

## Update on Pregnancy-Related Medicaid and Minimum Essential Coverage

Medicaid is a primary provider of health coverage for low-income pregnant women; the program covered nearly half of all births in the U.S. in 2010 (MACPAC 2013). The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) added another coverage option for pregnant women through subsidized exchange coverage. However, as a result of overlapping eligibility, this new option also created coordination challenges for both states and pregnant women themselves. The Commission looked at this issue in depth in its March 2014 report to Congress and updated guidance has clarified the options available to pregnant women.

In its March 2014 report, the Commission made two recommendations regarding coverage for pregnant women. The first was to require coverage of a full medical benefits package for women who are eligible through mandatory or optional pregnancy-related pathways, essentially ending the option for states to cover only pregnancy-related services. The second recommendation was to allow women enrolled in exchanges to retain their exchange coverage even if they become eligible for Medicaid under a pregnancy-related pathway. Together, these recommendations aimed to reduce current and potential inequities in covered benefits among pregnant women in different Medicaid eligibility groups, as well as mitigate churning between Medicaid and exchange plans for pregnant women.

Federal guidance has since clarified that pregnancy-related Medicaid coverage that provides full Medicaid benefits is considered minimum essential coverage (MEC). As a result, the coverage options available to most women depend on a woman's existing coverage, whether she is pregnant at the time of enrollment, and the time of year at which she seeks coverage (such as during open enrollment or after a qualifying event). The Centers for Medicare & Medicaid Services (CMS) also has reviewed state practices, finding that only three states (Arkansas, Idaho, and South Dakota) provide a limited benefit package that does not constitute MEC. However, additional coverage options may be available to women in these three states.

This brief reviews the issues that lead to the Commission's 2014 recommendations and provides further details on the updated guidance and Secretary-approved minimum essential coverage determinations.

## The Effect of Medicaid and Exchange Policies for Pregnant Women

**Medicaid benefits for pregnant women may vary by eligibility pathway.** All states are required to provide Medicaid coverage for pregnant women with incomes below 138 percent of the federal poverty



level (FPL).<sup>1</sup> Currently all but four states extend Medicaid coverage to pregnant women with higher incomes, and as of September 2015, the median eligibility threshold was 195 percent FPL (MACPAC 2015). Pregnant women may be entitled to the full Medicaid package depending upon the eligibility pathway but states are not required to provide full Medicaid benefits for women covered through poverty-level pregnancy pathways and may limit services to those related to pregnancy.<sup>2</sup> As a result, Medicaid benefit packages for pregnant women differ by eligibility pathway both across and within states.<sup>3</sup> Women who are otherwise eligible for Medicaid (e.g., under a low-income parent, adult, or disability pathway) and become pregnant can retain their existing coverage and generally are not required to shift to a pregnancy-related eligibility pathway.<sup>4</sup>

**Exchange coverage provides broader coverage than just pregnancy-related benefits, but it may have higher out-of-pocket costs or other disadvantages for pregnant women relative to Medicaid.** The ACA provides individuals with incomes between 100 and 400 percent FPL access to subsidized exchange coverage. In states that limit Medicaid benefits for pregnant women, exchange coverage offers a broader medical benefit package than Medicaid. At the same time, exchange coverage may come with higher premium and cost-sharing requirements than are typical in Medicaid, and may not provide enhanced maternity benefits offered by some Medicaid programs such as nutrition counseling, targeted case management, and psychosocial support services (MACPAC 2013).

**Medicaid eligibility generally makes individuals ineligible for exchange subsidies, but previous guidance provided an exception for certain pregnancy-related pathways by not considering them to be minimum essential coverage.** Individuals who are eligible for Medicaid that qualifies as MEC are ineligible for exchange subsidies.<sup>5</sup> Through regulations released in August 2013, the U.S. Department of the Treasury ruled that most Medicaid coverage is MEC. The rule specified, however, that women eligible through a pregnancy pathway that allows states to limit coverage to pregnancy-related benefits do not have MEC, regardless of what services the states actually covers. For Internal Revenue Services (IRS) purposes, these women are considered uninsured, and are therefore eligible to purchase exchange coverage with premium tax credits and cost-sharing subsidies if their incomes are above 100 percent FPL. However, if women who have Medicaid coverage that is not MEC do not acquire additional coverage, they could be subject to the ACA's personal responsibility penalty. Although 2014 penalties were waived for these women, at the time of the Commission's consideration of this issue in March 2014, it was possible that they could be imposed in future years (Treasury 2013 and IRS 2014a).<sup>6</sup>

**Commission recommendations.** Based on these circumstances, in March 2014 the Commission made two related recommendations regarding pregnancy-related Medicaid eligibility and minimum essential coverage:

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.



