Written Testimony
Of
The American Congress of Obstetricians and Gynecologists
Before the
House Energy and Commerce Subcommittee on Health
Regarding
Patient Relief from Collapsing Health Markets
February 2, 2017

Chairman Burgess, Ranking Member Green, and distinguished members of the Subcommittee on Health, thank you for giving the American Congress of Obstetricians and Gynecologists (ACOG), representing more than 58,000 physicians and partners in women's health, the opportunity to submit written testimony in response to your February 2, 2017 hearing titled "Patient Relief from Collapsing Health Markets." We look forward to working closely with you to preserve landmark women's health gains, and to improve the ACA for patients and providers. We hope you will view ACOG as a resource and trusted partner as you continue to examine our nation's health care system.

As the nation's leading organization of women's health providers, ACOG is keenly aware of many of the benefits, and shortfalls, of the Patient Protection and Affordable Care Act (ACA). ACOG has a strong history of supporting access to coverage and care for all women. While ACOG engaged extensively with Congress during the development of the ACA, we reluctantly opposed the final bill because of the inclusion, and exclusion, of several provisions that we believed undermined health reform's great promise.

However, ACOG does not support full repeal of the ACA. We stand strongly behind the landmark women's health gains achieved through the ACA, and urge the Congress not to turn back the clock on women's health.

ACOG's health reform principles (attached) serve as our guide to measuring the adequacy of all ACA reform proposals. Any reforms **must** preserve:

- Guaranteed maternity coverage for all women in all plans. This essential health benefit righted a wrong in our healthcare system, helping pregnant women access prenatal care and leading to healthier pregnancies and healthier babies. Every $1 spent on prenatal care saves $3.38, primarily in cost of low birthweight and preterm infants. Preterm birth costs our nation $26 billion annually – more than $50,000 for every infant born prematurely.
- Coverage with no cost sharing for women's preventive health services. More than 55 million women gained access to evidence-based preventive services under the ACA, including mammograms, immunizations, and contraception. This provision saved women $1.4 billion on out-of-pocket costs for contraception in one year, and has helped drive down the rate of unintended pregnancies.
- Direct access to ob-gyn care. Ob-gyns deliver primary and preventive care to women, and are often the only doctor a woman sees on a regular basis. This patient-centered protection guarantees our patients the ability to see their preferred physician.
- No pre-existing condition exclusions. Before the ACA, insurers dodged coverage in too many ways, including by refusing coverage of roughly 65 million women with pre-existing conditions, including prior C-section or having been the victim of domestic violence, can no longer be denied coverage. This important patient-centered protection must be maintained.

- No gender rating. Before the ACA, insurers charged women approximately $1 billion more annually and a 25-year old woman could pay 81% more than a man for identical coverage. Let's continue to make insurers play fair.
- No insurance coverage annual or lifetime limits or rescissions. Before the ACA, 39.5 million women were subject to coverage limits, leaving our patients with serious health issues vulnerable to losing coverage mid-treatment. This patient-centered protection is critical to our ability to care for our sickest patients.
- No excessive waiting periods (defined as longer than 90 days). Before the ACA, insurance companies could impose excessive waiting periods, such as 9-months or two years, before beneficiaries could use their coverage, including maternity coverage. That practice was the exact opposite of patient-centered, allowing insurers to collect monthly premiums and deny coverage for needed care.

ACOG supports thoughtful improvements to current law. We hope to work closely with the Subcommittee to reduce administrative burdens on patients and physicians, address unaffordably high deductible plans, correct the narrowing of networks, reform the medical liability system, and abolish the Independent Payment Advisory Board (IPAB).

Thank you for your consideration of these key provisions, which are imperative to the health of our patients. We look forward to continuing to engage with you and provide guidance as you further evaluate our nation's health care system and consider potential reforms.

ACOG
THE AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS

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ACOG Health Reform Principles

Good Economics. Good Women's Health.

Affordable access to care improves health and reduces health system and employer costs.

