

OBSTETRICS & GYNECOLOGY



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- Comments from the reviewers and editors (email to author requesting revisions)
- Response from the author (cover letter submitted with revised manuscript)*
- Email correspondence between the editorial office and the authors*

**The corresponding author has opted to make this information publicly available.*

Personal or nonessential information may be redacted at the editor's discretion.

Questions about these materials may be directed to the *Obstetrics & Gynecology* editorial office:

obgyn@greenjournal.org.

Date: Aug 15, 2018
To: "Mark Allen Clapp" [REDACTED]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-18-1361

RE: Manuscript Number ONG-18-1361

Preconception Coverage Before and After the Affordable Care Act Medicaid Expansions

Dear Dr. Clapp:

Your manuscript has been reviewed by the Editorial Board and by special expert referees. Although it is judged not acceptable for publication in Obstetrics & Gynecology in its present form, we would be willing to give further consideration to a revised version.

If you wish to consider revising your manuscript, you will first need to study carefully the enclosed reports submitted by the referees and editors. Each point raised requires a response, by either revising your manuscript or making a clear and convincing argument as to why no revision is needed. To facilitate our review, we prefer that the cover letter include the comments made by the reviewers and the editor followed by your response. The revised manuscript should indicate the position of all changes made. We suggest that you use the "track changes" feature in your word processing software to do so (rather than strikethrough or underline formatting).

Your paper will be maintained in active status for 21 days from the date of this letter. If we have not heard from you by Sep 04, 2018, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1:

General Comments: The authors describe survey study using PRAMS data, in which they compare rates of preconception uninsurance among women with childbirths in Medicaid expansion vs. non-expansion states, pre and post ACA. Their work is timely, significant, and rigorously conducted. The manuscript itself needs a little work to make their methods more understandable, to ensure that clinician readers understand the policy context for this work, and to make the clinical implications more clear.

Intro:

Line 67 - some clinicians may not fully understand Medicaid expansion. Perhaps include a statement that income eligibility for Medicaid varied widely prior to the ACA, from 18% FPL to 100%, etc.

The authors might also consider explaining that Medicaid expansion was made optional by the Supreme Court (and the nice natural experiment this affords)

Consider explaining that income eligibility for Medicaid is often more lenient during pregnancy

Methods:

Overall, more detail is needed in this section. Consider that the journal's readership is largely clinical.

State study design in first sentence of this section.

Describe diff in diff analysis technique for a non-researcher audience

79 - Briefly add more details about PRAMS (e.g., survey study, administered within a state to postpartum women)

Line 81: by "Medicaid coverage provisions" I think you mean income eligibility, correct? Consider clarifying.

Line 84/91 - consider adding rationale for including the demographics listed

Line 97 - provide rationale for testing in these two other groups (e.g., what might it mean if the association was/wasn't found to hold true in these groups?)

Discussion:

Line 136: please clarify that this is not all low-income women, but just those with a live-birth

Line 148: add disease management (preconception coverage may facilitate better management of chronic conditions prior to pregnancy, which can affect both the risk of pregnancy complications as well as the course of the chronic condition during pregnancy).

The authors should be clear that this is a sample of postpartum women with a live birth. It does not include women who had a pregnancy with a subsequent miscarriage or abortion. By excluding these women, we might be overestimating the drop in uninsurance rates

Line 178 - consider changing "completed pregnancies" to "live births"

Fig 1 - consider changing Y axis title from "% of pregnant women" to "% of women with a live birth" or something like that

Reviewer #2:

Excellent article! I'm so pleased to see this work and believe that this manuscript has the potential to help advocates at all levels better articulate the impact that the ACA can have on women and their future families. The only area in the paper that could more description is the section about "crowd out". I wasn't clear what that meant and felt that the finding about the shift from private to public insurance is very important. Some policy makers might find that concerning and could interpret that in ways that run counter to the larger study conclusions that increased access to postpartum health is essential for many reasons. If the authors could spend a little more time talking about that finding it would be helpful. I agree with the final sentence and recommendations for future study - well done. Nice work.

Reviewer #3:

The objective of this study was to determine if the effects of the ACA Medicaid expansions on preconception insurance coverage for low income women. The study used self-reported family income data as well as information on source of insurance from women who completed the PRAMS survey in a total of 15 states, of which 8 implemented Medicaid expansion. The findings were that after Medicaid expansion, the rate of preconception uninsurance decreased (but not significantly), rate of Medicaid increased significantly and private/other insurance decreased significantly.

The manuscript was well written. There are several areas that could benefit from clarification.

Line 76: Minor: this sentence uses the wording "change in outcomes" and I immediately thought about change in pregnancy outcomes (LBW, PTB, etc.). I think it might be clearer to say changes in self-reported insurance coverage since that is your only outcome.

Line 91: Please provide a rationale for including annual state unemployment rates among reproductive age women in your analysis.

Results/Table: Would you list the name of the states in the results or under Table 1? It is in the appendix but many readers may not read that and it would be good to have that information somewhere more accessible.

Line 110: Did you consider do statistical testing on the distributions for Table 1? The difference in education is quite striking and likely highly significant. When I read this sentence initially I thought you were attributing higher educational attainment to Medicaid expansion.

Line 128: You note that there were no significant changes in uninsurance in your sensitivity analysis but that is true for your main analysis as well. It says that in the discussion but not in the results although it is evident from the CIs.

Line 155: Please define or better describe the term "crowd-out". I assume here it is the result of the ability to be on Medicaid at a slightly higher income that is more cost effective to women than remaining on private insurance with perhaps fewer benefits.

Line 170: You mention that the question at the time of delivery has been validated but preconception insurance which you are studying here has not. How were the questions asked in terms of coverage and in terms of preconception vs prenatal care period? Were women asked if they switched insurance based on what they reported preconception?

General comment: Are you able to show in this and another manuscript if timing of enrollment in PNC changed over time? You mention the benefits of continuous insurance based on the literature but can you determine if any of these benefits were achieved based on this policy changes using PRAMS data?

Figure: Why did you choose to show the unadjusted trends rather than the adjusted trends? If there was space permitted by the journal, I would include all 9 panels - for low income women, for all women, and for women on Medicaid at the time of delivery.

