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Medicaid Expansion Fills Gaps in Maternal Health Coverage Leading to Healthier Mothers and Babies

by Adam Searing and Donna Cohen Ross

Key Findings

- New research shows states that expand Medicaid improve the health of women of childbearing age: increasing access to preventive care, reducing adverse health outcomes before, during and after pregnancies, and reducing maternal mortality rates.
- While more must be done, Medicaid expansion is an important means of addressing persistent racial disparities in maternal health and maternal mortality.
- Better health for women of childbearing age also means better health for their infants. States that have expanded Medicaid under the Affordable Care Act saw a 50 percent greater reduction in infant mortality than non-expansion states.
- The uninsured rate for women of childbearing age is nearly twice as high in states that have not expanded Medicaid compared to those that have expanded Medicaid (16 percent v. 9 percent). States with the highest uninsured rates for women of childbearing age are: Alabama, Alaska, Florida, Georgia, Idaho, Mississippi, Nevada, North Carolina, Oklahoma, South Carolina, Texas and Wyoming. Ten of these twelve states have not expanded Medicaid.

The authors would like to thank the American College of Obstetricians and Gynecologists and the March of Dimes for their contributions to this report.

Introduction

Disruptions in health coverage are associated with adverse health consequences.[1] This is especially true for women in their childbearing years, when a pregnancy means having health coverage is even more important. The stakes are high as the care a woman receives during pregnancy is critical to her own health, as well as to the health of her newborn. In the United States, maternal and infant mortality is higher than most other industrialized nations,[2] lending urgency to strategies to address the overall health of women.[3]

In this paper we review the substantial new research showing the significant improvements in access to health coverage for women of childbearing age achieved through the adoption of the Affordable Care Act's (ACA) Medicaid expansion. Better health coverage is important not just for women who are pregnant but also for women well before they become pregnant and well after childbirth. The American College of Obstetricians and Gynecologists (ACOG) recommends women have access to continuous health coverage in order to increase preventive care, reduce avoidable adverse obstetric and gynecologic health outcomes, increase early diagnosis of disease and reduce maternal mortality rates.[4] Research also finds that Medicaid expansion has an important role in reducing the significant and persistent racial disparities in maternal and infant health. And finally, new studies show that healthier mothers mean healthier infants—another benefit for states that expand Medicaid.

Pre-ACA Medicaid Expansions Focused on Pregnancy Status

Over the past four decades, in response to concerns about high rates of infant mortality and poor birth outcomes, states have increased Medicaid eligibility for pregnant women, making health care during pregnancy significantly more accessible for lower-income women.

While this has been a positive change for both mothers and children, it is only one part of a comprehensive strategy to improve maternal and child health. It has been established that the strong connection between the health of a mother and her baby begins well before pregnancy and continues long past the 60 days of post-partum coverage Medicaid typically provides.[5] This elevates the need for overall good health throughout a woman's childbearing years. Innovative efforts such as the University of North Carolina's 4th Trimester Project, in collaboration with groups like the March of Dimes, are highlighting how increasing coverage is a key part of a comprehensive strategy to improve the health of new mothers.[6]

The Effect of State Medicaid Expansions

Reviews of state data estimate the majority of pregnancy-related deaths are preventable.[7] Expanding access to health coverage is a key strategy for addressing this problem. A growing body of research demonstrates the ACA and implementation of state Medicaid expansions have had positive effects on the health of mothers and their infants. Recent studies show that state Medicaid expansions have helped to reduce the rates of both maternal deaths and infant mortality. Women are getting better health coverage before pregnancy, leading to improved prenatal nutrition and prenatal care. And postpartum coverage has improved for women, helping them get the care they need following the birth of their child. States that have expanded Medicaid also have decreased the likelihood that eligibility for coverage will fluctuate, resulting in losing and regaining coverage over a relatively short span of time, a phenomenon known as "churning." Breaks in health coverage can disrupt care and cause existing health conditions to become more serious and more difficult and expensive to treat.[8]

