Access in Brief: Postpartum Mental Health in Medicaid

About 20 percent of postpartum women are affected by mental health conditions, including mood disorders, such as postpartum depression, anxiety disorders, or bipolar disorder.[1] Depression, anxiety, and post-traumatic stress disorder are the most common mental health conditions among postpartum individuals. Diagnosis of postpartum depression is highest in the first three to four months postpartum (Hutchens and Kearney 2020). Postpartum psychosis is the most severe form of mental illness, common in women with preexisting mood disorders, and require immediate medical attention (Clarke et al. 2023, ACOG and AAP 2017).[2] In addition to affecting the mother, poor postpartum mental health can affect early childhood development of the infant, such as delays in cognitive and social-emotional development (Earls et al. 2019).

Maternal mortality often occurs in the weeks and months following childbirth.[3] Maternal mental health and substance use disorders were found to be the leading underlying cause of pregnancy-related deaths in 2020, accounting for more than 22 percent of postpartum deaths (Trost et al. 2024).[4] Maternal suicide exceeds hemorrhage and hypertensive disorders as a cause of maternal mortality in all women (ACOG and AAP 2017).[5]

To help identify and address postpartum mental health concerns and to prevent related deaths, professional organizations recommend postpartum mental health screenings. For example, the American College of Obstetricians and Gynecologists recommends that obstetric providers screen all birthing individuals for substance use, depression, and anxiety throughout various points during the prenatal and postpartum periods. Positive screens should be coupled with appropriate follow-up treatments (ACOG and AAP 2017). The American Academy of Pediatrics recommends pediatricians screen mothers for maternal depression during well-child visits (Earls et al. 2019).

Medicaid plays a critical role in providing maternity-related services for pregnant women, financing more than 41 percent of all births in the United States (CMS 2024a). Medicaid is also the single largest payer of behavioral health care, encompassing mental health and substance use treatment services. The Centers for Medicare & Medicaid Services (CMS) has issued guidance describing how states can provide Medicaid coverage for maternal or caregiver depression screenings during a well-child visit under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit (CMS 2016). Almost all state Medicaid agencies cover postpartum depression screenings and treatment. As of 2023, 11 states require, 26 states and the District of Columbia recommend, and 8 states allow maternal depression screenings as part of the well-child visit (NASHP 2023).[6] One study found that 88 percent of beneficiaries with a live birth in 2020 reported being screened for depression at their postpartum visit (CMS 2024a). In a 2021 survey of pregnancy-related services, only one state reported no coverage of postpartum depression treatment (Ranji et al. 2022). The majority of beneficiaries are enrolled in Medicaid managed care organizations (MCOs). States can create MCO requirements to address the quality of care received by postpartum beneficiaries. In 2023, only Arizona and Minnesota reported having a performance improvement project related to postpartum depression initiatives for their MCOs (CMS 2024b).

In this brief, we used data from the Postpartum Assessment of Health Survey (PAHS), which is a 12-month follow-up survey to the 2020 Centers for Disease Control (CDC) Pregnancy Risk Assessment Monitoring System (PRAMS) and surveys people who had a live birth in 2020. We examined differences in reported health status, access to care, use of services, and health status between Medicaid beneficiaries with and without mental health conditions. We also conducted a comparison analysis of those with mental health conditions by payer (Appendix A). Presence of mental health conditions, in this study, is based on respondent self-report of ever being diagnosed by a doctor or health care clinician with depression, anxiety, or other mood disorder. All analyses are

descriptive and do not adjust for socioeconomic or other factors that may also be associated with differences, or attempt to establish the reasons for these differences.

