ISSUE BRIEF
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Closing Gaps in Maternal Health Coverage: Assessing the Potential of a Postpartum Medicaid/CHIP Extension

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HIGHLIGHTS

- Our current system of publicly supported coverage options for pregnant and postpartum women is a complex patchwork that varies tremendously by income, immigration status, and state, leaving many new mothers uninsured.
- Approximately 123,000 of the nation's estimated 440,000 women uninsured during the first year postpartum would likely be newly eligible for Medicaid or the Children's Health Insurance Program (CHIP) if pregnancy-related coverage were extended for 12 months.
- Together with existing Medicaid and marketplace coverage, such an extension would mean that 70 percent of uninsured women would likely be eligible for some type of publicly subsidized coverage during the postpartum period.
- Extending pregnancy-related Medicaid/CHIP coverage for 12 months postpartum could increase the number of Americans with insurance during the postpartum period while expanding access to needed health care.

TOPLINES

- **The postpartum period a growing focus of efforts to address the U.S. maternal mortality crisis.**
- **Extending Medicaid and CHIP coverage related to pregnancy for 12 months postpartum would expand access to needed health care during a critical period.**

The Commonwealth Fund

INTRODUCTION

The United States is in the midst of a maternal morbidity and mortality crisis. An estimated 700 women* in the United States die each year from pregnancy-related causes, and many more experience severe maternal morbidity.[1] Moreover, there are wide 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.[2]

The postpartum period is a growing focus of efforts to address this crisis. Sometimes referred to as the "fourth trimester," it is a time of extensive physical and emotional change for mothers as they recover from delivery and adjust to life with a newborn — and it can be a precarious time for mothers' health.[3] More than half of pregnancy-related deaths occur after delivery: 40 percent occur 1 to 42 days postpartum and 11.7 percent from 43 to 365 days postpartum nationally, with even higher rates in some states.[4]

The good news is that more than half of pregnancy-related mortality overall and during the postpartum period is considered preventable.[5] This suggests that improvements to health coverage and care — including services that address physical, mental, reproductive, and behavioral health needs — can help reduce mortality rates. Meeting these needs has become even more critical during the COVID-19 pandemic and economic crisis.

There is substantial evidence pointing to the importance of insurance coverage during the postpartum period.[6] Although nearly all new mothers are covered by health insurance at the time of delivery, pregnancy-related coverage through Medicaid and the Children's Health Insurance Program (CHIP) expires just 60 days after the end of pregnancy. Research indicates that more than half of women who had Medicaid or CHIP coverage at delivery experienced "churn" — moving in and out of coverage — in the following six months, which would likely reduce access to care, especially during periods without insurance.

The Affordable Care Act's major coverage provisions, including Medicaid expansion and premium tax credits for marketplace coverage available since 2014, expanded coverage options for women, including those losing pregnancy-related Medicaid/CHIP coverage postpartum. These coverage provisions were associated with lower uninsured rates and improved access to care for women of reproductive age.[7] 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.[8] These increases in coverage also reduced coverage disparities for Black and Hispanic new mothers.[9]

Despite the coverage gains the ACA achieved, an estimated 11.5 percent of new mothers remained uninsured during the 2015–18 period, with rates even higher in some states.[10]

This issue brief assesses the current coverage landscape for pregnant and postpartum women and shows how a postpartum Medicaid/CHIP extension could benefit uninsured new mothers. We:

- provide an overview of existing publicly subsidized coverage options for pregnancy and the postpartum period, including covered benefits and cost-sharing requirements
- review recent state and federal legislative proposals to extend postpartum coverage options and examine how such reforms could expand the coverage landscape for new mothers
- estimate how many postpartum individuals would likely benefit from a 12-month postpartum Medicaid/CHIP extension, based on analysis of 2016–18 American Community Survey (ACS) data using the Urban Institute Health Policy Center's Medicaid/CHIP Eligibility Simulation Model.

* In this analysis, we use "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. However, we acknowledge that not all people who become pregnant or give birth identify as women.

