



# SOCIETY FOR PUBLIC HEALTH EDUCATION

*Global Leadership for Health Education & Health Promotion*

January 31, 2012

The Honorable Kathleen Sebelius  
Secretary of Health and Human Services  
The Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, D.C. 20201

Re: Essential Health Benefits Bulletin

Dear Secretary Sebelius:

The Society for Public Health Education welcomes the opportunity to comment on the HHS Essential Health Benefits Bulletin. These benefits serve as the pivotal gateway to improving access to necessary health services for millions of uninsured and underinsured Americans, especially as we embark on the most crucial years of health care reform implementation.

SOPHE is a 501 (c)(3) professional organization founded in 1950 to provide global leadership to the profession of health education and health promotion. SOPHE contributes to the health of all people and the elimination of health disparities through advances in health education theory and research; excellence in professional preparation and practice; and advocacy for public policies conducive to health. SOPHE is the *only* independent professional organization devoted exclusively to health education and health promotion. Members include behavioral scientists, faculty, practitioners, and students engaged in disease prevention and health promotion in both the public and private sectors. Collectively, SOPHE's 4,000 national and chapter members work in universities, medical/health care settings, businesses, voluntary health agencies, international organizations, and all branches of federal/state/local government.

As states define their own essential health benefits, we want to ensure that there will be equity in coverage for vital preventive services such as tobacco cessation and for proven self-care management and other services by individuals with multiple chronic conditions. Therefore, SOPHE would like to endorse the comments submitted by the American Lung Association, and further underscore the importance of covering smoking cessation programs for pregnant women. In addition we would like to reiterate comments that SOPHE has previously submitted on *A Strategic Framework 2010-2015 Optimum Health and Quality of Life for Individuals with Chronic Conditions*.

## ***Smoking among Pregnant Women***

Although smoking rates among women have been decreasing in the United States, an estimated 22% of women of reproductive age continued to smoke in 2006. During 2000-2004, an estimated 174,000 women in the United States died annually from smoking-attributable causes, and an estimated 776 infants died annually from causes attributed to maternal smoking during pregnancy.<sup>1</sup>

Breakdowns by age within racial/ethnic subpopulations demonstrated different trends over time. During 2000-2005, the prevalence of prenatal smoking increased significantly (from 30.0% to 32.8%) among non-Hispanic white women aged 20--24 years and decreased significantly (from 15.3% to 10.8%) among non-Hispanic white women aged  $\geq 35$  years. Among non-Hispanic black women aged 25-34 years, the prevalence of smoking increased significantly (from 8.9% to 12.0%). Among Alaska Natives aged 20-24 years, the prevalence of prenatal smoking decreased significantly (from 44.8% to 36.1%). Among American Indians, the prevalence of prenatal smoking decreased significantly among women aged  $< 20$  years (from 37.6% to 15.9%) and among women aged 20--24 years (from 30.9% to 17.0%).<sup>2</sup> These data emphasize the need to expand coverage for smoking cessation programs for pregnant women.

## ***Expanding Smoking Cessation Programs***

State Medicaid programs have been encouraged to provide smoking cessation counseling and prevention treatment services to pregnant smokers and to urge health care providers to screen all pregnant women for tobacco use. The Affordable Care Act currently requires all Medicaid programs to provide a comprehensive tobacco cessation benefit to pregnant women on Medicaid. In June 2011, the Centers for Medicare and Medicaid (CMS) issued a letter to state Medicaid directors detailing this requirement. However, the letter was not explicit in which treatments states are required to cover so it remains to be seen how this requirement will affect coverage policies.<sup>3</sup>

So that an opportunity is not missed, tobacco cessation treatments should be expanded and specified as a preventive service under essential health benefits package, similar to coverage received under the Federal Employees Health Benefits Program (FEHB).

## ***Individuals with Chronic Conditions***

SOPHE recommends including in the Essential Benefits to include proven self-care management (tools and models) and other services that specifically include the utilization and reimbursement of health education specialists and behavioral scientists. These professionals study, design, conduct, and evaluate comprehensive, evidence-based approaches for improving the health of all

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<sup>1</sup>Child Trends (2010). Mothers Who Smoke While Pregnant. Retrieved from: [www.childtrendsdatabank.org/?q=node/241](http://www.childtrendsdatabank.org/?q=node/241).

<sup>2</sup>Centers for Disease Control and Prevention. Trends in Smoking Before, During, and After Pregnancy --- Pregnancy Risk Assessment Monitoring System (PRAMS), United States, 31 Sites, 2000--2005. MMWR 2009;58(SS04): 1-29. Retrieved from: <http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5804a1.htm>

<sup>3</sup>American Lung Association. 2011. *Helping Smokers Quit: Tobacco Cessation Coverage 2011*. Retrieved from: <http://www.lungusa.org/assets/documents/publications/smoking-cessation/helping-smokers-quit-2011.pdf>

people. Health education activities can take place in a variety of settings such as schools, communities, health care facilities, businesses, universities and government agencies. The profession is recognized by the U.S. Department of Labor in the federal Standard Occupational Classification (SOC) system. Although health education specialists are employed under a range of job titles, (e.g., patient educators, health education teachers, public health educators, health program managers), the commonalities are their unique skills and competencies as health education specialists. Many thoroughly tested health education behavior change and self-management models, such as those published by Kate Lorig (Stanford) and Noreen Clark (University of Michigan) hold promise for widespread adoption among persons with MCC.

Consultation and involvement from a health education specialist will maximize efforts in designing patient materials to assist with patient education through the creation of culturally and linguistically appropriate information that guides a patient through a change process to improve adherence to recommendations and improves outcomes. Health services cannot be structured in a “one-size-fits-all” mentality. Rather, such services must be guided by the community and be culturally and linguistically appropriate and should minimally include: 1) Identification of service modalities and models which are appropriate and acceptable to the communities served, population densities, and targeted population subgroups; 2) identification and involvement of community resources and cross-system alliances for purposes of integrated (client) support and service delivery; 3) assurance of cultural competence at each level of care within the system; 4) the use of culturally competent indicators, adapted for specific minority cultural values and beliefs; 5) the inclusion of representatives of the minority groups present in the population when planning services; 6) the percentage of clients from the minority groups served by or under direct supervision of culturally competent staff; 7) client satisfaction with services, measured in a culturally competent manner; 8) the availability of adult interpreters/translators for families in need of interpretation or translation during service deliver; and 9) documentation that activities and materials are provided in the proportion of the primary language(s) in the population served.

### ***Transparency in Benchmark Selection***

SOPHE believes that state options for benchmark plans should be made publicly available. As it is the Administration’s intention to transform the health care system via an open and transparent process, comprehensive information for plans that are options for benchmark status should be displayed on the HHS website.

Thank you for consideration of these comments on the Essential Health Benefits Bulletin. SOPHE looks forward to working with you on implementing this and other provisions of the Affordable Care Act. Please contact Jerrica Mathis at [jmathis@sophe.org](mailto:jmathis@sophe.org) or 202-408-9804 with any additional questions.

Sincerely,



Elaine Auld, MPH, MCHES  
Chief Executive Officer