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Post-Partum Eligibility (Health Services -- Medical Assistance)

[LFB 2019-21 Budget Summary: Page 175, #15]

CURRENT LAW

In Wisconsin, most adults with household income up to 100% of the federal poverty level (FPL) are eligible for health care coverage under BadgerCare Plus. However, pregnant women may have household income of up to 306% of the FPL and still qualify for BadgerCare Plus. In determining the household's family size (for the purpose of determining the household's income as a percentage of the FPL), the number of children the woman is expecting is included. For example, a pregnant woman who is expecting one child and who resides with her husband is considered to be in a three-person household. In 2019, 306% of the FPL for a three-person family is $65,270.

Under federal law, all pregnant women who are enrolled in the medical assistance (MA) program remain eligible for MA coverage through the end of the month in which their 60-day post-partum period ends. For example, if a woman's child is born on April 7, the woman remains enrolled in MA through June 30.

When the woman's period of extended eligibility following delivery ends, the woman's eligibility for MA coverage is redetermined. The woman may remain enrolled in the program if she continues to meet all MA eligibility requirements, including the income limit that applies to nonpregnant, non-disabled adults (100% of the FPL). In 2019, 100% of the FPL is $21,330 per year for a three-member family. However, if her countable household income exceeds 100% of the FPL, she will be disenrolled from the program.

As required by federal law, a newborn child is automatically eligible for MA (BadgerCare Plus) coverage from the date he or she is born through the end of the month in which the child turns one year old if the natural mother was eligible for MA (or MA-supported emergency services) when the baby was born.

GOVERNOR

Increase funding for MA benefits by $22,880,000 ($9,609,600 GPR and $13,270,400 FED) in 2020-21 to reflect an estimate of the cost of extending MA coverage for post-partum women for an additional 10-month period, so that a woman would remain eligible for MA coverage until the last day of the month in which the 365th day after the last day of the pregnancy falls. Require DHS to seek approval from the federal Department of Health and Human Services to implement this change in program eligibility.

DISCUSSION POINTS

1. The Governor's recommendation is intended to ensure that post-partum women continue to have uninterrupted health care coverage, with no or nominal cost, for at least one year following delivery.

2. Women who are no longer eligible for MA following the current two-month post-partum period may have access to other health care coverage, including by: (a) purchasing an individual health plan offered on the benefit exchange (termination of MA coverage is a qualifying event that enables these women to enroll in a plan mid-year, outside of the normal enrollment period); or (b) obtaining coverage offered by an employer, which may include a spouse's employer-sponsored plan. However, due to the cost of premiums, deductibles, and copayments, some women in low-income households do not enroll in these plans, or if they do, may choose not to access services due to cost-sharing requirements. It is not known how many, or what percentage of post-partum women who were formerly enrolled in MA no longer have health care coverage following the two-month period of extended eligibility.

3. Disruptions in health care coverage can adversely affect the continuity and quality of health care services these women receive. Women experience disruptions in health care coverage before and after delivery because of changes in their employment and income status. For example, a woman who previously did not qualify for BadgerCare Plus may qualify for a limited period, then be disenrolled following the two-month post-partum period. Similarly, a woman may discontinue her employer-sponsored coverage if she decides to leave her job and remain at home to care for her child.

4. A recent study, summarized in the April, 2017 edition of Health Affairs, provides some information on health care coverage of women before and after childbirth, based on national survey data covering the period between 2005 and 2013. The study yielded information on the monthly insurance status of pregnant women, beginning three months prior to conception (as estimated by delivery dates), through six months following delivery. The insurance status of each woman in the study was coded in one of three categories: (a) MA or coverage under the children's health insurance program (CHIP); (b) private or other insurance coverage; and (c) no insurance.

5. The study found that leading up to delivery, the proportion of pregnant women who were uninsured decreased, while the proportion of pregnant women with Medicaid or CHIP coverage increased. This is not surprising, since all states have enacted higher maximum income standards for pregnant women than for other low-income populations as part of their MA programs. This is largely

due to the federal requirement that states provide pregnancy-related medical services to all women with family income under 138% of the FPL. However, the researchers found that, *after* delivery, the uninsurance rate for these women rose rapidly, nearly returning to the pre-pregnancy rate (23 percent six months after delivery, compared to 25 percent in the tenth month before delivery.)

