



PROPOSED ACTION
MEMORANDUM

Implementing Pregnancy SEPs on the ACA
Exchanges

Department of Health and Human Services
September 2023

I. Summary

On June 24, 2022, the Supreme Court issued its opinion in *Dobbs v. Jackson Women’s Health Organization*,¹ overturning more than 50 years of precedent and eliminating pregnant people’s constitutionally protected right to abortion care. Without the protected right to abortion care, state lawmakers are now emboldened to further restrict abortion access, going as far as completely banning abortion, limiting abortion care to the first 6 weeks of gestation (long before many people even find out they are pregnant), and limiting access to medical abortion care by threatening abortion providers and patients.² Given this background — as well as pre-existing maternal health disparities — it is imperative that the Biden Administration expand access to reproductive healthcare. One way the Administration can do so is by updating the eligibility window for pregnant people to enroll in marketplace plans through rulemaking and guidance under the Affordable Care Act (“ACA”).

One of the major advancements of the ACA was designating maternity care as an essential health benefit (“EHB”).³ Despite this requirement, pregnant people may still go without necessary health care because of rigid enrollment requirements on the health insurance exchanges. Ordinarily, an individual may enroll in healthcare coverage during the 10-week, limited open enrollment period (“OEP”) beginning in November.⁴ Outside of the OEP, HHS has also designated additional special enrollment periods (“SEPs”) that, when triggered by certain life events, allow individuals to enroll in a marketplace plan outside of the OEP window. These events include marriage, adoption, giving birth, and more recent SEPs have included those impacted by Covid-19 and those living under 150% of the Federal Poverty Level (FPL) who meet other criteria.⁵ However, becoming pregnant does not qualify an individual for a SEP under current regulations. This means that despite the broad scientific consensus regarding the importance of access to healthcare for pregnant people, including prenatal, contraceptive, and abortion care, a pregnant person may not be able to enroll in a Marketplace health plan until they give birth.

This memorandum recommends HHS adopt a SEP that recognizes pregnancy as an “exceptional circumstance” under 45 C.F.R. § 155.420(d)(9) and 42 U.S.C.A. § 18031. This SEP should be issued via sub-regulatory guidance for the federally-facilitated exchanges (“FFE’s”) and, eventually, via notice-and-comment rulemaking for all exchanges.

II. Justification

Without access to coverage, pregnant people may often be forced to forgo prenatal care due to high costs, which results in detrimental maternal health outcomes and much greater expenditures down the line.⁶ For

¹ No. 19-1392, 597 U.S. ____.

² See generally, Guttmacher Inst., *The State Abortion Policy Landscape One year Post-Roe* (June 2023), <https://www.guttmacher.org/2023/06/state-abortion-policy-landscape-one-year-post-roe>.

³ Amy Chen & Mimi Spalding, *State Creation of Special Enrollment Periods for Pregnancy*, NHeLP, (Jan. 26, 2017) <https://healthlaw.org/wp-content/uploads/2017/01/Pregnancy-SEP-FINAL-1.pdf>.

⁴ Healthcare.gov, A quick guide to the Health Insurance Marketplace®, <https://www.healthcare.gov/quick-guide/dates-and-deadlines/> (last accessed Aug 2, 2023).

⁵ 45 C.F.R. § 155.420(d)(1)-(8); see Exec. Order No. 14009, 86 FR 7793 (Jan. 28, 2021) (Covid-19 SEP); 88 F.R. 184, 53413 (September 27, 2021), codified at 45 §155.420(d)(16) (150% FPL SEP).

⁶ Jamille Fields Allsbrook & Osub Ahmed, Center for American Progress, *Building on the ACA: Administrative Actions to Improve Maternal Health* (Mar. 25, 2021), <https://www.americanprogress.org/article/building-aca-administrative-actions-improve-maternal-health/>.

example, pregnant people who do not receive prenatal care are at greater risk of preeclampsia, gestational diabetes, and pregnancy-related hypertension.⁷ In one study, researchers found that the median total cost for maternal and infant medical care for patients with preeclampsia was over \$40,000 and around \$24,000 for patients with hypertension.⁸ These costs are especially disastrous for patients that are un- or under-insured, and may have to pay out of pocket for uncovered costs. More broadly, qualitative research shows that when Medicaid patients are able to access prenatal care, they also are connected with other needed care⁹ — increasing the likelihood of detecting health problems that would otherwise go untreated.