Reviewer #4:

In this manuscript, the authors present an analysis of data acquired from the CDC's Pregnancy Risk Assessment Monitoring System (PRAM) to investigate how the Affordable Care Act impacted pre-conception insurance coverage. It is argued that pre-conception insurance coverage is important as it improves initiation and adequacy of early pre-natal care. The study sets up a quasi-experiment comparing states that expanded Medicaid versus those that did not. The outcomes are

compared using a difference-in-difference approach. I have the following specific questions/comments:

- 1) Overall the expanded Medicaid states always are better off than the non-expanded states. The full effect of the ACA occurred in 2014 although the law was signed in 2010. The message of the paper seems a bit mixed insofar as are we talking about the effect of the law on preconception insurance coverage from existence (i.e. 2010) or the full implementation of the law (i.e. 2014). Even in 2009 there are differences across these states that would arguably have nothing to do with the ACA. Beyond this, two more years beyond 2015 would be nice to see plotted to understand if the deflection at 2014 is real or artificial.
 - 2) The accuracy of self-reported insurance coverage, while mentioned in the limitations as perhaps less of a concern (Line 169), may vary by patient demographics. Among the targeted population, are the assurances still OK?
 - 3) These data seem a bit like a shell game. There is no identified change in the rates of uninsured patients across the state-based cohorts BUT we shifted private insured patients to Medicaid. The assumption is this was good because it avoided "churning." This is a worrisome assumption because while having vs. not having insurance would be recognized to matter (e.g. Line 150-151), it's less clear the coverage swapping matters.
 - 4) The first 2 paragraphs of the discussion seem in conflict with one another. Line 139 says, "reduction in uninsurance was not statistically significant" but then Line 144 says "½ of the increase in preconception Medicaid coverage was accounted for by a decrease in preconception uninsurance." If something is merely a trend then is it fair to devote a paragraph on the assumption that trend is indeed truth?
 - 5) Line 150 seems unfair in light of the fact that the study did not find these women had no insurance (the rate of uninsured was NOT reduced) but appeared to have different insurance. Perhaps "churning" is bad but it's a different argument.
- Overall, interesting idea but the findings seem to be being forced to say something they may not.

STATISTICAL EDITOR COMMENTS:

The Statistical Editor makes the following points that need to be addressed:

The manuscript is concisely written and the analysis is clear. There is a lot of detail in the supplement which should be summarized in the main body of the paper. For example a flow diagram showing the relationship of "all women" to "women < 138% of federal poverty level" to "women reporting medicaid prenatal coverage" would be helpful (see Table A1, not necessarily by year, but by epoch). Also, the appendix (e methods, page 2) cites that the CDC set a threshold for minimum response rates of 65% for 2007-2013 and 60% thereafter. Those response rates should be cited as a potential limitation to the study, particularly if the rates were differential for expansion vs non-expansion States during either of the time epochs. Need to provide more information regarding the response rates for the samples studied.

The multiple adjusters were cited on lines 90-92 and Tables 2 and 3 cite both the unadjusted and adjusted difference in differences with both 95% CI and their p-values.

If the CIs range includes 0 for this kind of estimate, then the inference is that it is NS at a $p < .05$ threshold. Therefore, line 49, and all of the other places where your data shows a non significant change in the article need to be revised to state there is no difference.

As space permits, I would like to include both crude and adjusted estimates in the Abstract, although the latter certainly take precedence. Perhaps the Abstract could be amended to clearly indicate in words which changes were statistically NS, but just numerical. I'm sure it's clear to the Authors, but to the first time reader, the writing may not be obvious.

Also, the hypothesis seems to be to evaluate how ACA Medicaid expansion affected "preconception insurance coverage among low-income women". The effect seems clear from Tables 2 and 3, from both the crude and adjusted analyses. That is, Medicaid coverage increased, private insurance decreased and both were statistically significant, albeit numerically modest changes. However, the overall effect was a NS change in uninsured rates for those women during preconception. The absolute rates of uninsured were quite different in expansion vs non-expansion States, but the change (difference pre and post ACA) for one cohort vs the other (the difference in differences) all had p-values much greater than .05.

I don't think that the Abstract reflects that summary very well. Especially lines 55-56 says only part of that conclusion, since Medicaid expansion occurred, but private insurance coverage decreased and the net effect was no change in expansion vs non-expansion States.

Both cohorts had lower rates of non-insured (and the non-expansion States had higher uninsured rates before and after ACA expansion), but the difference pre and post ACA by difference in differences was not statistically different.

EDITOR COMMENTS:

1. Thank you for your submission to Obstetrics & Gynecology. In addition to the comments from the reviewers above, you are being sent a notated PDF that contains the Editor's specific comments. Please review and consider the comments in this file prior to submitting your revised manuscript. These comments should be included in your point-by-point response cover letter.

The notated PDF is uploaded to this submission's record in Editorial Manager. If you cannot locate the file, contact Katie McDermott and she will send it by email – kmcdermott@greenjournal.org.

2. The Editors of Obstetrics & Gynecology are seeking to increase transparency around its peer-review process, in line with efforts to do so in international biomedical peer review publishing. If your article is accepted, we will be posting this revision letter as supplemental digital content to the published article online. Additionally, unless you choose to opt out, we will also be including your point-by-point response to the revision letter, as well as subsequent author queries. If you opt out of including your response, only the revision letter will be posted. Please reply to this letter with one of two responses:

1. OPT-IN: Yes, please publish my response letter and subsequent email correspondence related to author queries.
2. OPT-OUT: No, please do not publish my response letter and subsequent email correspondence related to author queries.

3. All studies should follow the principles set forth in the Helsinki Declaration of 1975, as revised in 2013, and manuscripts should be approved by the necessary authority before submission. Applicable original research studies should be reviewed by an institutional review board (IRB) or ethics committee. This review should be documented in your cover letter as well in the Materials and Methods section, with an explanation if the study was considered exempt. If your research is based on a publicly available data set approved by your IRB for exemption, please provide documentation of this in your cover letter by submitting the URL of the IRB web site outlining the exempt data sets or a letter from a representative of the IRB. In addition, insert a sentence in the Materials and Methods section stating that the study was approved or exempt from approval. In all cases, the complete name of the IRB should be provided in the manuscript.

4. Standard obstetric and gynecology data definitions have been developed through the reVITALize initiative, which was convened by the American College of Obstetricians and Gynecologists and the members of the Women's Health Registry Alliance. Obstetrics & Gynecology will be transitioning as much as possible to use of the reVITALize definitions, and we encourage authors to familiarize themselves with them. The obstetric data definitions are available at <http://links.lww.com/AOG/A515>, and the gynecology data definitions are available at <http://links.lww.com/AOG/A935>.

5. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Original Research reports should not exceed 22 typed, double-spaced pages (5,500 words). Stated page limits include all numbered pages in a manuscript (i.e., title page, précis, abstract, text, references, tables, boxes, figure legends, and appendixes).