We identified several differences in population characteristics, as well as postpartum health care access and utilization, between postpartum Medicaid beneficiaries with and without mental health conditions. About one-third of postpartum Medicaid beneficiaries reported being diagnosed with a mood disorder during the perinatal period compared to two-thirds who did not report any mental health conditions. Our analysis found that both groups had high rates of delaying or not getting needed care 12 to 14 months postpartum, but for different reasons. Older postpartum Medicaid beneficiaries with mental health conditions were significantly more likely to attend a postpartum care visit compared to younger beneficiaries. Although most postpartum Medicaid beneficiaries with mental health conditions reported similar rates of postpartum visit attendance, across racial and ethnic groups, there were differences in receipt of mental health treatments.

Population Characteristics

In the analysis below, we compare the characteristics of postpartum Medicaid beneficiaries with mental health conditions to those without mental health conditions. We examine the differences in demographics and clinical outcomes and analyze the social determinants of health among Medicaid beneficiaries.

Demographics

There were several demographic differences between postpartum Medicaid beneficiaries with mental health conditions and those without mental health conditions (Table 1). Among postpartum Medicaid beneficiaries with mental health conditions, a higher share lived in rural areas, were white, non-Hispanic, and spoke English as their primary language compared to beneficiaries without mental health conditions. A higher proportion of Medicaid beneficiaries with mental health conditions identify as lesbian, gay, bisexual, or other sexual orientation compared to those without mental health conditions.

TABLE 1. Demographic Characteristics of Postpartum Medicaid Beneficiaries, 2021–2022

Demographic characteristics	Share of postpartum Medicaid beneficiaries	
	With mental health conditions	Without mental health conditions
Age		
18–24	35.2%	31.3%
25–29	27.1	29.4
30–34	23.0	20.3
35+	14.8	19.0
Geography		
Urban or suburban	84.2	91.6*
Rural	15.8	8.4*
Race and ethnicity		
White, non-Hispanic	56.7	26.7*
Black, non-Hispanic	19.9	26.5
Hispanic	11.4	33.9*
Asian or SWANA or NHPI	–	9.4*
Native American or Alaska Native	–	–
Multiple races or ethnicities	9.8	3.1*
Education		
Less than high school	20.5	16.1
High school graduate or GED	36.5	42.5

Demographic characteristics	Share of postpartum Medicaid beneficiaries	
	With mental health conditions	Without mental health conditions
More than high school	43.1	41.5
Marital status		
Married or domestic partner	48.3	40.7
Not married or no domestic partner	51.7	59.3
Primary language		
English	94.0	65.7*
Spanish	4.3	22.1*
Other language	–	12.2*
Household income		
Less than 100 percent FPL	62.5	54.7
100–199 percent FPL	30.1	35.2
200 percent FPL or higher	7.4	10.2
Sexual orientation		
Heterosexual	90.0	96.1*
Lesbian, gay, bisexual, or other	10.0	3.9*

Notes: SWANA is Southwest Asian, Middle Eastern, or North African. NPHI is Native Hawaiian or Pacific Islander. GED is general education development. FPL is federal poverty level.

* Difference from those with a mental health condition is statistically different at the 0.05 level.

– Estimate not reported due to too small of a sample size or is unreliable because it has a relative standard error greater than or equal to 30 percent.

Source: MACPAC, 2024, analysis of 2021–2022 Postpartum Assessment of Health Survey.

Clinical characteristics

There were few differences in clinical characteristics between postpartum Medicaid beneficiaries with mental health conditions compared to Medicaid beneficiaries without mental health conditions (Table 2). Those with mental health conditions were more likely to have ever been diagnosed with either hypertension, diabetes, or asthma compared to those without mental health conditions. Those with mental health conditions were more likely give birth to an infant with low birthweight compared to those without mental health conditions.[7] Almost 70 percent of beneficiaries reported receiving their mental health diagnosis before pregnancy.

