligibility Rules and a 12-Month Postpartum Medicaid and CHIP Extension, 2016–2018



**Notes:** Among 440,000 uninsured new mothers. Mothers eligible for exchange subsidies have incomes between 100 percent and 400 percent of the federal poverty level; analysis does not account for whether a mother has access to affordable employer-sponsored insurance. Eligibility categories are mutually exclusive, with Medicaid eligibility preceding exchange subsidy eligibility. Mothers ineligible for subsidized coverage are ineligible for Medicaid and do not qualify for subsidized exchange coverage. Annualized counts are rounded to the nearest 1,000.

**Source:** Johnston et al. 2021.

## Continuity of care

Although individuals would likely experience changes at the end of the 12-month postpartum coverage period just as they do at the end of the current 60-day postpartum coverage period, extending the time frame would avoid disruptions during a critical clinical period. This would allow continuity in terms of benefits, cost sharing, and provider relationships for women who would otherwise be uninsured as well as for women who would have maintained coverage but shifted to another source of coverage. Although states must now screen and enroll a postpartum woman in other coverage (if eligible), additional steps required to apply for and enroll in alternative coverage can lead to gaps in coverage.

Extending postpartum coverage would affect access to care by limiting transitions between sources of coverage. In one study of coverage changes, almost 20 percent of individuals had to change at least one doctor, with 9 percent having to change both their primary care and specialty providers. Shifting providers was more common among individuals who had a gap in coverage. Changing coverage also affected use of prescription medications, with 16 percent of individuals with a coverage change switching prescriptions and 34 percent either skipping doses or stopping taking their medication. Regardless of whether they experienced a gap in coverage, individuals who changed coverage reported negative effects on the quality of care and health (Sommers et al. 2016).

Uninsured new mothers report similar problems with access to care. Within the last year, about one in five uninsured new mothers reported at least one unmet need due to cost. This includes an unmet need for medical care (14 percent), prescriptions (17 percent), and mental health care (2 percent). Slightly more than half (55 percent) of uninsured new mothers reported having a usual source of care, and 82 percent reported seeing an obstetrician-gynecologist in the past year. Among those who lost Medicaid coverage, many women experienced conditions indicating a need for ongoing care,

such as obesity (30 percent), gestational diabetes (11 percent), pregnancy-related hypertension (10 percent), and depression during pregnancy (12 percent). About one-third were recovering from a cesarean section (McMorrow et al. 2020b).

For some new mothers, it is especially important to maintain the connection to providers who oversaw their prenatal care and delivery hospitalization because they have established a trusting relationship and their providers understand their health history and ongoing care needs. A lack of continuity of care can lead to missed opportunities to improve outcomes. In its waiver application to extend the postpartum coverage period, Illinois cited poor continuity of care and a lack of care coordination as factors that contributed to death in 93 percent of preventable pregnancy-related deaths during the late postpartum period (IL HFS 2020).

Many of these postpartum individuals may return to Medicaid in the future, and ongoing care may lead to improvements in the women's health and reduce the chances of complications and higher costs during subsequent pregnancies. For example, New Jersey noted in its waiver application to extend the postpartum coverage period that 53 percent of pregnant women who lost Medicaid postpartum re-enrolled at some point over the following two years. If these women do not receive family planning services or care to manage chronic diseases and other health concerns, they may have greater risks with a future pregnancy and the program may face higher costs (NJ DHS 2020). In Colorado, the Medicaid expansion led to an increase in postpartum outpatient utilization, particularly among women who experienced severe maternal morbidity at delivery (Gordon et al. 2020).

## Implications for the health of the child

Studies have shown that the health and well-being of a mother can affect that of her child. For example, as discussed above, perinatal mood and anxiety disorders affect one in seven pregnant and postpartum women and can lead to adverse effects for both the mother and the child (Earls et

al. 2019, Luca et al. 2019). Studies have shown that postpartum depression leads to increased costs of medical care, inappropriate medical treatment of the infant, discontinuation of breastfeeding, family dysfunction, and an increased risk of abuse and neglect, and it adversely affects the critical early period of infant brain development (Earls et al. 2019). There are also longer-term effects, with children of women with persistent and severe depression at an increased risk for behavioral problems (Reeves and Krause 2019, Netsi et al. 2018, Ashman et al. 2008).

In 2016, CMS issued an informational bulletin detailing how Medicaid agencies may cover maternal depression screening as part of a well-child visit, which 33 states currently do (Mathematica 2020, CMS 2016). However, screening may have limited utility if the mother is uninsured and cannot access needed treatment services. The CMS guidance also clarified that if the provider identifies a problem, further diagnostic and treatment services exclusively for the mother are covered by Medicaid only if the mother is also enrolled (Boozang et al. 2020, CMS 2016).<sup>45</sup>

Extending coverage for parents can also have implications for coverage and service use among their children. Studies have shown that when parents are covered, their children are more likely to be insured (Rosenbaum and Whittington 2007, Sommers 2006). A recent study of the effect of the Medicaid expansion found that it was associated with increased receipt of recommended pediatric preventive care (Venkataramani et al. 2017). Aligning continuous coverage for both the mother and the deemed newborn might improve ongoing care and later coverage transitions for both of them following the first year postpartum (Johnson et al. 2020).<sup>46</sup>

## State flexibility

Whether the postpartum coverage period is a requirement or a state option has implications for state flexibility and the potential reach of the new coverage. Creating a state option to extend such coverage would allow states that have prioritized

coverage of this population (presumably as a mechanism to improve maternal health outcomes) to do so without a waiver, which would ease state and federal administrative burden. Making the extension a requirement would be a more directive approach to improving outcomes and would ensure that all eligible postpartum individuals receive the same coverage period regardless of where they live, consistent with the current policy.

A mandatory extension of the postpartum coverage period would also build on the legislative history of extending coverage to pregnant women as a way to address poor maternal and infant health outcomes.<sup>47</sup> Such an approach could help to ensure that all postpartum individuals receive ongoing medical care during their postpartum period, because a lack of coverage can be a barrier to receiving such care. Furthermore, Medicaid plays a considerable role in financing births. In 2018, Medicaid paid for 43 percent of all births nationally and for a greater share of deliveries by Hispanic, Black, and Indigenous women (MACPAC 2020a). Given the federal contribution in matching funds for these births, a mandatory extension of the coverage period could be viewed as an appropriate use of federal authority to improve health outcomes for a vulnerable population.

