Statement for the Record
Submitted to the Senate Finance Committee

Hearing to Consider the
Graham-Cassidy-Heller-Johnson Proposal

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The National Health Law Program is a national, non-profit organization that protects and advances the health rights of low income and underserved individuals. We strongly oppose the Graham-Cassidy-Heller-Johnson amendment ("Graham-Cassidy") as its substance would decimate the Medicaid program and throw the country's health care system into chaos. Further, we are extremely concerned about the lack of transparency regarding consideration of the Graham-Cassidy proposal. We strongly urge the Senate to ensure that any effort to restructure or change Medicaid -- a program whose financing structures have been in place for over 50 years – and the Affordable Care Act not move forward without formal hearings and mark-ups and a full score from the Congressional Budget Office regarding both impact on the deficit and coverage.

Medicaid is a vital program not only to the 74 million individuals enrolled at any point in time but also to health care providers, our communities, and states. Moreover, studies have shown that the Medicaid program has a positive economic effect for states and the influx of federal funds magnifies this impact. Medicaid funds not only directly support tens of thousands of health care providers and their staff throughout the country but the influx of federal dollars results in a multiplier effect indirectly affecting other businesses and industries as well.[1] The Graham-Cassidy proposal would effectively repeal Medicaid expansion (not even allowing states to

[1] Kaiser Family Foundation, *Medicaid Financing: How Does it Work and What are the Implications?* (May 20, 2015), *available at* http://kff.org/medicaid/issue-brief/medicaid-financing-how-does-it-work-and-what-are-the-implications/.

continue covering expansion enrollees at a regular Medicaid match) and convert Medicaid into a per capita cap coupled with billions of dollars in cuts. Every state will be impacted and all will be forced to make deep cuts in services and eligibility. Any legislation that fundamentally restructures Medicaid will have profound effects not only on the 74 million individuals currently covered, but also on the hospitals, community health centers, managed care plans, nursing facilities, group homes and other providers that serve them, as well as the state and counties and communities in which they live.

We also strongly oppose the changes the Graham-Cassidy proposal makes to the Affordable Care Act and the marketplaces. States would receive fixed funding and virtually unlimited flexibility to determine how to spend it. States would not be required to provide financial assistance to low-income individuals as the proposal repeals the ACA's tax credits and cost-sharing reductions. The one hearing scheduled in the Senate Finance Committee does not provide the transparency that changes of this magnitude deserve. Nor could it be considered "regular order" to move ahead without a full score from the Congressional Budget Office (CBO), as the Committees and the full Senate propose to do. The implications of the Graham-Cassidy proposal restructuring one-sixth of the economy of the country and its dramatic impact on low-income individuals, providers, states and counties, and for the integrity of the Medicaid program are too significant to rush the legislative process.

If the Senate takes up this legislation without undertaking the considered steps of "regular order" and without awaiting a full score from the Congressional Budget Office, the Senate will abdicate its basic responsibility to the American people. We strongly urge the Senate to return to the regular order that recently produced a bi-partisan bill to reauthorize the Children's Health Insurance Program and that was working on bipartisan solutions to stabilize the marketplaces.

We have specific concerns about the impact of the Graham-Cassidy proposal about Medicaid, women's health, and people with disabilities that we outline below.

Medicaid

Octavio is a sweet 8-year-old boy from Texas. He likes to swim, hike, bowl, and visit the zoo. He has autism and receives SSI Medicaid for his care. At age 2, he said only three words, and due to severe oral-motor and sensory issues, he could not eat solid food and still drank from a baby bottle. Thanks to speech and occupational therapies, Octavio began speaking, drinking from a cup, and eating regular food. Although he has made significant progress, Octavio is still developmentally delayed and needs many more years of therapy to become an independent adult. His mother, Rosanna stays at home to care for him. She says, "I am very concerned about Republican proposals to cut, cap, or block grant Medicaid. My son relies on Medicaid to cover his speech, occupational, and physical therapies as well as his doctor and dental visits. As it is, some doctors and therapists have stopped taking Medicaid because of red tape and low reimbursements rates. Further cuts and caps will destroy the program."

