

RESEARCH REPORT

Closing Postpartum Coverage Gaps and Improving Continuity and Affordability of Care through a Postpartum Medicaid/CHIP Extension

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Executive Summary

The current public health insurance landscape for postpartum women leaves many new mothersⁱ uninsured during the first year after pregnancy, because eligibility for pregnancy-related Medicaid/Children's Health Insurance Program (CHIP) coverage ends 60 days after pregnancy ends. Still other postpartum women may face obstacles while transitioning to another coverage type when pregnancy-related Medicaid/CHIP ends. In response to the maternal morbidity and mortality crisis in the United States—in which many poor outcomes occur postpartum—federal and state policymakers have proposed policies that would extend, or provide states the option to extend, pregnancy-related Medicaid/CHIP coverage for a full 12 months postpartum.

In this report, we assess how many uninsured new mothers would likely benefit from a 12-month postpartum Medicaid/CHIP extension, based on state of residence, income, citizenship status, and other eligibility criteria. To do so, we analyze prepandemic 2016–18 American Community Survey data, using the Urban Institute Health Policy Center's Medicaid/CHIP Eligibility Simulation Model.¹ We define new mothers as women ages 19 to 44 who reported giving birth in the prior year and uninsured new mothers as those who reported not having insurance coverage within the first year postpartum at the time of the survey. We find the following:

- Approximately 70 percent of the nation's estimated 440,000 women uninsured during the first year postpartum would likely be eligible for some type of publicly subsidized coverage if pregnancy-related Medicaid/CHIP were extended to 12 months postpartum. Among these new mothers,
 - » 28 percent, or 123,000 new mothers, would become newly eligible for Medicaid/CHIP through a postpartum extension;
 - » 27 percent are eligible for Medicaid under current policy but not enrolled; and
 - » 15 percent are both ineligible for Medicaid/CHIP under current policy and an extension but could qualify for subsidized Marketplace coverage if they lack access to affordable employer-sponsored insurance.

ⁱ This analysis uses the terms “women” and “mothers” to describe people who recently gave birth. We use these terms to align with the language in the Social Security Act, which defines Medicaid eligibility for pregnant and postpartum women. But we acknowledge that not all people who become pregnant or give birth identify as women. We remain committed to using respectful, inclusive language.

- Among the 30 percent of uninsured new mothers who would not be eligible for publicly subsidized coverage with a postpartum Medicaid/CHIP extension, 88 percent are noncitizens, who are barred from federally subsidized coverage. The remaining small share is primarily citizen new mothers with incomes above the eligibility thresholds for extended postpartum Medicaid/CHIP coverage or Marketplace subsidies.
- Gains in eligibility for Medicaid/CHIP under a postpartum extension would vary across uninsured new mothers. Thirty-eight percent of uninsured new mothers in states that have not expanded Medicaid eligibility under the Affordable Care Act would likely gain eligibility, compared with 13 percent in states that have expanded Medicaid eligibility.² Among uninsured new mothers who are citizens, 39 percent would become eligible for Medicaid/CHIP under an extension, compared with just 8 percent of those who are noncitizens. More than 40 percent of uninsured new mothers with incomes between 100 and 249 percent of the federal poverty level would become newly eligible for Medicaid/CHIP under a postpartum extension. Further, more than one-third of non-Hispanic Black (36.5 percent) and non-Hispanic white (35.6 percent) uninsured new mothers and about a quarter of Hispanic new mothers would likely gain eligibility under a postpartum Medicaid/CHIP extension.
- The number and share of uninsured new mothers likely to benefit from a postpartum Medicaid/CHIP extension varies by state, and nearly two-thirds of uninsured new mothers who would likely gain eligibility reside in just five states: Florida, Georgia, Missouri, North Carolina, and Texas.
- A postpartum Medicaid/CHIP extension could also benefit new mothers reporting private insurance coverage postpartum. When postpartum Medicaid/CHIP coverage ends 60 days after the end of pregnancy, some women shift to private insurance to remain covered. But under an extension, such mothers would instead be able to maintain Medicaid/CHIP during the postpartum period, not needing to switch coverage. An extension could also help women who are already eligible for Medicaid under current rules retain that coverage during the postpartum period. And continuous access to Medicaid could provide greater continuity of care, financial protection, and access to needed care for these women.

The COVID-19 pandemic and resulting recession have likely changed health care access, health insurance coverage, and income patterns among new mothers relative to when these data were collected in 2016–18 (Banthin and Holahan 2020; Banthin et al. 2020). Uninsurance among new mothers may now be even higher, and, as noted, we find many uninsured new mothers could benefit

from extending pregnancy-related Medicaid/CHIP to 12 months postpartum. Thus, legislation like the Helping Medicaid Offer Maternity Services Act, or Helping MOMS Act,³ which was considered by Congress in 2020 and would let states select the extension without a waiver under existing funding mechanisms, may now be even more crucial to ensuring new mothers' access to needed health care during the critical postpartum period.

Closing Postpartum Coverage Gaps and Improving Continuity and Affordability of Care through a Postpartum Medicaid/CHIP Extension

Two major coverage provisions of the Affordable Care Act (ACA) are Medicaid expansion to adults with incomes up to 138 percent of the federal poverty level (FPL) in some states and the availability of subsidized insurance coverage through Marketplace plans for people with incomes up to 400 percent of FPL. These provisions have resulted in large declines in uninsurance rates for adults in the United States (Antonisse et al. 2018). Important to understanding coverage patterns for new mothers, the ACA reduced uninsurance for parents, reproductive-age women with low incomes,ⁱⁱ and new mothers living in poverty—with greater improvements in states that expanded Medicaid—and reduced coverage disparities by race/ethnicity (Johnston et al. 2017, 2019; Johnston, McMorro, et al. 2020; McMorro et al. 2017).

Insurance coverage during the postpartum period helps facilitate affordable access to needed care following delivery, allowing women to address complications related to pregnancy, manage chronic conditions, and adapt to life with a newborn (ACOG 2018). Despite the critical nature of this period, many women experience health insurance “churn,” or transitions in and out of coverage or between coverage types, surrounding pregnancy (Daw et al. 2017). Though the ACA’s Medicaid expansion reduced rates of churn surrounding pregnancy, many women still experience this churn (Daw et al. 2020); in 2015–17, 20.9 percent of new mothers had experienced uninsurance at some point surrounding pregnancy, and 28.7 percent experienced a change in insurance status between delivery and six months postpartum.⁴

ⁱⁱ This analysis uses the terms “women” and “mothers” to describe people who recently gave birth. We use these terms to align with the language in the Social Security Act, which defines Medicaid eligibility for pregnant and postpartum women. But we acknowledge that not all people who become pregnant or give birth identify as women. We remain committed to using respectful, inclusive language.

Uninsurance surrounding pregnancy owes, in part, to the complex patchwork of publicly supported coverage options for pregnant and postpartum women, which vary by income, immigration status, and state of residence (Haley et al. 2021). For example, Medicaid/CHIP income thresholds for pregnancy-related coverage are higher than those for nonpregnant parents or other adults in all but two states (Idaho and Louisiana); the median threshold is 205 percent of FPL (Brooks et al. 2020). Therefore, many women lose coverage after pregnancy-related Medicaid/CHIP expires 60 days after pregnancy ends, because their incomes are too high to qualify for Medicaid through another pathway. Though many of these women may qualify for premium tax credits to subsidize purchasing insurance on the federal or state-based Marketplaces, only people without access to affordable⁵ employer-sponsored insurance (ESI) are eligible for such coverage. Moreover, Marketplace plans offer fewer financial protections than Medicaid/CHIP (Haley et al. 2021). Additional restrictions bar many noncitizen women from enrolling in Medicaid/CHIP or receiving Marketplace subsidies, even if they meet the income eligibility requirements. And for women eligible for subsidies, enrolling in Marketplace coverage requires changing insurance types, and possibly providers, during a vulnerable time.

Women's coverage options after pregnancy-related Medicaid/CHIP eligibility ends are much more limited in states that have not expanded Medicaid under the ACA, hereafter called nonexpansion states. In such states, parental Medicaid eligibility is typically set well below the FPL, resulting in a "coverage gap" for women with incomes too high to qualify for Medicaid but below the FPL, the minimum threshold for subsidized Marketplace coverage. Consequently, such women do not qualify for any subsidized coverage (Garfield, Orgera, and Damico 2020; Haley et al. 2021). Even in Medicaid expansion states, women who lose Medicaid/CHIP eligibility after pregnancy ends may have incomes too high to qualify for parental or adult Medicaid. Such women would likely meet income eligibility requirements for subsidized Marketplace coverage but not continuous Medicaid/CHIP coverage.

