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SMFM Special Statement: The Affordable Care Act's foundation of coverage: essential health benefits are essential

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Beginning in January 2014, the Affordable Care Act (ACA) required that all health insurance plans offered by individual and small-group markets, public and private health-care exchanges, and Medicaid include a comprehensive package of essential health benefits (EHBs) and be certified as having them. At a minimum, according to the law and subsequent US Department of Health and Human Services guidance, EHBs must include items and services in 10 categories, one of which is maternity and newborn care.[1]

Before the ACA was enacted in 2010, only 11 states required coverage of maternity benefits in individual health plans. Consequently, only 13% of individual health plans included maternity coverage.[2] Under some plans, past pregnancies were considered a preexisting condition, which disqualified some women; in other cases, maternity care was covered only through costly insurance riders.

Prior to the ACA, one estimate is that only 12% of health plans offered in the individual market included comprehensive maternity benefits.[3] Because nearly one half of all pregnancies are unplanned, some women would find themselves in insurance plans that lacked maternity coverage.

For women without any insurance coverage, the cost of maternity care is high. Maternity care, including labor, delivery, and postpartum care, has been estimated to cost more than one half of a woman's annual income. In 2010, the cost of an uncomplicated vaginal birth was $15,300 and that of a cesarean delivery was $20,400, adjusted for inflation.[4] Pregnancies with complications cost even more. For example, pregnancy-related hypertension, which affects up to 10% of pregnant women,[5] could cost an uninsured patient $18,562, and a postpartum hemorrhage could cost an additional $21,275.[6]

Before the advent of the ACA, even women with maternity care coverage could be exposed to high deductibles, coinsurance, or prolonged waiting periods to use available benefits, further shrinking access to maternity care. Moreover, some insurance plans did not cover all services related to pregnancy and delivery, or some maternity care providers were not within an approved list of providers. One example involves obstetric anesthesia. Women were often surprised to discover that anesthesia or analgesia given during labor and delivery was not covered by their plan, leading to thousands of dollars in charges following their hospital stay.

The ACA's maternity care provision was a welcome addition and includes coverage for prenatal, labor and delivery, and postpartum services. This mandatory benefit for maternity and newborn care as part of the ACA represents a considerable advance for women's health.

In addition to prenatal and postpartum care, delivery, and inpatient services for maternity care, the ACA also includes contraception services as an EHB, which have been demonstrated to benefit maternal and child health through the optimal spacing of pregnancies. An additional benefit mandated by the ACA is that these critical preventive services are covered fully without patient out-of-pocket costs (see Table). Thus, the ACA represents a major step forward for expanded access to affordable maternity care for eligible individuals.

Expansion of coverage to include maternity and newborn care, and the resultant health gains made by women following implementation of the ACA, has been associated with numerous economic and long-term health benefits, with substantial financial returns on investment.[3] For instance, Oregon recently expanded access to prenatal care for unauthorized immigrant women through the Emergency Medicaid Plus program. One study found that after the program was adopted, the number of prenatal visits, Tdap vaccinations, diabetes screenings, and well-child checks increased, and the probability of delivering extremely low-birth-weight infants and the infant mortality rate decreased among this population.[7] Expanding prenatal coverage for both mother and baby and providing preventative care during the postpartum period can also benefit the taxpayer. The monetary benefits of ensuring maternal and newborn care can be seen in the return on investment for contraception, in which spending $1 of public family-planning funding saves $3.74 in pregnancy-related costs for taxpayers.[8]

Since the implementation of the ACA, women are self-reporting that it is much easier to find an affordable plan in the marketplace and are consequently maintaining insurance at higher rates. Prior to the enactment of the ACA, one third of women surveyed by the Pregnancy Risk

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TABLE
Selected United States Preventive Services Task Force (USPSTF) A and B pregnancy-related recommendations[a,b]

