

# Without Maternity Coverage

The Need for Special Enrollment in  
the Health Insurance Marketplaces  
during Pregnancy

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YOUNG INVINCIBLES



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### About Young Invincibles

Young Invincibles is a non-partisan, non-profit organization that works to expand economic opportunity for young adults -- ages 18 to 34 years-old -- through policy analysis and advocacy. With offices in six major cities across the country, its research and organizing experts seek to elevate the voices of young adults in top policy debates, and provide solutions to major economic challenges for the Millennial generation.



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## Introduction

Eighty-three percent of new mothers are between the ages of 18 and 34 – so maternal health care is a critical issue for many young adults.<sup>1</sup> Before the Affordable Care Act (ACA), the majority of health insurance plans sold on the individual market did not cover maternity care.<sup>2</sup> Maternity care and delivery is expensive, ranging from \$10,000 to \$20,000 without complications.<sup>3</sup> Pregnant women who were uninsured or insured under a plan that did not include maternity care might have to pay out-of-pocket – or forgo maternity care services altogether.

The ACA sought to change this, by making maternity care one of 10 Essential Health Benefits (EHBs) that must be covered by plans sold on the individual and small group markets starting in 2014.<sup>4</sup> The Department of Health and Human Services (HHS) estimated that 8.7 million women would gain access to maternity coverage thanks to the law.<sup>5</sup> Today, maternity care is a covered benefit in all plans sold on the new health insurance marketplaces, as well as most job-based plans.<sup>6</sup>

Despite the steps forward, some pregnant women still do not have access to maternity care because they lack coverage or their health plan is exempt from the ACA's EHB requirement. Some women in this scenario can enroll in pregnancy-related Medicaid. Others, however, remain left in the same position as millions of women before the ACA – lacking access to covered maternity care. This can result in dire health and financial consequences. To fix the problem, we recommend making pregnancy a qualifying life event that allows pregnant women to enroll in new health insurance coverage through the marketplaces.

The following sections will look at why women need maternity care; what health plans still may not be covering maternity care post-ACA; and policy recommendations for ensuring all pregnant women can access and afford the care they need.

## Women Need Maternity Care

Maternity care can mitigate or prevent health risks associated with pregnancy. According to the Centers for Disease Control (CDC), “[e]arly initiation of prenatal care by pregnant women, and continuous monitoring of pregnancy by health providers, are key to preventing pregnancy-related complications and death.”<sup>7</sup> Several studies have looked at the potential of prenatal care to reduce pre-term births and improve birth outcomes.<sup>8</sup> Fewer studies have focused on the maternity care’s potential benefits to women<sup>9</sup> – which will be the focus of our discussion here. Specific diseases that pose health risks to pregnant women that could be mitigated by maternity care include: preeclampsia, placental abruption, diabetes, heart conditions, and Graves’ disease. While some of these conditions are rare, their consequences can be severe or even fatal for the mother, fetus, or both. And the costs of paying for pregnancy complications can be crippling without maternity coverage – reaching tens of thousands of dollars.<sup>10</sup>

## Preeclampsia

Preeclampsia is a pregnancy-induced disease associated with elevated blood pressure (hypertension) and kidney damage,<sup>11</sup> and impacts five to eight percent of all births in the US.<sup>12</sup> The disease can be life-threatening for the mother and/or fetus.<sup>13</sup> Preeclampsia is diagnosed by the elevation of the expectant mother’s blood pressure combined with excessive protein in her urine<sup>14</sup> – blood pressure and urine screens that detect proteins are part of prenatal exams. A woman’s condition can go from mild to severe very quickly,<sup>15</sup> so monitoring of the mother’s blood pressure at prenatal visits is key to detecting and treating the disease. Consequently, the U.S. Preventive Services Task Force (USPSTF) recommended that all pregnant women get screened for preeclampsia periodically throughout pregnancy.<sup>16</sup>

Preeclampsia screenings are low cost and can reduce the chances of paying for more expensive pregnancy-related complications.<sup>17</sup> HHS’s Healthcare Cost and Utilization Project (HCUP) found that in 2012, pregnancy-related hypertension costs an uninsured patient, on average, \$18,562.<sup>18</sup> Additionally, women with preeclampsia stay in the hospital longer and are more likely to have a Cesarean section (C-section) than women without the disease – both of which increase medical costs.<sup>19</sup>

## Placental Abruption

Placental abruption, which affects approximately one percent of pregnancies, occurs when the placenta separates from the wall of the uterus before delivery.<sup>20</sup> Abruption can lead to: shock due to blood loss, problems with blood clotting, kidney failure, removal of the uterus after delivery, or death.<sup>21</sup> While placental abruption often occurs suddenly, doctors can identify many risk factors during routine maternity care, including: blood pressure disorders, abnormalities in the amount of amniotic fluid, inflammation or rupture of the membranes surrounding the fetus, and preeclampsia.<sup>22</sup>

As with preeclampsia, routine maternity care that screens for risk factors for placental abruption is likely to be less expensive than the medical complications placental abruption causes. For example, HCUP found that in 2012, the average charge for an uninsured patient for a hemorrhage during pregnancy was \$21,275.<sup>23</sup> For a young mother without maternity coverage, this cost could be financially devastating.

