Pregnant and Postpartum Populations

When Biology Meets Bureaucracy

Jessica Martinez, 26, discovered she was pregnant in March while working part-time at a CVS pharmacy in Macon, Georgia. She made $14 an hour, worked 30 hours weekly, carried Medicaid through Georgia's expansion. Her doctor classified the pregnancy as high-risk at her first appointment: gestational diabetes, elevated blood pressure, family history of preeclampsia. She filed for medical exemption, received approval through her August due date.

The pregnancy grew complicated. Bed rest in June. Emergency hospitalization at 32 weeks in July. She delivered via emergency C-section on July 28th at 34 weeks. The baby, Lucia, weighed 4 pounds 3 ounces and spent three weeks in the NICU with respiratory distress and feeding difficulties. Jessica recovered from surgery, pumped every three hours, drove 45 minutes each way to the hospital daily.

On September 1st, with Lucia finally home, Jessica received notice that her exemption had expired August 27th. She needed to verify 80 hours monthly or obtain a new exemption within 30 days. She had slept three hours the night before. Lucia had appointments that day. She put the notice on the counter.

The following week she tried to navigate the process. The portal offered medical exemption requiring physician documentation, and caregiving exemption requiring childcare unavailability documentation. She hadn't had her six-week checkup yet. Three daycares told her they had waitlists of three to six months. She uploaded screenshots of daycare websites and a statement explaining no providers accepted infants her daughter's age.

At her September 20th OB appointment, she started crying and couldn't stop. The doctor diagnosed postpartum depression and anxiety, prescribed sertraline, completed the exemption form attesting to hypertension, incomplete surgical recovery, and postpartum mood disorder.

On October 8th, both applications were denied. Medical exemption denied because physician documentation indicated light activity capacity, interpreted as ability to work. Caregiving exemption denied because screenshots weren't acceptable documentation. She needed denial letters from three licensed childcare providers.

She had 30 days to appeal while managing an infant with special needs, attending multiple medical appointments weekly, dealing with postpartum depression, and functioning on fragmented sleep. She didn't file the appeal.

On November 15th, her coverage terminated. December brought pharmacy bills she couldn't pay. The sertraline cost $45 monthly without insurance. She stopped taking it. The postpartum depression worsened. She stopped therapy. Her blood pressure remained elevated.

In January, she went to the emergency department with chest pain. Hypertensive crisis, blood pressure 185/115. The ER physician admitted her, started medications, arranged for a social worker to help her reapply. Emergency Medicaid was approved within 48 hours. But the work requirement still applied. In 60 days she would face the same process.

A community health worker eventually helped her navigate the paperwork correctly. This time, applications were approved. Jessica maintained coverage through Lucia's first birthday, then returned to work. The system eventually worked.

But those four months without coverage created consequences that continue. The untreated depression became chronic. The uncontrolled hypertension caused kidney damage. The emergency hospitalization cost more than a year of coverage would have. The cascade began with an exemption system that couldn't accommodate complicated pregnancy, premature delivery, surgical recovery, infant medical needs, and postpartum mental health simultaneously.

Demographics and Scope

Pregnancy and postpartum circumstances affect 450,000-650,000 expansion adults annually, approximately 2.5-3.5% of the population subject to work requirements. These numbers reflect point-in-time prevalence, the women pregnant or recently postpartum at any given moment, while annual incidence runs higher since pregnancy is a temporary state with continuous turnover.

The expansion adult population is approximately 52% female, yielding roughly 9.6 million women among the 18.5 million expansion adults subject to work requirements. Of these women, approximately 38% fall within primary reproductive ages of 19-39, or about 3.6 million women potentially experiencing pregnancy during coverage periods. Annual pregnancy rates among Medicaid expansion populations run approximately 6-8% of reproductive-age women, translating to 220,000-290,000 pregnancies annually among expansion adult women.

