



New Mothers' Coverage Improved during the Public Health Emergency

Uninsurance Remained Higher in Nonexpansion States and in the South in 2021

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With high and growing rates of maternal mortality and most maternal deaths occurring following delivery, increasing attention is being paid to health insurance coverage and health care during the postpartum period (Hoyert 2023; Petersen et al. 2019; Haley et al. 2021a; Johnston et al. 2021; Rodin et al. 2019; Burroughs et al. 2021; Haley et al. 2022). Medicaid may have a particularly important role, given that in 2021, Medicaid financed more than 4 in 10 births in the United States.¹ Medicaid eligibility is more generous for pregnant people than for other nonelderly adults, but this coverage historically expired just 60 days after the end of pregnancy (Haley et al. 2021a). However, Congress enacted the Families First Coronavirus Response Act (FFCRA) in March 2020, which established a continuous coverage requirement mandating states not disenroll people from Medicaid, including those with pregnancy-related coverage, during the public health emergency (PHE).² The policy resulted in historic growth in Medicaid enrollment, reaching 93.9 million by March 2023 with the pregnancy-related coverage pathway experiencing the highest enrollment growth.³

Recent federal policy changes gave states a new option to extend Medicaid coverage in the postpartum period. As of August 1, 2023, 35 states and the District of Columbia had enacted⁴ a postpartum extension⁵ using an option under the American Rescue Plan Act of 2021 to extend pregnancy-related Medicaid/Children's Health Insurance Program (CHIP) coverage from 60 days to 12 months postpartum.⁶ Continuous coverage under the FFCRA effectively extended postpartum Medicaid coverage for those qualifying through the pregnancy-related pathway beyond the previous

federal 60-day limit. Thus, coverage changes under the continuous coverage requirement could inform state decisionmaking on adopting and implementing postpartum extensions and effective rollouts of related policies to improve coverage continuity more generally.

In this brief, we use American Community Survey (ACS) data to examine uninsurance among new mothers,⁷ focusing primarily on the period between 2019, before the pandemic had begun, and 2021, during the pandemic when the Medicaid continuous coverage requirement was in effect and the year the most recently collected data from the ACS are available. The following are our key findings:

- After relative stability between 2016 and 2019, uninsurance among new mothers fell by 14 percent between 2019 and 2021, despite rising unemployment.
 - » While uninsurance fell among new mothers, Medicaid coverage increased from 28.1 percent to 31.1 percent between 2019 and 2021.
 - » Despite this progress, 1 in 10 new mothers were uninsured in 2021, which places them at higher risk of experiencing unmet health needs and financial burdens.
- Improvements in coverage between 2019 and 2021 were large among some subgroups of new mothers who experienced lower rates of insurance coverage in 2019, but stark disparities remained by income, race and ethnicity, and citizenship status.
- While increases in new mothers' insurance coverage between 2019 and 2021 were concentrated in states that did not expand Medicaid under the Affordable Care Act (ACA) and in the South, new mothers in those states continued to be at substantially higher risk of being uninsured in 2021.
 - » New mothers living in nonexpansion states were 2.3 times more likely to be uninsured (15.9 percent) in 2021 than those living in states that had expanded Medicaid under the ACA (6.9 percent).
- In 2021, there was substantial state variation in uninsurance rates for new mothers among the 36 states where annual estimates could be reliably calculated. Four states (Massachusetts, Michigan, Minnesota, and New York) had rates below 5 percent. In comparison, three states (Georgia, Oklahoma, and Texas) had rates above 15 percent, with the highest rate (23.8 percent) found in Texas, which accounted for over one in four of the nation's uninsured new mothers in 2021.
- More than half of uninsured new mothers in 2021 lived in nonexpansion states and in the South.

Though we cannot directly attribute the coverage changes observed in the ACS to the Medicaid continuous coverage requirement, the declines in uninsurance and accompanying increases in Medicaid coverage among new mothers suggest that it may have been instrumental to the coverage gains experienced by new mothers during the pandemic. The improvement in coverage for new mothers between 2019 and 2021 is remarkable given that the unemployment rate rose during the pandemic, which historically would have led to an increase in uninsurance (Holahan and Garrett 2009; Fleming

2010). These findings suggest that states adopting postpartum extensions can expect that some new mothers will experience coverage gains while others may remain uninsured. However, the magnitude of those changes may differ from those that occurred during the continuous coverage period given the challenges states faced communicating effectively about the continuous coverage requirement to postpartum enrollees and their providers, potential state investments in outreach and engagement specific to their postpartum extensions, and pandemic-specific factors no longer present in the post-PHE period (Johnston, Haley, and Thomas 2021). The increases in apparent underreporting of Medicaid in survey data during the continuous coverage requirement (Hest, Lukanen, and Blewett 2022) also suggest that some of those who benefited from extended coverage may not have been aware of their coverage extension—reinforcing the importance of clearly conveying the extent of postpartum coverage for people covered by Medicaid under the implementation of new extensions.

With the expiration of the continuous coverage requirement as of April 1, 2023, states have begun to resume the process of redetermining eligibility for all enrollees, including those whose pregnancy-related coverage had been extended into the first year postpartum and beyond. The resumption of regular Medicaid renewal processes could put at risk the coverage gains that occurred for new mothers between 2019 and 2021, highlighting the need for careful unwinding of pandemic protections. Moreover, it will be important to assess whether the coverage gains that occurred following the continuous coverage requirement were associated with increased access to and use of needed health care to inform the implementation of new postpartum extensions (Johnston, Haley, and Thomas 2021).

At the same time, many people covered by pregnancy-related Medicaid/CHIP who are approaching the end of pregnancy will face a different coverage landscape than in 2019, with most states now adopting Medicaid/CHIP postpartum extensions. However, prior research has found that some uninsured new mothers who appear eligible for Medicaid remain unenrolled (Johnston et al. 2021). Thus, even with expanded coverage options, several strategies would be needed to ensure that coverage gains for new mothers are maintained or expanded upon, including broad and successful implementation of postpartum extensions and expansions in eligibility for public coverage outside of pregnancy (Johnston, Haley, and Thomas 2021). In addition, targeted efforts would be needed to connect subgroups of new mothers with higher rates of uninsurance to coverage (Haley et al. 2022). However, while new mothers in states adopting Medicaid expansion under the ACA and postpartum extensions may be poised to maintain some of these coverage gains, opportunities to access affordable coverage will remain limited in states not adopting these policies, leaving new mothers in those states to face higher risks of rising uninsurance in 2023 and beyond. Ensuring that new mothers are insured and the coverage includes access to affordable, high-quality, culturally effective care that meets their health needs is important for their health and well-being and the health, development, and well-being of their infants and families.

In subsequent sections, we present background information on relevant Medicaid/CHIP policies and findings from our analysis of health insurance coverage among new mothers, drawing on data from the ACS in 2019 and 2021. We conclude by discussing our key findings and implications for postpartum coverage and health in the current policy environment. Specifics of the data, methods, and limitations of our study are included in Appendix A.

Background

Uninsurance among new mothers is an ongoing concern in the United States, where childbearing people experience alarming rates of maternal morbidity and mortality, and people of color—particularly Black and Indigenous people—are at especially high risk (Hoyert 2023; Petersen et al. 2019; Burroughs et al. 2021). Further, most maternal deaths occur following delivery; about 33 percent occur more than seven days after delivery, and 12 percent occur more than six weeks after birth (Petersen et al. 2019). In 2016–2018, 11.9 percent of new mothers, or about 440,000 new mothers annually, were uninsured during the first year postpartum (Johnston et al. 2021). Lack of insurance coverage during this period can prevent new mothers from seeking needed care to address pregnancy-related complications, postpartum mental health, and chronic conditions (ACOG 2018).

Pregnant people and new mothers face a complex patchwork of public coverage options during the pregnancy and postpartum periods, with eligibility rules that vary by pregnancy status, income, immigration status, and state of residence (Haley et al. 2021a). Medicaid coverage during pregnancy is more generous than typical adult coverage. The median state offers pregnancy-related Medicaid/CHIP coverage with a threshold over twice the federal poverty level (FPL). In contrast, there are few pathways towards coverage for adults who are not parents, disabled, or pregnant in the states not adopting Medicaid expansion under the ACA; the median nonexpansion state’s threshold for parents is below 50 percent of FPL (Brooks, Gardner, and Yee 2023). Even in states adopting Medicaid expansion, the median state’s income eligibility threshold is 138 percent of FPL, almost always lower than during pregnancy. Pregnancy-related Medicaid/CHIP is also more generous concerning immigration status, though it does not reach all immigrants below relevant income thresholds. About half of states apply a five-year waiting period for coverage for lawfully residing immigrant pregnant people. Though twenty states effectively extend CHIP eligibility to pregnant people regardless of citizenship status via the “unborn child” pathway,⁸ this coverage is not as comprehensive as pregnancy-related Medicaid/CHIP and may not include any postpartum care for the birthing person (Manatt Health 2022; Brooks et al. 2023; Haley et al. 2021a).⁹ Only a few states use state funds to provide coverage to people regardless of immigration status.¹⁰ For many undocumented immigrants and lawfully present immigrants in states with a five-year waiting period, the only subsidized coverage option is emergency Medicaid at delivery which does not include prenatal or postpartum care (Haley et al. 2021a).

Longstanding federal law limited pregnancy-related Medicaid/CHIP coverage to 60 days after the end of pregnancy (Haley et al. 2021a). As a result, many people experience health insurance “churn,” or transitions in and out of coverage or between coverage types, surrounding pregnancy (Daw et al. 2017). Though the ACA’s Medicaid expansion reduced rates of churn surrounding pregnancy (Daw et al. 2020), 21.9 percent of new mothers with Medicaid-covered prenatal care became uninsured two to six months postpartum in 2015–2018 (Johnston et al. 2021). Uninsured new mothers face challenges accessing affordable health care, with about 1 in 5 uninsured new mothers reporting at least one unmet need for medical care because of cost in the past year and over half reporting they were very worried about paying their medical bills in 2015–2018 (McMorrow et al. 2020).

