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March of Dimes Comments to the Senate Finance Committee  
Expanding Health Care Coverage:  
Proposals to Provide Affordable Coverage to All Americans

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The March of Dimes Foundation is pleased to comment on the “Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans,” policy options document released by the Senate Finance Committee on May 11, 2009. 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 everyone in the U.S. has access to affordable, comprehensive health insurance. The March of Dimes greatly appreciates the many references to these issues in the document, and hopes Members of the Committee will find the Foundation’s comments useful in developing and advancing health reform legislation. We look forward to continuing to provide additional input as the Committee further refines its proposals and releases additional details.

## **Section I: Insurance Market Reforms**

### ***Prohibit the exclusion of coverage for pre-existing conditions (pages 2-3)***

The March of Dimes supports the proposal to prohibit the exclusion of coverage for pre-existing health conditions for all insurance plans in the non-group, micro-group and small group markets, and in the health insurance exchange. 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.

Women who receive prenatal 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 like substance use and poor nutrition. Such care thus helps improve the health of both mothers and infants. Postpartum care can help women appropriately space pregnancies, thereby reducing the risk of preterm birth. According to the Institute of Medicine, in 2005 the annual societal economic cost (medical, educational and lost productivity) associated with preterm birth in the U.S. was at least \$26.2 billion. During that same year 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).

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.

## **Section II: Making Coverage Affordable**

### ***Benefits (page 9)***

The March of Dimes supports the proposal to require all health insurance plans in the non-group, micro-group and small group markets, and in the health insurance exchange to cover maternity and newborn care. A 2006 Georgetown University study commissioned by the March of Dimes found that 19 states have adopted laws to require coverage of maternity care. In states without



such requirements, maternity coverage is typically not available in the individual and small group markets. 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. The March of Dimes supports the inclusion of newborn care in this policy as well, to ensure there are no gaps in timely access to care for infants immediately upon birth.

The March of Dimes is, however, concerned that the option currently articulated in the Committee document does not include pediatric care, beyond the newborn period, in the list of required medical benefits. Children have unique healthcare needs and require benefits designed to meet those needs and we therefore recommend strongly that explicit reference be made to the need for pediatric benefits.

The Foundation is extremely pleased that insurance plans would be prohibited from imposing lifetime limits on coverage or annual limits on any 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. Prohibition of such limits will make it easier for medically fragile children to maintain access to the care they need.

### **Section III: Public Health Insurance Option (pages 13-14)**

If the Committee chooses to create a new public health insurance option, the March of Dimes strongly recommends that this new plan meet Medicaid benefit standards for pregnant women and children. The new plan should cover the full scope of maternity care benefits. All children enrolled in any public plan should have the full Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services benefit. Children must have coverage for all recommended preventive care, as well as all medically necessary treatments. 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.

### **Section IV: Role of Public Programs**

#### ***Medicaid Coverage: Eligibility Standards and Methodologies (page 15)***

The March of Dimes supports requiring all state Medicaid programs to raise income eligibility for pregnant women and children to at least 150% of the Federal Poverty Limit (FPL). However, it is important to note that more than half the states already cover pregnant women and children at higher income levels, therefore we urge the Committee to ensure that the legislative directive does not provide states an incentive to lower coverage levels to the 150% minimum threshold.

In addition, the March of Dimes is concerned that the short term maintenance of effort provision included in the Committee's proposal would be allowed to expire simply upon determination of the Secretary. We believe the maintenance of effort requirement should remain in effect until Congress determines that a change in Medicaid coverage arrangements for vulnerable pregnant women and children is warranted. Therefore, the Foundation suggests that the Committee direct the Secretary to make recommendations to Congress regarding any modifications in coverage for

pregnant women and children, but that only Congress be permitted to extinguish the maintenance of effort requirement.

