Building on the ACA

Administrative Actions to Improve Maternal Health

By Jamille Fields Allsbrook and Osub Ahmed March 25, 2021

Since its passage in 2010, the Affordable Care Act (ACA) has improved health care coverage and quality for people across the United States, including pregnant and birthing people. Around 20 million people have gained health insurance through the ACA[1]—and, notably, the ACA resulted in the uninsurance rate among new mothers decreasing by 41 percent between 2012 and 2013 and 2015 and 2016.[2] In particular, the ACA helped increase affordability by providing financial assistance to individuals to purchase private health coverage, and it expanded eligibility for the Medicaid program. Its Medicaid expansion—which expanded coverage to people earning less than 138 percent of the federal poverty level and removed requirements that people have certain characteristics, such as being pregnant, being a parent or guardian, or having a qualifying disability—has also been associated with improved maternal health outcomes.[3]

Even more, the ACA helped to improve the quality of coverage for pregnant and birthing people by requiring individual and small group plans, as well as Medicaid expansion plans, to cover maternity and newborn care. Before the ACA, only 12 percent of plans in the individual health insurance market offered maternity benefits,[4] and 6 out of 10 people did not have maternity benefits.[5] Without the maternity and newborn benefit requirement, an estimated 13 million people would lose access to maternity services.[6] Additionally, most plans must cover select women's preventive services with no out-of-pocket costs to the enrollee. This includes services benefiting pregnant and postpartum women, such as breastfeeding counseling and supplies, screenings for gestational diabetes, and support around anxiety during pregnancy and the postpartum period. Services to plan or prevent pregnancy, such as contraceptives and well-woman visits, are also included.[7]

Despite this progress, inequities remain in maternal health care coverage and access. According to 2020 data, 30 million nonelderly people are uninsured in the United States, and Hispanic, Black, American Indian and Alaska Native, and Native Hawaiians and other Pacific Islander people, as well as people with low incomes, are consistently more likely to be uninsured compared with their non-Hispanic white counterparts.[8]

Without high-quality health care coverage, many people forgo necessary and preventive prenatal and postnatal care. Even before the COVID-19 pandemic and subsequent economic crisis, women were more likely to delay or go without care, skip recommended preventive care, forgo filling prescriptions, or report problems paying medical bills as a result of health care costs.[9] Access to comprehensive maternal and reproductive health care services has been shown to improve maternal health outcomes.[10]

Insurance coverage alone is not enough to achieve health equity—including maternal health equity. There has been an increased recognition of the need to move from traditional payment models, which pay providers per service, toward value-based care delivery, which attempts to pay based on quality. The ACA undertook reforms to incentivize providers to deliver high-quality care and improve care coordination, notably through the expansion of innovative payment models, patient-centered medical homes, and accountable care organizations (ACOs), among other changes.[11] These reforms moved the U.S. health care system toward a value-based care model and ensured that public payers were rewarding quality—not quantity—in care delivery.[12] However, there is evidence to suggest that not every community—particularly communities of color—is able to benefit from these reforms equally, and many of these innovative payment models have not been aimed at reducing racial and ethnic health disparities.[13] Illustratively, a study published in *Health Affairs* found that providers who serve a patient base that has a higher concentration of Black, low-income, uninsured, or disabled people, or people with less than a high school degree, were less likely to participate in ACOs.[14]

Additionally, there are costs associated with not taking action to improve existing health care disparities. This cost of inaction on maternal health care—that is, the costs resulting from inadequate or inaccessible maternity care that negatively affects women, their families, and society at large—should provide a strong impetus to build on the ACA to improve maternal health outcomes. When pregnant people are unable to access affordable, high-quality care during pregnancy, delivery, or in the postpartum period, they may be forced to pay out of pocket, face financial uncertainty, or go without care altogether. Many of these issues stem from the high cost of pregnancy itself. The average charge for a vaginal birth is around $15,300, while a caesarean section (C-section) costs around $20,400.[15] Complicated pregnancies can run exponentially higher. Given almost half of all pregnancies in the United States are unintended, it is frequently difficult for people to anticipate and build sufficient savings to cover maternal health-related costs. The Federal Reserve noted in a recent report that nearly 40 percent of people in the United States could not cover an unexpected $400 expense (a percentage that has almost certainly grown as a result of the current economic crisis).[16] Pregnancy and childbirth are the most costly hospital-based health services, according to an analysis of hospitals charges conducted by the Agency for Healthcare Research and Quality.[17] Notably, about two-thirds of all bankruptcies were the result of medical bills or illness-related work loss prior to the pandemic.[18]

The American Rescue Plan—federal legislation recently enacted to address the COVID-19 pandemic—includes provisions that represent a significant enhancement of the ACA. Relevant here, the law increases financial subsidies for people to purchase plans on ACA marketplaces, extends eligibility for these subsidies, provides federal financial incentives for states to expand their Medicaid programs, and creates a new option for states to further extend Medicaid coverage for pregnant people.[19] The recently reintroduced Black Maternal Health Momnibus Act of 2021, a collection of 12 federal bills designed to address maternal health disparities, also includes provisions related to payment and delivery models aimed at improving the quality of care for Black birthing people.[20]

This issue brief focuses on administrative actions that the Biden-Harris administration, as well as state leaders, can take to build on these legislative developments and improve upon the gains made under the ACA. The recommended actions include:

- Creating a special enrollment period for pregnancy to allow people to enroll in coverage outside of the ACA's limited open enrollment period.

- Establishing minimum coverage standards for maternal health to ensure that pregnant people and people who can become pregnant can access needed services across plans and geographic areas.

- Setting standards for network adequacy that guarantee meaningful access and choice of culturally competent providers and perinatal support workers, including midwives and doulas.

- Developing innovative payment and quality care models that, through focus and design, are aimed at eliminating maternal health disparities among Black and Indigenous people.

Create a special enrollment period for pregnancy

The ACA marketplaces—both the federally facilitated marketplace, Healthcare.gov, and the 15 state-based marketplaces—are online portals that give people the opportunity to compare and shop for plans that meet their care needs.[21] Notably, the vast majority of people who purchase plans on the marketplaces receive federal financial assistance through premium tax credits, which assist with monthly premiums, and/or cost-sharing reductions, which help to lower out-of-pocket costs such as copays and coinsurance. However, consumers can generally only purchase these plans during a limited open enrollment period, which in recent years has been six weeks beginning in November.[22] Those who have experienced qualifying life events, such as a recent move or job loss, may be eligible for a special enrollment period (SEP) that allows them to enroll in coverage outside of the open enrollment period.

