

Why the Affordable Care Act Matters for Women: Improving Health Insurance Coverage for Lower- and Moderate-Income Pregnant Women

OCTOBER 2015

The Affordable Care Act (ACA) is the greatest advance for women's health in a generation. Thanks to this law, many women of childbearing age have gained access to affordable health insurance for the first time. Implementation of the ACA has had a particularly significant impact on lower- and moderate-income pregnant women, improving their access to affordable coverage and care. This fact sheet provides an overview of coverage options that are available for lower- and moderate-income pregnant women and raises some important considerations that pregnant women should keep in mind when selecting health insurance plans.

Health Insurance Coverage Options for Pregnant Women

The ACA requires most people to have health coverage, and provides new coverage options and benefits for pregnant women. Unless a pregnant woman falls into an [exempted group](#), she needs to have minimum essential coverage. While multiple coverage options are now available to lower- and moderate-income pregnant women, most are likely to be choosing between enrolling in Medicaid and purchasing a subsidized health plan in the health insurance marketplace.

Medicaid Coverage

Enrolling in Medicaid brings significant benefits for eligible pregnant women, including coverage of maternity care services, including prenatal and postpartum care, and cost-sharing protections. Medicaid enrollees have access to designated essential health benefits and to a number of preventive health services. These preventive health services – including birth control and family planning services, screening for gestational diabetes, HIV and sexually transmitted infection screening and counseling, interpersonal violence screening, breastfeeding support and more – are provided without cost-sharing.

Federal law also prohibits any cost-sharing for pregnancy-related services covered by Medicaid, so these services are provided with no copays or coinsurance 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 five percent of family income.¹

However, many state Medicaid programs do *not* cover abortion services, except in limited circumstances. 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 do not – and many women on Medicaid are unable to access affordable abortion care. Medicaid offices can provide information about whether or not a state Medicaid program covers abortion care.

Eligibility for Medicaid

There is more than one pathway to Medicaid eligibility. The type and scope of available Medicaid coverage depends on the timing of a woman’s pregnancy, her income and her state’s Medicaid policies. At minimum, federal law requires states to offer Medicaid coverage of pregnancy-related services to pregnant women who have incomes up to 138 percent of the Federal Poverty Level (FPL) (\$16,243 for an individual, \$33,465 for a family of four²). Fortunately, many states offer special Medicaid coverage to pregnant women with incomes higher than 138 percent FPL.³ (Whether pregnant women with incomes higher than 138 percent FPL are eligible for traditional full-scope Medicaid benefits or for Medicaid coverage only for their pregnancy-related services varies by state.) The Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) also created an eligibility category for pregnant women to receive health coverage through CHIP in certain circumstances. Under CHIPRA, states may provide necessary prenatal, delivery and 60-day postpartum care to lower-income, uninsured pregnant women through an amendment to the state’s CHIP plan.⁴

Subsidized Marketplace Insurance

Many pregnant women are now able to purchase subsidized private insurance plans in the health insurance marketplace. Marketplace plans must be designated as qualified health plans (QHPs), which means that, among other requirements, they include a set of minimum essential health benefits, comply with limits on cost-sharing (including out-of-pocket costs) for those essential health benefits, and meet all applicable private-market reforms specified in the ACA.⁵

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The ACA specifically identifies maternity and newborn care as an essential health benefit that all QHPs must carry.⁶ Generally, a pregnant woman who enrolls in a QHP can expect that prenatal care, labor and delivery, and all diagnostic screenings will be covered by her plan. 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). So, it is important for women to examine marketplace plans closely and to carefully compare the maternity care-related benefits they offer.

All marketplace plans also carry cost-sharing protections for maternity care services. The deductibles and copays a woman pays out-of-pocket for her maternity care are limited to predetermined levels. All QHPs also 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 at no out-of-pocket cost, meaning no copays, coinsurance or deductibles.⁷

It is important that women ask whether the QHP of their choice includes coverage for abortion care. Unfortunately, the ACA permits lawmakers in states to prohibit plans in the marketplace that serve their state from covering abortion, and several states have chosen to do so. A state's marketplace or department of insurance can provide information about which plans in that marketplace cover abortion services.

