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Q&A on Pregnant Women's Coverage under Medicaid and the ACA

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The Affordable Care Act ("ACA") makes a number of changes that impact pregnant women who are enrolled in Medicaid and certain private health insurance plans. States have the opportunity to provide pregnant women with new or improved access to health care coverage and services. This Q&A addresses some common questions surrounding pregnant women's coverage under the ACA starting January 1, 2014.

Eligibility

Q1. If a woman is pregnant when she applies for coverage, what are her coverage options?

A. It depends on her household income and whether she satisfies other eligibility requirements.[1] Depending on her income and immigration status, the pregnant woman could be eligible for public health insurance or private health insurance with subsidies.

Full-Scope Medicaid Coverage. A pregnant woman might be eligible for full-scope Medicaid coverage. Her eligibility depends on her household, and potentially, also on the trimester of her pregnancy. Assuming she meets other eligibility criteria (e.g., residency in the state of application), a pregnant woman is entitled to full-scope Medicaid coverage during all trimesters of pregnancy if her pregnancy is medically verified and her household income does not exceed the limit set in her state by the cash assistance program ("AFDC") that was in effect on May 1, 1988.[2] States also have the option of providing pregnant women in their last trimester of pregnancy, without other dependent children, full-scope Medicaid coverage, if they meet the state's 1996 AFDC income standard for parents and other caretaker relatives in the state.[3]

Pregnancy-Related Coverage. If her household income exceeds the above described AFDC limits for full-scope Medicaid coverage, but is at or below 133% of the Federal

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[1] Medicaid is available to individuals under 65 who certain meet financial, residency, and immigration criteria.

[2] 42 U.S.C. §§ 1396a(a)(10)(A)(i)(III), 1396d(n)(1); Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010; 77 Fed. Reg. 17,144, 17,205 (March 23, 2012). Before 1996, individuals who qualified for AFDC cash assistance were automatically eligible for Medicaid. In 1996, as part of welfare reform, Congress delinked Medicaid and cash assistance. Congress also provided that individuals who met the income, resource, and family composition rules that applied to the state's AFDC program on July 16, 1996 must qualify for Medicaid.

[3] During her third trimester, the pregnant women is treated as if she has other dependent in her household.

Poverty Level (FPL) (or up to 185% FPL, depending on the state), the pregnant woman is entitled to Medicaid under the coverage category for "pregnancy-related services" and "conditions that might complicate the pregnancy."[4] States have the option of providing coverage at even higher levels, but states cannot drop coverage below 133% FPL (or up to 185% FPL, depending on the state). Once the state covers the pregnant women, the woman remains eligible through the month in which the 60-day postpartum period ends, even if she has a change in income otherwise making her ineligible.[5]

Medicaid Expansion. If a woman is pregnant at the point of application, she is not eligible for the Medicaid Expansion.[6] Question 2 below discusses Medicaid Expansion coverage for women who become pregnant *after* enrolling.

Children's Health Insurance Program ("CHIP"). States have the option of providing coverage to low-income pregnant women under the State CHIP plan.[7] This option is particularly important for women who are ineligible for other programs, like Medicaid, based on income or immigration status. States provide health care coverage for the pregnant woman and/or the pregnant woman's fetus.[8] Each state has discretion to establish maximum financial eligibility thresholds, but most states set caps well over 200% FPL.[9]

Basic Health Option. The ACA gives states the option of establishing a basic health program ("BHP") to provide health coverage to low-income individuals in lieu of offering those individuals coverage through a state health insurance Marketplace. Effective January 1, 2015, this option permits states to offer subsidized insurance to two groups of people: (1) adults with household incomes between 133% and 200% FPL; and (2) legal resident immigrants with household incomes below 133% FPL whose immigration status disqualifies them from coverage in Medicaid, i.e., immigrants who have been lawfully present in the United States for less than five years.[10] States can use this option to provide coverage to pregnant women who fall into either of these categories.

