TESTIMONY OF

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BEFORE THE EDUCATION AND LABOR COMMITTEE HEARING

"EXAMINING THREATS TO WORKERS WITH PREEXISTING CONDITIONS"

U.S. HOUSE OF REPRESENTATIVES

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Thank you, Mr. Chairman, for this opportunity to testify today before the Education and Labor Committee at this hearing, "Examining Threats to Workers with Preexisting Conditions." I am Dr. Rahul Gupta, Senior Vice President and Chief Medical and Health Officer at March of Dimes.

March of Dimes, a non-profit, non-partisan organization, fights for the health of all moms and babies. We educate the public about best practices, support lifesaving research, provide comfort and support to families in neonatal intensive care units, and advocate for the health of all moms and babies. March of Dimes promotes the health of women, children and families across the life course, from birth through adolescence and the childbearing years, with an emphasis on preconception, prenatal, interconception and infant health. Ensuring that women, children and families have access to timely, affordable, and high-quality health care is essential to achieving our goals.

In addition to representing March of Dimes, I bring my perspective from my experience working on the ground as a practicing physician in West Virginia, Alabama, Tennessee and Illinois and as a former state public health commissioner and local health officer. In each of these roles, I saw first-hand the negative impact a lack of access to affordable and comprehensive health insurance can have. This is especially true for our nation's most vulnerable, particularly people with pre-existing health conditions, including many pregnant women, new mothers, and their infants. As a past president of state medical association, I also have had the opportunity to represent my colleagues and the challenges they face as physicians practicing on the ground every single day.

Access to affordable health care coverage is a problem faced in their everyday lives by too many Americans with pre-existing conditions. As a primary care physician, it was not uncommon for me to treat women who were struggling with the high costs of employer-based health insurance or priced out of their employer's coverage altogether due to their pre-existing conditions. These women were in the impossible position of having to make choices between

getting the care they needed and affording their families' basic necessities, such as food or prescription medication.

Pre-existing Conditions Are Common Among Women of Childbearing Age

Pre-existing conditions are common among Americans. Six in every 10 adults in the U.S. have a chronic disease, and 4 in 10 have two or more.[1] Chronic conditions, such as high blood pressure, diabetes, heart disease, and obesity put women at higher risk of pregnancy complications. According to recent CDC studies, nearly half of women are overweight or obese before they become pregnant, which is associated with a higher risk of pregnancy complications.[2] One in 4 pregnancy-related deaths are related to heart conditions.[3] From 2005-2014, the prevalence of chronic conditions increased across all segments of the childbearing population, especially among women from rural and low-income communities and those with deliveries funded by Medicaid.[4] From 2008-2014, there was an increase in mental health conditions, including a 4.4-percentage point increase in anxiety disorders.[5]

For women in their childbearing years, reproductive health is a key concern. Each year in the U.S., over 3 million women deliver about 4 million babies.[6] About 12% of women aged 15-44 in the U.S. have difficulty getting pregnant or carrying a pregnancy to term.[7] Forty-five percent of all pregnancies in the U.S. are unintended, a figure that rises to 75% among teenagers.[8] About 1 in 7 women experience postpartum depression in the year after giving birth.[9] Millions of American women depend on access to contraception; 16% of all women of childbearing age use birth control pills, 8% are using an intrauterine device or implant, and over 14% are using female sterilization.[10]

The opioid epidemic has highlighted our nation's shortcomings in preventing and treating substance use disorder and its consequences, especially among pregnant women. Among 28 states studied during 1999–2013, the overall incidence of neonatal abstinence syndrome quadrupled from 1.5 per 1,000 hospital births in 1999, to 6.0 per 1,000 hospital births in 2013.[11]

In West Virginia, our overall incidence rate of NAS in 2017 was 50.6 cases per 1,000 live births (5.06%).[12] Three percent of pregnant women report binge drinking during pregnancy.[13] By 2014-2015, amphetamine use was identified among approximately 1% of deliveries in some parts of the U.S.; these deliveries were associated with higher incidence of preeclampsia, preterm delivery, and severe maternal morbidity and mortality.[14] Across our nation, women who are of childbearing age or pregnant are faced with a dire shortage of options for treatment and coverage.