Pre-ACA Medicaid Expansions for Pregnant Women and Coverage Churn for Women of Childbearing Age

In the late 1980s, prompted by high infant mortality rates, many states expanded Medicaid coverage for pregnant women. The state median income eligibility for pregnant women rose to 185 percent of the federal poverty level (FPL) by 2013 and is now 200 percent FPL.[9] Low-income parents could also obtain Medicaid coverage but at a much lower income level, typically well below 100 percent of FPL. The ACA's coverage changes, and particularly its expansion of Medicaid to both parents and adults without children in the home with incomes below 138 percent FPL, have the potential to change this situation dramatically. But the Supreme Court's decision to make Medicaid expansion optional for states, coupled with ideological objections to Medicaid expansion, led to some states rejecting the option. This has resulted in significant differences across the country in access to health coverage for women of childbearing age. (See Appendix A.)

In non-expansion states, the median Medicaid eligibility level for parents is 40 percent FPL or $8,532 per year for a family of three in 2019. This compares to a minimum parental eligibility level of 138 percent FPL ($29,435 for a family of three) in states that have expanded Medicaid.[10] And women of childbearing age who do not have children under age 19 or are currently not pregnant fare much worse in non-expansion states—they are simply not eligible for Medicaid at all unless they have a serious disability.

Such limited coverage for low-income women means coverage churn is more common in non-expansion states. Research consistently shows women of childbearing age experience high rates of transition between being covered

by different insurance providers or being covered and then becoming uninsured.[11] **While Medicaid's relatively high eligibility levels for pregnant women mean a woman's delivery is often covered, these same lower-income women are at significant risk of being uninsured in the critical months before pregnancy and after delivery.** A recent national study found that half of women who were insured by Medicaid for their delivery were uninsured prior to pregnancy.[12] And of these new mothers, 55 percent experienced another coverage gap in the six months after giving birth. The authors also note that "[t]he well-being of infants can also be negatively affected by their mothers' lack of insurance after delivery. Poor management of maternal mental health adversely affects a child's cognitive, behavioral, and socioemotional development."[13]

Table 1 shows that Medicaid expansion decisions have had a direct impact on the ability of women of childbearing age to obtain health coverage. While the ACA reduced the uninsured rate among women of childbearing age across all states, women living in states refusing the Medicaid expansion have generally experienced much smaller reductions and are more likely to remain uninsured. **States with above average declines in their uninsured rate for women of childbearing age are mainly states that have expanded Medicaid.**

States that have not expanded Medicaid generally do not cover women of childbearing age who do not have a disability if they are not pregnant or are not parents of dependent children. These states generally have extremely low eligibility levels for parents to qualify for Medicaid. For example, in Texas an income of more than $302 a month disqualifies the parents in a family of three from enrolling in Medicaid. See Table 2.

Medicaid Expansion Provides Benefits that Confer Two-Generation Advantages

ACA Medicaid expansions provide women of childbearing age their state's full benefit package for adults. These services can benefit their children, as well. For example:

- Maternal Depression Screening and Treatment. Research estimates that more than half (55 percent) of all infants in families with incomes below the poverty level are being raised by mothers with some form of depression.[a] In addition to the toll depression takes on the mother herself, it also can disrupt the formation of a strong parent-child relationship, which compromises a child's early brain development, with implications for cognitive, social and emotional health. State Medicaid programs must make depression screening without cost-sharing available to women enrolled under Medicaid expansions, and refer women at risk of perinatal depression to counseling. Many states have adopted the option to allow pediatric care providers to conduct maternal depression screenings as part of the well-child visit and also to deliver "dyadic treatment" to mother and child together.[b] In Medicaid expansion states, mothers have access to additional treatments they may need, such as more intensive therapy or medication.
- Tobacco Use Cessation. Medicaid enrollees are about twice as likely as the general U.S. population to smoke tobacco: 32 percent of beneficiaries identify themselves as smokers.[c] The ACA requires that all state Medicaid programs offer comprehensive tobacco cessation benefits without cost-sharing for pregnant women and for populations made newly eligible under Medicaid expansion. Smoking cessation can not only reduce a woman's risk of cardiovascular and respiratory disease, cancer and other chronic conditions, it also decreases the chances of pregnancy-related complications, including preterm birth, low birth weight, and sudden infant death syndrome. When adults quit smoking, they also reduce the likelihood that their children will suffer from exposure to second-hand smoke, which can trigger more frequent and severe asthma attacks and is associated with ear infections and even tooth decay.

