ISSUE BREIF

FEDERAL AND STATE COVERAGE REQUIREMENTS FOR *Postpartum Care*

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Overview

Most women[1] who give birth in the United States depend on health care coverage to pay for medically necessary care during the perinatal period.[2] Coverage may be obtained in myriad ways, including through Marketplace plans, employer-sponsored insurance (ESI), Medicaid, Medicare, TRICARE, the Children's Health Insurance Program (CHIP), or an individual health plan. Due to our fragmented healthcare coverage system, women often lack the necessary coverage to care for themselves adequately.

United States of Care's (USofCare) listening research revealed that women desire more support during the postpartum period,[3] when they felt their care from health care providers severely diminished. Recognizing the need to better understand the health benefits offered during the postpartum period and gaps resulting from a lack of standardized postpartum care, USofCare analyzed the federal and state coverage requirements for postpartum care.

Approach

For our analysis, we reviewed federally mandated postpartum coverage requirements, and the essential health benefits (EHB) benchmark plans[4] for all 50 states and the District of Columbia to understand better the minimum postpartum coverage benefits required for private health care plans.

For our federal coverage analysis, we examined:

- Affordable Care Act (ACA) requirements;
- U.S. Preventive Services Task Force (USPSTF) recommendations;
- Health Resources and Services Administration (HRSA) guidelines;
- Medicaid;
- Medicare;
- Children's Health Insurance Program; and
- TRICARE.

In addition to our federal coverage analysis discussed in the findings section, the accompanying spreadsheet captures postpartum-related services in state EHB-benchmark plans[5] based on publicly available information from the Centers for Medicare & Medicaid Services (CMS).

The following questions guided our analysis of requirements impacting the postpartum period in state EHB-benchmark plans:

- **Obstetrical Care Provider Definition & Limitations:** Does the plan define what an obstetrical care provider is? If so, are there any limitations?
- **Does the plan include midwives?** (Yes, Limitations, No): Does the plan provide coverage for midwives? If so, what type and under what conditions?
- **Birth Location:** Does the plan provide coverage for elective home births or licensed birth centers?
- **Definition of Maternity Care:** How does the plan define maternity care?
- **Additional Benefits:** Does the plan offer additional benefits to someone in the perinatal period? (e.g., home visiting programs & parenting education programs)
- **Breastfeeding Support:** How does the plan define breastfeeding support and supplies?
- **Maternity minimum stay (state-required benefit):** Does the state require plans to cover a maternity minimum stay?
- **Maternity coverage for dependent daughters (state-required benefit):** Does the state require plans to cover maternity care for dependent daughters (under 26)?
- **Case Management:** How does the plan define case management? Is there any mention of high-risk pregnancy?

COVERAGE DEFINITIONS

- **Individual Coverage:** Individual health insurance, also known as personal health insurance, covers a person or family. This type of coverage is purchased individually, as opposed to obtained through an employer or from a government health program (e.g., Medicaid or Medicare).
- **Small Group Coverage:** A small group is generally defined as a business with 1 to 50 employees. However, some states extend the definition to include businesses with up to 100 employees.
- **Large Group Coverage:** Large group health insurance plans are for companies with over 50 employees. Some states define large businesses as more than 100 employees rather than 50.

Findings

Our analysis reveals a patchwork of federal coverage requirements and requirements under individual state EHB-benchmark plans, creating significant variation in access to postpartum care across the country. This inconsistency in coverage requirements and emerging trends in policy priorities provide opportunities for improvements across states and to work towards comprehensive postpartum care. **Aligning federal and state policies to create a comprehensive and consistent standard of postpartum care can close gaps and improve maternal health.**

STATE EHB-BENCHMARK PLANS

According to the ACA, non-grandfathered health plans in the individual and small group markets must submit state-specific EHB-benchmark plans to CMS every few years; these plans set the standard for coverage of the essential health benefits (EHBs), which includes maternity and newborn care, and nine other categories of services. States may choose their benchmark plans by selecting (1) another state's EHB-benchmark plan, (2) replacing a category or categories of benefits from another state's EHB-benchmark plan, or (3) otherwise defining the state's EHB-benchmark plan (i.e., building a unique benchmark plan). Benchmark options include both a ceiling and a floor. For example, plans may not be less comprehensive than any 2017 benchmark options or a typical employer plan in the state, and they may not include more generous benefits than the most generous of the ten benchmark options the state had available in 2017. Furthermore, many states do not have a formal process for EHB benchmark selection.[6]

State EHB-benchmark plans establish the baseline for maternity care coverage, making them a critical lever for enhancing postpartum care. By expanding EHB-benchmark plans to include comprehensive postpartum services, states can significantly improve postpartum support, outcomes, and experiences for women. For example, the Expanwding Access to Women's Health Grant Program gives states the option to use grant funds to assess and update current EHB-benchmark plans to include a broader scope of benefits coverage for reproductive and maternal health services with the goal of improving access to women's health care, including maternal care.

