NATIONAL HEALTH LAW PROGRAM

Issue Brief

Using the Affordable Care Act and Other Opportunities to Address Maternal Mortality

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Introduction

Startling maternal mortality rates continue to plague the United States. Women of color disproportionately experience pregnancy or childbirth-related complications that ultimately end in their death. African American women in particular (regardless of their income level) are more likely to die of preventable complications.[1] The reasons for this disparity are simultaneously varied, complex, and unknown.

Although the Patient Protection and Affordable Care Act ("ACA") includes provisions that should improve maternal health, maternal mortality disparities require additional actions.[2] This Issue Brief examines specific elements of the ACA and Medicaid that could help reduce maternal mortality disparities that affect low-income women and women of color. These include implementing comprehensive national data collection systems on maternal deaths to highlight the need for sufficient maternity care performance measures and best practices; enabling women to remain healthier throughout their reproductive lives; ensuring seamless insurance coverage; and supporting state efforts to expedite Medicaid eligibility for pregnant women.

Background

Scope of the Problem

The United States continues to face the challenge of maternal mortality as a public health issue. Maternal mortality rates have not improved since 1982, and the racial health disparities associated with these deaths are "some of the widest disparities found in public health."[3]

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[1] D. Goffman, *et al*., *Predictors of Maternal Mortality and Near-Miss Morbidity*, 27 J. OF PERINATOLOGY 597 (2007), *available at* http://www.nature.com/jp/journal/v27/n10/full/7211810a.html#tbl3.

[2] Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (March 23, 2010). Amendments to the ACA were included in the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (March 30, 2010).

[3] U.S. Dep't of Health & Hum. Services, *Secretary's Advisory Committee on Infant Mortality*: *Meeting Minutes of August 2-3, 2011* (Aug. 2011), *available at*

Various accounts of the actual scope of instances of maternal mortality exist among authorities that collect this data. Moreover, authorities warn of an estimated 30 – 100% underreporting of maternal deaths.[4] In 2007, the U.S. registered 4,316,233 total births.[5] The National Center for Health Statistics reported 548 maternal deaths (12.7 per 100,000 live births) related to or triggered by pregnancy in 2007.[6] These deaths occurred during or within 42 days after the end of pregnancy. The mortality rate for African American women was 28.4 deaths per 100,000 live births, approximately three times the rates among white and Hispanic women (10.5 and 8.9 per 100,000, respectively).[7] In contrast, the Centers for Disease Control and Prevention ("CDC") attributed the maternal mortality rate to be as high as 34.8 deaths per 100,000 for African American women, compared to 14.5 for women of other races, and 11.3 for white women from 2006-2008.[8] Although maternal mortality particularly affects low-income women, the disparity in maternal mortality rates exists among women of color across all income levels.[9] Public health officials caution that such significant race and ethnic disparities are unusual in health data collection and raise questions about whether women of color are obtaining equal access to care.[10]

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http://www.hrsa.gov/advisorycommittees/mchbadvisory/InfantMortality/Meetings/20110802/august2011minutes.pdf.

[4] Am. Cong. of Obstetrics & Gynecology, *Improving Pregnancy Outcomes: Maternal Mortality Reviews and Standardized Reporting-ACOG State Legislative Toolkit* (2011), *available at* http://www.amchp.org/programsandtopics/data-assessment/projects/Documents/ACOG%20State%20Legislative%20Toolkit.FINAL.2011.pdf.

[5] U.S. Dep't of Health & Hum. Services, Centers for Disease Control & Prevention ("CDC"), *National Vital Statistics Reports* (Aug. 9, 2010), *available at* http://www.cdc.gov/nchs/data/nvsr/nvsr58/nvsr58_24.pdf.

[6] U.S. Dep't of Health & Hum. Services, Health Resources & Services Admin.("HRSA"), Maternal & Child Health Bureau, *Women's Health USA 2011* (2011), *available at* http://www.mchb.hrsa.gov/whusa11/hstat/hsrmh/pages/230mmm.html (*citing* U.S. Dep't of Health & Hum. Services, CDC, Nat'l Center for Health Stat., *Deaths: Final Data for 2007,* 58 NAT'L VITAL STAT. REP. 1 (May 20, 2010)).

[7] *Id. See also* Allison Bryant, *et al., Racial/Ethnic Disparities in Obstetrical Outcomes and Care: Prevalence and Determinants*, 202 AM. J. OF OBSTETRICS & GYNECOLOGY 335 (April 2010). Among Asian Pacific Islander women, Filipina and Samoan women experienced higher risks of pregnancy-related hypertension than other subgroups.

[8] U.S. Dep't of Health & Hum. Services, CDC, *Reproductive Health: Pregnancy Mortality Surveillance System*, *available at* http://www.cdc.gov/reproductivehealth/MaternalInfantHealth/PMSS.html.

