

**March of Dimes Foundation**

**Office of Government Affairs**

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The Honorable Edward M. Kennedy  
Chairman  
Committee on Health, Education, Labor and Pensions  
United States Senate  
Washington, DC 20510

June 12, 2009

Dear Chairman Kennedy,

The March of Dimes Foundation applauds your leadership and the leadership of the Members of the Health, Education, Labor and Pensions (HELP) Committee in developing the Affordable Health Choices Act. 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 numerous provisions in your bill that address these issues, and hopes that you and other Members of the Committee 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 Committee moves forward.

**Title I—Quality, Affordable Health Care for All Americans**

**Subtitle A Effective Coverage for All Americans**

**Sec. 2705 Prohibition of Preexisting Condition Exclusions or Other Discrimination Based on Health Status**

The March of Dimes supports the proposal to prohibit the exclusion from coverage for pre-existing health conditions for all insurance plans in the individual and group markets, and in plans obtained through the proposed 'Gateways'. 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.

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. 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 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.

#### **Sec. 2702 Guaranteed Availability of Coverage**

The March of Dimes supports the proposal to require all health insurers offering coverage in the individual or group market to accept every employer and individual that applies for coverage. This policy will make coverage more attainable for women who are pregnant and children with special healthcare needs—populations who are too often denied coverage.

#### **Sec. 2703 Guaranteed Renewability of Coverage**

The March of Dimes supports the proposal to require health insurers to renew coverage at the option of the individual. This policy will help prevent lapses in insurance coverage that can lead to delays in accessing needed medical care.

#### **Sec. 2706 Prohibiting Discrimination Against Individual Participants and Beneficiaries Based on Health Status**

The March of Dimes supports the proposal to prohibit health insurers from establishing rules for eligibility based on health status related factors. This policy will make coverage more attainable for women who are pregnant and children with special healthcare needs—populations who are too often denied coverage.

#### **Sec. 2707 Ensuring the Quality of Care**



The March of Dimes supports the inclusion of “child health measures” among the areas for which quality improvement incentives are provided. A recent study by Dr. Rita Mangione-Smith, published in the October 11, 2007 *New England Journal of Medicine* found that fewer than half of America’s children – regardless of insurance status – receive the right care in the right amount at the right time. This finding underscores the need for additional action by Congress to improve the quality of healthcare provided to our nation’s children.

### **Sec. 2708 Coverage of Preventive Health Services**

The March of Dimes supports coverage of preventive health services with minimal or no copays. The US Preventive Services Task Force awards an “A” rating to tobacco cessation counseling for pregnant women, making it a required benefit under this provision. Counseling is typically the first line of treatment recommended to pregnant smokers, but providers may choose 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 is crucially important for pregnant women given the extremely 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.

In addition to the smoking cessation benefit for pregnant women, The March of Dimes also supports the coverage for infants, children and adolescents of all preventive care and screenings described in the comprehensive guidelines supported by the U.S. Health Resources and Services Administration. The Foundation applauds the Committee for recognizing that children have unique needs with regard to preventive health services. 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.

The March of Dimes urges you and Members of the Committee to consider adopting a similar standard for women of childbearing age, recognizing that this population also has unique healthcare needs which are not fully recognized by the USPSTF. For example, these women should have coverage for family planning services and supplies as well as preconception and interconception care. Coverage of these essential services would ensure that more 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.

### **Sec. 2709 Extension of Dependent Coverage**

The March of Dimes supports permitting individuals up to age 26 to remain as dependents on their family's health coverage. This proposal will help reduce uninsurance among young women of childbearing age.

### **Sec. 2710 No Lifetime or Annual Limits**

The Foundation is extremely pleased that insurance plans would 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. Prohibition of such limits will make it easier for medically fragile children to maintain access to the care they need.

### **Subtitle B Available Coverage for All Americans**

#### **Sec. 141 Assumptions Regarding Medicaid**

The March of Dimes strongly supports the following assumptions: All individuals currently eligible for Medicaid will remain eligible for Medicaid, and states will be required to maintain levels of eligibility with regard to beneficiaries currently enrolled in Medicaid. The Foundation also supports extending these protections for pregnant women and children eligible for the Children's Health Insurance Program (CHIP). Medicaid currently finances over 40% of births and covers over 30 million children, including many children with significant medical needs who may otherwise be uninsured for the substantial health services they require.

### **Title XXXI Affordable Health Choices for All Americans**

#### **Subtitle A Affordable Choices**

#### **Sec. 3101 Affordable Choices of Health Benefit Plans**



### *Continued operation of state benefit requirements*

The March of Dimes supports protecting state benefit requirements. Numerous states have enacted laws to ensure access to such important benefits as well child care, maternity care, PKU formula, and cleft palate treatment. National health reform should build on such successes, and should not hamper the ability of states to provide enhanced benefits to their citizens.

### *Criteria for certification*

The March of Dimes supports establishing criteria to ensure that any health plan certified as a “qualified health plan” and allowed to be offered through a Gateway must provide coverage for at least the essential health care benefits established under section 3103(h), including maternity/newborn care and pediatric care.

