

Medicaid and Health Coverage for Low-Income Women in Pregnancy and After Childbirth

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Introduction

Good morning, Chairwoman Eshoo, Ranking Member Burgess, and Members of the Committee. I am Usha Ranji, Associate Director of Women's Health Policy at the Kaiser Family Foundation. Thank you for inviting me to testify about the role of Medicaid coverage for pregnant and postpartum women. The Kaiser Family Foundation, KFF, is a non-profit organization that provides non-partisan health policy analysis, polling, and journalism (Kaiser Health News) to inform policymakers, the media, the health policy community and the public. We are not associated with Kaiser Permanente or Kaiser Industries. In my testimony today, I will summarize KFF's research on Medicaid and postpartum coverage (Appendix 1) and address the following key points:

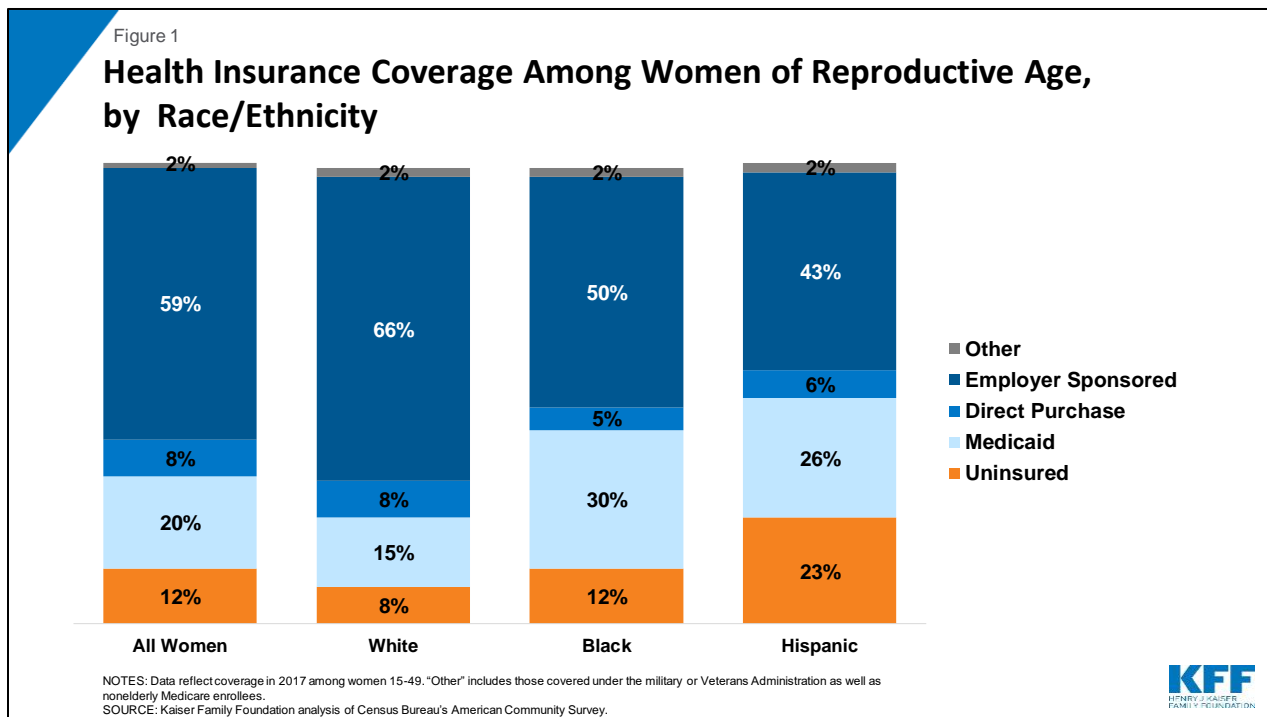
- Research shows that coverage before, during, and after pregnancy facilitates access to care that supports healthy pregnancies as well as positive maternal and infant outcomes after childbirth.
- Medicaid is the primary source of health coverage for low-income women, and a major financer of maternity care, covering more than four in ten births in the U.S. Research finds that for low-income women, Medicaid is comparable to private insurance in terms of many measures of access to care.
- States set eligibility criteria for Medicaid within federal guidelines. The federal minimum income level for pregnancy-related eligibility is effectively 138% of the federal poverty level, but many states set higher thresholds, recognizing the importance of coverage during the perinatal period. Pregnancy-related coverage ends after 60 days postpartum. Infants born to women with Medicaid coverage for pregnancy are eligible for Medicaid for the first year of life.
- Even without expanding Medicaid under the Affordable Care Act (ACA), states can expand access to Medicaid by broadening parental coverage. Prior to having the option to expand Medicaid eligibility under the ACA, 17 states and DC set income thresholds for parents that were at the poverty level or higher.
- Today, eligibility for women after childbirth varies because policymakers have made different decisions about whether to expand Medicaid as well as whether to increase income thresholds for parents -- even in states that have not adopted the Medicaid expansion.
- These state choices affect women's ability to stay on Medicaid after pregnancy ends. In expansion states, many postpartum women can remain on the program and those who do not qualify for Medicaid typically qualify for subsidies to assist with the costs of obtaining private insurance in state Marketplaces.
- To retain Medicaid coverage after pregnancy in the 14 non-expansion states, postpartum women need to requalify under their state's parent eligibility criteria, which are much lower than the income thresholds for pregnancy (from 17% to 100% of the federal poverty level).
- Women with incomes at or above 100% of poverty can qualify for ACA marketplace subsidies in all states, but in states with lower parental coverage thresholds, women with incomes between the state Medicaid eligibility level for parents and 100% of poverty may have no pathway to affordable coverage. This has implications for their ability to access needed health care services during this important life stage.
- Some states are undertaking efforts that rely on Medicaid to strengthen postpartum care and coverage for women. There are multiple initiatives under way to target services to different groups who have had a Medicaid funded birth and who may be more vulnerable, including those affected by substance use and mental health challenges.

