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Madison P. Harrell

University of Richmond School of Law

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COMMENT

EXPANDING MEDICAID IN THE POSTPARTUM PERIOD

INTRODUCTION

Medicaid has consistently been a vital resource for pregnant Americans. Currently, over 40% of births are covered by Medicaid in the United States.¹ However, despite the large number of pregnant individuals requiring Medicaid coverage for their births, the federal government has done little to ensure that these individuals keep coverage throughout the postpartum period. Federal law presently mandates that Medicaid provide coverage for just sixty days post-birth, at which point individuals would either need to transition to another plan or lose coverage altogether.² Additionally, while the majority of states have expanded Medicaid coverage under the Affordable Care Act (“ACA”), twelve states have not.³ This expansion allows individuals in expansion states with incomes at or below 138% of the federal poverty level (“FPL”) to transition to traditional Medicaid after the initial sixty-day postpartum period.⁴ However, in many nonexpansion states, eligibility requirements for Medicaid are far lower, which results in new parents becoming uninsured at higher rates.⁵

Unfortunately, expansion under the ACA also does not guarantee that all postpartum individuals will receive needed coverage once their Medicaid coverage ends.⁶ Further, the disjointed and

1. Usha Ranji, Ivette Gomez & Alina Salganicoff, *Expanding Postpartum Medicaid Coverage*, KFF (Mar. 9, 2021), <https://www.kff.org/womens-health-policy/issue-brief/expanding-postpartum-medicaid-coverage> [<https://perma.cc/96FX-YSGG>].

2. *See id.*; 42 U.S.C. § 1396a(a)(10)(C)(ii), (e)(5).

3. Ranji et al., *supra* note 1.

4. *Id.*

5. *See id.*

6. *See id.*

varying eligibility frameworks from state to state make Medicaid coverage and eligibility needlessly complicated, which results in inequitable access to care throughout the country.⁷ This variance can make obtaining or affording coverage difficult for postpartum individuals, putting them at risk of losing their health coverage and threatening their health.⁸

Maternal health outcomes, specifically maternal mortality and morbidity, are a pressing issue in American health care.⁹ Since 2000, maternal mortality rates in the United States have risen; while they have leveled off in recent years, the ratio of maternal deaths is still higher in the United States than in comparable countries.¹⁰ In response to this crisis, there has been growing recognition that postpartum care is ongoing and requires multiple visits and follow-up care that may last for a year or longer, especially for people who experience complications during pregnancy or birth.¹¹ There is a growing consensus that sixty days of coverage post-birth is simply not enough to address pressing postpartum health concerns.¹²

As a first step towards fixing the United States' maternal health problem, Congress should pass legislation to mandate Medicaid coverage during pregnancy and for one year postpartum for any individual with an income at or below 200% FPL. The expanded coverage should be funded by the federal government at an enhanced 100% matching rate, and eligible individuals should receive the full Medicaid benefits package. Additionally, to encourage states to cover as many pregnant individuals as possible, Congress should give states the option to expand Medicaid coverage for pregnant and postpartum individuals up to 400% FPL. States that adopt this option will also receive the 100% matching rate for the newly covered population.

Congress has already acknowledged a willingness to start down this path. In March 2021, President Biden signed the American

7. *See id.*

8. *See id.*

9. Stacy McMorrow & Genevieve Kenney, *Despite Progress Under the ACA, Many New Mothers Lack Insurance Coverage*, HEALTH AFFS. (Sept. 19, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180917.317923/full> [<https://perma.cc/2ZZ3-B9C5>].

10. Eugene Declercq & Laurie Zephyrin, *Maternal Mortality in the United States: A Primer*, COMMONWEALTH FUND (Dec. 16, 2020), https://www.commonwealthfund.org/sites/default/files/2020-12/Declercq_maternal_mortality_primer_db.pdf [<https://perma.cc/HTY2-ZVAV>].

11. Ranji et al., *supra* note 1.

12. *Id.*

Rescue Plan into law, which provided states the option to expand Medicaid access to one year postpartum, but this is not enough.¹³ Giving states the option to expand Medicaid access is an insufficient solution to addressing the country's postpartum coverage challenges. Some states have already proven they are unwilling to expand Medicaid coverage on their own,¹⁴ and this proposal eliminates that risk while still ensuring that states will not have to bear the financial burden of expansion. The federal government has the power to mandate this Medicaid expansion, and the ACA has shown that a state option often results in unequal access to care.¹⁵ Therefore, a federal mandate is the best solution to ensure adequate coverage for individuals in the year following birth and to help prevent postpartum maternal mortality and morbidity.

This Comment will discuss how the current Medicaid law is insufficient to address the issue of disappointing maternal health outcomes in the United States and how the federal government should begin to remedy the problem. First, I will shed light on the maternal health crisis in the United States, before discussing the history of pregnancy and postpartum Medicaid coverage. Then, I will outline the enactment of the Affordable Care Act, the subsequent court battle over its constitutionality, and the effects of that decision on the current landscape of pregnancy and postpartum Medicaid coverage. Finally, I will detail my proposal for Congress to mandate one year of postpartum coverage and discuss the relevant reasons supporting the necessity of such coverage before demonstrating the legality of the proposal under current law.

I. BACKGROUND

A. *The Maternal Health Crisis*

To comprehend the need for a full year of postpartum Medicaid coverage, one must make sense of the current maternal health crisis in the United States. While maternal mortality rates have been declining worldwide, as of 2017, the United States was one of only two countries to report a significant increase in its maternal

13. Edwin Park & Sabrina Corlette, *American Rescue Plan Act: Health Coverage Provisions Explained*, GEO. UNIV. HEALTH POL'Y INST. CTR. FOR CHILD. & FAMS. (Mar. 11, 2021), <https://ccf.georgetown.edu/2021/03/11/american-rescue-plan-act-health-coverage-provisions-explained> [https://perma.cc/374B-VUY7].

14. See Ranji et al., *supra* note 1.

15. See *id.*

mortality rate since the year 2000.¹⁶ As of 2018, the maternal mortality rate in the United States was 17.4 deaths per 100,000 live births, the worst among industrialized countries.¹⁷ This is a stark contrast to the two countries with the best outcomes, New Zealand and Norway, which boast ratios of 1.7 and 1.8 deaths per 100,000, respectively.¹⁸ In fact, the maternal mortality ratio in the United States is double the ratio of the next highest industrialized country, France, where the rate is 8.7 deaths per 100,000 live births.¹⁹

Only a third of maternal deaths occur during pregnancy, while 17% occur on the day of delivery.²⁰ Over half of pregnancy-related deaths occur during the postpartum period; 40% occur during the first six weeks, and nearly 12% occur between six weeks and one year postpartum.²¹ The good news is that more than half of pregnancy-related deaths, including postpartum deaths, are considered preventable.²² The bad news is that, currently, the United States is failing to prevent them.²³

The causes of maternal deaths vary widely.²⁴ Causes such as infection and hemorrhage are more likely to occur during or in the immediate aftermath of birth, when new parents are still in the hospital.²⁵ Unfortunately, new parents are not out of the woods if they leave the hospital safely, with heart conditions—particularly cardiomyopathy—and mental health conditions posing the highest threat during the postpartum period.²⁶ With a significant number of pregnancy-related deaths occurring more than six weeks

16. Declercq & Zephyrin, *supra* note 10.

17. *Id.*

18. Roosa Tikkanen, Munira Z. Gunja, Molly FitzGerald & Laurie Zephyrin, *Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries*, COMMONWEALTH FUND (Nov. 18, 2020), <https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries> [https://perma.cc/9FCR-J4BY].

