

Accelerated Analysis:

Analysis of California Assembly Bill AB 1102

Health care coverage: special enrollment periods: triggering event

Analysis Provided to the 2015-2016 California State Legislature, December 2015



AT A GLANCE

Assembly Bill AB 1102 would require a health care service plan or health insurer to allow a woman to enroll or change individual health benefits if she becomes pregnant. This bill would impact enrollees in both DMHC- and CDI-regulated plans and policies. This analysis was requested on April 10, 2015, for submission by April 22, 2015, representing an accelerated CHBRP review timeframe.

- **Enrollees covered.** CHBRP estimates that in 2016, 4.33 million of 25.8 million Californians have individual market plans and policies (state-regulated coverage that would be subject to Assembly Bill AB 1102). In addition, CHBRP estimates that 961,000 females between the ages of 15 and 44 remain uninsured (out of a total state population of 7.99 million in that demographic), of which 429,898 are documented residents.
- **Covered California demographics.** 21.7% of Covered California enrollees are women of child-bearing age. Therefore, AB 1102 would have a significant impact.
- **Impact on expenditures.** CHBRP only estimated projected impacts on Covered California. AB 1102 would also impact enrollees in the remaining DMHC and CDI individual markets outside Covered California. These impacts were not estimated in the limited time given for this analysis.
 - **Covered California.** CHBRP estimates a total maximum impact of 1.2% or \$75.8 million, or \$22.8 million increase and a minimum .4% or \$22.8 million increase in premium due to AB 1102.
- **Medical effectiveness and public health.** This bill would allow some enrollees earlier access to prenatal care services. There is clear and convincing evidence that prenatal care is medically effective and has positive public health impacts. Prenatal care reduces the risk of preterm birth, low birthweight, mother-to-child transmission of infectious disease, and other poor birth outcomes. There is also the potential to reduce morbidity and mortality and the associated societal costs.

BILL SUMMARY

AB 1102 (as amended, on March 26, 2015) would allow women in the individual market to change health insurance plans/policies (to a plan with different cost sharing and/or networks, for example); and would allow uninsured women to enroll in Covered California plans/policies outside the designated enrollment periods if the woman becomes pregnant.

POLICY CONTEXT

Existing Health Insurance

Maternity coverage is one of the 10 essential health benefits that must be covered by all health insurance plans and policies offered to individuals, families, and small groups. Health insurance for pregnancy, labor, delivery, and newborn baby care became mandatory in 2014 under the Affordable Care Act (ACA). For persons currently uninsured, there are specific periods in which enrollment for health insurance is currently allowed (qualifying events, a list of which is provided later in this analysis), and for those who qualify, certain public programs.

The ACA's subsidies, penalties, and promulgation of health insurance exchanges (like Covered California) have reduced the number of uninsured persons nationally, and in California, particularly. Other key policy points:

- The ACA and California State Law require coverage of maternity services in individual market plans/policies. ERISA plans have been required to cover maternity services since 1996.¹
- Public programs cover maternity services when women lack health insurance.

¹ Health Insurance Portability and Accountability Act of 1996.

Public Programs

Presently, pregnant women with low incomes can apply for Medi-Cal and, if eligible, receive coverage retroactive to the date of application.

Pregnant women can also apply through their provider² for **Medi-Cal Presumptive Eligibility (PE) for Pregnant Women**,³ which provides immediate, no-cost pregnancy-related care to low-income (up to 213% of Federal Poverty Level [FPL]⁴) pregnant women while their application is evaluated for ongoing Medi-Cal. This program also covers undocumented women. PE for pregnant women offers coverage for specific ambulatory (walk-in), pregnancy-related care, some lab tests, and prescription drugs for conditions related to pregnancy. PE for pregnant women is a temporary Medi-Cal Program. For ongoing Medi-Cal coverage, pregnant women may submit a full application during the PE period.

The Medi-Cal Access Program (MCAP), formerly the Access for Infants and Mothers (AIM) Program, provides low-cost affordable health coverage for middle-income pregnant women. Coverage under MCAP costs 1.5% of an enrollee's adjusted net annual income and is billed over a 12-month period.