Geographic concentration matters because birth rates, pregnancy complications, and healthcare infrastructure vary dramatically across expansion states. Southern expansion states show particularly high pregnancy rates among expansion enrollees. Louisiana and Arkansas data suggest that expansion adults account for 35-40% of Medicaid-covered births among adults. North Carolina's 2024 expansion saw high enrollment among women of reproductive age, partly driven by the state's previous lack of coverage for low-income adults not qualifying through pregnancy.

Pregnancy risk stratification reveals that the simple category of "pregnant" obscures substantial variation in work capacity and exemption needs. Approximately 52% of pregnancies among expansion populations qualify as high-risk due to maternal age, pre-existing conditions, substance use history, mental health conditions, or social determinants. Gestational diabetes affects 8-12%. Hypertensive disorders affect 7-10%. Preterm birth occurs in 12-14% of expansion adult pregnancies, exceeding the 10% general population rate. Each of these complications creates work limitations extending beyond the pregnancy itself.

Cesarean delivery, affecting approximately 32% of expansion adult births, creates surgical recovery needs lasting 8-12 weeks minimum. Postpartum complications including infection, hemorrhage, and wound complications affect 15-18% of expansion adult births, often requiring extended recovery. Severe maternal morbidity, while affecting only 1-2%, creates months-long recovery needs incompatible with any work activity.

Postpartum mental health conditions represent perhaps the most significant complication for work requirement compliance. Postpartum depression affects 15-20% of all new mothers, with higher rates among expansion populations facing housing instability, limited social support, or intimate partner violence. Postpartum anxiety affects 10-15%. These conditions typically peak 2-6 weeks

postpartum but often persist for months without treatment. Their onset frequently coincides with exemption expiration, creating coverage losses precisely when treatment becomes most necessary.

Infant health complexity compounds maternal factors in ways exemption systems struggle to address. Approximately 8-10% of infants born to expansion adults require NICU admission. Another 12-15% have health conditions requiring frequent medical appointments during early months. Severe infant complications affecting 2-3% create months of intensive caregiving incompatible with employment regardless of maternal physical recovery. Even healthy newborns require feeding every 2-3 hours initially, creating schedule constraints that standard employment cannot accommodate.

Childcare availability represents the practical constraint converting theoretical work capacity into actual impossibility. Infant childcare costs average $1,200-1,800 monthly in most markets, often exceeding what full-time minimum wage employment would generate. Licensed infant care capacity runs 30-40% below demand in most communities. Waitlists of 6-12 months are standard. Many providers don't accept infants under six weeks or three months. The practical reality is that even mothers physically capable of work often cannot access affordable, available infant care enabling employment.

The intersection of pregnancy with other exemption categories creates particularly complicated scenarios. Approximately 15-20% of pregnant expansion adults have pre-existing conditions that would qualify for medical exemption independent of pregnancy. Another 8-10% have caregiving responsibilities for other children or disabled family members. Roughly 5-8% face substance use disorders or serious mental illness. These overlapping vulnerabilities mean pregnancy often represents one barrier among several rather than an isolated episode requiring single-category exemption.

Racial and ethnic disparities in pregnancy outcomes create differential exposure to exemption system failures. Black women experience maternal mortality rates 2.6 times higher than white women and are significantly more likely to experience preterm birth, pregnancy complications, and severe maternal morbidity. Hispanic women face elevated rates of gestational diabetes and pregnancy-induced hypertension. These disparities mean that exemption systems failing to accommodate complications will disproportionately affect women of color, compounding existing health inequities.

The employment patterns of pregnant expansion adults shape their interaction with work requirements. Many work in jobs without paid leave, without schedule flexibility, and without accommodation for pregnancy-related limitations. Retail, food service, and healthcare aide positions, common among expansion adults, often involve standing, lifting, and irregular schedules incompatible with pregnancy complications. A woman placed on bed rest loses not only her income but her path to meeting work requirements, since her job doesn't allow modified duties and her employer won't hold her position through extended leave.