19. *Id.*

20. *Id.*

21. *Id.*

22. Jennifer Haley & Emily M. Johnston, *Closing Gaps in Maternal Health Coverage: Assessing the Potential of a Postpartum Medicaid/CHIP Extension*, COMMONWEALTH FUND (Jan. 29, 2021), <https://www.commonwealthfund.org/publications/issue-briefs/2021/jan/closing-gaps-maternal-health-postpartum-medicare-chip> [https://perma.cc/55QR-L2UN].

23. *Id.*

24. Declercq & Zephyrin, *supra* note 10.

25. *Id.*

26. *Id.*

postpartum, the risk remains acute for far longer than many may anticipate, and coverage must reflect that risk.²⁷

Further, the risk is not equal across the United States.²⁸ Approximately half of all U.S. states and territories are missing data in regards to maternal mortality, but of the states that do report, four reported ratios of greater than 30 deaths per 100,000 live births and only five reported ratios of less than 15 per 100,000 live births.²⁹ These statistics show that even in states that are considered success stories compared to others, the maternal mortality ratio is still higher than in comparable nations. Most of these deaths are considered preventable, highlighting the need for comprehensive and ongoing postpartum care.³⁰ Research has shown that coverage before, during, and after pregnancy leads to healthier pregnancies and more positive maternal and infant health outcomes following childbirth.³¹

B. *Pregnancy and Postpartum Medicaid Coverage and the Barriers to Care*

1. The Origins of Medicaid and Its Initial Expansions

Currently, over 40% of births in the United States are covered by Medicaid, highlighting the necessity of the program in addressing maternal health.³² However, Medicaid did not always fill this role. The program was initially signed into law in 1965 as Title XIX

27. *Id.*

28. Importantly, the disparities do not simply exist between states; they exist within them as well as between different racial groups. See Samantha Artiga, Olivia Pham, Kendal Orgera & Usha Ranji, *Racial Disparities in Maternal and Infant Health: An Overview*, KFF (Nov. 10, 2020), <https://www.kff.org/report-section/racial-disparities-in-maternal-and-infant-health-an-overview-issue-brief> [<https://perma.cc/L6US-C5X3>]. While the rate for white parents is still above the rate in comparable countries—12.7 per 100,000 live births—Black and American Indian/Alaska Native parents are three and two times more likely, respectively, to lose their lives. *Id.* These disparities persist even in states with lower-than-average mortality rates, such as California. *Id.* Discussion of racial disparities is unfortunately outside the scope of this paper, as is the focus on inequality in access to care between states and how that can be rectified. However, while greater access to care may lead to better outcomes among people of color due to the fact that they may gain health insurance, this proposal cannot be construed as a solution to the disparities between racial groups in maternal health outcomes. There are systemic issues at play that this proposal alone cannot address and that discussion of which is better suited for its own paper.

29. Declercq & Zephyrin, *supra* note 10.

30. Artiga et al., *supra* note 28.

31. *Id.*

32. Ranji et al., *supra* note 1.

of the Social Security Act by President Lyndon B. Johnson.³³ Medicaid's original goals were modest, acting as a joint federal-state program meant to bring health care to certain low-income and disabled individuals and families.³⁴ At first, eligibility was closely tied to the receipt of cash payments under certain federal assistance programs.³⁵ These programs targeted only the aged, blind, and disabled, along with some families with dependent children.³⁶ Far from being a comprehensive program, states often set very low-income eligibility levels.³⁷

This framework mostly remained in place until the mid- to late-1980s, when concerns about infant mortality and children's health prompted Congress to begin expanding Medicaid eligibility groups.³⁸ Despite being almost entirely contained to providing coverage to pregnant people and children, the amendments began a slow, yet steady, movement that ultimately culminated in the ACA's attempt to turn Medicaid into a health insurance program for all low-income Americans. Mostly done through budget reconciliation acts, the first major expansion to the Medicaid program came in 1984, when Congress required states to cover pregnant people for the first time but still tied eligibility to the receipt of federal cash assistance.³⁹ With the 1985 budget reconciliation process, Congress adopted two broader Medicaid expansions targeted at pregnant people. The first required states to cover pregnant people who meet state Aid to Families with Dependent Children ("AFDC") income eligibility levels, regardless of employment or

33. *A Timeline of Medicaid Coverage and Change*, DECO (Aug. 18, 2021), <https://www.decorm.com/a-timeline-of-medicaid-coverage-and-change> [https://perma.cc/4XVY-S8RH].

34. *Id.*

35. *Eligibility*, MEDICAID & CHIP PAYMENT AND ACCESS COMM'N, <https://www.macpac.gov/medicaid-101/eligibility> [https://perma.cc/VG85-GMXX].

36. *Id.*

37. *Id.*

38. Cindy Mann & Deborah Bachrach, *Medicaid as Health Insurer: Evolution and Implications*, COMMONWEALTH FUND (July 23, 2015), <https://www.commonwealthfund.org/blog/2015/medicaid-health-insurer-evolution-and-implications> [https://perma.cc/TVJ2-ZQ5V].

39. *Legislative Milestones in Medicaid and CHIP Coverage of Pregnant Women*, MEDICAID & CHIP PAYMENT ACCESS COMM'N [hereinafter *Legislative Milestones*], <https://www.macpac.gov/legislative-milestones-in-medicaid-and-chip-coverage-of-pregnant-women> [https://perma.cc/V35A-EKNV]; Deficit Reduction Act of 1984, Pub. L. No. 98-369, 98 Stat. 1104 (codified as 42 U.S.C. § 1396).

marital status, and the second mandated sixty days of postpartum coverage.⁴⁰

In 1986, Congress expanded potential eligibility again, giving states the option to cover all pregnant individuals with incomes at or below 100% FPL, regardless of AFDC status or eligibility.⁴¹ The bill also gave states the option to provide continuous coverage to pregnant individuals throughout their pregnancies and for sixty days postpartum, regardless of any changes in income or assets.⁴² Congress enacted another reform the next year, giving states the option to expand Medicaid coverage to pregnant individuals and infants up to 185% FPL.⁴³ Continuing the trend, Congress first mandated Medicaid coverage for pregnant individuals in families with income up to 100% FPL in 1988, before raising the threshold to 133% FPL in 1989, where the minimum requirement has remained since.⁴⁴ The last major pre-Affordable Care Act expansion came in 1990 when Congress required states to provide continuous coverage for all eligible pregnant individuals throughout pregnancy and for the sixty-day postpartum period, regardless of changes in income or assets.⁴⁵

2. The Enactment and Subsequent Battle over the Affordable Care Act

Medicaid expansion in regard to pregnant individuals remained largely stagnant from 1990 until the passage of the Affordable Care Act in 2010. Initially envisioned as an overhaul of the healthcare system meant to bring about universal health care for the first time in the United States, the ACA set out to mandate

40. *Legislative Milestones*, *supra* note 39; Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, 100 Stat. 201 (codified as § 1396(a)(e), 1396(a)(10)).

