MANDATED BENEFIT REVIEW OF HOUSE BILL 1196
AND SENATE BILL 673
SUBMITTED TO THE 192ND GENERAL COURT:

AN ACT ENSURING ACCESS TO FULL SPECTRUM PREGNANCY CARE

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CHIA.

Mandated Benefit Review of House Bill 1196 and Senate Bill 673 Submitted to the 192nd General Court:

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1.0 Benefit Mandate Overview: H.B. 1196 and S.B. 673: An Act ensuring access to full spectrum pregnancy care

1.1 History of the Bill

The Committee on Financial Services referred House Bill (H.B.) 1196 and Senate Bill (S.B.) 673, both entitled "An Act ensuring access to full spectrum pregnancy care,"[1] to the Massachusetts Center for Health Information and Analysis (CHIA) for review. Massachusetts General Law (MGL) Chapter 3 §38C requires CHIA to review the medical efficacy of treatments or services included in each mandated benefit bill referred to the agency by a legislative committee, should it become law. CHIA must also estimate each bill's fiscal impact, including changes to premiums and administrative expenses. The language in each bill is the same, and for the remainder of this report, "the bill" will collectively refer to H.B. 1196 and S.B. 673.

This report is not intended to determine whether the bill would constitute a health insurance benefit mandate for purposes of Commonwealth of Massachusetts (Commonwealth) defrayal under the Affordable Care Act (ACA), nor is it intended to assist with Commonwealth defrayal calculations if it is determined to be a health insurance benefit mandate requiring Commonwealth defrayal.

1.2 What Does the Bill Propose?

As submitted in the 192nd General Court of the Commonwealth, the bill calls for the inclusion of abortion and abortion-related care within the coverage mandate for prenatal care, childbirth, and postpartum care set forth in the MGL, [i] and provides that none of these services shall be subject to any deductible, coinsurance, copayment, or any other cost-sharing requirement. Furthermore, the coverage offered shall not impose unreasonable restrictions or delays.[2] The bill also provides for a coverage exemption for abortion and abortion-related care for policies offered by an employer that is a church or qualified church-controlled organization[ii,iii] at the request of the employer, provided the employer delivers written notice[iv] to prospective enrollees prior to the enrollment in the plan.

CHIA and its consultants submitted an inquiry to the sponsoring legislators and staff to clarify the bill's intent. The sponsors clarified the bill's intent is to:

[i] M.G.L. c.32A §17C, c.118E §10A, c.175 §47F, c.176A §8H, c.176B §4H, and c.176G §4I.

[ii] Pursuant to M.G.L. c.175 §47W, "church" means a church, a convention or association of churches, or an elementary or secondary school that is controlled, operated, or principally supported by a church or by a convention or association of churches. A "qualified church-controlled organization" means an organization described in Section 501(c)(3) of the federal Internal Revenue Code, other than an organization that: (i) offers goods, services or facilities for sale, other than on an incidental basis, to the general public, other than goods, services or facilities that are sold at a nominal charge that is substantially less than the cost of providing such goods, services or facilities; and (ii) normally receives more than 25 per cent of its support from: (A) governmental sources; (B) receipts from admissions, sales of merchandise, performance of services or furnishing of facilities, in activities which are not unrelated trades or businesses; or (C) both clauses (A) and (B).

[iii] Pursuant to M.G.L. c.176A §8W, c.176B §4W, and c.176G §4O, the terms "church or qualified church-controlled organization" are defined in 26 U.S.C. Section 3121(w)(3)(A) and (B).

[iv] The notice shall list the healthcare methods and services for which the employer will not provide coverage for religious reasons.

1. Remove barriers to the entire continuum of pregnancy-related services: prenatal care, childbirth, postpartum care, abortion, and abortion-related care

2. Provide equal access to high-quality, pregnancy-related care by eliminating cost as a barrier

1.3 Medical Efficacy of the Bill

In 2019, the Massachusetts fertility rate[v] was 49.6 per 1,000 women aged 15 – 44, with approximately 70,000 births.[3] Women require specialized care before (prenatal), during (childbirth), and after birth (postpartum). Prenatal care involves treatment and training to support a healthy pre-pregnancy, pregnancy,[vi] and childbirth,[vii] as well as to decrease risks during pregnancy and increase the chances of a safe and healthy delivery.[4] While skilled care during childbirth allows for immediate management of obstetric emergencies, postpartum care is important for detecting and treating a number of possible conditions including, but not limited to, infection and postpartum depression.[5] Maternity care[viii,6] services provided to a woman deliver lasting benefits to both the woman and the child.[7] Access to these services is critical to achieve positive health outcomes for pregnant women and their children.[8]

Within the spectrum of pregnancy-related services, abortion[ix] is an option sometimes chosen by women. Federal and state laws, as well as insurers' policies, shape the extent to which the almost one million women in the United States (U.S.) who have an abortion every year can utilize needed services.[9] Abortion coverage restrictions disproportionately affect poor and low-income women who have limited ability to pay for abortion services with out-of-pocket funds.[10]

1.4 Current Coverage

The Commonwealth currently requires coverage for prenatal care, childbirth, and postpartum care pursuant to MGL c.32A §17C, c.118E §10A, c.175 §47F, c.176A §8H, c.176B §4H, and c.176G §4I. BerryDunn surveyed 10 insurance carriers in the Commonwealth, and six responded. Maternity care and abortion are generally covered by insurance carriers in the Commonwealth.

1.5 Cost of Implementing the Bill

Requiring coverage for these benefits by fully insured health plans would result in an average annual increase, over five years, to the typical member's monthly health insurance premium of between $1.51 and $2.09 per member per month (PMPM) or between 0.23% and 0.32% of premium. The impact on premiums is driven by the provisions of the bill that remove cost sharing from maternity, abortion, and abortion-related services.

1.6 Plans Affected by the Proposed Benefit Mandate

The bill applies to commercial fully insured health insurance plans, hospital service corporations, medical service corporations, Health Maintenance Organizations (HMOs), and to both fully and self-insured plans operated by the Group Insurance Commission (GIC) for the benefit of public employees. The proposed mandate as drafted affects

[v] Fertility rate means births per 1,000 women 15 – 44 years of age.

[vi] Pregnancy is the term used to describe the period of time in which a fetus develops inside a woman's uterus.

[vii] Childbirth refers to both labor (the process of birth) and delivery (the birth itself).

[viii] Maternity care includes prenatal care, childbirth, and postpartum care, while pregnancy care refers to prenatal and postpartum care.

[ix] An abortion is a procedure to end pregnancy.

Medicaid/MassHealth; however, CHIA's analysis does not estimate the potential effect of the mandate on Medicaid expenditures.

1.7 Plans Not Affected by the Proposed Benefit Mandate

Self-insured plans (i.e., where the employer or policyholder retains the risk for medical expenses and uses a third-party administrator or insurer to provide only administrative functions), except for those provided by the GIC, are not subject to state-level health insurance mandates. State mandates do not apply to Medicare and Medicare Advantage plans or other federally funded plans, including TRICARE (covering military personnel and dependents), the Veterans Administration, and the Federal Employees Health Benefit Plan, the benefits for which are determined by or under rules set by the federal government.

Executive Summary Endnotes

[1] The 192nd General Court of the Commonwealth of Massachusetts, House Bill 1196 and Senate Bill 673, "An Act ensuring access to full spectrum pregnancy care." Accessed 16 April 2021: **https://malegislature.gov/Bills/192/H1196** and **https://malegislature.gov/Bills/192/S673**.These bills were previously submitted in the 191st General Court of the Commonwealth of Massachusetts as House Bill 1102 and Senate Bill 587, "An Act to establish health equity for pregnant persons." Accessed 15 December 2020: **https://malegislature.gov/Bills/191/H1102** and **https://malegislature.gov/Bills/191/S587**.