While a person can also qualify for an SEP for giving birth, pregnancy alone does not similarly qualify. As a result, a person who was previously uninsured or who has a non-ACA compliant plan, such as a short-term plan, could find themselves without access to needed services such as prenatal, gestational diabetes, and maternal mental health care. The U.S. Department of Health and Human Services (HHS) and state-based marketplaces should deem pregnancy a qualifying life event for an SEP and allow pregnant people to enroll in coverage. Some states have already created an SEP for pregnancy. For instance, in 2016, New York became the first state-based marketplace to create an SEP for pregnancy, followed by Connecticut, the District of Columbia, Vermont, Maryland, and New Jersey.[23] Still more could benefit from an SEP for pregnancy in every state: In 2018, 12 percent of women of reproductive age (15–44 years), or about 7.7 million women, were uninsured nationwide,[24] and more are underinsured without coverage of needed services.[25]

In addition to the importance of improving access to coverage for pregnant people, there is a strong cost argument for making pregnancy a qualifying life event for an SEP. Without coverage, prenatal visits, which can be as many as 10 to 15 visits and may require additional services such as amniocentesis, can total thousands of dollars.[26] Some pregnant people choose to delay or forgo prenatal care in the face of high out-of-pocket costs—a decision that, unfortunately, often leads to even greater costs down the road. Inadequate prenatal care carries numerous and costly risks, including an increased likelihood of preeclampsia, a pregnancy complication caused by high blood pressure, and gestational diabetes. For example, if left untreated, pregnancy-related hypertension can cost an uninsured patient more than $18,500, in addition to costs related to hospital stays.[27]

Women who do not receive prenatal care are also seven times more likely to have a preterm birth compared with women who attend the majority of their prenatal visits.[28] The cost of preterm birth is staggering: For example, according to a seminal report published by the Institute of Medicine (now known as the National Academy of Medicine) in 2007, preterm medical costs accrued from birth to age 7 were an additional $43,500 over similar medical costs for a term birth.[29] Meanwhile, excess maternal delivery costs due to preterm birth were approximately $5,200 more than the delivery costs associated with a term birth.[30] Ancillary costs, including for early education services and special intervention services, can drive this figure even higher.[31]

Establish minimum coverage standards for maternal health

The ACA's essential health benefits (EHB) requirement was intended to bring uniformity in coverage across plans, particularly in the individual and small group market, but there are still significant differences in services covered across states.[32] In particular, maternity and newborn care coverage continues to fluctuate across states. Since 2011,

HHS has allowed states to select a benchmark plan to define the specific services that must be covered under each EHB category, and the Trump administration issued guidance allowing even more flexibility among states' selection of benchmark plans. When HHS initially issued this guidance, the agency stated that it would reassess "whether enrollees have difficulties with access for reasons of coverage or cost," among other issues.[33] In 2011, the Institute of Medicine recommended that states have flexibility but similarly stated that the committee's solution at the time was to "build on what currently exists, learn over time, and make it better" and noted that "[t]he EHB package should be continuously improved and increasingly specific."[34]

More than a decade later, the federal government has the opportunity to set a minimum standard for the maternity and newborn care benefit, among other EHBs.[35] Indeed, state flexibility does not preclude the federal government from establishing a minimum federal standard, and HHS should issue regulations establishing a minimum standard for maternity care. Specifically, maternity care should be consistent with the services as recommended by medical experts, including the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics;[36] this should include preconception care, prenatal care, ancillary services, mental health screening and services, labor and delivery, and postpartum services, among others.[37] Even more, the number of prenatal visits and other services that are covered should be increased for complicated pregnancies. Before a federal standard is set, states can use its existing flexibility to incorporate these minimum standards independently.

Relatedly, HHS and state governments should enact regulations to fill gaps in the coverage of breastfeeding counseling and equipment. While most private and Medicaid expansion plans have to cover these services without out-of-pocket costs to the enrollee, traditional Medicaid plans—those plans for people who qualified for Medicaid before the ACA was implemented—are not subject to this requirement.[38] State Medicaid programs should ensure that the benefits of those eligible for Medicaid through the traditional pathway align with the benefits of the Medicaid expansion population. Additionally, plans currently have discretion over the breast pumps they must cover. HHS and states should ensure that plans cover—at a minimum—one breast pump from each of the most common types, including electric, manual, and battery-operated.

Additionally, non-ACA compliant health plans, which are not required to cover maternal health care services, should be limited, and clear notice should be given to consumers when a plan is not ACA compliant.[39] In particular, short-term plans should not last more than three months. These plans do not have to comply with the ACA benefit requirements, including stipulations to cover required preventive services such as well-woman visits or EHBs such as maternity care. Notably, a 2018 Kaiser Family Foundation analysis of short-term plans found that not one of the 24 short-term plans analyzed covered maternity care.[40] These plans are not required to adhere to consumer protections, such as excluding or charging more or outright denying coverage to people with preexisting conditions, including pregnancy; these plans are also not prohibited from charging women more for the same coverage as men.[41] Unfortunately, these plans are likely to attract younger, healthy people,

including people of reproductive age, into purchasing individual plans due to their low premiums.[42] People whose health plans do not include maternity benefits may find themselves in need of a maternity rider, or supplemental insurance. A rider has high premiums and requires enrollment prior to pregnancy, making it practically unworkable given that people would need to know in advance that they would need maternity services and the rider.

Similarly, health care sharing ministries—entities where people with common religious beliefs pay into a fund that pays for certain medical expenses for members—do not have, and frequently do not adhere to, ACA benefit and consumer standards.[43] Indeed, health care sharing ministries can prevent certain women from joining their plans; for example, some plans do not allow single pregnant women to receive coverage, while others require that women enroll before becoming pregnant.[44] These plans can also be costly to patients: A Commonwealth Fund analysis of five health care sharing ministries revealed that almost all plans imposed coverage caps.[45] One ministry noted that members are responsible for maternity costs exceeding $4,000 for an uncomplicated delivery and $6,000 for a medically necessary C-section. This cost would be in addition to the monthly membership, which generally ranges from $500 to $5,000.[46] Again, this may leave pregnant people in the lurch, as hospital charges for delivery can greatly exceed this limit. States can regulate health care sharing ministries beyond federal standards; however, 30 states have laws exempting health care sharing ministries from state insurance regulations.[47] HHS and state administrators should ensure that this coverage, at a minimum, meets ACA standards.

Ensure the diversity of health plans' provider networks

HHS should ensure that there is an adequate provider network for people seeking maternal health care. The ACA requires the secretary of HHS to issue regulations to ensure that health plans, at a minimum, have "a sufficient choice of providers,"[48] and these regulations require sufficiency in both the numbers and specialties of providers.[49] Additionally, health plans' provider networks are required to be inclusive of essential community providers, who are defined as providers serving low-income communities and areas with a shortage of health professionals, including certain family planning providers and HIV/AIDs clinics.[50] The Obama administration also previously issued guidance establishing more specific standards, such as time and distance standards, related to access to providers within certain specialties.[51]

An adequate provider network is necessary to ensure that having health coverage actually results in increased health care access and utilization. Specific to ensuring equitable access to maternal health services, it is necessary that health plans' provider networks include nonphysician providers and a broad range of perinatal workers.