Eligibility for Subsidies

Lower- and moderate-income individuals and families with incomes between 100 and 400 percent FPL (up to \$47,080 for an individual and \$97,000 for a family of four⁸) may be eligible for premium tax credits to reduce the cost of their health care premium. In order to receive these credits, individuals must not be eligible for public health care programs deemed to be minimum essential coverage, such as Medicare, Medicaid or CHIP, or have access to adequate, affordable coverage through an employer.⁹ (It is important to note, however, that if a woman is enrolled in a QHP when she becomes pregnant and her pregnancy makes her eligible for minimum-essential Medicaid coverage, she will *not* lose her eligibility for premium tax credits.¹⁰ She can stay enrolled in her subsidized QHP plan or cancel her QHP coverage and enroll in the Medicaid or CHIP program for which she is now eligible.¹¹)

In addition to premium tax credits, individuals or families with incomes between 100 and 250 percent FPL (up to \$29,425 for an individual and \$60,625 for a family of four¹²) may be eligible for cost-sharing subsidies, which reduce the amount an individual must pay out-of-pocket for health care. Eligible individuals or families must enroll in a Silver-level plan to receive cost-sharing subsidies.

Selecting a Health Plan: Key Considerations for Pregnant Women

Pregnant women who are comparing coverage options should consider:

1. How comprehensive are the benefits in the plan? Does the plan limit the number of prenatal visits or prenatal services I can access? Does the plan restrict my access to home birth, doula or midwifery services? What diagnostic tests can I have done?
2. How high is my monthly premium? Will premium tax credits make a plan that covers expected birth, delivery and perinatal care affordable?
3. What are my cost-sharing responsibilities? Does the plan have a high deductible? Is the copay unaffordable for my family?
4. How will my new baby gain health insurance coverage?
5. Does the plan cover all federally approved contraceptives so I can plan my future pregnancies after having the baby? Am I entitled to receive the generic contraceptive only or can I get brand name contraceptives?
6. What abortion services do I have access to?

How Can I Get More Information?

HealthCare.gov is a great, user-friendly resource for more information on eligibility for coverage programs, as well as important information on enrollment. Consumers can also call a **hotline, toll-free, at 1-800-318-2596**. The hotline is operational 24 hours a day, seven days a week.

1 The Henry J. Kaiser Family Foundation. (2015 March). *Medicaid Moving Forward*. Retrieved 15 August 2015, from: <http://kff.org/health-reform/issue-brief/medicaid-moving-forward/>

2 Values calculated by National Partnership based on data from: U.S. Dept. of Health and Human Services, Centers for Medicare & Medicaid Services. (2015). *2015 Poverty Guidelines*. Retrieved 22 October 2015, from <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/downloads/2015-federal-poverty-level-charts.pdf>

3 Kaiser Family Foundation. (2015 January). *Medicaid and CHIP Income Eligibility Limits for Pregnant Women as a Percent of the Federal Poverty Level*. Retrieved 15 August 2015, from: <http://kff.org/health-reform/state-indicator/medicaid-and-chip-income-eligibility-limits-for-pregnant-women-as-a-percent-of-the-federal-poverty-level/>

4 U.S. Dept. of Health and Human Services, Center for Medicaid and State Operations. (2009 May). *Letter to State Health Officials*. Retrieved 15 August 2015, from: <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO051109.pdf>

5 U.S. Dept. of Health and Human Services, Healthcare.gov. *Qualified Health Plan*. Retrieved 15 August 2015, from: <https://www.healthcare.gov/glossary/qualified-health-plan/>

6 U.S. Dept. of Health and Human Services, Healthcare.gov. *Essential Health Benefits*. Retrieved 15 August 2015, from: <https://www.healthcare.gov/glossary/essential-health-benefits/>

7 U.S. Dept. of Health and Human Services, Healthcare.gov. *Preventive Health Services for Women*. Retrieved 15 August 2015, from: <https://www.healthcare.gov/preventive-care-benefits/women/>

8 Georgetown University Health Policy Institute. (2015). *2015 Federal Poverty Level Guidelines*. Retrieved 15 August 2015, from <http://ccf.georgetown.edu/wp-content/uploads/2015/01/2015-Federal-Poverty-Guidelines.pdf>

9 Affordable employer coverage means that the amount of the premium paid for self-only coverage is not more than 9.5 percent of household income. Adequate coverage means that the plan meets the minimum value standard of paying at least 60 percent of the cost of services.

10 Internal Revenue Service. (2014 December). *Eligibility for Minimum Essential Coverage Under Pregnancy-Based Medicaid and CHIP Programs*. Retrieved 15 August 2015, from: http://www.irs.gov/irb/2014-49_IRB/ar08.html

11 Ibid.

12 See note 8.

The National Partnership for Women & Families is a nonprofit, nonpartisan advocacy group dedicated to promoting fairness in the workplace, access to quality health care and policies that help women and men meet the dual demands of work and family. More information is available at www.NationalPartnership.org.

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