THE AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS

Office of the President
Mark S. DeFrancesco, MD, MBA, FACOG

March 24, 2016

Sylvia Matthews Burwell
Secretary of Health and Human Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Jack Lew
Secretary of the Treasury
U.S. Department of Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20220

Tom Perez
Secretary of Labor
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20201

Re: CMS–10407 (OMB Control Number: 0938–1146) – Summary of Benefits and Coverage and Uniform Glossary

Dear Secretary Burwell, Secretary Lew and Secretary Perez:

On behalf of the American Congress of Obstetricians and Gynecologists (ACOG), representing over 58,000 physicians and partners in women's health, I am pleased to offer these comments to the Department of Health and Human Services, Department of Labor, and Department of Treasury (Departments) on the Summary of Benefits and Coverage and Uniform Glossary. We thank you and your Departments for your continued work to implement the Affordable Care Act (ACA) and make quality, affordable health insurance available to women. ACOG supports the goals of the Affordable Care Act (ACA) to expand women's access to continuous and meaningful health insurance coverage. Implementation of the ACA should ensure that women's unique health needs are being met, and it is with that goal in mind that we make the below recommendations on the summary of benefits and coverage (SBC).

"If you are pregnant" and "Peg is Having a Baby" Sections

As obstetric care providers, ACOG has concerns with the current version of the two Summary of Benefits and Coverage (SBC) sections that directly apply to childbearing women and the attendant documents that inform insurers how to fill out these sections. While the current SBC template illustrates principles of cost-sharing, the sample template sections, "If you are pregnant" and "Peg is Having a Baby," greatly underestimate what Peg and other women would pay. Our comments (including all proportions reported

below) rely in part on the Truven Health Analytics 2013 report, *The Cost of Having a Baby in the United States*, which includes nationally adjusted data on average commercial payments for vaginal birth.[1]

The posted Maternity Care Narrative coverage scenario clarifies that the patient "gives birth to a healthy child" and "mother and child are released on the second hospital day." Despite these instructions, the current SBC template does not inform prospective enrollees that the newborn incurs costs, which are generally substantial. In the Truven analysis, newborn payments add 46% to maternal payments in commercially-covered vaginal births.

Both "If you are pregnant" and "Peg is Having a Baby" currently use five lines to describe key associated services. In both areas, we strongly encourage the agencies to list the five most costly services, which account in the Truven analysis for 89% of all payments made for women and newborns in commercially-covered vaginal births. Further, these items would fit in the currently allotted space:

- Woman's professional fees [physician or nurse midwife fees for prenatal through postpartum care]
- Woman's facility fee
- Woman's anesthesia fee
- Baby's professional fee
- Baby's facility fee

We also recommend improving the clarifying text that appears immediately below "Peg is Having a Baby" where "(9 months of in-network pre-natal care and a hospital delivery)" appears. In lieu of this text, we recommend "(in-network prenatal through postpartum and newborn care, with uncomplicated vaginal hospital birth)." This language would:

- Clarify that this is about a situation without complications, which is less costly than a complicated birth
- Clarify that this is a vaginal birth, which is less costly than a Cesarean birth
- Use the shorter plain-language word "birth," which is preferable to the higher-literacy, medical term "delivery"
- Clarify that maternity care and this coverage example are inclusive of postpartum care
- Clarify that the newborn incurs costs and the coverage example includes the newborn's care
- Avoid the non-standard use of hyphens in "prenatal" and "postpartum"
- Retain "in-network" due to the potential for out-of-network cost-sharing

ACOG is also concerned with the reference to an anesthesia "visit." ACOG believes that this is confusing, as the principal anesthesia care that childbearing women receive at this time is anesthesia services during labor as an inpatient. Further, the current Proposed Guide for Coverage Examples Calculations – Maternity Care Narrative does not direct issuers to include in-labor anesthesia services. This seemingly runs counter to ACOG's and the American Society of Anesthesiologists' position on pain relief during

[1] Truven Health Analytics. (2013). The cost of having a baby in the United States. Retrieved from: http://transform.childbirthconnection.org/wp-content/uploads/2013/01/Cost-of-Having-a-Baby1.pdf

labor, which states that insurers that reimburse for obstetric care must not deny reimbursement for labor analgesia for lack of "other medical indications" if a woman requests analgesia.[2]

ACOG strongly encourages the Departments to include labor anesthesia services in the example, and to adjust the Guide for Coverage Examples Calculations to include anesthesia services and newborn facility and professional fees. It is especially important to include the above cost items and information in the maternity-related sections as this coverage example will still underestimate average maternal-newborn costs for a given plan because:

- One birth in three is by Cesarean, and total maternal-newborn payments when the birth is Cesarean are about 50% higher than when it is vaginal
- With a ten-month duration, many maternity episodes span two plan years; therefore, many women will incur two deductibles
- Many women unexpectedly have out-of-network anesthesia services and higher bills

"If you visit a health care provider's office or clinic: Preventive care/screening/immunization" Section

In the completed sample template of the Summary of Benefits and Coverage, the template includes language that encourages patients to check with their provider about whether a service is preventive. ACOG is deeply concerned that this sample language suggests to patients that their providers should know each patient's plan coverage. It also creates the false expectation that there will be no cost-sharing for visits when other non-preventive health services are delivered in conjunction with preventive care. ACOG does not believe that this language should be included in the finalized sample template and urges the Departments to remove this from the sample.

Abortion Coverage

ACOG appreciates the Departments' intent to align the SBC templates and instructions with the abortion coverage provisions outlined in the final rule issued on June 16, 2015. The final rule made clear that qualified health plans (QHPs) must disclose whether abortion services are covered or excluded, and whether such coverage is limited to "excepted abortion services" (life-endangerment, rape, and incest). While we appreciate that the SBC templates and instructions reinforce this requirement and that QHP issuers have clear instruction as to how they should disclose abortion coverage information in the SBC, abortion coverage information should be listed in the "Common Medical Event" portion of the SBC – not the "Excluded Services and Other Covered Services" section. Abortion is a legal, pregnancy-related medical service and should be reflected as such on the SBC.

ACOG believes that the SBC instructions should provide clear information about the scope of abortion coverage offered to health plans. Currently, the instructions make arbitrary distinctions between those plans that exclude all abortion services, those plans that cover "non-excepted abortion services" (abortion services beyond the specific instances of life-endangerment, rape, and incest), and those plans that only cover excepted abortion services. It is very possible that a QHP may cover excepted abortion services in addition to one or two additional dire circumstances, such as to protect a woman's health or where there is evidence of fetal impairment. Under the proposed instructions, however, this plan would note in its SBC

[2] Pain relief during labor. ACOG Committee Opinion No. 295. American College of Obstetricians and Gynecologists. Obstet Gynecol 2004;104:213.

that it covers abortion services, leading consumers to falsely believe that the plan offers coverage of abortion without restriction. Likewise, there may be a plan that offers abortion coverage only when a woman's life is at risk, which accounts for only one out of the three excepted abortion services. These are not hypothetical situations: three states restrict QHP coverage of abortion to specific instances beyond life-endangerment, rape, and incest, while seven restrict QHP coverage of abortion to just life-endangerment.[3]

In line with the underlying purpose of the SBC to ensure that consumers have unambiguous, baseline information about their coverage, we strongly urge the Departments to clarify the instructions so that issuers must clearly articulate the scope of abortion coverage offered through their QHPs. A QHP that covers abortion in the instances of life-endangerment, rape, incest, fetal impairment, and risk to a woman's health should list out those specific coverage limitations. Similarly, a QHP should not be allowed to use ambiguous language like "medically necessary" when describing abortion coverage; instead, a QHP should clarify in writing what conditions must be met for insurance coverage. Moreover, if abortion coverage information remains in the "Excluded Services and Other Covered Services" section of the SBC, the Departments should make it mandatory for a QHP to cross-reference to another plan document that more fully describes the coverage, as the "Excluded Services and Other Covered Services" section does not provide space to detail cost-sharing information.

Finally, while ACOG appreciates that the SBC instructions encourage non-QHP issuers to indicate whether abortion services are covered, we urge the Departments to amend the instructions so that all plans required to issue a SBC disclose whether or not abortion services are covered, in line with our comments above. The final rule, although explicitly requiring QHP issuers to disclose abortion services, does not preclude the same disclosure requirements for other issuers. Extending the same disclosure requirements to all plans' SBCs will help ensure that consumers shopping for coverage outside of the Marketplace also have access to the comprehensive information they need to select a health plan that best meets their needs.

We encourage the Departments to address these concerns in the new version and would be happy to support this process. For any issues that cannot be addressed at this time, we encourage the Departments to create a process to regularly consider opportunities for further SBC refinement moving forward. Again, thank you for the opportunity to comment on the Summary of Benefits and Coverage Templates, Instructions, and Related Materials. We hope you have found our comments helpful. Should you have any questions, please contact Rachel Gandell Tetlow, ACOG's Director of Federal Affairs, at rtetlow@acog.org or 202-863-2534.

Sincerely,

Mark S. DeFrancesco, MD, MBA, FACOG
President

[3] Guttmacher Institute. (2016). State policies in brief: Restricting insurance coverage of abortion. Retrieved from: http://www.guttmacher.org/statecenter/spibs/spib_RICA.pdf.