OVERVIEW OF PUBLIC COVERAGE OPTIONS FOR PREGNANT AND POSTPARTUM WOMEN

Federal rules require states to offer Medicaid to pregnant women with incomes up to at least 138 percent of the federal poverty level (FPL).[11] States can set income thresholds above this minimum, and many extend eligibility to higher levels through Medicaid or CHIP.[12]

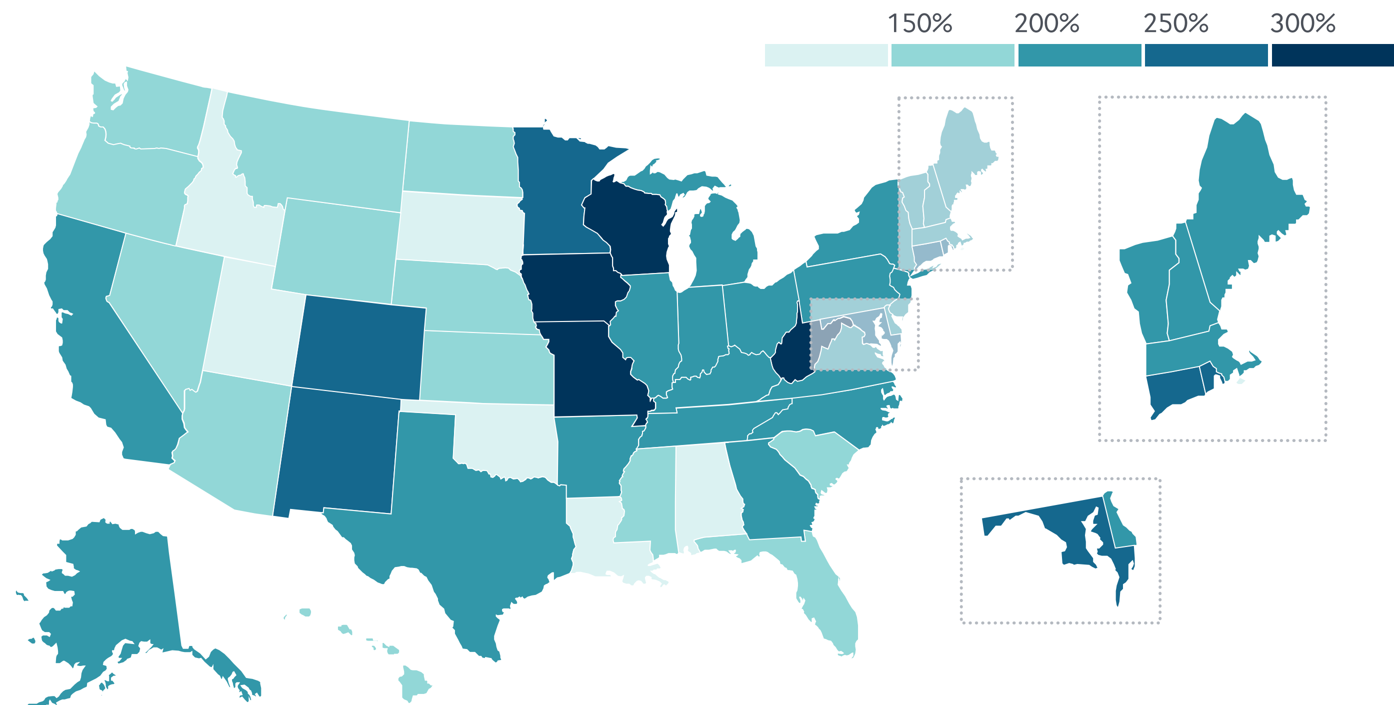
In most states, Medicaid/CHIP eligibility during pregnancy is more generous than it is for nonpregnant women. The median state income threshold to qualify for pregnancy-related Medicaid/CHIP coverage in 2020 is 205 percent of the federal poverty level (FPL) nationwide, well above the median Medicaid income threshold for nonpregnant adults (138% of FPL). Pregnancy-related eligibility ranges widely across states, from 138 percent of FPL in Idaho, Louisiana, Oklahoma, and South Dakota to 380 percent in Iowa (Exhibit 1).

Pregnancy-related coverage is federally required to cover only broadly defined services. Most states, however, include comprehensive benefits in pregnancy-related Medicaid/CHIP coverage, including the full range of nonpregnancy-related health care services, with minimal cost-sharing.

The 60-Day Cutoff and Postpartum Coverage Gaps

Pregnancy-related Medicaid/CHIP coverage, however, 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 or adults, which are typically lower than pregnancy-related thresholds.