1. **Per Capita Cap (PCC).** Since 1965, Medicaid has operated as a federal-state partnership where states receive on average 63% of the costs of Medicaid from the

federal government. The federal share is based on actual costs of providing services, and lower income states receive more federal funding. Graham-Cassidy limits the federal contribution to states, based on a state's historical expenditures inflated at a rate projected to be less than the yearly growth of Medicaid health care costs.[1] Beginning January 1, 2020, funding for state Medicaid programs will shrink over time, resulting in states cutting coverage and services for all beneficiaries. In addition, starting in 2025, states would be limited to an even lower growth rate than in the initial PCC years. Graham-Cassidy also imposes a penalty on states that spend above the national mean, starting in 2020 (two years earlier than BCRA). This penalty would be imposed even if a state spends more because care is more costly due to geography or other factors or because enrollees are older or sicker than in another state. If a state spends 25% more than the national mean for a particular eligibility group (e.g. seniors or people with disabilities), it would be lose .5-2% of its aggregate cap amount for the applicable group for that year unless the state is a "low density" state (less than 15 individuals per square mile). **We oppose converting Medicaid into per capita caps and strongly believe Medicaid's current financing structure must remain in place.**

2. **Medicaid Expansion**. Graham-Cassidy goes a step further than prior Senate bills by reducing the FMAP to 0% for any state that covers Medicaid expansion enrollees after 2020 (except Native Americans who meet certain "grandfathering" requirements). Experts estimate that 1.3 million individuals covered in the Medicaid expansion have a serious mental health diagnosis. Medicaid expansion has been associated with reducing significant unmet mental health care needs. By repealing Medicaid expansion, Graham-Cassidy turns back the clock on this progress. Even if a state wanted to continue covering Medicaid expansion enrollees, it could not get any federal funding and would have to pay 100% of the costs. Graham-Cassidy creates a new *block grant* for states to help pay for health coverage for consumers who would have been covered by Medicaid expansion, as well as those who would have received tax credits and cost-sharing reductions, among other factors. But the block grant funding is set at 17% less than current funding. **We oppose repealing the Medicaid Expansion option for states.**

3. **Shorter Eligibility Periods for Medicaid Expansion Enrollees.** While states can continue Medicaid Expansion through December 31, 2019 with a 90% federal match, Graham-Cassidy allows states to require those in the Medicaid expansion population to submit eligibility renewal paperwork every six months just to stay on Medicaid, beginning October 1, 2017. This will certainly result in more eligible enrollees losing their Medicaid coverage. **We oppose requirements for additional documentation due to shorter eligibility periods.**

4. **Work Requirements.** Graham-Cassidy allows states to impose work requirements on people who are not disabled, elderly, or pregnant Medicaid enrollees. Currently, nearly 8 in 10 Medicaid enrollees are part of a working family. Another 14% of Medicaid enrollees are currently looking for work. Yet, Graham-Cassidy would allow states to require work as a condition of eligibility, including enrollees who are caring for a parent or spouse and both parents in a two-parent household. Individuals receiving mental health or substance

use disorder services who are eligible through Medicaid expansion (rather than a disability category) would be required to work as a condition of receiving treatment, which could undermine their progress and recovery. Medicaid coverage makes it easier to find and sustain work and should not be denied to those who need care before being able to work. **We oppose work requirements in Medicaid.**

5. **Block Grant for Certain Populations.** In addition to requiring all states to operate within fixed caps, Graham-Cassidy also gives states the option to operate part of Medicaid program as a block grant as opposed to a PCC for people who are not elderly, disabled, pregnant adults. States would be locked in for a five-year period, and the growth rate would be lower than the initial per capita cap growth rate (although by 2025, both the PCC and block grant growth rates would be the same). **We oppose allowing states to operate Medicaid through a block grant for any eligibility group.**

6. **Presumptive Eligibility**. In addition to repealing the Medicaid expansion, Graham-Cassidy prevents states from using "presumptive eligibility" and express lane eligibility after January 1, 2020. This includes repealing the ability of states to permit their hospitals to use presumptive eligibility for pregnant women, children, individuals with breast and cervical cancer, and for family planning services and supplies to obtain immediate Medicaid coverage when they end up in emergency rooms or hospitalized for treatment without insurance means they will end up with medical debt. **We oppose repealing presumptive eligibility.**

