Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Women's Health Issues 30-6 (2020) 401–404

WOMEN'S HEALTH ISSUES
www.whijournal.com

Commentary

Preserving the Momentum to Extend Postpartum Medicaid Coverage

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Article history: Received 30 April 2020; Received in revised form 13 July 2020; Accepted 17 July 2020

The United States is the only well-resourced nation with a maternal mortality rate that is on the rise. According to the most recent data from the Centers for Disease Control and Prevention, approximately 935 pregnancy-related deaths occur in the United States each year (Hoyert & Miniño, 2020). Roughly two-thirds of these deaths are preventable, and an increasing percentage are happening in the late postpartum period, more than 43 days after the end of pregnancy (Davis, Smoots, & Goodman, 2019; Hoyert & Miniño, 2020). Policy makers are eager to implement various solutions to our nation's maternal health crisis, including solutions to eliminate racial inequities in maternal health outcomes. One response that has garnered growing support is extending Medicaid coverage for pregnant women beyond the statutorily mandated 60 days postpartum. This commentary explores the maternal health crisis in the United States and focuses specifically on extending Medicaid coverage beyond 60 days postpartum as one among many solutions to eradicating preventable maternal deaths. It also explores the potential implications—both positive and negative—of the coronavirus disease-19 (COVID-19) pandemic on maternal health policy making.

Medicaid Coverage for Pregnant Women

When the Medicaid program was created in 1965, it was designed as a health insurance program for individuals eligible for cash assistance. In this joint federal- and state-funded venture, the federal government sets baseline requirements for coverage and pays states matching rates for certain medical and social services. At its inception, the program provided health insurance coverage almost exclusively to single mothers and their children who qualified for cash assistance through the Aid to Families with Dependent Children program (Johnson, Applegate, & Gee, 2015). This eligibility methodology resulted in approximately one in eight women of reproductive age (15–44 years) benefiting from the program before the 1980s (Currie & Gruber, 1996).

As increasing rates of infant mortality captured the nation's attention in the mid 1980s, an unprecedented push began to extend public health insurance to more pregnant women (Rowland, Salganicoff, & Seliger Keenan, 1999). The basic premise was that with increased access to prenatal care, women would be healthier during their pregnancies and produce healthier babies. Between 1984 and 1990, the federal government mandated several policy changes and created a myriad of options for states to increase the number of pregnant women served by the Medicaid program. According to Currie and Gruber (1996), the eligibility changes of the late 1980s and early 1990s increased the fraction of pregnant women aged 15–44 years who were eligible for Medicaid from 12.4% to 43.3%, an overall increase of 250%. Importantly, this coverage would expire at 60 days postpartum.

Today, Medicaid pays for nearly half of all U.S. births, including 50% of births in rural areas, 60% of births to Latina women, and 66% of births to Black women (Medicaid and CHIP Payment and Access Commission [MACPAC], 2020). Although all states are required to provide coverage for pregnant women with incomes up to 138% of the federal poverty level, gaps in coverage remain. This is especially true for women who live in states that have not expanded Medicaid under the Patient Protection and Affordable Care Act. In Texas, for example, a pregnant woman earning up to 207% of the federal poverty level is eligible for coverage through 60 days after the end of her pregnancy. At day 61, she can only maintain her coverage if she is earning less than 17% of the federal poverty level, or $3,636 for a family of three (Ranji, Gomez, & Salganicoff, 2019). This inadequate coverage landscape left approximately 11.5%

This work did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

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1049-3867/$ - see front matter
https://doi.org/10.1016/j.whi.2020.07.006

of new mothers uninsured from 2015 to 2018 (McMorrow et al., 2020).

Medicaid Coverage Disruptions

One in three women in the United States experience discontinuous coverage before, during, or after pregnancy (Daw, Kozhimannil, & Admon, 2019). This phenomenon, known as perinatal insurance "churn"—or the cycling on and off and between health insurance—occurs most often in the postpartum period and is especially prevalent among women who rely on Medicaid for pregnancy-related care (Daw et al., 2019). Perinatal insurance churn is prominent across states regardless of Medicaid expansion status: one-half of women in nonexpansion states and nearly one in three women in expansion states experience churn in the perinatal period (Daw et al., 2019).

