

Without Maternity Coverage

The Need for Special Enrollment in
the Health Insurance Marketplaces
during Pregnancy

Christina Postolowski
December 2014



YOUNG**INVINCIBLES**



Acknowledgements

A special thanks to Aaron M. Smith for his research and assistance with this project.

About Young Invincibles

Young Invincibles is a non-partisan, non-profit organization that works to expand economic opportunity for young adults -- ages 18 to 34 years-old -- through policy analysis and advocacy. With offices in six major cities across the country, its research and organizing experts seek to elevate the voices of young adults in top policy debates, and provide solutions to major economic challenges for the Millennial generation.



Table of Contents

Introduction	4
Women Need Maternity Care	4
Preeclampsia	5
Placental Abruption	5
Complications from Diabetes	5
Complications from Heart Disease	6
Graves' Disease	6
Health Plans Without Maternity Coverage	7
Grandfathered Plans	7
Transitional Plans	7
Job-Based Dependent Coverage	8
Self-Funded Student Health Plans	8
Eligibility for Pregnancy-Related Medicaid	8
Eligibility for Marketplace Coverage	9
Policy Recommendations	9
Factors in Favor of Special Enrollment for Pregnancy	10
The Adverse Selection Problem	10
Recommendations	11
Endnotes	13

Introduction

Eighty-three percent of new mothers are between the ages of 18 and 34 – so maternal health care is a critical issue for many young adults.¹ Before the Affordable Care Act (ACA), the majority of health insurance plans sold on the individual market did not cover maternity care.² Maternity care and delivery is expensive, ranging from \$10,000 to \$20,000 without complications.³ Pregnant women who were uninsured or insured under a plan that did not include maternity care might have to pay out-of-pocket – or forgo maternity care services altogether.

The ACA sought to change this, by making maternity care one of 10 Essential Health Benefits (EHBs) that must be covered by plans sold on the individual and small group markets starting in 2014.⁴ The Department of Health and Human Services (HHS) estimated that 8.7 million women would gain access to maternity coverage thanks to the law.⁵ Today, maternity care is a covered benefit in all plans sold on the new health insurance marketplaces, as well as most job-based plans.⁶

Despite the steps forward, some pregnant women still do not have access to maternity care because they lack coverage or their health plan is exempt from the ACA's EHB requirement. Some women in this scenario can enroll in pregnancy-related Medicaid. Others, however, remain left in the same position as millions of women before the ACA – lacking access to covered maternity care. This can result in dire health and financial consequences. To fix the problem, we recommend making pregnancy a qualifying life event that allows pregnant women to enroll in new health insurance coverage through the marketplaces.

The following sections will look at why women need maternity care; what health plans still may not be covering maternity care post-ACA; and policy recommendations for ensuring all pregnant women can access and afford the care they need.

Women Need Maternity Care

Maternity care can mitigate or prevent health risks associated with pregnancy. According to the Centers for Disease Control (CDC), “[e]arly initiation of prenatal care by pregnant women, and continuous monitoring of pregnancy by health providers, are key to preventing pregnancy-related complications and death.”⁷ Several studies have looked at the potential of prenatal care to reduce pre-term births and improve birth outcomes.⁸ Fewer studies have focused on the maternity care’s potential benefits to women⁹ – which will be the focus of our discussion here. Specific diseases that pose health risks to pregnant women that could be mitigated by maternity care include: preeclampsia, placental abruption, diabetes, heart conditions, and Graves’ disease. While some of these conditions are rare, their consequences can be severe or even fatal for the mother, fetus, or both. And the costs of paying for pregnancy complications can be crippling without maternity coverage – reaching tens of thousands of dollars.¹⁰

Preeclampsia

Preeclampsia is a pregnancy-induced disease associated with elevated blood pressure (hypertension) and kidney damage,¹¹ and impacts five to eight percent of all births in the US.¹² The disease can be life-threatening for the mother and/or fetus.¹³ Preeclampsia is diagnosed by the elevation of the expectant mother’s blood pressure combined with excessive protein in her urine¹⁴ – blood pressure and urine screens that detect proteins are part of prenatal exams. A women’s condition can go from mild to severe very quickly,¹⁵ so monitoring of the mother’s blood pressure at prenatal visits is key to detecting and treating the disease. Consequently, the U.S. Preventive Services Task Force (USPSTF) recommended that all pregnant women get screened for preeclampsia periodically throughout pregnancy.¹⁶

Preeclampsia screenings are low cost and can reduce the chances of paying for more expensive pregnancy-related complications.¹⁷ HHS’s Healthcare Cost and Utilization Project (HCUP) found that in 2012, pregnancy-related hypertension costs an uninsured patient, on average, \$18,562.¹⁸ Additionally, women with preeclampsia stay in the hospital longer and are more likely to have a Cesarean section (C-section) than women without the disease – both of which increase medical costs.¹⁹

Placental Abruption

Placental abruption, which affects approximately one percent of pregnancies, occurs when the placenta separates from the wall of the uterus before delivery.²⁰ Abruption can lead to: shock due to blood loss, problems with blood clotting, kidney failure, removal of the uterus after delivery, or death.²¹ While placental abruption often occurs suddenly, doctors can identify many risk factors during routine maternity care, including: blood pressure disorders, abnormalities in the amount of amniotic fluid, inflammation or rupture of the membranes surrounding the fetus, and preeclampsia.²²

As with preeclampsia, routine maternity care that screens for risk factors for placental abruption is likely to be less expensive than the medical complications placental abruption causes. For example, HCUP found that in 2012, the average charge for an uninsured patient for a hemorrhage during pregnancy was \$21,275.²³ For a young mother without maternity coverage, this cost could be financially devastating.

