Maternal and Child Health Access

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TO: California Health Benefits Exchange Board
FROM: Lynn Kersey, MA, MPH, CLE, Executive Director
RE: Essential Health Benefits for Women
CC: CA HHS, CA DHCS, MRMIB

Delivered by electronic mail to: info@hbex.ca.gov, Yolanda.Richardson@hbex.ca.gov, David.Panush@hbex.ca.gov

Thank you for this opportunity to comment on essential health benefits under the Affordable Care Act (ACA).

The mission of Maternal and Child Health Access (MCHA) is to improve the health of low-income women and families through education, training, and direct services as well as administrative and other policy advocacy on health care and related rights. We help eligible women and their families to not only enroll in and retain publicly-funded health coverage but also access and effectively utilize quality health care services. In our 16 years, we have directly assisted thousands of women and their families through individual client support services and have also promoted the health care rights of hundreds of thousands more by fighting to preserve and improve health programs for low-income people throughout California.

MCHA is a member of the California Coalition for Reproductive Rights and strongly supports CCRR's comments concerning women's health coverage generally, including family planning, abortions, and all other reproductive health services.

MCHA now offers these additional comments, concerning benefits for pregnant and postpartum women and preconception and interconception care under the California Health Eligibility, Enrollment and Retention System (CalHEERS).

California's maternal mortality rate was a disturbing 49% higher in 2006-2008 than in 1999-2001.[1] African-American women in California are four times more likely to die from pregnancy-related causes than women in all other racial/ethnic groups, according to the state's most recent data.[2] Health insurance alone will not suffice to address these issues, but without comprehensive, accessible, quality coverage the challenges women face will be even more overwhelming.

Ensuring that all necessary benefits and services are part of CalHEERS "essential health benefits" is particularly important as these will affect not only Exchange enrollees but also the foundation for the Basic Health Option (BHO), should California adopt one, as well as the scope of benefits for Medi-Cal's 133% ACA expansion program.[3]

- **Comprehensive Perinatal Services:** In addition to prenatal medical visits and labor and delivery services, maternity benefits should include health education, nutrition counseling, prenatal vitamins, lactation consultation, manual as well as hospital-grade electric breast pumps, screening for intimate partner violence, substance abuse treatment, and other psychosocial services.

    - Each of these services for pregnant women is preventive in nature and would therefore help to halt escalating health care costs as well as to significantly reduce costs over time.

    - The savings accrue in health care costs for the woman as well as her newborn. The oft-cited savings of $3.38 not spent on costs of a low birth weight baby, for every $1 spent on prenatal care,[4] can be illustrated for prematurity as well: The average first-year medical costs, including both inpatient and outpatient care, are about 10 times greater for preterm infants than for full-term infants[5].

    - Breastfeeding support provides one of many concrete examples of how comprehensive perinatal services promote wellness and health while controlling health systems costs. According to the U.S. Surgeon General, there is a 32% higher risk of childhood obesity and a 64% higher risk of type 2 diabetes in children who are not breastfed.[6] Extensive research reviewed by the California Department of Public Health shows that breastfeeding reduces the mother's risk of breast and other cancers and benefits maternal health in other significant ways; it also protects a newborn's immune system, prevents respiratory illness and ear infections, reduces the risk of other serious diseases, and promotes a baby's growth, development and health in many other ways.[7] Researchers estimate that wider adoption of breastfeeding could save the U.S. health system billions of dollars a year.[8]

- **Preventive Dental Care:** Preventive benefits for pregnant and post-partum women should also include exams, cleanings and other basic dental benefits to address oral health conditions in order to prevent premature labor and delivery; babies born too soon are at high risk of dangerously low birth weights. Preventive dental services are essential to avoid oral infections such as gum disease, which has been linked to preterm birth.[9] According to a 2001 study, gum disease is as big a risk factor as smoking or alcohol use for having a low birth weight baby.[10]

    - Neonatal intensive care for a premature newborn typically runs into the hundreds of thousands of dollars; such costs can be avoided in many cases, for net savings in overall program costs, by the relatively low cost of basic oral health care for the mother during pregnancy. Such net program savings were a major reason why basic preventive dental benefits during pregnancy were added to the Medi-Cal program for adult women and retained after the elimination of most other adult Denti-Cal benefits in 2009.

