JOINT COMMITTEE ON FINANCIAL SERVICES
TESTIMONY OF NARAL PRO-CHOICE MASSACHUSETTS IN SUPPORT OF
H. 1196: *An Act ensuring access to full spectrum pregnancy care*
S. 673: *An Act ensuring access to full spectrum pregnancy care*
July 8, 2021

Chairs Murphy, Crighton, and members of the Committee:

The mission of NARAL Pro-Choice Massachusetts (NPCM), a statewide grassroots organization consisting of over 26,000 members, is to guarantee every individual full and equal access to a range of reproductive health options, including preventing unintended pregnancy, bearing healthy children, and choosing safe, legal abortion care.

NPCM strongly <u>SUPPORTS</u> passage of H. 1196 and S. 673, *An Act ensuring access to full spectrum pregnancy care*.

A right to reproductive health care — including care for pregnancy, delivery, abortion, and miscarriage — is not a real right unless every individual is able to access that care. One of the biggest barriers to accessing pregnancy and abortion-related care is the ability to pay. Massachusetts law, as currently written, requires insurers to offer coverage for childbirth and treatment of miscarriages *but permits cost-sharing*. This is insufficient for a state that prides itself on being a leader in equality and justice for all its residents. Economic, gender, and racial equality are all unattainable without expanded coverage and restrictions on cost-sharing.

While most people in Massachusetts have some form of health insurance, insurance plans increasingly include steep deductibles and copays. In 2015, nearly one million Massachusetts residents had a high deductible health plan.[1] Massachusetts families with employment-based insurance coverage still "devoted more than a quarter of all earnings to health care."[2] Additionally, the Massachusetts Health Policy Commission (HPC) calculates that between 2016

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[1] Massachusetts Medical Society, *Assessment of the Impact of High-Deductible Health Plans on Patient Health and the Financial Impact on Medical Practices* (2017), *available at* http://www.massmed.org/News-and-Publications/Research-and-Studies/High-Deductible-White-Paper-20.17/. A high deductible health plan, as defined by the Internal Revenue Service (IRS), is any insurance plan with an annual deductible of over $1,350 for single coverage or $2,700 for family coverage. Center for Health Information and Analysis (CHIA), *Findings from the 2019 Massachusetts Health Insurance Survey* (Apr. 2019) on 45, available at https://www.chiamass.gov/assets/docs/r/survey/mhis-2019/2019-MHIS-Report.pdf. Additionally, nearly half of Massachusetts residents were not offered choices among employer-provided health insurance plans.

[2] HPC DataPoints, *Issue 19: Persistently High Out-of-Pocket Costs Make Health Care Increasingly Unaffordable and Perpetuate Inequalities in Massachusetts*, Mass.gov (n.d.), *avaialble at* https://www.mass.gov/info-details/hpc-datapoints-issue-19-persistently-high-out-of-pocket-costs-make-health-care.

and 2018 approximately “40 cents of every additional dollar earned by Massachusetts families” went towards health care expenditures.[3]

Women disproportionately bear the burden of high out-of-pocket health care costs. In the United States, the most common cause of hospitalization is childbirth, and the cost of maternity and newborn care is greater than any other hospital expense.[4] That is largely the reason why women between the ages of 19 and 44 spent 62% more per capita on health care costs than their male counterparts in 2014.[5] Physician and clinic services spending — primarily because of the demands of pregnancy care — are over 91% higher for females than for males.[6] From this perspective, it becomes undeniable that full spectrum pregnancy care and health equity are issues of gender equality.

Full spectrum pregnancy care is also an issue of racial equity. Delivery-related complications, which raise the cost of maternity care and childbirth, are increasingly common and occur with greatest frequency among women of color and low-income women.[7] Women of color — particularly Black and Hispanic women — and low-income individuals are also among the groups most likely to report facing issues with affording their health care.[8] Additionally, Black and Hispanic women are more likely to engage in self-managed abortion care owing to affordability concerns.[9] No Bay State resident should have to skip or ration pregnancy-related services owing to costs.

As part of the bill review process, the Center for Health Information and Analysis (CHIA) completed a Mandatory Benefit Review (MBR) of this legislation that detailed several important statistics that underscore the viability and importance of this legislation. **Based on our own examination of annual health care spending,[10] the MBR indicates that this bill would**

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[3] HPC DataPoints, *Issue 19: Persistently High Out-of-Pocket Costs Make Health Care Increasingly Unaffordable and Perpetuate Inequalities in Massachusetts*

[4] Sakala C, Corry MP, Fund MM. *Evidence-Based Maternity Care: What It Is and What It Can Achieve*. New York, NY: Milbank Memorial Fund; 2008.

[5] Centers for Medicare and Medicaid Services, *U.S. Personal Health Care Spending by Age and Gender 2010 Highlights*, CMS.gov (2014), available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/AgeandGenderHighlights.pdf.

[6] Centers for Medicare and Medicaid Services, *U.S. Personal Health Care Spending by Age and Gender 2010 Highlights*.