Geographic variation in pregnancy support infrastructure affects exemption access dramatically. Maternity care deserts, areas without obstetric services within 30 miles, affect over 2 million women of reproductive age nationally. Rural expansion adults facing pregnancy complications may travel hours for prenatal care, making documentation of those complications more difficult and

Syam Adusumilli, Chief Evangelist, *syam.a@groundgame.health*

more burdensome. The physician providing obstetric care is far away. The documentation process assumes regular, convenient access to medical providers who understand exemption requirements.

Failure Modes: When Pregnancy Creates Impossible Compliance

The interaction between pregnancy's biological unpredictability, postpartum recovery's variable duration, infant care's intensive demands, and administrative systems' procedural rigidity creates systematic compliance impossibility for substantial portions of pregnant and postpartum populations. Understanding these failure modes matters because they reveal structural mismatches between policy assumptions and biological realities rather than individual failures to navigate systems properly.

The discrete episode assumption creates the foundational failure. Administrative systems treat pregnancy as a bounded medical condition with predictable timeline: conception, gestation, delivery, recovery, return to normal. Documentation reflects this assumption. Medical providers attest to pregnancy, estimate delivery dates, and states approve exemptions through delivery plus some postpartum period. The assumption holds that pregnancies proceed normally, deliveries are uncomplicated, recoveries are rapid, and within weeks or months women return to their pre-pregnancy capacity.

The reality involves cascading complexity that bounded exemptions cannot accommodate. High-risk pregnancy restrictions change unpredictably as conditions evolve. Preterm labor creates weeks of bed rest followed by early delivery, often triggering exemption expiration precisely when the most intensive phase begins. NICU admissions extend parental responsibilities far beyond expected postpartum timelines. Postpartum complications multiply recovery duration. Postpartum depression emerges weeks after delivery when exemptions have already expired. Breastfeeding challenges extend for months. The "discrete episode" becomes an open-ended transition with multiple overlapping crises.

The early delivery paradox illustrates this failure mode acutely. States typically approve pregnancy exemptions through estimated delivery dates, sometimes with automatic extensions of 30-60 days postpartum. But complications triggering early delivery also trigger early exemption expiration. A woman whose exemption runs through her September due date but delivers prematurely in July loses her exemption exactly when she enters the most intensive phase of infant care. The system structurally punishes complications.

The capacity documentation failure emerges because the capacity to work and the capacity to document exemption disappear simultaneously. Postpartum depression creates inability to work but also inability to navigate paperwork. NICU admissions consume all available time, leaving nothing for documentation gathering. C-section recovery limits physical capacity for work but also limits capacity to visit providers, collect forms, and submit applications. The exemption process assumes capacity to gather physician attestations, complete applications, track deadlines, respond to additional information requests, and appeal denials. Women facing complications, mental health challenges, or infant health crises lack this capacity exactly when they need exemptions most.

Provider burden creates compounding problems because pregnancy care is structurally fragmented. Obstetricians providing prenatal care often don't see patients postpartum beyond a single six-week checkup. Primary care providers may not be involved until months later. Pediatricians treating infant complications aren't positioned to document maternal work capacity. Mental health providers treating postpartum depression may not interface with exemption systems. No single provider sees the full picture, yet exemption systems require coordinated documentation from multiple providers who don't communicate with each other.

The six-week checkup timing mismatch illustrates this fragmentation. The standard postpartum obstetric visit occurs six weeks after delivery. Many exemption systems require physician documentation of ongoing medical need for postpartum exemption extensions. But exemptions often expire 30-60 days postpartum, meaning the documentation deadline arrives before the medical appointment where documentation could be obtained. Women must either schedule additional appointments specifically for exemption paperwork, adding burden during an already overwhelming period, or miss deadlines because their routine care doesn't align with administrative calendars.

The childcare availability assumption represents perhaps the most fundamental failure because work requirement policy implicitly assumes that mothers physically capable of work can access childcare enabling employment. The assumption collapses for infants. Infant care is expensive, scarce, has waitlists, and requires advance planning impossible during complicated pregnancies. A mother who delivers unexpectedly at 34 weeks hasn't had time to get on childcare waitlists. Her infant's medical complexity may disqualify them from standard providers anyway. Even mothers with uncomplicated deliveries face 6-12 month waitlists in most markets.

