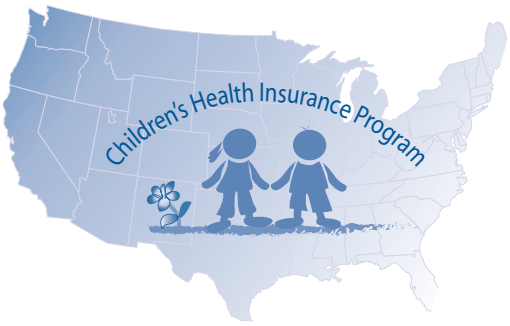

Covering Pregnant Women:
CHIPRA Offers a New Option

The Children's Health Insurance Program (CHIP) was created in 1997 to provide affordable health coverage to low-income children in working families who make too much money to be eligible for Medicaid but not enough to afford private coverage. The program currently covers more than 7 million children. In February 2009, after a protracted political fight, Congress enacted, and President Obama signed, legislation that renewed CHIP through the end of 2013 and expanded its scope. This series of issue briefs examines the new provisions that were included in the reauthorization and how they will affect implementation in the coming months.

When Congress passed the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), it strengthened the nation's commitment to providing women and children with comprehensive, quality health care. Before CHIPRA, federal law did not allow states to enroll pregnant women over age 18 in CHIP. Some states were able to work around that restriction and offered health coverage to pregnant women, but CHIPRA gives states a new option to provide pregnant women with comprehensive health care during pregnancy and for a limited postpartum period, and a simple administrative way to go about it.

Providing CHIP coverage to low-income pregnant women could solve an important problem for families that earn too much for Medicaid but who are unable to afford private insurance that includes maternity coverage. While health reform will help address this issue as well, the new coverage that was included in the health reform law will not be in place in most states until 2014. The CHIPRA provision that expands coverage for pregnant women gives states an option that they can implement now.[1]

Though states are facing budget shortfalls, expanding coverage to pregnant women through the CHIPRA option is cost-efficient and worth pursuing. Maternal and child health advocates have long argued that covering pregnant women increases their access to prenatal care, which improves women's health, helps families deliver healthier babies, and reduces future health care costs that are associated with poor prenatal care. By covering mothers during their pregnancy and for a period of time after giving birth, the new option will reduce the cost of medical care for newborns enrolled in CHIP, and it will save states money.

Expanding Coverage Improves Health and Saves Money

Many low-income pregnant women face barriers to getting the health care they need. Each year, approximately 70,000 women go without any form of prenatal care.[2] These women are more than three and one-half times as likely to have a low birth weight baby—one of the leading causes of infant mortality—and nearly three times as likely to give birth prematurely as other pregnant women.[3] One of the biggest obstacles these women face in getting prenatal care is a lack of health coverage. Among low-income women who receive no prenatal care, 41.5 percent are uninsured.[4]

For decades, the medical community has stressed the importance of prenatal care for keeping a mother and her baby healthy. Timely prenatal care can identify mothers who are at risk of delivering premature or low birth weight infants, and it provides the medical, nutritional, and educational interventions that lead to better birth outcomes.[5] Expanding coverage to previously uninsured pregnant women allows them to get the prenatal care they need. For example, a Florida study showed that expanding a public program to provide more women with access to prenatal care resulted in significantly fewer low birth weight babies compared with low-income women who were not enrolled in public health coverage.[6] By simplifying how states can cover pregnant women who otherwise may not have access to care and ensuring timely access to comprehensive coverage, the CHIPRA option will help women and their children stay healthy.

As states continue to face significant budget shortfalls, it is also important for advocates and policy makers to keep in mind that covering pregnant women in CHIP is cost-effective for states. Providing these women with adequate access to prenatal care means they give birth to healthier babies, who then enter the CHIP program with fewer health problems, which saves states money. Studies have found that every state dollar spent on prenatal care saves states between $2.57 and $3.38 in future medical costs.[7] Thus, expanding coverage for pregnant women is an important investment states can make now that will help them save money down the line.