States must evaluate eligibility for other Medicaid coverage categories when pregnancy-related Medicaid/CHIP coverage ends (Chen and Hayes 2020), which may help mothers maintain coverage. However, transitions to other Medicaid pathways still may not be seamless. Though pregnancy-related Medicaid/CHIP coverage is continuous during pregnancy, birth, and the first 60 days after delivery, new mothers eligible to enroll in or renew Medicaid/CHIP through another pathway after such coverage ends may still face barriers to remaining insured (Artiga and Pham 2019).⁶ Further, women no longer eligible for Medicaid may not be connected to Marketplace coverage, or they may not enroll because of the time and effort required to complete enrollment—especially while recovering from

delivery and caring for an infant. Still other women may choose not to enroll in Marketplace plans because of premiums and other costs that remain for subsidized plans.

Finally, beyond the patchwork nature of Medicaid, CHIP, and Marketplace eligibility policies, particularly in nonexpansion states, some women who experience uninsurance surrounding pregnancy may already be eligible for but not enrolled in subsidized coverage. In 2018, only approximately 86 percent of parents in expansion states who were eligible for Medicaid and did not have other coverage participated in the program, indicating many uninsured people appear to face barriers to enrollment.⁷

Federal and state policymakers, with support from professional health organizations and maternal health advocates, have proposed extending continuous pregnancy-related Medicaid/CHIP eligibility from 60 days to one year postpartum to address postpartum uninsurance. This is one part of a broader agenda to address alarmingly high rates of pregnancy-related mortality and morbidity and vast disparities in pregnancy-related outcomes by race and ethnicity in the US (American Academy of Family Physicians et al. 2019; Creanga et al. 2014; Eckert 2020; Equitable Maternal Health Coalition 2020; Stewart 2019; Petersen et al. 2019).⁸ As of this writing, very few states have implemented state-funded Medicaid/CHIP extensions, which are limited to women with certain health conditions. But, numerous states have proposed broader extensions and are awaiting federal approval, and Congress is considering federal legislation (Haley et al. 2021). Most of these proposals would effectively increase eligibility for new mothers in all but two states. In these proposals, the income threshold for postpartum coverage would be 6 to 242 percentage points of the FPL higher than that for parental Medicaid coverage (Haley et al. 2021). Such an extension could further reduce uninsurance among new mothers, particularly in nonexpansion states, and ensure burdensome coverage transitions do not result in loss of coverage or disruptions in care. Yet, the number of uninsured new mothers who could benefit from such eligibility extensions has not yet been estimated.

In this brief, we assess the extent to which uninsured new mothers could benefit from extending pregnancy-related Medicaid/CHIP eligibility for a full 12 months postpartum, as well as other subsidized health coverage options. To do so, we analyze 2016–18 American Community Survey (ACS) data using the Urban Institute Health Policy Center’s Medicaid/CHIP Eligibility Simulation Model. Our analysis assumes 2020 Medicaid/CHIP eligibility rules and that a postpartum Medicaid/CHIP extension would be in effect in all states.⁹ We further investigate the characteristics of uninsured new mothers most likely to benefit from a postpartum Medicaid/CHIP extension, uninsured new mothers’ likely eligibility for publicly subsidized coverage with and without a postpartum extension, and the characteristics of uninsured new mothers unlikely to be eligible for any publicly subsidized coverage option, even with extension of postpartum Medicaid/CHIP eligibility. We also

consider likely eligibility for extended postpartum Medicaid/CHIP among women with private insurance, because Medicaid/CHIP could provide greater financial protection and continuity of care than private insurance for some of these women.¹⁰

Because of the pandemic and related recession, patterns of uninsurance among new mothers have likely changed since our study period. Projections from 2020 estimated that 22 to 31 million workers would lose employment by the end of 2020, putting their access to ESI at risk (Banthin et al. 2020; Banthin and Holahan 2020). Though some of these workers and their families may be eligible for ESI through another family member, projections for the last three quarters of 2020 suggested 7.3 million fewer people would have had ESI over that period, 4.3 million more people would have been covered by Medicaid/CHIP, and 2.9 million more people would have become uninsured (Banthin et al. 2020). Thus, our estimates of likely eligibility for a postpartum Medicaid/CHIP extension, based on insurance status and income reported in 2016–18, likely understate the potential benefits of extending postpartum Medicaid/CHIP coverage in 2021.

Federal and state policy changes in response to the pandemic may further affect coverage patterns among new mothers in 2021 relative to 2016–18. To receive the enhanced federal matching rate in the Families First Coronavirus Response Act, states must provide continuous coverage through the end of the public health emergency for individuals enrolled in Medicaid during or after March 2020.¹¹ This means women enrolled in pregnancy-related Medicaid coverage before or during this period can maintain that coverage beyond 60 days postpartum for the duration of the public health crisis (though this does not apply to all enrollees, such as those with CHIP coverage). Access to Marketplace coverage has also changed temporarily, as some state-based Marketplaces have established new special enrollment periods and the Biden administration has announced an extension of the federal Marketplace enrollment period, allowing additional uninsured people to sign up for coverage outside the typical open enrollment window (Schwab, Giovannelli, and Lucia 2020).¹² Typically, people in states with a federal Marketplace have 60 days after losing their insurance to apply for Marketplace coverage (Blumberg et al. 2020). And coverage rates among new mothers could shift further when the continuous coverage requirement is rescinded at the end of the public health emergency. Given these policy changes, as well as likely changes in eligibility for income-based publicly subsidized coverage owing to rising unemployment, declining incomes, and underlying coverage changes since these data were collected (including in states newly adopting the ACA's Medicaid expansion), we also discuss how coverage patterns may have changed since our data were collected in 2016–18.

How Many New Mothers Uninsured Postpartum Could Benefit If Pregnancy-Related Medicaid/CHIP Were Extended to 12 Months Postpartum?

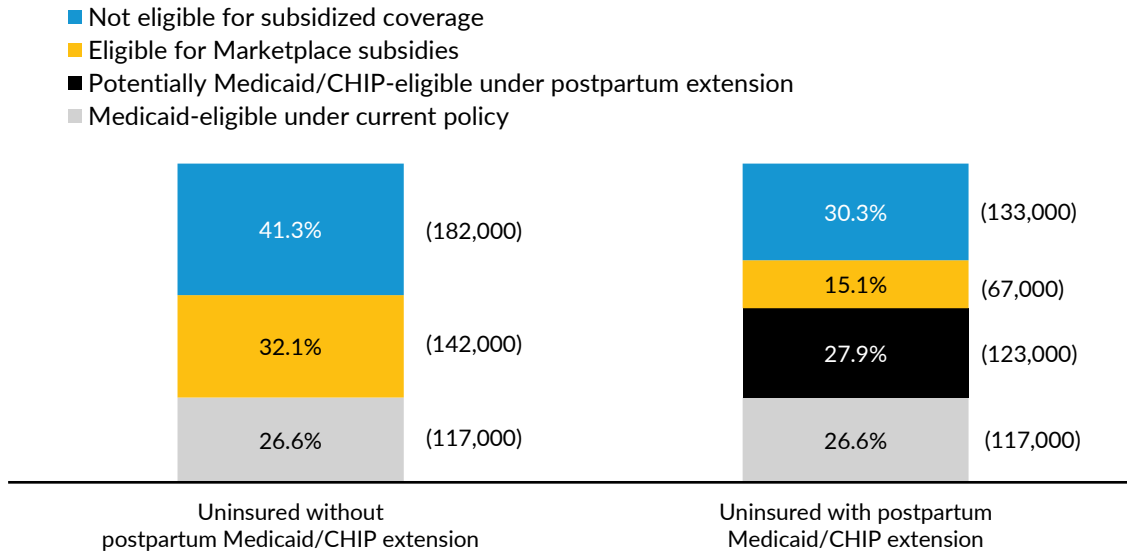
Despite coverage gains under the ACA, 11.9 percent of new mothers, or about 440,000 new mothers annually, were uninsured in 2016–18 (table A.1). We find approximately 54.5 percent of these uninsured new mothers would likely be eligible for Medicaid/CHIP coverage if pregnancy-related Medicaid/CHIP were extended to 12 months postpartum. This includes 27.9 percent who would become newly eligible if they were enrolled in Medicaid/CHIP at delivery (approximately 123,000 new mothers) and 26.6 percent likely already eligible for parental or ACA-expansion Medicaid but not enrolled (figure 1). Thus, a postpartum Medicaid/CHIP extension would more than double the share of uninsured new mothers likely eligible for Medicaid/CHIP coverage. An additional 15.1 percent of all uninsured new mothers in 2016–18 would be in the income range for subsidized Marketplace coverage and could take it up if they lack access to affordable employer-sponsored coverage. Consequently, 69.6 percent of uninsured new mothers in 2016–18 would be eligible for some type of publicly subsidized coverage under an extension of postpartum Medicaid/CHIP coverage. Further, such an extension would also reduce the share of uninsured new mothers likely only eligible for subsidized Marketplace coverage from 32.1 percent to 15.1 percent.

Even with a postpartum Medicaid/CHIP extension, 30.3 percent of uninsured new mothers in 2016–18 would still be ineligible for subsidized coverage. However, this share is higher, at 41.3 percent, without extending postpartum Medicaid/CHIP. This reduction can be attributed to eligibility gains for new mothers in the coverage gap under current policy, whose incomes are too high to qualify for parental Medicaid coverage but too low to qualify for Marketplace subsidies.

