

The Potential of Health Care Reform to Improve Pregnancy-Related Services and Outcomes

By Adam Sonfield

Having a child is, quite simply, expensive. Even putting aside the years of food, clothing, shelter, education and all the rest, the basic human functions of pregnancy and childbirth involve, in U.S. society, thousands of dollars in medical expenses for prenatal care, labor and delivery, and postpartum care for both the mother and the infant. And if there are any pregnancy-related complications, those costs can increase dramatically. Even a short stay for a newborn in intensive care can be expensive enough to bankrupt many American parents, if they must pay out of pocket.

At the same time, there can be dramatic health consequences for mothers and children if they do not obtain the appropriate care. And although there are a multitude of factors behind major health indicators like the rates of maternal mortality and preterm births, it is clear that financial hurdles—particularly for the uninsured and underinsured—are an important reason why the United States lags behind most other developed countries in this area. According to 2005 estimates from the World Health Organization and other United Nations agencies, the U.S. maternal mortality rate is higher than the rate in more than 30 other countries, including most of Europe. In fact, as was highlighted in a 2010 report from Amnesty International, the U.S. rates of maternal mortality and severe maternal complications have actually grown worse in recent years.

However, with the passage of the Patient Protection and Affordable Care Act in March 2010, Americans have new reason for optimism about improvements in maternal and child health. Health care reform has the potential to

improve access to and use of a wide range of health care services generally, and the law includes a sizable list of provisions focused specifically on pregnancy-related care. Better access to and use of care, in turn, has the potential to address the distressing disparities in maternal and child health found among certain segments of the U.S. population, and between the United States and other developed countries.

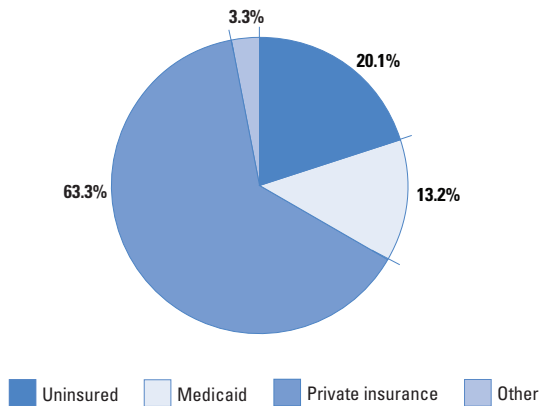
Coverage Before Reform

One of the primary impetuses for health care reform, of course, was the large numbers of U.S. residents who lacked health insurance. By the most recent government estimates, about 46 million people in the United States were uninsured, amounting to 17% of the U.S. population younger than 65. That number includes more than 12 million women of reproductive age (15–44), two in 10 women in that age-group (see chart, page 14).

Moreover, just having insurance does not necessarily ensure adequate coverage for pregnancy-related care. In this regard, lower-income women have a relative advantage because of protections built into public-sector coverage. The eight million women of reproductive age who are Medicaid enrollees are guaranteed coverage for maternity care and their infants' care. In addition, states provide coverage for pregnancy-related care under Medicaid and the Children's Health Insurance Program (CHIP) for some women who would otherwise not be eligible for the programs. States typically set their income-eligibility levels for pregnant women at or near 200% of the federal poverty level (the poverty level is currently \$18,310 for a family of three). In total, about four in 10 U.S. births are paid for by these

WOMEN'S COVERAGE TODAY

Two in 10 women of reproductive age (15–44) were uninsured in 2008, and six in 10 relied on private insurance.



Source: Guttmacher Institute tabulations from the Current Population Survey, 2009.

programs, although many women enroll in Medicaid or CHIP too late to receive adequate prenatal care. In every state, Medicaid coverage includes prenatal care and screenings, labor and delivery, and postpartum care for 60 days, although a 2009 study from the Kaiser Family Foundation found that some states exclude specific services, such as genetic counseling and screening or education and services to support breastfeeding, or specific providers, such as birth centers or doulas.