Coverage for Pregnant Women Prior to CHIPRA

Before CHIPRA, states could cover pregnant women in three different ways, as follows:

1. **Through Medicaid**

   Since 1984, states have been required to provide Medicaid coverage to pregnant women with incomes less than 133 percent of the federal poverty level ($24,352 for a family of three in 2010), with an option to expand this coverage to women with incomes up to 185 percent of poverty ($33,874 for a family of three in 2010).[8] As of March 2010, 37 states and the District of Columbia provide Medicaid coverage to pregnant women with incomes at or above 185 percent of poverty.[9]

2. Through Section 1115 Waivers

When CHIP was created in 1997, it did not include coverage for pregnant women. However, on July 31, 2000, the Clinton Administration issued guidance that, for the first time, allowed states to apply for waivers of federal CHIP law under Section 1115 of the Social Security Act. These waivers allowed states to enroll uninsured parents and pregnant women in CHIP under certain prescribed circumstances.[10]

Section 1115 waivers give states the flexibility to provide comprehensive health benefits to pregnant women throughout their pregnancies, as well as 60 days of postpartum care. However, CHIP funding is capped, and states are required to prioritize coverage for children over coverage for adults in the face of scarce resources. Before CHIP was reauthorized, many states were spending more than their allotments on children's coverage in CHIP and lacked additional CHIP funding to cover pregnant women. Thus, only six states currently cover pregnant women under these waivers (see Table 1 on page 4). CHIPRA makes this route obsolete by prohibiting states from seeking new waivers to cover pregnant women.

3. Through the "Unborn Child" Option

In 2002, the Department of Health and Human Services (HHS) provided an additional means of covering pregnant women when it revised the definition of the term "child" in the CHIP program to include the period from conception to birth.[11] States that elect this option are technically covering the fetus, not the pregnant woman herself. Therefore, only services that are related to pregnancy or conditions that could complicate pregnancy can be covered using this option; a pregnant woman is not covered for services related to her own health that do not affect the fetus. For example, she wouldn't be covered for health care that is related to treating a broken leg. In addition, postpartum services for the mother are not generally included.

Since this option provides coverage only for the fetus, which will be a U.S. citizen when it is born, a woman may receive prenatal care regardless of her immigration status, as long as she meets the other program criteria.

This option has proven to be somewhat more attractive to states, at least in part because it does not involve the bureaucratic complexity of applying for a Section 1115 waiver. As of 2009, 15 states used this option to extend coverage to pregnant women (see Table 1).

Table 1.

Current Options for Providing Coverage to Pregnant Women in CHIP

Coverage Option	Which Services Are Covered?	How Does CHIPRA Change this Option?	Which States Currently Do This?
Pregnant Woman State Plan Amendment	Provides comprehensive medical benefits to the mother and child during pregnancy and 60 days of postpartum care.	CHIPRA authorizes this for the first time. States can use this option concurrently with the Unborn Child State Plan Amendment option (see below).	N/A
Unborn Child State Plan Amendment	Covers the fetus, rather than the pregnant woman. Thus, only services related to the pregnancy or conditions that could complicate the pregnancy are covered. Postpartum services for the mother are not generally included.	CHIPRA allows states to continue using a state plan amendment to cover unborn children in CHIP. States can use this option concurrently with the Pregnant Woman State Plan Amendment option.	AR, CA, IL, LA, MA, MI, MN, NE, OK,* OR, RI, TN, TX, WA, WI
Section 1115 Waivers	States design their own benefits package, which can include comprehensive medical benefits for the mother and fetus during pregnancy and up to 60 days of postpartum care.	CHIPRA prevents any new states from obtaining Section 1115 waivers to cover pregnant women. The six states with existing waivers can choose to continue providing coverage for pregnant women under these waivers, or they can modify the waivers.	CO, ID, NV, NJ, RI, VA

Source: Donna Cohen Ross, Marian Jarlenski, Samantha Artiga, and Caryn Marks, *A Foundation for Health Reform: Findings of a 50 State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP for Children and Parents during 2009* (Washington: Kaiser Family Foundation, December 2009), available online at http://www.kff.org/medicaid/kcmu120809pkg.cfm. Data are as of December 2009.

