**Title:** Beyond 60 Days: The Effect of Postpartum Medicaid Eligibility on Continuity of Insurance Enrollment

**Abstract**

The 2021 American Rescue Act included a new option for states to extend postpartum Medicaid eligibility from 60 days to up to one year after the end of pregnancy. Using linked all payer claims, income, and birth record data from Colorado from 2014-2019, we evaluated the effect of postpartum Medicaid eligibility on continuity of insurance coverage in the postpartum year using a regression discontinuity design. We found that maintaining eligibility for Medicaid after childbirth improved stability of insurance enrollment in the postpartum year. Postpartum Medicaid eligibility led to 1.3 additional months of any postpartum insurance enrollment (p < 0.001), a 4 percentage point decrease in the probability of a postpartum disruption in coverage (p<0.001), and gaps in coverage that were 0.6 months shorter (p<0.001). Our findings indicate that postpartum transitions to commercial coverage may not be seamless, and states that extend postpartum Medicaid eligibility will improve continuity of postpartum insurance coverage for Medicaid enrollees.

**Introduction**

The postpartum period is an important target for policy intervention to improve maternal health outcomes. Though the postpartum period is traditionally defined as the first six weeks following childbirth, one-third of maternal mortality occurs up to one year postpartum. Postpartum complications of pregnancy include conditions related to postpartum depression, hypertensive disorders, and cardiovascular conditions, and rates of severe postpartum morbidity are rising.1,2 Access to health services in the year after childbirth is critical to address a range of health issues, including physical recovery from birth, family planning, mental health, and chronic conditions that may increase the risk of postpartum complications.3 Medicaid is a federal and state program that provides health insurance to low-income Americans. As the primary payer for 42 percent of all births and a disproportionate number of births to low-income women and women of color, Medicaid plays an important role in promoting access to care after childbirth.4,5 However, pregnancy-related Medicaid eligibility is time-limited, beginning at conception and ending at just 60 days postpartum.6 As a result, nearly 1 in 4 women with a Medicaid paid birth are uninsured two to six months postpartum.7

To maintain Medicaid eligibility beyond 60 days after birth, women must qualify for Medicaid as a parent, low-income adult, or other Medicaid eligibility category in their state. However, in all states, income eligibility limits for low-income parents and adults are lower than income eligibility limits for pregnancy.8 While this gap in eligibility is narrower in states that expanded Medicaid under the Affordable Care Act (ACA), postpartum Medicaid eligibility “cliffs” remain: the median eligibility threshold is 205 percent of the federal poverty level (FPL) for pregnant women and 138 percent FPL for low-income adults/parents.8 Women who are not eligible for Medicaid after 60 days postpartum must obtain commercial insurance through an employer, parent, spouse, or school, or purchase individual health insurance on the ACA Marketplace, for which they are eligible for a special enrollment period spanning 60 days after the birth of their child.

Requiring women to successfully enroll in an affordable insurance plan within a short period after birth may result in lapses in coverage and reduce access to care. Even if women are able to transition to alternative coverage, switching insurance is associated with delays in access, increases in emergency department utilization, lower rates of filled prescriptions, and a lower likelihood of reporting a usual source of care.9–11 Differences in provider networks, benefit design, and cost-sharing and premiums between Medicaid and commercial coverage may further hinder continuity of care among women who switch insurance postpartum.12

To promote continuity of postpartum coverage for Medicaid beneficiaries, Congress (the House of Representatives and the Senate in the U.S.) passed the American Rescue Plan Act on March 11, 2021., The law included a five-year state option for federal matching funds to be used to extend full-benefit Medicaid or Children’s Health Insurance Program (CHIP) coverage for up to one year after the end of pregnancy. Further, nineteen states and Washington D.C. have introduced proposals to extend postpartum Medicaid eligibility beyond 60 days, indicating significant state interest in this policy option.13 To date, Illinois is the only state to have extended benefits for all Medicaid-eligible pregnant women to 12 months postpartum as of April 12, 2021, though other states have implemented limited extensions for targeted populations.14,15

Evidence on the effect of extended postpartum Medicaid eligibility is crucial to help inform state decisions on whether to adopt the extension and how best to design these policies. The objective of this study was to evaluate the effect of postpartum Medicaid eligibility on continuity of insurance coverage in the year after birth. Using a unique linked dataset of all payer claims, income, and birth records from Colorado from 2014-2019, we compared continuity of insurance enrollment in the postpartum year among those with incomes below 138 percent FPL, who retain Medicaid eligibility beyond 60 days postpartum, to those with incomes between 139-265 percent FPL, who lose Medicaid eligibility at 60 days postpartum.