Beyond the Medicaid program, Marketplace coverage is available for citizens and some noncitizens with incomes above Medicaid levels and no access to employer-sponsored insurance deemed affordable¹¹ under the ACA, with available subsidies and cost-sharing reductions based on income. But subsidies require recipients to have family incomes at or above the FPL, resulting in a coverage gap for those earning less than the poverty level in nonexpansion states who are not eligible for either Medicaid or subsidized Marketplace coverage.

In response to the COVID-19 pandemic, which raised concerns about access to health insurance because of job loss, Congress enacted several policies that affected people with Medicaid, including those with pregnancy-related coverage. This included FFCRA's continuous coverage requirement, which mandated that states maintain Medicaid enrollment of all enrollees as of or after March 18, 2020, in exchange for enhanced federal funding. This requirement meant that people did not have to go through renewal processes to maintain coverage and that current Medicaid recipients would automatically remain enrolled even if their income rose above eligibility thresholds or if their eligibility status changed, including reaching the end of the typical 60-day postpartum period. This provision was in place throughout the remainder of the PHE until expiring on March 30, 2023, according to provisions of the Consolidated Appropriations Act of 2023.¹² As a result, Medicaid enrollment grew steeply, reaching 93.9 million by March 2023.¹³ In addition, in March 2021, Congress temporarily put into place (and subsequently extended) enhanced subsidies for Marketplace coverage that increased the size of subsidies and extended them to some people with incomes above 400 percent of FPL (Keith 2022).

Before 2021, states aiming to extend postpartum coverage past the typical 60-day period could obtain Section 1115 waivers to obtain federal funds or rely exclusively on state funding; as of October 2021, just two states had enacted postpartum extensions, and three had waivers under review by the Centers for Medicare & Medicaid Services (CMS) (Haley et al. 2021a). Under the American Rescue Plan Act of March 2021, states were given the option to use a state plan amendment to extend pregnancy-related Medicaid/CHIP coverage from 60 days to 12 months postpartum through 2027, an option made permanent in the Consolidated Appropriations Act.¹⁴ The postpartum extension would increase Medicaid/CHIP income thresholds for the first year after delivery compared with existing adult eligibility thresholds in nearly every state, with larger increases in nonexpansion states. As of April 1, 2023, 30 states and the District of Columbia had enacted a postpartum Medicaid/CHIP extension,¹⁵ but implementation was superseded by the continuous coverage requirement, and they are just now being rolled out in normal Medicaid operations as redeterminations resume.¹⁶ Since then, there has been a flurry of state actions toward implementing postpartum coverage extensions, including five more states that received approval of their state plan amendments from CMS and six more states passing legislation to enact state plan amendments awaiting CMS approval.¹⁷

Postpartum extensions include some documented immigrants who are lawfully residing with fewer than five years of residency status and eligible for pregnancy-related Medicaid/CHIP coverage but not for Medicaid outside of pregnancy (Haley et al. 2021a). However, such extensions would not help birthing people before pregnancy or after a year postpartum, and most would exclude those eligible only for unborn child CHIP and those who only qualify for emergency Medicaid. Prior research based on

data from 2016 to 2018 and income and immigration eligibility policies in 2020 found that nearly one-third of uninsured new mothers would be ineligible for Medicaid, CHIP, or subsidized Marketplace plans because of immigration-related eligibility restrictions even under extension in every state (Johnston et al. 2021).

As noted above, the Consolidated Appropriations Act eliminated the continuous coverage requirement in Medicaid enacted under the pandemic.¹⁸ As of April 1, 2023, states were allowed to begin the so-called “unwinding” process, that is, to resume conducting Medicaid eligibility redeterminations for all enrollees. During the unwinding, millions of people are projected to lose Medicaid either because they no longer qualify or have challenges completing renewal processes, with many at risk of becoming uninsured (Buettgens and Green 2022; ASPE 2022). Though states have flexibility in the timing of redeterminations for those with pregnancy-related coverage, postpartum people are of particular concern since many whose eligibility was extended will need to transition to other coverage to avoid becoming uninsured.¹⁹

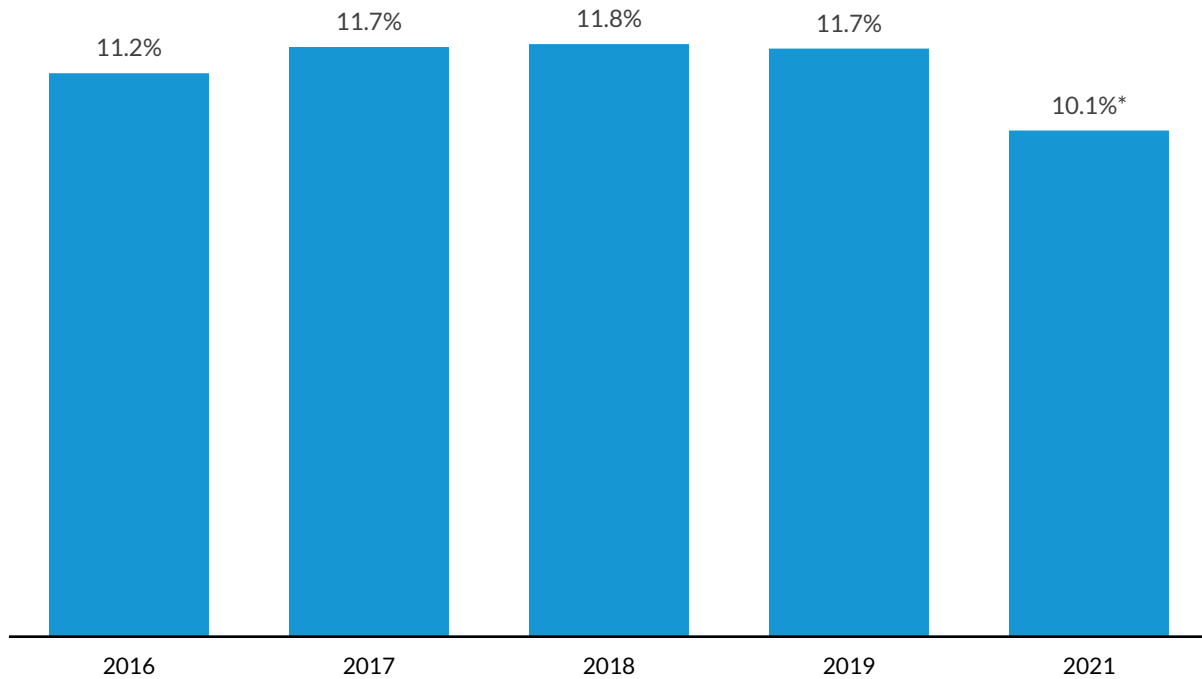
Results

After Relative Stability between 2016 and 2019, Uninsurance among New Mothers Fell by 14 Percent between 2019 and 2021, Corresponding with an Increase in Rates of Medicaid Coverage, Though 1 in 10 Remained Uninsured

Uninsurance among new mothers remained relatively steady during the 2016 to 2019 period, ranging between 11.2 and 11.8 percent (figure 1).²⁰ But uninsurance fell between 2019 and 2021²¹ from 11.7 percent to 10.1 percent, representing a 1.6 percentage point or 14 percent drop in uninsurance among new mothers.²² Despite this progress, 1 in 10 new mothers were uninsured in 2021, placing them at higher risk of experiencing unmet health needs and financial burdens.

FIGURE 1

Uninsurance Rate for New Mothers 19–44, 2016–2019 and 2021



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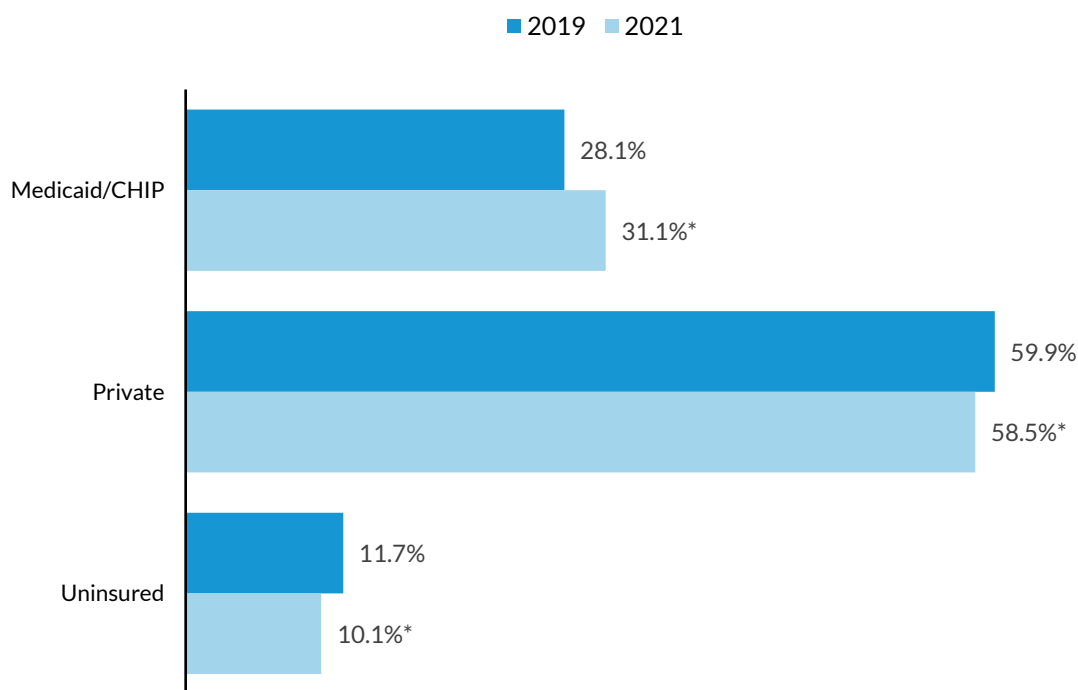
Source: Urban Institute analysis of American Community Survey data from the University of Minnesota Integrated Public Use Microdata Series USA, 2016–2019 and 2021.