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2.0 Medical Efficacy Assessment

The bill, as submitted in the 192nd General Court, would require fully insured plans to provide coverage for abortion and abortion-related care. The bill would prevent health insurers from imposing cost sharing on these services, as well as maternity services.[1]

MGL Chapter 3 §38C charges CHIA with reviewing the medical efficacy of proposed mandated health insurance benefits. Medical efficacy reviews summarize current literature on the effectiveness and use of the mandated treatment or service, and describe the potential impact of a mandated benefit on the quality of patient care and health status of the population.

Under the ACA, non-grandfathered health insurance plans must fully cover the costs of recommended preventive services without patient cost sharing (no deductibles, coinsurances, or copayments).[2,3] For pregnant women and children, mandated preventive services include a wide range of screenings and other services, including breastfeeding support and counseling and maternal depression screening for mothers of infants.[4,5]

This report proceeds in the following sections:

2.0 Medical Efficacy Assessment

- Section 2.1 Pregnancy and Abortion Prevalence
- Section 2.2 Maternity Care
  - 2.2.1 Prenatal Care
  - 2.2.2 Childbirth
  - 2.2.3 Postpartum Care
- Section 2.3 Abortion and Abortion-Related Care

3.0 Conclusion

2.1 Pregnancy and Abortion Prevalence

The U.S. pregnancy rates for women aged 24 or younger reached their lowest recorded levels in 2017,[x] continuing a longstanding decline in pregnancy rates for this age group that began in the late 1980s:[6]

- 14 pregnancies per 1,000 women aged 15 – 17 (peak 75 in 1989)
- 57 pregnancies per 1,000 women aged 18 – 19 (peak 175 in 1991)

[x] 2017 is the most recent year with reported pregnancy rates.

- 111 pregnancies per 1,000 women aged 20 – 24 (peak 202 in 1990)

In contrast, pregnancy rates for older age groups have been increasing since 1973. Rates for women aged 35 – 39 reached a historic high in 2016 of 73 per 1,000 women, and the rate for those 40 and older reached a record high in 2017 of 19 pregnancies per 1,000 women, respectively.[7] Pregnancies result in both births and abortions; however, birth and abortion rates do not always move or change in the same direction.[8]

Although the pregnancy rates among women aged 24 and younger have been declining while the rates for women older than 30 have been increasing over the past two-and-a-half decades, these trends reflect different underlying trends in birth and abortion rates:[9]

- Pregnancy rate declines among adolescents and young adults resulted in declines in both birth and abortion rates.
- For women in older age groups, the abortion rates have remained largely constant while birth rates have increased.

Trends in pregnancy, birth, and abortion rates at the state level have mostly followed national trends, with every state reporting declines in pregnancy rates among women under 20 years of age. In Massachusetts, the pregnancy, birth, and abortion rates by age group are set forth in Table 1 below:[10]

Table 1: Pregnancy, Birth, and Abortion Rates Per 1000 Women[xi]

AGE GROUP	15-17	18-19	20-24	25-29	30-34	35-39	40+
Pregnancy Rate	7.1	27.2	61.5	107.6	147.4	91.8	22.8
Birth Rate	3.7	13.0	32.3	69.2	108.5	66.9	15.5
Abortion Rate	2.4	10.5	20.6	22.3	15.7	10.4	3.9

According to the National Center for Health Statistics (NCHS),[xii] the general fertility rate[xiii] for the U.S. in 2019 was 58.2 per 1,000 women aged 15 – 44, representing a 2% decline from the rate of 59.1 in 2018,[11] while the fertility rate in Massachusetts increased slightly with a rate of 49.6 in 2019 compared to 49.5 in 2018.[12] The total number of births in the U.S. in 2019 was 3,745,540, a decrease from 3,791,712 in 2018; in Massachusetts, births increased from 69,109 in 2018 to 69,157 in 2019.[13,14] From 2018 to 2019 in both the U.S. and Massachusetts, the caesarean delivery rate decreased while the preterm birth rate rose.[15]

2.2 Maternity Care

[xi] All rates are the number of events per 1,000 women in a specified age group. Rates among women aged 40 or older are calculated as the number of events per 1,000 women aged 40 – 44. Data are tabulated according to the individual's age at the pregnancy outcome.

[xii] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, NCHS.

[xiii] General fertility rate or fertility rate is the number of births per 1,000 women aged 15 – 44.

Maternity care consists of prenatal[xiv] (before birth), childbirth (labor and delivery), and postpartum (after birth) healthcare for expectant mothers. [16,17,18]

2.2.1 Prenatal Care

Prenatal care helps decrease risk during pregnancy and helps increase the chance of a safe and healthy delivery; regular prenatal visits can help identify any problem or complications with a pregnancy before they become serious.[19] Ideally, prenatal care should begin at least three months before conception and include healthy habits to follow, including: quitting smoking; taking folic acid supplements daily; talking to a provider about medical conditions, taking dietary supplements, reviewing over-the-counter or prescription drugs being taken; and avoiding all contact with toxic substances and chemicals at home or work that could be harmful.[20]

By identifying treatable complications such as gestational diabetes,[xv,21] preeclampsia,[xvi,22] and ectopic pregnancies,[xvii,23] routine prenatal care improves the health of women.[24] Newborns of mothers who do not receive prenatal care are three times more likely to have a low birth weight and five times more likely to die than children born to mothers who receive prenatal care.[25] Although early and adequate prenatal care is important for encouraging a healthy pregnancy, with the first visit being scheduled as soon as a woman thinks she might be pregnant, women who reported being unable to access prenatal care as early as they wanted were: [26]

- Age 19 years or younger – 29.8%
- Non-Hispanic American Indian – 24.2%
- Non-Hispanic mothers of multiple race – 23.2%
- Non-Hispanic Black – 22.2% (compared to non-Hispanic Asian women – 15.1% and non-Hispanic White women – 14.7%)
- Lacking in transportation options – 13.9%
- Unaware of pregnancy – 37.1%

Although there are numerous reasons for delaying care, many pregnant women cite cost as the major barrier. Nearly 40% of mothers reported they delayed prenatal care because they lacked the money or insurance to pay for the visits.[27]

2.2.2 Childbirth

[xiv] Antenatal might also be used in lieu of prenatal.

[xv] Gestational diabetes mellitus (GDM) is defined as any degree of glucose intolerance with onset of first recognition during pregnancy. Approximately 7% of all pregnancies are complicated by GDM.

[xvi] Preeclampsia is a pregnancy complication that often begins after 20 weeks of pregnancy. It is characterized by high blood pressure and signs of damage to another organ system, most often the liver and kidneys.

[xvii] An ectopic pregnancy is a pregnancy where the fertilized egg does not implant in the main cavity of the uterus. Most ectopic pregnancies occur in the fallopian tube. Ectopic pregnancies cannot proceed normally, and the growing tissue might cause life-threatening bleeding for the mother if left untreated.

