AMERICAN COLLEGE of NURSE-MIDWIVES
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August 27, 2010

Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Attention: OCIIO–9994–IFC
P.O. Box 8016
Baltimore, MD 21244–1850

Subject: Comments on Interim Final Regulations Relating to Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections

On behalf of the members of the American College of Nurse-Midwives (ACNM), I am submitting the following comments in response to the U.S. Department of Health and Human Services (HHS) proposed interim-final rule dated June 28, 2010. ACNM wishes to make specific comments relating to Section 2719A regarding new patient protections authorized by the Affordable Care Act (ACA).

D. PHS Act Section 2719A, Patient Protections (26 CFR 54.9815–2719AT, 29 CFR 2590.715–2719A, 45 CFR 147.138)

Per the interim final regulation, Section 2719A of the Public Health Service Act imposes, with respect to a group health plan, or group or individual health insurance coverage, a set of requirements relating to the choice of a health care professional, and to benefits for emergency services. The statute and these interim final regulations provide that if a group health plan, or a health insurance issuer offering group or individual health insurance coverage, requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer must permit each participant, beneficiary, or enrollee to designate any participating primary care provider who is available to accept the participant, beneficiary, or enrollee. Under these interim final regulations, the plan or issuer must provide a notice informing each participant (or, in the individual market, the primary subscriber) of the terms of the plan or health insurance coverage regarding designation of a primary care provider.

The statute and these interim final regulations also provide rules for a group health plan, or a health insurance issuer offering group or individual health insurance coverage, that provides coverage for obstetrical or gynecological care and requires the designation of an in-network primary care provider. In such a case, the plan or issuer may not require authorization or referral by the plan, issuer, or any person (including a primary care provider) for a female participant, beneficiary, or enrollee who seeks obstetrical or gynecological care provided by an in-network

health care professional who specializes in obstetrics or gynecology. The plan or issuer must inform each participant (or, in the individual market, primary subscriber) that the plan or issuer may not require authorization or referral for obstetrical or gynecological care by a participating health care professional who specializes in obstetrics or gynecology. The plan or issuer must treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, by the professional who specializes in obstetrics or gynecology as the authorization of the primary care provider. For this purpose, a health care professional who specializes in obstetrics or gynecology is any individual who is authorized under applicable State law to provide obstetrical or gynecological care, and is not limited to a physician.

ACNM strongly supports these regulations as issued by HHS and believes they meet the intent of Congress to ensure women unfettered access to primary care and maternal health providers, including certified nurse-midwives (CNM) and certified midwives (CM) who have graduated from a midwifery education program accredited by the Accreditation Commission for Midwifery Education and who are licensed to practice in the State in which they provide services. ACNM appreciates the agency's work to move this section of the law forward as it provides vital protections for women seeking access to essential health care services.

ACNM also appreciates the guidance given in this regulation to health plans on how to communicate with enrollees about their rights to: (1) choose a primary care provider; and (2) obtain obstetrical or gynecological care without prior authorization. However, ACNM is concerned that the examples provided under the new regulations emphasize the selection of a "primary care physician" even though eligible primary care providers include CNMs, CMs, nurse practitioners, or other professionals with appropriate scope of practice as authorized by State law. ACNM encourages HHS to ensure that examples eliminate the reference to physician and adopt provider-neutral language such as *"Example 1. (i) Facts. A group health plan requires each participant to select a primary care provider for the participant and the participant's family."* ACNM supports HHS provision of model language in the rule to aid health plan communication with enrollees on their rights to designate the primary care provider of their choice and to directly access the services of obstetrical and gynecological professionals, and urges uniform incorporation of provider-neutral language.

Thank you for the opportunity to comment on this proposed rule. If you have questions regarding specific comments or general questions relating to midwifery services, please contact Patrick Cooney, ACNM's Federal Representative, at (202) 347-0034 or via email at patrick@federalgrp.com.

Sincerely,

Lorrie Kline Kaplan
Executive Director