## Complications from Diabetes

The American Diabetes Association recommends comprehensive prenatal care to protect the health of the mother and fetus from diabetes-related complications during pregnancy.<sup>24</sup> Approximately one third of women of childbearing age who have diabetes are undiagnosed.<sup>25</sup> Diabetes during pregnancy is associated with increased risk for: miscarriages and stillbirths,



abnormally large fetuses and resulting delivery complications, intrauterine developmental and growth abnormalities, and later development of obesity and type 2 diabetes in the child.<sup>26</sup> Treatment to normalize maternal blood sugar throughout pregnancy is necessary to reduce the likelihood of complications.<sup>27</sup> In addition to undiagnosed diabetes, between three and eight percent of pregnant women develop diabetes during pregnancy (gestational diabetes).<sup>28</sup> Like other forms of diabetes, gestational diabetes increases the risk of adverse consequences for both mother and fetus and requires treatment during pregnancy to reduce complications.<sup>29</sup>

In 2012, diabetes-induced complications to pregnancy or childbirth cost uninsured patients \$13,758 on average.<sup>30</sup> A 2008 report found that women with pre-existing diabetes complicating pregnancy were more than twice as likely to get a C-section than women without the condition, and more likely to be hospitalized for treatment of complications outside of delivery<sup>31</sup> – both of which increase costs.

### Complications from Heart Disease

Heart disease is one of the leading causes of maternal death.<sup>32</sup> Previously undiagnosed heart diseases can present symptoms for the first time during pregnancy, allowing the disease to be diagnosed.<sup>33</sup> Routine prenatal examinations can detect these symptoms, such as increased blood pressure and heart murmurs.<sup>34</sup> Similar to gestational diabetes, life-threatening heart disease can also develop as a new disease related to pregnancy.<sup>35</sup> As one medical journal states, “[the prevalence of heart disease in pregnant women and its potentially life-threatening consequences justify a careful . . . physical examination in all pregnant women.”<sup>36</sup>

### Graves’ Disease

Graves’ disease is an autoimmune disease that causes overproduction of thyroid hormones (hyperthyroidism),<sup>37</sup> which if untreated, can lead to pregnancy complications including miscarriage, preeclampsia, and maternal death.<sup>38</sup> Graves’ disease is thought to affect as many as three million people in the US,<sup>39</sup> and is most likely to affect young women between the ages of 20 and 40 – the age range when the majority of childbirths take place.<sup>40</sup> Because the symptoms of Graves’ disease often worsen in the first trimester, the disease (if previously undiagnosed) may be more likely to be detected during pregnancy.<sup>41</sup> Moreover, as with diabetes and heart disease, pregnancy might trigger Graves’ disease in some women.<sup>42</sup> Untreated or poorly treated Graves’ disease can lead to health complications during pregnancy, such as preeclampsia, preterm birth, placental abruption, miscarriage, and heart failure.<sup>43</sup> HHS advises that because “[t]he treatment needs of pregnant women with Graves’ disease often change, and an experienced doctor is needed to manage treatment during and after pregnancy.”<sup>44</sup>

Pregnancy-related diseases and complications can pose significant health risks to the pregnant woman and fetus. Maternity care is key to early detection of these complications, which can both improve women’s health outcomes and reduce their out-of-pocket medical costs. While

more health plans cover maternity care thanks to the ACA, too many still do not.

## Health Plans Without Maternity Coverage

Before the ACA, most employer-sponsored health plans included maternity coverage, but the majority of individual market plans did not.<sup>45</sup> While the ACA greatly increased the number of plans covering maternity care – by requiring all individual and small group plans to cover maternity care as an EHB – gaps in maternity coverage still persist. Women covered under grandfathered and transitional health plans, as a dependent on a parent’s employer-sponsored plan, or on self-funded student health plans still may not have maternity coverage. Some of these women may be able to enroll in pregnancy-related Medicaid and get access to maternity coverage if they meet their state’s income-eligibility requirements. However, women who do not qualify for pregnancy-related Medicaid may not be able to get on an insurance plan that covers maternity care while they are pregnant. As a result, these women may have to pay for maternity care out-of-pocket and/or forgo needed care – putting both their health and economic well-being at risk.

