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Changes in New Mothers' Health Care Access and Affordability under the Affordable Care Act

Stacey McMorrow, Emily M. Johnston, Tyler W. Thomas, and Genevieve M. Kenney

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The time after giving birth is critical to the health of new mothers and their children. Though most women have health insurance coverage during their pregnancy and delivery, new mothers often become uninsured postpartum, which can threaten their abilities to access and afford needed health care. Following implementation of the coverage provisions of the Affordable Care Act (ACA) in 2014, thousands of new mothers gained insurance coverage, but few analyses have assessed how much new mothers' health care access and affordability have improved under the law.

In this brief, we examine changes in access to and affordability of health care services for new mothers under the ACA using data from the National Health Interview Survey (NHIS).[1] We also assess whether changes in the demographic and socioeconomic characteristics of our sample of new mothers contributed to observed changes in health care access and affordability. We find the following:

- The uninsurance rate for new mothers fell from 20.2 percent in 2011 to 11.3 percent in 2015 and remained relatively stable through 2018.
- New mothers were less likely to report unmet health care needs due to cost after implementation of the ACA coverage expansions in 2014; between 2011–13 and 2015–18, the share of new mothers reporting unmet needs for medical care dropped by 60 percent, and

[1] The National Health Interview Survey only identifies women as biological mothers, meaning we cannot identify transgender, nonbinary, and other people who gave birth. We use the terms women and mothers throughout the analysis but recognize they may be limiting.

the shares reporting unmet needs for prescription medicines and specialist care fell by 40 percent and 44 percent.

- The share of new mothers very worried about paying their medical bills also fell from 20.9 percent in 2011–13 to 15.5 percent in 2015–18.
- In 2015–18, new mothers were more likely to report having seen a general doctor (60.9 percent versus 55.6 percent) and received a flu vaccine (52.5 percent versus 44.6 percent) in the past 12 months than in 2011–13.
- Changes in health care affordability and access were generally consistent with and without adjusting for new mothers' changing demographic and socioeconomic characteristics, suggesting these changing characteristics were not driving health care access and affordability improvements during the study period.

We find that new mothers experienced significant improvements in health care access and affordability after implementation of the ACA's major coverage provisions. Together with other evidence on the ACA's role in reducing uninsurance among women and new mothers and improving access to and affordability of health care among parents with low incomes and other adults, our results suggest the ACA likely contributed to new mothers' gains in health care access and affordability over the study period. But even after ACA implementation, many new mothers still faced barriers to accessing needed health care services, which can negatively affect their health and their family's well-being.

Background

New mothers have complex and interrelated health care needs, including those related to delivery, behavioral and reproductive health services, and treatment of chronic conditions. Moreover, there is increasing recognition that the postpartum period requires not just a single medical visit, but rather ongoing care tailored to each woman's needs (ACOG 2018).[1] Unfortunately, many mothers may struggle to get needed postpartum care because of financial and other barriers. From 2015 to 2018, about one in five uninsured new mothers reported an unmet need for medical care due to cost, and more than half were very worried about paying their medical bills (McMorrow et al. 2020).

Though most mothers have insurance coverage during their pregnancies and deliveries, many are uninsured before their pregnancy and become uninsured shortly after their child's birth. A recent 41-state study found that about one in three people who gave birth from 2015 to 2017 experienced an insurance disruption during the perinatal period.[2] Much of this churning can be attributed to state Medicaid policies, which provide more generous eligibility for pregnant women than other adults. Thus, many women become eligible for and enroll in Medicaid during their pregnancies but subsequently lose access to that coverage when their eligibility expires 60 days after delivery (Adams and Johnston 2016).

Though the ACA did not change pregnancy-related coverage, it included several provisions that can ease some coverage transitions surrounding pregnancy, such as the Medicaid expansions implemented in 32 states, including DC, between 2014 and 2018 and the introduction of federal subsidies to purchase private insurance through state and federal Marketplaces beginning in 2014. Nationally, the uninsurance rate among women who had recently given birth fell by 41 percent between 2012–13 and 2015–16,[3] but more than 450,000 new mothers remained uninsured in 2017. Though Black, Hispanic, and white new mothers experienced significant coverage gains under the ACA, racial and ethnic inequities persisted; both Hispanic and Black new mothers were significantly more likely to be uninsured than white new mothers in 2017 (Johnston et al. 2019).

New mothers' coverage gains were also larger in states that expanded Medicaid under the ACA, and Johnston and colleagues (2019) found that Medicaid expansion reduced uninsurance among citizen new mothers living in poverty by 28 percent (Johnston et al. 2019). Two additional studies of new mothers also found that the ACA Medicaid expansion had increased coverage among these women before pregnancy and at delivery (Clapp et al. 2018, 2019). Further, Daw and colleagues found that the ACA Medicaid expansion improved perinatal insurance continuity among mothers with low incomes (Daw et al. 2020).