[9] Kyriakos Markides, *Racial and Ethnic Disparities in Maternal Mortality in the United States*, Presentation before the annual clinical meeting of the American Association of Obstetrics and Gynecology (May 3, 2011), *available at* http://www.acog.org/~/media/Departments/Public%20Health%20and%20Social%20Issues/Racial%20And%20Ethnic%20Disparities%20In%20Maternal%20Mortality%20InThe%20US.pdf?dmc=1&ts=20130224T1356022027 (*citing* Lorraine Walker and Lorie Chesnutt, *Identifying Health Disparities and Social Inequities Affecting Childbearing Women and Infants*, 39 J. OBSTETRIC, GYNECOLOGIC, & NEONATAL NURSING 328 (May/June 2010)).

[10] U.S. Dep't of Health & Hum. Services, *Secretary's Advisory Committee*, *supra* note 3.

Several factors contribute to pregnancy-related deaths. The leading causes in 2006-2007 ranged from cardiovascular conditions (occurring in 13.5% of cases), to infections and hypertensive disorders of pregnancy (11.1% in both cases), and anesthesia complications (.6% of cases).[11] Other contributors to maternal mortality include hemorrhages, preeclampsia, and increased use of cesarean sections (and complications arising from these procedures).[12]

One CDC Division of Reproductive Health study determined that pregnant African American women did not have significantly different prevalence rates of five specific pregnancy-related complications of preeclampsia, eclampsia, abruption placentae (separation of the placenta from the uterine lining), placenta previa (bleeding due to the placenta being too close to the cervix), and postpartum hemorrhage.[13] Nevertheless, pregnant African American women were two to three times more likely to die from those same five pregnancy-related complications than white women.[14] The authors suggested that other factors contributed to the increased likelihood of death for pregnant African American women, such as delayed prenatal care during the first trimester, an increased likelihood of a pre-existing condition that harms their pregnancies (e.g., hypertension, diabetes, or obesity), and poor quality of overall health care in spite of insurance coverage and increased access to services.[15]

In addition to racial and ethnic disparities in maternal mortality, health disparities also exist in "near miss" situations, other major complications of pregnancy that could have resulted in death during pregnancy, childbirth, or within 42 days postpartum, if not for medical intervention or mitigating events.[16] Some of these near miss complications are eclampsia, hemorrhages requiring a transfusion, or conditions requiring intubation, intensive care, or life support.[17]

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[11] U.S. Dep't. of Health & Hum. Services, CDC, *Reproductive Health: Pregnancy-Related Mortality in the United States* (March 28, 2012), *available at* http://www.cdc.gov/reproductivehealth/MaternalInfantHealth/Pregnancy-relatedMortality.htm.

[12] GOPAL K. SINGH, PH.D., U.S. DEP'T. OF HEALTH & HUM. SERVICES, HRSA, MATERNAL MORTALITY IN THE UNITED STATES, 1935-2007: SUBSTANTIAL RACIAL/ETHNIC, SOCIOECONOMIC, & GEOGRAPHIC DISPARITIES PERSIST: A 75TH ANNIVERSARY PUBLICATION (2010), *available at* http://www.hrsa.gov/ourstories/mchb75th/mchb75maternalmortality.pdf. The author also noted that a recent study indicates eight to ten times higher maternal mortality risks for cesarean delivery compared with vaginal births. *See also* Am. Pub. Health Ass'n, Policy Number 201114: *Reducing U.S. Maternal Mortality as a Human Right* (Nov. 1, 2011), *available at* http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1430.

[13] Myra Tucker, *et al*., *The Black–White Disparity in Pregnancy-related Mortality from 5 Conditions: Differences in Prevalence and Case-fatality Rates*, 97 AM. J. PUB. HEALTH. 247 (2007).

[14] *Id.*

[15] *Id.*

[16] Haywood L. Brown, M.D., *et al.*, *Near-Miss Maternal Mortality in a Multiethnic Population, 21* ANNALS OF EPIDEMIOLOGY 73 (2011).

[17] U.S. Dep't of Health & Hum. Services, CDC, *Strategies to Reduce Pregnancy-Related Deaths: From Identification to Review and Action* (2001), *available at* http://www.cdc.gov/reproductivehealth/ProductsPubs/PDFs/Strategies_taged.pdf.

Data on near miss pregnancy occurrences from 1998-2005 indicated a 27% increase of instances that affect an estimated 34,000 women per year in the United States.[18] One study determined that complications of pregnancy frequently put Hispanic women in near miss situations, even if they previously did not have pre-existing medical conditions.[19] In addition, near miss incidents indicate a greater need to advise women of existing health issues that would complicate their pregnancies, expanded access to treatment and management of illnesses, contraception that could stabilize their conditions prior to intended pregnancies, and abortion services as necessary.[20]

Improved segmented data collection among providers and facilities and standardized maternity data reporting contribute to higher quality clinical care and performance measures.[21] Previously, Amnesty International confirmed that the lack of national standards for maternity care best practices and protocols continues to be a barrier to improved care.[22] Although the Centers for Medicare & Medicaid Services ("CMS") indicated that maternity care best practice protocols were under development for all facilities accepting Medicaid reimbursement, the national standards are not yet available.[23]

