Mandated Benefit Review of Senate Bill 789
Submitted to the 194th General Court:

An Act Relative to Insurance Coverage for Doula Services

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CHIA

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1.0 Executive Summary S.B. 789. "An Act relative to insurance coverage for doula services"

The Massachusetts Legislature's Joint Committee on Health Care Financing referred Senate Bill 789 (S.B. 789), titled, "An Act relative to insurance coverage for doula services" to the Massachusetts Center for Health Information and Analysis (CHIA) for review.[1] This report references S.B. 789 hereafter as "the bill."

The bill requires commercial insurers to provide coverage for doula services without cost sharing to individuals and families from conception until 12 months after pregnancy, labor, childbirth, adoption, miscarriage, stillbirth, or abortion. Insurers must cover at least 20 hours of prenatal and postpartum doula services without prior authorization at rates equivalent to or greater than MassHealth's reimbursement rate, as well as labor and delivery support. The bill prevents insurers from requiring referrals as a condition of reimbursement and from imposing additional credentialing requirements beyond those developed by the Massachusetts Department of Public Health. The mandate would establish the Doula Advisory Committee to consult about MassHealth's coverage of doula services and amends patients' rights to include doulas as part of labor and delivery.

1.1 What Are Doula Services?

A doula is a trained professional who provides physical, emotional, informational, and practical support to individuals and families during pregnancy, labor and delivery, postpartum recovery, and other pregnancy-related experiences, including miscarriage, stillbirth, abortion, and adoption.[2] Doulas complement the work of physicians, midwives, nurses, and other health care providers by offering continuous, relationship-based support throughout the perinatal period.[3] Doula services can include childbirth education, assistance with developing birth preferences, continuous labor support, postpartum recovery support, infant feeding guidance, accompaniment to medical and social service appointments, and connection to community-based resources.[4,5,6] Doulas may also support communication between patients and clinical providers and help individuals advocate for their preferences, needs, and cultural or linguistic considerations during care.[7,8,9] Doula services are designed to provide continuity of support before, during, and after birth and are intended to complement, rather than replace, clinical care.[10,11]

1.2 Current Coverage

Under the Affordable Care Act (ACA), non-legacy individual and small group health plans are required to cover Essential Health Benefits (EHBs), which include maternity and newborn care as one of the 10 mandated benefit categories. The Massachusetts EHB benchmark plan, in effect for plan years 2025 – 2027, includes coverage for maternity and newborn care.[12,13] Currently, however, commercial insurers are not required to provide coverage for doula services nationally and in Massachusetts. In BerryDunn's survey of commercial insurance carriers in the Commonwealth, one carrier responded that they provide coverage for 16 hours of doula services and one delivery without eligibility restrictions or cost sharing. Other carriers

do not currently cover doula services for the commercially insured population, but some provide doula service coverage for MassHealth members. Almost all carriers anticipate increased utilization of doula services if the bill passes.

1.3 Analysis Overview

The bill would require commercial health insurers to cover at least 20 hours of prenatal and postpartum doula services, as well as labor and delivery support, without prior authorization and at reimbursement rates equivalent to or greater than MassHealth rates. This analysis evaluates the potential impact of the proposed mandate on health insurance premiums by estimating both the incremental cost under current utilization and the additional cost associated with anticipated increases in utilization resulting from the mandate. The analysis focuses on individuals under age 65 enrolled in fully insured commercial health plans in the Commonwealth.

1.4 Estimated Cost of Enactment

Requiring coverage for this benefit by fully insured health plans would result in an average annual increase to the typical member's health insurance premium between $0.37 and $0.99 per member per month (PMPM) or between 0.05% and 0.12% of premium over a projection period of five years.

The mandate may generate cost offsets through reductions in costly adverse maternal and infant outcomes and interventions. However, estimating the magnitude of these potential offsets is beyond the scope of this report.

1.5 Efficacy Impact

The evidence on the efficacy of doula care is overall positive or neutral. Doulas serve as advocates for their clients by helping to express individuals' preferences,[14] including cultural and community needs.[15] Research highlights that doulas help reduce rates of unneeded birth interventions, including cesarean deliveries.[16,17,18,19] Their support reduces stress and helps the birthing person[i] feel empowered.[20] Among individuals who use doula services, most report lower stress levels and feel better equipped for the postpartum period.[21,22] Research suggests that doulas help mitigate health disparities through their client advocacy, especially for historically marginalized groups.[23,24,25,26,27]

[i] The language in this report strives to be respectful of individual identity. This bill uses "women," "pregnant person," "pregnant individual(s)" and "birthing person/people" interchangeably, and to align with the associated literature.

Endnotes

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An Act Relative to Insurance Coverage for Doula Services

MEDICAL EFFICACY ASSESSMENT

2.0 Medical Efficacy Assessment

The Massachusetts Legislature's Joint Committee on Health Care Financing referred Senate Bill 789 (S.B. 789), titled, "An Act relative to insurance coverage for doula services"[1] to the Massachusetts Center for Health Information and Analysis (CHIA) for review. This report references S.B. 789 hereafter as "the bill."

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M.G.L. Chapter 3 §38C charges CHIA with reviewing the medical efficacy of proposed mandated health insurance benefits.[2] Medical efficacy reviews summarize current literature on the effectiveness and use of the treatment or service and describe the potential impact of a mandated benefit on the quality of patient care and health status of the population.

This report proceeds in the following sections:

2.0 Medical Efficacy Assessment

- 2.1 Maternal Health in the United States and Massachusetts
- 2.2 Definition and Core Components of Doula Services
- 2.3 Efficacy of Doula Services
- 2.4 Access, Utilization, and State Comparisons
- 2.5 Current Coverage Nationally and Within Massachusetts

[ii] The language in this report strives to be respectful of individual identity. This bill uses "women", "pregnant person", and "birthing person" interchangeably and to align with the associated literature.

2.1 Maternal Health in the United States and Massachusetts

Maternal health in the United States has received increasing attention as negative outcomes continue to increase despite high health care spending. One strategy to address these outcomes has been to expand the perinatal workforce by extending insurance coverage for doula support.[3] Over the last 20 years, there has been growing recognition of the value of doula support, most notably their impact on reduced harm and improved perinatal health outcomes.[4]

Severe maternal morbidity (SMM)[iii] is unexpected and potentially life-threatening complications during labor and delivery, such as cardiac events, sepsis, or hemorrhage. These events can lead to negative short- and/or long-term health consequences.[5,6,7] An estimated 50,000 individuals are impacted by SMM annually across the United States,[8] with higher rates among non-White birthing individuals.[9] Individuals experiencing SMM have nearly twice the risk of death during the postpartum period compared to those without complications.[10]

In Massachusetts, the prevalence of SMM has been increasing since 2011, with nearly 400 birthing people affected annually.[11] Birthing people of color experience SMM at disproportionate rates compared to white birthing people,[12] independent of age, insurer, and other factors.[iv,13,14] The increasing SMM trend nationally and within Massachusetts could be partially explained by increased rates of preexisting conditions as a result of social disparities and health inequities.[15]

Although the maternal mortality rate has been decreasing over the last few years,[16] the United States has the highest maternal mortality rate among high-income countries.[17] As of 2024, the U.S. maternal mortality rate[v] was 17.9 deaths per 100,000 live births, and 649 women died from a pregnancy-related condition.[18] In Massachusetts, the pregnancy-related[vi,19] mortality ratio for 2021 was 18.4 deaths per 100,000 live births overall.[20] Nationally, and in the Commonwealth, more than 80% of pregnancy-related deaths are considered preventable.[21,22] American Indian, Black, and Asian women have an increased risk of pregnancy-related death compared to white women.[23] Nationally and in Massachusetts, Black women have significantly higher maternal mortality rates compared to other racial groups.[vii,24, 25] In the Commonwealth,

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[iii] SMM is categorized and identified by the following discharge diagnoses or procedural codes: acute myocardial infarction, aneurysm, acute renal failure, adult respiratory distress syndrome, amniotic fluid embolism, cardiac arrest/ventricular fibrillation, conversion of cardiac rhythm, disseminated intravascular coagulation, eclampsia, heart failure/arrest during surgery or procedure, puerperal cerebrovascular disorders, pulmonary edema/acute heart failure, severe anesthesia complications, sepsis, shock, sickle cell disease with crisis, air and thrombotic embolism, hysterectomy, temporary tracheostomy, and ventilation.