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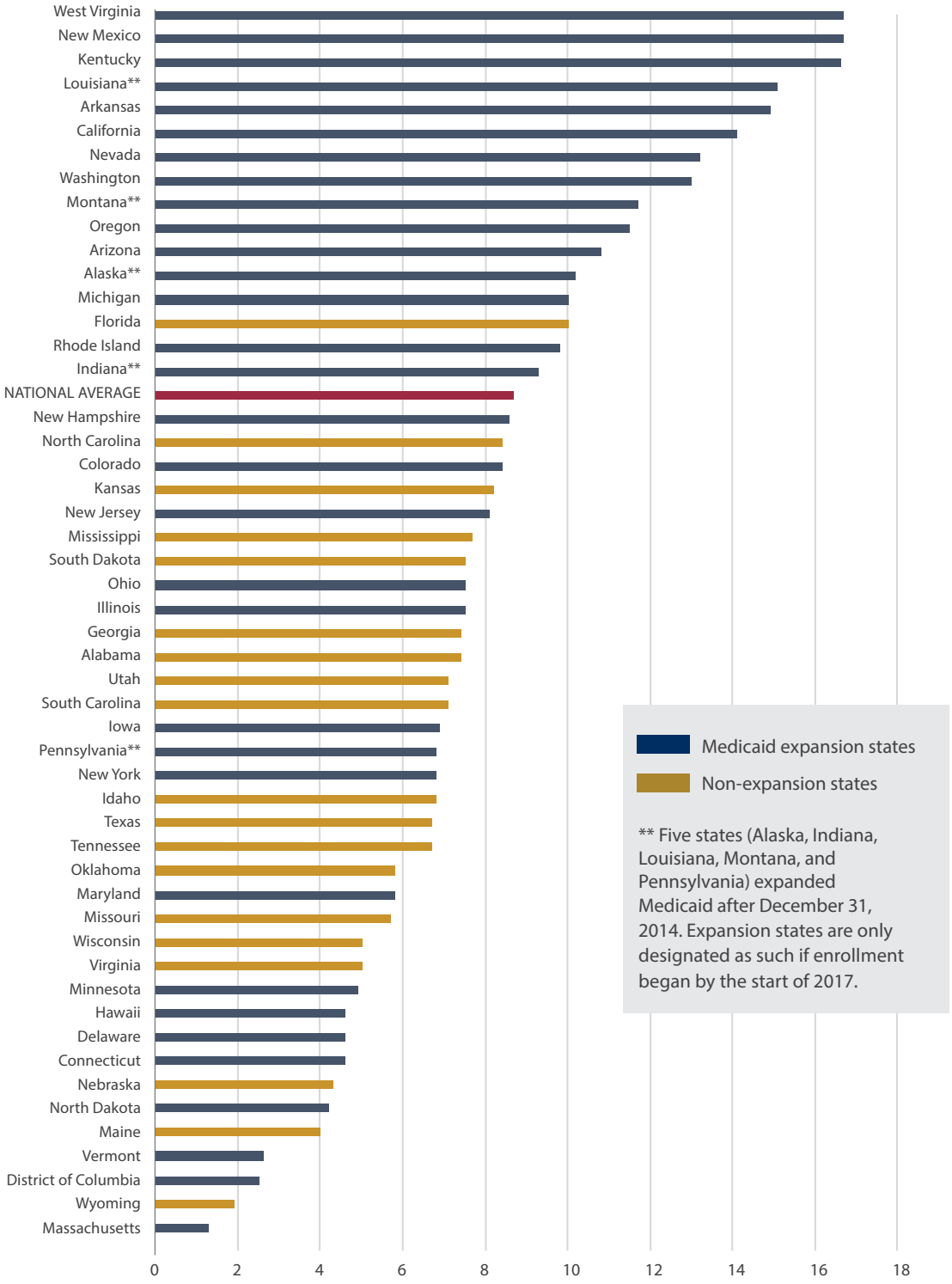
[a] Tracey Veriker, Jennifer Macomber, and Olivia Golden, "Infants of Depressed Mothers Living in Poverty: Opportunities to Identify and Serve," The Urban Institute. August 2010.

