



The American College of
Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

Office of the President
Haywood Brown, MD, FACOG

February 16, 2018

The Honorable Orrin Hatch
Chair
Senate Finance Committee
United States Senate
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Senate Finance Committee
United States Senate
Washington, DC 20510

Dear Chairman Hatch and Ranking Member Wyden:

On behalf of the American College of Obstetricians and Gynecologists, representing more than 58,000 physicians and partners dedicated to advancing women's health, thank you for the opportunity to share recommendations on ways the Senate Finance Committee can address the ongoing opioid epidemic. Our comments focus on policies that would benefit women, including pregnant and parenting women, with opioid use disorder (OUD).

Health professionals, public health advocates, and bipartisan policymakers recognize that the United States is in the midst of a major opioid epidemic. The incidence of OUD has risen dramatically over the past few years, including among women of reproductive age and pregnant and parenting women. According to the HHS Office of Women's Health, the number of women dying from overdose of prescription drugs rose 471 percent between 1999 and 2015, compared to 218 percent for men, and heroin deaths among women increased at more than twice the rate of men.ⁱ In rural areas, where the opioid crisis has hit hardest, pregnant women and women experiencing intimate partner violence are among populations with higher prevalence of misuse of prescription pain relievers.ⁱⁱ

Unsurprisingly, the high prevalence of OUD among reproductive-age women means more women are using opioids while pregnant. This is also reflected in the rising incidence of neonatal abstinence syndrome (NAS), an expected and treatable medical condition associated with drug withdrawal in newborns exposed to opioids, including medication-assisted treatment, or other drugs in utero. The unplanned pregnancy rate among women with OUD is 86 percent, a number that far surpasses the national average of 45 percent, making clear the need for increased access to contraception among women with OUD.ⁱⁱⁱ Untreated OUD during pregnancy is associated with significant obstetric morbidity and mortality.^{iv} Tragically, overdose and suicide are now the leading causes of maternal mortality in a growing number of states.^{v,vi,vii}

During pregnancy, most women who use substances, including opioids, are motivated to change unhealthy behaviors and quit or cut back. Those who cannot stop using have a substance use disorder. In other words, continued substance use in pregnancy is a characteristic of addiction, a chronic, relapsing brain disease.

Evidence-based treatment for pregnant and breastfeeding women with OUD includes the use of medication-assisted treatment (MAT) such as methadone and buprenorphine. MAT is the recommended

therapy for treating pregnant women with opioid use disorder, and is preferable to medically-supervised withdrawal, which is associated with higher relapse rates and poorer outcomes, including accidental overdose and obstetric complications. Use of MAT also improves adherence to prenatal care and addiction treatment programs. MAT, together with prenatal care, has been demonstrated to reduce the risk of obstetric complications among pregnant women with OUD.^{viii}

Threats of incarceration, immediate loss of child custody, and other potential punishments drive pregnant and parenting women away from vital prenatal care and substance use disorder treatment. Research has found that **non-punitive public health approaches to treatment result in better outcomes for both moms and babies**. Immediately postpartum, women who bond with their babies, including via skin-to-skin care and breastfeeding, are more likely to stay in treatment and connected to the health care system. Further, breastfeeding is associated with decreased severity of NAS symptoms and reduced length of hospital stay for the newborn.^{ix} Substance use disorder treatment that supports the family as a unit has proven effective for maintaining maternal sobriety and child well-being.

In 2015, the Government Accountability Office (GAO) found that “the program gap most frequently cited was the lack of available treatment programs for pregnant women...”^x In 2017, the GAO again cited barriers faced by pregnant women with OUD, including “the stigma faced by women who use opioids during pregnancy” and “limited coordination of care for mothers and infants with NAS,” making it “difficult for families to get the resources or support they need.”^{xi}

As the Committee considers approaches to address the opioid epidemic, we urge you to consider the unique health needs of women of reproductive age, including pregnant and parenting women. Specifically, we recommend:

- **Preserving Medicaid’s financing structure and ensuring continued and sufficient federal funding to support Medicaid expansion as currently available.** Proposals to reduce federal Medicaid expenditures by shifting costs to states or reducing enrollment or services will limit access to care for low-income women of reproductive age, including pregnant and parenting women, with OUD. Approximately 45 percent of births in the U.S. are financed by Medicaid, Medicaid covers the care of 80 percent of infants diagnosed with NAS,^{xii,xiii} and approximately 25 percent of Americans with OUD are Medicaid beneficiaries.^{xiv} Any changes to the Medicaid financing structure and/or Medicaid expansion will negatively impact access to care for this vulnerable population.
- **Exploring continuous coverage policies that would facilitate ongoing access to treatment for postpartum women.** Public and private coverage gaps mean loss of care or discontinuation of treatment. Women receiving pregnancy coverage through Medicaid or the Children’s Health Insurance Program (CHIP) may lose access to MAT weeks after giving birth, during a particularly vulnerable time when relapse risk increases if treatment is not continued.^{xv,xvi}
- **Ensuring continued access to women’s preventive care and the full range of contraceptives for Medicaid beneficiaries,** including women of reproductive age with OUD, to drive down the high rate of unplanned pregnancies in this group as well as the rate of babies born with NAS. Reject legislative and administrative efforts to condition payment for health care services on factors other than medical and legal qualifications and standards. Congress should not deny federal funds, including reimbursement for covered services provided to Medicaid beneficiaries, to

providers, programs, and health care facilities in cases where a provider is qualified to perform those services.

- **Improving access to the full range of contraceptives for Medicare beneficiaries**, including women of reproductive age with OUD. Medicare does not currently cover contraception for the purposes of preventing pregnancy, despite the fact that more than 900,000 women ages 18-44 receive insurance coverage through Medicare.^{xvii}
- **Supporting testing of new models to improve access to treatment for pregnant and parenting women with OUD, including telemedicine pilots.** Treatment gaps remain, despite continued efforts to increase the availability of programs tailored to the unique needs of pregnant and parenting women. Innovative models can help ensure treatment is effective and responsive to women's complex responsibilities, often as the primary or sole caregivers for their families. In addition:
 - **Ensure Section 501 of the Comprehensive Addiction and Recovery Act (CARA; Public Law 114-198) receives adequate funding to improve access for all women seeking treatment.** Section 501 authorized funds for treatment programs tailored specifically for pregnant and parenting women with OUD.
 - **Direct federal funds to ensure full implementation of the Protecting Our Infants Act: Final Strategy, created pursuant to Public Law 114-91.** The Strategy, released by HHS in 2017, made several recommendations to address gaps in research; gaps, overlaps, or duplication in relevant federal programs; and coordination of federal efforts to address NAS with recommendations regarding maternal and child prevention, treatment, and services. The October 2017 GAO report made one recommendation: to implement the Strategy.^{xviii} However, HHS is clear that "full implementation will be contingent upon funding."^{xix}
- **Expanding access to MAT for women of reproductive age, including pregnant and parenting women, by enabling certified nurse-midwives (CNMs) to prescribe buprenorphine.** In an ongoing effort to provide the best care for women suffering from OUD, ACOG offers buprenorphine training courses tailored to women's unique health needs for obstetrician-gynecologists and other health care providers. Treating, prescribing, and referring for MAT services are all within the scope of practice for CNMs. Expanding the qualified providers able to prescribe MAT will help us combat this ongoing epidemic.
- **Addressing barriers to accessing non-pharmacological pain relief**, including transportation and childcare options for women seeking treatment for pain. In addition, the Committee should ensure that acute and chronic pain management with opioids are not denied to women of reproductive age, including pregnant and parenting women, out of concern for NAS when they are otherwise recommended.^{xx}
- **Supporting legislation to address the rising maternal mortality rate.** The Maternal Health Accountability Act (S 1112), sponsored by Sens. Heitkamp and Capito, would assist states with the creation or expansion of maternal mortality review committees (MMRCs). MMRCs bring together local health care professionals to review individual maternal deaths and recommend specific ways to prevent future deaths. MMRCs are critical tools to understanding why women die related to pregnancy, including those linked to opioid overdose, and identifying opportunities for prevention.

