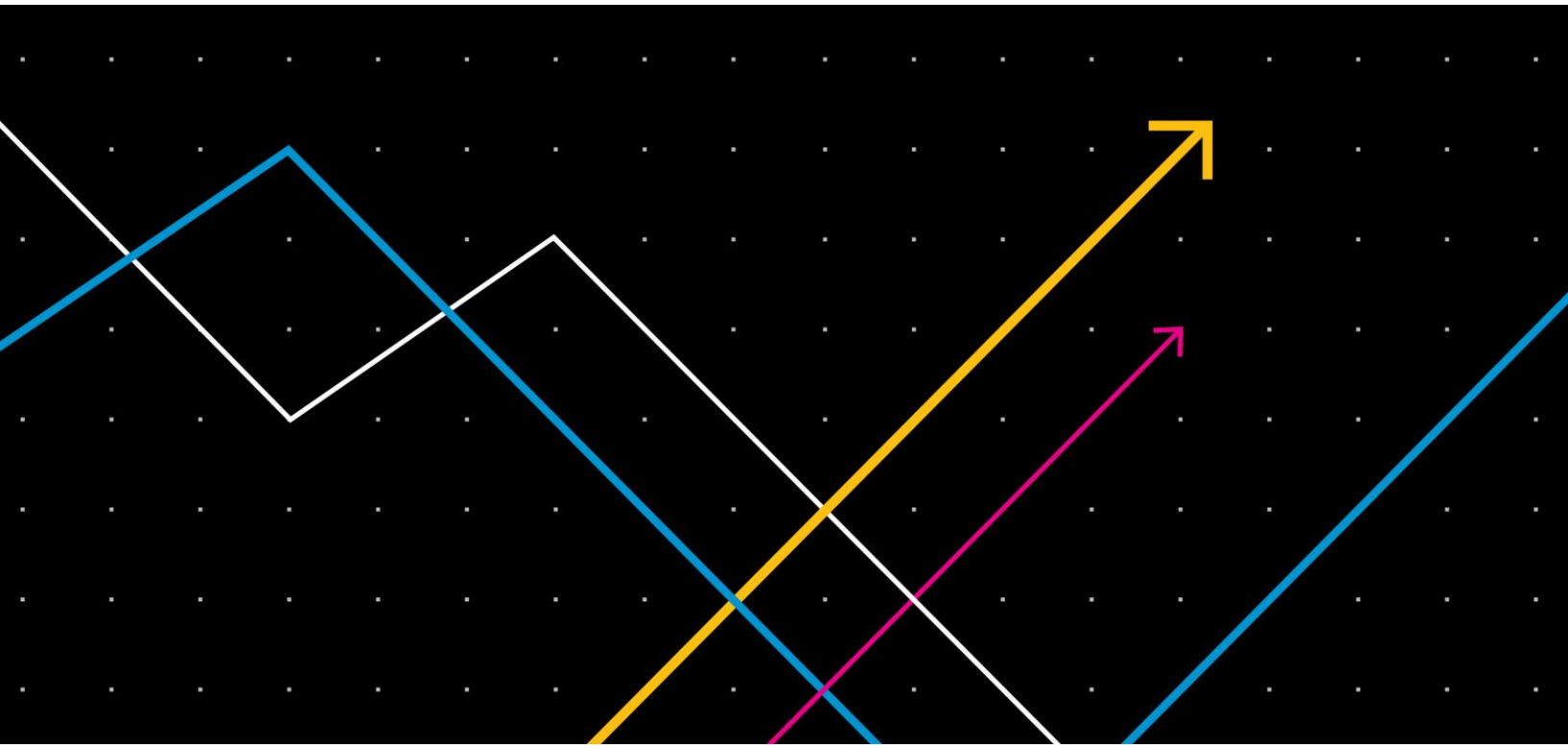

RESEARCH REPORT

The Public Health Insurance Landscape for Pregnant and Postpartum Women

State and Federal Policies in 2020

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Executive Summary

Concerns about high maternal morbidity and mortality rates in the United States have highlighted the circumstances of new mothers in the 12 months following the end of pregnancy. With many pregnancy-related complications and deaths occurring after delivery, and widening racial and ethnic disparities in maternal outcomes, there is growing interest in policy solutions to ensure new mothers have access to affordable health insurance coverage that addresses their physical, mental, reproductive, and behavioral health needs. Meeting these needs has become even more critical during the COVID-19 pandemic and economic crisis.

This report summarizes publicly subsidized coverage options for pregnant and postpartum women,[i] including Medicaid, the Children's Health Insurance Program (CHIP), and subsidized Marketplace coverage. We present state and federal eligibility policy details with respect to income and citizenship and documentation status, as well as information on covered benefits and cost-sharing requirements. We also summarize recently proposed state and federal legislation that would affect coverage options for postpartum women and assess how much such legislation could expand the coverage landscape for new mothers. We find the following:

- Though some women may have Medicaid coverage before becoming pregnant, Medicaid/CHIP eligibility during pregnancy is more generous than that for nonpregnant women in most states. The median state income threshold for pregnancy-related Medicaid/CHIP coverage in 2020 was 205 percent of the federal poverty level (FPL) nationwide, well above the median Medicaid income threshold for nonpregnant adults (138 percent of FPL). Pregnancy-related eligibility ranges widely across states, from 138 percent of FPL in Idaho, Louisiana, Oklahoma, and South Dakota to 380 percent of FPL in Iowa. Pregnancy-related coverage is federally required to cover only broadly defined pregnancy-related services, but most states include comprehensive benefits in pregnancy-related Medicaid/CHIP coverage, including the full range of non-pregnancy-related health care services, with minimal cost sharing.
- There is also substantial variation in states' pregnancy-related Medicaid/CHIP rules related to citizenship and documentation status. Twenty-six states require lawfully residing noncitizen

[i] This analysis uses the terms "women" and "mothers" to describe people who are pregnant or 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.

women to have five years of residency before becoming eligible for full pregnancy-related Medicaid/CHIP, but the other half of states allow these noncitizen women to enroll without a waiting period. Seventeen states extend CHIP eligibility to all pregnant women—regardless of their citizenship or documentation status—via the "unborn child" option, though this coverage may not be as comprehensive as pregnancy-related Medicaid/CHIP. In the remaining states without pathways to coverage for these groups of immigrant women, those who are ineligible because of citizenship or documentation status can receive only "emergency" Medicaid coverage for services at the time of delivery that does not cover prenatal or postpartum care.

- Pregnancy-related Medicaid/CHIP coverage expires about 60 days following the end of pregnancy. At that point, new mothers are subject to their state's regular Medicaid income eligibility thresholds for parents, which are typically lower than pregnancy-related thresholds. The median is 138 percent of FPL in states adopting the Affordable Care Act's (ACA's) Medicaid expansion, and the median is below 50 percent of FPL in nonexpansion states. Some new mothers who are ineligible for parental or ACA-expansion Medicaid may qualify for limited family planning coverage—which does not include comprehensive health benefits—or subsidized Marketplace coverage. But in most nonexpansion states, some low-income new mothers are in the "coverage gap" (with incomes too high to qualify for Medicaid but too low to qualify for subsidized Marketplace coverage), with no affordable comprehensive coverage options.
- Some pregnant and postpartum women who have family incomes between 100 and 400 percent of FPL and are not eligible for Medicaid/CHIP may qualify for premium tax credits to subsidize purchasing insurance on the federal or state-based Marketplaces. Women with incomes below 250 percent of FPL are further eligible for cost-sharing reductions. Marketplace plans must cover essential health benefits, including delivery, comprehensive prenatal and postpartum care, and family planning, but these plans generally have higher cost sharing than Medicaid/CHIP. Pregnancy does not qualify a woman for a special enrollment period outside annual open enrollment in most states, but birth of a child or losing pregnancy-related coverage does.
- Under current subsidized coverage options, gaps remain for women who lose pregnancy-related Medicaid/CHIP postpartum because their income is above their state's parent or ACA-expansion Medicaid eligibility threshold, including for women living in nonexpansion states who fall into the coverage gap and have incomes too high for Medicaid but too low for Marketplace subsidies. Gaps also remain for lawfully residing immigrants with less than five

years of residency who may be eligible for pregnancy-related Medicaid/CHIP but are not eligible as parents or adults, and for undocumented immigrants who are not eligible for Medicaid/CHIP except for emergency Medicaid coverage of services during delivery. Citizens and lawfully present immigrants who are not income eligible for Medicaid/CHIP may be eligible for subsidized Marketplace coverage with higher cost-sharing requirements than Medicaid/CHIP, but undocumented immigrants are not eligible for subsidized or unsubsidized Marketplace coverage.

- State and federal policymakers have proposed extending pregnancy-related Medicaid/CHIP coverage from 60 days to 12 months postpartum, which would considerably expand new mothers' coverage options in most states and promote continuous care during the postpartum period. Under such extensions, eligibility for new mothers would rise in every nonexpansion state, with increases in thresholds as a share of FPL ranging from 90 percentage points (in South Dakota) to 284 percentage points (in Missouri). Eligibility would rise for new mothers in all but two Medicaid expansion states (Idaho and Louisiana, which apply the same thresholds for pregnant women and parents), with increases ranging from 6 percentage points (in Utah) to 242 percentage points (in Iowa). Eligibility increases would be larger in nonexpansion states on average, with a median increase of 136 percentage points in nonexpansion states and 67 percentage points in expansion states, and postpartum extension would offer a new coverage option to postpartum women in the coverage gap. But some new mothers in expansion states would also gain eligibility. Postpartum extension would also offer Medicaid/CHIP to some lawfully residing immigrant women with fewer than five years' residency in states that cover pregnant women without a waiting period and to women whose only current affordable coverage option is Marketplace coverage, but Medicaid/CHIP would offer greater financial protection.
- Numerous federal and state-level bills were proposed in 2019 and 2020 to extend continuous postpartum coverage, using various approaches to financing, required state actions, target populations, and durations. In 2020, the House of Representatives passed the Helping MOMS Act, and California became the first state to extend Medicaid eligibility for 12 months for women with maternal mental health conditions using state funds. But no federal legislation has been passed by both the House and the Senate, none of the state plans requiring federal waiver approval have been approved, and several efforts have stalled because of the pandemic and economic crisis. This leaves many new mothers without publicly subsidized coverage options to prevent them from losing health insurance coverage, putting them at risk of experiencing critical coverage and care gaps during the current public health emergency.

The Public Health Insurance Landscape for Pregnant and Postpartum Women

The nation's maternal morbidity and mortality crisis is alarming and has worsened over time. An estimated 700 women die each year from pregnancy-related causes at a rate that has nearly doubled over recent decades, with many more women experiencing severe maternal morbidity (Callaghan, Creanga, and Kuklina 2012; MacDorman et al. 2016; Petersen et al. 2019).[1] Moreover, there are large racial and ethnic disparities in maternal outcomes, with Black and American Indian/Alaska Native women experiencing much higher rates of pregnancy-related mortality and morbidity than other groups (Creanga et al. 2014; Petersen et al. 2019).[2]

Also known as the "fourth trimester," the postpartum period is a time of extensive physical and emotional change for mothers as they recover from delivery and adjust to life with a newborn (ACOG 2018).[2] It can also be a precarious time for mothers' health. More than half of pregnancy-related deaths occur after delivery, with 40 percent occurring 1 to 42 days postpartum and 11.7 percent occurring from 43 to 365 days postpartum nationally—and at even higher rates in some states (Petersen et al. 2019; Tully, Steube, and Verbiest 2017). Complications leading to death in the postpartum period include cardiomyopathy, mental health conditions, embolism, and other health problems that arise related to the pregnancy (CDC Foundation 2018). More than half of pregnancy-related mortality overall and during the postpartum period is preventable, suggesting improvements to health coverage and care could reduce mortality rates (CDC Foundation 2018; Petersen et al. 2019).

Evidence has highlighted the importance of insurance coverage to meeting new mothers' health needs (Searing and Cohen Ross 2019). Nearly all new mothers are covered by health insurance at the time of delivery, and in 2018, Medicaid covered more than 4 in 10 births nationally and as many as 7 in 10 births in some states (MACPAC 2020b, Martin et al. 2019).[3] But pregnancy-related Medicaid/CHIP coverage expires just 60 days after the end of pregnancy. Research has indicated more than half of women who had Medicaid/CHIP coverage at delivery experienced "churn" (i.e.,

[2] This analysis uses the terms "women" and "mothers" to describe people who are pregnant or 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.

moved in and out of coverage) in the following six months, which would likely reduce access to care, especially during periods without insurance (Daw et al. 2017; Sommers et al. 2016). Even among women who maintain coverage, changing coverage types during this period could change what providers a woman sees, what benefits she is eligible for, and what cost sharing she is subject to, and it could delay care (AMCHP 2013; Chen and Hayes 2018; Sommers et al. 2016).

The ACA's major coverage provisions, including Medicaid expansion and premium tax credits for Marketplace coverage beginning in 2014, expanded coverage options for women losing pregnancy-related Medicaid/CHIP coverage postpartum. These coverage provisions were associated with increased insurance coverage and improved access to care for women of reproductive age (Daw and Sommers 2018; Johnston et al. 2017; Lee et al. 2020; Margerison et al. 2020). Medicaid expansion, specifically, was associated with coverage gains among new mothers that would be expected to improve their health care access and contribute to health gains (Daw et al. 2020; Gordon et al. 2020; MACPAC 2018; Searing and Cohen Ross 2019). These increases in coverage also reduced coverage disparities for Black and Hispanic new mothers (Johnston et al. 2019).

Despite these ACA-related coverage gains, an estimated 11.5 percent of new mothers remained uninsured during the 2015–18 period (McMorrow et al. 2020). And rates were even higher in some states. From 2015 through 2017, the share of new mothers who were uninsured was over 20 percent in Georgia, Oklahoma, and Texas.[4] Moreover, many uninsured new mothers reported physical and mental health problems, as well as unmet health needs (McMorrow et al. 2020). Black and Hispanic new mothers also remained more likely to be uninsured than white new mothers, highlighting systemic racism and other inequities that likely contribute to disparate health outcomes (Johnston et al. 2019; Novoa and Taylor 2018).

State and federal policymakers are pursuing efforts to reduce postpartum uninsurance as part of a broader effort to better understand and reduce maternal death rates. These efforts include the establishment of maternal mortality review committees in nearly every state, as well as the enactment of the Preventing Maternal Deaths Act of 2018.[5] With support from professional organizations focusing on maternal and child health and maternal mortality review committees, extending postpartum Medicaid/CHIP from 60 days to a full 12 months was proposed at the federal level and in several states before the pandemic (American Academies 2019; Eckert 2020; Equitable Maternal Health Coalition 2020; Stewart 2019).[6] Such an extension would be more than an efficient, targeted way to give many postpartum women—especially those with Medicaid/CHIP coverage for pregnancy and delivery, who are at higher risk of poor outcomes—a new coverage option. An extension would

also allow for continuous coverage during the first year after the end of pregnancy (Eckert 2020; Equitable Maternal Health Coalition 2020).

But the pandemic has complicated efforts to extend postpartum Medicaid/CHIP and has had effects on maternal health more broadly. Much of the recent state and federal legislative action has shifted to respond to the public health and economic crises, and financial strains during the recession may limit available funds for new initiatives. And though states have changed some Medicaid/CHIP policies during the emergency, most have not focused on pregnant or postpartum women or infants.[7] The pandemic is also temporarily changing the coverage landscape for postpartum women. Under the Families First Coronavirus Response Act (H.R. 6021, Pub. L. 116-127), states receive enhanced federal matching funds if their Medicaid programs do not change eligibility standards or reduce benefits and maintain continuous enrollment for families already enrolled during the public health emergency period and those who newly enroll. This means some postpartum women whose pregnancy-related Medicaid coverage would otherwise expire can temporarily stay enrolled in Medicaid through the public health emergency period (these provisions do not apply to all women with pregnancy-related coverage, such as those covered by CHIP and some noncitizens; CMS 2020).[8] But this maintenance-of-effort requirement will be suspended at the end of the month in which the emergency period ends, and it seems likely many new mothers whose pregnancy-related Medicaid/CHIP eligibility has been extended could become uninsured, unless additional coverage extensions are enacted.

In addition to changes in the coverage landscape, recent evidence suggests pregnant women who contract COVID-19 might be at increased risk for severe illness (Ellington et al. 2020). Beyond disease risk, the pandemic has necessitated far-reaching changes to how and where maternity care is delivered, such as modifications to birth settings and procedures, changes to regulations for nonphysician providers such as doulas and midwives, and increased use of telemedicine for perinatal care.[9] Effects of the pandemic and economic crisis extend to the postpartum period as well, through increased stress, fewer family and community resources to assist with child care, and financial, food, and housing insecurity under economic decline.[10] Moreover, these effects could further cultivate inequities. For instance, the pandemic's economic impacts are disproportionately affecting racial and ethnic groups already at risk of higher maternal health complications (Karpman et al. 2020).[11]

Below, we summarize publicly subsidized coverage options for pregnant and postpartum women across states in 2020, assess how much postpartum Medicaid/CHIP extension could expand coverage for new mothers, and consider federal and state efforts to extend coverage during the postpartum period. We conclude with a discussion of future policy considerations.

What Are the Publicly Subsidized Coverage Options for Pregnant Women?