**Methods**

*Study Design* *and Setting*

In Colorado, women with incomes up to 265 percent FPL are eligible for Medicaid or CHIP from conception through 60 days postpartum. After 60 days, only women with incomes at or below 138 percent FPL remain eligible for Medicaid under the state’s Medicaid expansion to low-income adults. Those with incomes between 139-265 percent FPL lose Medicaid eligibility and must find alternative health insurance coverage through an employer or the state Marketplace or become uninsured.

We take advantage of this quasi-random assignment of postpartum Medicaid eligibility based on income through a regression discontinuity design using the income eligibility threshold of 138 percent FPL ($24,000 for a family of two) as a sharp cutoff dividing postpartum Medicaid eligibility versus ineligibility. We assessed the effect of losing Medicaid eligibility postpartum on continuity of coverage in the postpartum year by comparing births to mothers with incomes below 138 percent FPL, who were eligible for Medicaid after 60 days postpartum, to those with incomes between 139-265 percent FPL, who were ineligible for Medicaid after 60 days postpartum.. The regression discontinuity design assumes that characteristics of those with incomes close to this arbitrary cutoff are similar, reducing differences across eligibility categories that could bias the effect of eligibility on insurance outcomes.

*Data and Sample*

We used a linked database containing the Colorado all payer claims database (APCD), state-wide birth records, and individual-level income for calendar years 2014-2019. The APCD was obtained from the Center for Improving Value in Health Care , birth records were obtained from the Colorado Department of Public Health and Environment , and income and Medicaid eligibility data were provided by the Department of Health Care Policy and Financing , which oversees Health First Colorado, the state’s Medicaid program. Birth records, income data, and claims were linked deterministically using social security numbers, dates of birth, and first and last names.

We limited our sample to Medicaid-financed births to women over 19 years of age between 2014-2018 to allow for one year of follow-up for all births (N=159,390). We then merged this sample of births with the income file and the birth records based on maternal social security numbers, dates of birth, and names; match rates were 98.9 percent for the income linkage and 96.1 percent for the birth record linkage. We excluded 9,382 records due to lack of a corresponding birth record, missing income, or because the date of delivery fell outside of the period that the state Medicaid agency indicated the mother was enrolled in Medicaid. Finally, we excluded 908 births to women who had incomes between 133-138 percent FPL (0.6 percent of the sample) as Medicaid administrators underreported incomes within this range likely as a result of the five percentage point income disregard used in calculating income eligibility for the Medicaid expansion population. Additional details on the data linkage and sample exclusions are provided in Appendices 1-2.16 Our final analytic sample included 157,666 births to women with incomes below 265 percent FPL.

*Measures*

Income was assessed at the household level as a percent of FPL. We defined postpartum Medicaid eligibility using an indicator variable for income less than or equal to 138 percent FPL; those with incomes between 139-265 percent FPL were classified as Medicaid-ineligible beyond 60 days postpartum. Because income can fluctuate over time and pregnancy-related Medicaid eligibility lasts until the end of the month that the 60-day postpartum limit falls, we used the income recorded in the Medicaid eligibility file in the month following 60 days postpartum.6 Fifty-eight percent of the sample had an updated income reported exactly at this time point. For the remainder of the sample who may have had their incomes updated or verified earlier than 60 days postpartum, we looked backwards from the target assignment date (month following 60 days postpartum) and assigned the closest recorded income to the target date, which had been updated within the preceding three months for the majority of births.