Despite considerable evidence of both prepregnancy and postpartum coverage changes under the ACA, little research has investigated changes in health care access and affordability for pregnant women or new mothers. Daw and Sommers (2019) found that women of reproductive age were less likely to face cost-related barriers to care and more likely to report having a usual source of care after the major ACA coverage provisions took effect. The study did not find significant changes in pregnant women's health care access or affordability, but its sample was small and resulting estimates imprecise. In a study comparing Medicaid enrollees in Colorado, which expanded Medicaid under the ACA, with those in Utah, which did not expand, Gordon and colleagues (2020) found that new mothers in Colorado were more likely to maintain coverage and use outpatient care after Medicaid expansion than were their counterparts in Utah.

In this brief, we document broader national changes in health care access, use, and affordability for new mothers under the ACA using 2011–18 data from the NHIS. This analysis highlights the potential benefits of increasing coverage for new mothers, including through additional state Medicaid expansions and state and federal proposals to extend postpartum Medicaid eligibility for up to one year.[4] But it also reveals remaining access and affordability challenges facing new mothers after the ACA. Understanding the challenges new mothers face in receiving needed care is especially important during the pandemic, which has put more mothers and families at risk of losing health insurance and made accessing needed care more difficult, even for those with coverage (Banthin et al. 2020; Gonzalez et al. 2020; Karpman, Gonzalez, and Kenney 2020; Karpman, Zuckerman, and Petersen 2020).[5]

Data and Methods

Using NHIS data obtained from the Integrated Public Use Microdata Series at the University of Minnesota (Blewett et al. 2019), we define new mothers as women ages 19 to 44 with an infant (younger than 1) whose NHIS record indicates they are the child's biological or adoptive mother. We identify uninsurance at the time of the survey and examine annual changes in uninsurance rates. We also examine several measures of health care affordability: having an unmet need due to cost in the past 12 months for five types of care (medical care, prescription medications, mental health care, follow-up care, or specialist care); delaying medical care because of cost; and being very or somewhat worried about paying medical bills (as opposed to being not at all worried). We also explore new mothers' access to and use of health care services by identifying whether they had a usual source of care (other than a hospital emergency department) at the time of the survey, had received a flu vaccine in the past 12 months, or had seen a general doctor, specialist, obstetrician/gynecologist, or mental health care provider in the past 12 months.

Because of sample size constraints, we pool data years before (2011–13) and after (2015–18) implementation of the major ACA coverage provisions in 2014 to examine how these affordability and access measures changed for new mothers. We exclude 2014 data from our analysis because the ACA's major coverage provisions had not been fully implemented, and many of our outcomes reflect experiences in the past 12 months. The changing composition of new mothers in our sample might contribute to changes in health care access and affordability, so we examine the demographic and socioeconomic characteristics of new mothers in both periods, including age, race/ethnicity, citizenship, region, marital status, education, and income relative to the federal poverty level (FPL). We identify these characteristics for inclusion based on their availability in the NHIS and evidence of their association with health care affordability and access (Andersen 1995; Andersen and Aday 1978; Daw and Sommers 2019).[6] We then estimate adjusted differences in access and affordability measures over time that account for these changes in sample composition. We first adjust for changes in age, race/ethnicity, citizenship, and region only, and then we further adjust for marital status, education, and income. Changes in the composition of new mothers may owe to secular trends in childbearing or idiosyncratic changes in the NHIS sample over time. However, if such changes are a result of the ACA coverage provisions, adjusting for these changes could understate the estimated change in outcomes associated with ACA implementation.

Because most of our access and affordability outcomes are part of the NHIS "sample-adult" questionnaire asked of one randomly selected adult in each family, we limit our analysis to new mothers who completed this questionnaire. We also exclude people missing information on covariates of interest (i.e., marital status, education, and citizenship) from all analyses so we can compare unadjusted and adjusted differences for the same samples. The resulting sample included just over 1,600 new mothers for 2011–13 and just under 1,600 new mothers for 2015–18. To examine differences in access and affordability between 2011–13 and 2015–18 or between groups of new mothers, we test whether the estimates were statistically different from zero using two-tailed t-tests.

All analyses use NHIS survey weights, and we adjust standard errors to account for the complex survey design.

The NHIS has several limitations, including three related to identifying new mothers. First, we identify new mothers based on the presence of a biological or adopted infant in the household, but surveys are known to undercount young children (US Census Bureau 2019). Second, we cannot exclude adoptive mothers who may face different health care needs than those recovering from pregnancy and childbirth. Third, the NHIS only identifies women as biological mothers, meaning we cannot identify transgender, nonbinary, and other people who give birth. Though we use the terms women and mothers throughout the analysis, we recognize they may be limiting.

