7 March 2017

Dear Senator/Representative [last name],

The Cincinnati Pediatric Society is a group of over 300 pediatricians, pediatric subspecialists, and pediatric nurse practitioners in the greater Cincinnati area. Our society is a local branch of the Ohio Chapter, American Academy of Pediatrics. As advocates for the regional health care of approximately 500,000 children, we are writing this letter urging you to protect their needs, many of which are represented in the Patient Protection and Affordable Care Act (PPACA, aka ACA or Obamacare) and safety net programs such as Medicaid.

Our region is rich in natural resources, Fortune 500 companies, schools, and universities. It is blessed with many wonderful parks and recreational areas, and is relatively free of natural disasters. We boast the world-class Cincinnati Children's Hospital, ranked #3 in the nation among all children's hospitals.

These assets, however, belie the health problems of our communities. In this letter, we outline three of the health challenges we face: high infant mortality, drug abuse, and poverty. We also state our support for programs and policies that guarantee a healthy and equitable future for all of our children. Medicaid and the Child Health Insurance Program (CHIP), which provide coverage to 1.2 million children of Ohio, are necessary to tackle these challenges.

We agree with the American Academy of Pediatrics president, Fernando Stein, MD, FAAP, who stated "that no child should be left worse off as a result of changes to our current health care system. Repealing the ACA without simultaneously enacting a replacement plan that would appropriately address the above elements would not serve the interests of children. Therefore, we strongly urge Congress to reject proposals that would disrupt coverage or otherwise compromise the care children receive."

We trust that you, an elected member of Congress, will consider the needs of all people as you debate changes in our national healthcare system. Included among our constituents are some of the most vulnerable residents of [your district,][the State of Ohio,] our children. Children do not vote, and most do not write letters to Congress, but they are our future.

We of the Cincinnati Pediatric Society have dedicated ourselves to advocating for children. We hope that you will engage in a dialogue with the American Academy of Pediatrics and its Ohio chapter so that we can work together to improve their health. We are counting on you to provide the children and families of [your district][the State of Ohio] with the comprehensive, affordable coverage they deserve.

Sincerely,

Kathleen McGovern, MD
President

Along with Cincinnati Pediatric Society Board members:

Camille Graham, MD	Denise Warrick, MD	Paul Bunch, MD
Phil Lichtenstein, MD	Dominick DeBlasio, MD	Christ Peltier, MD
Scott Callahan, MD	Charles Deitschel, MD	Robert Ingberg, MD

Infant mortality

The infant mortality rate in Hamilton County (9.3 per 1,000 live births 2011-2015) ranks 219th of 231 United States counties with populations over 250,000 (the average of the other counties is 5.8). Racial disparities exist - the infant mortality rate in Hamilton County of African Americans (16.3 per 1,000 live births) is almost three times that of whites (5.9). According to the CDC, two of the top five leading causes for infant mortality are preterm births and maternal complications of pregnancy, both of which can be closely associated with teen pregnancy. The teen birth rate per 1,000 women 15 – 19 years of age in Hamilton County (41) is 1.5 times the national teen birth rate (26.5).

High infant mortality is not just an urban problem. Adams County has an even higher teen birth rate (53) than Hamilton County and is more than double the national rate. In addition, the infant mortality rate (9.1 per 1,000 live births) and child mortality rate (109.7 per 100,000 children) in Adams County are higher than the United States average and *increasing*. These infants and their mothers are in need of both coverage and access to care.

Specifically note numbers 1, 2, 3, 4, 5, 7, 8, 10, and 11 below.

Opioid abuse and overdoses

The 2010-2015 heroin overdose death rates for some counties in our area are higher than that of the State of Ohio (18.2 per 100,000) and are increasing: Adams - 21.3; Brown - 38; Clermont - 32.6;
Preble – 23.8. The opioid epidemic in our area impacts children from conception to adulthood. Maternal opioid addiction has led to longer and more complicated hospital stays for infants with neonatal abstinence syndrome. Placement of many of these infants in foster care has strained families and led to disjointed medical care. These children are at high risk of having learning problems, behavioral problems, and future substance abuse. Families and children depend on continuous and adequate health insurance to address the child and family health problems. Gaps in care jeopardize outcomes for these children.

Specifically note numbers 4, 5, 8, 9, and 10 below.