Pregnancy-Related Medicaid/CHIP

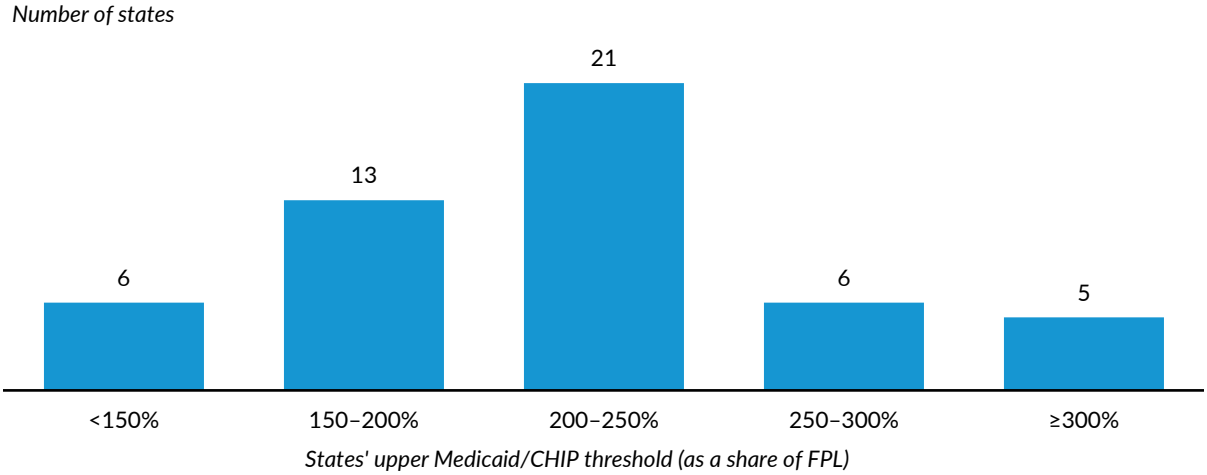
The median state income threshold to qualify for pregnancy-related Medicaid/CHIP is 205 percent of FPL nationwide, and coverage typically includes comprehensive benefits with minimal cost sharing. But income eligibility and immigration rules vary across states, and pregnancy-related coverage expires about 60 days postpartum.[12]

Who Is Eligible for Pregnancy-Related Medicaid/CHIP?

Federal rules require states to offer Medicaid to pregnant women with incomes up to at least 138 percent of FPL (Chen and Hayes 2018),[13] but states can set income thresholds above this minimum, and many extend Medicaid eligibility to higher levels (figure 1). States can also choose a state plan option to cover additional pregnant women (regardless of age) through CHIP at even higher income levels than their Medicaid programs, an option Colorado, Missouri, New Jersey, Rhode Island, Virginia, and West Virginia have adopted (Brooks et al. 2020). In Colorado, for instance, pregnant women with incomes up to 200 percent of FPL are eligible for pregnancy-related Medicaid, while those with incomes above 200 percent of FPL but below 265 percent of FPL are eligible for pregnancy-related CHIP. As for other Medicaid/CHIP expenditures, pregnancy-related coverage is jointly funded by states and the federal government, and the federal match rate varies according to state per capita income, ranging from the statutory minimum of 50 percent in high-income states to nearly 78 percent in low-income states (Mitchell 2020).

FIGURE 1

State Pregnancy-Related Medicaid/CHIP Income Eligibility Thresholds, as a Share of FPL, 2020



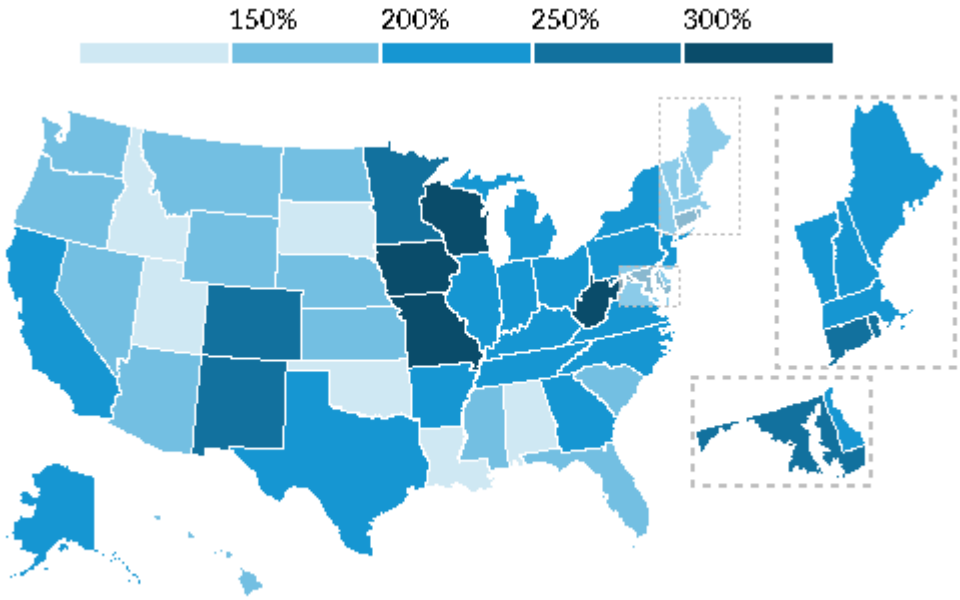
Source: Tricia Brooks, Lauren Roygardner, Samantha Artiga, Olivia Pham, and Rachel Dolan, *Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings from a 50-State Survey* (San Francisco: Kaiser Family Foundation, 2020).

Notes: CHIP = Children's Health Insurance Program; FPL = federal poverty level. Thresholds reflect income eligibility limits for pregnant women who meet Medicaid/CHIP immigration status requirements.

The median pregnancy-related upper income threshold in Medicaid or CHIP in 2020 is 205 percent of FPL,[14] or about $44,500 for a family of three (Brooks et al. 2020).[15] But this varies widely across states. Six states set their maximum Medicaid/CHIP thresholds below 150 percent of FPL, and 13 set them between 150 and 200 percent. Twenty-one states set them between 200 and 250 percent of FPL, 6 more set them between 250 and 300 percent, and 5 set them above 300 percent (figure 1). State thresholds are at the federal minimum of 138 percent of FPL in Idaho, Louisiana, Oklahoma, and South Dakota but are as high as 305 percent of FPL in Missouri and West Virginia, 306 percent of FPL in Wisconsin, 324 percent of FPL in the District of Columbia, and 380 percent of FPL in Iowa (figure 2), underscoring the fact that whether a woman is covered for her pregnancy largely depends on where she lives.

FIGURE 2

Pregnancy-Related Medicaid/CHIP Income Eligibility Thresholds, as a Share of FPL, by State, 2020



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Notes: CHIP = Children's Health Insurance Program; FPL = federal poverty level. Thresholds reflect income eligibility limits for pregnant women who meet Medicaid/CHIP immigration status requirements. Coverage is comprehensive in all states except Arkansas, New Mexico, North Carolina, and South Dakota, where benefits are limited to pregnancy-related services.

Pregnancy-related Medicaid/CHIP typically expires about 60 days after the end of pregnancy (ASTHO 2016).[16] But during the current emergency period, the Families First Coronavirus Response Act requires that states maintain continuous coverage for most Medicaid enrollees who would have otherwise lost coverage, which effectively temporarily suspends the 60-day limit.[17] But this extension of eligibility is required only until the end of the month in which the public health emergency ends, at which point new mothers whose coverage has been temporarily extended are likely to lose pregnancy-related eligibility.[18]

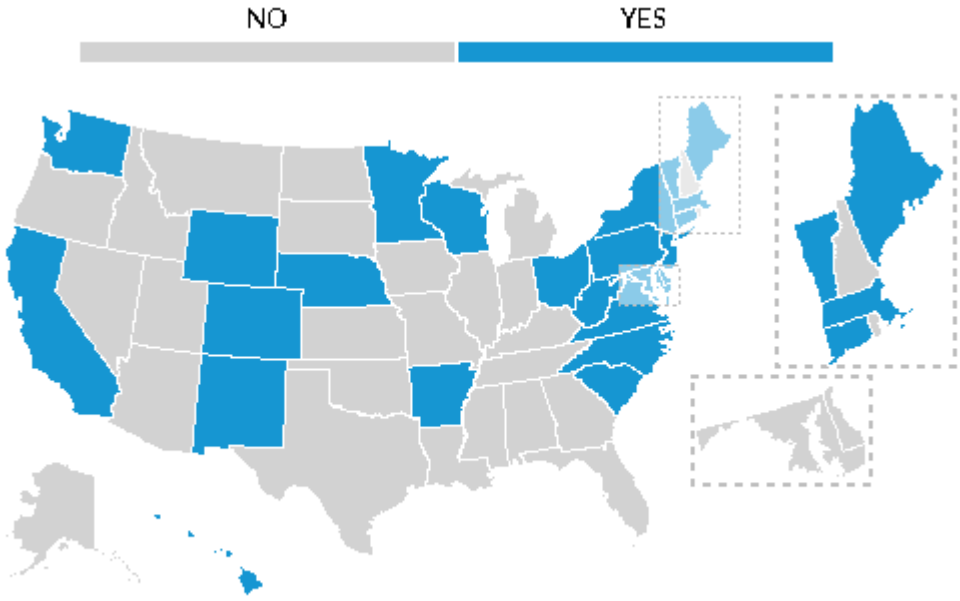
Which Immigrants Are Eligible for Pregnancy-Related Medicaid/CHIP?

Among women who meet the income eligibility requirements for pregnancy-related Medicaid/CHIP, coverage is available only for citizens and certain lawfully residing immigrants.[19] Citizens qualify in all states, and 25 states have adopted the option (via the Immigrant Children's Health Improvement Act)

to cover immigrant pregnant women who have been lawfully residing in the US for fewer than five years without a waiting period, thus expanding the number of immigrant women who can enroll (figure 3).[20] In the other half of states, noncitizens who have lived in the United States with qualified status for fewer than five years are ineligible.[21] Undocumented noncitizens are ineligible for pregnancy-related Medicaid/CHIP in every state.

FIGURE 3

Elimination of the Five-Year Waiting Period for Lawfully Residing Immigrants in Pregnancy-Related Medicaid/CHIP, by State, 2020



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Notes: CHIP = Children's Health Insurance Program. The colors refer to whether the state has adopted the option to cover immigrant pregnant women who have been lawfully residing in the US for less than five years, known as the Immigrant Children's Health Improvement Act option.

What Are the Benefits and Cost-Sharing Requirements in Pregnancy-Related Medicaid/CHIP?

Despite being required to cover only pregnancy-related services, states have the flexibility to define covered services, and nearly all states provide comprehensive benefits to meet women's health needs (Gifford et al. 2017). Federal law requires that pregnancy-related programs provide care "necessary for

the health of a pregnant woman and fetus, or that have become necessary as a result of the woman having been pregnant,"[22] but these are not formally defined, and most states interpret this broadly. Forty-seven of 51 pregnancy-related Medicaid programs and all six pregnancy-related CHIP programs provide a full Medicaid/CHIP benefit package that includes any medically necessary services to enrolled pregnant women, including non-pregnancy-related care. Programs in Arkansas, New Mexico, North Carolina, and South Dakota have defined "pregnancy-related" benefits more narrowly for some or all pregnant women. They cover mandated services such as prenatal care, delivery, postpartum care, and services that may complicate the pregnancy but may not cover other services for the mother, such as care for chronic conditions unrelated to the pregnancy (Brooks et al. 2020; Chen 2017; Chen 2018).[23] Meanwhile, some states also cover additional benefits specific to pregnant and postpartum women, such as postpartum home visits or doula services (Gifford et al. 2017).

Federal rules prohibit deductibles and copayments for pregnancy-related services and premiums for pregnant women with incomes below 150 percent of FPL (Chen and Hayes 2018).[24] Even for people with incomes above this threshold who may be subject to premiums, overall cost sharing, including premiums, cannot exceed 5 percent of family income.[25] Thus, pregnancy-related Medicaid/CHIP offers comprehensive benefits with substantial cost protection.

"Unborn-Child" CHIP Coverage

A third of states offer CHIP to unborn children, effectively covering women with any immigration status while they are pregnant, but benefits can be more limited than in pregnancy-related Medicaid/CHIP.

Who Is Eligible for Unborn Child CHIP?

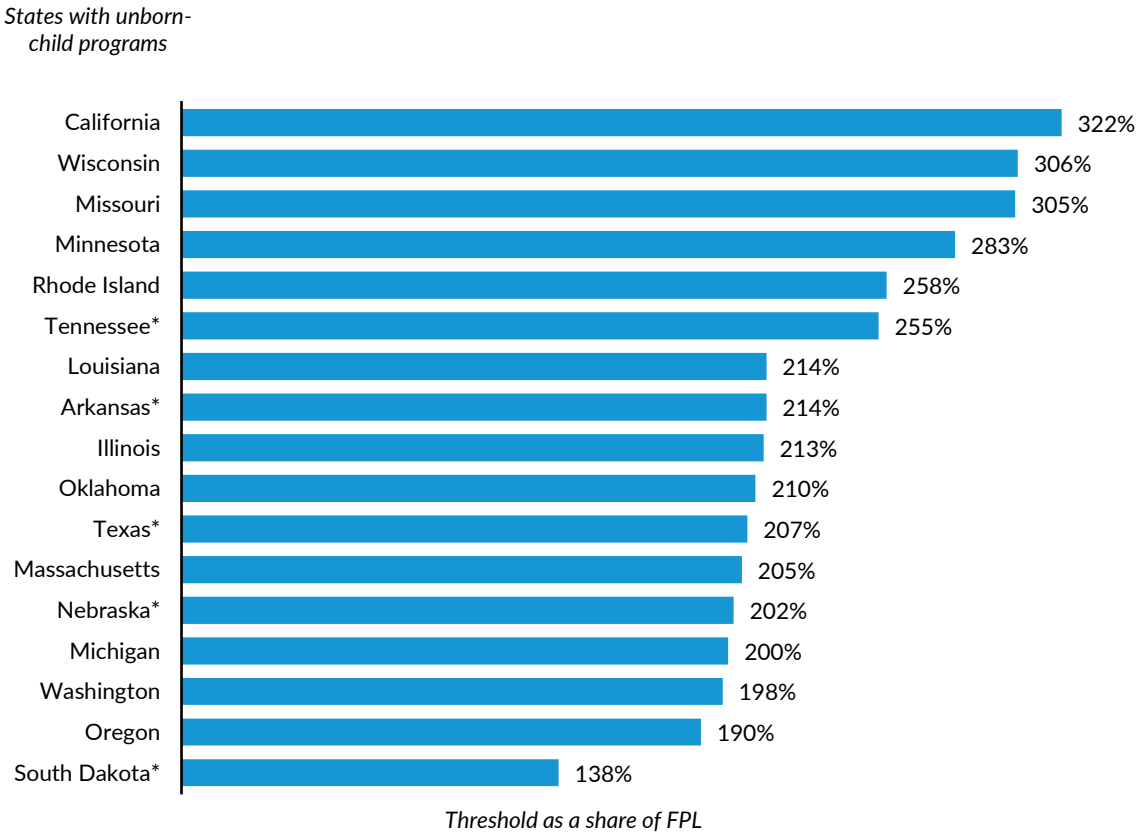
CHIP's unborn-child option allows states to provide CHIP coverage to fetuses as "targeted low-income children," effectively extending coverage of prenatal care and delivery to additional women. As of 2020, 17 states have adopted this option, with income thresholds ranging from below 200 percent of FPL in Oregon, South Dakota, and Washington to above 300 percent of FPL in California, Missouri, and Wisconsin (figure 4). Thirty-three states and the District of Columbia do not cover pregnant women via the unborn-child option.

Which Immigrants Are Eligible for Unborn-Child CHIP?

This option extends coverage to pregnant women who meet income eligibility requirements and lack other coverage or maternity benefits, on behalf of their unborn children. Because the option targets the child, rather than the mother, eligibility is not restricted based on the mother's citizenship or documentation status. Thus, women of any immigration status can qualify but only if they live in one of the 17 states that have adopted the option.

FIGURE 4

Unborn-Child CHIP Income Eligibility Thresholds, as a Share of FPL, by State, 2020



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Notes: CHIP = Children's Health Insurance Program; FPL = federal poverty level. Refers to state adoption of CHIP's unborn-child option to provide CHIP coverage to fetuses as "targeted low-income children."

* indicates benefits are not comprehensive.

Unborn-child CHIP thresholds vary relative to states' pregnancy-related Medicaid/CHIP thresholds. For instance, California's threshold of 322 percent of FPL is much higher than its pregnancy-related Medicaid threshold of 213 percent of FPL, covering additional women who would not otherwise qualify for Medicaid because of their incomes, as well as some women ineligible because of their immigration status. The threshold in Illinois (213 percent of FPL) is the same as the pregnancy-related Medicaid threshold, effectively extending eligibility to women regardless of immigration status at the same income levels as in pregnancy-related Medicaid.

What Are the Benefits and Cost-Sharing Requirements in Unborn-Child CHIP?