### Grandfathered Plans

The ACA grandfathered in certain individual and job-based plans that existed before, and have not changed since, the ACA was signed into law. These grandfathered plans do not have to cover EHBs, like maternity care.<sup>46</sup> While we do not know exactly how many women have a grandfathered plan that excludes maternity care, we have a general idea about the proportion of plans in the individual and group markets with grandfathered status. In 2010, HHS estimated that based on turnover in the individual insurance market, 40 to 67 percent of individual plans would no longer be grandfathered by 2014 – meaning that 33 to 60 percent of individual market plans may still be grandfathered today.<sup>47</sup> Similarly, Kaiser Family Foundation’s 2014 Employer Health Benefits Survey found that 35 percent of covered workers at small firms were enrolled in a grandfathered plan.<sup>48</sup>

### Transitional Plans

In addition to grandfathered plans, the Administration gave states the option of letting insurers continue individual and small group plans that would otherwise have been cancelled in 2014, because they did not comply with ACA standards, until October 1, 2017.<sup>49</sup> These “transitional plans” are not required to cover maternity care.<sup>50</sup> Thirty-five states are allowing issuers to continue transitional plans for one or more years, and 21 states are allowing issuers extend these plans through 2017.<sup>51</sup> We do not know how many women are covered on a transitional plan without maternity coverage. However, experts estimated that six to 10 million consumers got plan cancellation notices in 2013<sup>52</sup>; a proportion of these consumers could now be covered on a transitional plan, if their cancelled plan was continued and they reenrolled in that plan.

## Job-Based Dependent Coverage

Additionally, women covered as a dependent on a parent's job-based health plan may not have maternity coverage.<sup>53</sup> While the ACA's EHB requirements do not apply to large employer plans,<sup>54</sup> the Pregnancy Discrimination Act (PDA) of 1978 requires employers with 15 or more employees to cover maternity care for workers and their spouses.<sup>55</sup> However, the law does not require employers to cover maternity care for workers' non-spouse dependents.<sup>56</sup> In June 2013, the National Women's Law Center (NWLC) filed administrative complaints with HHS's Office of Civil Rights (OCR) against five institutions that exclude maternity coverage for non-spouse dependents under Section 1557 of the ACA, which bars sex discrimination in health care plans.<sup>57</sup> Pending resolution of these complaints by OCR, there may still be employer plans that don't cover maternity care for non-spouse dependents. Although we do not know how many companies still do not offer dependent maternity coverage, we do know that more than 1 million women ages 19 to 24 gave birth in 2012,<sup>58</sup> and there are an estimated 15 million young adults ages 19 to 25 who are covered under a parents health insurance policy.<sup>59</sup>

## Self-Funded Student Health Plans

Women with self-insured or self-funded student health plans (SHPs) may not have access to maternity coverage in 2015 or beyond. Self-funded student health plans (SHPs) are not required to cover EHBs, including maternity care.<sup>60</sup> Yet, in 2013, the Administration issued a final rule designating all self-funded SHPs beginning on or before December 31, 2014 as meeting the ACA's minimum essential coverage (MEC) requirement<sup>61</sup> – even if they do not offer comprehensive coverage that includes maternity care.<sup>62</sup> Currently, some self-funded SHPs do offer maternity benefits,<sup>63</sup> but others may not.<sup>64</sup> Starting in 2015, new or renewing self-funded SHPs will have to apply to HHS to be considered MEC. While HHS will presumably require coverage of EHBs like maternity care for plans to be designated MEC, the final rule does not explicitly say so<sup>65</sup>; nor is it certain that all self-funded SHPs may apply for the MEC designation. This means that women with self-funded SHPs could be left without maternity coverage beyond the 2014-2015 plan year. More than 300,000 students at an estimated 30 universities are covered by self-funded student plans.<sup>66</sup>

## Eligibility for Pregnancy-Related Medicaid

Women who are uninsured or have a grandfathered, transitional, or other plan that does not cover maternity care – referred to hereinafter as non-maternity plans – may be able to get maternity care while they're pregnant by signing up for pregnancy-related Medicaid. Pregnancy-related Medicaid, which is available in all 50 states, covers maternity care, delivery, and postpartum care for 60 days after childbirth.<sup>67</sup> Women can enroll in pregnancy-related