In addition to experiencing higher rates of perinatal insurance churn, women who rely on Medicaid for pregnancy-related care are at increased risk for experiencing an adverse maternal health outcome. In Illinois, for example, women covered by Medicaid during pregnancy were 2.5 times as likely to die within one year of pregnancy as women with private insurance (Illinois Department of Public Health, 2018). Even more concerning are the stark racial disparities in maternal mortality: Black women are three to four times more likely to die from a pregnancy-related complication than non-Hispanic White women (Petersen et al., 2019). For American Indian/Alaska Native women, the chances of experiencing a maternal death are 2.5 times higher than they are for White women (Petersen et al., 2019).

Black, indigenous, and Hispanic Spanish-speaking women are also disproportionately impacted by perinatal insurance churn. From 2015 to 2017, nearly one-half of all non-Hispanic Black women had discontinuous insurance from prepregnancy to postpartum, and one-half of Hispanic Spanish-speaking women became uninsured in the postpartum period (Daw, Kolenic, et al., 2020). This finding is unsurprising, given the existing data on racial and ethnic differences in insurance type at time of delivery. According to a 2016 report from the Centers for Disease Control and Prevention, a higher proportion of births to White women were paid by private insurance compared with births to Black, American Indian/Alaska Native, and Hispanic women (Martin et al., 2018). More recent data from the MACPAC confirms that, in 2018, Medicaid paid for a larger share of births to Black, Hispanic, and American Indian/Alaska Native women (MACPAC, 2020). According to researchers at the Urban Institute, from 2015 to 2018, one-half of all uninsured new mothers were Hispanic and 65.3% live in the South (McMorrow et al., 2020). Moreover, one-half of these women reported losing Medicaid or other coverage after pregnancy as the reason they were uninsured (McMorrow et al., 2020).

These socioeconomic and racial inequities are, in part, due to antiquated federal law that caps state Medicaid coverage for pregnant women at 60 days after the end of pregnancy. Although some women are able to successfully transition to other sources of coverage at this time, many are left in the untenable and unsafe position of being uninsured shortly after a major medical event. Achieving maternal health equity will require broad policy and practice change, including dismantling implicit bias and racism in the health care system (Howell, 2018; Scott, Britton, & McLemore, 2019), but reducing churn in the postpartum period can help to decrease disparities in outcomes (Eliason, 2020).

Extending Medicaid Coverage for Postpartum Women is a Smart, Cost-Effective Solution

Extending Medicaid coverage beyond 60 days postpartum has been recommended by several Maternal Mortality Review Committees (MMRCs)—the principal investigators of maternal death—as a way to decrease preventable maternal deaths, including those linked to cardiovascular disease, cardiomyopathy, and overdose and suicide. The most recent Illinois Maternal Morbidity and Mortality Report, issued by the Illinois Department of Public Health in October 2018, for example, recommends that Illinois "expand Medicaid eligibility for the postpartum period from 60 days to one year after delivery." Similarly, recent MMRC reports from Arizona, Georgia, Maryland, Texas, Utah, and Washington all call for extending Medicaid coverage (Arizona Department of Health Services, 2019; Georgia Department of Public Health, 2019; Maryland Department of Health, 2020; Texas Department of State Health Services, 2018; Utah Department of Health, 2018; Washington State Department of Health, 2017).

Given the increasing number of maternal deaths occurring beyond 60 days postpartum, it is not surprising that MMRCs are advocating for this policy change. Indeed, according to the Texas Maternal Mortality and Morbidity Task Force, 56% of all maternal deaths in Texas occurred more than 60 days after the end of pregnancy. In West Virginia, the proportion of deaths beyond 60 days postpartum is 62%. Beyond MMRCs, this policy has the support of more than 60 national organizations, including consumer groups, health plans, and medical societies like the American College of Obstetricians and Gynecologists and the American Medical Association.