Moreover, striking disparities exist among the health of mothers and babies of different racial and ethnic backgrounds. Black children face the highest child mortality rate among racial/ethnic groups – more than 2 times higher than the rate for Asian children and 1.5 times higher than the rate for white children.[15] There are dramatic variations in key measures like well-visits for women and infants among different racial and ethnic groups as well as geographic areas.

These chronic conditions can have tragic consequences, especially during pregnancy. Each year in the United States, about 700 women die of pregnancy-related causes, and more than 50,000 have severe pregnancy complications.[16] Despite the fact that many countries around the world have successfully reduced their maternal mortality rates since the 1990s, the U.S. rate is still higher than most other high-income countries,[17] and the U.S. maternal mortality rate has doubled in the past 25 years.[18] A significant racial and ethnic disparity in maternal mortality exists in the U.S., with black women being three to four times more likely to die from pregnancy-related causes compared to white women.[19,20]

The data clearly show that pre-existing conditions are common among women of childbearing age. As pregnancy or childbirth are also widely considered pre-existing conditions, the prevalence of at least one pre-existing condition in this population is almost universal. If conditions like preterm birth, birth defects or neonatal abstinence syndrome are considered to be pre-existing conditions, tens of millions of children could be subject to insurance discrimination throughout their lives.

The Affordable Care Act Instituted Important Protections for People with Pre-Existing Conditions

The Patient Protection and Affordable Care Act 2010 (ACA) contains a range of provisions to help ensure comprehensive, meaningful, and affordable coverage for women, children and families. Among its most important and popular provisions is the fact that the ACA requires health plans to cover all individuals regardless of pre-existing conditions. The law ensures that all Americans can obtain coverage without worrying that they will be subject to discrimination, whether outright denial of all coverage or carve outs related to the benefits they are most likely to need.

These pre-existing condition provisions are vital to the health and wellbeing of millions of Americans and their families. These provisions have not only ensured access to care for individuals with serious and chronic conditions, but have protected entire families who may otherwise have been unable to obtain coverage. Based on an analysis of the Commonwealth Fund Biennial Health Insurance Surveys, covering 2001–2016, the number of U.S. working-age women lacking health insurance has fallen by nearly half since 2010, when the ACA was enacted.[21] In 2018, approximately 10 million Americans were enrolled in health plans through the ACA marketplaces[22]. In 2017, 17 million individuals received coverage through the Medicaid expansion.[23]

I have personally treated many of these individuals, and I can say without a doubt that many of these so-called 'working poor' patients are able to continue to work because of this coverage and would otherwise be not only uninsured but unemployed. Without health insurance, they would not be able to afford treatment, which means they would have ended up in the emergency rooms in my community. Their expenses would be absorbed by the hospitals as uncompensated care, resulting in higher health care costs for everyone. Without regular access

to health care, they would be unable to remain healthy enough to continue working. Health insurance is vital to not only their health but their economic wellbeing.

It is important to note that the landscape of coverage for women of childbearing age was very different prior to passage of the ACA. According to one survey prior to passage of the ACA, 47% of people who tried to purchase insurance on the individual market were denied coverage, charged more, or had a condition excluded from their coverage.[24] An analysis from the U.S. Department of Health and Human Services found that between 2010 and 2014, when the ACA's major health insurance reforms first took effect, the share of Americans with pre-existing conditions who went uninsured all year fell by 22 percent, meaning 3.6 million *fewer* people went uninsured.[25]

A study funded by March of Dimes in 2015[26] showed that between summer 2013 and winter 2014–15, the uninsurance rate among women of childbearing age decreased from 19.6 percent to 13.3 percent as 5.5 million women gained coverage. At the same time, affordability of care improved, particularly for low-income women in Medicaid expansion states, who reported a 10.4 percentage-point decrease in unmet need for care because of cost. Together, these advances in coverage meant millions of women had access to health care to help them get healthy before they got pregnant, and to protect their health during and after pregnancy and childbirth.