In 2020, 12 of the 17 states with unborn-child CHIP programs (California, Illinois, Louisiana, Maryland, Massachusetts, Michigan, Missouri, Oklahoma, Oregon, Rhode Island, Washington, and Wisconsin) provide comprehensive benefits similar in scope to pregnancy-related Medicaid/CHIP, while the remainder offer more limited benefits. For instance, a state may not cover prescription drugs, mental health care, or management of preexisting conditions unless they affect the health of the fetus (ASTHO 2016; Brooks et al. 2020). In addition, though some programs cover certain postpartum services, other programs end upon the end of pregnancy or do not include postpartum care (ASTHO 2016).[26]

Cost sharing under the unborn-child eligibility pathway is generally low. Many states do not require any cost sharing, while others impose costs that are very low. For instance, California's program has an enrollment fee of 1.5 percent of family income (ASTHO 2016; California Health Care Foundation 2015).

Low-income noncitizens who are uninsured and do not meet the immigration requirements for pregnancy-related Medicaid/CHIP eligibility and who live in states that have not adopted the unborn-child option can qualify only for emergency Medicaid for coverage of services at the time of delivery (NILC 2020b). Emergency Medicaid is not comprehensive coverage, however, as it covers neither prenatal and postpartum services nor ongoing care for other health conditions.

What Are the Publicly Subsidized Coverage Options for New Mothers?

Parental and ACA-Expansion Medicaid

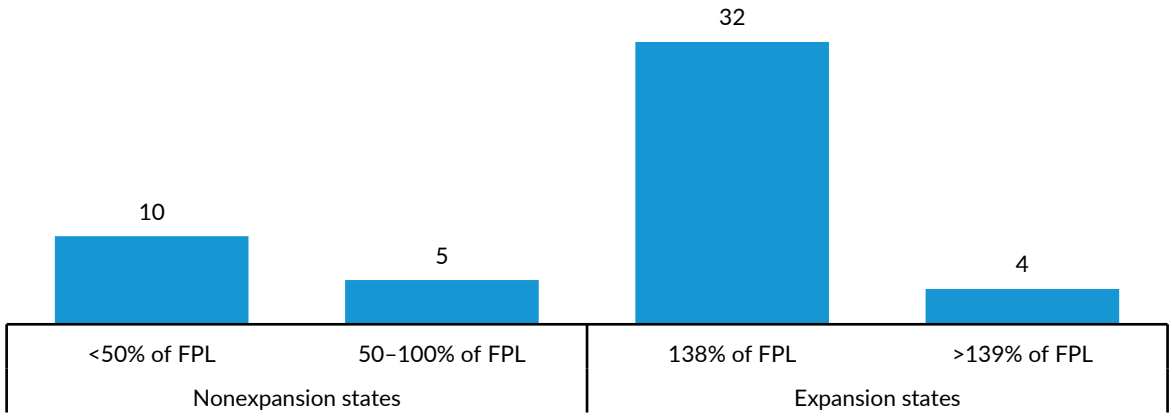
Pregnancy-related Medicaid/CHIP coverage expires two months postpartum. After that, mothers' eligibility for Medicaid/CHIP reverts to their state's regular Medicaid upper income thresholds for parents, which are usually much lower.[27]

Who Is Eligible for Parental and ACA-Expansion Medicaid?

Federal rules require that states offer Medicaid to some low-income parents via the traditional parental pathway under Section 1931 of the Social Security Act, and states can adopt higher thresholds under the ACA's Medicaid expansion, so Medicaid eligibility for nonpregnant parents (including new mothers more than 60 days postpartum[28]) varies dramatically depending on whether states have adopted the ACA's Medicaid expansion.

FIGURE 5

State Medicaid Income Eligibility Thresholds for New Mothers, as a Share of FPL, by State, 2020



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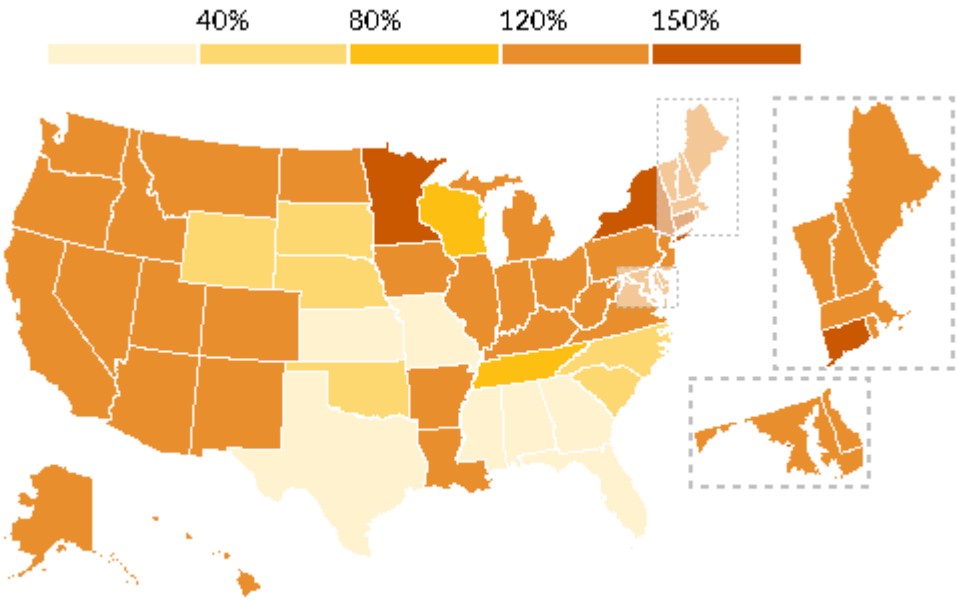
Notes: FPL = federal poverty level. Thresholds reflect income eligibility limits for parents who meet Medicaid immigration status requirements through traditional (Section 1931) Medicaid, Affordable Care Act Medicaid expansion, or Basic Health Program coverage. Thresholds do not include higher income limits available for pregnancy-related Medicaid eligibility within the first two months after the end of pregnancy. The "138% of FPL" category includes Indiana, which has a threshold of 139 percent of FPL.

In the 15 states that had not expanded Medicaid as of the beginning of 2020, new mothers are subject to income thresholds for traditional parental Medicaid, which are low. The median upper income threshold in nonexpansion states is 45 percent of FPL (or about $9,770 for a family of three), with 10 states' thresholds below 50 percent of FPL and 5 states' thresholds between 50 and 100 percent of FPL (figures 5 and 6). In the 36 Medicaid expansion states, upper income eligibility thresholds are higher, most often at the expansion limit of 138 percent of FPL, though Connecticut and the District of Columbia have extended Medicaid eligibility to 160 and 221 percent of FPL, respectively, and Minnesota and New York also cover adults between 138 and 200 percent of FPL through the Basic Health Program.[29] Overall, even in expansion states, eligibility levels for nonpregnant parents are, on average, much lower than for pregnancy-related coverage, leaving new mothers above their state's Medicaid income threshold for parents ineligible for Medicaid once the 60-day postpartum period has ended.

FIGURE 6

Medicaid Income Eligibility Thresholds for New Mothers, as a Share of FPL, by State, 2020



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Notes: FPL = federal poverty level. Thresholds reflect income eligibility limits for parents who meet Medicaid immigration status requirements through traditional (Section 1931) Medicaid, Affordable Care Act Medicaid expansion, or Basic Health Program coverage. Thresholds do not include higher income limits available for pregnancy-related Medicaid eligibility within the first two months after the end of pregnancy.

Which Immigrants Are Eligible for Parental and ACA-Expansion Medicaid?

There is no five-year-waiting-period exemption for nonpregnant adults who meet the income eligibility requirements for coverage, so parental and ACA-expansion Medicaid are limited to citizens and lawfully residing noncitizens with five years' residency—undocumented noncitizens and lawfully residing noncitizens with fewer than five years' residency are excluded.[30] This means not only that women receiving coverage under the unborn-child option, such as undocumented immigrant women, no longer qualify for subsidized coverage as parents after pregnancy-related eligibility expires but that lawfully residing new mothers with fewer than five years' residency who qualify for pregnancy-related Medicaid/CHIP in some states are ineligible to obtain Medicaid as a parent. Only California, the District of Columbia, Hawaii, Massachusetts, New Mexico, New York, and Pennsylvania use state funds to cover some nonpregnant parents who do not qualify because of immigration status (Brooks et al. 2020).

What Are the Benefits and Cost-Sharing Requirements in Parental and ACA-Expansion Medicaid?

Medicaid covers a broad range of benefits, including inpatient and outpatient hospital and physician services; family planning services; laboratory and X-ray services; prescription drugs; early and periodic screening, diagnostic, and treatment services for those up to age 21; emergency and nonemergency medical transportation; federally qualified health center services; and additional benefits at the state's discretion. For example, most states cover some nonemergency dental care for adults (Center for Health Care Strategies 2019).

Most states collect copayments for selected services, with 35 of the 51 traditional Medicaid programs and 22 of the 36 expansion programs requiring copayments for some or all adult enrollees (Brooks et al. 2020). But copayments are usually low, especially for families with low incomes. For example, maximum allowable copayments for persons with incomes below 100 percent of FPL are $10 for outpatient services, nonemergency use of emergency departments, and prescription drugs (Brooks et al. 2020). In addition, most states do not charge premiums for parents' Medicaid coverage, and they are generally prohibited from doing so for families earning below 150 percent of FPL unless

they have received a waiver. In 2020, only Arkansas, Indiana, Iowa, Michigan, and Montana charge premiums for adults' coverage, and these amounts are often low. Enrollees in Arkansas may pay a monthly premium of up to 2 percent of income, and adults in Iowa may pay up to $10 a month for coverage (Brooks et al. 2020). As with pregnancy-related coverage, total family out-of-pocket costs must not exceed 5 percent of family income (CMS 2020).

Family Planning Services

New mothers who lose pregnancy-related Medicaid/CHIP and are ineligible for parental and ACA-expansion Medicaid coverage may qualify for family planning services, but this benefit is not comprehensive coverage and is available in only 29 states.

Who Is Eligible for Family Planning Programs?

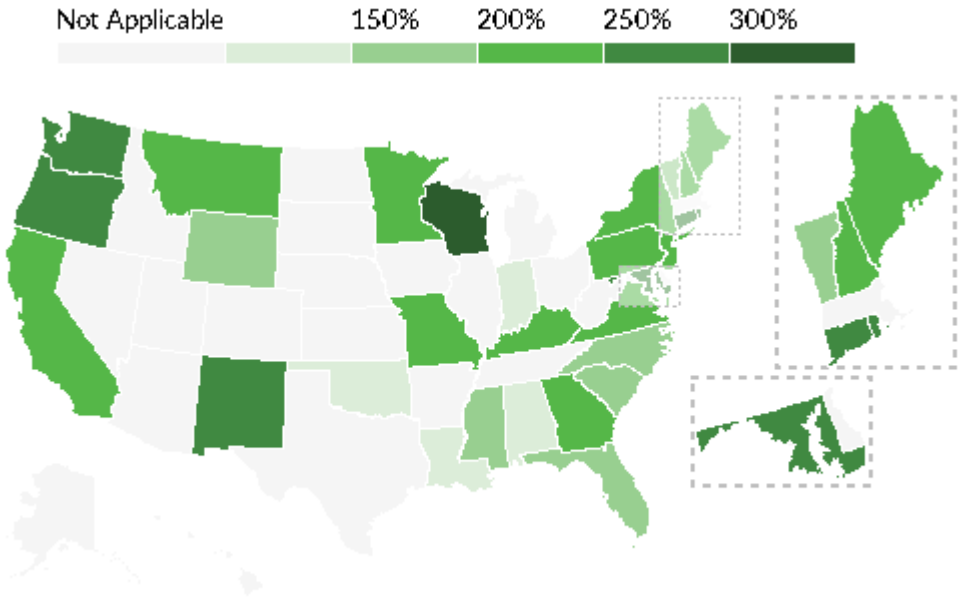
More than half of states have obtained Medicaid waivers or implemented state plan amendments that allow them to expand coverage of family planning–only services to adults not otherwise eligible for Medicaid. The median income eligibility level for these programs is just over 200 percent of FPL, ranging from 138 percent of FPL in Oklahoma to 306 percent in Wisconsin (figure 7).[31] Eligibility is most often based on income, but some programs are based on loss of pregnancy-related coverage. These programs, though, are not available in all states, including in some nonexpansion states, where women with low incomes do not have other affordable coverage options (Ranji, Gomez, and Salganicoff 2019). Beyond these family planning programs, some women may qualify for Title X or state- and locally funded family planning services, which are not included here.

Which Immigrants Are Eligible for Family Planning Programs?

Traditional Medicaid eligibility rules that restrict enrollment of noncitizens apply for family planning services. Thus, programs are limited to citizens and lawfully residing noncitizens with five years' residency who meet the income eligibility requirements (Angus and DeVoe 2010; Sonfield and Gold 2011). Undocumented noncitizens and lawfully residing noncitizens with less than five years' residency are therefore excluded.

FIGURE 7

Family Planning Medicaid Income Eligibility Thresholds, as a Share of FPL, by State, 2020



Source: Tricia Brooks, Lauren Roygardner, Samantha Artiga, Olivia Pham, and Rachel Dolan, *Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings from a 50-State Survey* (San Francisco: Kaiser Family Foundation, 2020).
Notes: FPL = federal poverty level. Refers to funding of services for family planning, not comprehensive coverage. In Florida and Kentucky, eligibility is limited to families losing Medicaid. In Rhode Island and Wyoming, eligibility is limited to families losing pregnancy-related coverage after the 60-day postpartum period ends.

What Are the Benefits and Cost-Sharing Requirements in Family Planning Programs?

Medicaid family planning programs generally cover services such as contraception counseling; contraceptive methods, devices, and procedures; Pap tests; and sexually transmitted infection screening, which can meet women's contraceptive needs and improve access to screening and preventive care if they do not qualify for other subsidized coverage options in the postpartum and interpregnancy periods (Orris et al. 2019; Wherry 2013). Premiums, deductibles, and copayments are prohibited in Medicaid-funded family planning coverage (National Family Planning and Reproductive Health Association 2019).[32]

Subsidized Marketplace Coverage

Some mothers, both pregnant and postpartum, whose incomes are too high to qualify for comprehensive Medicaid/CHIP but are below 400 percent of FPL may qualify for subsidized Marketplace coverage. Though benefits are comprehensive, Marketplace coverage generally offers less financial protection than Medicaid/CHIP.

Who Is Eligible for Subsidized Marketplace Coverage?

Eligibility requirements for Marketplace premium tax credits include having income between 100 and 400 percent of FPL, citizenship or lawfully residing immigration status, ineligibility for Medicaid/CHIP that meets minimum essential coverage requirements, and lack of access to affordable[33] employer-sponsored insurance. Though women eligible for parental Medicaid before or after delivery are not eligible for premium tax credits for Marketplace coverage, women enrolled in subsidized Marketplace coverage who become pregnant and newly qualify for pregnancy-related Medicaid/CHIP do not lose eligibility for premium tax credits unless they take up Medicaid/CHIP coverage (Chen and Hayes 2018; MACPAC 2016).[34] Thus, after becoming pregnant, some women with low incomes enrolled in subsidized Marketplace coverage may choose to maintain their Marketplace coverage during pregnancy, while others may choose to switch to pregnancy-related Medicaid/CHIP coverage.

Marketplace coverage can be purchased only once a year during annual open enrollment or during special enrollment periods. Only New York and Vermont establish special enrollment periods based on pregnancy, so most pregnant women can switch from a Marketplace plan to Medicaid/CHIP but cannot newly enroll in Marketplace coverage for their pregnancy. But childbirth or loss of pregnancy-related Medicaid/CHIP coverage activates a special enrollment period (Chen and Hayes 2018), which means women can enroll postpartum. A small number of states have also established limited, temporary Marketplace open enrollment periods in response to the pandemic (Straw, Lueck, and Aron-Dine 2020).[35]

Because Marketplace subsidies are available only to those with incomes above 100 percent of FPL, adults in nonexpansion states whose incomes are too high to qualify for parental Medicaid coverage but below 100 percent of FPL fall into the coverage gap (Garfield, Orgera, and Damico 2020). Thus, postpartum women with incomes above their state's parental Medicaid eligibility threshold but below 100 percent of FPL—a gap that occurs in 14 of the 15 nonexpansion states—do not currently qualify for any publicly subsidized comprehensive coverage.[36] Some women's Marketplace eligibility may also be limited by the so-called family glitch, because rules that require lack

of access to affordable employer-sponsored coverage define affordability based on individual, rather than family, coverage, so some people who may otherwise find coverage unaffordable may not qualify for subsidies (Brooks 2014; Buettgens, Dubay, and Kenney 2016; Johnson et al. 2020).

Which Immigrants Are Eligible for Subsidized Marketplace Coverage?

Lawfully residing immigrants (including those with incomes below 100 percent of FPL) who do not qualify for Medicaid/CHIP because of the five-year waiting period can qualify for subsidies if they meet income eligibility requirements, but undocumented immigrants cannot receive subsidies or purchase unsubsidized Marketplace coverage, regardless of income (Chen and Hayes 2018).

What Are the Benefits and Cost-Sharing Requirements for Subsidized Marketplace Coverage?

Marketplace plans must cover "essential health benefits" (i.e., ambulatory services; emergency services; hospitalization; pregnancy, maternity, and newborn care; mental health and substance use disorder services; prescription drugs; rehabilitative and habilitative services and devices; laboratory services, preventive and wellness services, and chronic disease management; and pediatric services). Marketplace plans may cover additional services but do not have to cover all the benefits offered in Medicaid, such as nonemergency medical transportation, services at federally qualified health centers, and additional services covered at the state's discretion, such as dental services.

