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# America's Maternal Mortality Crisis: The Crucial Role of Medicaid

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According to the Center for Disease Control and Prevention's (CDC) National Center for Health Statistics, in 2021, there were 1,205 pregnancy-related deaths in the U.S., a significant increase from previous years. This translates to a maternal mortality rate of 32.9 deaths per 100,000 live births. Even more alarming are the stark racial and ethnic disparities. Black women experience pregnancy-related deaths at a rate significantly higher than White or Hispanic women. These disparities highlight systemic inequities in health care access and quality.

The causes of pregnancy-related death are multifaceted. While pregnancy can certainly trigger new medical or mental health issues, it can also exacerbate existing, unrelated medical conditions. Thus, a report on Supporting Mom's Health in the Postpartum Period published by the National Conference of State Legislatures (NCSL) describes that "53% of pregnancy-related deaths occur 7 to 365 days postpartum," and "84% of all pregnancy-related deaths are considered preventable."

The most frequent underlying causes of pregnancy-related death are:

- Mental health conditions (22.7%)
- Hemorrhage (13.7%)
- Cardiac and coronary conditions (12.8%)
- Infection (9.2%)
- Thrombotic embolism (8.7%)

- Cardiomyopathy (8.5%)

A significant portion of pregnancy-related deaths occur in the postpartum period—the year following childbirth. The American College of Obstetricians and Gynecologists (ACOG) stresses that planning postpartum care should begin during pregnancy and cover the shift to parenthood and the birthing person's ongoing health needs. This proactive guidance should cover long-term management strategies for pre-existing health conditions like mental health, diabetes, high blood pressure, and obesity, including identifying a primary care provider for care beyond the postpartum period.

## Medicaid: A Potential Lifeline

In the U.S., Medicaid is the biggest single source of payment for maternity care, covering approximately 41% of all births. Private insurance, including both commercial and employer-sponsored plans, pays for roughly half, with the remainder covered by out-of-pocket payments, the Indian Health Service, or military health insurance.

Medicaid is especially crucial for maternity-related care, supporting a larger share of births within populations facing higher rates of pregnancy-related complications, and facilitating access to essential care throughout the preconception, prenatal, and postpartum periods. Medicaid beneficiaries utilize prenatal care more than uninsured individuals and experience better health outcomes.

## Medicaid Policy: Key Advancements

### Medicaid Expansion

The Affordable Care Act (ACA) prohibited insurers in the private market from charging women higher premiums when compared to men, mandated coverage for maternity care, and allowed states to expand the number of people who could qualify for Medicaid in that state. Due to these reforms, the uninsured rate among women ages 19 to 64, decreased from 18.5% to 9.7%, and by 2022; 8.4 million women had gained medical coverage.

Currently, federal law requires all states, including those that have not expanded Medicaid under the ACA's voluntary expansion for other low-income adults, to provide pregnancy-related Medicaid coverage to pregnant individuals with incomes up to at least 138% of the federal poverty level (FPL), and 32 states currently provide pregnancy-related coverage to individuals with incomes up to 200% of the FPL. However, coverage options for pre-pregnancy and postpartum periods also vary across states and are more limited in non-expansion states.

Research indicates that ACA Medicaid expansions have led to better preconception coverage for pregnant women, some enhancements in preconception health for women of reproductive age, and a notable drop in infant mortality rates. These findings suggest that, even with existing pregnancy-related Medicaid benefits, Medicaid expansion has likely contributed to improved pregnancy health, earlier access to care, and better birth outcomes. Greater access to Medicaid before pregnancy helps

address critical health risks like obesity, diabetes, and heart disease, which often contribute to maternal death, and research underscores "the importance of health insurance coverage in improving maternal outcomes and the crucial role that expanded Medicaid access could be playing in decreasing devastating disparities in maternal mortality in the United States."

### Extended Postpartum Medicaid Coverage

Federal law requires state Medicaid programs to cover individuals for 60 days after birth of the child. However, when this limited period ends, many women lose their Medicaid coverage, which often cuts off the woman's ability to access much, if any, postpartum care. Consequently, on average, 20% of people covered by Medicaid due to pregnancy become uninsured within six months postpartum, and this figure is almost twice as high in some states.

