Frequently Asked Questions: Health Insurance Coverage for Low- and Moderate-Income Pregnant Women

NOVEMBER 2013

The Affordable Care Act (ACA) expands the Medicaid program, making millions more Americans eligible for coverage. Additionally, in 2014 it will offer premium and cost-sharing assistance to eligible individuals who purchase private insurance in state marketplaces.

Eligibility for Subsidized Coverage

I am pregnant and have a low income. Am I eligible for Medicaid coverage?

Your Medicaid eligibility depends on the state in which you live. The type and scope of Medicaid coverage you may be eligible for depends on the timing of your pregnancy, your income, and your state’s Medicaid policies. You should check with your state Medicaid program to learn about your state’s specific eligibility rules. (Most state Medicaid programs have a website you can access.)

In all states, if you are pregnant, you are eligible for Medicaid coverage of your pregnancy-related services if your income is at or below 133 percent FPL.¹ You should check with your state Medicaid program for more information, as many states provide Medicaid coverage of pregnancy services to women with much higher incomes (most states cover pregnant women up to 185 percent FPL or even higher.)

To determine for what type of Medicaid coverage you may be eligible, your state will determine your income relative to your family size by counting you and the number of children that you are expecting to have as individual members of your family.² It is important to keep in mind that states can treat you differently than other members of your family when determining where you fall in relation to the FPL. States are not required to count an expected child as a family member when determining family size for another member of your household (such as your spouse or partner).³ Consequently, while you might be eligible for Medicaid coverage, your partner or spouse may not be. Your local Medicaid office can tell you how income-eligibility calculation is done for pregnant women vs. other family members.
I am pregnant, have a low income, and am an immigrant. Am I eligible for Medicaid?

You might be. Federal law bars lawfully present immigrants from accessing Medicaid coverage for their first five years of residency, except in emergency situations. States, however, have the option to use their own state funds to offer Medicaid coverage to some groups of lawfully present immigrants within the five-year waiting period. Seventeen states have opted to use state funds to provide Medicaid coverage to lawfully present pregnant immigrant women without a five-year waiting period. Three other states are considering this option. Additionally, some states use state funds to offer prenatal care to pregnant women regardless of their immigration status. Recently, the federal minimum residency requirements for Medicaid eligibility changed, so it is important to check with your state’s Medicaid office to determine what coverage options are available to you.

I am pregnant, have a low income and am younger than 19. Am I eligible for Medicaid?

In most states, the income eligibility rules for pregnant women who are age 18 and younger are different than rules for pregnant women age 19 and older. A pregnant teen’s eligibility may depend on her family income, her own income, a combination of the two, or on whether or not she lives at home. Check with your state’s Medicaid office to find out what eligibility policies apply to you.

Am I eligible for premium tax credits and/or for cost-sharing assistance?

If your income is between 100 percent and 400 percent of FPL (up to $45,960 for an individual and $94,200 for a family of four in 2013), you may be eligible for premium tax credits. You do not qualify for premium tax credits if you fall into any of these categories:

- You are eligible for Medicare, full Medicaid coverage, Veterans Benefits or other public programs.
- Your income is below 100 percent of FPL or higher than 400 percent FPL.
- You are offered adequate and affordable coverage through your employer. (Employer-sponsored coverage is considered adequate and affordable if it has an actuarial value of at least 60 percent and the plan’s premium cost does not exceed 9.5 percent of your household income.)
- You are presently incarcerated.
- You are a non-legal resident.

If you qualify for premium tax credits and have an income below 250 percent of FPL ($28,725 for an individual and $58,875 for a family of four in 2013), you may be eligible for cost-sharing assistance, as well. To receive cost-sharing assistance, you must enroll in one of the designated Silver-level plans offered in your state marketplace. (If you make below 250 percent FPL but choose a non-Silver-level plan, you will not qualify for cost-sharing reductions.)
I am a lawfully present immigrant and have a low income. I am not eligible for Medicaid because I only recently immigrated to the United States. Could I be eligible for premium tax credits?

You could be. Under the ACA, lawfully present immigrants who do not have employer-sponsored insurance and have incomes between 100 and 400 percent of FPL are eligible for tax premium credits and cost-sharing reductions. Lawfully present immigrants whose incomes are below 133 percent FPL, but who are not eligible for Medicaid because of the duration of their residency, are also eligible for premium tax credits and cost-sharing reductions.9

I have a very low income, but I don’t think I qualify for either Medicaid or premium tax credits. Is this possible?

Unfortunately, it might be. To be eligible for premium tax credits, you must have an income that is between 100 percent and 400 percent FPL. If your income is higher than your state’s Medicaid income eligibility cap but lower than 100 percent FPL, then you may be ineligible for both Medicaid and premium tax credits.