ACOG is a strong supporter of the landmark women's health gains made in the Affordable Care Act. Any attempt to reform our nation's health care system must not compromise or reduce these health insurance guarantees and protections. Alternative proposals must:

Maintain critical benefits

- **Guarantee maternity coverage** for all women in all plans. This coverage, leading to healthier outcomes and lower costs, was routinely excluded from private insurance plans prior to the ACA.
  - ✓ An estimated 8.7 million American women gained maternity services under the ACA. Previously, only 12% of individual market plans covered these services.[i]
  - ✓ Every $1 spent on prenatal care saves $3.38, primarily in reduced spending for low birthweight and preterm infants.[ii]
- Ensure full coverage and no cost-sharing for **women's preventive health services** under all plans, including the full range of FDA-approved contraceptives.
  - ✓ More than 55 million women gained access to preventive services, including mammograms, flu shots, and contraception without a copay or a deductible.
  - ✓ Women saved $1.4 billion on out-of-pocket costs for contraception in one year.[iii]
  - ✓ Currently, 49% of US pregnancies are unintended; unintended pregnancies resulted in approximately $12.5 billion in government expenditures in 2008.[iv]
- **Continue Medicaid coverage for tobacco cessation** services to pregnant women, leading to better care and lower costs.
  - ✓ Smoking during pregnancy is associated with intrauterine growth restriction, preterm birth, low birthweight, perinatal mortality, and ectopic pregnancy.
  - ✓ Up to 34% of sudden infant death syndrome (SIDS) cases can be attributed to prenatal maternal smoking.[v]
- **Maintain the Medicaid state plan option to expand coverage of family planning** services for low-income women.
  - ✓ Medicaid accounted for 75% of 2010 expenditures on publicly-funded family planning.[vi]
  - ✓ In 2010, every $1 invested in publicly-funded family planning services saved $7.09 in Medicaid expenditures that would have otherwise been needed to pay the medical costs of maternity and infant care.[vii]

Preserve market protections

- **Prohibit pre-existing condition** exclusions, **gender rating**, coverage rescissions, and annual and lifetime benefit caps.
  - ✓ Roughly 65 million women with pre-existing conditions, such as a prior C-section or a history of domestic violence, must not be denied coverage.
  - ✓ Prior to the ACA, gender rating cost women approximately $1 billion annually.[viii]
  - ✓ Insurers must guarantee renewability and availability of coverage.
- Ensure direct **access to ob-gyn care**.
  - ✓ Ob-gyns deliver primary and preventive care services to women. An ob-gyn is often the only doctor a woman sees on a regular basis. Reforms must not impose a barrier to this care.
- Allow **individuals through age 26** to maintain coverage on their parents' health insurance.
- Continue prohibition on **excessive waiting periods**.
  - ✓ Prior to the ACA, insurance companies could impose waiting periods ranging from 9 months to 2 years before maternity coverage could be used.[ix]

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- Ensure **premium subsidies** are available to help small employers and low-income individuals purchase private health insurance.
    - ✓ In 2011, nearly 40% of uninsured women had incomes between 139%-399% of the federal poverty level, making them eligible for subsidies.[x] Alternative proposals must ensure continued affordability.

Strengthen the health care safety net

- Continue **Medicaid expansion**, ensuring a public safety net for no-income and low-income non-pregnant women, and encourage all states to expand their Medicaid programs to cover this population. Thanks to Medicaid expansion:
    - ✓ Between 2010 and 2015, the uninsured rate among women ages 18-64 decreased from 19.3% to 10.8%, nearly half.[xi]
    - ✓ Hospital uncompensated care costs dropped by $10.4 billion in 2015.[xii]
- Preserve the changes to the Medicaid and CHIP application process and allow states to continue to give real-time determinations for non-disabled adults and children, to ensure that women, including pregnant women, can enroll in health insurance and begin accessing care in a timely manner.
- Continue identification and development of **Medicaid quality measures with multi-stakeholder input**.
    - ✓ Continued development and testing of quality measures, including those concerning maternity care, will further efforts to enhance the quality of health care delivered through Medicaid and lead to better outcomes.
- Maintain permanent authorization of the **Indian Health Care Improvement Act**.
    - ✓ The cornerstone legal authority for the provision of health care to American Indians and Alaska Natives, the Act modernized and improved health care provided to American Indian/Alaska Native populations, who generally experience lower health status and disproportionate disease burden.

