

## Postpartum Medicaid Eligibility Expansions and Postpartum Health Measures

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## **Abstract**

Maternal mortality and morbidity in the US are high compared to similar countries, and racial disparities exist, with many of these events occurring in the later postpartum period. Proposed federal and recently enacted state policy interventions extend pregnancy Medicaid from covering 60 days to a full year postpartum. We estimate the association between maintaining Medicaid eligibility in the later postpartum period (relative to only having pregnancy Medicaid eligibility) with postpartum checkup attendance and depressive symptoms using regression analysis, overall and stratified by race/ethnicity. People with postpartum Medicaid eligibility were 1.0-1.4% more likely to attend a postpartum checkup relative to those with only pregnancy Medicaid eligibility overall, primarily driven by a 3.8-4.0% higher likelihood among Hispanic postpartum people. Conversely, postpartum Medicaid is associated with a 2.2-2.3% lower likelihood of postpartum checkup attendance for Black postpartum people. Postpartum Medicaid eligibility is also associated with a 9.7-11.6% lower likelihood of self-reported depressive symptoms compared to only pregnancy Medicaid eligibility for white postpartum people only. Postpartum Medicaid eligibility is associated with some improvements in maternal healthcare utilization and mental health, but differences by race and ethnicity imply that inequitable systems and structures that cannot be overcome by insurance alone may also play an important role in postpartum health.

## Introduction

While maternal mortality has been falling in recent decades for nearly all high-income countries, it has risen in the United States,<sup>1</sup> and occurrences of severe maternal morbidity more than doubled from 1988-89 to 2010-11.<sup>2</sup> Additionally, within the United States there exist significant racial disparities in maternal mortality with 37.3 deaths per 100,000 births for non-Hispanic (NH) Black people compared to 14.9 for NH white people in 2018.<sup>3</sup> Because many of these deaths and morbidity events occur after pregnancy, the postpartum period is a key time in which preventive care and interaction with the health care system are necessary and may offer opportunities to reduce racial inequities.<sup>4</sup>

Of growing interest to policymakers at both the state<sup>5</sup> and federal level<sup>6</sup> is the possibility of expanding Medicaid coverage that many low-income pregnant people receive to cover the entire first year postpartum. Since the 1980s and 1990s, Medicaid has prioritized low-income pregnant people and now covers over 40% of births in the US.<sup>3</sup> The income guideline for pregnant people to qualify for Medicaid varies by state but must be at least 138% of the federal poverty level (FPL) and is over 300% FPL in some states. However, this pregnancy Medicaid coverage typically ends 60 days after delivery. After that period, non-disabled, adult postpartum people can only retain Medicaid coverage if they qualify under income eligibility thresholds for parental Medicaid, which are typically much less generous. There is the option to purchase subsidized Marketplace coverage for those between 100-400% FPL, but there is no option available for those below 100% FPL in states that did not expand Medicaid. This gap in coverage between pregnancy and parental Medicaid coverage means that many postpartum people may lose or change health insurance

during a particularly vulnerable period and may thus lose contact with the health care system.<sup>7</sup> In fact, Johnston and colleagues found that 21.9% of people enrolled in Medicaid for prenatal care became uninsured 2-6 months postpartum.<sup>8</sup>

The American Rescue Plan Act gives states the option to extend pregnancy Medicaid to a full year postpartum and federal legislation has also proposed a requirement of this extension, but there is limited knowledge on the potential effects of these policies. A recent study using American Community Survey (ACS) data estimated that 28% of uninsured and 16% of privately insured postpartum people would gain eligibility if all pregnancy Medicaid was extended to a full year.<sup>9</sup> A recent policy report from Gordon and coauthors estimates that 720,000 postpartum people would increase their Medicaid coverage to the full postpartum year.<sup>10</sup> Thus, we suspect that extending Medicaid to a full year postpartum has the potential to extend coverage to a substantial number and percent of postpartum people with Medicaid-covered births. The policies of interest increase Medicaid eligibility, although eligibility does not always translate into Medicaid coverage.