Research shows that coverage before, during, and after pregnancy is important to facilitate access to care that supports healthy pregnancies, as well as positive maternal and infant outcomes after childbirth. Research finds that for low-income women, Medicaid is comparable to private insurance in terms of many measures of access to care.

Efforts to improve coverage for pregnant women began in the mid-1980s in response to rising rates and stark disparities in infant mortality and low-birthweight. Led by the Southern Regional Taskforce on Infant Mortality, governors saw an opportunity to use Medicaid to play a role in improving birth outcomes by providing coverage to uninsured, low-income pregnant women as well as expanding eligibility for children. The federal government then raised the eligibility floor for Medicaid coverage and provided states with incentives to extend coverage for pregnancy even above the minimum requirement. This led to a substantial increase in Medicaid's coverage of low-income pregnant women, infants, and children up to age six and declines in the uninsured.¹

Research has shown that people with Medicaid coverage fare much better than their uninsured counterparts on several measures of access to care. One synthesis² of peer-reviewed literature concluded that the expansions for pregnancy eligibility contributed to "improvements in prenatal care use," while more recent analyses of federal data from the Pregnancy Risk Assessment Monitoring System (PRAMS) found significantly higher rates of timely and adequate prenatal care among pregnant women covered by Medicaid compared to uninsured women.^{3,4} Mothers covered by Medicaid are much more likely than those who are low-income and uninsured to have a usual source of care, recent doctor and dental visits, and other preventive services, such as screenings for breast and cervical cancers.⁵ Our own work at KFF finds that low-income women with private insurance use care at rates that are comparable to their privately-insured counterparts and significantly higher than those who are uninsured.⁶ Low-income women in Medicaid were also significantly less likely than those who are privately-insured to report that cost was a barrier to care.⁷

Today, there is continued need to improve maternal and infant health and a growing urgency to develop policy and programmatic responses to the rise in maternal mortality and morbidity and the wide racial and ethnic disparities in maternal outcomes.⁸ Medicaid plays a major role in health coverage for all low-income women, but particularly for women of color because they are more likely to be low-income (Figure 1). There is greater recognition that access to health care *throughout* a woman's reproductive years, including before and after a pregnancy, is essential for prevention, early detection, and treatment of some of the conditions that place women at higher risk for pregnancy-related complications, including cardiovascular disease, diabetes, and chronic hypertension. And, there is strong empirical evidence to support what families across the country know and experience on a daily basis - that a mother's ability to care for her own health and well-being is integral to her ability to do the same for her children.⁹



Medicaid is the primary source of health coverage for low-income women, and a major financier of maternity care, covering more than four in ten births in the U.S.