Complications from Diabetes

The American Diabetes Association recommends comprehensive prenatal care to protect the health of the mother and fetus from diabetes-related complications during pregnancy.²⁴ Approximately one third of women of childbearing age who have diabetes are undiagnosed.²⁵ Diabetes during pregnancy is associated with increased risk for: miscarriages and stillbirths,

abnormally large fetuses and resulting delivery complications, intrauterine developmental and growth abnormalities, and later development of obesity and type 2 diabetes in the child.²⁶ Treatment to normalize maternal blood sugar throughout pregnancy is necessary to reduce the likelihood of complications.²⁷ In addition to undiagnosed diabetes, between three and eight percent of pregnant women develop diabetes during pregnancy (gestational diabetes).²⁸ Like other forms of diabetes, gestational diabetes increases the risk of adverse consequences for both mother and fetus and requires treatment during pregnancy to reduce complications.²⁹

In 2012, diabetes-induced complications to pregnancy or childbirth cost uninsured patients \$13,758 on average.³⁰ A 2008 report found that women with pre-existing diabetes complicating pregnancy were more than twice as likely to get a C-section than women without the condition, and more likely to be hospitalized for treatment of complications outside of delivery³¹ – both of which increase costs.

Complications from Heart Disease

Heart disease is one of the leading causes of maternal death.³² Previously undiagnosed heart diseases can present symptoms for the first time during pregnancy, allowing the disease to be diagnosed.³³ Routine prenatal examinations can detect these symptoms, such as increased blood pressure and heart murmurs.³⁴ Similar to gestational diabetes, life-threatening heart disease can also develop as a new disease related to pregnancy.³⁵ As one medical journal states, “[the prevalence of heart disease in pregnant women and its potentially life-threatening consequences justify a careful . . . physical examination in all pregnant women.”³⁶

Graves’ Disease

Graves’ disease is an autoimmune disease that causes overproduction of thyroid hormones (hyperthyroidism),³⁷ which if untreated, can lead to pregnancy complications including miscarriage, preeclampsia, and maternal death.³⁸ Graves’ disease is thought to affect as many as three million people in the US,³⁹ and is most likely to affect young women between the ages of 20 and 40 – the age range when the majority of childbirths take place.⁴⁰ Because the symptoms of Graves’ disease often worsen in the first trimester, the disease (if previously undiagnosed) may be more likely to be detected during pregnancy.⁴¹ Moreover, as with diabetes and heart disease, pregnancy might trigger Graves’ disease in some women.⁴² Untreated or poorly treated Graves’ disease can lead to health complications during pregnancy, such as preeclampsia, preterm birth, placental abruption, miscarriage, and heart failure.⁴³ HHS advises that because “[t]he treatment needs of pregnant women with Graves’ disease often change, and an experienced doctor is needed to manage treatment during and after pregnancy.”⁴⁴

Pregnancy-related diseases and complications can pose significant health risks to the pregnant woman and fetus. Maternity care is key to early detection of these complications, which can both improve women’s health outcomes and reduce their out-of-pocket medical costs. While

more health plans cover maternity care thanks to the ACA, too many still do not.

Health Plans Without Maternity Coverage

Before the ACA, most employer-sponsored health plans included maternity coverage, but the majority of individual market plans did not.⁴⁵ While the ACA greatly increased the number of plans covering maternity care – by requiring all individual and small group plans to cover maternity care as an EHB – gaps in maternity coverage still persist. Women covered under grandfathered and transitional health plans, as a dependent on a parent’s employer-sponsored plan, or on self-funded student health plans still may not have maternity coverage. Some of these women may be able to enroll in pregnancy-related Medicaid and get access to maternity coverage if they meet their state’s income-eligibility requirements. However, women who do not qualify for pregnancy-related Medicaid may not be able to get on an insurance plan that covers maternity care while they are pregnant. As a result, these women may have to pay for maternity care out-of-pocket and/or forgo needed care – putting both their health and economic well-being at risk.

Grandfathered Plans

The ACA grandfathered in certain individual and job-based plans that existed before, and have not changed since, the ACA was signed into law. These grandfathered plans do not have to cover EHBs, like maternity care.⁴⁶ While we do not know exactly how many women have a grandfathered plan that excludes maternity care, we have a general idea about the proportion of plans in the individual and group markets with grandfathered status. In 2010, HHS estimated that based on turnover in the individual insurance market, 40 to 67 percent of individual plans would no longer be grandfathered by 2014 – meaning that 33 to 60 percent of individual market plans may still be grandfathered today.⁴⁷ Similarly, Kaiser Family Foundation’s 2014 Employer Health Benefits Survey found that 35 percent of covered workers at small firms were enrolled in a grandfathered plan.⁴⁸

Transitional Plans

In addition to grandfathered plans, the Administration gave states the option of letting insurers continue individual and small group plans that would otherwise have been cancelled in 2014, because they did not comply with ACA standards, until October 1, 2017.⁴⁹ These “transitional plans” are not required to cover maternity care.⁵⁰ Thirty-five states are allowing issuers to continue transitional plans for one or more years, and 21 states are allowing issuers extend these plans through 2017.⁵¹ We do not know how many women are covered on a transitional plan without maternity coverage. However, experts estimated that six to 10 million consumers got plan cancellation notices in 2013⁵²; a proportion of these consumers could now be covered on a transitional plan, if their cancelled plan was continued and they reenrolled in that plan.