Poverty

Poverty envelops 26% of children in Hamilton County, and 44% of the children of the City of Cincinnati. Many of these children go to bed hungry every night and rely on schools and social programs to supply enough food each day. There is a similar problem in the suburbs and rural areas: 46.4% of children in Brown County are eligible for free lunch, and 25.7% live in poverty. Many of these children have at least one parent who works. Eighty-one percent of Ohio children living in or near poverty rely on Medicaid and the Child Health Insurance Program (CHIP) to provide health insurance. Medicaid provides health coverage for 973,000 low-income children in the State of Ohio. As families move out of poverty, it is a steep climb - they need help getting health insurance.

Specifically note numbers 1, 3, 4, 5, 6, 7, 9 and 10 below.

Our response to proposed changes to, or replacement of, current law:

1. **We support Medicaid expansion by states.** Because of Medicaid expansion in Ohio and in our neighbor state, Kentucky, many more parents and grandparents now have health insurance. This has strengthened our communities. Parents who in the past neglected their own care are now able to get needed medical services, medicines, mental health, and substance abuse treatment in appropriate settings. Health coverage for parents and caregivers also has a positive impact on children. Parents who are enrolled in coverage are more likely to have children enrolled in coverage, and parents with coverage are also more likely to maintain their children's coverage over time. Healthy adults also stay in the workforce longer.
2. **We support the Early and Periodic Screening Diagnosis and Treatment (EPSDT) benefit of Medicaid.** EPSDT ensures children covered by Medicaid receive all medically necessary care, including physician and hospital visits and treatment, preventive well visits, immunizations, developmental screenings, dental, vision, and hearing services. Diagnosis and treatment of health problems as early as possible prevents deterioration of health, leads to better outcomes, and ensures a healthy adult workforce for Ohio.
3. **We support the Child Health Insurance Program (CHIP).** CHIP, known as Healthy Start in Ohio, covers children in working families who are not eligible for Medicaid and lack access to affordable private coverage. CHIP programs provide coverage with pediatric-appropriate benefits and networks, allowing children access to pediatric care in the community and at Cincinnati Children's Hospital. We encourage you to vote for extension of CHIP funding, which expires at the end of fiscal year 2017.
4. **We support affordable health care.** Currently, families with incomes between 100 and 400 percent of the federal poverty level (FPL) receive premium tax credits to purchase insurance, and families with incomes between 100 and 250 percent of the FPL receive cost-sharing subsidies to help them pay out-of-pocket costs. Premium and cost-sharing subsidies are vitally important to ensure that families can afford coverage. Health care that is not affordable puts families at risk for financial instability, medical bankruptcies, and, ultimately, falling into poverty.
5. **We support access to pediatric care.** We advocate for families retaining the right to designate a pediatrician as the child's primary care provider. Pediatricians are well-equipped to be the medical home for children as they are coordinators of care for the most vulnerable and high-risk children. Quality care for children relies on access to an adequate number of pediatric subspecialists, including mental health providers, and we support provisions that help correct pediatric subspecialist shortages.
6. **We support Medicaid-Medicare parity in reimbursement.** Children's health insurance coverage has reached historic levels of 96% enrollment in Ohio. Medicaid and CHIP cover 32% of the children of our State and another 8% are covered by other government-sponsored programs (Tri-Care, VA, or Medicare). Having an "insurance card" is a big benefit for children. But having insurance does not guarantee access to care. Many Ohio pediatricians do not accept more children with Medicaid into their practices because of low reimbursement, currently 50% to 60% of the cost of care in primary care practices, and 66% on average of the Medicare reimbursement. The disparity between Medicare and Medicaid reimbursement in many states is also a reminder of how the current payment system is weighted toward the end of life instead of its beginning, where there is a greater return on investment. In addition, federally qualified health centers (FQHC's) help provide access to primary care for low-income children and families, but the FQHC's of Southwest Ohio do not have enough providers or support staff to service this entire population, including children with Medicaid. We support universal Medicare-Medicaid parity as one mechanism to correct the inequity and to improve access to primary care for children.
7. **We support provision of preventive care and immunizations without cost sharing.** The Cincinnati Pediatric Society supports the coverage of preventive services and immunizations with no cost-sharing for families. The preventive services are those outlined in the AAP's *Bright Futures* guidelines as well as the Advisory Committee on Immunization Practices (ACIP) recommended

childhood and adolescent immunizations. We remember the times when many families would delay or defer care and immunizations because of co-payments and deductibles. Or they would forgo preventive care and come in for ill visits only because illness and disease, not wellness care, were covered. Returning to past policies would mean taking a giant step backward. It would be unethical for us to support any plan that does not guarantee this principle.