TABLE 2. Clinical Characteristics of Postpartum Medicaid Beneficiaries, 2021–2022

Clinical characteristics	Share of postpartum Medicaid beneficiaries	
	With mental health conditions	Without mental health conditions
Timing of mental health diagnosis[1]		
Before pregnancy	67.9%	N/A
During or after pregnancy	32.1	N/A
Health conditions diagnosed before, during, or after pregnancy		
Hypertension, diabetes, or asthma	37.5	26.0%*
Birth outcomes		
Preterm birth	14.1	9.7
Low birthweight	13.3	7.9*
Small for gestational age	12.4	11.1

Clinical characteristics	Share of postpartum Medicaid beneficiaries	
	With mental health conditions	Without mental health conditions
Delivery type		
Vaginal	64.1	68.7
Planned cesarean	19.5	16.3
Unplanned cesarean	16.3	15.0

Notes: N/A is not available. Small for gestational age is based on 10th percentile of weight.

[1] We did not statistically test the timing of mental health diagnosis, so cannot say whether the timing of diagnosis differs between those diagnosed before pregnancy and those diagnosed during or after pregnancy.

* Difference from those with mental health conditions is statistically different at the 0.05 level.

– Estimate not reported due to too small of a sample size or is unreliable because it has a relative standard error greater than or equal to 30 percent.

Source: MACPAC, 2024, analysis of 2021–2022 Postpartum Assessment of Health Survey.

Social determinants of health

Medicaid beneficiaries with mental health conditions were more likely to experience social concerns during the postpartum period than beneficiaries without mental health conditions (Table 3).[8] For example, 17.8 percent of postpartum individuals with mental health conditions reported having low social support compared to 7.7 percent of postpartum individuals without mental health conditions.[9] Postpartum individuals with mental health conditions were also more likely to report unstable housing, intimate partner violence, and everyday discrimination.

TABLE 3. Social Determinants of Health for Postpartum Medicaid Beneficiaries, 2021–2022

Social determinants	Share of postpartum Medicaid beneficiaries	
	With mental health conditions	Without mental health conditions
Low social support	17.8%	7.7%*
Food insecurity	21.0	19.6
Unstable housing	9.1	3.8*
Intimate partner violence	12.8	4.7*
Everyday discrimination	37.9	16.4*

Notes:

* Difference from those with mental health conditions is statistically different at the 0.05 level.

Source: MACPAC, 2024, analysis of 2021–2022 Postpartum Assessment of Health Survey.

Postpartum Health Care Access and Utilization

Postpartum Medicaid beneficiaries cited challenges to accessing health care in the 12 to 14 months after giving birth, regardless of mental health diagnosis (Table 4). The reasons for delaying or not receiving needed care since giving birth differed between the two groups, with Medicaid beneficiaries with mental health conditions more likely to report lack of childcare, or the inability to miss work or school as their reasons for not getting care.

TABLE 4. Selected Measures of Access for Postpartum Medicaid Beneficiaries, 2021–2022

Access measures	Share of postpartum Medicaid beneficiaries	
	With mental health conditions	Without mental health conditions
Health care access in the past 12 to 14 months postpartum		
No usual source of care	63.6%	55.7%
Delayed or did not get needed care	26.7	21.0
Reasons for delaying or not getting needed care since giving birth[1]		
No childcare	48.7	27.5*
Did not feel well enough	29.8	–
No transportation	29.5	–
Could not miss work or school	26.6	13.7*
COVID-19 concerns or in quarantine	20.6	13.3
Could not get an appointment	14.1	24.3
Cost of medical care	12.1	20.9
Types of care delayed or not received due to cost[1]		
Medical care (e.g., from a doctor, nurse, specialist, or hospital)	83.3	70.0
Mental health care (e.g., from a psychiatrist, therapist, or a mental health counselor)	58.3	–
Dental care	83.7	67.9
Cost related non-adherence		
Cost related non-adherence to prescription medicines	9.8	5.1

Notes: [1] This is among those who delayed or did not get needed care

* Difference from those with mental health conditions is statistically different at the 0.05 level.

– Estimate not reported due to too small of a sample size or is unreliable because it has a relative standard error greater than or equal to 30 percent.

Source: MACPAC, 2024, analysis of 2021–2022 Postpartum Assessment of Health Survey.

