CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

EXECUTIVE SUMMARY
Analysis of Assembly Bill 98: Maternity Services

A Report to the 2009-2010 California Legislature
March 16, 2009

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EXECUTIVE SUMMARY

California Health Benefits Review Program Analysis of Assembly Bill 98: Maternity Services

The California Health Benefits Review Program (CHBRP) undertook the analysis of Assembly Bill (AB) 98 in response to a request from the California Assembly Committee on Health on January 15, 2009, pursuant to the provisions of Senate Bill 1704 (Chapter 684, Statutes of 2006) as chaptered in Section 127600, et seq. of the California Health and Safety Code. This report provides an analysis of the medical, financial, and public health impacts of AB 98.

AB 98, introduced by Assembly Member Hector De La Torre, would require health insurance products regulated under the California Department of Insurance (CDI) to cover maternity services.[1] AB 98 defines maternity services to include prenatal care, ambulatory care maternity services, involuntary complications of pregnancy, neonatal care, and inpatient hospital maternity care including labor and delivery and postpartum care. AB 98 is similar to legislation introduced in prior sessions: AB 1962 (2008), Senate Bill (SB) 1555 (2004), and SB 897 (2003). Both AB 1962 and SB 1555 passed the Legislature during their respective sessions and were vetoed by the Governor.[2]

AB 98 would apply only to CDI-regulated policies (mostly including preferred provider organizations) and represent approximately 13.7% of the privately insured market in California. Health care service plans (including health maintenance organizations, point-of-service plans, and some preferred provider organizations), which are regulated by the Department of Managed Health Care (DMHC), make up the remaining portion of the privately insured market. However, although DMHC-regulated plans make up the majority of the privately insured market (which contains both the group and individual market segments), CDI-regulated policies represent a substantial portion of the *individual* market—about 51.8%.

Current laws and regulations governing DMHC-regulated health care service plans require coverage for maternity services under provisions related to "basic health care services." DMHC-regulated plans are required to cover maternity and pregnancy-related care under laws governing emergency and urgent care.[3] Regulations defining basic health care services specifically include prenatal care as preventive care that must be covered.[4] CDI-regulated plans currently have no such requirements.

The Federal Civil Rights Act requires employers that offer health insurance and have 15 or more employees to cover maternity services benefits at the same level as other health care benefits.[5] Complications of pregnancy are generally covered regardless of whether the health insurance

[1] AB 98 would add Section 10123.865 to the California Insurance Code.
[2] The legislative history of AB 1962, SB 1555, and SB 897 are available at www.leginfo.ca.gov. CHBRP conducted analyses of these bills and those reports are available at http://www.chbrp.org/completed_analyses/index.php.
[3] Section 1317.1 of the California Health and Safety Code
[4] Section 1300.67 of the California Code of Regulations, Title 28
[5] The Pregnancy Discrimination Act under Title VII of the Civil Rights Act of 1964

policy provides coverage for maternity benefits. Insurers are also required to cover newborns for the first 30 days of life regardless of whether the health insurance policy covers maternity services.[6]

The bill's definition of maternity services is generally consistent with the definitions of maternity services under health insurance: prenatal care (such as office visits and screening tests), labor and delivery services (including hospitalization), care resulting from complications related to a pregnancy; and postpartum/postnatal care.

In 2006, the birth rate in California was 71.3 births per 1,000 women of childbearing age, or more than 562,000 births (CDPH, 2009). The majority (85.9%) of births were to mothers who initiated prenatal care in the first trimester, with only 0.6% of women receiving no prenatal care (CDPH, 2009). Overall in California, there are approximately 75 maternal pregnancy-related deaths and 3,000 infant deaths per year (CDPH, 2007; MOD 2003-2005). Infant mortality is most frequently caused by birth defects (23.5% of deaths), followed by prematurity and low birth weight (15.6% of deaths), maternal complications of pregnancy (6.0% of deaths), and SIDS (5.2% of deaths) (CDPH, 2005). As will be discussed in further detail in the *Medical Effectiveness* section, specific prenatal care services can be effective in reducing the rate of preterm births, low–birth weight babies, transmission of infectious diseases, and other related infant and maternal morbidity and mortality.

