Oregon Foundation for Reproductive Health

Enrollment for Pregnancy Related Care

Women who become pregnant should be allowed to enroll in a Qualified Health Plan for coverage at the time they find out they're pregnant, even if it is outside the brief open enrollment period. Pregnant people who lack health insurance often go without necessary care, thus jeopardizing their health and that of their babies.

Currently, giving birth is considered a qualifying event that provides women with a special enrollment period to apply for coverage. Women who are seeking coverage in the Exchange (as well as those with employer-based or other private market coverage) can enroll themselves and their newborn(s) in coverage *only once they give birth*. Oregon has made a commitment that prenatal care is important through policies, health metrics, and programs designed to increase access for all Oregonians. We are requesting that DCBS create a 'special enrollment period' (SEP) in Oregon for individuals when they become pregnant, so they can enroll in coverage for critical pregnancy related care.

Pregnancy itself does not qualify for a special enrollment period in the Marketplace. While the Affordable Care Act (ACA) has greatly expanded access to maternity care for pregnant women, there are still women who lack access to comprehensive pregnancy related coverage. This population includes:

- √ pregnant people who are uninsured and do not income qualify for Medicaid coverage;
- √ people who are covered on a plan that still does not include any maternity coverage (e.g. canceled or transitional plans);
- √ people who have a plan that does not include coverage of the full pregnancy related benefits they need.

The Implications of Lack of Access to Care During Pregnancy

Insurance coverage is associated with early initiation of prenatal care. Early access to routine and recommended prenatal care is important for all women, and especially important for women at risk for poor birth outcomes. Supporting healthy pregnancies not only leads to better birth outcomes, but can also generate health care savings.

Research commissioned by the March of Dimes has shown that on average businesses spend 12 times more in health care costs for premature/low birthweight (LBW) infants than for uncomplicated births. Newborns with other selected complications, including congenital defects and co‐morbidities associated with prematurity or LBW, are more than twice as costly as newborns without complications. Among women at risk for poor birth outcomes, access to prenatal care reduces hospital and NICU admissions among infants, resulting in cost savings ranging from $1,768 to $5,560 per birth. In another intervention, intensive prenatal care for women with high-risk pregnancies saved $1.37 for every $1 invested in augmented prenatal care.

Almost half of all pregnancies are unintended. If a woman becomes pregnant outside of open enrollment and is uninsured or has insurance that doesn't cover pregnancy related care, she has little options to get the care she needs. As a result, many uninsured women forego the prenatal care they need, leading to worse health outcomes for themselves and their babies. Lack of prenatal care can lead to serious health

consequences for mother and child. Birth defects are one of the leading causes of infant deaths, accounting for more than 20% of all infant deaths. Some of these birth defects can be prevented and, with proper prenatal care, many can be detected before birth, enabling better care during and after birth. (Health people 2020**). Due to the association between prenatal care, health outcomes, and cost savings, it is imperative that individuals have the opportunity to enroll in coverage as soon as they discover they are pregnant.**

For women who previously had limited interaction with the health care system, pregnancy serves as an introduction into the health care system. A special enrollment period for pregnant women could improve continuity of coverage for both the woman and her children. Studies show that children are more likely to have health insurance if their parents are insured, and continuous coverage is associated with improved access to well-child care. Timely, affordable access to prenatal care is particularly important for women of color, who face significant pregnancy-related health disparities.[1] Ensuring that people have health insurance coverage throughout pregnancy and delivery will improve health outcomes for Oregon families.

Oregon Stats

- There were 45,557 live births in Oregon in 2014[2]
- Medicaid currently finances almost half of all babies born in Oregon
- 57, 502 women are enrolled in coverage through a state Exchange plan[3]
    - 40% of women enrolled are 18-44 y/o (~ 23,000)

Special Enrollment Plans Selected in Oregon February 23 – June 30, 2015 on HealthCare.gov :

OREGON	7,224	1,258	1,481	**1,852**	11,815
	Loss of Coverage	Denial of Medicaid	Tax Season	All Other SEPs (**including birth**)	Total

Oregon has made a commitment to better Maternal & Child Health outcomes:
Access to comprehensive maternity coverage allows women to access important pregnancy-related care, which is demonstrated to improve health outcomes for women and newborns and reduce financial costs for both consumers and insurers.