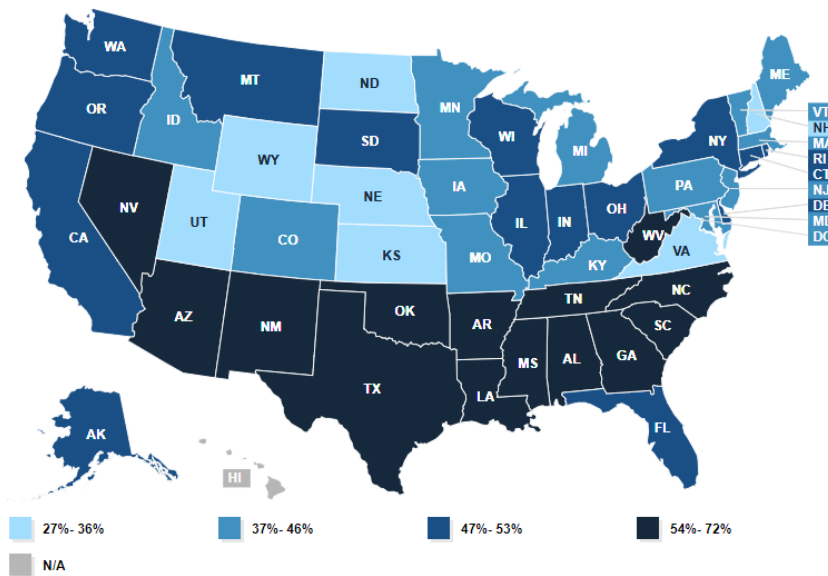
Medicaid has historically prioritized coverage for children and pregnant women. [Children](#) make up 43% of the Medicaid population overall, and among adult women on the program, two-thirds (67%) are in their reproductive years (19 to 49). The program now finances more than four in ten (43%) births nationally¹⁰ and more than half in some states (Figure 2).¹¹

While maternity care is a mandatory benefit that states must cover, states have discretion to determine the specific scope of maternity care benefits under Medicaid. All states cover prenatal care and delivery services. States that have expanded Medicaid eligibility under the ACA must cover all [preventive services](#) recommended by the United States Preventive Services Task Force (USPSTF) and Women’s Preventive Services Initiative (WPSI) for beneficiaries that qualify as a result of the expansion. These include many pregnancy-related services, such as prenatal visits, screening tests, and folic acid supplements. It also includes coverage for breastfeeding supports that extend to the postpartum period, with coverage for lactation consultation and breast pumps. [Many states](#) cover substance use treatment and home visiting services, and just a few now cover doula services.¹²

Under federal law, women who receive pregnancy-related services under Medicaid cannot be charged for any share of the cost of care, but after the postpartum period, that can change. A large body of [evidence](#) shows that even nominal cost sharing impedes access to care for low-income women and families. For low-income mothers, the lower cost sharing and absence of deductibles under Medicaid can be a major advantage over private insurance.

Figure 2

Medicaid is the Leading Financer of Maternity Care in Many States



NOTE: In the 2016 Kaiser Family Foundation Medicaid Budget Survey, states were asked to report the share of all births in the state that were financed by Medicaid in the most recent 12 month period for which data were available. States reported data from 2010-2016, which varied by calendar year, state fiscal year, and federal fiscal year.

SOURCE: Kaiser Family Foundation, *Implementing Coverage and Payment Initiatives: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2016 and 2017*.

States set income eligibility criteria for Medicaid within federal guidelines, and most extend coverage to pregnant women above the federally-required minimum of 138% of poverty, recognizing the importance of coverage during the perinatal period. Pregnancy-related coverage ends after 60 days postpartum. Infants born to women with Medicaid coverage for pregnancy are automatically enrolled in Medicaid for the first year of life.