Childbirth includes both labor (the process of birth) and delivery (the birth itself), the processes by which a baby is born.[28,29] In the U.S., childbirth is the most common reason for hospitalization; caesarean section is the most common surgery; and hospitals are the most common place of birth.[30,31]

In addition to hospitals, other birth settings include birth centers and places of residence. Providers involved in care during childbirth might include nurses, obstetricians, family physicians, pediatricians, and midwives.[32] A 2019 American College of Obstetricians and Gynecologists (ACOG) statement reaffirmed the need for standardized levels of care for accredited birth centers to improve maternal care, in part by facilitating the transfer of women with high-risk pregnancies.[33]

Although there are many care delivery settings and caregivers involved in childbirth, financing and policy choices impact different birth options.[34] Childbirth represents the single largest category of hospital-based expenditures in the U.S.[35] At $11,200 for a standard delivery and $15,000 for a C-section, per 2017 data, giving birth in the U.S. is far more expensive than in other industrialized countries.[36] Even for women with health insurance, childbirth often results in substantial out-of-pocket costs.[37] A recent study by the University of Michigan stated that despite the ACA requiring large, employer-based health plans to cover maternity care, some families' average out-of-pocket spending for maternity care increased from $3,069 in 2008 to $4,569 in 2015.[38]

2.2.1 Postpartum Care

Postpartum care refers to the period of time beginning right after birth and lasting six to eight weeks.[39] During the postpartum period, the mother goes through many physical and emotional changes while also learning to care for her newborn. Postpartum care involves getting proper rest, nutrition, and vaginal care.[40] It is also intended to ensure the physical and emotional recovery of mothers and their babies.[41] Postpartum home visits give providers an opportunity to address mental health concerns and allow them to assess social determinants of health, including needs for:[42]

- Food
- Housing
- Financial security
- Protection from domestic violence

Home visits by a nurse or midwife are associated with improved mental health and breastfeeding outcomes, as well as reduced healthcare costs.[43] However, if a woman does not have health coverage for her pregnancy, she might forgo prenatal and postnatal care that could identify risks and ensure steps are taken to prevent life-threatening complications.[44]

2.3 Abortion and Abortion-Related Care

Abortions are either medical[xviii] or surgical,[xix] and the type of abortion available is determined by the pregnancy week.[45,46] The majority of abortions are performed during the first trimester of pregnancy, with[xx] 92.2% being performed before 13 weeks' gestation.[47] Nearly all abortions are a result of unintended pregnancy.[48] Decades of research have demonstrated that legal induced abortion is safe, and mortality and serious complications are extremely rare.[49,50] Both surgical and medical methods are considered safe, and contraindications to either method are few. [51,52,53] Although risks increase with gestational age, the rates of complications are low and comparable between surgical and medical techniques.[54]

The number of abortions performed in the U.S. decreased 8% between 2014 and 2017 for women of reproductive age (15 – 44); in Massachusetts, the decrease was 12% for the same time interval.[55] From 2009 to 2018, the number, rate, and ratio of reported abortions decreased 22%, 24%, and 16%, respectively. In 2017, the total number, rate, and ratio of reported abortions decreased to historic lows for all three measures. [56]

Although the safety of abortion in the U.S. is well documented, women often report multiple barriers to obtaining abortion care, including: stigma of obtaining abortion care, travel time, long waits for an appointment, and cost.[57] Adolescents, people of color, those living in rural areas, those with low incomes, and incarcerated people can face disproportionate effects of restrictions on abortion access;[58] and although stigma and fear of violence might be less tangible than legislative and financial restrictions, they are powerful barriers to abortion.[59]

When restrictions are placed on abortion access, individuals who are unable to attain a wanted abortion report worse physical health and more economic insecurity compared to those who obtained an abortion.[60] As a result, ACOG supports the availability of high-quality reproductive health services for all patients, and also supports safe, legal abortion as a necessary component of comprehensive healthcare.[61] ACOG recommends that public and private insurance coverage of abortion care be included as essential healthcare services. It also advises that abortion care should not be subject to additional administrative or financial burdens.[62]

[xviii] Medical abortions involve taking medications.

[xix] There are two types of surgical abortion: aspiration abortion and dilation and evacuation (D&E) abortion.

[xx] The first trimester refers to the first 12 weeks of pregnancy.

3.0 Conclusion

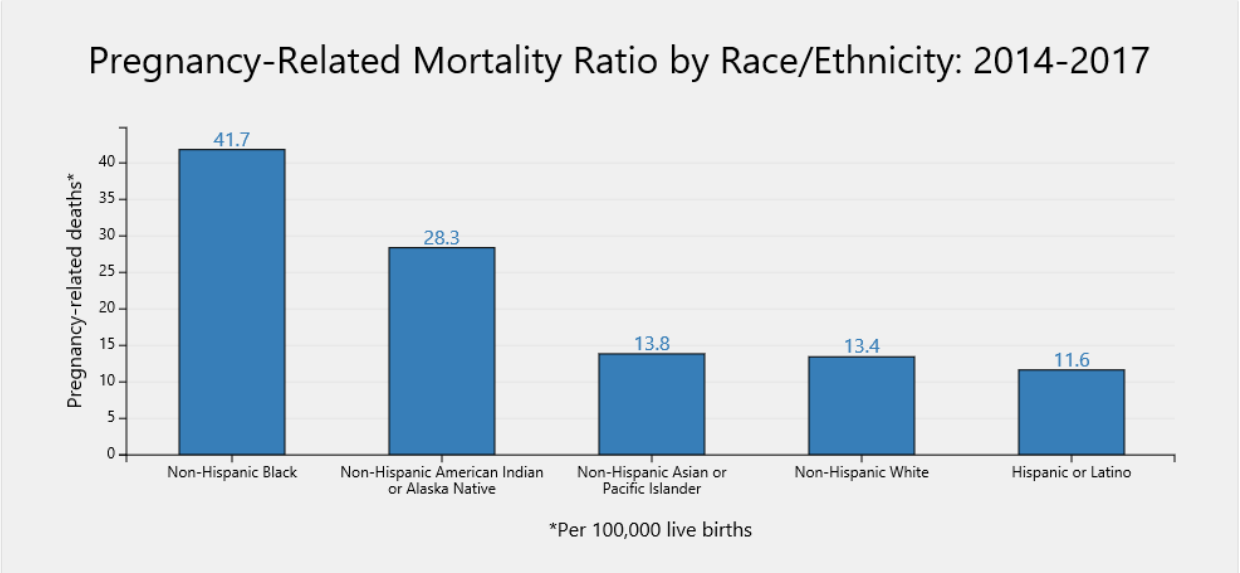
Pregnancy can have many complications that require care and that might result in the need for a caesarian delivery[63] (e.g., pre-eclampsia, placenta previa, anemia, depression, ectopic pregnancy).[64] Despite major advances in medical care, critical threats to maternal and infant health exist, with 31% of pregnant women in the U.S. experiencing pregnancy complications.[65]

The U.S. has a higher maternal mortality rate than any other industrialized country, which is particularly concerning given studies showing that 60% of maternal mortality deaths are preventable.[66] Maternal mortality rates vary considerably across racial and ethnic groups, and may be due to several factors including access to care, quality of care, prevalence of chronic conditions, structural racism, and implicit biases (Appendix A).[67] Women who represent racial or ethnic minorities have worse access to preconception and prenatal care, and they are more likely to deliver in lower-quality hospitals.[68] These racial and ethnic disparities in maternity care and outcomes have worsened over the past six decades, with black women still three to four times more likely to die from pregnancy-related deaths in the U.S.[69]

In the U.S., an estimated 1,200 women a year experience complications during pregnancy or childbirth that prove fatal, and 60,000 suffer complications that are near fatal. Women who lack health insurance are three to four times more likely to die of pregnancy-related complications than those who are insured.[70] Although the ACA requires employer-based plans to cover maternity services, plans are allowed to impose cost sharing, such as copayments and deductibles. Policies that eliminate out-of-pocket spending could reduce significant financial burdens on families.[71]

Beyond cost and coverage concerns for maternity care outcomes, barriers to abortion care can have significant consequences for patients.[72] The impact of abortion coverage restrictions disproportionately affects poor and low-income women who have limited ability to pay for abortion services with out-of-pocket funds, sometimes amounting to a substantial financial burden for many women.[73,74] Further, these barriers might become more pronounced with time as procedure costs increase and the number of available providers decreases.[75] These barriers often result in delays in receiving care, causing negative mental health impacts and leading some women to consider self-induction.[76,77]

Appendix A: Pregnancy-Related Deaths by Race/Ethnicity[78]



Endnotes

[1] The 192nd General Court of the Commonwealth of Massachusetts, House Bill 1196 and Senate Bill 673, "An Act ensuring access to full spectrum pregnancy care." Accessed 16 April 2021: **https://malegislature.gov/Bills/192/H1196** and **https://malegislature.gov/Bills/192/S673**.These bills were previously submitted in the 191st General Court of the Commonwealth of Massachusetts as House Bill 1102 and Senate Bill 587, "An Act to establish health equity for pregnant persons." Accessed 15 December 2020: **https://malegislature.gov/Bills/191/H1102** and **https://malegislature.gov/Bills/191/S587**.