Topic	Description
Bacteriuria screening	The USPSTF recommends screening for asymptomatic bacteriuria with urine culture in pregnant women at 12–16 weeks of gestation or at the first prenatal visit, if later.
Breastfeeding interventions	The USPSTF recommends providing interventions during pregnancy and after birth to support breastfeeding.
Folic acid supplementation	The USPSTF recommends that all women who are planning or capable of pregnancy take a daily supplement containing 0.4–0.8 mg (400–800 μg) of folic acid.
Gestational diabetes mellitus screening	The USPSTF recommends screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation.
Gonorrhea prophylactic medication (newborns)	The USPSTF recommends prophylactic ocular topical medication for all newborns for the prevention of gonococcal ophthalmia neonatorum.
Hemoglobinopathies screening (newborns)	The USPSTF recommends screening for sickle cell disease in newborns.
Hepatitis B screening	The USPSTF strongly recommends screening for hepatitis B virus infection in pregnant women at their first prenatal visit.
HIV screening	The USPSTF recommends that clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown.
Hypothyroidism screening (newborns)	The USPSTF recommends screening for congenital hypothyroidism in newborns.
Intimate partner violence screening	The USPSTF recommends that clinicians screen for intimate partner violence in women of reproductive age and provide or refer women who screen positive to ongoing support services.
Phenylketonuria screening (newborns)	The USPSTF recommends screening for phenylketonuria in newborns.
Aspirin for preeclampsia prevention	The USPSTF recommends the use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia.
Preeclampsia screening	The USPSTF recommends screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.
Rh incompatibility screening	The USPSTF strongly recommends Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.
Rh incompatibility screening	The USPSTF recommends repeated Rh (D) antibody testing for all unsensitized Rh (D)–negative women at 24–28 weeks of gestation, unless the biological father is known to be Rh (D) negative.
Tobacco use counseling	The USPSTF recommends that clinicians ask all pregnant women about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant women who use tobacco.
Syphilis screening	The USPSTF recommends that clinicians screen all pregnant women for syphilis infection.

USPSTF, US Preventive Services Task Force.

[a] US Preventive Services Task Force. USPSTF A and B recommendations. February 2019. Available at: https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/. Accessed April 4, 2019; [b] Health Resources and Services Administration. Women's preventive services guidelines. October 2017. Available at: https://www.hrsa.gov/womens-guidelines-2016/index.html. Accessed April 5, 2019.

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Assessment Monitoring System reported instability in their insurance status around the time of pregnancy.[9] Eighteen percent of women were uninsured in 2013[10]; after the ACA, this percentage was reduced to 11%.[11]

Additionally, states that have expanded Medicaid experienced a 4.7% decrease in uninsured rates for women compared with states that did not expand coverage.[12,13] Since the implementation of the ACA, women have taken advantage of the benefits afforded to them.

Although benefits vary from state to state, the ACA mandates that at a minimum outpatient and inpatient care must be covered.[12] This type of care can include services such as hospital charges, obstetric care, anesthesia, laboratory tests, prescriptions, and radiology.[14]

Additionally, the ACA also expanded women's health care by requiring coverage for certain preventive care services without patient cost sharing.[15] Health plans must cover these services without copayment, coinsurance, or deductible for in-network services. Preventive services that must be covered without copayment include the following:

- Grade A or B recommendations of the US Preventive Services Task Force (USPSTF)
- Preventive services for women identified by the Health Resources and Services Administration (HRSA) and the Institute of Medicine
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
- Preventive care and screenings for infants, children, and adolescents supported by HRSA
- Preventive care and screenings for women added under the Women's Health Amendment of the ACA

The Women's Health Amendment was intended to fill gaps in preventive care and screening services that were not included in the USPSTF A and B recommendations but were available at the time the amendment was finalized. These services include well-woman visits; screening for gestational diabetes; human papillomavirus DNA testing; counseling for sexually transmitted infections; counseling and screening for HIV; contraceptive methods and counseling; breastfeeding support, supplies, and counseling; and screening and counseling for interpersonal and domestic violence.

