

Medicaid and Health Coverage for Low-Income Women in Pregnancy and After Childbirth

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Prepared for the

Committee on Energy and Commerce, Subcommittee on Health

U.S. House of Representatives

Hearing on

Improving Maternal Health: Legislation to Advance Prevention Efforts and Access to Care

September 10, 2019



Introduction

Good morning, Chairwoman Eshoo, Ranking Member Burgess, and Members of the Committee. I am Usha Ranji, Associate Director of Women's Health Policy at the Kaiser Family Foundation. Thank you for inviting me to testify about the role of Medicaid coverage for pregnant and postpartum women. The Kaiser Family Foundation, KFF, is a non-profit organization that provides non-partisan health policy analysis, polling, and journalism (Kaiser Health News) to inform policymakers, the media, the health policy community and the public. We are not associated with Kaiser Permanente or Kaiser Industries. In my testimony today, I will summarize KFF's research on Medicaid and postpartum coverage (Appendix 1) and address the following key points:

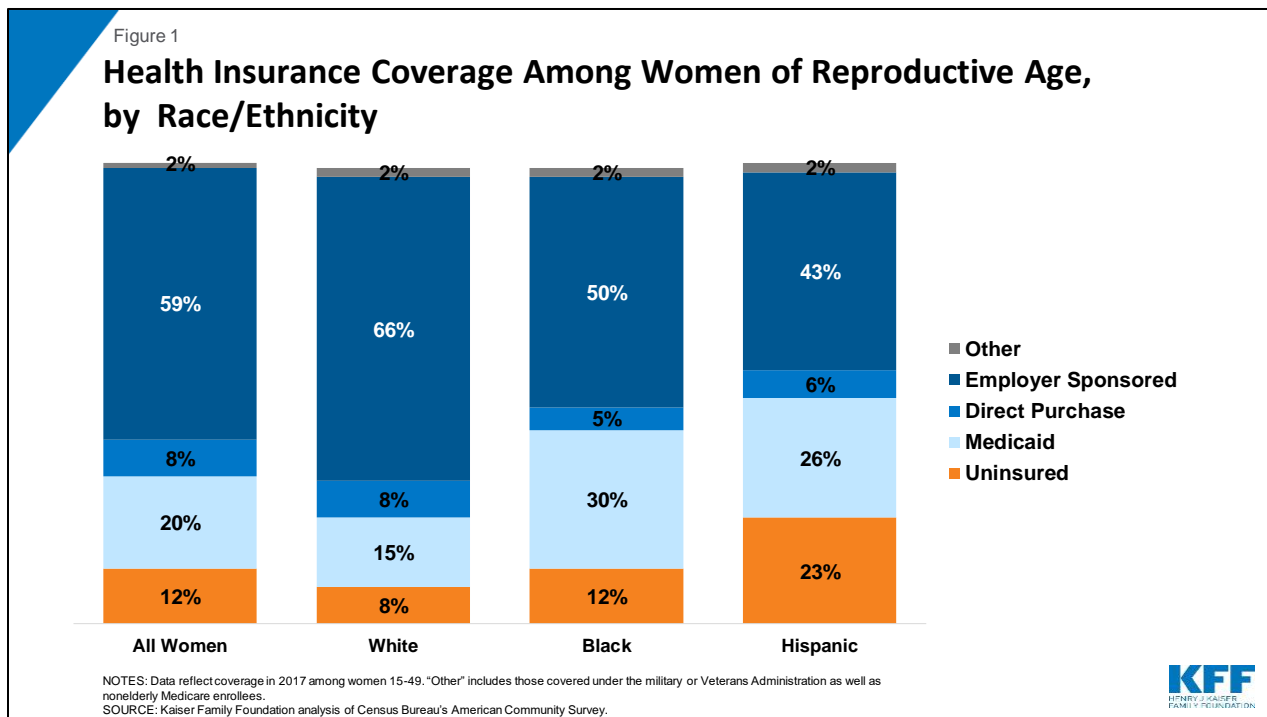
- Research shows that coverage before, during, and after pregnancy facilitates access to care that supports healthy pregnancies as well as positive maternal and infant outcomes after childbirth.
- Medicaid is the primary source of health coverage for low-income women, and a major financier of maternity care, covering more than four in ten births in the U.S. Research finds that for low-income women, Medicaid is comparable to private insurance in terms of many measures of access to care.
- States set eligibility criteria for Medicaid within federal guidelines. The federal minimum income level for pregnancy-related eligibility is effectively 138% of the federal poverty level, but many states set higher thresholds, recognizing the importance of coverage during the perinatal period. Pregnancy-related coverage ends after 60 days postpartum. Infants born to women with Medicaid coverage for pregnancy are eligible for Medicaid for the first year of life.
- Even without expanding Medicaid under the Affordable Care Act (ACA), states can expand access to Medicaid by broadening parental coverage. Prior to having the option to expand Medicaid eligibility under the ACA, 17 states and DC set income thresholds for parents that were at the poverty level or higher.
- Today, eligibility for women after childbirth varies because policymakers have made different decisions about whether to expand Medicaid as well as whether to increase income thresholds for parents -- even in states that have not adopted the Medicaid expansion.
- These state choices affect women's ability to stay on Medicaid after pregnancy ends. In expansion states, many postpartum women can remain on the program and those who do not qualify for Medicaid typically qualify for subsidies to assist with the costs of obtaining private insurance in state Marketplaces.
- To retain Medicaid coverage after pregnancy in the 14 non-expansion states, postpartum women need to requalify under their state's parent eligibility criteria, which are much lower than the income thresholds for pregnancy (from 17% to 100% of the federal poverty level).
- Women with incomes at or above 100% of poverty can qualify for ACA marketplace subsidies in all states, but in states with lower parental coverage thresholds, women with incomes between the state Medicaid eligibility level for parents and 100% of poverty may have no pathway to affordable coverage. This has implications for their ability to access needed health care services during this important life stage.
- Some states are undertaking efforts that rely on Medicaid to strengthen postpartum care and coverage for women. There are multiple initiatives under way to target services to different groups who have had a Medicaid funded birth and who may be more vulnerable, including those affected by substance use and mental health challenges.