Forgoing prenatal care has serious implications for infants as well: pregnant people who receive no prenatal care are almost 3 times more likely to experience a preterm birth compared to pregnant people who receive prenatal care, and the risk is even more pronounced for Black women.¹⁰ Preterm births (births occurring prior to 37 weeks) are one of the leading causes of infant mortality and a driver of high delivery costs as well as long-term ancillary costs such as early education and special intervention services.¹¹

Improving access to quality reproductive healthcare also accords with President Biden’s Executive Order addressing racial health disparities in public and private institutions.¹² Lack of access to prenatal care is associated with negative maternal and infant health outcomes for all individuals, but the stakes are higher for certain racial and ethnic identities.¹³ Pregnant people of color are also more likely to be uninsured prior to pregnancy and to lose coverage shortly after giving birth—with the effect of also limiting access to critical care such as prenatal services.¹⁴ Indeed, compared to their white counterparts, Black, American Indian and Alaska Native (AIAN), and Native Hawaiian and Pacific Islander (NHPI) individuals experience “higher shares of preterm births, low birthweight births, or births for which they received late or no prenatal care.”¹⁵ As a result, infants born to Black, AIAN, and NHPI mothers are at increased risk for mortality.¹⁶ Additionally, Black and Indigenous people experience pregnancy-related mortality rates up to three times higher than their white counterparts.¹⁷ With chronic conditions like cardiovascular problems among the leading causes of pregnancy-related deaths, consistency in coverage beyond the period of pregnancy and birth is an essential component of addressing disparities in maternal health across racial identities.¹⁸

Additionally, promoting prenatal care is especially important in the wake of *Dobbs*. Growing evidence indicates that newfound state restrictions on abortion access have precipitated an increase in the number of births and

⁷ *Id.*

⁸ Hao J, Hassen D, Hao Q, Graham J, Paglia MJ, Brown J, Cooper M, Schlieder V, Snyder SR. Maternal and Infant Health Care Costs Related to Preeclampsia. *Obstet Gynecol.* 2019 Dec;134(6):1227-1233. doi: 10.1097/AOG.0000000000003581. PMID: 31764733; PMCID: PMC6882523. (In 2015 dollars.)

⁹ Katherine Ehrenreich & Katrina Kimport, Prenatal Care as a Gateway to Other Health Care: A Qualitative Study, 32 *Women’s Health Issues* 6, 602-606 (2022), available at: <https://doi.org/10.1016/j.whi.2022.08.006>.

¹⁰ Vintzileos AM, Ananth CV, Smulian JC, Scorza WE, Knuppel RA. The impact of prenatal care in the United States on preterm births in the presence and absence of antenatal high-risk conditions. *Am J Obstet Gynecol.* 2002 Nov;187(5):1254-7. doi: 10.1067/mob.2002.127140. PMID: 12439515.

¹¹ Institute of Medicine (US) Committee on Understanding Premature Birth and Assuring Healthy Outcomes. *Preterm Birth: Causes, Consequences, and Prevention*. Behrman RE, Butler AS, editors. Washington (DC): National Academies Press (US); 2007. PMID: 20669423.

¹² Exec. Order No. 13985, 86 FR 7009 (Jan. 20, 2021).

¹³ Samantha Artiga, et al. *Racial Disparities in Maternal and Infant Health: An Overview*, KFF (Nov. 10, 2020) <https://www.kff.org/report-section/racial-disparities-in-maternal-and-infant-health-an-overview-issue-brief/>.

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ *Id.* “Infants born to Black and [Native Hawaiian and Pacific Islanders]... are over twice as likely to die relative to those born to White women.”

¹⁷ *Id.*

¹⁸ *Id.*

unplanned pregnancies,¹⁹ contracted the period of time in which pregnant people can make important decisions about their pregnancy, and placed more pregnant people at a higher risk for adverse maternal outcomes.²⁰ When patients are able to access prenatal care, especially earlier in their pregnancy, they are able to make informed decisions about their pregnancy, in consultation with their medical providers, including about abortion care. Abortion care has been linked to improved economic, educational, and health outcomes for pregnant people and their families.²¹ Offering a pregnancy SEP would also comport with President Biden’s August 2022 June 2023 Executive Orders responding to the *Dobbs* decision, which called for increased access to contraceptive and family planning healthcare and protecting access to reproductive health care.²²

Finally, by adopting a SEP that allows individuals to enroll when they become pregnant, HHS will increase access to comprehensive, affordable marketplace health insurance, another Biden administration priority.²³ For all these reasons, enabling access to comprehensive prenatal care as soon as a pregnant person finds out they are pregnant is critical to improving maternal and infant health outcomes.