Importantly, however, we do not know whether extending pregnancy Medicaid to the first year postpartum would improve health care utilization or health outcomes for people who would gain eligibility. A comparison between Colorado (which raised its parental Medicaid limit to 138 from 105% FPL in 2014) and Utah (which did not change its parental Medicaid eligibility threshold in this time period) found that new mothers in Colorado were more likely to utilize outpatient care<sup>11</sup>, but we do not know whether these findings would generalize nationally or differ by

race/ethnicity. To address this gap in the literature, we use a multistate sample to compare—among people who qualify for Medicaid during pregnancy—the likelihood of 1) attending a postpartum checkup and 2) self-reported postpartum depressive symptoms between those who are eligible for Medicaid in the later postpartum and those who are not. We examine impacts of postpartum Medicaid eligibility on both outcomes overall and stratified by race/ethnicity to assess whether impacts of a postpartum Medicaid extension would contribute to reducing racial and ethnic inequities in postpartum health.

## **Methods**

*Data:* We use the only multistate, postpartum survey, the Center for Disease Control's Pregnancy Risk Assessment Monitoring System (PRAMS) Phases 7 & 8, which provides a representative sample of people with live births for the years 2012 to 2018 from 42 participating states (N = 253,865). Approximately 97% of responses occur in our period of interest, i.e., 3-12 months postpartum with 90% occurring in the period 3-6 months postpartum.

*Eligibility Measures:* We focus on measuring Medicaid eligibility (not Medicaid coverage) because the policies of interest target Medicaid eligibility criteria (e.g., allowing people eligible for pregnancy Medicaid to keep coverage for a year postpartum). We estimate respondents' eligibility for a) pregnancy Medicaid and b) parental Medicaid by comparing self-reported household income for the year prior to birth to the FPL.<sup>12, 13</sup> While we use the term parental Medicaid, this measure captures eligibility for the most generous Medicaid option of either

Medicaid for low-income adults or parents specifically (i.e., it captures state Medicaid expansions for all adults). In PRAMS, household income is provided in ranges, so we calculate eligibility using both the minimum and maximum of the range. (Using the minimum of the income range, we will capture all respondents that are eligible but may also capture some ineligible respondents. Using the maximum, we will include only eligible respondents but may exclude some eligible respondents.)

This method allows us to define two groups of pregnancy Medicaid-eligible people: those with postpartum Medicaid eligibility and those falling in the pregnancy-parental Medicaid gap.

*Postpartum Medicaid-eligible* people are defined as those eligible for both pregnancy and parental Medicaid coverage, which allows them to maintain Medicaid eligibility throughout the year postpartum. *In the pregnancy-parental Medicaid gap* people are defined as those who qualify for pregnancy Medicaid and not for parental Medicaid. Thus, those in the pregnancy-parental eligibility gap currently lose Medicaid eligibility around 60 days postpartum and represent people who would benefit from an extension of pregnancy Medicaid.

*Sample:* We limit our analytic sample to those we estimate eligible for pregnancy Medicaid based on household income, year, and state of residence. To provide a range of estimates, we construct two samples to determine Medicaid eligibility: one using the minimum and one using the maximum of the income ranges.

We exclude mothers younger than 18 because they are likely eligible for programs targeted towards children. We also exclude observations with missing data on the maternal characteristics we use as covariates including income and household size (Appendix Exhibit A1). For each outcome separately, we exclude observations with a missing value for postpartum checkup or depressive symptoms. Specific sample sizes for each outcome and each subsample based on the minimum or maximum of the income range are displayed in Figure 2.

