# Policy Brief

WEST VIRGINIA CENTER ON BUDGET & POLICY

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# Extending Medicaid Coverage to Low-Income Postpartum Women Can Improve Their Health Outcomes

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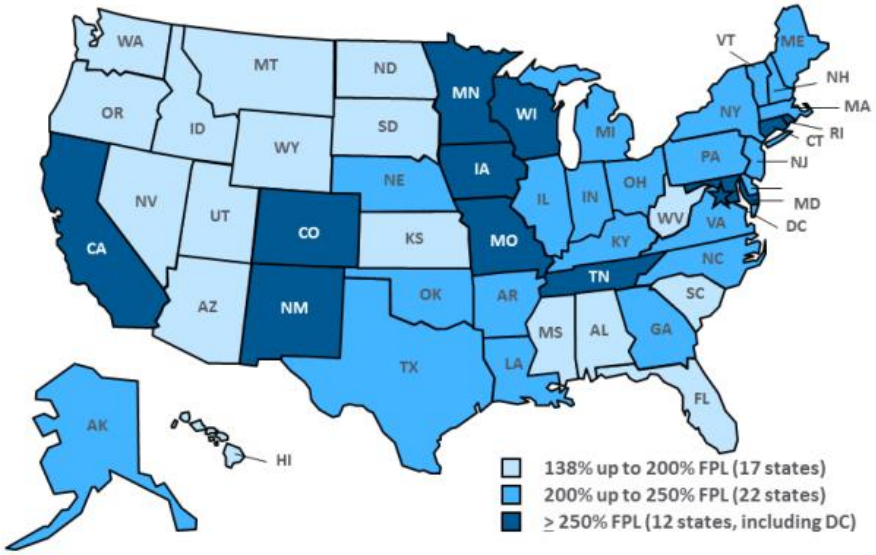
## Overview

In March 2019, West Virginia lawmakers passed Senate Bill 564 to raise the Medicaid eligibility for pregnant women to 300 percent of the Federal Poverty Level (FPL) while guaranteeing coverage for 60-days postpartum. By aligning West Virginia with current state trends and closing a health insurance gap, this policy will provide coverage for hundreds of pregnant women starting July 1, 2019. [1]

Research shows a multitude of health and financial benefits to providing health care to pregnant and postpartum women. It can address the issues of low birthweight, infant and maternal death, postpartum depression, opioid addiction, health problems for mothers, as well as those of their children. Extending Medicaid coverage beyond 60-days postpartum could have lasting short- and long-term benefits for those women, their children and families, and the state of West Virginia.

While SB 564 will help ensure healthier pregnancies, extending coverage to a least one-year postpartum would further improve the physical, mental, and financial health of West Virginia's women, children, and their families.

### Income Eligibility for Pregnant Women in Medicaid/CHIP, January 2019



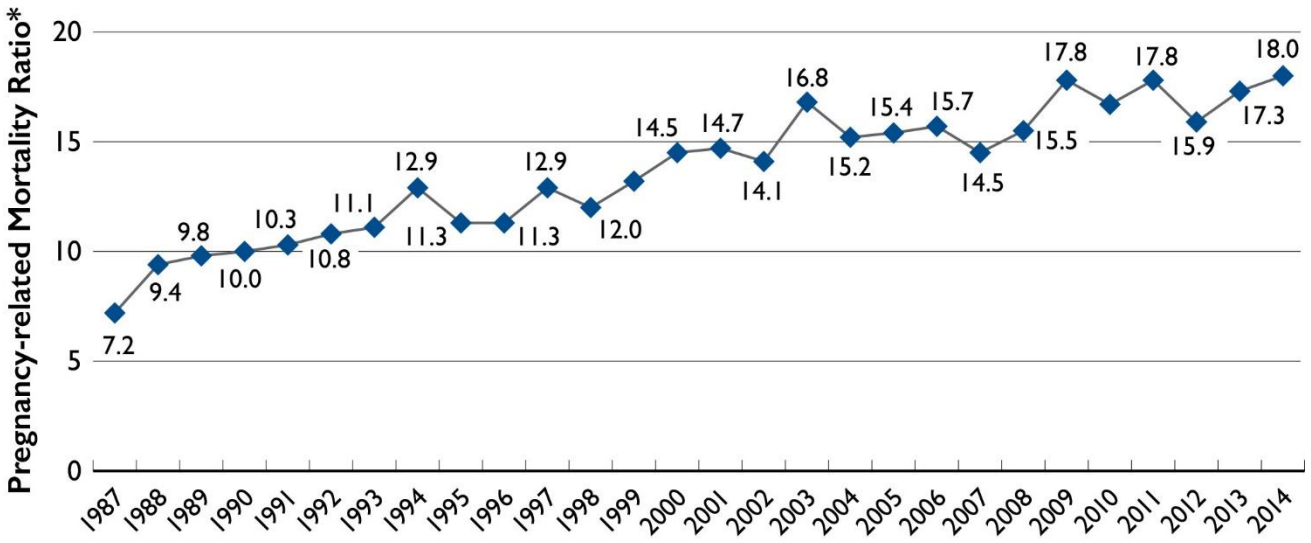

**Source:** Henry J Kaiser Family Foundation (March 2019) https://www.kff.org/medicaid/fact-sheet/where-are-states-today-medicaid-and-chip/

