March of Dimes Foundation

Office of Government Affairs
1146 19th Street, NW, 6th Floor
Washington, DC 20036
Telephone (202) 659-1800
Fax (202) 296-2964

marchofdimes.com
nacersano.org

The Honorable George Miller
Chairman
Education and Labor Committee
US House of Representatives
Washington, DC 20515

The Honorable Charles Rangel
Chairman
Ways and Means Committee
US House of Representatives
Washington, DC 20515

The Honorable Henry Waxman
Chairman
Energy and Commerce Committee
US House of Representatives
Washington, DC 20515

June 23, 2009

Dear Chairmen:

The March of Dimes Foundation applauds your leadership in developing draft legislation to provide affordable, high quality health care to all Americans and to improve our nation's health system. The mission of the March of Dimes to improve the health of women of childbearing age, infants and children by preventing preterm birth, birth defects and infant mortality can best be achieved if all women and children in the U.S. have access to affordable, comprehensive health insurance. The March of Dimes greatly appreciates the numerous provisions in your bill that address issues pertaining to these populations, and hopes that you and other Members of the Committees will find the Foundation's comments useful in refining and advancing health reform legislation. We look forward to continuing to provide additional input as the Committees move forward.

Division A—Affordable Health Care Choices

Title I—Protections and Standards for Qualified Health Benefits Plans

Subtitle B—Standards Guaranteeing Access to Affordable Coverage

Sec. 111. Prohibiting Pre-existing Condition Exclusions

The March of Dimes supports the proposal to prohibit the exclusion from coverage of pre-existing health conditions for all qualified health benefits plans. 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 coverage for maternity services. 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 would make it easier for such children to obtain coverage for the health services they need.

Sec. 112. Guaranteed Issue and Renewal for Insured Plans

The March of Dimes supports the proposal to guarantee availability and renewability of all health insurance coverage. This policy would make coverage more attainable for women who are pregnant and children with special healthcare needs—populations who are too often denied coverage. It will also help prevent lapses in insurance coverage that can lead to delays in accessing medically necessary care.

Subtitle C—Standards Guaranteeing Access to Essential Benefits

Sec. 122. Essential Benefits Package Defined

The Foundation is extremely pleased that insurance plans would be prohibited from imposing lifetime limits on coverage or annual limits on benefits. Such limits often create severe financial burdens on families whose children have serious and ongoing medical needs that require costly and often life-saving care. Prohibition of such limits will make it easier for medically fragile children to maintain access to the care they need.

Minimum Services to be Covered

The March of Dimes applauds the inclusion of maternity care; prescription drugs (including contraceptives and tobacco cessation pharmaceuticals); habilitative services; preventive services (including those recommended with a grade of A or B by the US Preventive Services Task Force, such as tobacco cessation counseling for pregnant women); vaccines; well baby and well child care, and oral, vision, hearing, equipment and supplies for children on the list of minimum services that qualified health benefits plans must cover.

In particular, the lack of accessible, affordable maternity coverage remains a very serious problem, especially for women employed in small businesses and for those who obtain their coverage through the individual health insurance market. A 2006 Georgetown University study commissioned by the March of Dimes found that 19 states have adopted laws to require some

level of coverage for maternity services. However, these laws vary in scope, and only five of the states (MA, MT, NJ, OR and WA) require all insurers in the individual market to cover comprehensive maternity care. In states without such requirements, maternity coverage is typically sold as an expensive rider to the underlying policy and only if the woman is not pregnant. If she is already pregnant, coverage is simply not available in the individual market.

It has been estimated that up to 14 million women rely on coverage through the individual insurance market, yet a survey conducted for the National Women's Law Center found that only 12% of 3,500 individual policies include the full spectrum of clinically recommended maternity care services, and these policies are available in less than half of the communities surveyed.

As you know, women who receive timely maternity care are more likely to have access to screening and diagnostic tests that can help identify problems early; services to manage developing and existing problems; and education, counseling, and referral to reduce risky behaviors including substance use and poor nutrition. Such care is important to the health of both mothers and infants, in fact, studies have shown that singleton infants born to mothers who received late or no prenatal care in 2004 were nearly twice as likely to be low birthweight, a costly and debilitating problem for infants. In addition, postpartum care has been shown to help women appropriately space pregnancies, reducing the risk of preterm birth which can be devastating for families and, according to the Institute of Medicine, accounted for more than $26 billion dollars in medical, educational, and lost productivity costs in 2005 alone.

The March of Dimes strongly supports the establishment of a federal standard to ensure maternity coverage is available to all women, regardless of where they live.