The amount Marketplace enrollees pay for coverage is based on income. For example, in 2020, enrollees with incomes from 133 to 150 percent of FPL receive subsidies that cap the amount they would pay for a benchmark plan at 3.09 to 4.12 percent of income, while those earning above 300 percent of FPL have a higher cap of 9.78 percent of income.[37] Furthermore, those with incomes below 250 percent of FPL are eligible for additional cost-sharing reductions to reduce deductibles and copayments, and total out-of-pocket costs are capped at about $8,000 for a person without cost-sharing reductions and at about $2,700 for a person with cost-sharing reductions.[38] But out-of-pocket costs in Marketplace plans are typically higher than in Medicaid, especially for people with more extensive health needs (Blavin et al. 2018; Buetel, Gunja, and Collins 2016; Chen 2018).[39] And though evidence suggests Marketplace coverage may improve provider access relative to Medicaid in general, differences in access between Marketplace and Medicaid coverage may be smaller for pregnant women than for other populations (Gordon et al. 2020; Selden, Lipton, and Decker 2017).

How Do Pregnant and Postpartum Women's Coverage Options Fit Together across States?

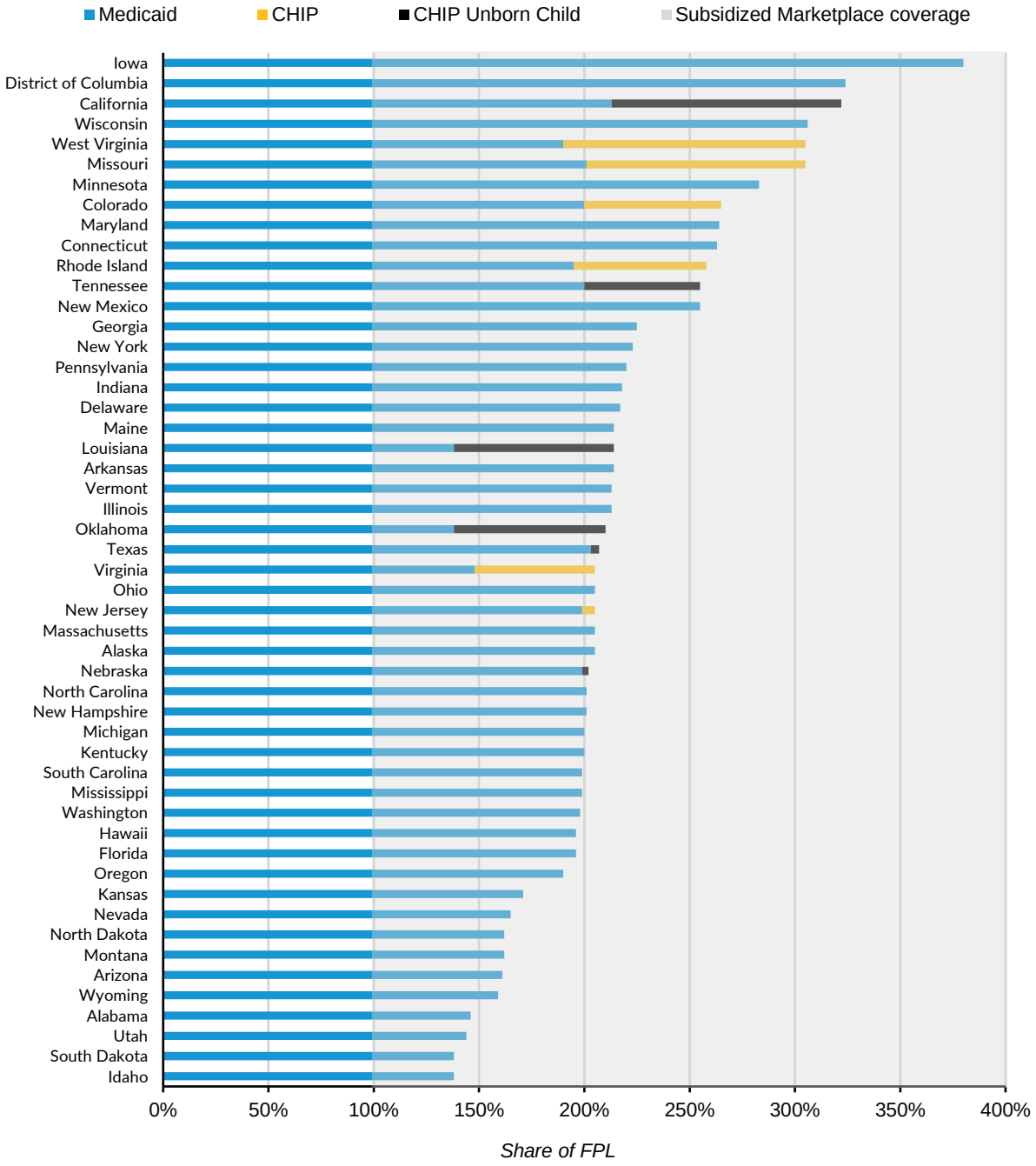
Coverage Options for Pregnant Women

Income eligibility thresholds for pregnancy-related Medicaid/CHIP are high, with most states offering comprehensive coverage to women with incomes at or above 200 percent of FPL.

Figure 8 summarizes states' pregnancy-related eligibility policies in 2020 for citizens and lawfully residing immigrant women with more than five years' residency.[40] Every state offers pregnancy-related Medicaid coverage, most at income levels higher than the federally mandated minimum of 138 percent of FPL, while many states also offer coverage at even higher income levels through CHIP's pregnancy-related or unborn-child pathways. Most states' upper thresholds are at or above 200 percent of FPL, with many extending beyond 250 percent of FPL and six extending beyond 300 percent of FPL. Pregnant women with incomes above these levels and below 400 percent of FPL can qualify for subsidized Marketplace coverage if they meet the other eligibility requirements.

FIGURE 8

Pregnancy-Related Medicaid/CHIP and Marketplace Income Eligibility Thresholds, as a Share of FPL, for Citizens and Lawfully Residing Noncitizens with More Than Five Years' Residency, by Program Type and State, 2020



Source: Tricia Brooks, Lauren Roygardner, Samantha Artiga, Olivia Pham, and Rachel Dolan, *Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings from a 50-State Survey* (San Francisco: Kaiser Family Foundation, 2020).

Notes: CHIP = Children's Health Insurance Program; FPL = federal poverty level. The shaded area indicates the income range for subsidized Marketplace coverage. Texas bars most lawfully residing immigrants from Medicaid coverage.

Not all coverage options offer the same benefits or require the same levels of cost sharing. Although benefits in all these options (except family planning) are mostly comprehensive, states have more flexibility to restrict services outside the pregnancy-related Medicaid/CHIP pathway (table 1). The biggest differences by coverage type are for cost sharing, which is low or nonexistent in Medicaid/CHIP but can reach above 9 percent of income for high-income women with Marketplace coverage whose incomes are nearly 400 percent of FPL.[41]

TABLE 1

Benefits and Cost-Sharing Requirements for Pregnant and Postpartum Women, by Coverage Type

	Benefits		
	Benefit requirements	**Common state benefits**	**Cost sharing**
Pregnancy-related Medicaid/CHIP	Pregnancy-related services (states have flexibility under a broad federal definition)	47 of 51 Medicaid programs and all 6 CHIP programs provide comprehensive benefits, with some covering additional benefits specific to pregnancy and postpartum care	Very low (federal law prohibits deductibles and copayments for pregnancy-related services and premiums for families earning below 150 percent of FPL; total family out-of-pocket costs are capped at 5 percent of income)
CHIP unborn-child coverage	Pregnancy-related services (not formally defined; state determined)	12 of 17 states cover comprehensive benefits, though some limit benefits to only those related to the pregnancy or fetus or exclude postpartum services	Very low (many states have no cost sharing or only very low costs)
Parental and ACA Medicaid Expansion	Covers many benefits, including inpatient and outpatient hospital and physician services; family planning services; laboratory and X-ray services; prescription drugs; early and periodic screening, diagnostic, and treatment services for people up to age 21; medical transportation; federally qualified health center services; and additional benefits at the state's discretion	High level of benefits covered, with some states covering additional services (e.g., dental coverage)	Low (35 of 51 traditional parental programs and 22 of 36 ACA-expansion programs charge nominal copayments for selected services, 46 of 51 states do not charge premiums, and total family out-of-pocket spending is capped at 5 percent of income)
Family planning	Family planning services and supplies (not formally defined; state determined)	Most states cover contraception, sexually transmitted infection counseling and testing, and Pap testing	None (premiums, deductibles, and copayments are prohibited in Medicaid-funded family planning coverage)
Marketplace	Must cover "essential health benefits" (ambulatory services; emergency services; hospitalization; pregnancy, maternity, and newborn care; mental health and substance use disorder services; prescription drugs; rehabilitative and habilitative services and devices; laboratory services, preventive and wellness services, and chronic disease management; and pediatric services) and may cover additional services but do not have to cover all Medicaid benefits	Some variation in additional services offered	Varies based on income and plan (premium tax credits are based on income, with low-income families paying a lower share of Marketplace premiums ranging from 2.06 to 9.78 percent of income in 2020; cost-sharing reduction credits are available for families earning less than 250 percent of FPL, and out-of-pocket spending is capped, but cost protection is lower than in Medicaid/CHIP)

Notes: ACA = Affordable Care Act; CHIP = Children's Health Insurance Program; FPL=federal poverty level. The ACA requires Medicaid and exchange plans to cover recommended preventive services with no cost sharing (including some pregnancy-specific services).

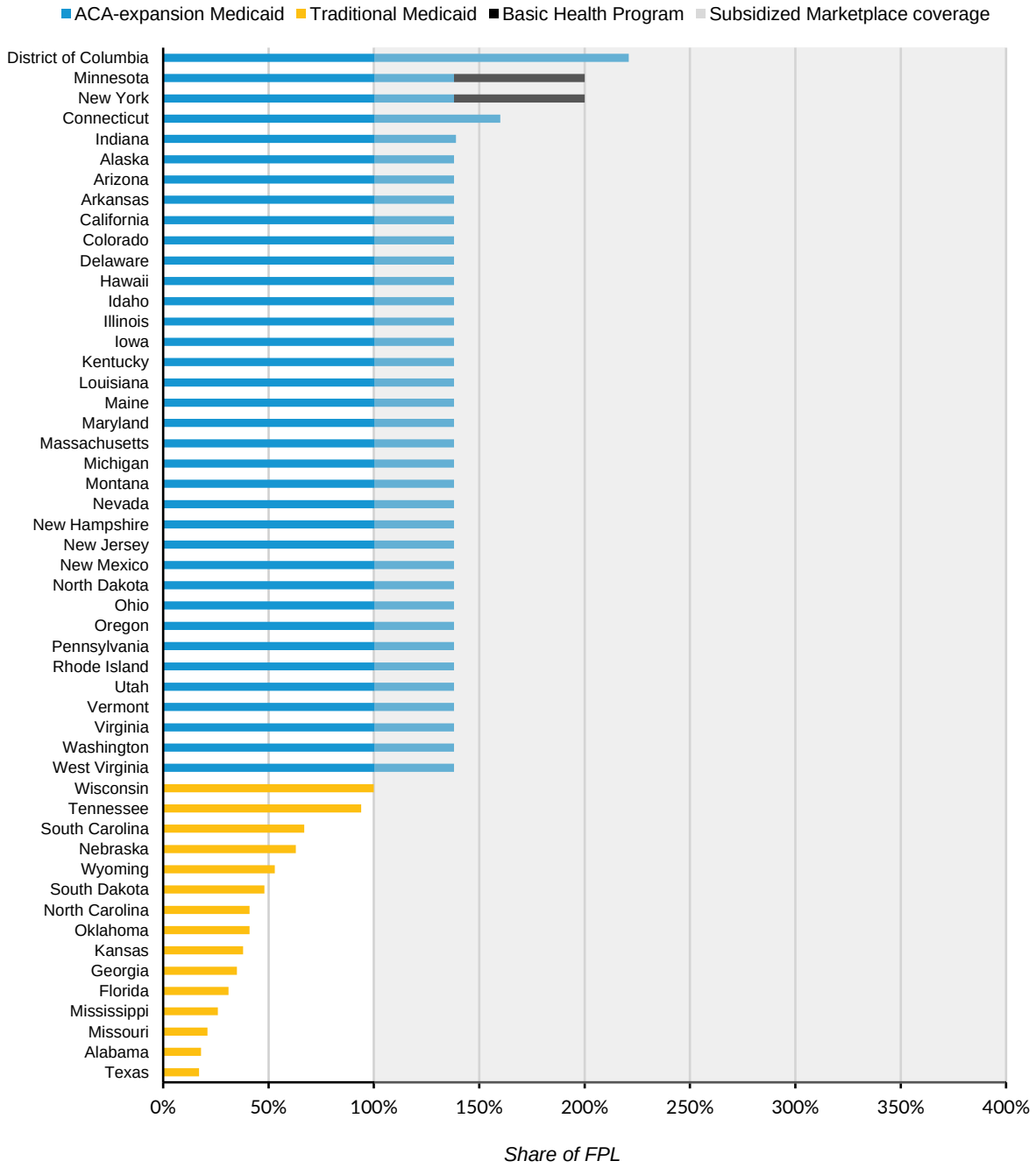
Coverage Options for New Mothers under Current Rules

After eligibility for pregnancy-related Medicaid/CHIP coverage expires 60 days postpartum, new mothers face lower parental Medicaid eligibility thresholds, leaving many without affordable coverage options.

Figure 9 summarizes Medicaid and Marketplace coverage options in 2020 for citizens and lawfully residing immigrant postpartum women with more than five years' residency after pregnancy-related eligibility expires. It illustrates how much lower income eligibility thresholds are for traditional Medicaid than they are for pregnancy-related Medicaid in most states, averaging 138 percent of FPL in states adopting the ACA's Medicaid expansion and below 100 percent of FPL (with most below 50 percent of FPL) in nonexpansion states. Marketplace eligibility, which has higher cost sharing than Medicaid, is available for some women with incomes between 100 and 400 percent of FPL. However, women in expansion states with incomes above 100 percent of FPL who are in the income range for both coverage types would not be eligible for premium tax credits because of their Medicaid eligibility. Most notably, new mothers in all nonexpansion states except Wisconsin who have incomes higher than their parental Medicaid thresholds but below 100 percent of FPL are in the coverage gap, with no affordable coverage options. And in other states, women who qualify for pregnancy-related Medicaid/CHIP and lose eligibility during the postpartum period become eligible only for the more expensive subsidized Marketplace coverage. Some new mothers may qualify for limited coverage for family planning services, but this does not include comprehensive health benefits.

FIGURE 9

Income Eligibility Thresholds for Publicly Subsidized Coverage Options for Citizen and Certain Lawfully Residing Noncitizen New Mothers under Current Rules, by State, 2020



Source: Tricia Brooks, Lauren Roygardner, Samantha Artiga, Olivia Pham, and Rachel Dolan, *Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings from a 50-State Survey* (San Francisco: Kaiser Family Foundation, 2020).

Notes: ACA = Affordable Care Act; FPL = federal poverty level. Certain lawfully residing noncitizens are those with five or more years' residency. New mothers gave birth 2 to 12 months ago. The figure shows parental Medicaid thresholds under 2020 rules.

Thresholds do not include higher income limits available for pregnancy-related Medicaid eligibility within the first 60 days after the end of pregnancy. The shaded area indicates the income range for subsidized Marketplace coverage. Families in the income range for both Medicaid and Marketplace coverage are ineligible for Marketplace coverage. Some new mothers may qualify for limited family planning benefits, but because this is not comprehensive coverage, it is not included here. Expansion states are shown at the top of the figure, and nonexpansion states are shown at the bottom, using state expansion status as of January 2020. Expansion states also offer traditional Medicaid at lower income levels than their ACA expansion levels. For simplicity, those thresholds are not shown. In Texas, most immigrants who have been legally present for more than five years are ineligible for Medicaid.

How Would New Mothers' Coverage Options Expand under 12-Month Postpartum Medicaid/CHIP Extension?

