Insuring Healthy Births

Promoting Optimal Childbirth Outcomes and Maternal Child Health in Pennsylvania

January 2009

healthy mothers, healthy babies

Maternity Care Coalition

Strengthening families, one baby at a time

United Way

www.momobile.org

PROMOTING SOLUTIONS FOR HEALTHY BIRTHS

More than fifteen years ago, in *The Case for Universal Maternity Care*,[1] two public health advocates proposed guaranteed access to a full range of maternity and infant care services for all pregnant women in the United States. In Pennsylvania today, this goal still seems far from attainment.

Based on the findings of our 2006 report, *Childbirth at a Crossroads*, Maternity Care Coalition (MCC) identified **health insurance** as a starting point to improving maternal and child health in our state and region. Since then, Pennsylvania Governor Ed Rendell put forth an ambitious proposal, *Prescription for Pennsylvania*, whose insurance component, *Cover All Pennsylvanians*, addressed some insurance concerns. Legislation that would have expanded insurance coverage for the uninsured passed the House of Representatives in March 2008 and died in the Senate in December 2008. A new legislative session begins in January 2009 and we will analyze the new initiatives from the perspective of families needing insurance coverage

On the federal level, we expect that the new Congress will take up healthcare proposals addressing the uninsured, and we ardently hope for a comprehensive solution that will insure a healthy nation.

While we wait, Maternity Care Coalition continues to seek solutions to "insure healthy births" in our region and in Pennsylvania. Over the past two years, we have reviewed the healthcare services needed to achieve this goal, as well as the demographics of the insured, the uninsured, and the under-insured in Pennsylvania. We have studied the role of health insurance in providing those services and the kinds of health insurance currently available in the state. We also examined other states' solutions and considered the lessons they've learned.

This report includes a summary of our research, our recommendations for change, and suggestions for overcoming specific barriers we identified. First, we turn our attention to the definition of the basic services needed to provide a comprehensive continuum of care for childbearing women.

WHAT SERVICES ARE NEEDED?

1. Preconception care:

- A general health assessment and preventive care that is age appropriate, whether the woman is a teenager or almost menopausal.
- Reproductive healthcare and family planning.
- Anticipatory counseling regarding the possibility of pregnancy; prenatal vitamins and folic acid, or other special care suggested by underlying medical conditions.
- Behavioral health diagnostic and treatment services including substance abuse prevention.

2. Prenatal care:

- Choice of certified nurse midwives, nurse practitioners, or physicians at practice sites convenient for the pregnant woman.
- Childbirth education, including full education on the options for labor and delivery and breastfeeding.
- Treatment of associated medical conditions, as well as psychiatric problems and substance dependence.
- Smoking cessation programs and nutritional counseling.
- Perinatal depression screening and if indicated, treatment.
- Assessment of the need for non-medical services, including housing, employment, childcare, food, transportation, and literacy/education/ language skills; case management as appropriate.

3. Birthing:

- Birth center options for low risk pregnancies.
- Facilities at all risk levels convenient to a woman's home or easy transportation.

4. Post-partum:

- Seamless transition to care needed for each woman.
- Services for behavioral health, primary care, or other care as needed.
- Ongoing primary care.
- Perinatal depression screening, and if indicated, treatment.
- Breastfeeding services, family planning and HIV testing, referral, and counseling.

It is critical to realize that most discussion of insurance and pregnant women, particularly in the context of public insurance programs, refers only to insuring the nine months of pregnancy and 60 days post-partum. This is because eligibility for the patchwork of current public programs is defined by diagnosis (pregnancy) or specific services (family planning) rather than by the basic universal need for healthcare. By the time the pregnant woman becomes insured, it is too late to prevent cases of mortality and morbidity that could have been mitigated by preventive primary care.

Services available through public insurance are thus far more limited than the comprehensive services discussed above, and more limited than those available to women who have private insurance, whether employer sponsored or individually purchased. MCC's goal is comprehensive insurance and access to care for all reproductive age women.

WHAT DOES IT COST TO HAVE A BABY?