6. The study also found that 41% of women who had MA or CHIP coverage at the time of delivery had the same type of insurance coverage continuously for the six-month period following delivery, compared with 64% of women who had private coverage at the time of delivery.

7. The study found that the number of uninsured months following delivery was much higher among women covered by MA or CHIP at the time of delivery than for women with private insurance coverage, with 55 percent of the MA or CHIP women having at least one uninsured month, and 25 percent of these women having two or more months of being without insurance over the six-month period following delivery.

8. Finally, the study identified several risk factors that are associated with lapses in health insurance coverage among these women after childbirth, including: (a) having an income of between 100% to 185% of poverty; (b) not speaking English at home; (c) being unmarried; and (d) having MA or CHIP coverage at the time of delivery.

9. In May, 2018, the American College of Obstetricians and Gynecologists' (ACOG's) Presidential Task Force on Redefining the Postpartum Visit published several recommendations, which stressed the need for ongoing post-partum care, rather than a single postpartum visit. The ACOG recommendations cited an estimate that 40% of all postpartum women, including women with and without health care coverage, do not attend a postpartum visit. The ACOG recommendations are summarized as an attachment to this paper.

10. Maintaining MA coverage for postpartum women for one year may reduce pregnancy-related mortality. The Centers for Disease Control and Prevention (CDC) administers a pregnancy mortality surveillance system that collects information on pregnancy-related deaths, which are deaths that occur during pregnancy or within one year of the pregnancy from any cause related to, or aggravated by, the pregnancy. The system produces a pregnancy-related mortality ratio, which is an estimate of the number of pregnancy-related deaths for every 100,000 live births. This ratio is often used as an indicator to measure the nation's health. Since the system was implemented, the CDC reports that, nationally, the pregnancy-related mortality ratio has increased from 7.2 deaths per 100,000 births in in 1987 to 18.0 deaths per 100,000 births in 2014 (the most recent year for which information is available). Possible causes of the rising pregnancy related mortality rates in the United States include pre-existing conditions, medical errors, and unequal access to care.

11. The CDC notes that considerable racial disparities in pregnancy-related mortality exist. For example, during the 2011-14 period, the pregnancy related mortality ratios were:

- 12.4 deaths per 100,000 live births for white women;
- 40.0 deaths per 100,000 live births for black women; and
- 17.8 deaths per 100,000 live births for women of other races.

12. Based on information from codes DHS uses to categorize different groups of MA enrollees, the administration estimates that, annually, of approximately 18,800 pregnant women who are enrolled in MA, approximately 6,500 women lose MA eligibility after the two-month post-partum period ends. The rest reside in households with income less than 100% of the FPL, so they remain eligible for MA coverage. DHS does not maintain information on the number of women who are disenrolled from MA each month because they reside in households with income that exceeds 100% of the FPL so it is not known if or when the women who are initially eligible for MA at the end of their post-partum coverage lose coverage.

13. The administration estimates that the average per member per month cost of providing post-partum MA coverage for these women is $352, based on historical costs of providing services to pregnant women, and making adjustments for costs that the MA program does not incur following delivery, such as maternity "kick" payments (supplemental payments the MA program provides to HMOs to cover costs of maternity care, which are excluded from capitation payments). The enrollment and average cost estimates used by the administration appear reasonable.

14. Based on these estimates, the administration calculated the 2020-21 annualized increase in MA costs by multiplying the estimated number of women by the average cost per woman and the number of additional months per year that coverage would be extended ($352 per woman per month x 10 months x 6,500 women = $22,880,000). The administration then applied a 58% FMAP rate to obtain the GPR and FED funding amounts ($9,609,600 GPR and $13,270,400 FED). Based on the current estimates of FMAPs in the 2020-21 (59.55%), the cost of the Governor's proposal is reestimated to be $9,225,000 GPR and $13,625,000 FED in 2020-21. Consequently, GPR funding in the bill could be reduced by $354,600 GPR in 2020-21 and FED funding could be increased by a corresponding amount to reflect a reestimate of the FMAP available to support the cost of this item [Alternative 1].

