NATIONAL HEALTH LAW PROGRAM

State Creation of Special Enrollment Periods for Pregnancy

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Introduction

The Affordable Care Act (ACA) changed the landscape of health care coverage in the United States by, among other things, identifying maternity care as one of ten essential health benefits (EHB). This means that maternity care must be covered by health insurance plans that are sold in individual and small group markets.[1] However, gaps in maternity coverage persist for many women, including those who have grandfathered or transitional health plans not subject to the EHB requirement.[2]

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[1] CHRISTINA POSTOLOWSWI, YOUNG INVINCIBLES, WITHOUT MATERNITY COVERAGE: THE NEED FOR SPECIAL ENROLMENT IN THE HEALTH INSURANCE MARKETPLACES DURING PREGNANCY 4 (2014), http://younginvincibles.org/wp-content/uploads/2015/02/Without-Maternity-Coverage-1.5.15_4.pdf [hereinafter YOUNG INVINCIBLES].

[2] *See generally* Timothy Jost, *Implementing Health Reform: Grandfathered Plans*, HEALTH AFFAIRS BLOG (June 15, 2010), http://healthaffairs.org/blog/2010/06/15/implementing-health-reform-grandfathered-plans (A grandfathered health plan is group health plan or health insurance coverage that was in existence on March 23, 2010 and that does not make a subsequent disqualifying change. These include self-insured plans and coverage from individual health insurance market. Grandfathered health plans are exempt from covering Essential Health Benefits.). Transitional plans are those that are not required to comply with coverage requirements under the ACA. These non-grandfathered plans, which otherwise would have been canceled or terminated, can be maintained through 2017. *See generally* Kevin Lucia et al., *Extended "Fix" for Canceled health Insurance Policies: Latest State Action*, COMMONWEALTH FUND (Nov. 21, 2014), http://www.commonwealthfund.org/publications/blog/2014/jun/adoption-of-the-presidents-extended-fix. *See also* Memorandum from Gary Cohen, Dir., Ctr. for Consumer Info. and Ins. Oversight on Extended Transition to Affordable Care Act- Compliant (Mar. 5, 2014) https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/transition-to-compliant-policies-03-06-2015.pdf (on file with Ctrs. for Medicare & Medicaid Servs.); *See also* Letter from Gary Cohen, Dir., Ctr. for Consumer Info. and Ins. Oversight, to Insurance Commissioners (Nov. 14, 2013), https://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11-14-2013.PDF (on file with Ctr. For Medicare & Medicaid Servs.). *See also* YOUNG INVINCIBLES, *supra* note 1, at 4

Moreover, research suggests that an increasing number of pregnant women in the U.S. have health conditions that increase the risk of complications during pregnancy and childbirth.[3] Early, adequate, and regular prenatal care is essential for healthy pregnancies and healthy babies, because it provides education, counseling, screening, and management for these preexisting health conditions and risk factors.[4]

According to the Centers for Disease Control and Prevention (CDC), the number of women dying as a result of pregnancy or childbirth in the U.S. is on the increase. In 1987, an estimated 7.2 maternal deaths occurred per 100,000 live births, while in 2012 that number more than doubled to 15.9 maternal deaths per 100,000 live births.[5] High-risk pregnancies and the number of women with inadequate access to preventive and maternal health care are known causes of maternal mortality rates. Women who do not receive prenatal care are three to four times more likely to die from pregnancy-related complications than women who do have access to prenatal care.[6] Various studies have found that between 25-40 percent of maternal deaths could have been prevented through improved access to and quality of medical care.[7]

The maternal mortality rate in the United States also masks disparities in outcomes on the basis of race.[8] Women of color are less likely to have access to adequate maternal health care services and more likely to die in pregnancy and childbirth than White women. [9] Black women who die as a result of pregnancy or childbirth are more likely to begin prenatal care in the second or third trimester, or not at all, as compared to White women.[10] American Indian and Alaska Native women have the highest rates of receiving late or no prenatal care of all groups, and are 3.6 times as likely as White women to receive late or no

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[3] CTRS. FOR DISEASE CONTROL & PREVENTION, PREGNANCY MORTALITY SURVEILLANCE SYSTEM (Jan. 21, 2016), http://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html. *See generally* Dina Fine Maron, *Has Maternal Mortality Really Doubled in the U.S.?*, SCI. AM.: HEALTH (June 8, 2015), http://www.scientificamerican.com/article/has-maternal-mortality-really-doubled-in-the-u-s.