### **Sec. 3103 Seeking the Best Medical Advice**

#### *Composition*

Any Medical Advisory Council that is established and tasked with making recommendations to the Secretary and Congress regarding essential health benefits should be required in statute to include representatives with clinical expertise in pediatrics, gynecology and obstetrics to ensure that the unique health needs of children and women of childbearing age (particularly those who are pregnant) are addressed by this Council.

#### *Elements of Report*

The March of Dimes applauds the inclusion of maternity and newborn care, prescription drugs (including contraceptives and tobacco cessation pharmaceuticals), habilitative services, and pediatric services on the list of essential health care benefits. The Foundation strongly urges that coverage of these services be among the criteria health plans must include to meet the threshold for minimum qualifying coverage. All women of childbearing age, infants and children must have access to coverage for these services regardless of where they obtain their health insurance.

The lack of accessible, affordable maternity coverage remains a tremendous problem, particularly 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 coverage of maternity care. 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 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. If she is already pregnant, such coverage is simply not available in the individual and small group markets.



More specifically, 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.

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.

#### *Required Elements for Consideration*

The March of Dimes supports the provision requiring the Council to take into account the health care needs of diverse segments of the population, including women and children. However, the Foundation is concerned that the Council may provide for the application of different criteria in determining benefits for young adults. The Massachusetts model for health reform also permits such young adult plans, and in that state, such plans may exclude prescription drugs (including contraceptives). Given that 50% of pregnancies are unplanned, contraception is a benefit sorely needed by this population. As noted above, the costliest health event faced by most young women of child bearing age is a pregnancy. It is imperative that plans offered to this population cover maternity care, as well as newborn and pediatric services for their children.

## **Title II Improving the Quality and Efficiency of Health Care**

### **Subtitle B Health Care Quality Improvements**

#### **Sec. 211 Health Care Delivery System Research; Quality Improvement Technical Assistance**

##### *Research Functions of the Patient Safety Research Center*

The March of Dimes supports the proposal to include among the Center's functions the implementation of national projects to improve care for patient populations requiring admission to a NICU. 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.

The Foundation also supports the proposal to expand demonstration projects for improving the quality of children's health care and the use of health information technology, such as through Pediatric Quality Improvement Collaboratives and Learning Networks.

### **Sec. 212 Grants to Establish Community Health Teams to Support a Medical Home Model**

The March of Dimes supports medical home models that recognize the unique health needs of children, and thanks the Chairman for specifically recognizing children in determining the criteria for health teams and medical homes.

### **Sec. 221 Office of Women's Health**

The March of Dimes supports codification of the Offices of Women's Health throughout HHS. Ensuring a continuous presence of women's health experts throughout the department and its agencies will serve to promote improving the health of women.

## **Title III Improving the Health of the American People**

### **Subtitle A: Modernizing Disease Prevention and Public Health Systems**

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 Public Health Investment Fund will establish a new and stable funding mechanism to implement this 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 as well as systemic health care costs. Moreover, such funding creates new jobs and can help revitalize the infrastructure of state, local, and community-based programs aimed at reducing rates of complex health problems. 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.

To ensure access to comprehensive services – preventive care as well as treatment -- that deliver improved health outcomes, a combination of clinical and community-based strategies are needed. Raising awareness of activities to promote health and prevent disease through a national education campaign should be a key component of the prevention and wellness strategy.



## **Subtitle B Increasing Access to Clinical Preventive Services**

### **Sec. 311 Right Choices Program**

The March of Dimes supports the creation of a temporary Right Choices Program to provide coverage of preventive services and referrals to safety net providers for treatments for uninsured individuals until they transition to affordable, accessible, comprehensive health insurance. Right Choices should cover all preventive services that this legislation would require private insurance to cover. Any pregnant women identified by Right Choices should quickly be provided access to maternity coverage. Any child for whom a medical need has been identified should be provided with a means to obtain all medically necessary treatment.

### **Subtitle D: Support for Prevention and Public Health Innovation**

The March of Dimes supports the emphasis on increasing research to optimize the delivery of public health services; better understand health disparities through data collection and analysis and foster health impact assessments. Central to this strategy is addressing 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 not be provided to NCHS. Funds currently devoted to acquiring so-called “enhanced” data would be reprogrammed to support upgrading the data collection infrastructure, including helping states implement the 2003 Revision of the U.S. Standard Certificate of Live Birth.

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 this legislation on the nation’s health.

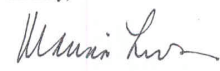
### **Conclusion**

While the draft bill does not currently include the establishment of a new public insurance plan, the March of Dimes understands that this issue is still being considered by the Committee. If the Committee chooses to create a new public 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. 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, it is our strong recommendation that all children enrolled in any public plan have the full Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services benefit. Children must also have coverage for all recommended preventive care, as well as all medically necessary treatments.



Once again, the March of Dimes looks forward to continuing to work closely with you, Chairman Kennedy, and other Members of the HELP Committee 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

