Maternal and Child Health Access

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September 15, 2009

Managed Risk Medical Insurance Board
Attn: Ms. Dianne Knox
1000 G Street, Suite 450
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Dianne.Knox@mrmib.ca.gov

RE: ER-5-09 Proposed Regulation Text, [AIM] Enrollment Limitation Relating to Insufficient Funding.

MRMIB meeting September 16, 2009.

Dear MRMIB and Ms. Knox:

We submit these comments on the draft proposed regulations for limiting AIM enrollments when funds are insufficient (ER-5-09) and look forward to working with MRMIB to prevent the need for closing AIM to any eligible woman.

1) With the AIM caseload falling, the draft proposed regulations are premature.

It is not yet clear whether or when new AIM enrollments would actually exceed available program funds. AIM enrollment has been declining, and, for fiscal year 2009-10, may be significantly below the approximate 12,500 annual enrollments of previous recent years.

The estimate for the AIM funding shortfall has dropped significantly from the time of the May Revision ($4.9 million State General Fund (SGF)) to the Board's August 20, 2009 meeting ($1.83 million SGF), and the estimated date for closing the program to new enrollments has been postponed from January to March 2010. Staff documents indicate that the closure may be postponed again if the AIM caseload continues to drop. Perhaps the new timing for payments to AIM health plans will also further affect expenditures in FY 2009-10.

While we do not fully understand the reasons for AIM's caseload decline, we believe it is likely due in significant part to the fact that many women in low wage jobs have lost their employment during the recent economic crisis and now qualify for Medi-Cal (where the income eligibility limit is 200% of poverty) instead of AIM (201%-300% of poverty). Jobs for low-income workers are not likely to come roaring back by early or even mid-2010, much less before the end of 2009.

In any event, solutions for addressing AIM's funding gap, should it persist, may materialize before March 2010. The Board will have the time and opportunity to re-visit enrollment closure

regulations for AIM when and if the extent of the funding shortfall solidifies and if no funding alternatives emerge. We stand ready to work with the Board and the Administration to ensure that AIM funding is available when needed.

2) Closing AIM to pregnant women is likely to cost the State money, not save it.

Closing AIM to new enrollments would be the classic "penny-wise, pound-foolish" response to a fiscal challenge and should be rejected on that basis alone.

Prenatal care not only saves lives—it also saves money. The prestigious Institutes of Medicine (IOM) (part of the National Academy of Sciences) have calculated that each dollar spent on providing adequate prenatal care can reduce total expenditures for medical care to low birth weight infants by $3.38 (1985 dollars) during the first year of life. Other investigators have computed different ratios, ranging from $1-$1 to as much as $1-$10 when life-long costs are factored in.

Because early and adequate prenatal care can help to prevent prematurity and low birth weights and otherwise promote improved birth outcomes, it is widely regarded by national health organizations, such as the IOM, the United States Public Health Service, and the American College of Obstetricians-Gynecologists, as well as California's Health and Human Services Agency as an important public health goal.

Women in prenatal care are more likely to be screened and receive diagnostic tests that can help to identify problems early; get services to manage developing and existing health problems; and receive education, counseling and referrals to reduce behaviors like smoking, substance use and poor nutrition that can adversely affect both maternal and fetal health. Such services can reduce the risk of premature births and low birth weights resulting from prematurity or other circumstances. Low birth weight newborns are at significantly increased risk for disabling and even life-threatening medical conditions.

Delaying or going without prenatal care may put both the mother and fetus at significantly increased risk of complications during the pregnancy and at and after the birth. This is especially so if the woman has any of a number of fairly common health conditions making the pregnancy high risk per se, such as obesity, high blood pressure, diabetes, asthma or heart disease.

For example, a 2004 study found that singleton infants born to mothers who received late or no prenatal care were nearly twice as likely to be low birth weight (less than 5 pounds, 8 ounces) as infants born to mothers who received early prenatal care—9.9% compared with 5.9%. As noted, avoiding low birth weights is a major health goal, because low birth weight newborns are significantly more likely to be sick or permanently disabled.

"Premature infants" often must endure a range of very invasive procedures in costly neonatal intensive care units to attempt to ensure their survival despite their underdevelopment—procedures that are also very expensive and would dwarf the cost of prenatal care had it been provided to the mother through AIM. Medical expenses for a single low birth weight newborn during just the first few weeks or months of life can run into the hundreds of thousands of dollars. The expense to Medi-Cal or Healthy Families for newborn medical care for even just a

few such births could quickly offset any savings to the State from closing AIM to new applicants.