Pre-Existing Conditions Protections Alone Are Not Enough

The ACA included a variety of provisions which aim to expand access to care, its quality, and its affordability. As described above, health plans may not base premiums on health status or deny coverage based on pre-existing conditions, such as being born with a birth defect or being pregnant. However, the requirement that all plans cover individuals with pre-existing conditions is not enough on its own to ensure people have access to the care they need. The ACA also addressed the availability of ten categories of Essential Health Benefits (EHBs) and

protected consumers against high premiums and out-of-pocket costs. Together, this package of provisions guarantee access, quality and affordability of coverage for women and their families.

The ACA's requirement that all plans cover 10 categories of EHBs was a critical step toward ensuring that Americans have access to the services and benefits they need. This provision prevents plans from excluding certain types of services, such as maternity care. Plans must also cover other types of services vital to maternal and child health, including well-woman and well-child preventive care, prescription drugs, and mental health services.

It is difficult to overstate the importance of these essential health benefits. Experience prior to passage of the ACA demonstrated abundantly that people with pre-existing conditions were often subject to benefits carve outs that targeted the services they were mostly likely to need. For example, prior to the ACA only 13% of plans in the individual market offered maternity care.[27] Only 11 states had passed mandates requiring individual plans to cover maternity benefits. As a result, too many families faced untenable choices between having a child and preserving their financial wellbeing.

In addition to EHBs, the ACA addressed a range of issues related to the affordability of coverage. Cost has been historically and remains one of the greatest barriers to care; if people are unable to afford insurance coverage, health care becomes all but inaccessible. When that relates to a pregnant woman or a woman attempting to become pregnant, it is simply unacceptable. According to a 2017 Kaiser Family Foundation study, half of uninsured women went without or delayed care because of costs. Almost as many postponed preventive services (47%) and skipped a recommended medical test or treatment (42%). [28] In October 2018, March of Dimes issued *Nowhere to Go: Maternity Care Deserts Across the U.S.*, a report showing that over 5 million women currently live in a maternity care desert.[29] One-third of this country's counties lack hospitals with services for pregnant women. About 150,000 babies are born in maternity care deserts every year. We need to increase, not decrease, access to these services in these areas.

Under the ACA, policies sold on the individual and small-group markets are prohibited from charging women higher premiums. This practice, known as gender rating, had been used by 92% of individual market plans.[30] Elimination of gender rating removes a significant penalty imposed on women simply because they are women. In other words, thanks to the ACA, being a woman is no longer a pre-existing condition.

In addition, health plans can no longer impose annual or lifetime caps. These caps imposed a dollar amount limit on coverage beyond which a policyholder was responsible for all costs. In the case of maternal and child health, these caps could be financially devastating for families. A woman with a high-risk pregnancy and delivery could easily exceed an annual cap if she experienced a complicated labor, leaving her unable to obtain needed care for the rest of the year. A baby born extremely pre-term who needed months of care in the neonatal intensive care unit could exhaust a lifetime cap before her first birthday.

In order to promote preventive health, the ACA required that certain preventive services be covered without cost-sharing. Among the important maternal and child health services that fall into this category are prenatal care, well-child visits, well-woman visits, screening for gestational diabetes, domestic violence screening, breastfeeding supplies such as breast pumps, and contraceptive services. As a result of these protections, a key barrier to services was removed for millions of women and families.

Finally, the ACA included a range of other tools to control the cost of premiums and cost-sharing, such as advance premium tax credits to subsidize premiums, limits on annual cost-sharing, medical loss ratio provisions, premium increase reviews, and more.

The triad of pre-existing conditions protections, essential health benefits, and affordability provisions represent a three-legged stool that supports access to comprehensive, quality, affordable coverage for all Americans. If any one of these supports is removed, the others are

inadequate to achieve those goals. All three must be maintained to protect and promote our nation's health, and especially the health of women, children and families.