Exhibit 1. Pregnancy-Related Medicaid/CHIP Income Eligibility Thresholds, as a Share of the Federal Poverty Level, by State, 2020



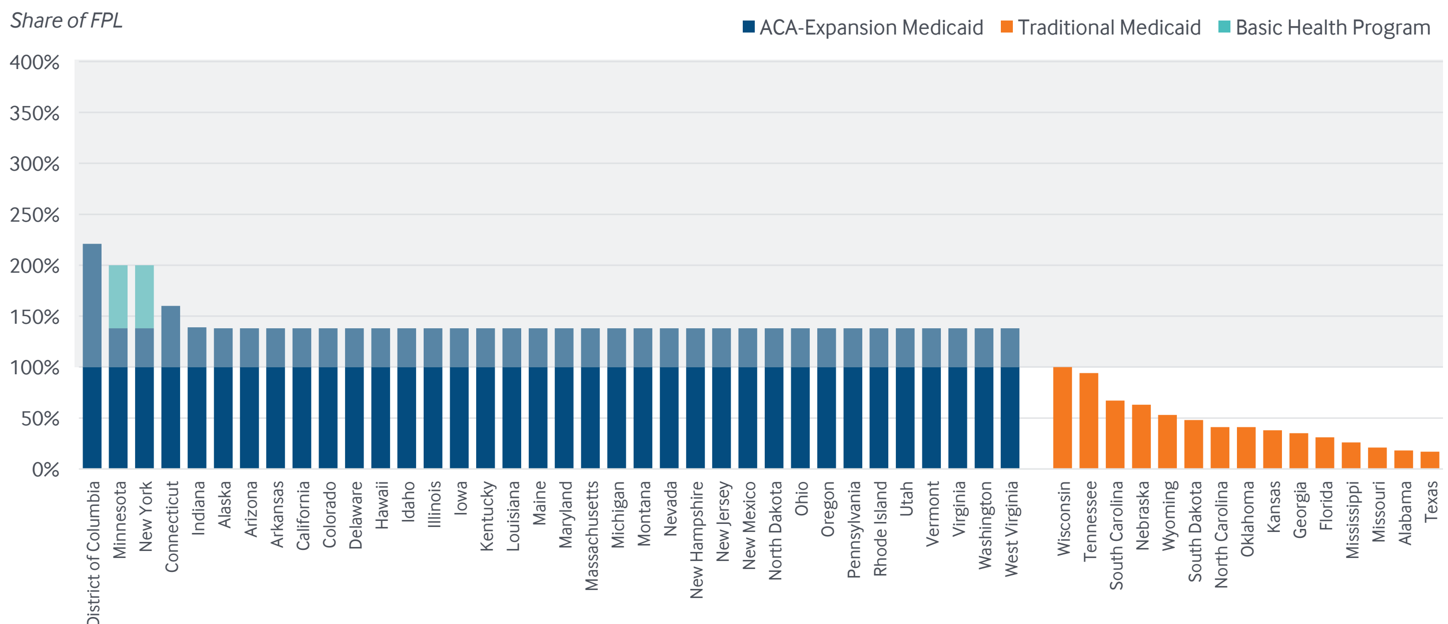
Notes: CHIP = Children's Health Insurance Program; FPL = federal poverty level. Thresholds reflect income eligibility limits for pregnant women who meet Medicaid/CHIP immigration status requirements. Coverage is comprehensive in all states except Arkansas, New Mexico, North Carolina, and South Dakota,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

Data: Tricia Brooks et al., *Medicaid and CHIP Eligibility, Enrollment, and Cost-Sharing Policies as of January 2020: Findings from a 50-State Survey* (Henry J. Kaiser Family Foundation, Mar. 2020).

Exhibit 2 summarizes Medicaid eligibility thresholds for parents after pregnancy-related eligibility expires in 2020. (These apply to citizens and lawfully residing immigrant postpartum women with more than five years' residency after pregnancy-related eligibility expires; for more detail on variation in eligibility according to immigration status, see here). The exhibit illustrates how low income eligibility thresholds are for traditional Medicaid relative to pregnancy-related Medicaid in most states: 138 percent of FPL in states adopting the ACA's Medicaid expansion, and below 100 percent of FPL (and most often below 50 percent of FPL) in nonexpansion states.

Some postpartum women who have family incomes between 100 percent and 400 percent of FPL and are not eligible for Medicaid may qualify for premium tax credits to subsidize the purchase of insurance on the federal or state-based marketplaces. Marketplace plans must cover essential health benefits, including delivery, comprehensive perinatal and postpartum care, and family planning. But these plans generally have higher cost-sharing and offer less financial protection than Medicaid or CHIP, which may pose a barrier to enrollment among women eligible for marketplace coverage. In most states, pregnancy is not a qualification for a special enrollment period outside of annual open enrollment, but the birth of a child or the loss of pregnancy-related coverage are qualifications. 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 a "coverage gap" and ineligible for marketplace subsidies, with no affordable coverage options.