Please limit your Introduction to 250 words and your Discussion to 750 words.

6. Specific rules govern the use of acknowledgments in the journal. Please edit your acknowledgments or provide more information in accordance with the following guidelines:

- * All financial support of the study must be acknowledged.
- * Any and all manuscript preparation assistance, including but not limited to topic development, data collection, analysis, writing, or editorial assistance, must be disclosed in the acknowledgments. Such acknowledgments must identify the entities that provided and paid for this assistance, whether directly or indirectly.
- * All persons who contributed to the work reported in the manuscript, but not sufficiently to be authors, must be acknowledged. Written permission must be obtained from all individuals named in the acknowledgments, as readers may infer their endorsement of the data and conclusions. Please note that your signature on the journal's author agreement form verifies that permission has been obtained from all named persons.
- * If all or part of the paper was presented at the Annual Clinical and Scientific Meeting of the American College of Obstetricians and Gynecologists or at any other organizational meeting, that presentation should be noted (include the exact dates and location of the meeting).

7. The most common deficiency in revised manuscripts involves the abstract. Be sure there are no inconsistencies between the Abstract and the manuscript, and that the Abstract has a clear conclusion statement based on the results found in the paper. Make sure that the abstract does not contain information that does not appear in the body text. If you submit a revision, please check the abstract carefully.

In addition, the abstract length should follow journal guidelines. The word limits for different article types are as follows:

Original Research articles, 300 words. Please provide a word count.

8. Only standard abbreviations and acronyms are allowed. A selected list is available online at <http://edmgr.ovid.com/ong/accounts/abbreviations.pdf>. Abbreviations and acronyms cannot be used in the title or précis. Abbreviations and acronyms must be spelled out the first time they are used in the abstract and again in the body of the manuscript.

9. The journal does not use the virgule symbol (/) in sentences with words. Please rephrase your text to avoid using "and/or," or similar constructions throughout the text. You may retain this symbol if you are using it to express data or a measurement.

10. (Line 177) We discourage claims of first reports since they are often difficult to prove. How do you know this is the first report? If this is based on a systematic search of the literature, that search should be described in the text (search engine, search terms, date range of search, and languages encompassed by the search). If on the other hand, it is not based on a systematic search but only on your level of awareness, it is not a claim we permit.

11. Please review the journal's Table Checklist to make sure that your tables conform to journal style. The Table Checklist is available online here: http://edmgr.ovid.com/ong/accounts/table_checklist.pdf.

12. Figure 1: Is this available in a higher resolution?

When you submit your revision, art saved in a digital format should accompany it. If your figure was created in Microsoft Word, Microsoft Excel, or Microsoft PowerPoint formats, please submit your original source file. Image files should not be copied and pasted into Microsoft Word or Microsoft PowerPoint.

When you submit your revision, art saved in a digital format should accompany it. Please upload each figure as a separate file to Editorial Manager (do not embed the figure in your manuscript file).

If the figures were created using a statistical program (eg, STATA, SPSS, SAS), please submit PDF or EPS files generated directly from the statistical program.

Figures should be saved as high-resolution TIFF files. The minimum requirements for resolution are 300 dpi for color or black and white photographs, and 600 dpi for images containing a photograph with text labeling or thin lines.

Figures should be no smaller than the journal column size of 3 1/4 inches. Art that is low resolution, digitized, adapted from slides, or downloaded from the Internet may not reproduce. Refer to the journal printer's web site (<http://cjs.cadmus.com/da/index.asp>) for more direction on digital art preparation.

13. To ensure a quality experience for those viewing supplemental digital content, the journal's publisher suggests that authors submit supplemental digital files no larger than 10 MB each. The exceptions to this rule are audio or video files, which are acceptable up to 100 MB. When submitting text files or tables as supplemental digital content with your revisions, please do not submit PDFs.

If you choose to revise your manuscript, please submit your revision via Editorial Manager for Obstetrics & Gynecology at <http://ong.editorialmanager.com>. It is essential that your cover letter list point-by-point the changes made in response to each criticism. Also, please save and submit your manuscript in a word processing format such as Microsoft Word.

If you submit a revision, we will assume that it has been developed in consultation with your co-authors, that each author has given approval to the final form of the revision, and that the agreement form signed by each author and submitted with the initial version remains valid.

Again, your paper will be maintained in active status for 21 days from the date of this letter. If we have not heard from you by Sep 04, 2018, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,

Nancy C. Chescheir
Editor in Chief of Obstetrics & Gynecology

2017 IMPACT FACTOR: 4.982
2017 IMPACT FACTOR RANKING: 5th out of 82 ob/gyn journals

If you would like your personal information to be removed from the database, please contact the publication office.

RESPONSE TO REVIEW

Manuscript #ONG-18-161

Preconception Coverage Before and After the Affordable Care Act Medicaid Expansions

Thank you for the opportunity to revise our manuscript.

We have addressed the Editor's, Reviewers' #1-4, and the Statistical Editor's comments within the word restriction guidelines of the journal. Each reviewer's comments and the associated changes are listed below. All changes can be reviewed in the "Track Changes" version of the revised manuscript.

Several changes affected material in the Appendix (e.g., removing the virgule throughout the manuscript); an updated version of the Appendix has been uploaded with the revised manuscript file.

We would be happy to make additional edits or revisions at your request.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Clapp', with a stylized, cursive script.

Mark Clapp, MD MPH



Editor's Inline Notes

Abstract

Page 3, Points #1-3: The objective statement has been framed.

Page 3, Points #4-5: This phrase has been deleted.

Page 3, Point #6: "Outcomes" has been changed to "insurance coverage."

Page 3, Point #7: The time frame of the study has been clarified.

Page 3, Point #8: The absolute effects as well as the effect size has been added to the abstract.

Page 3, Point #9: The reference to trends have been removed when not statistically significant.

Page 3, Point #10: The virgule in "private/other" has been removed. The phrase has been replaced with "non-Medicaid" coverage.

Page 3, Point #11: References to non-significant differences have been corrected.

Page 3, Point #12: The conclusion has been altered to represent the findings of the paper.

Introduction

Page 4, Point #1: The abbreviation for FPL has been removed in the text.

Results

Page 5, Point #1: The raw numbers and effect sizes have been added for the main and subgroup analyses.

Discussion

Page 6, Point #3: The primary findings are clarified and more clearly stated in the first paragraph of the discussion.

Page 7, Point #1: The basis for the conclusion on Medicaid continuity is more explicitly stated. This data was generated from a subgroup analysis of women who had Medicaid coverage for their delivery.