Health Insurance Marketplace ("Marketplace"). Under the ACA, pregnant women who do not qualify for Medicaid coverage that meets the definition of "minimum essential

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[4] 42 U.S.C. §§ 1396a(a)(10)(A)(i)(IV), (VI); 42 U.S.C. §§ 1396a(l)(1)(A)-(C), 2(A),(B); *see also* 77 Fed. Reg. 17144 at 17,205. Specifically, federal law requires that states provide Medicaid coverage to pregnant women whose household income is the higher of (1) 133% FPL or (2) the income standard, up to 185% FPL, that the state had established as of December 19, 1989 for determining eligibility for pregnant women, or, as of July 1, 1989, had authorizing legislation to do so. 42 C.F.R. § 435.116. This means that while no state can reduce eligibility levels below 133% of the FPL, some states cannot reduce eligibility levels below 185% of the FPL.

[5] 42 U.S.C. § 1396a(e)(6).

[6] 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII); 42 C.F.R. § 435.119(b) (defining eligibility for Medicaid Expansion).

[7] 42 U.S.C. § 1397ll(a).

[8] *Id*; 42 C.F.R. § 457.10 (defining "child" to mean an individual under age 19, including the period from conception to birth, so a state can elect to cover pregnant women as a means of covering "unborn children"); *see also* CMS, Dear State Health Official (May 11, 2009), (Sept. 2, 2009).

[9] *See* KAISER FAMILY FOUND., WHERE ARE STATES TODAY? MEDICAID AND CHIP ELIGIBILITY LEVELS FOR CHILDREN AND NON-DISABLED ADULTS (March 2013), http://kaiserfamilyfoundation.files.wordpress.com/2013/04/7993-03.pdf.

[10] 42 U.S.C. § 18051.

coverage", and have incomes between 100% FPL and 400% FPL, might quality for advance premium tax credits ("APTCs") and cost-sharing subsidies, which they can use to purchase health insurance through a Marketplace.[11] Certain immigrants under 133% FPL and subject to Medicaid's five-year bar are also eligible for APTCs.[12] Under federal law, the following types of Medicaid coverage are not considered "minimum essential coverage": family planning expansion under a state plan amendment; optional coverage of tuberculosis-related services; pregnancy-related Medicaid coverage; and coverage of medical emergency services only.[13]

Q2. Does a woman's eligibility change if she becomes pregnant while enrolled in public or private health insurance?

A. A pregnant woman's eligibility status may change due to her pregnancy, but she may have some choices about her source of coverage.

Medicaid. Generally, a woman who becomes pregnant while enrolled in any Medicaid category, will continue to be eligible for that category. If she becomes pregnant while enrolled in the Medicaid Expansion, she can remain with this full-coverage, at least until redetermination.[14] However, the state must inform the woman of the benefits afforded to pregnant women under the State's other coverage categories and give her the option to switch categories if she is eligible.[15]

Marketplace. The U.S. Department of the Treasury rules exclude pregnancy-related Medicaid coverage, even if it is comprehensive, from the definition of minimum essential coverage.[16] Thus, a woman who becomes pregnant while receiving coverage through a

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[11] 26 U.S.C. § 36B(c)(1)(A). Any "qualified individual" can obtain coverage through the Marketplace. *See* 42 U.S.C. § 18031(d)(2)(A). A "qualified individual" excludes an incarcerated person, and persons with certain immigration statuses. 42 C.F.R. § 155.305(a)(1)-(2).

[12] 26 U.S.C. § 36B(c)(1)(B).

[13] Shared Responsibility Payment for Not Maintaining Minimum Essential Coverage, 78 Fed. Reg. 53,646, 53,658 (Aug. 30, 2013). Although the final rule provides that family planning services under a state plan amendment are not considered minimum essential coverage, it is silent as to family planning waivers.

