

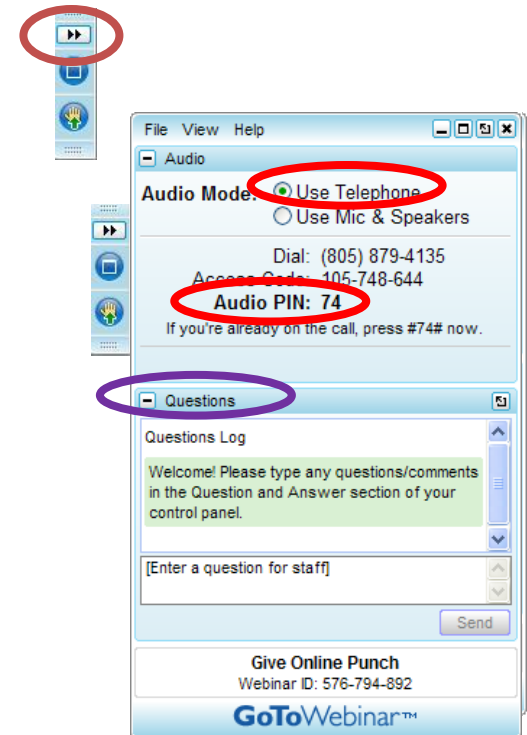
# Health Reform and Insurance Coverage for Pregnant Women



August 28, 2013

# GoToWebinar Interface

- Maximize/minimize your screen with the chevron symbol
- Telephone participants need to enter their audio pin
- Please share your questions and knowledge!
  - Ask a question using the questions log. We will answer as many questions as possible!



# Background

- All states cover pregnant women under Medicaid
  - Some go beyond 133% FPL
  - Up to 300% FPL in some states
- Some states cover all services in the State Plan; others cover only services related to pregnancy

## Background, continued

The ACA created new opportunities for women to obtain private and public health coverage

- Exchanges
  - Individuals with incomes between 100% and 400% FPL are likely eligible for premium subsidies (tax credits) if they do not have another offer of affordable, minimum essential coverage
- Medicaid Expansion
  - Women who are pregnant when applying are not eligible, but women who become pregnant after enrolling in the Medicaid expansion can stay

# Background, continued

For pregnant women, these new coverage opportunities intersect with existing Medicaid coverage during pregnancy

# Regulatory Background

Two major final regulations focus on Minimum Essential Coverage (MEC)

- HHS Minimum Essential Coverage
  - Does not address pregnancy Medicaid coverage
- Treasury Minimum Essential Coverage
  - Does address pregnancy Medicaid coverage

# Final Treasury Rule

- Pregnancy-related Medicaid coverage is not MEC
- What does this mean?
  - This should mean that women who are eligible for Medicaid because they are pregnant are still eligible for tax credits
  - Guidance expected that women who enroll in pregnancy related Medicaid in 2014 but do not enroll in exchange coverage will not face a tax penalty

## What Does This Mean?

- Question: When a woman becomes pregnant in the Exchange and is also eligible for Medicaid – what happens?
- Difficult to evaluate because it is unclear if women will be given a choice of coverage or allowed to enroll in both
  - This would complicate IT infrastructure – most systems are set up to automatically route people who are determined Medicaid eligible into Medicaid



# Coverage Options?

## **MEDICAID**

- Income level set by the state (in now repealed cash assistance program)

## **PREGNANT-RELATED MEDICAID**

- 133%-185% (depending on the state) of the federal poverty level (FPL)

## **MEDICAID EXPANSION**

- If pregnant at application, a woman is not eligible
- If become pregnant after enrollment remains eligible at higher match rate until redetermination

## **HEALTH INSURANCE MARKETPLACE (AKA EXCHANGE)**

- Health insurance marketplaces with one-stop eligibility and enrollment for individuals, including pregnant women
- Open enrollment starts October 1, coverage takes effect on January 1, 2014

# Where Can She Go?

## **If pregnant at application:**

- Medicaid and/or
- Marketplace

## **If not pregnant at application:**

- Medicaid Expansion,
- Medicaid, and/or
- Marketplace

# BENEFIT DIFFERENCES

## (Will likely vary by state)

### **MEDICAID**

- Full-Scope Medicaid
- Pregnancy-related Medicaid
- Medicaid Expansion
  - Alternative Benefit Plan (+ Essential Health Benefits (EHB)), including maternity and newborn care
- Some states
  - Offer pregnant women and pregnant minors additional services (e.g., case management, dental, hearing, vision, home health and personal care services).
  - Have state-only funding for abortion
- States must provide:
  - Transportation services
  - Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for minors under 21