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AN ACT ENSURING ACCESS TO FULL SPECTRUM PREGNANCY CARE

COST REPORT

1.0 Executive Summary

Massachusetts House Bill (H.B.) 1196 and Senate Bill (S.B.) 673, as submitted in the 192nd General Court of the Commonwealth of Massachusetts (Commonwealth), require the inclusion of abortion and abortion-related care within the coverage mandate for prenatal care, childbirth and postpartum care (maternity care) set forth in the Massachusetts General Laws.[xxi] In addition to the proposed coverage requirements, the bill also eliminates member cost sharing (i.e., deductible, coinsurance, copayments, or any other out-of-pocket requirements) for these services and prohibits the imposition of unreasonable restrictions or delays.

[1] The bill includes an exemption to the coverage of abortion and abortion-related care for church or qualified church-controlled organizations.[xxii,xxiii] The language in each bill is the same; and for the remainder of the report, "the bill" will collectively refer to H.B. 1196 and S.B. 673.

MGL Chapter 3 §38C charges CHIA with, among other duties, reviewing the potential impact of proposed mandated healthcare insurance benefits on the premiums paid by businesses and consumers. CHIA has engaged BerryDunn to provide an actuarial estimate of the effect enactment of the bill would have on the cost of health insurance in the Commonwealth. The report is required to identify the effects on healthcare costs, including premium and administrative expenses, of the proposed mandate.

This report is not intended to determine whether the bill would constitute a health insurance benefit mandate for purposes of state defrayal under the Affordable Care Act (ACA), nor is it intended to assist with state defrayal calculations if it is determined to be a health insurance benefit mandate requiring state defrayal.

1.1 Current Insurance Coverage

BerryDunn surveyed 10 insurance carriers in the Commonwealth, and six responded. Maternity care is currently covered with varying amounts of cost sharing. Preventive prenatal care is covered without member cost sharing. Childbirth and postpartum coverage is subject to member cost sharing which vary depending upon a member's specific coverage. In general, abortion and abortion-related services are covered. One of the respondent carriers indicated that fully insured indemnity plans exclude abortion coverage, but membership in that product is very limited. All carriers allow a religious exemption for abortion coverage.

The Commonwealth's benchmark plan covers prenatal, childbirth, and postpartum services, with no cost sharing for prenatal care, and no cost sharing for childbirth and postpartum care after the deductible for inpatient hospital

[xxi] M.G.L. c.32A §17C, c.118E §10A, c.175 §47F, c.176A §8H, c.176B §4H, and c.176G §4I

[xxii] Pursuant to M.G.L. c.175 §47W, "church" means a church, a convention or association of churches or an elementary or secondary school that is controlled, operated or principally supported by a church or by a convention or association of churches. A "qualified church-controlled organization" means an organization described in section 501(c)(3) of the federal Internal Revenue Code, other than an organization that: (i) offers goods, services or facilities for sale, other than on an incidental basis, to the general public, other than goods, services or facilities that are sold at a nominal charge that is substantially less than the cost of providing such goods, services or facilities; and (ii) normally receives more than 25 per cent of its support from: (A) governmental sources; (B) receipts from admissions, sales of merchandise, performance of services or furnishing of facilities, in activities which are not unrelated trades or businesses; or (C) both clauses (A) and (B).

[xxiii] Pursuant to M.G.L. c.176A §8W, c.176B §4W, and c.176G §4O, the terms "church or qualified church-controlled organization" are defined in 26 U.S.C. section 3121(w)(3)(A) and (B).

services is met.[2] In addition, the ACA requires coverage without cost sharing of evidenced-based items or services with an "A" or "B" rating by the United States Preventive Services Task Force (USPSTF),[3,4] several of which are relevant to prenatal, childbirth, and postpartum services.

No Commonwealth or federal law specifically requires coverage of abortion or abortion-related care. The Commonwealth's benchmark plan includes "voluntary termination of pregnancy" [abortion] with no quantitative limitation.[5] Pursuant to 45 CFR 156.115(c), no health plan is required to cover abortion services as part of the requirement to cover essential health benefits (EHBs), even if the benchmark plan includes abortion.

1.2 Analysis

BerryDunn estimated the impact of the bill by assessing the incremental effects of the requirement that insurers include abortion and abortion-related care with no member cost sharing within the coverage requirement for maternity care. It also required assessing the incremental impact of eliminating member cost sharing for maternity care. The incremental cost of abortion is estimated using claims data from the Massachusetts APCD to determine a PMPM cost for these services and applying that to membership for whom the services are not covered. The incremental cost of the elimination of member cost sharing for maternity care was estimated using claims data from the Massachusetts APCD to determine a PMPM cost for removal of member cost sharing. Combining the two components, and accounting for carrier retention, results in a baseline estimate of the proposed mandate's incremental effect on premiums, which is projected over the five years following the assumed January 1, 2022, implementation date of the proposed law. The estimates assume carriers will fully comply with the provisions of the bill if it becomes law.

1.3 Summary Results

Table ES-1 summarizes the estimated effect of the bill on premiums for fully insured plans over five years. This analysis estimates that the bill, if enacted as drafted for the 191st General Court, would increase fully insured premiums by as much as 0.32% on average over the next five years; a more likely increase is approximately 0.28%, equivalent to an average annual expenditure of $42.9 million over the period 2022 – 2026.

The impact on premiums is driven by the cost of eliminating member cost sharing for abortion and for maternity care. Variation between scenarios is attributable to the uncertainty surrounding the annual increase in member cost sharing amounts.

The impact of the bill on any one individual, employer group, or carrier might vary from the overall results, depending on the current level of benefits each receives or provides, and on how those benefits would change under the proposed language. The summary results reflect the fact that most carriers offer abortion coverage currently and the requirement of abortion coverage did not add any material impact.

Table ES-1: Summary Results

	2022	2023	2024	2025	2026	WEIGHTED AVERAGE	FIVE-YEAR TOTAL
Members (000s)	2,014	2,010	2,007	2,003	2,000		
Medical Expense Low ($000s)	$22,439	$31,062	$31,006	$30,954	$30,902	$31,009	$146,361
Medical Expense Mid ($000s)	$24,968	$35,498	$36,393	$37,315	$38,261	$36,533	$172,436
Medical Expense High ($000s)	$27,705	$40,428	$42,540	$44,767	$47,110	$42,913	$202,550
Premium Low ($000s)	$26,365	$36,497	$36,431	$36,370	$36,309	$36,435	$171,974
Premium Mid ($000s)	$29,337	$41,710	$42,762	$43,846	$44,956	$42,926	$202,612
Premium High ($000s)	$32,554	$47,503	$49,984	$52,601	$55,355	$50,423	$237,996
PMPM Low	$1.51	$1.51	$1.51	$1.51	$1.51	$1.51	$1.51
PMPM Mid	$1.68	$1.73	$1.78	$1.82	$1.87	$1.78	$1.78
PMPM High	$1.87	$1.97	$2.08	$2.19	$2.31	$2.09	$2.09
Estimated Monthly Premium	$590	$617	$645	$674	$704	$646	$646
Premium % Rise Low	0.256%	0.245%	0.235%	0.225%	0.215%	0.234%	0.234%
Premium % Rise Mid	0.285%	0.280%	0.276%	0.271%	0.266%	0.276%	0.276%
Premium % Rise High	0.317%	0.319%	0.322%	0.325%	0.328%	0.324%	0.324%

Executive Summary Endnotes

[1] The 192nd General Court of the Commonwealth of Massachusetts, House Bill 1196 and Senate Bill 673, "An Act ensuring access to full spectrum pregnancy care." Accessed 16 April 2021: **https://malegislature.gov/Bills/192/H1196** and **https://malegislature.gov/Bills/192/S673**.These bills were previously submitted in the 191st General Court of the Commonwealth of Massachusetts as House Bill 1102 and Senate Bill 587, "An Act to establish health equity for pregnant persons." Accessed 15 December 2020: **https://malegislature.gov/Bills/191/H1102** and **https://malegislature.gov/Bills/191/S587**.