During the Commission's deliberations, it was noted that states may have different priorities and prefer to focus program resources on other areas. As is the case with many other aspects of the Medicaid program, states vary considerably in the populations and benefits they cover, reflecting deliberate state choices in considering the health needs of their residents and the cost of paying for their care (MACPAC 2016b). As noted above, 13 states did not adopt the option for a continuous 60-day postpartum coverage period prior to Congress requiring them to do so (GAO 1989). However, with better medical knowledge about the clinical importance of the postpartum period, states may now be more interested in providing such coverage than they were in the 1980s. In the current coverage landscape, an option to extend the postpartum coverage period may be more attractive to states

that have not adopted the Medicaid expansion because it would fill an existing gap in coverage for postpartum women. It is reasonable to assume that not all states would adopt an optional extension, leaving some women without coverage after 60 days postpartum. Given the limited reach that an optional expansion would have and the inequities it would perpetuate, the Commission did not pursue this approach.

State and federal approaches to extending the postpartum coverage period to date have typically been limited in scope, primarily targeting women with SUD. Although this represents progress in covering additional postpartum women, such extensions would cover a smaller population relative to a mandatory extension for all individuals who received Medicaid while pregnant. In addition, the existing approaches discussed above may also reach only a segment of the intended population given the administrative challenges of identifying and maintaining coverage for women with a particular diagnosis and the potential for a diagnosis to occur after the traditional 60-day postpartum period has ended. The approach of limiting services to SUD treatment fails to address many of the causes of postpartum morbidity and mortality and does not align with the Commissioners' views that all pregnant and postpartum women should receive comprehensive coverage.

## Fiscal implications

Extending the postpartum period would have financial implications for states and the federal government. Under current the financing arrangement, costs to states and the federal government would increase to the extent that women who would otherwise go uninsured are covered. Costs to the federal government might decline to the extent that women losing Medicaid coverage following the postpartum period would have secured subsidized exchange coverage which is wholly federally financed. Effects across states would vary as a function of their current policies for

covering pregnant women and other adults (e.g., low-income parents and the new adult group).

The fiscal implications also depend upon whether the policy is mandatory or optional and the state's federal matching rate. Policymakers have used the federal matching rate as a policy lever, increasing the rate—sometimes temporarily and sometimes permanently—to help offset new expenditures or to encourage states to adopt various options (MACPAC 2016b). For example, higher federal matching rates have been used as incentives to states to expand eligibility through CHIP and to defray the cost of the new adult group under the ACA. Higher matching rates have also been made available to improve systems capacity and increase the use of family planning services and supports as well as home- and community-based services.<sup>48</sup>

## Recommendations

### Recommendation 2.1

Congress should extend the postpartum coverage period for individuals who were eligible and enrolled in Medicaid while pregnant to a full year of coverage, regardless of changes in income. Services provided to individuals during the extended postpartum coverage period will receive an enhanced 100 percent federal matching rate.

**Rationale.** An extension of the postpartum coverage period would build on the legislative history of expanding coverage to pregnant women as a way to address poor maternal and infant health outcomes. Individuals may experience considerable risks to their health and life during the postpartum period. One-third of pregnancy-related deaths occur postpartum and an increasing number of pregnant women have chronic conditions and behavioral health issues that may require continued medical care in the postpartum period (Brown et al. 2020; CDC 2020; Luca et al. 2019; Petersen et al. 2019; Admon et al. 2018, 2017; Tyer-Viola and Palan Lopez 2014). An extension of the coverage

period could help ensure that individuals receive ongoing medical care during their postpartum period, because a lack of coverage can be a barrier to receiving such care. Furthermore, given the racial and ethnic disparities in maternal outcomes, an extension of the postpartum coverage period would serve as a way to improve health equity. Finally, the health of the child is interwoven with that of the mother. As such, improving outcomes for the mother may also have implications for the health and well-being of the child (Rosenbaum and Whittington 2007).

The Commission discussed at length whether an extension of the postpartum period should be a requirement or state option. Requiring such an extension would be a more directive approach to improving outcomes and would also ensure that all eligible postpartum individuals receive the same coverage period regardless of where they live, consistent with the current policy. It is also reasonable to assume that not all states will adopt a state option, leaving some women without coverage after 60 days postpartum. Ultimately the Commission determined that a mandatory extension is needed to address gaps in coverage that affect maternal morbidity and mortality. Requiring states to provide a full year of coverage will ensure that the greatest number of postpartum individuals are reached and provides some level of equity across states.<sup>49</sup>

In the Commission's view, however, states should not be expected to bear the cost of such a mandate. Extending the postpartum period could potentially shift individuals who would be eligible under a category with a higher matching rate to coverage as pregnant women. As a pregnant woman, these individuals would instead receive the state's traditional matching rate, likely increasing costs for states. Furthermore, the current budget challenges states are facing due to COVID-19 and the accompanying economic downturn may make the cost of an extension of the postpartum coverage period more difficult for states to assume on their own.

The Commission discussed at great length the level of federal financial assistance states should receive, and eventually narrowed it down to a choice between a 90 percent or 100 percent federal match. On the one hand, a 90 percent match would reinforce that Medicaid is a state-federal partnership. It is a jointly financed program and states should continue to invest in the program. A 90 percent matching rate would still indicate the importance of the extension and would also provide parity with the Medicaid expansion.

The Commission, however, ultimately decided to recommend 100 percent federal funding to help offset the costs of a mandatory extension. As such this extension of coverage would not impose an unfunded mandate, especially given state budget constraints.

This recommendation would not alter the existing flexibility provided to states in establishing income eligibility thresholds for pregnancy-related and other eligibility pathways.

## Implications

**Federal spending.** A mandatory extension of the postpartum coverage period would result in increased one-year federal spending of \$750 million to \$2 billion. Costs over the 10-year budget window would be between \$30 billion and \$40 billion. These costs include the extension to CHIP discussed below.

**States.** Although the federal government would bear a greater share of the cost of an extended postpartum coverage period, states would need to adjust administrative processes to ensure that postpartum individuals remain enrolled through one year and claim the appropriate federal matching rate for them.

**Beneficiaries.** The Commission heard a number of moving stories in public comment at its January 2021 meeting that reinforced the importance of postpartum care for new mothers and their families. Our analysis indicated that this policy would ensure that postpartum individuals enrolled in Medicaid would be able to maintain their existing coverage for



a full year. Approximately 123,000 uninsured new mothers would become newly eligible for Medicaid or CHIP through an extension of the postpartum coverage period. More than one-third of Black, non-Hispanic, and white, non-Hispanic, uninsured new mothers and one quarter of Hispanic uninsured new mothers would become eligible under an extension of the postpartum coverage period (Johnston et al. 2021). With an extended postpartum coverage period, individuals may be more likely to access care for both complications from pregnancy and ongoing conditions, which may lead to better health outcomes. Furthermore, the recommendation would reduce the transitions in coverage during a particularly vulnerable time, allowing postpartum individuals to maintain their Medicaid coverage, thus keeping the same providers and benefits.