FIGURE 1

Share and Number of New Mothers Uninsured Postpartum and Estimated to Be Eligible for Subsidized Coverage under Current Eligibility Rules and a 12-Month Postpartum Medicaid/CHIP Extension, 2016–18

Among 440,000 uninsured new mothers



Source: Urban Institute analysis of 2016–18 American Community Survey data and 2020 Medicaid eligibility rules.

Notes: FPL = federal poverty level. CHIP = Children’s Health Insurance Program. New mothers are women who reported giving birth in the past 12 months. The sample is limited to mothers ages 19 to 44 without Medicare, Supplemental Security Income, or active military duty. Coverage is at the time of survey and adjusted for potential misreporting. Mothers eligible for Marketplace subsidies have incomes between 100 and 400 percent of FPL; we do not account for whether a mother has access to affordable employer-sponsored insurance. Eligibility categories are mutually exclusive in hierarchy, with Medicaid eligibility preceding Marketplace eligibility. Mothers ineligible for subsidized coverage are ineligible for Medicaid and do not qualify for subsidized Marketplace coverage. Annualized counts are noted in parentheses and rounded to the nearest 1,000.

In 2016–18, uninsurance rates among new mothers varied by demographic and socioeconomic subgroups (table A.1). We also find variation in who gains eligibility under a postpartum Medicaid/CHIP extension among uninsured new mothers (figure 2). For instance, 37.7 percent of uninsured new mothers in nonexpansion states would likely gain eligibility,¹³ reflecting low Medicaid eligibility thresholds for parents in these states. In expansion states, this share would be 12.5 percent. Relative gains would be even greater for new mothers in nonexpansion states because they experienced higher uninsurance rates (18.0 percent) than those in expansion states (7.7 percent) in 2016–18 (table A.1).¹⁴

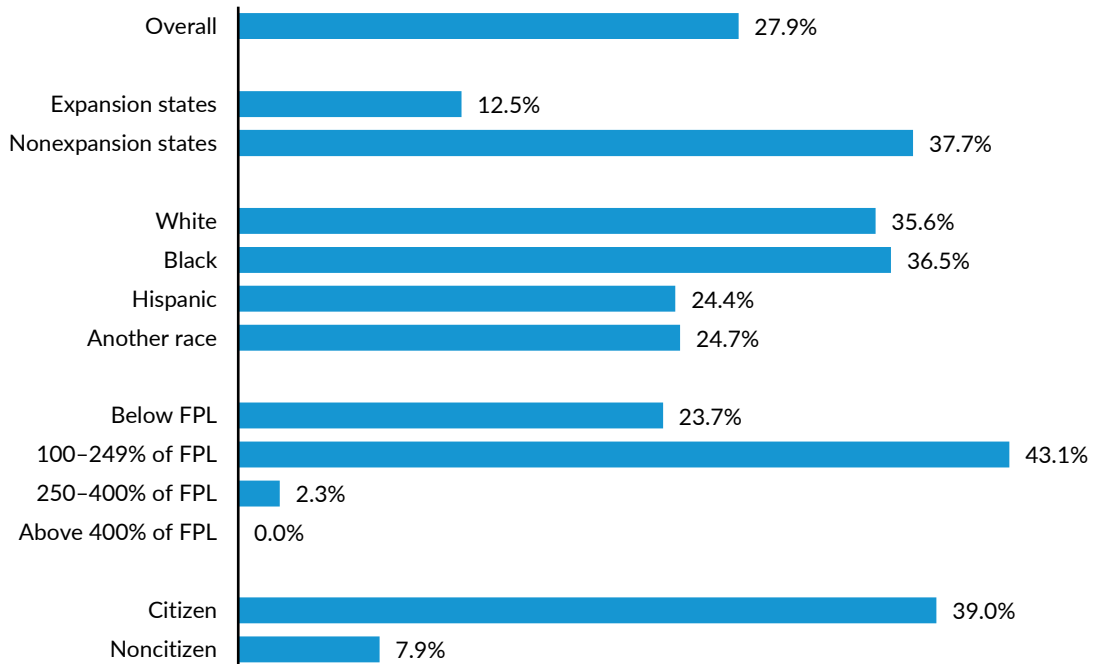
Reflecting variation in eligibility rules by immigration status, 39.0 percent of uninsured citizen new mothers would become newly eligible under a postpartum Medicaid/CHIP extension, compared with just 7.9 percent of noncitizen new mothers; in 2016–18, noncitizen new mothers experienced a much higher uninsurance rate than citizen new mothers (31.5 percent compared with 8.8 percent). About 43.1 percent of uninsured new mothers with incomes likely to qualify them for pregnancy-related Medicaid/CHIP but not Medicaid for parents or other adults in most states (100 to 249 percent of FPL) would become newly eligible for Medicaid/CHIP under a postpartum extension.

Finally, we find more than one-third of Black (36.5 percent) and white (35.6 percent) new mothers who are uninsured would likely gain eligibility under a postpartum extension.ⁱⁱⁱ In 2016–18, 12.3 percent of Black new mothers and 7.0 percent of white new mothers were uninsured (table A.1). Though both groups would therefore benefit from postpartum Medicaid/CHIP extension, Black mothers would gain more coverage than white mothers because of their higher postpartum uninsurance rate.¹⁵ A smaller share of Hispanic new mothers (24.4 percent) would likely gain eligibility, despite having had an uninsurance rate of 16.1 percent in 2016–18.

ⁱⁱⁱ We measure race and ethnicity based on respondents' self-reported responses to separate race and ethnicity questions on the ACS. All respondents who identify Hispanic ethnicity are classified as Hispanic, regardless of race. We stratify non-Hispanic respondents into three groups: non-Hispanic white (hereafter white); non-Hispanic Black (hereafter Black); and non-Hispanic respondents who identify another or multiple races (hereafter another race). We recognize the limitations of these terms and remain committed to employing respectful, inclusive language.

FIGURE 2

Share of New Mothers Uninsured Postpartum and Estimated to Be Newly Eligible for a Postpartum Medicaid/CHIP Extension, by Demographic and Socioeconomic Characteristics, 2016–18



Source: Urban Institute analysis of 2016–18 American Community Survey data and 2020 Medicaid eligibility rules.

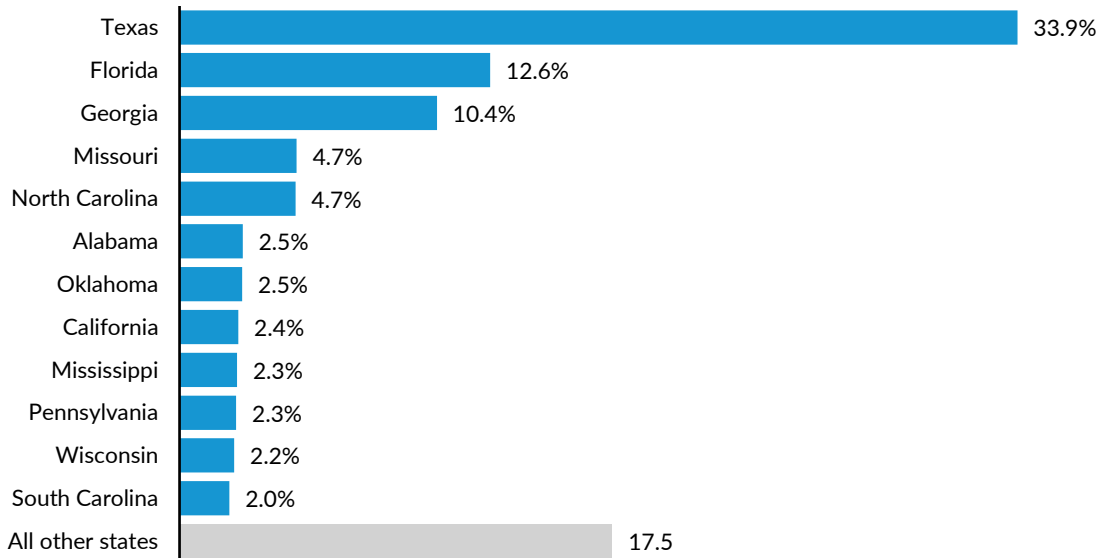
Notes: FPL = federal poverty level. CHIP = Children’s Health Insurance Program. New mothers are women who reported giving birth in the past 12 months. Respondents identifying as white, Black, or another race are not Hispanic. The sample is limited to mothers ages 19 to 44 without Medicare, Supplemental Security Income, or active military duty. Uninsured is at the time of survey and adjusted for potential misreporting. Medicaid expansion status is as of July 2016. Income is modified adjusted gross income relative to the federal poverty level.