7. **Retroactive Eligibility.** Medicaid currently provides coverage up to three months before the month an individual applies for coverage. This "retroactive coverage" protects individuals from medical expenses they incurred before they apply for Medicaid. An individual may not be able to apply for Medicaid immediately due to hospitalization, a disability, or other circumstances. Retroactive coverage provides that critical coverage and ensures providers are reimbursed for their costs and that low-income individuals do not end up facing severe medical debt or bankruptcy due to these medical expenses. Graham-Cassidy reduces retroactive coverage for most Medicaid beneficiaries to two months starting October 1, 2017. It requires states to maintain three months of retroactive coverage only for seniors and people with disabilities. **We oppose reducing retroactive eligibility.**

8. **Essential Health Benefits (EHBs) for Medicaid Expansion Beneficiaries**. Under the ACA, states that expanded coverage to non-pregnant childless adults had to provide coverage in at least the 10 "essential health benefit" categories. Graham-Cassidy repeals this requirement, effective December 31, 2019, resulting in beneficiaries losing services such as mental health and substance use disorder services and some no cost preventive health services. **We oppose repealing EHBs for Medicaid expansion enrollees.**

9. **Provider Taxes.** Graham-Cassidy reduces states' ability to use provider taxes to help pay the state's share of Medicaid. Cutting or eliminating provider taxes is a substantial

cost shift to states and threatens access to care for millions of Medicaid enrollees. It also undermines state flexibility to administer the Medicaid program without doing anything to achieve programmatic efficiencies or improve quality. **We oppose reductions to provider taxes.**

Women's Health

For Shyronn, a woman living with HIV in Georgia, having Medicaid allows her to be active in her community. With Medicaid, she does not worry about dying prematurely. Because of the services she receives through Medicaid, she can live a normal life expectancy, remain a productive citizen, and be there for her three children, including a 19-yearold son who is actively serving our country in the United States Marine Corps, a 14-year-old son who is engaged in school and community service projects, and her 4-year-old daughter who is a ray of life who brightens every soul she encounters. Medicaid has allowed her entire family to stay healthy even when money is tight. Shyronn is passionate about HIV prevention and empowering people living with HIV. She volunteers her time to educate her community, youth, and policymakers both in person and online about HIV risk, prevention and care. She is also a member of Positive Women's Network – USA, a national membership body of women that works to empower women living with HIV and develop their leadership skills. Shyronn relies on essential supportive services covered by Medicaid, such as mental health and case management, in order to contribute to her family and community. She says, "the mental health counseling and case management I receive through Medicaid work hand-in-hand to strengthen and support my ability to handle the ups and downs of life. Having Medicaid has motivated me to adhere to my medical appointments and treatment plans. When I did not have Medicaid, I rarely sought medical attention."

1. **Planned Parenthood.** The Graham-Cassidy bill resurrects the previous ACA repeal bills' provisions targeting Planned Parenthood by prohibiting the organization from participating in the Medicaid program for one year, starting on the date of the bill's enactment. This would mean many Medicaid enrollees would no longer be able to receive Medicaid-covered services from their trusted provider of choice. Excluding Planned Parenthood from the Medicaid program reduces access to essential preventive care, such as contraception, tests and treatment for sexually transmitted infections, and breast and cervical cancer screenings. Other safety-net providers such as community health centers lack the capacity to serve all the Medicaid enrollees who could no longer receive care at Planned Parenthood. As a result, in some areas of the country, particularly rural areas, people would lose access to critical reproductive health services. **We oppose excluding Planned Parenthood from the Medicaid program.**