III. Current State

During the Obama administration, advocates asked HHS to create a pregnancy SEP on the federal exchanges pursuant to statutory and regulatory authority under the ACA.²⁴ In 2015, HHS published a Notice of Benefit and Payment Parameters declining to establish a pregnancy SEP but noting that, under 45 C.F.R. § 155.420(d)(9), the agency retained the ability to provide for additional SEPs in “exceptional circumstances” and that it would “continue to exercise that authority through sub regulatory guidance.”²⁵ HHS also noted that states running their own exchanges could adopt pregnancy SEPs.²⁶

However, in a subsequent letter to Congress, HHS claimed that it “[did] not have the legal authority to establish pregnancy as an exceptional circumstance,” although the letter did not explain why.²⁷ Advocacy groups continue to push for a pregnancy SEP as part of a general framework seeking to close the maternal health gap.²⁸

¹⁹ Eleanor Klibanoff, *Nearly 10,000 more babies born in nine months under Texas’ restrictive abortion law, study finds*, Texas Tribune (June 30, 2023), <https://www.texastribune.org/2023/06/30/texas-abortion-johns-hopkins-study/>

²⁰ Kim Bellware & Emily Guskin, *Effects of Dobbs on maternal health care overwhelmingly negative, survey shows*, Wash. Post (June 21, 2023), <https://www.washingtonpost.com/politics/2023/06/21/obgyn-abortion-poll/>.

²¹ Caitlin Knowles Myers, Morgan Welch, Brookings Inst., *What can economic research tell us about the effect of abortion access on women’s lives?* (Nov. 30, 2021), <https://www.brookings.edu/articles/what-can-economic-research-tell-us-about-the-effect-of-abortion-access-on-womens-lives/>.

²² E.O. 14101, 88 FR 41815 (June 23, 2023) (“[I]t has never been more important to protect and expand access to family planning services”); E.O. 14079, 87 FR 49505 (August 3, 2022).

²³ Strengthening Medicaid and the Affordable Care Act, E.O. 14009 (Jan. 28, 2021).

²⁴ See 42 U.S.C. § 18031(c)(6); 45 C.F.R. § 155.420(d)(9).

²⁵ 80 Fed. Reg. 10750, 10798 (Feb. 27, 2015). “Furthermore, a State may establish additional special enrollment periods to supplement those described in this section as long as they are more consumer protective than those contained in this section and otherwise comply with applicable laws and regulations.”

²⁶ *Id.*

²⁷ Letter from Sylvia Burwell, Secretary of U.S. Department of Health and Human Services, <https://www.kff.org/wp-content/uploads/sites/3/2015/10/041015-hhs-letter-to-congress-on-maternity-care.pdf> (Apr. 10, 2015). The letter was in response to an earlier letter from Democratic senators requesting a pregnancy SEP.

²⁸ The maternal health gap refers to racial and economic disparities in maternal health outcomes in the United States. See generally Samantha Artiga, et al. *Racial Disparities in Maternal and Infant Health: An Overview*, KFF (Nov. 10, 2020) <https://www.kff.org/report-section/racial-disparities-in-maternal-and-infant-health-an-overview-issue-brief/>.

The Department’s 2015 decision shaped the landscape of pregnancy SEPs at the state level. Currently, 30 states use federally-facilitated exchanges, while 18, including D.C., have established state-based exchanges (SBEs).²⁹ The remaining 3 states — Arkansas, Oregon, and Virginia — have operated as state-based exchanges using the federal Healthcare.gov platform for enrollment purposes,³⁰ and Virginia plans to transition to fully state-run exchanges by the fall of 2023.³¹ Vermont,³² New York,³³ Connecticut,³⁴ and Maryland³⁵ — all of which operate SBEs — have adopted pregnancy SEPs through state legislation. Similarly, Maine, New Jersey and Washington, D.C., have used regulatory action to create pregnancy SEPs.³⁶ Approximately 9 SBEs have yet to issue their own pregnancy SEPs absent HHS guidelines.³⁷