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.

The Commission made these recommendations to ensure that the full Medicaid benefit package would be provided to all women and coverage would not be restricted to only pregnancy-related services for some women. Additionally, ruling that pregnancy-related coverage does not constitute MEC for women already enrolled in an exchange plan would allow them to keep that coverage despite eligibility for Medicaid as a result of their pregnancy, minimizing churning between Medicaid and the exchanges.

## Updated CMS and IRS guidance

In a November 7, 2014 State Health Official letter, CMS announced that pregnancy-related Medicaid coverage is considered MEC in states that have elected to provide pregnant women with the same coverage they provide to other Medicaid beneficiaries (CMS 2014). Following this guidance, 44 states reported that they aligned benefits for all pregnant women, while seven states reported that the benefits they provided were not the same.<sup>7</sup> CMS ruled that only three of these states (Arkansas, Idaho, and South Dakota) provide pregnancy-related coverage that is not considered MEC (CMS 2016). Women in these states who choose to enroll in pregnancy-related Medicaid will continue to be exempt from the personal responsibility (or individual mandate) payment if they secure a hardship exemption (CMS 2014).

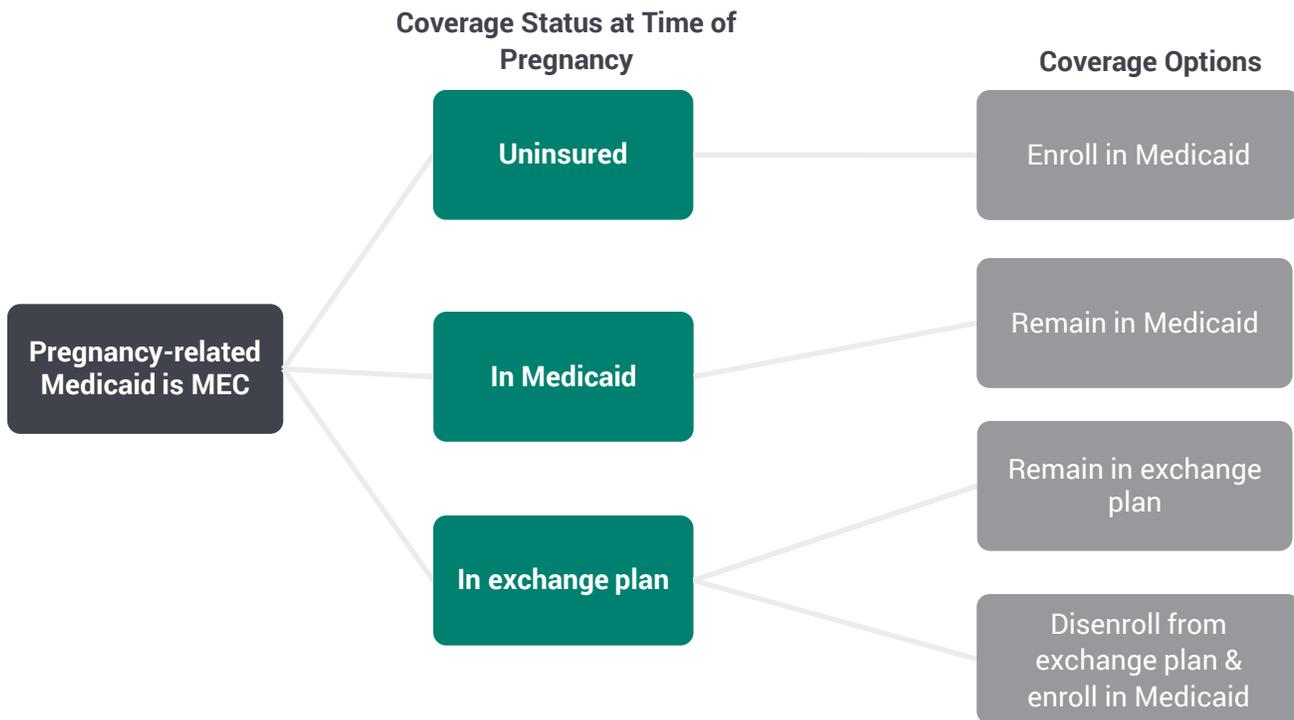
The IRS concurrently provided clarification on its policy in November 2014. Women who are enrolled in an exchange plan who become eligible for Medicaid as a result of their pregnancy will only be considered to have MEC for the purposes of premium tax credit eligibility if they choose to enroll in Medicaid. This will allow any woman who becomes eligible for Medicaid on the basis of pregnancy (regardless of whether that coverage is considered MEC) while enrolled in an exchange plan to retain that coverage or choose to enroll in Medicaid. However, the other coverage options available to a pregnant woman will depend upon whether her state is considered to provide full-scope Medicaid, if she is pregnant at the time of enrollment, and the time of year at which she seeks coverage (i.e., during open enrollment or after a qualifying event).