The *Medical Effectiveness* and *Public Health Impacts* sections of this report focus on the outcomes associated with prenatal care services because: (1) a majority of births occur in the hospital setting regardless of insurance status, (2) prenatal care services use would be most affected by the potential for out-of-pocket costs and thus most directly impacted by AB 98, (3) AB 98 would not affect coverage for infants, and (4) plans and policies that do not cover maternity services cover complications related to a pregnancy. The *Utilization, Cost, and Coverage Impact* analysis includes the full range of services that are considered to be "maternity services."

Medical Effectiveness

Studies of prenatal care can be divided into two major groups:

- Studies of the impact of variation in the number of prenatal care visits that pregnant women receive; and

- Studies of the effectiveness of specific medical services provided to pregnant women (e.g., laboratory tests, medications, etc.).

Randomized controlled trials (RCTs) have consistently found no statistically significant association between the numbers of prenatal visits pregnant women receive and birth outcomes for either infants or mothers.

[6] Insurance Code Section 10119 and Redlands Community Hospital v. New England Mutual (1994) 23 Cal. App. 4th 89

However, there is clear and convincing evidence from multiple RCTs that the following prenatal care services are effective in producing better birth outcomes for mothers and infants:

- Smoking cessation counseling
- Ultrasound to identify structural abnormalities and determine gestational age
- Folic acid to prevent neural tube defects
- Screening and treatment for asymptomatic bacteriuria
- Screening for hepatitis B
- Screening and treatment for human immunodeficiency virus
- Calcium supplements, aspirin, and anti-convulsants for treatment of hypertensive disorders
- Screening and prophylactic and therapeutic treatment for Rh(D) incompatibility
- Progestational agents to prevent preterm delivery
- Corticosteroids to promote maturation of lungs in fetuses scheduled for preterm delivery due to preeclampsia or other complications
- Magnesium sulfate to prevent neurological impairment in fetuses at risk for preterm delivery
- External cephalic version for breech presentation at term
- Membrane sweeping and induction of labor for prevention of postterm pregnancies

In addition, there is a preponderance of evidence from nonrandomized studies and/or a small number of RCTs that the following prenatal care services are effective:

- Screening for domestic violence
- Screening for Down syndrome, hemoglobinopathies, and Tay-Sachs disease
- Screening and treatment for chlamydia, gonorrhea, and syphilis
- Screening for group B streptococcus
- Screening and treatment for gestational diabetes
- Iron supplements for treatment of iron deficiency anemia
- Blood pressure monitoring for hypertensive disorders
- Screening for atypical red blood cell alloantibodies other than Rh(D) incompatibility
- Ultrasound to diagnose placenta previa

Utilization, Cost, and Coverage Impacts

Current Coverage of Maternity Benefits

Because maternity benefits are required to be provided by Knox-Keene[7] licensed DMHC-regulated plans, AB 98 targets CDI-regulated policies. About 2,370,000 Californians, or 11.1% of enrollees in plans subject to state regulation, are in the CDI-regulated market. CHBRP's survey of the largest health insurers in the state indicates the following:

- *Entire CDI-regulated market*: Most Californians enrolled in CDI-regulated policies (66%) currently have coverage for maternity benefits, including prenatal care and delivery services. All enrollees have coverage for complications of pregnancy.

- *CDI-regulated large- and small-group markets*: 100% of enrollees in CDI-regulated policies in the large- and small-group markets currently have maternity benefits. Therefore, the proposed mandate would impact only the enrollees in individual (non-group) CDI-regulated policies.

- *CDI-regulated individual market*: 22% of enrollees in CDI-regulated policies in the individual (non-group) insurance market currently have maternity benefits.

    - Of those who do not currently have coverage for maternity services, about one-quarter are women of childbearing age (19 to 44).

    - There is evidence that risk segmentation has already had a substantial impact on the CDI-regulated individual market, because in a previous analysis of SB 1555 in 2004, CHBRP estimated that approximately 82% of those in the individual market had maternity benefits.