Page 7, Point #2: Crowd out, and its possible implications, have been more thoroughly explained.

Page 8, Point #1: The primacy claim has been removed.

Page 8, Point #2: The conclusion has been reframed to better reflect the results.

Editors Comments

Comment: 1. Thank you for your submission to *Obstetrics & Gynecology*. In addition to the comments from the reviewers above, you are being sent a notated PDF that contains the Editor's specific comments. Please review and consider the comments in this file prior to submitting your revised manuscript. These comments should be included in your point-by-point response cover letter. ***The notated PDF is uploaded to this submission's record in Editorial Manager. If you cannot locate the file, contact Katie McDermott and she will send it by email – kmcdermott@greenjournal.org.***

Response: The Editor's specific comments have been reviewed and addressed above.

Comment: 2. The Editors of *Obstetrics & Gynecology* are seeking to increase transparency around its peer-review process, in line with efforts to do so in international biomedical peer review publishing. If your article is accepted, we will be posting this revision letter as supplemental digital content to the published article online. Additionally, unless you choose to opt out, we will also be including your point-by-point response to the revision letter, as well as subsequent author queries. If you opt out of including your response, only the revision letter will be posted. Please reply to this letter with one of two responses:

1. OPT-IN: Yes, please publish my response letter and subsequent email correspondence related to author queries.

2. OPT-OUT: No, please do not publish my response letter and subsequent email correspondence related to author queries.

Response: Yes, please publish my response letter and subsequent email correspondence related to author queries.

Comment: 3. All studies should follow the principles set forth in the Helsinki Declaration of 1975, as revised in 2013, and manuscripts should be approved by the necessary authority before submission. Applicable original research studies should be reviewed by an institutional review board (IRB) or ethics committee. This review should be documented in your cover letter as well in the Materials and Methods section, with an explanation if the study was considered exempt. If your research is based on a publicly available data set approved by your IRB for exemption, please provide documentation of this in your cover letter by submitting the URL of the IRB web site outlining the exempt data sets or a letter from a representative of the IRB. In addition, insert a sentence in the Materials and Methods section stating that the study was approved or exempt from approval. In all cases, the complete name of the IRB should be provided in the manuscript.

Response: The IRB exemption letter has been uploaded to the Editorial Manager.

Comment: 4. Standard obstetric and gynecology data definitions have been developed through the reVITALize initiative, which was convened by the American College of Obstetricians and Gynecologists and the members of the Women's Health Registry Alliance. *Obstetrics & Gynecology* will be transitioning as much as possible to use of the reVITALize definitions, and we encourage authors to familiarize themselves with them. The obstetric data definitions are available at <http://links.lww.com/AOG/A515>, and the gynecology data definitions are available at <http://links.lww.com/AOG/A935>.

Response: These definitions were reviewed.

Comment: 5. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Original Research reports should not exceed 22 typed, double-spaced pages (5,500 words). Stated page limits include all numbered pages in a manuscript (i.e., title page, précis, abstract, text, references, tables, boxes, figure legends, and appendixes). Please limit your Introduction to 250 words and your Discussion to 750 words.

Response: We have incorporated revisions while adhering to the journal word limits.

Comment: 6. Specific rules govern the use of acknowledgments in the journal. Please edit your acknowledgments or provide more information in accordance with the following guidelines:

* All financial support of the study must be acknowledged.

** Any and all manuscript preparation assistance, including but not limited to topic development, data collection, analysis, writing, or editorial assistance, must be disclosed in the acknowledgments. Such acknowledgments must identify the entities that provided and paid for this assistance, whether directly or indirectly.*

** All persons who contributed to the work reported in the manuscript, but not sufficiently to be authors, must be acknowledged. Written permission must be obtained from all individuals named in the acknowledgments, as readers may infer their endorsement of the data and conclusions. Please note that your signature on the journal's author agreement form verifies that permission has been obtained from all named persons.*

** If all or part of the paper was presented at the Annual Clinical and Scientific Meeting of the American College of Obstetricians and Gynecologists or at any other organizational meeting, that presentation should be noted.*

Response: We have adhered to the rules governing acknowledgments.

Comment: 7. *The most common deficiency in revised manuscripts involves the abstract. Be sure there are no inconsistencies between the Abstract and the manuscript, and that the Abstract has a clear conclusion statement based on the results found in the paper. Make sure that the abstract does not contain information that does not appear in the body text. If you submit a revision, please check the abstract carefully. In addition, the abstract length should follow journal guidelines. The word limits for different article types are as follows: Original Research articles, 300 words. Please provide a word count.*

Response: We have revised the manuscript. The changes requested by the editor have resulted in a word count that slightly exceeds 300 words. Please feel free to edit accordingly.

Comment: 8. *Only standard abbreviations and acronyms are allowed. A selected list is available online at <http://edmgr.ovid.com/ong/accounts/abbreviations.pdf>. Abbreviations and acronyms cannot be used in the title or précis. Abbreviations and acronyms must be spelled out the first time they are used in the abstract and again in the body of the manuscript.*

Response: The manuscript has been edited accordingly.

Comment: 9. *The journal does not use the virgule symbol (/) in sentences with words. Please rephrase your text to avoid using "and/or," or similar constructions throughout the text. You may retain this symbol if you are using it to express data or a measurement.*

Response: The insurance group "private/other" has been changed to "non-Medicaid" to adhere to this rule.

Comment: 10. (Line 177) *We discourage claims of first reports since they are often difficult to prove. How do you know this is the first report? If this is based on a systematic search of the literature, that search should be described in the text (search engine, search terms, date range of search, and languages encompassed by the search). If on the other hand, it is not based on a systematic search but only on your level of awareness, it is not a claim we permit.*

Response: This phrase has been removed to adhere to word count restrictions.

Comment: 11. *Please review the journal's Table Checklist to make sure that your tables conform to journal style. The Table Checklist is available online here: http://edmgr.ovid.com/ong/accounts/table_checklist.pdf.*

Response: The Table Checklist has been reviewed.

Comment: 12. *Figure 1: Is this available in a higher resolution?*

Response: A pdf file of Figure 1 has been included.

Comment: 13. *To ensure a quality experience for those viewing supplemental digital content, the journal's publisher suggests that authors submit supplemental digital files no larger than 10 MB each. The exceptions to this rule are audio or video files, which are acceptable up to 100 MB. When submitting text files or tables as supplemental digital content with your revisions, please do not submit PDFs.*

Response: The online supplement is <10 MB and uploaded as a word document.