## What this means for pregnant women's coverage options

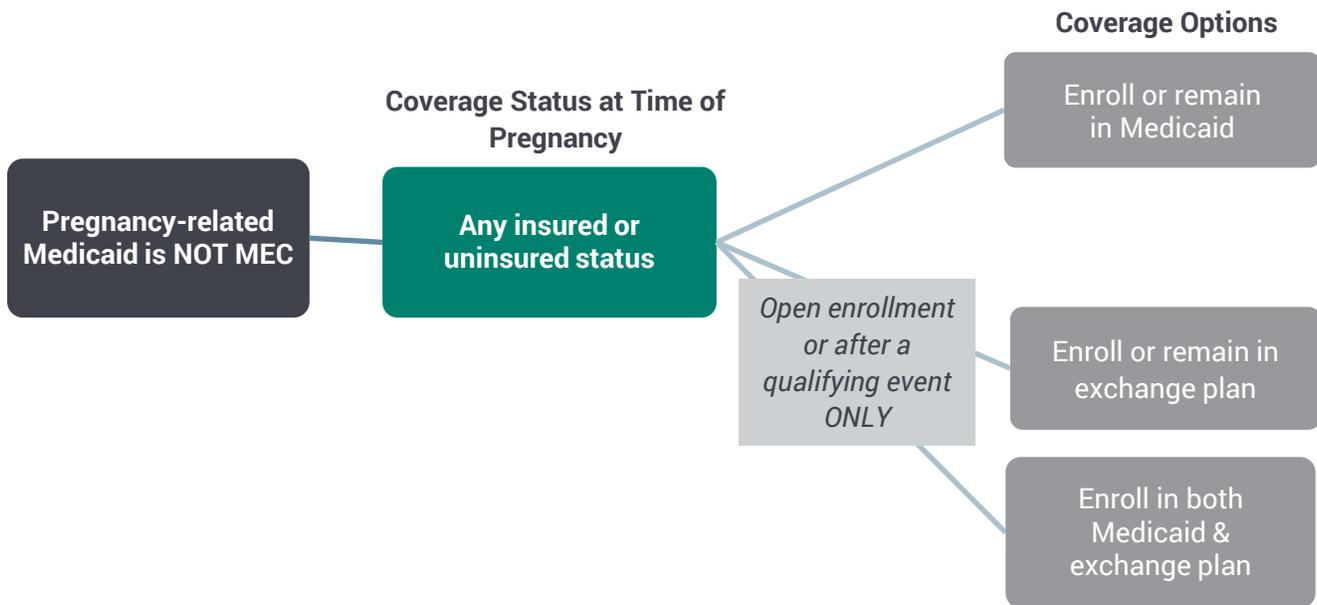
**Coverage options in the 48 states providing full Medicaid benefits.** Women who are eligible for pregnancy-related coverage that is MEC will not be able to enroll in both Medicaid and exchange coverage. If a woman is not enrolled in an exchange plan when she becomes pregnant, she only can enroll in Medicaid (CMS 2014 and IRS 2014b). She would have the option to enroll in subsidized exchange coverage after 60 days postpartum (Figure 1).