[b] "Maternal Depression Screening and Treatment: A Critical Role for Medicaid in the Care of Mothers and Children," CMS Informational Bulletin, May 16, 2016.

[c] L. Ku, B. Bruen, S.Steinmetz, and T. Bysshe, "Medicaid Tobacco Cessation: Big Gaps Remain In Efforts To Get Smokers To Quit," Health Affairs, Vol. 35, No. 1, January 2016.

Table 1. Percentage Point Decline in the Uninsured Rate for Women of Childbearing Age (18-44), 2013-2017



Source: Data is from a Georgetown University Center for Children and Families analysis of the U.S. Census Bureau American Community Survey (ACS) data, 2013 and 2017 single year estimates from the Integrated Public Use Microdata Series (IPUMS).

Table 2. Medicaid Income Eligibility Limit in Non-Expansion States for Adults as a Percentage of the Federal Poverty Level, January 2019

State	Parent upper eligibility limit (in a family of three) – percent of FPL	Parent upper eligibility limit (in a family of three) – monthly dollar amount	Childless adult eligibility limit (for an individual)
Alabama	18%	$320	0%
Florida	32%	$569	0%
Georgia	35%	$622	0%
Idaho*	25%	$444	0%
Kansas	38%	$675	0%
Mississippi	26%	$462	0%
Missouri	21%	$373	0%
Nebraska*	63%	$1,120	0%
North Carolina	42%	$747	0%
Oklahoma	42%	$747	0%
South Carolina	67%	$1,191	0%
South Dakota	49%	$871	0%
Tennessee	95%	$1,689	0%
Texas	17%	$302	0%
Utah*	60%	$1,067	0%
Wisconsin	100%	$1,778	100%
Wyoming	54%	$960	0%

Source: Based on a national survey conducted by Kaiser Family Foundation with the Georgetown University Center for Children on Families, 2019. See here for more information on the survey and this table.

*Idaho and Nebraska voters approved Medicaid expansion but the expansions are not in effect and may be limited. Utah voters also approved a Medicaid expansion but Utah's legislature passed a law limiting the expansion to only some of those originally eligible and capping enrollment at the discretion of the state.

Note: Among reproductive-age women who remained uninsured in 2016, about 20 percent were likely eligible for comprehensive Medicaid or Children's Health Insurance Program (CHIP) coverage based on their income, indicating that outreach and enrollment efforts could help boost participation.[14]

States Rejecting Medicaid Expansion are Missing an Opportunity to Address Stark Racial Disparities in Maternal Health