By contrast, for the 39 million reproductive-aged women with private insurance, coverage of pregnancy-related care is somewhat less certain and has, in fact, been a decades-long point of contention and concern. Under the Pregnancy Discrimination Act (PDA) of 1978, health plans sponsored by employers with 15 or more employees must cover pregnancy, childbirth and related medical conditions for employees and their spouses in the same way as they cover other medical conditions. Despite that landmark law, there are still legal gaps. Plans offered by smaller employers or in the individual market are not governed by the PDA, and even large employers can offer plans that exclude pregnancy-related care for “non-spouse dependents”—such as daughters of enrollees and their infants.

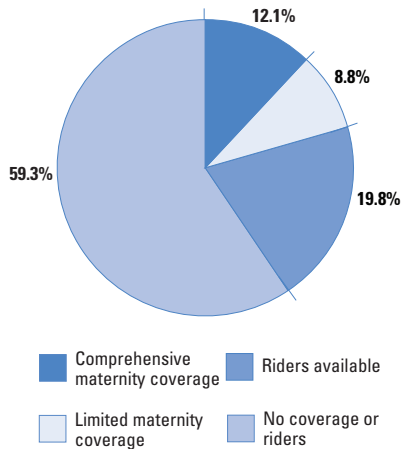
Some states have their own versions of the PDA that apply to smaller employers, and a handful of states require maternity coverage in all individual health plans. Nevertheless, the legal gaps persist and can translate into gaping craters in the real world. A 2008 study by the National Women’s Law Center found that among more than 3,500 individual insurance plans sold across the country, only 12% included comprehensive maternity coverage (see chart, page 15). In some cases, women could purchase a “rider” specifically for maternity coverage, but such add-on benefits can cost thousands of dollars per year and may have waiting periods and coverage limits. In addition, insurance plans may treat pregnancy itself or related conditions (such as a prior cesarean section) as grounds for denying coverage entirely, charging higher premiums or excluding pregnancy-related expenses as preexisting conditions.

The Coverage to Come

One expected consequence of health care reform is that considerably fewer women will be uninsured prior to pregnancy. According to estimates from the Congressional Budget Office, 32 million fewer Americans will be uninsured in 2019 than would otherwise be the case, as a result of two major coverage expansions slated to become effective in 2014. First, all states will be required to extend eligibility under their Medicaid programs to all U.S. citizens and longtime legal residents in families with incomes at or below 133% of poverty. (Currently, most states have considerably lower thresholds for parents—on average about 65% of poverty—and do not cover childless adults at any income.) Second, individuals and small employers will be able to purchase private insurance coverage through new, state-based marketplaces known as exchanges; most of the currently uninsured will be eligible for a federal subsidy to make that insurance affordable. Expanded coverage should mean that more women will have a regular doctor or health center they rely upon, and fewer women will need to scramble to pay for care during and after pregnancy, or for care for their newborns. It should also mean that more women will be able to plan their pregnancies using contraception, ensure they are in good health before conception and obtain early prenatal care—all of which are important factors in maternal and child health.

MARKET FAILURE

Most plans available in the individual market do not include any maternity coverage, and only a small fraction provide comprehensive coverage.



Note: Availability to a 30-year-old woman shopping in the individual insurance market using eHealthInsurance in 2008, among 3,512 plans. *Source:* National Women's Law Center, 2008.

Beyond its goal of expanding coverage, per se, health care reform includes specific provisions designed to make coverage better for women who are pregnant or trying to become pregnant. Most notably, maternal and newborn care is one of only 10 types of health care services explicitly required by law to be included in what will become widely known as the “essential health benefits package.” That package of services—which will be given greater detail by the U.S. Department of Health and Human Services sometime before 2014—will be covered for all enrollees in all plans sold in the new exchanges, as well as in any new individual and small group policies sold outside of the exchanges. All told, this mandate should eliminate most of the gaps in maternity coverage left by the PDA.