Uninsured new mothers who would likely benefit from a postpartum Medicaid/CHIP extension are heavily concentrated in several states: One-third of these new mothers live in Texas (figure 3). Another 23 percent live in Florida (12.6 percent) and Georgia (10.4 percent), states with among the highest uninsurance rates for new mothers (table A.2) and low parental Medicaid eligibility thresholds. Just five states (Florida, Georgia, Missouri, North Carolina, and Texas) are home to nearly two-thirds of uninsured new mothers who would likely benefit from a postpartum Medicaid/CHIP extension.

FIGURE 3

Distribution of New Mothers Uninsured Postpartum and Estimated to Be Newly Eligible for a Postpartum Medicaid/CHIP Extension, by State, 2016–18

Among 123,000 new mothers



Source: Urban Institute analysis of 2016–18 American Community Survey data and 2020 Medicaid eligibility rules.

Notes: FPL = federal poverty level. CHIP = Children's Health Insurance Program. New mothers are women who reported giving birth in the past 12 months. The sample is limited to mothers ages 19 to 44 without Medicare, Supplemental Security Income, or active military duty. Uninsured is at the time of survey and adjusted for potential misreporting. Income is modified adjusted gross income relative to the federal poverty level. All other states are those not shown, each of which has a share below 2.0 percent.

Who Are the New Mothers Uninsured Postpartum, According to Their Eligibility for Publicly Subsidized Coverage If Pregnancy-Related Medicaid/CHIP Were Extended to 12 Months Postpartum?

In this section, we describe the composition of all new mothers uninsured postpartum in 2016–18 (table 1). We then describe four mutually exclusive groups among these uninsured new mothers:

1. Those estimated to be newly eligible for Medicaid/CHIP coverage if pregnancy-related Medicaid/CHIP were extended to 12 months postpartum
2. Those estimated to be eligible for Medicaid/CHIP coverage under current policy
3. Those estimated to be eligible for Marketplace coverage
4. Those unlikely eligible for any publicly subsidized coverage

All mothers uninsured postpartum. Most uninsured new mothers reside in nonexpansion states (61.3 percent), are citizens (64.4 percent), and have incomes below 250 percent of FPL (46.1 percent have incomes under the FPL and 38.9 percent have incomes between 100 and 250 percent of FPL). Nearly two-thirds are Hispanic (65.2 percent), whereas 21.2 percent are white and 9.5 percent are Black (table 1).

Mothers newly eligible for Medicaid/CHIP coverage if pregnancy-related Medicaid/CHIP were extended to 12 months postpartum. Considering uninsured new mothers likely to become eligible for Medicaid/CHIP following extension, more than four in five reside in nonexpansion states (82.7 percent, or more than 101,000 mothers). But, more than 21,000 uninsured new mothers in states that expanded Medicaid could benefit as well. The vast majority of uninsured new mothers likely to become newly eligible are citizens (90.0 percent), and 60.0 percent have incomes between 100 and 250 percent of FPL. Considering patterns by race and ethnicity, 57.0 percent of those likely to become eligible under an extension are Hispanic, whereas 27.0 percent are white and 12.4 percent are Black, partly reflecting underlying variation in uninsurance rates across subgroups.

Mothers estimated to be eligible for Medicaid/CHIP coverage under current policy. New mothers uninsured in 2016–18 but likely already eligible for Medicaid under 2020 eligibility rules are evenly divided between expansion and nonexpansion states (51.0 percent versus 49.0 percent). Nearly three-quarters of these mothers were living in poverty.

Mothers estimated to be eligible for Marketplace coverage. Nearly half (49.0 percent) of the 66,000 new mothers uninsured in 2016–18 but in the income range for subsidized Marketplace coverage had incomes above 250 percent of FPL, and 43.7 percent had incomes between 100 and 250 percent of FPL. One in five (20.2 percent) were noncitizens, 57.8 percent lived in nonexpansion states, and 30.9 percent were white.

Mothers unlikely to be eligible for any subsidized coverage. The vast majority of the approximately 133,000 uninsured new mothers unlikely to be eligible for publicly subsidized coverage with or without a postpartum Medicaid/CHIP extension are noncitizens (87.6 percent), many of whom are barred from federally subsidized coverage. A small share are citizen new mothers with incomes above income thresholds for extended postpartum Medicaid/CHIP coverage or Marketplace subsidies.

TABLE 1

Composition of New Mothers Uninsured Postpartum, by Estimated Eligibility for Publicly Subsidized Coverage under a Postpartum Medicaid/CHIP Extension, 2016–18

	Uninsured New Mothers				
	All	Likely eligible for postpartum Medicaid/CHIP extension	Likely eligible for Medicaid under current policy	Likely eligible for Marketplace coverage	Unlikely eligible for any publicly subsidized coverage
State Medicaid expansion status					
Expansion	38.7%	17.3%	51.0%	42.2%	45.8%
Nonexpansion	61.3%	82.7%	49.0%	57.8%	54.2%
Race/ethnicity					
White	21.2%	27.0%	25.4%	30.9%	7.3%
Black	9.5%	12.4%	13.1%	8.4%	4.2%
Hispanic	65.2%	57.0%	56.5%	54.7%	85.5%
Another race	4.1%	3.6%	4.9%	6.0%	3.0%
Income					
Below FPL	46.1%	39.2%	73.5%	7.3%	47.8%
100–249% of FPL	38.9%	60.0%	22.1%	43.7%	31.9%
Above 250% of FPL	14.9%	0.8%	4.3%	49.0%	20.3%
Citizenship					
Citizen	64.4%	90.0%	88.3%	79.8%	12.4%
Noncitizen	35.6%	10.0%	11.7%	20.2%	87.6%
Sample size	10,234	2,978	2,629	1,698	2,929
Number of uninsured new mothers	440,000	123,000	117,000	67,000	133,000

Source: Urban Institute analysis of 2016–18 American Community Survey data and 2020 Medicaid eligibility rules.

Notes: FPL = federal poverty level. CHIP = Children’s Health Insurance Program. Current policy = 2020 Medicaid eligibility rules. New mothers are women who reported giving birth in the past 12 months. Respondents identifying as white, Black, or another race are not Hispanic. The sample is limited to mothers ages 19 to 44 without Medicare, Supplemental Security Income, or active military duty. Uninsured is at the time of survey and adjusted for potential misreporting. Income is modified adjusted

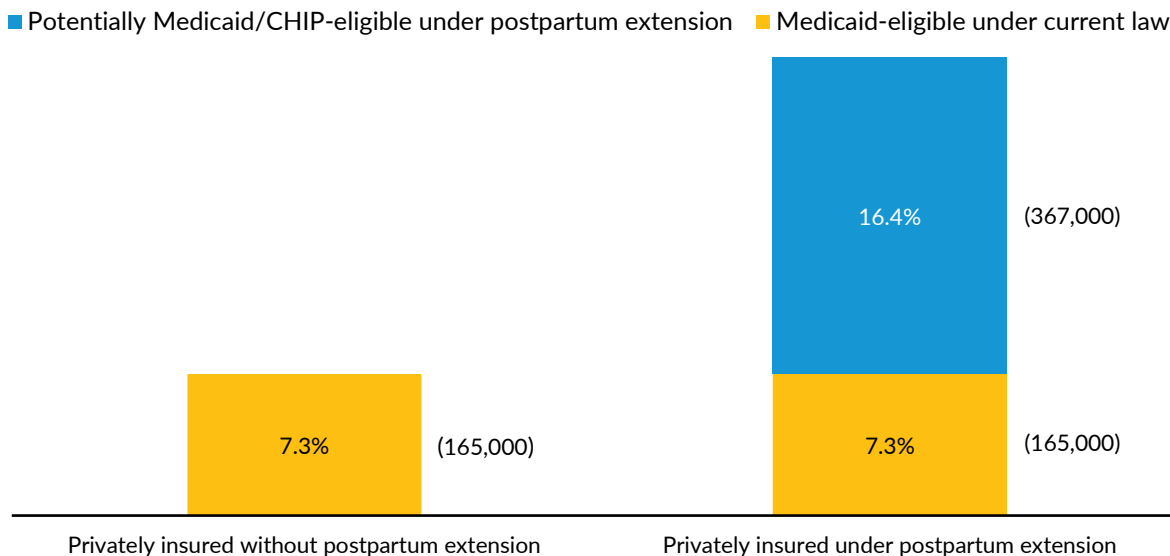
gross income relative to the federal poverty level. Expansion status is as of July 2016. Eligibility categories are mutually exclusive.

How Many New Mothers with Private Insurance Postpartum Could Benefit If Pregnancy-Related Medicaid/CHIP Were Extended to 12 Months Postpartum?

Though a postpartum Medicaid/CHIP extension primarily serves the uninsured, other new mothers could also benefit:¹⁶ Some new mothers covered by private insurance, including ESI or Marketplace coverage, during the first year postpartum might be eligible to maintain Medicaid/CHIP under a postpartum extension if they had pregnancy-related Medicaid/CHIP coverage during pregnancy. In 2016–18, we estimate 367,000 new mothers with private insurance during the first year postpartum met the income and immigration requirements for Medicaid/CHIP under a postpartum extension (figure 4). By allowing those with pregnancy-related Medicaid/CHIP at delivery to maintain such coverage after pregnancy, the extension would allow new mothers to benefit from the greater continuity of care and financial protection and lower cost-sharing requirements in Medicaid/CHIP relative to many private insurance plans (Haley et al. 2021; Johnston, Kenney, et al. 2020). It also eliminates the need to change coverage types and could, in turn, promote greater continuity of coverage and care.