Exhibit 2. Income Eligibility Thresholds for Publicly Subsidized Coverage Options for Citizen and Certain Lawfully Residing Noncitizen New Mothers Under Current Rules, by State, 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 exhibit 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 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. Medicaid expansion states also offer traditional Medicaid at lower income levels than their ACA expansion levels (not shown). In Texas, most immigrants legally present for more than five years are ineligible for Medicaid. 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.

Data: Tricia Brooks et al., *Medicaid and CHIP Eligibility, Enrollment, and Cost-Sharing Policies as of January 2020: Findings from a 50-State Survey* (Henry J. Kaiser Family Foundation, Mar. 2020).

BENEFITS OF EXTENDING MEDICAID/CHIP COVERAGE FOR 12 MONTHS POSTPARTUM

Policymakers at both the federal and state levels have proposed extending pregnancy-related Medicaid/CHIP coverage from 60 days to 12 months postpartum as an efficient, targeted way to give many postpartum women a new coverage option (see box for a summary of these proposals). Such an extension would allow for continuous coverage during the first year after delivery and could foster greater continuity of care.

Exhibit 3 illustrates how much new mothers' eligibility for Medicaid/CHIP could change if states extended pregnancy-related Medicaid/CHIP from 60 days to 12 months postpartum.

The effects of a 12-month postpartum extension such as that proposed in the Helping MOMS Act, which was under consideration by the 116th Congress, assuming adoption of the extension option in every state can be summarized as follows:

- 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 from 97 percentage points to 206 percentage points in nonexpansion states and by 6 to 242 percentage points in 34 of the 36 expansion states. (As currently proposed, eligibility for new mothers would not change in Idaho and Louisiana, which cover pregnant women at the same income level as nonpregnant women.)
- New mothers who already meet the requirements for Medicaid coverage as parents would likely have greater consistency in their providers and continuity in their care. That is because they would qualify for 12-month continuous coverage even if their income fluctuates throughout the year.
- In states that have not expanded Medicaid under the ACA, a 12-month postpartum extension would temporarily eliminate the coverage gap for postpartum women with incomes above the parental Medicaid threshold and below 100 percent of FPL.