*Outcome Measures:* Our outcome measures are postpartum checkup attendance and self-reported postpartum depressive symptoms. Postpartum checkup is constructed as a binary variable that equals 1 if the respondent answered yes to “Since your new baby was born, have you had a postpartum checkup for yourself? A postpartum checkup is the regular checkup a woman has about 4-6 weeks after she gives birth.” And 0 otherwise. While the recommended time of 4-6 weeks postpartum for a checkup falls within the pregnancy Medicaid coverage period, any difficulty scheduling or attending the appointment could cause it to fall outside the pregnancy Medicaid coverage period.

Self-reported postpartum depressive symptoms is constructed as a binary variable that equals 1 if a postpartum person reports “Always” or “Often” to either “Since your new baby was born, how often have you felt down, depressed, or hopeless?” or “Since your new baby was born, how often have you had little interest or little pleasure in doing things you usually enjoyed?” and 0 otherwise.

*Statistical Analysis:* To study the association of postpartum Medicaid eligibility compared to only pregnancy Medicaid eligibility with an outcome, we use a linear probability model. Our exposure of interest is an indicator for whether a postpartum person is *postpartum Medicaid-eligible* or *in the pregnancy-parental Medicaid gap*. Models also include respondents' years of education, age, race/ethnicity, parity, marital status, and income as covariates. We include income as a percentage of the FPL as a covariate to account for the fact that postpartum-eligible people have lower income on average than those who fall into the pregnancy-parental eligibility gap. All statistical analyses use the provided survey weights which account for nonresponse, noncoverage, and stratification by state and other sampling factors.

*Sensitivity Analyses:* In Appendix Exhibit A7, we additionally show specifications using only observations where Medicaid is the payer noted on the birth certificate rather than estimating pregnancy Medicaid eligibility. In Appendix Exhibit A8, we show results for births occurring from 2015-2018, the time period after which all required components of the ACA (Affordable Care Act) had been implemented, so that ACA-related changes in insurance cannot confound our findings.

## **Results**

Just under 50% of the sample is NH white, around 19% of the sample is NH Black, and around 23% of the sample is Hispanic, with other racial/ethnic groups making up less than 5% of the sample. Postpartum checkup attendance is highest for NH white people compared to NH Black and Hispanic overall and across all our insurance eligibility classifications. Self-report of



postpartum depressive symptoms is highest for NH Black people compared to NH white and Hispanic overall and across all our insurance eligibility classifications (Exhibit 1, Appendix Exhibit A3).

Results of regression analyses are displayed in Exhibit 2 overall and stratified by race/ethnicity with additional racial and ethnic groups (NH Native American/Alaskan Native/Hawaiian Native, NH Asian, NH Mixed/Other) displayed in Appendix Exhibits A5 & A6. We present all estimates as ranges of the point estimates from the two samples created by using the minimum and maximum of an income range. Among postpartum people who would have been eligible for pregnancy Medicaid, having postpartum Medicaid eligibility (relative to having only pregnancy Medicaid) was associated with a 0.9 to 1.2 percentage point higher likelihood of postpartum checkup attendance ( $p < 0.1$ ,  $p < 0.01$ ). For NH white postpartum people, there was a marginally significant association between having postpartum Medicaid eligibility and postpartum checkup attendance (0.6 to 0.9 percentage point increase;  $p > 0.1$ ,  $p < 0.1$ ). For Hispanic postpartum people, there was a larger positive association (3.2 to 3.4 percentage point increase;  $p < 0.01$ ,  $p < 0.01$ ). For NH Black postpartum people, there was a negative association between postpartum Medicaid eligibility and likelihood of reporting postpartum checkup attendance (-1.9, -2.0;  $p < 0.05$ ).

Having postpartum Medicaid eligibility compared to only pregnancy Medicaid eligibility was associated with a 1.2 percentage point lower likelihood of self-reported postpartum depressive symptoms overall ( $p < 0.05$ ,  $p < 0.01$ ). The association between postpartum Medicaid eligibility

and postpartum depressive symptoms was negative and statistically significant for NH white people (-1.6, -1.8;  $p < 0.01$ ) but not statistically significant for NH Black and Hispanic people.