Job-Based Dependent Coverage

Additionally, women covered as a dependent on a parent's job-based health plan may not have maternity coverage.⁵³ While the ACA's EHB requirements do not apply to large employer plans,⁵⁴ the Pregnancy Discrimination Act (PDA) of 1978 requires employers with 15 or more employees to cover maternity care for workers and their spouses.⁵⁵ However, the law does not require employers to cover maternity care for workers' non-spouse dependents.⁵⁶ In June 2013, the National Women's Law Center (NWLC) filed administrative complaints with HHS's Office of Civil Rights (OCR) against five institutions that exclude maternity coverage for non-spouse dependents under Section 1557 of the ACA, which bars sex discrimination in health care plans.⁵⁷ Pending resolution of these complaints by OCR, there may still be employer plans that don't cover maternity care for non-spouse dependents. Although we do not know how many companies still do not offer dependent maternity coverage, we do know that more than 1 million women ages 19 to 24 gave birth in 2012,⁵⁸ and there are an estimated 15 million young adults ages 19 to 25 who are covered under a parents health insurance policy.⁵⁹

Self-Funded Student Health Plans

Women with self-insured or self-funded student health plans (SHPs) may not have access to maternity coverage in 2015 or beyond. Self-funded student health plans (SHPs) are not required to cover EHBs, including maternity care.⁶⁰ Yet, in 2013, the Administration issued a final rule designating all self-funded SHPs beginning on or before December 31, 2014 as meeting the ACA's minimum essential coverage (MEC) requirement⁶¹ – even if they do not offer comprehensive coverage that includes maternity care.⁶² Currently, some self-funded SHPs do offer maternity benefits,⁶³ but others may not.⁶⁴ Starting in 2015, new or renewing self-funded SHPs will have to apply to HHS to be considered MEC. While HHS will presumably require coverage of EHBs like maternity care for plans to be designated MEC, the final rule does not explicitly say so⁶⁵; nor is it certain that all self-funded SHPs may apply for the MEC designation. This means that women with self-funded SHPs could be left without maternity coverage beyond the 2014-2015 plan year. More than 300,000 students at an estimated 30 universities are covered by self-funded student plans.⁶⁶

Eligibility for Pregnancy-Related Medicaid

Women who are uninsured or have a grandfathered, transitional, or other plan that does not cover maternity care – referred to hereinafter as non-maternity plans – may be able to get maternity care while they're pregnant by signing up for pregnancy-related Medicaid. Pregnancy-related Medicaid, which is available in all 50 states, covers maternity care, delivery, and postpartum care for 60 days after childbirth.⁶⁷ Women can enroll in pregnancy-related

Medicaid at any time, but have to meet their state's income requirements for the program to be eligible. The income threshold to be eligible for pregnancy-related Medicaid varies by state, ranging from 133 percent of the federal poverty level (FPL) in South Dakota to 375 percent of FPL in Iowa⁶⁸ – anywhere from about \$15,520 to \$43,760 for an individual, or \$20,920 to \$58,990 for a household of two.⁶⁹

In states with lower income-eligibility thresholds for pregnancy-related Medicaid, a woman could find herself slightly above the qualifying income level – but still unable to pay for maternity care out of pocket. For example, in thirteen states a pregnant woman has to make less than 167 percent of the poverty level – or about \$19,490 for a single person – to qualify for Medicaid. While a pregnant woman earning \$20,000 annually would not qualify for Medicaid in these states, it's also unlikely that she would be able to pay \$10,000 – or half of her annual salary – out-of-pocket for her maternity care and delivery. Without access to affordable health insurance coverage through the marketplace, she might face the choice of going without needed care or going into significant medical debt to get it.

Eligibility for Marketplace Coverage

All plans sold on the health insurance marketplaces cover EHBs, including maternity care. In contrast with pregnancy-related Medicaid, there are no income eligibility requirements to buy a plan on the marketplaces, but there are time restrictions on when one can do so. Consumers can enroll in a market place plan (a) through the marketplace's annual open enrollment period, or (b) through a 60-day special enrollment period (SEP) following a qualifying life event. The open enrollment period for the marketplaces is approximately three months long; if a woman without maternity coverage learns that she is pregnant during this three-month window, she can sign up for marketplace plan with maternity care. However, if this woman learns that she is pregnant during the other nine months of the year (outside of open enrollment), she could not enroll in marketplace plan to get maternity coverage.⁷⁰ That's because despite the availability of special enrollment in the health insurance marketplaces for a variety of life events, including childbirth, there is no SEP for pregnancy.⁷¹ This means that a woman can get a SEP to sign up for marketplace coverage within 60 days *after* she gives birth, but cannot sign up for coverage *while* she is pregnant.

Policy Recommendations

If a woman does not qualify for pregnancy-related Medicaid and becomes pregnant outside of the marketplace open enrollment period, she may not be able to sign up for health insurance while she's pregnant. If she is uninsured or has a non-maternity plan, she may not have access to maternity coverage – potentially putting her health and finances in jeopardy during her pregnancy. To avoid this, we propose making pregnancy a qualifying life event that triggers a SEP in the marketplaces. The serious health risks and high costs associated with pregnancy complications, continued existence of plans that do not cover maternity care, and fact that half

of pregnancies are unplanned weigh in favor of a marketplace SEP for pregnancy. While insurers historically have not allowed special enrollment for pregnancy due to concerns about adverse selection and risk-pool destabilization, the decreasing numbers of women without insurance and plans that do not offer maternity coverage post-ACA mitigate these concerns.

Factors in Favor of Special Enrollment for Pregnancy

Factors weighing in favor of a SEP for pregnancy include: (1) the high cost of maternity care; (2) the severe health risks associated with undiagnosed or untreated pregnancy-related diseases; (3) the continued existence of plans that do not cover maternity care; and (4) the fact that half of pregnancies are unplanned. As noted above, without insurance, maternity care and delivery can cost \$10,000 to \$20,000 without complications⁷² – with complications these procedures could cost tens of thousands of dollars.⁷³ The financial cost to a young parent of paying for maternity care and delivery out-of-pocket could be devastating.

Moreover, if a woman does not have access to an insurance plan that covers maternity care, she may forgo certain prenatal care because she cannot afford it. As discussed above, prenatal visits are crucial for detecting rare but severe diseases that can be caused by or diagnosed during pregnancy – including preeclampsia, placental abruption, diabetes, heart conditions, and Graves' disease. If untreated, these diseases can lead to severe morbidity or death of the mother and/or fetus. In fact, the American College of Obstetricians and Gynecologists (ACOG) estimates that “pregnancy-related maternal mortality is 3-4 times higher among women who receive no prenatal care compared to women who receive prenatal care.”⁷⁴

Furthermore, as discussed in the previous section, there are still several health insurance plans that may not cover maternity care. These include grandfathered and transitional health plans, employer plans that do not provide maternity coverage to non-spouse dependents, and certain self-funded student plans. A woman who is not planning on becoming pregnant may not know that her plan does not cover maternity care until she is already pregnant – and it is too late to sign up for marketplace coverage during open enrollment.⁷⁵

Finally, about 50 percent of pregnancies are unplanned.⁷⁶ If a woman (a) was planning on becoming pregnant and (b) knew that her plan did not cover maternity care, she could theoretically wait until the next marketplace open enrollment period, sign up for a new health plan covering maternity care, and then become pregnant. However, this is not the reality for at least half of women. A woman might need a SEP when she becomes pregnant precisely because she was not planning on becoming pregnant.