All continuity of coverage outcomes were computed in months as Medicaid eligibility is determined on a monthly basis. Our primary measures of continuity of postpartum Medicaid coverage were the mean number of months in coverage and the probability of a coverage disruption, defined as a gap between periods of insurance enrollment or a switch in insurance type (Medicaid, Marketplace, or commercial), both assessed over the 12 months following the date of delivery. As secondary outcomes, we examined the probability of a gap between insurance types, the mean duration of the gap, the probability of an insurance switch, and the mean number of insurance switches. To determine which type of insurance women were enrolled in during the postpartum year, we measured the probability of any enrollment in commercial insurance or Marketplace insurance, as well as the probability of being exclusively insured by Medicaid.

We used the birth record to measure maternal health and demographic characteristics, including age, race, ethnicity, education, marital status, maternal country of birth (U.S. versus non-U.S), and chronic disease status prior to pregnancy. We also assessed complications during pregnancy (gestational hypertension and diabetes) and delivery (preterm birth, eclampsia, HELLP, multiple births, admission to the ICU, blood transfusion, 3rd or 4th degree perineal laceration, ruptured uterus, or unplanned hysterectomy), and whether the infant was delivered via cesarean section.

*Statistical Analysis*

We first measured covariates means among births to women with incomes 0-138 percent FPL versus 139-265 percent FPL and tested for significant differences in slope at the 138 percent FPL cutoff.

Then, to visually assess the relationship between postpartum Medicaid eligibility and continuity of coverage outcomes, we plotted the distribution of each outcome by income. Finally, we used weighted least squares to estimate a parametric quadratic polynomial regression, weighting observations closest to the income threshold more heavily.17,18 Models included an indicator variable for postpartum Medicaid eligibility, income as a continuous variable, and an interaction term between these two variables. This interaction term was the estimate of interest, indicating whether the effect of postpartum Medicaid eligibility varied significantly for births above versus below the postpartum Medicaid eligibility cutoff. We included all covariates in each model to increase the precision of the estimates, and used clustered robust standard errors to account for unobserved correlations within mothers.

We conducted several supplementary analyses to confirm the robustness of our results. First, we generated scatter plots of each covariate and income to visually assess whether the distribution of each covariate shifted demonstrably at the 138 percent FPL cutoff, which would indicate that the cutoff is associated with characteristics of those eligible versus ineligible for postpartum Medicaid eligibility Second, We also tested a variety of functional forms with higher order polynomials. We selected the quadratic form due to model fit and evidence that lower-order polynomials are preferable in regression discontinuity estimation. In addition to estimating a parametric quadratic regression, we also implemented a local polynomial regression model within a narrow, “optimal” income bandwidth above and below 138 percent FPL. Second, we assessed the robustness of both the local polynomial and parametric models to the inclusion of the 908 births to women with incomes between 133-138 percent FPL. Third, we implemented a set of falsification tests using points in the income distribution at which postpartum Medicaid eligibility is unchanged (90 percent FPL and 200 percent FPL) to assess whether these false “treatments” were associated with any changes in postpartum insurance outcomes. Fourth, we implemented two sample restrictions as proxies for excluding women with emergency Medicaid eligibility. Emergency Medicaid provides coverage for emergency services only (including delivery hospitalizations) to individuals who meet all Medicaid eligibility criteria with the exception of citizenship requirements. First, we excluded births to women who were not born in the U.S. and were therefore less likely to be U.S. citizens who qualified for full pregnancy-related Medicaid benefits. Second, because emergency Medicaid coverage is limited to covering the costs of an acute, urgent event such as delivery, we also tested the exclusion of births to women who were only enrolled in Medicaid during the month of delivery.