Senators Debbie Stabenow (D-MI) and Chuck Grassley (R-IA) introduced the "Quality Care for Moms and Babies Act of 2013" (S.425) on February 28, 2013 to require the HHS Secretary to identify and fill gaps in maternity care quality measures on an ongoing basis in Medicaid and the Children's Health Insurance Program ("CHIP").[24] In addition, the legislation establishes grants to develop new quality measures and to convert current and future measures to electronic formats for data collection through electronic health records; and funds eligible maternity care collaboratives that reduce maternal morbidity rates.[25] As of the date of this issue brief, the bill is pending before the Senate Finance Committee. Comprehensive protocols, such as the ones included in the Quality Care for Moms and Babies Act are critical to determining appropriate care interventions to improve maternal health.

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[18] Debra Bingham, *et al., Maternal Mortality in the United States: A Human Rights Failure*, 83 CONTRACEPTION 189 (2011).
[19] Brown, *et al.*, *supra* note 16.
[20] *See* NATIONAL HEALTH LAW PROGRAM, HEALTH CARE REFUSALS: UNDERMINING QUALITY CARE FOR WOMEN (2010), *available at* http://www.healthlaw.org/images/stories/Health_Care_Refusals_Undermining_Quality_Care_for_Women.pdf.
[21] Peter B. Angood, M.D., *et al.*, *Blueprint for Action: Steps Toward a High-Quality, High-Value Maternity Care System*, 20 WOMEN'S HEALTH ISSUES S18 (2010).
[22] AMNESTY INTERNATIONAL, DEADLY DELIVERY: THE MATERNAL HEALTH CARE CRISIS IN THE USA 70-71 (2005).
[23] *Id.*
[24] S. 425, 113th Cong. (2013). *See also* H.R. 896, 113th Cong. (2013). Representative Eliot Engel (D-NY) also introduced the House version of the bill (H.R. 896) on February 23, 2013. On March 1, 2013, the legislation was referred to the House Committee on Energy and Commerce Subcommittee on Health.
[25] S. 425, 113th Cong. § 2 (2013).

Documenting Maternal Mortality to Determine Maternity Performance Measures and Best Practices

Deaths that can be attributed to pregnancy occur in all phases of pregnancy, labor, postpartum, and from complications relating to childbirth, abortion, or ectopic pregnancy. The use of vital statistics and careful definitions of these types of deaths is critical to properly identifying them. Accordingly, standardized data collection of maternal deaths is an important prerequisite for the development of national performance measures and best practices of quality maternity care. Stakeholders, including providers, all levels of government, advocacy organizations, and the health care industry, need to collaborate and coordinate their efforts to collect this data.[26] Underestimates of the true scope of the problem can result when stakeholders do not consistently collect the same types of pregnancy related death data. Inaccurate and under reporting of cases of maternal mortality add to the misperception of the magnitude of this issue.

The United States uses two methods for collecting and coding data on maternal mortality. One division of the CDC oversees both the National Vital Statistics System ("NVSS") and the World Health Organization ("WHO")'s International Classification of Diseases ("ICD").[27] State and local jurisdictions are responsible for registering births, deaths, marriages, divorces, and fetal deaths. Through contractual arrangements, NVSS compiles local birth and death data, analyzes it, and makes it publicly available.[28] The NVSS database includes the cause of death information that is recorded on death certificates (known as standard surveillance) to identify maternal deaths.[29] NVSS also complies with ICD regulations to code causes of death.[30] Although the NVSS remains a valuable resource, it does not always capture some causes of death information attributable to pregnancy.[31]

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[26] *See* U.S. Dep't of Health & Hum. Services, *Strategies to Reduce Pregnancy-Related Deaths, supra* note 16. Surveillance tasks consist of identifying pregnancy-related deaths, viewing medical and non-medical causes of death, analyzing and interpreting findings, and acting on the findings.

[27] The CDC's National Center for Health Statistics (NCHS) manages the National Vital Statistics System. The NCHS is also WHO's designee for coordinating all ICD disease classification activities in the U.S.

[28] *See* U.S. Dep't of Health & Hum. Services, CDC, *About the National Vital Statistics System* (May 10, 2012), *available at* http://www.cdc.gov/nchs/nvss/about_nvss.htm.

[29] *See* N.Y. CITY MATERNITY MORTALITY REV. PROJECT TEAM, BUREAU OF MATERNAL, INFANT AND REPRODUCTIVE HEALTH, PREGNANCY ASSOCIATED MORTALITY: NEW YORK CITY, 2001-2005, *available at* http://www.nyc.gov/html/doh/downloads/pdf/ms/ms-report-online.pdf.

[30] U.S. Dep't of Health & Hum. Services, CDC, National Vital Statistics System, *Instruction Manual: Instructions for Classifying Underlying Causes of Death, ICD-10* (2011), *available at* http://www.cdc.gov/nchs/data/dvs/2a2011.pdf.