Use of health care services

Medicaid enrollees with mental health conditions were more likely to receive any health care during the postpartum period compared to those without mental health conditions (Table 5). For example, Medicaid beneficiaries with mental health conditions were more likely to visit a primary care provider, specialist, or go to the emergency department compared to those without mental health conditions. A larger share of postpartum Medicaid beneficiaries with mental health conditions also received mental health or substance use disorder (SUD) treatment, including counseling or therapy services, medications, or psychiatric visits.

TABLE 5. Selected Health Care Utilization for Postpartum Medicaid Beneficiaries, 2021–2022

Utilization measures	Share of postpartum Medicaid beneficiaries	
	With mental health conditions	Without mental health conditions
Postpartum health care use in the past 12–14 months postpartum		
Any health care	84.2%	76.5%*
Postpartum visit attendance	70.8	63.5

Utilization measures	Share of postpartum Medicaid beneficiaries	
	With mental health conditions	Without mental health conditions
Any primary care	55.7	41.0*
Any specialist care	25.5	9.2*
Any dental care	26.0	24.4
Any emergency department use	32.2	18.0*
Any mental health or SUD treatment	68.3	14.2*
Types of mental health or SUD treatment received in the past 12–14 months postpartum		
Counseling or therapy	42.3	7.8*
Medication (e.g., antidepressants or anti-anxiety medications)	51.0	1.7*
Support group or care from an in-home visiting health professional (e.g., nurse or midwife)	5.8	4.2
Psychiatrist visit	19.3	1.9*

Notes: SUD is substance use disorder.

* Difference from those with mental health conditions is statistically different at the 0.05 level.

Source: MACPAC, 2024, analysis of 2021–2022 Postpartum Assessment of Health Survey.

Age comparison among Medicaid beneficiaries with a mental health condition

Selected access measures among postpartum Medicaid individuals with mental health conditions varied by age (Table 6). The proportion of postpartum Medicaid individuals with mental health conditions with no usual source of care at 12 to 14 months postpartum was significantly higher among beneficiaries 25 and older compared to beneficiaries 18 to 24 years old. Medicaid enrollees age 25 to 29 and age 30 to 34 were significantly more likely to attend a postpartum care visit compared to those age 18 to 24.

TABLE 6. Selected Measures of Access and Use of Care for Postpartum Medicaid Beneficiaries with Mental Health Conditions, by Age, 2021–2022

Access and utilization measures	Share of postpartum Medicaid beneficiaries with mental health conditions			
	Age 18–24	Age 25–29	Age 30–34	Age 35 and older
Total	**35.2%**	**27.1%**	**23.0%**	**14.8%**
Health care access in the past 12 to 14 months postpartum				
No usual source of care	45.9	73.4*	70.7*	76.8*
Delayed or did not get needed care	22.3	24.4	36.4	26.6
Reason for delaying or not getting needed care since giving birth[1]				
No childcare	41.6	58.0	49.1	46.2
Postpartum health care use in the past 12 to 14 months postpartum				
Any health care since childbirth	75.2	89.9	88.6	88.5
Postpartum visit attendance	58.4	76.3*	79.4*	76.8
Any primary care	47.0	60.0	62.9	56.6
Any specialist care	20.7	24.0	25.2	40.4
Any dental care	17.9	32.3	33.8*	–

Access and utilization measures	Share of postpartum Medicaid beneficiaries with mental health conditions			
	Age 18–24	Age 25–29	Age 30–34	Age 35 and older
Any emergency department use	37.1	30.0	29.0	–
Any mental health or SUD treatment	67.0	72.5	64.8	69.3
Types of mental health or SUD treatment received in the past 12 to 14 months postpartum				
Counseling or therapy	36.4	49.6	39.5	47.3
Medication (e.g., antidepressants or anti-anxiety medications)	51.8	51.4	48.2	52.8

Notes: The total percentages may not sum to 100 due to rounding. SUD is substance use disorder.