Research shows that coverage before, during, and after pregnancy is important to facilitate access to care that supports healthy pregnancies, as well as positive maternal and infant outcomes after childbirth. Research finds that for low-income women, Medicaid is comparable to private insurance in terms of many measures of access to care.

Efforts to improve coverage for pregnant women began in the mid-1980s in response to rising rates and stark disparities in infant mortality and low-birthweight. Led by the Southern Regional Taskforce on Infant Mortality, governors saw an opportunity to use Medicaid to play a role in improving birth outcomes by providing coverage to uninsured, low-income pregnant women as well as expanding eligibility for children. The federal government then raised the eligibility floor for Medicaid coverage and provided states with incentives to extend coverage for pregnancy even above the minimum requirement. This led to a substantial increase in Medicaid's coverage of low-income pregnant women, infants, and children up to age six and declines in the uninsured.¹

Research has shown that people with Medicaid coverage fare much better than their uninsured counterparts on several measures of access to care. One synthesis² of peer-reviewed literature concluded that the expansions for pregnancy eligibility contributed to "improvements in prenatal care use," while more recent analyses of federal data from the Pregnancy Risk Assessment Monitoring System (PRAMS) found significantly higher rates of timely and adequate prenatal care among pregnant women covered by Medicaid compared to uninsured women.^{3,4} Mothers covered by Medicaid are much more likely than those who are low-income and uninsured to have a usual source of care, recent doctor and dental visits, and other preventive services, such as screenings for breast and cervical cancers.⁵ Our own work at KFF finds that low-income women with private insurance use care at rates that are comparable to their privately-insured counterparts and significantly higher than those who are uninsured.⁶ Low-income women in Medicaid were also significantly less likely than those who are privately-insured to report that cost was a barrier to care.⁷

Today, there is continued need to improve maternal and infant health and a growing urgency to develop policy and programmatic responses to the rise in maternal mortality and morbidity and the wide racial and ethnic disparities in maternal outcomes.⁸ Medicaid plays a major role in health coverage for all low-income women, but particularly for women of color because they are more likely to be low-income (Figure 1). There is greater recognition that access to health care *throughout* a woman's reproductive years, including before and after a pregnancy, is essential for prevention, early detection, and treatment of some of the conditions that place women at higher risk for pregnancy-related complications, including cardiovascular disease, diabetes, and chronic hypertension. And, there is strong empirical evidence to support what families across the country know and experience on a daily basis - that a mother's ability to care for her own health and well-being is integral to her ability to do the same for her children.⁹