41. *Legislative Milestones*, *supra* note 39; Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, 100 Stat. 2050 (codified as § 1396(a)(10)(A)(ii)).

42. *Legislative Milestones*, *supra* note 39.

43. *Id.*; Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, 100 Stat. 1330 (codified as § 1396a(l)).

44. *Legislative Milestones*, *supra* note 39; Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, 100 Stat. 751 (codified as § 1396a(l)); Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2258 (codified as § 1396a). Due to the way FPL is calculated, 133% FPL actually works out to be 138% FPL. *See Medicaid Expansion & What it Means for You*, MEDICAID & CHIP, <https://www.health care.gov/medicaid-chip/medicaid-expansion-and-you> [<https://perma.cc/E76Z-ULUY>]. For the remainder of this Comment, all FPL percentages should be construed as including this 5% bonus.

45. *Legislative Milestones*, *supra* note 39; Omnibus Reconciliation Act of 1990, Pub. L. 101-508, 104 Stat. 1388-207-08 (codified as § 1396b(i)).

sweeping changes to the Medicaid program.⁴⁶ The most impactful of these changes was the expansion of Medicaid eligibility to all adults with incomes up to 138% FPL.⁴⁷ To offset the financial burden of greatly expanding eligibility for the program, the ACA provided that 100% of expansion costs would initially be covered by the federal government, with a stepwise decrease in federal cost-sharing to 90% in 2020.⁴⁸ In order to induce states to adopt this expansion framework, the ACA also empowered the Department of Health and Human Services to withhold all Medicaid funding from noncompliant states.⁴⁹ While not specifically targeting pregnant individuals, the expansion was aimed at low-income Americans, meaning many individuals who were pregnant or would become pregnant could enroll in traditional Medicaid instead of gaining eligibility through a pregnancy pathway.

Despite its admirable intentions, the ACA was immediately challenged in court. The ensuing battle was contentious, and the Supreme Court of the United States ultimately sounded the death knell on the goal of achieving universal health insurance coverage with its 2012 decision in *National Federation of Independent Business v. Sebelius*.⁵⁰ While opponents of the ACA failed in their goal to entirely eradicate the law, the Supreme Court ruled that the Medicaid expansion mandate was unconstitutional.⁵¹ The Government argued that it had the authority to enact this expansion because the Supreme Court had previously ruled that Congress has the power to condition the grant of federal funds upon the States taking certain actions that Congress itself could not require them to take.⁵² Unfortunately, the Court decided that the law did not simply incentivize states to adopt Medicaid expansion, but it

46. Christine Eibner, *The Affordable Care Act in Depth*, RAND CORP., <https://www.rand.org/health-care/key-topics/health-policy/aca/in-depth.html> [https://perma.cc/AF6K-Z3XA].

47. *Overview of the Affordable Care Act and Medicaid*, MEDICAID & CHIP PAYMENT & ACCESS COMM'N, <https://www.macpac.gov/subtopic/overview-of-the-affordable-care-act-and-medicare> [https://perma.cc/9NEK-R9V3] (July 6, 2020).

48. Charles Blahous, *The Affordable Care Act's Optional Medicaid Expansion: Considerations Facing State Governments*, MERCATUS CTR. (Mar. 5, 2013), <https://www.mercatus.org/publications/government-spending/affordable-care-acts-optional-medicare-expansion-considerations> [https://perma.cc/W83K-XU9E].

49. *Id.*

50. 567 U.S. 519 (2012).

51. *See id.* at 585.

52. *See id.* at 576.

instead amounted to unlawful coercion: a “gun to the head” in the Court’s own words.⁵³

While the Court recognized that Congress has “[t]he right to alter, amend, or repeal any provision” of the Medicaid Act,⁵⁴ it ultimately concluded that the proposed changes to the Medicaid program were not simply an alteration or amendment to the program, but instead effectively created a new Medicaid.⁵⁵ This, the court noted, was beyond the scope of Congress’s powers of change.⁵⁶ Nevertheless, the Court did not end all hope for Medicaid expansion, instead ruling that Congress may make the expansion optional for states to adopt of their own volition.⁵⁷

3. The Current Landscape of Medicaid Expansion and the Persisting Coverage Gap

In the years since the *Sebelius* decision, the majority of states have opted to expand their Medicaid programs. Thirty-one (including Washington, D.C.) expanded Medicaid under the ACA, while eight expanded it through a § 1115 waiver.⁵⁸ However, twelve states have failed to implement any type of Medicaid expansion, leaving many residents uninsured.⁵⁹ Because the ACA was originally drafted with the expectation that every state would implement the new Medicaid framework, the law as it stands following the *Sebelius* decision leaves individuals in states that did not expand unprotected.

In addition to Medicaid expansion, the ACA also set up a Health Insurance Marketplace where uninsured individuals could

53. *Id.* at 581.

54. *Id.* at 583; 42 U.S.C. § 1304.

55. *Sebelius*, 567 U.S. at 583–84.

56. *Id.* at 584.

57. *Id.* at 587.

58. *Where States Stand on Medicaid Expansion*, NAT’L ACAD. FOR ST. HEALTH POL’Y (Sept. 3, 2021), <https://www.nashp.org/states-stand-medicaid-expansion-decisions> [https://perma.cc/RASH-TNAJ]. Section 1115 waivers refer to applications made under § 1115 of the Social Security Act. *See* § 1115. These waivers give the Secretary of HHS the authority to approve state experimental, pilot, or demonstration projects that assist in promoting the objectives of Medicaid. *See About Section 1115 Demonstrations*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html> [https://perma.cc/R5W9-57KH].

59. *Where States Stand on Medicaid Expansion*, *supra* note 58. The states that have not expanded include Wyoming, South Dakota, Wisconsin, Kansas, Texas, Mississippi, Tennessee, North Carolina, Alabama, Georgia, South Carolina, and Florida. *See id.*

purchase private plans at affordable prices, aided by tax credits.⁶⁰ However, the tax credits were only made available to individuals with incomes between 100% and 400% FPL, with the expectation that Medicaid would simply cover all individuals with incomes below 138% FPL.⁶¹ Any adult whose income fell between the nonexpansion states' Medicaid eligibility threshold (on average about 41% FPL) and 100% FPL, who did not receive coverage from some other avenue, was thus left without any meaningful path towards coverage, thereby falling into the "coverage gap."⁶²

While all pregnant individuals with incomes up to 138% FPL must be covered under Medicaid until sixty days postpartum, many of these individuals are at risk of falling into the coverage gap when that time period is up. In fact, the Congressional Budget Office estimates that about 45% of postpartum individuals become uninsured when the sixty days of coverage expire.⁶³ When an individual loses their postpartum coverage after sixty days in nonexpansion states, they must requalify for Medicaid as a parent if they wish to stay in the program.⁶⁴ Unfortunately, the thresholds to qualify for coverage as a parent in these states are extremely low—ranging from just 17% FPL in Texas to 93% FPL in Tennessee—which often leaves new parents above state eligibility levels, but below 100% FPL vulnerable to becoming uninsured.⁶⁵

Overall, the ACA has resulted in a reduction in the uninsurance rates of postpartum individuals.⁶⁶ However, similar to maternal mortality rates, uninsurance rates differ depending on the state. While the uninsurance rate in expansion states fell by 56% from 2013 to 2016, postpartum individuals in nonexpansion states only

60. Rachel Garfield, Kendal Orgera & Anthony Damico, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*, KFF (Jan. 21, 2021), <https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicare> [<https://perma.cc/5FCF-BVPP>].