Midwives and doulas, in particular, have been associated with better maternal health outcomes and lower rates of medical interventions during birth.[52] Access to both midwives and doulas has also been shown to generate cost savings. A study from the University of Minnesota found that if the percentage of pregnancies (including births covered by both private plans and Medicaid) delivered at midwifery practices increased from 8.9 percent in 2018 to 20 percent in 2027, the 10-year cumulative cost savings would be $2.82 billion for private plans—benefiting both employers and employees—and $1.13 billion for state Medicaid programs—benefiting taxpayers as well as the federal and state government.[53] This increase in midwife-assisted delivery would also result in 30,000 fewer preterm births between 2018 and 2027. Similarly, a recent study modeling the cost-effectiveness of doula services found that such services could save up to $884 per doula-assisted pregnancy and that if all low-risk pregnant women received doula services, this would result in $247 million in savings.[54] Of course, cost savings alone should not determine birthing plans; however, access to a range of providers and birthing support is necessary for pregnant people to make meaningful decisions about their care.

While the ACA prohibits plans from discriminating against providers,[55] the law does not require private insurance plans to contract with certain providers, such as midwives, or birthing support people, such as doulas. The ACA does not require private plans to cover care delivered by any provider at a birthing center, as required in the Medicaid program.[56] In the absence of such a requirement, plan enrollees could find themselves without coverage for a midwife or doula, or their plan might cover these health care workers but not contract with any within their network.[57] Illustratively, private insurance typically does not cover doula care, and only a few Medicaid programs cover doula services.[58] Most private insurers and Medicaid plans cover certified nurse midwives (CNMs), but certified professional midwives (CPMs), who typically practice outside of the hospitals, are less frequently covered. CPMs are covered in only 13 state Medicaid programs, and six states require private insurers to cover these providers, according to 2017 data.[59] The Center for Consumer Information and Insurance Oversight (CCIO) within HHS and states should establish minimum network adequacy standards for private plans. Such standards could require a minimum percentage of available providers in an area—which is inclusive of doulas and midwives, including CNMs, CPMs, certified midwives, and community-based midwives—as well as require coverage for deliveries in birth centers. If a plan does not have a midwife or doula within its network, enrollees should be able to access this care out of network at the same cost level as in-network services.

Additionally, standards related to a plan enrollee's ability to access certain providers should explicitly include OBGYNs so as to ensure that people who do wish to access care from an OBGYN are able to do so. Studies have found that OBGYNs are among the most common providers from whom women receive care,[60] and nearly 60 percent of women report visiting an OBGYN regularly.[61] No matter the provider, there must be an adequate geographic distribution of providers as well as providers with flexible hours.

This is particularly important for people of color, who are more likely to work in jobs with limited paid sick leave and thus need after-hours care.[62] Additionally, there must be providers within the network who are trained to give culturally competent care, including providers trained on implicit bias and anti-racism. There must also be language access services to deliver care to people with limited English proficiency, which is particularly important for immigrants. Network adequacy standards alone cannot solve issues related to the provider workforce; however, these standards can encourage insurers to include available, qualified providers in their networks.

The Trump administration loosened the ACA network adequacy standards, including by shifting enforcement of these standards even more to the states.[63] This essentially left no federal oversight of compliance for existing network adequacy standards. Notably, a 2014 study found that 23 states did not have quantitative standards for regulating plans' networks, and states' ability to regulate these plans varied.[64] HHS should return to regulating plans' network adequacy and enforcing standards at the federal level. Relatedly, the ACA requires marketplace plans to include a directory of the providers included in plans' networks.[65] Given the demonstrable effect that the care delivery team has on maternal health outcomes, plan enrollees who are pregnant or planning to become pregnant must be able to rely upon their plans' provider networks as well as access these provider directories in order to make informed decisions when selecting a health plan. Unfortunately, multiple studies have found that provider directories are frequently inaccurate.[66] HHS and state regulators can assist with improving this accuracy by monitoring plans' provider networks and directories and holding the insurers that help to populate the directories accountable for inaccuracies.

Encourage states to adopt policies that expand Medicaid

As noted above, Medicaid expansion has been associated with lower maternal mortality rates, particularly among Black mothers,[67] and can play an important role in achieving maternal health equity. Due to systemic oppression and inequities, Black, Indigenous, and Latina women disproportionately rely upon the Medicaid program.[68] Furthermore, Medicaid funds nearly half of the nation's births and pays for a greater share of births than private payers in rural areas.[69] Following the ACA's coverage expansions, including Medicaid expansions, the percentage of new mothers who were uninsured fell 44 percent, and those reporting not having their medical care needs met due to cost decreased 59 percent.[70]

However, not every low-income person has access to the Medicaid program. Twelve states have not expanded their Medicaid programs, as was contemplated under the ACA.[71] Women who otherwise would not qualify for Medicaid except for their pregnancy status might be eligible for pregnancy-only Medicaid coverage, which entitles them to coverage for "pregnancy-related services" or services for "conditions that might complicate the pregnancy."[72] While access to these services can be lifesaving, women are only entitled to this coverage for around 60 days postpartum, unless

their state elects to extend this coverage. The federal government should encourage states to extend pregnancy-only Medicaid coverage beyond 60 days postpartum, and states should adopt this extension. Specifically, the Centers for Medicare & Medicaid Services within HHS can issue guidance encouraging states to extend Medicaid pregnancy-only coverage to at least one year postpartum and provide the full scope of available Medicaid benefits. To be clear, this does not replace the need for states to also expand their Medicaid programs, as the ACA intended, which should continue to be encouraged and adopted by states.

In recent years, some states have embarked on legislative and regulatory efforts to extend postpartum coverage beyond 60 days. Currently, six states—Illinois, South Carolina, New Jersey, Georgia, Indiana, and Missouri—have pending Section 1115 demonstration waivers to extend postpartum coverage, although in some cases not for the full 12 months or only for specific populations. Illustratively, Illinois has proposed extending pregnancy-only Medicaid coverage from 60 days to 12 months for women earning up to 200 percent of the federal poverty level, and it projects that extending this coverage will result in an additional 62,932 postpartum women enrolling in Medicaid each month.[73] This postpartum extension is in addition to the state's Medicaid expansion in 2014, through which more than 600,000 additional people have gained coverage as of April 2020.[74]

Expanding Medicaid and extending 12-month postpartum coverage is in line with the ACA's goal of creating affordable coverage and would also result in critical cost savings for pregnant and postpartum people. Analyzing one-year postpartum costs among birthing individuals with employer-based insurance, the Health Care Cost Institute found that the majority of postpartum spending occurs after two months.[75] This illustrates that people enrolled in Medicaid are also likely to continue to have numerous, costly postpartum needs well after 60 days postdelivery. Furthermore, an Urban Institute study found that among its study population of newly uninsured mothers nationwide—almost half of whom had lost their Medicaid or other insurance coverage after pregnancy—1 in 5 reported experiencing postpartum depression, and 1 in 3 had received a C-section. These findings led the study's authors to conclude that many of the women surveyed have unmet and sustained mental and physical health care needs during the postpartum period.[76]