[1] There were several other reasons respondents could report for delaying or not getting needed care, but the estimates are not reported due to too small of a sample size or unreliability because of a relative standard error greater than or equal to 30 percent.

* Difference from those aged 18–24 is statistically different at the 0.05 level.

– Estimate not reported due to too small of a sample size or is unreliable because it has a relative standard error greater than or equal to 30 percent.

Source: MACPAC, 2024, analysis of 2021–2022 Postpartum Assessment of Health Survey.

Race and ethnicity comparison among Medicaid beneficiaries with a mental health condition

Across racial and ethnic groups, postpartum Medicaid beneficiaries with mental conditions had varying rates for access and utilization measures (Table 7). Notably, 71.7 percent of white non-Hispanic beneficiaries reported no usual source of care, which is significantly greater than Hispanic beneficiaries (50.8 percent). Black, non-Hispanic beneficiaries with mental health conditions were significantly more likely to report lack of childcare as a reason for delaying or not receiving needed care after birth compared to white, non-Hispanic beneficiaries. Among Medicaid enrollees with mental health conditions, the proportion of respondents that reported receiving medications to treat mental health conditions was significantly lower among Black, non-Hispanic beneficiaries and Hispanic beneficiaries compared to white, non-Hispanic beneficiaries.

TABLE 7. Selected Measures of Access and Use of Care for Postpartum Medicaid Beneficiaries with Mental Health Conditions, by Race and Ethnicity, 2021–2022

Access and utilization measures	Share of postpartum Medicaid beneficiaries with mental health conditions			
	White, non-Hispanic	Black, non-Hispanic	Hispanic	Other, non-Hispanic
Total	**56.7%**	**19.9%**	**11.4%**	**11.8%**
Health care access in the past 12 to 14 months postpartum				
No usual source of care	71.7	52.1	50.8*	58.7
Delayed or did not get needed care	27.3	28.5	–	–
Reason for delaying or not getting needed care since giving birth[1]				
No childcare	38.0	79.1*	–	–
Postpartum health care use in the past 12 to 14 months postpartum				
Any health care	88.7	80.5	80.0	76.0
Postpartum visit attendance	73.8	69.2	65.4	66.3

Access and utilization measures	Share of postpartum Medicaid beneficiaries with mental health conditions			
	White, non-Hispanic	Black, non-Hispanic	Hispanic	Other, non-Hispanic
Any primary care	60.6	49.9	52.9	–
Any specialist care	30.9	–	17.7	–
Any dental care	26.8	–	37.4	–
Any emergency department use	30.7	46.3	32.1	–
Any mental health or SUD treatment	73.8	57.3	64.7	66.9
Types of mental health or SUD treatment received in the past 12 to 14 months postpartum				
Counseling or therapy	42.5	50.0	45.6	–
Medication (e.g., antidepressants or anti-anxiety medications)	62.4	36.9*	30.3*	41.7

Notes: The total percentages may not sum to 100 due to rounding. SUD is substance use disorder.

[1] There were several other reasons respondents could report for delaying or not getting needed care, but the estimates are not reported due to too small of a sample size or unreliability because of a relative standard error greater than or equal to 30 percent.

* Difference from white individuals is statistically different at the 0.05 level.

– Estimate not reported due to too small of a sample size or is unreliable because it has a relative standard error greater than or equal to 30 percent.

Source: MACPAC, 2024, analysis of 2021–2022 Postpartum Assessment of Health Survey.

Health Status

Medicaid enrollees with mental health conditions were significantly more likely than those without mental health conditions to self-report having poor or fair mental health (Table 8). Additionally, a greater proportion of Medicaid enrollees with mental health conditions reported having depressive or anxiety symptoms at 12 to 14 months after birth, as well as smoking tobacco or using marijuana some days or every day since giving birth.