Federal law requires that all states extend eligibility to pregnant women with incomes up to 138% of the federal poverty level (FPL), which equals \$29,435 for a family of three; however, most states go beyond this minimum threshold, ranging from 138% to 380% FPL (see Table 1 in the Appendix).

Pregnancy-related coverage for the mother must last through 60 days postpartum¹³ and the infant is eligible for Medicaid for the first year after birth. Following the 60 days postpartum period, the decision about coverage for women is up to the states and depends in part of whether the state has opted to expand Medicaid as allowed by the ACA or where they set parental income eligibility levels. Wisconsin, for example, has not expanded Medicaid under the ACA, but extends parental coverage to 100% FPL, which is higher than most other non-expansion states.

Infants born to women who had Medicaid during pregnancy are automatically enrolled in Medicaid for their first year. This allows access to numerous preventive services for many low-income families, including newborn screenings, immunizations, and well child visits. Notably, research finds that when mothers have Medicaid, there is greater retention of coverage for children as well.¹⁴

Historically, many postpartum women would become uninsured in the months following pregnancy because they had no pathway to coverage. Even today, the availability of Medicaid coverage for women in the postpartum period varies considerably by state.

Prior to implementation of the ACA, many women with Medicaid during pregnancy would become uninsured after the 60 days postpartum period ended. After this time, women would need to requalify for Medicaid as a parent, and all states set much lower income eligibility thresholds for parents, compared to pregnant women. Women with incomes above their state's parental eligibility level would likely be disenrolled from Medicaid after the postpartum coverage ended.

There is significant instability in health coverage among low-income women, a phenomenon known as “churning,” due in part to the volatility of employment and income levels for this population. A [national study](#) of women's insurance coverage during the perinatal period in the pre-ACA era found that more than half of women covered by Medicaid or CHIP at the time of delivery were uninsured at least one of the six months following delivery. This was far higher than the rate for women who had private insurance at the time of delivery (55% Medicaid compared to 35% private).¹⁵

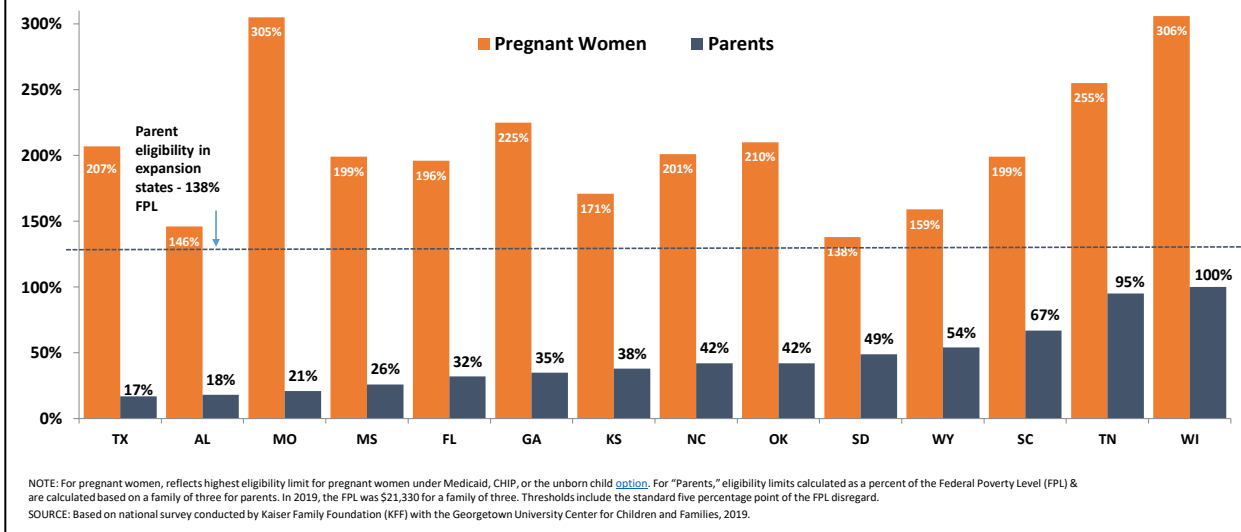
Even without expanding Medicaid under the ACA, states can expand access to Medicaid by broadening parental coverage. Prior to having the option to expand Medicaid eligibility under the ACA, 17 states and DC set income thresholds for parents that were at the poverty level or higher.