Another negative yet common byproduct of inadequate postpartum Medicaid coverage is insurance churn, or changes in insurance coverage over time (either cycling between insurance and uninsurance or between health plans). A 2017 *Health Affairs* study reported that 70 percent of people who were uninsured, 55 percent of people enrolled in Medicaid or the Children's Health Insurance Program, and 35 percent of people with private or government insurance at the time of delivery experienced at least one month of uninsurance in the six months following delivery.[77] Multiple studies have highlighted the need for continuous and uninterrupted coverage for pregnant and postpartum people. Churning poses both health and financial costs to patients,

insurers, the health care system, and taxpayers writ large. Churning can also lead to delays in receiving preventive care, reduced medication adherence, higher rates of emergency room visits, and increased hospitalizations.[78] It is important to note that in states that expanded their Medicaid programs, there have been marked improvements in continuity of coverage as well.[79]

Create innovative care models that pay for quality and promote the equitable delivery of care

The ACA authorized the creation of the Center for Medicare and Medicaid Innovation (CMMI) within HHS to design and implement innovative health care payment models. The office has previously operated models focused on maternal health, including those aimed at reducing early deliveries,[80] improving prenatal care,[81] and caring for mothers with substance use disorders.[82] There have also been state-based payment and delivery models aimed at improving maternal health. For example, state Medicaid programs have enacted maternity care homes, whereby patients are assigned a provider who coordinates their various medical needs, and the provider may receive payment incentives for delivering certain services or meeting specific quality metrics. In North Carolina, 70 percent of the pregnant people participating in the state's pregnancy medical home received prenatal care starting in the first trimester.[83] The Momnibus also includes bills that call on HHS to develop new care models: The Tech to Save Moms Act, introduced by Rep. Eddie Bernice Johnson (D-TX) and Sen. Bob Menendez (D-NJ), encourages the CMMI to consider developing a model that integrates telehealth services in the screening, monitoring, and management of pregnancy-related care.[84] The Impact to Save Moms Act, introduced by Rep. Jan Schakowsky (D-IL) and Sen. Bob Casey (D-PA), would also create a new perinatal care alternative payment model.[85] Additionally, the Data to Save Moms Act, introduced by Rep. Sharice Davids (D-KS) and Sen. Tina Smith (D-MN), would establish a Task Force on Maternal Health Data and Quality Measures. It would also require a review of existing quality measures, including a review of their effectiveness and the barriers preventing providers from implementing them, among other factors.[86] The Momnibus would provide funding to enact these models, but HHS also has the authority to develop the models through administrative actions.

The CMMI should exercise this authority to design a demonstration project that is focused on addressing maternal health inequities, particularly for Black and Indigenous pregnant people. These models should incorporate maternal health quality measures, such as the National Quality Forum-endorsed measures on C-sections or early elective deliveries (i.e., induced pregnancies and C-sections before 39 weeks) to discourage these procedures when not medically necessary.[87] Additionally, these models should incorporate reproductive health measures such as the patient-centered contraceptive counseling measure, which asks patients about whether they received the contraceptive care and counseling of their choosing. The CMMI should

also include quality family planning guidelines, which provide evidence-based recommendations to help people decide when and whether to become pregnant and which are associated with improved maternal health outcomes.[88] Such measures can also be incorporated into other insurance coverage requirements to ensure public and private plans are only paying for quality care.

It is also important that participating providers be racially and ethnically diverse and representative of the communities that they serve. Ensuring that providers receive cultural competency training has also been found to yield positive outcomes. A meta-analysis of 19 studies found that when providers received training in cultural competency, patients had improved health care access and utilization.[89] Providers who predominantly serve communities of color have also been frequently excluded from participating in innovative models; it is important that the agency provide increased funding and technical assistance to allow these providers an equal opportunity to participate in the demonstration project. Specifically, demonstration projects should include safety-net providers such as family planning providers, rural providers, and other providers who have been historically underfunded.[90] Additionally, nonphysician providers and birthing support such as midwives and doulas should be included given the known positive effect they have on maternal health outcomes. Within these models, participating providers, as well as other health care workers involved, should be required to receive implicit bias and anti-racism trainings.

Throughout and after the demonstration project, the participating entities should report patients' disaggregated data based on race, ethnicity, sex, gender, gender identity, sexual orientation, disability status, immigration status, English proficiency, income, and geographic location. This information should be considered when evaluating the effectiveness of the innovation model. Additionally, the evaluation should conduct a proper risk adjustment to account for social and environmental factors that are outside of the providers' control to ensure the quality of care delivered is properly assessed.[91] Some experts have rightly raised a concern that without proper risk adjustment, an unintended consequence of a value-based payment model could be the unfair penalization of providers who serve communities that have historically been disadvantaged in the health care system and thus came into the demonstration with poorer health.[92]

Overall, however, there are substantial cost savings associated with care coordination and value-based payment models.[93] This approach has been taken up in the maternity care context: A 2015 study in North Carolina showed that when women who were covered by Medicaid for at least part of their pregnancy were enrolled in the state's Baby Love Maternity Care Coordination program—a home visiting program that coordinated prenatal visits, mental health counseling, and childbirth education, among other services—they experienced a decline in preterm birth risk compared with a control group.[94] In regards to alternative payment models, Tennessee implemented a perinatal episode-of-care payment model that saved the state more than $4.7 million between 2014 and 2015 and led its C-section rate to drop from 31.4 percent in 2014 to 29.2 percent in 2015.[95]

Conclusion

There is a strong moral imperative as well as financial incentive to improve maternal health outcomes through federal and state administrative action. While there are costs associated with improving maternal health coverage and care delivery through coverage expansion and delivery system reform, they pale in comparison to the costs associated with the maternal health crisis itself. Diminished health and quality of life, loss of economic productivity, and, importantly, the ripple effects that a maternal death has on families, communities, and society at large highlight the urgent need to address this national crisis. This is of particular importance for Black and Indigenous people, who make up a disproportionate share of this human toll. By making investments to expand and improve comprehensive maternity coverage, diversify provider networks, and shepherd innovation in maternity care delivery and payment models, the United States will be better positioned to meet this crisis head-on, ensuring that all pregnant and postpartum people can experience healthy and safe pregnancies and continue to lead productive lives.

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Endnotes

1 Center on Budget and Policy Priorities, "Chart Book: Accomplishments of Affordable Care Act," March 19, 2019, available at https://www.cbpp.org/research/health/chart-book-accomplishments-of-affordable-care-act.

2 Stacey McMorrow and others, "Changes in New Mothers' Health Care Access and Affordability under the Affordable Care Act" (Washington: Urban Institute, 2020), available at https://www.urban.org/research/publication/changes-new-mothers-health-care-access-and-affordability-under-affordable-care-act.