MCAP provides affordable health care coverage for pregnant women who:

- Do not have health insurance OR have private insurance with a maternity-only deductible or copayment greater than \$500;
- Are not eligible for no-cost Medi-Cal or Medicare Part A and Part B; and
- Have family household income above no-cost Medi-Cal (which is generally for individuals under 138% FPL), but at or under 400% FPL.

² A current list of PE providers, listed by county, may be accessed here: <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/Find-a-Qualified-Provider-to-Enroll.aspx>

³ <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/PE.aspx>.

⁴ http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/Presumptive_Eligibility/FPLChart2014-2015.pdf

Policy Implications

At the national level, the Department of Health and Human Services (HHS) is being urged by many advocates to add another qualifying event to the list of ways individuals can buy an exchange plan during a "special enrollment period."⁵ This would classify pregnancy as a "qualifying life event," to let uninsured women who become pregnant purchase a health plan through Healthcare.gov within 60 days.

The addition of pregnancy would add to a list of qualifying life events that includes moving to a new state, drastic changes in income, marriage, divorce, and the birth of a baby and adoption (a complete list is provided in the Appendix).

Permitting people to enroll just when a health need arises could disrupt a basic tenet of insurance, which is to spread risk among policyholders to improve affordability. With pregnancy and a non-complicated childbirth costing about \$18,690 in California, there is the potential that the cost impact for this need would affect affordability for other enrollees, and impact risk pools.

INCREMENTAL IMPACT OF ASSEMBLY BILL AB 1102

Medical Effectiveness

CHBRP's review of the medical effectiveness of AB 1102 focuses on prenatal care because this bill could increase the number of pregnant women with health insurance and, thus, reduce out-of-pocket costs for prenatal care. Reducing out-of-pocket costs could, in turn, increase pregnant women's use of prenatal care. The medical effectiveness of services provided during labor and delivery was not considered because the vast majority of pregnant women in the United States give birth in hospitals regardless of their health insurance status. Evidence was drawn primarily from meta-analyses and systematic reviews published by the Cochrane Collaboration or in peer-reviewed journals and from

⁵ See appendix of this analysis for list of qualifying enrollment events.

systematic reviews conducted in conjunction with the preparation of evidence-based clinical practice guidelines.

There is clear and convincing evidence from meta-analyses and systematic reviews that certain prenatal care services produce better birth outcomes for mothers and infants. These services include screening tests, counseling regarding unhealthy behaviors, and treatments for diseases or conditions associated with poorer birth outcomes. For example, screening for hepatitis B and human immunodeficiency virus (HIV) enables obstetrical care providers to identify pregnant women with these diseases and ensure that they and/or their infants receive treatments that can reduce mother-to-child transmission of them. Screening for pre-eclampsia, a hypertensive disorder, is also important because this condition increases the risk that a mother will deliver her infant preterm. Preventing preterm birth is important because infants who are born prematurely are at increased risk of respiratory distress syndrome, cerebral palsy, blindness, deafness, and other severe conditions. Identifying pregnant women with pre-eclampsia and other risk factors for preterm birth and treating them with medications, such as antiplatelet agents, magnesium sulfate, and progesterational agents, reduces the risk of preterm birth and other poor birth outcomes. Providing counseling about behaviors that increase the risk of poor birth outcomes can also improve birth outcomes. For example, providing smoking cessation counseling to pregnant women who smoke reduces their risk of giving birth preterm or delivering a low-birthweight infant.

Further details about the medical effectiveness of prenatal services can be found in CHBRP's report on AB 185, which was issued in 2011.⁶

Benefit Coverage, Utilization, and Cost

CHBRP focused its fiscal projections on Covered California, based on the immediate access of administrative data, and the short timeframe for this analysis. CHBRP provides some qualitative comments about impacts to the individual plans and policies outside of Covered California, in both DMHC- and CDI-regulated markets.

⁶ Accessible at www.chbrp.org or via this [hyperlink](#).