Notes: New mothers are women ages 19 to 44 who are not living in group quarters and who reported giving birth in the past 12 months. Uninsured is at the time of survey. * indicates change between 2019 and 2021 is significant at the $p < 0.05$ level. Differences between 2017, 2018, and 2019 and 2016 are not significant. Data for 2020 are not shown because of data limitations (see Appendix A).

The decline in uninsurance among new mothers corresponded with an increase in their rate of Medicaid/CHIP coverage, rising from 28.1 percent to 31.1 percent between 2019 and 2021, and a small decline in private coverage (including employer-sponsored insurance, Marketplace plans, and other private insurance) from 59.9 percent to 58.5 percent (figure 2). In the same period following the start of the PHE, the uninsured rate for all nonelderly adults also declined, from 13.3 percent to 12.5 percent; however, the change was smaller than the change for new mothers, falling by less than 1 percentage point (data not shown). Coverage gains among nonelderly adults also corresponded with an increase in Medicaid coverage (14.6 percent in 2019 to 16.2 percent in 2021), though these increases in Medicaid were not as large as those for new mothers (data not shown).

FIGURE 2

Type of Health Insurance Coverage among New Mothers 19–44, 2019 and 2021



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Source: Urban Institute analysis of American Community Survey data from the University of Minnesota Integrated Public Use Microdata Series USA, 2019 and 2021.

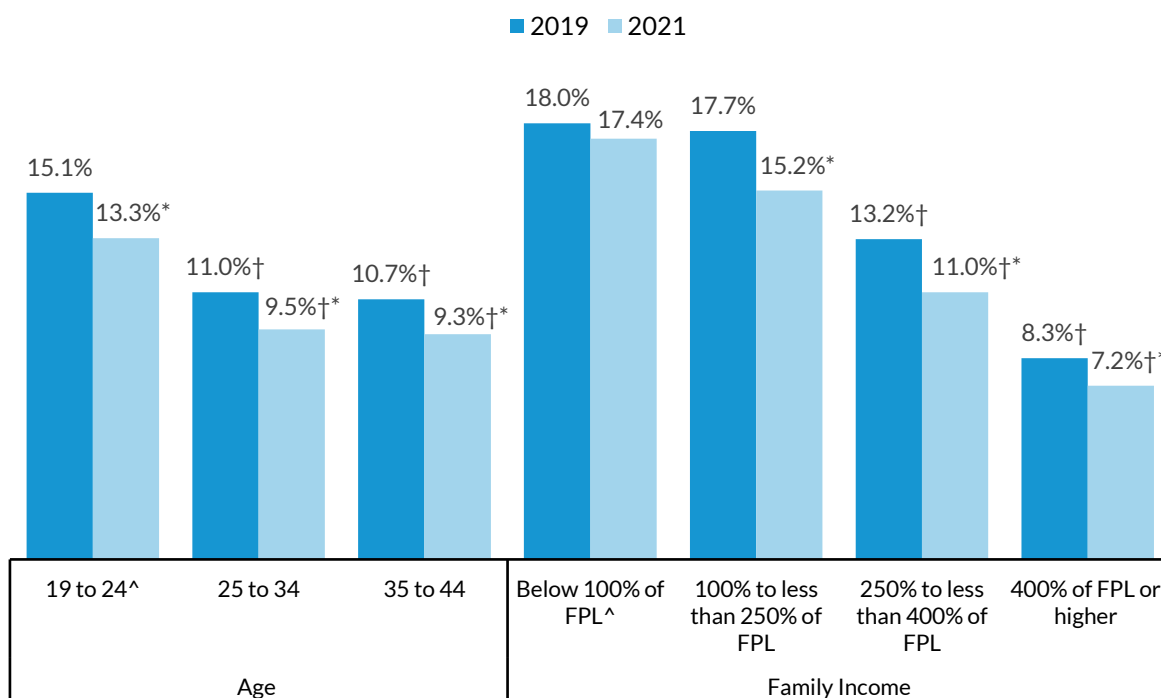
Notes: CHIP = Children’s Health Insurance Program. New mothers are women ages 19 to 44 who are not living in group quarters and who reported giving birth in the past 12 months. Health insurance coverage is at the time of survey, and respondents can report multiple types of coverage. Private coverage includes employer-sponsored insurance, Marketplace plans, and other sources of private insurance. All those reporting any Medicaid coverage are classified as having Medicaid. Estimates do not sum to 100 percent because of a small share of new mothers with Medicare and/or Veterans Affairs health insurance coverage. * indicates change between 2019 and 2021 is significant at the $p < 0.05$ level.

Improvements in Coverage between 2019 and 2021 Were Largest among Some Subgroups of New Mothers Who Experienced High Rates of Uninsurance in 2019, but Stark Disparities Remained by Income, Race and Ethnicity, and Citizenship Status

Uninsurance rates among new mothers in 2019 varied by maternal demographic and socioeconomic characteristics. Younger new mothers were more likely to be uninsured in 2019, including more than 1 in 7 new mothers aged 19 to 24 (15.1 percent), compared with 11.0 percent of those aged 25 to 34 and 10.7 percent of those aged 35 to 44 (figure 3). New mothers with lower family incomes were also more likely to be uninsured than those with higher incomes, with 18.0 percent of those living in poverty and 17.7 percent of those with incomes between 100 and 250 percent of FPL reporting uninsurance in 2019, compared with 8.3 percent of those with family incomes 400 percent of FPL or higher.

FIGURE 3

Uninsurance Rates for New Mothers 19–44, by Maternal Age and Family Income, 2019 and 2021



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Source: Urban Institute analysis of American Community Survey data from the University of Minnesota Integrated Public Use Microdata Series USA, 2019 and 2021.

Notes: FPL= federal poverty level. New mothers are women ages 19 to 44 who are not living in group quarters and who reported giving birth in the past 12 months. Uninsured is at the time of survey. Income is based on Modified Adjusted Gross Income as a ratio relative to 100 percent of FPL. * indicates change between 2019 and 2021 is significant at the 0.05 level. † indicates difference from reference group (^) within a year is significant at the 0.05 level.

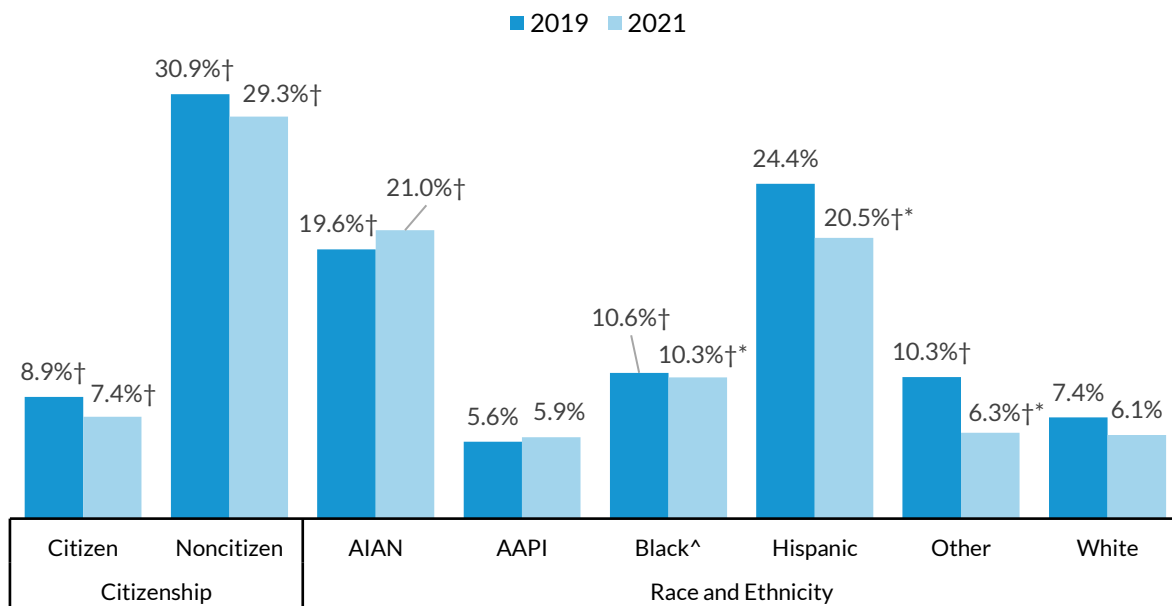
When considering differences by race and ethnicity, 19.6 percent of American Indian/Alaska Native (AIAN) new mothers²³ and 24.4 percent of Hispanic new mothers were uninsured in 2019, compared with 10.6 percent of Black new mothers, 10.3 percent of new mothers with other or multiple races, 7.4 percent of white new mothers, and 5.6 percent of Asian/Pacific Islander new mothers (figure 4). Noncitizen new mothers were over three times more likely than citizen new mothers to be uninsured (30.9 percent compared with 8.9 percent).