FIGURE 4

Share and Number of New Mothers with Private Insurance Postpartum Estimated to Be Eligible for Medicaid/CHIP under Current Eligibility Rules and a 12-Month Postpartum Medicaid/CHIP Extension, 2016–18



Source: Urban Institute analysis of 2016–18 American Community Survey data and 2020 Medicaid eligibility rules.

Notes: CHIP = Children’s Health Insurance Program. New mothers are women who reported giving birth in the past 12 months. The sample is limited to mothers ages 19 to 44 without Medicare, Supplemental Security Income, or active military duty. Coverage is at the time of survey and adjusted for potential misreporting. Private insurance is employer-sponsored insurance, nongroup/Marketplace coverage, and other private coverage. Eligibility for postpartum Medicaid/CHIP extension indicates meeting the income and immigration requirements for Medicaid/CHIP under a postpartum extension. Among the 367,000 new mothers who meet these requirements, only those with pregnancy-related Medicaid/CHIP coverage at delivery could maintain continuous Medicaid/CHIP coverage for a full year following pregnancy under a postpartum Medicaid/CHIP extension. Annualized counts are noted in parentheses and rounded to the nearest 1,000.

How Might the COVID-19 Pandemic Affect These Estimates?

These findings reflect the coverage patterns and income of new mothers in 2016–18. In typical times, we would expect only minor changes in estimates between 2016–18 and 2021, except in states like Idaho, Maine, Nebraska, Utah, and Virginia, which have expanded Medicaid since our analysis period and may have experienced corresponding increases in public coverage and declines in uninsurance. However, the COVID-19 pandemic and resulting recession have dramatically changed both coverage patterns and income since early 2020. Here, we discuss how those changes may affect uninsurance and likely eligibility for a postpartum Medicaid/CHIP extension among new mothers in 2021, compared with our 2016–18 estimates.

Based on projections of declines in ESI and increases in the number of uninsured people due to the COVID-19 recession (Banthin et al. 2020; Banthin and Holahan 2020), we expect more new mothers could be uninsured in 2021 than in our 2016–18 estimates. On the other hand, the share enrolled in Medicaid may be higher, because the Families First Coronavirus Response Act’s continuous coverage requirements mean some beneficiaries will remain temporarily enrolled in Medicaid until the public health emergency ends. Moreover, eligibility for publicly subsidized coverage may have shifted; under existing rules, more new mothers may now be eligible for Medicaid or Marketplace subsidies because of decreases in family income related to the recession. However, existing data do not allow us to assess the shares of new mothers enrolled in these programs versus remaining uninsured.

It is also unclear whether a different share and number of new mothers would be newly eligible for Medicaid/CHIP if a postpartum Medicaid/CHIP extension were implemented in 2021, instead of 2016–18. On the one hand, this number could be lower if new mothers’ incomes have fallen low enough to qualify for Medicaid under current eligibility thresholds. On the other hand, some new mothers whose incomes were above eligibility thresholds for current or potential extended postpartum Medicaid/CHIP may now have incomes that would qualify for them for the postpartum Medicaid/CHIP extension.

Beyond income changes, the number and share of women likely eligible may be affected by changes in birth rates. Because most births during 2020 were conceived before the pandemic, we do not expect the composition of new mothers to shift immediately. However, the pandemic and recession may change women’s childbearing preferences in 2021 and beyond. If birth rates fall or change differently by women’s incomes or immigration statuses, we would expect further differences in the estimated share and number of new mothers uninsured and likely eligible for Medicaid/CHIP under a postpartum extension.

Discussion

Numerous state and federal policies have been designed to reduce uninsurance among new mothers by extending pregnancy-related Medicaid/CHIP coverage for a full year postpartum, such as the Helping MOMS Act, passed by the House of Representatives in September 2020. Using data from 2016–18, we find approximately 70 percent of uninsured new mothers would likely be eligible for publicly subsidized health insurance if such an extension were implemented. Specifically, we estimate 28 percent of new mothers uninsured during the postpartum period, or about 123,000 mothers annually, would become eligible for Medicaid/CHIP through a postpartum extension. Another 27

percent are likely already eligible for Medicaid but not enrolled. A postpartum Medicaid/CHIP extension could also benefit new mothers reporting having private insurance coverage postpartum; our data show some mothers who had private coverage postpartum would have been able to maintain pregnancy-related Medicaid/CHIP coverage postpartum—instead of needing to switch coverage types to remain insured—had a postpartum Medicaid/CHIP extension been in place.

Though implementing a postpartum Medicaid/CHIP extension could reduce uninsurance among new mothers, several issues would remain.

Postpartum Medicaid/CHIP extension alone would not eliminate racial/ethnic inequities in maternal health. We find that extending postpartum Medicaid/CHIP would reduce uninsurance among new mothers in each racial and ethnic group we examined. Though an important first step, increasing coverage alone is unlikely to eliminate racial disparities in maternal health outcomes, especially the disproportionately high maternal mortality rate facing Black women (Petersen et al. 2019).¹⁷ We find similar shares of uninsured Black and white new mothers would become newly eligible for public coverage if pregnancy-related Medicaid/CHIP were extended for one year postpartum, and Black women would constitute about one in eight mothers likely eligible for an extension. This coverage would be expected to improve outcomes for Black women who would gain eligibility or are already enrolled in Medicaid and would newly receive 12-month continuous coverage. But, it would not benefit other Black mothers unless accompanied by investments to address inequities in access to and quality of care and other effects of systemic racism on health, especially those faced by Black mothers (Crear-Perry et al. 2020; Howell 2019; Taylor 2020; Taylor et al. 2020).¹⁸

Policy solutions would also need to focus on women already eligible for Medicaid and those eligible for subsidized Marketplace coverage but not enrolled. We find that 27 percent of currently uninsured new mothers are likely already eligible for Medicaid but not enrolled, underscoring that extending eligibility alone is insufficient to ensure new mothers are enrolled in and covered continuously by health insurance. This analysis suggests state systems and on-the-ground processes for determining Medicaid eligibility when pregnancy-related Medicaid/CHIP coverage ends are apparently not maintaining coverage for all eligible women and leaving many new mothers eligible for Medicaid under current policies uninsured. Thus, new mothers would benefit from outreach efforts to enroll them in coverage, as well as improvements to ensure systems check for eligibility through parental, ACA-expansion, or other pathways, as required, before disenrolling beneficiaries from Medicaid/CHIP when pregnancy-related coverage ends. Though a postpartum extension would not affect eligibility for the new mothers who already qualify for Medicaid through other pathways under current rules, it could lead to improvements in Medicaid eligibility and enrollment that further reduce postpartum uninsurance

among those new mothers. Moreover, such an extension could remove new mothers' barriers to maintaining coverage through eligibility pathways unrelated to pregnancy, leading to more continuous coverage and greater continuity of care.

We also find an estimated 15 percent of uninsured new mothers would likely meet the income and immigration requirements for subsidized Marketplace coverage, but not Medicaid/CHIP, under a postpartum Medicaid/CHIP extension. However, Marketplace eligibility rules require a person to lack access to affordable ESI, defined as individual coverage—rather than family coverage—costing 9.83 percent or less of an employee's household income.¹⁹ Thus, some of these new mothers may not qualify for Marketplace subsidies (Brooks 2014; Johnston, Kenney, et al. 2020). Even among mothers who qualify for Marketplace subsidies, some may be unaware of Marketplace coverage or tax credits and cost-sharing reductions for purchasing it, especially given recent cutbacks in health insurance navigator funding. These mothers may also face challenges with enrollment systems or be unaware that the birth of a child qualifies a family for a special enrollment period outside annual open enrollment (Cloud 2018).²⁰ Allowing working families with low incomes to receive Marketplace subsidies regardless of their eligibility for ESI, increasing subsidies and cost-sharing assistance to make Marketplace coverage more affordable, and improving outreach and enrollment assistance may be needed to connect more uninsured new mothers to coverage.

Many mothers, particularly noncitizens, would remain ineligible for publicly subsidized coverage even under a postpartum Medicaid/CHIP extension. Even with a postpartum Medicaid/CHIP extension, we find nearly one-third of uninsured new mothers, or 133,000 new mothers annually, would likely be ineligible for subsidized coverage through Medicaid, CHIP, or the Marketplaces. The vast majority are noncitizens, whereas a small share constitutes citizen new mothers with incomes above the thresholds for extended postpartum Medicaid/CHIP coverage or Marketplace subsidies. This finding highlights how the immigration-based eligibility rules for Medicaid/CHIP disproportionately exclude noncitizen new mothers from the program, resulting in higher rates of uninsurance and lower rates of eligibility for Medicaid/CHIP under both current rules and a postpartum extension. To boost these new mothers' eligibility and coverage rates, removing the five-year waiting period before legally present noncitizens can obtain Medicaid and eliminating federal rules barring undocumented immigrants from enrolling in Medicaid would be needed.