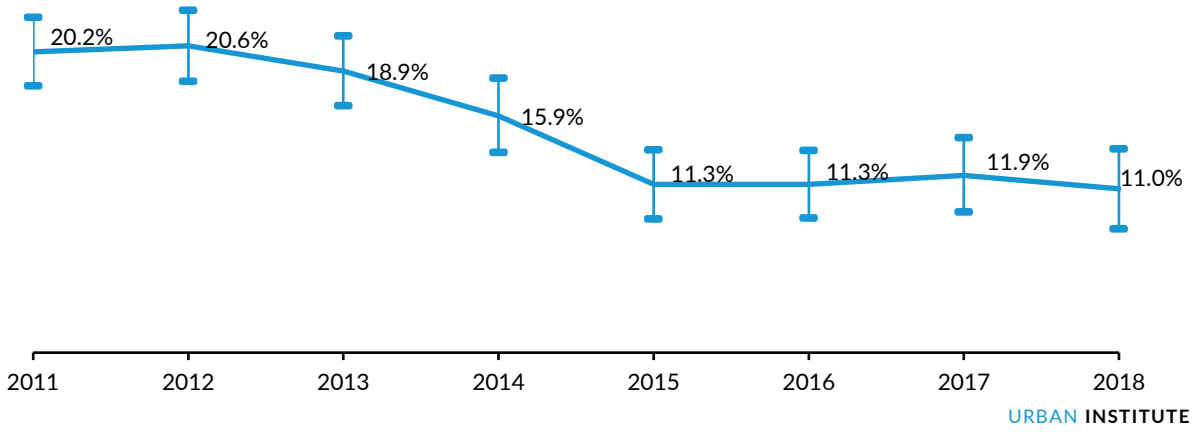
In addition, the small sample size of new mothers in the NHIS requires pooling data years to produce reliable estimates of access and affordability measures. This means we cannot examine annual trends in the pre– and post–ACA implementation periods. The small sample size also prevents us from analyzing differences in access and affordability outcomes by mothers' characteristics, such as race, ethnicity, or income. Moreover, including data from 2015 in our postimplementation estimates to boost sample size may understate the magnitude of changes in health care access and affordability following the ACA coverage expansions, because the one-year lookback period for many questions may include time before people gained coverage under the ACA. Finally, our estimates do not account for many changes occurring over this period beyond the ACA and do not reflect the causal impact of the ACA on new mothers' health care access and affordability.

Results

We find several improvements in new mothers' health care access and affordability over the study period. The uninsurance rate for new mothers fell from 20.2 percent in 2011 to 11.3 percent in 2015 and remained relatively stable until 2018 (figure 1). And relative to 2011–13, new mothers were less likely to report health care affordability problems in 2015–18 (figure 2). The share of new mothers with an unmet need for medical care due to cost fell by nearly 60 percent (from 6.9 percent in 2011–13 to 2.8 percent in 2015–18), and unmet needs for prescription drugs and specialist care fell by 40 percent and 44 percent. New mothers were also less likely to report delaying care because of cost in 2015–18 (4.8 percent) than they were in 2011–13 (7.8 percent), and the share of new mothers very worried about paying medical bills fell from 20.9 percent in 2011–13 to 15.5 percent in 2015–18.

FIGURE 1

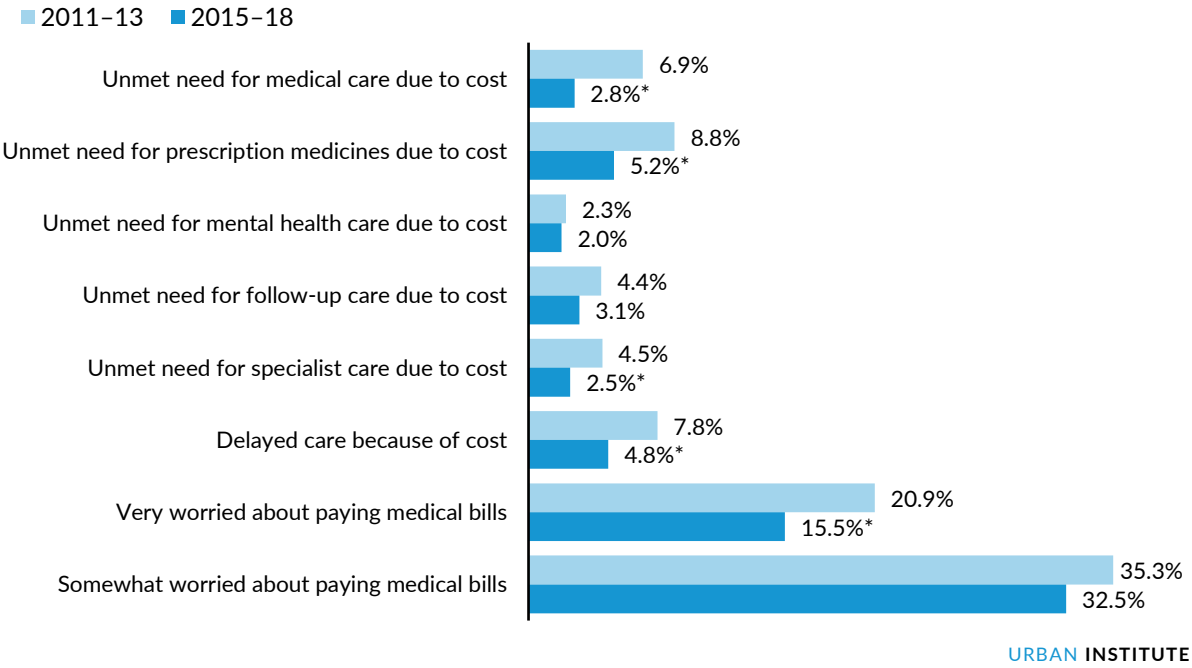
Share of New Mothers Who Are Uninsured, 2011–18



Source: Authors' analysis of the National Health Interview Survey, 2011–18.
Notes: New mothers are women ages 19 to 44 with a child younger than 1 whose National Health Interview Survey record indicates the woman is their biological or adoptive mother. Uninsurance is at the time of survey. The sample is limited to those not missing values for age, race/ethnicity, citizenship, region, education, and marital status. Error bars represent 95 percent confidence intervals. The pooled estimate for 2011–13 is 19.9 percent, which is statistically different from the pooled 2015–18 estimate of 11.4 percent at $p < 0.05$.