**Plans and providers.** Extending the postpartum coverage period would help ensure that providers could continue to provide and get paid for services furnished to individuals they have seen throughout pregnancy and delivery. This would allow them to treat conditions that arose because of pregnancy, but may also provide an opportunity to address other chronic conditions. Extending the postpartum coverage period, thereby avoiding the postpartum individual's need to shift coverage 60-days postpartum, could reduce the administrative burden on providers and plans and allow them to improve the management of the enrollee's care. Several professional societies, including ACOG, the American Medical Association, and the Society for Maternal-Fetal Medicine, have endorsed extending the postpartum period to 12 months (ACOG 2020b, SMFM 2020, AMA 2019).<sup>50</sup>

## Recommendation 2.2

Congress should extend the postpartum coverage period for individuals who were eligible and enrolled in the State Children's Health Insurance Program while pregnant (if the state provides such coverage) to a full year of coverage, regardless of changes in income.

**Rationale.** The same rationale for extending the postpartum coverage period for individuals in Medicaid applies to those who are covered in CHIP.<sup>51</sup> In the Commission's view, requiring an extended postpartum coverage period in both Medicaid and CHIP would ensure that individuals are provided the same length of coverage regardless of the program in which they are enrolled. Such an extension would maintain the consistent application of the coverage period across programs and provide additional protection to postpartum individuals in CHIP who do not currently have a continuous coverage period.<sup>52</sup>

This recommendation would not change the existing matching rate and states would continue to receive the CHIP enhanced matching rate for the extension of the postpartum coverage period.

### Implications

**Federal spending.** The federal cost of the extension is included in the estimate for extending the postpartum coverage period in Medicaid provided above.

**States.** The six states that cover low-income pregnant women in CHIP would face additional costs to extend the postpartum coverage period from the current 60 days to a full year, given that coverage for these women would be matched at the states' regular CHIP enhanced matching rates. States would also need to adjust administrative procedures to ensure that postpartum individuals receive a full year of continuous coverage. As new states adopt the option to cover pregnant women in CHIP, they would also face the added costs of the extended postpartum coverage period.

**Beneficiaries.** Similar to the implications for Medicaid, postpartum individuals enrolled in CHIP would maintain their existing coverage for a full year.<sup>53</sup> Such coverage may improve access to services, continuity of care, and health outcomes among postpartum individuals. The estimates presented in Recommendation 2.1 include individuals in CHIP. In fiscal year (FY) 2019, the states electing this option (excluding Missouri and West Virginia) covered 8,671 women, indicating the

approximate number of women in CHIP who will benefit from the extension.<sup>54</sup>

**Plans and providers.** As with the extension in Medicaid, extending the postpartum coverage period would help ensure that providers could continue to provide and get paid for services to individuals they have seen throughout pregnancy and delivery. An extension could also reduce administrative burden on providers and plans and assist them in efforts to improve the management of enrollees' care.

## Recommendation 2.3

Congress should require states to provide full Medicaid benefits to individuals enrolled in all pregnancy-related pathways.

**Rationale.** It is the view of the Commission that all pregnant and postpartum individuals should be provided comprehensive coverage and that states should not have the option to limit coverage to pregnancy-only services. Pregnancy-related services may be broad in scope because they are defined as those that are necessary for the health of the pregnant woman and fetus (42 CFR 440.210). However, the definitions differ across the five states providing pregnancy-only services and the provision of certain benefits may depend on a provider or plan determining that a particular service is pregnancy-related. Furthermore, services that are considered pregnancy-related while a woman is pregnant may not be considered pregnancy-related once the pregnancy ends. Requiring the full Medicaid benefit package for individuals enrolled in all pregnancy-related pathways may help to ensure the best possible birth and maternal health outcomes.

This recommendation would not limit states' ability to provide enhanced pregnancy benefits designed to improve maternal and birth outcomes to all pregnant women covered under the state plan. For example, given the possible link between periodontal disease and an increased risk for preterm birth, some states have extended dental coverage to pregnant women (MACPAC 2020a). At

the same time, it would not require states to extend coverage to any specific optional benefit.

## Implications

**Federal spending.** This recommendation would increase federal spending by less than \$50 million in one year, and by less than \$1 billion over the 10-year budget window. These are the smallest non-zero categories of spending used by the Congressional Budget Office when making budget estimates.

**States.** If the five states currently covering only pregnancy-related services are not providing a broad benefit package, covering additional medically necessary (but not pregnancy-related) services may increase expenditures. If almost all medically necessary services are already provided, however, expanding coverage to the full Medicaid benefit package should not add substantial costs. This recommendation would also prevent states from restricting coverage to pregnancy-related services in the future.

**Beneficiaries.** Under this recommendation, pregnant and postpartum women with pregnancy-only coverage in five states would become eligible for additional, non-pregnancy-related services that are not already covered.

**Plans and providers.** Requiring states to provide full Medicaid benefits would eliminate the need for providers to determine whether specific services are pregnancy related and allow them to bill for all Medicaid-covered services provided to pregnant women with Medicaid. Plans would not need to differentiate services or provide separate benefit packages for pregnancy-only services.

## Endnotes

<sup>1</sup> It is important to note that during the public health emergency related to COVID-19, pregnant women who reach the end of their postpartum period cannot be disenrolled due to the continuous coverage requirements tied to the enhanced federal matching rate provided by the Families First Coronavirus Relief Act (FFCRA, P.L. 116-127). FFCRA provides a temporary 6.2 percentage point increase to the federal medical assistance percentage (FMAP) through the end of the quarter in which the public health emergency and any extensions end. Among other requirements, states must provide continuous coverage to validly enrolled beneficiaries. That is, states must continue providing coverage to an individual who enrolled in Medicaid as of the date of enactment or during the emergency declaration period until the end of the month in which the emergency period ends, unless the individual requests to be disenrolled or is no longer a resident of the state. As such, validly enrolled pregnant women who would typically lose coverage at the end of the 60-day postpartum period will continue to have coverage until the end of the month in which the emergency period ends. The continuous enrollment provision does not apply to CHIP (CMS 2021a).

<sup>2</sup> MACPAC uses the terms pregnant and postpartum women because these are the terms used in Medicaid statute and regulations. However, other more inclusive terms are increasingly being used in recognition that not all individuals who become pregnant and give birth identify as women.