[7] See Berns SD, Kott A, eds. Toward Improving the Outcome of Pregnancy III: Enhancing Perinatal Health Through Quality, Safety and Performance Initiatives. White Plains, NY: March of Dimes National Foundation; 2010; Elixhauser A, Wier LM. Complicating Conditions of Pregnancy and Childbirth, 2008. Rockville, MD: Agency for Healthcare Research and Quality, HCUP STATISTICAL BRIEF 113 (2008), available at http://www.hcup-us. ahrq.gov/reports/statbriefs/sb113.pdf. Accessed January 15, 2013.

[8] Centers for Medicare and Medicaid Services, *U.S. Personal Health Care Spending by Age and Gender 2010 Highlights*.

[9] Jocelyn Solis-Moreira, *Study: Self-Managed Abortions Rise Alongside Abortion Restrictions*, Verywell Health, Dotdash (Jan. 4, 2021), www.verywellhealth.com/self-managed-abortions-supreme-court-abortion-pill-restriction-5095393.

[10] Center for Health Information and Analysis (CHIA), *Annual Report: Performance of the Massachusetts Health Care System*, March 2021, p. 5.

result in an increased cost for insurers equal to less than 1/10th of 1% of all health care spending in Massachusetts. This miniscule increase in spending could have a tremendous impact on the reduction of Black maternal mortality rates, as well as increase gender equity.

An Act ensuring access to full spectrum pregnancy care would require health insurance plans to cover all pregnancy-related care, including abortion care, prenatal care, childbirth, miscarriage management, and postpartum care, without any kind of cost-sharing. This would mean that women covered by state-regulated insurance plans in Massachusetts would be able to access medically necessary reproductive health care. This would help reduce economic disparities and enable doctors and patients to make the medical decision that is best for the patient without fear of cost or crippling medical debt, and would empower women deciding how and when they bear children.

Please give a favorable report to H. 1196 and S. 673, *An Act ensuring access to full spectrum pregnancy care*.

I. MASSACHUSETTS MUST HELP ENSURE ACCESS TO A FULL SPECTRUM OF REPRODUCTIVE HEALTH OPTIONS AND ENSURE THAT COST IS NOT A BARRIER TO RESIDENTS' REPRODUCTIVE HEALTH CARE CHOICES.

Lack of affordability of health care is resulting in an unmet need. Data from 2019 indicates that 27% of Massachusetts residents reported an inability to access needed medical care because of the cost of care within the previous year.[11] Beyond those who couldn't access care owing to cost, 48% of Bay Staters experienced difficulty accessing care because of affordability concerns.[12] For residents at or below 138% of the FPL (Federal Poverty Level), 68% report facing affordability issues.[13] Over one-third of insured residents faced an unexpected medical bill during the period in question.[14]

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[11] Center for Health Information and Analysis (CHIA), *Findings from the 2019 Massachusetts Health Insurance Survey* (Apr. 2019) at 46, *available at* https://www.chiamass.gov/assets/docs/r/survey/mhis-2019/2019-MHIS-Report.pdf.

[12] Center for Health Information and Analysis (CHIA), *Findings from the 2019 Massachusetts Health Insurance Survey* (Apr. 2019) at 6.

[13] Center for Health Information and Analysis (CHIA), *Findings from the 2019 Massachusetts Health Insurance Survey* (Apr. 2019) at 6. Among the affordability issues reported by Massachusetts residents, problems paying family medical bills was a concern for 16% of respondents; family medical debt concerned 17% of respondents; spending a high share of family income on out-of-pocket health care expenses concerned 15% of respondents; and having unmet need for health care due to costs affected 27% of respondents. *Id*. at 7.

[14] Center for Health Information and Analysis (CHIA), *Findings from the 2019 Massachusetts Health Insurance Survey* (Apr. 2019) at 7. Unexpected medical bills may come in the form of an unplanned pregnancy. In 2010, 47% of all Massachusetts pregnancies — or approximately 54,000 — were unintended. Guttmacher Institute, *State Facts About Unintended Pregnancy: Massachusetts* (2016), available at https://www.guttmacher.org/sites/default/files/factsheet/ma_18.pdf. Of these pregnancies, 43% were carried to term, 44% were terminated, and the remainder resulted in a miscarriage. *Id*.

Additionally, the number of Massachusetts residents on high deductible health plans (HDHPs) is significant and continues to grow: **over 1.2 million members and counting.**[15] At this point, approximately 36% of Massachusetts residents with private insurance are on HDHPs.[16] HDHPs, particularly among the small- and mid-sized Employer-Sponsored Insurance (ESI) plans and unsubsidized individual purchasers, experience the highest out of pocket health care costs growth rates: above 7%.[17] More than half, 52%, of the Massachusetts residents enrolled in HDHPs dealt with affordability issues in 2019.[18] While only 19% of Massachusetts residents with private health insurance thought it was necessary to forgo medical care to contain costs, a larger proportion, 31% of members insured with HDHPs, have.[19]

As a result of these factors, 17% of residents reported having family medical debt.[20] Most startlingly, **85% of this medical debt was incurred while the resident was already insured**.[21] This is owing, in part, to the fact that member cost-sharing and premiums are increasing at a faster rate than either wages or inflation.[22]

When situated within this context, it comes as no surprise that cost is currently a barrier to many Bay State residents seeking to start a family, end a pregnancy, or even just look after their own health following the birth of a child. In a recent study by Center for Health Information and Analysis (CHIA), **"birth of a child" was a reason stated in 13% of Massachusetts residents who reported having difficulty affording family medical bills** in the 12 months prior to the survey.[23] This is outrageous and is a problem that is within this legislature's authority to address.