[4] U.S. DEP'T OF HEALTH & HUM. SERVS., OFFICE ON WOMEN'S HEALTH, PREGNANCY: PRENATAL CARE AND TESTS, (Sep. 27, 2010), http://www.womenshealth.gov/pregnancy/you-are-pregnant/prenatal-care-tests.html.

[5] CTRS. FOR DISEASE CONTROL & PREVENTION, PREGNANCY MORTALITY SURVEILLANCE SYSTEM (Jan. 21, 2016), http://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html.

[6] *Deadly Delivery: The Maternal Health Care Crisis in the USA Summary,* AMNESTY INT'L 7 (March 2010), http://www.amnestyusa.org/pdfs/deadlydeliverysummary.pdf.

[7] *See* Berg CJ et al., *Preventability of pregnancy-related deaths: results of a state-wide review,* 106 Obstetrics & Gynecology 289 (Dec. 2005).

[8] Michelle Chen, *Death by Birth: Race and Maternal Mortality*, COLORLINES (Mar. 16, 2010, 9:47 PM), http://www.colorlines.com/articles/death-birth-race-and-maternal-mortality.

[9] *Deadly Delivery: The Maternal Health Care Crisis in the USA Summary,* AMNESTY INT'L 7 (March 2010), http://www.amnestyusa.org/pdfs/deadlydeliverysummary.pdf.

[10] Kelly Wallace, *Why is the Maternal Mortality Rate Going up in the United States?*, CNN: HEALTH, (Dec. 11, 2015, 9:10 AM), http://www.cnn.com/2015/12/01/health/maternal-mortality-rate-u-s-increasing-why/.

prenatal care.[11] While some of these disparities are addressed by access to Medicaid and the Children's Health Insurance Program (CHIP), racial disparities in maternal mortality rates exist across all levels of income, age, and education, making it important to address disparities through the Marketplace.[12]

Despite the importance of health coverage for pregnant women, some women are still unable to secure access to adequate maternal health care in the Marketplace, because pregnancy is not currently a qualifying event that triggers a special enrollment period. A special enrollment period, or SEP, allows health consumers to enroll in Marketplace coverage outside of the annual open enrollment period. Advocates both federally and in a number of states have sought to make pregnancy a qualifying life event that would trigger a special enrollment period (SEP), which would allow women to enroll in qualified health plan (QHP) coverage when they become pregnant.

This issue brief will provide an overview of SEPs, discuss state efforts to create a pregnancy SEP, and provide recommendations for advocates working on this issue.

Overview of Special Enrollment Periods

Individuals who do not qualify for public insurance, such as Medicare, Medicaid, CHIP, or employer-sponsored insurance coverage, may seek health coverage in the Marketplace. Consumers can only enroll in Marketplace coverage either during the annual open enrollment period (which usually lasts between two to three months) or through a 60-day special enrollment period (SEP) following a "qualifying life event."[13;14] The six circumstances under which qualifying life events trigger an SEP are detailed below.[15]

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[11] *Id.*

[12] Priya Agrawal and Linda Blount, *Why We Need to Pay Attention to Pregnant Women of Color,* THINK PROGRESS: HEALTH BLOG (Dec. 5. 2014, 12:05 PM), http://thinkprogress.org/health/2014/12/05/3599978/disparity-maternal-health/; *Maternal Mortality Exceeds U.S. Goal; Age and Racial Differences* Are Marked, 35 GUTTMACHER INST.: PERSPECTIVES ON SEXUAL HEALTH AND REPRODUCTIVE HEALTH 189 (Jul. 2003), https://www.guttmacher.org/about/journals/psrh/2003/07/maternal-mortality-exceeds-us-goal-age-and-racial-differences-are-marked. *See generally* Gopal K. Singh, *Maternal Mortality in the United States, 1935-2007: Substantial Racial/Ethnic, Socioeconomic, and Geographic Disparities Persist,* DEP'T OF HEALTH & HUMAN SERVS., MATERNAL & CHILD HEALTH BUREAU 1 (2010), http://www.hrsa.gov/ourstories/mchb75th/mchb75maternalmortality.pdf.