* Oklahoma invoked this option but has not yet implemented it

Covering Pregnant Women Using the New CHIPRA Option

With the enactment of CHIPRA, states now have three ways to cover pregnant women through CHIP: 1) the pregnant woman state plan amendment option, 2) the unborn child state plan amendment option, and 3) a Section 1115 waiver. (CHIPRA also changes the law to allow federal funds to be used to cover pregnant women who are legal immigrants and have been in the country for fewer than five years. For more information on this provision, see the Families USA brief, *Expanding Coverage for Recent Immigrants: CHIPRA Gives States New Options.*)

States that want to take advantage of the new option to cover pregnant women must meet certain criteria (see "CMS Guidance on Covering Pregnant Women" on page 7 to read more about how states can qualify) and must submit an application to the Centers for Medicare and Medicaid Services (CMS) to amend their current CHIP plans. (See "Resources for States" on page 9 for more information on the application process.)

Choosing the New Option: State Plan Amendments

CHIPRA allows states to easily and effectively provide comprehensive coverage to low-income pregnant women during pregnancy and for 60 days postpartum. The advantage of using a state plan amendment to do so is that it does not require budget neutrality like a Section 1115 waiver does. State plan amendments are also less onerous administratively than waivers, and because they establish coverage as a permanent part of states' CHIP programs, they do not require periodic renewal.

Health coverage that is provided through a state plan amendment effectively "sits on top of" a state's Medicaid coverage that is already in place for pregnant women—it must not displace existing Medicaid coverage for pregnant women. In order to use this new option, states must provide Medicaid to pregnant women with incomes up to at least 185 percent of poverty ($33,874 for a family of three in 2010. (Medicaid law currently requires states to cover pregnant women with incomes up to at least 133 percent of poverty, or $24,352 for a family of three in 2010.) *In addition*, states must provide CHIP to children with family incomes up to at least 200 percent of poverty ($36,620 for a family of three in 2010). Now, 37 states and the District of Columbia already do this and are therefore eligible to apply for a CHIP state plan amendment to further expand coverage for pregnant women (see Table 2 on page 6).[12]

Unlike the unborn child option, this new option provides pregnant women with more comprehensive benefits that include prenatal and delivery care, as well as 60 days of postpartum care. Cost-sharing and benefit rules under this option must be comparable to the rules for children in CHIP.

Under this option, states can also presumptively enroll pregnant women who appear to be eligible for coverage based on their gross incomes. Using "presumptive eligibility" allows women to obtain prenatal care immediately, rather than having to wait for states to make a complete eligibility determination. It also ensures that providers are paid for any services they deliver during the presumptive eligibility period, even if the pregnant woman is subsequently determined not to be eligible for the program. (A presumptive eligibility period lasts for up to 60 days, when the full eligibility determination must be completed for coverage to continue.) Enacting a presumptive eligibility policy may increase the likelihood of pregnant women enrolling in prenatal care by as much as 40 percent, and it may increase their likelihood of obtaining care in the first trimester by as much as 30 percent.[13]

Table 2.

State Upper Eligibility Levels for Children and Pregnant Women, as a Percent of the Federal Poverty Level