Coverage Options for New Mothers under a 12-Month Postpartum Medicaid/CHIP Extension

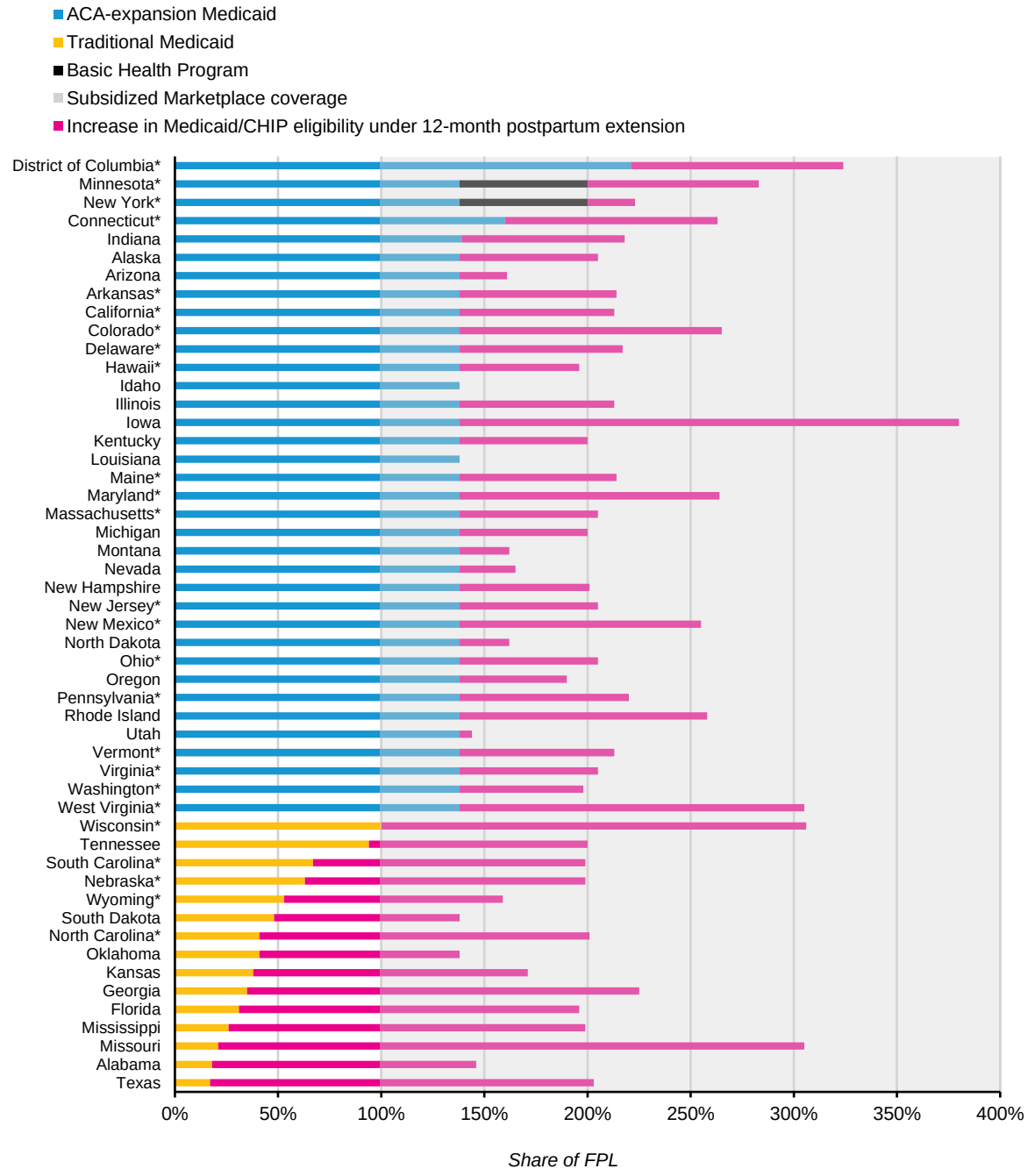
Extension of pregnancy-related Medicaid/CHIP from 60 days to 12 months postpartum would maintain eligibility thresholds at the higher pregnancy-related levels for 10 additional months, effectively expanding coverage options for new mothers in nearly every state.

Figure 10 builds on figure 9 to illustrate how much new mothers' eligibility would change if states extended pregnancy-related Medicaid/CHIP from 2 months to 12 months postpartum (states are grouped by ACA Medicaid expansion status). Such an extension, as defined by most recently proposed state and federal legislation, would not include unborn-child coverage and would extend pregnancy-related Medicaid/CHIP only for citizens, legal immigrants with at least five years' residency, and legal immigrants living in the United States for fewer than five years in the states covering them in pregnancy-related Medicaid/CHIP.

For example, new mothers in Texas who are past the 60-day postpartum limit are subject to the parental Medicaid income eligibility level shown in the black bar, which extends to just 17 percent of FPL. Thus, under current law, only women below this income level can maintain Medicaid after the 60-day postpartum limit, when they lose pregnancy-related coverage but qualify for parental Medicaid. But if a postpartum extension were implemented, additional women with incomes below the state's pregnancy-related limit (the yellow bar), which is 203 percent of FPL, could maintain coverage for a full year, effectively extending Medicaid coverage to many new mothers.

FIGURE 10

Income Eligibility Thresholds for Publicly Subsidized Coverage Options for New Mothers under Postpartum Medicaid/CHIP Extension, by State and Program Type, 2020



Source: Tricia Brooks, Lauren Roygardner, Samantha Artiga, Olivia Pham, and Rachel Dolan, *Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings from a 50-State Survey* (San Francisco: Kaiser Family Foundation, 2020).

Notes: ACA = Affordable Care Act; CHIP = Children's Health Insurance Program; FPL = federal poverty level. These coverage options are available to citizen and lawfully residing noncitizen (more than five years' residency) new mothers (2 to 12 months

after the end of pregnancy) under current rules and proposed 12-month postpartum Medicaid/CHIP extension. The shaded area indicates the income range for subsidized Marketplace coverage. Families in the income range for both Medicaid and Marketplace coverage are ineligible for Marketplace coverage. All states extend parental coverage to citizens and legally present noncitizens with more than five years' residency. Expansion states are shown at the top of the figure, and nonexpansion states are shown at the bottom, using state expansion status as of January 2020. Some new mothers may qualify for limited family planning benefits, but because this is not comprehensive coverage, it is not included here.
* indicates state also covers legally present noncitizen pregnant women with fewer than five years' residency in pregnancy-related Medicaid/CHIP.

The figure shows the following:

- Under a 12-month postpartum extension, Medicaid/CHIP eligibility for new mothers would continue at the higher pregnancy-related level for 10 additional months, effectively increasing upper income limits as a share of FPL in nearly every state. Thresholds would rise by 97 to 206 percentage points in nonexpansion states, with a median increase of 136 percentage points, and by 6 to 242 percentage points in 34 of the 36 expansion states, with a median increase of 67 percentage points. Eligibility for new mothers would not change in Idaho and Louisiana, which cover pregnant women with incomes up to 138 percent of FPL, the same level as for nonpregnant adults.
- Extending postpartum Medicaid for a full year after the end of pregnancy would also benefit women who already meet the requirements for Medicaid coverage as parents, because they would qualify for 12-month continuous coverage even if their income fluctuates throughout the year, which may allow for better consistency of providers and continuity of care.
- A 12-month postpartum extension would temporarily eliminate the coverage gap for postpartum women in nonexpansion states with incomes above the parental Medicaid threshold and below 100 percent of FPL. Medicaid/CHIP eligibility increases in nonexpansion states are also larger, on average. But pregnant women in many expansion states would also experience large increases in eligibility.
- Postpartum Medicaid/CHIP extension would also offer a new coverage option for lawfully residing immigrant new mothers with fewer than five years' residency in states that cover pregnant women without a waiting period (women in states without this option and undocumented immigrant women would not benefit from recently proposed policies).
- Some women whose only current affordable coverage option is Marketplace coverage (because of their incomes or because they are lawfully residing immigrants with fewer than five years' residency) would also gain Medicaid/CHIP eligibility under a 12-month postpartum

extension. Coverage provided under Medicaid/CHIP would require lower cost sharing and thus offer new mothers more financial protection than a Marketplace plan.

- A 12-month extension would also better align mothers' coverage with that of their infants because infants of Medicaid-enrolled mothers are automatically enrolled in Medicaid for their first year of life, not only improving mothers' access to care but likely ensuring continuous Medicaid enrollment for infants.[42]

What Is the Status of Federal and State Efforts to Extend Postpartum Medicaid/CHIP?

Policymakers in Congress and in at least 20 states attempted to enact postpartum Medicaid/CHIP extensions to new mothers during 2019 and 2020.

Federal Efforts to Extend Postpartum Medicaid/CHIP Coverage

In 2019 and 2020, five federal bills were proposed to extend Medicaid/CHIP coverage for 12 months continuously following the end of pregnancy (table 2). These bills reflect various approaches to financing and required state actions. The Patient Protection and Affordable Care Enhancement Act (H.R. 1425) would mandate states adopt a 12-month postpartum extension and would include not only a maintenance-of-effort requirement that states not reduce eligibility standards but also a requirement that pregnancy-related coverage provide comprehensive benefits. Conversely, the bipartisan Helping Medicaid Offer Maternity Services (Helping MOMS) Act of 2019 (H.R. 4996) would allow states to select the extension without a waiver requirement (a temporary federal matching rate enhancement was originally proposed as an incentive to extend coverage but later dropped). Other bills have proposed even higher levels of federal funding. The Mothers and Offspring Mortality and Morbidity Awareness (MOMMA's) Act (H.R. 1897 and S. 916) would be exclusively federally funded for the first 20 calendar quarters and matched at a 90 percent rate thereafter. Though some of these bills have not made legislative progress since 2019, the Helping MOMS Act was approved by the House Committee on Energy and Commerce in November 2019 and approved unanimously by the House of Representatives in September 2020 (the temporary federal match enhancement was dropped), and the Patient Protection and Affordable Care Enhancement Act was recently passed by the House of Representatives. But as of January 2021, progress on several of these bills has stalled, and it is not clear whether others will be proposed or enacted in 2021 or beyond.

State Efforts to Extend Postpartum Medicaid/CHIP Coverage

Meanwhile, nearly half of states have explored postpartum Medicaid/CHIP extensions in 2019 and 2020 (table 3). Most state proposals would use Section 1115 waiver authority under the Social Security Act to obtain joint federal and state funding for coverage extensions, requiring review and approval of waiver applications by the Centers for Medicare & Medicaid Services (CMS). Others would be financed using only state funds and would not need CMS approval. And although most proposals would extend Medicaid/CHIP coverage for a full year postpartum for all new mothers with pregnancy-related Medicaid/CHIP (similar to the federal proposals), some states have considered shorter extensions of six months or limited proposed extensions to targeted groups such as women with mental health conditions or substance use disorders.[43]

The potential impact of state-level action varies according to states' current Medicaid eligibility levels for new mothers. For instance, extension in expansion states such as Hawaii, Michigan, and Washington would increase Medicaid eligibility thresholds as a share of FPL by about 60 percentage points, while extension in a nonexpansion state such as Georgia would increase eligibility 190 percentage points, affecting a larger share of the state's population of new mothers. (But, if approved, Georgia's waiver would extend postpartum coverage for only six months.)

As of October 1, 2020, Illinois, Missouri, and New Jersey have Section 1115 waivers to extend Medicaid/CHIP for some or all postpartum women currently under review by CMS. It is unclear whether and under what conditions CMS will approve state efforts to extend Medicaid/CHIP or whether the change in administration will affect the likelihood of approval.

The economic crisis caused by the coronavirus pandemic has fueled efforts in a few states, but it has caused delays or discontinuations in other states. Only a few of the current postpartum extension proposals mention COVID-19, but some states have used the crisis to justify the need for extension. Missouri's proposal was created before the pandemic but now mentions the pandemic as a rationale justifying its approval, and Alabama's bill, which was proposed in March, mentions COVID-19 and its effects as a basis for the bill. But more commonly, state budget concerns have hindered advancement of extensions. California's 12-month postpartum extension for women with maternal mental health conditions was passed by the state legislature and signed into law in October 2019. Because it uses only state funds rather than a combination of state and federal funds, CMS approval was not required. But the pandemic delayed implementation. The program was implemented on August 1, 2020, and California became the first state to implement postpartum extension (County Welfare Directors

Association of California 2020).[44] Texas also implemented a limited extension on September 1, 2020, by adding one year of selected postpartum care services for Healthy Texas Women enrollees (Texas Health and Human Services 2020; Texas Medicaid and Healthcare Partnership 2020). Tennessee, Virginia, and Washington also delayed extension efforts because of budget shortfalls. Given budget crises are likely to persist for some time, these barriers may inhibit some states' efforts to enact postpartum extensions. But the outlook for ongoing or new efforts to adopt extension may shift as economic conditions and priorities change.

TABLE 2

Federal Efforts to Extend Postpartum Medicaid/CHIP Coverage, 2019–20

Proposal	Proposed extension (includes all postpartum women unless otherwise noted)	Status as of October 1, 2020	Recent activity	Funding mechanism
Patient Protection and Affordable Care Enhancement Act, H.R.1425	12-month extension with full benefits; mandatory for states with maintenance of effort required	Waiting for Senate	Passed in the US House of Representatives 6/29/2020	Current mechanism
Helping Medicaid Offer Maternity Services (Helping MOMS) Act, H.R.4996	12-month extension at state option	Referred to the Senate Committee on Finance	Passed in the US House of Representatives 9/30/2020	Current mechanism
Healthy MOMMIES Act, H.R.2602	12-month extension with full benefits; maintenance of effort required	Waiting on committee (presumed died in committee)	Referred to the Subcommittee on Health 5/16/2019	100% FMAP for additional expenditures
Healthy Maternity and Obstetric Medicine (Healthy MOM) Act, H.R.2778	12-month extension	Waiting on committee (presumed died in committee)	Referred to the Subcommittee on Health 5/9/2019	Current mechanism
Mothers and Offspring Mortality and Morbidity Awareness (MOMMA's) Act, H.R.1897	12-month extension; maintenance of effort required	Waiting on committee (presumed died in committee)	Referred to Subcommittee on Health 3/28/2019	100% FMAP for first 20 calendar quarters, 90% thereafter

Notes: ACA = Affordable Care Act; CHIP = Children's Health Insurance Program; CMS = Centers for Medicare & Medicaid Services; FMAP = federal medical assistance percentage. FPL = federal poverty level; 1115 waiver refers to the use of the US Department of Health and Human Services' authority under Section 1115 of the Social Security Act.

TABLE 3A

State Efforts to Extend Postpartum Medicaid/CHIP Coverage, 2019–20

Implemented

State: Proposal	Proposed extension (includes all postpartum women unless otherwise noted)	Status as of October 1, 2020	Recent activity	Funding mechanism	ACA Medicaid expansion status and current eligibility threshold for new mothers[a]	Pregnancy-related Medicaid/CHIP threshold[a] (eligibility threshold for new mothers if enacted)	Percentage-point increase in eligibility threshold if enacted[a]
California: AB-577/SB 104	12-month extension for those diagnosed with a maternal mental health condition	Delayed by pandemic but then implemented	Signed into law 10/12/19; implementation delayed as of 5/14/20 but then implemented 8/1/20	State-only funds	Expansion; 138%	213%	75%
Texas: Healthy Texas Women	12 months of additional postpartum care services for Healthy Texas Women enrollees	Implemented 9/1/20	Created per a mandate by HB 253 and SB 750 effective 9/1/19	State and federal funds	Nonexpansion; 17%	202%	185%

Notes: ACA = Affordable Care Act; CHIP = Children's Health Insurance Program; CMS = Centers for Medicare and Medicaid Services; FMAP = federal medical assistance percentage. FPL = federal poverty level; 1115 waiver refers to the use of the US Department of Health and Human Services' authority under Section 1115 of the Social Security Act.

[a] All eligibility thresholds are measured as a share of FPL.

TABLE 3B

State Efforts to Extend Postpartum Medicaid/CHIP Coverage, 2019–20

Under CMS review

State: Proposal	Proposed extension (includes all postpartum women unless otherwise noted)	Status as of October 1, 2020	Recent activity	Funding mechanism	ACA Medicaid expansion status and current eligibility threshold for new mothers[a]	Pregnancy-related Medicaid/CHIP threshold[a] (eligibility threshold for new mothers if enacted)	Percentage-point increase in eligibility threshold if enacted[a]
Illinois: SB 1909	12-month extension	Under CMS review	Passed; waiver submitted to CMS 12/31/19; CMS finished first review and approved completeness 1/14/20; currently under review	1115 waiver	Expansion; 138%	200%	62%
Missouri: Missouri Targeted Benefits for Pregnant Women	12-month extension of substance abuse treatment	Under CMS review	Passed; waiver submitted for CMS approval 2/25/20; federal comment period closed 3/2020; currently under review	1115 waiver	Nonexpansion; 21%	201%	180%
New Jersey: S2020	6-month coverage extension for those not already eligible for expansion Medicaid	Under CMS review	Passed; waiver amendment submitted 2/27/20; comment period began 4/1/20	1115 waiver	Expansion; 138%	205%	67%

Notes: ACA = Affordable Care Act; CHIP = Children's Health Insurance Program; CMS = Centers for Medicare and Medicaid Services; FMAP = federal medical assistance percentage. FPL = federal poverty level; 1115 waiver refers to the use of the US Department of Health and Human Services' authority under Section 1115 of the Social Security Act.[a] All eligibility thresholds are measured as a share of FPL.

TABLE 3C

State Efforts to Extend Postpartum Medicaid/CHIP Coverage, 2019–20

Delayed because of the COVID-19 pandemic

State: Proposal	Proposed extension (includes all postpartum women unless otherwise noted)	Status as of October 1, 2020	Recent activity	Funding mechanism	ACA Medicaid expansion status and current eligibility threshold for new mothers[a]	Pregnancy-related Medicaid/CHIP threshold[a] (eligibility threshold for new mothers if enacted)	Percentage-point increase in eligibility threshold if enacted[a]
Washington: HB 2381/SB 6128	12-month extension	Delayed by pandemic	Original budget proposed and approved 3/11/2020; Gov. Inslee vetoed 4/3/2020	1115 waiver	Expansion; 138%	198%	60%
Virginia: HB 30 (budget bill)	12-month extension	Delayed by pandemic	Passed and enrolled, state funding withheld due to pandemic 7/1/20	1115 wavier and state plan amendments	Expansion; 138%	205%	67%

Notes: ACA = Affordable Care Act; CHIP = Children's Health Insurance Program; CMS = Centers for Medicare and Medicaid Services; FMAP = federal medical assistance percentage. FPL = federal poverty level; 1115 waiver refers to the use of the US Department of Health and Human Services' authority under Section 1115 of the Social Security Act.