[13] YOUNG INVINCIBLES, *supra* note 1, at 9.

[14] Special Enrollment Periods, Ctr. on Budget & Policy Priorities, Health Reform: Beyond the Basics (Mar. 3, 2016), http://www.healthreformbeyondthebasics.org/wp-content/uploads/2015/06/SEP-Reference-Chart.pdf.

[15] Special Enrollment Periods, 45 C.F.R. § 155.420(d) (2016); Special Enrollment Periods, Ctr on Budget and Policy Priorities, Health Reform: Beyond the Basics (Mar. 3, 2016), http://www.healthreformbeyondthebasics.org/wp-content/uploads/2015/06/SEP-Reference-Chart.pdf.

1) Loss of qualifying health insurance coverage
    a. Health insurance through employer or COBRA
    b. Medicaid or CHIP eligibility
    c. Turning 26 for dependents covered under a parent's health plan
2) Change in household size
    a. Birth, adoption, or placement in foster care
    b. Getting married, divorced, or legally separated
    c. Death of a covered member of the household
3) Permanent change in primary place of living or residence[16]
    a. Moving to a home in a new ZIP code or county
    b. Moving to the U.S. from a foreign country or U.S. territory
    c. Moving to or from a shelter or other transitional housing
    d. A student or seasonal worker moving to or from the place that he or she attends school or works
    e. Being released from incarceration (detention, jail, or prison)
4) Change in eligibility for Marketplace coverage (or help paying for coverage)
    a. Becoming a U.S. citizen, national, or lawfully present individual
    b. Change in cost-sharing reduction (CSR) eligibility
    c. Gaining membership in a federally recognized tribe or status as an Alaska Native Claims Settlement Act (ANCSA) Corporation shareholder[17]
    d. Error, inaction, or misconduct in enrollment by the Marketplace or Medicaid agency or health plan (e.g. QHP misrepresentation or violation of a material provision in the plan)
5) "Other exceptional circumstances"
    a. Survivors of domestic violence or abuse or spousal abandonment
    b. Natural disaster or serious medical condition that prevented person from enrolling
    c. Starting or ending service as an AmeriCorps member

Although gaining a dependent through birth, adoption, or fostering a child triggers an SEP, the ACA did not include pregnancy as a life event that would allow for an SEP. Absent an SEP or open enrollment, a woman cannot sign up for or change coverage while she is

[16] *Special Enrollment Periods for the Health Insurance Marketplace*, DEP'T OF HEALTH AND HUM. SERVS., CTRS. OF MEDICARE AND MEDICAID SERVS. 2 (Starting July 2016, CMS requires that one must prove that they had qualifying health coverage for one or more days in the 60 days before the move, unless one is moving from a foreign country or United States territory.).

[17] *Coverage for American Indians & Alaska*, HEALTHCARE.GOV: AMERICAN INDIANS & ALASKA NATIVES, https://www.healthcare.gov/american-indians-alaska-natives/coverage/ (last visited July 1, 2016) (Members of federally recognized tribes and Alaska Native shareholders can enroll in Marketplace coverage any time of year and can change plans once a month.).

pregnant, but can only sign up for coverage within 60 days after giving birth.[18] During a time when health coverage is essential to a healthy pregnancy and delivery, a woman who is having a baby may not be able to access maternity care due to cost.[19] Maternity care is expensive, ranging from an estimated $10,000 to $20,000 without complications.[20] Thus, women who are uninsured or insured in a plan that does not include maternity care are left to either pay out-of-pocket, receive inconsistent care, or forgo receiving maternity care altogether.[21]

Federal Guidance

In February 2015, the U.S. Department of Health and Human Services (HHS) issued final regulations that, among other topics, addressed advocates' request for a pregnancy SEP. Despite requests by several commenters, HHS declined to establish pregnancy as a qualifying life event triggering an SEP.[22] In the preamble to the final rule, HHS reaffirmed its authority to provide for additional SEPs in the case of exceptional circumstances.[23] However, HHS explained that it was not authorized to mandate pregnancy as an "exceptional circumstance" but states may establish additional special enrollment periods to supplement federal qualifying life events as long as they contain consumer protections and otherwise comply with applicable laws and regulations.[24]