The impacts of a postpartum extension would vary across states. Underlying these national patterns, new mothers residing in some states have more to gain from a postpartum extension than others: Eighty-three percent of uninsured new mothers who would become newly eligible for Medicaid/CHIP under a postpartum extension reside in nonexpansion states. And more than half of such mothers live in just

three states, Georgia, Florida, and Texas, which have high uninsurance rates among new mothers and low parental eligibility thresholds. Though resulting gains in eligibility would differ by states' uninsurance rates and eligibility rules, a postpartum Medicaid/CHIP eligibility extension would not eliminate differences in eligibility between states; it would instead extend existing pregnancy-related eligibility rules, which vary widely by state (Haley et al. 2021).

The likelihood of state or federal action to reduce postpartum uninsurance is uncertain, as policymakers focus on the pandemic and adapt to a new federal administration and Congress. The pandemic may change state and federal actions to extend postpartum Medicaid/CHIP eligibility. And federal decisions, such as approval of waiver applications to extend postpartum Medicaid/CHIP coverage, may change under the new presidential administration. State officials may be motivated by the public health crisis and recession to enact policies to help their residents, which could include extending postpartum Medicaid/CHIP. However, Tennessee, Virginia, and Washington have delayed extension efforts because of state budget shortfalls (Haley et al. 2021), and across all states, budget shortfalls are estimated to be as great as \$75 billion in fiscal year 2020 and \$125 billion in fiscal year 2021.²¹ Medicaid can stress state budgets because of its countercyclical nature, in which enrollment grows during economic downturns.²² The Families First Coronavirus Response Act increased the share of federal funds available to match states' Medicaid/CHIP spending by 6.2 percentage points, so long as states maintain eligibility rules and premiums, cover COVID-19 testing and treatment, and provide continuous coverage for Medicaid enrollees through the end of the public health emergency, which currently extends through April 20, 2021 (Musumeci 2020).²³ However, policy analysts are concerned that if enhanced federal financial support is not increased or ends before state budgets recover, states will need to make cuts to Medicaid to address budget shortfalls. This could include cutting administrative staff who process eligibility, which could delay enrollment and increase uninsurance among new mothers and other groups; states could also reduce provider payment rates, which could limit access to care (Aron-Dine et al. 2020).

As many states face budget shortfalls in 2021, they may be reluctant to further extend eligibility for postpartum Medicaid/CHIP. On the other hand, new urgency about health equity and health risks for postpartum populations during the pandemic may spur new interest in Medicaid/CHIP extensions (Haley et al. 2021).

Conclusion

We find that extending pregnancy-related Medicaid/CHIP eligibility for a full year postpartum could make 123,000 otherwise uninsured new mothers newly eligible for Medicaid/CHIP and raise the share of uninsured new mothers likely eligible for subsidized coverage. In addition, under an extension, some mothers with pregnancy-related coverage who would otherwise switch to private coverage postpartum to avoid becoming uninsured would be able to maintain pregnancy-related Medicaid/CHIP postpartum, through which they may have stronger financial protections and greater continuity of care. A postpartum Medicaid/CHIP extension would also benefit women eligible for Medicaid/CHIP under current rules but uninsured, if implemented alongside improvements in eligibility and enrollment processes for postpartum women. Improving new mothers' health and well-being postpartum will depend on those eligible enrolling and staying enrolled in Medicaid/CHIP coverage and obtaining high-quality care (Manatt Health 2020). Insurance can help postpartum women meet their health care needs, such as treatment for depression, and reduce financial strain, benefitting women and their children and families (McMorrow, Dubay, et al. 2020; McMorrow, Johnston, et al. 2020). Though extending pregnancy-related Medicaid/CHIP eligibility for a full year postpartum would not reach all uninsured new mothers, it could provide affordable coverage to more than 100,000 new mothers and support increased access to needed care during the critical first year postpartum.

Appendix A. Data and Methods

For this analysis, we use data from the 2016–18 American Community Survey, fielded annually by the US Census Bureau, from the Integrated Public Use Microdata Series.²⁴ Annual estimates reported here reflect the average across pooled years 2016–18.

New mothers are identified as noninstitutionalized civilian women ages 19 to 44 who report giving birth in the past year. We exclude from this analysis new mothers on active military duty, who reside in noninstitutionalized group quarters, who report Medicare coverage, and who report receiving Supplemental Security Income because of their alternate coverage pathways and the complexities of assessing income for eligibility. Each year of the ACS includes a public-use sample of 33,000 to 35,000 new mothers, representing 3.7 to 3.8 million new mothers in the United States. This gives a total analytic sample size of 98,451 observations, representing 11.1 million new mothers, after the restrictions described above.

Eligibility for Medicaid, Postpartum Medicaid/CHIP Extension, and Marketplace Coverage

Estimated eligibility for Medicaid under current policy. To assess eligibility for Medicaid under current policy and a postpartum Medicaid/CHIP extension, we combine the individual and family information survey respondents provide with the Medicaid/CHIP eligibility rules for each woman’s state of residence (as noted, the District of Columbia is considered a state in this analysis). First, we determine whether new mothers appeared to be eligible for comprehensive Medicaid, including expanded Medicaid eligibility under the ACA in participating states; eligibility pathways for parents; eligibility related to disability or Supplemental Security Income receipt; and coverage for young adults ages 19 and 20 in some states (Brooks et al. 2016, 2017, 2018; Buettgens and Banthin 2020). To do so, we use the Urban Institute Health Policy Center’s Medicaid/CHIP Eligibility Simulation Model and the American Community Survey Health Insurance Policy Simulation Model, which incorporate Medicaid eligibility policies in 2016–18 and changes in some policies through January 1, 2020, as described later. Where immigration status factors into eligibility determination, we rely on imputed documentation status for noncitizens (Kenney et al. 2016). We include as Medicaid eligible those who meet other income and eligibility requirements and are imputed as documented and meeting residency requirements.²⁵ Kenney and colleagues (2016) provides further details on this methodology. We also include as eligible under current policy women who reside in Minnesota or New York and

have incomes between 138 and 200 percent of FPL and therefore qualify for the Basic Health Program.²⁶ Though most states' Medicaid eligibility rules did not shift dramatically during our study period or between then and the present year, four states (Idaho, Maine, Utah, and Virginia) adopted the ACA's Medicaid expansion following data collection for the 2016–18 ACS. To avoid overstating potential postpartum eligibility, we classify women who were ineligible for Medicaid under 2016–18 rules but had incomes below the ACA eligibility threshold (138 percent of FPL) in those four states as already eligible for Medicaid under existing policy. Thus, though we use 2016–18 data, estimates of eligibility rely on January 2020 rules and therefore overstate eligibility in those states relative to eligibility during the data years. Additionally, Nebraska expanded Medicaid on October 1, 2020, but because our policy cut-off is January 2020, we do not account for this expansion in our analysis. Only Louisiana changed expansion status during our data years, in July 2016; it is classified as an expansion state.

Potential eligibility for proposed postpartum Medicaid/CHIP extension. For women who did not appear to be eligible for Medicaid under current policy, we assessed whether they met 2020 income and immigration requirements for pregnancy-related Medicaid/CHIP coverage (Brooks et al. 2020). Mothers meeting these requirements could have qualified for a 12-month postpartum Medicaid/CHIP extension if one had been in place in every state and they had been enrolled in pregnancy-related Medicaid/CHIP for pregnancy or delivery (the ACS lacks information on coverage status at the time of delivery). We estimate income eligibility by comparing family income with 2020 pregnancy-related Medicaid/CHIP income thresholds. Women were determined to meet immigration-related rules if they were either citizens, noncitizens lawfully residing in the US for more than five years, or noncitizens lawfully residing in the US fewer than five years and living in a state that has adopted the option to cover this group without a waiting period as of 2020, known as the Immigrant Children's Health Improvement Act option. As stated above, women in states newly implementing the ACA's Medicaid expansion since 2018 were included as already eligible, rather than eligible for a postpartum Medicaid/CHIP extension. We assume income and immigration rules for a postpartum extension would be the same as those for pregnancy-related Medicaid/CHIP under current policy, without broadening or restricting enrollment based on income, immigration status, or other factors. In addition, current proposals to extend postpartum Medicaid/CHIP only include pregnancy-related Medicaid/CHIP coverage, not CHIP's Unborn Child option, which has been adopted by 17 states as of 2020 (Brooks et al. 2020). We therefore exclude eligibility for those programs here. We also exclude from eligibility mothers who would only qualify for "emergency" Medicaid coverage for services at birth, which is for women ineligible for Medicaid/CHIP.