<sup>3</sup> The postpartum coverage period is required under § 1902(e)(5) of the Social Security Act (the Act). It begins on the last day of the pregnancy and extends through the end of the month in which the 60-day period concludes (42 CFR 435.4, 42 CFR 440.210(a)(3)).

<sup>4</sup> Specifically, federal law requires that states provide Medicaid coverage to pregnant women whose household income is the higher of: (1) 133 percent FPL or (2) the income standard, up to 185 percent FPL, that the state had established as of December 19, 1989, for determining eligibility for pregnant women, or, as of July 1, 1989, had authorizing legislation to do so (42 CFR 435.116). As such, there are 19 states that have a mandatory minimum eligibility threshold for pregnant women above 133 percent FPL (MACPAC 2014, NGA 1990).

Prior to 2014, states had the flexibility to disregard income sources and amounts of their choosing when determining Medicaid and CHIP eligibility. Therefore, the income eligibility for pregnant women is effectively higher than the maximum of 185 percent FPL in a number of states.

<sup>5</sup> To qualify for the full range of benefits offered under Medicaid, individuals must be citizens or nationals of the United States or qualified aliens (which includes legal permanent residents, refugees, and asylees). Legal permanent residents are generally barred from receiving full Medicaid benefits for five years, after which coverage becomes a state option. However, children and pregnant women who are lawfully present may be covered during the five-year bar at state option. Non-qualified aliens (as well as qualified aliens subject to a five-year bar on full benefits) who meet income and all other eligibility criteria for the program can receive limited emergency Medicaid coverage only (MACPAC 2017a).

<sup>6</sup> Pregnant women in all categorically needy and medically needy eligibility groups under § 1902(a)(10) are entitled to continuous eligibility through the 60-day postpartum period, regardless of changes in income that would otherwise result in a loss of eligibility (§ 1902(e)(6) of the Act). This applies both to women whose eligibility is based on pregnancy and to women who are pregnant but eligible under a group unrelated to their pregnancy status (such as a low-income parent). However, women eligible on the basis of their pregnancy will no longer be eligible under the pregnancy-related group at the end of the postpartum period. For a woman covered under another pathway who becomes pregnant, the end of the postpartum period does not itself represent a change in circumstances likely to affect eligibility (CMS 2020a).

<sup>7</sup> Generally, when individuals are eligible for more than one category, they have a choice of which eligibility pathway to enroll in (42 CFR 435.404). States are not required to track the pregnancy status of current enrollees, so unless individuals self-identify, they would remain enrolled in their current eligibility group. Although pregnant women are not eligible for the new adult group that covers individuals with incomes below 133 percent FPL, the self-identification rule still applies, and those already enrolled in the group may remain in the group until the next regular eligibility renewal (CMS 2012a).

<sup>8</sup> To provide CHIP state plan coverage, state Medicaid programs must cover pregnant women with incomes up to 185 percent FPL (or up to the eligibility level the state had in place on July 1, 2008, whichever is higher). The CHIP upper income eligibility limit for pregnant women cannot be higher than the limit set for children, and states may not impose policies such as enrollment caps on targeted low-income children (§ 2112(b)(7) of the Act).

<sup>9</sup> Under CHIP coverage, the postpartum coverage period is 60 days, but the statutory text does not specifically provide continuous eligibility for pregnant women during pregnancy or the postpartum period (§ 2112(d)(2)(A) of the Act).

States also have the option to cover prenatal care for certain pregnant women using Title XXI funds under the unborn child option, defining the fetus as the targeted low-income child. This pathway covers services from conception to birth but not postpartum services (CMS 2002). However, CMS has permitted payment for postpartum care under the unborn child option in some states because the state has a global rate for pregnancy services that includes the cost of prenatal care, labor and delivery, and 60 days of postpartum care (Baumrucker 2008).

<sup>10</sup> For those who are eligible on the basis of pregnancy, the end of the 60-day postpartum period represents a change in circumstance. As such, the standard policies and procedures guiding any change in circumstance would apply. For individuals enrolled through other pathways, if the postpartum period ends after the individual's regularly scheduled renewal (i.e., 12 months after enrollment), the state would conduct a full renewal (42 CFR 435.916, CMS 2020a).

<sup>11</sup> Thirty-eight states and the District of Columbia have adopted the option to expand Medicaid to low-income adults; Missouri and Oklahoma opted to expand by voter referendum but have not yet implemented the expansion.

<sup>12</sup> There may be additional options for coverage in some states for pregnant women following the postpartum period. For example, states can provide Medicaid coverage for family planning services to individuals who are not otherwise eligible for Medicaid. For more, see endnote 35.

<sup>13</sup> Only individuals without access to affordable employer-sponsored insurance (ESI) are eligible for subsidized coverage. Affordable coverage is based on income and defined as self-only coverage with employee costs that do not exceed 9.83 percent of income (CMS 2021b).

<sup>14</sup> In Illinois, pregnant women who are not eligible for Medicaid due to immigration status receive the full Medicaid benefit package for 60 days postpartum under a CHIP Health Services Initiative (HSI).

<sup>15</sup> States can limit coverage to pregnancy-related services for women with family incomes above the May 1, 1988, AFDC levels, but women with family incomes below the 1988 AFDC levels must receive full Medicaid benefits. Specifically, states must provide full Medicaid coverage for certain mandatory and optional pathways under §§ 1931 and 1902(a)(10)(A)(i)(III), (ii)(I), and (ii)(IV). States may limit coverage to pregnancy-related services for other eligibility pathways (coverage under § 1902(a)(10)(A)(i)(IV) and (ii)(IX)) (MACPAC 2014, 2013).

States must provide limited coverage of emergency medical services to non-citizens who would qualify for full Medicaid benefits but for their immigration status, including unauthorized immigrants (§ 1903(v), 42 CFR 435.139, 42 CFR 435.406(b)). Under emergency Medicaid, pregnant women who are otherwise eligible for Medicaid but for their immigration status would receive the same state plan services as other pregnant women, including routine prenatal care, labor and delivery, and routine postpartum care (42 CFR 440.255(b)(2)). States may also provide additional services that may treat conditions that can complicate pregnancy. This differs from emergency Medicaid for non-pregnant individuals who are entitled to emergency services only (42 CFR 440.255(b)(1)).

