

Ensuring Continuous Coverage for Pregnant and Postpartum Medicaid Enrollees Under OBBBA

Laura Barrie Smith, Jennifer M. Haley, Eva H. Allen, and Genevieve M. Kenney

March 2026

Medicaid and the Children’s Health Insurance Program (CHIP) are key sources of health insurance coverage for pregnant and postpartum women,¹ covering over 4 in 10 of all births in the US (CMS 2024a). States must provide women who are enrolled in the programs continuous coverage throughout pregnancy, delivery, and at least 60 days postpartum, regardless of changes in income and without requiring eligibility redetermination.² Moreover, in the 49 states plus the District of Columbia that have extended postpartum coverage, the continuous coverage period lasts for a full year after the end of pregnancy.³ Although many pregnant and postpartum Medicaid enrollees are enrolled in a pregnancy-related eligibility pathway, some have coverage through other eligibility pathways, including the Affordable Care Act (ACA) expansion category. The 2025 budget reconciliation law, the One Big Beautiful Bill Act (OBBBA), introduced changes to Medicaid expansion coverage scheduled to begin in January 2027, requiring that expansion enrollees and applicants satisfy new work requirements and undergo more frequent eligibility redeterminations.⁴ Although the law exempts pregnant and postpartum women enrolled in the ACA expansion pathway from OBBBA’s work requirements, and pregnant and postpartum women are not subject to

semiannual eligibility checks because of pregnancy- and postpartum-related continuous coverage requirements, they could still be at risk of disenrollment if, in practice, state Medicaid agencies inadvertently subject them to the work requirements or semiannual redeterminations. Loss of coverage for pregnant and postpartum women could, in turn, compromise their health and health care access and cause financial and emotional hardship for them and their families.

In this brief, we assess how many pregnant and postpartum women may be at risk of coverage losses under OBBBA, analyzing 2022 Medicaid claims data from 36 of the 37 states (including DC) that had expanded coverage under the ACA by 2022.⁵ We also draw on existing literature and stakeholder interviews with Medicaid policy experts, maternal health advocates, and state Medicaid officials to identify challenges states may face in ensuring continuous coverage for pregnant and postpartum enrollees under OBBBA, as well as potential solutions.⁶

Our key findings are as follows:

- Among Medicaid enrollees who gave birth in 36 expansion states in 2022, 15.6 percent, or over 137,000 individuals, were in the ACA expansion category during the month they delivered, and 15.9 percent were in the expansion category six months following delivery. This share was even higher six months prior to delivery (23.8 percent in the expansion category).
- The share of enrollees in the expansion category during and after pregnancy varied considerably across expansion states. For instance, during the month of delivery, the share ranged from below 3 percent in Rhode Island (2.7 percent) and Utah (0.9 percent) to nearly 40 percent or higher in Louisiana (39.9 percent) and Montana (43.0 percent).
 - » Enrollees in California, Kentucky, Louisiana, New York, and Pennsylvania represented nearly half of all enrollees in the expansion category during the month of delivery.
- Historically, states have not needed to proactively track pregnancy among expansion enrollees, which could hinder their ability to automatically exempt pregnant and postpartum women from OBBBA's work requirements and more-frequent redeterminations. States also currently lack guidance from the Centers for Medicare & Medicaid Services (CMS) on how to ensure that pregnant and postpartum women do not inadvertently become subject to work requirements and semiannual eligibility checks.

The following actions and strategies could help Medicaid programs ensure continuous coverage of pregnant and postpartum expansion enrollees under OBBBA:

- State Medicaid agencies could make timely use of claims and encounter data to identify enrollees with pregnancy-related exemptions from work requirements, such as by requiring managed care plans to submit encounter data within a certain number of days and report pregnancy status directly to the agency.

- States could increase their rates of ex parte renewals and improve renewal processes, including by ensuring that enrollees can self-report pregnancy or postpartum status during renewal.
- State agencies could educate enrollees, providers, and other key maternal health stakeholders about OBBBA's changes to Medicaid eligibility and pregnant and postpartum women's entitlement to continuous coverage in Medicaid without semiannual redeterminations and their exemption from work requirements.
- CMS could release guidance on how states can ensure continuous coverage of pregnant and postpartum enrollees, such as under what conditions states may automatically transition pregnant and postpartum enrollees to the pregnancy eligibility category to eliminate the need for establishing exemptions from work requirements and suspending renewals during the perinatal period.⁷
- CMS could also update state enrollment reporting requirements to add timely public reporting on how OBBBA eligibility and redetermination processes are affecting enrollment and disenrollment, including reporting on pregnancy-related and postpartum exemptions from work requirements and enrollment changes among pregnant and postpartum women and other vulnerable populations.

Our findings suggest that pregnant and postpartum women with expansion coverage could be at risk of inappropriate disenrollment from Medicaid as work requirements and semiannual redeterminations become effective on January 1, 2027, which could threaten their coverage and access to health care during a crucial period in their lives. The following sections provide background about Medicaid coverage for pregnant and postpartum women and the relevant changes under OBBBA, describe our data and methods, present findings from our analysis of Medicaid claims data and from key informant interviews, and highlight strategies policymakers and maternal health stakeholders could consider to ensure continuous coverage of pregnant and postpartum women under OBBBA.

Background

Medicaid's Role During Pregnancy and the Postpartum Period

Pregnancy-related Medicaid/CHIP income eligibility is higher than other eligibility pathways for parents or other adults,⁸ with a median upper-income limit of 213 percent of the federal poverty level (FPL) compared with a median of 138 percent of FPL for adults in states that have adopted the ACA Medicaid expansion and a median of 29 percent of FPL for adults in nonexpansion states (Brooks et al. 2025).⁹ In addition, pregnant and postpartum women who qualify for Medicaid/CHIP are entitled to continuous coverage throughout the perinatal period. Since 1990, legislation has required that states provide continuous coverage for women throughout pregnancy and through the 60-day postpartum period, regardless of changes in income or assets.¹⁰ More recent federal legislation allows states to extend postpartum Medicaid/CHIP for a full year after the end of pregnancy for people who were

enrolled while pregnant.¹¹ Forty-nine states and the District of Columbia have adopted the postpartum extension as of March 2026.¹²

Medicaid programs enroll beneficiaries into different eligibility categories based on their characteristics and income.¹³ Major eligibility categories include children, pregnant women, parents, people with disabilities, low-income elderly people, and the ACA expansion for low-income adults. Women who identify their pregnancy when applying for coverage should be enrolled in the pregnancy-related eligibility category, but states are not required to change an enrollee's eligibility category when a person already enrolled in Medicaid under a different eligibility category becomes pregnant.¹⁴ Some states redetermine eligibility pathways when they become aware of enrollees' pregnancy and move them into the pregnancy-related pathway, which could provide them with more comprehensive benefits, such as dental coverage.¹⁵ Depending on the extent of data lags and other processes for identifying pregnancy, these transitions to the pregnancy category could occur at any point during pregnancy, at delivery, or during the postpartum period. Other states may choose to keep pregnant enrollees in their existing eligibility group, potentially because a pregnancy-triggered eligibility review could pose a risk of disenrollment and, in the case of the expansion category, because ACA expansion enrollees are eligible for enhanced federal matching payments relative to other eligibility pathways. CMS guidance indicates that either approach is permissible as long as states ensure continuous coverage and full pregnancy-related benefits for pregnant and postpartum enrollees, regardless of coverage pathway.¹⁶

States vary in their approaches to transitioning pregnant and postpartum enrollees between eligibility categories. A recent analysis of 2018 data across both expansion and nonexpansion states revealed that just over half (56.2 percent) of all Medicaid/CHIP-covered births were to individuals enrolled in pregnancy-related pathways, with the remainder enrolled in the parental category (29.5 percent), Medicaid expansion (8.2 percent), and other categories (6.1 percent) (Gordon et al. 2025). Furthermore, the study found considerable variation among the ACA expansion states in the share of 2018 births to enrollees in the Medicaid expansion category, ranging from 1.3 percent in Massachusetts to nearly half (49.3 percent) in Montana (Gordon et al. 2025).

Policy Changes Under OBBBA for ACA Medicaid Expansion Coverage

As described above, the 2025 budget reconciliation legislation introduced new semiannual redeterminations and work requirements for enrollees and applicants in the ACA expansion eligibility category (as well as some enrollees in nonexpansion states like Georgia and Wisconsin who adopted limited expansions through waiver programs) starting January 1, 2027.¹⁷ Under OBBBA, expansion coverage will be restricted to those who are identified as working or performing other qualifying activities at least 80 hours per month, unless they are exempt based on characteristics such as medical frailty, parenting children younger than age 14, pregnancy, or being eligible for postpartum coverage. In addition, OBBBA mandates eligibility redeterminations every six months for all expansion enrollees, effective January 1, 2027, in place of the annual redeterminations that were previously required for nonpregnant, nondisabled adults. Work requirements and more frequent eligibility redeterminations

are anticipated to lead to declines in Medicaid expansion enrollment (Buettgens et al. 2026a, 2026b). Prior research has identified the importance of states using existing data sources (such as those related to earnings and medical conditions) to automatically deem enrollees compliant or exempt to minimize the number of enrollees who would have to take action to prove their compliance or exemption, which places them at a high risk of disenrollment (Karpman et al. 2025). More frequent redeterminations also pose a risk of procedural disenrollment because of issues like difficulty reaching enrollees and administrative issues, such as missing paperwork or missed deadlines.¹⁸

As noted, the OBBBA statute exempts pregnant women and those eligible for postpartum coverage from the work requirement. Though the legislation does not list exceptions to semiannual redeterminations, pregnant and postpartum enrollees are entitled to continuous coverage throughout pregnancy and the postpartum period under preexisting laws.¹⁹ Nevertheless, expansion enrollees who are pregnant and postpartum are at risk of coverage loss under both of these provisions if they are not promptly identified as such in state data systems and flagged as exempt or moved to pregnancy-related or parental eligibility categories.²⁰

Data and Methods

Medicaid Claims Data Analysis

We used data from the 2021–2023 T-MSIS Analytic Files (TAF), which contain standardized enrollment and eligibility records, demographic characteristics, and claims and encounter records for all Medicaid/CHIP enrollees in all states. Following prior literature, we identified enrollees with live-birth deliveries covered by Medicaid in 2022 (Auty et al. 2024). For each enrollee, we observed their Medicaid enrollment status and eligibility group code during the month of delivery, as well as six months prior to delivery and six months following delivery. We classified eligibility group codes into five categories: expansion, pregnancy, parent, other eligibility category (including enrollees with births covered by CHIP), and not enrolled.²¹

Our analytic sample included enrollees with 2022 deliveries in 36 states that had adopted ACA Medicaid expansion as of January 2021 (Illinois was excluded because of previously documented eligibility group code data quality issues).²² We calculated the number and share of enrollees in each eligibility category during three perinatal time periods: six months prior to delivery, the month of delivery, and six months following delivery. We assessed state variation in the share of enrollees in the expansion category at each time period, and we tabulated the characteristics of enrollees in the expansion category, including age group (based on age at delivery), rurality (defined according to zip code of residence at delivery),²³ and diagnosed health conditions or complications during pregnancy/birth. These conditions and complications were limited to diagnosed issues recorded on claims within six months leading up to or during delivery and included preexisting (nongestational) hypertension, diabetes, or obesity; behavioral health conditions (substance use disorder,

anxiety/depression/mood disorders, and other mental/behavioral health conditions); preterm birth; cesarean section; and other pregnancy/delivery complications (Smith et al. 2025).