Reviewer 1

Introduction

Comment: *Line 67 - some clinicians may not fully understand Medicaid expansion. Perhaps include a statement that income eligibility for Medicaid varied widely prior to the ACA, from 18% FPL to 100%, etc. The authors might also consider explaining that Medicaid expansion was made optional by the Supreme Court (and the nice natural experiment this affords). Consider explaining that income eligibility for Medicaid is often more lenient during pregnancy.*

Response: We have added a statement on the variation in Medicaid eligibility prior to the ACA and clarified the expansion was at each state's discretion.

"Prior to the ACA, the income eligibility for Medicaid for non-pregnant women varied widely by state. The ACA included federal support for the expansion of state Medicaid programs to all nonelderly adults with incomes at or below 138% of the federal poverty level for those states that elected to participate."⁷

Methods

Comment: *Overall, more detail is needed in this section. Consider that the journal's readership is largely clinical. State study design in first sentence of this section. Describe diff in diff analysis technique for a non-researcher audience.*

Response: The methods have been expanded to include a basic overview of difference-in-difference analyses. In general, we attempted to write the methods to be interpretable to clinicians not familiar with these types of analyses. The technical details of the methods, full model specifications, and sensitivity analyses are included in the Online Supplement.

"We used a quasi-experimental, difference-in-difference (DID) design to compare changes in preconception insurance coverage among women with incomes at or below 138% the federal poverty level in expansion versus nonexpansion states before and after the Medicaid expansions. Difference-in-difference design uses longitudinal data to compare the effect of an intervention between an exposed and unexposed group. The differences in the outcomes pre- and post-intervention are calculated for both the exposed and unexposed groups and then compared; differences between the exposed and unexposed groups are attributed to the effect of the intervention."

Comment: *79 - Briefly add more details about PRAMS (e.g., survey study, administered within a state to postpartum women)*

Response: More information has been added in the Methods section. A full description is included in the Online Supplement.

"We used individual-level data from the Pregnancy Risk Assessment Monitoring System (PRAMS), which is administered by the Centers for Disease Control and Prevention (CDC) and overseen by state health departments.⁹ The PRAMS data set comprises survey responses from a sample of women that had a live birth; survey data is paired with birth certificate data. Patients from states with data available in the pre-policy analysis period (2009-2013) and the post-policy analysis period (2015) were included."

Comment: *Line 81: by "Medicaid coverage provisions" I think you mean income eligibility, correct? Consider clarifying.*

Response: We have made this clarification.

"We used multivariate linear regression models to compare the changes in preconception coverage between the nonexpansion and expansion states among women whose reported household incomes were at or below 138% the federal poverty level."

Comment: *Line 84/91 - consider adding rationale for including the demographics listed*

Response: We added a rationale for including the demographics in Methods.

"We compared patient demographics (maternal age, race, Hispanic ethnicity, education, marital status) before the

policy between expansion and nonexpansion states using chi-squared tests to understand differences in the baseline characteristics of women in both groups.”

Comment: *Line 97 - provide rationale for testing in these two other groups (e.g., what might it mean if the association was/wasn't found to hold true in these groups?)*

Response: The rationale for the subgroup analyses were clarified.

“The outcome was also tested in two other subgroups of women: 1) all women, regardless of income, and 2) women with prenatal Medicaid coverage. The outcome was tested in all women to compare the effects of Medicaid expansion in the larger population, as overall population uninsurance rates are commonly tracked and reported. Second, we selected the subgroup of women with Medicaid prenatal coverage to determine if the Medicaid expansion potentially resulted more women experiencing continuous Medicaid coverage between the preconception and prenatal period.”

Discussion

Comment: *Line 136: please clarify that this is not all low-income women, but just those with a live-birth*

Response: “We found an 8.6 percentage point increase in preconception Medicaid coverage among low-income women who had a live birth residing in states that expanded their Medicaid programs compared to those residing in nonexpansion states, representing a 20% increase relative to the pre-policy baseline.”

Comment: *Line 148: add disease management (preconception coverage may facilitate better management of chronic conditions prior to pregnancy, which can affect both the risk of pregnancy complications as well as the course of the chronic condition during pregnancy).*

Response: Disease management has been added but the original structure of this sentence was altered in attempts to comply with word count restrictions.

“Interventions in the preconception period, such as disease screening, disease management, and exposure avoidance counseling reduce pregnancy risks, and are associated with improved maternal and fetal outcomes.”

Comment: *The authors should be clear that this is a sample of postpartum women with a live birth. It does not include women who had a pregnancy with a subsequent miscarriage or abortion. By excluding these women, we might be overestimating the drop in uninsurance rates. Line 178 - consider changing "completed pregnancies" to "live births". Fig 1 - consider changing Y axis title from "% of pregnant women" to "% of women with a live birth" or something like that*

Response: We have attempted to make this clarification throughout the manuscript.

Reviewer #2

Comment: The only area in the paper that could more description is the section about "crowd out". I wasn't clear what that meant and felt that the finding about the shift from private to public insurance is very important. Some policy makers might find that concerning and could interpret that in ways that run counter to the larger study conclusions that increased access to postpartum health is essential for many reasons. If the authors could spend a little more time talking about that finding it would be helpful.

Response: We have attempted to clarify the principle of crowd out and its potential implications in this context.

“We found the increase in preconception Medicaid coverage was partially accounted for by a decrease in private insurance. Such private insurance “crowd out,” in which privately insured individuals switch to Medicaid once they become newly eligible, has been demonstrated in some studies of the Medicaid expansion in other populations, though results have been mixed.^{8,13} Crowd out could be beneficial in this population as fewer low-income women may experience coverage changes from non-Medicaid insurance preconception to Medicaid during their pregnancy. Switching between insurance types is associated with access barriers and care delays.¹⁴ Furthermore, compared to private coverage, Medicaid coverage has lower cost-sharing and provides additional benefits, such as social services, nutrition, and transportation in some states, which may reduce cost-related and other access barriers for low-income women.”

Reviewer #3

Comment: *Line 76: Minor: this sentence uses the wording "change in outcomes" and I immediately thought about change in pregnancy outcomes (LBW, PTB, etc.). I think it might be clearer to say changes in self-reported insurance coverage since that is your only outcome.*

Response: This phrasing has been changed to "changes in preconception coverage."

Comment: *Line 91: Please provide a rationale for including annual state unemployment rates among reproductive age women in your analysis.*

Response: The rationale for including state unemployment rate has been included.

