

March of Dimes Foundation

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The Honorable Nancy Pelosi  
Speaker of the House of Representatives  
H-232, US Capitol  
Washington, DC 20515

The Honorable George Miller  
Chairman, House Education and Labor Committee  
2181 Rayburn House Office Building  
Washington, DC 20515

The Honorable Charles Rangel  
Chairman  
House Ways and Means Committee  
1102 Longworth House Office Building  
Washington, DC 20515

The Honorable Henry Waxman  
Chairman  
House Energy and Commerce Committee  
2125 Rayburn House Office Building  
Washington, DC 20515

January 14, 2010

Dear Madame Speaker and Chairmen:

On behalf of 3 million volunteers and 1400 staff at the March of Dimes Foundation I am writing to comment on select provisions in the health reform bills passed by the House and Senate that are of great importance to women of childbearing age, infants and children. The March of Dimes commends your leadership in developing the Affordable Health Care for America Act (H.R. 3962) and securing House approval of this important legislation. As you negotiate a health reform conference agreement with the Senate, we urge you to work toward a final agreement that includes key provisions central to improving the health of women of childbearing age, infants and children. Please find the Foundation's comments below on key elements of the bills:

- Coverage of maternity care and pediatric benefits
- "Catastrophic" plans
- Medicaid and CHIP transition provisions
- Medicaid enhancements
- The Public Health Investment Fund

### **Private Health Insurance**

- **Prohibit pre-existing condition exclusions, annual and lifetime limits**
- **Require coverage of maternity care and pediatric benefits, including hearing and durable medical equipment**
- **Require coverage of preventive services delineated in "Bright Futures" and parallel document for women**
- **Permit young women enrolled in "catastrophic" plans who become pregnant to switch to a comprehensive plan without having to wait for open enrollment**

The March of Dimes strongly supports efforts taken in both the House and Senate bills to expand and improve private health coverage for women of childbearing age, infants and children, including the federal prohibition on pre-existing condition exclusions and annual and lifetime limits. Given that one in five women of childbearing age — 12.2 million— is uninsured according to Census Bureau data and that 50 percent of pregnancies are unplanned, the current practice of treating pregnancy as a pre-existing condition has made it impossible for too many pregnant women to obtain affordable health coverage for maternity care. Removing this barrier to coverage is a critically important component of health reform, particularly given that pregnancy is the most expensive event most families experience in their childbearing years. Prohibiting pre-existing condition exclusions is also extremely important for children with chronic medical needs, such as those associated with birth defects or preterm birth. This proposal will make it easier for such children to obtain coverage for the health care they need.

The Foundation is extremely pleased that there is broad agreement in both chambers that insurance plans should be prohibited from imposing lifetime limits on coverage or annual limits on benefits. Such limits impose severe financial burdens on families whose children have serious and ongoing medical needs that require costly and often life-saving care. In sum, prohibition of such limits will make it easier for medically fragile children to maintain access to the services they need.

The Foundation particularly supports requiring all insurance plans in the new Exchange(s) cover maternity care and that such plans offer a robust set of pediatric benefits. The lack of accessible, affordable maternity coverage remains a tremendous problem, particularly for women who obtain their coverage through small employers or via the individual health insurance market. A 2006 Georgetown University study commissioned by the March of Dimes found that 19 states had adopted laws to require coverage of maternity care. However, these laws varied in scope, and only five of the states (MA, MT, NJ, OR and WA) required all insurers in the individual market to cover maternity care. In states without such requirements, maternity coverage is typically available only through an expensive rider to the underlying policy and only if the woman is not pregnant when she enrolls in the plan. If she is already pregnant, such coverage is simply not available for purchase in the individual and small group markets. More specifically, 14 million women rely on coverage through the individual insurance market, yet a 2008 survey conducted for the National Women's Law Center found that only 12% of 3,500 individual policies included the full spectrum of clinically recommended maternity care services, and these policies were available in less than half of the communities surveyed.

Women who receive prenatal care are more likely to have access to screening and diagnostic tests that can help to identify problems early; services to manage developing and existing problems; and education, counseling, and referral to reduce risky behaviors like substance use and poor nutrition. Such care may thus improve the health of both mothers and infants. Singleton infants born to mothers who received late or no prenatal care in 2004 were nearly twice as likely to be low birthweight. Low birthweight accounts for 10 percent of all healthcare costs for children. Postpartum care has been shown to help women appropriately space pregnancies, reducing the risk of preterm birth which, according to the Institute of Medicine, accounted for more than \$26 billion dollars in medical, educational, and lost productivity costs in 2005 alone. A federal standard to ensure that maternity coverage is available to all women, regardless of where they live, is essential as part of health reform.