FIGURE 2

New Mothers' Health Care Affordability Problems, 2011–13 and 2015–18



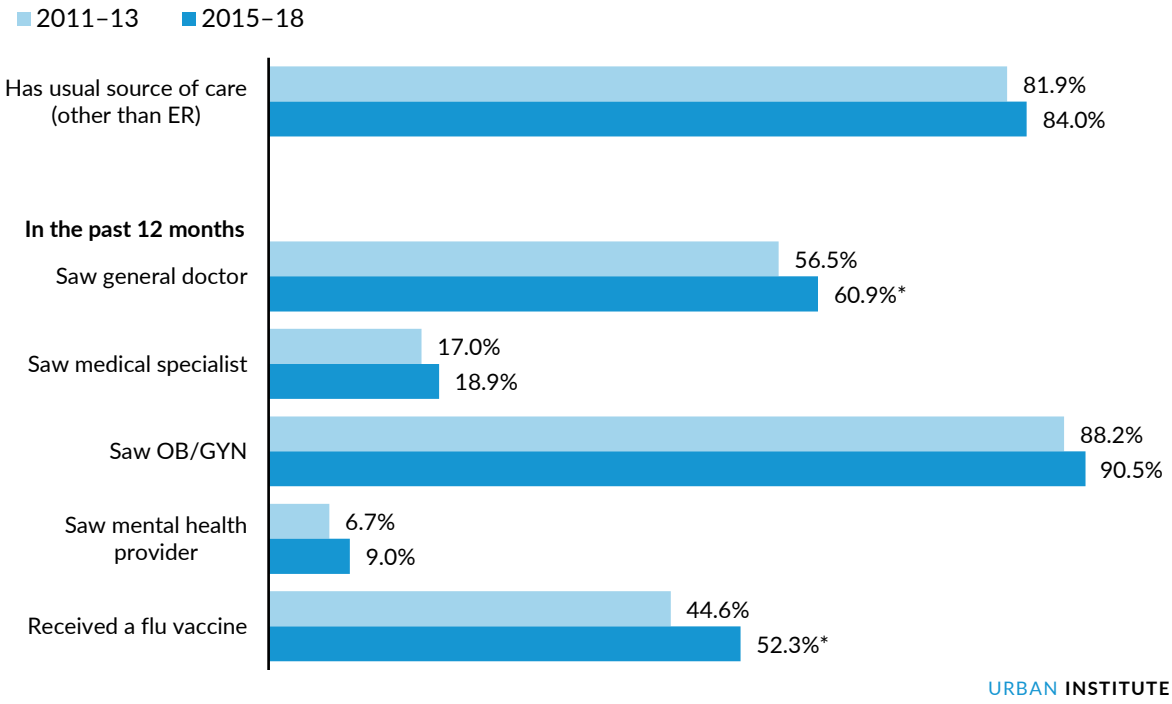
Source: Authors' analysis of the National Health Interview Survey, 2011–18.
Notes: New mothers are women ages 19 to 44 with a child younger than 1 whose National Health Interview Survey record indicates the woman is their biological or adoptive mother. Follow-up and specialist care questions were not asked in 2018.

Unmet needs and delayed care are for the past 12 months, and worries about paying medical bills are at the time of the survey. The sample is limited to adults who completed the sample-adult questionnaire and are not missing values for age, race/ethnicity, citizenship, region, education, and marital status.
* The 2015–18 estimate differs from the 2011–13 estimate at $p < 0.05$.

Relative to 2011–13, we found some improvements in health care access and use in 2015–18. As shown in figure 3, new mothers were more likely to report seeing a general doctor in the past year in 2015–18 (60.9 percent) than in 2011–13 (56.5 percent). The same was true for receiving a flu vaccine (52.3 percent versus 44.6 percent).

FIGURE 3

New Mothers' Health Care Access and Use, 2011–13 and 2015–18



Source: Authors' analysis of the National Health Interview Survey, 2011–18.
Notes: ER is hospital emergency room. OB/GYN is obstetrician/gynecologist. New mothers are women ages 19 to 44 with a child younger than 1 whose National Health Interview Survey record indicates the woman is their biological or adoptive mother. Usual source of care is at the time of the survey. The sample is limited to adults who completed the sample-adult questionnaire and are not missing values for age, race/ethnicity, citizenship, region, education, and marital status.
* The 2015–18 estimate differs from the 2011–13 estimate at $p < 0.05$.