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2.0 Introduction

The Committee on Financial Services referred House Bill 1196 and Senate Bill 673, both entitled, "An Act ensuring access to full spectrum pregnancy care,"

[1] to the Massachusetts Center for Health Information and Analysis (CHIA) for review. Massachusetts General Laws (MGL) Chapter 3 §38C requires CHIA to review and evaluate the potential fiscal impact of each mandated benefit bill referred to the agency by a legislative committee. The report is required to include the effects on healthcare costs, including premium and administrative expenses, of the proposed mandate. H.B. 1196 and S.B. 673 are identical and will therefore be collectively referred to as the "bill" for the remainder of the report.

Assessing the impact of the proposed mandate on premiums entails analyzing its incremental effect on spending by insurance plans. This, in turn, requires comparing spending under the provisions of the bill to spending under current statutes and current benefit plans for the relevant services.

This report is not intended to determine whether the bill would constitute a health insurance benefit mandate for purposes of state defrayal under the ACA, nor is it intended to assist with state defrayal calculations if it is determined to be a health insurance benefit mandate requiring state defrayal.

Section 3.0 of this analysis outlines the provisions and interpretations of the bill. Section 4.0 summarizes the methodology used for the estimate. Section 5.0 discusses important considerations in translating the bill's language into estimates of its incremental impact on healthcare costs and steps through the calculations. Section 6.0 discusses results.

2.1 Background

The bill, as submitted in the 191st General Court of the Commonwealth, requires insurance carriers to:

- Eliminate cost sharing (deductibles, coinsurance, copayments, or any other cost sharing requirement) for prenatal care, child birth, and postpartum care (collectively referred to as maternity care)
- Cover abortion and abortion-related care without cost sharing (i.e., deductibles, coinsurance, copayments, or any other cost sharing requirement)

The bill provides an exemption for abortion and abortion-related care for policies offered by an employer that is a church or qualified church-controlled organization[xxiv,xxv] at the request of the employer, provided that the employer invokes the exemption and delivers written notice[xxvi] to prospective enrollees prior to enrollment in the plan.

3.0 Interpretation of the Bill

3.1 Removal of Cost Sharing for Maternity Care

Massachusetts state law currently requires coverage of maternity care.[xxvii] In addition, the Affordable Care Act (ACA) requires non-grandfathered health plans in the individual and small group markets to cover EHBs, including "maternity and newborn care," which are defined by the state's benchmark plan. The Commonwealth's benchmark plan covers prenatal, childbirth, and postpartum services, with no cost sharing for prenatal care, and no cost sharing for childbirth and postpartum care after the deductible for inpatient hospital services is met. [2] In addition, the ACA requires coverage without cost sharing of evidenced-based items or services with an "A" or "B" rating by the United States Preventive Services Task Force (USPSTF),[3,4] several of which are relevant to prenatal, childbirth, and postpartum services. The bill's intent is to remove all remaining cost sharing for maternity services.

3.2 Coverage of Abortion and Abortion-Related Care without Cost Sharing

No Commonwealth or federal law specifically requires coverage of abortion or abortion-related care. The Commonwealth's benchmark plan includes "voluntary termination of pregnancy" [abortion] with no quantitative limitation.[5] Pursuant to 45 CFR 156.115(c), no health plan is required to cover abortion services as part of the requirement to cover EHBs, even if the benchmark plan includes abortion.[6] However, nothing prevents an insurer's ability to voluntarily cover abortion services or limit the Commonwealth's ability to require coverage of these services under State law.

The bill requires coverage of abortion and abortion-related care, and prevents cost sharing by members, while providing an exception for health plans purchased by church or qualified church-controlled organizations.

3.3 Plans Affected by the Proposed Mandate

[xxiv] Pursuant to M.G.L. c.175 §47W, "church" means a church, a convention or association of churches or an elementary or secondary school that is controlled, operated or principally supported by a church or by a convention or association of churches. A "qualified church-controlled organization" means an organization described in section 501(c)(3) of the federal Internal Revenue Code, other than an organization that: (i) offers goods, services or facilities for sale, other than on an incidental basis, to the general public, other than goods, services or facilities that are sold at a nominal charge that is substantially less than the cost of providing such goods, services or facilities; and (ii) normally receives more than 25 per cent of its support from: (A) governmental sources; (B) receipts from admissions, sales of merchandise, performance of services or furnishing of facilities, in activities which are not unrelated trades or businesses; or (C) both clauses (A) and (B).

[xxv] Pursuant to M.G.L. c.176A §8W, c.176B §4W, and c.176G §4O, the terms "church or qualified church-controlled organization" are defined in 26 U.S.C. section 3121(w)(3)(A) and (B).

[xxvi] The notice shall list the health care methods and services for which the employer will not provide coverage for religious reasons.

[xxvii] Define maternity

The bill as drafted amends statutes that regulate healthcare carriers in the Commonwealth. The bill amends the following chapters, each of which address a particular type of health insurance policy:

- Chapter 32A – Plans Operated by the Group Insurance Commission (GIC) for the Benefit of Public Employees
- Chapter 175 – Commercial Health Insurance Company Plans
- Chapter 176A – Hospital Service Corporation Plans
- Chapter 176B – Medical Service Corporation Plans
- Chapter 176G – Health Maintenance Organization (HMO) Plans

Self-insured plans, except for those managed by the GIC, are not subject to state-level health insurance benefit mandates. State mandates do not apply to Medicare or Medicare Advantage plans, the benefits of which are qualified by Medicare; this analysis excludes members of fully insured commercial plans over 64 years of age and does not address any potential effect on Medicare supplement plans, even to the extent they are regulated by state law. Furthermore, this analysis does not apply to MassHealth.

3.4 Covered Services

BerryDunn surveyed 10 insurance carriers in the Commonwealth, and 6 responded. Maternity care is currently covered with varying amounts of cost sharing. Preventive prenatal care is covered without member cost sharing. Childbirth and postpartum coverage is subject to member cost sharing, which varies depending upon a member's specific coverage. In general, abortion and abortion-related services are covered. However, one of the respondent carriers indicated that fully insured indemnity plans do not include coverage. One of the respondent carriers indicated that large groups can add a rider that excludes coverage for abortion and abortion-related care. However, currently there are no groups that have elected this rider. All carriers allow a religious exemption for abortion coverage. Current coverage and its impact to the incremental cost will be discussed in more detail in Section 5.1.

3.5 Existing Laws Affecting the Cost of the Bill

The bill's coverage requirements are not in conflict with any existing state or federal coverage requirements. There is overlap between the bill and the ACA's preventive health coverage requirements and coverage provided in the Massachusetts benchmark plan.

4.0 Methodology

4.1 Overview

Estimating the impact of the bill on premiums requires assessing the incremental impact of the requirement that insurers include abortion and abortion-related care within the coverage requirement for maternity care. It also requires assessing the incremental impact of eliminating member cost sharing for maternity care and for any abortion-related care that is already covered, taking into consideration the exemption for church or qualified church-controlled organizations.

The incremental cost of abortion is estimated using claims data from the Massachusetts APCD to determine a PMPM cost for these services and applying that cost to membership for whom the services are not covered. The incremental cost of the elimination of member cost sharing for maternity care and for abortion-related care is estimated using claims data from the Massachusetts APCD to determine a PMPM cost for member cost sharing. Combining the components, and accounting for carrier retention, results in a baseline estimate of the proposed mandate's incremental effect on premiums, which is projected over the five years following the assumed January 1, 2022 implementation date of the proposed law.

