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Senate Budget Would Throw Thousands of Pregnant Women Off of Medicaid

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EXECUTIVE SUMMARY:

- The NC Senate budget includes a provision that would change Medicaid eligibility requirements for pregnant women. Starting in 2014, pregnant women earning more than 133 percent of federal poverty level (about $15,282 for a single person) will no longer qualify for Medicaid.
- This change will throw thousands of pregnant women off of Medicaid and into the private insurance market.
- This move will hurt efforts to reduce infant mortality rates

THE BUDGET PASSED BY THE NORTH CAROLINA SENATE includes a special provision changing the state's Medicaid eligibility requirements for pregnant women. Under the Senate provision, starting in 2014, pregnant women earning more than 133 percent of federal poverty level (about $15,282 for a single person) will no longer qualify for Medicaid. Currently, pregnant women earning up to 185 percent of federal poverty level (about $21,256 for a single person) qualify for Medicaid. This change will impact thousands of women.

Reducing eligibility for pregnant women in Medicaid will cause many women to lose insurance coverage

The Senate proposal gives small vouchers to a narrow group of pregnant women who are removed from Medicaid to help purchase private insurance coverage. To qualify for the voucher, however, pregnant women must meet strict eligibility rules. For a woman to get full coverage during her entire pregnancy a woman must meet the following standards:

1. She must be uninsured. **Under the Affordable Care Act, someone is defined as insured if they have something called "Minimum Essential Coverage."** We don't have a final rule from the federal government about what type of insurance plans qualify as Minimum Essential Coverage but we know it will be limited. **Minimum Essential Benefits may not be required to cover pregnancy-related services.** Under the Senate provision a pregnant woman can't get a voucher if she has a plan that qualifies as Minimum Essential Coverage. In the proposed rule from the federal government only a few types of insurance plans do not meet the definition of Minimum Essential Coverage including standalone dental and vision plans, disease specific plans, and some health savings/high deductible plans.

2. **She cannot have a spouse who has an offer of affordable self-only coverage.** This requirement excludes most dependants of full-time state employees from the voucher program. Take a married couple where the husband is a state employee earning $25,000 per year and the wife is unemployed. The husband is insured through the State Health Plan because the 70/30 plan is premium free. The wife is uninsured because "employee + spouse" coverage is more than $6,000 per year for a 70/30 policy. Currently, the wife would qualify for Medicaid during her pregnancy. Under the Senate

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provision she would not get Medicaid, she would not get federal subsidies to purchase insurance, and she would not get a state voucher.

3. She must learn she is pregnant during the few months of open enrollment. Pregnancy does not trigger a special enrollment period under health reform. That means if a woman learns that she is pregnant outside of open enrollment she will not qualify for federal subsidies to purchase insurance coverage, which means she is also excluded from the state voucher program. A woman could enroll in coverage at the next open enrollment period but that could be the entire length of her pregnancy.

Women who have recently used tobacco products face higher insurance premiums

Besides the strict eligibility rules there are important questions left unanswered by the Senate provision. One of the most critical questions relates to pregnant women who have used tobacco products. Currently, it is a priority to move low-income pregnant women who use tobacco products into Medicaid to start tobacco cessation programs and offer support to protect the health of the mother and baby. The Senate budget provision puts this initiative in jeopardy.

After 2014 health insurance companies are restricted to considering a limited number of factors when adjusting premiums. They can, for example, adjust premiums based on the age or geographic region of the person purchasing insurance. Insurance companies can also increase premiums by 50 percent for individuals who have recently used tobacco products. Federal subsidies are not available to cover the portion of an individual's premium that increases due to tobacco use.

Low-income pregnant women who have recently used tobacco products will face unaffordable premiums, and it is unclear whether or not the state voucher will cover the full cost of these higher premiums.

Cost sharing is still too expensive even with federal subsidies and state voucher

Even if a low-income pregnant woman manages to qualify for federal subsidies and a state voucher to purchase insurance she will still face large out-of-pocket costs after the birth of her child. Federal health reform provides some relief from large out-of-pocket costs, but not enough to make such cost sharing affordable for low-income pregnant women.

Under the Senate proposal a pregnant woman earning $16,000 per year will make too much to qualify for Medicaid coverage. If this woman qualified for federal subsidies and a state voucher her out-of-pocket payments for in-network care of covered services would be capped at $2,200. Out-of-network care and uncovered services would not count toward this limit. If a woman faced $1,800 in out-of-network charges then her total payment for a single pregnancy and delivery will be one quarter of her annual income.

These problems and questions should give lawmakers great pause before making such a drastic change to state policy. If legislators are intent on reducing Medicaid eligibility for pregnant women they should at least delay implementation until 2015 when we have all of the final federal rules and we know how well the new health insurance marketplace works. The Senate provision threatens to set back efforts to reduce infant mortality rates and control costs in Medicaid.