The timing gap is structural. States offering 60-day postpartum exemptions assume women can return to work when exemptions expire. But childcare waitlists average 6-12 months. A mother delivering in January, recovering by March, faces exemption expiration in April but can't access childcare until September at earliest. The gap between recovery and childcare availability can span six months or longer. No amount of physical capacity for work overcomes the practical reality that infants need care and care isn't available.

The breastfeeding contradiction occurs because work requirements assume employment in standard workplace settings, but breastfeeding creates biological constraints incompatible with many jobs available to expansion adults. Newborns nurse every 2-3 hours. Even with pumping, mothers need breaks, refrigeration, privacy. Many retail, food service, and entry-level positions don't accommodate pumping despite legal requirements that are poorly enforced for low-wage workers with limited leverage.

The policy creates pressure to stop breastfeeding in order to maintain employment stability and work requirement compliance. This undermines public health recommendations prioritizing breastfeeding through at least six months. The irony is that Medicaid pays for infant formula that wouldn't be needed if mothers could continue breastfeeding, while work requirements create barriers to breastfeeding continuation. The cost of formula for a Medicaid-eligible infant for six months often exceeds the cost of work requirement exemption for a breastfeeding mother.

The exemption stacking problem emerges because pregnant women often have multiple qualifying circumstances requiring different documentation pathways that don't communicate with each

Syam Adusumilli, Chief Evangelist, *syam.a@groundgame.health*

other. A pregnant woman with depression needs both pregnancy exemption and mental health exemption. A pregnant woman caring for a disabled parent needs pregnancy exemption and caregiver exemption. Each category requires separate documentation even when circumstances overlap, creating multiplicative burden during periods of minimal capacity.

When pregnancy exemption expires before mental health exemption is processed, coverage gaps emerge. When both expire simultaneously postpartum, the woman must reapply for multiple categories while managing newborn care and mental health treatment. The systems don't recognize that pregnancy complicated by mental illness is a single situation requiring integrated response rather than parallel applications to separate bureaucratic processes.

The communication timing failure manifests when verification notices and exemption deadlines arrive during maximum crisis periods. Delivery hospitalization brings work verification notices to women managing surgical recovery, infant medical crises, and their own postpartum complications. The administrative calendars driving these notices don't align with biological timelines. Semi-annual redetermination means a woman becoming pregnant in month one of coverage faces redetermination in month six, potentially exactly when she's in late pregnancy or early postpartum.

The mixed-status family barrier affects substantial portions of the pregnant population. Many pregnant expansion adults live in mixed-status households where some family members are citizens, some are legal permanent residents, and some are undocumented. Any request for documentation creates fear that information provided could expose family members to immigration enforcement. This fear suppresses documentation of informal employment, prevents honest disclosure of household composition, and creates reluctance to engage with government systems at all, including exemption applications.

The appeals timeline impossibility is perhaps the cruelest failure mode. When initial exemption applications are denied, women have 30 days to appeal. But 30 days postpartum is exactly when complications peak, sleep deprivation is most severe, and capacity for administrative navigation is lowest. A woman denied exemption on day 30 postpartum must gather additional documentation and file an appeal while managing a one-month-old infant, recovering from delivery, and potentially dealing with postpartum mental health challenges. The timeline assumes capacity that doesn't exist.

The employment documentation challenge affects women working in informal arrangements common among low-income populations. A woman providing childcare for a neighbor's children, cleaning houses for cash, or working occasional shifts at a family business may be working but unable to document that work in ways exemption systems recognize. Pregnancy doesn't eliminate work, but it may shift employment toward informal arrangements more compatible with prenatal restrictions or early postpartum recovery. These arrangements don't generate paystubs, don't involve employer attestation, and don't satisfy verification requirements even though they represent genuine work effort.

The support network assumption fails women without family resources to fill administrative gaps. Middle-class women navigating work requirements during pregnancy often have partners, parents, or siblings who can help with documentation, childcare, and bureaucratic navigation. Expansion adults are more likely to lack these supports. Single mothers without extended family support must

manage everything alone. Women whose partners are incarcerated, deployed, or absent face pregnancy and postpartum challenges without backup. The exemption system assumes support that many women don't have.