[a] All eligibility thresholds are measured as a share of FPL.

TABLE 3D

State Efforts to Extend Postpartum Medicaid/CHIP Coverage, 2019–20

Passed state legislature

State: Proposal	Proposed extension (includes all postpartum women unless otherwise noted)	Status as of October 1, 2020	Recent activity	Funding mechanism	ACA Medicaid expansion status and current eligibility threshold for new mothers[a]	Pregnancy-related Medicaid/CHIP threshold[a] (eligibility threshold for new mothers if enacted)	Percentage-point increase in eligibility threshold if enacted[a]
Georgia: HB 1114	6-month extension	Signed by governor 6/29/20	Approved by House and Senate (if budget allows) 6/24/20	1115 waiver	Nonexpansion; 35%	225%	190%
Michigan: Appropriation	12-month extension	Signed by governor, 9/30/20	Budget review presented to governor	Federal and state funding	Expansion; 138%	200%	62%
Missouri: HB 1682[b]	12-month extension for those with postpartum depression or other mental health issues	Delivered to secretary of state 7/13/20	Approved by governor 7/13/20	1115 waiver	Nonexpansion; 21%	185%	164%

Notes: ACA = Affordable Care Act; CHIP = Children's Health Insurance Program; CMS = Centers for Medicare and Medicaid Services; FMAP = federal medical assistance percentage. FPL = federal poverty level; 1115 waiver refers to the use of the US Department of Health and Human Services' authority under Section 1115 of the Social Security Act.

[a] All eligibility thresholds are measured as a share of FPL.

[b] indicates bill language mentions COVID emergency as rationale for extension.

TABLE 3E

State Efforts to Extend Postpartum Medicaid/CHIP Coverage, 2019–20

Pending

State: Proposal	Proposed extension (includes all postpartum women unless otherwise noted)	Status as of October 1, 2020	Recent activity	Funding mechanism	ACA Medicaid expansion status and current eligibility threshold for new mothers[a]	Pregnancy-related Medicaid/CHIP threshold[a] (eligibility threshold for new mothers if enacted)	Percentage-point increase in eligibility threshold if enacted[a]
Alabama: HB 448[b]	12-month extension	Read by committee	Referred to committee 3/12/20	1115 waiver if deemed necessary	Nonexpansion; 18%	146%	128%
District of Columbia: B23-0362	12-month extension	Looks like no, held public hearing 12/18/19, nothing since	Introduced 6/25/19	Federal or state funding	Expansion; 221%	324%	103%
Maine: LD 1957	6-month extension	Carried over to any special session of the 129th legislature pursuant to Joint Order SP 788 3/17/20	Reported out of committee 3/2/20	1115 waiver, must submit by January 2021	Expansion; 138%	200%	62%
Missouri: HB 2495	12-month extension	In committee	Referred to health committee 5/15/20	1115 waiver through CHIP	Nonexpansion; 21%	300%	279%
New York: SB 7147	12-month extension	In committee	Referred to finance committee 1/22/20	1115 waiver	Expansion; 138%	223%	85%
Pennsylvania: HB 2108	12-month extension	In committee	Referred to health committee 12/9/19	1115 waiver	Expansion; 138%	220%	82%

State: Proposal	Proposed extension (includes all postpartum women unless otherwise noted)	Status as of October 1, 2020	Recent activity	Funding mechanism	ACA Medicaid expansion status and current eligibility threshold for new mothers[a]	Pregnancy-related Medicaid/CHIP threshold[a] (eligibility threshold for new mothers if enacted)	Percentage-point increase in eligibility threshold if enacted[a]
West Virginia: HB 4416	12-month extension	In committee	Referred to House finance committee 1/17/20	State funds unless federal approval comes first	Expansion; 138%	190%	52%

Notes: ACA = Affordable Care Act; CHIP = Children's Health Insurance Program; CMS = Centers for Medicare and Medicaid Services; FMAP = federal medical assistance percentage. FPL = federal poverty level; 1115 waiver refers to the use of the US Department of Health and Human Services' authority under Section 1115 of the Social Security Act. For simplicity, we consider the District of Columbia a state in this table.

[a] All eligibility thresholds are measured as a share of FPL.

[b] indicates bill language mentions COVID emergency as rationale for extension.

TABLE 3F

State Efforts to Extend Postpartum Medicaid/CHIP Coverage, 2019–20

Failed

State: Proposal	Proposed extension (includes all postpartum women unless otherwise noted)	Status as of October 1, 2020	Recent activity	Funding mechanism	ACA Medicaid expansion status and current eligibility threshold for new mothers[a]	Pregnancy-related Medicaid/CHIP threshold[a] (eligibility threshold for new mothers if enacted)	Percentage-point increase in eligibility threshold if enacted[a]
Hawaii: HB 1943	12-month extension	Died in committee	Referred to House committees 2/12/20	State-only funds	Expansion; 138%	185%	58%
Iowa: SF 2062	12-month extension	Failed 6/14/20	Referred to subcommittee 1/27/20	1115 waiver if deemed necessary	Expansion; 138%	380%	242%
Mississippi: SB 2801	12-month extension	Died in committee	Referred to Medicaid/Appropriations 2/17/20	1115 waiver	Nonexpansion; 26%	185%	159%
New Jersey: S 4111	6-month coverage extension for those not already eligible for expansion Medicaid	Died in committee	Referred to committee, died 9/12/2019	1115 waiver	Expansion; 138%	199%	61%
South Carolina: Community Engagement Section 1115 Demonstration Waiver Application for South Carolina Department of Health and	12-month extension	Withdrawn	Waiver approval denied 12/12/19	1115 waiver	Nonexpansion; 67%	199%	132%

State: Proposal	Proposed extension (includes all postpartum women unless otherwise noted)	Status as of October 1, 2020	Recent activity	Funding mechanism	ACA Medicaid expansion status and current eligibility threshold for new mothers[a]	Pregnancy-related Medicaid/CHIP threshold[a] (eligibility threshold for new mothers if enacted)	Percentage-point increase in eligibility threshold if enacted[a]
Human Services (SCDHHS)							
Tennessee: TennCare 2021 Budget	12-month extension	Failed	Removed from budget by governor	State and federal funds	Nonexpansion; 94%	200%	106%
Texas: HB744	12-month extension	Failed to pass	Failed to pass 5/13/19	1115 waiver if deemed necessary	Nonexpansion; 17%	203%	186%
Wisconsin: SB 630	Continuous (at least 12 month) postpartum extension for those receiving substance use disorder treatment while pregnant	Failed to pass	Failed to pass 4/1/20	1115 waiver	Nonexpansion, 100%	306%	206%

Notes: ACA = Affordable Care Act; CHIP = Children's Health Insurance Program; CMS = Centers for Medicare and Medicaid Services; FMAP = federal medical assistance percentage. FPL = federal poverty level; 1115 waiver refers to the use of the US Department of Health and Human Services' authority under Section 1115 of the Social Security Act.

[a] All eligibility thresholds are measured as a share of FPL.

Discussion

The nation's current system of publicly supported coverage options for pregnant and postpartum women is a complex patchwork that varies tremendously by income and immigration status and across states. Extending pregnancy-related Medicaid/CHIP coverage for 12 months postpartum would simplify and streamline one piece of this patchwork and expand coverage options for many new mothers in a program that offers comprehensive benefits with substantial cost protection. Still, such an extension would not create a uniform eligibility standard for Medicaid/CHIP coverage of new mothers across states. Rather, it would allow new mothers eligible for pregnancy-related Medicaid/CHIP coverage based on their state's eligibility policy to maintain this coverage for a full year postpartum. This would likely improve coverage rates among new mothers while supporting healthier maternal and infant outcomes during the critical one-year-postpartum period.

Adoption of 12-month continuous Medicaid/CHIP eligibility would not only offer many new mothers a new coverage option but would allow new mothers to remain enrolled in the same coverage type without a break or change in that coverage. This continuity would benefit women who would otherwise go uninsured after 60 days postpartum and women who would retain coverage in the postpartum period but who may otherwise experience churn between coverage types (e.g., Medicaid and Marketplace coverage or employer-sponsored insurance) or coverage pathways (e.g., pregnancy-related and parental Medicaid). It would also reduce the burdens on new mothers of applying for new coverage or switching coverage while recovering from childbirth and caring for their infants, and they would retain that coverage even if their family incomes fluctuate. Postpartum Medicaid/CHIP extension could improve continuity of care and health outcomes for new mothers and could have positive spillover effects on their children, such as increasing continuous coverage for infants during their first year and improving family financial security (Burak 2017; Sommers et al. 2016).[45]

Enacting legislation similar to the recent federal bills to extend postpartum Medicaid/CHIP would benefit new mothers across the country, but the new administration and Congress could take additional actions to improve postpartum coverage rates. For instance, a swift CMS approval of current Section 1115 waiver applications to implement state-level Medicaid/CHIP postpartum extensions would expand coverage options in several states while federal legislation is considered. Other possible federal actions include increasing the federally mandated minimum eligibility level for pregnancy-related coverage, which would both expand eligibility and reduce state variation. Federal action could also include reducing allowed cost-sharing requirements to make care more affordable

and encourage families to use services. For instance, Medicaid's out-of-pocket cost-sharing cap of 5 percent of income may be unaffordable for many women with low incomes.

Of course, at the state level, adoption of the ACA's Medicaid expansion by states that have not yet expanded would offer the most sweeping and dramatic improvement of coverage options. Such expansion would also eliminate the coverage gap not only in the postpartum period but prepregnancy, which could improve mothers' health during pregnancy and beyond, potentially contributing to health gains (Searing and Ross 2019).

The large number of postpartum extension proposals in Congress and across several states indicates strong interest in enacting postpartum coverage extensions in Medicaid/CHIP. Additional legislation that goes beyond coverage to consider other factors that shape maternal health would also likely be needed to improve maternal health outcomes and address inequities in the maternal health system more broadly. For instance, the Black Maternal Health Momnibus Act of 2020 would invest in social determinants of health, community-based organizations, data collection, and maternal mental health care, as well as target specific groups of mothers, such as veterans and incarcerated women.[46] Though the pandemic has impeded progress for some of these initiatives, the crisis also highlights the risks to maternal health and heightens the need for affordable, comprehensive, continuous health insurance coverage during the postpartum period to reduce maternal morbidity and mortality. Thus, the need to implement policy solutions to reduce coverage gaps among new mothers is more critical than ever.

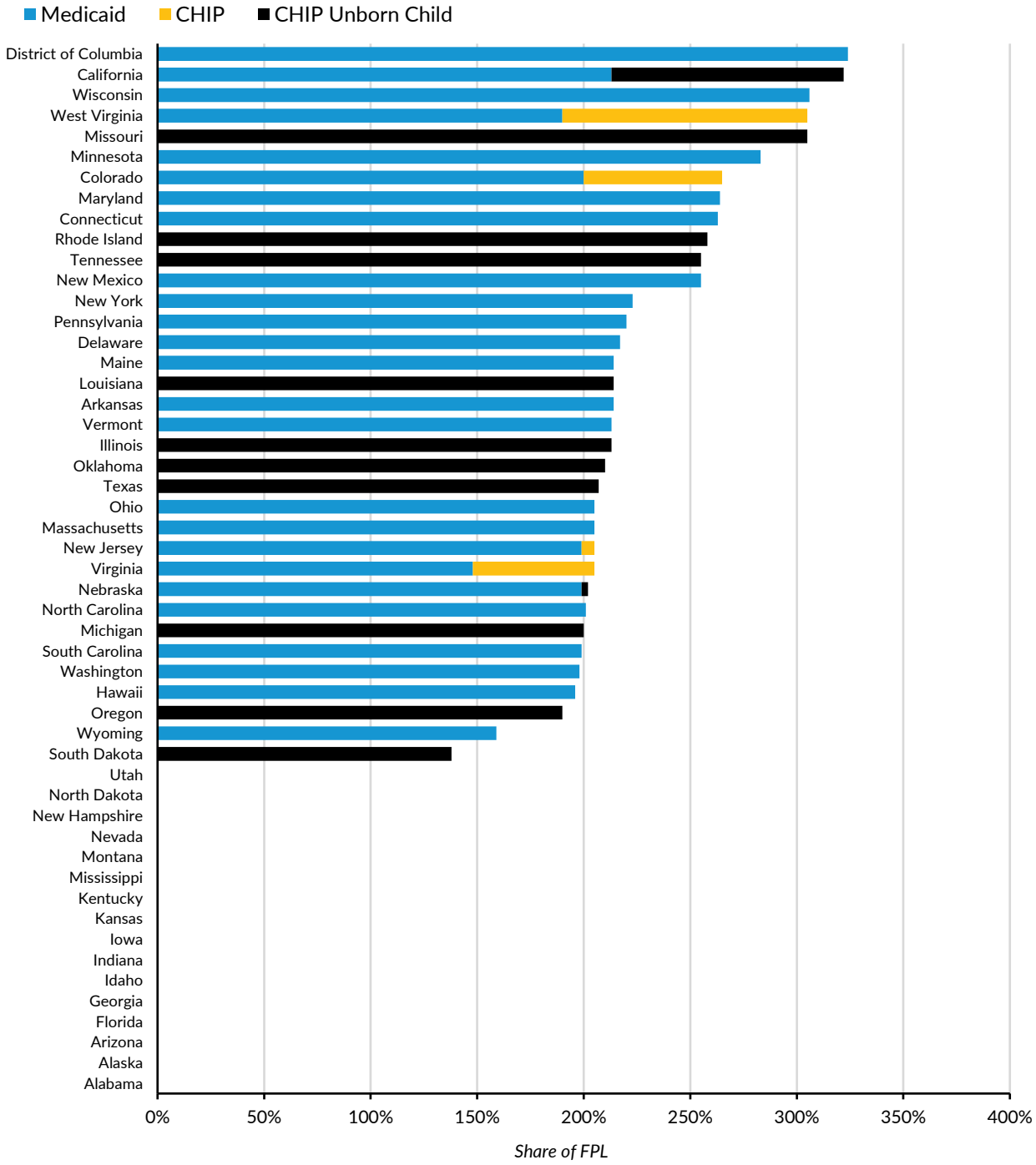
Appendix A. Eligibility for Noncitizen Pregnant Women

Because of variation in states' decisions for adopting the Immigrant Children's Health Improvement Act option and CHIP's unborn-child option, lawfully residing immigrant women with fewer than five years' residency have paths to Medicaid/CHIP eligibility while pregnant in 35 states using various approaches, including Medicaid, Medicaid and CHIP, and unborn-child coverage. Nearly every state that offers this coverage extends it to people with incomes at or above 200 percent of FPL, and 5 percent of such states extend it to those with incomes at or above 300 percent of FPL (figure A.1). The other 16 states do not extend Medicaid/CHIP eligibility to lawfully residing pregnant immigrant women with fewer than five years' residency, but some may qualify for Marketplace coverage.

Only the 17 states adopting CHIP's unborn-child option offer coverage to undocumented immigrant pregnant women (figure A.2). Of those states, most limit eligibility for the unborn-child option to people with incomes below 200 percent of FPL, and 3 states extend this coverage to those with incomes below 300 percent of FPL. But 34 states do not offer coverage to undocumented pregnant women, and undocumented immigrants cannot enroll in the ACA's Marketplaces.