[14] 77 Fed. Reg. at 17,149 (stating that state does not have to transfer a woman who becomes pregnant after she is already enrolled under the Medicaid Expansion category to coverage under the pregnancy-related services category); CMS, *Questions and Answers: Medicaid and the Affordable Care Act* at A.11 (Feb. 2013), http://www.medicaid.gov/state-resource-center/FAQ-medicaid-and-chip-affordable-care-act-implementation/downloads/aca-faq-bhp.pdf. However, it not clear whether a woman will have to switch to the pregnancy-related category if she comes up for redetermination while enrolled in the new Medicaid category for low-income adults.

[15] *Id.* at 17149; *see also* CMS, Questions and Answers: Medicaid and the Affordable Care Act at A11-A12 (Feb. 2013), http://www.medicaid.gov/state-resource-center/FAQ-medicaid-and-chip-affordable-care-act-implementation/downloads/aca-faq-bhp.pdf

[16] Department of the Treasury rules exclude coverage under 42 U.S.C. § 1396a(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) from the definition of minimum essential coverage. 78 Fed. Reg. at 53,658. The rules would appropriately permit a pregnant woman receiving coverage under 42 U.S.C. § 1396a(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) to take advantage of APTCs to purchase comprehensive health care coverage through a Marketplace, if she so desired. Department of the Treasury and IRS have indicated that they will issue guidance providing pregnant women covered in 2014 under pregnancy-

Marketplace might also qualify for pregnancy-related Medicaid coverage if she meets Medicaid eligibility criteria, including income and immigration criteria. She is then entitled to (1) use APTCs to purchase coverage through the Marketplace; (2) enroll in Medicaid; or (3) enroll in Medicaid under the pregnancy-related services category and use APTCs to purchase additional coverage through the Marketplace. It is possible that in some states (and/or the federally facilitated Marketplaces) the information-technology systems might not yet be set up to allow her to make that choice.

If a woman receiving coverage through the Marketplace becomes eligible for the Medicaid Expansion or another Medicaid category that is considered "minimum essential coverage" (e.g., because her income drops, her family size increases, etc.), she becomes ineligible for APTCs. If this happens she could enroll in the Medicaid. She would remain eligible to purchase coverage through the Marketplace without APTCs, but she most likely could not afford to do so.

Services

Q3. Does Medicaid provide pregnant women with comprehensive health insurance coverage?

A. Not necessarily.

Full-Scope Medicaid Coverage. States must provide full-scope Medicaid coverage to an eligible pregnant woman with income at or below the AFDC income standard discussed in Question 1 above.[17] States may also cover additional services related to pregnancy for pregnant women.[18]

Pregnancy-Related Coverage. For women enrolled in this category (*see* Question 1 above for eligibility requirements), states must provide Medicaid coverage for "pregnancy-related services" and "conditions that might complicate the pregnancy," which may include services for pregnant women that are not covered for non-pregnant

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related Medicaid only, and no other health insurance, with an exemption from penalties for not maintaining minimum essential coverage. *Id.* at 53,648. It is not clear what will happen after 2014.

[17] While full-scope Medicaid coverage is not available to individuals with certain immigration statuses (e.g., undocumented persons), states must cover treatment of "emergency medical conditions" including labor and delivery for all immigrants, including undocumented persons. 8 U.S.C. § 1611(b)(1)(A) ("not qualified" immigrants eligible for Medicaid for emergency medical conditions except for services related to organ transplant procedures); *see also* § 1611(b)(1)(C) (immigrants eligible for public health assistance for immunizations and treatment of communicable diseases); *see generally* 42 U.S.C. § 1395dd; 42 C.F.R. § 489.24; 42 U.S.C. § 1396b(v)(3) (defining emergency medical condition); 42 C.F.R. §§ 436.128, 440.255; CMS, State Medicaid Manual § 3211.11, § 3213.3.B-C (federal funding terminates after the emergency ends). Further, although federal law bars most immigrants from receiving full-scope Medicaid coverage for the first five years after entering the United States, an exception exists for some lawfully residing children and pregnant women living in states that have opted to lift this five-year bar. *See* CHIPRA § 214; *see also* CMS, Dear State Health Official (July 1, 2010).