Beyond the ACA Marketplaces, Medicaid and the Children’s Health Insurance Program (“CHIP”) offer pregnant individuals and eligible children access to health coverage under certain income conditions.³⁸ Under federal law, pregnant individuals are covered by Medicaid if they live at 138% of the FPL.³⁹ In fact, in 2021, 41% of births were covered by Medicaid.⁴⁰ Additionally, states have the option to provide coverage based on pregnancy for those who do not qualify for Medicaid through the traditional pathway; however, if they do so, states are only required to provide this coverage for up to 60 days postpartum.⁴¹ States can also increase this coverage to 12 months via a state plan amendment, and 36 states, including D.C., have implemented this coverage.⁴² States also have the option to expand their Medicaid programs under the ACA to people beyond 138% FPL, though 10 states have currently declined to expand their Medicaid program.⁴³ Among other things, Medicaid expansion has been associated with reduced levels of uninsurance and perinatal churn for women of reproductive age, increased prenatal and postpartum Medicaid coverage, and lower rates of maternal mortality.⁴⁴

²⁹ KFF, State Health Insurance Marketplace Types (2023) <https://www.kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/?currentTimeframe>.

³⁰ *Id.*

³¹ See Health Insurance Marketplaces by State, Healthinsurance.org, <https://www.healthinsurance.org/health-insurance-marketplaces/> (last visited July 14, 2023)

³² H. 620 (Act 120), Vt. Gen. Ass’y (2016), <https://legislature.vermont.gov/bill/status/2016/H.620>.

³³ NY S05972, Gen. Ass’y (2016), <https://www.billtrack50.com/BillDetail/649970>.

³⁴ H. B. 0127, C. H. 0355, MD Gen. Ass’y (Reg. Sess. 2019),

https://www.cga.ct.gov/asp/cgabillstatus/cgabillstatus.asp?selBillType=Bill&which_year=2018&bill_num=SB+206,

³⁵ <https://mgaleg.maryland.gov/mgaweb/Legislation/Details/HB0127/?ys=2019rs>.

³⁶ CoveMe.gov, Special Enrollment Periods (2022) <https://www.coverme.gov/sites/default/files/2022-01/Special%20Enrollment%20Periods%20Full%20List.pdf> (last accessed August 3, 2023) (Maine); Bulletin No. 20-35, Dep’t of Banking and Ins., State of New Jersey (Oct. 9, 2020), https://www.state.nj.us/dobi/bulletins/blt20_35.pdf (New Jersey); Pregnancy SEP HBX Resolution, Exec. Bd. of D.C. Benefit Exchange Authority (Jan. 8, 2020), <https://hbx.dc.gov/sites/default/files/dc/sites/hbx/publication/attachments/Resolution%20-%20Pregnancy%20SEP%20final-passed%20%281-8-20%29.pdf> (Washington, D.C.).

³⁷ Chen & Spalding, *supra* note 3 at 7. After requests from state senators, the California exchange declined to issue a pregnancy SEP, citing lack of HHS guidelines.

³⁸ Medicaid.gov, CHIP Eligibility, <https://www.medicaid.gov/chip/eligibility/index.html> (last accessed August 3, 2023).

³⁹ *Id.*

⁴⁰ KFF, Births Financed by Medicaid (2021), <https://www.kff.org/medicaid/state-indicator/births-financed-by-medicaid/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (accessed Jul 18, 2023).

⁴¹ KFF, Medicaid Postpartum Coverage Extension Tracker (Jul. 13, 2023), <https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/>.

⁴² *Id.*

⁴³ KFF, Status of State Medical Expansion Decisions: Interactive Map (Jul. 3, 2023), <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>.