*Limitations*

Our analysis has a number of limitations. First, our data is limited to Colorado and may not generalize to other state contexts. However, like all states, Colorado has pregnancy-related Medicaid income eligibility limits that exceed the income limits for parents or low-income adults, and like the majority of states, Colorado has expanded Medicaid to adults with incomes below 138 percent FPL.8,19,20 Second, while the APCD includes claims for all births to Medicaid-enrolled mothers in Colorado, the database excludes many commercial, self-insured payers who are not required to submit their claims to the APCD (those that submit do so voluntarily). Therefore, we were likely unable to observe postpartum enrollment for some women who switched into self-insured commercial plans in the year after birth which may have led to inaccuracies in the measurement of coverage switches or gaps for those we could not observe. For this reason, we did not equate the absence of enrollment in the APCD with lack of insurance. However, self-insured plans tend to include employees of very large firms who are typically higher-income, and thus are not likely a significant source of postpartum coverage for Medicaid enrollees.21(p10) Third, we were unable to measure income at the same point-in-time for all women in the study sample as Medicaid administrators can verify income for enrollees at different times throughout the year. This may introduce bias in our results if incomes are systematically inaccurate across eligibility groups. However, we use the gold standard of income data provided directly by the state Medicaid program and incomes were updated for nearly 60% of the sample the month following 60 days postpartum. Fourth, in some cases, Colorado Medicaid allows mothers and infants to share the same Medicaid ID after birth. Because infants are automatically eligible for Medicaid in their first year of life, ID sharing may result in an underestimate of postpartum coverage loss, biasing our findings towards the null. Finally, we only observed switches between broad types of insurance (Medicaid, Marketplace, and commercial), though switches between plans within each type of insurance may also disrupt continuity of care.

**Results**

*Sample Results*

Our analytic sample included 133,683 births to women with incomes below 138% FPL and 23,983 births to women with incomes between 139-265% FPL. Exhibit 1 shows the characteristics of births to women above and below 138 percent FPL and the coefficients for differences in slope on either side of the postpartum Medicaid eligibility cut-off. We find no evidence of discontinuities at 138 percent FPL for any covariates, with the exception of the proportion of mothers born outside of the U.S., which had a discontinuity of 0.05 at the 138 percent FPL threshold (*p*=0.001). Scatter plots of the distribution of each covariate across income show in Appendix 3 provide confirmatory, visual evidence of the lack of covariate discontinuities at the 138 percent FPL threshold.16

*Continuity of Coverage Results*

Exhibit 2 displays the mean number of months of insurance enrollment during the postpartum year by income with the predicted regression lines from our primary model. We found a sharp drop-off in the mean number of months of insurance coverage at the income threshold of 138 percent FPL, shown as a dashed vertical line. Exhibit 3 shows the probability of a coverage disruption in the postpartum year by income with regression lines plotted within the narrow bandwidth, displaying an increase in the rates of coverage disruptions at the postpartum Medicaid eligibility threshold. Among the full income sample, those with incomes below 138 percent FPL were enrolled for an average of 10.7 months compared to an average of 9.0 months among those with incomes above 139-265 percent FPL (results shown in Exhibit 4). The rate of postpartum coverage disruptions was 8 percent among those with incomes below 138 percent FPL compared to 21 percent among those with incomes above 138% FPL (Exhibit 4).

As shown in Exhibit 4, loss of postpartum Medicaid eligibility led to 1.3 fewer months of insurance enrollment (p<0.001) and a 4 percentage point increase in the probability of a coverage disruption during the 12 months postpartum (p<0.001). Postpartum Medicaid eligibility loss also resulted in more frequent coverage transitions (adjusted difference: 0.04, p<.008), coverage disruptions (adjusted difference: 0.02, p=0.001), and longer gaps between spells of insurance (adjusted difference: 0.07 months, p=0.003). Incomes 138-265 percent FPL threshold also led to a 2 percentage point increase in commercial enrollment (p=0.035), a 2 percentage point increase in Marketplace enrollment (p<0.001), and a 4 percentage point decrease in coverage exclusively in Medicaid during the postpartum year.

*Results of Sensitivity Analyses*

In sensitivity analyses reported in Appendix 7, we observed non-significant treatment effects close to zero at 90 percent and 200 percent FPL, the falsified “placebo” points in the income distribution.16 The results of the local polynomial regression models using a sample limited to a narrow range above and below 138 percent FPL were consistent with the results of the local models in direction, magnitude, and statistical significance (Appendix 5). The inclusion of births to women with incomes between 133-138 percent FPL did not alter our findings (Appendix 9). Excluding the 27 percent of births to non-U.S. born mothers resulted in small and inconsistent changes to the magnitude of the effects across continuity of coverage outcomes, but overall direction and statistical significance remained unchanged. Finally, excluding births to mothers who were enrolled in Medicaid only during the month of their delivery hospitalization did not alter our findings (Appendix 8).16