TABLE 8. Selected Health Measures of Postpartum Medicaid Beneficiaries, 2021–2022

Health measures	Share of postpartum Medicaid beneficiaries	
	With mental health conditions	Without mental health conditions
Self-reported overall health status at 12–14 months postpartum		
Poor or fair	24.4%	7.7%*
Good	42.6	40.5
Very good	21.3	33.5*
Excellent	11.7	18.4*
Self-reported mental health status at 12–14 months postpartum		
Poor or fair	36.0	10.0*
Good	40.2	37.6
Very good	17.2	28.4*
Excellent	–	24.0

Health measures	Share of postpartum Medicaid beneficiaries	
	With mental health conditions	Without mental health conditions
Mental health symptoms at 12–14 months postpartum		
Depressive symptoms	31.1	6.1*
Anxiety symptoms	22.9	6.6*
Substance use since giving birth[1]		
Smoking	37.8	12.2*
Marijuana use	27.5	7.5*

Notes:

[1] Use of other substances, including heavy drinking (eight or more drinks per week on average), prescription drug misuse, and other illicit drug use, were asked in the survey, but the estimates are not reported due to too small of a sample size or unreliability because of a relative standard error greater than or equal to 30 percent.

* Difference from those with mental health conditions is statistically different at the 0.05 level.

– Estimate not reported due to too small of a sample size or is unreliable because it has a relative standard error greater than or equal to 30 percent.

Source: MACPAC, 2024, analysis of 2021–2022 Postpartum Assessment of Health Survey.

Data and Methods

Data for this report are from the 2021-2022 PAHS, a 12-month follow-up survey to the 2020 CDC PRAMS. The 2020 PAHS was conducted in six states and New York City.[10] PRAMS respondents were given the opportunity to either opt-in (Michigan only) or opt-out (6 other jurisdictions) of participation in PAHS. Respondents in the PAHS sampling frame were then contacted by mail, phone, or email with the opportunity to participate. Participants had a limited window to respond to PAHS between 12 to 14 months after their live birth. Data collection occurred in monthly batches from January 2021 to March 2022. PAHS survey responses were linked on an individual level to PRAMS survey responses and a limited set of birth certificate variables.

The analytic sample included 4,438 PAHS respondents with complete information on lifetime diagnosis of mental health conditions and who reported either Medicaid or private insurance at birth. The demographic information was self-reported on the PAHS and any missing information was imputed from PRAMS or the birth certificate.

This survey was conducted during the COVID-19 pandemic so results may differ from other survey years.

Insurance Coverage

Insurance status at birth was defined as self-reported health insurance at the time of childbirth measured on PAHS. Private insurance included employer-sponsored coverage, marketplace plans, military coverage and TRICARE. If the insurance information was missing from PAHS, the primary payor for childbirth was imputed from the birth certificate.

Race and Ethnicity

Survey respondents self-identify their race and ethnicity. The six categories were white; Black; Hispanic or Latinx; Asian or Southwest Asian or Middle Eastern or North African or Native Hawaiian or Pacific Islander; Native American or Alaska Native; or multi-racial.

The estimates were not reportable for most racial and ethnic groups due to small sample sizes, so estimates were only reported for white, non-Hispanic; Black, non-Hispanic; Hispanic; and other, non-Hispanic individuals, which included all other reported races and ethnicities.

Endnotes

[1] MACPAC uses the term postpartum women as this is the term used in the statute and regulations. However, other terms are being used increasingly in recognition that not all individuals who become pregnant and give birth identify as women.

[2] Postpartum psychosis is a severe mental health condition that affects a person's sense of reality and can affect anyone who recently gave birth. Symptoms include severe anxiety, insomnia, paranoia, and delusions concerning one's self, the infant, and others (ACOG and AAP 2017).

[3] Over half of pregnancy-related deaths occur after childbirth, and one third take place between one week and one year after childbirth (Bauman et al. 2020).

[4] These deaths include suicide, overdose or poisoning related to substance use disorder, and other deaths determined by the maternal mortality review committee to be related to a mental health condition. Substance use disorders disproportionately affect Black and American Indian and Alaska Native individuals (Trost et al. 2024).