Medicaid at any time, but have to meet their state's income requirements for the program to be eligible. The income threshold to be eligible for pregnancy-related Medicaid varies by state, ranging from 133 percent of the federal poverty level (FPL) in South Dakota to 375 percent of FPL in Iowa<sup>68</sup> – anywhere from about \$15,520 to \$43,760 for an individual, or \$20,920 to \$58,990 for a household of two.<sup>69</sup>

In states with lower income-eligibility thresholds for pregnancy-related Medicaid, a woman could find herself slightly above the qualifying income level – but still unable to pay for maternity care out of pocket. For example, in thirteen states a pregnant woman has to make less than 167 percent of the poverty level – or about \$19,490 for a single person – to qualify for Medicaid. While a pregnant woman earning \$20,000 annually would not qualify for Medicaid in these states, it's also unlikely that she would be able to pay \$10,000 – or half of her annual salary – out-of-pocket for her maternity care and delivery. Without access to affordable health insurance coverage through the marketplace, she might face the choice of going without needed care or going into significant medical debt to get it.

## Eligibility for Marketplace Coverage

All plans sold on the health insurance marketplaces cover EHBs, including maternity care. In contrast with pregnancy-related Medicaid, there are no income eligibility requirements to buy a plan on the marketplaces, but there are time restrictions on when one can do so. Consumers can enroll in a market place plan (a) through the marketplace's annual open enrollment period, or (b) through a 60-day special enrollment period (SEP) following a qualifying life event. The open enrollment period for the marketplaces is approximately three months long; if a woman without maternity coverage learns that she is pregnant during this three-month window, she can sign up for marketplace plan with maternity care. However, if this woman learns that she is pregnant during the other nine months of the year (outside of open enrollment), she could not enroll in marketplace plan to get maternity coverage.<sup>70</sup> That's because despite the availability of special enrollment in the health insurance marketplaces for a variety of life events, including childbirth, there is no SEP for pregnancy.<sup>71</sup> This means that a woman can get a SEP to sign up for marketplace coverage within 60 days *after* she gives birth, but cannot sign up for coverage *while* she is pregnant.

## Policy Recommendations

If a woman does not qualify for pregnancy-related Medicaid and becomes pregnant outside of the marketplace open enrollment period, she may not be able to sign up for health insurance while she's pregnant. If she is uninsured or has a non-maternity plan, she may not have access to maternity coverage – potentially putting her health and finances in jeopardy during her pregnancy. To avoid this, we propose making pregnancy a qualifying life event that triggers a SEP in the marketplaces. The serious health risks and high costs associated with pregnancy complications, continued existence of plans that do not cover maternity care, and fact that half

of pregnancies are unplanned weigh in favor of a marketplace SEP for pregnancy. While insurers historically have not allowed special enrollment for pregnancy due to concerns about adverse selection and risk-pool destabilization, the decreasing numbers of women without insurance and plans that do not offer maternity coverage post-ACA mitigate these concerns.

### Factors in Favor of Special Enrollment for Pregnancy

Factors weighing in favor of a SEP for pregnancy include: (1) the high cost of maternity care; (2) the severe health risks associated with undiagnosed or untreated pregnancy-related diseases; (3) the continued existence of plans that do not cover maternity care; and (4) the fact that half of pregnancies are unplanned. As noted above, without insurance, maternity care and delivery can cost \$10,000 to \$20,000 without complications<sup>72</sup> – with complications these procedures could cost tens of thousands of dollars.<sup>73</sup> The financial cost to a young parent of paying for maternity care and delivery out-of-pocket could be devastating.

Moreover, if a woman does not have access to an insurance plan that covers maternity care, she may forgo certain prenatal care because she cannot afford it. As discussed above, prenatal visits are crucial for detecting rare but severe diseases that can be caused by or diagnosed during pregnancy – including preeclampsia, placental abruption, diabetes, heart conditions, and Graves' disease. If untreated, these diseases can lead to severe morbidity or death of the mother and/or fetus. In fact, the American College of Obstetricians and Gynecologists (ACOG) estimates that “pregnancy-related maternal mortality is 3-4 times higher among women who receive no prenatal care compared to women who receive prenatal care.”<sup>74</sup>

Furthermore, as discussed in the previous section, there are still several health insurance plans that may not cover maternity care. These include grandfathered and transitional health plans, employer plans that do not provide maternity coverage to non-spouse dependents, and certain self-funded student plans. A woman who is not planning on becoming pregnant may not know that her plan does not cover maternity care until she is already pregnant – and it is too late to sign up for marketplace coverage during open enrollment.<sup>75</sup>

Finally, about 50 percent of pregnancies are unplanned.<sup>76</sup> If a woman (a) was planning on becoming pregnant and (b) knew that her plan did not cover maternity care, she could theoretically wait until the next marketplace open enrollment period, sign up for a new health plan covering maternity care, and then become pregnant. However, this is not the reality for at least half of women. A woman might need a SEP when she becomes pregnant precisely because she was not planning on becoming pregnant.