Low-income childless adults who live in states that reject Medicaid expansion – and who have incomes below 100 percent FPL – are at high risk of being ineligible for both Medicaid and premium subsidies. Sadly, these adults fall into a coverage gap and may not be able to access affordable health insurance. (Adults with incomes below 100 percent FPL who are not eligible for Medicaid and do not have access to affordable minimum essential coverage will not be subject to the law’s shared responsibility tax penalty.10)

What If My Eligibility for Coverage Changes?

I think my pregnancy makes me eligible for Medicaid, but I haven’t applied yet. Can I still enroll even if I have been pregnant for several months?

If you are eligible for Medicaid coverage because you are pregnant, you can apply for and enroll in Medicaid at any point during your pregnancy.11 The timing of your pregnancy, your income, and the state in which you live will determine the type of Medicaid coverage for which you are eligible.

Many states have “presumptive eligibility” programs that provide temporary Medicaid coverage for expectant mothers while their Medicaid applications are pending approval. Additionally, qualified hospitals in all states that have opted to expand their Medicaid programs under the ACA can now apply presumptive eligibility to pregnant women and offer them prenatal services.12 Ask your doctor or state Medicaid office about whether your state allows for presumptive eligibility. You should seek prenatal care as early into your pregnancy as possible – and presumptive eligibility can help facilitate your transition into Medicaid.
Right now I qualify for premium tax credits and am enrolled in a subsidized private plan. What happens if I become pregnant and become eligible for Medicaid – do I have to enroll in Medicaid?

Under current interpretation of the ACA, you will lose your eligibility for premium tax credits if you become eligible for another form of health insurance that qualifies as minimum essential coverage, such as traditional Medicaid or Medicaid Expansion. Thus, if you become eligible for full Medicaid coverage because of your pregnancy, you will lose your eligibility for premium tax credits. If this happens and you can no longer afford to pay the entire premium cost of your private insurance plan, then you likely will need to enroll in a Medicaid plan.

However, you will only lose your eligibility for premium tax credits if you become eligible for another form of minimum essential coverage. Not all coverage options provide minimum essential coverage. For example, Medicaid programs that cover only pregnancy-related services are not providing minimum essential coverage, because they do not cover a broad enough scope of benefits. If you become eligible for a Medicaid coverage program that does not qualify as minimum essential coverage, then you will not lose your eligibility for premium tax credits.

Thus, if you are eligible for Medicaid coverage of just your pregnancy-related services (but not for full Medicaid coverage of all of your other health care needs), you may have the ability to choose between (a) staying with your Qualified Health Plan (QHP) (and, if you are eligible, continuing to receive premium and/or cost-sharing assistance) or (b) enrolling in a Medicaid plan that covers your pregnancy services. Ultimately, whether dually eligible pregnant women can enroll in both Medicaid pregnancy-only and a subsidized QHP may depend on a state’s marketplace and if its technology allows for dual eligibility assessment and enrollment.

If I qualify for Medicaid because I am pregnant, what happens after I have my baby? Will I have to leave Medicaid and purchase a private insurance plan?

If you currently qualify for Medicaid coverage because you are pregnant, you will remain eligible for the duration of your pregnancy and for 60 days post-delivery, regardless of changes in your family income. Once those 60 days expire, if you are no longer eligible for Medicaid coverage, you will need to purchase private insurance. You may be eligible for premium tax credits and cost-sharing assistance, depending on your family income.

If your baby was born while you were receiving Medicaid coverage, then your baby will remain covered under Medicaid for one year, until his or her first birthday.

What Coverage Option Is Right for Me?

I am pregnant and eligible for full Medicaid coverage. Is Medicaid right for me?

Major benefits associated with Medicaid enrollment include coverage of maternity care services, including prenatal and postpartum care, and cost-sharing protections. Medicaid
enrollees also will have access to designated essential health benefits and to a number of preventive health services. These preventive health services – which, amongst other benefits, includes family planning care and FDA-approved contraceptives, screening for gestational diabetes, HIV and STI screening and counseling, domestic violence screening, and breastfeeding support – must be provided without cost-sharing.

Federal law also prohibits any cost-sharing for pregnancy-related services, meaning these services are provided with no copays and are not subject to deductibles. Additionally, Medicaid includes an overall cost-sharing protection that limits all out-of-pocket expenses (for non-pregnancy-related care) to 5 percent of the family income. Given federal law’s broad definition of “pregnancy-related” services, pregnant women enrolled in Medicaid are often responsible for little to no cost-sharing for any health services they seek while pregnant.

Enrolling in Medicaid can also benefit your children. Infants born to pregnant women who are receiving Medicaid when they deliver are automatically eligible for Medicaid, and they remain automatically eligible for one year.

Many state Medicaid programs do not cover abortion services. Federal law bans the use of federal funds to cover abortion care for women on Medicaid, unless the pregnancy resulted from rape or incest or threatens the life of the woman. While some state Medicaid programs do cover abortions through the use of state funds, most programs do not – and many women on Medicaid are not able to access affordable abortion care. Your Medicaid office will be able to tell you whether your state’s Medicaid program covers abortion care.

