

3

CHAPTER



Issues in Pregnancy Coverage under Medicaid and Exchange Plans

Recommendations

Issues in Pregnancy Coverage under Medicaid and Exchange Plans

- 3.1** To align coverage for pregnant women, the Congress should require that states provide the same benefits to pregnant women who are eligible for Medicaid on the basis of their pregnancy that are furnished to women whose Medicaid eligibility is based on their status as parents of dependent children.

- 3.2** The Secretaries of the U.S. Department of Health and Human Services and the U.S. Department of the Treasury should specify that pregnancy-related Medicaid coverage does not constitute minimum essential coverage in cases involving women enrolled in qualified health plans.

Key Points

The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) will affect women of childbearing age in several ways, including by expanding Medicaid coverage to previously uninsured low-income women at or below 138 percent of the federal poverty level (FPL) in Medicaid-expansion states and by offering subsidized exchange coverage that includes maternity care to previously uninsured women with incomes above 100 percent FPL. This chapter describes how the ACA may affect eligibility and benefits for women eligible for Medicaid coverage for maternity benefits.

- ▶ Although states must provide services to all pregnant women at or below 138 percent FPL, they are not required to provide full Medicaid benefits; they may instead limit services to those related to pregnancy. As a result, Medicaid benefits for pregnant women currently differ by eligibility pathway both across and within states, with some pregnant women receiving fewer Medicaid benefits than pregnant women covered through other Medicaid eligibility pathways. The Commission recommends the elimination of coverage restricted to pregnancy-related services only.
- ▶ The U.S. Department of the Treasury has determined that most Medicaid coverage—including coverage for pregnant women through the Section 1931 low-income families eligibility pathway—is minimum essential coverage (MEC). However, coverage through pathways that allow states to restrict coverage to pregnancy services only—regardless of whether the state actually limits coverage—is not considered MEC for the purposes of the ACA's individual mandate.
- ▶ Because coverage through certain pathways is not considered MEC, women eligible for Medicaid under these pathways who are above 100 percent FPL can have Medicaid coverage, exchange coverage, or both concurrently. This could create issues of coordination of benefits between exchange plans and Medicaid, and potential confusion for women about their different benefit and cost-sharing options.
- ▶ If Recommendation 3.1 is adopted, then all Medicaid pregnancy coverage would be MEC. Women with subsidized exchange coverage who become pregnant and who would qualify for Medicaid based on their pregnancy would have to disenroll from exchange coverage and enroll in Medicaid for the duration of their pregnancy and postpartum period. The Commission recommends allowing women with exchange coverage who become eligible for Medicaid based on becoming pregnant to retain exchange coverage to avoid discontinuities in networks and care.

3

CHAPTER

Issues in Pregnancy Coverage under Medicaid and Exchange Plans

Medicaid has long played an important role in financing health care for low-income pregnant women, covering a vulnerable population and promoting healthy birth outcomes. The program covers almost half of all births in the United States (MACPAC 2013a). All states are required to provide pregnancy-related care for women below 138 percent of the federal poverty level (FPL), and all but nine states have extended Medicaid coverage to pregnant women with higher incomes.¹ Among those states, a majority (35 states and the District of Columbia) have raised their eligibility threshold for pregnant women to 190 percent FPL or higher (Appendix Table 3-A-1).

Although states must provide services to all pregnant women at or below 138 percent FPL, they are not required to provide full Medicaid benefits; they may instead limit services to those related to pregnancy.^{2,3} As a result, covered Medicaid benefits for pregnant women differ by eligibility pathway both across and within states, as described below.

The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) will affect women of childbearing age in several ways: by expanding Medicaid coverage to previously uninsured low-income women at or below 138 percent FPL in Medicaid expansion states; by offering subsidized exchange coverage that includes maternity care to previously uninsured women with incomes above Medicaid eligibility levels; and by streamlining Medicaid eligibility, which may simplify the application process and increase enrollment rates. These changes will likely increase the number of pregnant women with health insurance.

The new options for coverage of pregnant women may also create challenges and complexities for both states and pregnant women themselves. Two of these challenges are unique to the treatment of pregnant women. First, because pregnancy is a temporary state, coverage that is limited to pregnancy and the postpartum period creates transitional issues for enrollees as they move between different health insurance plans or different

sources of coverage. Such churning among different sources of coverage during pregnancy and the 60 days postpartum is likely to create discontinuities in care, when continuity of care is especially desirable.

Second, because state Medicaid programs are not required to provide full coverage to some pregnant women, women eligible only for pregnancy-related services may receive less generous benefits than do other people in their income group. When Medicaid was expanded to cover pregnant women based solely on their pregnancy status, it provided many pregnant women with coverage that was otherwise unavailable, even though benefits could be limited. Under the ACA, the alternative benefit package offered to the new adult group provides all essential health benefits (including maternity and non-maternity care) to all adults up to 138 percent FPL but excludes pregnant women because they are already eligible for Medicaid. Therefore, pregnant women with coverage limited to pregnancy-related services may now receive fewer benefits than if they were not pregnant.

In addition, subsidized exchange coverage available to individuals between 100 and 400 percent FPL also includes both maternity and non-maternity benefits. This means that higher-income pregnant women with such coverage may receive a broader benefit package than lower-income pregnant women with Medicaid coverage. At the same time, this coverage may come with higher premium and cost-sharing requirements than are typical in Medicaid and may exclude enhanced maternity benefits offered by Medicaid programs.^{4,5}

This chapter describes how the ACA may affect eligibility and benefits for both women at or below 138 percent FPL who may be newly eligible in states expanding their Medicaid programs, and women above 100 percent FPL who may be eligible for subsidized coverage through health

insurance exchanges. It also describes certain ACA-related issues that are unique to pregnant women.

The chapter concludes with two recommendations focused on reducing inequities in coverage among pregnant women in different Medicaid eligibility groups. One recommendation would require full Medicaid coverage for women who are eligible through mandatory or optional pregnancy-related pathways. If this recommendation is adopted, the Commission has made a companion recommendation that women enrolled in qualified health plans (QHPs) should be allowed to retain their QHP coverage even if their pregnancy makes them eligible for Medicaid.

Medicaid Eligibility and Benefits for Pregnant Women

States are required to cover all pregnant women below 138 percent FPL, and they have the option of providing coverage to pregnant women above that level. The period of coverage for women eligible for Medicaid on the basis of pregnancy is limited to the duration of the pregnancy and 60 days postpartum.^{6,7}

Currently, there are six possible Medicaid eligibility pathways that cover pregnant women (Table 3-1). Historically, the first pathways that covered pregnant women were limited to those meeting state income and resource standards for the former Aid to Families with Dependent Children (AFDC) program (referred to in this chapter as low-income family-related pathways). These women were eligible for full Medicaid coverage, as were women in three subsequent AFDC-related categories.