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[15] Center for Health Information and Analysis (CHIA), Performance of the Massachusetts Health Care System: Annual Report October 2019, at 6.

[16] Center for Health Information and Analysis (CHIA), AN INSIDE LOOK: Affordability Issues are More Common in High Deductible Health Plans (Mar. 2021) at 46, https://www.chiamass.gov/assets/docs/r/pubs/2021/Inside-Look-High-Deductible-Plans.pdf

[17] Center for Health Information and Analysis (CHIA), Performance of the Massachusetts Health Care System: Annual Report October 2019, at 7.

[18] Center for Health Information and Analysis (CHIA), AN INSIDE LOOK: Affordability Issues are More Common in High Deductible Health Plans. Compare this with only 39% of privately insured residents not on a HDHP. *Id*.

[19] Center for Health Information and Analysis (CHIA), AN INSIDE LOOK: Affordability Issues are More Common in High Deductible Health Plans (Mar. 2021).

[20] Center for Health Information and Analysis (CHIA), *Findings from the 2019 Massachusetts Health Insurance Survey* (Apr. 2019) at 46.

[21] Center for Health Information and Analysis (CHIA), *Findings from the 2019 Massachusetts Health Insurance Survey* (Apr. 2019) at 46.

[22] Center for Health Information and Analysis (CHIA), Performance of the Massachusetts Health Care System: Annual Report October 2019, at 5.

[23] Center for Health Information and Analysis (CHIA), *Findings from the 2019 Massachusetts Health Insurance Survey* (Apr. 2019) on 52. This is part of what forced 13.4% of "Massachusetts residents to resort to skipping needed medical care as a method of attempting to lower health care costs for themselves or their families. When only considering residents aged 19-64, the number is even higher: 15.8%. *Id*.

A. Miscarriage is the most common pregnancy complication and should be destigmatized through the removal of cost-sharing.

The most common pregnancy complication is miscarriage.[24] Some estimates indicated that between 15-20% of clinically recognized pregnancies end with a miscarriage within the first twenty weeks.[25] Other studies estimate that 25-50% of known pregnancies end in miscarriage prior to 14 weeks.[26] For these pregnancies and losses, the cost of medical care can be staggering.[27] If early enough in gestation, medication management for miscarriage costs around $500-600.[28] A surgical dilation and curettage ("D&C"), a medical procedure used to remove the tissue from inside the uterus, can range from $250-$1400 with insurance; without insurance a D&C can cost closer to $4,000-$9,000.[29] Those figures generally assume a complication free procedure, with complications the cost of the procedure, anesthesiologists, pathologists, etc. can be closer to $13,000 to $17,000.[30]

This is a potentially catastrophic financial blow to a woman already experiencing a devastating loss. The looming threat of medical bills after an emotionally draining miscarriage "can exponentially exacerbate or even thwart the grieving process."[31] Additionally, as medical bills come in, they serve as a traumatic itemized reminder of the pregnancy loss.[32]

An Act ensuring access to full spectrum pregnancy care would reform our state laws by requiring that all Massachusetts regulated health plans cover the full spectrum of pregnancy-related care, including miscarriage, without any cost-sharing or copays. This will guarantee that no one will ever have to suffer the indignity of receiving a bill after suffering a miscarriage or losing a pregnancy.

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[24] Katherine Hobson, *People Have Misconceptions About Miscarriage, And That Can Hurt*, NPR (May 8, 2015, 9:05 AM), *available at* https://www.npr.org/sections/health-shots/2015/05/08/404913568/people-have-misconceptions-about-miscarriage-and-that-hurts.
[25] Katherine Hobson, *People Have Misconceptions About Miscarriage, And That Can Hurt*.
[26] Jana L. Allison, Rebecca S. Sherwood, & Danny J. Schust, *Management of First Trimester Pregnancy Loss Can Be Safely Moved Into the Office*, 4 REV. OBSTET. GYNECOL.5 (2011).
[27] Jana L. Allison, Rebecca S. Sherwood, & Danny J. Schust, *Management of First Trimester Pregnancy Loss Can Be Safely Moved Into the Office*.
[28] *See* Jessica Grose, The Cost of a Miscarriage, SLATE.com (Mar. 26, 2015), *available at* https://slate.com/human-interest/2015/03/the-cost-of-a-miscarriage-we-talk-about-the-emotional-pain-but-not-the-financial-hurt.html; Haley Goldberg, Here's How Much My Miscarriage Cost—And Why I'm Sharing My Story, SELF.com (Feb. 24, 2017), *available at* https://www.self.com/story/miscarriage-costs; Catherine Pearson, *After Miscarriage Come The Bills*, HUFFINGTON POST (Apr. 4, 2019), *available at* https://www.huffpost.com/entry/after-a-miscarriage-next-come-the-bills_l_5c950630e4b0a6329e15eb83; Lisa H. Harris, Vanessa K. Dalton, & Timothy R. B. Johnson, *Surgical management of early pregnancy failure: history, politics, and safe, cost-effective care*, AM. J. OF OBSTETRICS & GYNECOLOGY 445e.1 (May 2007).
[29] *Id*.
[30] *Id*.
[31] Jessica Zucker, *The Cost of Miscarriage is High — Not Just Emotionally, But Financially*, Health.com (Feb. 26, 2021), *available at* https://www.health.com/money/miscarriage-symptoms-side-effects-costs.
[32] Jessica Zucker, *The Cost of Miscarriage is High — Not Just Emotionally, But Financially*.

