April 4, 2022

The Honorable Chiquita Brooks-LaSure
Administrator, Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Ave SW
Washington, DC 20201

RE: Notice of Rescission of Coverage and Disclosure Requirements for Patient Protection under the Affordable Care Act (CMS-10330)

Dear Administrator Brooks-LaSure:

On behalf of the American College of Obstetricians and Gynecologists (ACOG), representing more than 62,000 physicians and partners in women's health, I am pleased to offer the following comments in response to the Department of Health and Human Services' (HHS) Information Collection Request (ICR) on the notice of rescission of coverage and disclosure requirements for patient protection under the Affordable Care Act.

Notice of Rescission of Coverage and Disclosure Requirements for Patient Protection under the Affordable Care Act

Under the Affordable Care Act, the rescission notice is used by health plans to provide advance notice to certain individuals that their coverage may be cancelled as a result of fraud or intentional misrepresentation of material fact. These notices are an important safeguard to ensure patients know if and when they are going to lose coverage. ACOG supports the continued requirement for health plans to send rescission notices for patient protections. The Public Health Service (PHS) Act recently re-codified the patient protections related to patient choice of health care professional and extended the applicability of these provisions to grandfathered health plans for plan years beginning on or after January 1, 2022. This patient protection notification will be used by health plans to inform certain individuals of their right to choose a primary care provider or pediatrician and to use obstetrical/ gynecological services without prior authorization. Prior authorization requirements have proven to be significantly burdensome and negatively impact provider acceptance of Medicaid beneficiaries, as well as beneficiaries' outcomes. In a recent survey conducted by the American Medical Association, more than one-third (34%) of physicians reported that prior authorization led to a serious adverse event, such as hospitalization, disability, or even death, for a patient in their care.[i] Also, more than nine in 10 physicians (93%) reported care delays while waiting for health insurers to authorize necessary care, and more than four in five physicians (82%) said patients abandon treatment due to authorization struggles

with health insurers.[ii] ACOG strongly supports patients being able to choose their primary care provider or seek obstetric and gynecologic services without prior authorization to ensure timeliness of care.

The related provisions are finalized in the 2015 final regulations and 2021 interim final regulations titled "Requirements Related to Surprise Billing; Part I" (86 FR 36872, July 13, 2021). The 2015 final regulations, titled "Final Rules under the Affordable Care Act for Grandfathered Plans, Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, Dependent Coverage, Appeals, and Patient Protections" (80 FR 72192, November 18, 2015), also require that, if state law prohibits balance billing, or a plan or issuer is contractually responsible for any amounts balanced billed by an out-of-network emergency services provider, a plan or issuer must provide a participant, beneficiary or enrollee adequate and prominent notice of their lack of financial responsibility with respect to amounts balanced billed in order to prevent inadvertent payment by the individual. Under section 2719A of the PHS Act, the provision for out of network emergency services disclosure sunsets on January 1st, 2022. Plans and issuers are no longer required to provide this notice for plan years as of the beginning of this year. ACOG appreciates the steps taken to protect patients from out of network emergency costs and would encourage CMS to continue to require plans and insurers to continue this notification. It is important patients know and understand the financial responsibility for out of network emergencies, especially related to obstetrical emergencies. Unanticipated costs can discourage individuals from seeking care and for emergency situations there should be no barriers to accessing care. **ACOG recommends CMS continues to encourage plans and insurers to provide advance and prominent notice related to financial responsibility of out of network emergency services.**

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We appreciate the time taken to consider our comments. If you have any questions or wish to discuss these points further, please reach out to Taylor Platt, Manager, Health Policy (tplatt@acog.org) and Erin Lambie, Manager, Health Policy (elambie@acog.org), Health Economics and Practice Management.

Sincerely,

Lisa Satterfield, MS, MPH, CAE, CPH
Senior Director, Health Economics & Practice Management

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[i] American Medical Association (AMA). 2021 AMA Prior Authorization (PA) Physician Survey. 2022. Available at: https://www.ama-assn.org/system/files/prior-authorization-survey.pdf

[ii] Ibid