The composition of our sample of new mothers also changed over the study period (table 1). After 2014, new mothers were more likely to be married or living with a partner, to live in the Northeast, and to have a college degree than were new mothers in 2011–13. They were also less likely to have incomes below the FPL and more likely to have incomes above 400 percent of FPL than before the ACA.[7]

TABLE 1

New Mothers' Demographic and Socioeconomic Characteristics, 2011–13 and 2015–18

Percent

	2011–13	2015–18
Age		
19–25	31.9	27.7
26–34	52.5	54.5
35–44	15.6	17.8
Race/ethnicity		
Non-Hispanic white	55.9	54.8
Non-Hispanic Black	12.5	13.2
Hispanic	22.6	23.6
Non-Hispanic, other race	9.0	8.5
Citizenship		
Citizen	84.5	86.3
Noncitizen	15.5	13.7
Region		
Northeast	13.7	17.7*
Midwest	23.7	22.1
South	37.4	37.9
West	25.1	22.2
Marital status		
Married or lives with partner	79.3	83.3*
Widowed, separated, or divorced	5.1	3.5
Never married	15.5	13.3
Education		
Less than high school	16.0	10.2*
High school diploma	25.0	23.4
Some college	29.0	30.6
College degree	30.1	35.9*
Tax unit income		
At or below 100% of FPL	37.6	28.4*
101%–200% of FPL	18.8	20.6
201%–400% of FPL	22.4	25.4
Above 400% of FPL	21.2	25.7*

Source: Authors' analysis of the National Health Interview Survey, 2011–18.

Notes: FPL = federal poverty level. New mothers are women ages 19 to 44 with a child younger than 1 whose National Health Interview Survey record indicates the woman is their biological or adoptive mother. The sample is limited to adults who completed the sample-adult questionnaire and are not missing values for age, race/ethnicity, citizenship, region, education, and marital status.

* The 2015–18 estimate differs from the 2011–13 estimate at $p < 0.05$.

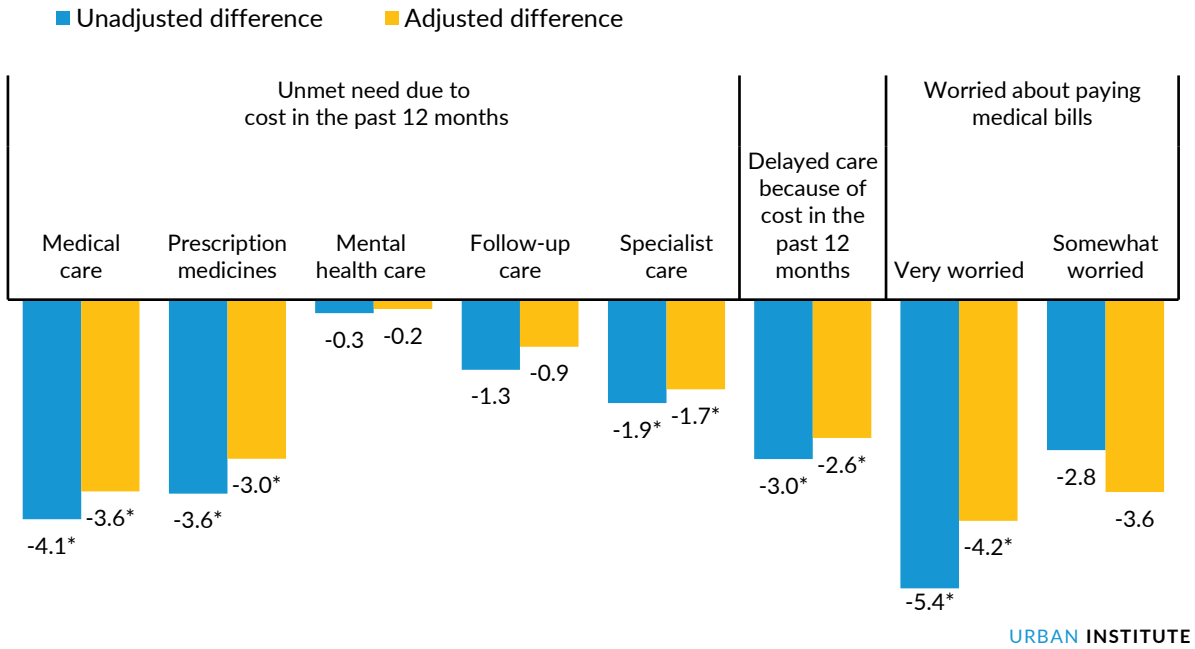
After adjusting for compositional changes in the age, race/ethnicity, citizenship, region, marital status, education, and income of new mothers, we find few meaningful changes in the patterns of health care affordability and access over time. Specifically, each statistically significant, unadjusted reduction in affordability problems appeared slightly smaller but remained significant after adjusting for compositional changes in the sample of new mothers (figure 4).

Similarly, adjusted increases in the share of new mothers who had seen a general doctor and received a flu shot in the past 12 months appeared smaller than the unadjusted changes, and the

adjusted increase in doctor visits was no longer statistically significant. However, the adjusted increase in the share of new mothers who had seen a mental health provider appeared slightly larger than the unadjusted change and was statistically significant (figure 5). Tables 2 and 3, located at the end of this brief, include partially adjusted differences that account for age, race/ethnicity, citizenship and region, but not marital status, income, or education, and the results are similar. The consistency between the unadjusted and adjusted differences suggests changes in the demographic and socioeconomic composition of new mothers over time are not likely responsible for the observed improvements in access and affordability.