When in 1986 Congress added pathways specific to pregnancy—requiring coverage up to 133 percent of poverty for all pregnant women and making it optional over 133 percent FPL—it allowed states to cover only pregnancy-related services (§1902(a)

TABLE 3-1. Benefits under Mandatory and Optional Medicaid Eligibility Pathways for which Pregnancy Status is an Eligibility Factor

| Medicaid Eligibility Pathways | Related Sections in the Social Security Act | Coverage May Be Limited to Pregnancy-Related |
|--|---|--|
| Mandatory Pathways | | |
| Section 1931 low-income families pathway – Pregnant women who already have children, at or below income level for former Aid to Families with Dependent Children (AFDC) program | 1931(b) and (d), 1902(a)(10)(A)(i)(I) | No |
| Qualified pregnant women and children pathway – Qualified pregnant women who do not already have children, at or below income level for former AFDC program | 1902(a)(10)(A)(i)(III) | No |
| Mandatory poverty-level-related pathway – Pregnant women with income above other mandatory levels but at or below an income level specified in statute (at or above 133 percent of the federal poverty level (FPL)) | 1902(a)(10)(A)(i)(IV), clause (VII) in the matter following 1902(a)(10)(G) | Yes |
| Optional Pathways | | |
| Pregnant women who meet former AFDC program financial criteria pathway | 1902(a)(10)(A)(ii)(I) | No |
| Pregnant women who would be eligible for former AFDC program if not institutionalized pathway | 1902(a)(10)(A)(ii)(IV) | No |
| Optional poverty-level-related pathway – Pregnant women above an income level specified in statute (at or above 133 percent FPL) | 1902(a)(10)(A)(ii)(IX), clause (VII) in the matter following 1902(a)(10)(G) | Yes |

Notes: Amounts indicated here as 133 percent FPL are now equivalent to 138 percent due to application of related income disregard and modified adjusted gross income (MAGI) conversion under the Patient Protection and Affordable Care Act. This table excludes an optional medically needy pathway under which pregnant women with incomes above regular mandatory and optional levels may qualify by incurring medical expenses that reduce their income to a specified limit. Medically needy benefits may be less than full Medicaid but are not limited on the basis of being pregnancy-related. Shaded rows indicate pathways that may restrict benefits to pregnancy-related service coverage only.

Sources: CMS 2012; CMS 2011; Social Security Act.

(10)(A)(i)(IV) of the Social Security Act (the Act)).⁸ These two eligibility pathways combined are referred to as poverty-level-related pregnancy pathways in this chapter.

Based on a preliminary analysis, more than 750,000 women currently qualify for Medicaid through

poverty-level-related pregnancy pathways, with the percentage of women eligible through a poverty-level-related pregnancy pathway varying by state (MACPAC 2013b). In determining which pregnancy-related pathway a woman should be enrolled in, states consider income, trimester of pregnancy, and linkage to other programs.⁹

Restricting coverage to pregnancy-related services.

As of September 2013, at least eight states were reported to cover only pregnancy-related services for most Medicaid-enrolled pregnant women: Alabama, California, Idaho, Indiana, Louisiana, Nevada, New Mexico, and North Carolina.¹⁰ According to preliminary estimates, more than 170,000 women have pregnancy-related coverage in these states (MACPAC 2013b).

Coverage of pregnancy-related services is fairly comprehensive, as the standard is medical necessity for the health of the mother and unborn child (42 CFR 440.210). There is little publicly available information on the extent to which pregnant women are denied care or providers are denied payment when benefits are limited to pregnancy-related services.¹¹ But advocates have noted instances in which women with Medicaid pregnancy-related service coverage only “could not access treatment for broken bones, osteomyelitis, brain tumor, or heart disease or physical therapy for sciatica or injuries sustained during delivery” (MCHA 2013).

Provider manuals (which describe the rules under which Medicaid claims may be paid in a given state) offer some guidance on how to distinguish between pregnancy-related services and others that are not considered related to the pregnancy. For example, the North Carolina Medicaid provider manual lists services that are considered directly related to pregnancy and adds that pregnancy-related coverage also includes:

services for conditions that—in the judgment of their physician—may complicate pregnancy. Conditions that may complicate the pregnancy can be further defined as any condition that may be problematic or detrimental to the well-being or health of the mother or the unborn fetus such as undiagnosed syncope [temporary loss of consciousness caused by a fall in blood pressure], excessive nausea and vomiting, anemia, and dental abscesses. (This list is not all-inclusive.)

(North Carolina Medicaid 2011).

It is also not clear how postpartum visits are treated or what conditions are considered pregnancy-related following a pregnancy. Services that are considered pregnancy-related while a woman is pregnant may not be considered pregnancy-related once the pregnancy ends. For example, a California provider manual describes influenza as a non-pregnancy postpartum condition. For non-pregnancy related visits, women may be subject to cost sharing (Medi-Cal 2002).

Enhanced benefits during pregnancy.

Regardless of whether they provide full or limited Medicaid coverage for pregnant women, states may also provide services related to the pregnancy that exceed those covered under an alternative benefit plan, a qualified health plan, or other coverage. For example, Louisiana and North Carolina both cover only pregnancy-related services for women eligible through poverty-level-related pathways, but provide enhanced pregnancy-related benefits. Louisiana provides nurse home visits to first-time, low-income mothers and families to improve maternal health, birth outcomes, and parental life course. North Carolina’s Baby Love Care Coordination Program extended intensive case management services (including risk assessment, plan of care development, referral to health and support providers, and follow-up) to all Medicaid-enrolled pregnant women (Hill et al. 2009). Several states also offer dental services to pregnant women but not to other adults (MACPAC 2013a).

Changes to Medicaid Coverage in 2014

The ACA created several changes in Medicaid that have implications for coverage of pregnant women. Their experiences will differ depending upon their income, whether their state expands coverage to the new adult group, and whether their state covers full Medicaid benefits or only those services related

to pregnancy. However, one change that will apply across the board is implementation of the new income determination rules that apply to all states and most Medicaid eligibility groups (including pregnant women), as well as the elimination of resource (asset) tests for these groups.

There is another change that affects women above and below 138 percent FPL in both expansion and non-expansion states. In its final rule on eligibility changes mandated by the ACA, the Centers for Medicare & Medicaid Services determined that states opting to limit coverage to pregnancy-related services are required to submit a state plan amendment that explains the state's basis for determining which services are not pregnancy-related and the rationale for not covering them (CMS 2012).