State	Pregnant Women Eligibility Levels For Medicaid or CHIP (2009)	Children Eligibility Levels For Medicaid or CHIP (2010)	State	Pregnant Women Eligibility Levels For Medicaid or CHIP (2009)	Children Eligibility Levels For Medicaid or CHIP (2010)
Alabama	133%	300%	Montana	150%	175%
Alaska	175%	175%	Nebraska	185%	185%
Arizona	150%	200%	Nevada	185%	200%
Arkansas	200%	200%	New Hampshire	185%	300%
California	200%	250%	New Jersey	200%	350%
Colorado	200%	205%	New Mexico	235%	235%
Connecticut	250%	300%	New York	200%	400%
Delaware	200%	200%	North Carolina	185%	200%
District of Columbia	300%	300%	North Dakota	133%	160%
Florida	185%	200%	Ohio	200%	200%
Georgia	200%	235%	Oklahoma	185%	185%
Hawaii	185%	300%	Oregon	185%	200%
Idaho	133%	185%	Pennsylvania	185%	300%
Illinois	200%	200%	Rhode Island	250%	250%
Indiana	200%	250%	South Carolina	185%	200%
Iowa	300%	300%	South Dakota	133%	200%
Kansas	150%	241%	Tennessee	250%	250%
Kentucky	185%	200%	Texas	185%	200%
Louisiana	200%	250%	Utah	133%	200%
Maine	200%	200%	Vermont	200%	300%
Maryland	250%	300%	Virginia	200%	200%
Massachusetts	200%	300%	Washington	185%	300%
Michigan	185%	200%	West Virginia	150%	250%
Minnesota	275%	275%	Wisconsin	300%	250%
Mississippi	185%	200%	Wyoming	133%	200%
Missouri	185%	300%			

Sources: Donna Cohen Ross, Marian Jarlenski, Samantha Artiga, and Caryn Marks, *A Foundation for Health Reform: Findings of a 50 State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP for Children and Parents during 2009* (Washington: Kaiser Family Foundation, December 2009); Vern Smith, Dennis Roberts, David Rousseau, and Tanya Schwartz, *CHIP Enrollment June 2009: An Update on Current Enrollment and Policy Directions* (Washington: Kaiser Commission on Medicaid and the Uninsured, April 2010).

What if My State Already Covers Pregnant Women?

States that covered pregnant women through a Section 1115 waiver or the unborn child option prior to the enactment of CHIPRA may continue to do so. In fact, the health reform law requires states to maintain their current eligibility levels in Medicaid and CHIP for pregnant women (as well as other populations) until at least January 1, 2014.

However, states that operate a Section 1115 waiver expansion may choose to forego their waiver and adopt the new state plan amendment option for covering pregnant women in CHIP, if they meet the conditions outlined by CMS (see "CMS Guidance on Covering Pregnant Women" below). This may be advantageous for states, as amending a state plan is less administratively burdensome than maintaining a waiver—it does not require budget neutrality or periodic renewal.

States may opt to use both the unborn child option and the new state plan amendment option to cover pregnant women concurrently, since these options may target different populations. In that case, states must identify which enrollees are in which plans to avoid duplication of payments for services.

CMS Guidance on Covering Pregnant Women

In May 2009, CMS offered guidance on what conditions a state must meet in order to be eligible for the new state plan amendment option, as follows:

- **States cannot use the option to supplant existing coverage.**
  - Only pregnant women who were not eligible for Medicaid as of July 1, 2008, can be covered under this option.
  - States can use this option to cover only pregnant women whose family income is above 185 percent of poverty ($26,955 for a pregnant woman in 2010) or the income level at which the state currently covers pregnant women under Medicaid, whichever is higher.
  - States cannot cover higher-income pregnant women without covering lower-income pregnant women.
- **Children's coverage still must be states' first priority in CHIP.**
  - States cannot cover pregnant women at higher income eligibility levels than they use for children in CHIP.
  - States must cover children with family incomes up to at least 200 percent of poverty ($36,620 for a family of three in 2010) before CMS will approve a state plan amendment for pregnant women.
  - States may not use the state plan amendment option if they impose caps or limitations on enrollment or waiting lists for low-income children in CHIP.

- **Eligible women should not face barriers to enrolling in coverage, and coverage should be affordable.**
  - States cannot exclude pregnant women with pre-existing conditions or require a waiting period for coverage.
  - No cost-sharing is allowed for preventive care or pregnancy-related services.

Why Should States Take up the CHIPRA Option?