All age and income groups saw a statistically significant reduction in uninsurance between 2019 and 2021, except for those living in poverty, for whom 17.4 percent remained uninsured in 2021 (figure 3). New mothers aged 25 to 34 and 35 to 44 experienced declines in uninsurance from 11.0 and 10.7 percent in 2019, respectively, to 9.5 and 9.3 percent in 2021, while uninsurance among those ages 19 to 24 fell from 15.1 percent to 13.3 percent. For new mothers with family incomes between 100 and 250 percent of FPL, uninsurance fell from 17.7 percent in 2019 to 15.2 percent in 2021, a 2.5 percentage point decline. Considering race, ethnicity, and citizenship, only Hispanic new mothers, new mothers

with other or multiple races, white new mothers, and new mothers who are citizens experienced a decrease in uninsurance between 2019 and 2021 (figure 4). Declines were especially large for Hispanic new mothers and those with other or multiple races (4.0 and 4.1 percentage points, respectively). New mothers who were Black, Asian/Pacific Islander, or noncitizens did not experience significant changes in uninsurance during this period.

Despite a narrowing of uninsurance rates among several subgroups, differences by subgroup remained, with new mothers ages 19 to 24 experiencing higher rates of uninsurance than those who were 25 to 34 or 35 to 44 in 2021 (13.3 percent compared with 9.5 percent and 9.3 percent, respectively). Similarly, new mothers living in poverty remained more than twice as likely to be uninsured than new mothers with incomes of 400 percent of FPL or higher in 2021 (17.4 percent compared with 7.2 percent, respectively). Hispanic and AIAN new mothers retained the highest uninsurance rates by race/ethnicity in 2021²⁴ (20.5 and 21.0 percentage points, respectively). Noncitizen new mothers were almost four times more likely to be uninsured than citizen new mothers in 2021 (29.3 percent compared with 7.4 percent, respectively).

FIGURE 4
Uninsurance Rates for New Mothers 19–44, by Maternal Citizenship and Race/Ethnicity, 2019 and 2021



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Source: Urban Institute analysis of American Community Survey data from the University of Minnesota Integrated Public Use Microdata Series USA, 2019 and 2021.

Notes: FPL=federal poverty level; AIAN=American Indian/Alaska Native ; AAPI=Asian American/Pacific Islander; Other=Other and multiple races. All groups except Hispanic are non-Hispanic. New mothers are women ages 19 to 44 who are not living in group quarters and who reported giving birth in the past 12 months. Uninsured is at the time of survey. Income is based on

Modified Adjusted Gross Income as a ratio relative to 100 percent of FPL. * indicates change between 2019 and 2021 is significant at the 0.05 level. † indicates difference from reference group (^) within a year is significant at the 0.05 level.

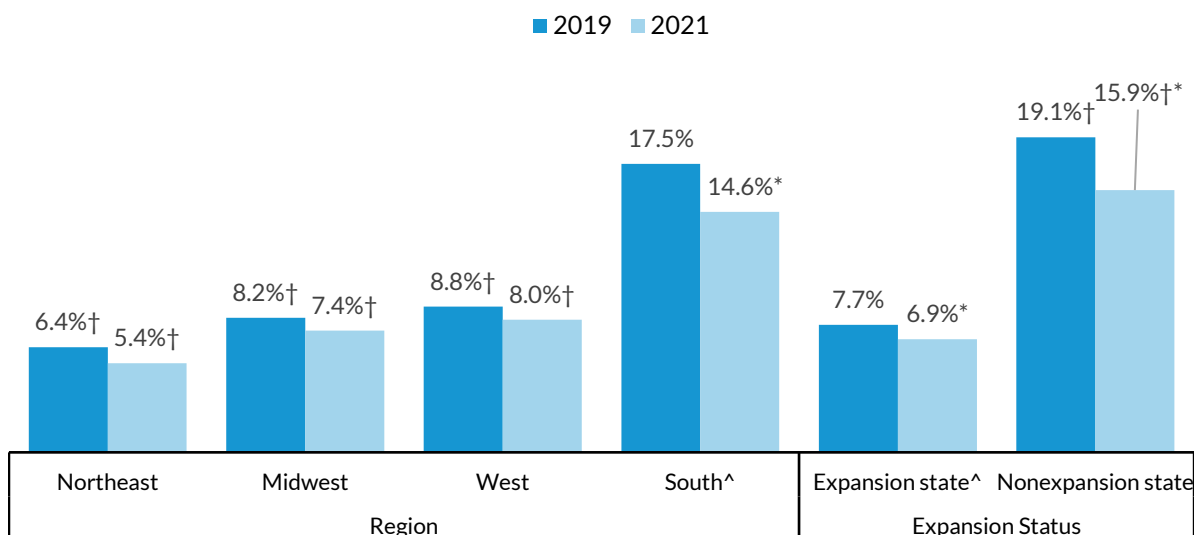
While Increases in New Mothers' Insurance Coverage between 2019 and 2021 Were Concentrated in Nonexpansion States and the South, New Mothers in Those States Continued to Be at Substantially Higher Risk of Being Uninsured in 2021

Stratifying states by their policies regarding Medicaid expansion under the ACA as of January 2021 and region reveals significant differences in patterns of uninsurance among new mothers in 2019 and changes between 2019 and 2021, though disparities in uninsurance across state groups persisted (figure 5). In 2019, states that had not expanded Medicaid eligibility under the ACA had rates of uninsurance that were almost two and a half times as high as among new mothers in Medicaid expansion states (19.1 percent compared with 7.7 percent, respectively). Relatedly, with most nonexpansion states in the South, new mothers in southern states also had much higher uninsurance rates than those in any other region (17.5 percent compared with 8.8, 8.2, and 6.4 percent in the West, Midwest, and Northeast, respectively).

Declines in uninsurance among new mothers between 2019 and 2021 somewhat narrowed differences in risks of uninsurance across state groups. Between 2019 and 2021, uninsurance among new mothers in nonexpansion states declined 3.2 percentage points to 15.9 percent, and uninsurance among new mothers in the South declined 2.9 percentage points to 14.6 percent, while expansion states and states in the other regions did not experience statistically significant changes. However, rates of uninsurance remained significantly higher in the South and nonexpansion states in 2021, with more than 1 in 7 new mothers in the South and nonexpansion states uninsured, compared with fewer than 1 in 12 in other states. New mothers living in nonexpansion states were 2.3 times more likely to be uninsured (15.9 percent) in 2021 than those living in states that had expanded Medicaid under the ACA (6.9 percent).

FIGURE 5

Uninsurance Rates for New Mothers 19–44, by Region and State Medicaid Expansion Status, 2019 and 2021



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Source: Urban Institute analysis of American Community Survey data from the University of Minnesota Integrated Public Use Microdata Series USA, 2019 and 2021.

Notes: New mothers are women ages 19 to 44 who are not living in group quarters and who reported giving birth in the past 12 months. Uninsured is at the time of survey. * indicates change between 2019 and 2021 is significant at the 0.05 level. † indicates difference between expansion and nonexpansion status is significant at the 0.05 level. Nonexpansion States include states that had not expanded Medicaid as of January 1, 2021: Alabama, Florida, Georgia, Kansas, Mississippi, Missouri, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming.

Table 1 presents estimates of uninsurance by state in 2019 and 2021 for the 35 states with sufficient sample size to assess rates for new mothers. In 2021, there was substantial state variation in uninsurance for new mothers among these states. Four states (Massachusetts, Michigan, Minnesota, and New York) had rates below 5 percent, while three states (Georgia, Oklahoma, and Texas) had rates above 15 percent, with the highest rate (23.8 percent) found in Texas, which accounted for over one in four of the nation's uninsured new mothers in 2021 (data not shown).

Among the 35 states with sufficient sample size to assess changes in coverage among new mothers between 2019 and 2021, seven experienced statistically significant declines in uninsurance.^{25,26} North Carolina and Mississippi—both nonexpansion states in the analysis period—experienced declines of about 8 percentage points (from 17.6 percent in 2019 to 9.2 percent in 2021 in North Carolina and from 19.4 percent in 2019 to 11.4 percent in 2021 in Mississippi), while Florida, Maryland, Ohio, South Carolina, and Texas experienced declines of over 3 percentage points. Some states with already high uninsurance rates in 2019 saw no significant change by 2021 during the continuous coverage provision, including Georgia, Missouri, and Nevada (17.2 percent, 13.4 percent, and 13.7 percent uninsured in 2021, respectively).