**I am not eligible for full Medicaid coverage, but I am eligible for Medicaid coverage of my pregnancy-related services. Is enrolling in my state’s program that offers Medicaid coverage for my pregnancy-related services the right choice for me?**

If you enroll in a Medicaid program that covers only pregnancy-related services, you can expect to receive comprehensive maternity care. “Pregnancy-related” services, at minimum, are defined as services that are necessary for the health of the pregnant woman and her fetus and include, amongst other benefits: prenatal care, delivery, postpartum care, family planning services, and services for any condition that might complicate the pregnancy, threaten carrying a fetus to full term, or create problems for a safe delivery.17 Most states use a very broad definition of what is considered “pregnancy related,” and many “pregnancy only” Medicaid programs closely resemble full Medicaid coverage.

Under the ACA, if a state wants to limit benefits offered to pregnant women who are ineligible for full Medicaid coverage to “pregnancy-related” services only, then the state must submit a State Plan Amendment to the federal Centers for Medicare and Medicaid Services (CMS). The state must explain why it does not believe the benefits in question are pregnancy-related and receive approval from CMS. Given the barriers CMS has put in place for states to reduce pregnancy-related Medicaid coverage, it is unlikely to be a problem in practice.

The benefits to enrolling in a Medicaid program that covers pregnancy services include maternity services covered with no cost sharing during pregnancy, delivery and for 60 days post-partum. Infants born to pregnant women who are receiving Medicaid when they
deliver are automatically eligible for Medicaid, and they remain eligible for one year. However, if you choose to enroll in a Medicaid program that covers pregnancy-related services, your plan most likely will not cover abortion services.

For calendar year 2014, pregnant women who have Medicaid “pregnancy only” coverage will not face a penalty under the ACA’s individual mandate provision, even though these plans are not providing what is considered minimum essential coverage. Still, pregnant women considering enrolling in a Medicaid “pregnancy only” plan should understand that Medicaid pregnancy-only coverage is not considered comprehensive coverage under the ACA.

My state offers Medicaid premium assistance as one option for receiving coverage through Medicaid. Is Medicaid premium assistance right for me?

Whether participating in Medicaid premium assistance is the right choice for you will depend on the state in which you live and what private plans are available through Medicaid premium assistance. When determining whether or not to participate in Medicaid premium assistance, you should make sure that your coverage options offer the same benefits, protections, legal rights and cost-sharing limitations that would otherwise be available to you through your state’s traditional Medicaid program.

If a state’s Medicaid premium assistance program is operated robustly and in strict compliance with Medicaid law, then it could potentially reduce the frequency with which a low-income person shifts between Medicaid coverage and coverage through a private plan purchased with subsidies in the state’s marketplace. For lower-income adults whose incomes fall close to the Medicaid eligibility line, switching between coverage programs can be disruptive to continuity of care if they are forced to go without coverage for periods of time.

I am pregnant and planning to buy health insurance in my state’s marketplace. What can I expect and what should I consider when deciding which plan is right for me?

Generally, all QHPs offered in state marketplaces are required to:
- Cover all essential health benefits;
- Limit cost-sharing for essential health benefits; and
- Offer coverage options that meet one of four levels of plan generosity (Platinum, Gold, Silver, and Bronze), based on actuarial value.

The ACA specifically identifies maternity and newborn care as an essential health benefit that all QHPs must carry. Generally, you can expect maternity care, labor and delivery, prenatal care, and all diagnostic screenings to be covered by any plan offered in your state’s marketplace. However, states do have flexibility when it comes to determining exactly what services are covered as part of the required maternity care benefit (and at what cost). Thus, it is important to examine plans closely and to compare carefully their maternity care-related benefits.
All plans in the marketplace also will carry cost-sharing protections for maternity care services; the deductibles and copays that you pay out-of-pocket for maternity care will be limited to predetermined levels. All QHPs must cover specific preventive women’s health services, including family planning care and contraceptives, well-woman visits, and cervical and breast cancer screenings. These preventive services must be covered with no out-of-pocket cost and without copays or deductibles.20

Finally, it is important to look carefully at plans offered in your state’s marketplace to see if they include coverage for abortion care. The ACA permits states to ban abortion coverage in state marketplaces. Several states have chosen to do this, so it is important to ask whether abortion coverage is available to you and to request information about which plans cover abortion services.21

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2 See 77 FR at 17151 (2012).
6 See http://v2011.nilc.org/immspbs/cdev/ICHIA/ICHIA-facts-2010-08-06.pdf. For more guidance on who qualifies as “lawfully-present” for the purposes of Medicaid coverage, please refer to the National Immigration Law Center’s resources at http://nilc.org/health.html.
15 http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Population/Pregnant-Women/Pregnant-Women.html
16 http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Population/Pregnant-Women/Pregnant-Women.html

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