61. *Id.*

62. *Id.* It is estimated that more than two million poor, uninsured adults fall into this coverage gap, though 77% are adults without dependent children. All of these individuals would be eligible for Medicaid had their state chosen to expand Medicaid. *See id.*

63. CONG. BUDGET OFF., COST ESTIMATE: RECONCILIATION RECOMMENDATIONS OF THE HOUSE COMMITTEE ON ENERGY AND COMMERCE 6 (2021).

64. Ranji et al., *supra* note 1, at 3.

65. *Medicaid Income Eligibility Limits for Adults as a Percent of the Federal Poverty Level*, KFF (Jan. 1, 2021), <https://www.kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level/?currentT> <https://perma.cc/VZ8R-PY9V> [https://perma.cc/VZ8R-PY9V].

66. *See* McMorrow & Kenney, *supra* note 9.

experienced a 29% decline in the uninsurance rate.⁶⁷ In fact, postpartum individuals in nonexpansion states are three times more likely to be uninsured three to six months after childbirth than individuals in expansion states.⁶⁸ As of 2016, three states still had uninsurance rates for postpartum individuals of more than 20%.⁶⁹ In contrast, the highest rate of uninsurance among expansion states was in Arkansas, which had an uninsurance rate of 12.8—though this number was down from 29.3 in 2012–2013.⁷⁰ As such, while state uninsurance rates are improving, there is still a long way to go.

4. Other Issues Preventing Coverage

States refusing to expand Medicaid is not the only barrier to care for individuals who lose their coverage after sixty days. For instance, in many states, the threshold to qualify for Medicaid coverage while pregnant is higher than the federally mandated 138% FPL, with a median eligibility threshold of 195% FPL.⁷¹ As such, many individuals, even in expansion states, will lose Medicaid coverage at the end of the sixty-day postpartum period and will be unable to secure Medicaid eligibility through another pathway. While many of these individuals have theoretical access to care through the ACA Marketplace with the assistance of tax credits, others will still be vulnerable to losing their coverage.⁷² This is because out-of-pocket costs for Marketplace plans are typically higher than Medicaid, which causes some people to simply forgo care even if that care is necessary.⁷³

Furthermore, transitioning from Medicaid to an exchange plan can have additional consequences that may affect the health of postpartum individuals. First, benefits may differ between Medicaid and exchange plans, which can interrupt continuity of care.⁷⁴ Additionally, being forced to switch to a new plan means that new

67. McMorrow & Kenney, *supra* note 9.

68. Hannah Katch, *State and Federal Policymakers Should Extend Postpartum Medicaid Coverage*, CTR. ON BUDGET & POL'Y PRIORITIES: OFF THE CHARTS (Aug. 27, 2020, 4:45 PM), <https://www.cbpp.org/blog/state-and-federal-policymakers-should-extend-postpartum-medicaid-coverage> [<https://perma.cc/QN75-9ZGF>].

69. McMorrow & Kenney, *supra* note 9.

70. *Id.*

71. MEDICAID & CHIP PAYMENT & ACCESS COMM'N, CHAPTER 2: ADVANCING MATERNAL AND INFANT HEALTH BY EXTENDING THE POSTPARTUM COVERAGE PERIOD 26–27 (2021).

72. *See id.* at 31.

73. *Id.*

74. *Id.*

parents will have to navigate the Health Insurance Marketplace to find coverage during an extremely stressful and busy time in their lives.⁷⁵ Data suggests that these parents are not always successful in this endeavor—about 43,000 uninsured new parents nationwide could likely have qualified for subsidized exchange coverage in 2017.⁷⁶ There are a number of possibilities as to why these parents remain uninsured; they could have been unaware such coverage was available, struggled with the enrollment process, or were simply unable to afford the premiums.⁷⁷ These issues can disrupt or prevent needed care for postpartum individuals and threaten their health.

5. Current Efforts to Expand Medicaid Coverage

There has been little successful federal action to address uninsurance among postpartum individuals in the years following the ACA. However, the fight for better coverage for postpartum individuals is again beginning to pick up steam, with a few notable, but small, victories. At the state level, twelve states have passed legislation to extend coverage beyond the federally mandated sixty-day period.⁷⁸ However, the majority of these states have not yet implemented the extension and are awaiting approval from the Centers for Medicare and Medicaid Services (“CMS”) in order to receive federal matching funds.⁷⁹

Currently, Illinois is the only state that has received approval from CMS to receive federal matching funds for expansion.⁸⁰ Illinois’s plan will ensure that postpartum individuals receive both continuity of care and the same benefits they received during the initial postpartum period, but not every state has elected to be so generous.⁸¹ A number of the states seeking CMS approval on their plans are instead choosing to be more selective with their coverage,

75. *Id.*

76. *Id.*

77. *Id.*

78. *Id.* at 37.

79. *Id.*

80. Maggie Clark, *HHS Secretary Becerra Approves Illinois Waiver Request to Extend Postpartum Medicaid Coverage*, GEO. UNIV. HEALTH POL’Y INST. CTR. FOR CHILD. & FAMS. (Apr. 12, 2021), <https://ccf.georgetown.edu/2021/04/12/hhs-secretary-becerra-approves-illinois-waiver-request-to-extend-postpartum-medicareid-coverage> [<https://perma.cc/K89Q-D3GV>].

81. MEDICAID & CHIP PAYMENT & ACCESS COMM’N, *supra* note 71, at 37.

with many only proposing to cover new parents with substance use disorder or other mental health concerns.⁸²

The federal government has also recently been making efforts to address the maternal health crisis in the United States. A number of federal bills mandating or providing a state option for a full year of postpartum Medicaid coverage have been introduced in Congress, though only one—which provided an option as opposed to a mandate—has passed a chamber.⁸³ However, while the targeted maternal health bills have largely failed thus far, the American Rescue Plan—the COVID-19 response bill signed into law by President Joe Biden—provides states the option to extend postpartum Medicaid coverage from sixty days to one year following pregnancy.⁸⁴ “The option will be available to states for seven years,” starting in 2022.⁸⁵

II. USING MEDICAID EXPANSION TO IMPROVE MATERNAL HEALTH OUTCOMES

A. *Proposal for a Pregnancy and Postpartum Medicaid Expansion*

Despite the small victories achieved by states and the American Rescue Plan, these efforts are simply not enough to address the maternal health crisis in the United States. While the American Rescue Plan in particular is a nice step towards addressing this crisis, a federal mandate of one year of postpartum Medicaid coverage for all individuals up to 200% FPL is necessary to begin to address the issue meaningfully. The Medicaid and CHIP Payment and Access Commission (“MACPAC”) has voted to recommend this action be taken, and its recommendations should be adopted with a few key additions.⁸⁶ MACPAC’s recommendations are as follows:

82. *Id.* at 37–38.