Our regression analyses are robust to defining our sample based on Medicaid-covered births rather than pregnancy Medicaid eligibility and using a 2015-2018 sample (instead of 2012-2018) in that results are all of the same sign and similar magnitudes to our main results (Appendix Exhibits A7 & A8).

## **Discussion**

In this article, we found that, for people who qualify for pregnancy Medicaid, maintaining Medicaid eligibility in the postpartum period is associated with a higher likelihood of attending a postpartum checkup—with the largest difference in likelihood among Hispanic people. Postpartum Medicaid eligibility is also associated with a lower likelihood of self-reported postpartum depressive symptoms—with the largest difference in likelihood among NH white people.

For people eligible for Medicaid during pregnancy, postpartum Medicaid eligibility is associated with a 1.0 to 1.4% increase in postpartum checkup attendance. When stratifying by race, however, this finding was positive and statistically significant only among Hispanic people, suggesting that insurance coverage may represent a larger barrier to utilization of care for Hispanics compared to other groups. On the other hand, postpartum Medicaid eligibility is associated with a decrease in postpartum checkup attendance for NH Black people. This

counterintuitive finding suggests that health insurance coverage may not translate to health care utilization equitably across race and may be driven by structural racism in the health care system and discriminatory medical care, resulting in medical distrust or delay of care.<sup>15</sup> Our results of an increase in postpartum checkup attendance overall align with the increased use of outpatient care previously found using a difference-in-differences framework to study a single state's Medicaid expansion.<sup>11</sup>

Postpartum Medicaid eligibility is associated with a decrease in self-reported postpartum depressive symptoms of 7.4 to 7.6% among people who are eligible for pregnancy Medicaid. These improvements appear to be driven by a negative association of 9.7 to 11.6% for NH white postpartum people. Potential mechanisms by which health insurance eligibility may impact mental health include reduced financial stress and increased access to affordable treatment to address symptoms.<sup>16</sup> Additionally, being eligible for public insurance reduces the pressure to return to work to maintain employer-provided insurance which may improve mental health by allowing time to heal from delivery or adjust to life changes.<sup>17</sup>

Associations between postpartum Medicaid eligibility and postpartum depressive symptoms are still negative but of a smaller magnitude or close to zero and not statistically significant for NH Black and Hispanic people. In our data, NH Black people have a higher occurrence of self-reported postpartum depressive symptoms relative to NH white people, but unlike NH white people, Medicaid eligibility in the later postpartum period does not have a significant association with improved symptoms. These results suggest that policies beyond extending

postpartum Medicaid eligibility are necessary to address postpartum depression for NH Black people. Policies addressing structural racism and discrimination in multiple sectors, including housing, education, employment, health care, and criminal justice are likely also necessary to increase equity across race and ethnicity in postpartum health outcomes.<sup>18</sup>

Our analyses are primarily limited by the data available in PRAMS. First, we lack usable data from 8 states and DC which prevents us from having a fully national sample. The absence of data for California and Florida, which together accounted for 31.4% of Hispanic births in 2018, should be noted when interpreting results for the Hispanic population. Another limitation of our data is that household income is only reported for the year prior to birth while Medicaid eligibility would be recalculated for many around 60 days postpartum. Further, we are missing income information for 10% of our sample and income is reported in ranges. To address income being reported in ranges, we produce estimates using both the minimum and maximum of income ranges and show that results are similar. Additionally, we do not have data on citizenship or lawful resident status, so we must assume all postpartum people would meet these eligibility criteria despite 6% of births being to undocumented immigrants in 2016.<sup>18</sup> Further, our postpartum checkup variable is not the ideal indicator for healthcare access or utilization from 60 days to a year postpartum because the checkup is intended to occur around 6 weeks postpartum, however it is the best measure we have of postpartum healthcare utilization.

Conversely, a major strength of our study is that we use PRAMS data, which is the only multistate source of data focusing on the experiences of people with a recent live birth. Another strength of our study is that we focus on eligibility measures, not reported insurance coverage, because the policies of interest target eligibility criteria.

