

November 27, 2017

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Dear Ms. Verma,

The March of Dimes, a unique collaboration of scientists, clinicians, parents, members of the business community, and other volunteers representing every state, the District of Columbia and Puerto Rico, appreciates this opportunity to comment on the proposed rule, "Patient Protection and Affordable Care Act: Benefit and Payment Parameters for 2019," file code CMS-9930-P, as published in the *Federal Register* on November 2, 2017.

As an organization dedicated to promoting healthy mothers and strong babies, the March of Dimes is concerned about the implications of the proposed rule for numerous aspects of maternal and child health. We urge you to consider revisions to the rule, as suggested below, in order to ensure that the law actively promotes the health of women and their families before, during and between pregnancies, as well as the health of infants and children.

Appropriate Benefits for Patients Should Be the Rule's Primary Focus

The March of Dimes respectfully submits that the primary focus of the rule should be ensuring that patients have appropriate coverage for the services they need, consistent with the essential health benefits (EHB) standard. Concerns such as cost and quality, while extremely important, should be considered secondary to the adequacy of coverage and should be placed in service to it, not in competition with it.

Today, all health plans governed by the Patient Protection and Affordable Care Act (ACA) are required to cover maternity and newborn care, a standard that has protected the peace of mind and financial wellbeing of millions of families. Prior to passage of the ACA, only about 13% of all plans offered on the individual market included any coverage for maternity care.¹ Only 11 states required that individual market plans cover important services like prenatal care, delivery, and care for the newborn.² There is ample historical evidence that, given the opportunity, insurers will choose to exclude these critically important maternal and child health benefits from plans. The March of Dimes is committed to ensuring that our nation does not return to a time when maternity and newborn coverage was only available as a costly rider, if at all. We therefore urge you to continue to prioritize patient needs and coverage of appropriate services as the primary goal of this rule.

The Rule Fails to Balance Concerns of Cost with Provision of Appropriate Benefits

In viewing the proposed rule in its totality, the March of Dimes is concerned that the changes would prioritize affordability of coverage to the likely detriment of provision of appropriate benefits. It is not a complicated matter to provide inexpensive coverage if plans fail to cover the benefits people need. The March of Dimes urges you to promote the affordability of coverage through avenues other than those allowing significant reductions in the type, value and scope of EHBs covered.

Numerous provisions of the rule not only allow but encourage states to scale back the benefits provided, largely in the name of improving affordability. It is important to distinguish between insurance affordability and the affordability of medical care itself. An inexpensive plan with skimpy coverage of maternity benefits may have lower premiums, but the resulting out-of-pocket cost to the patient of covering what should be essential health benefits could well be prohibitive. In some cases, pregnant women with insufficient coverage could forego necessary care, endangering both their and their baby's health. The March of Dimes exhorts CMS to find a more appropriate balance between the affordability of insurance coverage versus medical care than what is currently contained in the proposed rule.

Collectively, proposed changes such as those that would allow states to select from potentially atypical base benchmark plans, mix and match categories of EHBs from various benchmark plans, and substitute benefits between categories could easily have the effect of promoting a "race to the bottom," in which states seek to attract insurers to the individual market by allowing them to provide scanty coverage of benefits. Moreover, the ability to shift the actuarial value of EHBs among categories or allow benefits substitution could lead to situations in which insurers assemble benefits packages that are rich in little-used benefits but provide scanty coverage for those benefits most likely to be used, such as maternity and newborn coverage.

The March of Dimes is concerned that the proposed rule appears to reflect a fundamental shift in the agency's approach to EHBs, from viewing the law as setting a floor for benefits to having it serve as a ceiling. Once again, the central goal of the rule should be to ensure that patients can obtain the care they need, when they need it. Arbitrary cuts and limitations to services, including critical maternal and child health benefits, do not serve this goal. We urge the agency to scale back many of the proposed changes to ensure a more appropriate balance between coverage and affordability.

States Should Have Flexibility to Expand or Enhance Benefits without Penalty (§156.111 and §156.115)

While the proposed rule states numerous times that it seeks to improve states' flexibility around EHBs, in fact the vast majority of proposed changes would allow states to reduce, but not to enhance, their EHB packages. If the agency is truly committed to promoting state flexibility, then states should have the ability to make changes to expand or improve as well as reduce EHBs.