A third change affecting pregnant women both above and below 138 percent FPL is how the U.S. Department of the Treasury (Treasury) has determined whether poverty-level-related pregnancy coverage is minimum essential coverage (MEC). Under the ACA, all individuals are required to have insurance that is considered MEC, or pay a personal responsibility penalty. Individuals with incomes between 100 and 400 percent FPL are eligible for a subsidy to purchase insurance on an exchange. However, if they are eligible for other insurance through an employer or Medicaid that qualifies as MEC, they are not eligible for the subsidy. This creates several important policy issues for pregnant women seeking coverage.

Treasury has determined that most Medicaid coverage, including coverage for pregnant women through the Section 1931 low-income families eligibility pathway, is MEC. However, women who are eligible through a mandatory or optional poverty-level-related pregnancy pathway—regardless of whether the state restricts coverage to pregnancy-related services—do not have MEC for the purposes of the ACA's individual mandate. For Internal Revenue Service purposes, their coverage

is not considered to be MEC because states have the ability to limit benefits to those related to the pregnancy, even if they do not do so currently.

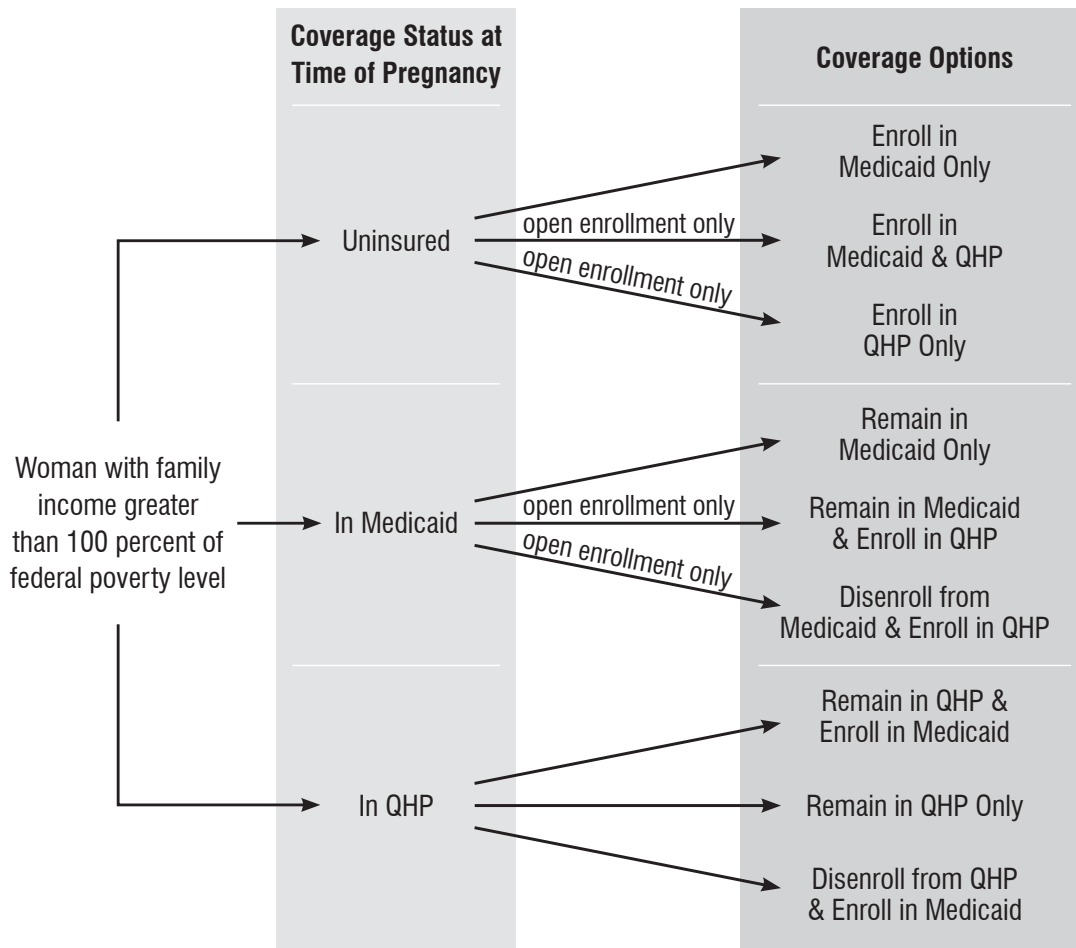
This has two implications. First, women with poverty-level-related pregnancy Medicaid coverage are eligible to purchase exchange coverage with premium tax credits and cost-sharing subsidies if their incomes are above 100 percent FPL. Second, if they do not acquire exchange coverage or some other form of MEC in addition to their Medicaid coverage, these women could be subject to the personal responsibility penalty when it is imposed in future years (Treasury 2013).

Because of the ruling that poverty-level-related pregnancy pathway coverage is not MEC, women eligible for Medicaid under these pathways who are above 100 percent FPL can have Medicaid coverage, exchange coverage, or both concurrently (Figure 3-1; Box 3-2). Pregnant women might have compelling reasons to choose any of these options depending on a host of factors such as timing, differences in benefits and out-of-pocket premium and cost-sharing amounts, and what the transitions between Medicaid and exchange coverage might mean in terms of provider networks and family coverage. These issues are discussed further below.

Pregnant women at or below 138 percent FPL.

In Medicaid-expansion states, uninsured women at or below 138 percent FPL who are pregnant when they apply for Medicaid are not eligible for the new adult group. They will instead qualify under a mandatory eligibility pathway related to their pregnancy. After two months postpartum, they will no longer be eligible for pregnancy-related coverage and will have to transition to the new adult group or to other coverage for which they are eligible, or to uninsured status. In the states that have opted to cover only pregnancy-related services, this may result in changing benefits (Box 3-1).

FIGURE 3-1. Women in Pregnancy-Related Pathways Over 100 Percent of the Federal Poverty Level (FPL): Coverage Options



Advantages and Disadvantages

| Medicaid Only: | QHP Only: | Medicaid and QHP: |
|--|---|---|
| ✓ Limited cost sharing | ✓ Coverage does not end after pregnancy | ✓ Limited cost sharing |
| ✓ Enhanced maternity benefits | ✗ Can only enroll during open season | ✓ Enhanced maternity benefits |
| ✓ Can enroll any time during pregnancy | ✗ More cost sharing | ✓ Can enroll any time during pregnancy (Medicaid) |
| ✗ Coverage ends two months post-partum | ✗ No Medicaid enhanced maternity benefits | ✓ Can remain in QHP after pregnancy (if eligible) |
| | | ✗ Coordination of benefits and network issues |

Note: QHP is a qualified health plan.

Source: Adapted from presentation by the Medicaid and CHIP Learning Collaborative, November 19, 2013.

BOX 3-1. Example of Medicaid Coverage for a Woman Below 138 Percent of the Federal Poverty Level (FPL) in an Expansion State with Pregnancy-Related Service Coverage Only

Ashley is a healthy 19-year-old who recently graduated from high school. Neither she nor her husband Anthony has health insurance. They have a gross family income of about \$14,400 per year, or 125 percent FPL.