The Adverse Selection Problem

Given these considerations, how come there is not a special enrollment opportunity in the marketplaces already? Insurers' main objection to creating an SEP for pregnancy is that it could

incentivize women to wait to sign up for health insurance until they become pregnant and need it to cover prenatal care and delivery. This is a problem known as adverse selection, which occurs when a product is only used by people who offer the worst return on investment.⁷⁷ If women wait until they become pregnant to get insurance, it could cost insurers more to cover those women (due to the expenses associated with maternity care), and the costs of doing so would have to be offset by other enrollees requiring fewer health care services and/or the insurers themselves. Adverse selection is a real concern in the health insurance industry and can lead to instability and/or increased costs for all consumers in the risk pool.⁷⁸

However, the decreasing number of women without insurance, and the decreasing number of plans that do not offer maternity coverage, means fewer women will need a SEP for pregnancy. This significantly reduces concerns about risk pool destabilization and premium increases.

The uninsured rate has been declining nationwide since the ACA's enactment,⁷⁹ and it is estimated that by 2019, health care reform could reduce the number of uninsured in the US by 32 million.⁸⁰ Several factors drive the trend, including the end of pre-existing condition discrimination (insurers can no longer deny coverage to people with pre-existing conditions), the availability of financial help to purchase insurance for many low- and middle-income families, and the individual mandate (the federal requirement to have insurance coverage). The availability of discounted coverage – and the annual penalty for those who fail to get covered – make it less likely that uninsured women will wait until they get pregnant to get insured, reducing the risk of adverse selection.

Additionally, since the ACA's enactment, the number of plans that do not cover maternity care has decreased,⁸¹ and this number will continue to fall over the next few years. In particular, people will not be able to enroll in transitional plans after October 2017, which could reduce the potential number of women who might seek a SEP because their plan does not cover maternity care. Similarly, the number of people in grandfathered plans, particularly in the individual market, is expected to decrease – as individuals in grandfathered plans switch to other individual or job-based coverage, and as insurers make certain changes to grandfathered plans that cause those plans to lose their grandfathered status.⁸²

Recommendations

Young Invincibles recommends that HHS create a SEP for pregnancy in the federal marketplace, and encourage state marketplaces to adopt a similar SEP, considering the severe health and financial consequences that can arise if women does not have maternity coverage, and the relatively small number of women who would seek an SEP for pregnancy.

Section 155.420(d) of Title 45 of the Code of Federal Regulations lists the qualifying life events that trigger a SEP in the health insurance marketplaces. In addition to the qualifying events listed in the regulation, HHS has the authority to provide for additional SEPs in the federal marketplace and encourage state marketplaces to adopt the same. To date, HHS has

added limited duration (e.g. in 2014 only) or permanent SEPs for a variety of qualifying events, including SEPs for: people eligible for or enrolled in COBRA coverage⁸³; people beginning or ending service in the AmeriCorps, VISTA, or National Civilian Community Corps programs⁸⁴; system-related, technical, and display errors⁸⁵; people with individual plans renewing outside of the open enrollment period⁸⁶; and people who lose a hardship exemption (an exemption from the requirement have coverage) during the year.⁸⁷

HHS has exercised its regulatory authority to add SEPs to ensure that people who do not have comprehensive coverage can enroll in a comprehensive marketplace plan. Women who find themselves pregnant and uninsured or with a plan that does not cover maternity care should have the same opportunity to access comprehensive coverage through the marketplaces. The ACA sought to expand access to maternity and newborn care because of the recognized health benefits of this coverage⁸⁸ – HHS should ensure that all women have access to this potentially life-saving maternity care.