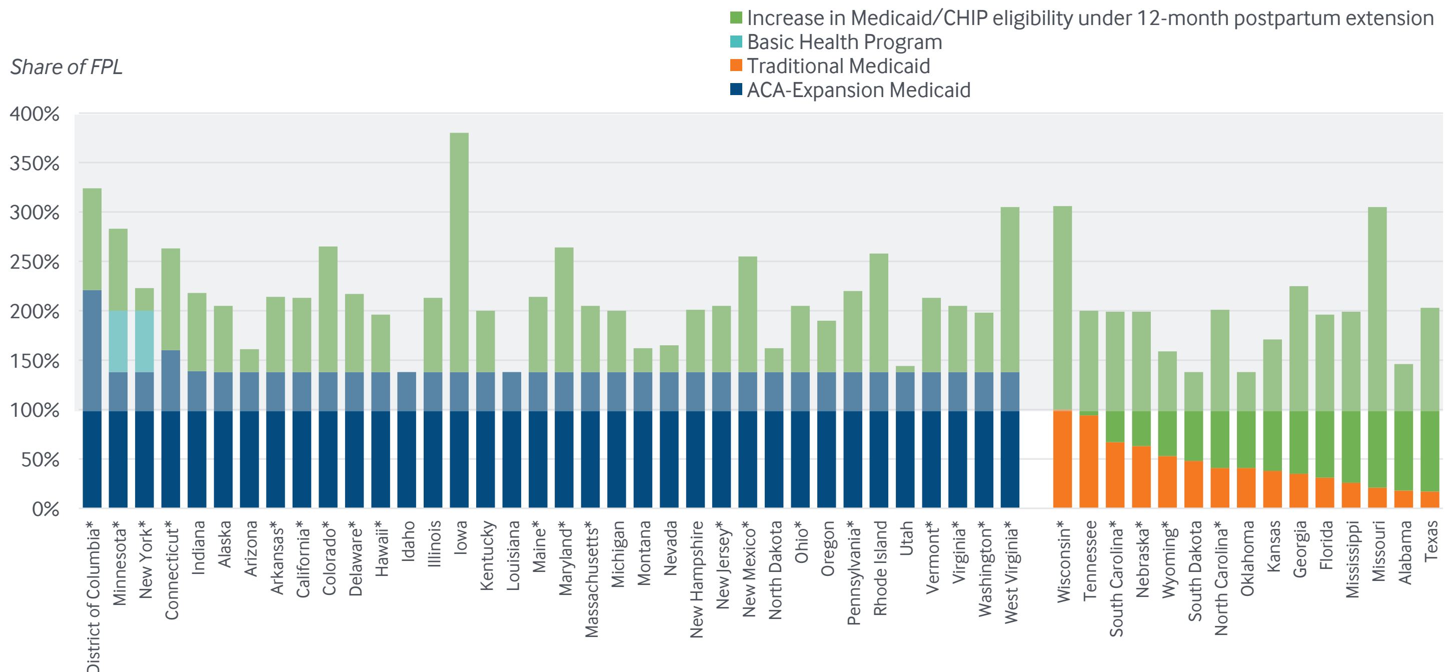
FEDERAL AND STATE EFFORTS TO EXTEND POSTPARTUM MEDICAID/CHIP COVERAGE

In 2019 and 2020, five federal bills were proposed to extend Medicaid/CHIP coverage for 12 months continuously following the end of pregnancy, reflecting various approaches to financing and required state actions. The **Helping Medicaid Offer Maternity Services (Helping MOMS) Act of 2019** (H.R. 4996), which would allow states to adopt an extension without requiring a federal waiver, was approved by the U.S. House of Representatives in September 2020 but was not considered by the Senate.

Meanwhile, nearly half of states have explored postpartum Medicaid/CHIP extensions in 2019 and 2020. Most 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 and 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.

Very few states have yet implemented postpartum extensions. **California's** 12-month postpartum extension for women with maternal mental health conditions was briefly delayed because of the pandemic and implemented in August 2020, and **Texas** implemented a limited extension in September 2020, by adding one year of selected postpartum services for Healthy Texas Women enrollees. Though several states have Section 1115 waivers to extend Medicaid/CHIP for some or all postpartum women currently under review by CMS, or have considered or passed legislation to apply for such waivers, it is unclear whether and under what conditions CMS will approve state efforts to extend Medicaid/CHIP.

Exhibit 3. Income Eligibility Thresholds for Publicly Subsidized Coverage Options for New Mothers Under Postpartum Medicaid/CHIP Extension, by State and Program Type, 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 on the left side of the figure, and nonexpansion states are shown on the right, using state expansion status as of January 2020. 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. 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.

Data: Tricia Brooks et al., *Medicaid and CHIP Eligibility, Enrollment, and Cost-Sharing Policies as of January 2020: Findings from a 50-State Survey* (Henry J. Kaiser Family Foundation, Mar. 2020).

Medicaid/CHIP eligibility increases in these states are also larger, on average. But pregnant women in many expansion states also would experience large increases in eligibility.

- Some women who currently may qualify for marketplace coverage would gain Medicaid/CHIP eligibility. Because coverage provided under Medicaid/CHIP would require lower cost-sharing, it would offer more financial protection than a marketplace plan.

HOW MANY PEOPLE WOULD BENEFIT FROM A 12-MONTH POSTPARTUM EXTENSION?

We assessed the extent to which new mothers who were uninsured in 2016–2018 could benefit from an extension of pregnancy-related Medicaid/CHIP eligibility for 12 months postpartum as well as from other subsidized coverage options. To do so, we analyzed data from the American Community Survey (ACS) from 2016–18, using the Urban Institute Health Policy Center's Medicaid/CHIP Eligibility Simulation Model and 2020 eligibility policies.[13] (For complete study methods, see the Urban Institute brief, *Closing Postpartum Coverage Gaps and Improving Continuity and Affordability of Care Through a Postpartum Medicaid/CHIP Extension*.)

