States are balancing the rights of addicted women with the health needs of their developing babies.

BY MARGARET WILE

Every three minutes, a woman shows up at an emergency room because of prescription drug misuse or abuse. Some of them are pregnant. And when they are, and they’ve been using opioids, it can mean death for the mother and painful withdrawal for the baby. A woman’s risk of dying during delivery increases fourfold if she is misusing or dependent on opioids, the American Society of Anesthesiologists reports.

It’s a $1.2 billion problem for states.

The devastation caused by opioid addiction is widely known. More than 33,000 people died from opioid-related overdoses in the United States in 2015, according to the Centers for Disease Control and Prevention.

Babies born “substance exposed” tend to eat and sleep poorly, potentially harming their development. The average hospital price tag to treat one of these babies is $93,400, the CDC estimates. The total annual cost in 2012 (the latest figures available) for caring for these newborns was $1.5 billion, of which $1.2 billion came out of state Medicaid budgets.

The consequences of addiction extend beyond mothers and babies to families, communities and states.

This is a national problem.

As this population of mothers grows, the challenge is protecting mothers’ rights while guarding the well-being of their future children. Some state legislatures and health departments are working hard to find a balance.

Pre- and Postnatal Care Is Vital

An estimated 86 percent of pregnancies among women who misuse opioids are unintended, and many don’t receive early or adequate prenatal care. A lack of prenatal care puts both mother and baby at risk. The chance that a baby will die before the age of 2 months is five times greater when a mother does not receive prenatal care than when she does, according to the Journal of Obstetrics and Gynecology. Lack of prenatal care also is associated with lower birth weight babies.

After the baby is born, the new mother and child still face dangers, especially when the mother is no longer covered by insurance or is unable to obtain daily maintenance medi-
cation, such as methadone. The National Institutes of Health recommend a daily dose of methadone for pregnant women who are trying to quit using opioids. Methadone is one of three medication-assisted treatments approved by the FDA. It reduces withdrawal symptoms and relieves the cravings associated with addiction without causing the euphoric and sedating feelings produced by opioids.

The rates of maternal death directly linked to opioid use and abuse continue to increase, the CDC reports. Accidental overdoses were the leading or secondary cause of maternal death in several states. This issue can be difficult to track, however, since there is no standard process for collecting data on maternal mortality nationwide.

Planned or unplanned, pregnancy can challenge any woman. For those struggling with a dependence problem, even those in recovery, it can be a nightmare.

This was the case for Claire, a woman who was in sustained recovery with the help of daily buprenorphine, a narcotic approved by the Food and Drug Administration to help manage opioid-withdrawal symptoms.

When Claire found out she was unintentionally pregnant, she sought prenatal care. Inexperienced in substance abuse treatment, the ob-gyn took Claire off buprenorphine. This led to a full relapse that included intravenous drug use when she was 30 weeks pregnant. She ended up returning to a treatment facility to get help and delivered a healthy baby. But not every woman experiences a happy ending like Claire did.

**Mom’s Health Care Coverage**

Pregnancy is an ideal time to tackle substance abuse, says South Dakota Senator Deb Soholt (R), a registered nurse. “Pregnancy is a short window. We can measure different results and very quickly see what efforts work best,” she says. “If we tap into that mother-bear feeling, we could change our outcomes, but it will take partnerships to accomplish this goal.”

The four primary sources of health coverage available to pregnant women are insurance through an employer, commercial insurance through health exchanges, Medicaid and, in some states, the Children’s Health Insurance Program.

The Affordable Care Act includes maternity care as one of the 10 essential health benefits included in all new individual and small-group policies, but it doesn’t include pregnancy as one of the “qualifying life events” that trigger an open enrollment period in states’ health exchanges. Low-income women who are not eligible for Medicaid and do not have their own commercial insurance often are left with few or no options for coverage of prenatal care.

In 2015, New York lawmakers addressed this omission by passing legislation that includes pregnancy as a qualifying life event, allowing women to enroll in the state health insurance exchange at any time during their pregnancy. It’s the only state that has done so. “As a mother,” Assem-
blywoman Aravella Simotas (D) said at the signing of the bill, which she sponsored, “I know firsthand how important prenatal care is, and this historic legislation ensures that women’s and children’s health are not placed at the mercy of an arbitrary date on the calendar.”