In January 2014, Ashley becomes pregnant. Both she and Anthony apply for coverage under the state's Medicaid expansion. Anthony qualifies for the new adult group, which covers the Medicaid alternative benefit package and is equivalent to full Medicaid coverage for all covered services (but not necessarily covering exactly the same services). However, because she is pregnant, Ashley does not qualify for the new adult group coverage and must be enrolled in the state's benefit for pregnant women, which covers only pregnancy-related services. She must pay out of pocket for any service that is not considered pregnancy-related.

Upon the birth of their daughter, Olivia, the baby is enrolled in Medicaid based on Ashley and Anthony's income. Two months later, Ashley's pregnancy coverage ends, but she qualifies for the new adult group with full Medicaid coverage.

BOX 3-2. Example of Coverage for a Woman above 138 Percent of the Federal Poverty Level (FPL) in a State with Medicaid Coverage for Pregnancy-Related Services Only

Karen is a 30-year-old woman with diabetes who is unmarried and works at a retail store that does not offer her health insurance. Her gross income is \$21,026 per year, or 183 percent FPL. In January 2014, Karen becomes pregnant and now needs insurance for prenatal care. In her state, the upper cut-off for Medicaid pregnancy-related coverage is 200 percent FPL, but only pregnancy-related services are covered. Because she becomes pregnant during an open enrollment period, she has the option of: 1) enrolling in Medicaid, 2) purchasing subsidized exchange coverage, or 3) both.

Medicaid. If Karen enrolls in Medicaid, she will have no premium and no cost sharing for pregnancy services, but she will have to pay out-of-pocket for any non-pregnancy-related services. Her coverage will end in November, or two months after the birth of her child. After 2014, if she does not purchase exchange or some other coverage during open enrollment, she will have to pay the personal responsibility penalty for not having minimum essential coverage (unless the penalty is waived in the future).

Exchange coverage. If she purchases a silver plan with the second-lowest premium in the exchange, her net annual payment for coverage will be \$1,610 after a subsidy. Because her income is below 250 percent FPL, she also qualifies for lower cost sharing in the plan, but costs for pregnancy-related services such as delivery will still be higher than in Medicaid. If Karen became pregnant after March 2014, she would not be able to enroll in exchange coverage until the next enrollment period (unless she had a qualifying life event other than the birth of her child).

Both Medicaid and exchange coverage. If Karen enrolls in both exchange coverage and Medicaid, she will have exchange-based coverage for non-pregnancy related services as well as Medicaid's more generous coverage of pregnancy-related services. She would still pay the subsidized premium for exchange coverage. The state would have to coordinate benefits, with Medicaid being the payer of last resort.

Source: Dollar amounts are based on the Kaiser Family Foundation Subsidy Calculator, which calculates premium assistance amounts for exchange coverage (KFF 2013).

The status of women who become pregnant when already enrolled in Medicaid is less clear. On the one hand, states are not required to track the pregnancy status of women already enrolled through the new adult group. On the other hand, pregnant women are allowed to request that the state move them to a pregnancy-related eligibility group if they want specific benefits that may not be available under the adult group benefit package. Whether this is advantageous would likely depend on the scope of benefits for pregnancy-related coverage in the alternative benefit plan in the state.

In states that are not expanding their Medicaid program to the new adult group, a pregnant woman's Medicaid eligibility will remain largely the same as it was prior to 2014, with the exception of the new income determination rules and the elimination of asset tests.

Pregnant women with incomes above 138 percent

FPL. With the expiration of the maintenance of effort (MOE) requirement for adults in 2014, states that currently cover pregnant women above 138 percent FPL have considerable discretion in determining how to cover this population. One caveat is that states that had an income standard above 138 percent FPL in effect for pregnant women in 1989 must keep their higher 1989 standard (§1902(l)(2) of the Act); this long-standing MOE requirement applies to 19 states (NGA 1990).

States have two options for reducing pregnancy-related coverage for women in this income range. First, they can reduce benefits for women eligible through poverty-level-related pregnancy pathways to provide pregnancy-related services only if they are not already doing so. This could affect pregnant women covered under these pathways at all income levels. Alternatively, they can reduce the eligibility level for pregnant women in those pathways to 138 percent FPL (or to their 1989 standard, if higher). Two states—Louisiana and Oklahoma—have

rolled back eligibility for pregnant women to 133 percent FPL and will cover pregnant women above that level through the CHIP unborn child option (Table 3-A-1).

If women in states that restrict eligibility do not have another source of coverage, or if they cannot afford an offer of employer-sponsored coverage or coverage offered by an exchange, they may become uninsured.

Interactions between Medicaid and Exchange Coverage for Pregnant Women

The complexity of coverage choices described above highlights the importance of the outreach and education that will be needed to inform pregnant women about their options. Medicaid program staff, exchange staff, and providers may also need education about coordination of benefits and cost sharing for women enrolled in both Medicaid and exchange programs and how to help choose the best source of coverage. Some factors that influence coverage choices between Medicaid and the exchanges are described below.

Timing. Medicaid and exchange coverage have different rules related to when women can enroll and how long coverage will last. Enrollment in the exchange is limited to annual open enrollment periods or to the occurrence of certain qualifying events. The birth of a child is a qualifying life event, but becoming pregnant is not.¹² In contrast, women can enroll in Medicaid at any time they are eligible.

Once enrolled in exchange coverage, a woman retains that coverage for the full year as long as premiums are paid (either through a subsidy or out of pocket). If a woman is enrolled in Medicaid on the basis of pregnancy, she retains that coverage until two months postpartum or until pregnancy ends. Depending on the timing of the pregnancy,

this may result in a loss of Medicaid coverage at any time during the year.

If a woman successfully gives birth, she can immediately enroll in the exchange because the birth of her child is a qualifying life event. If she experiences a miscarriage or terminates her pregnancy, however, this is not a qualifying life event. And because her poverty-level-related pregnancy Medicaid coverage is not MEC, the loss of that coverage also does not count as a qualifying life event. Instead, she would lose Medicaid coverage, and if she is not eligible for Medicaid through another pathway, she would have to wait until the next open enrollment period to sign up for exchange coverage.