Having a baby in the United States is a costly affair. While many complex medical procedures have been moved out of the hospital, childbirth – an event that once happened in the home – now takes place in a setting closer to an intensive care unit. Although insurers can place pressure on hospitals to discharge a patient quickly after a coronary angioplasty, by federal law hospitals must allow a woman to stay for two days following a normal vaginal delivery. **Pregnancy and childbirth now account for 25% of all hospitalizations in the United States.**

In 2004, The March of Dimes commissioned a study looking at childbirth charges and costs for privately insured women in the United States. The study group did not include women enrolled in managed care organizations because of the difficulty of studying various capitation agreements. They included all maternity services during delivery, services 9 months prior to delivery, and three months following delivery. They found:

- The average cost for a vaginal delivery was $7,737 and for a Cesarean delivery was $10,958. Provider charges were *double* both of these, but costs reflect discounts that insurers have negotiated with hospitals and providers.
- Costs varied by region with costs in the South 85% of the highest cost in the Northeast.
- 51% of the charges were hospital charges, not including radiology and laboratory services. Physician professional fees were just under 1/3 of the cost.
- In this employed/privately-insured population in 2004 (prior to the onset of many high deductible health plans) consumer co-insurance averaged $500.

http://www.kff.org/womenshealth/upload/whp061207othc.pdf.
The Healthcare Costs of Having a Baby.

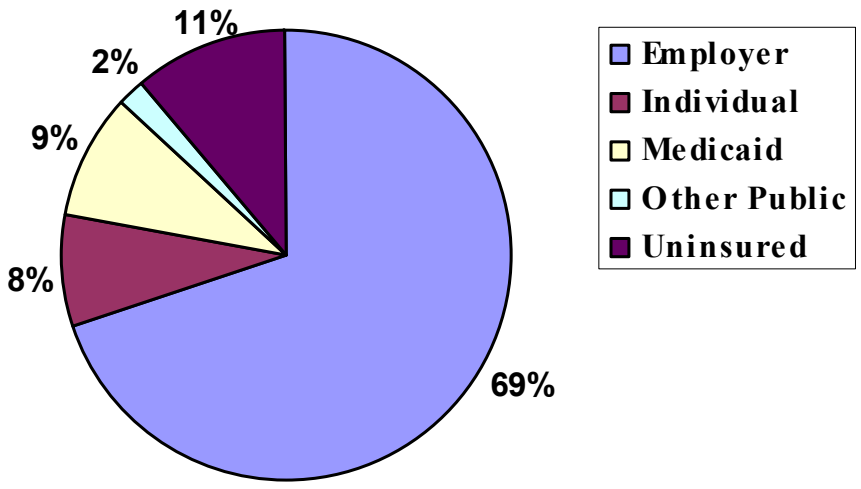
INSURED, UNINSURED, UNDER-INSURED IN PA: WHO AND HOW MANY?

The percentage of all Pennsylvanians without health insurance is 10%. Among women, the uninsured rate is 11.3%[2]. This will undoubtedly increase with the economic downturn. The uninsured are primarily low and moderate income working adults. Eighty percent come from families with one or more working adults, most of whom are not offered insurance at their jobs. Although a high percentage of immigrants are uninsured because they work in low wage jobs, most of the uninsured are native-born Americans. Racial and ethnic minorities comprise over one-half of the uninsured.

In Pennsylvania, an adult working full time at a minimum wage job has an income too high to qualify for Medicaid, but too low to purchase insurance. The uninsured are our friends and neighbors – the clerks in the stores, the workers at fast food restaurants and national discount stores, the parents of our children's friends. Young adults – the group most likely to become pregnant – are also the group most likely to be uninsured.

Pennsylvania is 7th out of 50 states in the percentage (85.5%) of *insured* adults residing in the state according to 2004-2006 census data.[3] This is attributable to the state's large percentage of older persons (insured by Medicare) and by the historical presence of unions. In 2005, 61.5% of Pennsylvania employers offered health insurance to employees, down 6% from 2003. Eighty-three percent of those employees purchase the insurance; employees pay an average of 15.7% of the premiums. The annual premium in 2007 for an employer health plan covering a family of four averaged nearly $12,100.