[31] U.S. Dep't of Health & Hum. Services, *About the National Vital Statistics System, supra* note 28.

Health authorities consider the ICD as a standard diagnostic tool for obtaining health management, clinical, and epidemiological objectives, as well as classifying causes of death.[32] The ICD collects national mortality and morbidity data in member countries of the WHO (like the U.S.). The WHO issues regulations requiring member countries to use a standard ICD format to classify and code health conditions and causes of death.[33] ICD codes also measure the health of population groups, and track the incidence and prevalence of diseases according to a number of variables (such as race, gender, and age).[34] As such, authorities consider updated versions of the ICD as more useful tools for coding maternal mortality data.[35]

The WHO published a definition of maternal mortality in the ninth revision of the ICD ("ICD-9").[36] The WHO Collaborating Center for the Family of International Classifications for North America ("North American Collaboration Center" or "NACC") reviews and updates the ICD.[37] The NACC, located in the CDC's National Center for Health Statistics ("NCHS"), coordinates mortality, morbidity, and disability classification data and promotes ICD functions for the U.S and Canada.[38] The NCHS manages all official disease classification activities in the U.S., including use, interpretation, and routine revisions of the ICD.[39]

The United States currently uses the ICD-9 for coding and classifying mortality data from death certificates.[40] The ICD-9 classifies a death as having a maternal cause

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[32] World Health Organization, *International Classification of Diseases* (2013), *available at* http://www.who.int/classifications/icd/en/.
[33] *Id.* Countries also use the ICD for making decisions relating to health resource allocation. *See also* U.S. Dep't of Health & Hum. Services, CDC, *Maternal Mortality and Related Concepts* (Feb. 2007), *available at* http://www.cdc.gov/nchs/data/series/sr_03/sr03_033.pdf.
[34] U.S. Dep't of Health & Hum. Services, CDC, *Classification of Diseases, Functioning and Disability: International Classification of Diseases* (Nov. 30, 2011), *available at* http://www.cdc.gov/nchs/icd/icd10.htm.
[35] *See* World Health Org., WHO Working Group on Maternal Mortality & Morbidity Classification, *The WHO Application of ICD-10 to Deaths During Pregnancy, Childbirth and the Puerperium: ICD-MM* (2012), *available at* http://www.slideshare.net/jadehais/icd-10-mm-2012.
[36] U.S. Dep't of Health & Hum. Services, CDC, Classification of Disease, Function, and Disability, *International Classification of Diseases, Ninth Revision – Clinical Modification* (Oct. 4, 2012), *available at* http://www.cdc.gov/nchs/icd/icd9cm.htm.
[37] U.S. Dep't of Health & Hum. Services, CDC, *The WHO Collaborating Center for the Family of International Classifications for North America* (Feb. 24, 2012), *available at* http://www.cdc.gov/nchs/icd/nacc.htm.
[38] U.S. Dep't of Health & Hum. Services, *International Classification of Diseases, Ninth Revision – Clinical Modification, supra* note 36.
[39] U.S. Dep't of Health & Hum. Services, CDC, *Classification of Diseases, Functioning and Disability* (Oct. 4, 2012), *available at* http://www.cdc.gov/nchs/icd.htm.
[40] U.S. Dep't of Health & Hum. Services, *International Classification of Diseases Ninth Revision – Clinical Modification, supra* note 36. *See also* U.S. Dep't of Health & Hum. Services, CDC, *Classification of Diseases, supra note 39*. The ICD-9-CM is the official classification system of assigning diagnostic codes and procedures for hospital utilization in the U.S.

only if pregnancy is part of the sequence of events that leads to death.[41] However, an updated version, the ICD-10, provides a more expansive set of cause of death codes, diagnostic coding rules, and procedures.[42] The ICD-10 includes deaths aggravated by pregnancy in the category of maternal deaths, such as deaths from existing chronic illnesses and non-obstetric conditions that developed during pregnancy.[43] The collection of this information is vital to capturing a complete picture of women's health status to develop strategies to prevent maternal mortality.

Discussion – The Affordable Care Act and Other Opportunities to Improve Maternal Health

Identifying Maternal Deaths through Uniform Data Collection Standards and Developing Maternity Performance Measures and Best Practices

In 2009, prior to the passage of the ACA, HHS released a final rule requiring certain entities to use the ICD-10 for medical coding purposes as of October 1, 2013.[44] The final rule also detailed an administrative simplification of the HHS Secretary's authority to adopt standards for particular electronic health transactions, such as the transfer of information among health plans, unique health code sets, and electronic signatures.[45] In addition, § 1104 of the ACA requires the HHS Secretary to regularly update standards for the electronic exchange of health information.[46] However, a subsequent final rule delayed the compliance date for HIPAA "covered entities" (e.g., health care providers transmitting information in electronic form, health plans, and health clearinghouses) to use the ICD-10 and adopt standards for electronic health transactions until October 1, 2014.[47]