## Maternal Mortality on the Rise

The United States has the worst Maternal Mortality Rate (MMR) of all developed nations.[2] The U.S. is one of only eight countries (and the only developed nation) where pregnancy-related deaths are increasing.[3] In fact, the maternal mortality rate (MMR) has decreased by 44 percent globally between 1990 and 2015 while maternal deaths continue to rise in the United States. Women giving birth today are 50 percent more likely to die either during or after pregnancy than their own mothers.[4] [5] To address this problem, nearly 30 states have created maternal mortality review boards.[6]

The average age a woman gives birth in the United States for the first time is a little over 26 years old.[7] A 26-year-old giving birth in 2014 would face an MMR of 18 out of 100,000 while her mother—26 years prior—was faced with an MMR of 9.4 out of 100,000.

### Trends in Pregnancy-Related Mortality in the United States: 1987-2014




***Note:** Number of pregnancy-related deaths per 100,000 live births per year.

**Source:** https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm

American women are three times more likely to die than Canadian women and six times as likely to die as Scandinavians due to pregnancy-related issues.[8] While maternal mortality is in decline across the globe, in the United States maternal mortality has *increased* over of the last 15 years. In fact:

- 49 countries have lower pregnancy-related deaths than the United States (including almost all of Europe, Canada, and many Asian and Middle Eastern countries)
- Black women are three-four times more likely to die from pregnancy-related causes than white women
- Women living in low-income areas are two times more likely to die
- For every maternal death, 50-70 women almost die in the United States
- Every 15 seconds a woman almost dies from pregnancy-related causes[9] [10]

Health coverage before, during, and after pregnancy can help reduce maternal mortality. The pregnancy-related death rate for women in the United States rivals that of opioid overdose deaths—between 20.7 and 30.1 women per 100,000 are estimated to have died because of pregnancy related complications in the United States in recent years[a] while opioid overdoes are estimated at 21.7 per 100,000 (West Virginia leads the nation in opioid deaths at 57.8 per 100,000). [11] [12] [13] [14] An estimated 63 percent of maternal deaths are preventable with access to health care.[15]

## Postpartum Care Provides a Continuity of Coverage for Better Healthy Outcomes

Prenatal and postpartum care are not just vital to preventing maternal deaths and increasing healthy outcomes for mothers and infants. Without them, women can experience a multitude of health and social problems that increase both personal and societal costs. Pregnancy-related issues do not end at delivery, or even in the 60 days following. According to a report by the Texas Maternal Mortality and Morbidity Task Force, over half of postpartum deaths in Texas between 2012 and 2015 happened after 60-days postpartum.[16] This finding in Texas reinforces how important it is for low-income women to have health care in the months and years following childbirth.

In addition, most states have extended Medicaid (and/or CHIP) funding for family planning services to low-income women who would become ineligible 60-days postpartum. A recent survey of 66 studies directly links family planning to educational and employment attainment leading to improved income, family stability, mental health, happiness, workforce participation, and child wellbeing, which is a promising result of extended Medicaid coverage. Extending coverage past the current 60 days after birth for all health care needs (not just family planning) will help further decrease maternal deaths, address issues of postpartum depression and opioid abuse, and arm women with family planning knowledge and tools.[17]

Of the nearly 63 percent of maternal deaths that are preventable each year in the United States, two direct causes stand out: cardiovascular and coronary issues (68% which are preventable) and hemorrhage (70% which are preventable).[18] These direct causes can, and often do, continue past 60-days postpartum leaving women who no longer qualify for Medicaid vulnerable.