- *Public programs*: The Medi-Cal and Aid to Infants and Mothers (AIM) programs cover maternity services for women who qualify. Pregnant women who are in households with incomes less than or equal to 200% of the Federal poverty level generally qualify for Medi-Cal. AIM provides coverage for both uninsured and underinsured women between 200% and 300% of the Federal poverty level. AIM defines underinsured women as those with private insurance who face out-of-pocket costs for maternity services greater than $500. CHBRP estimates that approximately 29% of privately insured women who deliver babies during 2009 and have no maternity benefits when they become pregnant may qualify for Medi-Cal or AIM.

    - Based on data from AIM, there is evidence of current cost-shifting to that program. As of 2008, about 7% of the women enrolled in AIM were simultaneously enrolled in private health insurance policies that did not cover maternity services. Another 10% of AIM enrollees were enrolled in private insurance policies that did cover maternity services.

    - CHBRP estimates that approximately 10,400 women enrolled in CDI-regulated policies with no maternity benefits at the time of pregnancy would give birth during 2009.

[7] Health maintenance organizations in California are licensed under the Knox-Keene Health Care Services Plan Act, which is part of the California Health and Safety Code.

- Of these women, approximately 2,300 would switch to Medi-Cal and another 700 would enroll in AIM following pregnancy. This is because their income eligibility would change following pregnancy (since pregnant women are considered a household of two and presumably their household income would not increase).

- Another 300 of these women may transfer to policies covering maternity that are offered by their existing carrier.

- The remaining 7,100 women would not have insurance coverage pre-mandate for their prenatal care and delivery.

Post-Mandate Coverage, Cost, and Utilization

- AB 98 would expand maternity services coverage to 805,000 enrollees with CDI-regulated individual policies, including 207,000 women aged 19 to 44 years.

- CHBRP estimates that there would not be a direct impact on Medi-Cal enrollment as a result of AB 98. Those women who currently have no maternity coverage and qualify for Medi-Cal after pregnancy would still shift to Medi-Cal post-mandate due to their income levels.

- Women enrolled in AIM who are currently enrolled in CDI-regulated individual policies that do not cover maternity services would have maternity coverage post-mandate. However, the out-of-pocket cost of maternity services in those policies would likely still be greater than $500 (adding up deductibles and copayments), so those women would still qualify for AIM. As AIM would be the secondary payer if women retain their private coverage, there may be a small shift of costs from AIM onto the private plans, depending on whether AIM plans seek reimbursement from the private plans.

- CHBRP estimates that approximately 7,100 pregnancies would be newly covered under CDI-regulated insurance policies post-mandate. The impact of expanded coverage on utilization is summarized below:

    - Overall, the mandate is estimated to have no impact on the number of deliveries, since the birth rate is not expected to change, post-mandate.
    - Most women are likely to continue to face large out-of-pocket expenditures for maternity services regardless of whether or not their insurance policy includes maternity benefits. This is because almost two-thirds of the women in CDI-regulated individual policies are currently in high-deductible health plans (HDHPs) and prenatal care is usually subject to the HDHP deductible. Even the women currently enrolled in non-HDHPs frequently face high cost-sharing requirements in the CDI-regulated individual market, and some might also choose to switch to HDHPs post-mandate in order to save on premiums.
    - Standard prenatal care is almost always bundled with delivery services and paid for as a single lump-sum fee to physicians. As women need the obstetrician's services for delivery, they are likely to pay this fee eventually, even if they must pay out of pocket. Thus, their only pre-mandate incentive to delay or avoid receipt of prenatal care is to postpone payment. To the extent that prenatal care and delivery services are bundled as a

fixed charge and women are aware of this fee structure, it is unlikely that AB 98 would have a large impact on utilization of standard prenatal care services. Furthermore, even if use of these services increased, it would not affect expenditures because the fee does not depend on the number of prenatal care visits made.

- Certain types of screening tests are not included in the standard prenatal care fee and might be used more frequently post-mandate if they are part of the maternity benefit, thereby affecting costs. The amount of the increase is difficult to estimate, as these tests would be subject to HDHP deductibles and women may treat them as out-of-pocket costs.