CHBRP provides information on four impacts, were AB 1102 legislation to be enacted. (Please see footnote for some underlying assumptions.)⁷

Estimated Impact 1. A percentage of currently enrolled Covered California women aged 19 to 44, enrolled as individuals, would be expected to drop coverage until needed for childbirth expenses. Maternity expenses are the highest health care expenditures the average woman will generally incur during childbearing ages. CHBRP estimated the impact on Covered California expenditures if 10% and 25% of women dropped coverage, representing a lower bound and upper bound.

- If 10% of women enrollees aged 19 to 44 dropped coverage, Covered California would experience a loss of premiums of \$87,799,549. If 25% of women enrollees aged 19 to 44 dropped coverage, Covered California would lose \$248,580,564 in premiums.
- The net cost is calculated by first accounting for the current claim costs for the total population,⁸ and then adjusted by the expected claims of the 10% or 25% of women expected to drop coverage. Then, the claim costs of those who add coverage (opt back in) is added back in. CHBRP estimates the total net premium increase needed for Impact 1 is:
 - \$69,066,448 if 25% drop coverage
 - \$15,993,904 if 10% drop coverage

Estimated Impact 2. Utilizing CalSIM projections for 2016, CHBRP also projected **potential new 6-month enrollment** in Covered California individual plans, by women of childbearing age who are currently uninsured. Due to the availability of premium subsidies for Covered

⁷ CHBRP used a baseline average cost of \$18,690 for deliveries (bundled cost for prenatal as well as delivery costs) (2012 Marketscan California trended at 3% per year to 2016), and \$118,813 per complicated birth, also trended forward to 2016. For this analysis, CHBRP estimates 10,083 annual Covered California deliveries and 67 annual complicated births (0.7% rate), based on 2013 OSHPD data. CHBRP uses a 3.6% implied deliveries per woman, aged 19 to 44.

⁸ Assumes a Minimum Loss Ratio of 80%. For additional information, see the Federal CMS website:

<http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Medical-Loss-Ratio.html>.

California enrollees under 400% FPL and/or the existing public program, CHBRP focused its modeling on the potential short-term enrollment of documented, uninsured women aged 15 to 44, which CalSIM estimates to be 429,898 in 2016.

CHBRP estimates that 3.6% of women aged 19 to 44 become pregnant each year. CHBRP estimates that among currently uninsured women who become pregnant (among the 3.6%, aged 19 to 44 who are above 401% FPL), 25% of these women would be expected to temporarily add coverage,⁹ for maternity/childbirth expenses.

- CHBRP estimates that this shift of new temporary enrollment would represent 489 new enrollees, who would pay a total of \$940,259 in premiums (in the six-month period), while incurring \$6,762,598 in claim costs, for a net impact to Covered California enrollees of \$5,822,339.¹⁰

Table 1. Summary of Premium Increases of Impacts 1 and 2

	Percent of women who drop coverage until they are pregnant	
	25%	10%
Loss of existing Women enrollees who now opt in when pregnant	\$69.1 million	\$16.0 million
Current >401% FPL uninsured who opt in when pregnant	\$6.8 million	\$6.8 million
Total premium increase needed	\$75.8 million	\$22.8 million
Increase %	1.2%	0.4%

⁹ CHBRP modeled this for an average six month period.

¹⁰ It is possible that some enrollees would stay enrolled, dampening the impact over the long term. However, such offsets may be canceled out if those retaining coverage beyond six months have higher than average health risks or needs.

Estimated Impact 3. An additional potential fiscal impact of AB 1102 is some enrollment churn within Covered California individual market plans and policies. Women enrollees may select a plan with a more affordable and limited provider network, only to change their plan within Covered California, upon pregnancy. This might allow for more provider and delivery choice, or in the case of high-risk pregnancies, for example, a broader selection of medical centers that could be more expensive than providers in a narrower plan’s network. While this scenario is plausible, it is difficult to project in a short timeframe, and would likely be of smaller magnitude than Impacts A and B.