End Notes

1. *Young Adults More Likely to Qualify for Special Enrollment* (Washington, DC: Young Invincibles, 2014), 3, accessed December 14, 2014, <http://younginvincibles.org/wp-content/uploads/2014/04/Young-Adults-and-Special-Enrollment-FINAL.pdf>.
2. *E.g. Turning To Fairness: Insurance discrimination against women today and the Affordable Care Act* (Washington, DC: National Women's Law Center (NWLC), 2012), 4, accessed December 14, 2014, http://www.nwlc.org/sites/default/files/pdfs/nwlc_2012_turningtofairness_report.pdf; "The Affordable Care Act and Women," US Department of Health and Human Services (HHS), last reviewed on November 5, 2014, <http://www.hhs.gov/healthcare/facts/factsheets/2012/03/women03202012a.html>.
3. *See, e.g.*, "What It Costs to Have a Baby," WebMD, last reviewed on March 04, 2013, <http://www.webmd.com/baby/features/cost-of-having-a-baby?page=2>; Shelley Frost, "Tips for Pregnant Women With No Health Insurance," *Livestrong.com*, last updated February 19, 2014, <http://www.livestrong.com/article/156581-tips-for-pregnant-women-with-no-health-insurance/>; Heidi Murkoff, "Pregnant and Uninsured," *What To Expect.com*, accessed December 14, 2014, <http://www.whattoexpect.com/pregnancy/ask-heidi/pregnant-and-uninsured.aspx>. The Healthcare Cost and Utilization Project (HCUP) found that the average cost for someone who is uninsured of a "normal" pregnancy and delivery is \$11,526. Data derived from: "Charges, \$ (mean) for multiple specific diagnoses," accessed December 17, 2014, <http://hcupnet.ahrq.gov/HCUPnet.jsp>.
4. *See, e.g.*, "Additional Information on Proposed State Essential Health Benefits Benchmark Plans," The Center for Consumer Information & Insurance Oversight (CCIIO), CMS.gov, accessed December 14, 2014, <http://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html>; "What Marketplace health plans cover," *Healthcare.gov*, accessed December 14, 2014, <https://www.healthcare.gov/coverage/what-marketplace-plans-cover/>.
5. Office of the Assistance Secretary for Planning and Evaluation (ASPE), *Essential Health Benefits: Individual Market Coverage* (Washington, DC: HHS, 2011), <http://aspe.hhs.gov/health/reports/2011/individualmarket/ib.shtml>.
6. The EHB requirement applies to non-grandfathered plans sold on the individual and small group markets. Sarah Barr, "FAQ: Grandfathered Health Plans," *Kaiser Health News* (KHN), November 13, 2013, <http://kaiserhealthnews.org/news/grandfathered-plans-faq/>. While large group plans do not have to cover the EHBs, state and federal anti-discrimination laws required most employer-based plans to cover maternity care before the ACA. Anna Benyo, "Misleading CBS Reporting of Maternity Benefits in the Affordable Care Act," *NWLC Blog*, October 30, 2013, <http://www.nwlc.org/our-blog/misleading-cbs-reporting-maternity-benefits-affordable-care-act>.
7. "Pregnancy-Related Deaths," Centers for Disease Control and Prevention (CDC), accessed December 14, 2014, <http://www.cdc.gov/reproductive-health/maternalinfanthealth/pregnancy-related-mortality.htm>.
8. *See, e.g.*, Committee to Study the Prevention of Low Birthweight, Institute of Medicine (IOM), *Preventing Low Birthweight* (Washington, DC: National Academies Press, 1985), <http://www.ncbi.nlm.nih.gov/books/NBK214456/>; McLaughlin et al., "Randomized Trial of Comprehensive Prenatal Care for low-Income Women: Effect on Infant Birth Weight," *Pediatrics* 89, no. 1 (1992): 128-32, <http://www.ncbi.nlm.nih.gov/pubmed/1727996>.
9. *See* Kevin Fiscella, "Does Prenatal Care Improve Birth Outcomes? A Critical Review," *Obstetrics & Gynecology* 85, no. 3 (1995): 326-329, http://journals.lww.com/greenjournal/Abstract/1995/03000/DOES_PRENATAL_CARE_IMPROVE_BIRTH_OUTCOMES_A.31.aspx.
10. *See, e.g.*, "Medicaid Coverage for Births and Family Planning Services is Essential," *Guttmacher Institute*, last updated October 11, 2010, <http://www.guttmacher.org/media/inthenews/2010/10/11/>; *The Cost of Prematurity to U.S. Employers* (New York: March of Dimes Foundation, 2008), accessed December 15, 2014, http://kaiserhealthnews.files.wordpress.com/2012/08/thomsonanalysis2008_summarydocument_final121208.pdf; Todd Zwillich, "Maternity Gap in High-Deductible

