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State Public Insurance Coverage Policies and Postpartum Care Among Immigrants

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IMPORTANCE Professional medical organizations recommend that adults receive routine postpartum care. Yet, some states restrict public insurance coverage for undocumented immigrants and recently documented immigrants (those who received legal documentation status within the past 5 years).

OBJECTIVE To examine the association between public insurance coverage and postpartum care among low-income immigrants and the difference in receipt of postpartum care among immigrants relative to nonimmigrants.

DESIGN, SETTING, AND PARTICIPANTS A pooled, cross-sectional analysis was conducted using data from the Pregnancy Risk Assessment Monitoring System for 19 states and New York City including low-income adults with a live birth between 2012 and 2019.

EXPOSURE Giving birth in a state that offered public insurance coverage for postpartum care to recently documented or undocumented immigrants.

MAIN OUTCOMES AND MEASURES Self-reported receipt of postpartum care by the category of coverage offered (full coverage: states that offered publicly funded postpartum care regardless of immigration status; moderate coverage: states that offered publicly funded postpartum care to lawfully residing immigrants without a 5-year waiting period, but did not offer postpartum care to undocumented immigrants; no coverage: states that did not offer publicly funded postpartum care to lawfully present immigrants before 5 years of legal residence or to undocumented immigrants).

RESULTS The study included 72 981 low-income adults (20 971 immigrants [29%] and 52 010 nonimmigrants [71%]). Of the 19 included states and New York City, 6 offered full coverage, 9 offered moderate coverage, and 4 offered no coverage; 1 state (Oregon) switched from offering moderate coverage to offering full coverage. Compared with the states that offered full coverage, receipt of postpartum care among immigrants was 7.0–percentage-points lower (95% CI, −10.6 to −3.4 percentage points) in the states that offered moderate coverage and 11.3–percentage-points lower (95% CI, −13.9 to −8.8 percentage points) in the states that offered no coverage. The differences in the receipt of postpartum care among immigrants relative to nonimmigrants were also associated with the coverage categories. Compared with the states that offered full coverage, there was a 3.3–percentage-point larger difference (95% CI, −5.3 to −1.4 percentage points) in the states that offered moderate coverage and a 7.7–percentage-point larger difference (95% CI, −10.3 to −5.0 percentage points) in the states that offered no coverage.

CONCLUSIONS AND RELEVANCE Compared with states without insurance restrictions, immigrants living in states with public insurance restrictions were less likely to receive postpartum care. Restricting public insurance coverage may be an important policy-driven barrier to receipt of recommended pregnancy care and improved maternal health among immigrants.

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Supplemental content

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Maternal morbidity and mortality are higher in the US than in any other high-income nation.[1,2] Health care after childbirth is essential because 65% of pregnancy-related deaths occur at least 1 day after childbirth, and 30% occur between 6 weeks and 1 year after childbirth.[3] During the postpartum period, adults are at particularly high risk for several common but treatable health conditions, including postpartum depression and hypertension.[4,5] Increasing receipt of high-quality postpartum care has the potential to reduce pregnancy-related deaths by increasing diagnosis and management of acute and chronic conditions. During routine postpartum care, which is recommended between 4 and 12 weeks postpartum,[6] adults undergo a full assessment of physical, social, and psychological well-being.

Although public health insurance plays a huge role in financing pregnancy-related and postpartum care of low-income pregnant adults in the US,[7] coverage options are limited for undocumented and recent immigrants. In half of the states, documented immigrants must wait 5 years after establishing legal residence (often referred to as a waiting period) to obtain Medicaid coverage during a pregnancy.[8] Meanwhile, undocumented immigrants are ineligible for coverage in the majority of states. Emergency Medicaid coverage requires states to cover the costs associated with labor and delivery care for all pregnant persons with qualifying incomes regardless of immigration status, but this coverage excludes routine prenatal and postpartum care. These restrictions potentially affect a large share of birthing adults because 23% of births in the US are to immigrants overall, with an estimated 6% of births to undocumented immigrants.[9,10]

States use a variety of mechanisms to cover income-eligible pregnant adults who would otherwise be subject to the waiting period or who are undocumented. These mechanisms include state-funded coverage and coverage provided by 2 different federal policy options: the Children's Health Insurance Program (CHIP) unborn child option and the CHIP Reauthorization Act (CHIPRA) of 2009. The CHIP unborn child option gives states discretion to determine what services are covered, whereas CHIPRA cannot be used to cover undocumented immigrants.[11,12] States that use state funding to create programs for financially eligible immigrants have discretion on both of these dimensions. Therefore, the populations covered and the extent of health care coverage for postpartum care varies across these policy options and by state.