The technology access barrier affects postpartum women disproportionately. Online portals requiring document uploads, account management, and deadline tracking assume reliable internet access, device availability, and digital literacy. A woman pumping breast milk every three hours, changing diapers constantly, and sleeping in fragments may have a smartphone but lack the sustained attention required to navigate complex digital interfaces. The device she uses one-handed while holding an infant doesn't display forms correctly. The upload fails repeatedly. The timeout logs her out before she completes the application. Technology designed for desktop users with uninterrupted time fails postpartum users with fragmented attention and single-handed device access.

State Policy Choices: Accommodation or Exclusion

The policy architecture states construct around pregnancy and postpartum populations reveals fundamental choices about maternal bodies, infant care, and the compatibility of early parenting with employment expectations. These aren't technical decisions about documentation requirements. They're philosophical choices about whether exemption systems should accommodate biological reality or demand that biology conform to administrative convenience.

Exemption duration reflects the first fundamental choice. Georgia's 30-day postpartum exemption treats pregnancy as a discrete medical event with rapid recovery. Louisiana's 12-month exemption recognizes that the first year involves ongoing challenges incompatible with standard employment. Research suggests uncomplicated vaginal deliveries require 6-8 weeks for physical recovery, C-sections require 8-12 weeks minimum, and postpartum mental health conditions often persist for months. Infant childcare waitlists average 6-12 months. These realities suggest that 30-60 day exemptions systematically mismatch actual recovery and caregiving timelines.

Documentation burden presents the second choice. Higher requirements theoretically prevent abuse but create barriers for women whose circumstances most clearly qualify yet whose capacity to document is most limited. A woman with severe postpartum depression needs exemption but may lack capacity to navigate paperwork. Documentation burden is inversely related to documentation capacity for populations most needing exemption.

Category integration poses the third choice. Should pregnancy, postpartum medical complications, mental health, and infant caregiving require separate applications, or should they be integrated categories recognizing these circumstances overlap? Separate categories force women to navigate multiple simultaneous applications during maximum crisis. Integrated categories can approve initial exemption at pregnancy identification and extend automatically through the first year.

Proactive versus reactive exemption represents the fourth choice. Should pregnancy identification trigger automatic exemption, or must women apply? The cost calculation favors proactive approaches: administrative costs of processing applications exceed costs of automatic exemption, while downstream costs of coverage losses far exceed costs of exemption for women who might have worked if required.

The fundamental tension underlying all these choices is between administrative controllability and biological accommodation. Systems designed for administrative convenience assume predictable timelines and capacity for engagement. Biology doesn't work that way. Administrative systems that can't accommodate variability will systematically fail populations whose circumstances deviate from assumptions.

State choices also reflect deeper assumptions about gender, work, and caregiving. The work requirement framework may be fundamentally incompatible with early parenthood, not because mothers don't want to work, but because infant care is work that markets don't recognize. The federalism dimension means women face dramatically different systems depending on residence. A woman in Louisiana has 12 months of automatic exemption. A woman in Georgia has 30 days. The biological realities are identical. The policy responses are radically different.

Stakeholder Roles in Supporting Pregnant and Postpartum Populations

The structural failures in exemption systems won't be solved by state policy alone. Multiple stakeholders must adapt their operations to prevent coverage losses among pregnant and postpartum women. Each stakeholder occupies a different position in the ecosystem and can address different failure modes.

Managed Care Organizations bear primary responsibility for identifying pregnant members early and supporting them through exemption processes. MCOs should use pharmacy claims for prenatal vitamins, diagnosis codes, and OB/GYN visits to trigger automatic assignment to maternity care coordination. Care coordinators managing panels of 150-200 pregnant members should understand exemption options and assist with documentation before deadlines arrive. When delivery claims appear, coordinators should proactively contact members about postpartum exemption transitions rather than waiting for members to navigate systems alone. MCOs that prevent coverage losses during pregnancy and postpartum avoid downstream costs of emergency interventions, untreated complications, and chronic condition development.