B. Abortion must be ensured as a meaningful right through requiring insurance plans to offer coverage for the procedure without cost-sharing.

A right to choose is meaningless if that choice cannot be accessed due to financial barriers. Furthermore, "how women pay for abortions may also influence at what stage in the pregnancy they are able to do so."[33] Abortions in the first trimester typically average $480,[34] where second trimester abortions average closer to $850.[35] Still, some women pay $3,500 or more for their abortions.[36] Bear in mind, this is just the cost of the procedure[37]:

> After navigating extreme restrictions and logistical needs to get to the clinic, another problem may arise for some patients: additional fees, which can range from $50-250 (on top of an average cost of $500 for a first trimester abortion), for factors entirely out of the patient's control, such as having a negative blood type, being over a certain weight, or having a twin pregnancy. Although additional fees are common among various medical procedures, the lack of public and private coverage for abortion costs makes them difficult for some to afford.[38]

In one study, 41% of all abortion patients indicated it was "somewhat or very difficult to pay for the procedure."[39] The high out of pocket costs are not because of a lack of insurance; in fact, in one of the largest national studies on abortion, insurance, and costs found that while only 36% of the patients surveyed lacked health insurance, 69% were paying out of pocket for the

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[33] Adam Sonfield, *Restrictions on Private Insurance Coverage of Abortion: A Danger to Abortion Access and Better U.S. Health Coverage,* Guttmacher Institute (Aug. 30, 2018), www.guttmacher.org/gpr/2018/06/restrictions-private-insurance-coverage-abortion-danger-abortion-access-and-better-us#.

[34] *See*, Heather D. Boonstra, *Abortion in the Lives of Women Struggling Financially: Why Insurance Coverage Matters*, Guttmacher Institute (21 Sept. 2018), www.guttmacher.org/gpr/2016/07/abortion-lives-women-struggling-financially-why-insurance-coverage-matters.; Rachel K. Jones, Ushma D. Upadhyay, and Tracy A. Weitz, At What Cost? Payment for Abortion Care by U.S. Women, 23 Women's Health Issues e173, e175 (2013), available at https://www.guttmacher.org/sites/default/files/pdfs/pubs/journals/j.whi.2013.03.001.pdf.

[35] Rachel K. Jones, Ushma D. Upadhyay, and Tracy A. Weitz, *At What Cost? Payment for Abortion Care by U.S. Women*, 23 Women's Health Issues e173, e175 (2013), available at https://www.guttmacher.org/sites/default/files/pdfs/pubs/journals/j.whi.2013.03.001.pdf.

[36] Rachel K. Jones, Ushma D. Upadhyay, and Tracy A. Weitz, *At What Cost? Payment for Abortion Care by U.S. Women*, 23 Women's Health Issues e173, 175 (2013).

[37] Only speaking of the cost of the procedure is inaccurate and potentially misleading, as there are multiple ancillary expenses faced by most women seeking abortions. These ancillary expenses may come in the form of transportation (mean, $44), and a minority also reported lost wages (mean, $198), childcare expenses (mean, $57) and other travel-related costs (mean, $140). Substantial minorities also delayed or did not pay bills such as rent (14%), food (16%), or utilities and other bills (30%) to pay for the abortion. Rachel K. Jones, Ushma D. Upadhyay, and Tracy A. Weitz, At What Cost? Payment for Abortion Care by U.S. Women, 23 Women's Health Issues e173 (2013).

[38] Paige Alexandria, *Laws Aren't The Only Barrier To Abortion Access. So Is Cost*, Talk Poverty: Center for American Progress (Jan. 28, 2020), talkpoverty.org/2020/01/28/abortion-cost-uninsured/.

[39] Rachel K. Jones, Ushma D. Upadhyay, and Tracy A. Weitz, At What Cost? Payment for Abortion Care by U.S. Women, 23 Women's Health Issues e173, e175 (2013).

procedure none-the-less. [40] Only 7% of the study population paid using private insurance.[41] The most commonly cited reason for privately insured patients not using their insurance to pay for the abortion was that the insurer did not cover the procedure—a problem faced by 46% of study participants.[42]

In fact, another study found that for over half of women receiving an abortion, the **out of pocket costs associated with their care was "equivalent to more than one-third of their monthly personal income."**[43] Given that most women who obtain abortions are poor or low income,[44] the cost of medical care and affordability issues may result in these families getting stuck in a "cycle of debt."[45]

In 2017, 18,590 abortions were provided in Massachusetts.[46] But the Hyde Amendment prohibits federal dollars from being used for abortion coverage for people insured by Medicaid.[47] While most private insurers appear to offer at least some coverage for abortion, not all do.