In 29 states, women who do not have commercial insurance and can’t afford it through their states’ health exchanges are eligible for Medicaid immediately through what is called “presumptive eligibility.” Presumptive eligibility allows hospitals and others to provide care and still get reimbursed before a woman’s paperwork has been processed and her full eligibility determined.

Once an eligible woman gives birth, she is covered under Medicaid for 60 days. After that, even if she no longer qualifies for Medicaid, her baby is still covered until his or her first birthday through the Children’s Health Insurance Program.

What States Are Doing

State lawmakers have taken several approaches to assist or intervene when a woman is misusing substances while pregnant. Twelve states require treatment providers to give priority to pregnant women.

West Virginia lawmakers passed legislation requiring Medicaid providers to prioritize substance-abuse treatment for pregnant women. Four state legislatures have passed laws protecting pregnant women in publicly funded treatment programs from discrimination.

Alaska reaches out to mothers who are at a high risk of abusing opioids during pregnancy through the federal Women, Infants and Children program, which provides supplemental food and nutritional education for low-income women who are pregnant or who have young children. WIC staff are trained to screen expecting mothers for substance misuse or abuse. This type of cross-agency work helps the state address women’s health needs no matter how or where they are receiving services.

It’s critical to provide services for women while they are pregnant, says Alaska’s chief medical officer, Dr. Jay Butler. “For some women,” he says, “becoming pregnant can be an opportunity for recovery readiness and openness to seek treatment.”

Physician-Mandated Reporting

Eighteen states require physicians to report pregnant women to child protective services if they suspect substance abuse. Iowa, Kentucky, Missouri and Oklahoma require physicians who suspect abuse to drug-test the woman.

Mandated-reporting laws, though well-intentioned, can have unintended consequences. Some pregnant women will avoid seeking prenatal care and treatment for substance use altogether because they fear what could happen to them or their babies. Tennessee lawmakers let a controversial 2014 law criminalizing substance abuse during pregnancy sunset after two years. The law allowed prosecutors to charge women with assault if a newborn’s “addiction or harm is a result of her illegal use of a narcotic drug taken while pregnant.” Its sponsor, Representative Terri Lynn Weaver (R), said the law urged women to choose between jail and treatment. But doctors and state officials noticed that pregnant women were not seeking prenatal care, and were delivering their babies in locations other than hospitals, out of fear of going to jail or losing their children.

Weaver said she believes the law had a positive impact and that available information doesn’t prove women were avoiding treatment. And she’s concerned about the future.

“Who is going to be the voice of these babies?” she said last year when the law expired.

It’s in the hope of finding voices for both the mothers and their babies that lawmakers are pressing forward, seeking solutions to one part of a complex and messy crisis.

CARA and Drug-Exposed Babies

The federal Comprehensive Addiction and Recovery Act was passed and signed into law with overwhelming bipartisan support in 2016. The law is a wide-ranging approach to substance-abuse prevention, intervention and treatment. CARA requires that health care providers notify child protective services when a child is born and identified as affected by substance abuse, withdrawal symptoms or fetal alcohol spectrum disorder. The law specifically removed “illegal” and now includes “affected by any substance.” The intent is to identify children who may have been exposed to legal drugs like prescription opioids and alcohol that may affect the child’s development.

Once a child is identified as affected by a substance, a “plan of safe care” must be created to address his or her health and safety needs and those of the family or caregiver. This change was an effort to make treatment a more family-centered approach.

“One of the things we found was that the stigma, shame and fear of using during pregnancy is much greater than any of us ever expected,” says Linda Carpenter, the in-depth technical assistance program director of the National Center on Substance Abuse and Child Welfare. “Policies we put in place may not be supporting those women. They may be doing just the opposite and driving women away from care and driving them out of your state and counties.”

Carpenter oversees the Substance Abuse and Mental Health Services Administration grant where they are working with six different states through an in-depth technical assistance program. Connecticut, Kentucky, New Jersey, Minnesota, Virginia and West Virginia are currently participating in this program.

As part of this project, Kentucky responded to the new law by establishing a pilot program requiring state agencies to work together and intervene with a plan of safe care before an at-risk child is born. Besides providing treatment for mother and child, the program also aims to bring consistency to the way hospitals screen for, test and report on substance-exposed newborns. Many hospitals and states remain uncertain whether CARA requires them to report medication-assisted treatments, such as methadone, and other prescription drugs, including those that are not opioids.