[5] The leading cause of maternal mortality varies when the data is stratified by race and ethnicity. Maternal mental health conditions are the leading cause of maternal death for white, non-Hispanic and Hispanic women. However, the leading cause of maternal death in Black, non-Hispanic women is cardiovascular conditions (CMS 2024a).

[6] As of 2023, the 11 states that require screenings are Arizona, Georgia, Maryland, Massachusetts, Michigan, Mississippi, Nevada, New Jersey, New Mexico, Pennsylvania, and Washington. The 26 states that recommend screenings are Alabama, Alaska, California, Delaware, Hawaii, Idaho, Illinois, Indiana, Iowa, Kentucky, Louisiana, Minnesota, Montana, North Carolina, North Dakota, Ohio, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, West Virginia, and Wyoming. The eight states that allow screenings are Colorado, Connecticut, Maine, Missouri, New York, Oregon, Virginia, and Wisconsin (NASHP 2023).

[7] Low birthweight is an infant that weighs less than 2500 grams.

[8] Social concerns are also known as health-related social needs (HRSNs). HRSNs refer to the social and economic needs that individuals experience that affect their ability to maintain their health and well-being. HRSNs include things such as housing instability, housing quality, food insecurity, employment, personal safety, and lack of transportation (HHS 2023).

[9] Low levels of social support or experiencing stressful life events during pregnancy or the early postpartum period are risk factors for postpartum depression (Robertson et al. 2004).

[10] The six states are Kansas, Michigan, New Jersey, Pennsylvania, Utah, and Virginia.

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APPENDIX A: Insurance Payer Comparison

TABLE A-1. Demographic Characteristics of Postpartum Individuals by Insurance Status, 2021–2022

Demographic characteristics	Postpartum Individuals with Mental Health Conditions	
	Medicaid	Private
Age		
18–24	35.2%	10.8%*
25–29	27.1	27.3
30–34	23.0	40.4*
35+	14.8	21.6*
Geography		
Urban or suburban	84.2	88.5
Rural	15.8	11.6
Race and ethnicity		
White, non-Hispanic	56.7	77.8*
Black, non-Hispanic	19.9	6.3*
Hispanic	11.4	6.8*
Asian or SWANA or NHPI	–	4.0*
Native American or Alaska Native	–	–
Multiple race	9.8	4.9
Education		
Less than high school	20.5	–
High school graduate or GED	36.5	12.5*
More than high school	43.1	86.9*
Marital status		
Married or domestic partner	48.3	10.3*
Not married or no domestic partner	51.7	89.7*
Primary language		
English	94.0	95.9
Spanish	4.3	–
Other	–	2.2
Household income		
Less than 100% FPL	83.4	12.0*
100–199% FPL	8.4	11.2
200–399% FPL	6.9	41.1*
400% FPL or higher	–	35.7
Sexual orientation		
Straight/heterosexual	90.0	92.1
Lesbian, gay, bisexual, or other	10.0	7.9

Notes: SWANA is Southwest Asian, Middle Eastern, or North African. NPHI is Native Hawaiian or Pacific Islander. FPL is federal poverty level. GED is general education development.

* Difference from those with Medicaid is statistically different at the 0.05 level.

– Estimate not reported due to too small of a sample size or is unreliable because it has a relative standard error greater than or equal to 30 percent.

Source: MACPAC, 2024, analysis of 2021–2022 Postpartum Assessment of Health Survey.

TABLE A-2. Social Determinants of Health for Postpartum Individuals by Insurance Status, 2021–2022

Social determinants	Postpartum Individuals with Mental Health Conditions	
	Medicaid	Private
Low social support	17.8%	11.0%
Food insecurity	21.0	7.2*
Unstable housing	9.1	–
Intimate partner violence	12.8	2.6*
Everyday discrimination	37.9	21.5*

Notes:

* Difference from those with Medicaid is statistically different at the 0.05 level

– Estimate not reported due to too small of a sample size or is unreliable because it has a relative standard error greater than or equal to 30 percent.