⁴⁴ Emily M. Johnston and others, “Post-ACA, More Than One-Third Of Women With Prenatal Medicaid Remained Uninsured Before Or After Pregnancy,” Health Affairs, April 2020, available at <https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.01678>; Jamie R. Daw, Katy Backes Kozhimannil, and Lindsay K. Admon, “High Rates Of Perinatal Insurance Churn Persist After The ACA,” Health Affairs, September 16, 2019, available at <https://www.healthaffairs.org/doi/10.1377/hblog20190913.387157/full/>; Erica L. Eliason, “Adoption of

Creating a special enrollment period for pregnancy would allow more pregnant people to qualify for coverage. In 2021, about 1 in 9 women (11%) between 19 and 64 years of age were uninsured in the United States.⁴⁵ However, there is considerable state-level variation in uninsured rates across the country, from 23% of women in Texas to 3% of women in Washington, D.C., Massachusetts, and Vermont.⁴⁶ Low-income women and women of color, as discussed in more detail above, are also at greater risk of being uninsured.⁴⁷ A federal SEP for pregnancy would help close the maternal gap by allowing pregnant women that live in states without a pregnancy SEP or who fall outside another qualifying period to access coverage early in their pregnancy.

IV. Proposed Action

HHS should adopt a pregnancy SEP. To be effective, the SEP should require no more than self-attestation of pregnancy—a standard used by states like Maryland and Vermont in determining who may qualify for a pregnancy SEP.⁴⁸ Additionally, the SEP window should open beginning on the date an individual discovers the pregnancy and last for approximately ninety days. Individuals should be able to choose for coverage to begin retroactively on the first of the month in which the individual became pregnant or the first of the month in which the individual received confirmation. These standards are in line with Medicaid requirements for pregnancy confirmation as well as enrollment guidelines issued by states with pregnancy SEPs such as Maryland, New York, and New Jersey.⁴⁹

To adopt a pregnancy SEP, HHS should: first, immediately issue sub-regulatory guidance establishing pregnancy as a SEP on the FFEs only; and, second, begin the notice and comment rulemaking process to establish a pregnancy SEP on both the FFEs and SBEs.

Legal Authority

In drafting the ACA, Congress explicitly granted the Secretary the authority to require special enrollment

Medicaid Expansion Is Associated with Lower Maternal Mortality,” *Women’s Health Issues* 30 (3) (2020): 147–152, available at <https://pubmed.ncbi.nlm.nih.gov/32111417/>.

⁴⁵ KFF, Women’s Health Insurance Coverage (Dec. 21, 2022), <https://www.kff.org/womens-health-policy/fact-sheet/womens-health-insurance-coverage/>.

⁴⁶ *Id.*

⁴⁷ *Id.*

⁴⁸ 42 C.F.R. § 457.380(e). States may create verification procedures consistent with regulations, “except that the State must accept self-attestation of pregnancy unless the State has information that is not reasonably compatible with such attestation.” See also *Verification Procedures and Eligibility Rules in the Federally-facilitated Exchange (FFE)*, DEPARTMENT OF HEALTH AND HUMAN SERVICES, https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/120919%2520verification%2520procedures%2520and%2520eligibility%2520rules%2520in%2520the%2520ffe_33.pdf. (Last visited, July 15, 2021); <https://www.marylandhbe.com/maryland-passed-senate-bill-36-establishing-a-special-enrollment-period-for-pregnant-women/>; <https://trackbill.com/s3/bills/MD/2019/HB/127/amendments/656082-01.pdf>; https://info.healthconnect.vermont.gov/sites/vhc/files/doc_library/QualifyingEvents_2021.pdf.

⁴⁹ See generally S.B. 5972, Reg. Sess. (Ny. 2015); DEPT. OF BANKING AND INSURANCE, OFF. OF THE COMMISSIONER, BULL. NO. 20-35, PREGNANCY QUALIFYING LIFE EVENT AND SPECIAL ENROLLMENT PERIOD (2020); H.B. 127, Reg. Sess. (Md. 2019); S.B. 206, Reg. Sess. (Ct. 2018).

periods and define what constitutes exceptional circumstances.⁵⁰ The Secretary must “require an Exchange to provide” special enrollment periods that are “specified in [the ERISA program] and other special enrollment periods under circumstances similar to such periods under [Medicare Part D].”⁵¹ One such period, according to the relevant part of the Medicare Part D statute, occurs when an individual has met “exceptional conditions ... as the Secretary may provide.”⁵² As a result, the Secretary possesses the statutory discretion to define the “exceptional conditions” that warrant the creation of new SEPs under the ACA as well; the Secretary has delegated this authority to state exchanges (and therefore itself, as the operator of FFEs) per 45 CFR § 155.420(d)(9).⁵³