FIGURE 4

Percentage-Point Changes in New Mothers' Health Care Affordability Problems, 2011–13 to 2015–18



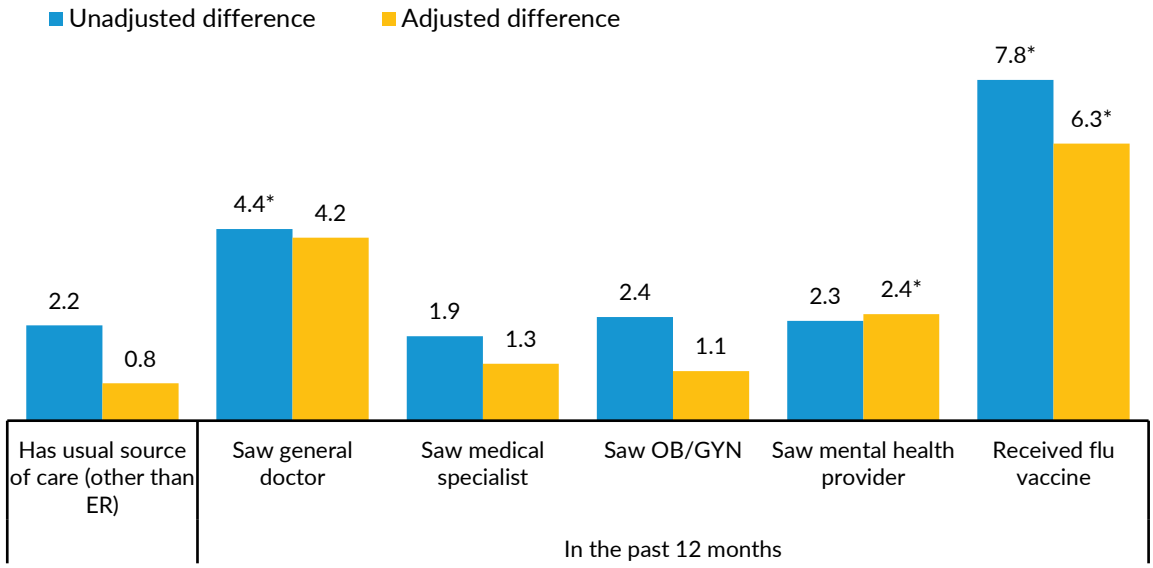
Source: Authors' analysis of the National Health Interview Survey, 2011–18.

Notes: New mothers are women ages 19 to 44 with a child younger than 1 whose National Health Interview Survey record indicates the woman is their biological or adoptive mother. Follow-up and specialist care questions were not asked in 2018. Worries about medical bills are at the time of the survey. Adjusted differences account for age, race, citizenship, region, marital status, education, and tax unit income. The sample is limited to adults who completed the sample-adult questionnaire and are not missing values for any covariates.

* The unadjusted or adjusted difference is statistically different from zero at $p < 0.05$.

FIGURE 5

Percentage-Point Changes in New Mothers' Health Care Access and Use, 2011–13 to 2015–18



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Source: Authors' analysis of the National Health Interview Survey, 2011–18.

Notes: ER = hospital emergency room. OB/GYN = obstetrician/gynecologist. New mothers are women ages 19 to 44 with a child younger than 1 whose National Health Interview Survey record indicates the woman is their biological or adoptive mother. Usual source of care is at the time of the survey. Adjusted differences account for age, race/ethnicity, citizenship, region, marital status, education, and tax unit income. The sample is limited to adults who completed the sample-adult questionnaire and are not missing values for any covariates.

* The unadjusted or adjusted difference is statistically different from zero at $p < 0.05$.

Discussion

As uninsurance declined among new mothers under the ACA, so did their problems affording needed care. Our results suggest new mothers were 60 percent less likely to have forgone medical care because of cost and were significantly less likely to have unmet needs for prescription drugs and specialist care after the ACA's coverage provisions took effect in 2014. New mothers were also less likely to be very worried about paying their medical bills after 2014, and more likely to have seen a general doctor and a mental health provider and to have received a flu vaccine. Our results are also largely consistent with and without adjusting for changes in new mothers' demographic and socioeconomic characteristics. Therefore, along with evidence of improved health coverage, access, and affordability for women of reproductive age (Daw and Sommers 2019) and of the ACA Medicaid expansion's impact on coverage for new mothers, parents, and other adults (Johnston et al. 2020; McMorrow et al. 2017; Wherry and Miller 2016), our results suggest the ACA coverage expansions likely helped reduce health care affordability problems and improve receipt of needed care among new mothers.[8]

Despite these coverage gains and associated improvements in health care affordability and access, more than 1 in 10 new mothers remained uninsured even after the major ACA coverage expansions took effect. Several policy proposals have focused on extending postpartum Medicaid coverage for up to one year, which a recent analysis found could benefit more than 200,000 uninsured, citizen new mothers with low incomes.[9] Our findings of improved health care access and affordability among new mothers following ACA coverage expansions suggest further extending coverage to new mothers could help even more new mothers access the care they need.