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[41] Isabelle L. Horon, Dr.P.H., *Underreporting of Maternal Deaths on Death Certificates and the Magnitude of the Problem of Maternal Mortality*, 95 AM. J. PUB. HEALTH 478, 479 (2005).
[42] *Id.*
[43] *Id.*
[44] HIPAA Administrative Simplification: Modifications to Medical Data Code Set Standards To Adopt ICD–10–CM and ICD–10–PCS, 74 Fed. Reg. 3,328 (Jan. 16, 2009). "Covered entities" subject to the Health Insurance Portability and Accountability Act (HIPAA) were required to comply with the Final Rule. These included health care providers performing transactions in electronic form, health clearinghouses, and health plans.
[45] *Id.* at 3,329.
[46] *See* Administrative Simplification: Adoption of a Standard for a Unique Health Plan Identifier, 72 Fed. Reg. 22,949 (Apr. 17, 2012). Section 1104 also requires updated implementation requirements and operating rules for the electronic exchange and use of health information technology for financial and administrative transactions.
[47] Administrative Simplification: Adoption of a Standard for a Unique Health Plan Identifier; Addition to the National Provider Identifier Requirements; and a Change to the Compliance Date for the International Classification of Diseases, 10th Edition (ICD–10–CM and ICD–10–PCS), 77 Fed. Reg. 54,710 (Sept. 5, 2012). Other entities that are not required to comply with HIPAA, such as workers' compensation programs and automobile and personal liability insurers could voluntarily transition to using the ICD-10 (along with HIPAA covered entities).

The passage of the ACA brought additional changes to data collection requirements that should help to identify the health status of underserved communities and individuals experiencing health disparities. Typically, identification of disparities is the first step towards determining appropriate prevention strategies. Prior to the ACA, it was difficult to effectively identify and monitor disparities because of inconsistent data collection and reporting practices. Section 4302 of the ACA now requires the HHS Secretary to create data collection standards for race, ethnicity, sex, primary language, and disability status.[48] In October 2011, HHS began promulgating uniform data collection standards for national population health surveys.[49]

The data collection requirements in § 4302 will be valuable to identifying disparities, but additional steps are necessary to effectively monitor maternal deaths. For example, the CDC currently requests death certificates of all women who died during pregnancy (or within a year of pregnancy) from 52 nation-wide reporting areas (in the 50 states, New York City, and Washington, DC).[50] This reviewed and summarized data helps to determine any relationships between the death and pregnancy. However, an Amnesty International survey revealed a systems deficiency in that 10 states do not include a standard checkbox for pregnancy status on their death certificate forms.[51] Moreover, while the CDC National Center for Health Statistics Standard Death Certificate format includes questions to identify the progression of a woman's pregnancy at the time of her death, not all state forms follow that format.[52] In addition, providers do not always accurately record pregnancy-related deaths on death certificates, making it more difficult to identify the scope of the problem accurately.[53]

Improved Data Collection Standards through Legislative Action

In addition to implementation of the ICD-10, other efforts propose to classify cases of maternal mortality in the U.S. more accurately. For example, on March 3, 2011, Representatives John Conyers (D-MI) and Diana DeGette (D-CO) introduced the Maternal Health Accountability Act of 2011 (H.R. 894) to address maternal health disparities (including near miss complications) impacting low-income women and women of color.[54] Among other provisions, H.R. 894 provided grants to states to develop data collection and reporting protocols, establish state maternal mortality

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[48] ACA § 4302.

[49] U.S. Dep't. of Health & Hum. Services, *Implementation Guidance on Data Collection Standards for Race, Ethnicity, Sex, Primary Language, and Disability Status* (Oct. 2011), *available at* http://aspe.hhs.gov/datacncl/standards/ACA/4302/index.pdf.

[50] U.S. Dep't. of Health & Hum. Services, *Reproductive Health: Pregnancy-Related Mortality in the United States, supra* note 11.

[51] AMNESTY INTERNATIONAL, *supra* note 22, at 87. *See also id.* (discussion relating to the need for physicians and other providers to receive more extensive training on correctly completing death certificate forms).

[52] *Id.*

[53] N.Y. ACAD. MED., MATERNAL MORTALITY IN N. Y.: A CALL TO ACTION – FINDINGS AND PRIORITY ACTION STEPS (Feb. 2011), *available at* http://www.nyam.org/news/publications/research-and-reports/pubs/Maternal-Mortality-in-New-York-A-Call-to-Action.pdf.

[54] Maternal Health Accountability Act of 2011, H.R. 894, 112th Cong. (2011).

review committees on pregnancy-related deaths, and decrease disparities in maternal health.[55] The House Subcommittee on Health received the bill on March 11, 2011, but there has been no further Congressional action. As of this writing, it is unknown if it will be re-introduced.