TABLE 1

Rates of Uninsurance for New Mothers Before and During the PHE by State, 2019 and 2021

| State | 2019 (percent) | 2021 (percent) | Change 2019–21 (percentage point) |
|----------------------|-------------------|-------------------|--------------------------------------|
| Alabama | 15.2 | 11.1 | -4.1 |
| Alaska | ‡ | ‡ | ‡ |
| Arizona | 13.6 | 10.3 | -3.3 |
| Arkansas | 7.9 | 11.5 | 3.7 |
| California | 6.9 | 7.0 | 0.1 |
| Colorado | 8.2 | 8.2 | 0.0 |
| Connecticut | 8.0 | 8.6 | 0.7 |
| Delaware | ‡ | ‡ | ‡ |
| District of Columbia | ‡ | ‡ | ‡ |
| Florida | 17.8 | 13.4 | -4.4 |
| Georgia | 16.9 | 17.2 | 0.3 |
| Hawaii | ‡ | ‡ | ‡ |
| Idaho | ‡ | ‡ | ‡ |
| Illinois | 7.5 | 9.2 | 1.6 |
| Indiana | 9.6 | 7.8 | -1.9 |
| Iowa | 6.0 | 5.9 | 0.0 |
| Kansas | 12.2 | 9.5 | -2.7 |
| Kentucky | 8.2 | 6.3 | -1.9 |
| Louisiana | 11.2 | 7.8 | -3.4 |
| Maine | ‡ | ‡ | ‡ |
| Maryland | 10.1 | 5.5 | -4.6 |
| Massachusetts | 3.4 | 1.9 | -1.5 |
| Michigan | 4.5 | 4.6 | 0.2 |
| Minnesota | 3.1 | 4.1 | 1.0 |
| Mississippi | 19.4 | 11.4 | -8.0 |
| Missouri | 14.0 | 13.4 | -0.6 |
| Montana | ‡ | ‡ | ‡ |
| Nebraska | ‡ | ‡ | ‡ |
| Nevada | 13.4 | 13.7 | 0.2 |
| New Hampshire | ‡ | ‡ | ‡ |
| New Jersey | 9.1 | 8.0 | -1.1 |
| New Mexico | ‡ | ‡ | ‡ |
| New York | 4.4 | 4.5 | 0.0 |
| North Carolina | 17.6 | 9.2 | -8.3 |
| North Dakota | ‡ | ‡ | ‡ |
| Ohio | 9.6 | 5.4 | -4.1 |
| Oklahoma | 23.8 | 19.4 | -4.4 |
| Oregon | 9.1 | 6.5 | -2.7 |
| Pennsylvania | 7.5 | 7.0 | -0.5 |
| Rhode Island | ‡ | ‡ | ‡ |
| South Carolina | 13.1 | 7.1 | -6.0 |
| South Dakota | ‡ | ‡ | ‡ |
| Tennessee | 11.0 | 10.7 | -0.3 |
| Texas | 27.1 | 23.8 | -3.3 |
| Utah | 10.7 | 10.8 | 0.0 |
| Vermont | ‡ | ‡ | ‡ |
| Virginia | 7.4 | 8.7 | 1.3 |
| Washington | 7.9 | 8.3 | 0.5 |
| West Virginia | ‡ | ‡ | ‡ |
| Wisconsin | 8.3 | 6.3 | -2.0 |
| Wyoming | ‡ | ‡ | ‡ |

Source: Urban Institute tabulations of American Community Survey data from the University of Minnesota Integrated Public Use Microdata Series USA, 2019 and 2021.

Notes: New mothers are women ages 19 to 44 who are not living in group quarters and who reported giving birth in the past 12 months. Uninsured is at the time of survey. * indicates change between 2019 and 2021 is significant at the $p < 0.05$ level. ‡ indicates state had insufficient sample size ($n < 250$) to report estimates.

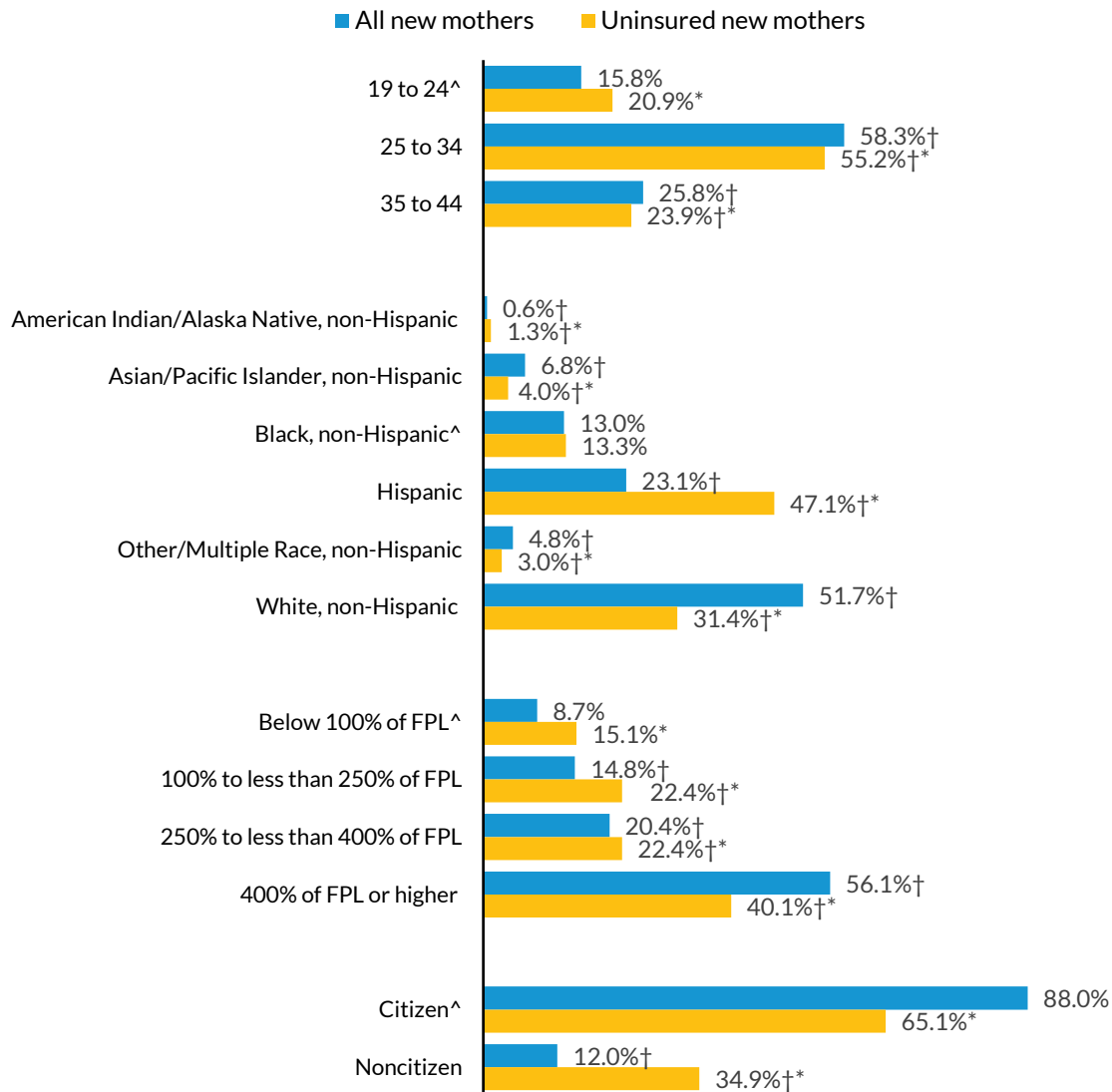
In 2021, Uninsured New Mothers Were Disproportionately Likely to Be Younger, to Be Hispanic, to Have Low Incomes, and to Be Noncitizens

The characteristics of new mothers who were uninsured in 2021 differ from the characteristics of new mothers overall. Consistent with higher uninsurance rates among younger new mothers, uninsured new mothers tended to be slightly younger than new mothers overall in 2021, with 20.9 percent of uninsured new mothers aged 19 to 25, compared with 15.8 percent of new mothers overall (figure 6). Not surprisingly, given the association of income and race/ethnicity with uninsurance rates described above, fewer uninsured new mothers had family incomes at 400 percent of FPL or higher than new mothers overall (40.1 percent compared with 56.1 percent, respectively), and a much larger share of uninsured new mothers were Hispanic compared with new mothers overall (47.1 percent and 23.1 percent, respectively).

Characteristics of uninsured new mothers also reveal information about their potential access to publicly subsidized health insurance coverage; just over 1 in 3 uninsured new mothers (34.9 percent) were noncitizens who are less likely to qualify for publicly supported coverage because of restrictions on Medicaid coverage by immigration status. Still, more than two-thirds of uninsured new mothers were citizens who do not face such barriers to eligibility. While uninsured new mothers had lower incomes than new mothers overall, 40.1 percent of uninsured new mothers had family incomes of 400 percent of FPL or higher, too high to qualify for Medicaid coverage. However, some may qualify for subsidies for Marketplace plans under recent subsidy extensions. Though Hispanic and AIAN new mothers had similarly high rates of uninsurance, nearly half of uninsured new mothers were Hispanic (47.1 percent), 31.4 percent were white, 13.3 percent were Black, and 1.3 percent were AIAN.

FIGURE 6

Socioeconomic and Demographic Characteristics of Uninsured New Mothers and All New Mothers 19–44, 2021



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Source: Urban Institute analysis of American Community Survey data from the University of Minnesota Integrated Public Use Microdata Series USA, 2021.

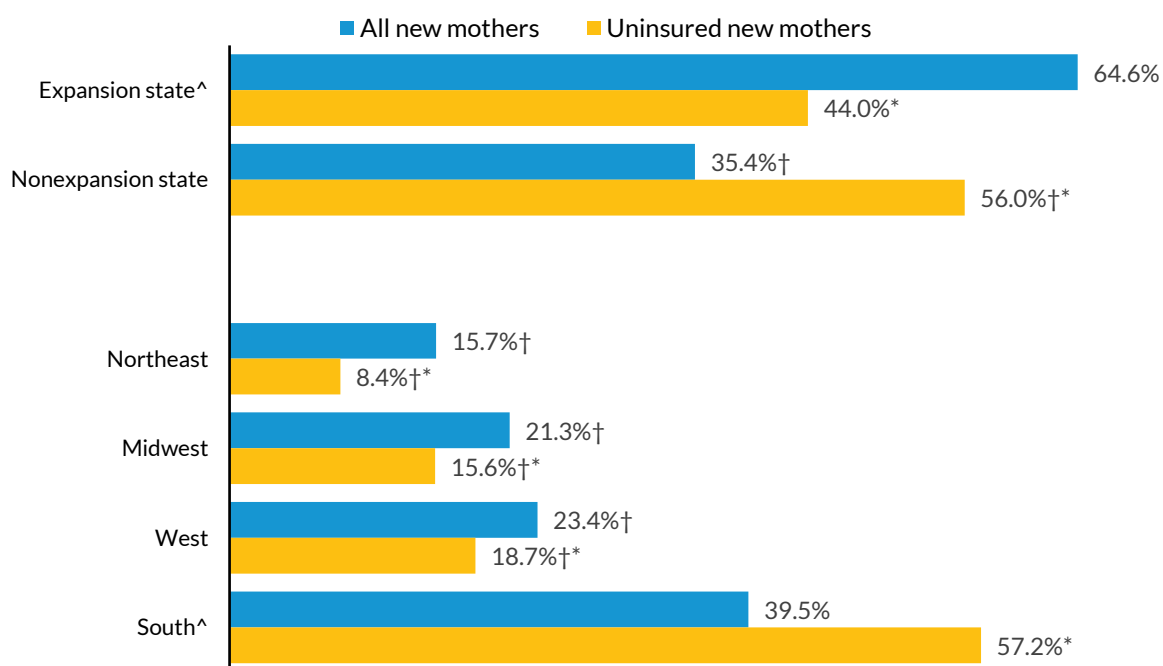
Notes: FPL=federal poverty level. New mothers are women ages 19 to 44 who are not living in group quarters and who reported giving birth in the past 12 months. Uninsured is at the time of survey. Income is based on Modified Adjusted Gross Income as a ratio relative to 100 percent of FPL. † indicates difference from reference group ([^]) is significant at the 0.05 level. * indicates difference between uninsured new mothers and all new mothers is significant at the 0.05 level. Nonexpansion States include states that had not expanded Medicaid as of January 1, 2021: Alabama, Florida, Georgia, Kansas, Mississippi, Missouri, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming.