Protect public health

- Provide **break time and a place at work for breastfeeding women to express milk**.
    - ✓ One study estimates that $3.6 billion would be saved annually in the cost of treating some childhood illnesses if breastfeeding rates were increased.
    - ✓ Children who were breastfed as infants have fewer childhood illnesses and fewer visits to the pediatrician's office, which leads to decreased parental absenteeism from work and lower health system costs.[xiii]
- Continue the **Patient-Centered Outcomes Research Institute** (PCORI) to advance the evidence on health outcomes through research.
    - ✓ The work of PCORI improves the quality of care and speeds implementation of evidence-based practices, positively impacting the rising rates of health care costs.
    - ✓ PCORI's work in women's health ranges from maternity patient reported outcomes, uterine fibroid management, reduction of preterm birth, contraceptive counseling, and maternal mental health.
- Continue the **Prevention and Public Health Fund**.
    - ✓ The Prevention Fund helps states keep communities healthy and safe via immunization programs, epidemiology and laboratory capacity grants, breast and cervical cancer screenings, smoking cessation programs, etc.
    - ✓ Every $1 invested in evidence-based prevention programs saves $5.60.[xiv]
- Continue the **Center for Medicare and Medicaid Innovation** (CMMI) to support the advancement of innovative payment and delivery system models.
    - ✓ The Strong Start for Mothers and Newborns initiative seeks to reduce preterm birth and other adverse birth outcomes.
    - ✓ The Medicare Access and CHIP Reauthorization Act (MACRA) law that repealed the flawed Sustained Growth Rate (SGR) relies on CMMI to test innovative payment models.

[i] Garrett, D. National Women's Law Center, Turning to Fairness: Insurance Discrimination Against Women Today and the Affordable Care Act (Mar. 2012), *available at* http://www.nwlc.org/sites/default/files/pdfs/nwlc_2012_turningtofairness_report.pdf.

[ii] Henderson JW. The Cost Effectiveness of Prenatal Care. Health Care Financing Review. 1994;15(4):21-32, *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4193436/.

[iii] Becker, N. V., & Polsky, D. (July 2015). Women Saw Large Decrease in Out-of-Pocket Spending for Contraceptives After ACA Mandate Removed Cost Sharing. *Health Affairs,* 34(7), pp. 1204-1211, *available at* http://content.healthaffairs.org/content/34/7/1204.abstract.

[iv] Access to contraception. Committee Opinion No. 615. American College of Obstetricians and Gynecologists. Obstet Gynecol 2015;125:250–5.

[v] Smoking cessation during pregnancy. Committee Opinion No. 471. American College of Obstetricians and Gynecologists. Obstet Gynecol 2010;116:1241–4.

[vi] Sonfield A and Gold RB, Public Funding for Family Planning, Sterilization and Abortion Services, FY 1980–2010, New York: Guttmacher Institute, 2012, *available at* https://www.guttmacher.org/report/public-funding-family-planning-sterilization-and-abortion-services-fy-1980-2010.

[vii] Frost JJ et al., Return on investment: a fuller assessment of the benefits and cost savings of the US publicly funded family planning program, *Milbank Quarterly*, 92(4):696–749, 2014, *available at* http://onlinelibrary.wiley.com/doi/10.1111/1468-0009.12080/abstract.

[viii] Garrett, D. Ibid.

[ix] Karen Pollitz et al., Kaiser Family Foundation, Maternity Care and Consumer-Driven Health Plans (June 2007).

[x] Health Reform: Implications for Women's Access to Coverage and Care. Issue Brief #7987-03. Kaiser Family Foundation. August 2013, *available at* https://kaiserfamilyfoundation.files.wordpress.com/2012/03/7987-03-health-reform-implications-for-women_s-access-to-coverage-and-care.pdf.

[xi] Simmons, A et. al. The Affordable Care Act: Promoting Better Health for Women. Office of the Assistant Secretary for Planning and Evaluation Issue Brief. Department of Health and Human Services. June 14, 2016, *available at* https://aspe.hhs.gov/sites/default/files/pdf/205066/ACAWomenHealthIssueBrief.pdf.

[xii] The Economic Record of the Obama Administration: Reforming the Health Care System. Council of Economic Advisers. Executive Office of the President. December 2016, *available at* https://www.whitehouse.gov/sites/default/files/page/files/20161213_cea_record_healh_care_reform.pdf

[xiii] Breastfeeding in underserved women: increasing initiation and continuation of breastfeeding. Committee Opinion No. 570. American College of Obstetricians and Gynecologists. Obstet Gynecol 2013;122:423–8.

[xiv] Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities. Issue Report. Trust for America's Health (February 2009), *available at* http://healthyamericans.org/reports/prevention08/Prevention08.pdf.