**Discussion**

In this regression discontinuity analysis of linked claims, income, and birth record data from Colorado, we found that eligibility for Medicaid beyond 60 days postpartum improved stability of insurance enrollment in the year after childbirth. Women with incomes below 138percent FPL who were eligible for postpartum Medicaid experienced longer durations of postpartum insurance enrollment, lower rates of gaps in coverage and insurance switches, and shorter coverage lapses. While insurance transitions are expected when women lose their eligibility for Medicaid, our results indicate that these transitions are not seamless, with women ineligible for Medicaid experiencing fewer months of coverage and worse insurance stability throughout the postpartum year.

While the magnitude of our adjusted effects were modest, we found that descriptively, those who were ineligible for Medicaid postpartum were nearly three times more likely to experience a coverage disruption and that gaps between spells of enrollment were over four times as long. Prior work using survey data has found higher rates of postpartum coverage disruptions than we observed in this analysis.22 It is possible that our results may underestimate the true magnitude of the effect of postpartum Medicaid eligibility loss due to inaccuracies in income measurement or Medicaid ID-sharing between mothers and infants in the Colorado APCD, as described in the limitations. However, the fact that we observe strong effects despite these concerns indicates that our findings are robust, though magnitudes should be interpreted taking these limitations into account.

This study adds to prior evidence that Medicaid eligibility expansions improve postpartum insurance enrollment. Two recent studies found that expansion was associated with improved perinatal insurance continuity and increased use of outpatient care in the postpartum period.23,24 However, these studies focused on aggregated, state-level differences in Medicaid expansion for low-income adults to 138 percent FPL under the ACA, a policy that was not explicitly targeted to cover postpartum women and retained the Medicaid eligibility coverage “cliff.” We build on this work by examining the causal effect of extending individual-level postpartum Medicaid eligibility, a closer analog to the state option for postpartum Medicaid extension included in the American Rescue Plan Act.

*Policy Implications*

Our findings have several implications for policy. First, these results indicate that states that extend postpartum Medicaid eligibility will likely improve stability of coverage for low-income, postpartum women. These increases in coverage may translate to improved access to care and postpartum maternal health.25 Our results likely underestimate the effects that postpartum Medicaid eligibility loss would have on women who live in states that have not expanded Medicaid under the ACA, particularly women with incomes under 100% FPL who have fewer postpartum coverage options. For example, in a non-expansion state like Texas, the Medicaid eligibility income limit for pregnant women is 203 percent FPL, but only 17 percent FPL for low-income parents.8,19 Women with incomes above 100 percent FPL can enroll in Marketplace coverage with premium subsidies, but those between 17-100 percent FPL are not eligible for affordable coverage. Thus, the postpartum Medicaid eligibility cut-off would likely have much larger coverage effects in non-expansion states compared to the effects we observe in Colorado, an expansion state.

Second, while Marketplace coverage may be available to many postpartum women who lose their Medicaid eligibility, policymakers should not necessarily consider it a substitute for retaining Medicaid. Prior work has found that women who transition to commercial insurance postpartum do not use outpatient care at the same rates as those who remain in Medicaid postpartum.24 We find that while women who lose Medicaid eligibility postpartum were more likely to transition to Marketplace or commercial insurance, they were also more likely to experience gaps in coverage and fewer months insured. This may be because if women miss the limited 60-day window for Marketplace special enrollment following the birth of their child, they must wait until the following open enrollment period to enroll.26 While subsidies for Marketplace insurance are available, this coverage may still be unaffordable: a family three with income of 205 percent FPL may pay up to 2.2 percent of income for the second-lowest cost silver plan and face out-of-pocket costs.27

A lack of information about Marketplace coverage and even about impending loss of coverage under Medicaid may also contribute to postpartum coverage gaps. Recent survey evidence suggests that information regarding the Marketplaces is not widespread, with 46 percent of respondents reporting they had limited knowledge about the coverage option.28Outreach resources to increase awareness of Marketplace coverage, increasing subsidies to make Marketplace coverage more affordable, and other policies that smooth the transition between Medicaid and Marketplace coverage may improve stability of postpartum insurance enrollment for women who lose Medicaid eligibility.