More than Half of Uninsured New Mothers in 2021 Lived in Nonexpansion States and in the South

Uninsured new mothers were not evenly distributed by region and state Medicaid expansion status in 2021, and they were disproportionately likely to live in the South and nonexpansion states (figure 7). Fifty-six percent of uninsured new mothers lived in nonexpansion states, and 57.2 percent lived in the South, compared with 35.4 percent and 39.5 percent of new mothers overall living in those states, respectively.

FIGURE 7

State Characteristics of Uninsured New Mothers and All New Mothers 19–44, 2021



URBAN INSTITUTE

Source: Urban Institute analysis of American Community Survey data from the University of Minnesota Integrated Public Use Microdata Series USA, 2021.

Notes: FPL=federal poverty level. New mothers are women ages 19 to 44 who are not living in group quarters and who reported giving birth in the past 12 months. Uninsured is at the time of survey. Income is based on Modified Adjusted Gross Income (MAGI) as a ratio relative to 100 percent of FPL. † indicates difference from reference group (^) is significant at the 0.05 level. * indicates difference between uninsured new mothers and all new mothers is significant at the 0.05 level. Nonexpansion states include states that had not expanded Medicaid as of January 1, 2021: Alabama, Florida, Georgia, Kansas, Mississippi, Missouri, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming.

Discussion

After remaining relatively stable between 2016 and 2019, new mothers' uninsurance dropped by about 14 percent between 2019 and 2021 during a period of rising unemployment. At the same time, Medicaid coverage rose from 28.1 percent to 31.1 percent. We cannot attribute the drops in uninsurance among new mothers to the Medicaid continuous coverage requirement and other pandemic-related policy changes during this period. Still, the findings are consistent with a link to the continuous coverage requirement since we also find that new mothers experienced a comparable rise in Medicaid/CHIP coverage over the period. The patterns we observe in the ACS are also consistent with Medicaid administrative data, which indicate substantial increases in enrollment in the pregnancy-related eligibility category during this period, and with evidence from the Current Population Survey, which found less postpartum coverage loss in the year following a birth during this period (Eliaison, Daw, and Steenland 2022). At the same time, this period was associated with a rise in apparent misreporting of coverage type in household surveys (Hest, Lukanen, and Blewett 2022), and some enrollees who maintained postpartum coverage may have been unaware of their coverage extension. It will be critical that future studies assess changes in health care access and utilization among new mothers during this period (Johnston, Haley, and Thomas 2021). In addition, coverage patterns may have changed since 2021 under additional shifts, including any changes in awareness of the Medicaid continuous coverage requirement that may have occurred in 2022 and early 2023.

Though these findings suggest coverage benefits of the Medicaid continuous coverage requirement for new mothers, more than 1 in 10 new mothers were uninsured in 2021 despite the requirement being in place. Moreover, these gains in coverage will not necessarily be sustained, as the resumption of regular Medicaid renewal processes could put at risk the coverage gains that occurred (Clark 2023b). Maternal mortality, including during the postpartum period, rose during the pandemic from 20.1 deaths per 100,000 live births in 2019 compared with 32.0 in 2021 (Hoyert 2023). COVID-19 infection, associated with adverse outcomes for pregnant people (Matsuo et al. 2023), and other upheaval related to the pandemic, may have been contributing factors. The recent rise in maternal mortality raises the urgency of identifying policy changes that produce better maternal outcomes during the postpartum period (Hoyert 2023). Thus, in addition to minimizing coverage losses among new mothers during the unwinding period, it will be essential to support other efforts that promote greater access to and use of high-quality health care and related services for birthing people in the postpartum period. Policy solutions to support these goals include the following:

Careful Unwinding of Pandemic Protections

With extended enrollment in pregnancy-related Medicaid continuing to climb after 2021 (CMS 2022), many postpartum people are facing the resumption of renewals in 2023 and 2024 during the unwinding of the Medicaid continuous coverage requirement. There is concern that postpartum people could be at risk of being inappropriately disenrolled if they are no longer within their state's postpartum period and now qualify for Medicaid through a different pathway, such as parent or adult coverage, but are not transitioned to that coverage (Johnston, Haley, and Thomas 2021). Coverage loss risks are likely greater

in nonexpansion states given the fewer pathways to eligibility outside of pregnancy, with many low-income residents of nonexpansion states falling into the coverage gap (Haley et al. 2021a). In addition, other unwinding policies will likely be critical to minimize coverage losses in the postpartum period, including conducting outreach via a variety of modes, maximizing reliance on *ex parte* renewal processes that use electronic information available to the state to verify enrollees' eligibility, and supporting so-called "warm handoffs" to other coverage options, such as Marketplaces, to successfully transfer new mothers losing Medicaid eligibility to other coverage.²⁷ Equipping navigators, providers, community health workers, community-based organizations, and other social services agencies that support new parents and families (such as the Special Supplemental Nutrition Program for Women and Children and the Supplemental Nutrition Assistance Program agencies) with information and resources to support clients who may be undergoing coverage transitions will also be important.

Broad and Successful Implementation of Postpartum Extensions

With 35 states and the District of Columbia having already enacted 12-month postpartum Medicaid/CHIP extensions by August 1, 2023, and others planning to enact such extensions, coverage options for new mothers are expanding nationwide. But implementing the required technical changes and communicating the policy changes while handling the large upheavals associated with unwinding could mean that state staff is stretched thin, raising risks that some enrollees may not retain coverage for which they are eligible or learn about their eligibility for extended coverage. Prior research found that even in the prepandemic period, some uninsured new mothers who appeared to qualify for Medicaid were not enrolled (Johnston et al. 2021). Others who automatically maintained coverage under the continuous coverage provision appeared to be unaware they were still insured and could continue using Medicaid to access needed health services (Johnston, Haley, and Thomas 2021). It will be important that states enacting postpartum extensions ensure people are informed about their extended Medicaid/CHIP coverage and supported in using it to obtain needed health services. Such efforts could be especially critical in nonexpansion states, where eligibility increases under adoption of extensions would be larger on average and there are more limited coverage options for parents who are not pregnant—many in the coverage gap without access to any publicly supported coverage options (Haley, Johnston, et al. 2021).

Texas, the state that had the highest rate of uninsurance among new mothers in 2021, has yet to expand Medicaid under the ACA, but Texas lawmakers recently approved a postpartum extension that would need to be submitted to and approved by CMS.²⁸ However, the policy may be insufficient to dramatically reduce postpartum uninsurance in the state, as many immigrants in Texas would be excluded even under the implementation of a postpartum extension. The state has not taken up the federal option to cover all documented immigrants in comprehensive pregnancy-related Medicaid/CHIP, meaning they could not access extended postpartum coverage. And while the state has an unborn child CHIP program to provide limited coverage during the prenatal period and delivery regardless of a pregnant person's immigration status, such coverage would not be included in the state's postpartum extension.

Expanding Eligibility for Public Coverage outside of Pregnancy

Even with significant uninsurance declines among new mothers in nonexpansion states and the South during the pandemic, most uninsured new mothers were still living in those states. Expansion in the remaining 10 nonexpansion states would likely reduce uninsurance among new mothers and reach other low-income people of reproductive age, supporting access to care before and after pregnancy.

In 2021, almost 1 in 3 uninsured new mothers were noncitizens. But outside of pregnancy-related coverage, which is available for some immigrants (Haley, Johnston, et al. 2021), many immigrants with lawful status for fewer than five years and immigrants who are undocumented have no access to publicly subsidized insurance because of rules barring them from federally supported coverage. Research has found that even under postpartum extension in every state, nearly one-third of uninsured new mothers would be ineligible for Medicaid, CHIP, or subsidized Marketplace plans because of immigration-related eligibility restrictions that were in place in 2020 (Johnston et al. 2021). Some states are including immigrants in extensions or even funding state expansions to more adults regardless of immigration status.²⁹ But many will remain ineligible without the removal of restrictions on federal Medicaid funding for such individuals or use of state-funded efforts to expand eligibility for excluded immigrants.