Differing benefits. Pregnancy-related services are likely comparable between Medicaid and exchanges in most states, but much is unknown about exactly what services are covered in QHPs and in Medicaid. Exchange plans and state exchanges have some flexibility when it comes to determining what services are covered as part of the required maternity care benefit (and at what cost). Also, as discussed above, it is not evident what Medicaid services are considered pregnancy-related in states that cover only pregnancy-related services or how these benefits would differ from benefits provided under exchange coverage. It is also important to emphasize that, for all pregnancy eligibility pathways, Medicaid may provide enhanced maternity benefits that are not routinely provided by QHPs or employer-sponsored insurance, such as the intensive case management and dental care.¹³

Premiums. Women who qualify for Medicaid through a pregnancy-related pathway do not have to pay premiums for that coverage. For exchange coverage, women may qualify for premium subsidies if they have incomes between 100 and 400 percent FPL, do not have access to affordable employer coverage, and are not eligible for full-benefit Medicaid. However, subsidies may not

cover the entire premium, and pregnant women will have to pay an amount that varies by income level. (For example, the amount may be 2 percent of income at 100 percent FPL.)

Cost sharing. Where services are covered by both Medicaid and exchange coverage, Medicaid will generally require lower cost sharing and prohibits it altogether for pregnancy-related care (CMS 2013a). Some prenatal care and essential preventive health benefits are covered with no cost sharing under exchange plans, but cost sharing is allowed for other services, including hospitalization for delivery.¹⁴ Qualifying women with incomes between 100 and 250 percent FPL may be eligible for reductions in their responsibilities for deductibles and copayments.

Churning. With the implementation of the exchanges, women who may have transitioned between Medicaid (with either full benefits or pregnancy-related services only) and uninsured status prior to the ACA may now transition back and forth between Medicaid and exchange coverage (or employer-sponsored coverage)—or being uninsured. Women going through these transitions as their pregnancy status changes could experience disruptions in care. In addition, such churning could be confusing for enrollees and administratively complicated for Medicaid programs, exchanges, and plans.¹⁵

Coordination of benefits. If women have both pregnancy-related coverage and exchange coverage, Medicaid programs and exchange plans will need to coordinate benefits. Medicaid would be the secondary payer, paying for services not included in a pregnant woman's exchange plan, as well as copayments and deductibles, but not premiums. Because exchange coverage must include coverage of maternity care, the Medicaid program will likely have little payment liability, except for some cost-sharing assistance; any enhanced maternity-related services; and in states offering full benefits,

any additional services covered in a state plan that are not covered in the exchange plans. These might include, for example, non-emergency transportation or similar services that are typically unique to Medicaid. In any case, current law requires that state Medicaid programs must pay the bills and then seek reimbursement from any other coverage, which may be administratively burdensome (§1902(a)(25)(E) of the Act).

Uninsurance. Some women may choose to forgo exchange coverage and be uninsured for reasons including costs. Depending on their income and other circumstances, they may be required to pay the shared responsibility penalty, which may be less than the cost-sharing amounts. Periods of uninsurance for pregnant women are problematic for both the health of the mother and the child because lack of prenatal and other maternity care is associated with poor birth outcomes. Spells of uninsurance are also associated with less care for health risks such as hypertension, obesity, and gynecological problems that can lead to high-cost, adverse birth outcomes (Johnson 2012).

Commission Recommendations

The ACA creates new options for coverage of pregnant women, but also potential challenges and complications. Treasury has determined that coverage through mandatory and optional poverty-level-related pregnancy pathways does not constitute MEC. This means that women who enroll through these pathways can have other coverage and may eventually have to pay a personal responsibility penalty if they do not obtain MEC through some other source. At the same time, one stated goal of the ACA, increasing administrative simplicity by streamlining eligibility, is in effect negated because pregnancy-related pathways are

treated differently from other eligibility pathways for tax and penalty purposes.

Two related recommendations would simplify eligibility determinations, reduce inequities in coverage between pregnant women and other enrolled adults, and streamline eligibility while also enabling pregnant women to receive enhanced maternity benefits through Medicaid but retain their exchange coverage if they so choose. The two recommendations that follow are related: Recommendation 3.2 applies only if Recommendation 3.1 is adopted.

Recommendation 3.1

To align coverage for pregnant women, the Congress should require that states provide the same benefits to pregnant women who are eligible for Medicaid on the basis of their pregnancy that are furnished to women whose Medicaid eligibility is based on their status as parents of dependent children.

Rationale

The Commission's recommendation is grounded in three arguments.

First, in order to ensure the best possible pregnancy and birth outcomes, coverage for pregnant women should not be restricted to coverage of only pregnancy-related services. States should also continue to evaluate the best approaches to providing coverage to pregnant women and to ensuring that Medicaid continues to promote healthy pregnancies and births.

Second, removing states' ability to limit coverage to certain services would allow Treasury to classify all pregnant women with Medicaid as having MEC. These women would therefore not be subject to any future personal responsibility penalty. In addition, although the ACA proposes to consolidate the six different Medicaid eligibility pathways for pregnant

women, the fact that the two poverty-related pathways do not lead to MEC means that these two pathways remain separate for tax purposes.

Third, this would prevent states from rolling back benefits in the future. Currently, eight or more states limit benefits for women who qualify on the basis of pregnancy, and additional states may restrict coverage in the future. Rolling back eligibility levels to 138 percent FPL or to the 1989 AFDC level could result in women previously covered by Medicaid with joint federal-state financing now being covered with fully federally funded exchange subsidies.

Women who enter Medicaid through the Section 1931 low-income families pathway are eligible for the full benefit package, including enhanced pregnancy services and non-maternity services with no cost sharing. This recommendation would require that women who enter Medicaid through poverty-level-related pregnancy pathways receive the same benefit package as pregnant women who enter through the Section 1931 low-income families pathway.

Nothing in this recommendation would limit states' ability to provide enhanced pregnancy benefits, designed to improve maternal and birth outcomes, to all pregnant women covered under the state plan. For example, several states have extended dental coverage only to pregnant women due to an emerging link between periodontal disease and an increased risk for preterm birth and low birth weight infants (MACPAC 2013a). Others provide targeted case management, medical home programs, and nutrition counseling not available to other Medicaid enrollees (MACPAC 2013a). Currently, a state may provide a greater amount, duration, or scope of services to pregnant women than it provides under its plan to other individuals who are eligible for Medicaid, under the following two conditions:

- ▶ These services must be pregnancy-related or related to any other condition which may complicate pregnancy (as defined in 42 CFR 440.210(a)(2)).
- ▶ These services must be provided in equal amount, duration, and scope to all pregnant women covered under the state plan (42 CFR 440.250(p)).

Implications

Federal spending. This recommendation would increase federal spending in 2015 by between \$50 and \$250 million. Over the five-year period from 2015 to 2019, this recommendation would increase federal spending by less than \$1 billion. These are the smallest non-zero categories of spending used by the Congressional Budget Office (CBO) when making budget estimates.