With regard to preventive services, the March of Dimes urges Members of the Committees to be mindful that women of childbearing age have unique healthcare needs which are not fully recognized by the USPSTF. For example, these women should have access to coverage for family planning services and supplies as well as preconception and interconception care. Coverage of these essential services would encourage more women to seek the care of a health professional before pregnancy, increasing the likelihood that when they do become pregnant, they will obtain timely 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.

The March of Dimes supports the proposal to prohibit cost sharing for preventive items and services, including well baby and well child care.

Sec. 123. Health Benefits Advisory Council

The March of Dimes supports the inclusion of consumer representatives and an expert on children's health in the Health Benefits Advisory Council. In addition, the Foundation recommends that the Council include an expert in obstetrics and gynecology be included on the

Council to ensure that the unique health needs of women of childbearing age are appropriately addressed.

Title II—Health Insurance Exchange and Related Provisions

Subtitle A—Health Insurance Exchange

Sec. 203. Benefits Package Levels

The March of Dimes supports the requirement that all plans in the Exchange offer the essential benefits package required under Title I of this bill.

The Foundation also supports protecting state benefit requirements. Numerous states have enacted laws to ensure access to such important benefits as well child care, maternity care, medical formula and foods as well as treatment for birth defects. National health reform should build on such successes, and should not inhibit the ability of states to provide enhanced benefits to their citizens.

Sec. 204. Contracts for the Offering of Exchange-Participating Health Benefits Plans

The March of Dimes strongly supports requiring that any Medicaid-eligible individuals who elect to enroll in insurance plans through the Exchange receive coverage for full Medicaid wrap-around services. It is particularly important that all Medicaid-eligible children, regardless of whether they obtain insurance through the exchange or elsewhere, retain access to the full Early and Periodic Screening, Diagnostic and Treatment services (EPSDT) benefit. A just released IOM study concludes that uninsured children with special health care needs are six to eight times more likely to have an unmet need for health care than their insured counterparts. Thus, the March of Dimes strongly recommends that children have access to coverage for all medically necessary treatments as well as recommended preventive care.

Sec. 205. Outreach and Enrollment of Exchange-Eligible Individuals and Employers in Exchange-Participating Health Benefits Plan

Coverage for Certain Newborns

The Foundation supports automatic Medicaid eligibility for infants born in the US who are not otherwise covered by appropriate health insurance. Such coverage will help ensure that infants receive crucial preventive services (including the recommended eight visits with a pediatrician during the first year of life) and that medically fragile infants, including those born preterm or with birth defects, have access to life sustaining care.

CHIP Transition

If the Committees proceed with the proposal to enroll children currently eligible for or enrolled in the Children's Health Insurance Program (CHIP) in health plans obtained through the

Exchange, we urge the Committees to ensure that access to comprehensive, pediatric appropriate benefits is maintained. In particular, children in states where CHIP is tied to the state's Medicaid program and who are currently covered for the full EPSDT benefit should be provided a complete wrap-around that protects their existing scope of benefits.

Subtitle B—Public Health Insurance Option

Sec.221. Establishment and Administration of a Public Health Insurance Option as an Exchange-Qualified Health Benefits Plan

If the Committees choose to create a new public insurance option, the March of Dimes strongly recommends that this new plan meet benefit standards for pregnant women and children recommended by the appropriate credentialing organizations—the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists (ACOG). The new plan should cover the full scope of maternity care benefits. All children enrolled in any public plan should have the full EPSDT benefit currently provided through Medicaid.

Division B—Medicare and Medicaid Improvements

Title VII—Miscellaneous Provisions

Sec. 1704. Grants to States for Quality Home Visitation Programs for Families with Young Children and Families Expecting Children

The March of Dimes supports providing federal funding for evidence-based home visitation programs for pregnant women and new mothers with the purpose of improving maternal and child health. The Foundation urges the Committees to include high rates of preterm birth, low birthweight and infant mortality among the criteria used to prioritize which communities will receive targeted funds through the program established by this provision. Home visitation programs have been found to reduce these poor birth outcomes. For example, the well regarded Resource Mothers program in Virginia has reduced low birthweight births among hard to reach populations of young women. Recent program evaluations found that in 2006-2007, the state low birth weight rate among teens was 10.5%, but for those enrolled in the Resource Mothers program, the low birth weight rate was 8.7%.

Title VIII—Medicaid and CHIP

Part 1—Medicaid and Health Reform

Sec. 1803. CHIP Maintenance of Effort

The March of Dimes strongly supports the maintenance of effort provision that will permit all pregnant women, infants and children currently eligible for CHIP to remain eligible for CHIP, and require states to maintain current levels of eligibility.

