

Human Service Committee Bill 245: Testimony of Senator Toni Harp, ^{10th}
 Co-sponsor of bill 245 with Sen. Edith Prague

Good morning Senator Harris, Representative Villano, Ranking Members and members of the Human Service Committee. I am presenting testimony on Committee Bill 245 for Sen. Toni Harp, 10th District.

The purpose of Committee Bill 245 is to improve timely access to health care for pregnant women that lack credible health insurance or maternity benefit coverage, promote timely access to health coverage and prenatal care for low income women that are in compliance with the federal law on citizenship documentation and provide maternal oral health as part of pregnancy care.

According to data from the Office of Health Care Access, uninsured childbirth or delivery discharges increased by 16.7% between 2004 and 2006. In 2006 there were 2579 uninsured births (see attached data). Overall 34% of these uninsured women were Hispanic. Several hospitals with high uninsured births have a significant number of Hispanic women.

Uninsured women tend to delay prenatal care services, receive fewer services and are less likely to have a usual source of medical care. While prenatal care cannot reduce all adverse birth outcomes, research suggests that there is an impact of prenatal care on low birth weights of "normal births". Adequate prenatal care is critical in identifying maternal health risks and implementing appropriate medical interventions to reduce these risks as well as adverse socioeconomic factors that influence the woman's health and that of the unborn child.

Women may be uninsured during pregnancy for various reasons:

- Once pregnant the woman does not have access to maternity benefits because these services may not be included in employer health plans or the woman is uninsured and pregnancy may be deemed a pre-existing condition in some private insurance plans. Consider that about 49% of pregnancies are unplanned. The group least apt to be insured in CT. are 20-39 year olds (Office of Health Care Access Household Survey 2006). Most of the uninsured are working adults.
- The pregnant woman is not eligible for Medicaid because of income that is over 185% federal poverty level (FPL) or she is over income for the State Administered General Assistance Program (SAGA).
- The pregnant woman is not a legal immigrant; however her baby born in a CT hospital is a citizen and often is eligible for Medicaid HUSKY A or HUSKY B, the State Children's Health Insurance Program (SCHIP).

Committee Bill 245 addresses the uninsured pregnant woman's access to prenatal care by:

- Seeking a waiver under federal law that would be funded through unspent SCHIP funds to provide health insurance coverage to women with incomes above 185% FPL (Medicaid

income eligibility) but less than 300% FPL. Currently CT does not have a program to insure pregnant women without credible insurance and incomes over 185% FPL.

- Establishing a health insurance program that uninsured pregnant women over 300% FPL can purchase. This would provide health coverage for those women that currently have no recourse but to pay for all their prenatal care and labor and delivery cost themselves.
- Developing a state-funded program that would cover prenatal medical services and targeted outreach to women that are not Medicaid or SCHIP eligible, primarily because of citizenship status. Labor and delivery services are currently paid for through the Medicaid medical emergency service provisions. Prenatal care and ancillary services are not covered.
- Implementing presumptive eligibility for Medicaid eligible pregnant women that would cover prenatal care services from the time of documentation of pregnancy. Qualified Entities would identify women eligible for Medicaid and assist them in completing a full HUSKY application. Federal interim regulations allow self attestation of citizenship and identity for those children and pregnant women that are Medicaid eligible. Documentation of citizenship and identity would be required at renewal of Medicaid coverage.

Maternal oral health status has been linked as a risk factor for birth outcomes. While there has not been established a direct relationship of maternal oral infections and preterm/low birth weight deliveries, recent research has found that undetected and untreated oral infections prior to and during pregnancy can be an added risk factor in adverse birth outcomes. Additionally, maternal oral infections can be transmitted to the baby. This contributes to early childhood carriers. Medicaid covers preventive dental services but not basic periodontal services such as scaling, root planning and oral cleanings more frequent than every six months that would identify and reduce oral infections. The effect of periodontal disease on the woman's overall health before and during pregnancy, birth outcomes and infant oral health cannot be discounted. HUSKY managed care organizations have begun to include questions about recent dental care in their maternal risk assessments and connect women without recent dental care to preventive dental care through their dental subcontractors.

Pregnant women that are Connecticut residents should have access to health coverage that ensures timely and adequate access to prenatal services. Overall health services for pregnant women should include oral health care to promote maternal and infant health. I urge you to adopt Committee Bill 245 as an important and necessary policy in providing pregnant women with access to prenatal care that will promote a healthy pregnancy and healthy baby.