[iv] A 2024 study from the Massachusetts Health Policy Commission (HPC) found that Black non-Hispanic birthing people with commercial insurance had a rate of SMM 17% higher compared to those with MassHealth coverage.

[v] The maternal mortality rate includes a death during pregnancy or within 42 days after giving birth.

[vi] Pregnancy-related deaths are deaths that occur during the perinatal period as a result of a new condition from pregnancy or exacerbation of an existing physical and/or mental health condition.

[vii] Nationally, the maternal mortality rate among Black women is 44.8 deaths per 100,000 live births, over three times the rate of white women (14.2 deaths per 100,000 live births). In Massachusetts, non-white birthing people experienced higher rates of death, with Black birthing people almost twice as likely to experience a pregnancy-related death (36.1 deaths per 100,000 live births).

the main contributing factors for maternal mortality included discrimination[viii] (44%), mental health conditions (44%), substance use disorder (56%), and lack of continuity of care and care coordination (48%).[26] Age can also increase risk of maternal mortality, particularly for pregnant individuals ages 40 and older.[27]

2.2 Definition and Core Components of Doula Services

The bill defines doula services as "physical, emotional, and informational support, but not medical care, provided by trained doulas." The bill further defines eight areas of doula services: [28]

1. "Continuous labor and delivery support, inclusive of all outcomes
2. Support for pregnancy or infant loss, including bereavement home or in-person visits
3. Accompanying individuals to health care and social services appointments
4. Connecting individuals to community-based and state- and federally-funded resources, including those which address social determinants of health
5. Being on-call around the time of birth, adoption, loss, or abortion, as well as providing on-call support in-person or via telehealth for individuals' questions or concerns
6. Support for other individuals providing care for a birthing or adoptive parent, including spouses, partners, and other family members
7. Educational and informational support, including, but not limited to, childbirth preparation, newborn care, perinatal mental health, and postpartum recovery
8. Empowering individuals to advocate for their preferences, needs and rights during pregnancy, labor and delivery, and postpartum."

Doulas act as liaisons between providers and their clients, helping to minimize fear and anxiety by clarifying medical jargon and focusing on the birthing person's feelings throughout the perinatal period.[29,30] Doulas provide continuity of care throughout pregnancy, attending appointments and building a relationship throughout the gestation period, whereas an individual's prenatal care provider might not be the provider present during birth or other procedures.[31,32] Additionally, doulas help merge the expertise of clinical providers with the lived experience of birthing individuals, positively impacting the perinatal experience and overall well-being.[33] Due to differing standards of care and reporting requirements, clinical staff might not be able to provide the one-on-one support an individual or family needs during birth, leading to dissatisfaction among birthing individuals.[34,35] Evidence suggests that doulas help reduce birth trauma by helping individuals advocate for and receive appropriate care, especially among individuals of color. [36] Individuals who utilize doula services generally report high levels of satisfaction with the care they receive,[37] noting

[viii] The study defined "discrimination" as "as treating someone less or more favorably based on the group, class or category they belong to resulting from biases, prejudices, and stereotyping."

improved self-empowerment, lower stress levels, lower need for clinical interventions, and increased ability to manage the postpartum transition. [38]

Many doulas specialize their services, providing expertise pertaining to a certain time period such as the prenatal, labor and birth, or postpartum period. Individuals working with birth doulas typically begin the relationship prenatally and receive continuous support through delivery, while postpartum doulas are generally engaged after birth for scheduled home visits. Doulas who offer full-spectrum support may accompany individuals across the entire continuum of pregnancy, while bereavement and abortion doulas typically provide more defined, time-limited support. Some doulas specialize in high-risk pregnancies; supporting individuals who seek abortions; or full-spectrum care and support throughout a pregnancy, including miscarriage or stillbirth.[39] Doula services span the full continuum of care and are typically delivered across three primary phases:

- Prenatal Support: During pregnancy, doulas provide education on childbirth, postpartum recovery, and infant care, while also helping individuals prepare birth plans and navigate the health care system. This might include attending prenatal visits, identifying risk factors or social needs, and connecting individuals to community-based resources.[40,41]
- Labor and Delivery Support: During labor, doulas provide continuous, in-person support that may include comfort measures such as positioning, breathing techniques, and physical support, as well as emotional reassurance. They also assist with communication between the birthing individual and clinical providers.[42]
- Postpartum Support: Following birth, doulas provide support related to physical recovery, infant feeding, and adjustment to caregiving. This might include providing lactation support, monitoring for warning signs of complications, and facilitating follow-up care.

2.3 Efficacy of Doula Services

Prenatal Care

Prenatal care[ix,43] typically includes assessment and monitoring of the pregnant person and fetus, including medical[x] and non-medical needs.[xi,44] Access to and regular use of prenatal care has been shown to improve outcomes for both the pregnant person and infant.[45,46,47] Although nationally, nearly 98% of pregnant individuals utilize prenatal care, almost a quarter of individuals do not receive care until after the first trimester, and about half do not get recommended care when needed.[48] In Massachusetts, about 83%

[ix] Prenatal care is defined as the health care, education, and counseling provided while pregnant.
[x] Medical needs include chronic conditions, mental health and substance use disorder history, surgeries, allergies, medications, oral health. Family history includes genetic conditions, chronic conditions, pregnancy loss or complications, and cancer.
[xi] Non-medical factors include an individual's characteristics and social identity, especially as it pertains to historic marginalization, current level of social support, assessment of past trauma (including intimate partner violence), current access to housing, food, transit, and health care, financial status, education level, and current employment.

of pregnant people with commercial insurance received the adequate number of prenatal visits at the right timing throughout pregnancy.[49] A 2024 qualitative study found doula care can help support individuals with chronic conditions such as hypertension, positively affecting pregnancy outcomes.[50]

Impact on Labor and Delivery Outcomes

Currently in the United States, 98.4% of births occur in hospitals with high rates of birth interventions. [51] Interventions commonly used include induction of labor (via medications or physical procedures), use of epidural (lower body anesthesia), intravenous fluids (IVs), and cesarean deliveries.[xii,52,53] Cesarean delivery carries immediate and long-term high risks for the birthing person,[54] including significantly increased risk of maternal morbidity and mortality compared to vaginal delivery.[55,56] Additionally, cesarean deliveries can cost insurers nearly double the amount of vaginal surgeries.[57] In 2022, 32.2% of national births[58] and 33.1% of births in the Commonwealth were delivered via cesarean.[59] In Massachusetts, the percentage of births delivered via cesarean has been increasing, especially among Black non-Hispanic birthing people.[xiii,60]

A 2019 study of over 2,000 individuals found that nationwide, over 17% of pregnant people reported they were treated poorly during labor and delivery; individuals reported that providers shouted at them, ignored requests for care or failed to respond to requests timely, disregarded physical privacy, withheld treatment, or provided unwanted treatment. These outcomes were more prevalent among Indigenous (32.8%), Hispanic (25%), and Black women (22.5%). Overall, women of color reported experiencing greater prevalence of mistreatment,[xiv] (37%) compared to white women (22.1%) across socioeconomic status. Additionally, among individuals who disclosed experiencing mistreatment during birth, nearly 40% reported feeling pressured into a medical intervention or procedure. Individuals who had unplanned cesarean deliveries or assisted vaginal deliveries were nearly four times as likely to report mistreatment.[61]

