Society for Maternal•Fetal Medicine
High-risk pregnancy experts

SMFM Position Statement

smfm.org

Society for Maternal-Fetal Medicine Position Statement: Extending Medicaid coverage for 12 months postpartum

Society for Maternal-Fetal Medicine (SMFM); Jordan Stone, MD; Suchitra Chandrasekaran, MD; SMFM Health Policy and Advocacy Committee

Position: The Society for Maternal-Fetal Medicine supports federal and state policies that expand Medicaid eligibility and extend Medicaid coverage through 12 months postpartum to address the maternal morbidity and mortality crisis and improve health equity. Access to coverage is essential to optimize maternal health following pregnancy and childbirth and avoid preventable causes of maternal morbidity and mortality that extend throughout the first year postpartum. The Society opposes policies such as work requirements or limitations on coverage for undocumented individuals that unnecessarily impose restrictions on Medicaid eligibility.

Key words: health equity, healthcare disparities, maternal morbidity, maternal mortality, policy, pregnancy complications

Background

Current Medicaid policy for pregnant people

Federal law[1] requires Medicaid coverage through at least 60 days postpartum for pregnant people with incomes at ≤138% of the federal poverty guidelines; in 2024, the federal poverty guideline was defined as $25,820 for a family of 3.[2] Medicaid is the largest single payer for childbirth services in the United States, funding approximately 40% of deliveries, and nearly two-thirds of births to pregnant persons identifying as non-Hispanic Black, American Indian, or Alaska Native.[3]

Eligibility for Medicaid is determined at the state level, leading to wide variation in who can obtain coverage and how long that coverage lasts. In large part because of the Affordable Care Act (ACA), many states have expanded access to Medicaid beyond the minimum federal income eligibility requirements.[4] However, in states that opted not to expand Medicaid through the ACA, income limits for nonpregnant adults range from 17% to 100% of the federal poverty guidelines.[5]

The length of Medicaid coverage after pregnancy is also highly variable nationwide. Before 2022, an estimated 22% of individuals with Medicaid because of pregnancy eligibility experienced a lapse in coverage within 6 months of delivery.[6] These rates were even higher in states that did not expand Medicaid eligibility under the ACA and among primarily Spanish-speaking beneficiaries. In response to this, and with the goal of improving maternal health and reducing disparities through coverage stability, a provision in the American Rescue Plan Act of 2021 gave states a new option to extend Medicaid postpartum coverage to 12 months via a state plan amendment.[7,8] This new option took effect on April 1, 2022, and was made permanent by the Consolidated Appropriations Act of 2023. As of March 2024, 46 states and the District of Columbia have already extended postpartum Medicaid coverage to a full year.

The postpartum opportunity and current gaps

The postpartum period is a critical window of opportunity for clinicians to engage patients in preventive care and chronic disease management to optimize lifelong health.[9] It is estimated that 1 in 5 pregnant people has a pregnancy complication that heralds an increased risk for future cardiovascular disease, such as gestational diabetes, hypertension, preterm birth, or delivery of a low birthweight infant.[10,11] In addition, mood disorders and substance use disorders, 2 of the most common complications of the perinatal period and leading drivers of maternal mortality, can be effectively treated if identified in the first year postpartum.[12,13] When compared with those with private insurance coverage, pregnant Medicaid beneficiaries are at increased risk for obstetric complications[14] and have a 2-fold higher risk of postpartum depression.[15]

The needs faced by individuals recovering from even routine childbirth are complex and largely unmet by the traditional postpartum care paradigm. An estimated 40% of pregnant people covered by Medicaid do not attend a postpartum visit within 6 weeks of delivery, leaving those

Corresponding Author: The Society for Maternal-Fetal Medicine: Health Policy and Advocacy Committee. smfm@smfm.org

whose coverage lapses after 60 days without the ability to obtain recommended care.[16]