Key Informant Interviews

In January and February 2026, we conducted six semistructured interviews with 11 key informants and exchanged email correspondence with one additional informant representing Medicaid policy experts, maternal health advocates, and state Medicaid eligibility officials to explore policies and practices guiding pregnancy and postpartum coverage for Medicaid enrollees in the expansion category. Topics included data sources and systems states are or could be using to identify pregnant enrollees in the expansion category, policies and procedures for transitioning pregnant and postpartum enrollees into the pregnancy-related eligibility category, implementation of postpartum extensions, states' plans for implementing OBBBA work requirements and semiannual eligibility checks, and information gaps and research needs to monitor implementation of OBBBA and its effects on pregnant and postpartum individuals. We then conducted a thematic analysis of the interview notes to identify common themes and key insights. We also reviewed available CMS guidance and policy materials related to pregnancy and postpartum coverage in Medicaid and CHIP.

Limitations

The findings from our analysis of TAF data reflect eligibility patterns for enrollees with Medicaid-paid deliveries in 2022, as this was the most recent year TAF data are available to observe enrollees through 12 months postpartum. However, patterns from this study period may not represent what we could expect to see for deliveries in 2027, when OBBBA work requirements and semiannual redeterminations take effect. For example, the COVID-19 public health emergency's continuous coverage provision, which prohibited states from disenrolling enrollees between early 2020 and early 2023, was still in effect during our study period, so some states may not have moved enrollees across eligibility categories in the same way that they would have absent the continuous coverage provision. Thus, the distribution of pregnant and postpartum enrollees across eligibility categories may not reflect patterns observed in a typical year. It is also possible that, absent the continuous coverage requirement, some enrollees would have lost their eligibility and therefore been disenrolled. However, prior analyses of 2018 deliveries (before the continuous coverage requirement) showed similar shares of enrollees in the expansion category during the delivery month as we find in 2022 (Gordon et al. 2025). In addition, eligibility category patterns in our data during the postpartum period may not reflect future patterns because many states' 12-month postpartum extensions were taking effect on a rolling basis during our study period, which may impact the way states handle eligibility redeterminations and eligibility categorizations for postpartum enrollees in the future. For example, under the extensions, states may automatically keep enrollees in the pregnancy pathway through the end of their 12th postpartum month, which could reduce the number of postpartum enrollees in the expansion category at six months following delivery relative to what we found in this analysis.

Second, we likely underestimate the number of pregnant and postpartum expansion enrollees for several reasons. Our analysis omits expansion enrollees in the four states (Missouri, North Carolina, Oklahoma, and South Dakota) that expanded Medicaid after January 2021, and, as noted above, we exclude Illinois because of data quality concerns. Additionally, our analysis only includes deliveries with live births; however, OBBBA’s exemptions and pregnancy and postpartum coverage protections would also apply to pregnant and postpartum enrollees without a live birth. We also do not assess Medicaid enrollment for waiver enrollees in states like Wisconsin and Georgia, who will likely be subject to work requirements, though CMS has not yet publicly indicated to which enrollees in states with limited expansion through waivers the requirements will apply (Meuse 2025).²⁴

Finally, the quality of the TAF data varies across states and years.²⁵ In three of the included study states—the District of Columbia, Hawaii, and New Jersey—the number of Medicaid-covered deliveries that we identified in the TAF varied by more than 20 percent from natality data published by the Centers for Disease Control and Prevention on the number of Medicaid-paid deliveries; results for these states should be interpreted with caution. Our measures of physical and behavioral health conditions, as well as pregnancy/birth complications, are limited to those that are observable on claims during pregnancy or delivery and likely understate underlying health needs among the population.

In the qualitative analysis, we interviewed a limited number of key informants and, as such, some important insights may be missing.

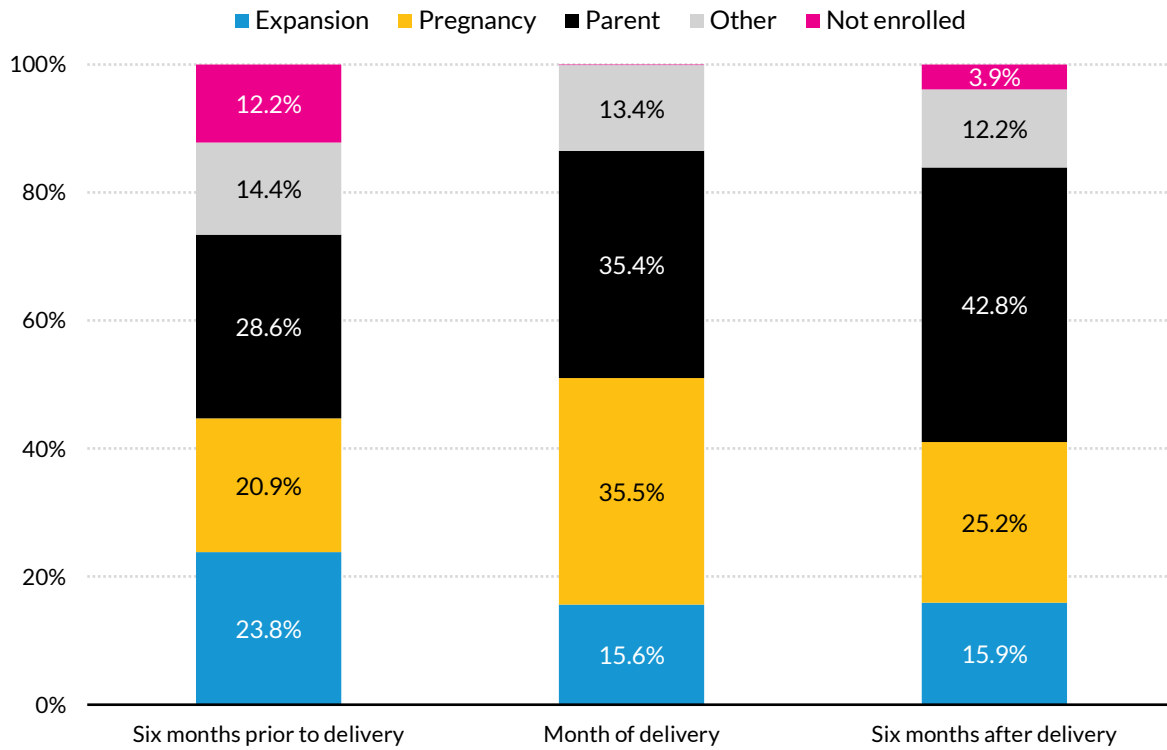
Findings

One in Seven Medicaid-Covered Live Births in Expansion States in 2022 Were to Expansion Enrollees

We identified 878,214 enrollees with Medicaid-covered live births in 2022 in the 36 expansion states (including the District of Columbia) we analyzed. Figure 1 depicts the shares of enrollees in each eligibility category six months before delivery, during the month of delivery, and six months after delivery. Six months prior to delivery, 23.8 percent of all pregnant Medicaid enrollees were in the expansion category. During the month of delivery, 15.6 percent were in the expansion category. Six months following delivery, 15.9 percent of postpartum enrollees were in the expansion category.

These patterns suggest significant movement of enrollees between eligibility categories over the perinatal period. But they also indicate that, in 2022, 137,008 individuals (i.e., 15.6 percent of 878,214 enrollees) gave birth as expansion enrollees in these 36 states. This suggests that many pregnant and postpartum women could be at risk of coverage loss if they are not automatically exempted from work requirements and become subject to semiannual redeterminations under OBBBA.

FIGURE 1
Eligibility Categories Before, During, and After Delivery Among Medicaid Enrollees in Expansion States, 2022



URBAN INSTITUTE

Source: Authors' analysis of T-MSIS data in 36 expansion states (including the District of Columbia).