Targeted Efforts to Connect Subgroups of New Mothers More Likely to Be Uninsured to Other Coverage

According to the ACS, Hispanic and AIAN new mothers remained much more likely than other racial and ethnic subgroups to be uninsured in 2021, consistent with evidence from before the pandemic (Johnston et al. 2019). With nearly half of uninsured new mothers being Hispanic, reductions in uninsurance may require both expansions in eligibility and multilingual, culturally effective outreach and enrollment efforts to better connect people with coverage for which they may be eligible. Strategies to help people with limited English proficiency maintain Medicaid coverage following the end of the continuous coverage requirement, including translated notices and multilingual assistance through call centers, may also be relevant for promoting continued coverage for Hispanic new mothers (Haldar et al. 2022). AIAN new mothers experienced high levels of uninsurance, though many classified as uninsured reported Indian Health Services (IHS) access. Additional strategies, such as strengthening partnerships with tribal organizations, would also help support AIAN enrollees, and the IHS could have an important role in maintaining connections to Medicaid given the extensive reliance on IHS services among AIAN new mothers.³⁰

We also find that more than 1 in 6 new mothers living in poverty remained uninsured in 2021 and that uninsurance among this group did not fall between 2019 and 2021, highlighting the need to better support those who may also be facing other financial hardships. In addition, some of the 4 in 10 uninsured new mothers with incomes above 400 percent of FPL may qualify for Marketplace premium tax credits recently extended to this income group. However, earlier research found limited awareness

of Marketplaces and available subsidies, suggesting outreach to moderate-income new mothers may be needed to better connect them to available plans (Haley and Wengle 2021).

Ensure Coverage Translates into Access to High Quality, Culturally Effective Care

Prior research has found that expanded coverage under the ACA improved new mothers' health care access, utilization, and affordability while reducing worries about paying for medical costs (McMorrow et al. 2020), consistent with gains experienced by women of reproductive age more generally (Daw and Sommers 2019). Some evidence suggests that extended coverage during the pandemic may have been associated with increased use of health services (Wang et al. 2022), though patterns of use of health services changed for many reasons during the pandemic (Gonzalez, Karpman, and Haley 2021; Gonzalez et al. 2021). Further research will be needed to assess whether declines in uninsurance observed in the ACS were associated with changes in health care access, use, and affordability and to assess the access, use, and affordability impacts of future policies, such as postpartum extensions. Promoting access to care for those who maintain Medicaid/CHIP eligibility under postpartum extensions will require alleviating barriers to care related to transportation, child care, and work; ensuring sufficient culturally effective providers to meet demand; and informing enrollees about their extended coverage so they can use it (Johnston, Haley, and Thomas 2021).

Moreover, though we found that Hispanic new mothers, white new mothers, and new mothers of additional or multiple races experienced declines in uninsurance between 2019 and 2021, the rate for their counterparts who were Black, Asian/Pacific Islander, or AIAN did not change. In 2021, 1 in 10 Black new mothers and 1 in 5 Hispanic and AIAN new mothers remained uninsured. Other research finds that racial disparities in maternal outcomes persisted and grew during the pandemic (Hoyert 2023). Additional efforts will be needed to reduce the harms that derive from structural racism and from the barriers Black and AIAN people face accessing high-quality, culturally effective care given their higher risks of adverse maternal outcomes (Taylor et al. 2019). Federal efforts, such as the Blueprint for Addressing the Maternal Health Crisis and Momnibus, and state-level efforts such as including doula services as covered Medicaid benefits, which have been associated with improving birth experiences and outcomes for people of color, are among initiatives currently being considered (White House 2022).³¹

Conclusion

Coverage among new mothers increased by 14 percent between 2019 and 2021, following relative stability between 2016 and 2019. Corresponding increases in Medicaid coverage during the same period indicate that declines in uninsurance may be due, in part, to the Medicaid continuous coverage provision implemented in March 2020. Coverage improved the most for new mothers living in the South, new mothers living in nonexpansion states, Hispanic new mothers, and new mothers with family incomes between 100 and 250 percent of FPL, though these subgroups still had among the highest rates of uninsurance in 2021. Coverage is likely to continue to vary across states, with new mothers in nonexpansion states likely at higher risk. But 1 in 10 new mothers were uninsured in 2021, and gains in

health insurance coverage for new mothers may be at risk as state Medicaid programs unwind pandemic protections like the continuous coverage requirement, highlighting the need for targeted efforts to connect postpartum populations to coverage and ensure their health needs are met.

Appendix A. Data and Methods

We use American Community Survey (ACS) data from 2016 to 2019 and 2021 to examine trends in uninsurance among new mothers, focusing primarily on changes between 2019 and 2021 to assess patterns just before and during the COVID-19 pandemic and Medicaid continuous coverage requirement. The ACS is a nationally representative survey conducted annually by the US Census Bureau, and we obtained the data from the University of Minnesota Integrated Public Use Microdata Series.³² We exclude data from 2020 because of the COVID-19 pandemic's impact on data collection for the 2020 ACS, which affected its validity and reliability such that the US Census Bureau declared 2020 ACS data should not be used for analysis (Daily et al. 2021).³³

We limit our sample to adult women of reproductive age (19 to 44) who reported giving birth in the past year and do not live in group quarters. Uninsurance refers to lacking health insurance coverage at the time of the survey. In prior work, we have applied a set of coverage edits to account for apparent misreporting of coverage in the ACS (Johnston et al. 2019; McMorrow et al. 2018), but because of changes to Medicaid eligibility under the continuous coverage requirement, these edits are not applicable for the 2021 data year. For consistency when measuring changes over time, we also do not apply coverage edits to the 2016 through 2019 data. Therefore, estimates of uninsurance among new mothers presented here may differ from previously published reports using data that incorporate such edits.

We first investigate differences in the number and share of uninsured new mothers during the 2016 to 2019 period and when comparing 2019 and 2021. We further assess changes in rates of uninsurance among new mothers by socioeconomic and demographic subgroups, including income relative to the FPL for each person's health insurance unit using an approach developed by the State Health Access Data Assistance Center (SHADAC 2021). Next, we assess changes in uninsurance rates by expansion of Medicaid under the ACA (Medicaid expansion). We classify the 36 states and the District of Columbia that had expanded Medicaid under the ACA by January 1, 2021, as expansion states, and all others as nonexpansion states.³⁴ We also describe changes in uninsurance between 2019 and 2021 by state, though we can only assess such changes in 35 states because of sample size limitations. We suppressed state-level rates of uninsurance among new mothers for states with unweighted sample sizes of fewer than 250 new mothers. Finally, we assess the socioeconomic, demographic, and state policy characteristics of uninsured new mothers in 2021 and compare these characteristics with those of all new mothers. When examining differences in uninsurance rates between 2019 and 2021 and between groups of new mothers, we use two-tailed t-tests to determine whether the estimates were statistically different from zero ($p < 0.05$ level).

This study has several limitations. First, cross-sectional estimates do not reflect causal effects of the Medicaid continuous coverage requirement on insurance coverage for new mothers because they do not account for other factors that may have affected coverage, such as changes in employment patterns and other factors related to the pandemic and associated economic shifts.

Second, the presence and type of health insurance coverage is likely measured with error. The structure of the survey question and response options, household composition and the flow of the survey, understanding of health insurance, and imputation of missing data can all contribute to misreporting of coverage status in household surveys such as the ACS (Boudreaux et al. 2015). Other analysis has found that the ACS undercounts Medicaid coverage compared with administrative data, and that the undercount increased in 2021 compared with earlier years (Hest, Lukanen, Blewett 2022). Thus, the estimates here may overstate the number and share of uninsured new mothers if some who report uninsurance are misreporting Medicaid coverage. However, we have no reason to believe that misreporting of Medicaid coverage would change the direction of reductions in uninsurance between 2019 and 2021 or change patterns of differences in insurance coverage between groups.

Third, rates of uninsurance for AIAN new mothers and for states with larger populations of AIAN new mothers are sensitive to consideration of Indian Health Services (IHS) coverage. In this brief, and by convention, reporting IHS as the sole source of coverage is considered uninsurance. We also considered alternative estimates if exclusive IHS access was classified as coverage when presenting uninsurance rates for AIAN new mothers and across states and noted any differences in findings.

Fourth, the ACS count of new mothers ages 19 to 44 is slightly higher in both 2019 and 2021 than the Centers for Disease Control and Prevention (CDC) count of births and National Health Interview Survey estimates for the count of births for the same age range of new mothers (data not shown; tables available upon request from the authors). The ACS also shows an increase of 100,000 births between 2019 and 2021, while the CDC count of births shows a decrease of about 70,000 births in the same period (Martin et al. 2018a; 2018b; 2019; 2021; Osterman et al. 2023). Because of these inconsistencies between data sources on the number of births each year, we focus on rates of uninsurance rather than counts of uninsured people in this analysis.

Fifth, fertility status on the ACS includes some imputed values, generally 8 to 9 percent between 2017 and 2019, and in 2021 the percent of imputed observations increased to 12.6 percent.³⁵ In addition, we analyze characteristics of uninsured new mothers in 2021 to inform efforts to connect uninsured new mothers with available coverage. However, coverage patterns are likely to shift in the 2023–24 period as states resume Medicaid redetermination processes following expiration of the continuous coverage requirement, so the number and characteristics of uninsured new mothers are very likely to have shifted since 2021. We do not capture mothers not living with their children at the time of the survey nor parents who may identify as mothers but who were not identified as female on the survey. Moreover, we may identify some parents who do not identify as mothers in our sample if identification as a female parent is not synonymous with motherhood. Finally, all survey responses are subject to recall and social desirability biases and thus may contain measurement error.

Additional analysis on changes in uninsurance between 2019 and 2021 and the distribution of uninsured new mothers across states from the ACS and comparisons of ACS estimates with those from other data sources are available from the authors upon request.