Following the February 2015 final regulations, state and national advocates and a number of Democratic members of Congress urged HHS to issue sub-regulatory guidance

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[18] *See generally* YOUNG INVINCIBLES, *supra* note 1, at 9. *Compare Still Open-Coverage in Medicaid and Chip*, HEALTHCARE.GOV: HEALTHCARE.GOV BLOG (April 16, 2014), https://www.healthcare.gov/blog/still-open-coverage-in-medicaid-and-chip/ (discussing individuals who are eligible for Medicaid and, thus, are not restricted to limited enrollment periods) *with* Health Insurance Marketplace, *Special Populations: Pregnant Women Fast Facts for Assisters*, DEP'T OF HEALTH AND HUM. SERVS., CTRS. OF MEDICARE AND MEDICAID SERVS. 1, https://marketplace.cms.gov/technical-assistance-resources/special-populations-pregnant-women.pdf (discussing individuals who are eligible for Medicaid and, thus, are not restricted to limited enrollment periods as Medicaid enrollment is available year round. "if a pregnant woman is seeking a Medicaid eligibility determination for herself, she is counted as one person plus the number of children expected to deliver.").

[19] *See generally* YOUNG INVINCIBLES, *supra* note 1.

[20] YOUNG INVINCIBLES, *supra* note 1, at 4.

[21] *Id.* at 7-9; YOUNG INVINCIBLES, *supra* note 1, at 9. Even though the Affordable Care Act requires health plans offered in the individual and small group markets to cover maternity care as one of the ten essential health benefits, some health plans may still not have maternity coverage, including grandfathered plans, transitional health plans, self-funded student health plans, or plans covering a dependent on a parent's employer-sponsored health plan.

[22] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016 80 Fed. Reg. 10750, 10798 (Feb. 27, 2015) (to be codified at 45 C.F.R. pts. 144, 147, 153-156, 158), https://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf.

[23] *Id*.

[24] *Id.*

authorizing an SEP for pregnancy. On April 10, 2015, HHS Secretary Sylvia Burwell issued a letter stating that she did not believe HHS had the legal authority to establish pregnancy as an "exceptional circumstance" qualifying for an SEP.[25]

Pregnancy SEPs

New York

In December 2015, New York became the first state-based Marketplace to enact a pregnancy SEP when Governor Cuomo signed Senate Bill 5972/Assembly Bill 6780 into law.[26] The senate bill passed unanimously.[27] This SEP was created under the federal regulatory authority which provides a catchall allowing an SEP where "the individual meets other exceptional circumstances as the Exchange may provide."[28]

New York's pregnancy SEP will allow pregnant women to enroll in a QHP through the state's Marketplace at any time rather than having to go without pregnancy coverage or waiting to apply for health coverage during the annual open enrollment period.[29]

Initially, advocates approached the New York State of Health (New York's state-based Marketplace) about adopting a pregnancy SEP administratively. In response, the Marketplace asserted that they did not have the authority to create a pregnancy SEP. However, within six months the legislature passed a bill that was signed by the Governor in November 2015. Proponents of the bill stressed that pregnancy was a time-limited event and explained the importance of prenatal care to keep both mothers and newborns healthy.[30]

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[25] Letter from Sylvia M. Burwell, Sec'y, Health and Hum. Servs., to Patty Murray, Senator (Apr. 10, 2015), http://strategichealthcare.net/wp-content/uploads/2015/04/041015-HHS-Letter-to-Congress-on-Maternity-Care.pdf.

[26] Press Release, Governor Andrew Cuomo, Governor Cuomo Signs Legislation to Make New York the First State in the Nation to Allow Pregnant Women to Enroll in the State Health Insurance Exchange at Any Time (Dec. 23, 2015), https://www.governor.ny.gov/news/governor-cuomo-signs-legislation-make-new-york-first-state-nation-allow-pregnant-women-enroll.

[27] NY STATE SENATE, ASSEMBLY BILL A6780B, https://www.nysenate.gov/legislation/bills/2015/a6780/amendment/b (last visited July 12, 2016) (63 votes in favor, 0 votes in opposition, and no abstains).