15. An alternative methodology could be used to estimate the costs of the proposal, based on a phase-in of these costs. If a waiver were approved and effective July 1, 2020, as assumed by the administration, in July, 2020 the first group of women who would otherwise lose MA coverage would instead retain that coverage in July (one-twelfth of the estimated 6,500 women (542) who would otherwise lose MA eligibility). In August, 2020, a second group of 542 women would retain coverage, while coverage would continue for the first group. This monthly cost increase would continue until April, 2021, when the costs of the extension would be fully phased in. Based on this methodology, funding in the bill could be reduced by $8,530,500 (-$3,778,000 GPR and -$4,752,500 FED) in 2020-21. Under this option, the bill would need to be modified so that the period of extended eligibility would first apply to women who would no longer be eligible for MA coverage as of June 30, 2020, or the effective date of the approved waiver, whichever date is later [Alternative 2].

Since the annualized GPR cost of this option ($9,330,600) would not be fully funded in 2020-21, this alternative, while reducing costs in 2020-21, would increase estimates of GPR commitments in the next budget by approximately $3.5 million in both 2021-22 and 2022-23.

16. To date, no other state has sought and received federal approval of a waiver enabling the state to extend the post-partum eligibility period for all pregnant women with MA coverage at the time of delivery.

17. Others would argue that there is no need to extend MA eligibility for postpartum women beyond the current two-month period. The current two-month period enables women to schedule a post-partum visit with their obstetrician-gynecologist, or primary care provider and to address any birth-related health conditions. Further, other programs, including the Family Foundations home visiting program, state and local health programs supported by the federal maternal and child health block grant and the state women's health block grant, are currently available to serve the health needs of post-partum women. Finally, it is not certain that the state would be successful in obtaining a waiver to implement the proposal. For these reasons, the Committee could delete the Governor's proposal from the bill [Alternative 3].

ALTERNATIVES

1. Adopt the Governor's recommendations, but reduce GPR funding by $354,600 and increase FED funding by $354,600 to reflect a reestimate of the FMAP available to support the cost of this item.

ALT 1	Change to Base	Change to Bill
GPR	$9,255,000	- $354,600
FED	13,625,000	354,600
Total	$22,880,000	$0

2. Modify the bill by reducing funding by $8,530,500 (-$3,778,000 GPR and -$4,752,500 FED) in 2020-21. Specify that that the period of extended eligibility would first apply to women who would no longer be eligible for MA coverage as of June 30, 2020, or the effective date of the approved waiver, whichever date is later.

ALT 2	Change to Base	Change to Bill
GPR	$5,831,600	- $3,778,000
FED	8,517,900	- 4,752,500
Total	$14,349,500	- $8,530,500

3. Take no action.

ALT 3	Change to Base	Change to Bill
GPR	$0	- $9,609,600
FED	0	- 13,270,400
Total	$0	- $22,880,000

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Attachment

ATTACHMENT

American College of Obstetricians and Gynecologists (ACOG) Recommendations

- To optimize the health of women and infants, post-partum care should become an ongoing process, rather than a single encounter, with services and support tailored to each woman's individual needs.

- Anticipatory guidance should begin during pregnancy and development of a postpartum care plan that addresses the transition to parenthood and well-women care.

- Prenatal discussions should include the woman's reproductive life plans, including a desire for and timing of any future pregnancies. A woman's future pregnancy intentions provide a context for shared decision-making regarding contraceptive options.

- All women should ideally have contact with a maternal care provider within the first three weeks postpartum. This initial assessment should be followed up with ongoing care as needed concluding with a comprehensive postpartum visit no later than 12 weeks after birth.

- The timing of the comprehensive postpartum visit should be individualized and woman centered.

- The comprehensive postpartum visit should include a full assessment of physical, social, and psychological well-being.

- Women with pregnancies complicated by preterm birth, gestational diabetes, or hypertensive disorders of pregnancy should be counseled that these disorders are associated with higher lifetime risk of maternal cardio metabolic disease.

- Women with chronic medical conditions, such as hypertensive disorders, obesity, diabetes, thyroid disorders, renal disease, mood disorders, and substance use disorders should be counseled regarding the importance of timely follow-up with their obstetrician-gynecologists or primary care providers for ongoing coordination of care.

- For a woman who has experienced a miscarriage, stillbirth, or neonatal death, it is essential to ensure follow-up with an obstetrician-gynecologist or other obstetric care provider.

- Optimizing care and support for postpartum families will require policy changes. Changes in the scope of postpartum care should be facilitated by reimbursement policies that support postpartum care as an ongoing process, rather than an isolated visit.