In states that have implemented Medicaid expansion, there is alignment between the minimum income eligibility level for pregnancy and the expansion threshold at 138% of poverty. As a result, qualifying postpartum women in these states with incomes up to 138% of poverty can retain Medicaid coverage after pregnancy-related coverage ends. Continuous Medicaid coverage can promote greater continuity of care by allowing postpartum women to remain within the same provider network and care system that she saw during pregnancy. Those with higher incomes can qualify for federal subsidies in the Marketplaces up to 400% of poverty. There is a pathway to coverage and assistance for most postpartum women in expansion states.

Women with incomes above 100% of poverty can qualify for ACA marketplace subsidies in all states, but in states with very low parental coverage thresholds such those in many non-expansion states, women with incomes between the state Medicaid eligibility level for parents and 100% of poverty may have no pathway to affordable coverage. This has implications for their ability to access needed health care services during this important life stage.

In the 14 states that have not changed their Medicaid program eligibility levels, postpartum women need to requalify for Medicaid under the parental eligibility category to stay on the program after pregnancy coverage ends. However, Medicaid income eligibility levels for [parents](#) are much lower than for pregnant women, ranging from 17% to 100% of poverty in those states (Figure 3).

Figure 3
Medicaid Eligibility Thresholds for Pregnant Women Compared to Parents in Non-Expansion States, 2019



Marketplace premium subsidies are only available for those with incomes between 100% and 400% of poverty. Therefore, if a postpartum woman’s income is above the state’s Medicaid eligibility level for parents but below the federal poverty line (\$21,330 annually for a family of three), she would not qualify for either Medicaid or private insurance subsidies. As a result, many women in non-expansion states become uninsured after pregnancy-related coverage ends (60 days postpartum) because they do not have access to Medicaid or federal subsidies. We refer to this group as falling into the “coverage gap.”

Some states are now undertaking efforts that rely on Medicaid to strengthen postpartum care and coverage for women. There are multiple initiatives under way to target services to different groups of women who have had a Medicaid funded birth and who may be more vulnerable, including those affected by substance use and mental health challenges.

Some states are seeking to extend Medicaid coverage to postpartum women with related health challenges. For example, policymakers in [Missouri](#) have submitted a waiver application to the federal government to help finance a Medicaid extension for postpartum women in need of substance use treatment. The [CDC](#) found a four-fold increase in the number of women with opioid use disorder at labor and delivery between 1999 and 2014.¹⁶

The [American College of Obstetricians and Gynecologists \(ACOG\)](#) recommends that postpartum women with substance use disorders should have access to and continue use of treatment services, including pharmacotherapy. The postpartum period can be a particularly susceptible time for relapse, with loss of insurance and access to care considered a potential trigger for relapse. [CMS](#) currently has a funding opportunity for up to 12 states to develop programs to care for pregnant and postpartum women with opioid use disorder.

[California](#) has approved a policy to extend Medicaid coverage for a year to any individual with a maternal mental health condition. For a new mother who needs medications, for example, to manage postpartum depression, this extension of Medicaid coverage could fill an otherwise unaffordable gap, particularly since Medicaid would not impose cost sharing charges. Postpartum depression can occur anytime in the first year after delivery, making the frequency of well child visits during that year a chance for identifying and screening for maternal depression. Recognizing this opportunity, in 2016 [CMS](#) approved coverage of postpartum depression screening for women during well child visits. Under the CMS initiative, if the woman is enrolled in Medicaid, treatment services can be covered under Medicaid. If a woman is uninsured, for example in a non-expansion state, in order for Medicaid to cover the treatment under the child, the treatment must involve the child, such as family therapy.

Earlier this year, [Illinois](#) enacted an extension of Medicaid postpartum coverage to one year for women with incomes up to 200% of poverty. The state is in the process of applying for an 1115 waiver to procure federal financing assistance.