3 Adam Searing and Donna Cohen Ross, "Medicaid Expansion Fills Gaps in Maternal Health Coverage Leading to Healthier Mothers and Babies" (Washington: Georgetown University Health Policy Institute, 2019), available at https://ccf.georgetown.edu/2019/05/09/medicaid-expansion-fills-gaps-in-maternal-health-coverage-leading-to-healthier-mothers-and-babies/.

4 National Women's Law Center, "Turning to Fairness: Insurance discrimination against women today and the Affordable Care Act" (Washington: 2012), available at https://www.nwlc.org/sites/default/files/pdfs/nwlc_2012_turningtofairness_report.pdf.

5 Dania Palanker, JoAnn Volk, and Justin Giovannelli, "Eliminating Essential Health Benefits Will Shift Financial Risk Back to Consumers," The Commonwealth Fund, March 24, 2017, available at https://www.commonwealthfund.org/blog/2017/eliminating-essential-health-benefits-will-shift-financial-risk-back-consumers.

6 Jamille Fields Allsbrook, "Repealing the ACA During the Coronavirus Pandemic Would Be Devastating for Women's Health and Economic Security" Center for American Progress, October 14, 2020, available at https://www.americanprogress.org/issues/women/news/2020/10/14/491553/repealing-aca-coronavirus-pandemic-devastating-womens-health-economic-security/.

7 Health Resources & Services Administration, "Women's Preventive Services Guidelines," available at https://www.hrsa.gov/womens-guidelines/index.html (last accessed March 2021).

8 Robin A. Cohen and others, "Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January–June 2020" (Washington: National Center for Health Statistics, 2021), available at https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur202102-508.pdf; Sofia Carratala and Connor Maxwell, "Health Disparities by Race and Ethnicity" (Washington: Center for American Progress, 2020), available at https://www.americanprogress.org/issues/race/reports/2020/05/07/484742/health-disparities-race-ethnicity/.

9 Kaiser Family Foundation, "Women's Coverage, Access, and Affordability: Key Findings from the 2017 Kaiser Women's Health Survey" March 13, 2018, available at https://www.kff.org/womens-health-policy/issue-brief/womens-coverage-access-and-affordability-key-findings-from-the-2017-kaiser-womens-health-survey/.

10 Jamila Taylor and others, "Eliminating Racial Disparities in Maternal and Infant Mortality: A Comprehensive Policy Blueprint" (Washington: Center for American Progress, 2019), available at https://www.americanprogress.org/issues/women/reports/2019/05/02/469186/eliminating-racial-disparities-maternal-infant-mortality/; Anusha Ravi, "Limiting Abortion Access Contributes to Poor Maternal Health Outcomes" (Washington: Center for American Progress, 2018), available at https://www.americanprogress.org/issues/women/reports/2018/06/13/451891/limiting-abortion-access-contributes-poor-maternal-health-outcomes/.

11 Ezekiel J. Emanuel, Amol S. Navathe, and Cathy Zhang, "Evaluating The ACA's Delivery System Reforms," Health Affairs Blog, March 13, 2020, available at https://www.healthaffairs.org/do/10.1377/hblog20200312.516650/full/.

12 Health Payer Intelligence, "The Defining Features of Current Value-Based Care Models," September 23, 2019, available at https://healthpayerintelligence.com/news/the-defining-features-of-current-value-based-care-models.

13 Sinsi Hernández-Cancio and others, "A Framework for Advancing Health Equity and Value: Policy Options for Reducing Health Inequities by Transforming Health Care Delivery and Payment Systems" (Washington: Families USA, 2018), available at https://familiesusa.org/wp-content/uploads/2018/06/FamiliesUSA_Policy-Options_Report.pdf.

14 Laura C. Yasaitis and others, "Physicians' Participation In ACOs Is Lower In Places With Vulnerable Populations Than In More Affluent Communities," *Health Affairs* 35 (8) (2016): 1382–1390, available at https://pubmed.ncbi.nlm.nih.gov/27503961/.

15 Adam Sonfield, "No One Benefits If Women Lose Coverage for Maternity Care" (Washington: Guttmacher Institute, 2017), available at https://www.guttmacher.org/gpr/2017/06/no-one-benefits-if-women-lose-coverage-maternity-care.

16 Board of Governors of the Federal Reserve System, "Report on the Economic Well-Being of U.S. Households in 2018 – May 2019," available at https://www.federalreserve.gov/publications/2019-economic-well-being-of-us-households-in-2018-dealing-with-unexpected-expenses.htm (last accessed March 2021).

17 Lauren M. Wier and Roxanne M. Andrews, "The National Hospital Bill: The Most Expensive Conditions by Payer, 2008," Agency for Healthcare Research and Quality, March 2011, available at https://www.hcup-us.ahrq.gov/reports/statbriefs/sb107.jsp.

18 David U. Himmelstein and others, "Medical Bankruptcy: Still Common Despite the Affordable Care Act," *American Journal of Public Health* 109 (3) (2019): 431–433, available at https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2018.304901.

19 Edwin Park and Sabrina Corlette, "American Rescue Plan Act: Health Coverage Provisions Explained" (Washington: Georgetown University Health Policy Institute, 2021), available at https://ccf.georgetown.edu/wp-content/uploads/2021/03/American-Rescue-Plan-signed-fix-2.pdf; Katie Keith, "Final Coverage Provisions In The American Rescue Plan And What Comes Next," Health Affairs Blog, March 11, 2021, available at https://www.healthaffairs.org/do/10.1377/hblog20210311.725837/full/.

20 H.R. 959, Black Maternal Health Momnibus Act of 2021, 117th Cong. 1st sess. (February 8, 2021), available at https://www.congress.gov/bill/117th-congress/house-bill/959/text.

21 Kaiser Family Foundation, "State Health Insurance Marketplace Types, 2021," available at https://www.kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last accessed March 2021).

22 HealthCare.gov, "2021 Open Enrollment is just days away!", October 29, 2020, available at https://www.healthcare.gov/blog/2021-enrollment-days-away/.