83. *Analysis of Federal Bills to Strengthen Maternal Health Care*, KFF (Dec. 21, 2020), <https://www.kff.org/womens-health-policy/fact-sheet/analysis-of-federal-bills-to-strengthen-maternal-health-care> [<https://perma.cc/5GMG-QM86>].

84. Edwin Park, *House-Passed American Rescue Plan Act Would Spur Medicaid Expansion and Promote Maternal Health*, GEO. UNIV. HEALTH POL’Y INST. CTR. FOR CHILD. & FAMS. (Mar. 1, 2021), <https://ccf.georgetown.edu/2021/03/01/house-passed-american-rescue-plan-act-would-spur-medicaid-expansion-and-promote-maternal-health> [<https://perma.cc/Z5CL-7G5G>].

85. *Id.*

86. See MEDICAID & CHIP PAYMENT & ACCESS COMM’N, *supra* note 71, at 25. The Children’s Health Insurance Program (“CHIP”) “provides low-cost health coverage to children in families that earn too much money to qualify for Medicaid.” *The Children’s Health*

First, “Congress should extend the postpartum coverage period for individuals who were eligible and enrolled in Medicaid while pregnant to a full year of coverage, regardless of changes in income. Services provided to individuals during the extended postpartum coverage period will receive an enhanced 100 percent federal matching rate.”⁸⁷ Further, “Congress should require states to provide full Medicaid benefits to individuals enrolled in all pregnancy-related pathways.”⁸⁸

In addition to the above recommendations from MACPAC, Congress should adopt the following measures as well. Instead of simply having eligibility be based on state income eligibility criteria, as proposed by MACPAC, Congress should raise the eligibility floor from 138% FPL to 200% FPL for all pregnant and postpartum individuals. This would set the income eligibility floor near the national average, which, as of October 2020, sat at 195% FPL.⁸⁹ While coverage would be mandated at the 200% FPL threshold, states above this line would be free to keep their current threshold. Further, to provide additional incentive to cover as many pregnant and postpartum individuals as possible, Congress should give states the option to expand Medicaid coverage for pregnant and postpartum individuals up to 400% FPL with the same 100% federal matching rates for the newly covered populations. This combination of mandates, options, and 100% federal funding will allow states some flexibility and choice while also ensuring that the most vulnerable postpartum individuals are covered throughout the first year following their pregnancies.

There are a few key reasons why this mandate is the best option, and the rest of this Comment will discuss them in detail. First will be a discussion on how experts agree that increased access to care improves maternal health outcomes and that losing coverage after sixty days threatens maternal health. Second, this Comment will detail how the ACA has shown that expansion states are doing better at improving maternal health outcomes than nonexpansion states and how that proves the need for this mandate. Third, I will articulate how an optional expansion is simply an inefficient solution to this issue based on the precedent of the ACA, before arguing that states are less likely to challenge a relatively targeted

Insurance Program (CHIP), HEALTHCARE.GOV, <https://www.healthcare.gov/medicaid-chip/chil-drens-health-insurance-program> [https://perma.cc/4HPK-8DV2].

87. *Id.*

88. *Id.*

89. *Id.* at 27.

expansion funded completely by the federal government. Fourth, I will briefly discuss how past and current efforts in the realm of maternal health coverage are simply inadequate, and the federal government must go further to properly address the maternal health crisis. Finally, I will outline the legality of this mandate under the precedent set by *National Federation of Independent Business v. Sebelius*, and I will end with a description and rebuke of possible opposition.

B. Access to Care Is Necessary in the Extended Postpartum Period

This mandate is a necessary first step towards addressing the maternal health crisis in the United States. Given the current landscape of maternal health in this country,⁹⁰ Congress must act to protect the health of postpartum individuals from 61 to 365 days postpartum. The risk of maternal mortality and morbidity does not end when new parents leave the hospital, and the current sixty-day cutoff for postpartum Medicaid coverage is inconsistent with the medical and socioeconomic needs of postpartum individuals.⁹¹ Policy and maternal health experts agree that expanding Medicaid coverage to a full year postpartum is a key policy to adopt in the fight towards achieving better maternal health outcomes. Over 275 national and state-based organizations endorse this proposal, including medical societies such as the American College of Obstetricians and Gynecologists.⁹² The proposal is also a leading recommendation among state departments of health and maternal mortality review committees.⁹³

In its 2021 report to Congress on Medicaid and CHIP, MACPAC explained a number of the effects expanding postpartum Medicaid coverage may have on maternal health.⁹⁴ The first is that this mandate will increase health equity by ensuring access to coverage, leading to better maternal health outcomes for postpartum

90. See *supra* section II.A.

91. Gray Babbs, Lois McCloskey & Sarah H. Gordon, *Expanding Postpartum Medicaid Benefits to Combat Maternal Mortality and Morbidity*, HEALTH AFFS. (Jan. 14, 2021), <https://www.healthaffairs.org/doi/10.1377/hblog20210111.655056/full> [<https://perma.cc/B6BE-U8AL>].

92. *Extend Postpartum Medicaid Coverage*, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, <https://www.acog.org/advocacy/policy-priorities/extend-postpartum-medicare-coverage> [<https://perma.cc/47GC-HKPU>].

93. *Id.*

94. MEDICAID & CHIP PAYMENT & ACCESS COMM'N, *supra* note 71, at 34.

parents.⁹⁵ Losing insurance coverage contributes to poor maternal health outcomes, and uninsurance still persists despite progress under the ACA, proving a need for further action.⁹⁶ Further, ensuring continuity of care is an essential consideration when discussing maternal health. Postpartum individuals who experienced a gap in coverage reported negative effects on quality of care and their health, and uninsured postpartum individuals report even further issues with access to care.⁹⁷ In fact, one in five postpartum individuals reported at least one unmet medical need due to cost, highlighting the need for continued Medicaid coverage, which has little to no cost-sharing obligation.⁹⁸

MACPAC emphasizes that ensuring continuity of care can have a lasting effect, leading to more positive outcomes in subsequent pregnancies.⁹⁹ Pregnant individuals often build a trusting relationship with the health care workers who provide them with prenatal and delivery care.¹⁰⁰ The workers who oversaw this care also have a better understanding of the health history of these patients, along with their ongoing care needs.¹⁰¹ Breaking this continuity and forcing postpartum individuals to reestablish doctor-patient relationships can lead to missed care opportunities that result in better health outcomes down the road.¹⁰² Conversely, research in Illinois identified “poor continuity of care and lack of care coordination as factors that contributed to death in [93%] of preventable pregnancy-related deaths during the late postpartum period.”¹⁰³ Research in other states has also found that continuity of care leads to better utilization of outpatient services and reduces risks in subsequent pregnancies.¹⁰⁴ These considerations further illustrate the need for this proposal to ensure positive maternal health outcomes.

95. *Id.* at 40–41.

96. *See id.*

97. *Id.* at 43.

98. *Id.*

99. *Id.* at 43.