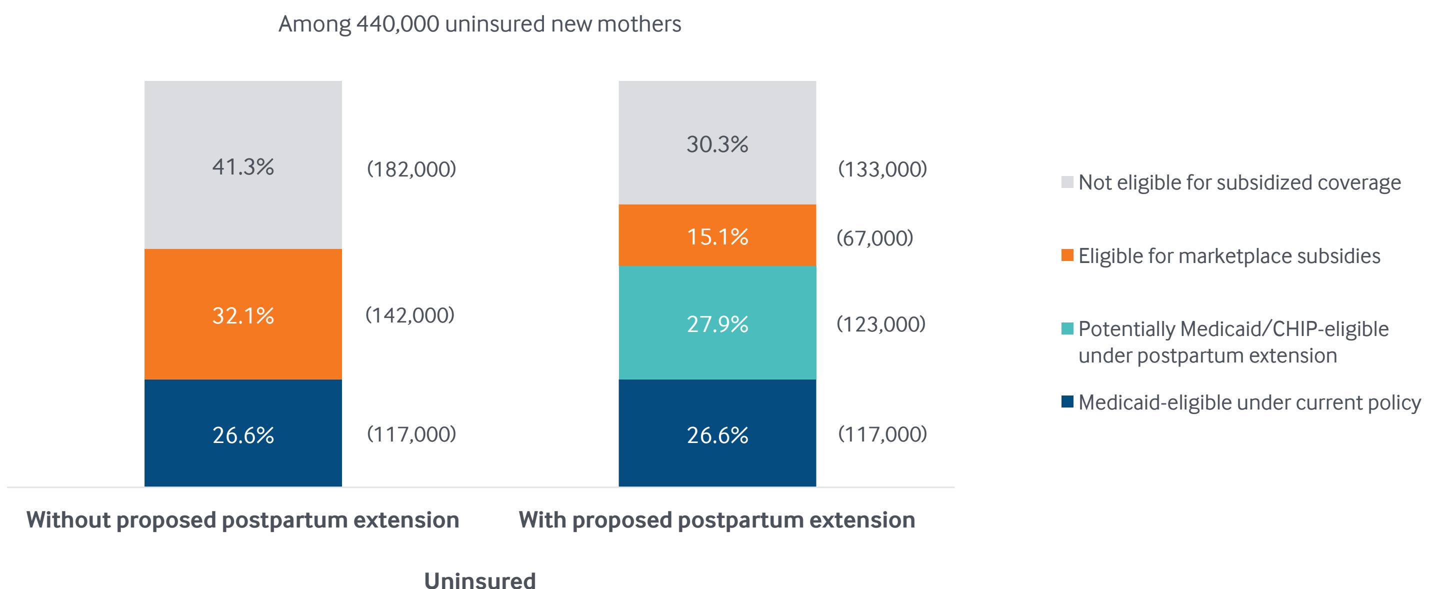
According to the findings of our analysis, if pregnancy-related Medicaid/CHIP were extended for 12 months postpartum:

- **Approximately 70 percent of the nation's estimated 440,000 uninsured new mothers would likely be eligible for some type of publicly subsidized coverage** (Exhibit 4). This includes an estimated:
  - 28 percent who would become newly eligible for Medicaid/CHIP through a postpartum extension (approximately 123,000 new mothers)
  - 27 percent who are eligible for Medicaid under current policy but not enrolled
  - 15 percent who would not be eligible for Medicaid/CHIP under current policy or an extension but could qualify for subsidized marketplace coverage if they lack access to affordable employer-sponsored insurance.

  Among the remaining 30 percent of uninsured new mothers who would not be eligible for publicly subsidized coverage with a postpartum Medicaid/CHIP extension, 88 percent are noncitizens who are barred from federally subsidized coverage. The remaining small share are primarily citizen new mothers with incomes above eligibility thresholds for either extended postpartum Medicaid/CHIP coverage or marketplace subsidies.

- **Gains in eligibility under a postpartum Medicaid/CHIP extension would vary across subgroups of uninsured new mothers.** For instance, 38 percent of uninsured new mothers in states not expanding Medicaid would likely gain eligibility, compared with just 13 percent in expansion states. And 39 percent of uninsured citizen new mothers would become newly eligible, compared with just 8 percent who were not citizens. More than four in 10 uninsured new mothers

Exhibit 4. Share and Number of New Mothers Uninsured Postpartum and Estimated to Be Eligible for Subsidized Coverage Under Current Eligibility Rules and a 12-Month Postpartum Medicaid/CHIP Extension, 2016–18



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

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

with incomes between 100 percent and 249 percent of FPL would become newly eligible for Medicaid/CHIP under an extension. Furthermore, over one-third of non-Hispanic Black (36.5%) and non-Hispanic white (35.6%) uninsured new mothers, as well as about a quarter of Hispanic new mothers would likely gain eligibility under a postpartum extension.

- **The number and share of new mothers likely to benefit would vary by state.** Nearly two-thirds of uninsured new mothers who would likely gain eligibility through a postpartum extension reside in just five southern states: Florida, Georgia, Missouri, North Carolina, and Texas.
- **The COVID-19 pandemic and resulting recession have likely changed access, coverage, and income patterns among new mothers.** Our estimates of likely eligibility for a postpartum Medicaid/CHIP extension, based on insurance status and income reported in 2016–18, likely understate the potential benefit to new mothers in 2021.