[18] *See* 42 C.F.R. §§ 440.210(a)(2), 440.250(p).

adults.[19] Some states define "pregnancy-related" and "conditions likely to complicate the pregnancy" as comprehensive Medicaid coverage.[20] Other states, however, provide pregnant women less than comprehensive coverage by narrowly defining services related to or complicating pregnancy. In these states, pregnant women with incomes between the state's AFDC level and 133% FPL (or up to 185% FPL, depending on the state) receive the full range of prenatal, pregnancy, post-partum, and family planning services, but less than comprehensive coverage.

The U.S. Department of Health and Human Services ("HHS") has appropriately articulated the expectation that states should provide pregnant women comprehensive coverage. Pursuant to HHS rules issued in March 2012, states may not deny pregnant women medically necessary services they provide to non-pregnant adults, unless they obtain HHS approval to do so.[21] These federal rules require a state to justify in a state plan amendment for HHS' approval the state's basis for determining that excluded services are not pregnancy-related.

Q4. Must private insurance plans cover maternity services?

A. Yes. Under the ACA, beginning in 2014, all new health insurance plans in the individual and small group markets, including qualified health plans ("QHPs") sold through a Marketplace, must cover ten categories of services and items listed in the ACA as Essential Health Benefits ("EHBs"). One of these categories is "maternity and newborn care."[22] HHS has not specified what must be covered under the category of "maternity" care. Rather, HHS delegated to the states authority to define the EHB.[23] Thus, the specific benefits covered under the maternity services category will likely vary by state.

Q5. Do a pregnant woman's cost-sharing obligations for prenatal care depend on her source of health insurance coverage?

A. Probably not.

Medicaid: Medicaid law prohibits states from charging deductibles, copayments, or similar charges for services that are related to pregnancy or conditions that might complicate pregnancy, regardless of the Medicaid category in which the woman is

[19] 42 U.S.C. § 1396a(a)(10),(VII) of the text following subsection (G), as originally enacted by the Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9401(c); 42 C.F.R. 43.
[20] We use comprehensive coverage here when discussing the benefits provided to individuals eligible under the pregnancy-related Medicaid category. We use it to mean that the state provides this group full Medicaid coverage under their state plan.
[21] *See* 77 Fed. Reg. at 17148-49; Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment, 78 Fed. Reg. 42160, 42281 (July 15, 2013).
[22] 42 U.S.C. § 18022(b)(1)(D).
[23] Essential Health Benefits Bulletin, Center for Consumer Information and Insurance Oversight, Dec. 16, 2011, http://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf.

enrolled.[24] As noted above, HHS has made clear that it presumes "pregnancy related services" to include all services otherwise covered under the state plan unless the state has justified classification of a service as not pregnancy-related in its state plan.

Marketplace: The ACA requires new group health plans and health insurance issuers to cover women's health preventive care and screenings in accordance with guidelines supported by the Health Resources and Services Administration ("HRSA"). HRSA's guidelines require health plans to cover well-women visits, which includes visits for prenatal care, without cost-sharing.[25] However, pregnant women in the Marketplace could have cost-sharing for other pregnancy-related services, such as labor and delivery services and post-partum care. It is unclear at this time whether some insurers may also designate some services as not included in prenatal care and therefore impose cost-sharing.

Additional Factors to Consider

Q6. What factors might impact a woman's choice of coverage?

A. The benefits package, cost, plan choice, provider networks, and likelihood of having to transition to another program all bear upon a woman's best choice of coverage. Below are some specific factors to consider.

Benefits	☐ Does the state's pregnancy-related coverage Medicaid program offer comprehensive coverage? ☐ Does the state Medicaid program offer additional pregnancy benefits not covered by Marketplace plans, such as transportation, adult hearing, vision, dental, home health, or personal care services? ☐ Does a pregnant child or adolescent under 21 need Early and Periodic Screening, Diagnostic, and Treatment services available in Medicaid, but not through the Marketplace? ☐ Will a pregnant woman with a chronic condition be better off in Medicaid due to limitations on prescription drug coverage in the plans available through the Marketplace? ☐ Will switching from the Marketplace to Medicaid cause problematic interruptions in care or changes in providers, in particular for women with chronic conditions?
Cost	☐ Is Medicaid coverage more affordable than Marketplace coverage with APTCs and cost-sharing reductions? ☐ Can the woman enroll in Medicaid and also use APTCs to purchase Marketplace coverage?