States. If states that cover only pregnancy-related services are not providing a large number of services, covering additional medically necessary (but not pregnancy-related) services could raise expenditures. If almost all medically necessary services are in fact provided through these programs, however, expanding coverage to full Medicaid should not add substantial costs to the program. Providing the full benefit package would constitute MEC, and thus prevent pregnant women from having exchange and Medicaid coverage simultaneously. This would reduce the need to coordinate benefits across these programs except as described in the companion Recommendation 3.2, but might increase costs to the extent that Medicaid becomes the primary payer rather than the secondary payer for these services.

Federal government. Eliminating pregnancy-related service coverage only would make fewer women eligible for exchange coverage, which would reduce the amount of subsidies paid by the federal government. At the same time, it would

increase the amount the federal government would pay in Medicaid costs to the extent that these women would begin using services that are not pregnancy-related and previously not covered by Medicaid in some states.

Enrollees. Based on a preliminary analysis, more than 170,000 women currently qualify for Medicaid through a poverty-related pregnancy-related pathway, and the percentage of women eligible through pregnancy-related pathways varies by state (MACPAC 2013b). However, since all states have the option of restricting coverage for women in pregnancy-related pathways, the number of women could increase in the future. This recommendation would prevent this occurrence. Pregnant women with pregnancy-related service coverage only would become eligible for additional (non-pregnancy-related) services not already covered. Pregnancy-related Medicaid coverage would be considered MEC so that women would not have to pay a personal responsibility penalty if it is not waived in the future.

Churning could increase as uninsured eligible pregnant women would be assigned to Medicaid and could not purchase on the exchange until after delivery. Recommendation 3.2 is aimed at reducing this problem. Pregnant enrollees in QHPs would not have to disenroll and enroll in Medicaid (if eligible), could retain their QHP network providers, and could maintain continuous enrollment. If they enrolled in the state Medicaid program as well, they would have reduced cost sharing and potentially enhanced pregnancy benefits.

Providers. Eliminating the ability to limit Medicaid benefits to cover only pregnancy-related services would eliminate the need for providers to determine whether specific services are pregnancy related. They would be able to bill for all Medicaid-covered services provided to pregnant women with Medicaid.

Recommendation 3.2

The Secretaries of the U.S. Department of Health and Human Services and the U.S. Department of the Treasury should specify that pregnancy-related Medicaid coverage does not constitute minimum essential coverage in cases involving women enrolled in qualified health plans.

Rationale

Under Recommendation 3.1, all pregnant women who qualify for Medicaid would be eligible for full benefits, which would be MEC. Were Recommendation 3.1 to be adopted, this additional recommendation would allow women already enrolled in QHPs to retain that coverage—and federal subsidies—even if they become eligible for Medicaid under a pregnancy pathway. In the absence of this change, if poverty-level-related pregnancy Medicaid coverage were considered MEC, women in qualified exchange coverage who become pregnant would have to disenroll from their QHPs and enroll in Medicaid. It should be noted that this recommendation is only relevant if states no longer have the option of providing coverage of only pregnancy-related services and if all Medicaid coverage for pregnant women is considered MEC.

By allowing pregnant women to remain in their QHP, churning would be reduced between Medicaid-only and QHP coverage. Medicaid pregnancy-related coverage is limited in duration to a maximum of 11 months (9 months of pregnancy and 2 months postpartum), but QHP coverage is not limited in this way. Therefore, requiring women to disenroll from their QHP solely on the basis of their pregnancy would constitute an unnecessary disruption to their QHP coverage.

While there are advantages and disadvantages to both QHP and Medicaid coverage, and to having both concurrently, a woman should not be involuntarily disenrolled from QHP

coverage solely because she becomes pregnant and therefore becomes eligible for Medicaid. By remaining in QHP coverage, she would retain her current network of providers and would have no disruptions in care between pregnancies, or after delivery. By enrolling concurrently in Medicaid, she could avoid interruptions in QHP coverage and receive cost-sharing assistance from Medicaid. It should be up to each woman to weigh the advantages of switching from QHP to Medicaid coverage, or retaining her QHP coverage.

This recommendation also would align the policy for QHP coverage with current policy for employer-sponsored insurance. Low-income women who have employer-sponsored health insurance do not have to disenroll if they become pregnant and become eligible for Medicaid.

Implications

Federal spending. This recommendation does not change current law or regulation; therefore it has no impact on federal spending relative to the current CBO baseline.

States. Pregnant women with exchange coverage who are also eligible for Medicaid would be allowed to retain their exchange coverage, as is current law. The adoption of Recommendation 3.2 would reduce some of the Medicaid benefit-related costs related to Recommendation 3.1, because exchange coverage would be the primary payer. States might have some additional administrative costs due to the need to coordinate benefits.

Federal government. This recommendation does not change current law or regulation. If Recommendation 3.1 is enacted, Recommendation 3.2 may increase federal spending for women who retain their exchange coverage. Those women would have been disenrolled from their exchange coverage once poverty-level-related Medicaid pregnancy coverage was considered MEC.

Enrollees. Pregnant enrollees in QHPs would not have to disenroll and enroll in Medicaid (if eligible), could retain their QHP network providers, and could maintain continuous enrollment, as they can under current law and regulation.

Providers. Under current law and regulation, providers would have to coordinate benefits for women enrolled in both QHPs and Medicaid. If Recommendation 3.2 were implemented, this would be true for women with both exchange and Medicaid coverage at the time they became pregnant but not for women not enrolled in exchange coverage at the time they become pregnant. If Recommendation 3.2 is adopted, newly pregnant women eligible for Medicaid would receive Medicaid full-benefit coverage only.

Endnotes

¹ As part of the modified adjusted gross income (MAGI)-based eligibility determinations for populations that include pregnant women, states will be required to disregard income equal to 5 percent FPL starting in 2014. For this reason, mandatory income eligibility for pregnant women is often referred to at its effective level of 138 percent FPL, even though federal statute specifies 133 percent FPL. Two additional factors also lead mandatory eligibility levels for pregnant women to exceed 133 percent FPL (or 138 percent FPL, including the mandatory 5 percent of income disregard) and to vary by state. First, as part of the move to MAGI-based eligibility determinations, states were required to convert their eligibility thresholds to account for pre-Patient Protection and Affordable Care Act (ACA) income disregards that had previously increased their effective levels above the 133 percent FPL specified in the statute. Following this conversion (and excluding the mandatory 5 percent of income disregard), only four states remain at 133 percent FPL as of 2014, and the next lowest state is at 139 percent FPL (see Appendix Table 3-A-1). Second, there are 19 states whose pre-ACA mandatory eligibility levels for pregnant women ranged from 150 to 185 percent FPL, due to the fact that they had already expanded to these levels when legislation (P.L. 101-239) was enacted in 1989 to mandate coverage of pregnant women up to at least 133 percent FPL (NGA 1990).

² “Full Medicaid benefits” in this chapter refers to the benefits provided to women over the age of 21 with dependents, who have coverage for all mandatory and optional services specified in the state plan amendment, not only those services related to pregnancy.