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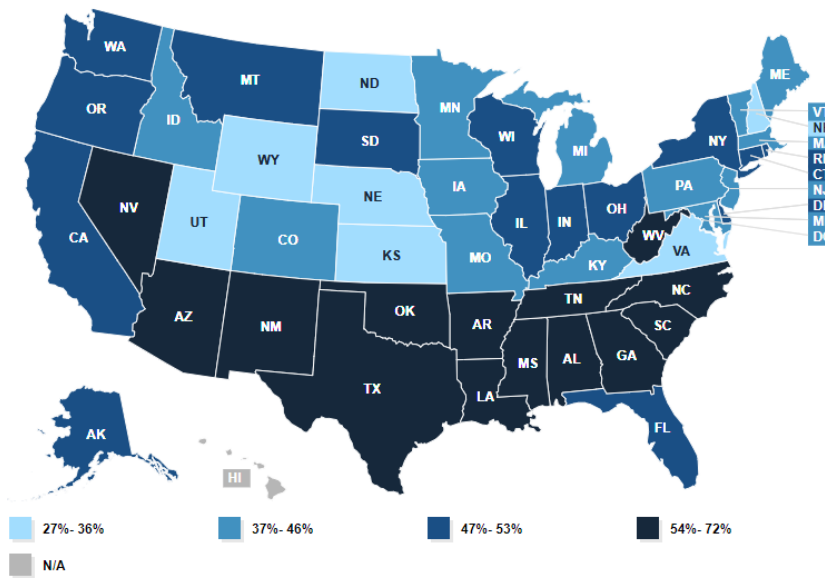
Medicaid has historically prioritized coverage for children and pregnant women. [Children](#) make up 43% of the Medicaid population overall, and among adult women on the program, two-thirds (67%) are in their reproductive years (19 to 49). The program now finances more than four in ten (43%) births nationally¹⁰ and more than half in some states (Figure 2).¹¹

While maternity care is a mandatory benefit that states must cover, states have discretion to determine the specific scope of maternity care benefits under Medicaid. All states cover prenatal care and delivery services. States that have expanded Medicaid eligibility under the ACA must cover all [preventive services](#) recommended by the United States Preventive Services Task Force (USPSTF) and Women's Preventive Services Initiative (WPSI) for beneficiaries that qualify as a result of the expansion. These include many pregnancy-related services, such as prenatal visits, screening tests, and folic acid supplements. It also includes coverage for breastfeeding supports that extend to the postpartum period, with coverage for lactation consultation and breast pumps. [Many states](#) cover substance use treatment and home visiting services, and just a few now cover doula services.¹²

Under federal law, women who receive pregnancy-related services under Medicaid cannot be charged for any share of the cost of care, but after the postpartum period, that can change. A large body of [evidence](#) shows that even nominal cost sharing impedes access to care for low-income women and families. For low-income mothers, the lower cost sharing and absence of deductibles under Medicaid can be a major advantage over private insurance.

Figure 2

Medicaid is the Leading Financer of Maternity Care in Many States



NOTE: In the 2016 Kaiser Family Foundation Medicaid Budget Survey, states were asked to report the share of all births in the state that were financed by Medicaid in the most recent 12 month period for which data were available. States reported data from 2010-2016, which varied by calendar year, state fiscal year, and federal fiscal year.
SOURCE: Kaiser Family Foundation, *Implementing Coverage and Payment Initiatives: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2016 and 2017*.

States set income eligibility criteria for Medicaid within federal guidelines, and most extend coverage to pregnant women above the federally-required minimum of 138% of poverty, recognizing the importance of coverage during the perinatal period. Pregnancy-related coverage ends after 60 days postpartum. Infants born to women with Medicaid coverage for pregnancy are automatically enrolled in Medicaid for the first year of life.

Federal law requires that all states extend eligibility to pregnant women with incomes up to 138% of the federal poverty level (FPL), which equals \$29,435 for a family of three; however, most states go beyond this minimum threshold, ranging from 138% to 380% FPL (see Table 1 in the Appendix).

Pregnancy-related coverage for the mother must last through 60 days postpartum¹³ and the infant is eligible for Medicaid for the first year after birth. Following the 60 days postpartum period, the decision about coverage for women is up to the states and depends in part of whether the state has opted to expand Medicaid as allowed by the ACA or where they set parental income eligibility levels. Wisconsin, for example, has not expanded Medicaid under the ACA, but extends parental coverage to 100% FPL, which is higher than most other non-expansion states.