This puts women in a precarious position. While some women are able to borrow from family, receive assistance from abortion funds, or sell personal belongings to finance their abortions, other women have to resort to even more drastic measures.[48] Affordability issues have forced

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[40] Rachel K. Jones, Ushma D. Upadhyay, and Tracy A. Weitz, At What Cost? Payment for Abortion Care by U.S. Women, 23 Women's Health Issues e173 (2013).
[41] Rachel K. Jones, Ushma D. Upadhyay, and Tracy A. Weitz, At What Cost? Payment for Abortion Care by U.S. Women, 23 Women's Health Issues e173 (2013).
[42] Rachel K. Jones, Ushma D. Upadhyay, and Tracy A. Weitz, At What Cost? Payment for Abortion Care by U.S. Women, 23 Women's Health Issues e173 (2013).
[43] The University of California, San Francisco Turnaway Study, as cited by Heather D. Boonstra, *Abortion in the Lives of Women Struggling Financially: Why Insurance Coverage Matters*, Guttmacher Institute (21 Sept. 2018), www.guttmacher.org/gpr/2016/07/abortion-lives-women-struggling-financially-why-insurance-coverage-matters.
[44] Patients categorized as low income accounted for 75% of all abortions in 2014. Heather D. Boonstra, *Abortion in the Lives of Women Struggling Financially: Why Insurance Coverage Matters*, Guttmacher Institute (21 Sept. 2018), www.guttmacher.org/gpr/2016/07/abortion-lives-women-struggling-financially-why-insurance-coverage-matters; *see also*, Rachel K. Jones, Ushma D. Upadhyay, and Tracy A. Weitz, At What Cost? Payment for Abortion Care by U.S. Women, 23 Women's Health Issues e173 (2013).
[45] Paige Alexandria, *Laws Aren't The Only Barrier To Abortion Access. So Is Cost*.
[46] Guttmacher Institute, State Facts About Abortion (Fact Sheet): Massachusetts (Jan. 2021), *available at* https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-massachusetts.
[47] Heather D. Boonstra, *Abortion in the Lives of Women Struggling Financially: Why Insurance Coverage Matters*, Guttmacher Institute (21 Sept. 2018), www.guttmacher.org/gpr/2016/07/abortion-lives-women-struggling-financially-why-insurance-coverage-matters. Additionally complicating matter is the fact that cost-sharing reduction (CSR) payments, a mechanism for lowering deductibles, copayments, and coinsurance for enrollees with incomes up to 250 percent of the federal poverty level, is prohibited for abortion assistace. Anusha Ravi, *How the U.S. Health Insurance System Excludes Abortion*, Center for American Progress (20 July 2018, 1:00 PM), www.americanprogress.org/issues/women/reports/2018/07/20/453572/u-s-health-insurance-system-excludes-abortion/.
[48] Heather D. Boonstra, *Abortion in the Lives of Women Struggling Financially: Why Insurance Coverage Matters*.

women to “delay or forgo paying utility bills or rent, or buying food for themselves and their children;”[49] or skip other needed medical care.[50]

Other women have chosen self-managed abortion care rather than face medical bills that could leave them impoverished.[51] Approximately 7% of women living in the United States will engage in self-managed abortion care during their lifetimes,[52] and reports indicate this number is increasing.[53] **Of the women who attempt self-managed abortion care, 25.2% were deterred from receiving care in a hospital or clinic setting because of the cost of receiving care at a clinic.**[54] Black and Hispanic women are more likely to attempt self-managed abortion care—driving home that this is an issue of racial justice.[55]

Still other women experience such delays in their care that they are forced to carry the pregnancies to term.[56] One study concluded that approximately **one in four women who want an abortion are unable to obtain one** owing to inability to pay and/or lack of insurance coverage.[57] The costs of being unable to obtain abortion because of affordability issues have lasting impacts. Women forced to carry a pregnancy to term were more likely to suffer from depression or anxiety after five years compared to peers who were able to obtain an abortion.[58] Additionally, women unable to obtain an abortion “were more likely than those who obtained an abortion to be unemployed, receiving public assistance and living below the federal poverty level for years afterwards—despite having similar economic circumstances a year before seeking the abortion.”[59] Perhaps even more startling, a 2018 study indicates children of mothers