We are mindful that the House bill in particular requires hearing benefits and durable medical equipment to be among the covered services for children, and the Foundation strongly recommends these reference to these benefits be included in final legislation. In addition, we support both bills'

requirement that preventive services be covered, and particularly recommend inclusion of the Senate’s language referencing the scope of preventive services delineated in the current version of “Bright Futures.”<sup>1</sup> Children have unique needs with regard to preventive health services that are not fully recognized by the United States Preventive Services Task Force (USPSTF), therefore a broader scope of reference – such as that offered by “Bright Futures”-- is needed. For example, within the first year of life, it is medically recommended that an infant visit his/her pediatrician 8 times to ensure proper development monitoring, yet the USPSTF is silent on this recommendation]. In addition, the Foundation strongly urges negotiators to accept the Senate bill language calling for the creation of a parallel document for women’s health services and required coverage of services specified in that document. USPSTF recommendations are silent on such critical services as preconception care which helps promote women’s health and the health of their future pregnancies and children, so this additional resource that identifies clinically recommended preventive health services for women is critical. Studies show that certain health services, if provided to a woman before pregnancy, can improve the health of a future pregnancy. Often, women do not realize that they are pregnant at the outset, and the first prenatal visit with a physician typically does not occur before 6-12 weeks after conception. Beginning care at this point misses opportunities to intervene before crucial early weeks of fetal development. Broadbased coverage for preconception and interconception services will improve the capacity of providers to identify conditions and behaviors that, left untreated, can adversely impact a future pregnancy. Diagnosing problems early will optimize the opportunity for providers to intervene appropriately. Examples include tobacco cessation services, nutrition counseling, and controlling chronic conditions such as hypertension or diabetes.

If you and others who are working to reconcile the two bills elect to include the Senate provision pertaining to catastrophic plans for young adults, the March of Dimes strongly encourages you to ensure that young women in these plans who become pregnant have the option to switch to a comprehensive plan with more appropriate cost sharing rules. The so-called “catastrophic” plans require satisfaction of an annual deductible of nearly \$6,000 per individual (nearly \$12,000 for a family) before maternity care benefits are reimbursable. To ensure that she has access to affordable maternity services, when a young woman enrolled in one these plans becomes pregnant, she should be permitted to elect to move to a more appropriate plan without having to wait for the next open enrollment period. Marriage, birth or adoption of a child, and change of employment are already considered ‘qualifying life events’ that trigger the option for enrollees to change their insurance coverage outside the open enrollment period. Because half of pregnancies are unplanned, it is important to ensure out of pocket costs borne by you women and their families not be excessive. To ignore this very serious problem is to create incentives for young women to delay or forego needed maternity services, and for this reason, we strongly encourage conferees to add a ‘qualifying life event’ provision if the final bill includes a ‘catastrophic plan’ option.

### **Public Programs — Medicaid and CHIP**

- **Medicaid and CHIP maintenance of effort during transition to reformed health system**
- **HHS study comparing CHIP coverage to that which is available in the new Exchange(s)**
- **Extension of funding for CHIP through 2015**

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<sup>1</sup> *Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents—Third Edition.* ed by Joseph F. Hagan Jr. MD, FAAP; Judith S. Shaw, RN, MPH, EdD; and Paula Duncan, MD, FAAP. American Academy of Pediatrics, 2008.

- **Medicaid coverage of tobacco cessation counseling and pharmaceuticals for pregnant women**
- **State option to improve Medicaid eligibility and coverage of family planning**
- **Creation and funding of evidence-based home visitation programs to improve maternal and child health for at risk pregnant women, new mothers, infants and children**

Congress and the states have already made excellent progress in extending coverage to millions of pregnant women and children through Medicaid and the Children's Health Insurance Program (CHIP). In order to protect coverage for those who rely upon these programs as the nation transitions to a reformed health system, the March of Dimes supports robust maintenance of effort provisions that enable individuals enrolled in publicly supported programs to transition smoothly and without loss of health coverage. The Foundation is grateful that both the House and Senate bills include a requirement that the Secretary of Health and Human Services undertake a study comparing CHIP coverage to that which is available in the new Exchange(s) to ensure a smooth transition without loss of coverage or access to services. Extension of funding for CHIP through 2015 as proposed by the Senate is essential to ensure that a safety net remains available to enrolled children and pregnant women during this transition period.