Finally, our results suggest that the postpartum Medicaid extension option in the American Rescue Plan has many potential benefits, including providing continuous Medicaid coverage during a period when women are at highest risk of postpartum complications and granting more leeway for women to find alternative coverage and avoid gaps in coverage. Future work should also examine the effects of extended postpartum Medicaid eligibility on costs, utilization, and health outcomes.

However, extending postpartum Medicaid eligibility simply moves the eligibility cliff from 60 days to 12 months postpartum.29 When the extension ends, women will be faced with the same challenges of identifying and enrolling in alternative health insurance coverage. Policy options such as a Basic Health Plan or a public option may offer more durable improvements in stability of coverage for women in their child-bearing years.

*Conclusion*

In conclusion, we found that postpartum Medicaid eligibility increased stability of health insurance enrollment in the postpartum year, and that the loss of postpartum Medicaid eligibility resulted in fewer months of postpartum insurance enrollment and more frequent insurance disruptions. Postpartum Medicaid extensions offer a promising state option to improve postpartum stability of coverage and promote postpartum maternal health through enhancing access and continuity of care, though other policy solutions may be needed to smooth insurance transitions for low-income women.

Endnotes:

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EXHIBIT 1 (table)  
Caption: Characteristics of Colorado Women with Medicaid-Financed Births with Incomes Above versus Below 138% of the Federal Poverty Level, 2014-2018  
Source/Notes: SOURCE [Authors’ analysis of linked all payer claims data, income, and birth records for Medicaid-financed births in Colorado from 2014-2018.] NOTES [Mean values are among full sample of women with incomes between 0-265% FPL at the time of birth. Discontinuity is the regression coefficient at the cutoff of 138% FPL for regressions with the covariate of interest as the outcome and all other covariates as controls, with standard errors clustered at the mother level.]

EXHIBIT 2 (figure)  
Caption: Mean Duration of Insurance Enrollment during the Postpartum Year by Income as a Percentage of the Federal Poverty Level (FPL)  
Source/Notes: SOURCE [Authors’ analysis of linked all payer claims data, income, and birth records for Medicaid-financed births in Colorado from 2014-2018.] NOTES [Dashed vertical line indicates 138% of the federal poverty level, the income threshold for Medicaid eligibility for low-income adults in Colorado. Each dot represents a binned average of values along the income distribution; each bin includes an average of 2,732 births. The shaded region indicates data-driven income bandwidth. The blue regression lines were obtained from a local polynomial regression discontinuity model.]

EXHIBIT 3 (figure)  
Caption: Rates of Coverage Disruptions during the Postpartum Year by Income as a Percentage of the Federal Poverty Level (FPL)  
Source/Notes: SOURCE [Authors’ analysis of linked all payer claims data, income, and birth records for Medicaid-financed births in Colorado from 2014-2018.] NOTES [Dashed vertical line indicates 138% of the federal poverty level, the income threshold for Medicaid eligibility for low-income adults in Colorado. Each dot represents a binned average of values along the income distribution; each bin includes an average of 2,732 births. The shaded region indicates data-driven income bandwidth. The blue regression lines were obtained from a local polynomial regression discontinuity model.]

EXHIBIT 4 (table)  
Caption: Type of Insurance Coverage and Continuity of Enrollment during the Postpartum Year by Income-Based Pregnancy-Related Medicaid Eligibility

Source/Notes: SOURCE [Authors’ analysis of linked all payer claims data, income, and birth records for Medicaid-financed births in Colorado from 2014-2018.] NOTES [Columns 1 and 2 display the mean values among the full income sample of births to women with incomes below 265% FPL. Clustered standard errors at the mother-level are shown below means in parentheses; 95% confidence intervals are shown below regression coefficients in brackets. \* *p* < 0.05; \*\* *p* < 0.01; \*\*\* *p* < 0.001.]