[24] 42 U.S.C. §§ 1396o(a)(2)(B), 1396o(b)(2)(B); 42 C.F.R. § 447.53(b)(2); Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges; Eligibility and Enrollment; 78 Fed. Reg. 42,160, 42,281 (July 15, 2013). States may, however, impose monthly premiums (but not other cost-sharing) on pregnant women with incomes above 150% of the FPL. 42 U.S.C. § 1396o(c).
[25] HHS, Health Res. & Servs. Admin., Women's Preventive Services: Required Health Plan Coverage Guidelines, http://www.hrsa.gov/womensguidelines.

Provider	☐ Is there a preferred provider available in one program, but not another?
Transitioning	☐ Must or should the woman transition to another program after the end of her post-partum period? ☐ Must or should the woman transition to another program during her pregnancy because she becomes pregnant?
Family Coverage	☐ Does her family's coverage impact the program that the pregnant woman prefers?

Q7. What can states do to ensure that women have continuity of coverage and care?

A. There are significant concerns that transitioning from one source of coverage to another can create harmful disruptions in care for pregnant women, especially for women with fragile health conditions. There are a number of steps that states can take to minimize or eliminate those risks. A few options are discussed below.

Bridge plans. States can use "bridge plans" to improve continuity of care for lower income people who experience income fluctuations that cause their eligibility for programs changes to change.[26] A bridge plan is an insurance plan offered by a Medicaid insurer in a Marketplace to people transitioning off of Medicaid or the CHIP due to increases in income. If a pregnant woman were enrolled in a bridge plan, she would stay with the same plan and provider network whether she is enrolled in Medicaid, CHIP, or a QHP in the Marketplace.

Premium assistance. Under this option, a state can use Medicaid funds to pay the premiums for adults and children to purchase coverage through private health plans.[27] A state Medicaid program could use premium assistance for a limited time period to enroll a Medicaid-eligible pregnant woman in a QHP through the Marketplace. All Medicaid rules and protections would still apply. This option could help avoid the need to switch plans or providers during eligibility changes.[28]

Coordination between programs. States can design systems that allow women to transition seamlessly, with continuity of comprehensive coverage, between public programs and subsidized private insurance in the Marketplace. Federal rules would allow women to have simultaneous coverage under both Medicaid and the Marketplace plans.[29] The programs would share responsibility for providing a woman with information about all of the programs for which she is eligible, including information about benefits and costs. For example, the state could develop a health insurance

[26] HHS, Ctrs. for Medicare & Medicaid Servs., *Frequently Asked Questions on Exchanges, Market Reforms and Medicaid* 6-7 (Dec. 10, 2012).
[27] CMS, *Medicaid and the Affordable Care Act: Premium Assistance* (March 2013), http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf.
[28] Under pre-ACA Medicaid law, if an adult or child under 19 is eligible for Medicaid and for employer-sponsored coverage the state could also use Medicaid funds to purchase coverage through the employer plan. 42 U.S.C. § 1396e; 42 U.S.C. § 1396e-1(a).
[29] *See* 78 Fed. Reg. at 53,658.

"smart card" that would enable the woman to seamlessly access both Medicaid and private plan services, and that would ensure that the provider knows whether or not to collect a co-payment and which program to bill for her care. The programs should also coordinate provider networks and referral patterns to ensure that the woman can access her regular sources of care, as well as all of her covered benefits, in a seamless and timely manner, regardless of the program in which she is enrolled. If a pregnant woman's eligibility for a program changes, the programs should work together to ensure that the woman does not experience discontinuity of care or coverage while transitioning between programs.