Fewer public coverage options during the postpartum period likely translate into lower health care use because many immigrants lack access to other sources of coverage. In the US, among low-income individuals of reproductive age, 48% of noncitizen immigrants are uninsured compared with 16% of nonimmigrants.[13] Even though lawfully present immigrants who are in the 5-year waiting period can sign up for Affordable Care Act Marketplace plans and premium tax credits, undocumented immigrants are not eligible to enroll in Marketplace coverage.[14]

Despite limited public insurance coverage for undocumented and recently documented immigrants during the postpartum period, little evidence exists examining receipt of postpartum care among low-income immigrants and on the potential role of state coverage policies. The paucity of research in this area is due in part to a lack of state- or national-level population-representative data that contain variables measuring maternal place of birth and use of postpartum care. To our knowledge, there are no publicly available secondary data sources that contain this information. In addition, no publicly available data source exists with complete documentation of state public insurance coverage policies for undocumented and recently documented immigrants during the postpartum period.

In the current study, existing data limitations were overcome by creating a novel data set linking state pregnancy surveillance data with the state birth certificate variable measuring maternal place of birth from 19 states and New York City. Use of this data set enabled documentation of receipt of postpartum care among low-income immigrants, which had not previously been studied beyond the local level. A detailed state policy review also was conducted to determine the availability of public insurance coverage for undocumented and recently documented immigrants during the postpartum period. These data were used to provide the first available evidence on the relationship between state public insurance availability for immigrants and receipt of postpartum care among low-income immigrants.

Key Points

Question Are state public insurance coverage policies associated with postpartum care among low-income immigrants?

Findings In this cross-sectional study including 72 981 low-income adults, immigrants living in states that restrict public insurance coverage for undocumented and recent immigrants were less likely to have received postpartum care compared with immigrants in states without such restrictions.

Meaning Insurance restrictions for immigrants may be a barrier to receipt of recommended postpartum care.

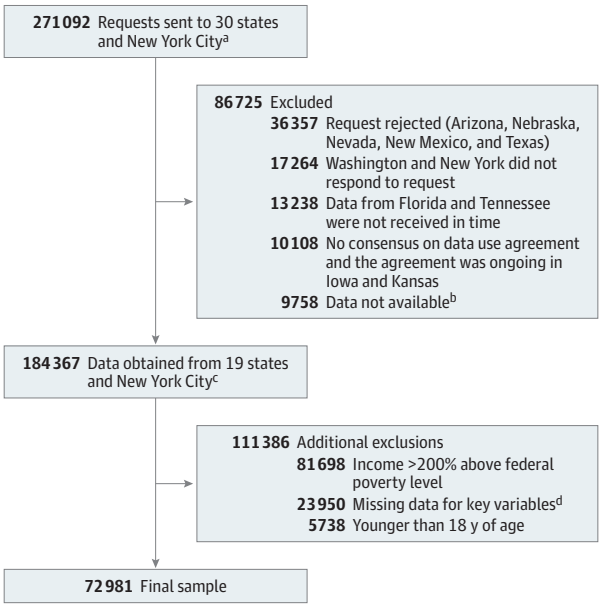
Methods

Data Sources

This study used data from the Pregnancy Risk Assessment Monitoring System (PRAMS) from 2012 through 2019. The management of PRAMS is conducted jointly by the US Centers for Disease Control and Prevention (CDC) and state health departments using standardized methods. Each state participating in PRAMS conducts surveys each year of a representative sample of between 1000 and 3000 adults with a recent live birth (based on birth certificate records).[15] The survey is conducted between 2 and 6 months after childbirth and collects information from respondents on health care use before, during, and after pregnancy, including postpartum health care.[15]

PRAMS does not contain information on maternal place of birth (US or non-US); a prior study[16] of public insurance

Figure 1. Inclusion and Exclusion Criteria for Low-Income Adults in the Pregnancy Risk Assessment Monitoring System



[a] The 30 states sent requests for data on low-income adults were Alaska, Arizona, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Iowa, Kansas, Maryland, Massachusetts, Michigan, Minnesota, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas, Utah, Virginia, and Washington.

[b] Data were (1) not released by the state (in 2015 for Georgia and in 2013 for North Carolina), (2) not ready for release by the state at the time of analysis (in 2019 for Oklahoma), or (3) linkage was not available (in 2012-2015, 2018, and 2019 for New Jersey).