[28] 45 C.F.R. § 155.420(d)(9),

[29] *Special Enrollment Periods*, NY STATE OF HEALTH: THE OFFICIAL HEALTH PLAN MARKETPLACE (2013), http://info.nystateofhealth.ny.gov/SpecialEnrollmentPeriods.

[30] Telephone Interview with Georgana Hanson and Ericka Hancox, Family Planning Advocates of New York State (Feb. 12, 2016) (Advocates also cited studies that found any level of prenatal care for adolescent mothers would save the United States up to $3,242 per person in cost of caring for low-weight newborns, an important point, as it is often younger people -- who find themselves with an unintended pregnancy, and who

Vermont

In 2016, Vermont introduced a contraceptive equity bill (H. 620) to "specify the contraceptive products and services that must be included in health insurance plans, as well as restrictions on cost-sharing for contraceptive services."[31] The legislative history of the bill indicates that the Vermont State Senate proposed an amendment to add pregnancy SEP language, which remained in the final bill that was signed into law by Governor Shumlin.

California

In California, Senators Boxer and Feinstein sent a letter to Covered California, the state-based Marketplace, in early 2015 urging it to create an SEP for pregnancy. Covered California responded that "absent HHS guidelines, Covered California is unable to even consider making pregnancy a qualifying life event that would trigger a special enrollment period." Subsequently, Assemblymember Miguel Santiago (D-Los Angeles) introduced a bill—Assembly Bill (AB) 1102--to create a pregnancy SEP.[32] The bill passed through the state assembly, but was subsequently amended by the Senate Health Committee to eliminate the pregnancy SEP.[33]

Advocates in other states have also pursued efforts to enact pregnancy SEPs, but thus far none other than New York and Vermont have been successful.

Remaining Challenges

Although the New York and Vermont pregnancy SEP successes have invigorated advocates around this issue, challenges remain.

The Omnibus Budget Reconciliation Act of 1987 set a floor for Medicaid eligibility for pregnant women, and requires that states not reduce their eligibility limits for pregnant women below either: 1) 133% FPL; or 2) the Medicaid limit in place in that state as of December 1989, where such limit was higher than 133% FPL.[34] Some advocates have

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could not afford health insurance premiums and who thus were not already covered – who the pregnancy SEP will likely benefit).

[31] H. 620, 2016 Gen. Assemb., Reg. Sess. (Vt. 2016).

[32] Women's Health Policy Report, *Calif. Assembly Passes Bill Making Pregnancy a Qualifying Event for Insurance Enrollment*, NAT'L P'SHIP FOR WOMEN AND FAMILIES (June 8, 2015), http://go.nationalpartnership.org/site/News2?abbr=daily2_&page=NewsArticle&id=47977&security=1201&news_iv_ctrl=-1.

[33] *Id.*

[34] 42 U.S.C. §§ 1396a(a)(10)(A)(i)(IV), 1396a(l)(1)(A), 1396a(l)(2)(A)(i-ii, iv) (2016).

raised the concern that a pregnancy SEP could trigger a state to roll back the income eligibility threshold for pregnancy-related Medicaid, opting instead for those women to be covered through the Marketplace by 100 percent federally funded tax credits.[35] The chart in Appendix A lists the current state income limits for Medicaid coverage for pregnant women (updated as of March 2016), next to the minimum income limit below which the state cannot drop, as dictated by the limit in place as of December 1989.

Yet even in the absence of pregnancy SEPs, there have already been attempts to roll back coverage for pregnant women. Louisiana and Oklahoma reduced Medicaid eligibility and transferred pregnant women into Marketplace or CHIP coverage (the "unborn child" option, which may not provide postpartum care) in Fiscal Year (FY) 2014.[36] Louisiana in particular rolled back coverage under an apparent mistaken notion that there was already an SEP for pregnancy.[37] Ohio, which has an income eligibility limit up to 200% of the federal poverty level (FPL) for pregnant women, had initially proposed reducing the pregnancy eligibility to 138% FPL.[38] Meanwhile, Connecticut Governor Dannel Malloy wanted to reduce pregnancy eligibility to 138% FPL from the current 263% FPL, but his budget proposal was rejected by state lawmakers.[39] Maryland also proposed cutting back to 185% FPL (it is currently at 264% FPL).[40] With states already trying to roll back Medicaid coverage for pregnant women, it is clear that a pregnancy SEP is needed now more than ever to ensure

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[35] The advanced premium tax credits provided for qualifying marketplace enrollees are federally funded, whereas Medicaid is jointly funded by the state and the federal government. The federal government did give states an incentive to expand Medicaid by paying 100% of Medicaid costs for those newly eligible for Medicaid through the expansion, from the years 2014 to 2016. The federal share then gradually phases down to 90% of the Medicaid cost in 2020, and will remain at that level. However, pregnant women are not eligible for the expansion program.