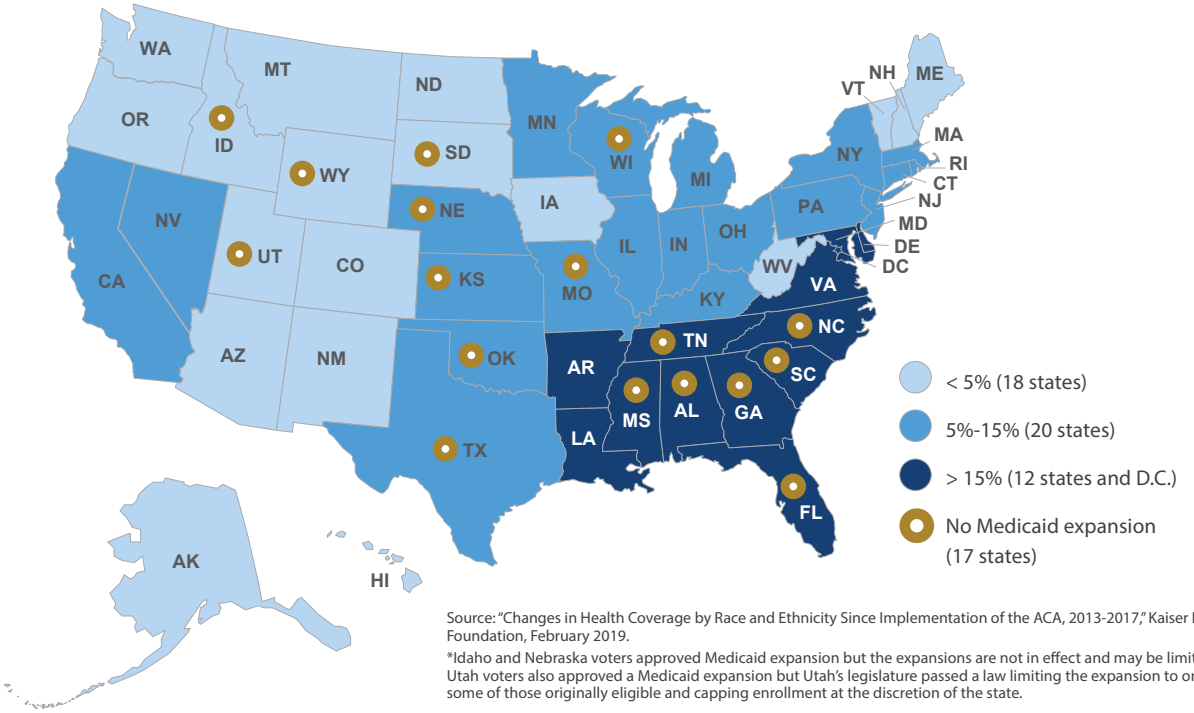
While strategies to increase women's health coverage have had positive effects, especially in states that have expanded Medicaid, stark racial disparities with respect to maternal mortality and maternal health persist. A recent commentary in the Journal of the American Medical Association noted that "African American women are nearly three times as likely to die of complications related to pregnancy and childbirth compared with white women . . . a gap that has not narrowed in decades."[15] The most recent comprehensive study on these disparities in the *American Journal of Obstetrics and Gynecology* found:

> "[B]lack women had a higher adjusted rate of severe maternal morbidity than white women. Our results confirm that the high risk of adverse outcomes faced by black women who give birth in comparison with white women in the United States and are similar to findings by others."[16]

Unsurprisingly, nonelderly adults are much more likely to be uninsured in states that have not expanded Medicaid.[17] Recent data specifically on women of childbearing age are not available, but overall this disparity in uninsured rates is magnified when race is taken into account. For example, the uninsured rate among nonelderly African Americans is 14 percent in states that haven't expanded Medicaid compared to 8 percent in expansion states. Nonelderly white children and adults (ages 0-64) experience lower overall rates of uninsurance: 10 percent in states that haven't expanded Medicaid compared to 6 percent in expansion states.[18] In Southern states, which make up the majority of those that have not expanded Medicaid, African Americans are disproportionately affected and experience higher uninsured rates. This is due in large part to the fact that the states that have not expanded Medicaid have larger shares of black residents.[19]

While multiple factors contribute to improving maternal health, new research is finding Medicaid coverage is a critical piece of the puzzle, especially for addressing racial inequities in access to affordable coverage and care.[20]

Share of Total Population that is Black by State and Current Medicaid Expansion Status



Source: "Changes in Health Coverage by Race and Ethnicity Since Implementation of the ACA, 2013-2017," Kaiser Family Foundation, February 2019.

*Idaho and Nebraska voters approved Medicaid expansion but the expansions are not in effect and may be limited. Utah voters also approved a Medicaid expansion but Utah's legislature passed a law limiting the expansion to only some of those originally eligible and capping enrollment at the discretion of the state.