23 Raising Women's Voices, "New York becomes first state with Special Enrollment Period for pregnancy" (Boston: Community Catalyst, 2016), available at https://www.communitycatalyst.org/resources/alerts/RWV-NY-Pregnancy-SEP-Fact-Sheet.pdf?tr=y&auid=1640971; NY S05972, 2015-2016 General Assembly (December 22, 2015), available at https://www.billtrack50.com/BillDetail/649970; An Act Authorizing Pregnancy As A Qualifying Event For Special Enrollment Periods For Certain Individuals, Public Act No.18-43, Connecticut General Assembly (June 1, 2018), available at https://www.cga.ct.gov/asp/cgabillstatus/cgabillstatus.asp?selBillType=Bill&which_year=2018&bill_num=SB+206; Executive Board of the District of Columbia Health Benefit Exchange Authority, "Resolution: To define an additional 'exceptional circumstance' for a Special Enrollment Period related to individuals who are pregnant" (Washington: 2020), available at https://hbx.dc.gov/sites/default/files/dc/sites/hbx/publication/attachments/Resolution%20-%20Pregnancy%20SEP%20final-passed%20%281-8-20%29.pdf; An act relating to health insurance and Medicaid coverage for contraceptives, Act 120, Vermont General Assembly (May 23, 2016), available at https://legislature.vermont.gov/bill/status/2016/H.620; Maryland Health Connection, "Are you pregnant? Enroll in a health plan with Maryland Health Connection!", available at https://www.marylandhealthconnection.gov/pregnancy-sep/ (last accessed March 2021); ILSA Inc., "New Jersey Implements Special Enrollment Period for Pregnant Individuals," Press release, October 9, 2020, available at https://www.ilsainc.com/insurance-industry/new-jersey-implements-special-enrollment-period-for-pregnant-individuals/.

24 To arrive at this figure, the authors first determined the number of female U.S. residents aged 15 to 44 years in 2018 using U.S. Census Bureau data (approximately 64 million women) and then applied the Guttmacher Institute's 12 percent uninsured rate to calculate the total number of uninsured women of reproductive age in 2018 (about 7.7 million women). Guttmacher Institute, "Fewer U.S. women of reproductive age were uninsured in 2018 than in 2013," January 27, 2020, available at https://www.guttmacher.org/infographic/2020/fewer-us-women-reproductive-age-were-uninsured-2018-2013; U.S. Census Bureau, "Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States: April 1, 2010 to July 1, 2019," available at https://www2.census.gov/programs-surveys/popest/tables/2010-2019/national/asrh/nc-est2019-agesex.xlsx (last accessed March 2021).

25 Sara R. Collins, Munira Z. Gunja, and Gabriella N. Aboulafia, "U.S. Health Insurance Coverage in 2020: A Looming Crisis in Affordability" (New York: The Commonwealth Fund, 2020), available at https://www.commonwealthfund.org/publications/issue-briefs/2020/aug/looming-crisis-health-coverage-2020-biennial.

26 Office on Women's Health, "Prenatal care and tests," U.S. Department of Health and Human Services, available at https://www.womenshealth.gov/pregnancy/youre-pregnant-now-what/prenatal-care-and-tests (last accessed March 2021); Lloyd Vries, "An Alternative To Amnio," CBS News, November 11, 2003, available at https://www.cbsnews.com/news/an-alternative-to-amnio/.

27 Christina Postolowski, "Without Maternity Coverage: The Need for Special Enrollment in the Health Insurance Marketplaces during Pregnancy" (Washington: Young Invincibles, 2014), available at https://younginvincibles.org/wp-content/uploads/2017/05/Without-Maternity-Coverage-1.5.15_4.pdf.

28 Katherine E. Debiec and others, "Inadequate prenatal care and risk of preterm delivery among adolescents: a retrospective study over 10 years," *American Journal of Obstetrics & Gynecology* 203 (2) (2021): 122.E1–122.E6, available at https://www.ajog.org/article/S0002-9378(10)00288-7/fulltext.

29 The authors adjusted the study's 2005 dollars to 2021 dollars using the U.S. Bureau of Labor Statistics' Consumer Price Index Inflation Calculator, available at https://www.bls.gov/data/inflation_calculator.htm; R.E. Behrman and A.S. Butler, "Preterm Birth: Causes, Consequences, and Prevention" (Washington: National Academy Press, 2007), available at https://www.ncbi.nlm.nih.gov/books/NBK11358/.

30 Ibid.

31 Ibid.

32 Amanda Cassidy, "Essential Health Benefits (Updated)" (Bethesda, MD: Health Affairs, 2013), available at https://www.healthaffairs.org/do/10.1377/hpb20130502.454771/full/.

33 Center for Consumer Information and Insurance Oversight, "Essential Health Benefits Bulletin" (Washington: 2011), available at https://www.cms.gov/CCIIO/Resources/Files/Downloads/essential_health_benefits_bulletin.pdf.

34 Institute of Medicine, "Essential Health Benefits: Balancing Coverage and Cost" (Washington: 2012), available at https://www.nap.edu/catalog/13234/essential-health-benefits-balancing-coverage-and-cost.

35 This issue brief is focused on maternal and newborn care and thus is not opining on the other 10 EHB categories.

36 *American College of Obstetricians and Gynecologists*, "Levels of Maternal Care," 134 (2) (2019): e41–e55, available at https://www.acog.org/clinical/clinical-guidance/obstetric-care-consensus/articles/2019/08/levels-of-maternal-care.

37 National Partnership for Women and Families, "Guidelines for States on Maternity Care In the Essential Health Benefits Package" (Washington: 2012), available at http://go.nationalpartnership.org/site/DocServer/REPRO_Guidelines_for_States_on_Maternity_Care7.30.12.pdf?docID=11181.

38 National Women's Law Center, "Toolkit: New Benefits for Breastfeeding Moms: Facts and Tools to Understand Your Coverage under the Health Care Law" (Washington: 2014), available at https://www.nwlc.org/sites/default/files/pdfs/final_nwlcbreastfeedingtoolkit2014_edit.pdf.

39 Maura Calsyn and Nicole Rapfogel, "Administrative Actions To Reverse Sabotage and Lower Costs in the ACA Marketplaces" (Washington: Center for American Progress, 2020), available at https://www.americanprogress.org/issues/healthcare/reports/2020/07/14/487610/administrative-actions-reverse-sabotage-lower-costs-aca-marketplaces/.

40 Kaiser Family Foundation, "Analysis: Most Short-Term Health Plans Don't Cover Drug Treatment or Prescriptions Drugs, and None Cover Maternity Care," Press release, April 23, 2018, available at https://www.kff.org/health-reform/press-release/analysis-most-short-term-health-plans-dont-cover-drug-treatment-or-prescription-drugs-and-none-cover-maternity-care/.

41 Katie Keith, "New Congressional Investigation of Short-Term Plans," Health Affairs Blog, June 26, 2020, available at https://www.healthaffairs.org/do/10.1377/hblog20200626.227261/full/; Lisa L. Gill, "The High Cost of Cheap Health Insurance," *Consumer Reports*, Febraury 13, 2021, available at https://www.consumerreports.org/health-insurance/the-high-cost-of-cheap-health-insurance/#:~:text=And%20whereas%20ACA%20plans%20also,twice%20as%20much%20as%20men.

42 Institute for Healthcare Policy & Innovation, "Short-Term Health Plans: State Options to Support the Health of Moms and Babies" (Ann Arbor, MI: University of Michigan, 2019), available at https://ihpi.umich.edu/news/ihpi-briefs/STPs-Maternity-Care.

43 JoAnn Volk, Justin Giovannelli, and Christina L. Goe, "States Take Action on Health Care Sharing Ministries, But More Could Be Done to Protect Consumers," Commonwealth Fund, February 19, 2020, available at https://www.commonwealthfund.org/blog/2020/states-take-action-health-care-sharing-ministries-more-could-be-done-protect-consumers.