### Implications for Policy

Currently, the American Rescue Plan Act of 2021 gives states the option to extend pregnancy Medicaid to a full year postpartum using a state plan amendment beginning on April 1, 2022. Moreover, recent legislation at the federal level proposed a requirement for pregnancy Medicaid to be extended to 12 months postpartum in all states.<sup>6</sup> Thirteen states have implemented, and 22 states are considering such state plan amendments or section 1115 waivers (as of 5-19-22),<sup>5</sup> and the federal policy debate continues. Yet, little empirical evidence exists on whether postpartum extension of Medicaid will achieve the intended goals of reducing maternal morbidity and mortality, coverage gaps, and racial disparities, making findings from our study critically important to this policy debate.

### Conclusions

To our knowledge, the current study is the first to provide multistate estimates of the associations between continuous Medicaid eligibility in the later postpartum period and postpartum health outcomes. Our results suggest that postpartum Medicaid eligibility is associated with some improvements in maternal healthcare utilization and mental health. However, differences by race and ethnicity imply that inequitable systems and structures that

cannot be overcome by insurance alone may also play an important role in postpartum health. Thus, more comprehensive policies beyond insurance eligibility may be necessary to improve maternal health outcomes.

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## Notes

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Exhibit 1 (table)

Caption: Survey-weighted means of maternal characteristics among those with pregnancy Medicaid eligibility

	Using Minimum of Income Ranges <sup>a</sup>				Using Maximum of Income Ranges <sup>a</sup>			
	All Pregnancy Medicaid Eligible	Fall in Eligibility Gap	Postpartum Medicaid Eligible	Chi <sup>2</sup> Test p-value <sup>b</sup>	All Pregnancy Medicaid Eligible	Fall in Eligibility Gap	Postpartum Medicaid Eligible	Chi <sup>2</sup> Test p-value <sup>b</sup>
<b>Outcomes</b>								
Postpartum Checkup	86.8	89.7	85.3	0.00	86.1	86.7	85.6	0.00
Postpartum Depressive Symptoms	15.7	13.1	16.9	0.00	16.3	16.1	16.5	0.23
<b>Maternal Characteristics</b>								
Race/Ethnicity								
NH white	49.2	58.8	44.7	0.00	47.2	51.2	43.8	0.00
NH Black	18.7	14.3	20.8	0.00	19.4	18.8	20.0	0.00
Hispanic	22.9	19.4	24.7	0.00	24.1	22.4	25.5	0.00
NH NA/NAK/NHI	1.4	1.0	1.5	0.00	1.4	1.3	1.5	0.00
NH Asian	4.2	3.4	4.6	0.00	4.2	3.0	5.3	0.00
NH Mixed/Other	3.6	3.1	3.8	0.00	3.6	3.4	3.8	0.02
Marital Status								
Married	44.4	60.9	36.8	0.00	41.8	47.0	37.3	0.00
Parity								
Previous Birth	68.1	69.8	67.3	0.00	68.4	67.6	69.2	0.00
Age								
18-19	5.8	3.5	6.8	0.00	6.2	6.2	6.2	0.74
20-24	29.5	24.9	31.6	0.00	19.2	31.0	30.1	0.05
25-29	31.7	33.5	30.8	0.00	30.2	31.4	31.2	0.66
30-34	21.0	24.8	19.2	0.00	29.9	20.3	20.1	0.63