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[49] Heather D. Boonstra, *Abortion in the Lives of Women Struggling Financially: Why Insurance Coverage Matters*.
[50] cite
[51] Jocelyn Solis-Moreira, *Study: Self-Managed Abortions Rise Alongside Abortion Restrictions*, Verywell Health, Dotdash (Jan. 4, 2021), www.verywellhealth.com/self-managed-abortions-supreme-court-abortion-pill-restriction-5095393; Sarah McCammon, *With Abortion Restrictions On The Rise, Some Women Induce Their Own*, NPR (Sept. 19, 2019), www.npr.org/2019/09/19/759761114/with-abortion-restrictions-on-the-rise-some-women-induce-their-own.
[52] Jocelyn Solis-Moreira, *Study: Self-Managed Abortions Rise Alongside Abortion Restrictions*, Verywell Health, Dotdash (Jan. 4, 2021), www.verywellhealth.com/self-managed-abortions-supreme-court-abortion-pill-restriction-5095393.
[53] Sarah McCammon, *With Abortion Restrictions On The Rise, Some Women Induce Their Own*, NPR (Sept. 19, 2019), www.npr.org/2019/09/19/759761114/with-abortion-restrictions-on-the-rise-some-women-induce-their-own.
[54] Jocelyn Solis-Moreira, *Study: Self-Managed Abortions Rise Alongside Abortion Restrictions*.
[55] Jocelyn Solis-Moreira, *Study: Self-Managed Abortions Rise Alongside Abortion Restrictions*.
[56] Heather D. Boonstra, *Abortion in the Lives of Women Struggling Financially: Why Insurance Coverage Matters*.
[57] Heather D. Boonstra, *Abortion in the Lives of Women Struggling Financially: Why Insurance Coverage Matters*.
[58] Melissa Healey, *Women’s Health Worsened over 5 Years after Being Denied an Abortion*, Study Says, Los Angeles Times (June 11, 2019), https://www.latimes.com/science/la-sci-abortion-denied-womens-health-worsens-20190611-story.html
[59] Adam Sonfield, *Restrictions on Private Insurance Coverage of Abortion: A Danger to Abortion Access and Better U.S. Health Coverage,* Guttmacher Institute (Aug. 30, 2018), www.guttmacher.org/gpr/2018/06/restrictions-private-insurance-coverage-abortion-danger-abortion-access-and-better-us#.

who sought but were denied an abortion, were slightly more likely to miss developmental milestones throughout life.[60]

Women, families, and children are seeing their lives detrimentally impacted due to the high cost of care related to pregnancy and abortion. *An Act ensuring access to full spectrum pregnancy care* would reform our state laws by requiring that all Massachusetts regulated health plans cover the full spectrum of pregnancy-related care, including abortions, without any cost-sharing or copays. This will protect the right to an abortion as something beyond a theory and ensure the procedure is financially accessible to Massachusetts residents, which in turn protects the health and economic security of Massachusetts families.

C. Childbirth and maternity care are universal needs that must be addressed so that new families are not straddled with insurmountable debt resulting from childbirth costs.

In 2017, 70,704 Massachusetts residents gave birth.[61] Yet, these families may be economically disadvantaged because of it. According to data from the Center for Medicare and Medicaid Services, the most common cause of hospitalization is childbirth, and the cost of maternity and newborn care is greater than any other hospital expense.[62] By 2015 the average out-of-pocket cost for childbirth rose to $4,569.[63] The costs of delivery for a single birth are staggering: a vaginal birth with insurance averages $7,741.64; a vaginal birth without insurance averages $14,549.03; a C-section with insurance averages $11,012.54; and a C-section without insurance averages $19,879.60.[64]

In addition to rising out-of-pocket costs, women are also paying a higher proportion of the costs than they have in the past:

> Women who had vaginal births paid about 13% of expenses in 2008. By 2015, that percentage of cost-sharing had risen to 21%. For women who had cesarean sections, which are more expensive than vaginal births, the proportion of costs women absorbed rose from 10% to 15% over the same time period.[65]

This is particularly disconcerting given that 31.6% of Massachusetts births in 2017 were cesarean deliveries.[66] Additionally, many health insurance plans do not cover maternity care for

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[60] Melissa Healey, *Women's Health Worsened over 5 Years after Being Denied an Abortion*.
[61] Massachusetts Department of Public Health, *Massachusetts Births 2017* (Nov. 2019) at 8, *available at* https://www.mass.gov/doc/2017-birth-report-updated-0/download.
[62] Sakala C, Corry MP, Fund MM. Evidence-Based Maternity Care: What It Is and What It Can Achieve. New York, NY: Milbank Memorial Fund; 2008.
[63] Erin Schumaker, *Giving birth can come with staggering out-of-pocket costs*, ABC News (Jan. 6, 2020), *available at* https://abcnews.go.com/Health/baby-leave-mothers-staggering-bills/story?id=68021472.
[64] Hillary Hoffower and Taylor Borden, How much it costs to have a baby in every state, whether you have health insurance or don't, Business Insider (Dec. 9, 2019, 12:56 PM), https://www.businessinsider.com/how-much-does-it-cost-to-have-a-baby-2018-4?r=US&IR=T/
[65] Erin Schumaker, *Giving birth can come with staggering out-of-pocket costs*.. While these may be the cost averages, they do not necessarily reflect out-of-pocket spending.
[66] Massachusetts Department of Public Health, *Massachusetts Births 2017* (Nov. 2019) at 8.