- Plans,” WebMD News, June 12, 2007, <http://www.webmd.com/baby/news/20070612/maternity-gap-high-deductable-plans>.
11. Mayo Clinic Staff, “Preeclampsia: Definition,” Mayo Clinic, July 3, 2014, <http://www.mayoclinic.org/diseases-conditions/preeclampsia/basics/definition/con-20031644>.
 12. Statistic includes preeclampsia and related hypertensive disorders. “FAQs,” Preeclampsia Foundation, last updated on December 20, 2013, <http://www.preeclampsia.org/health-information/faqs>.
 13. “FAQs,” Preeclampsia Foundation, last updated on December 20, 2013, <http://www.preeclampsia.org/health-information/faqs>.
 14. Ibid.
 15. Ibid.
 16. “Preeclampsia (Screening),” National Business Group on Health, last updated January 31, 2011, <https://www.businessgrouphealth.org/preventive/topics/preeclampsia.cfm>.
 17. Ibid.
 18. Data derived from: 2012 Healthcare Cost and Utilization Project (HCUP), “Charges, \$ (mean) for multiple specific diagnoses,” accessed December 17, 2014, <http://hcupnet.ahrq.gov/HCUPnet.jsp?Id=3C792B7F5BE1973A&Form=DispTab&JS=Y&Action=Accept>.
 19. “Preeclampsia (Screening),” National Business Group on Health, last updated January 31, 2011, <https://www.businessgrouphealth.org/preventive/topics/preeclampsia.cfm>.
 20. Mayo Clinic Staff, “Placental abruption: Definition,” Mayo Clinic, December 13, 2014, <http://www.mayoclinic.org/diseases-conditions/placental-abruption/basics/definition/con-20024292>.
 21. Mayo Clinic Staff, “Placental abruption: Complications,” Mayo Clinic, December 13, 2014, <http://www.mayoclinic.org/diseases-conditions/placental-abruption/basics/complications/con-20024292>.
 22. “Placental Abruption (Abruptio Placentae),” Virtual Medical Centre, last modified March 18, 2014, <http://www.myvmc.com/diseases/placental-abruption-abruptio-placentae/#Statistics>.
 23. Data derived from: 2012 HCUP, “Charges, \$ (mean) for multiple specific diagnoses,” accessed December 17, 2014, <http://hcupnet.ahrq.gov/HCUPnet.jsp?Id=3C792B7F5BE1973A&Form=DispTab&JS=Y&Action=Accept>.
 24. Ibid.
 25. Gloria L.A. Beckles and Patricia E. Thompson-Reid, ed., *Diabetes Women’s Health & Across the Life Stages* (Atlanta: CDC, 2001), 71, <http://www.cdc.gov/diabetes/pubs/pdf/women.pdf>.
 26. Ibid.
 27. Ibid.
 28. Ibid.
 29. Division of Diabetes Translation, “National Diabetes Statistics Report, 2014” (Atlanta: CDC, 2014), 10, <http://www.cdc.gov/diabetes/pubs/statsreport14/national-diabetes-report-web.pdf>.
 30. Data derived from: 2012 HCUP, “Charges, \$ (mean) for multiple specific diagnoses,” accessed December 17, 2014, <http://hcupnet.ahrq.gov/HCUPnet.jsp?Id=3C792B7F5BE1973A&Form=DispTab&JS=Y&Action=Accept>.
 31. Lauren M. Wier et al., *Hospitalizations Related to Diabetes in Pregnancy*, 2008 (Rockville, MD: Agency for Healthcare Research and Quality, 2010), 2, <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb102.pdf>.
 32. J. Zöllner, R. Curry and M. Johnson, “The contribution of heart disease to maternal mortality,” *Current Opinion in Obstetrics and Gynecology* 25, no. 2 (2013): 91-7, <http://www.ncbi.nlm.nih.gov/pubmed/23411474>.
 33. P. G. Pieper, “Expected and unexpected cardiac problems during pregnancy,” *Netherlands Heart Journal* 16, no. 12 (2008): 403-405, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2612107/>.
 34. “Heart Disease & Pregnancy,” Cleveland Clinic, last revised October 2012, <http://my.clevelandclinic.org/services/heart/disorders/heart-disease-pregnancy#htn>.
 35. P. G. Pieper, “Expected and unexpected cardiac problems during pregnancy,” *Netherlands Heart Journal* 16, no. 12 (2008): 403-405, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2612107/>.
 36. Ibid.
 37. Mayo Clinic Staff, “Graves’ Disease: Definition,” Mayo Clinic, July 1, 2014, <http://www.mayoclinic.org/diseases-conditions/graves-disease/basics/definition/con-20025811>.
 38. Mayo Clinic Staff, “Graves’ Disease: Complications,” Mayo Clinic, July 1, 2014, <http://www.mayoclinic.org/diseases-conditions/graves-disease/basics/complications/con-20025811>.
 39. “Prevalence and Incidence of Graves Disease,” RightDiagnosis, last updated June 17, 2014, http://www.rightdiagnosis.com/g/graves_disease/prevalence.htm.
 40. Daniela Cihakova, “Graves’ Disease,” Autoimmune Disease Research Center, Johns Hopkins Medical Institutions, last modified September 10, 2001, <http://autoimmune.pathology.jhmi.edu/diseases.cfm?systemID=3&DiseaseID=21>; “Who gets graves disease,” <http://www.womenshealth.gov/publications/our-publications/fact-sheet/graves-disease.html#c>
 41. “Graves’ Disease Fact Sheet,” Office of Women’s Health, HHS, last updated July 16, 2012, <http://www.womenshealth.gov/publications/our-publications/fact-sheet/graves-disease.html#i>.
 42. Ibid.
 43. Ibid.
 44. Ibid.
 45. “Maternity Care,” National Women’s Law Center (NWLC), accessed December 20, 2014, <http://hrc.nwlc.org/policy-indicators/maternity-care>.
 46. E.g. “What Marketplace Plans Cover,” Health-care.gov, accessed December 20, 2014, <https://www.healthcare.gov/coverage/what-marketplace-plans-cover/>; “Grandfathered health insurance plans,” Healthcare.gov, accessed December 14, 2014, <https://www.healthcare.gov/health-care-law-protections/grandfathered-plans/>.
 47. Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act (PPACA); Interim Final Rule and Proposed Rule, 75 Fed. Reg. 116, 34553 (June 17, 2010), <http://www.gpo.gov/fdsys/pkg/FR-2010-06-17/pdf/2010-14488.pdf>.
 48. Small firm is defined here are 3-199 employees, so this example includes both small and large employers as defined by the ACA – or both employers that do and do not have to cover EHBs, respectively. *2014 Employer Health Benefits Survey* (Menlo Park, CA: The Henry J. Kaiser Family Foundation (KFF), 2014), Exhibit 13.3, <http://kff.org/report-section/ehbs-2014-section-thirteen-grandfathered-health-plans/>. The ACA’s EHB requirement applies to small employers, which the ACA generally defines as employers with 1-100 employees; states have the option of defining small groups as employers with 1-50 employees through 2016, which most states have done. 42 U.S.C. § 18024(b)(2)-(3), <http://www.law.cornell.edu/uscode/text/42/18024>; *Navigator Resource Guide On Private Health Insurance Coverage & The Health Insurance Marketplace* (Washington, DC: Georgetown University Center on Health Insurance Reforms (CHIR), 2013), 98, <http://www.rwjf.org/content/dam/farm/reports/reports/2013/rwjf408970>.
 49. GARY COHEN, DIRECTOR, CCIIO, INSURANCE STANDARDS BULLETIN SERIES – EXTENSION OF TRANSITIONAL POLICY THROUGH OCTOBER 1, 2016 (MARCH 5, 2014), <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/transition-to-compliant-policies-03-06-2015.pdf>. The Administration bulletin allows insurers to continue to offer these ACA non-compliant plans until October 1, 2016, which means people could be enrolled in these plans through plan years ending in October 1, 2017.
 50. The Administration bulletin states that “...policies subject to the transitional relief are not considered to be out of compliance with the following provi-

