



U.S. Health Care Reform Legislation Offers Major New Benefits to Childbearing Women and Newborns*

Carol Sakala, PhD, MSPH

After decades of failed attempts to substantially reform the United States health care system, President Barack Obama signed the far-reaching Patient Protection and Affordable Care Act into law in March 2010 (1). Within this 906-page legislation, also known as PPACA or the Affordable Care Act, are numerous provisions that collectively offer exceptional gains to childbearing women and newborns, including greater access to, and affordability of, maternity care; provisions that close prior loopholes; and new benefits and programs. This column summarizes provisions in the new legislation that are most relevant to these populations.

Access and Affordability

Medicaid is a large federal-state safety net program with categorical provisions for covering low-income pregnant women and newborns. In 2006, Medicaid covered 42 percent of women's childbirth-related hospital stays across the nation (2) and a similar proportion of newborn care. Before implementation of the new health care reform provisions, many uninsured young women have not been eligible for Medicaid or other insurance coverage until becoming pregnant. For example, a nine-state study found that from 17 to 41 percent of childbearing women lacked insurance prior to pregnancy, with 13 to 35 percent transitioning to Medicaid at some point during pregnancy (3). Lack of insurance before pregnancy has limited the ability of a large segment of childbearing women to use health services to plan a successful pregnancy. Furthermore, the process of establishing Medicaid eligibility after confirming pregnancy has been a barrier to timely access to prenatal care.

Three PPACA provisions will dramatically change this situation. First, whereas previously states were required to cover uninsured pregnant women with incomes up to 133 percent of the federal poverty level (4), beginning in 2014 they will be required to provide at least minimal essential health services to all uninsured persons in this income range, with the option of covering individuals above that level (Section 2001). This provision has the potential to add coverage for up to 8.2 million women younger than 65 years (when all become eligible for the Medicare program, which is a federally

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administered system of health insurance available to persons aged 65 and over), or half of those without insurance (5).

Second, also beginning in 2014, uninsured women with low and moderate incomes (100%-400% of federal poverty level) will have access to subsidies for purchasing health insurance through state insurance “exchanges,” with discounts ranging from two-thirds to one-third of the cost, depending on income level (Section 1402). Up to 41 percent of uninsured women, or an additional 7 million women under age 65, will be eligible for this provision (5).

Third, access of young adults to health insurance will be increased. This population segment has been especially vulnerable to losing health insurance when reaching age 19 years or graduating from high school or college, resulting in high rates of being uninsured, which in turn, has affected access to health care, reduced well-being, and increased medical debt (6). The new law has already required that individual and group health insurance policies with coverage for dependent children extend it through age 25 years (Section 2714).

A further crucial PPACA protection for childbearing women and newborns is inclusion of maternal and newborn care in a defined package of “essential health benefits” (Section 1302). Beginning in 2014 essential services must be covered in policies available through insurance exchanges and the individual and small group (i.e., businesses with up to 100 employees) markets. In the individual market, such coverage has been excluded in the vast majority of policies or available only by paying large surcharges, after long waiting periods, or with limited and inadequate coverage (6).

Starting in 2014, access to maternity care will be greatly improved through a market reform that prohibits exclusion of coverage for preexisting conditions or other discrimination based on health status. This protection applies to group and individual health insurance policies (Section 2704). In the past, uninsured pregnant women have largely been ineligible to purchase private insurance or, if they could purchase insurance during their pregnancies, the coverage generally did not include maternity care for the present pregnancy. More recently, some insurers have deemed women who had a previous cesarean birth to be ineligible for maternity care coverage (6), and there are anecdotes of similar practices, such as excluding coverage of pelvic floor problems among women who have had an episiotomy. Such practices will be illegal in 2014.

Covered Services

The Affordable Care Act requires that state Medicaid programs offer as a covered service without cost sharing comprehensive smoking cessation services for pregnant women, beginning in 2010. Benefits include diagnostic, therapeutic, and counseling services, as well as prescription and nonprescription stop smoking agents approved by the Food and Drug Administration for use by pregnant smokers (Section 4107). Smoking cessation programs for pregnant women reduce smoking in late pregnancy and are associated with reduced low birthweight and preterm birth (7).

In recent years, Medicaid beneficiaries in some states have lost access to birth center coverage, and many freestanding birth centers have been threatened with closure due to loss of Medicaid reimbursement. Although birth centers have traditionally been

reimbursed within Medicaid programs, some state Medicaid programs had recently begun to deny birth center claims and legislation had not mandated such coverage for Medicaid beneficiaries. A PPACA provision requires coverage of care in freestanding birth centers that meet state regulatory requirements, beginning in 2010. The law requires reimbursement of birth attendants who are recognized by states for care within their scope of practice (Section 2301). Birth centers offer exceptional quality and value for childbearing women who do not have serious health conditions or risks (8).