Individuals who receive support from a doula report improved birth experiences, including decreased labor time, reduced cesarean surgeries[62] and assisted vaginal births,[xv,63,64] and decreased use of pain medications during labor.[65] Some studies report that doula care resulted in lower odds of epidural and drug use and other studies report no differences.[66] Additionally, doulas provide emotional continuity and non-

[xii] Cesarean delivery, often called a C-section, is regarded as a safe and common surgery to deliver a baby, either electively, or when a provider deems the risk of vaginal delivery as too high for the birthing person and/or the infant.
[xiii] In the Commonwealth, the percentage of births delivered via cesarean has increased nearly 11% since the 1990s. DPH reported that in 2022, Black non-Hispanic birthing people had the highest prevalence of cesarean deliveries (36.1%).
[xiv] Examples of mistreatment include abusive behavior (physical, sexual, and/or verbal), stigma, discrimination, lack of respect and/or autonomy, violation of privacy, neglect, and failure to meet standards of care.
[xv] Assisted vaginal delivery or birth, also called instrumental vaginal delivery or birth, refers to the use of forceps or vacuums to help with delivery. Assisted vaginal births can lead to tissue injury, urinary incontinence, or fecal incontinence for the birthing person, and potential external and internal risks for the infant.

clinical support that might address psychological dimensions of the birth experience that clinical providers are not positioned to address within standard visit structures.[67]

Infant Mortality

Infant mortality, defined as the death of a live-born infant before the first birthday, is a key indicator of population health and the quality of maternal and newborn care. In 2022, the national infant mortality rate was 5.6 deaths per 1,000 live births, representing a 3% increase from 2021 and marking the first statistically significant increase in two decades.[68] The primary causes of infant death include congenital anomalies, disorders related to preterm birth and low birthweight, sudden infant death syndrome (SIDS), and maternal complications.[69] Preterm birth and low birthweight, which are themselves associated with inadequate prenatal care, chronic stress, and structural inequities, are among the most modifiable contributors to infant mortality.[70] Doula support has been associated with reductions in preterm birth and low birthweight, suggesting a potential pathway through which doula coverage could contribute to improved infant survival outcomes, though the evidence base specific to the commercially insured population remains limited.[71,72]

Postpartum Support and Maternal Mental Health

The postpartum period is an especially vulnerable time, with a third of pregnancy-related deaths occurring within the year following birth.[73] In addition, an estimated 23% – 40% of postpartum individuals do not attend a postpartum visit[xvi],[74, 75,76] because of logistical, financial, or social factors,[xvii],[77,78] increasing the risk that birthing complications remain unaddressed.[79] A 2023 survey of currently or previously pregnant individuals across the U.S. showed that after birth, over 40% reported receiving less than a week of support.[80] This lack of follow-up care increases the risk that birthing complications will be unaddressed.[81]

Perinatal mental health conditions, including depression, anxiety, post-traumatic stress disorder, and psychosis, are among the most common complications of pregnancy and the postpartum period.[82] Perinatal mood and anxiety disorders (PMADs) affect up to one in five pregnant and postpartum individuals and are the leading cause of pregnancy-related death in some analyses.[83] In Massachusetts, mental health conditions were identified as a contributing factor in 44% of pregnancy-related deaths between 2020 – 2021.[84] Postpartum depression (PPD), a type of PMAD, is a common complication that can occur within the first year after childbirth,[85] with higher prevalence among Black postpartum individuals.[86,87] PPD often results in negative short- and long-term consequences for both the birthing person and child.[xviii],[88,89]

[xvi] A postpartum visit includes at least one of the following: an assessment with a health care provider within three weeks postpartum and a comprehensive visit no later than 12 weeks after birth.

[xvii] Factors include patient (personal traits, genetic pre-dispositions, lack of knowledge of warning signs), community (availability of supports), provider (misdiagnoses, ineffective treatment), facility and/or systems factors (reimbursement models, lack of appointment availability, poor coordination of care).

[xviii] Effects of PPD for the birthing person include interrupted maternal-infant attachment, reduced sleep, recurring and intrusive negative thoughts, suicidal ideation, increased substance use, strained social relationships, difficulties with breast/chestfeeding,

Evidence shows a positive association between doula support and lower rates of PPD, anxiety, and other mental health conditions in the postpartum period.[90] A 2022 study of doula services among Medicaid recipients found that doula support during labor and birth alone reduced the odds of PPD and/or anxiety by nearly 65%.[91]

Pregnancy and Infant Loss

Pregnancy and infant loss, including miscarriage, stillbirth, and neonatal death, affects a substantial proportion of individuals and families each year and is associated with significant psychological morbidity. In the United States, approximately 10% – 20% of known pregnancies end in miscarriage, and the national stillbirth rate was 5.73 per 1,000 births in 2022.[92] Grief and trauma following pregnancy or infant loss are well-documented and can include acute grief, post-traumatic stress, depression, anxiety, and complicated bereavement.[93] Doulas specializing in reproductive loss, sometimes referred to as bereavement doulas or loss doulas, provide individualized emotional, informational, and practical support to individuals and families navigating miscarriage, stillbirth, and infant death.[94] Research suggests that continuous support during and after pregnancy loss could help reduce psychological distress, improve feelings of agency and dignity, and facilitate access to appropriate grief resources.[95]

Abortion

Abortion doulas can help individuals prepare for and manage the procedural or medication experience, and access follow-up care and support.[96,xix] A 2014 randomized controlled trial found that individuals who received continuous support from a trained doula during a surgical abortion procedure reported significantly lower pain and anxiety compared to those who received standard care alone.[97] A 2023 study similarly found that doula support during abortion care was associated with improvements in patient experience, self-efficacy, and satisfaction with care.[98] A 2025 systematic review noted that one randomized controlled trial comparing standard care to doula support found that doulas might reduce anxiety and improve the overall experience of individuals who seek to end their pregnancies, though the authors noted a need for additional research with larger and more diverse samples.[99] Individuals seeking abortion care might experience a range of emotions and physical experiences, including anxiety, pain, grief, and relief, and might face logistical barriers, including transportation, childcare, cost, and stigma.[100]

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and/or persistent depression. Children born to individuals with PPD have increased risk of cognitive, behavioral, emotional, psychiatric, and medical conditions, when PPD is left untreated.

[xix] The U.S. Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization* (2022), which overturned *Roe v. Wade* (1973), could potentially increase demand for abortion-related doula services in Massachusetts as a result of individuals traveling from states with more restrictive abortion laws. However, neither the experts consulted for this report nor the reviewed literature explicitly identified capacity constraints for abortion-related doula services.