100. *Id.*

101. *Id.*

102. *Id.*

103. *Id.*

104. *See id.*

C. Coverage and Outcomes in Expansion vs. Nonexpansion States

The maternal health effects of Medicaid expansion under the ACA are a powerful endorsement of the proposal to expand postpartum Medicaid coverage in all states. Currently, available research shows the importance of widening Medicaid eligibility criteria. While postpartum uninsurance persists in even Medicaid expansion states, research shows that Medicaid expansion is associated with higher rates of postpartum coverage.¹⁰⁵ Though both expansion and nonexpansion states have low uninsurance rates at the time of delivery (2.2% and 4.8% respectively), stark contrast in coverage can be seen in the postpartum period, with nonexpansion states showing an uninsurance rate of 21.5% compared to 7.2% in expansion states.¹⁰⁶ These disparities threaten the health of postpartum individuals and contribute to the ongoing maternal health crisis in the United States. If certain states are unwilling to expand Medicaid so that low-income individuals will be covered before, during, and after pregnancy, then Congress must take action to ensure that Medicaid coverage for pregnancy lasts long enough to neutralize the most serious maternal health risks.

In addition to contributing to lower uninsurance rates, Medicaid expansion has also been linked to a decrease in maternal mortality.¹⁰⁷ An analysis of data from 1999 to 2016 found that Medicaid expansion resulted in a drop of 1.6 deaths per 100,000 live births.¹⁰⁸ While some of this drop may be caused by increased access to care prior to conception, continued access to Medicaid increases continuity of care, which is critical to ensuring positive maternal health outcomes and reducing mortality and morbidity rates.¹⁰⁹ Given the relative recentness of large-scale Medicaid

105. Jamie R. Daw, Katy Backes Kozhimannil & Lindsay K. Admon, *High Rates of Perinatal Insurance Churn Persist After the ACA*, HEALTH AFFS. (Sept. 16, 2019), <https://www.healthaffairs.org/doi/10.1377/hblog20190913.387157/full> [<https://perma.cc/2R5H-JHKG>].

106. *Id.*

107. Laurie Zephyrin, Akeiisa Coleman, Rachel Nuzum & Yaphet Getachew, *Increasing Postpartum Medicaid Coverage Could Reduce Maternal Deaths and Improve Outcomes*, COMMONWEALTH FUND (Nov. 21, 2019), <https://www.commonwealthfund.org/blog/2019/increasing-postpartum-medicaid-coverage> [<https://perma.cc/GNA9-56JD>].

108. ADAM SEARING & DONNA COHEN ROSS, GEO. UNIV. HEALTH POL'Y INST. CTR. FOR CHILD. & FAMS., *MEDICAID EXPANSION FILLS GAPS IN MATERNAL HEALTH COVERAGE LEADING TO HEALTHIER MOTHERS AND BABIES 7* (2019), <https://ccf.georgetown.edu/wp-content/uploads/2019/05/Maternal-Health-3a.pdf> [<https://perma.cc/4UWA-GRX6>].

109. Maggie Clark, *Medicaid Expansion Helped Close Coverage Gaps for Pregnant Women, New Study Finds*, GEO. UNIV. HEALTH POL'Y INST. CTR. FOR CHILD. & FAMS.

expansion in the United States, it is hard to know exactly what effect expanded access will have on long term rates of maternal mortality and morbidity, particularly when comparing expansion with nonexpansion states. Nevertheless, there is no reason to wait around and find out, as maternal health experts are largely in agreement that expanding postpartum Medicaid access is a vital step the government can take in the fight against maternal mortality.¹¹⁰

D. *Optional Expansion Is Not Enough*

The past seven years have shown that simply providing states the option to expand health care coverage is inadequate to address disparities in access to care. Despite the generous incentives provided by the federal government under the ACA, namely the 100% starting federal matching rate, twelve states are still resisting calls to expand Medicaid coverage.¹¹¹ The federal government has recognized that these holdouts are likely to persist, which may be why the American Rescue Plan provides a more targeted option for states.¹¹² However, that provision simply does not go far enough. While it does provide states with a simpler pathway to covering postpartum individuals when compared to the traditional § 1115 waiver option, the benefits are likely too conservative to be attractive to nonexpansion states.

The American Rescue Plan only offers federal matching at the regular matching rate, which may make states less willing to adopt the plan due to cost.¹¹³ Further, though many states have already made strides towards extending Medicaid coverage in the postpartum period, the current economic landscape of the country may threaten these proposals. State fiscal crises and the financial burden caused by the COVID-19 pandemic have already led two states

(Sept. 14, 2020), <https://ccf.georgetown.edu/2020/09/14/medicaid-expansion-helped-close-coverage-gaps-for-pregnant-women-new-study-finds> [<https://perma.cc/372K-TWP4>].

110. See, e.g., Emily Eckert, *It's Past Time to Provide Continuous Medicaid Coverage for One Year Postpartum*, HEALTH AFFS. (Feb. 6, 2020), <https://www.healthaffairs.org/doi/10.1377/hblog20200203.639479/full> [<https://perma.cc/4AV4-XLR8>].

111. *Status of State Medicaid Expansion Decisions: Interactive Map*, KFF (Oct. 8, 2021), <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map> [<https://perma.cc/6WSG-2BEN>].

112. Maggie Clark, *Unpacking the Postpartum Coverage Extension Option in the COVID-19 Relief Bill*, GEO. UNIV. HEALTH POL'Y INST. CTR. FOR CHILD. & FAMS. (Feb. 22, 2021), <https://ccf.georgetown.edu/2021/02/22/unpacking-postpartum-coverage-extension-option-covid-relief-bill> [<https://perma.cc/P77V-XHU4>].

113. See *id.*

to reverse or consider reversing their plans.¹¹⁴ Given these financial considerations, states should not be forced to carry the financial burden of increased postpartum Medicaid coverage when the federal government has the power to fully fund it. Ensuring postpartum care is too important to be left on the cutting room floor due to insufficient state funds.

Furthermore, the incentive behind this proposal is to begin a process towards achieving equity of care among all pregnant and postpartum Americans as a way to improve maternal health outcomes. Allowing states to choose for themselves whether they implement this needed policy runs the risk of further exacerbating existing disparities in access to care. MACPAC agrees; while the commission originally wavered between recommending a mandate or an option, it ultimately determined that a mandatory expansion is necessary to address coverage gaps and improve outcomes.¹¹⁵ MACPAC argues that “[r]equiring states to provide a full year of coverage will ensure that the greatest number of postpartum individuals are reached,” a necessary step toward achieving “some level of equity across states.”¹¹⁶ A nationwide problem requires a nationwide solution, and this proposal offers one.

E. Federal Incentives Will Reduce Resistance

Though the attempt to mandate comprehensive Medicaid expansion under the ACA prompted backlash from many states, this narrow and targeted expansion is less likely to result in the same fervor. It is true that the ACA also initially provided for 100% federal matching funds for full-scope Medicaid expansion, but this proposal would not reduce those funds after a number of years. This proposal ensures that no state will have to bear the financial burden of expansion. As a result, states need not fear that the current budget challenges they are facing will be exacerbated by expanding coverage for ten additional months.

