Guidelines for States on Maternity Care In the Essential Health Benefits Package

Section 2707(a) of the Patient Protection and Affordable Care Act (ACA) requires that all new health insurance plans in the individual and small group markets, including qualified health plans sold through health insurance exchanges, provide at least the Essential Health Benefits (EHB) package.[1] Section 1302(b) of the ACA identifies a core set of ten categories to be included in the EHB, one of which is **maternity and newborn care**.[2] For most categories, the Department of Health and Human Services (HHS) has not specified what must be covered; the Department issued a pre-rule bulletin allowing states to select their EHB package from a list of options.[3]

The National Partnership for Women & Families and Childbirth Connection urge states to use the guidelines below in selecting an EHB package to ensure the coverage will provide sufficient quality maternity care.

It is crucial for women's and babies' health that states ensure that the maternity care package provided under the EHB is as comprehensive as possible. Maternity care plays an extensive role in promoting good health, impacting everyone at the beginning of life and 80 - 85 percent of all women for one or more extended episodes of care. Care of childbearing women and newborns is the most common hospital condition for private payers and Medicaid. Coverage of comprehensive preconception and prenatal care results in better health outcomes for mothers and babies by allowing health care providers to identify and treat health issues early. For example, babies born to women who do not get prenatal care are three times more likely to have a low birth weight and five times more likely to die than if their mothers do get care.[4] Similarly, providing care to the baby and the mother in the postpartum period is crucial to ensuring good short- and long-term health outcomes and identifying any potential health issues.

An effective EHB package is foundational to providing high quality maternity care. Currently, most individual health plans fail to provide any insurance coverage for maternity care, which means women insured on the individual market without complications face expenses that average $10,652 or more.[5]

Some insurers offer maternity coverage only as a rider, which may have a long waiting period and thus may not kick in during the time it is needed, or it may offer less than adequate coverage.[6] A 2009 study revealed that only 13 percent of the 3,600 individual market plans reviewed offered maternity coverage for a 30-year-old woman.[7] A congressional investigation showed that not only is maternity coverage inadequate, but

insurers will continue to provide insufficient coverage unless compelled to do better through clear requirements.[8] In the congressional study, women who were able to get coverage often found that it did not cover the services and care they needed.[9]

The table below details the items states should cover when selecting plans to serve as their EHB benchmarks as recommended by health professionals including Childbirth Connection, the American Congress of Obstetricians and Gynecologists (ACOG) and the American Medical Association.[10] The table is followed by additional ways to ensure adequate maternity coverage. When analyzing potential benchmark plans, states should assess if these items and services are covered and whether they are subject to any limits.

Type of Care[11]	Examples of What Should be Included
Annual preconception evaluation for women planning pregnancy	▸ Genetic counseling; ▸ Review of pre-existing conditions and counseling with respect to childbearing; ▸ Social support screening and counseling; and ▸ Guidance and ongoing support, as needed, about lifestyle issues, including nutrition; vitamins; exercise; weight; use of tobacco, alcohol, and other substances; environmental exposures; and interpersonal violence.
Prenatal care	▸ Health history and assessment and care plan; ▸ Fetal evaluation; ▸ Nutrition, weight gain, breastfeeding, childbirth, and parenting education; ▸ Screening and ongoing support, as needed, for conditions that impact pregnancy, including interpersonal violence; stress; risk of preterm birth; HIV and other Sexually Transmitted Infections; and ▸ Coordination of prenatal care with delivery services.
Ancillary services	▸ Ultrasound; ▸ Laboratory services; ▸ Diagnostic tests; ▸ Immunizations; ▸ Oral health services; ▸ Newborn services; ▸ Auxiliary services for women with disabilities; and ▸ Genetic screening, testing and counseling, as appropriate.

Mental health screening and services	▸ Screening and treatment for depression and other mood disorders in the prenatal and postpartum periods.
Substance abuse counseling and treatment	▸ Screening and treatment for abuse of tobacco, alcohol, prescription, over-the-counter, and illegal drugs, and other harmful substances in the prenatal and postpartum periods.
Medications	▸ Prenatal and postpartum assessment and counseling about the safety and effectiveness of any ongoing and new prescription and over-the-counter medications with respect to maternal health, fetal development, and breastfeeding; and ▸ Prescription drugs.
Labor and delivery	▸ Comfort measures and anesthesia services; ▸ Care for pregnancy-related complications; and ▸ Care in facility appropriate for patient's maternal-fetal risk.
Postpartum evaluation and services to 8 weeks after birth	▸ Family planning services; ▸ Sterilization; ▸ Guidance and ongoing support, as needed, for weight control, exercise, nutrition, and other preventive services; and new-onset conditions such as gestational diabetes and infection; and ▸ Breastfeeding evaluation and education.