Adoption

The bill extends doula eligibility to adoptive parents through 12 months post-adoption. Adoptive parents might experience challenges similar to the postpartum period, including depression, attachment concerns, and the demands of infant care, yet are less likely to be screened or receive support.[101,102] Doulas providing adoption support can offer informational guidance, emotional support during the transition, lactation assistance where applicable, and connection to community and clinical resources.[103]

Impact Among Historically Marginalized Groups

While much of the available research on perinatal disparities focuses on race and ethnicity, disparities are also documented among other historically marginalized groups, including LGBTQ+ individuals and people with disabilities, though the literature in these areas is more limited. Doulas are positioned to support populations that face elevated perinatal risks and systemic barriers to equitable care. Nationally and in the Commonwealth, racial and ethnic groups experience persistent maternal and child health disparities irrespective of socioeconomic status.[104,105] Non-white individuals, LGBTQ+ individuals, and women with disabilities endure higher rates of cesarean deliveries, preterm births, PPD, high rates of discrimination, SMM, and maternal mortality.[106,107,108,109] Research also indicates that pregnant women with disabilities often face fragmented care, compounded by provider bias and insufficient knowledge about how to adequately support this population.[110] A few studies also noted the importance of doulas providing linguistically concordant care, either provided directly by doulas or through coordination of interpreter services, to improve perinatal outcomes.[111,112,113] In addition, although research is currently limited, available studies have identified increased perinatal risks and adverse outcomes among individuals with multiple marginalized identities.[114,115]

Researchers suggest that doulas can improve the birthing experience for historically marginalized groups by disrupting and preventing harms such as racial bias, implicit bias, the withholding of necessary pain medication, unnecessary birth interventions, and advocating for their client.[116] Doulas can mitigate disparities by providing individualized, culturally, and linguistically concordant care, and advocating for their client.[117,118,119,120,121]

Evidence Limitations

Across the literature, the amount of evidence available for each doula type varies. Study outcomes vary by number of individuals in the study, implementation of the doula benefit, and the outcome measured. [122] Data that is currently available is limited by the outcomes measured in each study.[123] Further, doula services, although non-clinical, are often evaluated using clinical measures, minimizing a holistic view of the full effect of services (e.g., client satisfaction, mental health, well-being).[124] As implementation of doula services becomes more widespread, researchers assert that additional indicators should be used to better understand the full impact of doulas on maternal and child outcomes.[125] In addition, many studies have small sample sizes due to limited coverage for doula services and lack of integration of doulas at the time the research was conducted, potentially affecting the generalizability of studies.[126]

Doula Certification and Credentialing

There are no national certification guidelines for doulas, but several certificate programs are currently used and well recognized within the profession. In early 2026, the Massachusetts Department of Public Health (DPH) and Bureau of Family Health and Nutrition implemented a voluntary and free doula certification program.[127] The bill stipulates that insurers must follow and may not impose greater credentialing requirements beyond those developed by the Massachusetts DPH. [128] Additionally, doulas authorized as MassHealth providers are deemed automatically compliant with DPH's requirements.[129]

Professional Organizations

Professional organizations play a key role in defining doula scope of practice and supporting integration into maternity care. Guidance from the International Childbirth Education Association (ICEA) describes doulas as non-clinical professionals who provide continuous physical, emotional, and informational support during pregnancy, birth, and the postpartum period, including education, comfort measures, and connections to community resources.[130,131] Clinical organizations such as the American College of Nurse-Midwives (ACNM) and the American Academy of Family Physicians (AAFP) similarly recognize doulas as complementary members of the care team who do not provide medical care but enhance patient experience, communication, and engagement in decision-making.[132,133] Across organizations, there is broad consensus that doula support contributes to patient-centered care and continuity; however, organizations also recognize the importance of clear role definition and standardized training to support effective integration into health care systems.[134]

2.4 Access, Utilization, and State Comparison

Integration of Doulas Within Maternity Care Teams and Care Delivery Settings

A 2023 qualitative study found that providers generally have a positive view of working with doulas and recommend doulas as part of the birthing team.[135] Because doulas provide continuous and undivided support, many providers found that they could better focus on medical and clinical aspects of care. [136,137,138] Further, providers reported delivering higher quality of care and improved communication with birthing individuals due to a greater sense of provider accountability attributed to doula presence during labor and delivery.[139,140,141] Some providers feel that, although rare, doulas can sometimes overstep their roles by advocating for the birthing person, which could result in perceived mistrust of the provider and tension among the birthing team.[142,143] Other providers noted that the increased advocacy and accountability shifted power dynamics in the patient-provider relationship, allowing for birthing individuals to be more informed about procedures and reducing mistreatment, especially for birthing individuals of color.[144] In a 2025 study, providers found doulas particularly helpful during unmedicated birth, as some mid-level providers might be increasingly unfamiliar with this type of delivery.[145] Overall, a majority of providers express being amenable to incorporating doula's expertise within the birthing team,[146] yet some remain hesitant.[147] In 2022, 36% of Massachusetts doulas reported experiencing pushback from health care providers.[148] Both doulas and

providers emphasize the importance of effective communication to best collaborate, integrate different areas of expertise, and facilitate a positive birthing environment. [149,150,151]

Current Utilization of and Demand for Doula Services

Generally, some individuals have limited knowledge or misconceptions about doula services[152] and researches suggest that doula services are underutilized.[153] Nationally, an estimated 6% of pregnant individuals utilize doulas, with cost of care cited as a main barrier.[154] Currently, most commercially insured individuals would have to pay out-of-pocket for doula care, with estimates ranging up to $2,000 throughout the care continuum, including birth services.[155] A 2022 study on the current and future landscape of doulas in Massachusetts reported that lack of insurance coverage was a barrier to accessing services; nearly two-thirds of doulas provided care to individuals who could pay out-of-pocket.[156]

Role of Doulas in Improving Access, Patient Experience, and Culturally Congruent Care

Existing doula programs in Massachusetts are concentrated within a small number of health systems and primarily serve high-risk or underserved populations rather than all birthing people statewide. Boston Medical Center's Birth Sisters Program, one of the state's longest-standing doula programs, offers community-based, multicultural doula support, including prenatal home visits, labor support, and postpartum assistance, to at-risk birthing people.[157] Mass General Brigham launched its Birth Partners Doula pilot in 2022 as part of its United Against Racism initiative, focusing on pregnant people with the highest risk of adverse outcomes. The program prioritizes pairing patients with doulas who share their language and cultural background; as of early 2024, the program had matched approximately 140 patients with doulas.[158] Baystate Health's Moms Do Care Engaging Mothers for Positive Outcomes with Early Referrals (EMPOWER) program at Baystate Franklin Medical Center in Greenfield integrates doula support into a broader team-based model for pregnant and postpartum individuals with substance use disorder (SUD), alongside recovery coaches, nurse navigators, and care coordinators.[159] At the state-level, the Massachusetts Health Policy Commission's Birth Equity and Support through the Inclusion of Doula expertise (BESIDE) investment program awarded approximately $390,000 in 2021 to Boston Medical Center ($196,924) and Baystate Medical Center ($193,457) to expand access to doula services for Black birthing people and to address documented racial inequities in maternal health outcomes.[160] These programs reflect that access to doula services in Massachusetts currently depends largely on institutional-specific initiatives and grant funding, rather than on a systematic coverage framework. In a 2022 survey, many noted a lack of doulas outside of the Boston area.[161]

2.5 Current Coverage Nationally and Within Massachusetts

Federal and State Coverage

Currently, there are no federal requirements for commercial insurers to cover doula services. In Massachusetts, most commercial insurers do not currently provide coverage for doula services. Although outside of the scope of this report, in 2024 MassHealth began providing coverage for doula services[162] and covers eight visits during the perinatal period without prior authorization, as well as doula support during labor and delivery.[163]

Other States' Coverage and Implementation Approaches

Most state mandates requiring private insurance coverage of doula services are recent, and formal evaluation data specific to the commercially insured population are not yet available. The cost-effectiveness and utilization evidence summarized below draws primarily from the Medicaid context and from modeling studies. Therefore, findings might not be directly generalizable to the commercial population.