Since 2014, HHS has used this regulatory authority to issue sub-regulatory guidance creating SEPs on the FFEs for survivors of domestic violence,⁵⁴ individuals enrolled in COBRA, AmeriCorps, or VISTA programs,⁵⁵ and to those impacted by the COVID-19 pandemic.⁵⁶ HHS has also finalized notice-and-comment rulemaking to create a monthly SEP for individuals whose household income falls below the 150% FPL and are eligible for advance payments of the premium tax credit (APTC).⁵⁷ The Department’s exceptional circumstance SEPs listed above have tended to follow life events that either greatly impact an individual’s socio-economic status — and therefore, their access to quality healthcare — or were unforeseen. Pregnancy fits both categories. Pregnancy often precedes a shift in resources going toward child-rearing, which constitutes a significant change in financial stability for many individuals and families.⁵⁸ Meanwhile, roughly 45% of all pregnancies in the United States are labeled as “unplanned.”⁵⁹

Guidance versus rulemaking

HHS could choose to offer a pregnancy SEP either through sub-regulatory guidance (only for FFEs) or through rulemaking (which could reach all exchanges); each route has advantages, and we ultimately recommend the Department pursue both.

Current regulations at 45 C.F.R. § 155.420(d)(9) grant exchanges substantial discretion to establish “exceptional circumstances” SEPs—an authority HHS can exercise on the FFEs through sub-regulatory guidance. As

⁵⁰ 42 U.S.C. § 18031(c)(1)-(6) (outlining the responsibilities of the Secretary).

⁵¹ 42 USC § 18031(c)(6)(C).

⁵² 42 U.S. Code § 1395w-101(b)(3)(C) (allowing for special enrollment periods for those who meet “exceptional conditions ... as the Secretary may provide”).

⁵³ (“The qualified individual or enrollee, or his or her dependent, demonstrates to the Exchange, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Exchange may provide”).

⁵⁴ See *Victims of Domestic Abuse*, Department of Health and Human Services (Mar. 31, 2014)

<https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/victims-domestic-violence-guidance-3-31-2014.pdf> [hereinafter Domestic Violence SEP Bulletin].

⁵⁵ See *Special Enrollment Periods and Hardship Exemptions for Persons Meeting Certain Criteria*, Department of Health and Human Services (May 2, 2014) <https://www.cms.gov/ccio/resources/regulations-and-guidance/downloads/sep-and-hardship-faq-5-1-2014.pdf> [hereinafter COBRA SEP Bulletin].

⁵⁶ The COVID-19 SEP was established in part by executive order issued by the Biden administration, which referred to 155.420(d)(9) in citing authority agencies may rely on for creating SEPs. See Exec. Order No. 14009, 86 FR 7793 (Jan. 28, 2021). The COVID-19 SEP was available to uninsured and underinsured individuals from February 15, 2021 through May 15, 2021.

⁵⁷ 88 F.R. 184, 53413 (September 27, 2021). Codified at 45 §155.420(d)(16).

⁵⁸ Conservative figures estimate a middle-income family can expect to spend nearly \$13,000 annually per child and up to \$233,610 to raise a child to age 17. See Mark Lino, *The Cost of Raising a Child*, USDA (Feb. 18, 2020), <https://www.usda.gov/media/blog/2017/01/13/cost-raising-child>. The federal government recognizes the financial implications of raising a child in myriad ways, including by providing tax credits to many parents and families. Pub. 972 (Child Tax Credit and Credit for Other Dependents), IRS (Jan. 11, 2021) <https://www.irs.gov/pub/irs-pdf/p972.pdf>.

⁵⁹ Unintended Pregnancy in the United States, Guttmacher Institute (Jan. 2019) <https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states>.

described above, HHS has periodically invoked this authority to create new SEPs, including the domestic violence SEP, later codified at § 155.420(d)(10) through rulemaking.⁶⁰ The regulatory authority to define these “exceptional circumstances” rests with the exchange; however, such definitions must be in accordance with HHS guidelines.⁶¹ The federal government can use this authority to establish SEPs via sub-regulatory guidance on the FFEs in its capacity as the administrator of these exchanges.⁶² It could simultaneously encourage the remaining SBEs that do not currently offer a pregnancy SEP to follow suit but could not mandate they do so through guidance. Subregulatory guidance is likely the most expeditious path toward instituting a pregnancy SEP that would cover the most amount of people. For example, in 2021, in half of the states (15) which have FFE’s reproductive-age women are more likely to be uninsured as compared to the national average.⁶³ And, all of the states that have yet to expand Medicaid have FFEs.⁶⁴ However, we would recommend that HHS eventually codify the SEP through notice-and-comment rulemaking.⁶⁵