"As insurance coverage is strongly correlated with employment, state unemployment rates were included to adjust for extrinsic economic factors that may be influencing uninsurance rates during the same time period."

Comment: *Would you list the name of the states in the results or under Table 1? It is in the appendix but many readers may not read that and it would be good to have that information somewhere more accessible.*

Response: The names of the states have been included in the manuscript.

"We identified 30,495 low-income women from 8 expansion states (HI, IL, MD, MI, NJ, OR, WA, WV) and 26,561 patients from 7 nonexpansion states (AR, ME, MO, NE, OK, UT, WY)."

Comment: *Line 110: Did you consider do statistical testing on the distributions for Table 1? The difference in education is quite striking and likely highly significant. When I read this sentence initially I thought you were attributing higher educational attainment to Medicaid expansion.*

Response: P-values have been noted at the bottom of Table 1.

Comment: *Line 128: You note that there were no significant changes in uninsurance in your sensitivity analysis but that is true for your main analysis as well. It says that in the discussion but not in the results although it is evident from the CIs.*

Response: The findings from the main analysis are clarified.

"Table 2 reports the unadjusted and adjusted results from the DID models. The percent of women with preconception Medicaid coverage was 30.8% pre-policy and 35.6% post-policy in nonexpansion states and 43.2% pre-policy and 56.8% post-policy in expansion states. There was a significantly greater increase in Medicaid coverage in expansion states after the policy implementation (unadjusted DID estimate +8.5 percentage points [95% confidence interval (CI) 1.2 to 15.9], adjusted DID estimate +8.6 [95%CI 1.1 to 16.0]). Rates of preconception uninsurance among low-income women were 44.2% pre-policy and 34.4% post-policy in nonexpansion states and 37.4% pre-policy and 23.5% post-policy in expansion states. There was no significant difference in the changes in uninsurance between the two groups in the post-policy period (unadjusted DID estimate -3.9 percentage points [95%CI -10.6 to 2.8], adjusted DID estimate -4.1 [95%CI -11.1 to 2.9]). In this population of low-income women, non-Medicaid insurance coverage was 25.3% pre-policy and 30.5% post-policy in nonexpansion states and 19.4% pre-policy and 19.7% post-policy in expansion states. Relative to non-expansion states, there was a significant decrease in non-Medicaid coverage in the expansion states in the post-policy period (unadjusted DID estimate -4.8 [95%CI -8.5 to -1.2], adjusted DID estimate -4.7 [95%CI -8.3 to -1.1])."

Comment: *Line 155: Please define or better describe the term "crowd-out". I assume here it is the result of the ability to be on Medicaid at a slightly higher income that is more cost effective to women than remaining on private insurance with perhaps fewer benefits.*

Response: We have included a better description and expanded the discussion on this phenomenon.

"We found the increase in preconception Medicaid coverage was partially accounted for by a decrease in private insurance. Such private insurance "crowd out," in which privately insured individuals switch to Medicaid once they become newly eligible, has been demonstrated in some studies of the Medicaid expansion in other populations, though results have been mixed.^{8,13} Crowd out could be beneficial in this population as fewer low-

income women may experience coverage changes from non-Medicaid insurance preconception to Medicaid during their pregnancy. Switching between insurance types is associated with access barriers and care delays.¹⁴ Furthermore, compared to private coverage, Medicaid coverage has lower cost-sharing and provides additional benefits, such as social services, nutrition, and transportation in some states, which may reduce cost-related and other access barriers for low-income women.”

Comment: Line 170: You mention that the question at the time of delivery has been validated but preconception insurance which you are studying here has not. How were the questions asked in terms of coverage and in terms of preconception vs prenatal care period? Were women asked if they switched insurance based on what they reported preconception?

Response: Women were asked about the type of insurance coverage they had in the 1 month prior to conception and the type of insurance they had for the delivery. Women were not explicitly asked if they switched insurance plans. The reason why previous studies have examined the validity of the PRAMS question on insurance for delivery and not the question on preconception insurance is because payment for delivery (and not preconception or prenatal coverage) is included on the birth certificate and can serve as a gold standard comparison.

Comment: General comment: Are you able to show in this and another manuscript if timing of enrollment in PNC changed over time? You mention the benefits of continuous insurance based on the literature but can you determine if any of these benefits were achieved based on this policy changes using PRAMS data?

Response: We are currently examining the effects of this policy on birth outcomes and prenatal care using a different data set as the PRAMS sample size was too small to detect downstream effects on health outcomes. These results will be forthcoming.

Comment: Figure: Why did you choose to show the unadjusted trends rather than the adjusted trends? If there was space permitted by the journal, I would include all 9 panels - for low income women, for all women, and for women on Medicaid at the time of delivery.

Response: We believe it’s helpful to show unadjusted trends since these plots give the reader a direct view of the raw data. In difference-in-difference analysis in particular, it is common practice to show unadjusted trends to allow the reader to visually evaluate the plausibility of the parallel trends assumption (without regression adjustment), i.e. to compare the trends in the outcomes in the pre-policy period between the exposed and control group.

Reviewer #4

Comment: Overall the expanded Medicaid states always are better off than the non-expanded states. The full effect of the ACA occurred in 2014 although the law was signed in 2010. The message of the paper seems a bit mixed insofar as are we talking about the effect of the law on preconception insurance coverage from existence (i.e. 2010) or the full implementation of the law (i.e. 2014). Even in 2009 there are differences across these states that would arguably have nothing to do with the ACA. Beyond this, two more years beyond 2015 would be nice to see plotted to understand if the deflection at 2014 is real or artificial.

Response: We have focused on one component of the ACA, which was not equally applied across all states in the United States – Medicaid expansion. While the law was signed in 2010, the major provisions, including Medicaid expansion, individual mandate, and health insurance exchanges, did not go into effect until 2014. We have used all available data to derive the current conclusions; unfortunately, there is a lag between data collection, availability, and analysis. While it would be ideal to have many more years post-expansion, health policies are being evaluated and changed frequently, often at a pace much faster than these types of analyses can be conducted. Thus, we are hoping to add these initial effects to the literature on the ACA in pregnant women. We plan to continue to study the impact of these policy changes with additional analyses as more data becomes available.

Comment: The accuracy of self-reported insurance coverage, while mentioned in the limitations as perhaps less of a concern (Line 169), may vary by patient demographics. Among the targeted population, are the assurances still OK?