Ensuring Women Stay Healthier Throughout their Reproductive Lives: Public and Private insurance for Pregnant Women

Prevention of maternal mortality significantly depends on the timely identification of women who may be at risk and need appropriate screenings and treatment. For example, in 2011, stakeholders convened by the New York Academy of Medicine noted the increase in the number of women giving birth who have contributing factors for maternal death, such as increased age, being overweight, and having undetected chronic health conditions.[56] They proposed a number of recommendations including standardized data collection, improved preventive services, screening and identifying high risk pregnant women, and access to affordable services to prevent maternal disparities. The ACA includes several provisions that will help to address this particular need.

The ACA and Pregnant Women

The ACA mandates that most Americans enroll in public or private health insurance coverage.[57] The ACA also provides for premium subsidies and cost-sharing supports to make health insurance more affordable. It requires states to establish American Health Benefit Insurance Exchanges ("Exchanges") by January 1, 2014, administered by government agencies or non-profit entities, through which individuals may purchase coverage. Only "Qualified Health Plans ("QHPs") meeting ACA standards can be sold in the Exchanges. Exchanges must also serve to inform individuals of their eligibility for any relevant state or local health program.

Health plans in the individual and small group markets both inside and outside of the Exchanges must include certain essential health benefits ("EHBs"), such as maternity and newborn care, ambulatory patient services, and preventive and wellness services and chronic disease management.[58] Prior to the ACA, insurance plans could routinely require lengthy waiting periods for maternity coverage or exclude it from

[55] *Id.* § 3, § 5.
[56] *See e.g.,* N.Y. ACAD. MED., MATERNAL MORTALITY IN N. Y., *supra* note 53.
[57] ACA § 1501. *See generally* National Health Law Program, *Fact Sheet, Federal Health Reform: The Patient Protection and Affordable Care Act of 2010* (June 2010), *available at* http://www.healthlaw.org/images/stories/PPACA_Fact_Sheet.pdf.
[58] ACA § 1302(b)(1). Other essential benefits are emergency services, hospitalization, mental health and substance abuse disorder services, (including behavioral health services), prescription drugs, rehabilitation and habilitation services, laboratory services, and pediatric services (including oral and vision care).

benefit packages altogether.[59] Women would often be unaware of these delays and exclusions until they sought prenatal care services. As a result, many women obtained prenatal care in later stages of their pregnancies or not at all.

Moreover, the ACA requires that most private insurance plans cover a wide range of preventive services, including services particular to women's health, without cost sharing. HHS Health Resources and Services Administration ("HRSA") health plan guidelines, based on recommendations made by the Institute of Medicine ("IOM"), require coverage of eight specific women's health preventive services including contraception and well-woman visits.[60] The HRSA guidelines explicitly require coverage of prenatal care without cost sharing. In addition, the guidelines recognize that several well-woman visits (or prenatal care visits) might be necessary for women to receive recommended services, based on their health status and other risk factors. This requirement should help address chronic health factors experienced by women at risk for maternal mortality.

In addition, the HRSA guidelines require these additional screenings and services that can improve some aspect of maternal health:

- screening for gestational diabetes;
- testing for human papillomavirus (HPV);
- counseling for sexually transmitted infections (STIs);
- counseling and screening for human immune-deficiency virus (HIV);
- breastfeeding support, supplies, and counseling;
- screening and counseling for interpersonal and domestic violence; and
- all FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling for women with reproductive capacity.[61]

These services are essential for improving maternal health; however, coverage of other critical services for pregnant women, such as dental care, remains unfulfilled. Pregnant women are particularly susceptible to oral health problems that, if left untreated, would be harmful to their health and the health of their infants.[62] Although the ACA does not require coverage of oral health services for adults as part of privately

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[59] Nat'l Women's L. Center, *Still Nowhere to Turn: Insurance Companies Treat Women Like A Pre-Existing Condition* (2009), *available at* http://www.nwlc.org/sites/default/files/pdfs/stillnowheretoturn.pdf.

[60] U.S. Dep't of Health & Hum. Services, HRSA, *Women's Preventive Services: Required Health Plan Coverage Guidelines, available at* http://www.hrsa.gov/womensguidelines/; INSTIT. OF MED. OF THE NAT'L ACAD., CLINICAL PREVENTIVE SERVICES FOR WOMEN: CLOSING THE GAPS 167 (2011).

[61] U.S. Dep't of Health & Hum. Services, HRSA, *Women's Preventive Services*, *supra* note 60.

[62] *See generally* National Health Law Program, *Dental Coverage for Low Income Pregnant Women* (April 2012), *available at* http://www.healthlaw.org/images/stories/DC_Oral_Health_Care_Pregnant_Women_04-05-12.pdf. Pregnant women can experience tooth decay aggravated by fluctuating hormone levels and reduced immune systems.

covered health plans, health exchanges may offer independent dental plans at additional cost.[63]

Medicaid and Pregnancy

Medicaid finances an estimated 40% of all births in the U.S.[64] It serves as an important source of coverage for prenatal, maternity, and post-partum services for low-income women of reproductive age who meet the eligibility requirements of income and resource limits, citizenship status, and state residency.[65] Women of color comprise approximately half of all non-elderly Medicaid female enrollees ages 19 to 64.[66] More details on Medicaid coverage of reproductive health services are in NHeLP's publication, *An Advocate's Guide to Reproductive Health in the Medicaid Program*.[67]