- sions of the Public Health Service Act (PHS Act): ... Section 2707 (relating to comprehensive health insurance coverage)." Ibid. PHS Section 2707(a) contains the requirement that individual and small group plans must cover EHBs. 42 U.S. Code § 300gg-6(a), <http://www.law.cornell.edu/uscode/text/42/300gg-6>.
51. See "State Responses to Administration Policy on Coverage Extensions," America's Health Insurance Plans (AHIP), last updated June 6, 2014, <http://www.ahipcoverage.com/wp-content/uploads/2014/06/Coverage-Extension-Map-6.6.14.pdf>.
 52. Based on HHS's estimate that 40 to 67 percent of individual plans would no longer be grandfathered by 2014, and the estimate that there are 15 million individual plans. See Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act (PPACA); Interim Final Rule and Proposed Rule, 75 Fed. Reg. 116, 34553 (June 17, 2010), <http://www.gpo.gov/fdsys/pkg/FR-2010-06-17/pdf/2010-14488.pdf>; Sarah Kliff, "This is why Obamacare is canceling some people's insurance plans," The Washington Post, October 29, 2013, <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/10/29/this-is-why-obamacare-is-cancelling-some-peoples-insurance-plans/> (Sarah Kliff estimates that seven to 12 million people may have received plan cancellation notices, but she rounds HHS's estimate of 40 to 67 percent up to "between half and three-quarters").
 53. Michelle Andrews, "Some Plans Deny Pregnancy Coverage For Dependent Children," KHN, August 6, 2012, <http://kaiserhealthnews.org/news/under-26-pregnancy-coverage-michelle-andrews-080712/>.
 54. E.g. *Navigator Resource Guide On Private Health Insurance Coverage & The Health Insurance Marketplace* (Washington, DC: CHIR, 2013), 100, accessed December 21, 2014, <http://www.rwjf.org/content/dam/farm/reports/reports/2013/rwjf408970>.
 55. E.g. "Facts About Pregnancy Discrimination," The U.S. Equal Employment Opportunity Commission (EEOC), last modified September 8, 2008, <http://www.eeoc.gov/facts/fs-preg.html>; Adam Sonfield, "The Potential of Health Care Reform to Improve Pregnancy-Related Services and Outcomes," *Guttmacher Policy Review* 13, no. 3(2010), <https://www.guttmacher.org/pubs/gpr/13/3/gpr130313.html>.
 56. Michelle Andrews, "Some Plans Deny Pregnancy Coverage For Dependent Children," KHN, August 6, 2012, <http://kaiserhealthnews.org/news/under-26-pregnancy-coverage-michelle-andrews-080712/>.
 57. "NWLC Files Complaints Against Five Institutions for Sex Discrimination in Health Care Coverage," National Women's Law Center (NWLC), last updated June 2013, <http://www.nwlc.org/press-release/nwlc-files-complaints-against-five-institutions-sex-discrimination-health-care-coverage>.
 58. The CDC data is divided into births to women ages 19-24, 25-29, etc. Joyce A. Martin et al., "Births: Final Data for 2012," *National Vital Statistics Reports* 62, no. 9 (2013): Table 2, http://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62_09.pdf.
 59. Sara R. Collins et al., *Covering Young Adults Under the Affordable Care Act: The Importance of Outreach and Medicaid Expansion* (New York: The Commonwealth Fund, 2013), <http://www.commonwealthfund.org/publications/issue-briefs/2013/aug/covering-young-adults-under-the-affordable-care-act>.
 60. See Student Health Insurance Coverage Final Rule, 77 Fed. Reg. 55, 16455 (March 21, 2012), <https://www.federalregister.gov/articles/2012/03/21/2012-6359/student-health-insurance-coverage>; *Navigator Resource Guide On Private Health Insurance Coverage & The Health Insurance Marketplace* (Washington, DC: CHIR, 2013), 84, accessed December 21, 2014, <http://www.rwjf.org/content/dam/farm/reports/reports/2013/rwjf408970>.
 61. Miscellaneous Minimum Essential Coverage Provisions Final Rule, 78 Fed. Reg. 126, 39515 (July 1, 2013), <http://www.gpo.gov/fdsys/pkg/FR-2013-07-01/pdf/2013-15530.pdf>; "Plan types that count as coverage," HealthCare.gov, accessed December 22, 2014, <https://www.healthcare.gov/fees-exemptions/plans-that-count-as-coverage/>. The ACA's individual mandate requires most individuals to have what's known as minimum essential coverage (MEC) or pay a tax penalty.
 62. E.g. Sabrina Corlette, "An Unfortunate Decision on Student Health Plan Coverage," CHIRblog, June 27, 2013, <http://chirblog.org/unfortunate-decision-on-student-health-plan-coverage/>; Doug Lederman, "U.S. Exempts Some Student Health Plans," Inside Higher Ed, January 31, 2013, <https://www.insidehighered.com/news/2013/01/31/us-says-self-funded-student-health-plans-meet-obamacare-threshold>.
 63. E.g. "About UC SHIP," University of California Student Health Insurance Plan, accessed December 21, 2014, <http://www.ucop.edu/ucship/about/index.html>.
 64. See Doug Lederman, "U.S. Exempts Some Student Health Plans," *Inside Higher Ed*, January 31, 2013, <https://www.insidehighered.com/news/2013/01/31/us-says-self-funded-student-health-plans-meet-obamacare-threshold> ("In proposing that self-funded plans qualify as meeting the 'minimum essential coverage' standard, the Department of Health and Human Services did not suggest that it had examined the existing programs to ensure that they comply with the ACA's minimum requirements for other plans.")
 65. E.g. Sabrina Corlette, "An Unfortunate Decision on Student Health Plan Coverage," CHIRblog, June 27, 2013, <http://chirblog.org/unfortunate-decision-on-student-health-plan-coverage/>.
 66. Nanette Asimov and Victoria Colliver, "Obamacare loophole threatens UC students," *San Francisco Chronicle*, January 29, 2013, <http://www.sfgate.com/health/article/Obamacare-loophole-threatens-UC-students-4234269.php>.
 67. "Pregnant Women," Medicaid.gov, CMS, accessed December 15, 2014, <http://www.medicaid.gov/medicaid-chip-program-information/by-population/pregnant-women/pregnant-women.html>.
 68. "State Medicaid and CHIP Income Eligibility Standards," CMS, last updated July 1, 2014, <http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/Medicaid-and-CHIP-Eligibility-Levels-Table.pdf>.
 69. "2014 Poverty Guidelines," ASPE, HHS, last updated January 22, 2014, <http://aspe.hhs.gov/pov-erty/14poverty.cfm>.
 70. There is an exception – members of federally recognized tribes and Alaska natives can enroll in marketplace plans year-round. "Your options outside Open Enrollment," Healthcare.gov, accessed December 15, 2014, <https://www.healthcare.gov/coverage-outside-open-enrollment/your-options/>.
 71. See, e.g., "Can I buy or change private health plan coverage outside of Open Enrollment?" Health Reform FAQs, KFF, accessed December 15, 2014, <http://kff.org/health-reform/faq/health-reform-frequently-asked-questions/#question-can-i-buy-or-change-private-health-plan-coverage-outside-of-open-enrollment>.
 72. See, e.g., "What It Costs to Have a Baby," WebMD, last reviewed on March 04, 2013, <http://www.webmd.com/baby/features/cost-of-having-a-baby?page=2>; Shelley Frost, "Tips for Pregnant Women With No Health Insurance," Livestrong.com, last updated February 19, 2014, <http://www.livestrong.com/article/156581-tips-for-pregnant-women-with-no-health-insurance/>; Heidi Murkoff, "Pregnant and Uninsured," What To Expect.com, accessed December 14, 2014, <http://www.whattoexpect.com/pregnancy/ask-heidi/pregnant-and-uninsured.aspx>.
 73. See, e.g., "Medicaid Coverage for Births and Family Planning Services is Essential," Guttmacher Institute, last updated October 11, 2010, <http://www.guttmacher.org/media/inthenews/2010/10/11/The-Cost-of-Prematurity-to-U.S.-Employers> (New York: March of Dimes Foundation, 2008), accessed December 15, 2014, http://kaiserhealthnews.files.wordpress.com/2012/08/thomsonanalysis2008_summarydocument_final121208.pdf; Todd Zwillich, "Maternity Gap in High-Deductible Plans," WebMD News, June 12, 2007, <http://www.webmd.com/baby/news/20070612/maternity-gap-high-deductible-plans>.
 74. *Women and Health Insurance: By the Numbers* (Washington, DC: The American College of Obstetricians and Gynecologists (ACOG), 2008), 2, accessed December 21, 2014, <http://www.acog.org/~media/Departments/Government%20Relations%20and%20Outreach/hcfwhcfa-numbers.pdf?dmc=1&ts=20120624T1105550955>.