Rhode Island and Louisiana currently require doula coverage in private insurance plans, with three additional states in the process of implementing similar requirements (see Table 1). Following Rhode Island's implementation, doulas reported increased inquiries from potential clients, suggesting early demand signals, though plan-level utilization data have not been released publicly.[164] Prior to any insurance mandates, doula care in the United States was largely limited to middle- and high-income individuals who could pay out-of-pocket, with only approximately 6% of U.S. births involving a doula.[165] This historically low baseline suggests that coverage mandates have significant potential to shift utilization patterns in the commercial population. A 2025 qualitative study of health plans and large employers in California found that commercial coverage decisions are driven primarily by payer priorities, particularly commitments to birth equity, as well as the weight of clinical evidence and consumer demand. This study identified this as an area where commercial coverage might be expanded as awareness and advocacy grow.[166]

Research in the Medicaid context has shown that the higher costs associated with cesarean versus vaginal deliveries can make reimbursement for doula services cost-effective, and that preventing birth complications for mothers and newborns could be an additional source of savings.[167] Nationally, studies have projected that broader doula coverage could reduce costs,[168] with some estimates as high as billions of dollars by reducing cesarean births and infant hospitalizations due to preterm birth.[169] However, low reimbursement rates and the financial and administrative burden of participating in private insurance networks remain persistent challenges that might dampen utilization gains even after mandates take effect.[170] The current available evidence, primarily sourced from the Medicaid population, suggests that state legislative mandates are likely to increase utilization among the commercially insured population relative to the pre-mandate baseline, with a likely expectation of downstream cost offsets. However, state-specific commercial population outcome data are not yet available to quantify the magnitude of these

effects. In addition to state commercial and Medicaid coverage efforts, many commercial insurers offering employer-sponsored plans have begun providing coverage for doula services within the last year.[171,172]

Table 1: State Legislative Overview: Private Insurance Coverage of Doula Services

State	Legislation	Coverage Requirements (Commercial/Private Plans)	Implementation Status and Notable Impacts
Rhode Island	H 5929 (enacted 2021; eff. July 1, 2022)[173]	Requires coverage in all fully insured commercial plans issued after July 1, 2022, including marketplace and small group employer plans. Each insurer defines coverage per its own reimbursement, credentialing, and contracting requirements.[174]	First state to fully implement a private insurance doula coverage requirement. Following implementation, Rhode Island doulas reported increased inquiries from potential clients. However, low reimbursement rates and administrative burden of participating in insurance networks remain challenges.[175]
Louisiana	HB 272 (enacted June 2023; eff. Jan. 1, 2025)[176]	Requires coverage in state-regulated private plans that cover maternity services. Does not specify scope of covered services; permits insurers to impose a per-pregnancy reimbursement cap of $1,500.[177]	Louisiana is the only state to mandate private insurance doula coverage without a parallel Medicaid benefit. Implementation began January 1, 2025.[178]
Colorado	SB24-175 (enacted June 2024; eff. July 1, 2025)[179]	Requires state-regulated private plans to cover three hours of prenatal doula care, three hours of postpartum doula care, and support during labor and delivery.[180]	Data on the impact of this bill is not yet available.[181,182]
Illinois	HB 5142 (enacted July 2024; eff. Jan. 1, 2026)[183]	Requires state-regulated private plans to cover at least 16 prenatal visits, labor and delivery support, and 16 postpartum home visits with a perinatal doula, beginning in 2026.[184]	Illinois's parallel Medicaid doula benefit went into effect in December 2024. Commercial population utilization and cost impact data are not yet available.
Delaware	HB 362 (enacted Sept. 2024; eff. Jan. 1, 2026)[185]	Requires both Medicaid and state-regulated private plans to cover three prenatal and three postpartum doula visits plus labor and delivery support. Private plans will additionally be required to cover further postpartum visits upon recommendation of a licensed clinical provider.[186]	Commercial population utilization and cost impact data are not yet available.[187]

3.0 Conclusion

Adverse maternal and infant health outcomes continue to grow both nationally and in Massachusetts, with pronounced effects among historically marginalized groups.[188,189] Doulas can help mitigate harms by providing physical, emotional, informational, and other non-clinical support to birthing individuals and family members.[190,191] Research shows that doula services are correlated with improved clinical and non-clinical outcomes throughout the perinatal period for birthing individuals and infants.[192,193] Professional organizations generally support doulas as an integral part of the birthing team.[194,195,196] Providers report mostly positive experiences working alongside doulas; both doulas and providers emphasize the importance of clear role delineation and effective communication to facilitate a positive birthing environment and best incorporate respective expertise.[197,198,199,200]

Doula services are gaining national attention as an effective strategy to improve health outcomes and support perinatal individuals.[201] Currently, while there is a high interest in doula services, utilization does not reflect level of interest, mostly due to high costs and a lack of health care coverage.[202,203] Doula services are incorporated into some hospital systems in the Commonwealth despite a lack of insurance reimbursement.[204,205,206] Two states have fully implemented mandated insurance coverage of doula services, with three additional states in the process of implementing similar requirements,[207,208] and nearly 30 states cover doula services as part of their Medicaid programs.[209]

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An Act Relative to Insurance Coverage for Doula Services

ACTUARIAL ASSESSMENT

4.0 Actuarial Assessment

4.1 Background

The bill requires commercial health insurers to cover doula services without cost sharing for individuals and families, from conception until 12 months after pregnancy, labor, childbirth, adoption, miscarriage, stillbirth, or abortion. Coverage must include at least 20 hours of prenatal and postpartum doula services without prior authorization, as well as labor and delivery support, at rates equivalent to or greater than MassHealth's reimbursement rates. The bill prohibits insurers from requiring referrals as a condition of reimbursement and from imposing credentialing requirements beyond those established by the Massachusetts Department of Public Health. It also establishes a Doula Advisory Committee to consult on MassHealth's coverage of doula services and amends patients' rights to include doulas as part of labor and delivery care.[1]

4.2 Plans Affected by the Proposed Mandate

The bill amends statutes that regulate commercial health care carriers in the Commonwealth. It includes the following sections, each of which addresses statutes dealing with a particular type of health insurance policy when issued or renewed in the Commonwealth:

- Chapter 32A – Plans Operated by the Group Insurance Commission (GIC) for the Benefit of Public Employees
- Chapter 175 – Commercial Health Insurance Companies
- Chapter 176A – Hospital Service Corporations
- Chapter 176B – Medical Service Corporations
- Chapter 176G – Health Maintenance Organizations (HMOs)

This analysis includes members under 65 years of age who have fully insured commercial plans.

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, 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 the rules set by, the federal government. The bill would require coverage for a benefit that may be beyond what is within the Division of Insurance (DOI)- designated Essential Health Benefits (EHBs), but further analysis is required. Any state benefit

mandate that exceeds the state's definition of EHBs could require the defrayal of the additional cost incurred by enrollees in qualified health plans (QHPs) under federal law.

4.3 Existing Laws Affecting the Cost of the Mandate

Under the ACA, non-legacy individual and small group health plans are required to cover EHBs, which include maternity and newborn care as one of the 10 mandated benefit categories. This EHB category generally encompasses services intended to support pregnancy, labor, delivery, and postpartum care. Doula services could be considered within this category, as doulas provide continuous physical, emotional, and informational support during labor and delivery, and may provide prenatal and postpartum support. However, the ACA does not explicitly identify doula services as a distinct or standalone covered benefit.[2]

In Massachusetts, EHB coverage for maternity and newborn care is defined by the benchmark plan in effect for plan years 2025–2027. This provides a broad baseline for maternity coverage, though the benchmark plan does not explicitly list doula services as covered benefits.[3,4] Currently, insurers are not required to provide coverage for doula services, nationally or in Massachusetts for the commercially insured population.