EXHIBIT 1: Characteristics of Colorado Women with Medicaid-Financed Births with Incomes Above versus Below the Income Cutoff for Postpartum Medicaid Eligibility (138% of the Federal Poverty Level), 2014-2018

|  |  |  |  |
| --- | --- | --- | --- |
| Descriptive Characteristics | Income as a Percentage of the Federal Poverty Level (FPL) | | Discontinuity at the 138% FPL income cutoff |
|  | ≤138% FPL | 139-265% FPL |  |
| Age, Mean | 27.18 | 28.27 | 0.27 |
| Race and Ethnicity, % |  |  |  |
| White | 73.94 | 77.26 | 0.01 |
| Black | 9.83 | 7.49 | 0.00 |
| Asian | 3.21 | 4.70 | 0.00 |
| Hispanic | 47.39 | 40.22 | 0.00 |
| Other Race | 13.02 | 10.55 | 0.00 |
| Born outside US, % | 27.04 | 29.48 | 0.05\*\*\* |
| Education, % |  |  |  |
| High School | 77.65 | 86.41 | -0.01 |
| College | 17.27 | 30.15 | 0.01 |
| Married, % | 53.95 | 76.38 | -0.01 |
| Number of Prenatal Visits, Mean | 10.41 | 10.85 | 0.03 |
| Prenatal Care Initiated in First 3 Months of Pregnancy, % | 70.49 | 76.37 | -0.00 |
| Pre-Existing Chronic Conditions Prior to Pregnancy, % | 27.70 | 26.49 | 0.01 |
| Preterm Birth, % | 9.02 | 7.24 | 0.01 |
| Maternal Complications, % | 12.86 | 12.67 | -0.01 |
| Cesarean-Section Births, % | 23.96 | 23.64 | -0.02 |
| *N* (births) | 133,683 | 23,983 |  |

Source: Authors’ analysis of linked all payer claims data, income, and birth records for Medicaid-financed births in Colorado from 2014-2018. Notes: Mean values are among full sample of women with incomes between 0-265% FPL at the time of birth. Discontinuity is the regression coefficient at the cutoff of 138% FPL for regressions with the covariate of interest as the outcome and all other covariates as controls, with standard errors clustered at the mother level. \*p<0.10, \*\*p<0.05, \*\*\* p<0.01, \*\*\*\*p< 0.001.

EXHIBIT 4: Type of Insurance Coverage and Continuity of Enrollment during the Postpartum Year by Income-Based Pregnancy-Related Medicaid Eligibility

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Unadjusted Means by Income | | | Adjusted Difference |
| Outcome | <138% FPL | 139-265% FPL | Unadjusted Difference |  |
| **Continuity of Coverage** |  |  |  |  |
| Mean enrollment duration (months) | 10.66 | 8.96 | -1.7 | -1.27\*\*\*\* |
| Coverage disruption rate (gap or switch), % | 8 | 21 | 13 | 0.04\*\*\*\* |
| Mean number of coverage disruptions (gap or switch) | 0.11 | 0.32 | 0.21 | 0.05\*\*\* |
| Mean number of coverage gaps | 0.02 | 0.07 | 0.05 | 0.02\*\*\* |
| Mean duration of coverage gaps (months) | 0.06 | 0.27 | 0.21 | 0.07\*\*\* |
| Mean number of coverage switches | 0.09 | 0.26 | 0.17 | 0.04\*\*\* |
| Coverage switch rate, % | 7 | 20 | 13 | 0.04\*\*\*\* |
| Coverage gap rate, % | 2 | 6 | 4 | 0.01\*\*\* |
|  |  |  |  |  |
| **Type of Enrollment** |  |  |  |  |
| Any commercial, % | 6 | 12 | 6 | 0.02\*\* |
| Any Marketplace, % | 1 | 8 | 7 | 0.02\*\*\*\* |
| Only Medicaid, % | 93 | 80 | -13 | -0.04\*\*\*\* |

Source: Authors’ analysis of linked all payer claims data, income, and birth records for Medicaid-financed births in Colorado from 2014-2018. Notes: Columns 1 and 2 display the mean values among the full income sample of births to women with incomes below 265% FPL. Clustered standard errors at the mother-level are shown below means in parentheses; 95% confidence intervals are shown below regression coefficients in brackets. \*p<0.10, \*\*p<0.05, \*\*\* p<0.01, \*\*\*\*p< 0.001.