With regard to the design of benefit packages, the Foundation urges inclusion in the final bill of Medicaid coverage of tobacco cessation counseling and pharmaceuticals for pregnant women and improvement of Medicaid eligibility and coverage of family planning as envisioned in both the House and Senate bills. Counseling is typically the first line of clinical treatment recommended to pregnant smokers, but providers should have the option to prescribe pharmacotherapy in cases where counseling fails. Health plans should cover both tobacco cessation counseling and pharmaceuticals for pregnant women.

A comprehensive tobacco cessation benefit is crucially important for pregnant women given the well documented negative impact of smoking on pregnancy health and birth outcomes. Women who smoke during pregnancy are more likely than nonsmokers to have a low birthweight or preterm baby. Conservative estimates indicate that at least one out of every ten pregnant women smoke, accounting for half a million births per year. According to a 2004 Surgeon General's report, "Health Consequences of Smoking," infants of women who quit smoking by the end of the first trimester have weight and body measurements comparable to infants of nonsmokers. The October 2005 Committee Opinion issued by the American College of Obstetricians and Gynecologists (ACOG) indicates that health risks associated with pregnancy include intrauterine growth restriction, placenta previa, and abruptio placentae. Adverse pregnancy outcomes include premature rupture of membranes, low birthweight, and perinatal mortality. Evidence also suggests that smoking is associated with an increase in ectopic pregnancies. ACOG reports a strong association between smoking during pregnancy and sudden infant death syndrome (SIDS). Children born to mothers who smoke during pregnancy are at increased risk for asthma, infantile colic, and childhood obesity. According to ACOG, it is estimated that eliminating smoking during pregnancy would reduce infant deaths by 5% and reduce the incidence of singleton low birth weight infants by 10.4%.

Pregnant women on Medicaid are 2.5 times more likely than other pregnant women to smoke, according to Medicaid data analyzed by the Centers for Disease Control and Prevention (CDC). Moreover, joint estimates by the CDC and the Centers for Medicare and Medicaid Services, have found that smoking-attributable neonatal health care costs for Medicaid total almost \$228 million, or about \$738 per pregnant smoker.

Prenatal smoking cessation programs have been shown to have a protective effect on intrauterine growth retardation. In 2006, a National Institutes of Health (NIH) state-of-the-science panel found that tobacco cessation interventions could double or triple quit rates if they were made accessible to more smokers. The panel found that smoking cessation interventions/treatments such as nicotine replacement therapy and counseling were individually effective, and even more effective in combination. A study in the July 2001 American Journal of Preventive Medicine ranked the effectiveness of various clinical preventive services recommended by the U.S. Preventive Services Task Force (USPSTF), using a one to ten scale, with ten being the highest possible score. Of the thirty preventive services evaluated, tobacco cessation ranked second in its degree of effectiveness, scoring a nine out of 10 (the highest ranking was for childhood vaccines which scored a 10). By comparison, other preventive services covered by Medicaid, colorectal cancer screening received a score of eight and mammography screening scored a six. The Committee Opinion issued by the American College of Obstetricians and Gynecologists noted that an office based protocol that systematically identifies pregnant women who smoke and offers treatment has been proven to increase quit rates.

The most cost-effective population to target for smoking cessation programs is pregnant women. Pregnant women incur an additional \$704 in neonatal healthcare costs compared to nonsmokers. Clinical trials have shown that, for every \$1 invested in smoking cessation programs for pregnant women, \$7.75 are saved in short-term medical costs and an additional \$7.63 (in year 2002 dollars) are saved in long-term costs by preventing disability among low birth weight infants who survive.

The USPSTF found ‘good evidence’ that extended or augmented smoking cessation counseling (5 to 15 minutes) using messages and self-help materials tailored for pregnant smokers, compared with brief generic counseling interventions alone, substantially increases abstinence rates during pregnancy and leads to increased birth weights. The USPSTF concluded that reducing smoking during pregnancy is likely to have substantial health benefits for both the baby and the expectant mother.

The March of Dimes strongly supports the proposal in both bills to improve Medicaid eligibility and coverage of family planning without having to obtain a waiver. Approximately half of all pregnancies in the US are unplanned, and there is a strong correlation between unintended pregnancy and failure to obtain timely prenatal care. By giving states the option to cover family planning services without having to obtain a federal waiver, low-income women will be able to obtain care from a health professional before pregnancy, increasing the likelihood that when they do become pregnant, they will be provided early prenatal care. In addition, numerous studies have shown that pregnancies spaced too closely together present a medical risk factor for preterm birth, the principal cause of newborn death. Appropriately spacing pregnancies — for which access to family planning services is critically important — has been shown to reduce the risk of preterm birth.