Closing AIM to new applicants, even for just a short period of time, could also result in delays in women enrolling and gaining access to prenatal care even *after* the program re-opens: this was the Board's experience when AIM was re-opened after closure in February through July 1994. *See*, *Historical Milestones of the Managed Risk Medical Insurance Board,* Dennis Gilliam (May 25, 2006), pp. 4-5.

For all of the above reasons, closing AIM to new enrollments is to be avoided at all costs.

3) If the AIM program is ever closed to new enrollments, AIM applications received during the closure must be forwarded to the county for a Medi-Cal eligibility review.

As explained above, closing AIM to new enrollments is not only unnecessary but also counter-productive. Should program closure nevertheless be ordered by the Board at any time, all of the applications must be forwarded to the counties for a Medi-Cal eligibility determination (unless a woman has checked the box on her AIM application indicating that she does not wish to be considered for Medi-Cal).

Nearly 66% of AIM program costs are funded by federal CHIP dollars. Pregnant women who qualify for Medi-Cal are entitled to be enrolled there instead of in California's separate CHIP program. This is especially important should AIM ever be closed to enrollment due to a funding shortfall.

The AIM program screens only for Medi-Cal's federal poverty level (FPL) program, and even then, AIM does not use all of the same income-counting rules that the counties use for screening for FPL eligibility In addition, pregnant women may qualify for Medi-Cal under many Medi-Cal programs other than the FPL program, with or without a share of cost (SOC).

It is important to note that not only "free" Medi-Cal but also SOC Medi-Cal can be very important for pregnant women needing a payment source to cover the birth, since Medi-Cal will pay bills above the amount of a woman's SOC and the cost of hospital labor and delivery services is likely to exceed most women's SOC. In addition, depending on the individual woman's circumstances, she may be able to apply incurred medical bills to her SOC obligation over the month(s) of the 60-day postpartum period[1] or beyond to continue to access medical services through Medi-Cal.

It is also important to note that the newborns of women covered by Medi-Cal for the delivery, with or without SOC, are themselves deemed eligible at birth for Medi-Cal for the first 12 months of life without an application. These newborns are also deemed to have met Medi-Cal's citizenship documentation requirements *for life.*

[1] Medi-Cal for pregnant women with no other basis of eligibility ends at the end of the month in which the 60th day post-partum occurs. AIM eligibility, in contrast, ends on the 60th day post-partum.

Focusing the limited time, energy and resources of AIM and MRMIB staff on developing a process for forwarding applications to the county for a Medi-Cal eligibility review under all Medi-Cal programs for which a woman may qualify would reduce the number of pregnant women who would remain uninsured during any times for which the Board declares an AIM funding shortfall. We would be happy to work with the Board and staff on developing the necessary procedures.

4) **If the AIM program is ever closed to new enrollments, eligible applicants who still wish to participate in AIM should be enrolled as soon as the program re-opens, based on the date of the AIM application and with PE for prenatal care and retroactive coverage for labor and delivery services.**

Under proposed § 2699.202(c), a woman's AIM application would be summarily denied during periods in which the Board has declared program funding to be insufficient to accommodate new enrollments. As we emphasize above, the AIM program must forward women's applications to the county for a complete Medi-Cal eligibility review whenever AIM is closed to new enrollments.

In addition, the Board should log the date on which AIM receives a woman's application, and, when the Executive Director revives AIM enrollments (*see* subdivision (b) of proposed § 2699.202), AIM should conduct an eligibility review for each woman on the list, starting by contacting the applicant to learn whether she still wishes to participate in AIM and, if so, whether she was denied Medi-Cal coverage with no SOC by the county for her pregnancy.

Women who still wish to participate in AIM, were denied no SOC Medi-Cal by the county, are still within the 30th week of pregnancy (7 ½ months), and are screened as meeting AIM's income eligibility requirements should then be given immediate access to a new presumptive eligibility (PE) program (authorized under federal law for pregnant women in CHIP-funded programs) pending the final eligibility determination for AIM and effective date of health plan coverage. PE will be essential for prenatal care for applicants placed on the AIM "waiting list", because under AIM's usual procedures, eligible women may wait up to 20 days for health coverage to begin, or longer if the application on file with AIM is considered incomplete (*see* Title 10, California Code of Regulations, §§ 2699.203(a), 2699.209(a)).

Then, once the woman's AIM has been approved, her coverage should be retroactive to the date of her AIM application. Because labor and delivery expenses are not covered benefits under PE for pregnant women, this new retroactive AIM coverage would be needed by women who have their babies either while on the waiting list or after AIM re-opens but before their AIM health plan coverage takes effect.

Thank you for this opportunity to comment. As always, we look forward to continuing to work with the Board and staff on these important issues.

Sincerely,

/S/

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cc: S. Kimberly Belshé, Secretary, California Health and Human Services Agency