4.2 Data Sources

The primary data sources used in the analysis are:

- Information about the intended effect of the bill, gathered from the bill's legislative sponsors
- Survey responses from commercial health insurance carriers in the Commonwealth that describe current coverage
- The Massachusetts APCD
- Academic literature, published reports, and population data, cited as appropriate

4.3 Steps in the Analysis

BerryDunn performed analytic steps summarized in this section to estimate the bill's impact on premiums.

1. **Estimated the marginal costs to insurers for abortion and abortion-related care**

   To estimate the impact of the cost of abortion, BerryDunn:

   A. Used claims data from the APCD and determined the allowed PMPM cost for carriers that currently cover abortion and abortion-related services

   B. Multiplied the PMPM cost for abortion and abortion-related services by the membership for the carriers that do not currently cover abortion to determine the annual cost of requiring coverage

   C. Used claims data from the APCD and determined the total member cost sharing amounts for abortion and abortion-related services

   D. Summed the cost of services currently not covered (from Step B) and the cost sharing, for abortion services that are covered (from Step C), to calculate the total marginal cost of abortion and abortion-related services

E. Divided the marginal cost of abortion and abortion-related services from Step D by the total membership to calculate the marginal PMPM cost for abortion and abortion-related services

2. **Estimated the marginal cost to insurers from eliminating any deductible, coinsurance, copayments, or any other member cost sharing from maternity care coverage**

   To estimate the elimination of member cost sharing and calculate the annual marginal cost, BerryDunn:

   A. Used claims data from the APCD and determined the total member cost sharing amounts for prenatal care, childbirth, and postpartum care

   B. Divided the cost sharing amounts by the corresponding membership to calculate the marginal PMPM cost for carriers to eliminate member cost sharing.

3. **Calculated the impact of the combined projected claim costs on insurance premiums**

   To calculate the impact on health insurance premiums, BerryDunn:

   C. A. Summed the estimated marginal PMPM costs for abortion and abortion-related services from step one and the removal of member cost sharing for maternity care from step two

   D. B. Projected the baseline cost forward over the five-year analysis period using an estimated increase in hospital and professional services over the period

   E. C. Estimated the fully insured Commonwealth population under age 65, projected for the next five years (2022 – 2026)

   F. D. Multiplied the estimated incremental paid PMPM cost of the mandate by the projected population estimate to calculate the total estimated marginal claims cost of the bill

   G. E. Estimated insurer retention (administrative costs, taxes, and profit) and applied the estimate to the final incremental claims cost calculated in Step D

4.4 Limitations

In general, carriers currently provide coverage for abortion and abortion-related care, so the marginal cost of the bill is due to eliminating member cost sharing. Determining how member cost sharing will change over time is uncertain. Deductibles and copayments are fixed dollar amounts, and unless the carrier or employer makes changes, the dollar amounts remain fixed. Employers often increase deductibles and copays to keep pace with premium increases. However, the extent to which cost sharing amounts will increase depends upon overall premium increases and employer group budgets.

In addition, BerryDunn did not adjust for a potential impact of COVID-19 on maternity care utilization and the number of abortions performed. A COVID-19 surge could impact maternity care utilization and the number of fully insured members receiving abortions. COVID-19 has impacted the number of commercial, fully insured members in 2020. Fully insured membership declined due to increased unemployment. However, the impact that the COVID-19 outbreak will have on unemployment in the 2022 – 2026 projection period is uncertain.

The more detailed, step-by-step description of the estimation process in the next sections addresses these uncertainties further.

5.0 Analysis

This section describes the calculations outlined in the previous section in more detail. The analysis includes development of a best estimate middle-cost scenario, as well as a low-cost scenario using assumptions that produced a lower estimate and a high-cost scenario using more conservative assumptions that produced a higher-estimated cost impact.

Section 5.1 describes the steps used to calculate the cost of requiring abortion and abortion-related services with no member cost sharing. Section 5.2 describes the steps used to calculate the requirement of eliminating member cost sharing from coverage of maternity care. Section 5.3 describes the steps used to aggregate the costs. Section 5.4 describes the steps to project the fully insured population age 0 – 64 in the Commonwealth over the 2022 – 2026 analysis period. Section 5.5 calculates the total estimated marginal cost of the bill. Section 5.6 describes the steps to adjust the projected marginal costs for carrier retention to arrive at an estimate of the bill's effect on premiums for fully insured plans.

5.1 Covering Abortion and Abortion-Related Services

Estimated the cost of uncovered abortion and abortion-related services and the cost of member cost sharing for currently covered abortion and abortion-related services

BerryDunn used 2018 claims data from the APCD to calculate the PMPM cost for carriers that currently cover abortion and abortion-related services. As discussed previously, all of the carriers responding to the survey currently cover abortion. In one case, a carrier excludes coverage for a specific product, and this product was isolated so that only data that included coverage for abortion was used. Since the mandate requires that claims be covered with no member cost sharing, BerryDunn used allowed claim amounts. BerryDunn divided the allowed claims cost by the corresponding membership to determine the PMPM amount. The PMPM costs are reflected in Table 1.

Table 1: Estimated 2018 Cost of Abortion and Abortion-Related Services

	2018 COST
Allowed Claims	$8,059,111
Membership	22,131,521
Allowed PMPM	$0.36

Next BerryDunn reviewed claims data in the APCD and verified that there were no abortion claims for the one carrier's indemnity product that excludes coverage. This product has very little membership. BerryDunn also reviewed all APCD data by carrier, including those not responding to the survey, and found that all carriers provided abortion coverage with the exception of one small carrier, which did not have any abortion claims. BerryDunn

multiplied the PMPM cost for abortion and abortion-related services by the total membership for whom abortion is not currently covered to determine the annual cost of requiring coverage. BerryDunn divided the marginal cost of uncovered abortion and abortion-related services by the total commercial fully insured membership to calculate the marginal PMPM cost for uncovered abortion and abortion-related services. The marginal PMPM costs are immaterial, and effectively zero as shown in Table 2.

Table 2: Estimated Marginal PMPM Cost of Uncovered Abortion and Abortion-Related Services

	2018 COST
Allowed PMPM	$0.36
Membership without Abortion Coverage	22,854
Incremental Cost	$8,322
Total Membership	22,424,302
Incremental PMPM	$0.00

Similar to maternity care, the bill requires insurers to eliminate any deductible, coinsurance, copayments, or any other member cost sharing from abortion and abortion-related services. Using the 2018 claims data in the APCD, BerryDunn measured the member cost sharing amounts for abortion and abortion-related care and divided by the corresponding membership to calculate the marginal PMPM cost. The resulting marginal PMPM costs are reflected in Table 3.

Table 3: Estimated 2018 Member Cost Sharing for Abortion and Abortion-Related Services

	2018 COST
Total Member Cost Sharing Amount	$1,179,915
Corresponding Membership	22,131,521
Member Cost Sharing PMPM	$0.05

5.2 Eliminating Member Cost Sharing for Maternity Care

Estimated the cost of eliminating any deductible, coinsurance, copayments, or any other member cost sharing from maternity care

The bill requires insurers to eliminate any deductible, coinsurance, copayments, or any other member cost sharing from maternity care. Using 2018 claims data in the APCD, BerryDunn measured the member cost sharing amounts for maternity care and divided by the corresponding membership to calculate the PMPM. The resulting incremental PMPM costs are reflected in Table 4.

Table 4: Estimated 2018 Member Cost Sharing

	2018 COST
Total Member Cost Sharing Amount	$27,696,026
Corresponding Membership	22,424,302
Member Cost Sharing PMPM	$1.24

BerryDunn combined the marginal claims cost of abortion and abortion-related services and maternity care in the next section.

5.3 Combining Abortion and Maternity Care Costs

Combined the marginal claims cost for abortion and abortion-related services, and the removal of member cost sharing for maternity care

BerryDunn summed the estimated marginal PMPM costs for abortion from Table 3 and the marginal cost for removal of member cost sharing for maternity care from Table 4. Results are shown in Table 5.