Estimates based on the analysis presented here roughly align with similar estimates based on different methodologies and data years. For instance, using 2017 ACS data, McMorrow and colleagues identified 451,000 uninsured new mothers, 217,000 of whom were citizens with incomes below 200 percent of FPL, who are likely already eligible for Medicaid or could qualify for extended postpartum coverage if it were implemented.²⁷ However, these estimates combine eligibility for existing Medicaid pathways with potential new eligibility under an extension and, thus, differ from the estimates presented here. Similarly, Johnston, McMorrow, and colleagues (2020) identifies 451,000 uninsured new mothers in 2017; of those, 173,000 were citizens with incomes below 138 percent of FPL and 115,000 were citizens with incomes above 138 percent of FPL. These estimates did not assess likely eligibility for Medicaid/CHIP under existing Medicaid pathways or specifically consider the income range likely to benefit from a postpartum extension.

Potential eligibility for subsidized Marketplace coverage. For women who did not appear eligible for Medicaid under current rules or a proposed postpartum Medicaid/CHIP extension, we also assess whether they were in the income range to qualify for subsidized Marketplace coverage (i.e., had incomes between 100 and 400 percent of FPL and were citizens or lawfully residing immigrants). Further, we include as potentially eligible for subsidized Marketplace coverage lawfully residing immigrants (including those with incomes below the FPL), who do not qualify for Medicaid because of the five-year waiting period. Notably, eligibility for premium tax credits also requires a person to lack access to “affordable” ESI; however, this analysis does not consider such access and only assesses whether a woman meets the income and immigration requirements to be eligible for subsidized Marketplace coverage. Thus, some women in this group may not be estimated to qualify for such coverage if their ESI access could be assessed.

Analysis

We classify mothers by the following coverage statuses, incorporating edits to address potential misclassification of coverage in the ACS: (1) uninsured, (2) enrolled in Medicaid/CHIP, or (3) insured through ESI, nongroup/Marketplace coverage, or other private coverage at the time of the survey. First, we estimate counts and shares of uninsured new mothers eligible for Medicaid under current policy, potentially newly eligible for Medicaid/CHIP under a 12-month postpartum extension, meeting the income and immigration requirements for Marketplace subsidies, and not qualifying for any publicly subsidized coverage option. We present estimates for the US overall and by selected characteristics, including state ACA Medicaid expansion status as of July 2016, income, citizenship status, race/ethnicity, and state of residence. We document the characteristics of uninsured new

mothers assigned to each eligibility classification. We also assess eligibility for privately insured new mothers, for whom extended postpartum Medicaid could become an alternative coverage option if they could have maintained pregnancy-related Medicaid/CHIP coverage after delivery, rather than switching to private coverage.

All subnational analyses are limited to subgroups with a pooled sample size of 250 or more new mothers.

Limitations

As we note in other analyses of health insurance coverage and Medicaid/CHIP eligibility, both coverage and eligibility statuses are likely measured with error. When estimating eligibility, we find “ineligible reporters,” or people who appear ineligible for Medicaid/CHIP under current policy (mostly because a person’s family income is above their state’s Medicaid/CHIP threshold) but report having such coverage. These inconsistencies may owe to misreporting of income, family size/structure, coverage status, or other characteristics. They may also owe to our inability to estimate eligibility for all available coverage pathways for adults (e.g., medically needy eligibility, for people with high medical expenses relative to family income, and temporary Transitional Medical Assistance, for people who lose eligibility because of increased earnings or hours of employment) because of a lack of data on medical expenditures and prior Medicaid enrollment. Inconsistencies in coverage may also owe to a disconnection across time frames; the ACS income measurement reflects the prior 12 months, whereas Medicaid/CHIP eligibility is based on income at the time of application or renewal. Moreover, because we find a larger share of ineligible reporters among new mothers in nonexpansion states than expansion states, measurement error could bias comparisons across these two groups of states.

These limitations may lead to bias in estimating potential eligibility for 12-month postpartum Medicaid/CHIP among new mothers. The presence of ineligible reporters in our model suggests we may be understating Medicaid eligibility under current policy. This, in turn, may mean some women we identify as potentially eligible under a postpartum extension may, in fact, already qualify under current policy through a coverage pathway we cannot assess. In addition, families with infants may be more likely than other families to experience variation in income over time, given changes in household characteristics, such as work status, hours worked, and income, as families adjust to their newborn and mothers recover from childbirth. Therefore, estimated eligibility based on income over the prior year, which may include the period before birth, may not reflect circumstances during the postpartum period. For instance, a woman who works full time before delivery but lacks paid employment during the postpartum period, while she cares for her newborn, may appear ineligible for Medicaid under

current policy and eligible for a postpartum extension, according to family income over the prior 12 months. But, considering only income at the time of the survey, she may, in fact, qualify for Medicaid under current policy. Based on our understanding of proposed legislation, a woman must be enrolled in pregnancy-related Medicaid/CHIP for pregnancy and delivery to qualify for extended postpartum coverage. But because we only have information on new mothers' insurance coverage at the time of the survey (after pregnancy), we base our estimates of potential eligibility for a postpartum extension on a woman's likely eligibility for extended pregnancy-related Medicaid/CHIP, not on her actual use of pregnancy-related Medicaid/CHIP.

In addition, to avoid overstating potential eligibility for a postpartum extension, we apply January 2020 pregnancy-related eligibility rules and state ACA Medicaid expansion decisions when analyzing 2016–18 data. However, changes in the underlying coverage and income distribution may have occurred during that time, especially in states with large policy changes (e.g., adoption of the ACA's Medicaid expansion). Moreover, because these estimates rely on prepandemic data, they do not account for shifts in income and coverage status during the pandemic and associated recession. The number of uninsured new mothers may now be higher than when these data were collected because of losses of employer-sponsored coverage. Likely eligibility for Medicaid/CHIP under current rules and a proposed extension and eligibility for Marketplace subsidies may have also shifted, given changes in the income distribution during the recession. Though we discuss potential shifts in our findings based on these changes, the available data do not allow us to assess these patterns. We also do not account for increases in Medicaid enrollment owing to the recession and the temporarily extended continuous coverage provision in the Families First Coronavirus Response Act

Finally, the available data do not allow us to precisely estimate the impacts of a postpartum extension for women reporting Medicaid coverage at the time of the survey. Some of these new mothers are likely eligible for Medicaid through pathways unrelated to pregnancy, meaning their coverage would continue past the postpartum period. Yet, others may be within 60 days of delivery and covered by pregnancy-related Medicaid/CHIP. For some of these women, we can identify a Medicaid eligibility pathway under current policy, whereas others either appear eligible for extended postpartum eligibility or their eligibility pathway cannot be identified. However, we lack data on the number of months since birth and thus cannot identify which new mothers are at risk of losing reported pregnancy-related coverage under current policy and could therefore benefit from a postpartum extension. We also lack the details needed to assess every Medicaid eligibility pathway under current policy, so we cannot assess how many of these women would benefit from a postpartum extension. However, many Medicaid-enrolled women would likely still benefit from a 12-

month postpartum extension, because it would allow them to keep the same coverage without having to worry about changing eligibility pathways, renewing coverage, or losing coverage during their first year postpartum if their income or other circumstances change.

Appendix B. Supplementary Tables

TABLE A.1

Number and Share of New Mothers Uninsured Postpartum, by Demographic and Socioeconomic Characteristics, 2016–18

	Thousands of uninsured new mothers	Uninsurance rate
All new mothers	440	11.9
State Medicaid expansion status		
Expansion	170	7.7
Nonexpansion	270	18.0
Race/ethnicity		
White	93	7.0
Black	42	12.3
Hispanic	287	16.1
Another race	18	7.1
Income		
Below FPL	203	21.7
100–249% of FPL	171	15.2
Above 250% of FPL	44	6.5
Above 400% of FPL	22	2.3
Citizenship		
Citizen	283	8.8
Noncitizen	156	31.5

Source: Urban Institute analysis of 2016–18 American Community Survey data.

Notes: N = 10,234. FPL = federal poverty level. New mothers are women who reported giving birth in the past 12 months.

Respondents identifying as white, Black, or another race are not Hispanic. The sample is limited to women ages 19 to 44 without Medicare, Supplemental Security Income, or active military duty. Uninsured is at the time of survey and corrected for apparent misreporting. Income is modified adjusted gross income relative to the federal poverty level. Expansion status is as of July 2016. Numbers of new mothers are rounded to the nearest 1,000.

TABLE A.2

Number and Share of New Mothers Uninsured Postpartum, by State, 2016–18

	Thousands of uninsured new mothers	Uninsurance rate
US	440	11.9
Texas	105	28.0
Georgia	26	20.5
Oklahoma	11	20.3
Florida	40	18.5
Mississippi	5	15.5
Alabama	8	14.2
North Carolina	16	13.6
South Carolina	8	13.0
Missouri	9	12.0
New Jersey	11	11.5
Virginia ^a	10	11.1
Utah ^a	6	10.6
Indiana	8	10.5
Arizona	8	10.0
Louisiana ^b	5	9.7
Washington	9	9.1
Wisconsin	6	8.7
Maryland	6	8.5
Colorado	5	8.1
Pennsylvania	11	8.0
Illinois	12	7.9
California	33	7.4
Tennessee	5	7.2
Ohio	10	6.9
New York	11	5.5
Michigan	6	5.4

Source: Urban Institute analysis of 2016–18 American Community Survey data.