These are just a few examples of the ways that states can leverage Medicaid to enhance care and coverage for low-income pregnant women and after childbirth when they have become mothers.

For women, the need for health care services does not end two months after childbirth, even though their health coverage might. The year after a delivering baby is a not only a medically vulnerable time for many women, but even for those who appear to be healthy, postpartum care in the year after having a child is critical. The evidence on this is clear — having health coverage promotes access to care, especially for low-income people, and the lack of coverage is associated with poorer health outcomes. The availability of coverage to postpartum women, particularly for those who are low-income can improve their use of critical services and lead to better outcomes for women and their families.

Appendix

See attached Appendix: Kaiser Family Foundation, "[Expanding Postpartum Medicaid Coverage.](#)"

References

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- ¹ Rowland, et al. [The Key to the Door: Medicaid’s Role in Improving Health Care for Women and Children.](#)” *Annual Reviews of Public Health*, 1999.
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- ¹² Kaiser Family Foundation, [Medicaid Coverage of Pregnancy and Perinatal Benefits](#), April 2017.
- ¹³ Pregnancy coverage under Medicaid ends for the woman on the last day of the month that is 60 days after the pregnancy ends.
- ¹⁴ Sommers BD. “[Insuring children or insuring families: do parental and sibling coverage lead to improved retention of children in Medicaid and CHIP?](#)” *J Health Econ*, November 2006.
- ¹⁵ Daw, et al. “[Women in the United States Experience High Rates of Coverage Churn in Months Before and After Childbirth.](#)” *Health Affairs*, April 2017.
- ¹⁶ Centers for Disease Control and Prevention, “[Opioid Use Disorder Documented at Delivery Hospitalization.](#)” *MMWR*, August 10, 2018.

Expanding Postpartum Medicaid Coverage

Usha Ranji, Ivette Gomez, and Alina Salganicoff

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

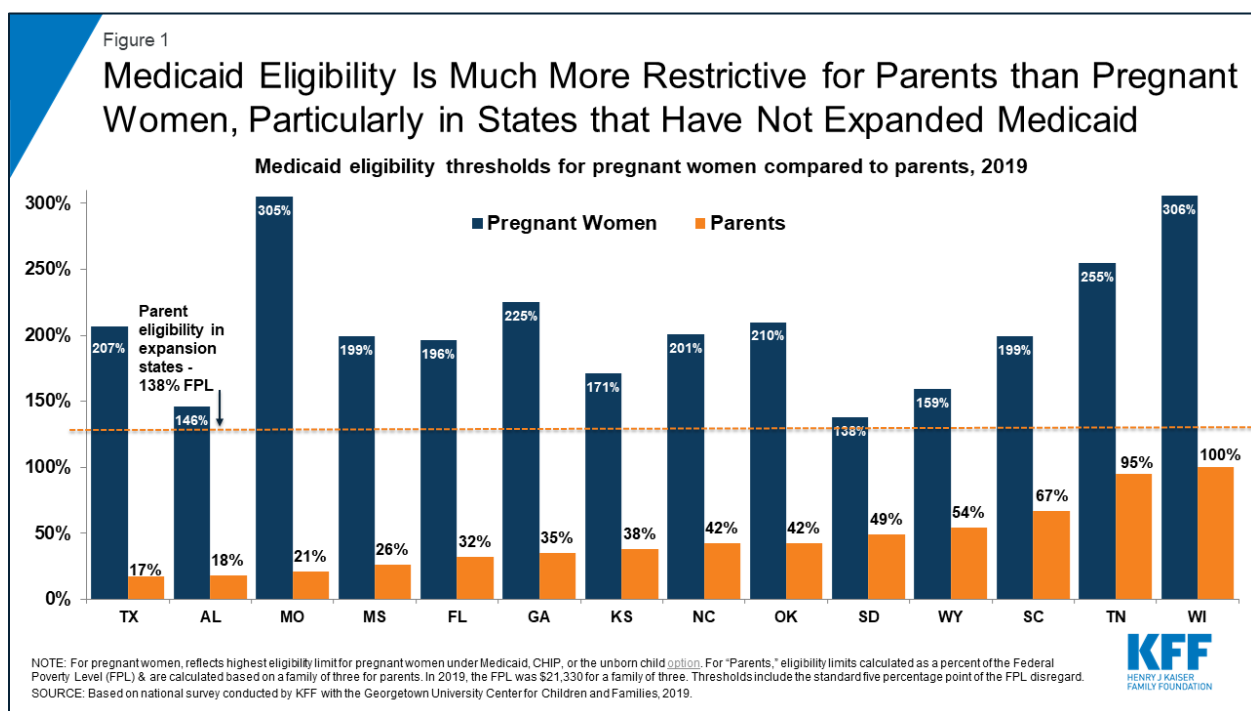
What is Medicaid's role for pregnancy and postpartum care?