- **No copayments, no utilization controls unrelated to medical need:** Copayments and other restrictions that limit access or utilization, such as caps on the number of monthly or yearly

visits, lifetime benefits limits, or other non-medical limitations on the amount of care, should also be rejected for all perinatal services as well as for any service for individuals with income at or below 200% of poverty. Extensive research has shown that even a small co-payment constitutes a barrier to care, especially for individuals at these income levels.

- **Benefits and Network Integration and Coordination:** To function effectively for prevention, cost-containment and women's health promotion, the essential health benefits package for the Exchange should also be capable of seamless integration and coordination with the benefits offered by Medi-Cal's full and limited scope programs, the Access for Infants and Mothers (AIM) program, and/or the BHO.

    - A growing body of research indicates that the condition of women's health and their access to care during the childbearing years, both before an initial pregnancy and between subsequent ones, have major impacts on pregnancy outcomes for the mother as well as the newborn.[11] The overarching goals of preconception and interconception care are to: 1) promote women's overall health through health education and timely access to needed medical and psychosocial services; 2) identify pregnancy risks early through screening; and 3) timely address identified risks.

    - Depending on her income level and a series of policy decisions that the state has yet to make, a woman's eligibility under CalHEERS may change significantly based on whether she is pregnant or not. Benefits integration and coordination among the various programs in which a woman may be enrolled are therefore key concerns:

        - for overall simplicity of administration of CalHEERS;

        - to promote ease of access and avoid disruptions in both preconception and interconception care; and

        - to assist in establishing coordinated standards for provider networks for prenatal and post-partum services among all programs, with appropriate medical homes for maximizing the quality of women's care before, during and after pregnancy.

- **Opt out of managed care when necessary to preserve continuity of care during pregnancy**: Based on MCHA's experience with clients enrolling in AIM or Medi-Cal, ensuring that plan networks have the necessary provider contracts or other arrangements to ensure access to all covered program benefits as well as continuity of care during pregnancy will remain a major challenge under CalHEERS. Due to such challenges for network adequacy, Medi-Cal, for example, has historically allowed pregnant women transitioning from a fee-for-service Medi-Cal program to Medi-Cal managed care to stay with their fee-for-service prenatal providers until after the 60-day postpartum period when a woman's existing provider(s) for either routine or specialty (e.g., endocrinologist, cardiologist) prenatal care would no longer be available to her in managed care. Similar policies should be adopted for all CalHEERS programs so that a woman who wishes to maintain an existing provider relationship during pregnancy will be able to do so easily.

Endnotes:

[1]California Maternal Quality Care Collaborative: http://www.cmqcc.org/maternal_mortality.

[2]*The California Pregnancy-Associated Mortality Review: Report from 2002-2003 Maternal Death Reviews*, California Department of Public Health (April 2011).

[3] A variety of factors complicate eligibility for pregnant women under Medi-Cal and the ACA.

On the one hand, California is required by the Medicaid Act to cover pregnant women to at least 185% of poverty, and Medi-Cal's "Federal Poverty Level" (FPL) program for pregnant women now goes to 200%. This eligibility rule is extremely beneficial to women with too much income to qualify for the usual Medi-Cal family coverage program (where the income limit is 100%) in that it ensures women will receive Medi-Cal's cost-sharing protections and comprehensive perinatal services during pregnancy.

On the other hand, however, major difficulties arise from the fact that the state has so far chosen to limit women's Medi-Cal FPL coverage to "pregnancy-related care", excluding services that the state may decide on a case-by-case basis are not related to pregnancy (e.g., treatment for a broken hand or brain tumor).

Complicating matters further is a proposed federal regulation implementing the ACA that excludes pregnant women who are eligible for Medicaid's FPL program from the 133% expansion program. Unless the proposed federal eligibility rule is changed, pregnant women in California with very low-incomes of 101-133% of poverty would also be excluded from the 133% expansion program, along with the pregnant women at 134-200%.