Source of Insurance for Women in PA, ages 19-64[4]



The graph above shows that 77% of Pennsylvania women between 19 and 64 have some form of private insurance, either employer based or individually purchased. However, this age grouping

is somewhat misleading, because Pennsylvanians between 35 and 64 are more likely to be covered by insurance and those between 19 and 34 are less likely to be covered. And sadly, **being insured does not necessarily protect women from also being "under-insured"** – a broad term indicating that the beneficiary does not have adequate coverage to meet potential healthcare needs – either because the benefits do not meet the needs, or because the financial cost-sharing required (co-pays, deductibles) is unaffordable. This is a tremendous working class, and middle class, burden.

In 2004, 16 million U. S. adults were estimated to be under-insured, a number that has grown as inadequate insurance policies have grown in number. **Women who purchase individual, as opposed to employer sponsored coverage, are at particularly high risk of being under-insured.** In addition, even women who have the state sponsored adultBasic insurance do not have comprehensive coverage that meets the needs of pregnant women as defined on page 3. They too are under-insured.

In Pennsylvania and nationally, Medicaid represents the most important program for insuring low-income pregnant women. In April 2008 there were 15,505 women enrolled statewide in the Medicaid category for pregnant women.

The State of Pennsylvania repeated a 2004 resident survey on health insurance status during 2007-2008 and released the report January 29, 2009.[5] Available data show wide variation:

- For adults in Elk and Montgomery counties, only 6.9% and 7% respectively lack health insurance; in Union County, 23.56% of adults under 64 lack insurance.[6]
- Fifty seven (of 67) counties have more than 10% of adults between 19 and 64 who lack insurance. Twenty-one counties have 15% or more of their adults uninsured.

There is a common public misconception that all low-income persons have health insurance through Medicaid. Keep in mind that nationally, 26% of women on Medicaid have Medicaid only because they are pregnant. When not pregnant, they are uninsured. Temporary state residents like students and visitors are only eligible for emergency medical assistance for the birth.

In 2006, just under 30% of the state's population was considered low income (under 200% of the Federal Poverty Level), but only half of this low-income population was enrolled in Medicaid. (For a complete description of the Federal Poverty Level, see the chart on page 17). Many of these people (e.g., a family of four whose household income is $42,400 per year) are uninsured because though considered low income by the Federal government, they are still **above the Medicaid income limit and cannot afford other health insurance.** Should this family of four seek insurance on their own, a search on www.ehealthinsurance.com for two parents in their late 20's with an infant and a two-year-old found the cheapest non-high deductible plan was $7,000 per year. The family would still have to pay $30 for every office visit, which adds up with well-child care for infants and toddlers.

Sometimes people are uninsured – even though they qualify for Medicaid – because they are uninformed or unable to negotiate the healthcare system. Those with limited English proficiency,

limited literacy, mental illness, substance abuse, or developmental disabilities have a difficult time understanding and complying with the requirements of public benefit programs. Reaching this population presents different challenges than extending eligibility, but it is no less important.

For many **legal immigrants**, eligibility for Medicaid is tied to their length of residency in the U.S. Thus the burden of funding coverage for legal immigrants during their first five years in the country has fallen to states and local safety net providers. Pennsylvania is one of 22 states that provide this coverage for legal immigrant children in SCHIP and legal pregnant women in Medicaid. Our neighboring states of New York, New Jersey and Delaware also do so. Ohio and West Virginia do not. Legal immigrants who are offered health benefits by an employer are of course, eligible for those benefits.

Undocumented immigrant women are able to receive "emergency medical assistance" to cover the cost of childbirth, but **are not eligible to receive insurance for prenatal care**. If properly applied for, and billed for, this "emergency" insurance will pay physicians and hospitals in Pennsylvania under the fee-for-service Medicaid system. There is no coverage for the postpartum or pre-conceptual periods.

