Welcome to the 115th Congress

January 2017
January 23, 2017

Dear Member of Congress:

On behalf of the American Congress of Obstetricians and Gynecologists (ACOG), representing over 58,000 physicians and partners in women’s health, congratulations on your election to the 115th Congress.

ACOG is the leading authority on women’s health. For more than 65 years, the US Congress has sought out our moderate voice and our commitment to ensuring public policy based on facts, science, and evidence-based medicine. Our overarching goal is to ensure the highest quality care for women. We accomplish this goal through the development of clinical care recommendations, supporting continuing medical education for physicians, and educating our patients and the public on important women’s health care issues.

ACOG has a strong history of bipartisanship, finding common ground with Members of Congress across the political spectrum and highlighting women’s health as a center issue. Ob-gyns live and practice in nearly every congressional district and in every state. We invite you to consider us your trusted source for evidence-based women’s health information.

Nearly 500 our ob-gyn leaders from across the nation will be in Washington, DC on Tuesday March 14th, to discuss key women’s health issues with their members of Congress. This briefing packet gives you important background on many of the critical issues facing women’s health in the 115th Congress.

Once again, congratulations on your election. We look forward to working with you to advance our shared goals and hope you’ll always contact us with questions or for more information.

Sincerely,

Thomas M. Gellhaus, MD, FACOG
President
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.¹
  ✓ Every $1 spent on prenatal care saves $3.38, primarily in reduced spending for low birthweight and preterm infants.²

• **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.³
  ✓ Currently, 49% of US pregnancies are unintended; unintended pregnancies resulted in approximately $12.5 billion in government expenditures in 2008.⁴

• **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.⁵

• **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.⁶
  ✓ 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.⁷

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.⁸
  ✓ 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.⁹
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.


viii Garrett, D. Ibid.

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


By The Numbers: Women’s Health Before the Affordable Care Act

Don’t Turn Back the Clock on Women’s Health

Background
ACOG reluctantly opposed the Patient Protection and Affordable Care Act (ACA) in 2010, but fought hard for the women’s health gains included in the law. While not perfect, the ACA made landmark improvements for women’s health that must be preserved.

Number of Uninsured
- **General Population:** In 2006, 47 million people in the US, 15.8% of the population, were uninsured, an increase of 2 million people over the previous year.¹
- **Women of Childbearing Age (ages 15-44):** One in five women of childbearing age (12.6 million) was uninsured in 2006.
  - Accounts for 27.2% of all the uninsured in the US.
  - Uninsured rate for women of childbearing age (20.4%) was greater than for all Americans under age 65 (17.8%).²
- **Pregnant Women:** Nearly one-third of women reported lacking health insurance or transitioning between types of coverage around the time of pregnancy in 2009.³

Coverage Practices
- **Gender Rating:** In 2012, a 25-year-old woman could pay 81% more than a man for identical coverage.⁴ The ACA banned this practice starting in 2014.
- **Maternity Care:** In 2008, only 12% of insurance policies on the individual market covered maternity care.⁵
- **Waiting Period:** Insurance companies could impose waiting periods up to a year before maternity coverage could be used.⁶
- **Lifetime Limits:** Pre-ACA, 39.5 million women were subject to lifetime coverage limits, leaving those with serious health issues vulnerable to losing coverage mid-treatment.⁷

Women Without Insurance Are Sicker
- Uninsured women with breast cancer are 30–50% more likely to die from the disease.
- Uninsured non-elderly women (ages 18–64) are three times less likely to have had a Pap test in the last three years, with a 60% greater risk of late-stage cervical cancer diagnosis.
- Only half of uninsured women (50%) have a regular doctor, compared to 89% of privately-insured women.⁸,⁹
- Uninsured pregnant women are less likely to seek prenatal care in the first trimester and to receive the optimal number of visits during their pregnancy. They have a 31% higher likelihood of experiencing an adverse health outcome after giving birth.¹⁰
- Inadequate use of prenatal care is associated with increased risks of low birthweight babies, preterm birth, neonatal mortality, infant mortality and maternal mortality.¹¹


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


viii Kaiser Family Foundation, 2004 Kaiser Women’s Health Survey.

ix Kaiser Family Foundation, Women and Health Care: A National Profile: Key Findings from the Kaiser Women’s Health Survey, 2005.

x Institute of Medicine, Insuring America’s Health: Principles and Recommendations, 2004.