In particular, the proposal to require states to defray the cost of any benefits that may be added to EHBs through their selection of a new base benchmark plan, or through changes to categories

within the base benchmark plan, represents a powerful disincentive for states to improve their EHB packages. Similarly, the establishment of a federal EHB standard beyond which states would have to defray the costs of added EHBs would not serve the best interests of patients, including mothers and infants.

In the case of maternal and child health, the March of Dimes has made considerable investments in advancing the discovery of new ways to prevent and treat preterm birth and other adverse birth outcomes. It would be a tremendous disservice to all Americans if innovative or lifesaving new therapies cannot be added to plans because states lack the resources to defray their cost. We therefore urge you strongly not to require states to defray the cost of new benefits that are added to EHBs as states select a new benchmark plan or a new specific category of benchmark benefits.

The March of Dimes is also concerned about the restrictions placed upon the composition of a set of benefits that may be selected by the state to become its benchmark plan. The rule states that such a package may not be any more “generous” than the most generous plan among a set of comparison plans, and may not include more than the ten categories of essential health benefits. Once again, if state flexibility is truly the goal, then states should have the freedom to expand their benchmark packages as they see fit without superfluous restrictions from HHS.

States Should Not Be Permitted to Substitute Benefits Between Categories (§156.111 and §156.115)

The March of Dimes is deeply concerned that the rule proposes allowing the substitution of actuarially-equivalent benefits between categories. As noted above, many years of practical experience have shown that insurers in the individual market will remove or reduce maternity and newborn care services from plans if given the opportunity. We believe this proposed change would allow some insurers to provide the minimum possible benefits for pregnant women and their infants, while shifting the actuarial value of the package toward other types of benefits that are required by substantially fewer people. The March of Dimes therefore strongly urges CMS to abandon the proposal to allow plans to substitute benefits between different EHB categories.

Changes to Essential Health Benefits Will Have Impacts Outside the Exchanges (§156.111, §156.115)

The March of Dimes would like to note that certain changes to EHBs could have significant other implications both within and outside the individual insurance market. Because the ban on annual and lifetime limits only applies to EHBs, any reduction in EHBs could result in much higher out-of-pocket costs for patients and families, regardless of the type of commercial coverage they have. Mothers with high-risk pregnancies and whose babies are born preterm, low birthweight, or with birth defects will find that if certain services are no longer covered, they may become so costly as to be out of reach. In the case of an infant requiring neonatal intensive care for weeks or months, families could well find themselves bankrupted by their inadequate coverage, as they too often were prior to passage of the ACA. We therefore urge you proceed with the utmost caution on any changes that will impact the scope or type of EHBs that must be covered.

State Public Notice and Public Comment Periods Should Be Ample (§156)

The March of Dimes urges CMS to set consistent, reasonable standards for states to provide public notice and public comment periods. Our organization advocates for maternal and child health in all 50 states, the District of Columbia and Puerto Rico. Attempting to determine the notice and comment periods on a state-by-state basis represents a tremendous barrier to our participation in those processes, not to mention a waste of valuable resources. We urge you to set standards across all states that will encourage, rather than inhibit, organizations like ours to bring our input and expertise to those review and comment processes.

Effective Date of Base Benchmark Plan Changes

The March of Dimes reiterates its serious concerns with the proposed changes to the benchmark plan process. However, if CMS moves forward with these policy changes, we believe strongly that the base benchmark plan changes proposed at §156.100 should take effect in plan year 2020. States, insurers, providers and consumers would all benefit from additional time to understand these changes and their implications.

Qualified Health Plan Certification, Network Adequacy (§156.230) and Essential Community Providers (§156.235)

The March of Dimes believes the federal government should retain an active role in reviewing and enforcing standards for network adequacy and essential community providers, given the importance of both for maternal and child health.

Women with high-risk pregnancies and their infants must have access to facilities that are fully qualified to care for them both. Over the past few years, experience has shown that insurance plans will often attempt to exclude from their networks teaching hospitals, children's hospitals, and other institutions which, while sometimes higher cost facilities, may be the only option for women to obtain the appropriate level of care for themselves and their babies. In those situations, women may be compelled either to give birth in a facility they know may be unable to care for them, or to deliver their baby at an out-of-network institution and incur very high out-of-pocket costs.