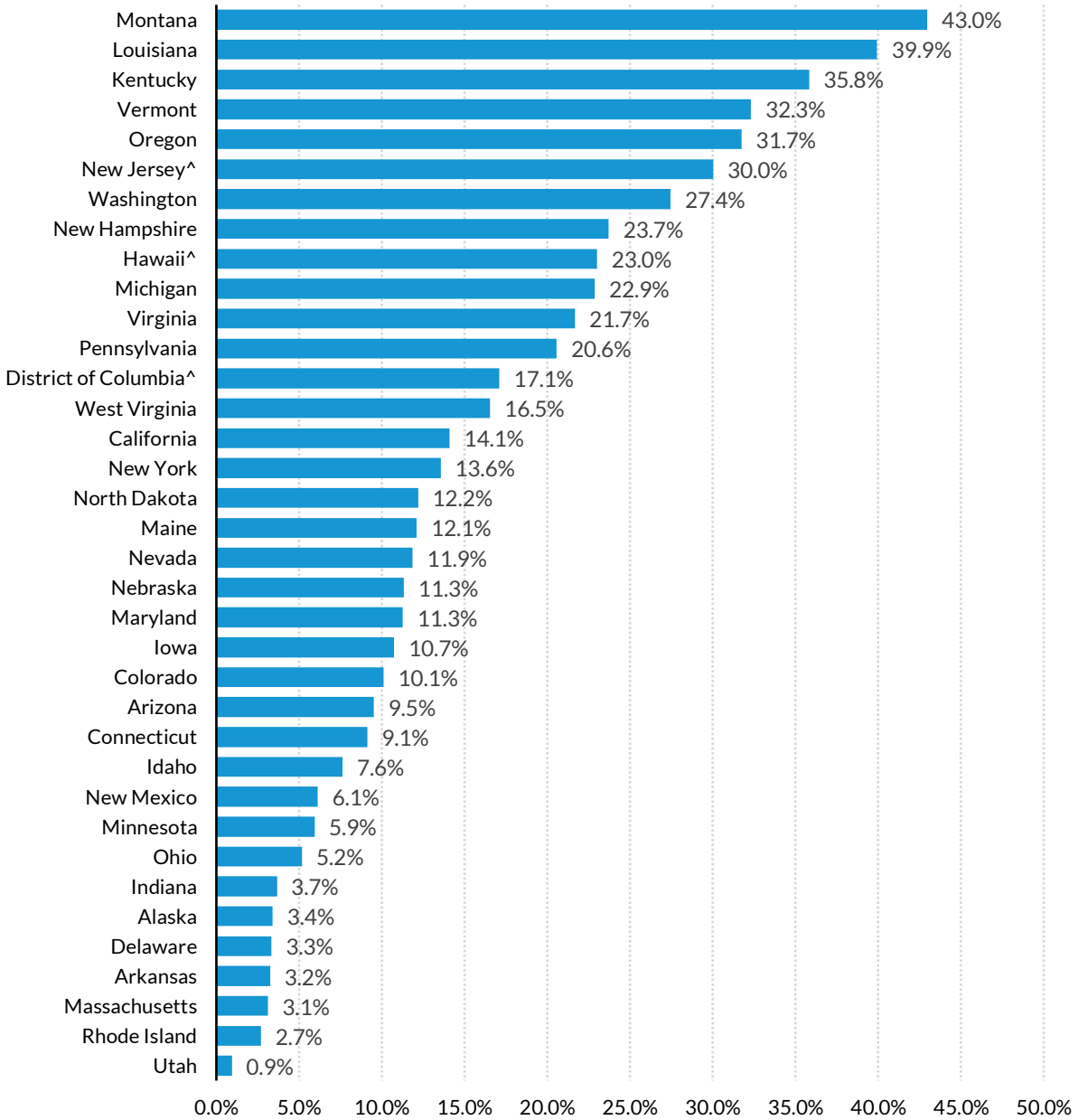
Notes: Sample includes 878,214 enrollees with a Medicaid/CHIP-covered live birth in 2022 in 36 states that had adopted the Affordable Care Act Medicaid expansions as of 2021.

The Share of Pregnant and Postpartum Enrollees in the Expansion Eligibility Category Varied Widely Across States

The share of enrollees in the expansion category at six months prior, in the month of, and six months after delivery varied considerably across states. Figure 2 depicts this variation for the month of delivery. During the month of delivery, the share of pregnant enrollees in the expansion category was below 3 percent in Rhode Island (2.7 percent) and Utah (0.9 percent) and below 10 percent in another 11 expansion states. In 12 states, the share of enrollees in the expansion category was over 20 percent, and the share was over 30 percent in five states: Montana (43.0 percent), Louisiana (39.9 percent), Kentucky (35.8 percent), Vermont (32.3 percent), and Oregon (31.7 percent).

FIGURE 2

Share of Medicaid Enrollees in the ACA Expansion Eligibility Category During the Month of Delivery, by State, 2022



URBAN INSTITUTE

Source: Authors' analysis of T-MSIS data in 36 expansion states (including the District of Columbia).

Notes: ACA = Affordable Care Act. Sample includes 878,214 enrollees with a Medicaid/CHIP-covered live birth in 2022. ^State has potential data quality issues; results should be interpreted with caution.

Similar to the month of delivery, states varied considerably in the share of enrollees in the expansion category at six months before delivery and six months postpartum. Six months prior to delivery, the share of enrollees in the expansion category was below 8 percent in Arkansas (7.9 percent), Massachusetts (7.8 percent), and Indiana (2.6 percent) and was over 40 percent in Louisiana (49.9 percent), Montana (42.8 percent), and Vermont (41.4 percent; appendix figure A.1); the rank order of states was similar six months before delivery to the month of delivery (figure 2). Six months after delivery, the share of enrollees in the expansion category was below 2 percent in Minnesota (1.9 percent) and Connecticut (1.3 percent) and over 40 percent in Oregon (48.1 percent) and Montana (42.7 percent; appendix figure A.2). The rank order of states six months after delivery was again mostly similar to the month of delivery, with some exceptions. For example, in Idaho, only 7.6 percent of enrollees were in the expansion category during the month of delivery (ranking 26th of the 36 states), but this share was 33.6 percent at six months after delivery (ranking 6th of 36); in Connecticut, the share was 9.1 percent during the month of delivery (ranking 25th of 36) but 1.3 percent six months after delivery (ranking 36th of 36); and in Utah, the share was 0.9 percent during the month of delivery (ranking 36th of 36) but 25.9 percent six months after delivery (ranking 10th of 36).

Differences across states in the share of enrollees in the ACA expansion category likely reflect variation in the processes that states use to assign or transition enrollees across eligibility categories or other differences in their eligibility and enrollment systems,²⁶ and suggest that the number of pregnant and postpartum women in the expansion group will vary substantially across states as they implement OBBBA.

Table 1 shows the number of expansion-covered enrollees covered at the month of delivery by state. Over 15 percent of all expansion-covered enrollees who gave birth were in California (21,209), followed by 14,313 in Louisiana, 11,451 in New York, 10,445 in Pennsylvania, and 10,028 in Kentucky. Together, these five states comprise nearly half (49.2 percent) of expansion enrollees who gave birth across all 36 states in our sample.

TABLE 1

ACA Medicaid Expansion Enrollees During the Month of Delivery, by State, 2022

	Number of expansion enrollees with a live birth in state	Cumulative share of expansion enrollees with a live birth (%)
California	21,209	15.5%
Louisiana	14,313	25.9%
New York	11,451	34.3%
Pennsylvania	10,445	41.9%
Kentucky	10,028	49.2%
Michigan	9,633	56.3%
Washington	9,255	63.0%
Virginia	7,532	68.5%
New Jersey [^]	5,912	72.8%
Oregon	5,690	77.0%
Arizona	3,735	79.7%
Maryland	3,132	82.0%
Ohio	2,936	84.1%
Colorado	2,491	86.0%
Nevada	1,855	87.3%
Montana	1,817	88.6%
Iowa	1,763	89.9%
West Virginia	1,572	91.1%
Hawaii [^]	1,447	92.1%
Minnesota	1,336	93.1%
Indiana	1,333	94.1%
Connecticut	1,290	95.0%
Nebraska	988	95.7%
New Mexico	837	96.3%
Massachusetts	821	96.9%
New Hampshire	703	97.5%
Vermont	661	97.9%
Idaho	586	98.4%
Maine	563	98.8%
District of Columbia [^]	478	99.1%
Arkansas	430	99.4%
North Dakota	291	99.7%
Delaware	149	99.8%
Alaska	123	99.9%
Utah	102	99.9%
Rhode Island	101	100.0%

Source: Authors' analysis of T-MSIS data in 36 expansion states (including the District of Columbia).

Notes: ACA = Affordable Care Act. Expansion coverage refers to month of delivery. Sample includes 878,214 enrollees with a Medicaid/CHIP-covered live birth in 2022. [^]State has potential data quality issues; results should be interpreted with caution.

Over Half of Pregnant Expansion Enrollees Had Chronic Physical and/or Behavioral Health Conditions

Table 2 shows characteristics of enrollees in the expansion category during the month of delivery, indicating that many pregnant and postpartum expansion enrollees who could be at risk of losing coverage starting in 2027 under OBBBA face health issues. More than one-third (34.1 percent) were younger than 25 years old. Approximately 52.1 percent had a chronic physical and/or behavioral health

condition. This included 30.9 percent with preexisting diabetes, hypertension, or obesity; 31.4 percent with a diagnosed behavioral health condition; and 10.2 percent with both (data not shown). Furthermore, 12.2 percent of enrollees with expansion coverage had preterm birth; 28.0 percent had a cesarean section; and 30.7 percent experienced another type of pregnancy or delivery complication.

TABLE 2
Characteristics of Medicaid Enrollees in the ACA Expansion Eligibility Category During the Month of Delivery, 2022

	Number	Share (%)
Age in years (at delivery)		
Younger than 25	46,727	34.1%
25–34	71,795	52.4%
35 or older	18,486	13.5%
Urban/rural residence (at delivery)^		
Urban	111,460	81.4%
Rural	25,231	18.4%
Health conditions during pregnancy (not mutually exclusive)		
Preexisting (nongestational) diabetes, hypertension, or obesity	42,285	30.9%
Behavioral health diagnosis	43,081	31.4%
Any of the above conditions	71,381	52.1%
Pregnancy/delivery complications (not mutually exclusive)		
Preterm birth	16,667	12.2%
Cesarean section	38,382	28.0%
Other complication	42,114	30.7%

Source: Authors’ analysis of T-MSIS data in 36 expansion states (including the District of Columbia).

Notes: ACA = Affordable Care Act. Sample includes 137,008 enrollees with a Medicaid/CHIP-covered live birth in 2022 who were in the ACA expansion eligibility category during the month of delivery. ^317 expansion enrollees (0.2 percent) had a missing value for rurality.