Medicaid Is Important for Women’s Health

Background
Medicaid, a federal-state partnership, provides health care to 72 million Americans, 49 million of whom are women. Medicaid is the primary source of public maternity and family planning coverage in the U.S., covering 48% of all U.S. births in 2010 and playing a critical role in ensuring healthy moms and healthy babies through access to pregnancy-related care. Many state Medicaid programs provide comprehensive care, including primary care services such as cancer and domestic violence screenings.

Medicaid is also a key driver in our economy: girls enrolled in Medicaid as children are more likely to attend college, and had higher cumulative wages by age 28, showing an estimated $656 increase in wages for each additional year of Medicaid eligibility.

Any Medicaid reform must continue to ensure low-income women access to needed health care services.

Issue
Proposals have been offered to change the Medicaid financing structure, usually reducing federal expenditures by shifting costs to the states and/or reducing enrollment or services. These proposals may also limit state participation in the Medicaid expansion program, further limiting access to care.

Concerns
- **Per Capita Caps**: A maximum annual amount that the federal government will pay per beneficiary, sometimes varying by beneficiary type.
  - **Concern**: The cap may not be sufficient to cover the cost of care for Medicaid-eligible individuals most in need of care, including pregnant women with complications.
- **Block Grants**: An annual dollar limit on federal funding to state Medicaid programs.
  - **Concern**: A federal limit may not take into account enrollment growth or other increases in health spending, especially those associated with state economic downturns. If the federal funds run out, states would likely respond by cutting benefits, limiting eligibility, or cutting physician payments, any of which would reduce access to care for low-income women.
- **Blended FMAP**: Federal financial matching payment (FMAP) amounts vary significantly for different Medicaid populations and services. Often, higher federal rates are offered for care considered to be especially valuable to this population, including family planning, which the federal government covers at 90%. Blended FMAP proposals would create a single matching rate for all populations and services in each state.
  - **Concern**: The blended FMAP would likely be set at an amount that would reduce total federal Medicaid dollars. States would have to make up the difference or respond as under a block grant.
- **Limits on Provider Taxes**: 49 states and the District of Columbia rely on providers to help pay a share of the Medicaid programs. This proposal would limit these provider contributions.
  - **Concern**: Without this revenue, states would have to make up the difference through general funds and/or cut their programs.

Solution
Congress should maintain Medicaid’s current financing structure to ensure women’s continued access to essential services. Decreased funding for obstetric and preventive women’s health services will increase costs. ACOG is committed to working with Congress to find efficiencies and savings in the Medicaid program through care coordination programs and proven cost-effective care. In addition, ACOG is also committed to ensuring access to care for low-income women by supporting appropriate payment rates in Medicaid for ob-gyns.
Center for Medicaid and CHIP Services. (2016). Medicaid & CHIP: July 2016 monthly applications, eligibility determinations and enrollment report. (Amount also includes enrollment in the Children’s Health Insurance Program (CHIP).)


Medicare Is Important for Women’s Health

Changes to the Medicare program profoundly impact women and women’s health care providers. Ob-gyns care for women across the life course; approximately 92% of ob-gyns participate in the Medicare program. Medicare serves as a critical source of coverage for older women. Medicare payment and coverage policies serve as a baseline for TRICARE, which covers ob-gyn care for active-duty servicewomen and female dependents, and private insurers and Medicaid often use Medicare as a guide in setting their own policies.

Privatizing Medicare

ACOG does not support proposals to transition Medicare into a premium support program. This move would have a disproportionate and regressive impact on women, who live longer and often have fewer retirement savings due in part to the gender wage gap. A recent survey found that women face nearly 20% higher health care costs in retirement than men. Medicare changes that would result in higher out-of-pocket costs for beneficiaries would hurt women’s ability to access needed gynecologic and other health care services.

Medicare Access and CHIP Reauthorization Act (MACRA)

The transition from the broken Sustainable Growth Rate (SGR) formula to the new MACRA Quality Payment Program (QPP) will be a years-long process. ACOG was a strong supporter of SGR repeal and is committed to ensuring this new payment program is a success for ob-gyns and our patients. As the new law continues to be implemented and new models are tested, we may look to the US Congress and the administration for legislative and regulatory assistance.

We urge the Congress and the administration to note that repeal of the Affordable Care Act, including repeal of the Center for Medicare & Medicaid Innovation (CMMI), will threaten the success of MACRA.

We look forward to working with the new Congress to ensure the program works for patients and physicians and that we continue this forward momentum.