- Among all enrollees in state-regulated policies (both CDI-regulated and DMHC-regulated), total health expenditures are estimated to increase by $29.7 million, or 0.04%, as a result of this mandate (see row labeled "Total Annual Expenditures" in Table 1). As the total number of deliveries and average cost associated with each delivery is not expected to increase, the mandate primarily shifts costs from individuals to insurers. CHBRP assumes that the administrative expenses for health plans will increase in proportion to the increase in their covered health care costs, leading to an estimated increase in overall expenditures. Note that the increase in total expenditures is a total of:

  - The increase in premium expenditures in the individual market: $89.3 million (see row labeled "Premium expenditures for individually purchased insurance" in Table 1).
  - The increase in out-of-pocket expenditures for maternity benefits covered by insurance (e.g., copayments and deductibles): $21.5 million (see row labeled "Individual out-of-pocket expenditures for covered benefits").
  - The reduction in out-of-pocket expenditures for maternity benefits not currently covered by insurance: $81.1 million (see row labeled "Out-of-pocket expenditures for noncovered benefits").

- All of the costs of the mandate would be concentrated in the CDI-regulated individual market, where total expenditures are estimated to increase by 1.10% and premiums by 4.24%. Per member per month (PMPM) premiums are estimated to increase by an *average* of $7.17 in this market.

  - Insurance premiums in the individual market are stratified by age bands, so premiums are likely to increase more for younger individuals (particularly ages 19 to 29) than for older individuals. CHBRP estimates that for the majority of individuals in the CDI-regulated individual market who do not currently have maternity benefits, AB 98 would *increase* average premiums by 2.01% to 27.47% among those 20 to 44 years old, depending on the age of the enrollee. Among the minority of individuals in the CDI-regulated individual market who currently have maternity benefits, AB 98 is expected to *decrease* average premiums by 1.30% to 19.46%.

  - Premiums are currently gender-rated for 59% of individually purchased CDI-regulated health insurance products in California. Under gender rating, the premium increases resulting from the mandate could be greater for women than men.

- In addition to varying with age and gender, premium changes could vary across policies, depending on how women of a given age self-select into different policies based on their likelihood of getting pregnant.

- The estimated premium increases may result in approximately 7,600 newly uninsured. It is likely that these newly uninsured would disproportionately consist of younger individuals and women, if they experience the greatest premium increases.

Public Health Impacts

- An increase in the utilization of effective prenatal care services by pregnant women could lead to a reduction in infant and maternal mortality and improve health outcomes, such as the rates of low birth weight or preterm births, infectious disease transmissions, and respiratory distress syndrome.

- CHBRP is unable to estimate what the impact of AB 98 will be on the utilization of prenatal care. A lower bound estimate would assume that there will be no increase in the utilization of effective prenatal care services because these pregnant women will likely still face high out-of-pocket costs. An upper bound estimate would assume that all 7,100 newly covered pregnancies would have financial barriers to prenatal care removed and thus an increase in the utilization of effective prenatal care services, and corresponding health outcomes would be expected.

- Despite poorer health outcomes for babies born to black women, such as increased rates of preterm birth, low birth weight, and infant mortality, there is no evidence that AB 98 would have an impact on prenatal care utilization rates among black women specifically, or reduce these disparities in health outcomes.

- The passage of AB 98 could disproportionately impact women because, to the extent that insurance premiums are gender-rated, women would experience relatively higher premium increases than men.

- In California, 10.9% of babies are born preterm and there are 3,000 infant deaths each year. It is estimated that each premature birth costs society approximately $51,600. To the extent that AB 98 increases 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.