HHS could also take a more forceful approach and mandate all FFEs and SBEs offer pregnancy SEPs by commencing a notice-and-comment rulemaking to that effect per its authority under 42 U.S.C. § 18031(c)(6)(C). HHS has often chosen not to impose its statutory authority on the SBEs — most recent SEPs were merely *encouraged* at the state level⁶⁶ — but the Department retains the ability to require all exchanges to adopt a SEP, including those operating as SBEs. One notable exception is the notice-and-comment rulemaking that created the SEP for individuals whose household income falls under 150% of the FPL.⁶⁷ Of course, a rulemaking could

⁶⁰ Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018; Amendments to Special Enrollment Periods and the Consumer Operated and Oriented Plan Program, 81 Fed. Reg. 94058, 94127 (Dec. 22, 2016). As recently as 2021, HHS proposed a new SEP via notice-and-comment rulemaking. If an individual’s household income does not exceed 150% of the federal poverty level, they will be eligible for a special enrollment period on the FFEs. This SEP is not mandated for SBEs. See Patient Protection and Affordable Care Act; Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond Proposed Rule, 86 Fed. Reg. 35156, 35157 (proposed Jul. 1, 2021).

⁶¹ 45 C.F.R. § 155.420(d)(9). The proposed rule did not include a requirement that an “exceptional circumstance” must align with HHS guidelines, but HHS added this limiting language after commenters asked for more specificity. *Compare* 76 FR 136, 41866, 41918 (July 15, 2011) (“(9) A qualified individual or enrollee meets other exceptional circumstances as the Exchange or HHS may provide.”) to 77 FR 59, 18310 at 18463 (“(9) A qualified individual or enrollee demonstrates to the Exchange, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Exchange may provide.”); *see* 77 FR at 18393 (“...Regarding the special enrollment period for individuals with exceptional circumstances, outlined in proposed § 155.420(d)(9), many commenters supported the broad language, while several others recommended more specificity. A few commenters recommended that States, not HHS, determine the exceptional circumstances... We have modified the language in § 155.420(d)(9) to permit individuals to request a special enrollment period by demonstrating to their Exchange that they meet exceptional circumstances. The modified language establishes that individuals must demonstrate such circumstances in accordance with guidelines issued by HHS. Consistent with examples outlined in the proposed rule preamble, HHS’s guidance for this special enrollment period will outline circumstances when HHS may grant special enrollment periods directly, such as in cases of natural disasters.”)

Notably, HHS declined comments that asked HHS to allow States, not HHS, determine exceptional circumstances. 77 FR at 18393.

⁶² Most SEPs created outside of the OEP have been issued via sub-regulatory guidance under CFR 155.420(d)(9). *See generally* Domestic Violence SEP Bulletin, .

⁶³ In 2021, Alabama (14%), Alaska (13%), Arizona (13%), Florida (16%), Georgia (16%), Kansas (12%), Mississippi (16%), Missouri (12%) North Carolina (13%), Oklahoma (18%), South Carolina (13%), South Dakota (13%), Tennessee (12%), Texas (23%), and Wyoming (15%) had higher uninsurance rates for non-elderly women than the national average (11%). *See* KFF, Women’s Health Insurance Coverage, *supra* note 45.

⁶⁴ *See* KFF, *Status of State Action on the Medicaid Expansion Decision* (Jul. 27, 2023), available at:

<https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>.

⁶⁵ As with the domestic violence SEP, codification may occur through notice and comment rulemaking after issuing sub-regulatory guidance.

⁶⁶ *See* Domestic Violence SEP, *supra* note x, COBRA SEP Bulletin, *supra* note x.

⁶⁷ 86 F.R. 184, 53413 (September 27, 2021).

restrict itself to FFEs too (either in lieu of or following the subregulatory guidance option noted in the previous paragraph). Promulgating a rule through the notice-and-comment process will provide more durability in the event a future administration is hostile to this reform.