Table 5: Total Incremental PMPM

	2018 COST
Abortion Cost Sharing PMPM	$0.05
Maternity Care Cost Sharing	$1.24
Total PMPM	$1.29

It is uncertain how member cost sharing will change over time. Deductible and copayments are fixed dollar amounts; and unless the carrier or employer makes changes, the dollar amounts remain fixed. Member coinsurance amounts increase over time with claims cost increases. Eighty six percent of the 2018 member cost sharing impacted by the proposed bill stems from fixed deductibles and copays. Employers often increase deductibles and copays to keep pace with premium increases. In the high scenario, BerryDunn assumed that employers would increase cost share levels at the same pace that claims cost increases. Therefore the long-term national average projection for cost increases to hospital and physician services (5.4%) was used to project PMPM cost for maternity care and abortion cost sharing amounts[7]. In the low scenario, BerryDunn assumed that cost sharing would not increase over time and in the mid scenario, BerryDunn assumed that cost sharing would increase by 2.7% per year on average. BerryDunn multiplied the PMPM amounts from Table 4 by the annual cost increases to estimate the PMPM cost of maternity care and abortion cost sharing amounts over the projection period and Table 6 shows these results.

Table 6: Estimated Marginal PMPM Cost

	2022	2023	2024	2025	2026
Low Scenario	$1.29	$1.29	$1.29	$1.29	$1.29
Mid Scenario	$1.43	$1.47	$1.51	$1.55	$1.59

	2022	2023	2024	2025	2026
High Scenario	$1.59	$1.68	$1.77	$1.86	$1.96

5.4 Projected Fully Insured Population in the Commonwealth

Table 7 presents the projected, fully insured population in the Commonwealth (ages 0 to 64) from 2022 through 2026. Appendix A describes the projection methodology and sources of these values.

Table 7: Projected Fully Insured Population in the Commonwealth, Ages 0 – 64

2022	2023	2024	2025	2026
2,014,007	2,010,132	2,006,510	2,003,142	1,999,776

5.5 Total Marginal Medical Expense

Multiplying the total estimated PMPM cost by the projected fully insured membership over the analysis period (2022 – 2026) results in the total cost (medical expense) associated with the proposed requirement, as shown in Table 8. BerryDunn's analysis assumes the bill, if enacted, would be effective on January 1, 2022.[xxviii]

Table 8: Estimated Marginal Cost of Abortion and Maternity Care

	2022	2023	2024	2025	2026
Low Scenario	$22,438,544	$31,061,539	$31,005,573	$30,953,528	$30,901,514
Mid Scenario	$24,967,909	$35,498,282	$36,393,263	$37,315,414	$38,260,861
High Scenario	$27,705,317	$40,428,120	$42,539,506	$44,766,686	$47,110,386

5.6 Carrier Retention and Increase in Premium

Carriers include their retention expense in fully insured premiums. Retention expense includes general administration, commissions, taxes, fees, and contribution to surplus or profit. Assuming an average retention rate of 14.9% based on CHIA's analysis of fully insured premium retention in the Commonwealth,[8] the increase in medical expense was adjusted upward to approximate the total impact on premiums in Table 9.

Table 9: Estimate of Increase in Carrier Premium Expense

	2022	2023	2024	2025	2026
Low Scenario	$26,365,248	$36,497,252	$36,431,492	$36,370,339	$36,309,222
Mid Scenario	$29,337,247	$41,710,417	$42,762,018	$43,845,543	$44,956,442

[xxviii] The analysis assumes the mandate would be effective for policies issued and renewed on or after January 1, 2022. Based on an assumed renewal distribution by month, by market segment, and by the Commonwealth market segment composition, 72.1% of the member months exposed in 2022 will have the proposed mandate coverage in effect during calendar year 2022. The annual dollar impact of the mandate in 2022 was estimated using the estimated PMPM and applying it to 72.1% of the member months exposed.

	2022	2023	2024	2025	2026
High Scenario	$32,553,697	$47,502,967	$49,983,842	$52,600,775	$55,354,618

6.0 Results

The estimated impact of the proposed requirement on medical expense and premiums is explained in Section 6.1 and summarized on the following page in Table 10. The analysis includes development of a best estimate "mid-level" scenario, as well as a low-level scenario using assumptions that produced a lower estimate and a high-level scenario using more conservative assumptions that produced a higher estimated impact.

The impact on premiums is driven by the provisions of the bill that require carriers to cover abortion and abortion-related services with no cost sharing and to eliminate member cost sharing from maternity care. Variation between scenarios is attributable to the uncertainty surrounding the annual increase in member cost sharing amounts included in member's benefit plans.

6.1 Five-Year Estimated Impact

Table 10 presents the projected net impact of the bill on medical expense and premiums for each year over the 2022 – 2026 period using a projection of Commonwealth fully insured membership. The low scenario would result in $36.4 million per year on average. It assumes a no annual increase in cost sharing amounts. The high scenario's projected impact is $50.4 million and assumes a 5.4% annual increase in cost sharing amounts. The mid scenario would result in average, annual costs of $42.9 million, or an average of 0.28% of premiums. It assumes a 2.7% annual increase in cost sharing amounts.

The impact of the proposed law on any one individual, employer group, or carrier might vary from the overall results, depending on the current level of benefits each receives or provides and on how benefits would change under the proposed language. Some religious employers do not currently offer coverage for abortion and abortion-related services, and BerryDunn assumed they will continue that practice under the religious exemption in the proposed bill.

Table 10: Summary Results

	2022	2023	2024	2025	2026	WEIGHTED AVERAGE	FIVE-YEAR TOTAL
Members (000s)	2,014	2,010	2,007	2,003	2,000		
Medical Expense Low ($000s)	$22,439	$31,062	$31,006	$30,954	$30,902	$31,009	$146,361
Medical Expense Mid ($000s)	$24,968	$35,498	$36,393	$37,315	$38,261	$36,533	$172,436
Medical Expense High ($000s)	$27,705	$40,428	$42,540	$44,767	$47,110	$42,913	$202,550
Premium Low ($000s)	$26,365	$36,497	$36,431	$36,370	$36,309	$36,435	$171,974
Premium Mid ($000s)	$29,337	$41,710	$42,762	$43,846	$44,956	$42,926	$202,612
Premium High ($000s)	$32,554	$47,503	$49,984	$52,601	$55,355	$50,423	$237,996
PMPM Low	$1.51	$1.51	$1.51	$1.51	$1.51	$1.51	$1.51
PMPM Mid	$1.68	$1.73	$1.78	$1.82	$1.87	$1.78	$1.78
PMPM High	$1.87	$1.97	$2.08	$2.19	$2.31	$2.09	$2.09
Estimated Monthly Premium	$590	$617	$645	$674	$704	$646	$646
Premium % Rise Low	0.256%	0.245%	0.235%	0.225%	0.215%	0.234%	0.234%
Premium % Rise Mid	0.285%	0.280%	0.276%	0.271%	0.266%	0.276%	0.276%
Premium % Rise High	0.317%	0.319%	0.322%	0.325%	0.328%	0.324%	0.324%

The total projected medical expense and premium dollars are calculated using PMPM results and the projected fully insured membership from 2022 – 2026. Due to the impact of the COVID-19 outbreak on the economy, there is a great deal of uncertainty around the anticipated level of commercial fully insured membership over the next five years. In 2020, commercial fully insured membership is approximately 3% less than 2019, with a shift to both uninsured and MassHealth coverage. BerryDunn is conservatively assuming economic recovery by 2022.

6.2 Impact on the GIC

Findings from BerryDunn's carrier surveys indicate that benefit offerings for GIC and other commercial plans in the Commonwealth are similar. For this reason, the bill's estimated impact on GIC's incremental PMPM medical expense is assumed to be the same as other fully insured plans in the Commonwealth. To separately estimate the total medical expense for the GIC, BerryDunn applied the PMPM medical expense to the GIC membership.