Undocumented women represent a very small but important portion of the uninsured. In FY 2006-07 2,597 women in Pennsylvania gave birth under emergency medical assistance. The largest number outside of Philadelphia was in Berks County. In Philadelphia, many childbirth professionals estimate more than 1,000 undocumented women per year seek prenatal care. Their children born here are citizens. In the medical and public health literature, there is general agreement that we have a moral and financial interest in the health of these mothers, their pregnancies, and their babies. States with high immigrant populations have agreed and offered insurance. "New growth" states such as North Carolina, or low immigrant population states such as Pennsylvania, have not yet come to the same conclusion.

More data of note from the 2004 and 2008 Pennsylvania surveys:

- The percentage of uninsured has increased from 7.4% in 2004 to 8.2% in 2007. The number of individuals with private health insurance also decreased from 66% in 2004 to 62% in 2008.
- 70% of the uninsured are working and 48% work for small employers.

It is not that Pennsylvanians do not want health insurance. AdultBasic Insurance, a state-subsidized program, had **90,000 people on its waiting list in May 2008, which grew to 183,000 individuals in January 2009**. Each month, according to the Department of Insurance website, the waiting list has grown *for every county in the state.*

Women Want Health Insurance

An analysis of adultBasic enrollment, and the wait-list, shows us the desperate need for health insurance for women in Pennsylvania. According to figures supplied by the Department of Insurance, as of December 2008:

- 67,382 women between the ages of 19 and 45 are currently on the adultBasic waiting list. Of these women, 25% are ages 19-25; 38% are ages 26-35, and 37% ages 36-45. This represents an increase of 19,657 women in six months!
- Another 15,514 women between 46 and 55 are also on the waiting list, compared to 9,700 in May.
- 63% of women on the waiting list have incomes less than $20,000 per year; 21% have incomes of less than $10,000 per year. The latter are below poverty level if they are single. *Although these women would be Medicaid eligible if pregnant, they remain ineligible and uninsured if they are not pregnant.*

WHAT MATERNITY CARE/ COVERAGE OPTIONS DO WOMEN HAVE?

To ensure optimal childbirth outcomes and maternal/child health, **women need care and support before, during, and after pregnancy.** Good clinical care means preconception, pregnancy and post-partum care. Yet, our financing mechanisms for healthcare do not promote continuity of care throughout our life cycles, or even throughout a woman's childbearing years. Therefore, it is very difficult for women to receive good clinical care when relying on the available insurance and **financing mechanisms that vary depending on the income, employment status and citizen documentation of the women.** Unfortunately, the options available are not likely to give Pennsylvania healthy mothers and healthy babies:

Very low income women qualify for public funding through the Medicaid system administered by the PA Department of Public Welfare from the time pregnancy is confirmed until 60 days post- partum. Their Medicaid eligibility category does not offer additional or routine care for these women before or after the pregnancy.

Uninsured women who are not eligible for ongoing publicly funded care (including undocumented immigrant women) **are eligible for emergency medical assistance only.** There only is funding for the birth-the same funding that is used for uninsured accident victims in an emergency room. There is no care for the woman before or after the birth of the baby. No funding is available for further care of **any** uninsured mother.

To cover the costs of prenatal and post-partum care for women with no insurance, doctors, hospitals and clinics will often make private payment arrangements. The number of women paying out-of-pocket, and the arrangements they have with providers and hospitals, is extremely

difficult to ascertain. Hospitals receiving funds from the tobacco settlement for uncompensated care are required to have charity care policies, but these vary from hospital to hospital.[7]

Alternatively, uninsured women may receive prenatal and post-partum care at safety net institutions such as city-funded clinics, Federally Qualified Health Centers, rural health programs, or other "free clinics," which often have long waits for service.

Women whose income is above the Medicaid eligibility level (e.g., single women who earn more than $25,900 a year) **must depend on their employers to offer health benefits with maternity coverage.** If an employer does not offer maternity coverage (or does not provide insurance at all) a woman can purchase insurance herself, or go without.

A woman who needs to buy insurance has several ways to obtain it for herself:

1. Apply to purchase adultBasic which is partially subsidized through a program administered by the PA Insurance Department and
   -Be on the waiting list of approximately one year, or
   -Purchase the adultBasic insurance at the unsubsidized rate (approximately $300/month.)
2. Purchase her own insurance through a commercial insurance company that is regulated by the PA Insurance Department under "Individual Market" guidelines.