4.4 Current Coverage

BerryDunn surveyed Massachusetts insurance carriers in the Commonwealth, with respondents representing 86% of the Commonwealth's fully insured commercial membership.[xx] Key findings from this survey include:

- Most carriers responded that they do not currently cover doula services for the commercially insured population. One carrier does not cover doula services as a standard medical benefit but offers virtual doula services through a third-party vendor partnership and piloted an in-person doula program in 2024.
- Most carriers anticipated an increase in utilization of doula services, should the bill pass.
- Several carriers raised credentialing as a significant implementation consideration. One carrier noted that doula reimbursement would need to occur via invoice rather than through the standard claims process.
- One carrier raised concerns about the proposed 20-hour coverage threshold, noting that typical standards of care for prenatal and postpartum doula services, including birth attendance, generally fall within 8 to 10 hours, suggesting the proposed limit may exceed conventional utilization patterns.

[xx]BerryDunn surveyed 10 insurance carriers in the Commonwealth (although Tufts Health Plan and Harvard Pilgrim Health Care recently merged, they are accounted for separately); responses represent six carriers and 86% coverage of members.

5.0 Methodology

5.1 Overview

Estimating the impact of this mandate on premiums requires evaluating the cost and utilization of the mandated services relative to current coverage levels. These components were combined with adjustments for carrier retention to produce a baseline estimate of the proposed mandate's incremental effect on premiums. This impact was then projected over a five-year period beginning on January 1, 2027, as the implementation date if the bill becomes law.

5.2 Data Sources

The primary data sources used in the analysis are as follows:

- Survey of commercial carriers in the Commonwealth regarding descriptions of current coverage
- Interviews with medical experts
- Massachusetts All Payers Claims Database (APCD) data
- Published scholarly literature, reports, and population data, cited as appropriate

5.3 Steps in the Analysis

1. Estimated the marginal costs for insurers to doula services.

A. Estimated annual number of births in Massachusetts based on literature research.
B. Calculated the percentage of women[xxi] at childbearing age (15 – 49) with fully insured commercial coverage among all women in the same age group.
C. Estimated the annual number of births covered by fully insured commercial insurance by applying the percentage calculated in Step 1B to the total annual live births estimated in Step 1A.
D. Developed a range of doula service uptake rates based on literature research.
E. Estimated the number of doula service users[xxii] by multiplying the total target users from Step 1C by the uptake rates from Step 1D.
F. Calculated the unit cost of doula visits[xxiii] and doula labor and delivery support using MassHealth data from APCD, as MassHealth began covering doula services in 2024.

[xxi] The Massachusetts APCD categorizes members by sex as a binary variable and therefore identifies the eligible birthing population using women ages 15 – 49.
[xxii] "Doula service users" refers to the estimated number of individuals who utilize any combination of doula services covered under the proposed mandate, including prenatal and postpartum doula visits and/or labor and delivery support.
[xxiii] "Doula visits" refers to a subset of doula service users who received prenatal and/or postpartum doula visits. This distinction is used in the labor and delivery utilization calculation to reflect that not all doula visit users will also receive labor and delivery support.

G. Estimated the average commercial insurance price markup relative to MassHealth by using average cost difference for obstetrics and gynecological (OB/GYN) services as a proxy based on literature research. Applied this markup percentage to the MassHealth rates from Step 1F to estimate unit costs under commercial insurance.
H. Analyzed the average number of doula visits based on APCD data for MassHealth users.
I. Developed a doula labor and delivery usage assumption by analyzing the percentage of users who had doula visits in the first three months of 2024 and also received doula labor and delivery support.
J. Calculated the user cost of doula visits by multiplying the commercial unit cost from Step 1G by the average number of doula visits from Step 1H.
K. Calculated the user cost of labor and delivery support by multiplying the commercial unit cost from Step 1G by the percentage of users receiving labor and delivery support from Step 1I.
L. Added the results from Step 1J and Step 1K to calculate the total user cost of doula service.
M. Calculated the annual incremental cost of covering doula services by multiplying the estimated users from Step 1E by the average user cost from Step 1L.
N. Divided the total dollar impact from Step 1M by the total calendar year 2024 fully insured commercial membership to calculate the marginal cost PMPM associated with the mandate.

2. Calculated the impact of the projected claim costs on insurance premiums.

A. Estimated the fully insured Commonwealth population under age 65 for the next five years (2027 – 2031).
B. Projected the incremental PMPM costs for 2027 through 2031 by applying an average annual medical inflation factor and a ramp-up factor assuming gradual increase in doula service utilization.
C. Multiplied the projected PMPM incremental net cost of the mandate from Step 2B by the projected population estimate from Step 2A to calculate the total estimated marginal claims cost of the bill.
D. Estimated insurer retention (i.e., administrative costs, taxes, and profit) and applied the estimate to the final incremental claims cost calculated in Step 2C to calculate the bill's effect on premiums.

5.4 Assumptions and Limitations

Doula service utilization is subject to substantial uncertainty and may be affected by multiple factors, including member awareness and education, provider referrals, cultural preferences, accessibility, and the availability of trained doulas. Access constraints may be particularly important in rural areas or regions with limited doula provider capacity. Early experience from Medicaid programs suggests that initial uptake may be low when doula coverage is first introduced, although utilization may increase over time as members, providers, and doulas become more familiar with the benefit.

To account for this uncertainty, BerryDunn developed a range of uptake assumptions for the cost analysis. These assumptions were informed by literature research and supplemented by limited early MassHealth experience observed in the 2024 APCD after MassHealth began covering doula services in 2024. MassHealth doula utilization provides a credible and grounded benchmark, with the expectation that patterns may differ somewhat for the commercially fully insured population.

BerryDunn also assumed that doula utilization would ramp up during the first year of commercial coverage and then stabilize at the assumed utilization scenarios for Years 2 – 5. A first-year ramp-up factor was applied to reflect the expected gradual increase in awareness, provider capacity, and member use of the benefit following implementation. The analysis also assumes that provider capacity will be sufficient to support the utilization scenarios modeled. If doula supply is constrained, actual utilization may be lower; conversely, expanded provider recruitment, certification, or network development could increase utilization over time.

BerryDunn estimated commercial unit costs by applying a commercial-to-MassHealth markup assumption. This markup was developed using OB/GYN service reimbursement as a percentage of Medicare rates as a proxy. Actual commercial reimbursement for doula services may differ depending on carrier contracting approaches, provider supply, billing and coding practices, and reimbursement arrangements used for these services.

For purposes of this analysis, BerryDunn focused on live births as the eligible population for estimating doula service utilization. Although doula services may begin during pregnancy, typical doula engagement often starts in the second trimester. Because pregnancy loss rates are lower after this stage, and because the cost of doula visits is relatively low compared to labor and delivery support, BerryDunn used the live birth population as the starting target population for estimating doula service use. This approach may exclude some members who receive prenatal doula visits but do not ultimately have a live birth; however, the potential cost impact of these excluded services is expected to be limited relative to the overall cost estimate.

The analysis does not include potential indirect cost offsets associated with doula services. Such offsets could include reductions in cesarean deliveries, preterm births, low birthweight births, maternal complications, emergency department utilization, or other downstream medical and non-medical costs.

While literature suggests that doula services may be associated with improved maternal and infant outcomes, estimating the magnitude and timing of these potential offsets was outside the scope of this analysis. Doula services may also overlap with certain existing services offered by carriers, but BerryDunn did not include any potential cost offsets associated with such overlap. As a result, cost estimates reflect the gross incremental cost of covering doula services and do not incorporate potential savings or offsets.

The analysis also does not explicitly account for virtual doula services. One carrier noted that it offers virtual doula services through an online platform; however, these services were not identifiable in the APCD data used for this analysis. As a result, BerryDunn did not include the potential impact of virtual doula services in the cost estimates. To the extent that virtual doula services substitute for, supplement, or increase access to in-person doula services, actual utilization and cost may differ from estimates presented in this analysis.