Medicaid Expansion: Benefits for Women of Childbearing Age

When states decide to expand Medicaid, the resulting gains in coverage provide benefits that promote preventive health practices and can protect women and their children from serious health conditions and even death. Better coverage is the starting point for better care overall. In addition to the well-known advantages of being insured during pregnancy, coordination and quality of care during the pre-pregnancy period and during the postpartum period—sometimes called the "4th trimester"—are especially important.[21]

Several new studies provide insights into the impacts of Medicaid expansion for women of childbearing age including increased health coverage, earlier prenatal care, better overall care, lower rates of maternal mortality and a reduction in infant mortality.

1. Better health coverage for reproductive-age women

Overall, the ACA has had a major impact on increasing coverage for all women of reproductive age. This is due not only to Medicaid expansions but also other coverage changes like the expansion of dependent coverage to young adults up to age 26, the premium tax credit, elimination of pre-existing condition exclusions, and required coverage of maternity care. However, some low-income women are still at risk. Research published in the American Journal of Public Health reported "significant reductions in uninsurance and increases in nongroup private insurance and Medicaid among reproductive-aged women" in the first three years following the ACA's implementation. Across states, the authors identified the ACA as the cause of a 7.4 percentage-point decrease in the probability of uninsurance for reproductive age women. **Low-income women in non-expansion states were identified as a main group still at risk for lack of coverage.**[22]

2. Earlier initiation of prenatal care

The first long-term study examining the effect of pre-ACA Medicaid expansions on women of childbearing age found multiple positive effects. Medicaid expansions improved coverage prior to pregnancy and led to "earlier initiation and improved adequacy of prenatal care among pregnant mothers." Based on the findings, the author concluded that **"More recent state expansions in Medicaid under the ACA have the potential to impact even more women and children as they extend eligibility to all low-income women regardless of parental or pregnancy status."**[23]

3. Better care before women become pregnant

In Ohio, a 2018 study found that after the state's Medicaid expansion there was almost a 12 percentage-point increase in Medicaid enrollment for first-time mothers before they became pregnant. This improved access to proper prenatal care in the first 16 weeks after they became pregnant. **The researchers identified significant increases in the receipt of all recommended health screens and a nearly 14 percentage-point increase in receipt of prenatal vitamins for first-time mothers, compared with increases of 5 and 4 percentage points, respectively, for women with previous pregnancies.** Prenatal vitamins typically contain more iron and folic acid than standard adult multivitamins. They help prevent anemia during pregnancy and neural tube birth defects (such as spina bifida), which compromise a baby's brain and spinal cord development. While the authors caution the results also depend on other factors, including some unique to Ohio, the benefits for lower-income women in the state are clear after Medicaid expansion.[24]

4. Lower rates of maternal mortality

Findings from a study presented at the AcademyHealth National Health Policy Conference in February 2019 showed a link between implementation of Medicaid expansion under the ACA and lower rates of maternal mortality. An analysis of data from 1999 to 2016 from the National Center for Health Statistics compared maternal mortality rates in Medicaid expansion states with rates in states that did not expand. The study found that Medicaid expansion was associated with lower rates of maternal mortality, reflecting 1.6 fewer maternal deaths per 100,000 women. The researchers suggest that the reduction in maternal death rates is associated with women having increased access to Medicaid prior to pregnancy, which presented the opportunity to address pre-pregnancy risk factors such as obesity, diabetes and heart disease and also to begin prenatal care in a timely manner.[25]