BerryDunn assumed the proposed legislative change will apply to self-insured plans that the GIC operates for state and local employees, with an effective date of July 1, 2022. Because of the July effective date, the results in 2022 are approximately one-half of an annual value. Table 11 breaks out the GIC's self-insured membership, as well as the corresponding incremental medical expense.

Table 11: GIC Summary Results

GIC SELF-INSURED	2022	2023	2024	2025	2026	WEIGHTED AVERAGE	FIVE-YEAR TOTAL
Members (000s)	2,014	2,010	2,007	2,003	2,000		
Members (000s)	314	313	312	312	311		
Medical Expense Low ($000s)	$2,424	$4,837	$4,827	$4,818	$4,809	$4,828	$21,715
Medical Expense Mid ($000s)	$2,697	$5,528	$5,666	$5,808	$5,954	$5,703	$25,654

Endnotes

[1] The 192nd General Court of the Commonwealth of Massachusetts, House Bill 1196 and Senate Bill 673, "An Act ensuring access to full spectrum pregnancy care." Accessed 16 April 2021: **https://malegislature.gov/Bills/192/H1196** and **https://malegislature.gov/Bills/192/S673**.These bills were previously submitted in the 191st General Court of the Commonwealth of Massachusetts as House Bill 1102 and Senate Bill 587, "An Act to establish health equity for pregnant persons." Accessed 15 December 2020: **https://malegislature.gov/Bills/191/H1102** and **https://malegislature.gov/Bills/191/S587**.

[2] CMS.gov. Centers for Medicare & Medicaid Services. Information on Essential Benefits (EHB) Benchmark Plans. Accessed 15 February 2021: **https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb; https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP-Summary_MA_4816.zip/**.

[3] 45 CFR 147.130: Accessed 15 February 2021: **https://www.ecfr.gov/cgi-bin/text-idx?node=pt45.1.147&rgn=div5#se45.2.147_1130**.

[4] U.S. Preventive Services Task Force. A and B Recommendations. Accessed 15 February 2021: **https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations**.

[5] CMS.gov. Centers for Medicare & Medicaid Services. Information on Essential Benefits (EHB) Benchmark Plans. Accessed 15 February 2021: **https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP-Summary_MA_4816.zip/**.

[6] 45 CFR 156.115(c): Accessed 24 March 2021: **https://www.ecfr.gov/cgi-bin/text-idx?SID=e21c448818e2644dcc02a2a296009b71&mc=true&node=se45.1.156_1115&rgn=div8**.

[7] U.S. Centers for Medicare and Medicaid Services (CMS), Office of the Actuary. National Health Expenditure Projections. Table 6, Hospital Care Expenditures and Table 7, Physician and Clinical Services Expenditures; Aggregate and per Capita Amounts, Percent Distribution and Annual Percent Change by Source of Funds: Calendar Years 2019-2026; Private Insurance. Accessed 4 February 2021: **https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html**.

[8] Massachusetts Center for Health Information and Analysis. Annual Report on the Massachusetts Health Care System, September 2019. Accessed 29 October 2020: **http://www.chiamass.gov/annual-report**.

Appendix A: Membership Affected by the Proposed Language

Membership potentially affected by proposed mandated change criteria include Commonwealth residents with fully insured, employer-sponsored health insurance issued by a Commonwealth-licensed company (including through the GIC); non-residents with fully insured, employer-sponsored insurance issued in the Commonwealth; Commonwealth residents with individual (direct) health insurance coverage; and lives covered by GIC self-insured coverage.

Please note these are unprecedented economic circumstances, due to the COVID-19 outbreak, which makes estimating membership extremely challenging. Membership projections are used to determine the total dollar impact of the proposed mandate in question; however, variations in the membership forecast will not affect the general magnitude of the dollar estimates. As such, given the uncertainty, BerryDunn took a simplified approach to the membership projections as described below. These membership projections are not intended to be used for any other purpose than producing the total dollar range in this study. Further, to assess how recent volatility in commercial enrollment levels may affect these cost estimates, please note that the PMPM and percent of premium estimates are unaffected because they are per-person estimates, and the total dollar estimates will vary by the same percentage as any percentage change in enrollment levels.

The 2018 Massachusetts APCD formed the base for the projections. The Massachusetts APCD provided fully insured membership by insurance carrier. The Massachusetts APCD was also used to estimate the number of non-residents covered by a Commonwealth policy. These are typically cases in which a non-resident works for a Commonwealth employer that offers employer-sponsored coverage. Adjustments were made to the data for membership not in the Massachusetts APCD, based on published membership reports available from CHIA and the Massachusetts Department of Insurance (DOI).

CHIA publishes monthly enrollment summaries in addition to its biannual enrollment trends report and supporting databook (enrollment-trends-March-2020-databook

[1] and Monthly Enrollment Summary – August 2020[2]), which provides enrollment data for Commonwealth residents by insurance carrier for most carriers (some small carriers are excluded). CHIA uses supplemental information beyond the data in the Massachusetts APCD to develop its enrollment trends report. The supplemental data was used to adjust the resident totals from the Massachusetts APCD. In 2020, commercial, fully insured membership is 2.9% less than in 2019 with a shift to both uninsured and MassHealth coverage. The impact of the COVID-19 outbreak on fully insured employers over the five-year projected period is uncertain. BerryDunn took a high-level conservative approach and assumed that membership would revert to 2019 levels by January 1, 2022. Given this approach, the 2021 assumption is dependent upon emerging 2020 fully insured membership levels.

The DOI published reports titled Quarterly Report of HMO Membership in Closed Network Health Plans as of December 31, 2018[3], and Massachusetts Division of Insurance Annual Report Membership in MEDICAL Insured Preferred Provider Plans by County as of December 31, 2018[4]. These reports provide fully insured covered members for licensed Commonwealth insurers where the member's primary residence is in the Commonwealth. The DOI reporting includes all insurance carriers and was used to supplement the Massachusetts APCD membership for small carriers not in the Massachusetts APCD.

The distribution of members by age and gender was estimated using Massachusetts APCD population distribution ratios and was checked for reasonableness and validated against U.S. Census Bureau data.[5] Membership was projected from 2020 – 2025 using Massachusetts Department of Transportation population growth rate estimates by age and gender.[6]

Projections for the GIC self-insured lives were developed using the GIC base data for 2018, and 2019 received directly from the GIC as well as the same projected growth rates from the Census Bureau that were used for the Commonwealth population. Breakdowns of the GIC self-insured lives by gender and age were based on the Census Bureau distributions.

Appendix A Endnotes

[1] Center for Health Information and Analysis. Estimates of fully insured and self-insured membership by insurance carrier. Accessed 15 November 2020. **www.chiamass.gov/enrollment-in-health-insurance/**.

[2] Center for Health Information and Analysis. Estimates of fully insured and self-insured membership by insurance carrier. Accessed 15 November 2020. **www.chiamass.gov/enrollment-in-health-insurance/**.

[3] Massachusetts Department of Insurance. HMO Group Membership and HMO Individual Membership Accessed 12 November 2020 https://www.mass.gov/doc/group-members/download **https://www.mass.gov/doc/individual-members/download**.

[4] Massachusetts Department of Insurance. Membership 2018. Accessed 12 November 2020 **https://www.mass.gov/doc/2018-ippp-medical-plans/download**.

[5] U.S. Census Bureau. Annual Estimates of the Population for the United States, Regions, States, and Puerto Rico: April 1, 2010 to July 1, 2018. Accessed 12 November 2020: **https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk**.

[6] Massachusetts Department of Transportation. Socio-Economic Projections for 2020 Regional Transportation Plans. Accessed 12 November 2020: **https://www.mass.gov/lists/socio-economic-projections-for-2020-regional-transportation-plans**.

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