Infants born to women who had Medicaid during pregnancy are automatically enrolled in Medicaid for their first year. This allows access to numerous preventive services for many low-income families, including newborn screenings, immunizations, and well child visits. Notably, research finds that when mothers have Medicaid, there is greater retention of coverage for children as well.¹⁴

Historically, many postpartum women would become uninsured in the months following pregnancy because they had no pathway to coverage. Even today, the availability of Medicaid coverage for women in the postpartum period varies considerably by state.

Prior to implementation of the ACA, many women with Medicaid during pregnancy would become uninsured after the 60 days postpartum period ended. After this time, women would need to requalify for Medicaid as a parent, and all states set much lower income eligibility thresholds for parents, compared to pregnant women. Women with incomes above their state's parental eligibility level would likely be disenrolled from Medicaid after the postpartum coverage ended.

There is significant instability in health coverage among low-income women, a phenomenon known as “churning,” due in part to the volatility of employment and income levels for this population. A [national study](#) of women's insurance coverage during the perinatal period in the pre-ACA era found that more than half of women covered by Medicaid or CHIP at the time of delivery were uninsured at least one of the six months following delivery. This was far higher than the rate for women who had private insurance at the time of delivery (55% Medicaid compared to 35% private).¹⁵

Even without expanding Medicaid under the ACA, states can expand access to Medicaid by broadening parental coverage. Prior to having the option to expand Medicaid eligibility under the ACA, 17 states and DC set income thresholds for parents that were at the poverty level or higher.

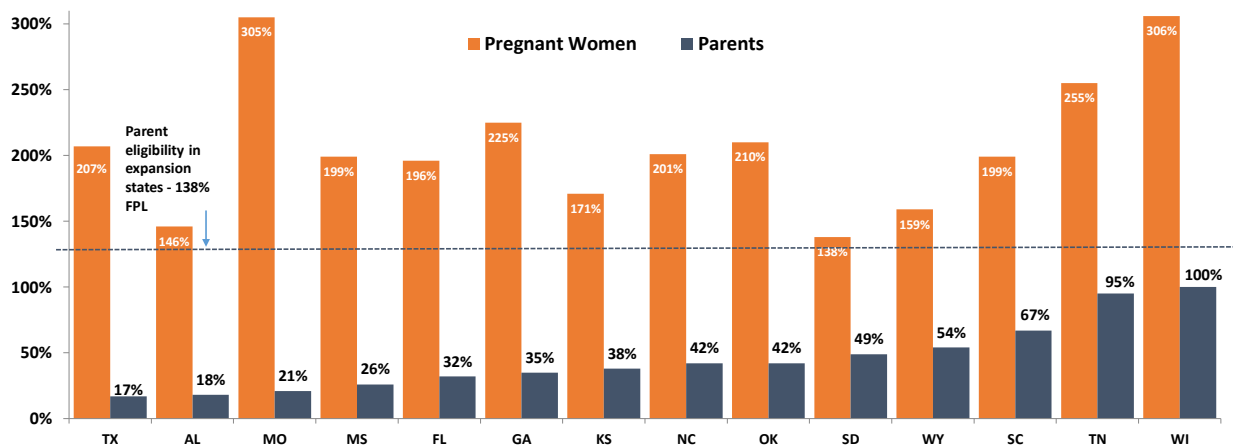
In states that have implemented Medicaid expansion, there is alignment between the minimum income eligibility level for pregnancy and the expansion threshold at 138% of poverty. As a result, qualifying postpartum women in these states with incomes up to 138% of poverty can retain Medicaid coverage after pregnancy-related coverage ends. Continuous Medicaid coverage can promote greater continuity of care by allowing postpartum women to remain within the same provider network and care system that she saw during pregnancy. Those with higher incomes can qualify for federal subsidies in the Marketplaces up to 400% of poverty. There is a pathway to coverage and assistance for most postpartum women in expansion states.

Women with incomes above 100% of poverty can qualify for ACA marketplace subsidies in all states, but in states with very low parental coverage thresholds such those in many non-expansion states, women with incomes between the state Medicaid eligibility level for parents and 100% of poverty may have no pathway to affordable coverage. This has implications for their ability to access needed health care services during this important life stage.