<sup>16</sup> A related issue is whether such coverage is considered to be minimum essential coverage (MEC) for purposes of exchange subsidy eligibility. Medicaid eligibility, including pregnancy-related coverage that provides full Medicaid benefits, generally makes individuals ineligible for exchange subsidies because it is considered MEC. CMS reviewed state practices in 2016 and found that only three states (Arkansas, Idaho, and South Dakota) provided a limited benefit package that did not constitute MEC (MACPAC 2016a). In 2019, Idaho began providing the full Medicaid benefit package to pregnant women; that coverage would now be considered MEC (ID DHW 2019).

<sup>17</sup> Each managed care organization in New Mexico offers its enrollees additional benefits (termed value-added services) on top of the standard Medicaid benefit package.

<sup>18</sup> A state may provide a greater amount, duration, or scope of services to pregnant women than it provides under its plan to other individuals who are eligible for Medicaid, under the following two conditions. First, these services must be pregnancy-related or related to another condition that may complicate pregnancy (as defined in 42 CFR 440.210(a)(2)). Second, these services must be provided in equal amount, duration, and scope to all pregnant women covered under the state plan (42 CFR 440.250(p)).

<sup>19</sup> Some postpartum individuals would also transition to ESI. Given the variability in the availability of such coverage, as well as the benefits provided and costs associated with such coverage, we do not discuss the implications of shifting to ESI following the postpartum period.

<sup>20</sup> Adults enrolled in Medicaid under the new adult group must be offered an alternative benefit plan (ABP) that covers the 10 essential health benefits (EHBs). These benefits are ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and SUD services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. The Mental Health Parity and Addiction Equity Act (P.L. 110-343) applies to alternative benefit plans (CMS 2012b).

<sup>21</sup> Exchange plans must also cover the 10 EHBs. The benefit packages in exchange plans may differ from those offered by Medicaid to the new adult group or pregnant women. However, Medicaid may provide enhanced maternity benefits that are not routinely provided by exchange plans, such as the intensive case management.

<sup>22</sup> The ACA set a single income eligibility disregard equal to 5 percentage points of the FPL for groups whose eligibility is determined using modified adjusted gross income. For this reason, eligibility is often referred to at its effective level of 138 percent FPL, even though the federal statute specifies 133 percent FPL.

<sup>23</sup> High uninsurance rates among Hispanic women are attributable, in part, to citizenship status. When the study's authors restricted the analysis to citizens, the 2017 uninsurance rate for Hispanic new mothers (13.8 percent) was still higher than other groups (Johnston et al. 2019).

<sup>24</sup> Some researchers suggest that perinatal outcomes for Hispanic women should be reported separately by country of origin to account for the growing disparity in birth outcomes for U.S. born and non-U.S. born Hispanic women. However, the Pregnancy Risk Assessment Monitoring System (PRAMS) does not include information on maternal place of birth or immigration status. Both analyses by Daw and colleagues use primary language (English or Spanish) as a proxy for country of origin and immigration status for Hispanic women (Daw et al. 2021, 2020a).

<sup>25</sup> Across states, racial and ethnic disparities in the postpartum uninsurance rate tended to be similar in direction but varied in terms of magnitude.

<sup>26</sup> See endnote 5.

<sup>27</sup> There were no significant changes in disparities among Hispanic infants.

<sup>28</sup> The coalition endorsing the postpartum care recommendation included ACOG, the Academy of Breastfeeding Medicine, the American College of Nurse-Midwives (ACNM), the National Association of Nurse Practitioners in Women's Health (NPWH), the Society for Academic Specialists in General Obstetrics and Gynecology, and the Society for Maternal–Fetal Medicine (SMFM). The coalition endorsing the interpregnancy care recommendation included ACNM, ACOG, NPWH, and SMFM.

<sup>29</sup> Interpregnancy care is the care provided to women of childbearing age who are between pregnancies with the goal of improving outcomes for women and infants (ACOG and SMFM 2019).

<sup>30</sup> Pregnancy-related death is defined as the death of a woman while pregnant or within one year of the end of a pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy (CDC 2019).

The National Center for Health Statistics (NCHS) also reports data on maternal mortality through the National Vital

Statistics System (NVSS). These data rely on the definition of maternal mortality used by the World Health Organization (WHO): deaths of women while pregnant or within 42 days of being pregnant, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes. Due to implementation of the standard death certificate, NCHS did not publish the maternal mortality rate (MMR) between 2008 and 2017 (Hoyert and Miniño 2020). However, in comparison to other countries, the U.S. estimate of the maternal mortality ratio (19 maternal deaths per 100,000 live births), is higher than those seen in Europe (10 per 100,000) and Australia (7 per 100,000). Despite the uncertainty around the rate, it is believed that there have been actual increases in the MMR between 2000 and 2017 in the United States (WHO 2019).

<sup>31</sup> These deaths are considered pregnancy-associated deaths—the death of a woman while pregnant or within one year of the termination of pregnancy, regardless of the cause. However, depending upon the particular circumstances of the case and the criteria used in the review, they may or may not be considered pregnancy-related.

<sup>32</sup> About 60 percent of pregnancy-related deaths overall may be preventable. Preventability did not significantly differ by race or ethnicity, with 57.4 percent of deaths among Black women, 62.7 percent among white women, and 58.3 percent among Hispanic women determined to be preventable. Preventability was also similar by timing of pregnancy-related death: 59.0 percent during pregnancy, 53.3 percent during delivery, 57.1 percent 1–6 days postpartum, 66.7 percent 7–42 days postpartum, and 61.9 percent 43–365 days postpartum (Petersen 2019a).

<sup>33</sup> Other state Maternal Mortality Review Committees (MMRCs) have found that the majority of pregnancy-related deaths are among women with Medicaid, although these findings are not specific to the postpartum period. For example, 62 percent of women who died in Louisiana between 2011 and 2016 had Medicaid; 69 percent of maternal deaths in Texas in 2012 were to women enrolled in Medicaid at the time of delivery; and in 83 percent of the maternal deaths in West Virginia between 2007 and 2013, Medicaid was the primary coverage source during delivery (LA DOH 2018, TX DHHS 2018, WV DHHR 2015).

<sup>34</sup> The technical specifications for the measure limit the postpartum visit time frame to between 21 and 56 days after delivery. As such, women may have received a postpartum visit, but outside of that time frame. The technical specifications for the measure are being updated for the 2021 reporting cycle to encompass a wider time frame and to align with recommendations from ACOG.

Additionally, most states pay for maternity care in Medicaid and CHIP using a bundled payment for professional services provided during the perinatal period, including prenatal care, labor and delivery, and postpartum care. Bundled payments can create data quality and measurement issues because providers bill for the entire bundle rather than the component services, making it hard to track postpartum visits without undertaking costly medical chart review (CMS 2019a).