adult dependents.[67] Or, if the plan does cover dependents, they may be exempt from the deductible.[68] Up to 4.2 million women ages 19 to 25 may be affected by this practice, which is particularly problematic for pregnancy care.[69]

All of these factors can contribute to inadequate prenatal care. This is an actual, tangible concern as government data indicates that between 2016 and 2018 the percentage of births to mothers who received adequate prenatal care *declined* from 82.3% to 80.5%."[70] **The implication of this is that 19.5% of Massachusetts mothers are giving birth without receiving adequate prenatal care.** Delayed or deferred prenatal treatment can demonstrably lead to poorer birth outcomes.[71] **For example, women who forgo prenatal care are seven times more likely to give birth prematurely; additionally, the infants these women do give birth to are five times more likely to die.[72]** This is wholly unacceptable and must be rectified[73]—this Act is one step towards accomplishing that.

An Act ensuring access to full spectrum pregnancy care would reform our state laws by requiring that all Massachusetts regulated health plans cover the full spectrum of pregnancy-related care, prenatal care, childbirth, postpartum care, etc., without any cost-sharing or copays. This will ensure that cost is no longer a barrier to women and families getting the care they need, and that they aren't saddled with insurmountable debt post-pregnancy. Furthermore, this helps to create a health care system that is more gender-equitable, promotes racial justice, and doesn't punish people for their ability to become pregnant, their decision to raise a family, or their decision to end a pregnancy.

High deductibles and copays can put women in an impossible position: scrape together enough funds by going without other basic necessities, incur medical debt, or forgo basic health care. These are unacceptable options that bar access to health care services. While other states

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[67] Megan Leonhardt, *This 24-year-old mistakenly thought her health insurance covered her pregnancy—and 4.2 million others like her may be at risk*, CNBC (Nov. 26, 2019), *available at* https://www.cnbc.com/2019/11/26/when-your-insurer-does-not-cover-your-maternity-costs.html.
[68] Megan Leonhardt, *This 24-year-old mistakenly thought her health insurance covered her pregnancy—and 4.2 million others like her may be at risk*.
[69] Megan Leonhardt, *This 24-year-old mistakenly thought her health insurance covered her pregnancy—and 4.2 million others like her may be at risk*.
[70] Massachusetts Department of Public Health, *Massachusetts Births 2017* (Nov. 2019) at 8.
[71] Erin Schumaker, *Giving birth can come with staggering out-of-pocket costs*.
[72] Leana Wen, *I'm Pregnant. What Would Happen If I Couldn't Afford Health Care?*, NPR (Mar. 11, 2017), *available at* https://www.npr.org/sections/health-shots/2017/03/11/519416036/im-pregnant-what-would-happen-if-i-couldnt-afford-health-care.
[73] Even beyond the very real moral need to address premature birth and negative health outcomes that may result from inadequate prenatal care, there are strong economic reasons as well: The medical cost for care associated with prematurity is staggering $79,000, compared to $1,000 for a healthy newborn. Leana Wen, *I'm Pregnant. What Would Happen If I Couldn't Afford Health Care?*, NPR (Mar. 11, 2017), *available at* https://www.npr.org/sections/health-shots/2017/03/11/519416036/im-pregnant-what-would-happen-if-i-couldnt-afford-health-care. Hospitalization costs alone can be upwards of $500,000 for the first year of life and intensive care can cost millions of dollars for new families. *Id*. At the same time, studies indicate that early intervention can cut costs and save lives, with five dollars saved for every dollar spent on prenatal care. *Id*.

have taken steps to protect women and ensure they are able to access perinatal services — including abortion care — Massachusetts has an opportunity to provide needed and timely leadership in this area.[74] Despite the Commonwealth's leadership in health care, insurance coverage, and equality, not all state residents can access reproductive health care — high deductible plans force Bay Staters to forgo needed treatment and services.

II. *AN ACT ENSURING ACCESS TO FULL SPECTRUM PREGNANCY CARE* PROMOTES ECONOMIC JUSTICE THROUGH CENTERING GENDER AND RACIAL EQUALITY.

It is critical that Massachusetts take action because no woman should have to choose between feeding her family or getting necessary medical treatment. This Act promotes economic justice through centering gender and racial justice. There are compelling ethical and economic reasons to work towards gender parity: gender equality has been recognized as a sustainable development goal by the United Nations and a Millennium Development Goal by the World Health Organization;[75] gender equality increases business productivity;[76] and gender equality is important to the overall health of the larger community. Likewise, there are compelling ethical and economic reasons to work towards racial equality: the United States has the highest maternal mortality rate in the developed world and maternal mortality disproportionately affects women and families of color; more than half of the 700 annual deaths are preventable with adequate and timely prenatal care.[77]

Pregnancy is uniquely important to all of us, and inevitably impacts us all in one way or another. We're fortunate to have an exceptional health care system in Massachusetts that does a superior job of caring for patients. But the system that cares for pregnant women also sets them back once they leave the hospital. We must reimagine our health care system to center and support the needs of women, pregnant people, families, and communities of color. **We should be the ones dictating our care, not our deductibles or insurance plans.**

As mentioned previously, women disproportionately bear the burden of high out-of-pocket health care costs. In the United States, the most common cause of hospitalization is childbirth, and the cost of maternity and newborn care is greater than any other hospital expense.[78] That is largely the reason why women between the ages of 19 and 44 spend 62% more per capita on health

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[74] California, New York, Oregon and Washington require all state-regulated health insurance policies to include coverage for abortion and treat maternity coverage and abortion coverage neutrally or equally. Oregon also requires all private state insurance plans to cover abortion care without any copay, coinsurance or deductible.