Further, prohibiting state use of income disregards for all Medicaid eligible populations would most certainly reduce eligibility and coverage — the very antithesis of the Committee’s stated goals and the Foundation respectfully encourages the Committee to reconsider this ill advised proposal.

***Options for Medicaid Coverage (pages 16-18)***

All federal Medicaid protections must be maintained for the vulnerable populations currently eligible for this program, even if they obtain their health coverage through employer-sponsored insurance (ESI) or through the new exchange. For example, all Medicaid eligible children, regardless of their source of coverage, must continue to have access to the full EPSDT benefit. Further, the option to forego traditional Medicaid in favor of one of these other options must rest with the eligible individual and not with the administering agency or plan.

***Children’s Health Insurance Program (CHIP) (pages 21-22)***

The March of Dimes supports the maintenance of effort provision that would prohibit states from reducing CHIP eligibility, but has the same concerns expressed with regard to Medicaid concerning the provision’s expiration. To ensure that pregnant women and children who rely upon CHIP maintain access to appropriate health coverage, an act of Congress should be the only mechanism for extinguishing the maintenance of effort provision.

While the March of Dimes supports the proposed CHIP income eligibility increase to 275 percent FPL, the Foundation remains troubled that forbidding state use of income disregards may have the effect of reducing eligibility for coverage. The Committee’s proposal to require EPSDT for all children enrolled in CHIP is a very good step and critically important to ensure that children enrolled in this program have access to the medical care they require. Limiting cost-sharing under CHIP to Medicaid’s cost-sharing rules will also help needy families afford medically necessary care for their children.

***Other Improvements to Medicaid: Enrollment and Retention Simplification (page 23)***

The March of Dimes commends the Committee for proposing numerous steps to ease Medicaid enrollment, including eliminating the state option to use face-to-face interviews to determine Medicaid eligibility, requiring states to implement 12-month continuous eligibility, and extending automatic renewal and Express Lane renewal to all Medicaid beneficiaries. Each of these steps is important in providing timely access to services and in helping to prevent needless coverage disruptions. In addition, simplified renewal processes help prevent children from losing coverage.

In addition to these mechanisms, the March of Dimes also recommends that states be required to implement presumptive eligibility for all pregnant women and children in Medicaid and CHIP.



Presumptive eligibility allows states to cover applicants temporarily until eligibility can be fully determined. States may permit health care providers, schools, and other agencies to determine presumptive eligibility. Experience has demonstrated that presumptive eligibility increases the proportion of pregnant women on Medicaid who receive early prenatal care. Parents of uninsured children report being much more likely to enroll their youngsters in Medicaid if they are permitted to do so immediately or through a doctor's office or clinic.

### ***Medicaid Family Planning Services and Supplies (page 24)***

The March of Dimes applauds the Committee 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 allowing Medicaid programs to cover family planning services without having to obtain a federal waiver, low income women will be under 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.

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 or 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 recommends that Congress permit federal reimbursement for Medicaid coverage of certain preconception and interconception care benefits, including: (1) screening and assessment; (2) health promotion and counseling; (3) interventions as recommended by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics and the U.S. Centers for Disease Control and Prevention.

### ***Medicaid Coverage of Prescription Drugs (pages 26-27)***

The March of Dimes supports the Committee proposal to make prescription drugs a mandatory benefit for the categorically and medically needy, as well as the proposal to eliminate smoking cessation drugs from Medicaid's excluded drug list. It is critical for all women of childbearing age who rely on Medicaid to have access to medically appropriate tobacco cessation services, including both counseling and pharmacological interventions.

### ***Transparency in Medicaid and CHIP Section 1115 Waivers (pages 28-29)***

The March of Dimes supports the Committee’s proposal to impose statutory requirements regarding transparency in the development, implementation and evaluation of Medicaid and CHIP section 1115 demonstration programs that impact eligibility, enrollment, benefits, cost-sharing, and financing. It is extremely important that the public be thoroughly informed of these proposed changes to their state Medicaid programs early in the process and well in advance of any proposal’s adoption. The public must also have sufficient opportunity to comment on these proposals.