<sup>35</sup> Medicaid family planning programs are another pathway to provide limited care in the postpartum period. States can provide family planning services through the state plan; however, for a state to limit the services to a particular category of individuals (such as postpartum women), it needs a Section 1115 demonstration waiver. As of January 2020, 29 states offer family planning services through either the state plan option or a waiver (Brooks et al. 2020). Family planning services and supplies are reimbursable at a 90 percent federal matching rate; family planning-related services (e.g., medical diagnosis provided pursuant to a family planning service) are reimbursed at the state's traditional matching rate (CMS 2010). These matching rates apply regardless of eligibility group, meaning that family planning services provided to a postpartum woman enrolled in full Medicaid would also receive the 90-percent matching rate.

<sup>36</sup> States interested in drawing down federal financial support need a waiver to extend coverage beyond the statutorily mandated 60-day postpartum period, regardless of whether the state is targeting a particular category of women (e.g., those with SUD). As of January 2021, South Carolina is the only state that has secured approval of a Section 1115 waiver to extend the postpartum period beyond the provision of family planning services.

<sup>37</sup> D.C. Act 23-390, August 14, 2020, Postpartum Coverage Expansion Amendment Act of 2020, amending D.C. Code § 31-3861 et seq. [https://lms.dccouncil.us/downloads/LIMS/42720/Signed\\_Act/B23-0326-Signed\\_Act.pdf](https://lms.dccouncil.us/downloads/LIMS/42720/Signed_Act/B23-0326-Signed_Act.pdf).

<sup>38</sup> Georgia House Bill 1114, July 16, 2020, Relating to medical assistance generally, amending Ga. Code Ann. § 49-4-159 (2020). <http://www.legis.ga.gov/Legislation/20192020/194813.pdf>.

<sup>39</sup> Illinois included an extension of the postpartum period for legal permanent residents in the five-year waiting period in its demonstration request.

<sup>40</sup> Missouri House Bill 1682, July 13, 2020, Relating to health care, amending Mo. Rev. Stat. §§ 190.092–610.100 (2020). <https://www.house.mo.gov/billtracking/bills201/hlrbillspdf/4231S.06T.pdf>.

<sup>41</sup> New Jersey specified in its demonstration application that the extended coverage would apply only to pregnant women who do not otherwise qualify for coverage through another eligibility category. This means that only women with incomes above 133 percent FPL, who would not qualify under the Medicaid expansion, would be affected by the change (NJ DHS 2020).

<sup>42</sup> Virginia House Bill 5005 (Chapter 56), Budget Bill, November 19, 2020. Office of Health and Human Resources, Item 313 (Department of Medical Assistance Services). <https://budget.lis.virginia.gov/item/2020/2/HB5005/Chapter/1/313/>.

<sup>43</sup> Helping MOMS Act of 2020, H.R. 4996, 116th Cong. (2nd Sess. 2020). <https://www.congress.gov/bill/116th-congress/house-bill/4996/text>. According to the Congressional Budget Office (CBO), H.R. 4966 would have a net federal savings of \$894 million over the next 10 years (CBO 2020). The House legislation offsets the cost of the extension by removing the cap on rebates for outpatient drugs covered by Medicaid (a prior MACPAC recommendation). The CBO score is only an assessment of the pay-as-you-go effects, so there are no further details about the actual cost of extending the postpartum coverage period or estimates of how many individuals might secure coverage.

<sup>44</sup> Most states' Medicaid eligibility rules did not shift dramatically during these three years or since. However, four states (Idaho, Maine, Utah, and Virginia) adopted the ACA's Medicaid expansion following data collection for the 2016–2018 American Community Survey. To avoid overstating potential postpartum eligibility, the researchers classified women who were ineligible for Medicaid under rules during

2016–2018 but below the ACA eligibility threshold of 138 percent of FPL in those four states as already eligible for Medicaid under existing policy.

<sup>45</sup> Mothers who are not eligible for Medicaid may benefit from services, such as family therapy, that are directed to treating the health and well-being of the child.

<sup>46</sup> States must provide Medicaid or CHIP to children from birth until the child's first birthday, without application, if the child's mother was eligible for and received covered services under Medicaid or CHIP. These infants are referred to as deemed newborns (§§ 1902(e)(4), 2112(e); 42 CFR 435.117, 42 CFR 457.360).

<sup>47</sup> As already noted, between 1984 and 1990, Congress repeatedly expanded Medicaid eligibility for low-income pregnant women, creating new mandatory and optional eligibility groups. Some of these expansions started as options, but most were later made mandatory. Chief Justice Roberts noted in his opinion on the ACA that such prior amendments to Medicaid altered and expanded the boundaries of the original coverage groups (disabled, blind, elderly, and needy families with dependent children) (*Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519 (2012)).

<sup>48</sup> States have not always taken opportunities to draw enhanced federal match. For example, Section 2703 of the ACA provides authority for state Medicaid programs to create health homes for persons with chronic conditions or serious mental illness. Although this option provides a 90-percent federal match for two years, fewer than half of states have adopted it (KFF 2020). As such, even with a higher matching rate, states may choose not to extend the postpartum coverage period if it is not consistent with state priorities.

<sup>49</sup> The principle outlined in the Commission's recommendations is the importance of an extended postpartum coverage period to address the health needs of enrolled individuals. The Commission did not discuss the application of such changes to individuals receiving services under emergency Medicaid and in CHIP under the unborn child option; these may best be addressed through additional changes to the statute or regulations.

<sup>50</sup> MMRCs in a number of states have also recommended extending postpartum coverage for pregnant women (MACPAC 2020a).

<sup>51</sup> See endnote 49.

<sup>52</sup> See endnote 9.

<sup>53</sup> In addition, there may be some young adults (under age 19) covered in CHIP as targeted low-income children who received services while pregnant and are not currently entitled to the 60-day postpartum coverage period. Extending the postpartum coverage period to these individuals may also be addressed through changes in the statute.

<sup>54</sup> Data based on MACPAC analysis of fiscal year 2019 CHIP Statistical Enrollment Data System data as of January 3, 2021. Missouri did not report CHIP enrollment for pregnant women in FY 2019. West Virginia expanded coverage to pregnant women in CHIP in 2019 (WV DHHR 2019).

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## Commission Vote on Recommendations

In its authorizing language in the Social Security Act (42 USC 1396), Congress requires MACPAC to review Medicaid and CHIP program policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendation included in this report, and the corresponding voting record below, fulfill this mandate.

Per the Commission’s policies regarding conflicts of interest, the Commission’s conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendation that Congress extend the postpartum coverage period in Medicaid and the State Children’s Health Insurance Program (CHIP) and require full Medicaid benefits in all pregnancy-related eligibility pathways. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on the recommendations in this chapter on January 29, 2021.