³ Specifically, federal law requires that states provide Medicaid coverage to pregnant women whose household income is the higher of 133 percent FPL or the income standard, up to 185 percent FPL, that the state had established as of December 19, 1989, for determining eligibility for pregnant women, or, as of July 1, 1989, had authorizing legislation to do so (42 CFR 435.116).

⁴ As discussed later in this chapter, a woman who is eligible for Medicaid through a pregnancy-related eligibility pathway and who has income above 100 percent FPL could simultaneously enroll in Medicaid and subsidized exchange coverage, but she would have to pay an exchange premium that varies by income level. (For example, the amount may be 2 percent of income at 100 percent FPL.) In such cases, Medicaid would be the secondary payer after the exchange plan and would provide wrap-around coverage of cost-sharing amounts and Medicaid services not included in the exchange plan.

⁵ Immigrants with incomes below 133 percent FPL who would be eligible for Medicaid but for their immigration status are also eligible for advanced premium tax credits.

⁶ The postpartum period may vary by state. In some states, it is exactly 60 days from date of birth, in others it is until the end of the month in which the 60th day occurs.

⁷ Non-citizen pregnant women who are unauthorized or illegally present, or who are legal immigrants subject to a five-year ban on eligibility—but who otherwise meet all other Medicaid eligibility requirements—are eligible for emergency Medicaid coverage that is limited to labor and delivery services and excludes prenatal or postpartum care. Because these women are not covered by Medicaid for the duration of their pregnancies, the issues raised in this chapter are not directly applicable to these women.

⁸ Prior to implementation of the ACA, the threshold was 133 percent FPL with state-specific disregards. After implementation, the threshold is 133 percent FPL with a flat 5 percent income disregard, which is why we refer to it as 138 percent FPL for both periods.

⁹ For example, states have the option under Section 1931 406(g)(2) of the Act, as in effect prior to enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) to provide full Medicaid coverage for pregnant women with no dependent children during the third trimester of pregnancy (CMS 2012). States are required to cover “qualified pregnant women” during all trimesters of pregnancy for full Medicaid benefits if they meet the financial eligibility requirements for this group (CMS 2012).

¹⁰ MACPAC analysis of state Medicaid websites and discussions with Medicaid directors in Alabama, Louisiana, Indiana, and New Mexico.

¹¹ In November 2013, MACPAC staff reached out to Medicaid directors in states identified as providing pregnancy-related service coverage only.

¹² Other qualifying life events include changes in family composition through death, divorce, or adoption; losing minimum essential health coverage through job loss or other events; and several other events (45 CFR 155.420(a)).

¹³ See MACPAC's June 2013 *Report to the Congress on Medicaid and CHIP*, Chapter 1, for a detailed description of pregnancy-related eligibility and benefits under the Medicaid program and Medicaid-enhanced maternity services. For example, 35 state Medicaid programs cover prenatal risk assessments, 30 cover home visiting, 28 cover health education, 27 cover nutritional counseling, and 30 cover psychosocial counseling (Hill et al. 2009).

¹⁴ Essential health benefits required with no cost sharing by exchange plans include anemia screening on a routine basis for pregnant women; screening for urinary tract or other infections for pregnant women; counseling about genetic testing for women at higher risk; comprehensive support and counseling from trained providers, as well as breastfeeding supplies for pregnant or nursing women; folic acid supplements for women who may become pregnant; gestational diabetes screening for women 24 to 28 weeks pregnant and for those at high risk for developing gestational diabetes; hepatitis B screening for pregnant women at their first prenatal visit; and Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk (CMS 2011b).

¹⁵ For additional information on churning, see Chapter 2 of this report.

References

- Advisory Board Company, The. 2014. Where the states stand on Medicaid expansion. Washington, DC: The Advisory Board Company Daily Briefing, January 24. <http://www.advisory.com/Daily-Briefing/Resources/Primers/MedicaidMap>.
- Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013a. Cost sharing out of pocket costs. Baltimore, MD: CMS. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Cost-Sharing/Cost-Sharing-Out-of-Pocket-Costs.html>.
- Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013b. State Medicaid and CHIP income eligibility standards effective January 1, 2014. Baltimore, MD: CMS. <http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/Medicaid-and-CHIP-Eligibility-Levels-Table.pdf>.
- Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2012. Medicaid program: Eligibility changes under the Affordable Care Act of 2010. Final rule. *Federal Register* 77, no. 57 (March 23): 17143–17217. <http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-6560.pdf>.
- Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2011a. Medicaid program: Eligibility changes under the Affordable Care Act of 2010. Proposed rule. *Federal Register* 76, no. 159 (August 17): 51148–51199. <http://www.gpo.gov/fdsys/pkg/FR-2011-08-17/pdf/2011-20756.pdf>.
- Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2011b. Group health plans and health insurance issuers relating to coverage of preventive services under the Patient Protection and Affordable Care Act. Interim final rules, with request for comments. *Federal Register* 76, no. 149 (August 3): 46621–46625. <http://www.gpo.gov/fdsys/pkg/FR-2011-08-03/pdf/2011-19684.pdf>.
- Hill, I.T., S. Hogan, L. Palmer, et al. 2009. *Medicaid outreach and enrollment for pregnant women: What is the state of the art?* Washington, DC: Urban Institute. http://www.urban.org/UploadedPDF/411898_pregnant_women.pdf.
- Johnson, K. 2012. *Addressing women's health needs and improving birth outcomes: Results from a peer-to-peer state Medicaid learning project.* Commonwealth Fund Issue Brief, no. 1629, vol. 21. New York, NY: The Commonwealth Fund. http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2012/Aug/1620_Johnson_addressing_womens_htl_needs_improving_birth_ib.pdf.
- Kaiser Family Foundation (KFF). 2014. *Status of state action on the Medicaid expansion decision.* Washington, DC: KFF. <http://kff.org/medicaid/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act>.
- Kaiser Family Foundation (KFF). 2013. *Subsidy calculator: Premium assistance for coverage in exchanges.* Washington, DC: KFF. <http://kff.org/interactive/subsidy-calculator>.
- Maternal and Child Health Access (MCHA). 2013. MCHA alert, July 23. Los Angeles, CA: MCHA. <http://www.mchaccess.org/pdfs/alerts/Regular%20Session%20Memo%20July%2023%202013.pdf>.
- Medi-Cal, California Department of Health Care Services. 2002. *Pregnancy: Early care and diagnostic services.* Sacramento, CA: Medi-Cal. http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/pregearly_m00o03.doc.
- Medicaid and CHIP Payment and Access Commission (MACPAC). 2013a. *Report to the Congress on Medicaid and CHIP.* June 2013. Washington, DC: MACPAC. <http://www.macpac.gov/reports>.
- Medicaid and CHIP Payment and Access Commission (MACPAC). 2013b. Unpublished analysis of 2008 Medicaid Statistical Information System (MSIS) data. Washington, DC: MACPAC.
- National Governors Association (NGA). 2011. *2010 Maternal and child health update: States make progress towards improving systems of care.* Washington, DC: NGA. <http://www.nga.org/files/live/sites/NGA/files/pdf/MCHUPDATE2010.PDF>.
- National Governors Association (NGA). 1990. *State coverage of pregnant women and children—January 1990.* Washington, DC: NGA. <http://www.nga.org/files/live/sites/NGA/files/pdf/MCHUPDATE0190.pdf>.
- North Carolina Division of Medical Assistance (North Carolina Medicaid). 2011. *Division of Medical Assistance (Obstetrics): Clinical coverage policy no. 1E-5.* <http://www.ncdhhs.gov/dma/mp/1E5.pdf>.
- State Refor(u)m. 2014. Tracking Medicaid expansion decisions: a closer look at legislative activity. Washington, DC: State Refor(u)m. <https://www.statereforum.org/node/11675>.
- U.S. Department of the Treasury (Treasury). 2013. Shared responsibility payment for not maintaining minimum essential coverage. Final regulations. *Federal Register* 78, no. 169 (August 30): 53646–53664. <http://www.healthreformgmps.org/wp-content/uploads/mec-8-30.pdf>.