[36] Vernon K. Smith et al, *Medicaid in an Era of Health & Delivery System Reform: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2014 and 2015*, KAISER FAMILY FOUND. AND NAT'L ASS'N OF MEDICAID DIRS. (Oct. 2014), https://mmcp.dhmh.maryland.gov/Documents/KFF-NAMD_Medicaid%20in%20an%20Era%20of%20Health%20Delivery%20System%20Reform.pdf.

[37] Katherine Don, *How Louisiana Slashed Medicaid Funding for Pregnant Women and Blamed a Typo*, REWIRE (Mar. 19, 2014, 4:42 PM), http://rhrealitycheck.org/article/2014/03/19/typo-led-louisiana-slashing-medicaid-funding-pregnant-women.

[38] Catherine Candisky, *Medicaid Cuts Could Put Ohio Babies at Risk, Advocates Say*, COLUMBUS DISPATCH (May 29, 2015, 6:05 AM), http://www.dispatch.com/content/stories/local/2015/05/29/cuts-could-put-ohio-babies-at-risk.html (noting that Ohio ranks 47th in the nation for infant mortality and last for Black babies, who die at twice the rate of White babies).

[39] Sharon Langer, *Unintended Consequences of the ACA: Retraction of Medicaid Eligibility for Parents in Connecticut*, GEO. U. HEALTH POL'Y INST.,CTR. FOR CHILDREN & FAMILIES: A CHILDREN'S HEALTH POL'Y BLOG (Aug. 27, 2015), http://ccf.georgetown.edu/all/unintended-consequences-aca-retraction-medicaid-eligibility-parents-connecticut (discussing in "Strategy and Recommendations" the Connecticut Governor Malloy's mistaken attempt to reduce the eligibility for pregnant women to 138% FPL when, in actuality, the floor for Connecticut eligibility is 185% FPL).

[40] Erin Cox, *Critics fault Hogan's plan to cut Medicaid spending*, BALT. SUN (Feb. 13, 2015, 6:51 PM), http://www.baltimoresun.com/news/maryland/bs-md-medicaid-cuts-20150213-story.html.

that women receive the care they need throughout their pregnancies and postpartum period.

Additionally, in the 2017 proposed Benefit and Payment Parameters Rule, HHS implied that state-based Marketplaces that use the federal platform may not add state-specific special enrollment periods beyond the defined list.[41;42] Specifically, in addressing the need for states relying on the federal platform to comply with all rules vis-à-vis the federal eligibility and enrollment infrastructure, HHS stated that: "For example, [State-based Exchanges on the Federal Platform] special enrollment periods must be administered within the guidelines of the [Federally Facilitated Exchange]special enrollment periods, as it is not possible at this time for the FFE to accommodate State customization in policy or operations, such as State-specific SEPs, application questions, display elements in plan compare, or data analysis."[43] However, it is of note that HHS's objection is based on limited ability to customize the federal platform application to different state scenarios, rather than an opposition to the underlying policy proposal. This does not necessarily mean that HHS would oppose a state-specific SEP if the operationalization issue could be resolved.

Recommendations

Whether or not to pursue a pregnancy SEP depends on several factors, including the political climate of a given state. Given the lack of a federal pregnancy SEP, a one-sized-fits-all approach likely will not be successful. It is important to work in collaboration with state advocates in assessing options and opportunities to pursue state authorization or enactment of pregnancy SEPs. However, when looking at whether to pursue a pregnancy specific SEP, consider the following recommendations:

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[41] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017, 80 Fed. Reg. 75487, 75554 (proposed Dec. 2, 2015) (to be codified at 45 C.F.R. pts. 144, 146, 147 et al), https://www.federalregister.gov/articles/2015/12/02/2015-29884/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2017.