44 JoAnn Volk, Emily Curran, and Justin Giovannelli, "Health Care Sharing Ministries: What Are the Risks to Consumers and Insurance Markets?" (New York: Commonwealth Fund, 2018), available at https://www.commonwealthfund.org/sites/default/files/2018-08/Volk_hlt_care_sharing_ministries.pdf.

45 Ibid.

46 Ibid.

47 Kevin Lucia and others, "State Regulation of Coverage Options Outside of the Affordable Care Act: Limiting the Risk to the Individual Market" (New York: Commonwealth Fund, 2018), available at https://www.commonwealthfund.org/publications/fund-reports/2018/mar/state-regulation-coverage-options-outside-affordable-care-act.

48 Affordable choices of health benefit plans, 42 U.S.C. 18031(c)(1)(B) (March 23, 2010), available at https://www.law.cornell.edu/uscode/text/42/18031.

49 Affordable choices of health benefit plans, 42 U.S. Code § 18031 (March 23, 2010), available at https://www.law.cornell.edu/uscode/text/42/18031; Network adequacy standards, 45 CFR § 156.230 (March 8, 2016), available at https://www.law.cornell.edu/cfr/text/45/156.230.

50 Essential community providers, 45 CFR 156.235 (October 1, 2014), available at https://www.law.cornell.edu/cfr/text/45/156.235.

51 Center for Medicare & Medicaid Services, "Draft 2017 Letter to Issuers in the Federally-facilitates Marketplaces," December 23, 2015, available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Draft-2017-Letter-to-Issuers-12-23-2015_508.pdf.

52 Nora Ellmann, "Community-Based Doulas and Midwives: Key to Addressing the U.S. Maternal Health Crisis" (Washington: Center for American Progress, 2020), available at https://www.americanprogress.org/issues/women/reports/2020/04/14/483114/community-based-doulas-midwives/.

53 Katy B. Kozhimannil, Laura Attanasio, and Fernando Alarid-Escudero, "More Midwife-Led Care Could Generate Cost Savings and Health Improvements" (Minneapolis: University of Minnesota School of Public Health, 2019), available at https://www.sph.umn.edu/sph-2018/wp-content/uploads/docs/policy-brief-midwife-led-care-nov-2019.pdf.

54 Karen S. Greiner and others, "The Cost-Effectiveness of Professional Doula Care for a Woman's First Two Births: A Decision Analysis Model," *Journal of Midwifery & Women's Health* 64 (4) (2019): 410–420, available at https://onlinelibrary.wiley.com/doi/abs/10.1111/jmwh.12972; Sharon Muza, "Research Review: Doula Care Not Only Improves Outcomes But It Is Cost-Effective Also," Lamaze International, May 21, 2019, available at https://www.lamaze.org/Connecting-the-Dots/research-review-doula-care-not-only-improves-outcomes-but-it-is-cost-effective-also-1.

55 Centers for Medicare & Medicaid Services, "Affordable Care Act Implementation FAQs – Set 15," available at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs15 (last accessed March 2021); Amy N. Moore, "ACA Prohibits Discrimination Against Licensed Providers," Inside Compensation, July 31, 2014, available at https://www.insidecompensation.com/2014/07/31/aca-prohibits-discrimination-against-licensed-providers/.

56 Michelle Andrews, "Health Law Provides No Guarantees Of Access To Midwives, Birthing Centers," Kaiser Health News, March 4, 2014, available at https://khn.org/news/michelle-andrews-health-law-provides-no-guarantees-of-access-to-midwives/.

57 Ibid.

58 Amy Chen and Alexis Robles-Fradet, "Building A Successful Program for Medi-Cal Coverage for Doula Care: Findings From A Survey of Doulas in California" (Washington: National Health Law Program, 2020), available at https://healthlaw.org/resource/doulareport/.

59 Ellmann, "Community-Based Doulas and Midwives."

60 Kaiser Family Foundation, "Women's Connections to the Healthcare Delivery System: Key Findings from the 2017 Kaiser Women's Health Survey" (San Francisco: 2018), available at https://www.kff.org/womens-health-policy/issue-brief/womens-connections-to-the-healthcare-delivery-system-key-findings-from-the-2017-kaiser-womens-health-survey/.

61 Planned Parenthood, "The Urgent Need for Planned Parenthood Health Centers" (Washington: 2016), available at https://www.plannedparenthood.org/uploads/filer_public/17/80/1780c9fc-c4d3-48bc-946b-3ae147f5ffe2/20161207_defunding_fs_d01_5.pdf.

62 Families USA, "Network Adequacy and Health Equity: Improving Private Health Insurance Provider Networks for Communities of Color" (Washington: 2014), available at https://familiesusa.org/wp-content/uploads/2019/09/ACT_Network-Adequacy-Brief_final_082214_web.pdf.

63 Centers for Medicare and Medicaid Services, "Guidance to States on Review of Qualified Health Plan Certification Standards in Federally-facilitated Marketplaces for Plan Years 2018 and Later" (Washington: U.S. Department of Health and Human Services, 2017), available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/QHP-Certifcation-Reviews-Guidance-41317.pdf.

64 Mark Hall and Caitlin Brandt, "Network Adequacy Under The Trump Administration," Health Affairs Blog, September 14, 2017, available at https://www.healthaffairs.org/do/10.1377/hblog20170914.061958/full/.

65 Sabrina Corlette and others, "Narrow Provider Networks in New Health Plans: Balancing Affordability with Access to Quality Care" (Washington: Georgetown University Health Policy Institute and the Urban Institute, 2014), https://www.urban.org/sites/default/files/publication/22601/413135-Narrow-Provider-Networks-in-New-Health-Plans.PDF.

66 Corlette and others, "Narrow Provider Networks in New Health Plans"; Michael S. Adelberg and others, "Improving the Accuracy of Health Plan Provider Directories" (New York: Commonwealth Fund, 2019), available at https://www.commonwealthfund.org/publications/journal-article/2019/jun/improving-accuracy-health-plan-provider-directories.

67 Erica L. Eliason, "Adoption of Medicaid Expansion Is Associated with Lower Maternal Mortality," *Women's Health Issues* 30 (3) (2020): 147–152, available at https://pubmed.ncbi.nlm.nih.gov/32111417/.

68 Kaiser Family Foundation, "Medicaid Coverage Rates for the Nonelderly by Race/Ethnicity," available at https://www.kff.org/medicaid/state-indicator/nonelderly-medicaid-rate-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last accessed March 2021).

69 Medicaid and CHIP Payment and Access Commission, "Report to Congress on Medicaid and CHIP: Chapter 5: Medicaid's Role in Maternal Health" (Washington: 2020), available at https://www.macpac.gov/wp-content/uploads/2020/06/Chapter-5-Medicaid%E2%80%99s-Role-in-Maternal-Health.pdf.