Chapter 3 Appendix

APPENDIX TABLE 3-A-1. Medicaid Eligibility Levels, Limits on Pregnancy-Related Benefits, Number of Medicaid Births, and Status of Medicaid Expansion

| State | Eligibility Level (% FPL) for Medicaid Pregnancy Coverage, January 2014 ¹ | Limits Benefits for Pregnancy-Related Eligibility Pathways, November 2013 ² | Number of Medicaid Births (2008, 2009 or 2010) | Source of Birth Data | Medicaid Expansion Status, January 2014 |
|----------------------|--|--|--|----------------------|---|
| Alabama | 141 | x | 27,570 | c | No |
| Alaska | 200 | | 5,891 | c | No |
| Arizona | 156 | | 84,805 | a | Yes |
| Arkansas | 209 | | 37,235 | a | Yes |
| California | 208 | x | 495,252 | a | Yes |
| Colorado | 195 | | 60,266 | a | Yes |
| Connecticut | 258 | | 14,500 | c | Yes |
| Delaware | 209 | | 6,202 | c | Yes |
| District of Columbia | 319 | | NA | | Yes |
| Florida | 191 | | 209,525 | a | No |
| Georgia | 220 | | 66,607 | b | No |
| Hawaii | 191 | | 15,804 | a | Yes |
| Idaho | 133 | x | 9,618 | b | No |
| Illinois | 208 | | 157,019 | a | Yes |
| Indiana | 208 | x | 41,793 | c | No |
| Iowa | 375 | | 38,043 | a | Yes |
| Kansas | 166 | | 38,951 | a | No |
| Kentucky | 195 | | 50,343 | a | Yes |
| Louisiana | 133 | x | 37,722 | b | No |
| Maine | 209 | | 12,463 | a | No |
| Maryland | 259 | | 68,089 | a | Yes |
| Massachusetts | 200 | | 71,810 | a | Yes |
| Michigan | 195 | | 112,481 | a | Yes |
| Minnesota | 278 | | 63,563 | a | Yes |
| Mississippi | 194 | | 27,142 | b | No |

APPENDIX TABLE 3-A-1, Continued

| State | Eligibility Level (% FPL) for Medicaid Pregnancy Coverage, January 2014 ¹ | Limits Benefits for Pregnancy-Related Eligibility Pathways, November 2013 ² | Number of Medicaid Births (2008, 2009 or 2010) | Source of Birth Data | Medicaid Expansion Status, January 2014 |
|----------------|--|--|--|----------------------|---|
| Missouri | 205 | | 75,278 | a | Actively deciding |
| Montana | 159 | | 12,076 | c | No |
| Nebraska | 194 | | 25,667 | a | No |
| Nevada | 159 | x | 34,458 | a | Yes |
| New Hampshire | 196 | | 3,912 | c | Actively deciding |
| New Jersey | 194 | | 103,130 | a | Yes |
| New Mexico | 250 | x | 24,917 | a | Yes |
| New York | 218 | | 239,999 | a | Yes |
| North Carolina | 196 | x | 116,184 | a | No |
| North Dakota | 147 | | 2,424 | b | Yes |
| Ohio | 200 | | 10,391 | b | Yes |
| Oklahoma | 133 | | 48,758 | a | No |
| Oregon | 185 | | 43,538 | a | Yes |
| Pennsylvania | 215 | | 57,371 | c | Actively deciding |
| Rhode Island | 190 | | 11,815 | a | Yes |
| South Carolina | 194 | | 54,510 | a | No |
| South Dakota | 133 | | 4,662 | c | No |
| Tennessee | 195 | | 73,816 | a | No |
| Texas | 198 | | 369,475 | a | No |
| Utah | 139 | | 51,941 | a | Actively deciding |
| Vermont | 208 | | 5,630 | a | Yes |
| Virginia | 143 | | 28,047 | c | Actively deciding |
| Washington | 193 | | 79,463 | a | Yes |
| West Virginia | 158 | | 19,753 | a | Yes |
| Wisconsin | 301 | | 66,037 | a | No |
| Wyoming | 154 | | 6,234 | a | No |

Notes: FPL is federal poverty level.

¹ Eligibility levels in effect as of January 1, 2014, based on information current as of September 30, 2013, provided to the Centers for Medicare & Medicaid Services (CMS) by states either for purposes of federally facilitated marketplace programming of state-specific Medicaid/State Children’s Health Insurance Program rules, through state plan amendments, or by direct request from CMS. These levels are subject to change.

² MACPAC identified these states through state Medicaid websites and communication with Medicaid directors in November 2013. There may be additional states that limit services to those that are pregnancy-related for some subset of their pregnant enrollees.

Sources: Eligibility: CMS 2013b.

Medicaid Birth Counts: (a) HealthCare Cost and Utilization Project, Nationwide Inpatient Sample and State Inpatient Databases. Data are for 2010; (b) Medicaid Statistical Information System (MSIS). Data are for 2008; (c) NGA 2011. Data are for 2010. For more information about the data sources and methodologies for counting Medicaid births, see: Medicaid and CHIP Payment and Access Commission. 2013. *Counting the number and percentage of annual births in the Medicaid program at the national, state and sub-state levels*. Washington DC: MACPAC. <http://www.macpac.gov/publications>.

Medicaid Expansion Status: MACPAC analysis of KFF 2014, The Advisory Board Company 2014, State Refor(u)m 2014, and media accounts.