5. Reductions in infant mortality

A study released in 2018 examined Medicaid expansions under the Affordable Care Act and their effect on the infant mortality rate in the United States. The researchers point out that since Medicaid covers a large proportion of maternal, infant, and child health care, as well as specific services related to pregnancy, maternity, pediatric care, chronic disease management, breastfeeding support, contraception, mental health and substance use disorder screening and treatment, and other behavioral health services; **"Medicaid expansion may be among the most important ways in which the ACA could improve maternal and child health indicators, such as the infant mortality rate."** Their analysis found that the infant mortality rate declined in both Medicaid expansion and non-expansion states between 2010 and 2016, however, **the decline in Medicaid expansion states was more than 50 percent greater than in non-expansion states.** The research also showed that the decline in infant mortality rates linked to Medicaid expansion were greatest among African American infants, which drove the overall decline and helped to substantially reduce the racial disparity in infant mortality rates.[26] And this improvement was not limited to overall infant mortality. Another recently released study examining the effect of state Medicaid expansions on overall birth outcomes found that while the rates of preterm birth and low birth weight did not show a change, there were significant improvements for African American infants relative to white infants. State Medicaid expansion was associated with "significant improvements in disparities for black infants relative to white infants for the four outcomes studied, including preterm birth, very preterm birth, low birth weight, and very low birth weight."[27]

Conclusion

Medicaid expansion under the Affordable Care Act offers affordable, comprehensive health coverage to women who would likely otherwise go without access to needed care. Most states have longstanding, generous Medicaid coverage for pregnant women, however, the pre-pregnancy coverage churn and post-partum (or "4th trimester") coverage gaps leave women without a full continuum of care. Prior to pregnancy, this can mean a significant missed opportunity to attend to health issues that pose high risks during pregnancy for mother and child. Similarly, a sudden plunge into uninsured status after the Medicaid post-partum period of 60 days can force women to abandon medication or other ongoing treatment they may need. And despite improved coverage during pregnancy, troubling racial maternal and infant health disparities persist, especially in Medicaid non-expansion states.

Recent studies show that Medicaid expansion has increased coverage rates for women during the childbearing years, has reduced the rate of women of childbearing age who are uninsured, and has improved health outcomes. Medicaid expansion has also played a role in reducing rates of maternal death, decreasing infant mortality rates, and improving the potential for optimal birth outcomes that can increase the prospects for a healthy childhood. Finally, it is clear if the remaining non-expansion states want to address significant racial disparities in maternal and infant health, expanding Medicaid is a critical first step.

Additional research could further illuminate the value of Medicaid expansion for women and their children. Many of the benefits Medicaid provides—smoking cessation treatment, treatment for substance use disorders, maternal depression screening and treatment, oral healthcare and other benefits—are likely to have positive two-generation impacts on women and their children.

Appendix A. Medicaid Income Eligibility Limit for Adults as a Percent of the FPL, January 2019

State	Parent upper eligibility limit (in a family of three) – percent of FPL	Parent upper eligibility limit (in a family of three) – monthly dollar amount	Childless adult eligibility limit (for an individual)
Alabama	18%	$320	0%
Alaska	138%	$3,066	138%
Arizona	138%	$2,453	138%
Arkansas	138%	$2,453	138%
California	138%	$2,453	138%
Colorado	138%	$2,453	138%
Connecticut	155%	$2,755	138%
Delaware	138%	$2,453	138%
District of Columbia	221%	$3,928	215%
Florida	32%	$569	0%
Georgia	35%	$622	0%
Hawaii	138%	$2,822	138%
Idaho*	25%	$444	0%
Illinois	138%	$2,453	138%
Indiana	139%	$2,471	139%
Iowa	138%	$2,453	138%
Kansas	38%	$675	0%
Kentucky	138%	$2,453	138%
Louisiana	138%	$2,453	138%
Maine**	138%	$2,453	138%
Maryland	138%	$2,453	138%
Massachusetts	138%	$2,453	138%
Michigan	138%	$2,453	138%
Minnesota	138%	$2,453	138%
Mississippi	26%	$462	0%
Missouri	21%	$373	0%
Montana	138%	$2,453	138%
Nebraska*	63%	$1,120	0%
Nevada	138%	$2,453	138%
New Hampshire	138%	$2,453	138%
New Jersey	138%	$2,453	138%
New Mexico	138%	$2,453	138%
New York	138%	$2,453	138%
North Carolina	42%	$747	0%
North Dakota	138%	$2,453	138%
Ohio	138%	$2,453	138%
Oklahoma	42%	$747	0%
Oregon	138%	$2,453	138%
Pennsylvania	138%	$2,453	138%
Rhode Island	138%	$2,453	138%
South Carolina	67%	$1,191	0%
South Dakota	49%	$871	0%
Tennessee	95%	$1,689	0%
Texas	17%	$302	0%
Utah*	60%	$1,067	0%
Vermont	138%	$2,453	138%
Virginia**	138%	$2,453	138%
Washington	138%	$2,453	138%
West Virginia	138%	$2,453	138%
Wisconsin	100%	$1,778	100%
Wyoming	54%	$960	0%