Recognizing the critical need to improve maternal health outcomes, particularly for vulnerable populations, the U.S. Department of Health and Human Services (HHS) committed to investigating and researching causes and solutions to address pregnancy-related death. The American Rescue Plan Act of 2021 (ARPA), which went into effect on April 1, 2022, allowed states to temporarily utilize a state plan amendment to extend postpartum Medicaid coverage in that state for up to a year, and, the Consolidated Appropriations Act of 2024 (CAA) made the option to extend Medicaid during the postpartum period permanent (flexibilities offered under ARPA were limited to five years). Since the ARPA went into effect, the Medicaid programs in 49 states and the District of Columbia have implemented a 12-month extension of Medicaid coverage during the postpartum period.

## Challenges and the Path Forward

The One Big Beautiful Bill (OBBBA), which was passed by Congress on July 3 and signed into law by President Trump on July 4, outlines the largest cuts to Medicaid funding since the Medicaid Program was implemented in 1965. The Congressional Budget Office estimates that OBBBA will reduce federal Medicaid spending by $911 billion over the next ten years and lead to over 10 million people becoming uninsured.

Under OBBBA, the majority of savings will be achieved through three specific policy changes: (1) requiring states to implement work requirements for the expansion group; (2) changes I Medicaid enrollment and renewal procedures; and (3) limiting states' ability to raise their share of Medicaid funds through provider taxes.

According to the Center on Budget and Policy Priorities, work requirements alone put up to 36 million people at risk of losing Medicaid coverage. Women make up 53% of nonelderly adults enrolled in the Medicaid program and therefore could be highly impacted by these changes. Although the work requirements outlined in OBBBA mandate exemptions for pregnant women, obtaining and maintaining a valid exemption can be administratively challenging and lead to interruptions in access to Medicaid-covered prenatal, maternal, and postnatal care. A 2019 study published in the New England Journal of Medicine found that:

> Implementation of the first-ever work requirements in Medicaid in 2018 was associated with significant losses in health insurance coverage in the initial 6 months of the policy but no significant change in employment. Lack of awareness and confusion about the reporting requirements were common, which may explain why thousands of persons lost coverage even though more than 95% of the target population appeared to meet the requirements or qualify for an exemption.

Under OBBBA, the determination and redetermination processes for Medicaid coverage will also become more complex. For certain Medicaid enrollees, OBBBA requires states to conduct eligibility redeterminations every six months, rather than annually. Coverage gaps often result from increased requirements of this sort due to procedural disenrollments. As described by the Urban Institute:

> Many Medicaid coverage losses are not caused by the person becoming ineligible. Instead, they are procedural disenrollments (i.e., disenrollment without being declared ineligible by the state, such as because the enrollee has not received redetermination information in the mail or has not responded to requests for information within the timeframe requested by the state).

Therefore, increasing the need for redetermination, as stipulated by OBBBA, is likely to result in women losing Medicaid coverage for maternal and postpartum care despite the woman continuing to qualify for Medicaid.

The federal government and the states jointly finance Medicaid. The federal share is determined by the Federal Medical Assistance Percentage (FMAP). FMAP is based on a state's per capita income, meaning lower-income states receive a higher match from the federal government. To increase their federal Medicaid match, most states utilize provider taxes. Provider taxes, levied on the revenue of health care providers like hospitals and nursing facilities, generate state revenue that is then reinvested into Medicaid services. Because the federal government matches a state's FMAP rate, the additional funds allocated by the state to its Medicaid program, result in the state being able to receive more Medicaid funding from the federal government.

OBBBA works to prohibit states from establishing new provider taxes and reduces rates of existing provider taxes in Medicaid expansion states through an annually decreasing cap, from the current 6% of net patient revenues, to 5.5% of net patient revenues in 2028, down to 3.5% of net patient revenues by 2032. Limiting a state's ability to use provider taxes inevitably means the state will receive less federal Medicaid funding. Due to this reduction in overall Medicaid funding, the state may be forced to offer fewer Medicaid services or to implement more stringent Medicaid eligibility requirements, making it more difficult for pregnant women to qualify for Medicaid and/or reducing the range of services offered to women during pregnancy and the postpartum period.

In line with these concerns about the implications of the Medicaid cuts included in OBBBA, the American Hospital Association (AHA), issued a statement:

> The sheer magnitude of the level of reductions to the Medicaid program alone will impact all patients, not just Medicaid beneficiaries, in every community across the nation. Hospitals — especially in rural and underserved areas — will be forced to

make difficult decisions about whether they will have to reduce services, reduce staff and potentially consider closing their doors.

Given the high rate of maternal mortality and morbidity in the United States, investment in proven strategies to eliminate preventable deaths and enhance women's health is critical. OBBBA's provisions restrict Medicaid eligibility, reduce funding, and create barriers to accessing crucial maternal care, directly counteracting these essential goals.

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