***Automatic Countercyclical Stabilizer (pages 31-32)***

The March of Dimes is pleased that the Committee has proposed a mechanism to help FMAP respond more quickly to economic downturns. The Foundation has repeatedly endorsed FMAP increases during times of need to ensure that states are able to cover the increasing number of Medicaid eligible women of childbearing age and children without making cuts to Medicaid eligibility or benefits. When economic conditions result in job loss and loss of health insurance, it is extremely important for the federal government to be able to respond quickly to help states ensure Medicaid coverage is made available for those who qualify for the program.

**Section VI: Options to Improve Access to Preventive Services and Encourage Healthy Lifestyles**

***Prevention and Wellness in Medicaid (pages 46-47)***

The March of Dimes enthusiastically applauds the Committee’s proposal for requiring Medicaid coverage for comprehensive tobacco cessation services for pregnant women without cost-sharing for such services. To clarify, comprehensive tobacco cessation services include both counseling and pharmaceuticals. Counseling is typically the first line of treatment recommended to 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 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.

### ***Prevention and Wellness Innovation Grants (pages 47-48)***

The March of Dimes is pleased that the Committee proposes a significant investment in state prevention programs. The Foundation suggests that preconception and interconception care be included in the types of activities states may provide with these grant funds. Studies show that certain health services, if provided to a woman before pregnancy, can improve the health of a future pregnancy.

## **Section VIII: Options to Address Health Disparities (pages 56-61)**

Significant racial disparities exist among maternal and infant health outcomes. Women of color and their children face great challenges in obtaining needed healthcare as well as devastating health effects that can result from lack of access to care. In 2007, 37% of Hispanic women of childbearing age and 24% of black women (non-Hispanic) of child-bearing age were uninsured according to figures prepared by the U.S. Census Bureau. (National average is nearly 20%.) As noted above and documented by the National Academy of Sciences Institute of Medicine, uninsured pregnant women have a difficult time accessing maternity care. Approximately 25% of black and Hispanic pregnant women did not get prenatal care in the first three months of pregnancy (National average is 16%.) By comparison to the national average, black infants are more likely to be born prematurely according to the National Center for Health Statistics. In 2005, over 18% of black infants (non-Hispanic) were born preterm, compared with an overall rate of 12.7% nationwide. Prematurity/low birthweight was the leading cause of infant mortality for non-Hispanic black infants in 2004, according to the National Center for Health Statistics. Infant mortality was highest in the black (non-Hispanic) community. In 2004 nearly 13.6 per 1,000 live births according to the National Center for Health Statistics. (National average is 6.8 per 1,000 births.)

The March of Dimes supports improving the collection of health disparities data for the Medicaid and CHIP populations. In addition, the March of Dimes strongly supports eliminating the five-year waiting period for non-pregnant adult legal immigrants. This policy will help expand access to coverage for women of childbearing age.

### ***Reduction in Infant Mortality and Improved Maternal Well-Being (page 61)***

The March of Dimes commends the Committee for its commitment to increase federal funding for states, tribes and territories to develop and implement targeted approaches to reducing infant mortality and its related causes and consequences, such as preterm birth, infant and child disability, reduced health status of women of childbearing age and maternal mortality.

In the United States in 2005, 28,384 infants died before reaching their first birthday, an infant mortality rate of 6.9 per 1,000 live births. Birth defects are the leading cause for infant mortality, followed by preterm birth and low birthweight.

Numerous programs nationwide exist that have an evidence base of reducing infant mortality, its causes, and its risk factors. For example, 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 79%. Another example, the Resource Mothers program in Virginia, provides lay community health workers to serve as mentors to pregnant teens. This program has reduced low birthweight among participants. We encourage the Committee to consider a broad range of resources in determining the evidence base on which it will rely for design of this program.

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