[42] Press Release, Ctrs. for Medicare & Medicaid Servs., Special Enrollment Periods for the Health Insurance Marketplace (May 06, 2016), https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-05-06.html.

[43] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017, 80 Fed. Reg. 75487, 75554 (proposed Dec. 2, 2015) (to be codified at 45 C.F.R. pts. 144, 146, 147 et al), https://www.federalregister.gov/articles/2015/12/02/2015-29884/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2017. (A State-based Exchange on the Federal Platform (SBE-FP) is a new Exchange model introduced by HHS and Center for Medicare and Medicaid Services (CMS) in late 2015. In this type of Exchange, a state would run its own Exchange, but would do so using the Federal eligibility and enrollment platform and infrastructure. The Federally Facilitated Exchange (FFE) is the Exchange operated by HHS. It functions as the Exchange for states that did not choose to set up their own Exchange, or who did not get approval for their own Exchange.).

- ➔ Focus efforts to create pregnancy SEPs in states where the administration would be open to a maintenance of effort provision for Medicaid eligibility. Such provisions typically require states to maintain coverage above a certain threshold in order to receive federal funding for specific programs. Here, for instance, a maintenance of effort provision would require that states passing pregnancy SEPs not drop their Medicaid income eligibility thresholds for pregnant women below their current levels for a set period of time.
- ➔ Target pregnancy SEPs in states where a rollback of coverage would be unlikely based on the administration's support for expanded access, or where there is little room for too far a rollback of coverage because the floor set for Medicaid eligibility is already high. For example, Hawaii's current Medicaid income eligibility limit for pregnant women is 196% FPL. The state is not permitted to reduce their eligibility limit for pregnant women below 185%. Thus, there is limited room for the state to roll back the income eligibility threshold for pregnant women.

Conclusion

While the Affordable Care Act expanded coverage options for many individuals and families, some pregnant women continue to encounter barriers to access and gaps in coverage. Some advocates have seized upon pregnancy SEPs as one solution to help pregnant women obtain timely access to adequate health care coverage that meets their needs. While this issue brief has summarized some of the existing national and state efforts to create a pregnancy SEP, it has also highlighted some of the challenges that remain, and provided recommendations for advocates seeking to pursue these efforts at the state level.

Appendix A

This chart lists the current state income limits for Medicaid coverage for pregnant women, as well as the minimum limit allowed, which is based on the limit in place in 1989.

STATE	MEDICAID INCOME ELIGIBILITY LIMIT AS OF JANUARY 2016 (Percent of the FPL)	MEDICAID INCOME ELIGIBILITY MINIMUM SET BY OBRA '86/'87/89 (Percent of the FPL)[44]
Alabama	146%	100%
Alaska	205%	100%
Arizona	161%	100%
Arkansas	214%	100%
California	213%	185%
Colorado	200%	75%
Connecticut	263%	185%
Delaware	217%	100%
D.C.	211%	100%
Florida	196%	150%
Georgia	225%	100%
Hawaii	196%	185%
Idaho	138%	75%
Illinois	213%	100%
Indiana	218%	100%
Iowa	380%	185%
Kansas	171%	150%
Kentucky	200%	125%
Louisiana	138%	100%
Maine	214%	185%
Maryland	264%	185%
Massachusetts	205%	185%
Michigan	200%	185%
Minnesota	283%	185%
Mississippi	199%	185%
Missouri	201%	100%
Montana	162%	100%

[44] *MCH Update: State Coverage of Pregnant Women and Children – July 1990*, NAT'L GOVERNORS' ASS'N 11 tbl.1 (July 1990).

Nebraska	199%	100%
Nevada	165%	75%
New Hampshire	201%	75%
New Jersey	199%	100%
New Mexico	255%	100%
New York	223%	185%
North Carolina	201%	150%
North Dakota	152%	75%
Ohio	205%	100%
Oklahoma	138%	100%
Oregon	190%	85%
Pennsylvania	220%	100%
Rhode Island	195%	185%
South Carolina	199%	185%
South Dakota	138%	100%
Tennessee	200%	100%
Texas	203%	130%
Utah	144%	100%
Vermont	213%	185%
Virginia	148%	100%
Washington	198%	185%
West Virginia	163%	150%
Wisconsin	306%	82%
Wyoming	159%	100%