Beginning in 2010, all new health plans are required to offer, at no extra cost to the patient, all services and screenings recommended by the U.S. Preventive Services Task Force. For childbearing women, the recommended services include folic acid supplementation, breastfeeding counseling before and after birth, tobacco use counseling, and screening for several conditions, and for newborns, prophylactic gonorrhea eye medication and screening for various conditions (9). The plans will also be required to offer additional preventive care and screenings to women, infants, and other groups that the federal Health Resources and Services Administration will identify (Section 2713).

New Programs for Childbearing Families

PPACA establishes a Maternal, Infant and Early Childhood Home Visiting Program to award grants for services in at-risk communities, with a focus on strengthening families and community resources and improving maternal and newborn health, child health, and school readiness. A call for applications was issued in 2010 (Section 2951). Provisions in Section 2952 include research for postpartum depression and support and education for families experiencing this condition, beginning in 2010.

The Affordable Care Act directs the Secretary of Health and Human Services to create a Pregnancy Assistance Fund and award grants to states to assist pregnant and parenting teens and women who are enrolled in higher education programs with child care, housing, baby supplies and food, and other support and protective services, beginning in 2010 (Section 10212). The act also provides grants to organizations to provide personal responsibility education to young people to reduce pregnancy and sexually transmitted infection rates by delaying sexual activity and increasing contraceptive use when sexually active, beginning in 2010 (Section 2953).

Maternity Care Workforce

Although Medicare covers just a fraction of births in the United States, its fee schedule greatly influences the reimbursement levels of other payers. The Affordable Care Act specifies that the Medicare fee schedule will reimburse certified nurse-midwives at the rate of 100 percent of the physician rate, beginning in 2011, replacing a prior 65 percent rate of reimbursement (Section 3114). This 100 percent reimbursement may be expected to increase access to nurse-midwifery care, enable the growth of independent nurse-midwifery practice, and make nurse-midwives more visible in group practices and health plans, because the previous reduced rate of reimbursement provided incentives to bill at 100 percent levels through physician colleagues.

Workplace Protection

The act directs employers to provide new mothers with a reasonable break time to express milk for a nursing infant for 1 year after the birth and a private place that is not a bathroom for doing so. Employers of fewer than 50 employees are not subject to the requirement if doing so would pose difficulty or expense that significantly impacts the business (Section 4207). This protection is intended to address a major barrier to meeting recommended breastfeeding goals.

Patient-Friendly Health Care System

Within a year after passage of PPACA, the legislation directs the Secretary of Health and Human Services to develop uniform standards for health plans and insurers to describe coverage and present definitions, including the presentation of pregnancy benefits (Section 2715). The act prohibits health plans and health insurers from requiring any authorization or referral for females to seek the care of a specialist in obstetrics or gynecology. Plans and insurers are directed to treat obstetric and gynecologic care, and the ordering of any related items and services as if they were the authorization of a primary care provider (Section 2719a).

Data Collection

The act directs the Secretary of Health and Human Services to include surveillance of oral health in the Pregnancy Risk Assessment Monitoring System (PRAMS) survey (Section 399LL).

Broader Provisions to Help Childbearing Women and Newborns

With increasing recognition that maternity care is a major segment of the U.S. health care system (8), numerous general provisions of PPACA are also likely to give significant attention to the needs of childbearing families. These include:

- establishing in 2010 the Center for Medicare and Medicaid Innovation within the Centers for Medicare and Medicaid Services to test new payment mechanisms, foster patient-centered care, and improve quality (Section 3021);
- establishing in 2010 a multi-stakeholder National Healthcare Workforce Commission to develop a national workforce strategy, focusing on integration, access to needed skills, and needed alignment of health professions education; the scope includes physicians, nurses, nurse-midwives, and nurse practitioners (Section 5101);
- developing a health care quality measurement program for adult beneficiaries of Medicaid, beginning in 2010 (Section 2701);
- improving women's health by supporting within several federal agencies Women's Health Offices with responsibility for setting goals and objectives, providing advice and consultation, monitoring this population, and creating resources, beginning in 2010 (Section 3509);

- facilitating shared decision making by developing standards for patient decision aids; endorsing, developing, and updating such aids; and developing resources to foster their use beginning in 2010 (Section 3506);
- making grants to build the community health workforce to deliver evidence-based interventions in underserved communities beginning in 2010 (Section 5313);
- making grants to states for demonstrations to plan, implement, and evaluate alternatives to tort litigation (Section 10607); and
- requiring enhanced collection and reporting of data on race, ethnicity, sex, primary language, disability status, and for underserved and frontier populations by 2012 (Section 3101).

The effectiveness of this ambitious piece of legislation now depends on the quality of implementation within a large, complex, health system and a polarized political environment. It is hoped that the new provisions will quickly bear fruit and favorably influence key maternal and newborn health indicators that have stagnated or been moving in the wrong direction in recent years (8).

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