FIGURE A.1

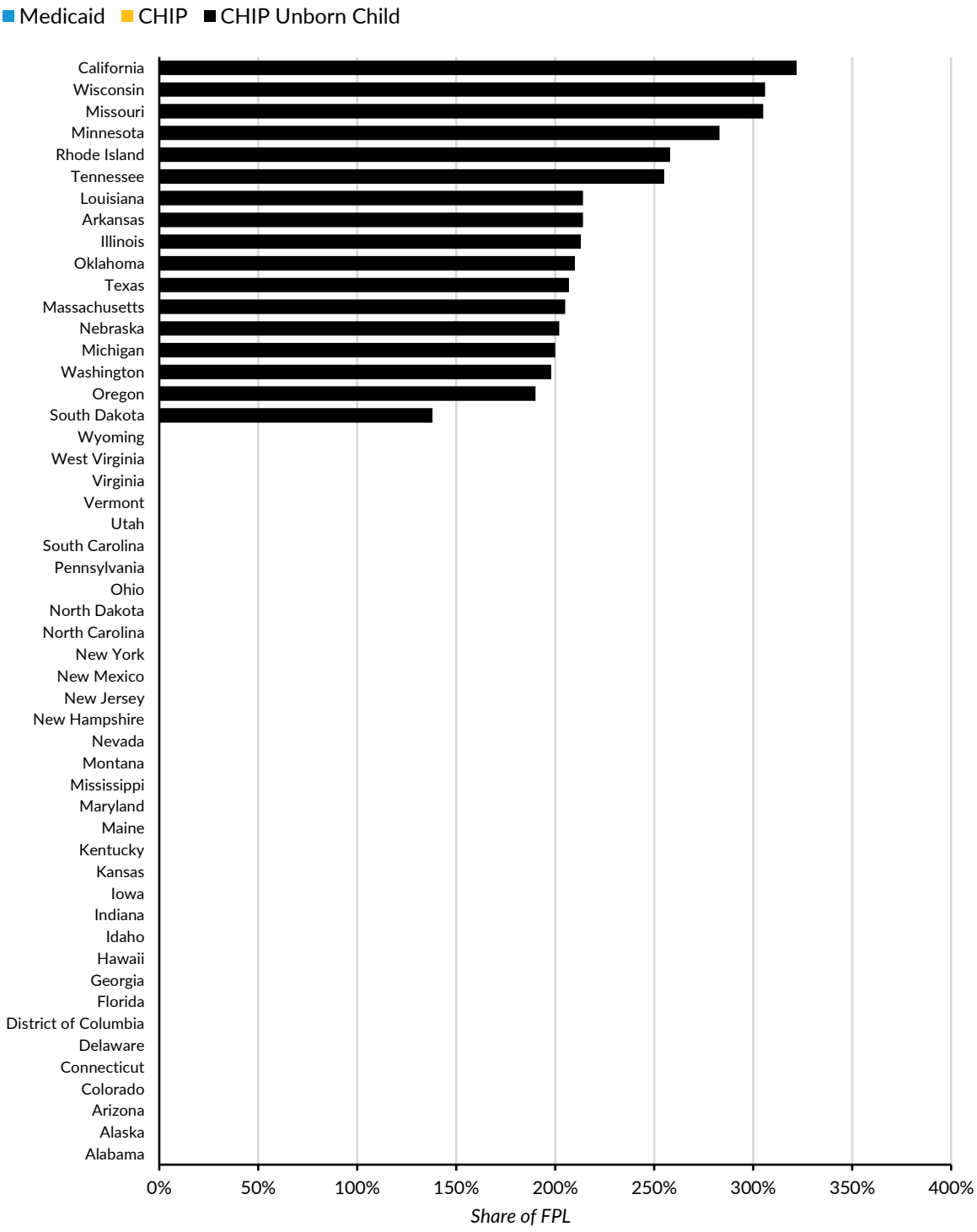
Pregnancy-Related Medicaid/CHIP and Marketplace Income Eligibility Thresholds, as a Share of FPL, for Lawfully Residing Noncitizens with Fewer Than Five Years' Residency, by Program Type and State, 2020



Source: Tricia Brooks, Lauren Roygardner, Samantha Artiga, Olivia Pham, and Rachel Dolan, *Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings from a 50-State Survey* (San Francisco: Kaiser Family Foundation, 2020).
Notes: CHIP = Children's Health Insurance Program; FPL = federal poverty level. No bar for a state indicates the state does not offer pregnancy-related Medicaid/CHIP coverage for this group. The shaded area indicates the income range for subsidized Marketplace coverage. In addition, legally present immigrants with incomes below 100 percent of FPL who cannot enroll in Medicaid because they are in the five-year waiting period may be eligible for Marketplace subsidies.

FIGURE A.2

Pregnancy-Related CHIP Income Eligibility Thresholds, as a Share of FPL, for Undocumented Immigrants, by Program Type and State, 2020



Source: Tricia Brooks, Lauren Roygardner, Samantha Artiga, Olivia Pham, and Rachel Dolan, *Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings from a 50-State Survey* (San Francisco: Kaiser Family Foundation, 2020).

Notes: FPL = federal poverty level. No bar for a state indicates the state does not offer pregnancy-related CHIP coverage for this group. California, Illinois, Louisiana, Maryland, Massachusetts, Michigan, Missouri, Oklahoma, Oregon, Rhode Island, Washington, and Wisconsin provide comprehensive benefits similar in scope to pregnancy-related Medicaid. Benefits in the remaining states are more limited. The District of Columbia, Massachusetts, New Jersey, New York, Oregon, and Washington provide additional services to pregnant women who meet the income requirement but not the immigration status requirement of Medicaid using state-only funds. Undocumented immigrants are not eligible for Marketplace subsidies.

Appendix B. Summary of State-Level Rules

TABLE B.1

Income and Immigration Status Eligibility Rules for Pregnancy-Related Medicaid/CHIP, Unborn-Child CHIP, Parental Coverage, and Family Planning Services, as a Share of FPL, by State, 2020

	Medicaid/CHIP Pregnancy-Related Income Limits			Lawfully Residing Immigrant Pregnant Women Covered without 5-Year Wait (ICHIA Option)					
	Medicaid	CHIP	Medicaid /CHIP	Medicaid	CHIP	Medicaid /CHIP	Unborn-child CHIP	Parental/ ACA expansion	Family planning
United States (median/total)	200%	262%	205%	25 Yes	4 Yes	25 Yes	213%	138%	205%
Alabama	146%	N/A	146%				N/A	18%	146%
Alaska	205%	N/A	205%				N/A	138%	N/A
Arizona	161%	N/A	161%				N/A	138%	N/A
Arkansas	214%	N/A	214%	Yes		Yes	214%	138%	N/A
California	213%	N/A	213%	Yes		Yes	322%	138%	205%
Colorado	200%	265%	265%	Yes	Yes	Yes	N/A	138%	N/A
Connecticut	263%	N/A	263%	Yes		Yes	N/A	160%	263%
Delaware	217%	N/A	217%	Yes		Yes	N/A	138%	N/A
District of Columbia	324%	N/A	324%	Yes		Yes	N/A	221%	N/A
Florida	196%	N/A	196%				N/A	31%	190%
Georgia	225%	N/A	225%				N/A	35%	216%
Hawaii	196%	N/A	196%	Yes		Yes	N/A	138%	N/A
Idaho	138%	N/A	138%				N/A	138%	N/A
Illinois	213%	N/A	213%				213%	138%	N/A
Indiana	218%	N/A	218%				N/A	139%	148%
Iowa	380%	N/A	380%				N/A	138%	N/A
Kansas	171%	N/A	171%				N/A	38%	N/A
Kentucky	200%	N/A	200%				N/A	138%	218%
Louisiana	138%	N/A	138%				214%	138%	138%
Maine	214%	N/A	214%	Yes		Yes	N/A	138%	214%
Maryland	264%	N/A	264%	Yes		Yes	N/A	138%	264%
Massachusetts	205%	N/A	205%	Yes		Yes	205%	138%	N/A
Michigan	200%	N/A	200%				200%	138%	N/A
Minnesota	283%	N/A	283%	Yes		Yes	283%	200%	205%
Mississippi	199%	N/A	199%				N/A	26%	199%

	Medicaid/CHIP Pregnancy-Related Income Limits			Lawfully Residing Immigrant Pregnant Women Covered without 5-Year Wait (ICHIA Option)					
	Medicaid	CHIP	Medicaid /CHIP	Medicaid	CHIP	Medicaid /CHIP	Unborn-child CHIP	Parental/ ACA expansion	Family planning
Missouri	201%	305%	305%				305%	21%	206%
Montana	162%	N/A	162%				N/A	138%	216%
Nebraska	199%	N/A	199%	Yes		Yes	202%	63%	N/A
Nevada	165%	N/A	165%				N/A	138%	N/A
New Hampshire	201%	N/A	201%				N/A	138%	201%
New Jersey	199%	205%	205%	Yes	Yes	Yes	N/A	138%	205%
New Mexico	255%	N/A	255%	Yes		Yes	N/A	138%	255%
New York	223%	N/A	223%	Yes		Yes	N/A	200%	223%
North Carolina	201%	N/A	201%	Yes		Yes	N/A	41%	200%
North Dakota	162%	N/A	162%				N/A	138%	N/A
Ohio	205%	N/A	205%	Yes		Yes	N/A	138%	N/A
Oklahoma	138%	N/A	138%				210%	41%	138%
Oregon	190%	N/A	190%				190%	138%	255%
Pennsylvania	220%	N/A	220%	Yes		Yes	N/A	138%	220%
Rhode Island	195%	258%	258%				258%	138%	258%
South Carolina	199%	N/A	199%	Yes		Yes	N/A	67%	199%
South Dakota	138%	N/A	138%				138%	48%	N/A
Tennessee	200%	N/A	200%				255%	94%	N/A
Texas	203%	N/A	203%				207%	17%	N/A
Utah	144%	N/A	144%				N/A	138%	N/A
Vermont	213%	N/A	213%	Yes		Yes	N/A	138%	200%
Virginia	148%	205%	205%	Yes	Yes	Yes	N/A	138%	205%
Washington	198%	N/A	198%	Yes		Yes	198%	138%	265%
West Virginia	190%	305%	305%	Yes	Yes	Yes	N/A	138%	N/A
Wisconsin	306%	N/A	306%	Yes		Yes	306%	100%	306%
Wyoming	159%	N/A	159%	Yes		Yes	N/A	53%	159%

Source: Tricia Brooks, Lauren Roygardner, Samantha Artiga, Olivia Pham, and Rachel Dolan, *Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings from a 50-State Survey* (San Francisco: Kaiser Family Foundation, 2020).

Notes: ACA = Affordable Care Act; CHIP = Children's Health Insurance Program; FPL = federal poverty level; ICHIA = Immigrant Children's Health and Improvement Act.

Notes

[1] "Severe Maternal Morbidity in the United States," Centers for Disease Control and Prevention, last updated January 31, 2020, https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html; and "Pregnancy Mortality Surveillance System," Centers for Disease Control and Prevention, last updated February 4, 2020, https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm.

[2] "The 4th Trimester Project," University of North Carolina at Chapel Hill School of Social Work, Jordan Institute for Families, accessed November 5, 2020, https://jordaninstituteforfamilies.org/collaborate/community-initiatives/4thtrimesterproject/.

[3] See also "Births Financed by Medicaid," Kaiser Family Foundation, accessed November 5, 2020, https://www.kff.org/medicaid/state-indicator/births-financed-by-medicaid/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

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

[5] Association of State and Territorial Health Officials (ASTHO), "States Tackle the Climbing Maternal Mortality Rate in the US," ASTHO Experts blog, March 18, 2020, https://www.astho.org/StatePublicHealth/States-Tackle-Climbing-Maternal-Mortality-Rate-in-the-US/03-18-20/; and Katy Backes Kozhimannil, Elaine Hernandez, Dara Mendez, and Theresa Chapple-McGruder, "Beyond the Preventing Maternal Deaths Act: Implementation and Further Policy Change," Health Affairs blog, February 4, 2019, https://www.healthaffairs.org/do/10.1377/hblog20190130.914004/full/.

[6] 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/; 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; "View Each State's Efforts to Extend Medicaid Coverage to Postpartum Women," National Academy for State Health Policy, last updated September 29, 2020, https://www.nashp.org/view-each-states-efforts-to-extend-medicaid-coverage-to-postpartum-women/.

[7] "Medicaid Emergency Authority Tracker: Approved State Actions to Address COVID-19," Kaiser Family Foundation, November 2, 2020, https://www.kff.org/coronavirus-covid-19/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/.

[8] Because of rules prohibiting reductions in benefits, women in states with more limited pregnancy-related benefits can switch to ACA-expansion coverage after pregnancy-related coverage expires. See Kelly Whitener, "Families First Coronavirus Response Act: Impact on Pregnant Women Covered by Medicaid and CHIP," *Say Ahhh!* (blog), Georgetown University Health Policy Institute Center for Children and Families, March 26, 2020, https://ccf.georgetown.edu/2020/03/26/families-first-coronavirus-response-act-impact-on-pregnant-women-covered-by-medicaid-and-chip/.

[9] Xenia Shih Bion, "Efforts to Reduce Black Maternal Mortality Complicated by COVID-19," California Health Care Foundation blog, April 20, 2020, https://www.chcf.org/blog/efforts-reduce-black-maternal-mortality-complicated-covid-19/; Taylor Platt, "States Implement Strategies to Safeguard Pregnant Women during the

COVID-19 Pandemic," National Academy for State Health Policy, April 20, 2020, https://www.nashp.org/states-implement-strategies-to-safeguard-pregnant-women-during-the-covid-19-pandemic/; Gabriela Weigel, "Novel Coronavirus 'COVID-19': Special Considerations for Pregnant Women," Henry J. Kaiser Family Foundation, March 17, 2020, https://www.kff.org/womens-health-policy/issue-brief/novel-coronavirus-covid-19-special-considerations-for-pregnant-women/; and Laurie Zephyrin, "Caring for Moms during the COVID-19 Pandemic," *To the Point* (blog), Commonwealth Fund, April 15, 2020, https://www.commonwealthfund.org/blog/2020/caring-moms-during-covid-19-pandemic?utm_source=alert&utm_medium=email&utm_campaign=Delivery%20System%20Reform.

[10] 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/; and Nina Martin, "What Coronavirus Means for Pregnancy, and Other Things New and Expecting Mothers Should Know," *ProPublica*, March 19, 2020, https://www.propublica.org/article/coronavirus-and-pregnancy-expecting-mothers-q-and-a.

[11] "Addressing Health Equity during the COVID-19 Pandemic," American College of Obstetricians and Gynecologists, May 11, 2020, https://www.acog.org/clinical-information/policy-and-position-statements/position-statements/2020/addressing-health-equity-during-the-covid-19-pandemic; and Platt, "States Implement Strategies."

[12] Some pregnant women may have additional coverage pathways not described here. For instance, disabled women may qualify for disability-related Medicaid or Medicare coverage that would have different eligibility than what is presented here. Teenagers up to age 19 may qualify for Medicaid/CHIP coverage as children, including during and after pregnancy, and some states offer income-based eligibility for 19- and 20-year-olds. Other women receive perinatal coverage through the Veterans Administration or TRICARE.

[13] The required minimum is 133 percent of FPL. Adding a standard 5 percentage-point income disregard, the effective minimum is 138 percent of FPL. Some states' mandated limits are higher, up to 185 percent of FPL, based on their Aid to Families with Dependent Children income limits in 1988 (Chen and Hayes 2018). Income eligibility is based on modified adjusted gross income for the family unit, which considers the unborn child part of the unit when determining income eligibility. Women applying for Medicaid/CHIP who are pregnant at the time of application who fall below both the pregnancy-related income threshold and other eligibility thresholds would be enrolled in pregnancy-related Medicaid/CHIP, while those already enrolled must be offered the option to either switch to pregnancy-related Medicaid/CHIP or stay in that coverage (Chen and Hayes 2018).

[14] 2020 policy thresholds and rules summarized in this report are as of January 2020. Appendix B presents eligibility rules for each pathway for the 50 states and the District of Columbia.

[15] Some states use different eligibility criteria for certain groups. For instance, California disregards all income of unmarried pregnant women younger than 21, Maryland disregards all income of pregnant teenagers younger than 18, New York does not apply an income test for pregnant women younger than 21, and Michigan extends eligibility to 400 percent of FPL for pregnant women served by the water system in Flint, Michigan (MACPAC 2020).

[16] Benefits can extend longer, to the last day of the month in which the 60th day after the end of pregnancy falls. Some states also offer eligibility for even longer for some women. For instance, Colorado's Special Connections program provides substance use disorder treatment for 12 months (MACPAC 2020).

[17] Whitener, "Families First Coronavirus Response Act."

[18] Whitener, "Families First Coronavirus Response Act."

[19] Immigrants are eligible for Medicaid/CHIP if they are "qualified noncitizens," including lawful permanent residents or green-card holders and other groups of immigrants. Individuals are eligible for the five-year waiting period exemption in Medicaid/CHIP if they are "lawfully residing"—that is, lawfully present and

otherwise eligible for the programs. See NILC (2020a) and "Coverage for Lawfully Present Immigrants," HealthCare.gov, accessed November 5, 2020, https://www.healthcare.gov/immigrants/lawfully-present-immigrants/.

[20] Furthermore, the District of Columbia, Massachusetts, New Jersey, New York, Oregon, and Washington provide additional services to pregnant women who meet the income requirements but not the immigration status requirements of Medicaid using state-only funds (Brooks et al. 2020).

[21] There are exceptions to the five-year waiting period for certain immigrants, such as refugees and asylees (CMS 2020). Texas bars most lawfully residing immigrant adults with more than five years' residency from eligibility for Medicaid (NILC 2020a).

[22] 42 C.F.R. § 440.210(a)(2)(i).

[23] But we do not know whether services not directly related to the pregnancy, such as chronic conditions, may be considered necessary to the health of the woman or fetus in practice. Also, during the presumptive eligibility determination process, only pregnancy-related services are covered.

[24] "Cost Sharing Out of Pocket Costs: Out of Pocket Costs," Medicaid.gov, accessed November 5, 2020, https://www.medicaid.gov/medicaid/cost-sharing/cost-sharing-out-pocket-costs/index.html.

[25] "Cost Sharing Out of Pocket Costs," Medicaid.gov.

[26] Centers for Medicare & Medicaid Services regional administrators, letter to state health officials, September 3, 2009, https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/downloads/SHO090309.pdf.

[27] Some postpartum women may have additional coverage pathways not described here. For instance, disabled women may qualify for disability-related Medicaid or Medicare coverage that would have different eligibility than what is presented here. Other women receive perinatal coverage through the Veterans Administration or TRICARE.