Those who choose to purchase commercial insurance will often find that maternity care is not included in the policies offered. Pennsylvania does not require that health insurance sold by insurers to individuals include maternity care (nine states do mandate that insurers selling individual insurance cover maternity care). Maternity coverage can be expensive, can require the purchase of separate riders, can have waiting periods, or caps on benefits.

Individual market health insurance is state-regulated and thus its terms can be changed at the state level. In a recent report[8] on the individual insurance market, Families USA noted that Pennsylvania lacks many consumer protections that are valuable in the individual market.

PENNSYLVANIA DOES NOT:

- Require that insurers sell insurance to all applicants.
- Require alternative coverage options (high risk pools) for uninsurables (those with serious pre-existing conditions).
- Prohibit higher premiums based on health status.
- Have advance state review of rates.
- Require insurance companies to spend at least 75% of premiums on actual health care.
- Limit how far back into a person's medical history the insurer can look to determine coverage.
- Review decisions to revoke coverage or require an appeals process when coverage is revoked.

If a woman is employed, the insurance opportunities depend on the size of her employer:

- A small employer has the opportunity to purchase an insurance product that is regulated as the "small group market" by the Insurance Department.
- A large employer with over 50 employees has a different set of Insurance Department regulations to follow.
- If the employer is large enough to self-insure health benefits, there are no government regulations to follow.

Employer-sponsored insurance and individually purchased insurance generally provide a woman with continuous coverage before and after pregnancy. For those women who don't have employer-sponsored insurance, while they may be able to piece together a patchwork quilt of coverage from safety net institutions, Medicaid family planning programs, and Medicaid or SCHIP, these options do not currently offer continuous comprehensive care.

In obstetrics, there are **few safety net providers who both provide prenatal care and attend births, thereby creating a serious lack of continuity.** Safety net providers are usually "low tech", needing to refer women to hospitals or other sites for ultrasounds, high risk care, or specialized interventions. Safety net providers are often dependent on "the kindness of strangers" – funders, volunteers, and providers interested in working with low-income communities. An example of the serious consequences of this fragility was the closure of maternity services at a federally qualified health center in Norristown because it was unable to secure physician back-up for midwives.

The Pennsylvania Association of Community Health Centers represents the statewide federally qualified health centers (FQHCs), operating in 39 of the state's 67 counties. These health centers (and they include all the city clinics in Philadelphia) see 18% of the uninsured persons in the state.[9] These centers receive grant funding from the federal government, and can receive funding from the Pennsylvania Department of Health on a 1:1 match/challenge-grant basis. For maternal and child health, some safety net institutions also receive Title V funding. Lancaster General Hospital has attempted to address the need in its community by expanding outpatient safety net facilities, partnering with an FQHC, and using funds from a Department of Health Challenge Grant.

SOME SAD AND SHOCKING PENNSYLVANIA STATISTICS

- Pennsylvania has the lowest percentage of state/governmental healthcare facilities in the country.
- We have no remaining public hospitals.
- Pennsylvania is one of 15 states (and is the most populous of those states) that does not provide direct funding to community health centers (FQHCs).[10]
- In the 5-county Philadelphia area, although there are numerous health centers, they have inadequate funding, and sometimes too few providers, or provider organizations willing to contract to meet the obstetrical and other needs of their patients.
- Elsewhere in the state, FQHCs cannot offer obstetrical services because they lack providers.

WHAT CAN WE LEARN FROM OTHER STATES?

In response to the challenges facing Pennsylvania, are there other states whose experience in insuring healthy births would be helpful to us? **States that currently cover the largest number of pregnant women have done so through a combination of Medicaid and SCHIP plus creation or expansion of public health maternal and child health initiatives.** (SCHIP is the federally funded State Children Health Insurance Program that permits a higher reimbursement than Medicaid. Some states have used SCHIP to cover pregnancy by declaring the fetus a child.) Nineteen states and the District of Columbia currently insure pregnant women, either under Medicaid, SCHIP or a combination, up to 200% FPL. Six states (California, Connecticut, Iowa, Maryland, Minnesota, Rhode Island) and the District of Columbia insure women who are over 200% FPL. Nine states increased Medicaid income eligibility in the last year, reflecting widespread agreement on the need to provide coverage to pregnant women.