Notes

- ¹ National Center for Health Statistics, “National Vital Statistic System: Birth Data,” Atlanta: CDC, <https://www.cdc.gov/nchs/nvss/births.htm>.
- ² The Consolidated Appropriations Act of 2023, signed into law on December 29, 2022, delinked FFCRA’s continuous coverage provision from the PHE, and allowed states to resume redetermination processes as early as April 1, 2023; Jennifer Tolbert and Meghana Ammula, “10 Things to Know About the Unwinding of the Medicaid Continuous Enrollment Provision,” San Francisco: KFF, <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-provision/>.
- ³ Maggie Clark and Aubrianna Osorio, “Medicaid Pregnancy Coverage Fills a Critical Health Insurance Gap During Pandemic, Data Shows.” *Say Ahhh!* (blog), Georgetown Center for Children and Families, March 31, 2022, <https://ccf.georgetown.edu/2022/03/31/medicaid-pregnancy-coverage-fills-a-critical-health-insurance-gap-during-pandemic-data-shows/>.
- ⁴ In this brief, we consider states to have “enacted” a postpartum coverage extension when both state and federal policymakers have approved the extension and states can begin extending coverage immediately (either SPA approval confirmation from CMS and the effective date, OR the letter approving an amendment to the states’ 1115 waiver), based on “Medicaid Postpartum Coverage Extension Tracker,” San Francisco: KFF, <https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/>; States categorized as “planning to implement a 12-month extension” are not considered states that have “enacted” a postpartum Medicaid coverage extension.
- ⁵ “Medicaid Postpartum Coverage Extension Tracker,” KFF (blog), June 15, 2023, <https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/>.
- ⁶ US Congress, House, [Consolidated Appropriations Act of 2023](#), HR 2617, 117th Cong., introduced in House April 16, 2021.
- ⁷ Throughout this report, we strive to use inclusive pregnancy-related language to reflect the diverse identities of people who get pregnant and use pregnancy and postpartum care. When discussing the analysis, we use the terms “women” and “mothers” to describe people who recently gave birth to align with the language in the Social Security Act, which defines Medicaid eligibility for pregnant and postpartum women, and language in the ACS, which defines sex as “female” or “male.” But we acknowledge that not all people who become pregnant or give birth identify as women. We remain committed to using respectful, inclusive language.
- ⁸ This CHIP state plan amendment option allows states to cover low-income children between conception and birth, effectively offering prenatal care and delivery for pregnant people who fall below income thresholds regardless of their immigration status. People with unborn child CHIP coverage would not be eligible for 12-month extensions of comprehensive Medicaid/CHIP without additional state efforts to cover this population.
- ⁹ “Health Coverage and Care of Immigrants,” KFF (blog), December 20, 2022, <https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-and-care-of-immigrants/>.
- ¹⁰ “Health Coverage and Care of Immigrants.”
- ¹¹ “Affordable coverage,” Centers for Medicare & Medicaid Services, accessed August 24, 2023, <https://www.healthcare.gov/glossary/affordable-coverage/#:~:text=In%202023%2C%20a%20job%2Dbased,meet%20the%20minimum%20value%20standard.>
- ¹² US Congress, House, [Consolidated Appropriations Act of 2023](#), HR 2617.

- ¹³ CMS (Centers for Medicare & Medicaid Services), “March 2023 Medicaid and CHIP Enrollment Trends Snapshot,” accessed August 28, 2023.
- ¹⁴ Maggie Clark, “Permanent Medicaid Postpartum Coverage Option, Maternal Health Infrastructure Investments in 2022 Year-End Omnibus Bill,” *Say Ahhh!* (blog), Georgetown Center for Children and Families, January 4, 2023, <https://ccf.georgetown.edu/2023/01/04/permanent-medicaid-postpartum-coverage-option-maternal-health-infrastructure-investments-in-2022-year-end-omnibus-bill/>.
- ¹⁵ “Medicaid Postpartum Coverage Extension Tracker.”
- ¹⁶ States which enacted a postpartum Medicaid extension as of April 1, 2023, include Alabama, California, Colorado, Connecticut, the District of Columbia, Florida, Georgia, Hawaii, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Virginia, Washington, and West Virginia. Those without such extensions as of April 1, 2023, include Alaska, Arizona, Arkansas, Delaware, Idaho, Iowa, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New York, Rhode Island, South Dakota, Texas, Utah, Vermont Wisconsin, and Wyoming; “Medicaid Postpartum Coverage Extension Tracker.”
- ¹⁷ “Medicaid Postpartum Coverage Extension Tracker.”
- ¹⁸ The Consolidated Appropriations Act of 2023 also included 12-month continuous eligibility for children enrolled in Medicaid/CHIP, effective January 1, 2024; Clark, “Permanent Medicaid Postpartum Coverage Option, Maternal Health Infrastructure Investments in 2022 Year-End Omnibus Bill.”
- ¹⁹ Maggie Clark, “Medicaid Unwinding Risks Maternal Health Coverage Gains During Pandemic,” *Say Ahhh!* (blog) Georgetown Center for Children and Families, March 3, 2023, <https://ccf.georgetown.edu/2023/03/03/medicaid-unwinding-risks-maternal-health-coverage-gains-during-pandemic/>.
- ²⁰ Though we observed small changes in uninsurance between 2016 and 2019 among new mothers, they were not statistically significant. Other studies demonstrated increases in uninsurance for parents and children in the same period (Haley et al. 2021b), suggesting that smaller sample sizes (and thus slightly less precise estimates) for new mothers could be one of the reasons for the lack of statistical significance.
- ²¹ As noted in Appendix A, we exclude data from 2020 because of the COVID-19 pandemic’s impact on data collection for the 2020 ACS which affected its validity and reliability such that the US Census Bureau declared 2020 ACS data should not be used for analysis (Daily et al. 2021); Ceci A. Villa Ross, Hyon B. Shin, and Matthew C. Marlay, “Pandemic Impact on 2020 American Community Survey 1-Year Data,” *Random Samplings* (blog), United States Census Bureau, October 27, 2021, <https://www.census.gov/newsroom/blogs/random-samplings/2021/10/pandemic-impact-on-2020-ac-s-1-year-data.html>.
- ²² Information on the estimated numbers of uninsured new mothers is available upon request from the authors; however, these results should be interpreted with caution given differences in counts of new mothers and births between data sources and over time.
- ²³ Estimates of uninsurance for AIAN new mothers are sensitive to the treatment of Indian Health Services (IHS) access; by convention, exclusive reliance on IHS is considered uninsurance. The uninsurance rate among AIAN new mothers would drop from 19.6 to 5.6 percent in 2019 if exclusive IHS access were considered coverage (data not shown).
- ²⁴ The uninsurance rate among AIAN new mothers would drop from 21.0 to 3.2 percent in 2021 if exclusive IHS access were considered coverage (data not shown). The change in uninsurance among AIAN new mothers was not statistically significant when considering exclusive reliance on IHS as uninsurance nor when considering exclusive reliance on the IHS as coverage.
- ²⁵ Some state estimates of insurance coverage are sensitive to the treatment of IHS access, particularly for states with large shares of AIAN new mothers. Exclusive reliance on IHS access is, by convention, treated as uninsurance. If classifying IHS access as coverage, uninsurance in Oklahoma would drop from 23.8 to 20.5 percent in 2019 and from 19.4 to 15.5 percent in 2021, but the change would not be statistically significant in either approach. Differences in all other states with and without defining IHS-only coverage as uninsurance were smaller, varying by less than one percentage point. For all states, the magnitude and statistical significance of

changes between 2019 and 2021 were similar (differing by less than a percentage point). However, because of small sample sizes, these estimates should be treated with caution.

- ²⁶ Among the 50 states and the District of Columbia, 16 states did not have sufficient sample size to report uninsurance rates among new mothers between 2019 and 2021: Alaska, Delaware, District of Columbia, Hawaii, Idaho, Maine, Montana, Nebraska, New Hampshire, New Mexico, North Dakota, Rhode Island, South Dakota, Vermont, West Virginia, and Wyoming.
- ²⁷ “50-State Unwinding Tracker,” Georgetown Health Policy Institute Center for Children and Families, April 1, 2023, accessed August 24, 2023, <https://ccf.georgetown.edu/2023/04/01/state-unwinding-tracker/>.
- ²⁸ Bettie Cross, “Texas Extends Postpartum Medicaid Coverage to 12 Months,” *CBS Austin*, June 17, 2023, <https://cbsaustin.com/news/local/texas-extends-postpartum-medicaid-coverage-to-12-months-house-bill-12-governor-greg-abbott-young-invincibles-legislation-tx-lege-children-babies>.
- ²⁹ “Health Coverage and Care of Immigrants.”
- ³⁰ “Unwinding Guidance & Resources,” Centers for Medicare & Medicaid Services, accessed July 27, 2023, <https://www.cms.gov/aian-unwinding>.
- ³¹ Tomas Guarnizo, “Doula Services in Medicaid: State Progress in 2022.” *Say Ahhh! (blog) Georgetown Center for Children and Families*, June 2, 2022, <https://ccf.georgetown.edu/2022/06/02/doula-services-in-medicaid-state-progress-in-2022/>.
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- ³³ Villa Ross et al., “Pandemic Impact on 2020 American Community Survey 1-Year Data.”
- ³⁴ Nonexpansion states as of January 1, 2021, include Alabama, Florida, Georgia, Kansas, Mississippi, Missouri, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming; Status of “State Medicaid Expansion Decisions: Interactive Map,” Kaiser Family Foundation, accessed August 24, 2023, <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>.
- ³⁵ “Item Allocation Rates,” United States Census Bureau, accessed June 20, 2023, <https://www.census.gov/acs/www/methodology/sample-size-and-data-quality/item-allocation-rates/>.

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