30-34	9.7	10.7	9.2	0.00	14.4	8.9	9.8	0.00
≥ 40	2.4	2.7	2.3	0.01	3.1	2.2	2.5	0.04
Years of Education								
0-8	4.4	2.8	5.2	0.00	4.8	3.8	5.7	0.00
9-11	13.6	7.8	16.2	0.00	14.6	12.6	16.4	0.00
12	36.0	30.7	38.4	0.00	37.3	36.3	38.2	0.00
13-15	33.6	38.5	31.3	0.00	32.8	34.7	31.2	0.00
≥ 16	12.4	20.2	8.8	0.00	10.4	12.6	8.5	0.00
Household Income								
0-49% FPL	39.9	1.6	57.8	0.00	5.1	2.7	7.1	0.00
50-99% FPL	30.3	35.3	28.0	0.00	61.5	49.2	72.2	0.00
100-149% FPL	19.6	33.0	13.4	0.00	21.9	24.8	19.3	0.00
150-199% FPL	8.2	24.0	0.9	0.00	10.0	19.9	1.4	0.00
200-249% FPL	1.6	4.9	0.0	0.00	1.3	2.8	0.0	0.00
250-299% FPL	0.5	1.3	0.0	0.00	0.3	0.6	0.0	0.00
≥300% FPL	0.0	0.0	0.0	0.00	0.0	0.0	0.0	0.00

NOTES: <sup>a</sup> Min. and max. samples are the samples constructed using either the minimum or maximum of the income range. See Methods Appendix for further details.

<sup>b</sup> Reports the p-value for a Chi<sup>2</sup> test of the differences in survey-weighted means for Fall in Eligibility Gap and Postpartum Medicaid Eligible groups.

EXHIBIT 2 (table)

Caption: Differences in postpartum health measures associated with postpartum Medicaid eligibility among those with pregnancy Medicaid eligibility

	All		NH white		NH Black		Hispanic	
	Postpartum Checkup	Postpartum Depressive Symptoms	Postpartum Checkup	Postpartum Depressive Symptoms	Postpartum Checkup	Postpartum Depressive Symptoms	Postpartum Checkup	Postpartum Depressive Symptoms
<b>Percentage Point Difference (<math>\beta \times 100</math>)<sup>b</sup></b>								
Postpartum Medicaid Eligible <sup>a</sup>								
Min. Sample <sup>c</sup>	0.9*	-1.2**	0.6	-1.8***	-2.0**	0.3	3.2***	-1.3
(95% CI)	(-0.0, 1.8)	(-2.1, -0.2)	(-0.5, 1.6)	(-3.1, -0.6)	(-3.9, -0.1)	(-2.1, 2.6)	(0.8, 5.6)	(-3.5, 0.9)
Max. Sample <sup>c</sup>	1.2***	-1.2***	0.9*	-1.6***	-1.9**	-0.3	3.4***	-0.9
(95% CI)	(0.4, 2.0)	(-2.0, -0.3)	(-0.1, 2.0)	(-2.8, -0.4)	(-3.5, -0.4)	(-2.1, 1.6)	(1.3, 5.5)	(-2.7, 0.9)
<b>Observations</b>								
Min. Sample <sup>c</sup>	123,441	123,800	49,550	49,635	29,249	29,340	25,089	25,205
Max. Sample <sup>c</sup>	111,646	111,975	42,810	42,879	27,448	27,535	23,609	23,722
<b>Mean</b>								
Min. Sample <sup>c</sup>	86.8	15.7	88.0	15.5	86.2	18.9	84.9	12.0
Max. Sample <sup>c</sup>	86.1	16.3	87.3	16.5	85.8	19.4	84.7	12.1

Source/Notes:

SOURCE: Authors' analysis of data from PRAMS, 2012-2018.

NOTES:

Significance: \* p<0.10, \*\*p<0.05, \*\*\*p<0.01.

<sup>a</sup>Postpartum Medicaid eligible refers to those eligible for both pregnancy and parental Medicaid. Reference group is those that fall in the pregnancy-parental Medicaid eligibility gap (i.e., eligible for pregnancy Medicaid and ineligible for parental Medicaid).

<sup>b</sup>Models control for household income as a percent of FPL, years of education, age, race/ethnicity, marital status, and parity.

<sup>c</sup>Min. and max. samples are the samples constructed using either the minimum or maximum of the income range. See Methods Appendix for further details.

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