6.0 Analysis and Results

This section further details the calculations outlined in the previous section. The analysis includes a best estimate middle-cost scenario, a low-cost scenario, and a high-cost scenario using more conservative assumptions. The analysis section proceeds as follows: Section 6.1 describes the steps used to calculate the incremental cost of the bill. Section 6.2 projects the fully insured population aged 0 – 64 in the Commonwealth over the years 2027 – 2031. Section 6.3 calculates the total marginal medical expense. Section 6.4 adjusts these projections for carrier retention to arrive at an estimate of the bill's effect on premiums for fully insured plans.

6.1 Incremental Cost of Mandate

In 2024, there were an estimated 68,184 live births in Massachusetts.[5] Approximately 37% of females of childbearing age were assumed to be enrolled in fully insured commercial insurance. Childbearing age was defined as ages 15 to 49. This assumption was based on BerryDunn's membership estimates, as shown in Appendix A. This resulted in an estimated starting eligible population of 25,395 members.

BerryDunn developed doula service uptake assumptions by drawing on a review of available literature, Medicaid program experience in other states, and limited Massachusetts Medicaid experience reflected in APCD data. Evidence suggests a wide gap between interest in doula care and actual access. One study estimated that approximately 6% of birthing individuals gave birth with doula support, while 59% of those without a doula were aware of doula care and 27% of those reported wanting one but being unable to access one.[6] A 2025 Harris Poll survey found that 21% of individuals who had given birth used a doula, while 19% wanted one but could not, with over a third citing financial constraints or lack of insurance coverage as the primary barrier.[7] Experience from states with Medicaid doula coverage illustrates variability in early uptake. Colorado reported approximately 4% utilization in the first year of its benefit,[8] while Virginia saw less than 1% between 2022 and 2024,[9] reflecting challenges related to low reimbursement rates, administrative burden, and limited beneficiary awareness. Massachusetts APCD data indicated approximately 3% utilization during the initial year of MassHealth doula coverage.

Based on this evidence, BerryDunn developed a range of assumed uptake rates to reflect both current observed utilization and the potential for unmet demand to be realized once coverage is available. The low scenario assumes 15% uptake, the mid scenario assumes 25%, and the high scenario assumes 40%. This range accounts for uncertainty associated with a newly covered benefit and the expectation that utilization may increase over time as member awareness, provider referrals, and doula availability grow.

Table 2. Estimated Users of Doula Services

	Uptake Rate	Estimated Users of Doula Services
Low Scenario	15%	3,809
Mid Scenario	25%	6,349
High Scenario	40%	10,158

Next, BerryDunn estimated the unit cost of doula visits and doula labor and delivery support using MassHealth data from the APCD, as MassHealth began covering doula services in 2024. Because commercial insurance prices are generally higher than MassHealth reimbursement rates, the analysis estimated the average commercial insurance markup relative to MassHealth using the average cost difference for OB/GYN services as a proxy based on literature research.[10,11] This markup percentage was then applied to the MassHealth rates to estimate commercial insurance unit costs for doula services.

The average number of doula visits was calculated using APCD data for MassHealth members. BerryDunn focused on members who received doula labor and delivery support from July through August 2024 to allow sufficient time to observe their perinatal doula visits.

The labor and delivery support utilization assumption was developed based on the observed percentage of members who had doula visits during the first three months of 2024 and also received doula labor and delivery support, allowing for a sufficient observation window. The observed utilization of doula labor and delivery support was 80% among doula visit users. To account for the fact that some doula visit users only received postpartum visits—and that not all doula visit users will receive labor and delivery support due to factors such as personal preference or doula availability during labor—BerryDunn assumed a 90% utilization rate for doula labor and delivery support.

The estimated user cost of doula visits was calculated by multiplying the commercial unit cost by the average number of doula visits. The estimated user cost of labor and delivery support was calculated by multiplying the commercial unit cost by the percentage of users receiving labor and delivery support. These two components were then added together to estimate the total average user cost of doula services, which is approximately $1,800.

The annual incremental cost of covering doula services was then calculated by multiplying the estimated number of users by the total average user cost. Finally, the total dollar impact was divided by total calendar year 2024 fully insured commercial carrier membership to calculate the marginal cost PMPM associated with the mandate.

Table 3. Marginal Costs to Insurers for Mandated Coverage

	Total Incremental PMPM Cost under Mandate
Low Scenario	$0.28
Mid Scenario	$0.47
High Scenario	$0.75

BerryDunn trended the PMPM impact shown in Table 3 from the 2024 base year to the five-year projection period presented in Table 4 using the long-term average national projection for cost increases to physician and clinical services (calculated at 4.5%).[12] BerryDunn assumed that utilization of doula services would ramp up in the first year under the proposed mandate, which was supported by the monthly utilization data from 2024 APCD data for MassHealth. A ramp-up factor of 0.5 was applied to the 2027 estimated increased utilization cost impact. Utilization was then assumed to hold flat for years 2028 through 2031.

Table 4. Projected PMPM Costs to Insurers for Mandated Coverage

	2027	2028	2029	2030	2031
Low Scenario	$0.16	$0.34	$0.35	$0.37	$0.38
Mid Scenario	$0.27	$0.56	$0.59	$0.61	$0.64
High Scenario	$0.43	$0.90	$0.94	$0.98	$1.03

6.2 Projected Fully Insured Population in the Commonwealth

Table shows the Commonwealth's fully insured population (ages 0 – 64) projected for the next five years. Appendix A describes the sources of these values.

Table 5. Projected Fully Insured Population in the Commonwealth, Ages 0 – 64

Year	2027	2028	2029	2030	2031
Total (0 – 64)	2,034,557	2,044,527	2,036,221	2,028,278	2,024,429

6.3 Total Marginal Medical Expense

The analysis assumes the mandate would be effective for policies issued and renewed on or after January 1, 2027. As discussed above, a ramp-up factor of 0.5 is applied in the first year to account for the gradual utilization increase of doula services.

Furthermore, based on an assumed renewal distribution by month, market segment, and Commonwealth market segment composition, 72.1% of the member months exposed in 2027 will have the proposed mandate coverage in effect during calendar year 2027. The annual dollar impact of the mandate in 2027 was estimated using the estimated PMPM and applying it to 72.1% of the member months exposed.

Multiplying the total estimated PMPM cost by the projected fully insured membership over the analysis period results in the total cost (medical expense) associated with the proposed requirement, as shown in Table

Table 6. Estimated Marginal Claims Cost

	2027	2028	2029	2030	2031
Low Scenario	$2,839,157	$8,271,333	$8,609,456	$8,962,859	$9,349,530
Mid Scenario	$4,731,928	$13,785,554	$14,349,093	$14,938,099	$15,582,550
High Scenario	$7,571,085	$22,056,887	$22,958,549	$23,900,958	$24,932,080

6.4 Carrier Retention and Increase in Premium

Assuming an average retention rate of 11.3%—based on CHIA's analysis of administrative costs and profit in the Commonwealth[13]—the increase in medical expenses was adjusted upward to approximate the total impact on premiums. Table 7 displays the result.