8. **We support Essential Health Benefits (EHBs).** A comprehensive, functioning, quality pediatric primary care system relies on the retention and expansion of essential health benefits. EHBs are an evidence-based platform that guarantees to patients services that improve and maintain health, regardless of insurance, family income, or neighborhood. This protection must be strengthened for children. Inclusion of EHBs ensures that insurance plans meet minimum benefit standards and include mental health services; dental care; vision; hearing; and rehabilitative and habilitative services and devices. The last category includes speech, occupational, physical therapies; hearing aids; and wheelchairs. These services will help children with autism, cerebral palsy, deafness, and other developmental disabilities become functioning adults.
9. **We support the individual mandate.** It will be financially impossible to have comprehensive quality coverage for everyone without universal coverage. When children and young adults lack insurance, they will likely get care in expensive sites of care, such as hospital emergency rooms, but hospitals will receive little compensation for these services. Without a universal mandate, many young people will go "bare," leaving the healthcare system to absorb the cost of their care. These costs will be passed on to those who pay, so we all will pay in the long run.
10. **We support dependents staying on their parents' insurance until age 26.** This protection offers essential coverage to a population that otherwise might forego health insurance at a time when health risks may emerge. We support an important corollary provision to provide Medicaid coverage to former foster care children up to age 26. For young people who do not qualify, we support the individual mandate with tax credits and subsidies (see 1. and 4. above)
11. **We support full coverage of contraceptive services.** At the beginning of this decade, just 12 percent of health policies available to a 30-year-old woman on the individual market offered maternity benefits, according to research by the National Women's Law Center. Those that did often charged extra for the coverage and required a waiting period of a year or more. We support EHBs that include pregnancy, maternity, and newborn care. We endorse full coverage of EHBs for women, including provision of contraceptive and maternity services without copayments, deductibles, or co-insurance. This will help reduce the high infant mortality rate and prematurity rates in our region. Spacing of pregnancies leads to higher birth weight babies, prevents prematurity, and improves the health of the mother. Reproductive health is family health.
12. **We reject the formation of high risk pools and support universal coverage for children with preexisting conditions.** Current law prevents insurers from (1) denying coverage to children with preexisting health conditions, including congenital anomalies and birth defects, (2) retroactively denying coverage, and (3) limiting the amount of lifetime and annual coverage. These three protections ensure that no child is denied coverage, and that coverage is not rescinded so that insurers do not have to pay expensive claims. High risk pools for people with pre-existing conditions or catastrophic illnesses have not been successful in states that have formed them. Steering patients into these pools could become discriminatory as assignment will vary by state, and services will depend on the insurance plan and availability of providers and resources.
13. **We reject health savings accounts (HSAs) as the solution and support a public option in addition to tax credits and subsidies as means to help decrease costs to families.** Relying on voluntary contributions to HSAs to defray deductible healthcare expenses ignores the real expenses of many young families with incomes below $90,000. Even if the contributions are tax-deductible, most families do not have enough disposable income to put into HSAs to cover deductibles. HSAs will favor high-income earners, thereby increasing disparities in access and care. A public option, in addition to private options through the marketplaces currently, may provide a cheaper alternative and aid in driving down costs to patients and families.

14. **We reject any gap in coverage as acceptable and support the continuation of the individual mandate.** One solution considered under "repeal and replace" is the elimination of the individual mandate. It has been proposed that people can enroll within a year of losing coverage, but people who wait longer than a year will pay more (a penalty). We reject this proposal. Proper preventive care and health outcomes depend on a *continuous longitudinal relationship* with a medical home and with subspecialists. This proposal encourages those without known medical conditions to drop out. Many of those will be older teens and young adults. Families and young adults may not be able to afford the higher premiums if they extend the waiting period past one year, and during this time they will likely visit the emergency room instead of a primary care physician for a serious illness. Given the cost of emergency room care, it is unlikely that most will ever pay for services.
15. **We reject Medicaid block grants and support need-based federal matched funding.** Restructuring Medicaid with reduced federal funding will force states to pit children's needs against other vulnerable groups, including adults with disabilities and the elderly. Currently federal matching funds to states expand or shrink as the number of individuals enrolled or the cost of providing services changes based on need. Block grants or per capita caps that set limits on federal Medicaid funding – which accounts for 72 percent of all federal funding received by Ohio – will shift financial risk to the state to fill the gaps. This will put the 1.2 million Ohio children who rely on Medicaid and CHIP at risk.

In summary, the Cincinnati Pediatric Society supports comprehensive, affordable and universal healthcare for all children and their families. The recent national changes in healthcare delivery and payment, although imperfect, have provided a massive step in the right direction towards this goal. We ask that you consider the many benefits that this legislation has created for our country and especially our children. Rather than discard and replace current law, please consider working with your fellow members of Congress and the healthcare community to build upon what has already been started.