Regardless of whether it opts for sub-regulatory guidance or rulemaking, HHS will need to explain its change in position from the 2015 letter to Congress.⁶⁸

V. Risk Analysis

Given its 2015 letter to Congress,⁶⁹ HHS will need to adequately justify and explain the basis of its policy shift. When an agency pursues a change in policy, such a change must satisfy requirements articulated in the Administrative Procedure Act (“APA”) and by the Supreme Court.⁷⁰

The Department will need to (1) explicitly recognize it is enacting a change in policy rather than ignoring rules “already on the books” and (2) demonstrate that there are good reasons for implementing the new policy.⁷¹ Generally, a more detailed justification is required if the new policy will be informed by new factual findings and if the prior policy “engendered serious reliance interests that must be taken into account.”⁷² Certainly, insurers will argue that they historically have not had to allow pregnant individuals to enroll outside of the OEP.

But the Department can offer several good reasons for a policy shift. First, as described in more detail above, the post-*Roe* landscape of reproductive health care access, including abortion care, is significantly different than the one HHS contemplated in 2015. As states continue to push abortion care further out of reach, it is vital that pregnant people are able to confirm pregnancies early in order to access the prenatal or abortion care they need. Without access to healthcare during this vital period, pregnant people are at higher risk for adverse maternal outcomes and may lose their ability to access legal abortion care in their state.

Insurers will also probably argue that a pregnancy SEP will result in adverse selection as individuals enroll in plans due to sudden health needs. The Department should rebut this argument by asserting recent coverage gains indicate fewer people would need this SEP, and that many of the ones who do were previously healthy enough to go without insurance.⁷³ Further, quality and early prenatal care is associated with lower overall healthcare expenditures, fewer complications during and after childbirth (which can be costly), and better outcomes for pregnant people and their children.⁷⁴ And, when patients have access to early prenatal care, they are well-positioned to make personal decisions about their care, including abortion care, which has downstream

⁶⁸ See *infra* Part V “Risk Analysis.”

⁶⁹ See Letter from Sylvia Burwell, *supra* note 18.

⁷⁰ The APA allows a Court to review an agency decision and hold it unlawful if it is found to be “arbitrary [and] capricious”. 5 U.S.C. § 706(2)(A). See also *Motor Vehicle Mfrs. Ass’n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29 (1983) (finding the National Highway Traffic Safety Administration failed to adequately explain its basis for rescinding a rule requiring installation of seatbelts, noting a lack of ample explanation of data, reasoning, and consideration of facts).

⁷¹ *F.C.C. v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (1999).

⁷² *Id.*

⁷³ *Marketplace Enrollment, 2014-2021*, KFF, <https://www.kff.org/health-reform/state-indicator/marketplace-enrollment/?currentTimeframe=>. (Last visited August 30, 2021).

⁷⁴ See generally, Thomas Moore, et al., The perinatal and economic impact of prenatal care in a low-socioeconomic population, 154 *Am. J. of Obstetrics & Gynecology* 29-33, 22 (Jan. 1986), available at: <https://www.sciencedirect.com/science/article/abs/pii/000293788690387X>.

effects on healthcare costs. Notably, states that already use pregnancy SEPs demonstrated reductions in premiums between 2018 and 2020 compared to those SBEs operating without a pregnancy SEP.⁷⁵

Finally, insurers may also have qualms with the SEP length and dates of coverage; however, the Department should indicate that more flexible enrollment will present more opportunities for access to prenatal coverage that will ultimately cut costs insurers typically have to absorb when a parent, having forgone prenatal care, enrolls after giving birth.

VI. Conclusion

HHS should adopt a pregnancy SEP by issuing sub-regulatory guidance establishing pregnancy as a SEP on the FFEs, and, eventually, use notice and comment rulemaking to establish a pregnancy SEP on all exchanges. A federal pregnancy SEP would significantly enhance pregnant people's access to quality insurance coverage at a critical healthcare juncture and during a crisis of reproductive care.

⁷⁵ Rachel Fehr, et al. *How ACA Marketplace Premiums Are Changing by County in 2020*, KFF (Nov. 7, 2019) <https://www.kff.org/health-costs/issue-brief/how-aca-marketplace-premiums-are-changing-by-county-in-2020/>.