Watch for Problematic Limits

Insurers should not be allowed to limit the frequency a service or item will be covered or only cover an item or service if the patient meets certain criteria. While some limits may be reasonable and evidence-based, others can be arbitrary and used to restrict needed care or steer consumers into or away from certain plans, which is inconsistent with the ACA's clear intention to guarantee that at least the 10 benefit categories are consistently covered. In some instances, arbitrary service limits could seriously interfere with necessary care. States should beware potential benchmark plans with discriminatory or otherwise unreasonable limits that would violate the nondiscrimination protections in the ACA, and should be careful not to incorporate such limits into their final benchmark packages.[12]

Limit Swapping

In addition, the pre-rule bulletin issued by HHS allows for insurers to deviate from the state's selected EHB benchmark by swapping actuarially equivalent benefits within or across categories of the EHB. It is critical that states limit insurers' ability to do so. First, it is not clear that actuarial models in use today can accurately measure subtle differences in benefits, even though such differences could be significant in their impact on individual

plan enrollees. Second, if plans covered by the EHB package are allowed to have flexibility, it can be expected that health plans offered in the individual market will vary considerably making it difficult for women to make decisions about coverage. Additionally, plans may try to offer very low levels of maternity coverage – for instance, by dropping services or reducing the number of covered ultrasounds or doctor's visits, while increasing coverage in other categories. Finally, insurers may be able to modify coverage levels within the maternity care category to limit access to higher cost services and/or services related to more complex cases.

Confirm Maternity Coverage for Non-Spouse Dependents

States should also monitor whether dependent children are excluded from maternity coverage by potential benchmark plans. The ACA requires all plans incorporating the essential health benefits to cover maternity care and does not include exceptions for dependent children. Therefore, if the benchmark selected does not cover maternity care for dependents, states should ensure that their final state EHB packages do not incorporate this exclusion. This will guarantee that the EHB complies with the maternity coverage requirements, as well as the provisions of the ACA prohibiting discrimination on the basis of sex or age.[13]

Maternity care is as important for dependent children as it is for adults. Although teen pregnancy rates have been dropping in recent years, the United States still has the highest teen pregnancy rate in the developed world.[14] In 2010, 367,752 girls aged 15 to 19 gave birth in the United States.[15] Minors are less likely to seek prenatal care early and more likely to have pregnancy complications and adverse pregnancy outcomes than adult women.[16] Therefore, comprehensive maternity care is crucially important for ensuring a healthy pregnancy. Moreover, since dependent children may now stay on their parents' insurance until age 26, substantially more women of childbearing age will be covered as dependents, and the law's clear intent is for them to have access to the full scope of EHBs provided to everyone enrolled in the plan.

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1 42 U.S.C. 300gg–6.

2 42 U.S.C. 18022; 10 required categories are:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Laboratory services;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Pediatric services, including oral and vision care;
- Prescription drugs;
- Preventive and wellness services and chronic disease management; and
- Rehabilitative and habilitative services and devices.

3 U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, Essential Health Benefits Bulletin (Dec. 2011), *available at* http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf.

The options for benchmark plans include:

- The largest HMO plan in the state;
- One of the three largest small group plans in the state by enrollment;
- One of the three largest state employee health plans by enrollment; or
- One of the three largest federal employee health plan options by enrollment.

4 U.S. Department of Health and Human Services, Office of Women's Health, Prenatal Care Fact Sheet (March 2009), *available at* http://www.womenshealth.gov/publications/our-publications/fact-sheet/prenatal-care.pdf.

5 Thomson Reuters; *Summary of: The Cost of Prematurity and Complicated Deliveries to U.S. Employers* (October 29, 2008); *available at* http://www.marchofdimes.com/peristats/pdfdocs/cts/ThomsonAnalysis2008_SummaryDocument_final121208.pdf

6 *Focus on Health Reform: Impact of Health Reform on Women's Access to Coverage and Care;* Kaiser Family Foundation (December 2010), *available at* http://www.kff.org/womenshealth/upload/7987.pdf.

7 National Women's Law Center; *Still Nowhere to Turn: Insurance Companies Treat Women Like a Pre-Existing Condition* (2009), *available at* http://www.nwlc.org/sites/default/files/pdfs/stillnowheretoturn.pdf.

8 Memorandum from Henry Waxman and Bart Stupak to Members of the Committee on Energy and Commerce (Oct. 12, 2010), *available at* http://democrats.energycommerce.house.gov/Press_111/20101012/Memo.Maternity.Coverage.Individual.Market.2010.10.12.pdf.

9 *Id.*

10 Some of these items and services could reasonably fall within multiple EHB categories – for example, prenatal care could be considered to be part of either the maternity care category or as the category covering preventive services. States should ensure that all items and services listed are included in the benchmark package, regardless of how they are classified. It is worth noting, however, that how items and services are classified may be important if insurers are allowed to make substitutions.

11 *See*, ACOG, *Health Care for Women, Health Care for All: A Reform Agenda, Essential Benefits* (Feb. 2008), *available at* http://www.acog.org/~/media/Departments/Government%20Relations%20and%20Outreach/hcfwhcfa-essentialbenefits.pdf?dmc=1&ts=20120503T1112453153; American Medical Association and the National Committee for Quality Assurance, Maternity Care Measures (2012).

12 See, Affordable Care Act §1557, 42 U.S.C. 18116 (2010); §1302(b), 42 U.S.C. 18022(b) (2010).

13 See, Affordable Care Act §1557, 42 U.S.C. 18116 (2010); §1302(b), 42 U.S.C. 18022(b) (2010).

14 Brady Hamilton and Stephanie Ventura, NCHS Data Brief: Birth Rates for U.S. Teenagers Reach Historic Laws for all Age and Ethnic Groups, Centers for Disease Control and Prevention National Center for Health Statistics (April 2012), *available at* http://www.cdc.gov/nchs/data/databriefs/db89.pdf.

15 *Id.*

16 *See*, Xi-Kuan Chen, et al, Teenage Pregnancy and Adverse Birth Outcomes: a Large Population Based Retrospective Cohort Study, International Journal of Epidemiology (Jan. 2007).