Medicaid Agencies May Face Challenges to Ensuring Coverage Continuity for Expansion Enrollees in the Perinatal Period Under OBBBA

As described earlier, under current Medicaid policy, states must provide eligible enrollees continuous Medicaid coverage throughout pregnancy and the postpartum period (which is mandated to last through at least 60 days after the end of pregnancy and that would last through 12 months postpartum in all but one state),²⁷ regardless of changes in income, and without requiring eligibility redetermination.²⁸ This means that expansion enrollees who become pregnant should not be subject to either OBBBA’s semiannual redetermination schedule or work requirements until after their 12-month postpartum coverage ends (and, if they still qualify for expansion coverage, should remain exempt from work requirements while caring for a child younger than age 14).

However, successfully implementing this exemption and ensuring continuity of coverage requires that state agencies are aware of enrollees’ pregnancy and postpartum status and maintain their enrollment. Key informants we interviewed highlighted many potential challenges that Medicaid agencies may experience that increase the risk of coverage loss for pregnant and postpartum expansion

enrollees under OBBBA. We categorize these challenges into three areas: (1) challenges to timely identification of pregnancy status among expansion enrollees; (2) challenges to timely identification of postpartum status among expansion enrollees; and (3) incomplete guidance regarding OBBBA implementation currently available from CMS.

Challenges to Timely Identification of Pregnancy Status among Expansion Enrollees

Key informants highlighted several issues and barriers that may prevent state agencies from promptly identifying pregnant enrollees in the expansion group, including current policy and practice challenges, system and data challenges, and limited and inconsistent uptake of enrollee and provider reporting processes.

Policy and practice challenges. Key informants noted that current policy and practice do not encourage state Medicaid agencies to promptly identify pregnancy among expansion enrollees. First, states are not required to monitor expansion enrollees for pregnancy or transfer them to the pregnancy-related eligibility category, though states are encouraged to inform enrollees of pregnancy benefits and transition those who request a change in coverage category.²⁹ According to some informants, states may not have an incentive to shift pregnant expansion enrollees into the pregnancy pathway because the benefits are usually the same, but states receive a higher federal match for expansion enrollees. It is not clear how consistently states track when expansion enrollees get pregnant, and states differ in their approaches to transitioning enrollees to pregnancy-related pathways. In fact, one key informant raised privacy concerns regarding states automatically transitioning expansion enrollees to pregnancy pathways based on claims data alone, without action by the enrollee. In addition, some noted that transitions between eligibility groups could pose a risk of disenrollment in the event that a transition triggers a need for additional information or verifications.

System and data challenges. According to key informants, claims and utilization data are a major source of information for how states could identify if an enrollee becomes pregnant, but many described significant data lags (of weeks, months, or more) between medical services rendered and utilization data being reported to the Medicaid agency. Timeliness of claims data to identify pregnancy may be further complicated by the fact that many Medicaid enrollees face barriers to timely access to prenatal care, with only about 66 percent receiving prenatal care in their first trimester in 2022.³⁰ Even if data are transmitted to the state in a timely way, one informant pointed out that state claims databases often do not directly interface with eligibility and enrollment systems, further delaying transmission of critical information to activate appropriate flags or eligibility codes to ensure continuity of coverage for pregnant and postpartum enrollees. And some noted that many states' data systems are complex and difficult to update. One key informant described states' data systems as "kept in place with duct tape and prayers," noting challenges with operability and integration across various systems. Moreover, they acknowledged that changes to data systems are also very expensive to implement, especially at a time when state Medicaid agencies are stretched thin in terms of resources and staff capacity.

“To say the problem is complicated is an understatement—there are too many moving parts.”

—Key informant

Another key informant reported that while many states are planning to use claims data to identify individuals who may be exempt from work requirements based on medical frailty or medical needs, it is not clear that they will include pregnancy-related diagnostic codes in these searches. Furthermore, many Medicaid programs pay for some maternity care in a single bundled payment (also known as a global fee), which includes all care delivered during the perinatal period, with a claim usually submitted at or shortly after the delivery.³¹ This means that if states rely on claims data to identify and exempt pregnant enrollees from work requirements, some pregnant enrollees may not be recognized as such until after they deliver. These scenarios illustrate the potential risk that some expansion enrollees who become pregnant will not be promptly identified and could therefore be incorrectly subject to work requirements and semiannual eligibility checks.

Enrollee and provider challenges related to the reporting of pregnancy status. States may be able to use other sources of information to identify pregnancy, such as enrollee self-reports; provider notifications; information from health plans and other state programs such as the Women, Infants, and Children program and Supplemental Nutrition Assistance Program; and electronic health records, but little is known about how consistent, comprehensive, and timely these approaches may be in identifying pregnancy. As noted earlier, enrollees who become pregnant have the option to submit a change-in-circumstances form to the Medicaid agency. For example, Missouri expressly encourages expansion enrollees to report pregnancy, at which point the agency would determine a person’s eligibility for the pregnancy-related pathway and transfer them out of expansion coverage.³² But according to key informants, enrollees may not know about this option or may not think this step is important. For instance, if there is no difference in benefits or if reporting a change of circumstances is administratively challenging, some expansion enrollees may choose not to report their pregnancy.

Some states have processes for providers to report pregnancy and delivery directly to the agency. For example, one key informant noted that in Washington State, providers can report a birth using a specific form to expeditiously enroll a newborn in Medicaid. Ohio reportedly encourages prenatal care providers to screen pregnant women at their first visit for health and social risks, which then allows the agency to offer care coordination and other supports to enrollees who are determined to have high-risk pregnancies.³³ A key informant suggested this information could also be used to flag expansion enrollees as exempt from work requirements and semiannual eligibility checks, but raised concerns that providers may not be consistently using the forms. However, new reporting initiatives may require considerable resources and attention to ensure widespread adoption and create concerns about new administrative burdens for providers and health plans. For example, the initial low submission of the

pregnancy risk assessments in Ohio reportedly prompted the state to introduce an incentive payment to encourage more providers to complete the pregnancy risk assessments.³⁴

Finally, some interviewees also raised concerns that state pregnancy reporting systems could be used for surveillance and criminalization of women who experience miscarriage or terminate a pregnancy, and that protections would need to be built in to prevent that use. A similar concern could include potential legal risks for enrollees in states that have enacted punitive policies related to substance use during pregnancy. Key informants emphasized the need for strong safeguards and concluded that pregnancy reporting systems have limitations and risks that should be carefully considered by states and CMS.

Challenges to Timely Identification of Postpartum Status Among Expansion Enrollees

CMS guidance on postpartum extensions specifies that all Medicaid enrollees in states that adopted the postpartum extension are entitled to 12 months of coverage following the end of pregnancy, regardless of eligibility category, and that enrollees can remain enrolled in the eligibility group they had during pregnancy through the end of the postpartum period.³⁵ This means that expansion enrollees who become pregnant and are not shifted to the pregnancy-related category can stay in the expansion category throughout the 12 months postpartum. Limited information is available about how states operationalized the postpartum extensions, including what data and policies agencies use to identify the end of pregnancy and how they determine the end of the 12-month postpartum period.

As described in the previous section, there are many limitations to how quickly states can identify pregnancy and delivery in the expansion group (or other eligibility groups outside of pregnancy pathways). Postpartum individuals may be identified when a newborn is added to their household by eligibility caseworkers. However, an analysis of 2010–18 CMS data found that, on average, more than half a million infants with Medicaid-financed births were not continuously enrolled during the first year of life, which suggests some states struggle with timely newborn enrollment processes (Johnson K 2021). This means not only that some infants erroneously lack coverage but that some are not attached to their mothers' eligibility cases, which would then prevent states from applying the extended postpartum coverage and work requirement exemption to a new parent.

Because delivery is a high-cost service that also includes separate facility fees paid to hospitals and birth centers, some key informants were hopeful that a state agency would learn shortly after delivery, at the latest, that an enrollee is eligible for postpartum coverage and exemption from work requirements. But once again, key informants noted instances when claims data may not be a timely source of information about deliveries, such as deliveries with major complications and follow-up care that may be billed weeks or even months later. Other potential challenges to identifying postpartum status could include scenarios where a pregnancy does not end with a live birth or when an infant does not reside with the birthing parent.

Anecdotal evidence, including a class action lawsuit in one state, suggests that some eligible enrollees may inappropriately lose coverage in the postpartum year.³⁶ This raises concerns that some eligible enrollees may in fact not be identified as postpartum, meaning both that they may not receive

12-month postpartum coverage in the states that have adopted that policy and that they could become subject to OBBBA's work requirements and semiannual eligibility checks.

Insufficient CMS Guidance About OBBBA Implementation

As noted above, OBBBA specifies that CMS should release guidance on work requirements by June 2026, which is only a few months before notices will need to go out regarding the new policies and implementation will begin. CMS has thus far provided only limited guidance on operationalizing work requirements,³⁷ and recently released guidance³⁸ on semiannual redeterminations did not specifically mention pregnant and postpartum expansion enrollees or reiterate that they should not be subject to redeterminations during the perinatal period.³⁹ Given how little time there is until implementation, states and their vendors are already making changes to their eligibility and enrollment systems, which requires substantial time for programming, testing, and troubleshooting. They risk having to redo their work if the guidance outlines conditions different from those they planned for. Thus, key informants noted that the sooner CMS can provide additional detailed guidance, the better.

Informants identified some areas related specifically to pregnancy and postpartum enrollees where guidance would be particularly helpful. For instance, they hoped CMS would clarify that the new semiannual eligibility redetermination policy does not apply to pregnant and postpartum individuals who are enrolled in the expansion category, given the preexisting coverage continuity protections for them. They also hoped CMS would require states to implement procedures to ensure that coverage not be discontinued during pregnancy or the postpartum period and that renewal processes specifically assess enrollees' pregnancy status. In addition, several key informants encouraged CMS to allow for self-reporting of pregnancy and postpartum status for the purposes of identifying enrollees who are exempt from the work requirement.

Actions That Can Promote Continuous Coverage During the Perinatal Period Under OBBBA

Key informants noted that some pregnant and postpartum enrollees may be at greater risk of coverage losses. When required to proactively manually verify their eligibility, pregnant and postpartum enrollees who face health challenges—such as mothers with serious physical and mental health challenges and delivery complications, as well as those whose infants are born prematurely or with health concerns and admitted to NICUs—may experience problems responding in a timely way to agency requests for information or documentation. Another group of enrollees who may be at a higher risk of procedural disenrollment are those whose pregnancy does not end with a live birth or whose infants are going into foster care or adoption.