One of the most important provisions of the ACA for low-income women is the expansion of Medicaid eligibility. The ACA expands Medicaid coverage to uninsured individuals with incomes of up to 138% FPL who are not currently eligible for traditional Medicaid (i.e., they are not pregnant, parenting or disabled) in 2014.[68] Women in the expansion category will have the opportunity to obtain needed comprehensive screening and treatment for existing chronic health issues and to improve their health status prior to pregnancy. However, as of March 2013, only about 25 state governors support the Expansion.[69] Leadership in the remaining states either is undecided or opposes expanding Medicaid eligibility. As a result, uninsured and eligible low-income women residing in states not participating in the Expansion stand to lose an opportunity

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[63] ACA § 1311(d)(2)(B)(ii), 42 U.S.C. § 18031(d)(2)(B)(ii).

[64] Kaiser Health News, *Short Takes: The KHN Blog, HHS Seeks to Cut Preterm Births* (Feb. 8, 2012), *available at* http://capsules.kaiserhealthnews.org/index.php/2012/02/hhs-seeks-to-cut-preterm-births-but-medicaid-still-pays-for-them/.

[65] ACA § 435.116(b). States must enroll pregnant women with family incomes up to 133% of the federal poverty level (FPL) in Medicaid (pregnancy is a mandatory eligibility category). However, eligibility levels are higher in states that have covered pregnant women with incomes up to 185% FPL as of December 19, 1989. *See* 42 U.S.C. § 1641; 42 U.S.C. § 1396b(v). Some states provide pregnancy coverage at income levels above 185%. Legal immigrants who arrive in the U.S. after August 22, 1996 cannot obtain Medicaid for at least five years. However, Medicaid will cover treatment for emergency medical conditions including labor and delivery for these individuals and undocumented persons.

[66] Kaiser Fam. Found., *Medicaid's Role for Women Across the Lifespan: Current Issues & The Impact of the Affordable Care Act* (Jan. 2012), *available at* http://www.kff.org/womenshealth/upload/7213-03.pdf. In 2010, African American women were 24% of Medicaid enrollees, while Hispanic and Asian women were 20% and 4%, respectively. American Indian/Aleutian Eskimo, Pacific Islander, and women of two or more races comprised 2% of Medicaid female enrollees.

[67] NATIONAL HEALTH LAW PROGRAM, AN ADVOCATE'S GUIDE TO REPRODUCTIVE HEALTH IN THE MEDICAID PROGRAM (2010) and the ACA Update, *available at* http://www.healthlaw.org/images/stories/NHeLP_ReproMedicaid_Guide_11.pdf; http://www.healthlaw.org/images/stories/2011_09_26_NHeLP_Repro_Advocates_Guide.pdf.

[68] 42 U.S.C. § 1396a(a)(10)(A)(i).

[69] The Advisory Board Company, *Where Each State Stands on ACA's Medicaid Expansion* (March 4, 2013), *available at* http://www.advisory.com/Daily-Briefing/2012/11/09/MedicaidMap.

to obtain coverage for needed preventive, screening, and treatment services that could help to improve their health status prior to pregnancy.

Currently, in most states pregnant women can qualify for Medicaid at a higher income level than non-pregnant adults. Federal law requires that states cover pregnant women up to 133% FPL.[70] States also have the option to provide coverage of pregnant women with higher incomes of up to 185% FPL (about $15,130 per year for a single mother with one child). States must provide Medicaid coverage for pregnancy related services (including services for conditions that might complicate pregnancy) and 60-days post-partum pregnancy related services.[71] States also have the option to provide coverage to other groups, such as women with breast and cervical cancer.[72]

Timely access to health care coverage is critical to ensuring that pregnant women at risk for negative maternal outcomes begin prenatal care immediately. States have the option of providing "presumptive eligibility" or expedited temporary Medicaid eligibility to pregnant women.[73] This expedited process allows pregnant women to obtain prenatal care from "qualified providers" who can certify the status of the pregnancy and begin prenatal care. Qualified providers receive assurance of reimbursement for providing ambulatory prenatal care services while the potential enrollee completes the permanent Medicaid application.[74] Qualified providers can include ambulatory health facilities (hospitals, clinics, rural health clinics); and clinics receiving funding through the Title V Maternal and Child Health Services Block Grant program, the Public Health Service Act, or the Indian Health Improvement Act.[75] However, presumptive eligibility is optional, and 14 states did not participate in the program in 2008.[76] Among the reasons states do not participate in presumptive eligibility