Similarly, the reduction of the essential community provider (ECP) standard from 30 to 20 percent is problematic. Once again, patients may be denied access to the only source of services for infants born preterm, low birthweight, or with birth defects or other special health care needs. CMS has not presented evidence that a higher standard poses a significant challenge for issuers.

The March of Dimes urges CMS to continue playing a key role in overseeing both network adequacy and essential community providers, rather than delegating these responsibilities exclusively to the states or accrediting bodies.

CHIP Buy-in Programs and Minimum Essential Coverage (§156.602, §156.604)

The March of Dimes agrees with CMS that CHIP buy-in programs may sometimes represent the best coverage option for certain families, depending on the benefits, cost-sharing and the

family's needs. Without access to a CHIP buy-in plan, some families might not be able to obtain coverage at all. In these cases, CMS should ensure that these programs provide well-designed plans that meet children's unique needs and the minimum essential coverage (MEC) requirements so families are not penalized if they are enrolled.

In the case of CHIP programs that may now or in the future offer a buy-in option for pregnant women, it is critically important that CMS distinguish those that offer comprehensive coverage from those that offer only pregnancy-related coverage. States that exercise the Unborn Child Option under CHIP extend coverage only to the fetus, and may not cover the full services needed by the pregnant woman to protect her health. A pregnant woman with a high risk medical condition, or who develops pregnancy related complications, requires appropriate services to protect the health and wellbeing of both herself and the fetus. While such coverage may be preferable to being uninsured, it unfortunately is inadequate and should not be afforded the designation of minimum essential coverage.

Special Enrollment Period for Women Who Lose CHIP Coverage After Pregnancy (§155.420)

The March of Dimes strongly supports the rule's proposal to allow mothers who lose CHIP coverage obtained during pregnancy to qualify for a special enrollment period (SEP). Clearly, it is critically important for new mothers to have health insurance to cover any necessary postpartum care after their CHIP coverage expires, and to help them improve their health in preparation for any future pregnancy. We appreciate CMS's recognition that approximately 370,000 pregnant women are covered by CHIP each year,³ and that many of these women are at high risk for being uninsured after their CHIP coverage ends.

The March of Dimes also supports the rule's proposals to exempt individuals in "bare" countries from having to maintain continuous coverage in order to qualify for an SEP. While we continue to oppose continuous coverage requirements as a pre-requisite for SEP availability in general, we support this proposal to extend access to coverage for those who may have lost it, which is especially important for women of childbearing age.

Pregnancy Should Trigger a Special Enrollment Period

The March of Dimes urges CMS once again to designate pregnancy as a triggering event for a special enrollment period. Existing regulations allow a special enrollment period when a qualified individual gains a dependent through birth or adoption. Unfortunately, women themselves are left with no options to enroll in comprehensive coverage during pregnancy itself. As a result, women may find themselves uninsured or trapped in catastrophic plans that fail to cover many important prenatal care services. They may therefore delay or forgo important prenatal and maternity care during pregnancy because of lack of coverage. A special enrollment period is especially important for young adults, who are at high risk for unintended pregnancies and also targeted for enrollment in catastrophic coverage. In fact, over half of pregnancies among women ages 20 to 29 are unintended, the highest rate among any age group.⁴ We strongly urge CMS to include a provision to ensure a special enrollment period is available for women to enroll in coverage or change plans in the event of pregnancy.

Recommendations for Improving Innovation and Value-Based Coverage

The March of Dimes appreciates CMS's solicitation of opportunities to encourage innovation and promote value-based coverage. We believe firmly that many such opportunities exist that can be pursued without reducing or limiting EHBs or other important patient protections. Examples include:

Promoting preventive care: CMS should actively promote preventive health care, including pediatric well child visits, women's preventive health benefits, and prenatal care as required to be covered under EHBs. Prevention is a highly cost-effective way to reduce spending at all levels of the health care system while simultaneously improving patient and family health. Preventive health benefits should be maintained and, if possible, expanded.