Recognizing potential areas of concern and uncertainty in the current systems and processes, key informants believed state and federal policymakers and other maternal health stakeholders should proactively address challenges to continuous coverage for pregnant and postpartum women under OBBBA. Drawing on available literature as well as on concerns and suggestions made by key

informants, we identified the following set of actions for helping pregnant and postpartum women maintain coverage under OBBBA, which are grouped by stakeholder type.

Actions for State Medicaid Agencies

- **Improve the timeliness of data reporting to automate exemptions.** Multiple key informants indicated that improving information management systems should be states' top priority. To promptly identify pregnancy and other conditions that are eligible for exemptions from work requirements, states could consider several strategies to obtain claims data on faster timelines, including requiring managed care organizations to submit encounter data within 30 days and report pregnancy status directly to the agency, and establish connections with statewide health information exchange systems to obtain real-time claims data, where possible. Moreover, states could ensure that information management systems are well-maintained and interoperable—such that a medical claim identifying pregnancy or information about pregnancy from another public program in the state would automatically exempt a person from Medicaid work requirements and suspend redeterminations.
- **Increase use of ex parte renewals and improve renewal processes.** To streamline and strengthen renewal processes, states can adopt several strategies to increase the rates of ex parte renewals, in which states can automatically assess eligibility using available data, such as wage data or information from other human service agencies, without the need for beneficiary action (CMS 2024b).⁴⁰ In addition, key informants recommended that states revise their current renewal forms and expressly ensure that enrollees can easily self-identify pregnancy during renewal.
- **If permitted by CMS and feasible without causing disruptions in coverage or care, consider transitioning all pregnant and postpartum enrollees to the pregnancy eligibility category.** Moving all identified pregnant and postpartum enrollees from expansion to pregnancy-related coverage could be administratively simpler for states to ensure coverage continuity among pregnant and postpartum women, as that would eliminate the need for exempting them from work requirements and establishing exceptions from semiannual renewals during the perinatal period. On conclusion of the 12-month postpartum period, however, states would need to conduct redeterminations and ensure that enrollees who are found eligible to transition to the expansion group automatically qualify for the parental exemption from work requirements, when applicable.
- **Educate enrollees, providers, and other maternal health stakeholders about OBBBA changes to Medicaid eligibility.** As part of the planning for OBBBA, states could regularly convene key stakeholders—including other state agencies, provider groups, health plans, legal aid organizations, community-based organizations, and other organizations that have contact with women during the perinatal period—to provide updates about federal guidance and obtain input on state implementation choices. Medicaid agencies could also work with state maternal health coalitions, early childhood and/or home visiting systems, and other maternal-related working groups to codevelop educational materials and outreach strategies that ensure

enrollees and health and social service agencies and providers who serve them are aware that pregnant and postpartum women are entitled to continuous coverage in Medicaid and exempt from work requirements and semiannual redeterminations. They could also develop materials explaining how exemptions will be implemented, including how pregnancy and postpartum status will be assessed, how pregnant and postpartum women or their health care providers can confirm exemption status or report a pregnancy, and how enrollees can appeal or reapply in the case of erroneous disenrollment.

- **Monitor implementation of OBBBA eligibility policies.** Even in the absence of federal requirements, states could adapt reporting practices from the recent unwinding of the Medicaid continuous coverage requirement⁴¹ to track how enrollment in the program is changing under OBBBA, such as how many enrollees obtain exemptions and for which circumstances, how many comply with work requirements, and the reasons for program disenrollment.⁴² Additionally, monitoring enrollment changes by enrollee characteristics, particularly for vulnerable populations—such as pregnant and postpartum women, people with chronic behavioral or physical health conditions, rural populations, and people from racial and ethnic minority groups—would allow state agencies and other stakeholders to identify populations that may need additional support and inform systems changes that help ensure they can successfully obtain allowable exemptions or report compliance activities.

Actions for CMS

- **Expedite comprehensive OBBBA implementation guidance to states and allow self-reporting of pregnancy for purposes of exemptions from work requirements.** Key informants noted that the more time states have to set up their systems and processes and educate enrollees and key stakeholders about OBBBA changes and how they apply to pregnant and postpartum enrollees, the more successful implementation will be. They believed guidance should specifically reinforce that expansion enrollees who are pregnant or eligible for the 12-month postpartum period are not subject to semiannual eligibility checks and should identify steps and processes states must take to ensure continuous coverage of pregnant and postpartum people. It will be important for CMS to remind states that they must use available data to assess enrollees' eligibility for pregnancy- or postpartum-related exemptions, inquire about pregnancy status as part of semiannual eligibility checks, and allow enrollees to self-report pregnancy to gain an exemption from work requirements. Further guidance is needed regarding how often states must review or reestablish an exemption and under what circumstances states will be permitted to automatically transition expansion enrollees who become pregnant into pregnancy-related pathways, drawing on best practices and examples from states that identify pregnancy status among enrollees and/or transition pregnant expansion enrollees efficiently. In addition, one informant suggested the guidance should be comprehensive and transparent, and include decisions and information CMS has communicated to states in the interim period.
- **Monitor state implementation of OBBBA through mandatory public reporting.** CMS could consider mandatory monthly public reporting by states to allow the agency and key stakeholders to monitor how enrollment and disenrollment patterns are changing as Medicaid agencies

implement work requirements and semiannual eligibility checks. This reporting could be incorporated into the existing Medicaid and CHIP Eligibility Processing Data Reports by adding additional metrics relevant to work requirements.⁴³ These indicators could be disaggregated by specific populations that are eligible for exemptions from work requirements, including pregnant and postpartum women, as well as other characteristics such as urban/rural residence, diagnosed health conditions, and race and ethnicity.

Actions for Advocates, Providers, Researchers, and Other Maternal Health Stakeholders

- ***Educate patients and community members.*** Trusted messengers such as providers and representatives of organizations that serve pregnant women and new parents could share information about the availability of pregnancy-related coverage and coverage protections for pregnant and postpartum women, including how enrollees can find out if the Medicaid program has provided them with an exemption from work requirements. Ideally, these groups would collaborate with and inform state Medicaid agencies and managed care organizations on developing simple and effective messaging and outreach strategies.
- ***Monitor implementation and establish early-warning systems.*** State advocacy and watchdog groups and broader stakeholder coalitions could establish feedback loops with Medicaid agencies or county-level eligibility offices to promptly raise awareness about systemic issues and develop expedited processes for reinstating any eligible pregnant and postpartum women who may be inadvertently disenrolled.
- ***Proactively support Medicaid enrollees in navigating new requirements.*** Organizations could train staff and/or provide referrals to community-based navigation services to help Medicaid enrollees navigate semiannual renewals, work requirements, exemption requests, and appeals in the event people erroneously lose coverage.
- ***Advocate for transparency on the implementation of OBBBA.*** Groups promoting coverage and access to care for perinatal populations could highlight the need for states to provide regular updates on data sources and other processes they are using for implementation and on program enrollment changes.
- ***Prioritize research on how OBBBA affects coverage of pregnant and postpartum enrollees.*** Research will be needed on how states assess pregnancy/postpartum status and ensure exemption from work requirements and protections from redeterminations during pregnancy and through the postpartum period under OBBBA and 12-month postpartum extensions.

Conclusion

Our analysis suggests that well over 100,000 pregnant and postpartum women are likely to be in the Medicaid expansion eligibility category in 2027 and, if not automatically identified as pregnant or postpartum by state Medicaid agencies, could be at risk of disenrollment under OBBBA's work requirements and redetermination requirements. Analyzing Medicaid claims data from 36 ACA Medicaid expansion states, we found that just over one-quarter of individuals with Medicaid-covered

live births in 2022 were enrolled in the expansion eligibility category six months prior to giving birth, and that nearly 16 percent—or over 130,000 individuals—were enrolled in the expansion category in the month they gave birth. This number is likely an underestimate since it excludes enrollees from Illinois because of data quality concerns and from the four states (Missouri, North Carolina, Oklahoma, and South Dakota) that expanded Medicaid after our study period.

Although pregnancy qualifies as an exemption from the new work requirements that will apply to expansion enrollees under OBBBA, pregnant enrollees in the expansion category may be incorrectly subjected to this policy—and at risk of losing their coverage during semiannual redeterminations—if the state is not aware of their pregnancy status. Our findings indicate that some states could face serious challenges in promptly identifying pregnancy among expansion enrollees, raising concerns about the extent of potential coverage losses for pregnant Medicaid enrollees under the new law.

Postpartum expansion enrollees may also be at risk for OBBBA-related coverage loss. All but one expansion state has extended pregnancy-related Medicaid coverage through 12 months postpartum, which means postpartum enrollees should remain exempt from work requirements and semiannual redeterminations at least through this 12-month period. Our analysis shows that nearly 16 percent of enrollees with live births in 2022 were in the expansion eligibility pathway at six months following delivery. It is unclear how effectively or in what variety of ways states have operationalized the 12-month postpartum coverage extension, but challenges that prevent timely identification of pregnancy may well extend to the postpartum period. If expansion enrollees are not promptly identified in state systems as postpartum, they may risk disenrollment under work requirements and semiannual redeterminations.

We document considerable differences by state in the share of pregnant and postpartum enrollees in the expansion category, suggesting coverage risks under OBBBA will be a much greater threat in some states than others. For example, five states (Montana, Louisiana, Kentucky, Vermont, and Oregon) had more than 30 percent of enrollees in the expansion category during the month of delivery, while seven states (Utah, Rhode Island, Massachusetts, Arkansas, Delaware, Alaska, and Indiana) had less than 5 percent. Overall, half of all births to enrollees with ACA expansion coverage occurred in just five states: California, Kentucky, Louisiana, New York, and Pennsylvania. This wide variation likely reflects differences in the processes that states use to assign or transition enrollees across eligibility categories, and may present an important opportunity for states to learn from each other. Identifying and disseminating best practices for efficiently and effectively identifying pregnant expansion enrollees so they can be protected from disenrollment under OBBBA's provisions may help mitigate coverage disruptions.