As national health reform is implemented, states may be hesitant to cover new populations because of the uncertainty of what lies ahead. In addition, many states are facing unprecedented budget shortfalls. However, there are many reasons why states should move forward with expanding coverage to pregnant women in CHIP regardless of what happens with national health reform, as follows:

- ### Covering pregnant women improves their health and saves states money.
  - By expanding coverage, states can provide prenatal care to thousands of pregnant women who would have otherwise been uninsured.
  - Since the babies born to these women are eligible for Medicaid or CHIP regardless of whether their mothers are covered, it is to the state's advantage to ensure that their mothers have access to comprehensive prenatal care. Covering these mothers means that they give birth to healthier babies, which saves the state money in the long run by reducing health care costs.
  - Research shows that children born to women who receive adequate prenatal care are significantly more likely to receive well-child visits and proper immunizations.[14]
- ### Covering pregnant women can help enroll more kids in CHIP.
  - Children born to mothers who are enrolled in Medicaid or CHIP are automatically enrolled in Medicaid or CHIP for the first year of their life. Therefore, expanding coverage to pregnant women will ensure that more newborns have access to medical care without delay.
- ### Covering pregnant women simplifies family coverage.
  - States can use this option to align eligibility levels for children and pregnant women. As of March 2010, only 14 states plus the District of Columbia offered coverage to pregnant women and newborns at the same eligibility levels (see Table 2).
  - Allowing families to be covered together means everyone in the family gets health care from the same provider network, with the same cost-sharing rules, renewal processes, and other policies. This makes coverage simpler for families and helps them understand and use that coverage.

Conclusion

The state plan amendment option in CHIPRA presents states with an exciting new opportunity to protect the health of low-income women and their babies. This new option is simpler and less administratively burdensome for states to implement, and unlike the unborn child option, it can also be used to provide comprehensive benefits to pregnant women through pregnancy, delivery, and 60 days postpartum. States that take advantage of this new opportunity will help guarantee that uninsured pregnant women with incomes at or above the Medicaid income eligibility thresholds have timely access to the care that they need. Moreover, there are 36 states whose eligibility levels for pregnant women are different from their eligibility levels for children in CHIP. These states in particular should be encouraged to consider taking up this option.[15] This will help ensure that children who are enrolled in CHIP are born healthy, which means states will spend fewer dollars covering them. States that take advantage of this new option can provide comprehensive coverage to those women who need it now, and they can receive full federal funding for this effort once national health reform is implemented.

Resources for States

CMS letter to state health officials on the new option to cover pregnant women:
http://www.cms.hhs.gov/SMDL/downloads/SHO051109.pdf

CMS list of frequently asked questions about the new option:
http://www.cms.hhs.gov/smdl/downloads/SHO090309.pdf

Sample state plan amendment for coverage of pregnant women:
http://www.cms.hhs.gov/SMDL/downloads/SHO051109att.pdf

Endnotes

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[8] When determining income eligibility for pregnant women in Medicaid and CHIP, both the mother and unborn child are counted as members of the household.

[9] Donna Cohen Ross, Marian Jarlenski, Samantha Artiga, and Caryn Marks, *A Foundation for Health Reform: Findings of a 50 State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP for Children and Parents during 2009* (Washington: Kaiser Family Foundation, December 2009).

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[11] 67 *Federal Registe*r 61955, 61974 (Oct. 2, 2002), revising 42 C.F.R. § 457.10.

[12] Kaiser State Health Facts Online, *Income Eligibility Levels for Pregnant Women by Annual Income and as a Percent of Federal Poverty Level (FPL), 2009*, available online at http://www.statehealthfacts.org/comparetable.jsp?ind=206&cat=4, accessed on March 1, 2010.

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[14] Michael Kogan, Greg Alexander, Brian Jack, and Marilee Allen, "The Association between Adequacy of Prenatal Care Utilization and Subsequent Pediatric Care Utilization in the United States," *Pediatrics* 102, no. 1 (July 1998): 25-30.

[15] Kaiser State Health Facts Online, op. cit.

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