### **MARKETPLACE**

- Some state flexibility
  - Qualified Health Plans (QHPs) must cover the EHB, which include maternity and newborn care
  - QHPs must also cover prenatal care as preventive service without cost-sharing

# Cost Differences?

## MEDICAID

- **No** deductibles, copayments, etc. for services related to pregnancy or conditions that might complicate the pregnancy, including
  - Prenatal care, labor and delivery
- Above 150% of the FPL may charge limited premiums
- After 2014, will women in pregnancy-related Medicaid be assessed a penalty for not having minimum essential coverage?

## MARKETPLACE

- APTCs up to 400% of the FPL
- Cost-sharing reductions up to 250% of the FPL
- **No** cost-sharing for prenatal care, but there might be cost-sharing for labor and delivery

# Continuity of Coverage and Care

## **TRANSITIONING MIGHT MEAN CHANGES IN**

- Provider networks,
- Benefits,
- Cost-sharing protections, and
- Family coverage

# Notice

A woman needs good information about her options to make a decision!

- Effective and timely notice, including appeal rights
- Confidentiality

# Potential Options to Reduce Disruption in Coverage and Care

**BRIDGE PLANS:** Medicaid insurers offer coverage in the Marketplace.

**PREMIUM ASSISTANCE:** Medicaid program uses premium assistance to enroll a Medicaid eligible woman in Marketplace QHP.

- “Wrap” or “supplemental” benefits

## ENROLLMENT IN MEDICAID & MARKETPLACE

# One Size Does Not Fit All

## KEEP IN MIND:

- After 2014, liability for shared responsibility payment?
- Programs should work together to ensure continuity of coverage, cost-sharing protections, and access to complete network of providers and all covered benefits.
- Presumptive eligibility and enrollment periods
- Eligibility criteria (immigration status, FPL, etc.)
- Benefits (scope and accessibility)
- Cost (protections and timeliness of payment)
  - Medicaid's third-party liability rules
- Provider network
- Confidentiality
- How long will she stay?
- Family coverage



# History of Title V

- Enacted in 1935 as part of the Social Security Act
- The Title V Maternal and Child Health Program is the Nation's oldest Federal-State partnership
- The foundation for ensuring the health of the Nation's mothers, women, children and youth, including children and youth with special health care needs and their families.
- States and jurisdictions must match every \$4 of Federal Title V money that they receive by at least \$3 of State and/or local money. This "match" results in more than \$6 billion being available annually for maternal and child health programs at the State and local levels.

# Design of the Title V Program

- Focuses **exclusively** on the **entire maternal and child health population**;
- Encompasses **infrastructure, population-based, enabling, and direct services for the maternal and child health population**;
- Requires a unique **partnership** arrangement between Federal, State and local entities;
- Requires each State to work collaboratively with other organizations to conduct a State-wide, comprehensive **Needs Assessment every 5 years**;
- Based on the findings of the Needs Assessment, requires each State to identify State priorities to **comprehensively address the needs of the MCH population and guide the use of the Maternal and Child Health Block Grant funds**; and
- May serve as the **payer of last resort for direct services for the maternal and child health population that are not covered by any other program**. To ensure continuity of care, when there is no other payer.

# Goals of Title V

- **Assure access to quality** care, especially for those with low-incomes or limited availability of care;
- Reduce **infant mortality**;
- **Provide and ensure access** to comprehensive **prenatal and postnatal** care to women (especially low-income and at risk pregnant women);
- Increase the number of children receiving **health assessments** and **follow-up diagnostic and treatment services**;
- Provide and ensure access to **preventive and child care services** as well as **rehabilitative services** for certain children;
- Implement family-centered, community-based, **systems of coordinated care** for **children with special healthcare needs**; and
- Provide **toll-free hotlines** and assistance in **applying for services to pregnant women with infants and children** who are eligible for Title XIX (Medicaid).