### The Adverse Selection Problem

Given these considerations, how come there is not a special enrollment opportunity in the marketplaces already? Insurers' main objection to creating an SEP for pregnancy is that it could

incentivize women to wait to sign up for health insurance until they become pregnant and need it to cover prenatal care and delivery. This is a problem known as adverse selection, which occurs when a product is only used by people who offer the worst return on investment.<sup>77</sup> If women wait until they become pregnant to get insurance, it could cost insurers more to cover those women (due to the expenses associated with maternity care), and the costs of doing so would have to be offset by other enrollees requiring fewer health care services and/or the insurers themselves. Adverse selection is a real concern in the health insurance industry and can lead to instability and/or increased costs for all consumers in the risk pool.<sup>78</sup>

However, the decreasing number of women without insurance, and the decreasing number of plans that do not offer maternity coverage, means fewer women will need a SEP for pregnancy. This significantly reduces concerns about risk pool destabilization and premium increases.

The uninsured rate has been declining nationwide since the ACA's enactment,<sup>79</sup> and it is estimated that by 2019, health care reform could reduce the number of uninsured in the US by 32 million.<sup>80</sup> Several factors drive the trend, including the end of pre-existing condition discrimination (insurers can no longer deny coverage to people with pre-existing conditions), the availability of financial help to purchase insurance for many low- and middle-income families, and the individual mandate (the federal requirement to have insurance coverage). The availability of discounted coverage – and the annual penalty for those who fail to get covered – make it less likely that uninsured women will wait until they get pregnant to get insured, reducing the risk of adverse selection.

Additionally, since the ACA's enactment, the number of plans that do not cover maternity care has decreased,<sup>81</sup> and this number will continue to fall over the next few years. In particular, people will not be able to enroll in transitional plans after October 2017, which could reduce the potential number of women who might seek a SEP because their plan does not cover maternity care. Similarly, the number of people in grandfathered plans, particularly in the individual market, is expected to decrease – as individuals in grandfathered plans switch to other individual or job-based coverage, and as insurers make certain changes to grandfathered plans that cause those plans to lose their grandfathered status.<sup>82</sup>

### Recommendations

Young Invincibles recommends that HHS create a SEP for pregnancy in the federal marketplace, and encourage state marketplaces to adopt a similar SEP, considering the severe health and financial consequences that can arise if women does not have maternity coverage, and the relatively small number of women who would seek an SEP for pregnancy.

Section 155.420(d) of Title 45 of the Code of Federal Regulations lists the qualifying life events that trigger a SEP in the health insurance marketplaces. In addition to the qualifying events listed in the regulation, HHS has the authority to provide for additional SEPs in the federal marketplace and encourage state marketplaces to adopt the same. To date, HHS has



added limited duration (e.g. in 2014 only) or permanent SEPs for a variety of qualifying events, including SEPs for: people eligible for or enrolled in COBRA coverage<sup>83</sup>; people beginning or ending service in the AmeriCorps, VISTA, or National Civilian Community Corps programs<sup>84</sup>; system-related, technical, and display errors<sup>85</sup>; people with individual plans renewing outside of the open enrollment period<sup>86</sup>; and people who lose a hardship exemption (an exemption from the requirement have coverage) during the year.<sup>87</sup>

HHS has exercised its regulatory authority to add SEPs to ensure that people who do not have comprehensive coverage can enroll in a comprehensive marketplace plan. Women who find themselves pregnant and uninsured or with a plan that does not cover maternity care should have the same opportunity to access comprehensive coverage through the marketplaces. The ACA sought to expand access to maternity and newborn care because of the recognized health benefits of this coverage<sup>88</sup> – HHS should ensure that all women have access to this potentially life-saving maternity care.

## End Notes

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  50. The Administration bulletin states that “...policies subject to the transitional relief are not considered to be out of compliance with the following provi-



- sions of the Public Health Service Act (PHS Act): ... Section 2707 (relating to comprehensive health insurance coverage)." Ibid. PHS Section 2707(a) contains the requirement that individual and small group plans must cover EHBs. 42 U.S. Code § 300gg-6(a), <http://www.law.cornell.edu/uscode/text/42/300gg-6>.
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