Estimated Impact 4. Using the CalSIM 1.9.2 estimates for 2016, CHBRP has the ability to predict the increase in percentage of uninsured population for every 1% increase in private health insurance premiums¹¹. CHBRP estimates that a 1% premium increase in the individual market will lead to a drop in enrollment, resulting in a 0.31% increase (about 8,000 more uninsured individuals in both DMHC- and CDI-regulated plans in 2016). CHBRP estimates that up to 3,300 Covered California individual enrollees may become uninsured if 25% of women enrollees aged 19 to 44 drop existing coverage (estimated Impact A), due to the increased cost premiums, in addition to the impacts noted above.

Covered California Demographics

CHBRP’s age and gender demographic for Covered California enrollees in individual plans is provided to highlight the impacts on that enrollee population. CHBRP reminds readers that AB 1102 impacts individual health plans and policies beyond Covered California.¹²

CHBRP’s demographic survey of health plans informs this analysis with the following key pieces of demographic information about Covered California’s individual enrollees.

¹¹ For information on CHBRP’s methodology, see CHBRP’s March 2015 publication at: http://www.chbrp.org/analysis_methodology/docs/CHBRP_uninsured_impact_paper_FINAL_031615.pdf.

¹² For 2016, CHBRP estimates 513,000 individual members in CDI outside of Covered California, and 1.365 million DMHC individual enrollees outside of Covered California.

- 21.7% of enrollees in Covered California's individual market are women of childbearing age.
- Total women enrollees in Covered California under 65 outnumber males by 11%.
- Women with individual policies in Covered California aged 19 to 44 outnumber male enrollees 235,513 to 209,247, also by 11%.
- Total enrollment (of enrollees purchasing individual policies in Covered California is 1,086,226 members, of which 574,720 are female and 511,506 are male.

Public Health

If insured women switch from one plan to another, CHBRP uses the simplifying assumption that no change in utilization of prenatal care and labor and delivery occur because coverage for prenatal services already exists among all plans and policies (per ACA or common practice in ERISA [Employee Retirement Income Security Act of 1974] plans); therefore, no insurance or financial barrier exists to preclude recommended utilization of prenatal care as soon as a pregnancy is confirmed.

If a pregnant woman is uninsured, utilization of prenatal care services would increase somewhat because women would not be able to activate new insurance until the beginning of the second trimester at the earliest, due to the insurance administrative process. Labor and delivery utilization and health outcomes would not change postmandate due to state law requiring hospitals to provide such services regardless of ability to pay or citizenship status.

CHBRP does note the possibility for poorer health outcomes for those newly uninsured (women who decide to drop coverage), as well as increased enrollee expenses for health among this group of women.

Background of Maternity Services

Maternity services benefits generally include prenatal care, such as office visits and screening tests; labor and delivery services, including hospitalization; care resulting from complications related to a pregnancy; and postnatal care. The California birth rate in 2012 was 63.3/1,000 women aged 15 to 44 years (standard childbearing age)

or about 503,000 births in total (CDC, 2013). The California Department of Finance projects the number of annual births will increase to about 518,000, by 2020 (CDOF, 2014).

Prenatal care

There appear to be two populations of pregnant women who may be affected by AB 1102: those who are insured with maternity benefits and those who are uninsured at time of conception. Results of a 2012 California survey indicated that 40.6% of uninsured women of childbearing age and 20.2% of privately insured women had mistimed or unwanted pregnancies (MIHA, 2012). Of California's privately insured women, about 94% initiated prenatal care in their first trimester, the point at which prenatal care is most effective. About 61% of California's uninsured women initiated prenatal care in their first trimester (MIHA, 2012). In 2013, of all pregnant women in California, 82% initiated prenatal care in their first trimester, 13% initiated in the second trimester and 3% initiated in the third trimester (the remaining 2% were unknown or initiated no care) (CDPH, 2015a). Women applying for coverage through Covered California may receive coverage earlier than those who apply in the private marketplace due to different regulatory requirements of the ACA.