Uninsured childbirth or delivery discharges, FYs 2004 - 2006

Hospital	2004	2005	2006	Change 04-06 (%)	06 top 10 rank
Bradley Memorial Hospital and Health Center	<6	<6	<6	-	
Bristol Hospital	15	8	<6	-	
Connecticut Children's Medical Center	17	<6	6	-64.7	
Day Kimball Hospital	11	<6	<6	-	
Griffin Hospital	6	8	<6	-	5
Hospital of Saint Raphael	13	24	48	269.2	3
Johnson Memorial Hospital	14	10	<6	-	
Manchester Memorial Hospital	16	8	15	-6.3	7
MidState Medical Center	121	110	129	6.6	7
New Britain General Hospital	39	43	51	30.8	
Norwalk Hospital	233	329	411	76.4	1
Saint Francis Hospital	24	25	73	204.2	
Saint Vincent's Medical Center	165	152	267	61.8	6 2
Stamford Hospital	88	158	233	164.8	4
William W. Backus Hospital	79	77	97	22.8	8
Yale-New Haven Hospital	70	69	90	28.6	9 10
Total	2209	2153	2579	16.7	

Source : CT Office of Health Care Access Inpatient Acute Care Hospital Discharge Database.

Delivery and Childbirth DRGs 370-391.

Uninsured hospitalizations whose primary payer was either self-pay, no charge, and other.

Entries with less than six hospitalizations have been replaced with "<6" to protect patient confidentiality.

PREEMIE Act, S. 707

*Legislation passed
July 10, 2016 Congress*

S. 707, the Prematurity Research Expansion and Education for Mothers who deliver Infants Early or “the PREEMIE Act”, introduced by Senators Alexander and Dodd, is designed to expand research into the causes and prevention of prematurity and to increase education and support services related to prematurity.

Purpose. (Section 2)

1. Reduce rates of preterm labor and delivery
2. Promote the use of evidence-based care for pregnant women at risk of preterm labor and for infants born preterm, and
3. Reduce infant mortality and disabilities caused by prematurity

Expansion of federal research related to preterm labor and delivery, treatment, and outcomes of preterm and low birthweight infants. (Section 3)

- Authorizes the Centers for Disease Control and Prevention (CDC) to expand, intensify and coordinate research related to prematurity.
- Asks the CDC to conduct studies on the relationship between prematurity, birth defects and developmental disabilities.
- Asks the CDC to collect additional information such as maternal and infant clinical/medical information to link with their existing Pregnancy Risk Assessment Monitoring System (PRAMS) to track pregnancy outcomes and prevent preterm birth.
 - As it currently exists, PRAMS is a survey sent home to mothers after they deliver. All the CDC gets back is the survey from the mother. They have no medical information or outcomes information for either the mother or baby. Collecting that additional information could give a more complete picture of outcomes of preterm births and potentially some of the causes of preterm births.
- Asks the Secretary to assess other relevant tools, systems, surveys, etc. to ensure that they include information related to some of the known risk factors of low birth weight and preterm birth.

Public and health care provider education and support service grants. (Section 4)

- Awards grants for demonstration projects to improve the provision of information on prematurity to health care providers and to improve the treatment and outcomes for babies born prematurely. It is one grant program with three possible activities that may be funded:
 - To establish programs to test and evaluate strategies to provide information and education to health care providers and the public related to prematurity.
 - To improve treatments and outcomes for babies born prematurely.

- To respond to informational and emotional needs of families during the stay of a preterm infant in a neonatal intensive care unit, during the transition of the infant home, and in the event of a newborn death.

Establishment of an Interagency Coordinating Council on Prematurity and Low Birthweight. (Section 5)

- Authorizes an existing Interagency Coordinating Council at HHS.
- The Council will include (and does include now) representatives of the Department of Health and Human Services agencies that conduct prematurity-related activities.
- The Council will:
 - Annually report to the Secretary and Congress on current activities related to prematurity.
 - Oversee the coordination of the implementation of this Act.

Surgeon General's Conference on Preterm Birth. (Section 6)

- Within 1 year, the Surgeon General will hold a conference on preterm birth.
- The conference will review findings and reports issued by the Interagency Coordinating Council, the Institute of Medicine, key stakeholders, and any other relevant body.
- The conference will establish an agenda for activities in both public and private sectors that will speed the identification of, and treatments for, the causes of preterm labor and delivery. The agenda will be reported to Congress.