But, additional progress would likely require broader Medicaid expansions in the remaining states and/or enhanced Marketplace subsidies, as well as increased outreach and enrollment efforts to mothers already eligible for these coverage options. Future coverage expansions could also be designed to reduce existing inequities in health insurance coverage for Black and Hispanic women, who have high uninsurance rates. Black new mothers' high uninsurance rate is particularly concerning because Black women face greater maternal morbidity and mortality than white women and are less likely to receive appropriate postpartum care (Howell 2018; Howell et al. 2017).

Moreover, though new mothers' rates of unmet health care needs were relatively low following ACA implementation, nearly 50 percent of new mothers reported being at least somewhat worried about paying their medical bills, and only 61 percent had seen a general doctor in the past year. In addition, a related NHIS analysis found that health care affordability and access problems were particularly pronounced for uninsured new mothers (McMorrow et al. 2020). Investing in providers that accept Medicaid and serve uninsured and underinsured people, such as federally qualified health centers, could further improve health care access and reduce health care affordability concerns for new mothers.

Maintaining improvements in health care access, affordability, and use under the ACA will also require continued efforts to uphold the law and minimize threats against it. One such threat is the Trump administration's public charge rule, which reduced enrollment in Medicaid and the Children's Health Insurance Program among immigrant families with children (Haley et al. 2020). The administration's proposal to remove antidiscrimination protections in the ACA also poses a threat to equitable access to health care for LGBTQ new mothers, especially those who are transgender.[10] These are just two of many threats to the ACA that could slow or reverse gains made since the law's implementation.[11]

Even those who have and maintain insurance coverage can face challenges accessing needed care, however. These challenges can include cost-sharing obligations or barriers unrelated to health care costs, like a lack of reliable transportation, unaffordable child care options, limited access to paid family leave, a lack of culturally effective providers, and limited information about needed care. New mothers, in particular, may face such barriers as they navigate the complexities of obtaining care for themselves and their infants after giving birth (Tully, Stuebe, and Verbiest 2017). For Black new mothers, specifically, racism creates additional barriers to accessing quality health care and must be addressed in policy solutions designed to improve new mothers' access to needed care (Taylor et al. 2019).

Opportunities to improve new mothers' access to care include using an infant's early doctor visits to assess maternal well-being; developing more holistic, family-friendly provider practices; and investing in community-based care, such as community health workers, home visiting programs, and phone-, text-, or app-based supports (ACOG 2018; Taylor et al. 2019; Verbiest, Tully, and Stuebe 2017).[12] Such options may require changes to the way services are billed and paid by both public and private payers, investment in care coordination across providers, and outreach to ensure women know all their options for accessing care (Howell et al. 2017; Waldrop 2019). Because Medicaid covers a large share of births, state Medicaid managed-care contracts offer an opportunity to create formal incentives and requirements for implementing these improvements.[13]

During the pandemic, many of these challenges could be exacerbated by public health precautions that have closed some provider offices, restricted visits to patients only, and disrupted many transportation options. Simultaneously, social distancing has reduced in-home supports, the pandemic is straining families' abilities to afford food and housing, and stress and anxiety may be particularly high for new mothers (Karpman et al. 2020). Thus, barriers to obtaining care may be even greater today, and ensuring new mothers can feasibly and safely obtain needed in-person care, as well as virtual support where possible, will be essential for both mothers' and children's health during and after the public health crisis. Ultimately, the goal of expanding access to consistent coverage and care for women throughout their reproductive years is to improve health outcomes for mothers and children, and broader reforms both inside and outside the health care system are a critical step toward this goal.

TABLE 2

Percentage-Point Changes in New Mothers' Health Care Affordability Problems, 2011–13 to 2015–18

	Unadjusted difference	Partially adjusted difference	Fully adjusted difference
Unmet health care need due to cost in the past 12 months			
Medical care	-4.1*	-4.1*	-3.6*
Prescription medicines	-3.6*	-3.5*	-3.0*
Mental health care	-0.3	-0.3	-0.2
Follow-up care	-1.3	-1.2	-0.9
Specialist care	-1.9*	-1.9*	-1.7*
Delayed care because of cost in the past 12 months	-3.0*	-3.0*	-2.6*
Worried about medical bills			
Very worried	-5.4*	-5.0*	-4.2*
Somewhat worried	-2.8	-2.9	-3.6
Not worried at all	8.3*	7.9*	7.8*

Source: Authors' analysis of the National Health Interview Survey, 2011–18.

Notes: New mothers are women ages 19 to 44 with a child younger than 1 whose National Health Interview Survey record indicates the woman is their biological or adoptive mother. Follow-up and specialist care questions were not asked in 2018. Worries about medical bills are at the time of the survey. Partially adjusted differences account for age, race/ethnicity, citizenship, and region; fully adjusted differences account for those characteristics and marital status, education, and tax unit income. The sample is limited to adults who completed the sample-adult questionnaire and are not missing values for any covariates.

* The unadjusted or adjusted difference is statistically different from zero at $p < 0.05$.