We also find that more than half of expansion enrollees who were pregnant in 2022 had diagnosed physical and/or behavioral health conditions—and likely many more enrollees experienced undiagnosed issues—suggesting that any gaps in coverage for pregnant enrollees could undermine their overall health and well-being and increase risks for poor maternal and infant health outcomes.⁴⁴ This could compound the harms for low-income pregnant and postpartum women that are anticipated from other changes in health care access and nutrition assistance under OBBBA related to Medicaid and SNAP

eligibility restrictions for certain immigrants and financing cuts to Medicaid and SNAP programs (Giannarelli et al. 2025).⁴⁵

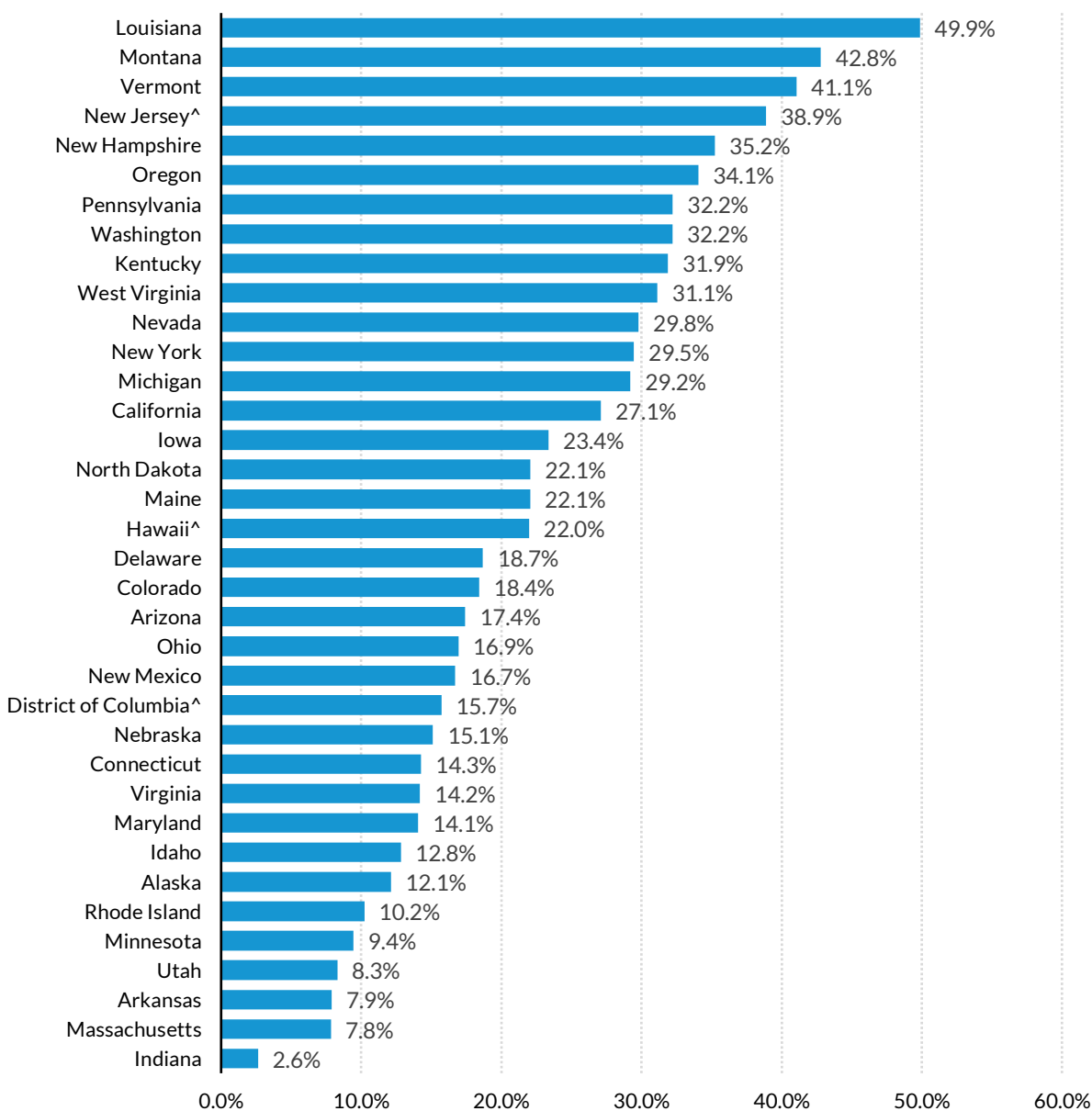
State Medicaid agencies will need to act quickly to improve their data, systems, and processes to allow for the timely identification of pregnancy and increase ex parte redeterminations, while managing complex privacy and legal risks. It will also be important for state Medicaid agencies to educate enrollees, providers, and other maternal health stakeholders about the continuous coverage protections during the perinatal period and the exemptions for pregnant and postpartum women from work requirements, and to develop feedback loops and early-warning systems to quickly resolve any inappropriate disenrollments among eligible pregnant and postpartum enrollees. Timely public reporting and enrollment dashboards will be critical for allowing agencies and partner organizations to monitor the effects of OBBBA on enrollment changes among pregnant and postpartum women and other vulnerable groups, and use this information to improve systems, procedures, and outreach to enrollees experiencing high rates of disenrollment.

OBBBA introduces new risks for coverage and continuity of care in the perinatal period, which could worsen already poor maternal health outcomes in the US and stall recent progress on maternal and infant health improvement efforts (Artiga et al. 2020; Harris 2023). However, broad awareness of these challenges and proactive steps by state and federal policymakers and other maternal health stakeholders could help mitigate these risks. Further progress on improving maternal health will likely depend on states' continued provision of comprehensive perinatal coverage and benefits, including by maintaining or expanding income eligibility for pregnancy-related Medicaid and effectively implementing postpartum coverage extensions.⁴⁶

Appendix A. Supplemental Figures

FIGURE A.1

Share of Medicaid Enrollees in the ACA Expansion Eligibility Category Six Months Prior to Delivery, by State, 2022



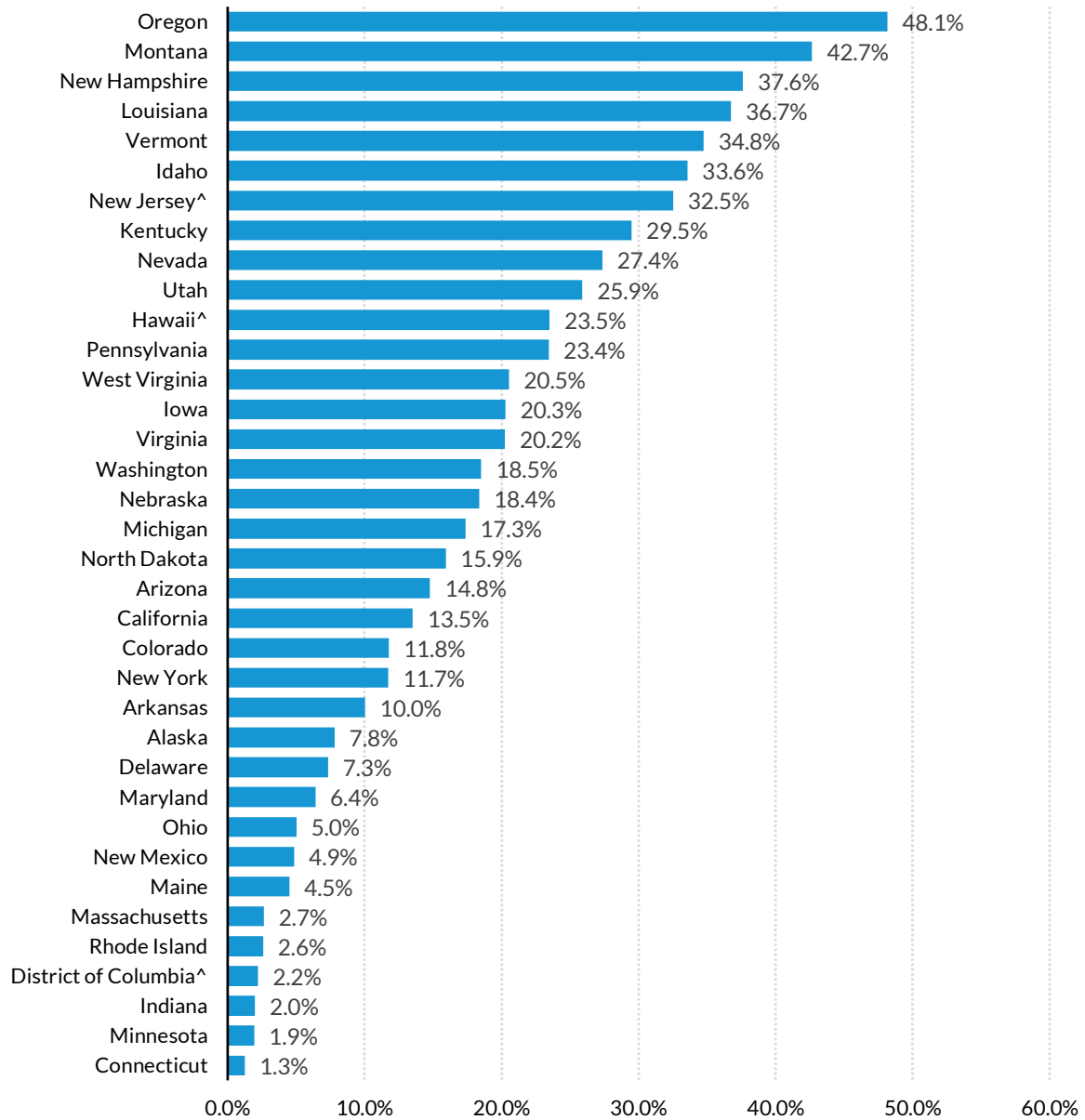
URBAN INSTITUTE

Source: Authors' analysis of T-MSIS data in 36 expansion states (including the District of Columbia).