DISCUSSION

The nation's current system of publicly supported coverage options for pregnant and postpartum individuals is a complex patchwork that varies tremendously by income, immigration status, and state. Extending pregnancy-related Medicaid/CHIP coverage for 12 months postpartum would simplify and streamline one piece of this patchwork. Doing so would expand coverage options for many. We estimate that 28 percent of new mothers who were uninsured during the postpartum period — or about 123,000 annually — would become eligible through a postpartum extension. Another 27 percent are likely already eligible for Medicaid but not enrolled.

Not only would many uninsured new mothers have a new coverage option, but they could remain enrolled in the same coverage type they had during the prenatal and delivery period without a break or change in that coverage. This continuity would benefit individuals who would otherwise go uninsured after 60 days postpartum and those who would retain coverage in the postpartum period but who otherwise shift between coverage types (such as Medicaid and marketplace coverage or employer-sponsored insurance), or coverage pathways (such as pregnancy-related Medicaid and parental Medicaid). It would reduce the burdens on new mothers needing to apply to maintain or obtain coverage or to switch coverage while recovering from delivery, dealing with complications related to pregnancy, and caring for their infants. And even if family income fluctuated, coverage would remain intact for a full year.

Postpartum Medicaid/CHIP extension also could improve continuity of care and health outcomes. And it could have positive spillover effects on children — for example, by increasing continuous coverage for infants during their first year, supporting the mental and physical health of new mothers and their ability to care for their infants, and improving family financial security.[14]

Other Federal and State Actions That Could Help

In addition to passing legislation to implement postpartum extension, the federal government has other options to improve postpartum coverage options. For instance, swift 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 being considered.

Of course, 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. Expanding Medicaid also would eliminate the coverage gap not only in the postpartum period but also prepregnancy, which could improve mothers' health during pregnancy and beyond.[15] Moreover, our finding that many uninsured new mothers appear to already qualify for Medicaid under current policy underscores that eligibility alone is insufficient to ensure continuous coverage, pointing to the importance of expanded outreach and improved enrollment and retention systems.

The large number of postpartum extension proposals in Congress and across states in recent years indicates strong interest in enacting postpartum Medicaid/CHIP coverage extensions. Additional reforms that consider factors other than coverage that shape maternal health would also likely be needed to improve outcomes and address inequities in the maternal health system more broadly. For instance, the Black Maternal Health Momnibus Act of 2020 was proposed to 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.[16]

COVID-19 has impeded progress for some of these initiatives and likely exacerbated racial inequities. At the same time, however, the pandemic highlights the risks of inaction. To help address the nation's maternal morbidity and mortality crisis, it is clear that, more than ever, we need policy solutions to ensure affordable, comprehensive, continuous coverage and access to care during the postpartum period.

NOTES

1. "Severe Maternal Morbidity in the United States," Centers for Disease Control and Prevention, updated Jan. 31, 2020; and "Pregnancy Mortality Surveillance System," Centers for Disease Control and Prevention, updated Nov. 25, 2020. Also see William M. Callaghan, Andreea A. Creanga, and Elena V. Kuklina, "Severe Maternal Morbidity Among Delivery and Postpartum Hospitalizations in the United States," *Obstetrics and Gynecology* 120, no. 5 (Nov. 2012): 1029–36; Marian F. MacDorman et al., "Is the United States Maternal Mortality Rate Increasing? Disentangling Trends from Measurement Issues," *Obstetrics and Gynecology* 128, no. 3 (Sept. 2016): 447–55; and Emily E. Petersen et al., "Vital Signs: Pregnancy-Related Deaths, United States, 2011–2015, and Strategies for Prevention, 13 States, 2013–2017," *Morbidity and Mortality Weekly Report* 68, no. 18 (May 10, 2019): 423–29.

2. Andreea A. Creanga et al., "Racial and Ethnic Disparities in Severe Maternal Morbidity: A Multistate Analysis, 2008–2010," *American Journal of Obstetrics and Gynecology* 210, no. 5 (May 2014): 435 e1–e8; and Petersen et al., "Vital Signs," 2019.

3. "The 4th Trimester Project," University of North Carolina at Chapel Hill School of Social Work, Jordan Institute for Families, accessed Nov. 5, 2020. Also see ACOG (American College of Obstetricians and Gynecologists) Committee Opinion No. 736, "Optimizing Postpartum Care," *Obstetrics and Gynecology* 131, no. 5 (May 2018): 949–51.

4. Petersen et al., "Vital Signs," 2019; and Kristin P. Tully, Alison M. Stuebe, and Sarah B. Verbiest, "The Fourth Trimester: A Critical Transition Period with Unmet Maternal Health Needs," *American Journal of Obstetrics and Gynecology* 217, no. 1 (July 2017): 37–41.