Response: Self-reported measures are always subject to the possibility of reporting and/or recall error and thus we acknowledged this limitation in the discussion. However, previous studies of the reliability of the validity of PRAMS insurance measures, including Medicaid payment (which would only apply to low-income women), have shown high concordance with other data sources (e.g. birth certificate data). We cite two of these studies in the limitations. While the PRAMS preconception insurance question has not been validated because of a lack of a readily comparable gold standard, this question is asked in a similar way to the validated measure and the data is collected in the same survey modality as the delivery insurance questions. Further, accuracy of reporting is only a threat to this study design if the reporting error is differential *over time* between the two groups, which we have no a priori reason to believe would be the case.

Comment: These data seem a bit like a shell game. There is no identified change in the rates of uninsured patients across the state-based cohorts BUT we shifted private insured patients to Medicaid. The assumption is this was good because it avoided "churning." This is a worrisome assumption because while having vs. not having insurance would be recognized to matter (e.g. Line 150-151), its less clear the coverage swapping matters.

Response: We clarified the concept of crowd out and how this may be beneficial to women.
“We found the increase in preconception Medicaid coverage was partially accounted for by a decrease in private insurance. Such private insurance “crowd out,” in which privately insured individuals switch to Medicaid once they become newly eligible, has been demonstrated in some studies of the Medicaid expansion in other populations, though results have been mixed.^{8,13} Crowd out could be beneficial in this population as fewer low-income women may experience coverage changes from non-Medicaid insurance preconception to Medicaid during their pregnancy. Switching between insurance types is associated with access barriers and care delays.¹⁴ Furthermore, compared to private coverage, Medicaid coverage has lower cost-sharing and provides additional benefits, such as social services, nutrition, and transportation in some states, which may reduce cost-related and other access barriers for low-income women.”

Comment: The first 2 paragraphs of the discussion seem in conflict with one another. Line 139 says, "reduction in uninsurance was not statistically significant" but then Line 144 says "1/2 of the increase in preconception Medicaid coverage was accounted for by a decrease in preconception uninsurance." If something is merely a trend then is it fair to devote a paragraph on the assumption that trend is indeed truth?

Response: Paragraphs 1 and 2 of the discussion have been reframed to better reflect the results of this study.

Comment: Line 150 seems unfair in light of the fact that the study did not find these women had no insurance (the rate of uninsured was NOT reduced) but appeared to have different insurance. Perhaps "churning" is bad but it's a different argument.

Response: We have restructured this paragraph (#2 in the discussion) to address the comments raised by several reviewers.

Statistical Editor

Comment: There is a lot of detail in the supplement which should be summarized in the main body of the paper. For example a flow diagram showing the relationship of "all women" to "women < 138% of federal poverty level" to "women reporting medicaid prenatal coverage" would be helpful (see Table A1, not necessarily by year, but by epoch).

Response: In response to other review comments, we added additional detail to the Methods to more clearly describe the study design, the PRAMS data, regression adjustment, and subgroup analyses. We hope this helps to add some of this detail to the main body of the text (while staying with text and table/figure limits). If there is additional information that should be moved from the Supplement into the main body of the text, including a flow diagram (perhaps instead of the existing Table 1), we would be happy to provide that. The subsample has also been more explicitly noted in the results.

"We identified 30,495 of 76,587 women who were low income from 8 expansion states (HI, IL, MD, MI, NJ, OR, WA, WV) and 26,561 of 61,910 who were low income from 7 nonexpansion states (AR, ME, MO, NE, OK, UT, WY)."

Comment: Also, the appendix (e methods, page 2) cites that the CDC set a threshold for minimum response rates of 65% for 2007-2013 and 60% thereafter. Those response rates should be cited as a potential limitation to the study, particularly if the rates were differential for expansion vs non-expansion States during either of the time epochs. Need to provide more information regarding the response rates for the samples studied.

Response: This potential limitation has been addressed in the Discussion.

"Furthermore, states' annual response rates for the PRAMS survey are not published, though a minimum threshold set by the CDC must be met to be published; the results could be biased if the characteristics of responders changed differentially between the nonexpansion and expansion groups over time."

Comment: The multiple adjustors were cited on lines 90-92 and Tables 2 and 3 cite both the unadjusted and adjusted difference in differences with both 95% CI and their p-values. If the CIs range includes 0 for this kind of estimate, then the inference is that it is NS at a $p < .05$ threshold. Therefore, line 49, and all of the other places where your data shows a non significant change in the article need to be revised to state there is no difference.

Response: All references to findings with $p > 0.05$ have been edited to note their non-significance.

Comment: As space permits, I would like to include both crude and adjusted estimates in the Abstract, although the latter certainly take precedence. Perhaps the Abstract could be amended to clearly indicate in words which changes were statistically NS, but just numerical. I'm sure it's clear to the Authors, but to the first time reader, the writing may not be obvious.

Response: We attempted to include both crude and adjusted estimates, but the word count exceeded 400 words. The final version of the abstract does not include the crude estimates. However, we have included the version of the abstract with both estimates should the Editor wish to use this paragraph instead.

Results section with both crude and adjusted estimates:

"Results: The study sample included 30,495 women from 8 states that expanded Medicaid under the ACA and 26,561 patients from 7 states in that did not. The rate of preconception Medicaid coverage was 30.8% pre-policy and 35.6% post-policy in nonexpansion states and 43.2% pre-policy and 56.8% post-policy in expansion states. There was a significantly greater increase in Medicaid coverage in expansion states (unadjusted DID estimate +8.5 percentage points [95%CI 1.2 to 15.9], adjusted DID estimate +8.6 [95%CI 1.1 to 16.0]). Rates of preconception uninsurance were 44.2% pre-policy and 34.4% post-policy in nonexpansion states and 37.4% pre-policy and 23.5% post-policy in expansion states. There was no significant difference in the changes in uninsurance between the two groups in the post-policy period (unadjusted DID estimate -3.9 percentage points [95% confidence interval (CI) -10.6 to 2.8], adjusted DID estimate -4.1 [95%CI -11.1 to 2.9]). Non-Medicaid insurance coverage was 25.3% pre-policy and 30.5% post-policy in nonexpansion states and 19.4% pre-policy and 19.7% post-policy in expansion states. Relative to nonexpansion states, there was a significant decrease in non-Medicaid coverage in the expansion states in the post-policy period (unadjusted DID estimate -4.8 [95%CI -

8.5 to -1.2], adjusted DID estimate -4.7 [95%CI -8.3 to -1.1]). The results were robust to alternate model specifications and study period definitions.”