Notes: New mothers are women who reported giving birth in the past 12 months. The sample is limited to mothers ages 19 to 44 without Medicare, Supplemental Security Income, or active military duty. Uninsured is at the time of survey and corrected for apparent misreporting. Numbers of new mothers are rounded to the nearest 1,000. States not shown all have 5,000 or fewer uninsured new mothers.

^a Virginia and Utah expanded Medicaid after 2016–18. Therefore, these estimates are likely greater than estimates of uninsurance in these states following expansion.

^b Louisiana expanded Medicaid in July 2016. Therefore, Louisiana estimates, which include six months before expansion, likely somewhat overstate uninsurance after expansion.

Notes

- ¹ We apply January 2020 eligibility rules for pregnancy-related Medicaid/CHIP thresholds and expansion Medicaid thresholds. Specifically, we model Medicaid eligibility as 138 percent of FPL for the four states that implemented Medicaid expansion between January 1, 2018, and January 1, 2020: Idaho, Maine, Utah, and Virginia. Nebraska expanded Medicaid on October 1, 2020, but because our policy cutoff is January 2020, we do not account for this expansion in our analysis. In states that have not expanded Medicaid under the ACA, some thresholds are defined based on dollar amounts, creating small changes in thresholds as a share of FPL over time. For nonexpansion states, we apply 2016–18 eligibility thresholds to the corresponding year. In Connecticut, an expansion state with changing eligibility thresholds, we also apply the corresponding threshold for years 2016–18. See the appendix for more detail on study data and methods.
- ² For simplicity, the District of Columbia is considered a state for this analysis.
- ³ [Helping MOMs Act of 2020](#), H.R. 4996, 116th Cong. (2019–20).
- ⁴ 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/doi/10.1377/hblog20190913.387157/full/>.
- ⁵ Affordable coverage is based on income and defined as self-only coverage with employee costs that do not exceed 9.83 percent of income. See “Affordable Coverage,” HealthCare.gov, accessed January 19, 2021, <https://www.healthcare.gov/glossary/affordable-coverage/>.
- ⁶ Kay Johnson, Sara Rosenbaum, and Morgan Handley, “The Next Steps to Advance Maternal and Child Health in Medicaid: Filling Gaps in Postpartum Coverage and Newborn Enrollment,” *Health Affairs Blog*, January 9, 2020, <https://www.healthaffairs.org/doi/10.1377/hblog20191230.967912/full>.
- ⁷ Authors’ calculations of 2018 American Community Survey data using the Urban Institute Health Policy Center’s Medicaid/CHIP Eligibility Simulation Model.
- ⁸ American College of Obstetricians and Gynecologists, “ACOG Statement on AMA Support for 12 Months of Postpartum Coverage under Medicaid,” news release, June 12, 2019, <https://www.acog.org/news/news-releases/2019/06/acog-statement-on-ama-support-for-12-months-of-postpartum-coverage-under-medicaid>; 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/doi/10.1377/hblog20200203.639479/full/>; “View Each State’s Efforts to Extend Medicaid Coverage to Postpartum Women,” National Academy for State Health Policy, updated December 28, 2020, <https://www.nashp.org/view-each-states-efforts-to-extend-medicaid-coverage-to-postpartum-women/>.
- ⁹ See the data and methods appendix for more detail.
- ¹⁰ We do not examine access to subsidized coverage options among new mothers reporting Medicaid/CHIP coverage in 2016–18. Though some of these mothers may benefit from a postpartum extension if they are within 60 days of the end of pregnancy, and therefore at risk of losing Medicaid/CHIP, data limitations do not allow us to identify these women. Nor can we further assess the specific pathway through which these mothers obtained Medicaid/CHIP. We therefore acknowledge that additional new mothers could benefit from a postpartum extension. See the data and methods appendix.
- ¹¹ Sara Rosenbaum, Devon R. Minnick, Maria Velasquez, and Morgan Handley, “Administration Effectively Rescinds ‘Families First’ Medicaid Continuous Enrollment Protection,” *Health Affairs Blog*, November 18, 2020, <https://www.healthaffairs.org/doi/10.1377/hblog20201116.26547/full/>.
- ¹² Amy Goldstein, “Biden to Reopen ACA Insurance Marketplaces as Pandemic Has Cost Millions of Americans Their Coverage,” *Washington Post*, January 25, 2021, <https://www.washingtonpost.com/health/biden-to->

reopen-aca-insurance-marketplaces-as-pandemic-has-cost-millions-of-american-their-coverage/2021/01/25/ccfc2402-5e74-11eb-9061-07abcc1f9229_story.html.

- ¹³ States are classified by ACA Medicaid expansion status as of July 31, 2016. Expansion states are AK, AZ, AR, CA, CO, CT, DC, DE, HI, IL, IN, IA, KY, LA, MD, MA, MI, MN, MT, NV, NH, NJ, NM, NY, ND, OH, OR, PA, RI, VT, WA, and WV. Nonexpansion states are AL, FL, GA, ID, KS, ME, MS, MO, NE, NC, OK, SC, SD, TN, TX, UT, VA, WI, and WY. Only Louisiana changed expansion status during our data years, in July 2016, and is classified as an expansion state. Four states (Idaho, Maine, Utah, and Virginia) adopted the ACA's Medicaid expansion between the 2016–18 ACS and January 1, 2020. Nebraska expanded Medicaid on October 1, 2020, but because our policy cutoff is January 2020, we do not account for this expansion in our analysis. To avoid overstating potential postpartum eligibility, we classify women ineligible for Medicaid under 2016–18 rules but with incomes below the ACA eligibility threshold of 138 percent of FPL in Idaho, Maine, Utah, and Virginia as already eligible for Medicaid under existing policy. Therefore, though we use 2016–18 data, estimates of eligibility rely on January 2020 rules. We therefore overstate eligibility in Idaho, Maine, Utah, and Virginia relative to eligibility during the data years.
- ¹⁴ Coverage patterns according to expansion status may have shifted somewhat since the study period, especially in states newly adopting the expansion since July 2016.
- ¹⁵ The share of uninsured new mothers likely eligible for Medicaid coverage under current policy is 31.9 percent for white new mothers and 36.9 percent for Black new mothers (data not shown).
- ¹⁶ Some new mothers reporting Medicaid/CHIP coverage at the time of the survey were likely eligible for Medicaid as parents or adults and could retain that coverage. However, others may be within 60 days after pregnancy and still covered by pregnancy-related Medicaid/CHIP but at risk of becoming uninsured after this coverage expires, if they do not otherwise qualify for Medicaid. A person's Medicaid/CHIP eligibility pathway and month of the end of pregnancy are not available in the ACS data. Therefore, we cannot assess whether new mothers who report Medicaid/CHIP coverage are still covered by pregnancy-related Medicaid/CHIP coverage within 60 days after pregnancy, or if their Medicaid/CHIP coverage is through a pathway unrelated to pregnancy that will continue past 60 days (e.g., parental, ACA-expansion, or disability-based Medicaid).
- ¹⁷ American Indian/Alaska Native women also experience high rates of pregnancy-related deaths. We are unable to analyze their coverage because of the small sample size of uninsured new mothers who identify as American Indian/Alaska Native in our data.
- ¹⁸ Katy Backes Kozhimannil and Marie Zimmerman, "Keeping Moms Alive: Medicaid Policy Changes and Ideas for Systems Transformation," *Health Affairs Blog*, March 2, 2020, <https://www.healthaffairs.org/doi/10.1377/hblog20200228.150620/full/>.
- ¹⁹ "Affordable Coverage," HealthCare.gov.
- ²⁰ "Having a Baby? You Can Enroll in or Change Your Health Coverage," *HealthCare.gov Blog*, accessed January 28, 2021, <https://www.healthcare.gov/blog/special-enrollment-period-child-birth/>.
- ²¹ Lucy Dadayan, "COVID-19 Pandemic Could Slash 2020-21 State Revenues By \$200 Billion," *Tax Vox* (blog), Urban-Brookings Tax Policy Center, July 1, 2020, <https://www.taxpolicycenter.org/taxvox/covid-19-pandemic-could-slash-2020-21-state-revenues-200-billion>.
- ²² Allan Baumgarten and Katherine Hempstead, "Recession and Medicaid Budgets: What Are the Options?" *Health Affairs Blog*, September 10, 2020, <https://www.healthaffairs.org/doi/10.1377/hblog20200908.169117/full/>.
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- ²⁶ The Basic Health Program reduces premiums and out-of-pocket cost sharing for those eligible for Marketplace coverage with incomes below 200 percent of FPL.
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