Recently, multiple states have sought to expand not just maternity coverage, but all insurance coverage. Governors and state legislators have recognized the growing crisis of the uninsured, and the reality that paying for uninsured care devolves to states. Governors in numerous states, including Pennsylvania, have proposed public/private expansion programs; in many states advocates have also proposed single payer plans.

Similar to proposals in Governor Rendell's original health care reform efforts, the programs include expansion of existing Medicaid and SCHIP programs to take advantage of federal matches, creation of state subsidized insurance products administered through the private sector, and premium subsidies. Additional features may include individual or business mandates, and possible reforms of the insurance industry in the state. Several of these coverage expansions have high cost-sharing. Most of the non-single payer plans are based on expanding the scope and availability of employer sponsored insurance in combination with public insurance. They include individual mandates, employer mandates, COBRA coverage expansions, health savings accounts, and subsidized insurance vehicles.

While these programs are not usually targeted at expanding coverage for pregnant women, they would clearly do so if passed. Very few, if any, address the undocumented. States with plans currently in place (Maine, Vermont and Massachusetts) still have significant numbers of uninsured, and have not solved the conundrum of increased access without increased costs.

California and Illinois are other states often cited as **models for coverage of maternal and child health.** They have **combined and expanded coverage options and removed some enrollment barriers.** They also have active public health programs (including public hospitals) that promote maternal and child health.

While each state has unique circumstances, Pennsylvania is faced with a disparate system that serves some of the people some of the time for some of their pregnancies. **Our system seems to be built on the needs of funders and suppliers, not the needs of the women** who need health insurance. Fragmented funding does not support a basic level of care to support healthy outcomes for Pennsylvania's families. In the next section we outline the needs from the

perspective of childbearing families and the changes that should be made in the Commonwealth for healthy family outcomes.

WHAT ARE THE PRIORITIES FOR ADDRESSING PENNSYLVANIA'S HEALTH INSURANCE CHALLENGES?

MCC believes that health insurance should:

- Provide access for the healthcare that women need to stay healthy in all phases of life, regardless of income or employment.
- Follow clinical care standards for both physical and behavioral health.
- Be affordable for all women, including those who are not eligible for publicly funded coverage.
- Always cover pregnancy, since childbirth is the most common reason for hospitalization.

Health insurance for maternity services should be viewed through a consumer lens so that the Commonwealth's laws and regulations coincide with quality clinical care, not the sale of products that are defined by the seller and purchaser. We have identified three consumer-focused changes that would vastly improve healthcare for childbearing women in Pennsylvania:

1. Include maternity benefits in all products and not permit maternity as a supplemental option.
2. Eliminate gender and age from community ratings. (A community rating is a method for calculating health insurance premiums based on the average costs for the community rather than the characteristics of an individual.)
3. Exclude pregnancy from the list of pre-existing conditions.

To enact these changes, we need to understand who has the authority to make the changes and how they can be implemented.

WHO ARE THE REGULATORS?

There are three different executive departments, as well as the legislature, overseeing commercial and public insurance programs. In addition to the PA Insurance Department and the Department of Public Welfare, the PA Health Department is also involved in health insurance regulation. The Health Department regulates managed care plans, whether offered through a commercial insurance carrier or publicly funded. The PA Health Department also monitors hospitals that report how much uncompensated care they have given to the uninsured.

WHAT OPPORTUNITIES EXIST FOR CHANGE?

Opportunities for the Insurance Department:

The Pennsylvania Insurance Department oversees the regulation of commercial health insurance products for women of childbearing age. To provide information for women and families, the department should:

- Issue regular reports for women and families about available health insurance products and provide comparative information to help consumers weigh their options. An online shopper's guide for families would be a very useful tool.
- At least annually produce a comparison of the products available for maternity coverage, describing benefits, premiums, deductibles and out-of-pocket costs.
- Create a "Bill of Rights" for all women ages 18 to 45, the prime childbearing years, to alert consumers of their rights and recommend cautions before buying any insurance products. (A similar document was produced in August 08 for Older Pennsylvanians).