Table 7. Estimate of Increase in Carrier Premium

	2027	2028	2029	2030	2031
Low Scenario	$3,199,278	$9,320,474	$9,701,485	$10,099,714	$10,535,430
Mid Scenario	$5,332,129	$15,534,123	$16,169,141	$16,832,857	$17,559,050
High Scenario	$8,531,407	$24,854,596	$25,870,626	$26,932,571	$28,094,481

7.0 Results

7.1 Five-Year Estimated Impact

For each year in the five-year analysis period, Table 8 displays the projected net impact of the proposed language on medical expenses and premiums using a projection of the Commonwealth's fully insured membership. Note that the relevant provisions are assumed to take effect on January 1, 2027.[xxiv]

Table 8. Summary Results

	2027	2028	2029	2030	2031	WEIGHTED AVERAGE	FIVE-YEAR TOTAL
Average Members (000s)	2,035	2,045	2,036	2,028	2,024	N/A	N/A
Medical Expense Low ($000s)	$2,839	$8,271	$8,609	$8,963	$9,350	$8,056	$38,032
Medical Expense Mid ($000s)	$4,732	$13,786	$14,349	$14,938	$15,583	$13,427	$63,387
Medical Expense High ($000s)	$7,571	$22,057	$22,959	$23,901	$24,932	$21,483	$101,420
Additional Premium Low ($000s)	$3,199	$9,320	$9,701	$10,100	$10,535	$9,078	$42,856
Additional Premium Mid ($000s)	$5,332	$15,534	$16,169	$16,833	$17,559	$15,130	$71,427
Additional Premium High ($000s)	$8,531	$24,855	$25,871	$26,933	$28,094	$24,208	$114,284
PMPM Low	$0.18	$0.38	$0.40	$0.41	$0.43	$0.37	$0.37
PMPM Mid	$0.30	$0.63	$0.66	$0.69	$0.72	$0.62	$0.62
PMPM High	$0.48	$1.01	$1.06	$1.11	$1.16	$0.99	$0.99
Estimated Premium PMPM	$729	$761	$794	$829	$865	$796	$796
Premium % Rise Low	0.02%	0.05%	0.05%	0.05%	0.05%	0.05%	0.05%
Premium % Rise Mid	0.04%	0.08%	0.08%	0.08%	0.08%	0.08%	0.08%
Premium % Rise High	0.07%	0.13%	0.13%	0.13%	0.13%	0.12%	0.12%

7.2 Impact on GIC

The proposed mandate would apply to self-insured plans operating for state and local employees by the GIC. The benefit offerings of GIC plans are similar to most other commercial plans in Massachusetts. This section describes the results for the GIC.

[xxiv] With an assumed start date of January 1, 2027, dollars were estimated at 72.1% of the annual cost based upon an assumed renewal distribution by month (January – December) by market segment and the Massachusetts market segment composition.

Findings from BerryDunn's carrier survey indicate that benefit offerings for GIC and other commercial plans in the Commonwealth are similar. For this reason, the cost of the bill for GIC will likely be similar to the cost for other fully insured plans in the Commonwealth.

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, 2027, in alignment with the Commonwealth's fiscal year. Due to the July effective date, the results in 2027 are approximately one-half of the annual value. Table 9 outlines the GIC's self-insured membership as well as the corresponding incremental medical expense.

Table 9. GIC Summary Results

	2027	2028	2029	2030	2031	WEIGHTED AVERAGE	FIVE-YEAR TOTAL
Members (000s)	308	306	305	303	302		
Medical Expense Low ($000s)	$298	$1,239	$1,288	$1,339	$1,397	$1,237	$5,561
Medical Expense Mid ($000s)	$496	$2,064	$2,147	$2,232	$2,328	$2,062	$9,268
Medical Expense High ($000s)	$794	$3,303	$3,434	$3,572	$3,725	$3,299	$14,829

Endnotes

[1] *Op. cit.* S.B. 789. An Act relative to insurance coverage for doula services.

[2] Centers for Medicare & Medicaid Services. Information on Essential Health Benefits (EHB) Benchmark Plans. Last Modified March 13, 2026. Accessed March 31, 2026. https://www.cms.gov/marketplace/resources/data/essential-health-benefits.

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[4] *Op. cit.* Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. HMO Blue® New England $2,000 Deductible Plan Option, Schedule of Benefits.

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[11] Skopec L, Pugazhendhi A, Zuckerman S. Updated Medicaid-to-Medicare Fee Index: Medicaid Physician Fees Still Lag Behind Medicare Physician Fees [Abstract Only]. Published May 5, 2025. Accessed June 4, 2026. https://www.healthaffairs.org/doi/10.1377/hlthaff.2024.01530.

[12] U.S. Centers for Medicare & Medicaid Services, Office of the Actuary. National Health Expenditure Projections. "Table 7, Physician and Clinical Services Expenditures; Levels, Percent Change, and Percent Distribution, ; Private Insurance." Accessed May 29, 2026. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html.

[13] Massachusetts Center for Health Information and Analysis. Annual Report on the Massachusetts Health Care System. March 2026. Accessed May 8, 2026. https://www.chiamass.gov/annual-report/.

Appendix A: Membership Affected by the Proposed Language

Membership potentially affected by the proposed mandated change includes Commonwealth residents with fully insured, employer-sponsored health insurance (ESI) issued by a Commonwealth-licensed company (including through the GIC); nonresidents with fully insured, ESI issued in the Commonwealth; Commonwealth residents with individual (direct) health insurance coverage; and lives covered by GIC self-insured coverage. Other populations within the self-insured commercial sector are excluded from the state coverage mandate due to federal Employee Retirement Income Security Act (ERISA) protections of self-insured plans. The 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. To assess how recent volatility in commercial enrollment levels might affect these cost estimates, please note the PMPM and percentage 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.

CHIA-reported enrollment data formed the basis for membership projections. CHIA publishes a biannual enrollment trends report and supporting databook (enrollment-trends-Data Through September 2025 databook),[1] which provide enrollment data for Commonwealth residents by insurance carrier for most carriers, excluding some small carriers. CHIA uses supplemental information beyond the data in the APCD to develop its enrollment trends report and adjust the resident totals from the APCD. For the base year 2020 in the membership projection, the 2020 APCD and published 2020 membership reports available from the Massachusetts Division of Insurance (DOI) [2,3] were used to develop a factor to adjust the CHIA enrollment data for the few small carriers not present in the enrollment report. The adjustment was trended forward to 2025 and applied to CHIA enrollment data.

In 2021, commercial, fully insured membership was 5.6% less than in 2019, with a shift to both uninsured and MassHealth coverage. As part of the public health emergency (PHE), members were not disenrolled from MassHealth coverage even when they no longer passed eligibility criteria. Shortly before the PHE ended, redetermination efforts began in April 2023 and were anticipated to occur over a 12-month period. Many of the individuals subject to redetermination will no longer be eligible for MassHealth coverage. It is anticipated that a portion of individuals losing coverage will be eligible for coverage in individual ACA plans and ESI. MassHealth's monthly caseload reports[4] indicated coverage redeterminations were largely completed by June 2024. The Massachusetts Health Connector's monthly reports[5] showed membership growth stabilized through December 2024, likely due to disenrolled MassHealth members enrolling in individual plans. CHIA's quarterly enrollment trends report[6] showed stable total membership in private commercial group insurance, with a shift from fully insured to self-insured plans. Based on this information, BerryDunn estimated the final 2024 membership impacted by the proposed mandate.

The distribution of members by age and gender was estimated using APCD population distribution ratios, checked for reasonableness and validated against U.S. Census Bureau data.[7] Membership was projected from 2025 to 2050, with growth rate estimates by age and gender derived from a Massachusetts population projection from UMass Donahue Institute.[8]

Projections for the GIC self-insured lives were developed using the GIC base data for 2018, 2019, and 2025, which BerryDunn received directly from the GIC, as well as the same projected growth rates from the Census Bureau used for the Commonwealth population. BerryDunn accounted for municipalities that are expected to join GIC effective July 2026. This information was incorporated into the GIC membership projection. Breakdowns of the GIC self-insured lives by gender and age were based on U.S. Census Bureau distributions.

Endnotes

[1] Center for Health Information and Analysis. Estimates of fully insured and self-insured membership by insurance carrier. Accessed May 29, 2026. https://www.chiamass.gov/enrollment-in-health-insurance.

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