Not only is this policy rooted in clinical evidence, but it is also likely to save money for both the states and the federal government. Evidence suggests that reducing churn in the Medicaid program lowers monthly per capita spending (MACPAC, 2014). In addition, keeping postpartum women insured presents the opportunity to address any ongoing health concerns, including those unrelated to pregnancy, before they become progressively severe and potentially impact long-term health or a future pregnancy. This factor is especially important for women with Medicaid coverage, who are more likely to have had a prior preterm birth or low birthweight baby and to experience certain chronic conditions, such as substance use disorder (MACPAC, 2018). Further, by providing 12 months of continuous coverage after the end of pregnancy, states can create administrative efficiencies and therefore generate cost savings by conducting a mother's redetermination at the same time as her infant's instead of doing two separate redeterminations at different times (Equitable Maternal Health Coalition, 2020).

Policy Momentum and the Impact of COVID-19

In 2019, the idea of extending Medicaid coverage for pregnant women beyond 60 days postpartum made significant progress on Capitol Hill. Bipartisan legislation advanced unanimously out of the House Energy and Commerce Committee that would incentivize states to extend coverage for women with a Medicaid-covered birth. This legislation (H.R. 4996, Helping Medicaid Offer Maternity Services [Helping MOMS] Act) would create a state plan option to extend coverage and include a 5% increase in the federal share of Medicaid dollars for the first year of implementation. In other words, the coverage extension would be optional for states, and those that choose to adopt it

would receive a temporary increase in the federal share of monies for covering this population. Following on this success, in early 2020, the Senate Finance Committee began conversations with stakeholders to develop a maternal health package to include Medicaid reforms. By early March, however, policy makers suspended other business to prioritize responding to the COVID-19 national emergency.

Months later, COVID-19 continues to take a toll on the U.S. health care system, including maternity care. Hospitals have converted obstetric wards into intensive care units to make space for an influx of patients diagnosed with the virus, limited the number of birth companions present during labor and delivery, and even offered to discharge women earlier than normal to get them in and out of the hospital as quickly as possible. To further complicate a strained system, anxiety about giving birth in hospitals amid a pandemic has resulted in obstetric patients making decisions inconsistent with their birth plans, such as home birth and other alternative birth options. The fact is, unlike other nonessential health care services that can be delayed or delivered in alternative settings, maternity care cannot be as flexible under the conditions of a pandemic.

The overlapping crises of maternal mortality and COVID-19 are particularly pronounced among low-income women and communities of color. As mentioned, it is well-established that Black women in the United States are three to four times more likely to die from a pregnancy-related cause than non-Hispanic White women (Petersen et al., 2019). Similarly, data on confirmed COVID-19 cases and deaths reveals the disproportionate impact the virus is having on communities of color (Garg et al., 2020). Although at present it may seem like the COVID-19 pandemic has suspended efforts to eliminate preventable maternal mortality in this country, COVID-19 could be the catalyst for meaningful, impactful maternal health policy change.

The Families First Coronavirus Response Act, signed into law March 18, 2020, prohibits states from disenrolling individuals from the Medicaid program throughout the duration of the COVID-19 national emergency declaration. The "continuous coverage" provision is one of several rules that states must abide by to receive enhanced federal funding for certain Medicaid expenditures during the COVID-19 pandemic. As noted in guidance from the Centers for Medicare and Medicaid Services, the continuous coverage requirement applies to all Medicaid beneficiaries, including pregnant women. This means that, during the duration of the national emergency, states are prohibited from disenrolling women from the program at 60 days postpartum. This policy, although temporary and currently slated to expire at the conclusion of the national emergency, has the potential to save women's lives regardless of their pregnancy or COVID-19 status. It is a step in the right direction.

Where Do We Go from Here?

As members of Congress weigh which policies and other regulatory flexibilities initiated during COVID-19 should remain in place after the national emergency, continuous coverage for postpartum women on Medicaid must rise to the top of the list. Elected officials should double down on their efforts to extend postpartum Medicaid coverage. Some are already doing so—in late June, House Democrats introduced H.R. 1425, the Patient Protection and Affordable Care Enhancement Act, which includes a mandatory extension of postpartum coverage. Advancing H.R. 4996, the Helping MOMS Act, would also help to facilitate more permanent access to Medicaid coverage for women who have recently experienced pregnancy.

Women on Medicaid should be guaranteed one year of continuous coverage postpartum. Granting women this right will align their coverage with that of their infant, as all infants born to women on Medicaid are guaranteed coverage through the first year of life. Extending coverage is one policy, among many, that will help end preventable maternal mortality and reduce racial inequities in maternal health outcomes.

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