[75] World Health Organization, Millennium Development Goals (MDGs), WHO.int (2019), https://www.who.int/topics/millennium_development_goals/about/en/.

[76] Sameer Areff, How Gender Equality Can Lead To A More Productive And Inspired World, Forbes (Jun 20, 2018), https://www.forbes.com/sites/sap/2018/06/20/how-gender-equality-can-lead-to-a-more-productive-and-inspired-world/#14c874947bff.

[77] Erin Schumaker, *Giving birth can come with staggering out-of-pocket costs*.

[78] Sakala C, Corry MP, Fund MM. *Evidence-Based Maternity Care: What It Is and What It Can Achieve*. New York, NY: Milbank Memorial Fund; 2008.

care costs than their male counterparts.[79] While only accounting for 51% of the total population, female spending accounted for 56% of total personal health care (PHC) spending in 2014 with female spending reaching $1.4 trillion.[80] Per capita health spending for females during this period was $8,811.[81]

All Bay Staters, especially those in communities of color, need the ability to decide if, when, and how to have a family, as well as the ability to raise these families in safe and sustainable communities. Racial disparities in maternal health undermine this. Racial disparities in maternal mortality are staggering, with Black women and American Indian women experiencing mortality rates three times and two and a half times greater, respectively, than white women.[82]

Access to quality care undoubtedly plays a role in this disparity. Black and Hispanic Massachusetts residents are more likely to face affordability issues accessing health care than their white counterparts; additionally, Hispanic residents reported cost as the reason for their unmet need for health care with greater frequency than any other group.[83] Overall, 47% of white, 50.9% of Black, and 57.5% of Hispanic residents reported at least one affordability issue; 21.1% of white, 27.8% of Black, and 23.8% of Hispanic residents reported multiple affordability issues.[84] Twenty percent of Black and 19% of Hispanic residents also report having issues paying family medical bills; 19.6% of Black and 14.2% of Hispanic residents reported family medical debt; 16.5% of Black and 14.3% of Hispanic residents reported spending a high share of their family income on out of pocket expenses.[85]

This is an issue of gender and racial equality. Our health care system was not created with women or pregnant people in mind, and institutional racism in the provision of health care harms communities of color. Massachusetts is already combatting an epidemic of racial inequities in maternal health–**Black women in Massachusetts are twice as likely as white women to die from pregnancy-related complications**. Black and Brown women and pregnant people need greater access to the full spectrum of pregnancy care now more than ever, but lack of affordability often makes health care inaccessible to low-income communities, communities of color, and immigrants. We cannot allow high out of pocket costs to undermine our efforts to protect Black and Brown women, families, and pregnant people.

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[79] Centers for Medicare and Medicaid Services, *U.S. Personal Health Care Spending by Age and Gender 2010 Highlights*.
[80] Centers for Medicare and Medicaid Services, *U.S. Personal Health Care Spending by Age and Gender 2010 Highlights*.
[81] Centers for Medicare and Medicaid Services, *U.S. Personal Health Care Spending by Age and Gender 2010 Highlights*.
[82] CDC, Pregnancy Mortality Surveillance System https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm
[83] Center for Health Information and Analysis (CHIA), *Findings from the 2019 Massachusetts Health Insurance Survey*.
[84] Center for Health Information and Analysis (CHIA), *Findings from the 2019 Massachusetts Health Insurance Survey*.
[85] Center for Health Information and Analysis (CHIA), *Findings from the 2019 Massachusetts Health Insurance Survey*.

This legislation fosters a culture of support and sends a strong message that Massachusetts has a vested interest in the health and wellbeing of all residents of the Commonwealth. It also sends a powerful signal that Massachusetts cares about economic, gender, and racial equality. Reproductive health is a key value, and as national leaders in health care Massachusetts should boldly say as much and articulate a clear vision of reproductive freedom.

Please give a favorable report to H. 1196 and S. 673, *An Act ensuring access to full spectrum pregnancy care*.

Massachusetts can continue to lead the nation in securing health equity by ensuring every woman can access the care she needs without having to incur massive debt or worry about what other necessities she may have to go without. Medical decisions throughout pregnancy should be guided by a woman's health, not her ability to afford proper care. Massachusetts led the way on universal health care and it now has a unique opportunity to lead the nation by removing financial barriers to accessing complete reproductive health care. Therefore, I respectfully ask that this bill receive a favorable report.

If I can answer any of your questions about this bill, please contact me at rebecca@prochoicemass.org or 617-556-8800.