[c] Of the 19 states that provided data, the data were obtained directly from the state for those with years listed in parentheses: Alaska, Colorado (in 2014), Connecticut (in 2013), Delaware, Georgia (in 2014 and 2016), Hawaii, Illinois, Maryland, Massachusetts, Michigan (in 2014), Minnesota (in 2014-2017), New Jersey, North Carolina (in 2012 and 2014-2016), Oklahoma, Oregon (in 2014, 2016, and 2017), Pennsylvania, Rhode Island (in 2015), Utah, and Virginia (in 2012-2014).

[d] Observations were missing for maternal place of birth, income, regression controls (age, years of education, and marital status), and the main outcome of interest (postpartum care) and these individuals were removed from the study data set.

policies for immigrants using PRAMS examined outcomes for all low-income respondents. To overcome this empirical challenge, we requested the state birth certificate variable on maternal place of birth from individual state health departments, along with the PRAMS respondent ID, which would allow this information to be merged with the PRAMS data. We focused on a sample of states that had a sufficient share of state births to immigrants to ensure precise state-level estimates of the study outcomes.

In total, we contacted 30 states and New York City. Additional information appears in the eMethods in Supplement 1. Of the 30 states, 2 states did not respond to the request for data and 5 rejected the request. We excluded 1 state with a high rate of missing data for the maternal place of birth variable and a second state for which we did not receive the data by the time of this analysis in March 2023. We were unable to reach consensus on a data use agreement for 2 additional states. We also excluded 9 survey years of data from the states included in our sample because they were not released by the state in time for this analysis or when linkage to maternal place of birth was not feasible. In addition, we excluded observations that were missing data for maternal place of birth, income, any of the regression controls (age, years of education, marital status) or for the outcome variable (postpartum care) (**Figure 1**).

Study Population

The final sample included PRAMS data from 19 states and New York City. Some states did not conduct a PRAMS survey during all of the study years. In some of the states and during some of the years, the PRAMS surveys did not yield a sufficiently large response rate for the data to be released by the CDC. We requested these data directly from the states and incorporated them into the analysis whenever possible (eTables 1-2 in Supplement 1).

We merged the birth certificate variable on maternal place of birth with the PRAMS data for all included years for the states and New York City to determine whether each respondent was an immigrant or a nonimmigrant. To identify individuals who would be eligible for Medicaid pregnancy coverage, as well as public coverage under alternative state mechanisms, we restricted the study sample to adults with household incomes below 200% of the federal poverty level during the 12 months before childbirth. We used self-reported household size and the midpoint of the income category reported (eg, $0 to $16 000). We also restricted the sample to adults because state public coverage policies can differ for children and adolescents.[17]

Study Outcome

The primary outcome was self-reported receipt of postpartum care by state coverage category (full, moderate, or no). A postpartum visit was ascertained using the PRAMS survey question: "Since your new baby was born, have you had a postpartum checkup for yourself?"

Exposure Categories

To document state variation in public coverage policies for immigrants after pregnancy in the sample states, we collected and analyzed policy documentation from each state. Relevant policy documents included statutes, regulations, clinician manuals, and clinician bulletins. In some cases, we also contacted state officials for assistance in locating appropriate documentation.

Using this information, we classified coverage into the following categories: (1) full coverage: states that offered publicly funded postpartum care regardless of immigration status; (2) moderate coverage: states that offered publicly funded postpartum care to lawfully residing immigrants without a 5-year waiting period, but did not offer postpartum care to undocumented immigrants; (3) no coverage: states that did not offer publicly funded postpartum care to lawfully present immigrants before 5 years of legal residence or to undocumented immigrants.

Table. Characteristics of Low-Income Immigrants and Nonimmigrants Using Pregnancy Risk Assessment Monitoring System Survey Data, 2012-2019