Other potential state concerns with Medicaid expansion under the ACA are also absent in this proposal. The Supreme Court concluded that Medicaid expansion under the ACA was not simply an alteration of the existing Medicaid program, but that it was

114. Katch, *supra* note 68.

115. MEDICAID & CHIP PAYMENT & ACCESS COMM’N, *supra* note 71, at 45–46.

116. *Id.* at 46.

essentially tasking states with the creation of a brand-new program.¹¹⁷ This drastic change, combined with the fear of the financial burden and ideological opposition, likely contributed to some states refusing to expand Medicaid.¹¹⁸ However, these concerns have no place here. This proposal does not require every state to drastically overhaul its Medicaid system. While this plan does increase the federal eligibility threshold from 138% FPL to 200% FPL, the national average for eligibility for pregnancy-related Medicaid coverage is already at 195% FPL.¹¹⁹ This means that states will not have to significantly adjust their programs to accommodate an influx of new enrollees. In fact, many states will not have to adjust their programs at all. Furthermore, while an additional ten months of coverage may seem daunting on paper, there is no drastic change needed to state Medicaid infrastructure under this proposal. The vast majority of eligible individuals are already able to enroll in the Medicaid programs of their state under current law; this expansion simply allows them to stay in the program for a longer period of time. As a result, this proposal effectively combines two important considerations: increasing access to postpartum health care and ensuring that state systems are not overburdened.

F. *Past and Current Efforts Are Insufficient*

Despite coverage gains under the ACA, more must be done to prevent uninsurance during the postpartum period. While postpartum individuals in expansion states were more likely to be insured than those in nonexpansion states, uninsurance remained nonetheless.¹²⁰ Furthermore, even in expansion states, postpartum individuals with incomes above 138% FPL would need to transition out of Medicaid and into some other health insurance plan, likely an ACA Marketplace plan.¹²¹ Unfortunately, this transition is not always easy, and it does not always come to fruition. Researchers estimate that about 43,000 uninsured postpartum individuals

117. Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 583–84 (2012).

118. See Karen Brooks Harper, *Medicaid Expansion for Uninsured Texans Had Bipartisan Support, But Lawmakers Won't Pass It This Session*, TEX. TRIB. (May 7, 2021), <https://www.texastribune.org/2021/05/07/texas-medicaid-expansion-legislature> [https://perma.cc/23LV-GGP2]; Kimberly Leonard, *Opposing Medicaid Expansion*, U.S. NEWS (Dec. 4, 2015), <https://www.usnews.com/news/the-report/articles/2015/12/04/opposing-medicaid-expansion> [https://perma.cc/534E-486A].

119. MEDICAID & CHIP PAYMENT & ACCESS COMM'N, *supra* note 71, at 26–27.

120. McMorrow & Kenney, *supra* note 9.

121. MEDICAID & CHIP PAYMENT & ACCESS COMM'N, *supra* note 71, at 30–31.

nationwide had incomes between 138% and 200% FPL in 2017 and could have qualified for subsidies to purchase an ACA Marketplace plan.¹²² However, there are numerous barriers to this care; some individuals are unaware this option exists, others struggle with the enrollment process, and perhaps most importantly, some simply struggle to afford the premiums.¹²³

By contrast, this proposal would eliminate many of those barriers. Because the plan would cover all postpartum individuals up to 200% FPL, many new parents would simply get to keep their existing Medicaid coverage. This means new parents could keep their same providers, ensuring the benefits of continuity of care. Further, data shows that postpartum individuals who remain eligible for Medicaid at the end of the sixty-day period generally face little to no changes in out-of-pocket costs, which promotes access to care.¹²⁴ This proposal allows this benefit to be enjoyed by all postpartum individuals with incomes at or below 200% FPL, increasing the opportunity for consistent enrollment throughout the first postpartum year.

Furthermore, current state efforts simply do not go far enough towards ensuring access to care in the postpartum period. While twelve states have extended or passed legislation to extend Medicaid coverage beyond the traditional sixty-day period, a number of these states have proposed limitations on who is eligible for that care and what the care entails.¹²⁵ These limitations include restricting it to individuals suffering from substance use disorder or other mental health conditions and only providing family planning and targeted postpartum care.¹²⁶ This piecemeal approach to postpartum care is simply inadequate to address the maternal health crisis in the United States. While many postpartum deaths are the result of mental health conditions, these proposals cannot account for the needs of individuals suffering from other potentially deadly conditions, such as cardiomyopathy.¹²⁷ Given state budget constraints, it is unsurprising states are choosing to target care to a smaller group of postpartum individuals, but this highlights the necessity of a fully funded and comprehensive federal mandate.

122. *Id.* at 31.

123. *Id.*

124. *Id.* at 30.

125. *Id.* at 37–38.

126. *Id.*

127. *Id.* at 35.

G. *Issues of Legality in the Face of NFIB v. Sebelius*

Given the Supreme Court's decision in the *National Federation of Independent Business v. Sebelius* case, some may worry that the proposal outlined in this paper would be unconstitutional. After all, this too is a mandated Medicaid expansion aiming to increase coverage of low-income individuals. However, the similarities stop there, and nothing in the *Sebelius* decision prevents Congress from implementing this proposal.¹²⁸

The Court's main issue with the Medicaid expansion mandate of the ACA was not that Congress lacked the power to alter or amend eligibility under the Social Security Act.¹²⁹ The Court's issue was that the ACA's proposed mandate was not simply an alteration or amendment, but instead it effectively created a new Medicaid program.¹³⁰ The Court summarily stated that Medicaid was designed to cover certain categories of needy Americans: the disabled, the blind, the elderly, and needy families with dependent children.¹³¹ The Court stated that the earlier amendments were perfectly permissible because they simply expanded the boundaries of existing eligibility categories.¹³² By contrast, the Court concluded that the ACA instead aimed to transform Medicaid into "a comprehensive national plan to provide universal health insurance coverage."¹³³ This, the Court decided, was not a change that fell within the scope of altering or amending the Social Security Act.¹³⁴

This proposal faces none of those same shortfalls and comfortably fits within the bounds that the Court articulated as permissible. In his plurality opinion, Chief Justice John Roberts explicitly mentions prior Medicaid expansions requiring coverage of pregnant individuals when responding to Justice Ruth Bader Ginsburg's dissent.¹³⁵ In refuting Justice Ginsburg's conclusions that the ACA expansion was comparable to the pregnancy-related expansions of the 1980s, Justice Roberts states that those amendments "can hardly be described as a major change in a program

128. See generally *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519 (2012).

129. *Id.* at 583.

130. *Id.*

131. *Id.*

132. *Id.*

133. *Id.*

134. *Id.* at 584.