### Advancing Maternal and Infant Health by Extending the Postpartum Coverage Period

2.1 Congress should extend the postpartum coverage period for individuals who were eligible and enrolled in Medicaid while pregnant to a full year of coverage, regardless of changes in income. Services provided to individuals during the extended postpartum coverage period will receive an enhanced 100 percent federal matching rate.

Yes: Barker, Bella, Brooks, Burwell, Carter, Cerise, Davis, Douglas, George, Gordon, Gorton, Lampkin, Milligan, Retchin, Szilagyi, Weno

16	Yes
1	Abstain

Abstain: Scanlon

2.2 Congress should extend the postpartum coverage period for individuals who were eligible and enrolled in the State Children’s Health Insurance Program while pregnant (if the state provides such coverage) to a full year of coverage, regardless of changes in income.

Yes: Barker, Bella, Brooks, Burwell, Carter, Cerise, Davis, Douglas, George, Gordon, Gorton, Lampkin, Milligan, Retchin, Scanlon, Szilagyi, Weno

17	Yes
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2.3 Congress should require states to provide full Medicaid benefits to individuals enrolled in all pregnancy-related pathways.

Yes: Barker, Bella, Brooks, Burwell, Carter, Cerise, Davis, Douglas, George, Gordon, Gorton, Lampkin, Milligan, Retchin, Scanlon, Szilagyi, Weno

17	Yes
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# APPENDIX 2A: Medicaid and CHIP Coverage for Pregnant Women

**TABLE 2A-1.** Legislative Milestones in Medicaid and CHIP Coverage of Pregnant Women

Year	Statute
<b>1984</b>	<p>Deficit Reduction Act of 1984 (P.L. 98-369): Required states to provide Medicaid to:</p> <ul style="list-style-type: none"> <li>• a pregnant woman with no other dependent children who would be a single parent (or a parent with the other parent incapacitated) and eligible for Aid to Families with Dependent Children (AFDC) if the child were born; and</li> <li>• a pregnant woman in a family with two able-bodied parents (one of whom must be unemployed), who would be eligible for AFDC if the child were born.</li> </ul>
<b>1985</b>	<p>Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272):</p> <ul style="list-style-type: none"> <li>• required states to cover pregnant women meeting state AFDC income and resource standards, regardless of employment or marital status;</li> <li>• required 60 days postpartum coverage for pregnant women; and</li> <li>• provided that pregnancy-related services available to covered women need not be available to other Medicaid enrollees.</li> </ul>
<b>1986</b>	<p>Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509):</p> <ul style="list-style-type: none"> <li>• gave states the option to cover all pregnant women and children up to age five in families with incomes at or below 100 percent of the federal poverty level (FPL), regardless of their AFDC eligibility status or assets;</li> <li>• gave states the option to provide continuous coverage to a woman throughout her pregnancy and for 60 days following delivery regardless of changes in income or assets; and</li> <li>• permitted states to provide ambulatory prenatal care to women during a presumptive eligibility period of up to 45 days, if: <ul style="list-style-type: none"> <li>– the woman has begun maternity care with a qualified provider,</li> <li>– the provider determines that the woman's family income falls below the applicable Medicaid standard and notifies the state of the woman's eligibility within five working days, and</li> <li>– the woman applies for such benefits within 14 days of being presumed eligible.</li> </ul> </li> </ul>
<b>1987</b>	<p>Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203):</p> <ul style="list-style-type: none"> <li>• gave states the option to extend Medicaid coverage to pregnant women and infants up to 185 percent FPL.</li> </ul>
<b>1988</b>	<p>Medicare Catastrophic Coverage Act of 1988 (MCCA, P.L. 100-360):</p> <ul style="list-style-type: none"> <li>• required states to phase in Medicaid coverage for all pregnant women and infants in families with incomes up to 100 percent FPL. (Much of MCCA was repealed in 1989, but provisions related to pregnant women were retained.)</li> </ul>

Year	Statute
<b>1989</b>	Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239): <ul style="list-style-type: none"> <li>• required Medicaid coverage for all pregnant women (and children under age six) in families with incomes at or below 133 percent FPL.</li> </ul>
<b>1990</b>	Omnibus Reconciliation Act of 1990 (P.L. 101-508): <ul style="list-style-type: none"> <li>• required states to provide continuous coverage for women throughout pregnancy and through the 60-day postpartum period regardless of changes in income or assets.</li> </ul>
<b>1996</b>	Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193): <ul style="list-style-type: none"> <li>• prohibited Medicaid coverage for non-emergency services to otherwise eligible legal non-citizens entering the United States on or after August 22, 1996 (including pregnant women), until they have resided in the United States for five years; and</li> <li>• permitted coverage after the five-year ban at state option.</li> </ul>
<b>2009</b>	Children’s Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3): <ul style="list-style-type: none"> <li>• permitted states to cover lawfully residing pregnant women and children through Medicaid and CHIP without regard to the five-year residency requirement; and</li> <li>• allowed states to cover low-income pregnant women under CHIP through a state plan amendment.</li> </ul>
<b>2010</b>	Patient Protection and Affordable Care Act of 2010 (P.L. 111-148, as amended): <ul style="list-style-type: none"> <li>• added tobacco cessation programs for pregnant women and services provided at freestanding birth centers as mandatory benefits.</li> </ul>

**Sources:** MACPAC, 2020 analysis. Medicaid and CHIP Payment and Access Commission (MACPAC). 2013. Chapter 1: Maternity services: Examining eligibility and coverage in Medicaid and CHIP. In Report to Congress on Medicaid and CHIP. June 2013. Washington, DC: MACPAC. <https://www.macpac.gov/wp-content/uploads/2013/06/Maternity-Services-Examining-Eligibility-and-Coverage-in-Medicaid-and-CHIP.pdf>.