Graduate Medical Education (GME)

GME funding is critical to maintaining an adequate ob-gyn workforce. Medicare is the largest single funding source, contributing $11.3 billion a year to train residents.

- The number of ob-gyns trained has plateaued since the 1980s and has not kept pace with the growing population of women in the US, which is predicted to increase 36% by 2050, resulting in a 25% shortage of ob-gyns.
- 49% of the 3,107 U.S. counties lack an ob-gyn; nearly 9.5 million Americans (3%) live in those predominantly rural counties.
- America has the world’s best doctors because we have the world’s best teaching hospitals. Teaching hospitals discover cures, provide critical services that save American lives, and care for all Americans, insured or uninsured.
- Cuts to Medicare GME payments means that teaching hospitals would train fewer residents, exacerbating the physician shortage and limiting access to care for many Americans.
Reproductive Health Principles

The American Congress of Obstetricians and Gynecologists (ACOG) supports access to high-quality, affordable reproductive health services as an integral component of women’s health care.

Access to Contraception

Contraception was named by the Centers for Disease Control and Prevention as one of the 10 great public health achievements of the 20th century. ACOG supports comprehensive and no-cost access to all U.S. Food and Drug Administration-approved contraceptives with no cost sharing as a vital component of women’s health care.1

Access to contraception supports healthy women and healthy babies

• Contraception allows women to plan and space their pregnancies and to achieve optimal health before becoming pregnant.
• The ability to avoid pregnancy can be lifesaving for women with serious medical conditions such as heart disease, diabetes, lupus, and high blood pressure.
• Non-contraceptive benefits include decreased bleeding and pain with menstrual periods and reduced risk of gynecologic disorders, including endometrial and ovarian cancer.
• Adequate birth spacing lowers the risk of low birth weight and preterm birth.
• When women can plan their pregnancies, they are more likely to seek prenatal care.3

Access to contraception makes economic sense

• Ensuring access to family planning is very cost-effective for federal and state governments.
• Each dollar spent on publicly funded family planning services saves the Medicaid program $7.09.4
• The economic burden of unintended pregnancy costs taxpayers $12.5 billion dollars each year.5
• The ability to plan a pregnancy increases engagement of women in the workforce and improves economic stability for women and their families.6

Access to contraception is common ground

• Each year, approximately half of all pregnancies are unintended; unintended pregnancies are a major driver in the rate of abortion.7
• The most effective way to reduce abortions is to prevent unintended pregnancy by improving access to consistent, effective, and affordable contraception.
• It is estimated that in 2014, were it not for publicly funded family planning, the U.S. rate of unintended pregnancy, unplanned birth, and abortion would have been 68 percent higher.8
• Ninety-nine percent of sexually active women in the U.S. use some form of contraception.9

Access to Abortion

ACOG supports access to safe, legal abortion as a necessary component of women’s health care.10

Health care decisions should be made by a woman and her doctor, free from political interference

• Like all medical matters, decisions regarding abortion should be made by patients in consultation with their health care providers and without political interference.11

Legal abortion is extremely safe
In the United States, 88 percent of abortions occur within the first trimester, when abortion is safest. Serious complications from abortions at all gestational ages are rare.\textsuperscript{12}

A woman’s decision to have an abortion hinges on many factors\textsuperscript{13}
- Factors include, but are not limited to, contraceptive failure, inability to access or use contraceptives, rape, incest, intimate partner violence, fetal anomalies, illness during pregnancy, and exposure to teratogenic medications.
- Pregnancy complications may be so severe that an abortion is the only measure to preserve a woman’s health or save her life.

If abortion is illegal or highly restricted, women will resort to unsafe means, bringing our Nation back to the days of dangerous back alley or self-inflicted abortions
- Today, approximately 21 million women around the world obtain unsafe, illegal abortions each year, and complications from these unsafe procedures account for approximately 13 percent of all maternal deaths, nearly 50,000 annually.\textsuperscript{14,15}
- It is estimated that as recently as the 1940s, more than 1,000 women died each year from unsafe abortions in the United States.\textsuperscript{16}

\textsuperscript{2} Ibid.
\textsuperscript{6} Sonfield A, Hasstedt K, Kavanaugh ML, Anderson R. The social and economic benefits of women’s ability to determine whether and when to have children. New York (NY): Guttmacher Institute; 2013.
\textsuperscript{13} Increasing Access to Abortion. Committee Opinion 613.
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