# AMCHP's National Center on Health Reform Implementation

ASSOCIATION OF MATERNAL & CHILD HEALTH PROGRAMS

August 2013

## Who Will Be Covered for What in 2014?

*An Overview of Projected Public and Private Insurance Coverage and Essential Health Benefits for Maternal and Child Health Populations under the Affordable Care Act*

### The AMCHP Role

*AMCHP supports state maternal and child health (MCH) programs and provides national leadership on issues affecting women and children. We work with partners at the national, state and local levels to promote women's health; provide and promote family-centered, community-based, coordinated care for women and children; and facilitate the development of community-based systems of services for women, children and their families.*

*The AMCHP National Center for Health Reform Implementation provides state MCH leaders and their partners with the information, tools and resources to optimize the opportunities presented by the Patient Protection and Affordable Care Act (ACA) for improving services, systems and health outcomes for MCH populations.*

Many states are preparing for open health insurance enrollment in October 2013 and the new health insurance plans beginning in 2014 under the Affordable Care Act (ACA). State Title V maternal and child health (MCH) programs can play a role in educating women, children and their families about projected eligibility levels for various health insurance coverage options as well as eligibility for minimum health plan benefit levels. State MCH programs also can begin to anticipate where there may be potential gaps in health insurance coverage and benefits for MCH populations.

This fact sheet is designed to assist state MCH programs in these efforts. Figures 1 and 2 outline the federal minimum eligibility levels for each income scenario, including identified and potential gaps in eligibility for MCH populations both with and without Medicaid expansion. The Table 1 is designed to be interactive, where hyperlinks direct readers to detailed resources as well as source documents. The table highlights the projected minimum or essential health insurance benefits for MCH populations, including children and youth with special health care needs (CYSHCN), for each of the following coverage options or scenarios: Medicaid, Children's Health Insurance Plan (CHIP), insurance purchased through the health insurance marketplace (aka health insurance exchange), employment-based insurance plans, and safety-net services for those remaining uninsured. It is important to note that eligibility for public insurance coverage is limited to those who live in the United States, have satisfactory immigration status, and are not incarcerated.<sup>1,2</sup>

These charts provide an overview of federal benefit and coverage requirements under the ACA. However, the actual benefits package, cost sharing and affordability for families will vary widely depending on the state. These charts will be updated as needed in response to any funding or policy changes as the ACA is implemented.



# ACA Implementation: Pregnant Women in Maryland

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# About the Coalition

- Nonpartisan alliance of individuals and 94 state-wide organizations.
- Work collaboratively to ensure all Marylanders have the health care they need and deserve.
- Advance policies and legislation; educate, reach out and engage; advocate and take action.
- Partners and Funders: National Women's Law Center, Open Society Institute- Baltimore and Raising Women's Voices

[www.mdhealthcarereform.org](http://www.mdhealthcarereform.org)

# Maryland's ACA Implementation

## Keys to Success:

- State-based Exchange

- Stakeholder Site – [www.marylandhbe.com](http://www.marylandhbe.com)
- Public Site - Maryland Health Connection  
[www.marylandhealthconnection.gov](http://www.marylandhealthconnection.gov)

- Medicaid Expansion

- Inclusive Stakeholder Process

- Legislation – Three Exchange Laws
- Policy – Advisory Committees



# Pregnant Women: The Core Issue



- Maryland's Medicaid Program – Up to 250%FPL
  - Comprehensive Maternity benefits
    - Dental coverage
    - No cost-sharing
    - Newborns enrolled in Medicaid
- ACA Factor
  - 139% to 400% Eligible for Qualified Health Plans with Advanced Premium Tax Credits
  - Eligibility for Medicaid – 139% to 250%



# Pregnant Women

## The Options



### **Option 1 – Dis-enroll from QHP:**

- Enroll in Medicaid during pregnancy and 60 days post-partum
  - FPL status will not be re-checked during this period
- Re-enroll in QHP

### **Option 2 – Remain in QHP:**

- Medicaid to cover during pregnancy and 60 days post-partum:
  - full cost of their premiums
  - cost-sharing
  - dental benefit package.

# Pregnant Women: The Decision



## Option 1 – Why?

- IRS rules
- Maryland's IT Systems

# Pregnant Woman at 148% FPL: A Case Study

- Enrolled in QHP Maryland Health Connection
- Eligible for APTC
- Six months later becomes pregnant
- Knows to self-identify
- Dis-enrolls from QHP
- Enrolls in Medicaid – through 60 days post partum
- Baby automatically enrolled in Medicaid
- 61 days postpartum – mother is dis-enrolled from Medicaid and re-enrolled in a QHP; or
- Doesn't self-identify and goes through open enrollment
  - automatically dis-enrolled from her QHP.