Opportunities for DPW:

The Department of Public Welfare is responsible for distributing Medicaid funds that enable income-eligible women to receive healthcare.

The current Medicaid eligibility categories do not permit access to the full range of reproductive services without changing providers for pre-conception, prenatal, birth, and post-partum care. The Department of Public Welfare systems should support the woman based on income eligibility, not pregnancy status. With a DPW voucher she could purchase pre-conception care, family planning, prenatal and post-partum care. She could then receive services with continuity of care as a model.

Opportunities for publicly subsidized programs in both DPW and Insurance:

- Ensure that adultBasic services permit the full range of services that women may need, including behavioral health services.
- Integrate all publicly funded programs to offer seamless services with premiums based on the woman's income. The woman should be able to choose her provider rather than have the provider dictated by the funding stream.
- Merge AdultBasic and Medicaid systems so that services are not disrupted when a woman moves between these two funding streams. Make continuous care and continuity of care the standard for all services and contracts.

Opportunities for the PA Health Department:

Act 68 in Pennsylvania specifies standards for managed care plans. The PA Health Department regulates the plans based on medical necessity and size of each network of providers. Regulators must:

- Increase standards for the number and availability of prenatal and birthing options in each managed care network.
- Conduct an annual review of each managed care health plan to include the number of clients/customers/members of childbearing age, the number of prenatal care sites, the number of full time equivalents of child birth professionals and the type of professional, e.g. certified nurse midwife, obstetrician, family practitioner, physician assistant, etc. Publicize the results.
- Ensure that plans clearly list co-pays, co-insurance, deductibles, out-of-pocket maximums, benefit limits and exclusions.
- Include and segregate the number of individuals receiving prenatal, birthing, and post-partum patient care and dollar amount for the care in hospitals' required reports for uncompensated care. Publish these reports annually.

Opportunities for the State Legislature:
Based on the current regulations, the following changes will need **legislation** before the Insurance Department can make any changes:

For the individual market:

- Include maternity service in all individual insurance products. Maternity coverage must be a mandate (as it is in our neighboring states of NJ and NY).
- Exclude pregnancy from list of pre-existing conditions.
- Implement "guaranteed issue", ensuring that if an insurance company offers health insurance in this market, they must offer it to everyone. Insurance companies should not be able to choose who can purchase the insurance.

For small group benefit packages:

- Apply community ratings, meaning that the premium for all people is the same without regard to sex, health, age or demographic characteristics of an individual.
- Exclude pregnancy from list of pre-existing conditions.
- Implement "guaranteed issue".

For large group employer packages:

- Include the full range of women's reproductive services whenever health benefits are offered.
- Exclude pregnancy from list of pre-existing conditions.

In addition, for all citizens, lawmakers should pass legislation that:

- Protects employees who work in firms with fewer than 15 employees, requiring these firms to treat pregnancy as any other illness, as federal law requires of employers with 15 or more employees.
- Ensures all insurance programs provide prenatal, intraconception, and post-partum care as a wellness benefit.
- Ensures that both providers and facilities receive financial incentives from all public and commercial insurance to use certified nurse midwives and other forms of professional care.
- Requires rates for maternity care services must be made public. Consumers should be able to choose among plans based on a comparison of the premium charged, the amount of the co-pay, and the amount of the benefit they will receive if they need to use the care.
- Stipulates that funding for adultBasic is increased to cover all women of childbearing age currently on the waiting list.

Opportunities for both the Governor and Legislature:

- Since PA has no remaining public hospitals, the Commonwealth should finance efforts to prevent poor birth outcomes, rather than paying for the results with increased expenditures for neonatal intensive care units.
- To reduce disparities in maternal and child health outcomes, reimburse providers for all Medicaid birth services, similar to the successful model in Illinois. In 2004, the Illinois General Assembly passed legislation specifically to improve outcomes on the 80,000 births covered by Medicaid each year. The appropriation provides "reimbursement for all prenatal and perinatal health care services…for the purpose of preventing low birth weight infants, reducing the need for neonatal intensive care hospital services and promoting perinatal health."
- Identify a commission that will work to ensure all women receive maternity care to prevent poor birth outcomes. Similar commissions exist in New Jersey and Illinois.
- Provide universal maternal healthcare for all residents, regardless of citizenship status. Since children born in PA are US citizens, it makes sense to provide healthcare to pregnant women to have healthy children.