[28] Parental eligibility lasts beyond the first year postpartum. Parents who meet the eligibility requirements can qualify if their child is younger than 18 (or older if enrolled in school full time). In addition, some pregnant and postpartum women may already have parental or ACA-expansion Medicaid coverage and may keep that coverage during pregnancy and the postpartum period (Chen and Hayes 2018).

[29] 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. See "Basic Health Program," Medicaid.gov, accessed November 5, 2020, https://www.medicaid.gov/basic-health-program/index.html.

[30] Texas bars most lawfully residing immigrant adults with more than five years' residency from eligibility for Medicaid (NILC 2020a).

[31] Some states limit eligibility to individuals losing Medicaid/CHIP eligibility. Iowa and Texas offer family planning benefits using only state funds (Brooks et al. 2020). Also, information sources on states' family planning programs vary. See, for example, "Medicaid Family Planning Eligibility," Guttmacher Institute, last updated November 1, 2020, https://www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions.

[32] Usha Ranji, Yali Bair, and Alina Salganicoff, "Medicaid and Family Planning: Background and Implications of the ACA," Henry J. Kaiser Family Foundation, February 3, 2016, https://www.kff.org/report-section/medicaid-and-family-planning-appendix-1-women-with-full-medicaid-benefits-and-share-that-are-reproductive-age-by-state/view/print/.

[33] Affordable coverage is based on income and defined as an employee contribution for individual coverage at a maximum of 9.78 percent of income; see 26 CFR § 601.105 (2019): Examination of returns and claims for refund, credit, or abatement; determination of correct tax liability.

[34] Women who qualify for pregnancy-related Medicaid/CHIP who reside in Arkansas and South Dakota, where coverage does not meet the requirements for minimum essential coverage, can qualify for Marketplace subsidies (Brooks et al. 2020). Whitener, "Families First Coronavirus Response Act."

[35] See also Olivia Hoppe, "Navigating Coverage during the COVID-19 Pandemic: Frequently Asked Questions," *Say Ahhh!* (blog), Georgetown University Health Policy Institute Center for Children and Families, March 28, 2020, https://ccf.georgetown.edu/2020/03/28/navigating-coverage-during-the-covid-19-pandemic-frequently-asked-questions/.

[36] Postpartum women in the coverage gap may purchase unsubsidized Marketplace coverage, but given their low incomes and the high prices for unsubsidized coverage, it is unlikely to be affordable (Garfield, Orgera, and Damico 2020).

[37] "Explaining Health Care Reform: Questions about Health Insurance Subsidies," Henry J. Kaiser Family Foundation, October 30, 2020, https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-questions-about-health-insurance-subsidies/.

[38] "Explaining Health Care Reform," Henry J. Kaiser Family Foundation.

[39] Sean Miskell, "Study: Medicaid Offers Stronger Cost Sharing Protections Compared with Marketplace Coverage," Center on Health Insurance Reforms blog, June 22, 2016, http://chirblog.org/study-medicaid-offers-stronger-cost-sharing-protections-compared-with-marketplace-coverage/; and National Academy for State Health Policy, "CHIP Coverage Is Important for Pregnant Women Too," November 15, 2016, https://www.nashp.org/chip-coverage-is-important-for-pregnant-women-too/.

[40] Comparable figures for lawfully residing immigrant women with fewer than five years' residency and undocumented women are included in appendix A.

[41] Evidence indicates cost sharing can affect use of health services (Brook et al. 2006).

[42] 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/do/10.1377/hblog20191230.967912/full/.

[43] Table 2 includes only proposals that would implement a postpartum extension. For instance, we do not include Delaware's Senate Concurrent Resolution 66, which mandates only the study of a 12-month postpartum Medicaid extension. Nor do we include Tennessee's Amendment 42, which proposed to extend postpartum coverage for 12 months but does not include policies to implement such an extension. We also note the state-funded extension of the Healthy Texas Women program on September 1, 2020, only adds specific postpartum services.

[44] California Department of Health Care Services, "Provisional Postpartum Care Extension," news release, July 31, 2020, https://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_30223_01.aspx.

[45] Johnson, Rosenbaum, and Handley, "The Next Steps."

[46] "About the Black Maternal Health Momnibus Act of 2020," Black Maternal Health Caucus, accessed November 4, 2020, https://blackmaternalhealthcaucus-underwood.house.gov/Momnibus.

References

ACOG (American College of Obstetricians and Gynecologists). 2018. "Optimizing Postpartum Care." *Obstetrics and Gynecology* 131 (5): e140–50.

AMCHP (Association of Maternal and Child Health Programs). 2013. "Health Reform and Insurance Coverage for Pregnant Women." Presentation given at the Health Reform and Insurance Coverage for Pregnant Women Webinar Series, August 28.

American Academies (American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Physicians, American Osteopathic Association, and American Psychiatric Association). 2019. "Helping Ensure Healthy Mothers and Healthy Babies: Eliminating Preventable Maternal Mortality and Morbidity." Leawood, Kansas: American Academy of Family Physicians.

Angus, Lisa, and Jennifer DeVoe. 2010. "Evidence That the Citizenship Mandate Curtailed Participation in Oregon's Medicaid Family Planning Program." *Health Affairs* 29 (4): 690–98.

ASTHO (Association of State and Territorial Health Officials). 2016. "State Children's Health Insurance Program (S-CHIP) Coverage During Pregnancy." Arlington, VA: ASTHO.

Beutel, Sophie, Munira Z. Gunja, and Sara R. Collins. 2016. "How Much Financial Protection Do Marketplace Plans Provide in States Not Expanding Medicaid?" New York: Commonwealth Fund.

Blavin, Fredric, Michael Karpman, Genevieve M. Kenney, and Benjamin D. Sommers. 2018. "Medicaid versus Marketplace Coverage for Near-Poor Adults: Effects on Out-of-Pocket Spending and Coverage." *Health Affairs* 37 (2): 299–307.

Brook, Robert H., Emmett B. Keeler, Kathleen N. Lohr, Joseph P. Newhouse, John E. Ware, William H. Rogers, and Allyson Ross Davies, et al. 2006. "The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate." Santa Monica, CA: RAND Corporation.

Brooks, Tricia. 2014. "The Family Glitch." Bethesda, MD: Health Affairs.

Brooks, Tricia, Lauren Roygardner, Samantha Artiga, Olivia Pham, and Rachel Dolan. 2020. *Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings from a 50-State Survey*. San Francisco: Kaiser Family Foundation.

Buettgens, Matthew, Lisa Dubay, and Genevieve M. Kenney. 2016. "Marketplace Subsidies: Changing The 'Family Glitch' Reduces Family Health Spending But Increases Government Costs." *Health Affairs* 35 (7): 1167–75. https://doi.org/10.1377/hlthaff.2015.1491.

Burak, Elizabeth Wright. 2017. "Health Coverage for Parents and Caregivers Helps Children." Washington, DC: Georgetown University Health Policy Institute Center for Children and Families.

California Health Care Foundation. 2015. "Two More Years: What Does Continued CHIP Funding Mean for California?" Oakland: California Health Care Foundation.

Callaghan, William M., Andreea A. Creanga, and Elena V. Kuklina. 2012. "Severe Maternal Morbidity among Delivery and Postpartum Hospitalizations in the United States." *Obstetrics and Gynecology* 120 (5): 1029–36.

CDC Foundation. 2018. "Report from Nine Maternal Mortality Review Committees." Atlanta: CDC Foundation.

Center for Health Care Strategies. 2019. "Medicaid Adult Dental Benefits: An Overview." Trenton, NJ: Center for Health Care Strategies.

Chen, Amy. 2017. "Pregnancy-Related Medicaid and Minimum Essential Coverage." Washington, DC: National Health Law Program.

Chen, Amy, and Emily Hayes. 2018. "Q&A on Pregnant Women's Coverage Under Medicaid and the ACA." Washington, DC: National Health Law Program.

CMS (Centers for Medicare and Medicaid Services). 2020. "Families First Coronavirus Response Act–Increased FMAP FAQs." Baltimore: CMS.

County Welfare Directors Association of California. 2020. "State Budget Update #3: 2020-21 May Revision." Sacramento: County Welfare Directors Association of California.

Creanga, Andreea A., Brian T. Bateman, Elena V. Kuklina, and William M. Callaghan. 2014. "Racial and Ethnic Disparities in Severe Maternal Morbidity: A Multistate Analysis, 2008–2010." *American Journal of Obstetrics and Gynecology* 210 (5): 435 e1–8.

Daw, Jamie R., and Benjamin D. Sommers. 2018. "The Affordable Care Act and Access to Care for Reproductive-Aged and Pregnant Women in the United States, 2010–2016." *American Journal of Public Health* 109 (4): 565–71.

Daw, Jamie R., Tyler N. A. Winkelman, Vanessa K. Dalton, Katy B. Kozhimannil, and Lindsay K. Admon. 2020. "Medicaid Expansion Improved Perinatal Insurance Continuity for Low-Income Women." *Health Affairs* 39 (9).

Daw, Jamie R., Laura A. Hatfield, Katherine Swartz, and Benjamin D. Sommers. 2017. "Women in the United States Experience High Rates of Coverage 'Churn' in Months before and after Childbirth." *Health Affairs* 36 (4).

Eckert, Emily. 2020. "Preserving the Momentum to Extend Postpartum Medicaid Coverage." S1049-3867 (20): 30071–2.

Ellington Sascha, Penelope Strid, Van T. Tong, Van T. Tong, Kate Woodworth, Romeo R. Galang, Laura D. Zambrano, John Nahabedian, Kayla Anderson, and Suzanne M. Gilboa. 2020. "Characteristics of Women of Reproductive Age with Laboratory-Confirmed SARS-CoV-2 Infection by Pregnancy Status—United States, January 22–June 7, 2020." *Morbidity and Mortality Weekly Report* 69 (25): 770–75.

Equitable Maternal Health Coalition. 2020. *Making the Case for Extending Medicaid Coverage Beyond 60 Days Postpartum: A Toolkit for State Advocates*. Arlington, VA: Equitable Maternal Health Coalition.

Garfield, Rachel, Kendal Orgera, and Anthony Damico. 2020. "The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid." Menlo Park, CA: Kaiser Family Foundation.

Gifford, Kathy, Jenna Walls, Usha Ranji, Alina Salganicoff, and Ivette Gomez. 2017. *Medicaid Coverage of Pregnancy and Perinatal Benefits: Results from a State Survey*. Menlo Park, CA: Kaiser Family Foundation.

Gordon, Sarah H., Benjamin D. Sommers, Ira B. Wilson, and Amal N. Triveldi. 2020. "Effects of Medicaid Expansion on Postpartum Coverage and Outpatient Utilization." *Health Affairs* 39 (1).

Johnston, Emily M., Stacey McMorrow, Tyler W. Thomas, and Genevieve M. Kenney. 2019. "Racial Disparities in Uninsurance among New Mothers Following the Affordable Care Act." Washington, DC: Urban Institute.

———. 2020. "ACA Medicaid Expansion and Insurance Coverage among New Mothers Living in Poverty." *Pediatrics* 145 (5).

Johnston, Emily M., Andrea E. Strahan, Peter Joski, Anne L. Dunlop, and E. Kathleen Adams. 2017. "Impacts of the Affordable Care Act's Medicaid Expansion on Women of Reproductive Age: Differences by Parental Status and State Policies." *Women's Health Issues* 28 (2): 122–29.

Karpman, Michael, Stephen Zuckerman, Dulce Gonzalez, and Genevieve M. Kenney. 2020. "The COVID-19 Pandemic Is Straining Families' Abilities to Afford Basic Needs: Low-Income and Hispanic Families the Hardest Hit." Washington, DC: Urban Institute.

Lee Lois K., Alyna Chien, Amanda Stewart, Larissa Truschel, Jennifer Hoffmann, Elyse Portillo, Lydia E. Pace, Mark Clapp, Alison A. Galbraith. 2020. "Women's Coverage, Utilization, Affordability, and Health after the ACA: A Review of the Literature." *Health Affairs* 39 (3): 387–94.

MacDorman, Marian F., Eugene Declercq, Howard Cabral, and Christine Morton. 2016. "Is the United States Maternal Mortality Rate Increasing? Disentangling Trends from Measurement Issues." *Obstetrics and Gynecology* 128 (3): 447–55.

MACPAC (Medicaid and CHIP Payment and Access Commission). 2016. "Update on Pregnancy-Related Medicaid and Minimum Essential Coverage." Washington, DC: MACPAC.

———. 2018. "Access in Brief: Pregnant Women and Medicaid." Washington, DC: MACPAC.

———. 2020a. "Inventory of State-Level Medicaid Policies, Programs, and Initiatives to Improve Maternity Care and Outcomes." Washington, DC: MACPAC.

———. 2020b. "Medicaid's Role in Financing Maternity Care." Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2020/01/Medicaid's-Role-in-Financing-Maternity-Care.pdf

Margerison Claire E., Colleen MacCallum, Jiajia Chen, Yasamean Zamani-Hank, and Robert Kaestner. 2020. "Impacts of Medicaid Expansion on Health among Women of Reproductive Age." *American Journal of Preventive Medicine* 58 (1): 1–11.

Martin, Joyce A., Brady E. Hamilton, Michelle J.K. Osterman, and Anne K. Driscoll. 2019. "Births: Final Data for 2018." Hyattsville, MD: National Center for Health Statistics.

Martin, Nina. 2020. "What Coronavirus Means for Pregnancy, and Other Things New and Expecting Mothers Should Know." ProPublica. https://www.propublica.org/article/coronavirus-and-pregnancy-expecting-mothers-q-and-a

McMorrow, Stacey, Lisa Dubay, Genevieve M. Kenney, Emily M. Johnston, and Clara Alvarez Caraveo. 2020. "Uninsured New Mothers' Health and Health Care Challenges Highlight the Benefits of Increasing Postpartum Medicaid Coverage." Washington, DC: Urban Institute.

Mitchell, Alison. 2020. "Medicaid's Federal Medical Assistance Parentage (FMAP)." Washington, DC: Congressional Research Service.

National Family Planning and Reproductive Health Association. 2019. "Fact Sheet: Medicaid." Washington, DC: National Family Planning and Reproductive Health Association.

NILC (National Immigration Law Center). 2020a. "Medical Assistance Programs for Immigrants in Various States." Los Angeles: NILC.

———. 2020b. "Update on Access to Health Care for Immigrants and Their Families." Los Angeles: NILC.

Novoa, Cristina, and Jamila Taylor. 2018. "Exploring African Americans' High Maternal and Infant Death Rates." Washington, DC: Center for American Progress.

Orris, Allison, Gayle Mauser, Deborah Bachrach, and April Grady. 2019. *Enhancing Access to Family Planning Services in Medicaid: A Toolkit for States*. New York: Manatt.

Petersen, Emily E., Nicole L. Davis, David Goodman, Shanna Cox, Nikki Mayes, Emily Johnston, Carla Syverson, et al. 2019. "Vital Signs: Pregnancy-Related Deaths, United States, 2011–2015, and Strategies for Prevention, 13 States, 2013–2017." *Morbidity and Mortality Weekly Report* 68 (18): 423–29.

Ranji, Usha, Ivette Gomez, and Alina Salganicoff. 2019. "Expanding Postpartum Medicaid Coverage." Menlo Park, CA: Kaiser Family Foundation.

Searing, Adam, and Donna Cohen Ross. 2019. "Medicaid Expansion Fills Gaps in Maternal Health Coverage Leading to Healthier Mothers and Babies." Washington, DC: Georgetown University Health Policy Institute Center for Children and Families.

Selden, Thomas M., Brandy J. Lipton, and Sandra L. Decker. 2017. "Medicaid Expansion and Marketplace Eligibility Both Increased Coverage, with Trade-Offs in Access, Affordability." *Health Affairs* 36 (12).

Sommers, Benjamin D., Rebecca Gourevitch, Bethany Maylone, Robert J. Blendon, and Arnold M. Epstein. 2016. "Insurance Churning Rates for Low-Income Adults under Health Reform: Lower Than Expected but Still Harmful for Many." *Health Affairs* 35 (10).

Sonfield, Adam, and Rachel Benson Gold. 2011. "Medicaid Family Planning Expansions: Lessons Learned and Implications for the Future." New York: Guttmacher Institute.

Stewart, Stacey D. 2019. Statement before the House Energy and Commerce Committee's Subcommittee on Health, Washington, DC: September 10.

Straw, Tara, Sarah Lueck, and Aviva Aron-Dine. 2020. "Congress Should Bolster ACA Marketplace Coverage amid COVID-19." Washington, DC: Center on Budget and Policy Priorities.

Texas Health and Human Services. 2020. "Postpartum Depression Strategic Plan." Austin: Texas Health and Human Services.

Texas Medicaid and Healthcare Partnership. 2020. "Healthy Texas Women (HTW) Plus Services Available September 1, 2020." Austin: Texas Medicaid and Healthcare Partnership.

Tully, Kristin P., Alison M. Stuebe, and Sarah B. Verbiest. 2017. "The Fourth Trimester: A Critical Transition Period with Unmet Maternal Health Needs." *American Journal of Obstetrics and Gynecology* 217 (1): 37–41.

Wherry, Laura R. 2013. "Medicaid Family Planning Expansions and Related Preventive Care." *American Journal of Public Health* 103 (9): 1577–582.

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