[1] While this brief primarily uses the term "women", we acknowledge that not all individuals who give birth identify as women. Our findings are based on listening research conducted with participants who all self-identified as women. We recognize the postpartum experiences and health care needs of transgender men and non-binary individuals may differ significantly from those of cisgender women.

[2] The perinatal period is defined as the time when a woman becomes pregnant and up to a year after delivery.

[3] The Centers for Disease Control and Prevention define the postpartum period as the first year following delivery.

[4] An EHB-benchmark plan is a set of benefits that comprehensive individual and small group health insurance coverage must provide. An EBH-benchmark plan is considered the standard for essential health benefits (EHBs).

[5] US of Care analyzed the most recent state EHB-benchmark plan that was available, including plans covering years 2017 - 2025, and more recent plans covering years 2024 - 2025.

[6] In the Department of Health and Human Services Notice of Benefit and Payment Parameters for 2025 Final Rule, CMS finalized updates to the EHB-benchmark plan update process. Notably, CMS will no longer require the replacement of entire benchmark plans, and will instead allow the selection or update of subsets of benefits.

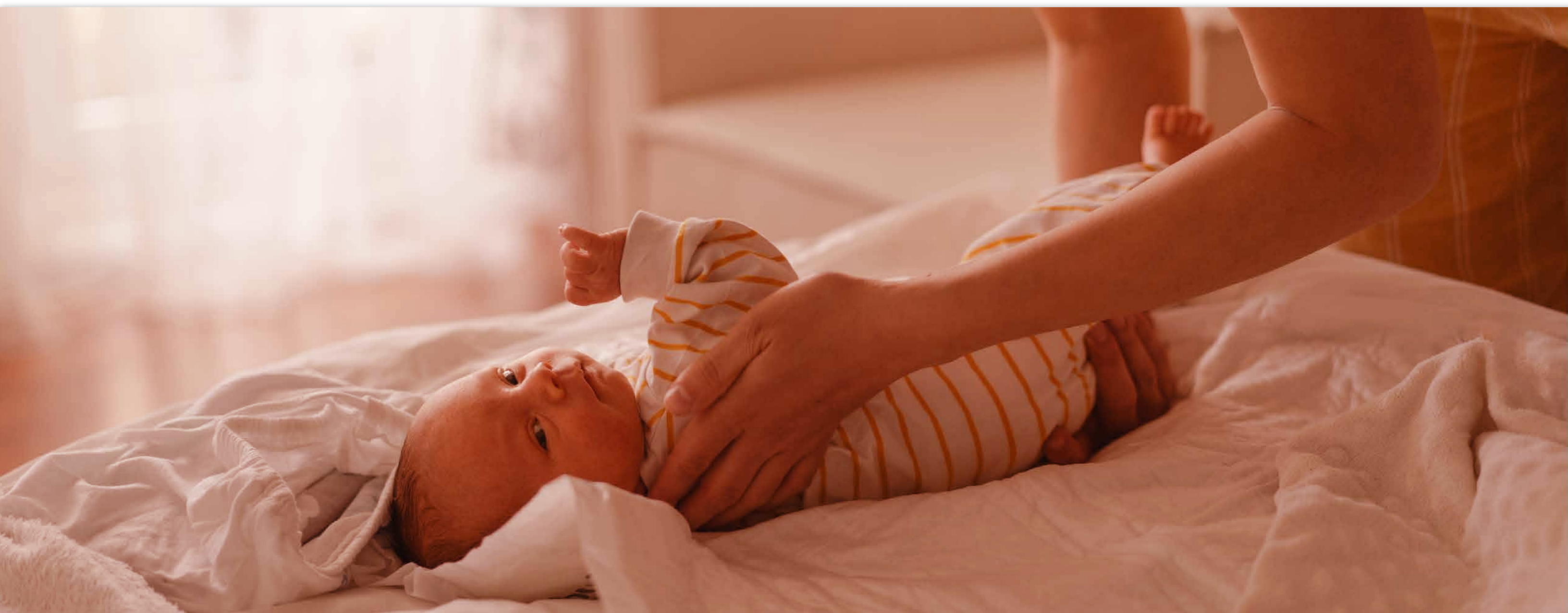
Federal

The federally mandated requirements for maternity care coverage are minimal, leaving interpretation and opportunities for innovation up to the state regulators and health plan administrators.