Endnotes

[1] Kotch Jonathan B and Barber-Madden Rosemary. The case for universal maternity care. In Kotch et al, (eds) A Pound of Prevention: The case for universal maternity care in the U.S. American Public Health Association Washington DC 1992. pages 252-271.
[2] From 2007 Current Population Survey data as reported by the National Women's Law Center www.nwlc.org
[3] http://www.census.gov/prod/2007pubs/p60-233.pdf
[4] www.kff.org found at www.statehealthfacts.org
[5] PA Dept of insurance website http://www.ins.state.pa.us/ins/site/default.asp
[6] Information from Pennsylvania Department of Insurance available at http://www.rxforpa.com/assets/pdfs/allcountieswranks.pdf accessed May 2008
[7] For a listing of current Philadelphia area hospitals and charity care policies see Hospital Accountability Project on the website of the Pennsylvania Health Law Project, www.phlp.org.
[8] Failing grades: state consumer protections in the individual health insurance market. Families USA June 2008. Accessed at www.familiesusa.org.
[9] Advocacy position paper, Pennsylvania Association of Community Health Centers http://www.paforum.com/documents/PACHCPOLICYPAPERS.pdf
[10] Testimony, Senate Public Health and Welfare committee, April 9 2008. Cindy Christ

Federal Poverty Levels

A word about income and Federal Poverty Levels

Each year in February the Federal government issues updated numbers for the Federal Poverty guidelines. These numbers are used to determine financial eligibility for certain federal and state programs. They are also often used by other organizations (e.g. hospitals) to determine eligibility for reduced fees. They are referred to as FPL, or federal poverty level. The numbers are the same for all 48 mainland states, regardless of regional differences in cost-of-living. FPL is calculated on the basis of household size; a pregnant woman and her single fetus count as two persons. A woman pregnant with twins has a household of 3. Monthly and annual incomes for 2008 at several levels of FPL for a family of 2, 4, and 6 are noted below because they are frequently referred to in this report. Please note that these are 2008 estimates.

Tables: 2008 Federal Poverty Levels by Monthly and Yearly income

Table 1: Family of 2

	100% FPL	133% FPL	185% FPL	200% FPL	250% FPL	300% FPL
Monthly	**$1,167**	**$1,552**	**$2,159**	**$2334**	**$2,918**	**$3501**
Yearly	**$14,000**	**$18620**	**$25,900**	**$28,000**	**$35,000**	**$42,000**

Table 2: Family of 4

	100% FPL	133% FPL	185% FPL	200% FPL	250% FPL	300% FPL
Monthly	**$1,766.67**	**$2,349.67**	**$2,650**	**$3,533.33**	**$4,416.67**	**$5,300**
Yearly	**$21,200**	**$28,196**	**$31,800**	**$42,400**	**$53,000**	**$63,600**

Table 3: Family of 6

	100% FPL	133% FPL	185% FPL	200% FPL	250% FPL	300% FPL
Monthly	**$2,367**	**$3,148**	**$4,379**	**$4733**	**$5,917**	**$7,101**
Yearly	**$28,400**	**$37,776**	**$52,548**	**$56,800**	**$71,000**	**$85,212**

Table 4: Family of 8

	100% FPL	133% FPL	185% FPL	200% FPL	250% FPL	300% FPL
Monthly	**$2,967**	**$3,946**	**$5,489**	**$5933**	**$7,417**	**$8,901**
Yearly	**$35,600**	**$47,352**	**$65,868**	**$71,200**	**$89,000**	**$106,812**

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And, a final thank you to all who are reading this report and concerned about Insuring Healthy Births. **Please join with us at www.MOMobile.org.**