Source: MACPAC, 2024, analysis of 2021–2022 Postpartum Assessment of Health Survey.

TABLE A-3. Selected Measures of Access and Use of Care for Postpartum Individuals by Insurance Status, 2021–2022

Access measures	Postpartum Individuals with Mental Health Conditions	
	Medicaid	Private
Health care access in the past 12 to 14 months postpartum		
No usual source of care	63.6%	80.7%*
Delayed or did not get needed care	26.7	25.6
Reasons for delaying or not getting needed care since giving birth		
Cost of medical care	12.1	17.3
No childcare	48.7	39.8
No transportation	29.5	–
Did not feel well enough	29.8	11.1*
Could not miss work or school	26.6	22.6
Could not get an appointment	14.1	15.4
COVID-19 concerns or in quarantine	20.6	31.9
Types of care delayed or not received due to cost		
Medical care (e.g., from a doctor, nurse, specialist, or hospital)	83.3	58.1
Mental health care (e.g., from a psychiatrist, therapist, or a mental health counselor)	58.3	71.6
Dental care	83.7	46.2*
Cost related non-adherence		
Cost related non-adherence to prescription medicines	9.8	5.0

Notes:

* Difference from those with Medicaid is statistically different at the 0.05 level.

– Estimate not reported due to too small of a sample size or is unreliable because it has a relative standard error greater than or equal to 30 percent.

Source: MACPAC, 2024, analysis of 2021–2022 Postpartum Assessment of Health Survey.

TABLE A-4. Selected Health Care Utilization for Postpartum Individuals by Insurance Status, 2021–2022

Utilization measures	Postpartum Individuals with Mental Health Conditions	
	Medicaid	Private
Postpartum health care use in the past 12–14 months postpartum		
Any health care since childbirth	84.2%	97.1%*
Postpartum visit attendance	70.8	89.3*
Any primary care	55.7	69.6*
Any specialist care	25.5	34.3
Any dental care	26.0	52.4*
Any emergency department use	32.2	19.2*
Any mental health or SUD treatment	68.3	70.0
Types of mental health or SUD treatment received in the past 12–14 months postpartum		
Counseling or therapy	42.3	41.6
Medication (e.g., antidepressants or anti-anxiety medications)	51.0	54.4
Support group or care from an in-home visiting health professional (e.g., nurse or midwife)	5.8	3.0
Psychiatrist visit	19.3	18.3

Notes: SUD is substance use disorder.

* Difference from those with Medicaid is statistically different at the 0.05 level.

Source: MACPAC, 2024, analysis of 2021–2022 Postpartum Assessment of Health Survey.

TABLE A-5. Selected Health Measures of Postpartum Individuals by Insurance Status, 2021–2022

Health measures	Postpartum Individuals with Mental Health Conditions	
	Medicaid	Private
Self-reported overall health status at 12–14 months postpartum		
Poor or fair	24.4%	9.3%*
Good	42.6	36.7
Very good	21.3	43.3*
Excellent	11.7	10.7
Self-reported mental health status at 12–14 months postpartum		
Poor or fair	36.0	25.4*
Good	40.2	44.5
Very good	17.2	27.2*
Excellent	–	2.9
Mental health symptoms at 12–14 months postpartum		
Depressive symptoms	31.1	25.2
Anxiety symptoms	22.9	12.4*
Substance use since giving birth		
Heavy drinking	–	3.0

Health measures	Postpartum Individuals with Mental Health Conditions	
	Medicaid	Private
Smoking	37.8	10.2*
Marijuana use	27.5	12.1*
Prescription drug or illicit drug misuse	–	1.6

Notes:

* Difference from those with mental health conditions is statistically different at the 0.05 level.

– Estimate not reported due to too small of a sample size or is unreliable because it has a relative standard error greater than or equal to 30 percent.

Source: MACPAC, 2024, analysis of 2021–2022 Postpartum Assessment of Health Survey.