Table 1. Summary of Coverage, Utilization, and Cost Impacts of AB 98

	Before Mandate	After Mandate	Increase/ Decrease	Change After Mandate
Coverage				
Total population in plans subject to state regulation (a)	21,340,000	21,340,000	0	0.00%
Total population subject to AB 98				
In large- and small-group plans	1,332,000	1,332,000	0	0.00%
In individual plans	1,038,000	1,038,000	0	0.00%
Total	2,370,000	2,370,000	0	0.00%
Percentage of individuals in CDI-regulated policies with maternity coverage				
In large- and small-group plans	100%	100%	0.00%	0.00%
In individual plans	22%	100%	77.55%	345.49%
Total	66%	100%	33.97%	51.44%
Number of individuals in CDI-regulated policies with maternity coverage				
In large- and small-group plans	1,332,000	1,332,000	0	0.00%
In individual plans	233,000	1,038,000	805,000	345.49%
Total	1,565,000	2,370,000	805,000	51.44%
Utilization and Cost				
Number of individuals in CDI-regulated policies with uncomplicated pregnancies				
Pregnancy covered by private insurance	20,000	27,100	7,100	35.43%
Pregnancy covered by AIM or Medi-Cal	3,000	3,000	0	0.00%
Pregnancy not covered by insurance	7,100	0	-7,100	-100.00%
Total	30,100	30,100	0	0.00%
Average cost per uncomplicated pregnancy	$11,300	$11,300	$0	0.00%
Expenditures				
Premium expenditures by private employers for group insurance	$50,546,207,000	$50,546,207,000	$0	0.00%
Premium expenditures for individually purchased insurance (b)	$5,944,229,000	$6,033,527,000	$89,298,000	1.50%
Premium expenditures by individuals with group insurance, CalPERS, Healthy Families, AIM, or MRMIP (c)	$13,475,994,000	$13,475,994,000	$0	0.00%

Table 1. Summary of Coverage, Utilization, and Cost Impacts of AB 98 (Cont'd)

CalPERS employer expenditures	$3,161,160,000	$3,161,160,000	$0	0.00%
Medi-Cal state expenditures (d)	$3,976,620,000	$3,976,620,000	$0	0.00%
Healthy Families state expenditures	$643,247,000	$643,247,000	$0	0.00%
Individual out-of-pocket expenditures for covered benefits (deductibles, copayments, etc.)	$6,367,363,000	$6,388,819,000	$21,456,000	0.34%
Out-of-pocket expenditures for noncovered benefits	$81,092,000	$0	-$81,092,000	-100.00%
Total Annual Expenditures	$84,195,912,000	$84,225,574,000	$29,662,000	0.04%

Source: California Health Benefits Review Program, 2009.

Notes: (a) This population includes privately insured (group and individual) and publicly insured (e.g., CalPERS, Medi-Cal, Healthy Families, AIM, MRMIP) individuals enrolled in health insurance products regulated by DMHC or CDI. Population includes enrollees aged 0 to 64 years and enrollees 65 years or older covered by employer-sponsored insurance.

(b) Premium expenditures by individuals include employee contributions to employer-sponsored health insurance and member contributions to public insurance.

(c) Of the CalPERS employer expenditures, about 59% are state expenditures for CalPERS members who are state employees.

(d) Medi-Cal state expenditures for members under 65 years of age include expenditures for individuals covered by the Major Risk Medical Insurance Program (MRMIP) and Access for Infants and Mothers (AIM) program.

Key: CalPERS = California Public Employees' Retirement System.

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California Health Benefits Review Program Committees and Staff

A group of faculty and staff undertakes most of the analysis that informs reports by the California Health Benefits Review Program (CHBRP). The CHBRP **Faculty Task Force** comprises rotating representatives from six University of California (UC) campuses and three private universities in California. In addition to these representatives, there are other ongoing contributors to CHBRP from UC. This larger group provides advice to the CHBRP staff on the overall administration of the program and conducts much of the analysis. The CHBRP **staff** coordinates the efforts of the Faculty Task Force, works with Task Force members in preparing parts of the analysis, and coordinates all external communications, including those with the California Legislature. The level of involvement of members of the CHBRP Faculty Task Force and staff varies on each report, with individual participants more closely involved in the preparation of some reports and less involved in others.

As required by the CHBRP authorizing legislation, UC contracts with a certified actuary, Milliman Inc. (Milliman), to assist in assessing the financial impact of each benefit mandate bill. Milliman also helped with the initial development of CHBRP methods for assessing that impact.

The **National Advisory Council** provides expert reviews of draft analyses and offers general guidance on the program to CHBRP staff and the Faculty Task Force. CHBRP is grateful for the valuable assistance and thoughtful critiques provided by the members of the National Advisory Council. However, the Council does not necessarily approve or disapprove of or endorse this report. CHBRP assumes full responsibility for the report and the accuracy of its contents.

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