The new law also prohibits many of the abusive practices that insurance companies have used to avoid adequately covering pregnant women and infants: Starting in 2014, health plans will no longer be allowed to exclude or limit coverage for care related to preexisting conditions, or deny health coverage entirely to people because of such conditions. For minors, that protection starts in September 2010. Similarly, plans in 2014 will be barred from charging higher premiums to

women than to men, a common practice known as gender rating that is based on the fact that women make greater use of their insurance.

In addition, some key pregnancy-related services will be available with no cost-sharing. All new private health plans, starting in September 2010, will be required to cover—without any out-of-pocket costs—a series of preventive care items and services (related article, Spring 2010, page 2). As described in preliminary regulations issued by the administration in July, the list of services today includes folic acid supplements to prevent certain birth defects, STI testing for pregnant women, smoking cessation counseling (also newly required under Medicaid) and a variety of other screenings and vaccinations that are important components of prenatal care, along with all of the preventive care needed for infants. That list is slated to expand next year, when yet-unwritten women's preventive care guidelines are issued by the Institute of Medicine.

Beyond Coverage

Expanding and improving insurance coverage was arguably the central goal of health care reform; however, Congress also rightly recognized that expanded coverage will mean little if patients do not have access to health care providers willing and able to serve them. Numerous studies have estimated that the United States faces major shortages of medical providers, and expanding the pool of insured Americans could only be expected to exacerbate those shortages. Of particular concern is the fact that, according to data from the Center for Studying Health System Change, large proportions of U.S. providers are refusing to take new Medicaid patients or to serve Medicaid patients at all, because of what they see as inadequate reimbursement and excessive red-tape.

To address these concerns, the health care reform law includes numerous provisions to bolster the provider network through such means as expanding provider training, encouraging providers to work in underserved communities and testing out models for reforming reimbursement. For example, the law includes new funding to establish interdisciplinary “commu-

nity health teams” to support primary care and obstetrics and gynecology practices that serve as central coordinators for their patients’ care. Perhaps most importantly for Medicaid enrollees and other low-income patients, Congress devoted additional funding of \$11 billion over five years to dramatically expand the U.S. network of community health centers, to help ensure that the newly insured have a place to seek care (see chart). Even before that expansion in funds, those health centers provided pregnancy-related care to nearly half a million women in 2008—more than one in 10 women giving birth. The law also requires insurance plans in the new exchanges to contract with these health centers and many other safety-net providers; securing such contracts has often been difficult for smaller clinics, which have little leverage with insurers.

These efforts should help at least some women to have a source of care before, during and after pregnancy. Of particular note for pregnant women is that the law requires state Medicaid programs to provide reimbursement for the services provided by freestanding birth centers. And it requires certified nurse-midwives to be reimbursed by Medicare at the same rate as physicians, a substantial boost over current rates that can be expected to influence the practices of

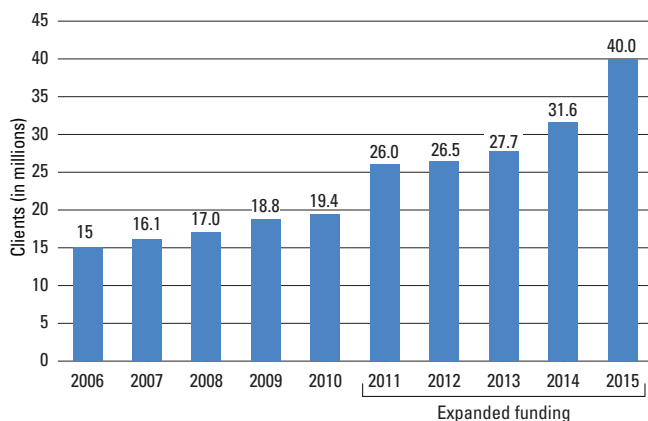
Medicaid and private plans as well. Both provisions should make it more financially viable for women to choose these options for childbirth and for these types of providers to expand their practices, and should help mitigate the current shortage of obstetricians in the process. In addition, starting in September 2010, the health care reform law will require all new health plans to allow women to visit a specialist for obstetric or gynecologic care without a referral or prior authorization from a primary care provider. Although 36 states and the District of Columbia had similar “direct access” laws in place as of 2008, those laws do not apply to employers that self-insure, and prior authorization has been a common requirement even for pregnant women.