75. See, e.g., Michelle Andrews, "Some Plans Deny Pregnancy Coverage For Dependent Children," *KHN*, August 6, 2012, <http://kaiserhealthnews.org/news/under-26-pregnancy-coverage-michelle-andrews-080712/>.
76. Lawrence Finer and Mia Zolna, "Shifts in Intended and Unintended Pregnancies in the United States, 2001–2008," *American Journal of Public Health* 104, no. S1 (2014): S45, <http://www.guttmacher.org/pubs/journals/ajph.2013.301416.pdf>.
77. E.g., Tejvan Pettinger, "Adverse Selection," *Economicshelp.org*, accessed December 15, 2014, <http://www.economicshelp.org/blog/glossary/adverse-selection/>.
78. *Explaining Health Care Reform: Risk Adjustment, Reinsurance, and Risk Corridors* (Menlo Park, CA: KFF, 2014), 1, <http://kaiserfamilyfoundation.files.wordpress.com/2014/01/8544-explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors1.pdf>.
79. E.g., Margot Sanger-Katz, "Has the percentage of uninsured people been reduced?" in "Is the Affordable Care Act Working?" *The New York Times*, October 26, 2014, http://www.nytimes.com/interactive/2014/10/27/us/is-the-affordable-care-act-working.html?_r=0#uninsured.
80. DOUGLAS W. ELMENDORF, DIRECTOR, CONGRESSIONAL BUDGET OFFICE (CBO), REPORT TO NANCY PELOSI, SPEAKER, U.S. HOUSE OF REPRESENTATIVES ON THE IMPACT OF THE PPACA, 9, <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11379/amendreconprop.pdf>.
81. In 2011 HHS predicted 8.7 million women would get maternity care thanks to health care reform. ASPE, *Essential Health Benefits: Individual Market Coverage* (Washington, DC: HHS, 2011), <http://aspe.hhs.gov/health/reports/2011/individualmarket/ib.shtml>.
82. Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the PPACA; Interim Final Rule and Proposed Rule, 75 Fed. Reg. 116, 34553 (June 17, 2010), <http://www.gpo.gov/fdsys/pkg/FR-2010-06-17/pdf/2010-14488.pdf>.
83. CMS, HHS, GUIDANCE ON SPECIAL ENROLLMENT PERIODS (SEPS) AND HARDSHIP EXEMPTIONS FOR PERSONS MEETING CERTAIN CRITERIA (MAY 2, 2014), 2, <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/SEP-and-hardship-FAQ-5-1-2014.pdf>.
84. *Ibid.*, 3.
85. CCIIO, CMS, GUIDANCE FOR ISSUERS ON SEPS FOR COMPLEX CASES IN THE FEDERALLY-FACILITATED MARKETPLACE AFTER THE INITIAL OPEN ENROLLMENT PERIOD (MARCH 26, 2014), 2-3, <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/complex-cases-SEP-3-26-2014.pdf>.
86. CMS PRODUCT NO. 11794, SEPS FOR COMPLEX CASES IN THE HEALTH INSURANCE MARKETPLACE (SEPTEMBER 2014), 2, <https://marketplace.cms.gov/outreach-and-education/sep-complex-cases.pdf>.
87. GARY COHEN, CMS DEPUTY ADMINISTRATOR AND DIRECTOR, CCIIO, GUIDANCE ON HARDSHIP EXEMPTION CRITERIA AND SEPS (JUNE 26, 2013), 2-3, <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/exemptions-guidance-6-26-2013.pdf>.
88. See *Essential Health Benefits: Balancing Coverage and Cost* (Washington, DC: IOM, 2011), 2, http://www.iom.edu/~media/Files/Report%20Files/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost/Essential%20Health%20Benefits%20RB_FINAL.pdf.