Beyond physical health, women are especially susceptible to depression in their childbearing years. For women who suffer from depression, 55 percent have their first episode in the months after giving birth—postpartum depression can start anywhere up to 12 months after childbirth.[19] In fact, one in seven women will suffer from postpartum depression or similar illness and that number climbs to one in four for low-income women.[20] For low-income, first-time mothers, nearly 40% were found to have symptoms of postpartum depression at six-months postpartum.[21] One study estimated that nearly 40% of women with untreated postpartum depression are at greater risk for recurring or chronic depression throughout the rest of their lives. Additionally, postpartum depression often interferes with a mother's ability to connect to and take care of her newborn--potentially leading to health and behavioral issues

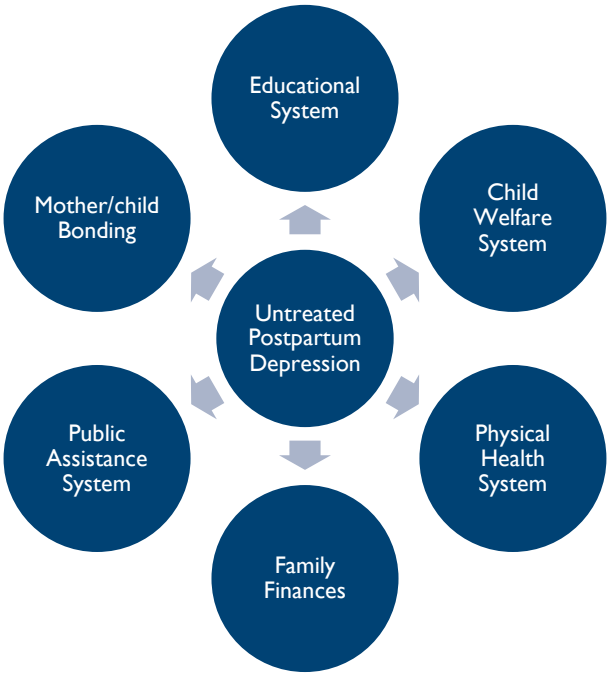
[a] Until 2017, not all states allowed a checkbox on death certificates for pregnancy-related deaths so the data for years prior is sparse. Starting in 1986, the CDC requested the death certificates of all pregnancy-related deaths from each state, but these were likely under-reported deaths because many states did not specifically record maternal deaths. Many studies have tried to estimate maternal mortality for a single year or a selections of years (but not every year) making longitudinal data on maternal deaths in the United States from a single source difficult to come by therefore, most data sources are incomplete. Estimates therefore vary widely.

for her baby. So not only does this disproportionately effect low-income women who cannot afford treatment, it creates two generations of suffering. [22]

Additionally, 20 percent of postpartum deaths can be attributed to suicide, the second-most-common cause of death in postpartum women.[23] Research has estimated the annual cost of not treating mothers with depression at $7,200 in lost wages and productivity alone per sufferer.[24] Postpartum depression is related to a number of negative outcomes for both mother and child: lower employment and wages, greater childhood developmental delays and poor academic performance, and child maltreatment and neglect.[25] And there is strong evidence that maternal mental illness places families at high risk for homelessness, raising costs even more.[26] These issues can strain the health care system, schools, child welfare organizations, and the financial well-being of families.

FIGURE 1

**Public and Private Effects of Postpartum Depression**




**Source:** Adopted from Sontag-Padilla, Shultz, Reynolds, Lovejoy, and Firth (2013), Rand Corporation

Research has suggested that the short- and long-term public benefits of treating the health care needs of mothers with postpartum depression exceed the costs that arise out of not providing treatment. The effects of postpartum depression are not limited to the health of the mother and child. In fact, depressed mothers are more likely to be unemployed (20 percent versus 8 percent) leading to a greater need for public assistance. Treatment of depression, on the other hand, has been shown to improve work participation, work productivity, and decrease absenteeism.[b27]

Extending the time eligible for Medicaid can also be key to treating the opioid crisis for low-income mothers. Between 1999 and 2014, the incidence of Opioid Use Disorder (OUD) in pregnant women more than quadrupled.[28] While many of these women receive treatment during pregnancy through

[b] For more information on the effects of postpartum depression on mothers, children, and public services see: https://www.rand.org/content/dam/rand/pubs/research_reports/RR400/RR404/RAND_RR404.pdf

Medicaid, it can abruptly end at 60-days postpartum for those no longer qualifying. Stopping treatment can cause relapse, putting these mothers at a greater risk of overdose because of a decrease in tolerance while pregnant and in treatment.[29] Additionally, billions of dollars are spent each year on children entering or remaining in the child welfare system as mothers with OUD remain untreated and/or die.[30] Extending coverage beyond 60 days—for at least a year—would help ensure more of these women stay in recovery getting the help they need.

## Providing Health Coverage to Mothers Provides Long-Term Benefits to Their Children

When Medicaid coverage was expanded in the early 1980s, an entire cohort of babies was born with their mother's pregnancy covered by Medicaid. Recent studies have found that providing Medicaid coverage to pregnant and postpartum women improved the long-term health of their children and boosted their educational and job prospects. These now-adults have decreased health problems such as obesity, diabetes, endocrine, nutritional and metabolic diseases, and immunity disorders saving potential millions in health care costs over time.

