Written Testimony
Of
The American College of Obstetricians and Gynecologists
Submitted by:
Hal C. Lawrence, III, MD, FACOG
Before the
House Committee on Energy and Commerce
Subcommittee on Health
Regarding
Combating the Opioid Crisis: Prevention and Public Health Solutions
March 21, 2018

Chairman Burgess, Ranking Member Green, and distinguished Members of the House Energy and Commerce Subcommittee on Health, thank you for the opportunity to submit written testimony in response to your February 28, 2018 hearing titled "Combating the Opioid Crisis: Prevention and Public Health Solutions." The American College of Obstetricians and Gynecologists (ACOG), representing more than 58,000 physicians and partners dedicated to advancing women's health, appreciates the Committee's attention to this important issue. I hope you will view ACOG as a resource and trusted partner as you continue to examine strategies to combat the ongoing opioid crisis.

I am the Executive Vice President and Chief Executive Officer at ACOG and in this capacity am keenly aware of the increase in opioid use disorder and overdose and its impact on the women we serve and their families. My testimony will focus on the need for greater access to evidence-based treatment for pregnant and parenting women and the need for responses to opioid use during pregnancy to remain in the public health space.

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 opioid use disorder (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) report titled *Prenatal Drug Use and Newborn Health: Federal Efforts Need Better Planning and Coordination* found that "the program gap most frequently cited was the lack of available treatment programs for pregnant women…"[x] In 2017, the GAO report titled *Newborn Health: Federal Action Needed to Address Neonatal Abstinence Syndrome* 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 policies to address the ongoing opioid epidemic, we urge you to consider the following:

- The need for urgent action to address the rising maternal mortality rate in the United States. States with maternal mortality review committees (MMRCs) bring together multi-disciplinary health care professionals to review individual maternal deaths and recommend policy solutions to prevent them in the future. MMRCs are critical tools to

understanding maternal deaths, including those linked to opioid overdose, and identifying opportunities for prevention. **Advance H.R. 1318, the Preventing Maternal Deaths Act**, introduced by Reps. Herrera Beutler (R-WA), DeGette (D-CO), and Costello (R-PA) to assist states with the creation or expansion of MMRCs.

- **Support 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.
    - **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.[xii] However, HHS is clear that "full implementation will be contingent upon funding."[xiii]

- Critical gaps in public and private insurance coverage lead to gaps in care or discontinuation of treatment. Women receiving pregnancy coverage through Medicaid or the Children's Health Insurance Program (CHIP) may lose their access to MAT weeks after giving birth, during a particularly vulnerable time when relapse risk increases if treatment is not continued. **Explore coverage policies that ensure continued access to treatment for women postpartum.**

- **Preserve Medicaid's financing structure and ensure 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 42.6 percent of births in the U.S. are financed by Medicaid, Medicaid covers the care of 80 percent of infants diagnosed with NAS,[xiv,xv] and approximately 25 percent of Americans with OUD are Medicaid beneficiaries.[xvi] Any changes to the Medicaid financing structure and/or Medicaid expansion will negatively impact access to care for this vulnerable population.

- Facilitate 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 currently 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.[xvii] Our shared priority is that infants born to families struggling with OUD have safe homes, and that the family unit is preserved when possible.

- Section 503 of CARA added requirements for states to develop infant plans of safe care in instances when an infant experiences NAS following opioid exposure in utero. Unfortunately, those requirements came without resources for implementation or clear guidance, and has the potential to unintentionally lump together women who use illicit substances with those in active treatment or with a current prescription from a licensed health care provider. **States need additional guidance, funds, and resources from the federal government to ensure infant safety and to keep families intact when appropriate.**
- States are encountering barriers to providing affected families the services they need to heal. If we are to truly help children impacted by this epidemic achieve their potential, we must apply a treatment-focused public health approach. Unfortunately, our current system is too often a punitive one that leaves pregnant and parenting women less likely to seek treatment and incentivizes placing children in foster care when they could safely remain at home with the appropriate treatment and support services. **Ensure full implementation of the Family First Prevention Services Act** (Division E, Title VII of the Bipartisan Budget Act; Public Law 115-123) to expand access to treatment services for vulnerable families while helping them stay together and heal.

- Improve access to primary care and the full range of contraceptive options for women with private insurance with opioid use disorder. With a high unplanned pregnancy rate among women with opioid use disorder, to reduce the rate of NAS we must increase access to care for women, including access contraception with no cost-sharing. **Advance H.R. 4082, the Protect Access to Birth Control Act** introduced by Rep. DeGette to ensure continued access to coverage for women with private insurance.

- **Ensure 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.

- **Improve 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.[xviii]

- **Continue to promote research into pharmacological and nonpharmacological treatments** for both pregnant and breastfeeding women with opioid use disorder; non-opioid pharmacotherapies for pain management for women, including pregnant women; and both pharmacological and nonpharmacological treatments for newborns with NAS.

- **Address 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.[xix]

- Expand 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. **Advance H.R. 3692, the Addiction Treatment Access Improvement Act**, introduced by Reps. Tonko (D-NY) and Lujan (D-NM), to expand the qualified providers able to prescribe MAT.

- **Reject 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 submit written testimony, and for your thoughtful approach to this issue. We look forward to working closely with you as you consider additional strategies to address the impact of the ongoing opioid crisis. I hope that you will consider ACOG a trusted partner in this space and will let us know if we can provide any additional assistance.

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[xii] Ibid.

[xiii] 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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[xvi] Medicaid and CHIP Payment and Access Commission. June 2017.

[xvii] Opioid use and opioid use disorder in pregnancy. 2017.

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