In addition, the March of Dimes strongly supports provisions in both bills to create and fund evidence-based home visitation programs for at risk pregnant women, new mothers, infants and young children — and strongly recommends that preterm birth, the single most important driver of newborn death, be a focus for these programs which are intended to lead to substantial improvement in maternal and child health. Studies have found that in some jurisdictions, home visitation for high risk pregnant women and mothers through the Nurse-Family Partnership reduced preterm births among women who smoked by nearly 80%. Another example, the Resource Mothers program in Virginia, provides lay community health workers to serve as mentors to pregnant teens. Over the 18 year history of this program, the number of low birthweight infants born to participants has decreased dramatically.

## **Quality**

In addition to its focus on efforts to expand health coverage, the March of Dimes is very supportive of the efforts by both the House and Senate to improve quality, safety and accountability in the health care system. As the House bill states, “Improving the provision of obstetrical and neonatal care, such as through the appropriate use of cesarean sections and the implementation of best practices for labor and delivery care” is vital to reducing the rate of preterm birth and improving infant health. The March of Dimes agrees with the Senate bill’s inclusion of NICU patients as a targeted group for whom quality and safety improvements are needed. The most medically fragile newborns typically receive care in the NICU, including those born preterm. More than 500,000 infants were born prematurely in 2004 (about one in eight). In 2005, the average first year medical costs, including both inpatient and outpatient care were about 10 times greater for preterm (\$32,325) than for term infants (\$3,325). The March of Dimes has worked closely with the Centers for Medicare and Medicaid Services (CMS), the Agency for Health Research and Quality (AHRQ) and the National Initiative for Children’s Healthcare Quality (NICHQ) on the Neonatal Outcomes Improvement Project, in which three states (New York, North Carolina and Ohio) are piloting the use of evidence-based clinical interventions designed to improve care for high risk NICU patients. With enhanced federal support for pediatric quality improvement efforts, more states can take the necessary steps to improve care for all children who require NICU care.

## **Public Health**

The March of Dimes is deeply appreciative of the efforts by Members of both the House and Senate to use health reform as an opportunity to make significant investments in the nation’s public health system and we encourage negotiators to include in the conference agreement the highest possible level of funding for prevention and public health, and no less than the House approved commitment of \$33.9 billion to initiate the Public Health Investment Fund. Specifically, the creation of this fund will establish a new and stable funding mechanism that will facilitate investing in wellness and prevention and help stave off the onset of costly conditions (including birth defects and preterm birth), thereby averting the need for expensive – and often lifelong -- treatment. Funding prevention and wellness programs will help revitalize the public health infrastructure of states and communities and reduce both the short and long term costs associated with communicable diseases as well as chronic conditions including heart disease and diabetes.

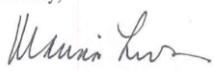
In addition, the Foundation strongly supports the intent of both bills to increase federal resources for the modernization of state vital statistics information systems. Unfortunately, only 60 percent of states and territories use the 2003 birth certificates and 56 percent have adopted the 2003 death certificate. Providing additional federal support would enable the National Center on Health Statistics (NCHS) to help fund efforts by the remaining states and territories to modernize their vital statistics infrastructure without undermining the scope and quality of data collected on a national basis. As I am sure you would agree, collecting, analyzing and reporting current vital statistics information is essential to understanding the status of Americans’ health and to evaluating the impact of a reformed health care system.

The Foundation also supports permanent reauthorization of the 317 immunization program that serves as a lifeline for childhood vaccinations. Infants are particularly vulnerable to infectious diseases, which is why it is critical to protect them through immunization. The Centers for Disease Control and Prevention (CDC)

has found that, each day, nearly 12,000 babies are born in the U.S. who will need to be immunized against 14 vaccine-preventable diseases before age two. The CDC National Immunization Program supports states, communities, and territorial public health agencies through grants to reduce the incidence of disability and death resulting from vaccine-preventable diseases. The March of Dimes urges Congress to permanently reauthorize this program to ensure stability in resources essential to protecting the health of America's children.

Once again, thank you for your efforts to craft a health reform conference agreement that includes meaningful and long overdue improvements in health coverage and care for women of childbearing age, infants and children. All of us at the Foundation stand ready to lend our support as you work toward a final compromise bill.

Sincerely,



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