# Option 1: The Challenges

- Administratively Difficult
  - Pregnant woman to self-identify
  - Extensive outreach and education
    - Navigator and assister training
  - Continuity of Care
  - Proper handling of tax credits
  - Provider reimbursement complexity
  - State agency coordination
  - Data collection

# Key Challenge: Self Identification – Exchange and Medicaid

- How to ensure women self-identify if they become pregnant?
- How to ensure notification is consistent, designed using plain language that meets health literacy, cultural competency and privacy standards?
- When should notification occur?
- How often and through what venues?
- What training will be provided to navigators, assisters, brokers, call center and certified application counselors?
- How would grievance and appeals process be handled?

# Key Challenge: Self-Identification – Qualified Health Plans

- What will QHPs do proactively to determine which of their members are eligible to self-identify?
- Should QHPs attempt to reach out to potentially eligible women prior to a pregnancy as well as after?
  - What information would they provide to their providers?
- What steps should be taken to ensure that QHPs don't selectively “identify” members who are high risk pregnancies?

# Key Challenge: Women of Child-bearing Age: Outreach and Education

Specialized outreach and education required for populations that include:

- Immigrants
- Low-proficiency English speakers
- Those with behavioral health issues
- Homeless
- Jail and re-entry populations
- Former foster youth

# Key Challenge: Continuity of Care – Maryland Health Progress Act of 2013

- Beginning in 2015 all receiving plans must:
  - Honor prior authorizations for certain treatments, including pregnancy
  - Allow individual to continue treatment with current provider at a rate agreed upon by carrier and provider
  - Honor Medicaid fee-for-service prior authorizations:
- Provisions are in effect for the lesser of 90 days or current course of treatment
- Not applicable when members transition from commercial carriers into Medicaid FFS programs but ARE applicable when they transition FROM Medicaid FFS



## Key Challenge: Privacy

- How can we ensure that:
  - young women (<26) who are listed under their parent's plan and become pregnant retain privacy over their health status?
  - a woman's privacy is guaranteed if she doesn't want her pregnancy disclosed?
  - Pregnant women aren't being singled out and treated differently than others?

# Pregnant Women: Next Steps

Advocates Have a Role:

- Consumer Assistance Training
  - Content
  - Special populations
- Policy Analysis and Recommendations
- Tracking Enrollment
  - Collecting Data
  - Collecting Stories

# **Pregnancy Coverage Options in Georgia: More Questions than Answers**

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# Women's Current Coverage Options

- Medicaid for pregnant women to 200% FPL
- Medicaid covers 60% of births
- Current churn: no coverage until next pregnancy
- Family planning waiver implementation is spotty
- Uninsured: 25% of women, 3<sup>rd</sup> highest in U.S.

# Unprepared for 2014

- Medicaid
  - No meetings re: interplay between Medicaid and exchange
  - No planning for pregnant women 138%-200% FPL
- Providers
  - No efforts to educate patients
  - No practice preparation for billing/insurance transition issues
- Patients
  - Concern about cost of plans on exchange
  - Confusion about how to participate in the system

# Conflicting Answers in State Medicaid Office

- Women who would have qualified for Medicaid, but live in non-expansion states? Required to purchase private coverage? Subsidies?
- Deadline for states to opt in to Medicaid expansion?
- Can states opt out again down the line?

# Pregnancy-Specific Concerns

- Default if no state policy is issued to address women 138-200% FPL?
- Option to drop exchange plan to obtain Medicaid? Is a state law necessary to provide this option?
- Global fee for pregnancy care for women cycling on and off Medicaid and exchange

# Needs in States

- Strategies for approaching government stakeholders **AND** identifying alternative, extra-governmental pressure points
- Help with provider education
  - To prepare their patients
  - To harness physicians as invested advocates for policy development
- Consensus-building policy alternatives to “traditional” Medicaid expansion: Arkansas model?



# QUESTIONS?

**National Health Law Program**

[singh@healthlaw.org](mailto:singh@healthlaw.org)

[www.healthlaw.org](http://www.healthlaw.org)

**National Women's Law Center**

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**American Congress of Obstetricians and  
Gynecologists**

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**March of Dimes**

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**National Partnership for Women & Families**

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**Association of Maternal and Child Health  
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