	Proportion (95% CI)[a]	
	Immigrants (n = 20 971)	Nonimmigrants (n = 52 010)
Age group, y		
20-24	16.6 (15.8-17.3)	36.4 (35.7-37.1)
25-29	30.8 (29.8-31.8)	34.2 (33.6-34.9)
30-34	29.7 (28.7-30.6)	19.3 (18.8-19.9)
>34	22.9 (22.1-23.8)	10.0 (9.6-10.4)
Race[b]	(n = 20 813)	(n = 51 505)
American Indian or Alaska Native	0.1 (0-0.1)	1.6 (1.5-1.7)
Black	15.0 (14.3-15.7)	26.1 (25.5-26.7)
Chinese	5.7 (5.3-6.2)	0.1 (0-0.1)
Filipino	1.5 (1.2-1.7)	0.2 (0.1-0.2)
Japanese	0.2 (0.1-0.2)	0 (0-0.1)
Other Asian or Native Hawaiian	8.4 (7.8-8.9)	1.0 (0.9-1.1)
Other Non-White or Multiple	26.8 (25.9-27.7)	7.3 (7.0-7.6)
White	42.3 (41.4-43.3)	63.8 (63.1-64.4)
Hispanic ethnicity[b]	56.4 (55.4-57.3) [n = 20 919]	12.5 (12.1-12.9) [n = 51 840]
Duration of education, y		
<12	32.8 (31.8-33.7)	12.8 (12.3-13.3)
12	30.5 (29.5-31.5)	37.6 (36.9-38.3)
13-15	21.3 (20.5-22.1)	39.4 (38.7-40.1)
≥16	15.4 (14.7-16.1)	10.2 (9.8-10.6)
Income <federal poverty level[c]	60.2 (59.2-61.3)	55.3 (54.6-56.0)
Married	59.0 (58.0-60.0)	38.7 (38.0-39.3)
Previous live births	(n = 20 895)	(n = 51 866)
0	26.2 (25.3-27.1)	29.0 (28.4-29.7)
1	32.0 (31.0-33.0)	31.8 (31.2-32.5)
2	23.4 (22.5-24.3)	20.2 (19.6-20.7)
≥3	18.4 (17.6-19.2)	19.0 (18.4-19.5)
Used English as survey language	52.9 (51.9-53.9) [n = 20 970]	98.3 (98.2-98.5)
Category of coverage offered by each of the 19 included states and New York City		
Full coverage[d]	48.7 (48.4-48.9)	37.5 (37.3-37.7)
Moderate coverage[e]	41.5 (41.2-41.7)	44.4 (44.2-44.6)
No coverage[f]	9.9 (9.7-10.0)	18.1 (18.0-18.2)

[a] All analyses accounted for nonresponse, no coverage, and the complex sampling design.

[b] Derived from birth certificate records. Race and ethnicity were self-reported using closed categories. Multiple selection of categories was allowed.

[c] In 2019, the cutoff was $25 750 for a family of 4.

[d] Offered publicly funded postpartum care regardless of immigration status.

[e] Offered publicly funded postpartum care to lawfully residing immigrants without a 5-year waiting period, but did not offer postpartum care to undocumented immigrants.

[f] Did not offer publicly funded postpartum care to lawfully present immigrants before 5 years of legal residence or to undocumented immigrants.

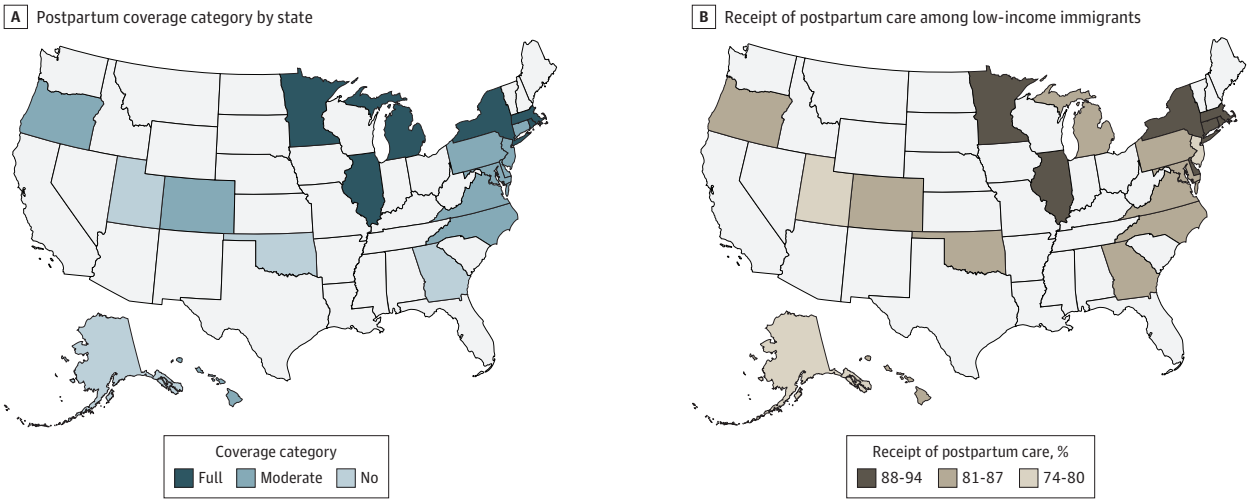
Statistical Analysis

A descriptive analysis was conducted to examine state coverage policies and receipt of postpartum care among low-income immigrants. The average rates for receipt of postpartum care are reported separately for immigrants and nonimmigrants for states within each coverage category (full, moderate, or no).