- **Facilitating better collaboration between health care providers and the child welfare system in responding to the rise of opioid use disorder among pregnant and parenting women and NAS.** This epidemic is increasingly leading to children being placed in kinship care or foster care homes. State child welfare agencies do not have the resources necessary to address the impact of this epidemic on families. Obstetric care providers have an ethical responsibility to their pregnant and parenting patients with substance use disorder to discourage the separation of parents from their children solely based on substance use disorder, either suspected or confirmed.^{xxi} Our shared priority is that infants born to families struggling with opioid use disorder have safe homes, and that the family unit is preserved when possible.
- **Rejecting proposals to legislate prescriber practices.** Addressing this ongoing epidemic will require dedication and partnership between policymakers, health care providers, and the public. Mandating prescribing practices and provider education requirements in federal legislation is an inappropriate political interference in the practice of medicine. Instead, efforts to engage prescribers should focus on collaborative provider partnerships with the federal government through multi-stakeholder efforts to increase public awareness, and provider training and education.

Thank you again for the opportunity to provide input on ways the Senate Finance Committee can continue to address the ongoing opioid epidemic. We hope you will give full consideration to ACOG's recommendations, and the unique needs of women of reproductive age, including pregnant and parenting women. We look forward to working with you on this important issue. If you have any questions, please do not hesitate to contact Rachel Tetlow at 202-863-2534 or rtetlow@acog.org.

Sincerely,

A handwritten signature in black ink, appearing to read 'Haywood Brown', with a stylized flourish at the end.

Haywood Brown, MD, FACOG
President

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- ⁱ U.S. Department of Health and Human Services Office on Women's Health. Final Report: Opioid Use, Misuse, and Overdose in Women. July 2017. Retrieved from <https://www.womenshealth.gov/files/documents/final-report-opioid-508.pdf>.
- ⁱⁱ Medicaid and CHIP Payment and Access Commission. Report to Congress on Medicaid and CHIP. June 2017. Retrieved from <https://www.macpac.gov/wp-content/uploads/2017/06/June-2017-Report-to-Congress-on-Medicaid-and-CHIP.pdf>.
- ⁱⁱⁱ Heil S, Jones H, Arria A, et al. "Unintended pregnancy in opioid-abusing women." *J Subst Abuse Treat*. 2011 Mar, 40(2): 199-202.
- ^{iv} Maeda, A, et al. (2014) Opioid abuse and dependence during pregnancy: Temporal trends and obstetrical outcomes. *Anesthesiology*; 121:1156-65.
- ^v Metz TD, Rovner P, Hoffman MC, Allshouse AA, Beckwith KM, Binswanger IA. Maternal deaths from suicide and overdose in Colorado, 2004–2012. *Obstet Gynecol* 2016;128:1233–40.
- ^{vi} Maryland Department of Health and Mental Hygiene Prevention and Health Promotion Administration. Maryland Maternal Mortality Review: 2016 Annual Report. Retrieved from http://healthymaryland.org/wp-content/uploads/2011/05/MMR_Report_2016_clean-copy_FINAL.pdf
- ^{vii} Pregnancy-Associated Deaths from Drug Overdose in Virginia, 1999-2007: A report from the Virginia Maternal Mortality Review Team. April 2015.
- ^{viii} Opioid use and opioid use disorder in pregnancy. Committee Opinion No. 711. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2017;130:e81–94.
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- ^{xiv} Medicaid and CHIP Payment and Access Commission. June 2017.
- ^{xv} Opioid use and opioid use disorder in pregnancy. 2017.
- ^{xvi} Gopman S. Prenatal and postpartum care of women with substance use disorders. *Obstet Gynecol Clin North Am* 2014;41:213–28.
- ^{xvii} Private and Public Coverage of Contraceptive Services and Supplies in the United States, (The Henry J. Kaiser Family Foundation, July 10, 2015). Retrieved from <https://www.kff.org/womens-health-policy/fact-sheet/private-and-public-coverage-of-contraceptive-services-and-supplies-in-the-united-states/>.
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- ^{xix} Protecting Our Infants Act: Final Strategy. Submitted by the Behavioral Health Coordinating Council Subcommittee on Prescription Drug Abuse. Retrieved from https://www.samhsa.gov/sites/default/files/topics/specific_populations/final-strategy-protect-our-infants.pdf
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