Non-expansion states

Source: Based on a national survey conducted by Kaiser Family Foundation with the Georgetown University Center for Children on Families, 2019. See here and here for more information on the survey and this table.

* Idaho and Nebraska voters approved Medicaid expansions but the expansions are not in effect and may be limited.

** Medicaid expansions in Maine and Virginia did not go into effect until 2019.

Appendix B. Uninsured Rates by State for Women of Child-Bearing Age (18-44), Comparing Rates for 2013 and 2017

Region	Uninsured Percent 2013 for Women Ages 18-44	Uninsured Percent 2017 for Women Ages 18-44	Percentage Point Change 2013-2017
US Total	21.0	12.3	-8.7
Alabama	23.0	15.6	-7.4
Alaska	25.5	15.3	-10.2
Arizona	24.2	13.4	-10.8
Arkansas	26.3	11.4	-14.9
California	23.4	9.3	-14.1
Colorado	18.6	10.2	-8.4
Connecticut	12.1	7.5	-4.6
Delaware	12.7	8.1	-4.6
District of Columbia	5.5	3.0	-2.5
Florida	29.0	19	-10.0
Georgia	27.5	20.1	-7.4
Hawaii	9.8	5.2	-4.6
Idaho	24.4	17.6	-6.8
Illinois	17.2	9.7	-7.5
Indiana	21.0	11.7	-9.3
Iowa	12.7	5.8	-6.9
Kansas	20.2	12.0	-8.2
Kentucky	24.0	7.4	-16.6
Louisiana	25.9	10.8	-15.1
Maine	15.8	11.8	-4.0
Maryland	13.9	8.1	-5.8
Massachusetts	4.6	3.3	-1.3
Michigan	16.4	6.4	-10.0
Minnesota	10.8	5.9	-4.9
Mississippi	26.2	18.5	-7.7
Missouri	19.6	13.9	-5.7
Montana	23.7	12.0	-11.7
Nebraska	16.8	12.5	-4.3
Nevada	29.0	15.8	-13.2
New Hampshire	16.5	7.9	-8.6
New Jersey	19.7	11.6	-8.1
New Mexico	29.8	13.1	-16.7
New York	14.2	7.4	-6.8
North Carolina	24.1	15.7	-8.4
North Dakota	14.4	10.2	-4.2
Ohio	15.1	7.6	-7.5
Oklahoma	27.2	21.4	-5.8
Oregon	20.8	9.3	-11.5
Pennsylvania	13.9	7.1	-6.8
Rhode Island	15.8	6.0	-9.8
South Carolina	23.9	16.8	-7.1
South Dakota	19.8	12.3	-7.5
Tennessee	18.9	12.2	-6.7
Texas	32.2	25.5	-6.7
Utah	18.3	11.2	-7.1
Vermont	8.0	5.4	-2.6
Virginia	17.4	12.4	-5.0
Washington	21.4	8.4	-13.0
West Virginia	24.6	7.9	-16.7
Wisconsin	11.8	6.8	-5.0
Wyoming	19.4	17.5	-1.9

Source: Data is from a Georgetown University Center for Children and Families analysis of the U.S. Census Bureau American Community Survey (ACS) data, 2013 and 2017 single year estimates from the Integrated Public Use Microdata Series (IPUMS).

Endnotes

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