- Under the ACA, all health insurance companies, including fully-insured, self-insured, and individual health plans, must provide clear, consistent, and comparable information about consumers' health benefits and coverage.
- Additionally, the ACA requires all plans to cover preventive services recommended by the U.S. Preventive Services Task Force (USPSTF) with an A or B rating. The USPSTF recommendations related to the postpartum period include:
    - **Screening for Depression:** The USPSTF recommends screening for depression in the adult population, including pregnant and postpartum persons and older adults.
    - **Prevention Interventions for Depression:** The USPSTF recommends that clinicians provide or refer pregnant and postpartum persons who are at increased risk of perinatal depression to counseling interventions.
    - **Screening for Anxiety:** The USPSTF recommends screening for anxiety disorders in adults, including pregnant and postpartum persons.
    - **Interventions for Breastfeeding:** The USPSTF concludes with moderate certainty that interventions to support breastfeeding have a moderate net benefit for women and their children.
- All private health care plans, except those that maintain "grandfathered" status, must cover preventive services outlined in the Women's Preventive Services Guidelines without charging a copayment or coinsurance for those who use in-network providers. WPSI guidelines related to postpartum care include:
    - **Breastfeeding Services and Supplies:** Plans must cover comprehensive lactation support services (including consultation, counseling, education by clinicians and peer support services, and breastfeeding equipment and supplies) to optimize the successful initiation and maintenance of breastfeeding.
    - **Contraception:** Adolescent and adult women should have access to the full range of contraceptives and contraceptive care to prevent unintended pregnancies and improve birth outcomes. Contraceptive care includes screening, education, counseling, and provision of contraceptives (including in the immediate postpartum period).
    - **Screening for Anxiety:** Plans must cover screening for anxiety in adolescent and adult women, including those who are pregnant or postpartum.
    - **Screening for Diabetes after Pregnancy:** Women with a history of gestational diabetes mellitus who are not currently pregnant and who have not previously been diagnosed with type 2 diabetes should be screened for diabetes post-pregnancy. Initial testing should ideally occur within the first year postpartum and can be conducted as early as four to six weeks postpartum.
    - **Well-Woman Preventive Visits:** Women should receive at least one preventive care visit annually, beginning in adolescence and continuing across the lifespan, to ensure all recommended preventive services are provided. Well-women visits also include a postpartum visit that covers anxiety screening; breastfeeding counseling, services, and supplies; contraception and contraceptive care; depression screening and preventative interventions; diabetes screening (as needed); folic acid supplementation; interpersonal and domestic violence screening; substance use screening and assessment; and tobacco screening and counseling.

- Under the Newborns' and Mothers' Health Protection Act, large-group health plans may not restrict benefits for mothers or newborns for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. After consulting with the mother, the attending provider may decide to discharge the mother and her newborn child earlier.
- Federal Medicaid statute requires coverage of prenatal care, delivery, postpartum care, and family planning, as well as services for conditions that may threaten to carry the fetus to full term or the fetus' safe delivery. The state ultimately decides what broad set of services are covered. As of August 2024, 47 states and the District of Columbia have extended postpartum coverage up to 12 months following delivery and two states are planning on implementing the extension.

- Medicare covers "reasonable and necessary services associated with pregnancy," including postnatal care for a miscarriage or a medically necessary abortion.
- Under the Children's Health Insurance Program (CHIP), coverage may be provided to the pregnant woman directly or to the fetus. If coverage is provided to the pregnant woman directly, then coverage is typically comprehensive and is the equivalent of Medicaid coverage in the state. If coverage is provided to the fetus, then services may not be comprehensive concerning the needs of the pregnant woman. CHIP coverage must be provided for at least 60 days; however, coverage length varies by state.
- TRICARE covers maternity care services related to conception, pregnancy, and delivery, including prenatal and postpartum care (generally for six weeks after delivery) and the treatment of pregnancy complications. TRICARE also covers breast pumps, breast pump supplies, and breastfeeding counseling.