Expanding access to contraception: As a subset of preventive care, contraception plays a vital role in allowing women to space their births appropriately and thereby improve both their own health and the health of future children. Pregnancies that start less than 18 months after birth are associated with delayed prenatal care and adverse birth outcomes, including preterm birth, neonatal morbidity, and low birthweight.^{5,6,7} Further, these poor birth outcomes are often associated with ongoing health problems such as developmental delay, asthma, and vision and hearing loss.⁸ In the United States, between 2006 and 2010, about 33% of pregnancies among women with a previous live birth began less than 18 months after the prior birth, placing mothers and infants at risk for adverse health outcomes.⁹ Access to services that promote appropriate birth spacing can reduce the risk for poor birth outcomes such as preterm birth and low birthweight.¹⁰ The March of Dimes urges CMS to promote birth spacing interventions that are supported by scientific evidence and are most effective in improving maternal and child health outcomes, including broad insurance coverage without cost-sharing for all forms of contraception approved by the Food and Drug Administration.

Reducing unnecessary care: Patients and providers should be educated and empowered to recognize and question unnecessary interventions. For example, some hospitals and providers still have unacceptably high rates of early elective deliveries (in which a baby is delivered preterm without a medically necessary reason), and some patients still ask their doctors to deliver a baby too early. Such practices can have high costs for both patients and the health care system. Unfortunately, a recent study showed that there was no improvement between 2014 and 2017 in either provider awareness of the issue of low-value care or in their ability to dissuade their patients from pursuing such interventions.¹¹ CMS could pursue a range of efforts with both providers and patients to reduce the use of low-value care.

Increasing care coordination: Too often, patients find it difficult to obtain the care they know they need to get and stay healthy. For some patients, care coordination can play a critical role in improving their compliance and resulting health and wellbeing. For pregnant women, maternity medical homes have shown promising results in improving birth outcomes and maternal health.^{12,13} For children with special health care needs, care coordination can be vital in helping parents navigate the complexity of the health care system. Care coordination can help guarantee not only that needs for specialty care are met, but also that routine care, such as childhood immunizations, is performed.

Expanding person-centered care: Too often, our health care system expects patients to figure out how to compensate for the shortcomings of a system that was designed to meet the needs of providers and institutions rather than theirs. For example, women who have had a prior

preterm birth are recommended to receive weekly injections of the drug 17-alpha hydroxyprogesterone (17p) during a following pregnancy to prevent a repeat preterm birth. Because the drug is so expensive, however, many providers will not stock it in their offices. Some women therefore must have a prescription for 17p filled, pay for it out of pocket, bring the medication to their physician's office to be injected, and then submit a claim for reimbursement to their insurance company – every week for much of their pregnancy. Clearly, this situation is not person-centered; to the contrary, it presents numerous barriers to uptake of a proven, effective intervention. CMS should pursue opportunities to partner with stakeholders to develop innovative, person-centered solutions to cases like this one, which are rife across the health care system.

Supporting innovative models: CMS should expand efforts to support innovative models and urge their uptake after sufficient evidence of their effectiveness has been gathered. For example, there is a strong and growing body of evidence that group prenatal care can improve outcomes for both mother and child.^{14,15} In this model, expectant mothers receive prenatal care on a monthly basis in a supportive group setting with women whose pregnancies are of similar gestational ages. During each visit, expectant mothers have more time with their care providers than they would during their standard individual prenatal checkups, and they benefit from prenatal care education and vital social and emotional support from other mothers. This environment can empower women to take control of their pregnancy care and fosters relationships that can last throughout their pregnancies and beyond. CMS should work with health plans and other stakeholders to foster the development of such models and to promote them based on evidence of their positive impact.

Once again, the March of Dimes appreciates the opportunity to comment on this important rule. If we can provide further information or otherwise be of assistance, please contact Senior Vice President for Public Policy and Government Affairs Cynthia Pellegrini at cpellegrini@marchofdimes.org or 202/659-1800.

Sincerely,



Paul E. Jarris, MD MBA
Chief Medical Officer

¹ National Women's Law Center. [Still Nowhere to Turn: Insurance Companies Treat Women Like a Pre-Existing Condition](#), October 9, 2009.

² Kaiser Family Foundation. [Pre-ACA State Maternity Coverage Mandates: Individual and Small Group Markets, 2010](#).

³ March of Dimes. CHIP Coverage for Pregnant Women. <https://www.marchofdimes.org/materials/MOD-IssueBrief-Chip-Coverage-Pregnant-Women-November-2016.pdf>

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