Many preventive services identified by HRSA are also crucial components of prenatal care,[16] including annual well-woman visits; testing for sexually transmitted infections, such as human papillomavirus and HIV; screening for pregestational and gestational diabetes; and counseling about breastfeeding, contraception, postpartum depression, and domestic violence.[17]

Benefits of maternal and newborn care as an EHB

The benefits of maintaining maternal and newborn care as an EHB can be seen throughout the life of the child. A study on the effects of the Medicaid expansion in the United States for cohorts of individuals born between 1979 and 1993 examined whether increased eligibility for prenatal Medicaid coverage influenced subsequent health outcomes when they became adults. It was found that when children whose mothers became eligible for Medicaid during the prenatal period reached adulthood, they had lower rates of obesity and fewer preventable hospitalizations throughout their lifetime. Furthermore, individuals in this cohort had higher rates of high school graduation and less reliance on public assistance as adults compared with those who were eligible for Medicaid for fewer years of childhood.[18]

While there may be greater up-front costs to providing access to maternity and newborn care through Medicaid and private or individual plans, the costs of health care across the life span are reduced. When individuals are set up for success at birth because of improved pregnancy outcomes, lower stress, and more frequent physician visits and regular immunizations,[19] their lives are predicted to be healthier and less costly to the community. Maternity and newborn care benefits the mother, the child, and society for decades to come.

Consequences of not covering maternal and newborn care as an EHB

There is significant concern that either repeal or revision of the ACA could eliminate or erode EHBs, including maternity and newborn care. Removal of these benefits would sharply limit access to care and would have a negative impact on the current and future health outcomes for women and their babies.[7]

Removal of maternity and newborn care as an EHB could prompt more healthy individuals to leave the insurance pool, thus reducing the number of less risky individuals (defined as adverse selection) and further increasing insurance prices. Adverse selection also may occur following the repeal of the individual mandate to purchase insurance that took effect in January 2019, which may lead to an unraveling of the insurance market.

These changes could be problematic because 45% of pregnancies in the United States are unplanned.[20] About 43 million women of reproductive age (70%) are at risk of unintended pregnancy; that is, they are sexually active and could become pregnant without correct and consistent use of contraception.[21] These women may elect to drop coverage on the chance that they will not become pregnant. However, in 2010, 1.5 million unplanned births were covered by US public insurance programs.[22] It is in the taxpayer's best interest for women in this category to maintain insurance coverage and enter pregnancy as healthy as possible because of the long-term costs related to unplanned and complicated pregnancies.

Additionally, maternity care accounts for only 3% of insurance premiums.[23] Removing maternity care as an EHB would not reduce financial costs as greatly as other options. Furthermore, eliminating maternity care would undermine maternal and infant health by making it harder for women to receive preventative care during pregnancy or manage complications after delivery.

The United States' rising rates of maternal and infant mortality is a challenge, with widening gaps in disparities and higher rates among black women.[24] According to the World Health Organization, "ensuring universal health coverage for comprehensive reproductive, maternal, and newborn care"[25] is critical to reducing these rates.

Removing maternity and newborn care as an EHB would be an enormous step backward and would contribute to an already alarming public health problem.

Finally, inadequate and unequal provision of maternity care leads to persistent and worsening disparities, which disproportionately affects women living in certain states. As was seen after the Supreme Court decision regarding Medicaid expansion,[26] allowing individual states to decide which services should be covered leads to inequitable care for women across the country.

These problems would be compounded should maternity and newborn care be removed as an EHB. For instance, in New York (which chose to expand Medicaid coverage), noncovered pregnancy benefits include midwifery services and childbirth classes.[27] In Texas (which chose not to expand Medicaid coverage), coverage is notably sparser.[28] EHBs must have clear and consistent frameworks across the nation to provide equitable care and reduce health disparities.

Call to action

Maternity care is crucial because (1) it establishes a healthy start to a child's life, and (2) it serves as a critical time period or window in a woman's life to positively influence her future health. As such, optimal care during pregnancy and afterward for women and children has a tremendous impact on the health of our nation.

Maternity and newborn care must remain an EHB covered by the individual marketplace, Medicaid, and private insurance plans. The benefits of maintaining this designation have immediate implications not only for women but also for children throughout their life span. The cost to employers and the nation if maternal and newborn care is removed as an EHB is staggering, as can be gleaned from the gains in health and health care that have been made since the adoption of the ACA.[29]

Coverage for pregnancy and neonatal care should be viewed as a long-term investment in the health and well-being of the nation. It is the position of the Society for Maternal-Fetal Medicine that the decision to remove maternal and newborn care as an EHB would compromise our nation's health and is fiscally counterintuitive.

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