Logistic regression was used to estimate the association between state coverage policies and receipt of postpartum care. Using the classification system described above, indicator variables for each state coverage category were created. One state switched coverage categories during the study period and was assigned to the new category starting in the year of the policy implementation. The regression model included an indicator for immigrants, indicators for moderate coverage and no coverage, and interactions between these indicators and the indicator for immigrants. Full coverage was used as the reference category.

The adjusted models also included indicators for year and state and individual-level control variables (income as a percentage of the federal poverty level, marital status, age groups, and years of education). Marginal effects (as estimated from the logistic regression results) are reported. All analyses were conducted using survey design variables to account for nonresponse, noncoverage, and the complex sampling design used by PRAMS.

Figure 2. Public Insurance Coverage and Receipt of Postpartum Care Among Low-Income Immigrants



Parts A and B are equal area projections that were designed to reflect the state geographic size (except for Alaska and Hawaii); they do not reflect population size. Oregon was classified as a moderate coverage state for 2012-2017 and a full coverage state for 2018-2019. In part B, the data for receipt of postpartum care are limited to New York City. The years included appear in parentheses by coverage category: (1) full coverage: Illinois (2012-2019), Massachusetts (2012-2019), Minnesota (2012-2019), New York City (2012-2019), Oregon (2012-2019), and Rhode Island (2012-2019); (2) moderate coverage: Colorado (2012-2019), Connecticut (2013-2019), Delaware (2012-2019), Hawaii (2012-2016 and 2019), Maryland (2012-2019), Michigan (2012-2019), New Jersey (2016-2017), North Carolina (2012 and 2014-2019), Oregon (2012-2019), Pennsylvania (2012-2019), and Virginia (2012-2019); and (3) no coverage: Alaska (2012-2019), Georgia (2012-2014 and 2016-2019), Oklahoma (2012-2018), and Utah (2012-2019). The means were estimated using Pregnancy Risk Assessment Monitoring System survey design variables to account for nonresponse, no coverage, and the complex sampling design.

Using this model, the difference in receipt of postpartum care for immigrants in the states with moderate coverage or no coverage was examined compared with their counterparts in the states with full coverage. We hypothesized that states with restricted public insurance coverage for postpartum care among immigrants might have other co-occurring policies or factors that reduce receipt of postpartum care among low-income adults regardless of immigration status. Therefore, we also examined the difference in receipt of postpartum care among nonimmigrants by state coverage category, as well as the difference in receipt of postpartum care among immigrants relative to nonimmigrants. When examining relative differences, the nonimmigrant respondents serve as a comparison group to net out any general differences in access to care across state environments that are not related to postpartum coverage policies for immigrants.

Sensitivity Analyses

In subgroup analyses, the associations between state coverage policies and receipt of postpartum care were examined separately by race and ethnicity. We expected that the state coverage policies would be greater determinants for receipt of postpartum care among Hispanic immigrants, given the large share of undocumented immigrants in the US who were born in Latin America.[18]