Failure to meet the health needs of those in the postpartum period has profound consequences. The United States is the only developed country with a rising maternal mortality rate, and nearly a third of maternal deaths occur after 42 days postpartum.[17] Lack of care for both acute postpartum needs and chronic medical problems leads to preventable complications and exacerbates health disparities.[18] Furthermore, pregnancy conditions may either begin during or extend into the postpartum period, making continuous access to care and coverage critical. For example, peripartum cardiomyopathy presents most often in the postpartum period and may require extended treatment with a multidisciplinary care team far beyond 6 weeks.[19] Maternal mental health disorders, such as postpartum depression, are often not identified until the traditional 6-week postpartum visit, and treatment is often needed for up to 1 year.[15] Hypertension in pregnancy may last up to 12 weeks postpartum, with many cases persisting as poorly controlled chronic hypertension well beyond that if untreated.[20] Arbitrary time limits on access to coverage erect unnecessary roadblocks to adequate postpartum care. Fewer than 1 in 3 patients receive any prepregnancy counseling, a service that prevents complications in future pregnancies; preconception care in the United States saves $5 for every $1 spent, making it cost-effective and lifesaving.[21]

Continuing Medicaid access for 12 months postpartum

Current evidence suggests that access to Medicaid coverage improves engagement with care and improves outcomes for those with access to such coverage.[22] Expanded coverage has been associated with improved access to preconception care[23] and early prenatal care[24] and reductions in disparities in preterm birthweight and low birthweight infants.[25] Although multifaceted strategies are needed, continued Medicaid coverage through the first year postpartum is a necessary step to reduce maternal mortality, address disparities, and improve the health of families, especially considering that more than half of pregnancy-related deaths occur between 1 week and 1 year postpartum.[17]

Ensuring that people have access to affordable and comprehensive healthcare coverage during the postpartum year is an essential component of maternal and child healthcare. Policies that support and provide this coverage are crucial for the overall health of families and communities.

REFERENCES

1. The Patient Protection and Affordable Care Act. Available at: https://www.congress.gov/111/plaws/publ148/PLAW-111publ148.pdf. Accessed April 18, 2024.

2. Poverty guidelines. Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services. Available at: https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines/prior-hhs-poverty-guidelines-federal-register-references/2024-poverty-guidelines-computations. Accessed May 3, 2024.

3. Osterman MJK, Hamilton BE, Martin JA, Driscoll AK, Valenzuela CP. Births: final data for 2021. Natl Vital Stat Rep 2023;72:1–53.

4. Medicaid expansion & what it means for you. Department of Health & Human Services. Available at: https://www.healthcare.gov/medicaid-chip/medicaid-expansion-and-you/. Accessed October 19, 2023.

5. Status of state Medicaid expansion decisions: interactive map. Kaiser Family Foundation. Available at: https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/. Accessed October 19, 2023.

6. Johnston EM, McMorrow S, Alvarez Caraveo C, Dubay L. Post-ACA, more than one-third of women with prenatal Medicaid remained uninsured before or after pregnancy. Health Aff (Millwood) 2021;40:571–8.

7. H.R.1319 - American Rescue Plan Act of 2021 117th Congress (2021-2022). Available at: https://www.congress.gov/bill/117th-congress/house-bill/1319. Accessed April 18, 2024.

8. Ranji U, Salganicoff A, Gomez I. Postpartum coverage extension in the American rescue plan act of 2021. Kaiser Family Foundation. Available at: https://www.kff.org/policy-watch/postpartum-coverage-extension-in-the-american-rescue-plan-act-of-2021/. Accessed October 19, 2023.

9. Smith GN, Saade G. SMFM white paper: pregnancy as a window to future health. Society for Maternal-Fetal Medicine. Available at: https://www.smfm.org/news/pregnancy-as-a-window-to-future-health. Accessed May 3, 2024.

10. Täufer Cederlöf E, Lundgren M, Lindahl B, Christersson C. Pregnancy complications and risk of cardiovascular disease later in life: a nationwide cohort study. J Am Heart Assoc 2022;11:e023079.

11. Parikh NI, Gonzalez JM, Anderson CAM, et al. Adverse pregnancy outcomes and cardiovascular disease risk: unique opportunities for cardiovascular disease prevention in women: a scientific statement from the American Heart Association. Circulation 2021;143:e902–16.

12. Byatt N, Carter D, Deligiannidis KM, et al. Position statement on screening and treatment of mood and anxiety disorders during pregnancy and postpartum. APA Off Actions; 2018. Available at: https://www.psychiatry.org/getattachment/c5db4e7b-6405-4655-aecb-bc79d5efb4ea/Position-Screening-and-Treatment-Mood-Anxiety-Disorders-During-Pregnancy-Postpartum.pdf. Accessed April 18, 2024.