**TABLE 2A-2.** Medicaid and CHIP Income Eligibility Levels as a Percentage of the FPL for Pregnant Women, Parents, and Other Adults, by State, October 2020

State	Pregnant women in Medicaid <sup>1</sup>	Pregnant women in CHIP <sup>2</sup>	Parents and caretaker relatives of dependent children <sup>3</sup>	Additional individuals age 19–64 <sup>4</sup>
Alabama	141%	–	13%	–
Alaska	200	–	132	133%
Arizona	156	–	106	133
Arkansas	209	–	15	133
California	208	–	109	133
Colorado	195	260%	68	133
Connecticut	258	–	155	133
Delaware	212	–	87	133
District of Columbia	319	–	216	210 <sup>5</sup>
Florida	191	–	27	– <sup>5</sup>
Georgia	220	–	32 <sup>6</sup>	– <sup>7</sup>
Hawaii	191	–	105	133
Idaho	133	–	22	133
Illinois	208	–	133	133
Indiana	208	–	17	133
Iowa	375	–	50	133
Kansas	166	–	33	–
Kentucky	195	–	22	133
Louisiana	133	–	19	133
Maine	209	–	100	133 <sup>5</sup>
Maryland	259	–	123	133
Massachusetts	200	–	133	133 <sup>5</sup>
Michigan	195	–	54	133
Minnesota	278	–	133 <sup>8</sup>	133 <sup>8</sup>
Mississippi	194	–	21	–
Missouri	196	300	17 <sup>6</sup>	– <sup>7,9</sup>
Montana	157	–	24	133
Nebraska	194	–	58	133
Nevada	160	–	31	133
New Hampshire	196	–	63	133

State	Pregnant women in Medicaid <sup>1</sup>	Pregnant women in CHIP <sup>2</sup>	Parents and caretaker relatives of dependent children <sup>3</sup>	Additional individuals age 19–64 <sup>4</sup>
New Jersey	194%	200%	29%	133%
New Mexico	250	–	42	133
New York	218	–	133 <sup>8</sup>	133 <sup>8</sup>
North Carolina	196	–	41	– <sup>5</sup>
North Dakota	157	–	49	133
Ohio	200	–	90	133
Oklahoma	133	–	38 <sup>6</sup>	– <sup>7,9</sup>
Oregon	185	–	38	133
Pennsylvania	215	–	33	133
Rhode Island	190	253	116	133
South Carolina	194	–	95	– <sup>7</sup>
South Dakota	133	–	53	–
Tennessee	195	–	96	–
Texas	198	–	14	–
Utah	139	–	41	133 <sup>7</sup>
Vermont	208	–	49	133
Virginia	143	200	49	133
Washington	193	–	37	133
West Virginia	185	300	18	133
Wisconsin	301	–	95	95
Wyoming	154	–	51	–

**Notes:** As of January 2021, 100 percent of the federal poverty level (FPL) in the lower 48 states and the District of Columbia was \$12,880 for an individual plus \$4,540 for each additional family member. Prior to 2014, states had the flexibility to disregard income sources and amounts of their choosing when determining Medicaid and CHIP eligibility. In 2014, uniform modified adjusted gross income (MAGI) rules became mandatory for determining Medicaid and CHIP eligibility for most children and adults under age 65 eligible for Medicaid on a basis other than disability, including the groups shown in this table. As a result, states are now required to use MAGI-converted eligibility levels that account for the change in income-counting rules. The eligibility levels shown in this table reflect these MAGI-converted levels or another MAGI-based income limit in effect in each state for these groups as of October 2020. Under federal regulations, the effective income limits may be 5 percentage points higher than the percentage of FPL shown in this table to account for a general income disregard that applies to an individual's eligibility under the group with the highest income standard, rather than for particular eligibility groups within Medicaid or CHIP.

States are required to provide Medicaid coverage for parents and other caretaker relatives (and their dependent children), at or above the state's 1988 Aid to Families with Dependent Children eligibility levels. Under regular Medicaid state plan rules, states may opt to cover additional parents and caretaker relatives, children age 19–20, and other individuals age 19–64 who have incomes less than or equal to 133 percent FPL and are not pregnant or eligible for Medicare. Certain states provide coverage under demonstration programs authorized under Section 1115 of the Social Security Act (the Act), which allow them to operate their Medicaid programs

with additional flexibility outside of regular Medicaid state plan rules. As noted in this table, the covered benefits under these waivers may be more limited than those provided under regular state plan rules and might not be available to all individuals at the income levels shown.

– Dash indicates that state does not provide coverage under this eligibility pathway.

<sup>1</sup> This column includes full-scope coverage and coverage for pregnancy-related services in Medicaid. States can also provide coverage for family planning services to individuals who do not qualify for full Medicaid benefits. Family planning-only coverage is not included here.

<sup>2</sup> This column includes states that have adopted the option to cover pregnant women in CHIP through a state plan amendment or an extension of an existing Section 1115 waiver. States also have the option to cover pregnant women using the unborn child option, defining the fetus as the targeted low-income child. This table does not include the unborn child option because those women are not eligible for postpartum services.

<sup>3</sup> These data show Medicaid state plan coverage of the eligibility group for parents and other caretaker relatives. In states that use dollar amounts rather than percentage of FPL to determine eligibility for parents, dollar amounts were converted to percentage of FPL, and the highest percentage was selected to reflect eligibility level for the group. Parents and caretaker relatives with income above the reported threshold for this group may be eligible for coverage under the new adult group (under § 1902(a)(10)(A)(i)(VIII) of the Act) in states that have adopted the expansion.

<sup>4</sup> Reflects state plan coverage under Section 1902(a)(10)(A)(i)(VIII) of the Act for individuals who are age 19–64, have incomes less than or equal to 133 percent FPL, and are not pregnant or eligible for Medicare; state plan coverage for children age 19–20 where indicated; and Section 1115 waiver coverage that is not subject to the limitations indicated in note 6.

<sup>5</sup> The state covers ages 19 and 20 up to the following levels: DC: 216 percent, FL: 27 percent, MA: 150 percent, ME: 156 percent, and NC: 41 percent.

<sup>6</sup> Reflects parent coverage under the Medicaid state plan. The state has some additional coverage above state plan eligibility standards through a Section 1115 demonstration or a pending demonstration proposal. The demonstration includes limitations on eligibility or benefits, is not offered to all residents of the state, or includes an enrollment cap. Georgia will implement this coverage on July 1, 2021, at the earliest.

<sup>7</sup> The state has a Section 1115 demonstration that provides Medicaid coverage to some low-income adults. The demonstration includes limitations on eligibility or benefits, is not offered to all residents of the state, or includes an enrollment cap. Georgia will implement this coverage on July 1, 2021, at the earliest.

<sup>8</sup> In Minnesota and New York, individuals with incomes greater than 133 percent FPL but not exceeding 200 percent FPL are covered under the Basic Health Program.

<sup>9</sup> Missouri and Oklahoma have opted to expand coverage to the new adult group by voter referendum, but have not yet implemented it.

**Source:** CMS, 2020, Medicaid, Children’s Health Insurance Program, & Basic Health Program Eligibility Levels, <https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-childrens-health-insurance-program-basic-health-program-eligibility-levels/index.html>.