Notes: ACA = Affordable Care Act. Sample includes 878,214 enrollees with a Medicaid/Children's Health Insurance Program-covered live birth in 2022. [^] State has potential data quality issues; results should be interpreted with caution.

FIGURE A.2

Share of Medicaid Enrollees in the ACA Expansion Eligibility Category Six Months After Delivery, by State, 2022



URBAN INSTITUTE

Source: Authors' analysis of T-MSIS data in 36 expansion states (including the District of Columbia).

Notes: ACA = Affordable Care Act. Sample includes 878,214 enrollees with a Medicaid/Children's Health Insurance Program-covered live birth in 2022. ^ State has potential data quality issues; results should be interpreted with caution.

Notes

- ¹ We use the term “women” to align with the language in the Social Security Act, which defines Medicaid eligibility for pregnant and postpartum women. We acknowledge that not all people who become pregnant or give birth identify as women.
- ² OBRA 1990, Omnibus Reconciliation Act of 1990 (P.L. 101–508); Daniel Tsai, “[RE: Improving Maternal Health and Extending Postpartum Coverage in Medicaid and the Children’s Health Insurance Program \(CHIP\)](#),” Medicaid.gov, December 7, 2021.
- ³ All but one state has adopted 12-month postpartum extensions. “Medicaid Postpartum Coverage Extension Tracker,” KFF, accessed on March 19, 2026, <https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/>; Tanisha Mondestin, “Wisconsin Passes 12-Month Postpartum Medicaid Extension, Leaving Arkansas as the Last State Without It,” Georgetown University McCourt School of Public Policy Center for Children and Families (blog), February 27, 2026, <https://ccf.georgetown.edu/2026/02/27/wisconsin-passes-12-month-postpartum-medicaid-extension-leaving-arkansas-as-the-last-state-without-it/>.
- ⁴ One Big Beautiful Bill Act, Pub. L. No. 119–21, 139 Stat. 72 (2025), <https://www.congress.gov/bill/119th-congress/house-bill/1/text>.
- ⁵ As described further below, our analysis omits Illinois due to data quality issues and does not include the four states—Missouri, North Carolina, Oklahoma, and South Dakota—that expanded Medicaid after January 2021.
- ⁶ As described further below, our analysis includes every state that had adopted the ACA’s Medicaid expansion by January 2021 except Illinois.
- ⁷ We broadly define the perinatal period as the time spanning pregnancy, childbirth, and one year postpartum.
- ⁸ As of 2025, six states covered some pregnant women with incomes above their pregnancy-related Medicaid levels with CHIP funds (Brooks et al. 2025). Some youth with CHIP coverage may also have CHIP-covered births. However, the majority of Medicaid/CHIP-covered births are covered by Medicaid.
- ⁹ Immigrant eligibility rules are also more expansive for pregnancy-related coverage than for nonpregnant adults in many states (Brooks et al. 2025).
- ¹⁰ OBRA 1990, Omnibus Reconciliation Act of 1990 (P.L. 101–508).
- ¹¹ American Rescue Plan Act of 2021, Pub. L. No. 117–2 135 Stat. 4 (2021), <https://www.congress.gov/bill/117th-congress/house-bill/1319/text>; [Consolidated Appropriations Act of 2023](#), Pub. L. No. 117–328, 136 Stat. 4459 (2022); and Tsai, “RE: Improving Maternal Health and Extending Postpartum Coverage.”
- ¹² “Medicaid Postpartum Coverage Extension Tracker”; Mondestin, “Wisconsin Passes 12-Month Postpartum Medicaid Extension.”
- ¹³ “Eligibility,” Medicaid and CHIP Payment and Access Commission, accessed March 25, 2026, <https://www.macpac.gov/medicaid-101/eligibility>.
- ¹⁴ “[Implementation Guide: Medicaid State Plan Eligibility Eligibility Groups – Mandatory Coverage Pregnant Women](#),” Medicaid, accessed March 25, 2026; “42 U.S. Code § 1396a - State plans for medical assistance,” Legal Information Institute, Cornell School of Law, accessed March 25, 2026, <https://www.law.cornell.edu/uscode/text/42/1396a>; Tsai, “RE: Improving Maternal Health and Extending Postpartum Coverage.”
- ¹⁵ “Medicaid Coverage of Pregnancy-Related Services: Findings from a 2021 State Survey,” KFF, accessed March 25, 2026, <https://www.kff.org/womens-health-policy/medicaid-coverage-of-pregnancy-related-services-findings-from-a-2021-state-survey/>.
- ¹⁶ Tsai, “RE: Improving Maternal Health and Extending Postpartum Coverage.”
- ¹⁷ One Big Beautiful Bill Act, Pub. L. No. 119–21, 139 Stat. 72 (2025).

- ¹⁸ Jennifer M. Haley, Lisa Dubay, Jameson Carter, and Stephen Zuckerman, “More-Frequent Medicaid Redeterminations Would Reduce Health Insurance Coverage and Increase Administrative Costs,” *Urban Wire*, Urban Institute, May 21, 2025, <https://www.urban.org/urban-wire/more-frequent-medicaid-redeterminations-would-reduce-health-insurance-coverage-and>.
- ¹⁹ OBRA 1990, Omnibus Reconciliation Act of 1990 (P.L. 101–508); American Rescue Plan Act of 2021, Pub. L. 117–2; Consolidated Appropriations Act of 2023, Pub. L. 117–328.
- ²⁰ Jennifer M. Haley, Genevieve M. Kenney, Eva H. Allen, and Michael Karpman, “Medicaid Work Requirements Could Threaten Parents’ and Children’s Coverage and Well-Being,” Georgetown University McCourt School of Public Policy Center for Children and Families (blog), May 19, 2025, <https://ccf.georgetown.edu/2025/05/19/medicaid-work-requirements-could-threaten-parents-and-childrens-coverage-and-well-being>.
- ²¹ “Expansion” included eligibility group codes 72, 73, 74, and 75. “Pregnancy” included eligibility group codes 05, 53, 64, 67, and 68. “Parent” included eligibility group codes 01, 27, and 56. “Other” included all other eligibility group codes and dual eligibility or restricted benefits, regardless of eligibility group code. In rare cases of multiple eligibility group codes in the same month, we applied the following hierarchy: pregnancy, parent, expansion, other.
- ²² “Single Topic Map View - DQ Atlas,” Medicaid.gov, accessed February 20, 2026, <https://www.medicaid.gov/dq-atlas/landing/topics/single/map>.
- ²³ “Rural–Urban Commuting Area Codes,” USDA ERS, accessed March 14, 2022, <https://www.ers.usda.gov/data-products/rural-urban-commuting-area-codes>.
- ²⁴ Joan Alker, “CMS Guidance on Medicaid Work Requirements Leaves States Hanging,” Georgetown University McCourt School of Public Policy Center for Children and Families, December 11, 2025, <https://ccf.georgetown.edu/2025/12/11/cms-guidance-on-medicaid-work-requirements-leaves-states-hanging>.
- ²⁵ “DQ Atlas,” Medicaid.gov, accessed March 2, 2026, <https://www.medicaid.gov/dq-atlas/welcome>.
- ²⁶ High shares for some states may reflect relatively low income eligibility thresholds for parental coverage. For example, Kentucky, Louisiana, and Montana each have parental coverage income thresholds below 25 percent of FPL. However, other states with parental thresholds below 25 percent of FPL (e.g., Arkansas and Indiana) have relatively low shares of enrollees in the expansion category—suggesting the differences in share of pregnant and postpartum enrollees in the expansion category across states are not entirely explained by differences in income eligibility thresholds for parental coverage.
- ²⁷ “Medicaid Postpartum Coverage Extension Tracker,” KFF, accessed on March 19, 2026, <https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/>.
- ²⁸ OBRA 1990, Omnibus Reconciliation Act of 1990 (P.L. 101–508); Tsai, “RE: Improving Maternal Health and Extending Postpartum Coverage.”
- ²⁹ “[Questions and Answers: Medicaid and the Affordable Care Act](#),” Medicaid.gov, February 2013.
- ³⁰ Elevance Health, “[Late Medicaid Enrollment during Pregnancy Increases Risk of Mortality](#),” September 2024.
- ³¹ Health Care Payment Learning and Action Network. “[Clinical Episode Payment Models: Maternity Care](#).” Accessed March 26, 2026, “Bundled Payments for Prenatal Care—DQ Atlas,” Medicaid.gov, accessed March 25, 2026, <https://www.medicaid.gov/dq-atlas/landing/topics/single/map>.
- ³² “Adult Medicaid Expansion and MO HealthNet Coverage FAQs,” Missouri Department of Social Services, accessed March 25, 2026, <https://mydss.mo.gov/adult-medicaid-expansion-and-mo-healthnet-coverage-faqs-0>.
- ³³ “PRAF 2.0 FAQs,” Ohio Department of Medicaid, accessed March 25, 2026, <https://medicaid.ohio.gov/resources-for-providers/special-programs-and-initiatives/praf/praf-2.0-faqs>.
- ³⁴ Beejadi Mukunda, “Medicaid Providers Take Note: Submitting the Pregnancy Risk Assessment Form Can Save Babies’ Lives,” Ohio Association of Health Plans (blog), April 3, 2023, <https://oahp.org/2023/04/03/medicaidproviders-take-note-submitting-the-pregnancy-risk-assessment-form-can-save-babies-lives>.