5. Petersen et al., "Vital Signs," 2019; and CDC Foundation, *Report from Nine Maternal Mortality Review Committees* (CDC Foundation, 2018).

6. Adam Searing and Donna Cohen Ross, *Medicaid Expansion Fills Gaps in Maternal Health Coverage Leading to Healthier Mothers and Babies* (Georgetown University Health Policy Institute, Center for Children and Families, May 2019).

7. Jamie R. Daw and Benjamin D. Sommers, "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, no. 4 (Apr. 2019): 565–71; Emily M. Johnston et al., "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, no. 2 (Mar.-Apr. 2018): 122–29; Lois K. Lee et al., "Women's Coverage, Utilization, Affordability, and Health after the ACA: A Review of the Literature," *Health Affairs* 39, no. 3 (Mar. 2020): 387–94; and Claire E. Margerison et al., "Impacts of Medicaid Expansion on Health Among Women of Reproductive Age," *American Journal of Preventive Medicine* 58, no. 1 (Jan. 2020): 1–11.

8. Daw and Sommers, "Affordable Care Act and Access," 2018; Sarah H. Gordon et al., "Effects of Medicaid Expansion on Postpartum Coverage and Outpatient Utilization," *Health Affairs* 39, no. 1 (Jan. 2020): 77–84; Medicaid and CHIP Payment and Access Commission, Access in Brief: Pregnant Women and Medicaid (MACPAC, Nov. 2018); and Searing and Cohen Ross, *Medicaid Expansion Fills,* 2019.

9. Emily M. Johnston et al., *Racial Disparities in Uninsurance among New Mothers Following the Affordable Care Act* (Urban Institute, July 2019).

10. Stacey McMorrow et al., *Uninsured New Mothers' Health and Health Care Challenges Highlight the Benefits of Increasing Postpartum Medicaid Coverage* (Urban Institute, May 2020).

11. 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; see Amy Chen, *Pregnancy-Related Medicaid and Minimum Essential Coverage* (National Health Law Program, Jan. 2017). Income eligibility is based on modified adjusted gross income for the family unit, which considers the unborn child part of the unit size 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; meanwhile, those already enrolled must be offered the option to either switch to pregnancy-related Medicaid/CHIP or stay in that coverage. See Amy Chen and Emily Hayes, Q&A on Pregnant Women's Coverage Under Medicaid and the ACA (National Health Law Program, Sept. 2018).

12. Tricia Brooks et al., *Medicaid and CHIP Eligibility, Enrollment, and Cost-Sharing Policies as of January 2020: Findings from a 50-State Survey* (Henry J. Kaiser Family Foundation, Mar. 2020).

13. We applied January 2020 eligibility rules for pregnancy-related Medicaid/CHIP thresholds and expansion Medicaid thresholds, including the four states that implemented the ACA's Medicaid expansion between 2018 and January 1, 2020: Idaho, Maine, Utah, and Virginia. For nonexpansion states and Connecticut (an expansion state with changing eligibility thresholds), we applied 2016–2018 eligibility thresholds to the corresponding year. Changes in the underlying coverage and income distributions may have changed between 2016–2018

data and 2020 eligibility rules, especially in states with large policy changes (e.g., adoption of the Medicaid expansion), and additional changes may have occurred during the pandemic and associated recession. Both coverage and eligibility status are likely measured with error, such as error owing to misreporting of characteristics, disconnection across time frames, and our inability to estimate eligibility for all available coverage pathways for adults under current law. Moreover, measurement error in estimating Medicaid eligibility under current law appears larger in nonexpansion states, potentially leading to overstating potential eligibility for 12-month postpartum Medicaid/CHIP among new mothers in nonexpansion states. See the appendix of *Closing Postpartum Coverage Gaps and Improving Continuity and Affordability of Care Through a Postpartum Medicaid/CHIP Extension* for more detail on study data and methods.

14. Kay Johnson, Sara Rosenbaum, and 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,* Jan. 9, 2020. Also see Elizabeth Wright Burak, *Health Coverage for Parents and Caregivers Helps Children* (Georgetown University Health Policy Institute, Center for Children and Families, Mar. 2017); and Benjamin D. Sommers et al., "Insurance Churning Rates for Low-Income Adults Under Health Reform: Lower Than Expected but Still Harmful for Many," *Health Affairs* 35, no. 10 (Oct. 2016): 1816–24.

15. Searing and Cohen Ross, *Medicaid Expansion Fills,* 2019.

16. "About the Black Maternal Health Momnibus Act of 2020," Black Maternal Health Caucus, accessed Nov. 4, 2020.

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