**FIGURE 1.** Coverage Options for Pregnant Women in States Providing Full Medicaid Benefits



**Coverage options in the three states providing limited pregnancy-related benefits.** In Arkansas, Idaho, and South Dakota, where pregnancy-related benefits are not considered MEC, pregnant women who qualify through a pregnancy-related pathway may enroll in Medicaid, an exchange plan, or both.<sup>8</sup> However, unlike Medicaid, which allows eligible individuals to enroll at any time, enrollment in exchange plans is limited to annual open enrollment periods or following certain qualifying events. While the birth of a child is a qualifying life event, becoming pregnant is not.<sup>9</sup> In these three states, the birth of the child would result in a special enrollment period and a woman's eligibility for non-MEC Medicaid would not prevent her from enrolling in an exchange plan immediately upon delivery (Figure 2).

**FIGURE 2.** Coverage Options for Pregnant Women in States Providing Limited Benefits



## Conclusion

At the time of the Commission’s consideration of this issue, data suggested approximately 174,000 women whose births were covered by Medicaid received only pregnancy-related services (MACPAC 2013). However, following the CMS and IRS rulings, women who receive this limited coverage reside in just three states, likely making those who continue to be at risk under the provision far lower. As state decisions regarding benefits are subject to change, MACPAC will continue to monitor this issue.

## Endnotes

<sup>1</sup> Specifically, federal law requires that states provide Medicaid coverage to pregnant women whose household income is the higher of: (1) 133 percent FPL or (2) 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 C.F.R. § 435.116). A number of states have expanded beyond these mandatory minimums.

<sup>2</sup> Mandatory coverage for pregnant women under Section 1931 and 1902(a)(10)(A)(i)(III), as well as coverage through the optional pathways of 1902(a)(10)(A)(ii)(I) and 1902(a)(10)(A)(ii)(IV) must provide full Medicaid coverage. However, for women covered under 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX), states may limit coverage to pregnancy-related services. ‘Full Medicaid benefits’ in this paper 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 SPA, not only those services related to pregnancy.

<sup>3</sup> As of September 2013, at least eight states were reported to cover only pregnancy-related services for most of their pregnant women: Alabama, California, Idaho, Indiana, Louisiana, Nevada, New Mexico, and North Carolina (MACPAC 2014).

<sup>4</sup> Generally, when an individual is eligible for more than one category, she has a choice of which eligibility pathway in which to enroll (42 CFR 435.404). States are not required to track the pregnancy status of current enrollees, so unless she self-identifies, she would remain enrolled in her current eligibility group. Although pregnant women are not eligible for the new adult group that covers individuals with incomes below 138 percent FPL, the self-identification rule still applies and those already enrolled in the group may remain in the group.

<sup>5</sup> Throughout this brief, the purchase of an exchange plan implies the use of subsidies to do so. Pregnant women would not be prevented from purchasing an exchange plan at full cost without subsidies if they chose, but would be precluded from receiving subsidies if they had other minimum essential coverage.

<sup>6</sup> Because women may not have known at the time of enrollment that their Medicaid coverage was not considered MEC, the IRS determined that the shared responsibility penalty (also known as the mandate penalty) would not apply in 2014 (IRS 2014a).

<sup>7</sup> The seven states that provide different benefits to pregnant women are Alabama, Arkansas, California, Idaho, New Mexico, North Carolina, and South Dakota.

<sup>8</sup> In states where poverty-level pregnancy-related coverage is not considered MEC, coverage for pregnant women through other pathways (such as Section 1931 coverage for low-income parents) is still considered MEC because states are unable to limit the benefit package to just pregnancy-related services. As such, there will be some states where pregnancy-related coverage through one eligibility pathway is considered MEC, but through another pathway, it is not.

<sup>9</sup> There are two exceptions—New York and Vermont—that have designated pregnancy as a qualifying event for a special enrollment period (Vermont 2016, New York 2015). Other qualifying life events include changes in family composition through death, divorce, or adoption; losing MEC through job loss or other reasons; and several others (45 CFR 155.420).

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