Obstetric Providers serve as the primary documentation source for pregnancy exemptions yet often don't understand work requirement policy. OB practices should integrate exemption documentation into standard prenatal workflows rather than treating it as separate administrative burden. Simple attestation forms completed during routine visits, ideally integrated into EHR systems, can eliminate the documentation gaps that occur when women must request forms separately. Postpartum visits at six weeks provide opportunities not just for physical recovery assessment but for mental health screening and exemption renewal support. Practices serving high Medicaid populations should employ or partner with community health workers who can help pregnant patients understand exemption options during prenatal care.

Employers shape whether pregnant workers can maintain employment compatible with medical restrictions. Retail, food service, and healthcare aide employers, common among expansion adults, often cannot accommodate pregnancy complications requiring modified duties or reduced hours. But employers who can offer flexible scheduling, temporary reassignment to less physically demanding tasks, or gradual return-to-work arrangements help pregnant employees maintain both income and work requirement compliance. Employers should also understand that employees

Syam Adusumilli, Chief Evangelist, *syam.a@groundgame.health*

navigating postpartum exemption processes may need brief time during shifts for phone calls or documentation submission.

Educational Institutions provide qualifying activities that may be more compatible with pregnancy than employment. Community colleges offering evening or online courses can help pregnant women accumulate qualifying hours when physical employment becomes impossible. Education during pregnancy positions women for better employment after postpartum recovery. GED programs, vocational training, and job readiness courses all count toward work requirements and offer flexibility that jobs often don't. Pregnant women placed on bed rest can complete online coursework. Women in early postpartum recovery can watch lecture videos during infant feeding.

Community-Based Organizations and Community Health Workers provide navigation support that prevents documentation failures. CBOs embedded in communities serving high numbers of expansion adults can identify pregnant women early, explain exemption processes before deadlines become urgent, and assist with documentation gathering. Peer navigator programs employing mothers who have successfully navigated pregnancy and postpartum exemptions provide uniquely effective support because peer navigators understand practical challenges from lived experience. Community health workers already serving maternal-child health populations can add work requirement navigation to existing home visits, reaching women who might not attend clinic appointments due to transportation barriers, housing instability, or mental health challenges.

The common thread across stakeholders is proactive intervention before crises occur. Jessica Martinez's coverage loss happened not because she was unwilling to comply but because no one helped her navigate documentation during the period when she lacked capacity to navigate alone. An MCO care coordinator contacting her after delivery, an OB completing exemption paperwork at a prenatal visit, a community health worker explaining caregiving exemption documentation requirements could each have prevented the cascade of complications that followed. The absence of any stakeholder stepping into that navigation role left her alone with documentation requirements she couldn't meet during a period when meeting them was impossible.

Jessica's Situation as Structural Pattern

Jessica Martinez's experience follows predictable trajectories when exemption systems assume circumstances they cannot accommodate. Her 30-day postpartum exemption expiring during maximum crisis was structurally inevitable. Her inability to navigate documentation while managing infant medical needs and postpartum depression reflected the fundamental mismatch between documentation requirements and documentation capacity. Her denials for insufficient evidence reflected standards that don't account for how childcare waitlists work or how postpartum complications manifest.

The coverage gap created medical consequences that will persist for years. The emergency hospitalization cost the state more than exemption would have. The chronic conditions now requiring ongoing management will generate healthcare costs for decades. Prevention required only that exemption systems accommodate actual complexity rather than demanding documentation during crisis.

The policy question is whether requirements should apply uniform standards, accepting substantial compliance failures among women whose need is greatest, or accommodate documented complexity, accepting that accommodation requires administrative investment and categorical flexibility. December 2026 will reveal which philosophy states adopt. Jessica's situation, multiplied across hundreds of thousands of pregnant and postpartum expansion adults, will demonstrate whether policy accommodates human reproduction or demands that reproduction accommodate policy.

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