Economic Loss

The economic loss associated with poor pregnancy health outcomes consists of the direct costs of providing medical care and the indirect costs related to lost productivity and other special services needed to treat infants with additional health care needs. It has been estimated that the annual societal economic burden associated with preterm births is an average of \$51,600 per infant born preterm (IOM, 2006). More than one-fifth of this cost (\$11,200 per preterm infant) is associated with lost household and labor market productivity (IOM, 2006). In California, 10.1% of babies are born prematurely. To the extent that AB 1102 could increase the utilization of effective prenatal care that can reduce outcomes such as preterm births and related infant mortality, there is a potential to reduce morbidity and mortality and the associated societal costs.

Appendix: Existing Enrollment Opportunities (Qualifying Events) Under the Affordable Care Act

Currently allowed special open enrollment triggers:

Involuntary loss of other coverage that is qualified as [minimum essential coverage](#). (Cancelling the plan or failing to pay the premiums does not count as involuntary loss.) Loss of coverage that isn't minimum essential coverage does not trigger a special open enrollment, but [new regulations](#) do provide one exception in the case of loss of pregnancy-related Medicaid coverage. Women who become ineligible for pregnancy-related coverage do have access to a special open enrollment period. The special open enrollment begins 60 days before the termination date, so it's possible to get a new ACA-compliant plan with no gap in coverage.¹³

Individual plan renewing outside of the regular open enrollment. HHS issued a [regulation](#) in late May 2014 that included a provision to allow a special open enrollment for people whose health plan is renewing — but not terminating — outside of regular open enrollment.

Becoming a dependent or gaining a dependent as a result of birth, adoption, or placement in foster care. Coverage is back-dated to the date of birth, adoption, or placement in foster care ([new regulations](#) also allow parents the option to select a later effective date).

The current [regulation](#) states that anyone who “gains a dependent or becomes a dependent” is eligible for a special open enrollment window, which includes both the parents and the new baby or newly adopted or fostered child. However, this does not currently include pregnancy leading up to childbirth.

¹³ See details in [Section \(d\)\(6\)\(iii\)](#) the code of federal regulations 155.420, and the [updated regulation](#) that makes advance open enrollment possible for people with individual coverage as well as employer-sponsored coverage. Enrollees also have 60 days after the plan ends during which a person can select a new [ACA-compliant plan](#). In that case, the effective date will be the first of the following month.

Marriage. Enrollees have a 60-day open enrollment window that begins on the wedding day.

Divorce. The loss of existing health insurance because of a divorce qualifies for a special open enrollment based on the loss of coverage rule discussed above.

Becoming a United States citizen (this qualifying event only applies within the exchanges — carriers selling coverage off-exchange are not required to offer a special enrollment period for people who gain citizenship or lawful presence in the U.S.).

A permanent move to an area where different [qualified health plans](#) (QHPs) are available. A permanent move to a new state will always trigger a special open enrollment period, because each state has its own health plans. But even a move within a state can be a qualifying event, as some states have QHPs that are only offered in certain regions of the state.

An error or problem with enrollment (or non-enrollment) that was the fault of the exchange, HHS, or an enrollment assister. In this case, the exchange can properly enroll the person (or change plans) outside of open enrollment in order to remedy the problem.

Employer-sponsored coverage reducing benefits such that it no longer provides minimum value, or becomes unaffordable (defined as requiring the employee to pay more than 9.5% of income for [just the employee's portion of the coverage](#)) for the upcoming plan year.

Additional qualifying events apply to people who are already enrolled in the exchange:

If income changes and makes people newly eligible (or ineligible) for [premium tax credits](#) or [cost-sharing subsidies](#), people may qualify for a special open enrollment. Previous versions of the federal register stated that this open enrollment applied even for people who were not already enrolled in a QHP, but that is incorrect.

Medicaid enrollment is also year-round. For people who are near the threshold where Medicaid eligibility ends and exchange subsidy eligibility

begins, there may be some “churning” during the year, when slight income fluctuations result in a change in eligibility.

If income increases above the Medicaid eligibility threshold, there’s a special open enrollment window triggered by loss of other coverage.

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