- ³⁵ Tsai, “RE: Improving Maternal Health and Extending Postpartum Coverage.”
- ³⁶ Lawsuits pending in Florida allege that the Medicaid agency terminated coverage of eligible women; see Jackie Llanos, “Florida Wrongly Kicked Postpartum Women and Their Newborns out of Medicaid,” *Florida Phoenix*, July 29, 2024, <https://floridaphoenix.com/2024/07/29/florida-wrongly-kicked-postpartum-women-and-their-newborns-out-of-medicaid/>; Eva H. Allen, Jennifer M. Haley, and Sofia Hinojosa, “Leveraging Georgia’s Postpartum Medicaid Extension for Improved Maternal Health,” Urban Institute, May 30, 2025, <https://www.urban.org/research/publication/leveraging-georgias-postpartum-medicaid-extension-improved-maternal-health>.
- ³⁷ Dan Brillman, “[Section 71119 of the ‘Working Families Tax Cut’ Legislation, Public Law 119- 21: Requirements for States to Establish Medicaid Community Engagement Requirements for Certain Individuals](#),” *CMCS Informational Bulletin*, December 8, 2025.
- ³⁸ Dan Brillman, “[RE: Implementation of ‘Eligibility Redeterminations](#),” Section 71107 of the “Working Families Tax Cut” Legislation (Public Law 119-21), March 6, 2026.
- ³⁹ Tricia Brooks, “CMS Releases Guidance on 6-Month Medicaid Renewals for Expansion Adults,” Georgetown University McCourt School of Public Policy Center for Children and Families (blog), March 6, 2026, <https://ccf.georgetown.edu/2026/03/06/cms-releases-guidance-on-6-month-medicaid-renewals-for-expansion-adults>.
- ⁴⁰ Daniel Tsai, “[Use of Unwinding-Related Strategies to Support Long-Term Improvements to State Medicaid Eligibility and Enrollment Processes](#),” *CMCS Informational Bulletin*, November 14, 2024; and “Adoption or Continuation of Policies Allowed As 1902(e)(14)(A) Waivers During Unwinding, as of January 2025,” KFF, accessed March 25, 2026, <https://www.kff.org/state-health-policy-data/state-indicator/adoption-continuation-of-policies-allowed-as-1902e14a-waivers-during-unwinding/>.
- ⁴¹ Elizabeth Lukanen, Emily Zylla, and Lindsey Theis, “State Dashboards to Monitor the Unwinding of the Medicaid Continuous Coverage Requirement,” SHADAC, January 11, 2024, <https://www.shadac.org/news/dashboards-monitor-continuous-unwind-shvsEP>.
- ⁴² Tricia Brooks, “Let’s Start a Conversation about Data to Monitor the Impact of H.R. 1’s Work Reporting Requirements,” Center for Children & Families (CCF) of the Georgetown University McCourt School of Public Policy (blog), February 4, 2026, <https://ccf.georgetown.edu/2026/02/04/lets-start-a-conversation-about-data-to-monitor-the-impact-of-h-r-1s-work-reporting-requirements/>.
- ⁴³ “Medicaid and CHIP Eligibility Operations and Enrollment Snapshot,” Medicaid.gov, accessed March 25, 2026, <https://www.medicaid.gov/medicaid-and-chip-eligibility-operations-and-enrollment-snapshot>.
- ⁴⁴ Lindsay Admon, Vanessa Dalton, and Michelle Moniz, “Increasing Rates of Chronic Conditions Putting More Moms, Babies at Risk,” University of Michigan Institute for Healthcare Policy & Innovation, November 8, 2017, <https://ihpi.umich.edu/news/increasing-rates-chronic-conditions-putting-more-moms-babies-risk>.
- ⁴⁵ Annaliese Johnson, Zoe D’Angelo, and Susan Kennedy, “Medicaid Cuts Threaten Pregnancy and Postpartum Coverage, Access to Care, and Health,” *Health Affairs*, October 20, 2025, <https://www.healthaffairs.org/content/forefront/medicaid-cuts-threaten-pregnancy-and-postpartum-coverage-access-care-and-health>.
- ⁴⁶ Eva H. Allen and Jennifer M. Haley, “Robust Implementation of Medicaid Postpartum Extensions Needed to Maintain Maternal Health Momentum,” Milbank Memorial Fund, November 6, 2025, <https://www.milbank.org/2025/11/robust-implementation-of-medicaid-postpartum-extensions-key-to-maintaining-maternal-health-momentum/>.

References

- Artiga, Samantha, Olivia Pham, Usha Ranji, and Kendal Orgera. 2020. “[Medicaid Initiatives to Improve Maternal and Infant Health and Address Racial Disparities](#).” San Francisco: KFF.

- Auty Samantha G., Jamie R. Daw, Lindsay K. Admon, and Sarah H. Gordon. 2024. "Comparing Approaches to Identify Live Births Using the Transformed Medicaid Statistical Information System." *Health Services Research* 59 (1): e14233. <https://doi.org/10.1111/1475-6773.14233>.
- Brooks, Tricia, Jennifer Tolbert, Anna Mudumala, Amaya Diana, Allea Gardner, Aubrianna Osorio, and Shoshi Preuss. 2025. "[Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies as States Resume Routine Operations](#)." San Francisco: KFF.
- Buettgens, Matthew, Jameson Carter, and Fernando Hernandez. 2026a. "[OBBBA's Six-Month Redetermination Could Reduce Medicaid Expansion Enrollment by 2.0 to 3.1 Million in 2028](#)." Washington, DC: Urban Institute.
- Buettgens, Matthew, Michael Karpman, Jennifer M. Haley, Jameson Carter, and Genevieve M. Kenney. 2026b. "[Projected Reductions in Medicaid Expansion Enrollment Under OBBBA's Work Requirements and Six-Month Redeterminations: National and State Estimates for 2028](#)." Washington, DC: Urban Institute.
- CMS (Centers for Medicare & Medicaid Services). 2024a. "[2024 Medicaid & CHIP Beneficiaries at a Glance: Maternal Health](#)." Baltimore, MD: CMS.
- . 2024b. "[Basic Requirements for Conducting Ex Parte Renewals of Medicaid and CHIP Eligibility](#)." Baltimore, MD: CMS.
- Giannarelli, Linda, Sarah Minton, Laura Wheaton, Ilham Dehry, Paul Johnson, Joyce Morton, and Kevin Werner. 2025. "[House Reconciliation Bill Will Hit Lowest-Income Families the Hardest: A Summary of Preliminary Research Findings](#)." Washington, DC: Urban Institute.
- Gordon, Sarah H., Amelia Whitman, Thomas Buchmueller, and Benjamin D. Sommers. 2025. "Medicaid Eligibility Category among Enrollees with Medicaid-Paid Births in 2018." *Health Services Research* 61 (1): e70053. <https://doi.org/10.1111/1475-6773.70053>.
- Harris, Emily. 2023. "US Maternal Mortality Continues to Worsen." *JAMA* 329 (15): 1248. <https://doi.org/10.1001/jama.2023.5254>.
- Johnson K. 2021. [Missing Babies: Best Practices for Ensuring Continuous Enrollment in Medicaid and Access to EPSDT](#) Washington, DC: Johnson Group Consulting.
- Karpman, Michael, Jennifer M. Haley, and Genevieve M. Kenney. 2025. [Assessing Potential Coverage Losses among Medicaid Expansion Enrollees under a Federal Medicaid Work Requirements](#). Washington, DC: Urban Institute.
- Meuse, Dan. 2025. "[Medicaid Work Reporting Requirements: Implementation Basics and State Decision Points](#)." Princeton, NJ: State Health and Value Strategies.
- Smith, Laura B., Claire O'Brien, Keqin Wei, Timothy A. Waidmann, and Genevieve M. Kenney. 2025. "Medicaid-Covered Health Care Visits during the Postpartum Year: Variation by Enrollee Characteristics and State." *Health Affairs Scholar* 3 (2): qxaf055. <https://doi.org/10.1093/haschl/qxaf055>.

About the Authors

Laura Barrie Smith is a senior research associate in the Health Policy Division at the Urban Institute. Her research examines how health care policies shape access to and receipt of health care with a focus on Medicaid-covered populations. Her current work assesses Medicaid policies aimed at improving coverage continuity and access to care among children and pregnant/postpartum enrollees using Medicaid claims data. Smith holds a BA in mathematics from St. Olaf College and a PhD in health services research, with an emphasis in health economics, from the University of Minnesota.

Jennifer M. Haley is a principal research associate in the Health Policy Division. She focuses on maternal, child, and parental health and health care, especially related to Medicaid, CHIP, and health insurance Marketplaces. Her recent research has assessed safety net access for children in immigrant

families, implementation of Medicaid/CHIP postpartum extensions and multiyear continuous eligibility policies, and other issues related to coverage and care for children, pregnant and postpartum individuals, and families. Haley holds an MA in sociology from Temple University.

Eva H. Allen is a senior research associate in the Health Policy Division, where her work focuses on the effects of Medicaid policies and initiatives on underserved populations, including people with chronic physical and mental health conditions, pregnant and postpartum women, and children.

Genevieve M. Kenney is an institute fellow and the former vice president in the Health Policy Division. She is a nationally renowned expert on Medicaid, CHIP, health insurance coverage, health care access and quality, and health outcomes for low-income adults, children, and families. She has played a lead role in several Medicaid and CHIP evaluations, including multiple congressionally mandated CHIP evaluations, and has conducted national and state-level evaluations of expansions for children, pregnant women, and parents, the implementation of managed care, family planning waivers, and other policy changes in Medicaid and CHIP. In her current work, she is assessing federal and state Medicaid policy changes under OBBBA, reproductive health access, and policies aimed at improving outcomes in the postpartum period. She received a master's degree in statistics and a doctoral degree in economics from the University of Michigan.

Acknowledgments

This brief was funded by the David and Lucile Packard Foundation. Data access was supported by the Robert Wood Johnson Foundation. We are grateful to them and to all our funders, who make it possible for Urban to advance its mission.

The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders. Funders do not determine research findings or the insights and recommendations of Urban experts. Further information on the Urban Institute’s funding principles is available at urban.org/fundingprinciples.

The authors gratefully thank interviewees for their very helpful insights; Keqin Wei and Claire O’Brien for assistance with T-MSIS data analysis; Sofia Hinojosa for assistance with key informant interviews; Elisabeth Wright Burak, Tricia Brooks, Emily Johnston, and Tisamarie Sherry for helpful feedback; and Rachel Fudge and Sarah LaCorte for editorial support.



ABOUT THE URBAN INSTITUTE

The Urban Institute is a nonprofit research organization founded on one simple idea: To improve lives and strengthen communities, we need practices and policies that work. For more than 50 years, that has been our charge. By equipping changemakers with evidence and solutions, together we can create a future where every person and community has the opportunity and power to thrive.

Copyright © March 2026. Urban Institute. Permission is granted for reproduction of this file, with attribution to the Urban Institute.