It is likely that as this cohort ages, additional health benefits will emerge. Those covered by expanded Medicaid in-utero were also more likely to graduate from high school and earn higher wages and were less likely to receive public support such as food stamps than people born without health care coverage.[31]

## The High Cost of Postpartum Health Insurance

Under current West Virginia law, a woman earning from 139 to 300 percent of the FPL would lose her health insurance coverage through Medicaid 60-days postpartum. A single mother, at 139 percent of the FPL, would need to spend $66/month for a silver plan on the insurance marketplace while the same woman at 300 percent of the FPL would pay $406/month. This includes the cost of the plan minus any income-based subsidies (this is just one of the plans available, bronze would be slightly less and the two more expensive options in the Marketplace—gold and platinum—would be more).[32] In addition, her out-of-pocket costs could be extremely high. A silver plan can have up to $7,900 deductible (for a single person, married it could be $15,800).

This can be unaffordable for many women earning too much for Medicaid when the average monthly cost of rent and utilities in West Virginia alone are over $900.[33] [34] And this does not include food, transportation, student loans, consumer debt, or any other expenses. The following table shows an estimate of how much silver plans on the Health Insurance Marketplace would cost for families earning 139 and 300 percent of the FPL (assuming that there are no smokers in the plan), including any subsidies:

| | 139% of the FPL, 2018 | Silver Plan Month/Year | 300% of the FPL, 2018 | Silver Plan Month/year |
|---|---|---|---|---|
| **Single mother with 1 child** | $22,879 | $66/$796 | $49,380 | $406/$4,872 |
| **Single mother with 2 children** | $28,884 | $84/$1,005 | $62,340 | $512/$6,144 |
| **2 parent household with 1 child** | $28,884 | $84/$1,005 | $62,340 | $512/$6,144 |
| **2 parent household with 2 children** | $34,889 | $101/$1,214 | $75,300 | $619/$7,428 |

**Source:** HealthCare.gov

Employer-based health insurance is becoming equally unaffordable for many, especially those with low incomes. While median household income for West Virginians rose less than five percent between 2010 and 2016, health insurance deductibles for employer-sponsored health insurance plans more than doubled. West Virginia was ranked fifth-highest in the nation for employer-sponsored health insurance family premiums which grew as a share of household income to 16.2% from 2010 to 2016.[35]

### Extending Medicaid Coverage to Low-Income Women for At Least a Year After Childbirth Could Help West Virginia's Economy and the Financial Health of Families

Covering the costs for postpartum health issues, including mental wellness and addiction, could save money for families and boost the state's economy. According to the WV Department of Health and Human Services, the average cost of postpartum care a low-income woman would be approximately $3,000 annually. West Virginia would likely need to apply for a Section 1115 Medicaid Waiver to expand postpartum coverage beyond 60 days and for federal matching funding.

In order to use a waiver to fund Medicaid extension passed 60-days postpartum, West Virginia would have to show that the extension would be budget neutral (that the proposed change would save the federal and state government money, or at least not cost more money). This means offering evidence that providing extended Medicaid (at approximately $3,000 per person per year as stated above) would show budget neutrality over five years. Given the high costs associated with low-income women not having postpartum care, this likely would be a relatively easy ask—over half of states have extended care for family planning through Medicaid in this manner[36] and the costs of preventable deaths, postpartum mental illness, and the devastation resulting from the opioid crisis are exceedingly high for individuals, families, and society. A number of studies has shown that Medicaid expansion has resulted in a net positive for state budgets by decreasing state and local spending on uncompensated care, increasing tax revenue from increased spending on health care, increased revenue from state taxes on health care providers, and lower demand for other state-sponsored programs for low-income, uninsured individuals.[37]

## Conclusion

This year West Virginia took positive steps to ensure that mothers and their newborns get a healthy start. Senate Bill 564 expands Medicaid coverage to hundreds of mothers and their babies, including care for new mothers up to 60 days after their baby is born. In the last 12 months, there were 535 West Virginia new mothers who gave birth without health insurance.[38] Some will be covered under expanded Medicaid to pregnant women from SB 564 but will lose Medicaid coverage after 60 days postpartum. Lawmakers can make this positive step even better by extending this coverage to at least one-year postpartum. Many poor physical and mental health outcomes for women—including maternal death—can directly and indirectly be addressed through extending Medicaid for this population beyond 60 days. This, along with expanding income eligibility under SB 484, can ensure more women and their children are healthier and more productive now and in the future.

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