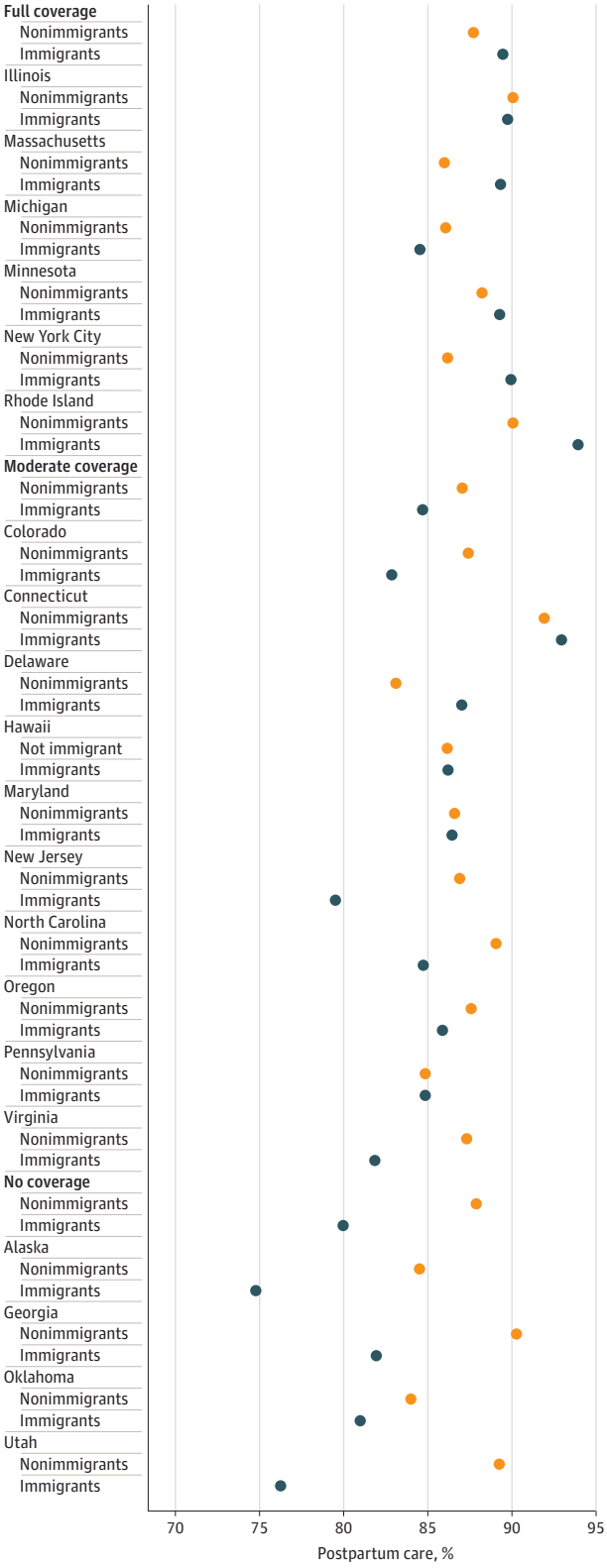
Several analyses also were conducted to examine whether the results were sensitive to analytic decisions. First, a wild-cluster bootstrap procedure was used to adjust for state-level clustering. Second, the sample was restricted to years that met the CDC's minimum response rate. Third, the sample was restricted to states with data available for all study years (14 of 20 states).

Results

The total sample included 72 981 low-income adults; 20 971 were born outside the US (immigrants) (29%) and 52 010 were born in the US (nonimmigrants) (71%). Immigrants were older compared with nonimmigrants (52.6% were aged ≥30 years vs 29.3%, respectively), more likely to identify as Hispanic (56.4% vs 12.5%), more likely to be married (59.0% vs 38.7%), and less likely to have completed the survey in English (52.9% vs 98.3%). Immigrants were more likely than nonimmigrants to have fewer than 12 years of education (32.8% vs 12.8%, respectively), but were also more likely to have 16 years or more of education (15.4% vs 10.2%) (**Table**).

Of the 19 states and New York City included in this study, 6 covered postpartum care for both undocumented and recently documented immigrants during the 5-year waiting period (full coverage category). Nine states covered postpartum care for documented immigrants during the 5-year waiting period but not for undocumented immigrants (moderate coverage category). Four states did not cover postpartum care for undocumented or recently documented immigrants during the 5-year waiting period (no coverage category). Oregon provided moderate coverage for postpartum care between 2012 and 2017 and switched to full coverage for 2018 and 2019 (**Figure 2**A). The estimated rates for receipt of postpartum

Figure 3. Postpartum Care by State and Coverage Category, 2012-2019[a]



[a] Data are for 2013-2019 for CT; 2012-2014, 2016-2019 for GA; 2012-2016, 2019 for HI; 2012, 2014-2019 for NC; 2016-2017 for NJ; and 2012-2018 for OK. The means were estimated using PRAMS survey design variables to account for nonresponse, no coverage, and the complex sampling design.

care among low-income immigrants for each state appear in Figure 2B.

The proportions of adults who received postpartum care by state and state coverage category appear in **Figure 3**. In the states with full coverage, 89.5% of immigrants received postpartum care compared with 87.7% of nonimmigrants. In the states with moderate coverage, 84.7% of immigrants received postpartum care compared with 87.0% of nonimmigrants. In the states with no coverage, 80.0% of immigrants received postpartum care compared with 87.9% of nonimmigrants.