Without all these protections, a single complicated pregnancy or birth could result in a lifelong inability to gain insurance or coverage that is affordable. March of Dimes urges policymakers to make sure that these important consumer protections remain in place so that all women and infants can access the affordable, quality health care and services they need.

Any Changes to the Law Should Ensure Greater Access to Comprehensive, Affordable Care

March of Dimes believes that any changes to the Affordable Care Act or other laws must be undertaken with the goal of providing Americans with greater options for comprehensive, quality, affordable health care. Each of these issues is equally important and inter-connected: comprehensiveness, quality and affordability. It is useless to provide access to cheaper coverage if it fails to cover the services women and families need. Comprehensive, quality health care is out of reach if coverage is not affordable. And affordable coverage with full benefits is not enough if entire categories of people are excluded based on their health status, gender or other factors.

March of Dimes is deeply troubled by the filing and arguments in the case *Texas v. United States*. This lawsuit, filed by a group of state attorneys general and governors, appears to have been undertaken as a legal exercise divorced from any real appreciation of its ramifications for millions of Americans, their health and their wellbeing. With the recent decision of a federal court judge to declare the ACA unconstitutional in its entirety, the plaintiffs appear to be in a classic situation of "the dog that caught the car." They were caught off-guard by their own victory and now are unsure how to explain that they have argued for an action that will cost millions of Americans their health insurance coverage and potentially even their lives. March of Dimes joined 37 other major patient groups in expressing our opposition to this decision and calling on the Supreme Court to reject it.[31]

Beyond *Texas v. United States,* March of Dimes is deeply concerned about efforts by the Administration to promote access to short-term, limited duration insurance plans that would not have to comply with many of the protections under the ACA.[32] We are especially concerned that these plans are not required to cover essential health benefits, including maternity care, mental health, and substance use treatment, and could again exclude or charge patients more based on their pre-existing health conditions. Since these slimmed-down plans offer far fewer benefits, they can be offered at lower premiums.[33] In some cases, however, consumers will be lured in by low premiums only to find that their plan fails to cover the services they need. March of Dimes supports efforts like those in California, New Jersey and New York, where state legislatures have voted to limit the ability of non-compliant short-term plans to be sold, and we encourage other states to do the same.

Given that almost half of all pregnancies in the U.S. are unintended, a lack of coverage for preventive care like contraception as well as prenatal, maternity and newborn care could be disastrous for women who carry such limited policies. And while recent reports indicate that many of the plans now being offered do cover maternity and newborn care,[34] there is no protection available for women and families if they choose not to do so in the future.

A host of other proposals from the Administration are also causing deep concern because they undermine the ACA's goals of providing access to affordable, comprehensive and quality health care. The newly-released Notice of Benefits and Payment Parameters contains provisions that will make coverage more expensive for families by reducing the value of their tax subsidies. It would also increase the annual out-of-pocket limit on medical expenses. Proposals like these take money out of the pockets of hard-working families and put it directly into the pockets of insurance companies. March of Dimes looks forward to completing our analysis of this proposal rule, offering comments expressing our dismay with these proposals, and recommending alternative actions. Efforts like those currently being pursued by the Administration to lower

drug costs are laudable, but they will be of little use if Americans are burdened by skyrocketing premiums and cost-sharing or unable to obtain affordable health coverage at all.

Conclusion

Whatever changes may be undertaken to our nation's health laws and systems, they must be made with the express and central goal of improving access to coverage and care that is accessible, comprehensive and affordable. None of these three goals can be sacrificed; they must work together to provide all women, children and families with meaningful access to the health care they need and deserve. This concept is no different than when I'm seeing a patient in my office. I endeavor to provide her with the highest quality care in a compassionate manner, keeping in mind that she shouldn't have to sacrifice her next trip to the grocery store in exchange. I sincerely hope that we can provide this guarantee to all Americans.

Thank you, Mr. Chairman and members of the committee, for holding today's hearing. March of Dimes looks forward to working with you on a bipartisan basis to continue the progress we have made in expanding access to health coverage for people with pre-existing conditions.

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