135. *Id.* at 584–85.

that—from its inception—provided health care for ‘families with dependent children.’”¹³⁶

While the Court explicitly refused to draw a line as to what a permissible expansion amendment would entail, this proposal stays clearly within the purview of the Social Security Act and the *Sebelius* opinion. Given that states already cover pregnant and postpartum individuals, with an average national eligibility threshold of 195% FPL, the majority of people who would be eligible for extended coverage under this proposal are already within current Medicaid eligibility categories.¹³⁷ This proposal, to use Justice Roberts’s own words, is merely a shift in degree, not kind.¹³⁸ Rather than creating a new Medicaid system, such as the one proposed by the ACA, this proposal simply expands the boundaries of an existing Medicaid eligibility category.¹³⁹

Furthermore, this proposal cannot be seen as the federal government unconstitutionally coercing the states into taking drastic actions, another concern articulated by the *Sebelius* Court.¹⁴⁰ Under this proposal, states do not stand to lose all their Medicaid funding should they choose not to adopt the expansion.¹⁴¹ Instead, the language of the Social Security Act will simply be amended to require extended eligibility. Further, the cost of the extra ten months of coverage will be entirely covered by the federal government with a 100% federal matching rate. Far from the “gun to the head” the Court determined ACA expansion to entail,¹⁴² this proposal is a simple shift in degree of existing Medicaid infrastructure, with a relatively small burden placed on the states. In fact, this is an even less burdensome amendment than the original 1980s amendments requiring states to begin covering pregnant individuals. Here, the existing infrastructure already exists, many of the individuals are already enrolled, and there will be no extra cost to the states. This proposal is exactly the kind of alteration or amendment envisioned by the Social Security Act and cosigned by the Supreme Court.

136. *Id.*

137. MEDICAID & CHIP PAYMENT & ACCESS COMM’N, *supra* note 71, at 27.

138. *Sebelius*, 567 U.S. at 583.

139. *Id.*

140. *Id.* at 581.

141. *Id.*

142. *Id.*

H. *Potential Opposition Is Misguided*

In the government, there is rarely such a thing as a universally popular proposal, and this would likely be no different. The government did recently take its first step towards ensuring one year of postpartum coverage with the American Rescue Plan.¹⁴³ However, the bill passed both chambers of Congress without a single Republican vote.¹⁴⁴ Given that this was a large COVID-19 relief bill, not a bill specifically targeting maternal health, these votes are not necessarily indicative of Republican opposition to the policy in general. However, congressional Republicans have continually advocated for cuts in Medicaid spending,¹⁴⁵ and this proposal would necessarily require an increase in the Medicaid budget due to the enhanced matching rate. Further, while some have cosponsored bills to provide a similar state *option* to expand Medicaid coverage to one year post birth, not a single congressional Republican cosponsored any of the bills introduced during the 116th Congress that proposed *mandating* such an expansion.¹⁴⁶

Instead, Republican proposals to address the maternal health crisis include increasing data collection on maternal deaths and implementing a national standard of best medical practices.¹⁴⁷ As opposed to simply expanding care to ensure that postpartum women are covered in the year following birth, Republicans are instead focused on “getting a better picture of how many pregnant and postpartum women actually need coverage before exploring how to expand access to care.”¹⁴⁸ However, continuing to study the problem without taking further action is unlikely to lead to marked progress in the fight against maternal mortality and morbidity. Researchers agree that extending Medicaid coverage to cover a full year postpartum is a necessary step towards addressing the health concerns of postpartum individuals.¹⁴⁹ More research into maternal health outcomes can, and should, be done in conjunction with

143. Ranji et al., *supra* note 1.

144. *American Rescue Plan Act of 2021*, BALLOTPEDIA, https://ballotpedia.org/American_Rescue_Plan_Act_of_2021 [https://perma.cc/K27F-69F8].

145. *Id.*

146. *Analysis of Federal Bills to Strengthen Maternal Health Care*, *supra* note 83.

147. Renuka Rayasam & Brianna Ehley, *Efforts to Save New Moms Clash with GOP's Medicaid Cuts*, POLITICO (June 14, 2019), <https://www.politico.com/story/2019/06/14/new-moms-clash-gop-medicaid-cuts-1364564> [https://perma.cc/FN9J-U492].

148. *Id.*

149. *Extend Postpartum Medicaid Coverage*, *supra* note 92.

this proposal. However, research alone is inadequate when immediate action is an available and necessary option.

Further, while the contentious fight over the implementation of the ACA caused health care policy to become a largely partisan issue among lawmakers, the American people generally hold a favorable view of Medicaid.¹⁵⁰ Though there are currently no studies specifically asking Americans about expanding Medicaid access for postpartum individuals, the majority of Americans support both the Medicaid program in general, and Medicaid expansion in particular.¹⁵¹ One poll found that three-fourths of Americans have either a “very favorable” (39%) or “somewhat favorable” (36%) view of Medicaid, while only one-fifth have an unfavorable view.¹⁵² This support for Medicaid was also largely bipartisan, with 85% of Democrats, 76% of Independents, and 65% of Republicans surveyed viewing the program favorably.¹⁵³ Further, the 2019 poll surveyed people in the fourteen states that had not yet expanded Medicaid at the time and found that 61% of individuals living in those states supported Medicaid expansion.¹⁵⁴ Public support for Medicaid, expert opinion on addressing subpar maternal health outcomes, and individual state efforts to address these issues prove that opposition to this type of proposal is misplaced, and currently proposed solutions with a narrower scope are simply inadequate to properly address this country’s maternal health crisis.

CONCLUSION

Maternal mortality is a crisis in the United States. However, the federal government has thus far largely failed to address it. A primary concern in the fight for better maternal health outcomes is access to continued Medicaid coverage in the year following birth. Unfortunately, current federal law mandates that state Medicaid programs cover individuals who had a Medicaid-funded birth for just sixty days postpartum. While the American Rescue Plan provides states the option to expand this coverage to one year postpartum without needing to apply for a waiver, this approach is simply

150. *Data Note: 5 Charts About Public Opinion on Medicaid*, KFF (Feb. 28, 2020), <https://www.kff.org/medicaid/poll-finding/data-note-5-charts-about-public-opinion-on-medicaid> [<https://perma.cc/7EST-VUGV>].

151. *Id.*

152. *Id.*

153. *Id.*

154. *Id.*

not aggressive enough to address the pressing maternal health crisis. Providing states with the option to expand coverage has shown to be ineffective at providing adequate and equitable access to care across the country. Instead, Congress should pass legislation mandating that states cover individuals with incomes at or below 200% FPL—or the higher state eligibility level—for one year postpartum under the full Medicaid benefits package. Further, the federal government should cover the cost of this expansion with an enhanced 100% federal matching rate for the ten additional months of care.

Guaranteeing that all individuals have health insurance during pregnancy and for the year following childbirth is a necessary stride towards addressing maternal mortality and poor health outcomes for postpartum individuals in the United States. Medicaid expansion under the ACA has already been proven to improve maternal health outcomes and reduce maternal mortality, and further expanding Medicaid expansion will only continue this progress.¹⁵⁵ As maternal mortality rates continue to stay at alarming levels in the United States, Congress can no longer ignore the pressing need for change.

This proposal alone cannot solve the problem of maternal mortality and morbidity. There are numerous other social, political, and medical factors that have led to the current landscape of maternal health in the United States. These factors will need to be addressed holistically to truly combat the maternal health crisis and catch the United States up with other industrialized countries. Nevertheless, while expanding Medicaid access may only be the first step in tackling this crisis, it is a significant stride forward that the federal government should take immediately.

*Madison P. Harrell **

155. Erica L. Eliason, *Adoption of Medicaid Expansion Is Associated with Lower Maternal Mortality*, 30 WOMEN'S HEALTH ISSUES 147, 151 (2020).

* J.D. Candidate, 2022, University of Richmond School of Law; B.A., 2019, University of Kansas. I would like to thank Professor Rachel Suddarth for her support and guidance in writing this Comment.