State EHB-Benchmark Plans

The ACA requires non-grandfathered health insurance coverage in the individual and small group markets to cover essential health benefits (EHB), including well-woman visits, prenatal care, and labor and delivery services. Overall, plans need more clarity on coverage benefits. For example, states' definitions of maternity care varied widely. Several states (16) did not mention the postpartum period when defining maternity care. Thus, while we have attempted to catalog what is covered under each EHB-benchmark plan, our analysis may be impaired due to a lack of transparency.

Additionally, we recognized a significant variation between EHB-benchmark plans regarding what they cover and the level of description of coverage requirements. Our analysis revealed numerous coverage gaps in the postpartum period that further perpetuate health disparities.

- **Midwives:** Most state plans cover certified nurse midwives, but only a few states (6) cover other types, such as certified professional midwives.[8]
- **Birth Centers and Home Births:** About one in four states (16) cover deliveries in licensed birthing centers, while only a handful of states (4) cover elective home births. Alaska's plan explicitly states that plan benefits are also extended to cover necessary "supplies" for home births and birthing centers.[9]
- **Breastfeeding Support:** Based on USPSTF recommendations and WPSI guidelines, breastfeeding support is a requirement for state EHB-benchmark plans. Despite the federal requirement, 19 states do not mention "breastfeeding" or "lactation" in their approved plans. While Connecticut's EHB-benchmark plan covers comprehensive lactation visits for two months after delivery, Wisconsin listed breast pumps as an excluded item under "personal care, comfort or convenience."

- **Additional Benefits:** Several plans offer additional benefits for new mothers, such as home visits, parent education programs, and extended hospital stays.
    - Home Visits: Twenty states and the District of Columbia require at least one home visit to the mother and newborn within 24 to 72 hours following discharge from the hospital. These visits typically cover parent education, assistance in breast or bottle feeding, and assessment of the newborn and mother (including any necessary maternal or neonatal tests). However, many states only offer these home visits if the mother is discharged early.
    - Parent Education Programs: Many state EHB-benchmark plans offer plan-specific virtual education programs that provide educational materials for pregnancy and postpartum and connect mothers with nurses or case managers. Massachusetts' EHB-benchmark plan also provides up to $90 reimbursement for completed childbirth classes.
    - Extended Hospital Stays: Two states cover extended hospital stays for the mother and newborn. Maryland requires coverage of additional hospitalization for the newborn for up to four days whenever a mother is required to remain hospitalized after childbirth for medical reasons and requests that the newborn stay in the hospital. In Washington state, there is no limit to the length of the mother's stay; the length of the newborn's stay may be equivalent to the mother's length of stay.
- **State-required benefits:** States can require state-regulated plans (e.g., individual, small group, state employee, etc.) to cover specific health benefits.
    - Maternity minimum stay: The federal Newborns' and Mothers' Health Protection Act (the Newborns' Act) requires self-insured health plans to provide a minimum length of stay in the hospital following childbirth. Most states have a law requiring minimum maternity stay. If a state has a law regulating a minimum stay similar to the Newborns' Act and coverage is provided by an insurance company, then state law will apply.
    - Maternity coverage for dependent children: Plans are not required to cover labor and delivery for dependent children[10]; however, two states have passed laws requiring full maternity coverage for dependent children, and the West Virginia state EHB-benchmark plan specifically includes maternity coverage for dependent children.

Conclusion

This analysis highlights significant gaps and inconsistencies in federal and state postpartum care coverage requirements. While some foundational benefits exist, state approaches to defining and enhancing postpartum care services vary widely. Aligning federal and state policies to establish a comprehensive and consistent standard of postpartum care can improve access to essential postpartum care services and positively impact maternal health outcomes.

[7] Under the ACA, grandfathered health plans are those existing without major changes to their provisions since the date of the ACA's enactment (March 23, 2010).

[8] Midwives offer high-quality, high-touch care that is associated with lower episiotomy rates, higher breastfeeding rates, and a greater sense of respect and autonomy for the patient. They also serve to increase access to care in underserved areas.

[9] Low-risk home and birth center births are associated with lower intervention rates, which can lead to fewer postpartum complications and injuries. Enabling more women access to home and birth center births also increases access to care that is more likely to be culturally congruent.

[10] The ACA requires health plans to cover dependent children up to the age of 26, regardless of marital status.