Comment: Also, the hypothesis seems to be to evaluate how ACA Medicaid expansion affected "preconception insurance coverage among low-income women". The effect seems clear from Tables 2 and 3, from both the crude and adjusted analyses. That is, Medicaid coverage increased, private insurance decreased and both were statistically significant, albeit numerically modest changes. However, the overall effect was a NS change in uninsured rates for those women during preconception. The absolute rates of uninsured were quite different in expansion vs non-expansion States, but the change (difference pre and post ACA) for one cohort vs the other (the difference in differences) all had p-values much greater than .05. I don't think that the Abstract reflects that summary very well. Especially lines 55-56 says only part of that conclusion, since Medicaid expansion occurred, but private insurance coverage decreased and the net effect was no change in expansion vs non-expansion States. Both cohorts had lower rates of non-insured (and the non-expansion States had higher uninsured rates before and after ACA expansion), but the difference pre and post ACA by difference in differences was not statistically different.

Response: These findings have been more explicitly stated Abstract, Results, and Discussion.

From: [REDACTED]
To: [Randi Zung](#)
Subject: Re: Your Revised Manuscript 18-1361R1
Date: Thursday, September 6, 2018 5:02:52 PM
Attachments: [18-1361R1 ms \(9-6-18v3\) mc.docx](#)
[Appendix - Revised \(9-6-18\) mc.docx](#)

Randi, I have labeled all components of the Online Supplement with an individual Appendix # and updated the references throughout the manuscript.
Please let me know how this looks.
Thanks!
Mark

On Sep 6, 2018, at 3:42 PM, Randi Zung <RZung@greenjournal.org> wrote:

External Email - Use Caution

Dear Dr. Clapp:

Thank you for your prompt reply.

In version 3 of your manuscript (attached here), we need you to insert citation numbers for the items that appear in your Appendix. They should appear as "Appendix 1," "Appendix 2," and so on. I have edited your manuscript and Appendix file for the first two components. Would you please add the correct numbers for the rest of your Appendix components?

The latest versions of your manuscript and Appendix are attached. Please send me your updated files when you are finished.

Thanks,
Randi

From: Clapp, Mark A.,M.D.,M.P.H. [REDACTED]
Sent: Thursday, September 6, 2018 3:24 PM
To: Randi Zung <RZung@greenjournal.org>
Subject: Re: Your Revised Manuscript 18-1361R1

Ms. Zung,

I have addressed all of the comments below and responded directly in the manuscript. I have attached the updated manuscript (with track changes), updated appendix (with list of PRAMS working group members), and the STROBE checklist.

I have removed the in-text references to the individual tables/figures in Appendix and

instead directed the reader to the Appendix. Do you want me to separate the Appendix items into Appendix 1, 2, etc.?

Please let me know what other changes/edits are needed.

Thanks!

Mark

On Sep 6, 2018, at 9:37 AM, Randi Zung <RZung@greenjournal.org> wrote:

External Email - Use Caution

Dear Dr. Clapp:

Your revised manuscript is being reviewed by the Editors. Before a final decision can be made, we need you to address the following queries. Please make the requested changes to the latest version of your manuscript that is attached to this email. **Please track your changes and leave the ones made by the Editorial Office.** Please also note your responses to the author queries in your email message back to me.

1. General: The Editor has made edits to the manuscript using track changes. Please review them to make sure they are correct.
2. Please provide a completed STROBE checklist. The checklist is available at <http://www.editorialmanager.com/ong/default.aspx>.
3. Please cite this as Appendix 1 and include the list of names in your appendixes file. See query on page 6. Your Appendix file is attached so you can make these edits directly to the file. Please send an updated file back to us.
4. Line 65 and Table 2: Table 2 says 34.3%. Which is correct? Data should match throughout the submission.
5. Line 133: Please correct your in-text citations for your appendixes, as well as your appendixes file.
 - a. Each item should be cited in order in the text as "Appendix 1, "Appendix 2," etc., regardless of whether it's text, table or a figure.
 - b. Reorder/renumber your tables as needed.
 - c. There is no in-text citation for "Table A2."
6. Line 135: Would you add more details about why the study was exempt?

7. Line 138: It's unclear what the totals (76,587 and 61,910) represent. Do these represent the total # of women in the PRAMS data base for the expansion and non-expansion states and the smaller numbers representing of the total those that are low income.? So to be clear, the study is confined to 30,495 women in the expansion states and 26,561 in the non-expansion states. Correct?

8. Line 145: The main analysis groups being 30,495 and 26,561?

9. Line 162: Could you please remind us here who is represented by subgroups? I had to look back to the M&M section to figure this out and quick reminder here may be helpful to the readers.

To facilitate the review process, we would appreciate receiving a response within 48 hours.

Best,
Randi Zung

--
Randi Zung (Ms.)
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<Appendix - Revised.docx><18-1361R1 ms (9-6-18v2).docx>

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<Appendix - Revised (9-6-18).docx><18-1361R1 ms (9-6-18v3).docx>

From: [REDACTED]
To: [Stephanie Casway](#)
Subject: Re: O&G Figure Revision: 18-1361
Date: Wednesday, September 5, 2018 10:40:19 AM

Looks great! Do we need to write out “confidence interval” instead of CI? Will leave that decision up to you.

Thanks!

Mark

On Sep 5, 2018, at 10:37 AM, Stephanie Casway <SCasway@greenjournal.org> wrote:

External Email - Use Caution

Hi Mark,

Attached you will find an updated legend with A, B, and C marked. My apologies for the oversight!

From: Clapp, Mark A., M.D., M.P.H. [REDACTED]
Sent: Wednesday, September 5, 2018 10:35 AM
To: Stephanie Casway <SCasway@greenjournal.org>
Subject: Re: O&G Figure Revision: 18-1361

Hi Stephanie, where on the figure or legend will A/B/C be labeled?

Thanks!

Mark

On Sep 5, 2018, at 10:29 AM, Stephanie Casway <SCasway@greenjournal.org> wrote:

External Email - Use Caution

Good Morning Dr. Clapp,

Your figure has been edited, and PDFs of the figure and legend are attached for your review. Please review the figure and legend CAREFULLY for any mistakes.

PLEASE NOTE: Any changes to the figures must be made now. Changes made at later stages are expensive and time-consuming and may result in the delay of your article's publication.

To avoid a delay, I would be grateful to receive a reply no later than Friday, 9/7. Thank you for your help.

Best wishes,

Stephanie Casway, MA
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Obstetrics & Gynecology
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Washington, DC 20024
Ph: (202) 314-2339
Fax: (202) 479-0830
scasway@greenjournal.org

<18-1361 Fig 1 (9-5-18 v1).pdf><18-1361 Legend.pdf>

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<18-1361 Legend.pdf>