TABLE 3

Percentage-Point Changes in New Mothers' Health Care Access and Use, 2011–13 to 2015–18

	Unadjusted difference	Partially adjusted difference	Fully adjusted difference
Has usual source of care (other than ER)	2.2	1.6	0.8
In the past 12 months			
Saw general doctor	4.4*	4.1	4.2
Saw medical specialist	1.9	1.4	1.3
Saw OB/GYN	2.4	2.1	1.1
Saw mental health provider	2.3	2.1	2.4*
Received a flu vaccine	7.8*	7.4*	6.3*

Source: Authors' analysis of the National Health Interview Survey, 2011–18.

Notes: ER = hospital emergency room. OB/GYN = obstetrician/gynecologist. New mothers are women ages 19 to 44 with a child younger than 1 whose National Health Interview Survey record indicates the woman is their biological or adoptive mother. Usual source of care is at the time of the survey. Partially adjusted differences account for age, race/ethnicity, citizenship, and region; fully adjusted differences account for those characteristics and marital status, education, and tax unit income. The sample is limited to adults who completed the sample-adult questionnaire and are not missing values for any covariates.

* The unadjusted or adjusted difference is statistically different from zero at $p < 0.05$.

Notes

[1] Alison Stuebe, Jennifer E. Moore, Pooja Mittal, Lakshmi Reddy, Lisa Kane Low, and Haywood Brown, "Extending Medicaid Coverage for Postpartum Moms," *Health Affairs Blog*, May 6, 2019, https://www.healthaffairs.org/do/10.1377/hblog20190501.254675/full/.

[2] Jamie R. Daw, Katy Backes Kozhimannil, and Lindsay K. Admon, "High Rates of Perinatal Insurance Churn Persist after the ACA," *Health Affairs Blog*, September 16, 2019, https://www.healthaffairs.org/do/10.1377/hblog20190913.387157/full/.

[3] Stacey McMorrow and Genevieve M. Kenney, "Despite Progress under the ACA, Many New Mothers Lack Insurance Coverage," *Health Affairs Blog*, September 19, 2018, https://www.healthaffairs.org/do/10.1377/hblog20180917.317923/full/.

[4] Emily Eckert, "It's Past Time to Provide Continuous Medicaid Coverage for One Year Postpartum," *Health Affairs Blog*, February 6, 2020, https://www.healthaffairs.org/do/10.1377/hblog20200203.639479/full/.

[5] Bethany Kotlar, "Amidst the COVID-19 Pandemic, We Must Remember Maternal Health," Maternal Health Task Force blog, April 18, 2020, https://www.mhtf.org/2020/04/18/amidst-the-covid-19-pandemic-we-must-remember-maternal-health/; JoNel Aleccia and Laura Ungar, "Born Into a Pandemic: Virus Complicates Births for Moms and Babies," *Kaiser Health News*, April 24, 2020, https://khn.org/news/born-into-a-pandemic-virus-complicates-births-for-moms-and-babies/.

[6] "Summary Health Statistics," Centers for Disease Control and Prevention, National Center for Health Statistics, updated February 27, 2020, https://www.cdc.gov/nchs/nhis/SHS.htm.

[7] Some of these compositional changes could be related to the ACA if, for example, increases in access to contraception under the law helped women with lower incomes and less education avoid unplanned pregnancies and births. In that case, adjusting for these characteristics when examining changes in affordability and access over time would understate the estimated changes in outcomes associated with ACA implementation.

[8] To fully assess the impact of the ACA, particularly Medicaid expansion, on these outcomes for new mothers, we need to access restricted NHIS data containing state identifiers, which are located at the National Center for Health Statistics research data center. When the data center reopens after the public health emergency, we will assess whether the sample size of new mothers with low incomes across states can support an analysis of Medicaid expansion's effects on new mothers' outcomes.

[9] Stacey McMorrow, Genevieve M. Kenney, Emily M. Johnston, and Jennifer M. Haley, "Extending Postpartum Medicaid Coverage Beyond 60 Days Could Benefit Over 200,000 Low-Income Uninsured Citizen New Mothers," *The Incidental Economist* (blog), February 4, 2020, https://theincidentaleconomist.com/wordpress/extending-postpartum-medicaid/.

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[11] Center on Budget and Policy Priorities, "Sabotage Watch: Tracking Efforts to Undermine the ACA," updated July 22, 2020, https://www.cbpp.org/sabotage-watch-tracking-efforts-to-undermine-the-aca.

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About the Authors

Stacey McMorrow is a principal research associate in the Health Policy Center at the Urban Institute. She has extensive experience using quantitative methods to study the factors that affect individual health insurance coverage and access to care as well as the impacts of state and national health reforms on employers and individuals.

Emily M. Johnston is a research associate in the Health Policy Center. She studies health insurance coverage, access to care, Medicaid policy, reproductive health, and maternal and infant health with a focus on the effects of state and federal policies on the health and well-being of women and their families.

Tyler W. Thomas is a research assistant in the Health Policy Center. He uses data from federal surveys to study insurance coverage and health care access, use, and affordability.

Genevieve M. Kenney is a senior fellow and vice president of the Health Policy Center. She has been conducting policy research for over 25 years and is a nationally renowned expert on Medicaid, CHIP, and broader health insurance coverage and health issues facing low-income children and families.

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500 L'Enfant Plaza SW
Washington, DC 20024

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