In the adjusted regression models, compared with the states with full coverage, the proportion of immigrants who received postpartum care was 7.0-percentage-points lower (95% CI, −10.6 to −3.4 percentage points) in the states with moderate coverage and 11.3-percentage-points lower (95% CI, −13.9 to −8.8 percentage points) in the states with no coverage (**Figure 4**). Compared with the states with full coverage, receipt of postpartum care also was lower among nonimmigrants in the states with moderate coverage (−3.6 percentage points [95% CI, −7.0 to −0.3 percentage points]) and in the states with no coverage (−3.7 percentage points [95% CI, −5.6 to −1.8 percentage points]) (Figure 4).

Compared with the states with full coverage, receipt of postpartum care among immigrants relative to nonimmigrants was 3.3-percentage-points lower (95% CI, −5.3 to −1.4 percentage points) in the states with moderate coverage and 7.7-percentage-points lower (95% CI, −10.3 to −5.0 percentage points) in the states with no coverage (Figure 4). These estimates remained statistically significant when the SEs were clustered by state using a bootstrap procedure (eTable 3 in Supplement 1). These results were also robust to the exclusion of years of PRAMS data that did not meet the CDC response rate threshold (eTable 4 in Supplement 1) and to the exclusion of the states with missing years of data (eTable 5 in Supplement 1).

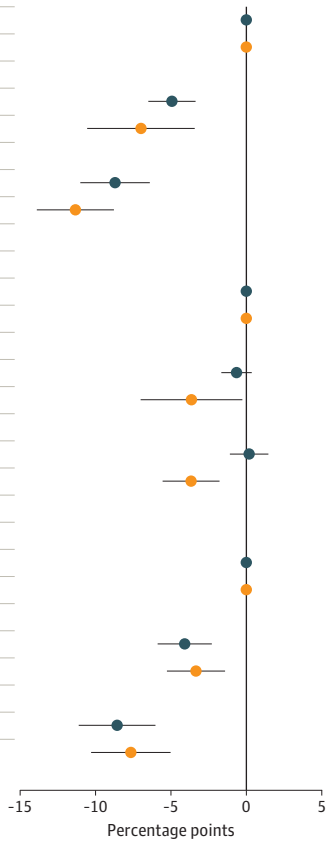
In the subgroup analysis, the difference in receipt of postpartum care for immigrants relative to nonimmigrants between the states with no coverage and the states with full coverage was largest for Hispanic respondents (−13.0 percentage points [95% CI, −17.7 to −8.3 percentage points]), as was the difference between the states with moderate coverage and the states with full coverage (−6.0 percentage points [95% CI, −9.5 to −2.6 percentage points]). The coefficient estimates were smaller and not statistically significant for the other racial and ethnic groups (eTable 6 in the Supplement 1).

Discussion

In states without public insurance for undocumented immigrants and recently documented immigrants, low-income immigrants were 11.3 percentage points less likely to have received postpartum care than those living in states without these restrictions. Low-income immigrants living in states that covered postpartum care for recently documented immigrants, but not undocumented immigrants, were 7.0 percentage points less likely to have received postpartum care compared their counterparts in states that cover all immigrants. Nonimmigrants

Figure 4. Association Between State Coverage Category and Receipt of Postpartum Care

	Difference relative to full coverage, percentage points (95% CI)	*P* value
Immigrants (n = 20 971)		
Full coverage		
Unadjusted	Reference	
Adjusted	Reference	
Moderate vs full coverage		
Unadjusted	-4.9 (-6.5 to -3.4)	<.001
Adjusted	-7.0 (-10.6 to -3.4)	<.001
No vs full coverage		
Unadjusted	-8.7 (-11.0 to -6.4)	<.001
Adjusted	-11.3 (-13.9 to -8.8)	<.001
Nonimmigrants (n = 52 010)		
Full coverage		
Unadjusted	Reference	
Adjusted	Reference	
Moderate vs full coverage		
Unadjusted	-0.7 (-1.7 to 0.3)	.20
Adjusted	-3.6 (-7.0 to -0.3)	.03
No vs full coverage		
Unadjusted	0.2 (-1.1 to 1.4)	.79
Adjusted	-3.7 (-5.6 to -1.8)	<.001
Total (N = 72 981)		
Full coverage		
Unadjusted	Reference	
Adjusted	Reference	
Moderate vs full coverage		
Unadjusted	-4.1 (-5.9 to -2.3)	<.001
Adjusted	-3.3 (-5.3 to -1.4)	.001
No vs full coverage		
Unadjusted	-8.6 (-11.1 to -6.0)	<.001
Adjusted	-7.7 (-10.3 to -5.0)	<.001