13. ACOG committee opinion no. 757: screening for perinatal depression. Obstet Gynecol 2018;132:e208–12.

14. Margerison CE, Catov J, Holzman C. Pregnancy as a window to racial disparities in hypertension. J Womens Health (Larchmt) 2019;28:152–61.

15. Sherman LJ, Ali MM. Diagnosis of postpartum depression and timing and types of treatment received differ for women with private and Medicaid coverage. Womens Health Issues 2018;28:524–9.

16. ACOG committee opinion no. 736: optimizing postpartum care. Obstet Gynecol 2018;131:e140–50.

17. Trost SL, Beauregard J, Njie F, et al. Pregnancy-related deaths: data from maternal mortality review committees in 36 US states, 2017—2019. Centers for Disease Control and Prevention; 2022. Available at: https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/data-mmrc.html. Accessed April 18, 2024.

18. Bancks MP, Kershaw K, Carson AP, Gordon-Larsen P, Schreiner PJ, Carnethon MR. Association of modifiable risk factors in young adulthood with racial disparity in incident Type 2 diabetes during middle adulthood. JAMA 2017;318:2457–65.

19. Searing A, Ross DC. Medicaid expansion fills gaps in maternal health coverage leading to healthier mothers and babies. Georgetown University Press McCourt School of Public Policy. Available at: https://ccf.georgetown.edu/2019/05/09/medicaid-expansion-fills-gaps-in-maternal-health-coverage-leading-to-healthier-mothers-and-babies/. Accessed October 19, 2023.

20. Bauersachs J, König T, van der Meer P, et al. Pathophysiology, diagnosis and management of peripartum cardiomyopathy: a position statement from the Heart Failure Association of the European Society of Cardiology Study Group on peripartum cardiomyopathy. Eur J Heart Fail 2019;21:827–43.

21. Grosse SD, Sotnikov SV, Leatherman S, Curtis M. The business case for preconception care: methods and issues. Matern Child Health J 2006;10(Suppl):S93–9.

22. Podymow T, August P. Postpartum course of gestational hypertension and preeclampsia. Hypertens Pregnancy 2010;29:294–300.
23. Margerison CE, MacCallum CL, Chen J, Zamani-Hank Y, Kaestner R. Impacts of Medicaid expansion on health among women of reproductive age. Am J Prev Med 2020;58:1–11.
24. Adams EK, Dunlop AL, Strahan AE, Joski P, Applegate M, Sierra E. Prepregnancy insurance and timely prenatal care for Medicaid births: before and after the Affordable Care Act in Ohio. J Womens Health (Larchmt) 2019;28:654–64.
25. Brown CC, Moore JE, Felix HC, et al. Association of state Medicaid expansion status with low birth weight and preterm birth. JAMA 2019;321:1598–609.

All authors and committee members have filed a disclosure of interests delineating personal, professional, business, or other relevant financial or nonfinancial interests in relation to this publication. Any substantial conflicts of interest have been addressed through a process approved by the Society for Maternal-Fetal Medicine (SMFM) Board of Directors. SMFM has neither solicited nor accepted any commercial involvement in the specific content development of this publication.

This document has undergone an internal peer review through a multilevel committee process within SMFM. This review involves critique and feedback from the SMFM Health Policy and Advocacy and Document Review Committees and final approval by the SMFM Executive Committee. SMFM accepts sole responsibility for the document content. SMFM publications do not undergo editorial and peer review by the American Journal of Obstetrics & Gynecology. The SMFM Health Policy and Advocacy Committee reviews publications every 24 months and issues updates as needed. Further details regarding SMFM publications can be found at www.smfm.org/publications.

SMFM recognizes that obstetrical patients have diverse gender identities and is striving to use gender-inclusive language in all of its publications. SMFM will be using terms such as "pregnant person" and "pregnant individual" instead of "pregnant woman" and will use the singular pronoun "they." When describing study populations used in research, SMFM will use the gender terminology reported by the study investigators.

Reprints will not be available.

 © 2024 Published by Elsevier Inc. https://doi.org/10.1016/j.ajog.2024.04.008