In the 14 states that have not changed their Medicaid program eligibility levels, postpartum women need to requalify for Medicaid under the parental eligibility category to stay on the program after pregnancy coverage ends. However, Medicaid income eligibility levels for [parents](#) are much lower than for pregnant women, ranging from 17% to 100% of poverty in those states (Figure 3).

Figure 3

Medicaid Eligibility Thresholds for Pregnant Women Compared to Parents in Non-Expansion States, 2019



NOTE: For pregnant women, reflects highest eligibility limit for pregnant women under Medicaid, CHIP, or the unborn child option. For "Parents," eligibility limits calculated as a percent of the Federal Poverty Level (FPL) & are calculated based on a family of three for parents. In 2019, the FPL was \$21,330 for a family of three. Thresholds include the standard five percentage point of the FPL disregard.
 SOURCE: Based on national survey conducted by Kaiser Family Foundation (KFF) with the Georgetown University Center for Children and Families, 2019.

Marketplace premium subsidies are only available for those with incomes between 100% and 400% of poverty. Therefore, if a postpartum woman’s income is above the state’s Medicaid eligibility level for parents but below the federal poverty line (\$21,330 annually for a family of three), she would not qualify for either Medicaid or private insurance subsidies. As a result, many women in non-expansion states become uninsured after pregnancy-related coverage ends (60 days postpartum) because they do not have access to Medicaid or federal subsidies. We refer to this group as falling into the “coverage gap.”

Some states are now undertaking efforts that rely on Medicaid to strengthen postpartum care and coverage for women. There are multiple initiatives under way to target services to different groups of women who have had a Medicaid funded birth and who may be more vulnerable, including those affected by substance use and mental health challenges.

Some states are seeking to extend Medicaid coverage to postpartum women with related health challenges. For example, policymakers in [Missouri](#) have submitted a waiver application to the federal government to help finance a Medicaid extension for postpartum women in need of substance use treatment. The [CDC](#) found a four-fold increase in the number of women with opioid use disorder at labor and delivery between 1999 and 2014.¹⁶

The American College of Obstetricians and Gynecologists ([ACOG](#)) recommends that postpartum women with substance use disorders should have access to and continue use of treatment services, including pharmacotherapy. The postpartum period can be a particularly susceptible time for relapse, with loss of insurance and access to care considered a potential trigger for relapse. [CMS](#) currently has a funding opportunity for up to 12 states to develop programs to care for pregnant and postpartum women with opioid use disorder.

California has approved a policy to extend Medicaid coverage for a year to any individual with a maternal mental health condition. For a new mother who needs medications, for example, to manage postpartum depression, this extension of Medicaid coverage could fill an otherwise unaffordable gap, particularly since Medicaid would not impose cost sharing charges. Postpartum depression can occur anytime in the first year after delivery, making the frequency of well child visits during that year a chance for identifying and screening for maternal depression. Recognizing this opportunity, in 2016 CMS approved coverage of postpartum depression screening for women during well child visits. Under the CMS initiative, if the woman is enrolled in Medicaid, treatment services can be covered under Medicaid. If a woman is uninsured, for example in a non-expansion state, in order for Medicaid to cover the treatment under the child, the treatment must involve the child, such as family therapy.

Earlier this year, Illinois enacted an extension of Medicaid postpartum coverage to one year for women with incomes up to 200% of poverty. The state is in the process of applying for an 1115 waiver to procure federal financing assistance.

These are just a few examples of the ways that states can leverage Medicaid to enhance care and coverage for low-income pregnant women and after childbirth when they have become mothers.

For women, the need for health care services does not end two months after childbirth, even though their health coverage might. The year after a delivering baby is a not only a medically vulnerable time for many women, but even for those who appear to be healthy, postpartum care in the year after having a child is critical. The evidence on this is clear — having health coverage promotes access to care, especially for low-income people, and the lack of coverage is associated with poorer health outcomes. The availability of coverage to postpartum women, particularly for those who are low-income can improve their use of critical services and lead to better outcomes for women and their families.

Appendix

See attached Appendix: Kaiser Family Foundation, [“Expanding Postpartum Medicaid Coverage.”](#)

References

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¹¹ Kaiser Family Foundation, State Health Facts: [Medicaid Enrollees by Enrollment Group](#), 2014.

¹² Kaiser Family Foundation, [Medicaid Coverage of Pregnancy and Perinatal Benefits](#), April 2017.

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