The states with full coverage offered publicly funded postpartum care regardless of immigration status. The states with moderate coverage offered publicly funded postpartum care to lawfully residing immigrants without a 5-year waiting period, but did not offer postpartum care to undocumented immigrants. The states with no coverage did not offer publicly funded postpartum care to lawfully present immigrants before 5 years of legal residence or to undocumented immigrants. The adjusted models included controls for income, marital status, age, and years of education and fixed effects for state and year. All analyses were calculated using Pregnancy Risk Assessment Monitoring System survey design variables to account for nonresponse, no coverage, and the complex sampling design.

living in states with restricted coverage were also less likely to have received postpartum care, indicating that there may be differences across state coverage categories in access to care that are unrelated to coverage policies for immigrants. After taking this into account by examining differences in receipt of postpartum care by immigrants relative to nonimmigrants, the estimates still showed that immigrants were significantly less likely to have received postpartum care in states with restrictive coverage.

Few studies have compared receipt of postpartum care between states with public insurance coverage vs those without public insurance coverage for undocumented immigrants and recently documented immigrants. One recent study found that Oregon's expansion of coverage to undocumented immigrants increased receipt of postpartum care and contraceptive use.[19] Another recent study found that receipt of postpartum care was similar among immigrants and nonimmigrants in New York City, which covers all low-income immigrants.[20] The current study makes a substantial contribution to the existing literature by documenting a significant negative association between state public insurance policies that restrict eligibility by immigration status and receipt of postpartum care in a large sample of states with large immigrant populations.

Limited access to postpartum care for immigrants may have important clinical implications such as decreased diagnosis and treatment of postpartum depression[21] and other common causes of postpartum morbidity[22] or increased risk of readmission for hypertensive complications.[22,23] Limited postpartum care could also result in less well-controlled diabetes and hypertension because the postpartum visit is used to identify and refer patients for ongoing chronic disease care.[24] Missed opportunities for the treatment and management of chronic health conditions could have important implications for the long-term health of these immigrant parents[25] and birth outcomes for any future pregnancies.[26]

Policies providing public insurance coverage to undocumented and recently documented immigrants is an active area of policy implementation. As recently as 2022, Kentucky adopted CHIPRA, bringing the total number of states with this policy option to 26.[8,27] In addition, Maryland and Virginia have adopted policies during the last 5 years to cover pregnancy care, including postpartum care though 60 days postpartum for undocumented immigrants using the CHIP unborn child option

and Oregon began to offer coverage for postpartum care using state funds.[28-30]

Recent efforts to extend Medicaid pregnancy coverage from 60 days postpartum to 12 months postpartum also have implications for immigrants. Optional Medicaid extensions for postpartum care were made possible by the American Rescue Plan Act of 2021.[31] As of May 4, 2023, the District of Columbia and 33 states have already implemented this extension, and an additional 9 states are planning implementation.[31] Immigrants who qualify for Medicaid under CHIPRA are eligible for the 12-month extension for postpartum care.[32] However, undocumented immigrants will not be eligible for the extension for postpartum care through the American Rescue Plan Act.[33] So far, 7 of the implementing states (California, Illinois, Maryland, Massachusetts, Minnesota, Rhode Island, and Washington) have extended coverage for postpartum care regardless of immigration status.[34] Excluding undocumented immigrants from the 12-month extension in other states will likely exacerbate existing disparities in insurance coverage and health care access between nonimmigrants and undocumented immigrants.

Limitations

This study has several limitations. First, the study results may not be generalizable to other states, particularly those with more or less generous Medicaid eligibility criteria and differences in the availability of clinicians or prevalence of immigrants in the population. Nonetheless, the sample of 19 states and New York City provides much larger representation than the prior literature.

Second, we were not able to determine respondents' documentation status in the PRAMS data or the number of years since legal documentation. Therefore, there was no subset study sample to examine only the population of adults who would be affected by the coverage policies. This limitation likely attenuated the differences that would be observed if comparing undocumented immigrants or recently documented immigrants only.

Third, state coverage policies may be related to other state policies or factors that affect coverage for postpartum care for immigrants, which were not examined. In addition, the data lack the health information needed to examine the relationship between state coverage policies and maternal morbidity or mortality.

Conclusions

Compared with states without insurance restrictions, immigrants living in states with public insurance restrictions were less likely to receive postpartum care. Restricting public insurance coverage may be an important policy-driven barrier to receipt of recommended pregnancy care and improved maternal health among immigrants.

ARTICLE INFORMATION

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