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[70] 42 U.S.C. §§ 1396a(a)(10)(A)(i)(IV),(VI); 42 U.S.C. §§ 1396a(l)(1)(A)-(C), 2(A), (B).
[71] Medicaid Program - Eligibility Changes Under the Affordable Care Act of 2010, 77 Fed. Reg. 17144, 17204 (Mar. 23, 2012). The 60-day post-partum period concludes after the last day of the month in which the 60-day period ends.
[72] *See, e.g.*, Breast and Cervical Cancer Prevention and Treatment Act of 2000, Pub. L. No. 106-354, 114 Stat. 1381. Low-income and uninsured women can obtain full Medicaid coverage for the period that they need treatment of breast and cervical cancer. *See also* 42 U.S.C. § 1396a(aa).
[73] *See also* Elena Tyler Broaddus, *Presumptive Eligibility for Pregnant Women*, State Health Policy Monitor (Dec. 2008), *available at* http://nashp.org/sites/default/files/Presumptive%20Eligibility%20Monitor.pdf?q=files/Presumptive%20Eligibility%20Monitor.pdf. States can structure their respective presumptive eligibility policies by determining which providers are eligible to certify presumptive eligibility, deciding whether to require proof of income and asset tests, and indicating the procedures women must follow to enroll in Medicaid.
[74] 42 U.S.C. §§ 1396a(a)(47), 1396r-1.
[75] 42 U.S.C. § 1396r-l(b)(2). Other qualified entities are Medicaid and CHIP eligibility agencies, organizations that provide emergency food and shelter, and any other agency the state deems able to make a presumptive eligibility determination (pending federal approval).
[76] Broaddus, *supra* note 73.

are concerns about paying for presumptive eligibility, a lack of legislative support, and other existing state mechanisms that expedite Medicaid applications.[77]

After the 60-day post-partum coverage ends – depending on an enrollee's income and resource levels, and if she resides in a state that participates in the Expansion – the woman may then be eligible for traditional Medicaid coverage, a Medicaid Alternate Benefits Plan for newly eligible individuals, or a health plan in the state health Exchange.

A disruption in coverage after the 60-day post-partum period can be problematic, particularly for women experiencing chronic health issues that could negatively affect their health during any subsequent pregnancies. Coverage lapses can lead to delays in preventive screenings and treatment, more missed diagnoses, and limited access to needed prescription drugs.[78] In addition, disruption of the patient-provider relationship negatively influences the ability to coordinate patient care appropriately.[79]

Continuous and seamless eligibility for health care coverage that includes family planning services and chronic health care screening and management, while maintaining continuity of care, would improve women's health status.

State Medicaid programs have the flexibility to implement optional services as specific prevention outreach efforts to promote healthier pregnancies, such as targeted case management, prenatal risk assessments, health education, preconception counseling, nutritional counseling, and substance abuse treatment. In 2007, Nebraska, West Virginia, and New Hampshire did not offer any of these services, compared to Wisconsin, South Carolina, and Delaware (offering at least two or more).[80] Collaborative agreements between local organizations and state and federal programs form the basis of supportive efforts for most of these programs. For example, Connecticut's "Healthy Start" program specifically targets enrolling eligible uninsured low-income women into Medicaid, while also focusing on specific high-risk populations, such as migrant women, adolescents, women in homeless shelters, and refugees.[81] Healthy Start uses Title V Maternal-Child Health Block Grant funding and federal Medicaid matching funds to administer contracts with a variety of organizations that assist pregnant women and children in enrolling in Medicaid and provide case management services.[82]

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[77] *Id.*
[78] Jill Bernstein, *et al., How Does Insurance Coverage Improve Health Outcomes?* Mathematica Policy Research Issue Brief (April 2010), *available at* http://www.mathematica-mpr.com/publications/PDFs/health/reformhealthcare_IB1.pdf .
[79] *See* U.S. DEP'T OF HEALTH & HUM. SERVICES, AGENCY FOR HEALTH CARE RESEARCH & QUALITY, NAT'L HEALTH DISPARITIES REPORT (2010).
[80] Nat'l Acad. for State Health Pol'y & the Urban Inst., *Medicaid Outreach and Enrollment for Pregnant Women: What Is the State of the Art?* (March 2009), *available at* http://www.urban.org/UploadedPDF/411898_pregnant_women.pdf.
[81] *Id.*
[82] *Id.*

Conclusion

The U.S. continues to face significant maternal mortality rates among low-income women and women of color. Chronic health conditions and other complications of pregnancy contribute to near misses and deaths of pregnant women throughout all phases of pregnancy and childbirth. Implementation of the ACA creates additional opportunities for upgraded and consistent data collection methods, yet delays in widespread use of the ICD-10, non-standardized state death certificate forms, and inaccurate recording of pregnancy-related deaths prevent stakeholders from obtaining a complete view of the scope of maternal disparities, and hamper efforts to reduce maternal mortality. The ACA also offers several possible approaches to addressing underlying health conditions and gaps in coverage by requiring coverage of maternity care as an EHB, incorporating the Women's Preventive Services Guidelines, and covering more uninsured women through the Medicaid Expansion. However, stakeholders need to consider additional efforts to prevent adverse maternal outcomes, such as targeted case management, expansion of expedited health care coverage for prenatal care, and continuous health care coverage after the post-partum period.