Maintenance of Medicaid Effort

The Foundation also strongly supports the Medicaid maintenance of effort provision that will permit all individuals currently eligible for Medicaid to remain eligible for the program, and require states to maintain current levels of eligibility. Medicaid currently finances nearly 45% of births nationwide (and more than half of all births in many states) and also covers over 30 million children, including more than half of the children with significant medical needs who would otherwise be uninsured for the substantial health services they require.

Part 2—Prevention

Sec. 1812. Tobacco Cessation

The Foundation enthusiastically applauds the Committees' proposal to require Medicaid coverage for comprehensive tobacco cessation services for pregnant women without cost-sharing for such services. Pregnant women on Medicaid are 2.5 times more likely than other pregnant women to smoke, according to 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. Comprehensive tobacco cessation services include both counseling and pharmaceuticals. Counseling is the first line of treatment recommended for pregnant smokers, but providers may choose to prescribe pharmacotherapy in cases where counseling fails.

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 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%.

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 ACOG 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.

Sec. 1813. Optional Coverage of Nurse Home Visitation Services

The March of Dimes supports the provision to permit states to cover through Medicaid nurse home visitation for families with a first time pregnant woman or child under age 2. The Foundation also supports coverage for evidence-based programs that are effective in improving maternal or child health and pregnancy outcomes, including lengthening intervals between pregnancies. Studies have found that home visitation for high risk pregnant women and mothers through the Nurse-Family Partnership reduced preterm births among women who smoked by up to 79%.

Sec. 1814. State Eligibility Option for Family Planning Services

The March of Dimes applauds the Committees for its proposal to permit states to cover non-pregnant low-income women in Medicaid 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 to family planning services, 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. Preconception and interconception care allow providers to identify conditions and behaviors that can impact a future pregnancy and provide appropriate intervention. Examples include tobacco cessation services, nutrition counseling, and controlling chronic conditions such as hypertension or diabetes. The March of Dimes also recommends that in establishing a state option to enroll young women in family planning, Congress also permit federal reimbursement for payment of preconception and interconception care benefits, including: (1) screening and assessment; (2) health promotion and counseling; (3) interventions as recommended by ACOG, AAP, and CDC.

Division C—Public Health and Workforce Development

Title I—Community Health Centers

The March of Dimes supports a five year reauthorization and increased funding commitment for Community Health Centers. Health Centers are an important source of obstetric and pediatric care.

Title III —Prevention and Wellness

Sec. 2301. Prevention and Wellness

The March of Dimes strongly supports the commitment to strengthen the public health system and create a national strategy to promote good health. Specifically, the creation of a Prevention and Wellness Trust will establish a new and stable funding mechanism to implement a national strategy. Investing in wellness and prevention can help stave off costly conditions (including birth defects and preterm birth) and thereby avert the need for expensive – and often lifelong -- treatment. Funding public health prevention and wellness programs is a down payment toward reducing individual and holds promise for reducing systemic health care costs as well. For example, repeated studies have shown that timely intervention through immunizations generates both short and long term cost savings and results in overall better health across the lifespan.

The March of Dimes urges the Committees to specifically address the National Vital Statistics System in health reform. For more than a year, the National Center for Health Statistics has been taking steps toward limiting the scope of data it purchases from states for the National Vital Statistics System. A plan is already underway to reduce significantly the scope of data obtained from all states to a limited "core" set. For women and children, the populations of greatest interest to the March of Dimes Foundation, approximately 75% of data routinely used to monitor maternal and infant health (including prenatal care, smoking during pregnancy, medical risk

factors, and educational attainment of parents) would be reclassified as "enhanced" and would no longer be provided to NCHS. Funds currently devoted to acquiring so-called "enhanced" data would be reprogrammed for other uses.

<u>If such national data is no longer obtained and analyzed by NCHS, it will not be possible to measure and track the full impact of health reform legislation on the nation's health.</u>

Title IV – Quality and Surveillance

Sec. 2401 - Implementation of Best Practices in the Delivery of Health Care

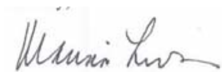
The March of Dimes supports the emphasis on improving the quality of health care. Specifically, the Foundation applauds the inclusion of obstetrics and neonatal care as an initial priority of the newly established Center for Quality Improvement. As the legislative language states "Improving the provision 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.

Sec. 2402 - Assistant Secretary for Health Information

The March of Dimes supports elevating the importance of collecting and disseminating of health information with the Department of Health and Human Services. The Foundation suggests further clarification as to how the National Center on Health Statistics would fit within the new Bureau of Health Information.

Once again, the March of Dimes looks forward to continuing to work closely with you and other Members of your Committees to ensure that health reform meets the needs of women of childbearing age, infants and children.

Sincerely,



Marina L. Weiss, Ph.D.
Senior Vice President, Public Policy
and Government Affairs

march of dimes