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

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

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

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



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

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

incomes between the income limit for parents and 100% FPL, placing them in the “[coverage gap](#)” and making private insurance unaffordable.

Why is coverage for postpartum care important?

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

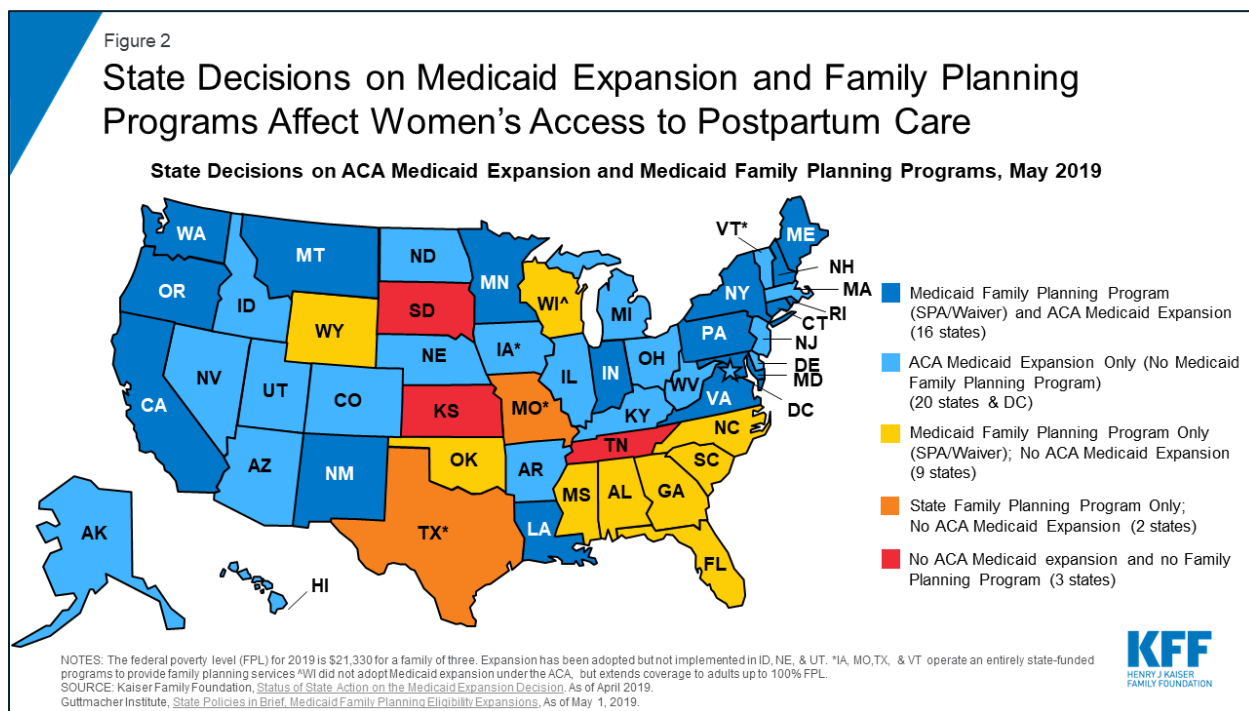
One of the most common complications for pregnant and postpartum women is depression. The American College of Obstetricians and Gynecologists ([ACOG](#)) estimates that 14-23% of pregnant women and as much as a quarter of postpartum women experience depression. Several studies have found higher rates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

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

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

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

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



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

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

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

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

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

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

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

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

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

Conclusion

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