70 Hannah Katch, "Medicaid Expansion Improves Postpartum Coverage, Access to Care" (Washington: Center on Budget and Policy Priorities, 2020), available at https://www.cbpp.org/blog/medicaid-expansion-improves-postpartum-coverage-access-to-care.

71 Kaiser Family Foundation, "Status of State Medicaid Expansion Decisions: Interactive Map," March 12, 2021, available at https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/.

72 Amy Chen, "Q&A on Pregnant Women's Coverage Under Medicaid and the ACA," National Health Law Program, September 5, 2018, available at https://healthlaw.org/resource/qa-on-pregnant-womens-coverage-under-medicaid-and-the-aca/.

73 The 62,932 people who Ilinois projects will be newly eligible for postpartum coverage following its Medicaid extension is the sum of the following: "an additional 55,788 postpartum member months per year for U.S. Citizens, an additional 1,211 postpartum member months qualified immigrants who meet the five year waiting period, and an additional 5,933 postpartum member months for qualified immigrants in their five year waiting period"; Illinois Department of Healthcare and Family Services, "Notice of Public Information: Section 1115 Research and Demonstration Waiver" (Chicago: 2019), available at https://www.illinois.gov/hfs/SiteCollectionDocuments/112719PublicNotice1115EligibilityWaiverFINAL.pdf.

74 Healthinsurance.org, "Illinois and the ACA's Medicaid expansion," available at https://www.healthinsurance.org/illinois-medicaid/ (last accessed March 2021).

75 Aaron Bloschichak and Katie Martin, "Most Postpartum Spending Occurs Beyond 60 Days After Delivery," Health Care Cost Institute, May 13, 2020, available at https://healthcostinstitute.org/hcci-research/most-postpartum-spending-occurs-beyond-60-days-after-delivery#:~:text=Per%20person%20spending%20for%20the,spending%20was%20just%20above%20%243%2C100.

76 Stacey McMorrow and others, "Uninsured New Mothers' Health and Health Care Challenges Highlight the Benefits of Increasing Postpartum Medicaid Coverage" (Washington: The Urban Institute, 2020), available at https://www.urban.org/sites/default/files/publication/102296/uninsured-new-mothers-health-and-health-care-challenges-highlight-the-benefits-of-increasing-postpartum-medicaid-coverage_0.pdf.

77 Jamie R. Daw and others, "Women In The United States Experience High Rates Of Coverage 'Churn' In Months Before And After Childbirth," *Health Affairs* 36 (4) (2017): 598–606, available at https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.1241.

78 Niko Lehman-White and Saeed Aminzadeh, "Reducing Churn to Increase Value in Health Care: Solutions for Payers, Providers, and Policymakers," The Health Care Blog, May 15, 2019, available at https://thehealthcareblog.com/blog/2019/05/15/reducing-churn-to-increase-value-in-health-care-solutions-for-payers-providers-and-policymakers/.

79 Jamie R. Daw and others, "Medicaid Expansion Improved Perinatal insurance Continuity For Low-Income Women," *Health Affairs* 39 (9) (2020), available at https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.01835.

80 Centers for Medicare & Medicaid Services, "Strong Start for Mothers and Newborns Initiative: Effort to Reduce Early Elective Deliveries," available at https://innovation.cms.gov/innovation-models/strong-start-strategy-1 (last accessed March 2021).

81 Centers for Medicare & Medicaid Services, "Strong Start for Mothers and Newborns Initiative: Enhanced Prenatal Care Models," available at https://innovation.cms.gov/innovation-models/strong-start-strategy-2 (last accessed March 2021).

82 Centers for Medicare & Medicaid Services, "Maternal Opioid Misuse (MOM) Model," available at https://innovation.cms.gov/innovation-models/maternal-opioid-misuse-model (last accessed March 2021).

83 Medicaid and CHIP Payment and Access Commission, "June 2020 Report to Congress on Medicaid and CHIP" (Washington: 2020), available at https://www.macpac.gov/publication/june-2020-report-to-congress-on-medicaid-and-chip/.

84 Tech to Save Moms Act, H.R. 6138, 116th Cong., 2nd sess. (March 9, 2020), available at https://www.congress.gov/bill/116th-congress/house-bill/6138.

85 IMPACT to Save Moms Act of 2020, H.R. 6137, 116th Cong., 2nd sess. (March 9, 2020), available at https://www.congress.gov/bill/116th-congress/house-bill/6137.

86 Data to Save Moms Act of 2020, H.R. 6165, 116th Cong., 2nd sess. (March 10, 2020), available at https://www.congress.gov/bill/116th-congress/house-bill/6165/text.

87 National Quality Forum, "NQF Endorses Perinatal Measures," Press release, April 2, 2012, available at https://www.qualityforum.org/News_And_Resources/Press_Releases/2012/NQF_Endorses_Perinatal_Measures.aspx.

88 University of California San Francisco, "The Person-Centered Contraceptive Counseling Measure," available at https://pcccmeasure.ucsf.edu/ (last accessed March 2021); Centers for Disease Control and Prevention, "Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs," *Morbidity and Mortality Weekly Report* 63 (4) (2014), available at https://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf; Loretta Gavin, Karen Pazol, and Katherine Ahrens, "Update: Providing Quality Family Planning Services – Recommendations from CDC and the U.S. Office of Population Affairs, 2017," *Morbidity and Mortality Weekly Report* 66 (50) (2017): 1383–1385, available at https://www.cdc.gov/mmwr/volumes/66/wr/mm6650a4.htm.

89 Mandy Truong, Yin Paradies, and Naomi Priest, "Interventions to improve cultural competency in healthcare: a systemic review of reviews," *BMC Health Services Research* 14 (2014): 99, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3946184/.

90 Hernández-Cancio and others, "A Framework for Advancing Health Equity and Value."

91 Ibid.

92 Karen E. Joynt Maddox, "Financial Incentives and Vulnerable Populations – Will Alternative Payment Models Help or Hurt?", *New England Journal of Medicine* 378 (2018): 977–979, available at https://www.nejm.org/doi/full/10.1056/NEJMp1715455.

93 Dhruv Khullar and Dave A. Chokshi, "Can Better Care Coordination Lower Health Care Costs?", *JAMA Network Open* 1 (7) (2018): e184295, available at https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2712173.

94 Marianna M. Hillemeier and others, "Effects of Maternity Care Coordination on Pregnancy Outcomes: Propensity-Weighted Analyses," *Maternal and Child Health Journal* 19 (1) (2015): 121–127, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4459720/.

95 Derica Smith and Carrie Hanlon, "Case Study: Tennessee's Perinatal Episode of Care Payment Strategy Promotes Improved Birth Outcomes" (Portland, ME: National Academy for State Health Policy, 2017), available at https://www.nashp.org/wp-content/uploads/2017/10/Tennessee-Case-Study-Final.pdf.