1- Coordinated Care Organization metrics for MCH included entry into early prenatal care and reduce elective inductions before 39 weeks;

[1] AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS COMMITTEE ON HEALTH CARE FOR UNDERSERVED WOMEN, RACIAL AND ETHNIC DISPARITIES IN WOMEN'S HEALTH, OPINION NO. 317 (2005)http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for- Underserved-Women/Racial-and-Ethnic-Disparities-in-Womens-Health (highlighting disproportionate levels of pre- term births, maternal mortality and infant mortality among women of color).

[2] The Center for Health Statistics Oregon resident births by county of residence, 2010-2014

[3] OR Marketplace Female Enrollment through June 2015 Data Sources: HHS, Office of the Assistant Secretary for Planning & Evaluation's national report at county-level data updated July 2015; State Health Access Data Assistance Center Analysis using 2013 census data

2- 2015 Legislation expanded coverage so more women can access prenatal care; CAWEM Plus services are available to all pregnant CAWEM-eligible women statewide until the day after childbirth, including Medicaid coverage for labor, delivery and prenatal care.
3- Oregon Medicaid has continuous enrollment and presumptive eligibility on pregnancy status for women who are pregnant up to 190% FPL, with full health insurance until 60 days post-partum.

Minimal Market Impact

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. 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, especially in Oregon.

The uninsured rate has declined in Oregon to 5%. Several factors drive the trend, including the end of pre-existing condition discrimination, the availability of financial help to purchase insurance, the individual mandate, and Medicaid expansion. 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, 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 they 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.

- Vauhini Vara at The New Yorker, profiles the SEP policy efforts noting "the argument in favor of making pregnancy a qualifying life event seems so logical, and the support for it is proving so strong, that one might wonder why it hasn't happened already."
- Princeton economist Janet Currie notes that **the cost of creating the special enrollment period would likely be minimal:** "any potentially higher costs would probably be kept to a minimum"
- Two professors of Public Administration with a specialization in Health Management and Policy at Portland State University submitted testimony in favor, "Allowing pregnant women to enroll in a Qualified Health Plan at the time pregnancy is detected would likely have an *insignificant impact* on the insurance marketplace."

Oregon Associations endorse SEP for Women who are Pregnant:

- Oregon Foundation for Reproductive Health
- Oregon Law Center
- Coalition of Community Health Clinics
- Oregon Primary Care Association
- Network for Reproductive Options
- Cascade AIDS Project
- Future Generation Collaboration
- Oregon Public Health Association

National Interest

The *Healthy Mom Act* introduced to the US Senate in Oct. 2015 was Co- Sponsored by Senator Merkley, and includes a special enrollment period for pregnant individuals, beginning on the date on which the pregnancy is reported to the Exchange; beginning after 2016 Open Enrollment.

- New York Gov. Cuomo signed into law a bill that lets pregnant women enroll in the state's health insurance exchange outside of the narrow enrollment window. The bill passed unanimously and makes New York State the first in the nation to classify pregnancy as a "qualifying event" triggering a special enrollment period for the state's health exchange(www.capitalnewyork.com).

- Vermont Gov. Peter Shumlin signed into law a bill that permits women to enroll in a health insurance plan immediately if pregnant instead of delaying enrollment until an open enrollment period or a birth. The law will take effect on July 1, 2016 (www.womenshealthpolicyreport.org).

Media

April 2016: The Lund Report- *State Regulators Scuttle Talk of Year-Round Insurance Enrollment for Pregnant Women*
https://www.thelundreport.org/content/state-regulators-scuttle-talk-year-round-insurance-enrollment

Feb 2016: *HHS Must Remove Barriers To Coverage For Pregnant Women*
http://healthaffairs.org/blog/2016/02/19/hhs-must-remove-barriers-to-coverage-for-pregnant-women/

Nov 2015: The Lund Report- *Health Advocates Want Year-Round Enrollment for Pregnant Women*
https://www.thelundreport.org/content/health-advocates-want-year-round-enrollment-pregnant-women

Feb 2015: NPR- *Pregnant And Uninsured? Don't Count On Obamacare Coverage*
http://www.npr.org/sections/health-shots/2015/02/18/387191283/pregnant-and-uninsured-dont-count-on-obamacare-coverage

Oct 2014: THE YOUNG INVISIBLES: *Without Maternity Coverage*
http://younginvincibles.org/wp-content/uploads/2015/02/Without-Maternity-Coverage-1.5.15_4.pdf