In contrast, the ACA seems clear that individuals in limited scope Medicaid programs that do not meet the test for EHBs—such as Medi-Cal's 200% program for pregnant women—are not excluded from a BHO under § 1331(e)(1) if the ACA. Federal regulatory or sub-regulatory guidance on this issue, however, is still pending.

These interrelated eligibility issues make the comments we submit on EHBs with respect to maternity benefits, preconception and interconception care all the more pressing.

[4] Institute of Medicine. Preventing Low Birthweight. Washington, DC: National Academy Press, 1985.

[5] Institute of Medicine, *Preterm Birth: Causes, Consequences and Prevention*, Washington, DC: National Academy Press, 2006.

[6] *The Surgeon General's Call to Action to Support Breastfeeding* (January 20, 2011), http://www.surgeongeneral.gov/topics/breastfeeding/calltoactiontosupportbreastfeeding.pdf; *see also,* USPSTF, Primary Care Interventions to Promote Breastfeeding: Recommendation Statement (October 2008) (Grade A and B for various breastfeeding interventions), http://www.uspreventiveservicestaskforce.org/uspstf08/breastfeeding/brfeedrs.htm.

[7] *Breastfeeding: Investing in California's Future,* California Department of Public Health (January 2007), http://www.cdph.ca.gov/programs/breastfeeding/Documents/MO-BreastfeedingFullDocument.pdf

[8] http://sfgate.com/cgi-bin/article.cgi?f=/c/a/2010/04/05/MNUS1CPND0.DTL (April 5, 2010).

[9] *See, e.g.*: Yalcin F., Basegmez C., Isik G., Berber L., Eskinazi E., Soydinc M., Issever H., and Onan U. The Effects of Periodontal Therapy on Intracrevicular Prostaglandin E_2 Concentrations and Clinical Parameters in Pregnancy. *Journal of Periodontology*, 2002;73:173-177 (circulating levels of progesterone increase during pregnancy, stimulating production of prostaglandins, and these possibly result in pregnancy gingivitis (gum disease)).

Jeffcoat, M., et al., Current Evidence Regarding Periodontal Disease as a Risk Factor in Preterm Birth, *Annals of Periodontology*. 2001; 6:183-188 (examples of bacterial infections causing spontaneous abortion, preterm delivery, and low birth weight infants; bacteria that cause periodontal infection can enter the bloodstream and can reach the placenta; bacteria also stimulate an immune response associated with preterm labor).

Guthmiller J. M., Hassebroek-Johnson J.R., Weenig D.R., Georgia, Johnson K., Lester Kirchner H., Kohout F.J., and Hunter S.K., Periodontal Disease in Pregnancy Complicated by Type I Diabetes*, Journal of Periodontology.* 2001; 72 (11):1485-1490 (periodontal inflammation and destruction are increased in pregnant diabetics as compared to non-diabetic pregnant patients).

Offenbacher S., Lieffi S., Jared H., Madianosi P.N., Champagnei C., Murtha A., Boggess K.A., and Beck J.D., Maternal Periodontitis Impairs Fetal Growth, *Annals of Periodontology*. 2001; 6:164-174 (mothers who suffer from gum disease are significantly more likely to deliver their babies prematurely than women without gum disease).

López N.J., Patricio C. Smith P.C., and Gutierrez J., Periodontal Therapy May Reduce the Risk of Preterm Low Birth Weight in Women With Periodontal Disease: A Randomized Controlled Trial. *Journal of Periodontology*. August 2002; 73:911-924 (periodontal disease appears to be an independent risk factor for preterm low birth weight; periodontal therapy significantly reduced the rates of preterm low birth weight in the study population).

[10] Offenbacher S., Lieffi S., Jared H., Madianosi P.N., Champagnei C., Murtha A., Boggess K.A., and Beck J.D., Maternal Periodontitis Impairs Fetal Growth, *Annals of Periodontology*. 2001; 6:164-174.

[11] CDC. Recommendations to improve preconception health and health care---United States: a report of the CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care. MMWR 2006;55 [No. RR-6].