Despite its usual description, “health care reform” also includes three provisions related to pregnancy and parenting that go even beyond the realm of health insurance and health care to address broader public health and social outcomes. The largest of these is a new investment of \$1.5 billion over five years in evidence-based programs that send nurses or other experts to families’ homes to provide education and guidance about pregnancy and parenting, with a focus on parents deemed high risk because of their income, age, community or history of problems such as child neglect or substance abuse. Several models for these home visiting programs have been implemented and evaluated across the country, piecing together smaller pots of funding from numerous public and private sources; the most successful of them have demonstrated substantial improvements in pregnancy-related outcomes, as well as parenting skills, school readiness, economic self-sufficiency and other outcomes beyond health (related article, Summer 2009, page 11). The sizable new funding stream is designed to eventually allow for nationwide access to home visiting services for any at-risk families that welcome them.

The law also includes \$25 million annually for 10 years for grants to states to support pregnant and parenting teens and women. States can apply to use this money to provide or establish connections to a wide range of services—from housing to baby clothes to prenatal care—to college

EXPANDED CAPACITY

Health care reform should enable community health centers to double the number of patients they serve annually—a number that already includes almost half a million women for pregnancy-related care.



Note: Data past 2008 are projected. Source: National Association of Community Health Centers, 2010.

and high school students either on campus or in the community. They can also direct grant money toward assistance for pregnant women experiencing intimate partner violence, and for outreach and education campaigns to promote these and similar resources. Finally, the law authorizes funding to provide education, treatment and support to women suffering from postpartum depression and to their families, along with research to study the mental health consequences related to pregnancy.

Potential for Progress

For maternal and child health advocates, this multipronged approach comes none too soon. The 2010 Amnesty International report is but the latest to raise alarms over what some consider a crisis in U.S. maternal health, particularly among disadvantaged women. For example, nearly one-quarter of black women initiate prenatal care late or not at all, according to CDC data, a rate that is more than twice as high as their white counterparts. This disparity contributes to disparate health outcomes as well, with black women experiencing at least twice the rates of low-birth-weight births, infant mortality and maternal mortality as white women. Major disparities also exist by geography, income and education.

Many immigrants—both documented and undocumented—are also at a disadvantage, even after health care reform. Although a 1986 federal law requires hospitals to provide labor and delivery

care to all women, regardless of immigration status, women without legal status have long been barred from Medicaid and CHIP for their prenatal and postpartum care, and the new law bars them not only from receiving federal subsidies for private insurance, but also from purchasing even unsubsidized insurance through the exchanges. The news is better for legal immigrants, as a 2009 law allowed states to cover pregnancy-related care for recent immigrants under Medicaid and CHIP, eliminating a five-year waiting period put in place in 1996.

Granted, coverage and access are not the only determinants of health care use. Women face a host of other difficulties, ranging from logistical hurdles (e.g., transportation, child care and a lack of personal or sick time at work) to quality of care issues (e.g., the need for language services, cultural competency training and night and weekend hours) to social barriers (e.g., low health literacy, immigration concerns, mistrust of providers and discrimination). Moreover, health care use is only one factor affecting individual and community health status, and U.S. health disparities are in large part a result of broader societal inequities, from the availability of jobs and education to the prevalence of crime and pollution. Nevertheless, improved insurance coverage and access to affordable, appropriate health care is an essential first step to help address the nation's disparities in maternal and child health. www.gutmacher.org