2. **Private Coverage.** Nearly 7 million women and girls selected a private insurance marketplace plan during the 2016 open enrollment period.[2] The majority relied on the ACA's federal subsidies to help make the coverage more affordable. Graham-Cassidy eliminates the ACA's current income-based premium tax credits and cost-sharing reductions effective January 1, 2020. The bill then proposes to replace both Medicaid expansion and marketplace subsidies with a time-limited block grant that is set at 17% less than current funding, and which would phase out completely after 2026.[3] Taken together, these changes would raise premiums, increase deductibles, and make it harder for women and girls to afford high-quality comprehensive health care that meets their needs. **We oppose repealing the ACA's provisions governing marketplaces, tax credits and cost-sharing assistance.**

3. **Abortion Care in Private Plans.** The Graham-Cassidy bill includes restrictions that prohibit individuals and small employers, effective January 1, 2018, from using federal tax credits to purchase private health insurance plans that include abortion coverage beyond the Hyde exceptions.[4] The bill also specifically prohibits individuals from using their Health Savings Accounts to pay for a High Deductible Health Plan that covers abortion beyond the Hyde exceptions, also effective January 1, 2018. These provisions could cause insurance companies to stop offering plans that include abortion coverage altogether, thereby putting abortion access further out of reach for women in the private market. The provisions are also of particular concern for states that broadly require abortion coverage in all or most of their private plans, such as California and New York. The restriction either forces these states to change their policies on abortion coverage, or run the risk of dramatically reducing the number of state residents who are eligible for federal tax credits. **We oppose restrictions on purchasing plans that cover abortion.**

Rachel, who lives in Illinois, was overjoyed, but also overwhelmed when she found out that she was pregnant. Though her pregnancy was planned, Rachel did not have maternity coverage though her part-time job. She intended to find a way to scrape together money and pay for her prenatal care out of pocket. Rachel knew she wanted to give birth at home, so she started to do research about what was available in her hometown. Rachel met with a midwife shortly after she confirmed her pregnancy. The midwife told Rachel that she was probably eligible to get Medicaid to help her with the cost of prenatal care and labor and delivery. The midwife advised Rachel on how to apply, and explained to her exactly what she needed to do and bring to the Medicaid office in order to apply. Rachel was found eligible for pregnancy-based Medicaid, which she used throughout her pregnancy. She was able to use Medicaid for all the care she needed during her pregnancy including labs, dental care, ultrasounds, and screening tests. Her pregnancy was healthy and uneventful, and she gave birth to her son Owen at home surrounded by her family and friends, just as she wanted. After giving birth, Rachel was able to get all of her postpartum care through Medicaid too, including getting an IUD put in to avoid getting pregnant again before she was ready. Rachel struggled with breastfeeding, but with Medicaid she was able to see a lactation consultant and get a breast pump; she was also connected to a breastfeeding support resource group. In addition, her newborn son was immediately enrolled into Medicaid and was able to get the well visits, screenings, and immunizations he needed in his first year of life. After giving birth, Rachel was still working part-

time and trying make ends meet. Rachel says that her ability to stay on Medicaid while she was adjusting to having a newborn was "so important!" She adds, "Medicaid is what allowed me to get the care I needed as new mom and to take care of my baby."

People with Disabilities

Julie, who lives in Colorado, was diagnosed with Multiple Sclerosis in the late 80s at age 20. Over the next several years, she had more than a dozen hospitalizations with no way to pay for them, even though she was working. After almost dying from being uninsured and uninsurable, she was able to get coverage through Medicaid Home and Community Based Services (HCBS). In more than 20 years on Medicaid HCBS, she has not been in a hospital at all. To get on Medicaid, Julie had to stop working for pay and go on Social Security Disability. In late 2012, Colorado created a Medicaid Buy-In for Working Adults with Disabilities. As a result, she was able to start working for pay, with her salary ranging from $10,000 to $50,000 over the past few years. She was able to give up Social Security Disability and now receives only Medicaid and happily pays a premium. Medicaid provides her personal care, including a high quality wheelchair for both indoors and outdoors which is not available through Medicare or most insurance companies. She also requires more than $1000 a month of medications and supplies. Because she can work, she is able to give back to the community personally and through her job as the director of a nonprofit organization, the Colorado Cross-Disability Coalition. Without Medicaid, Julie fears she would be unable to function enough to work and certainly cost the system more via inability to meet needs causing illnesses that require hospital visits that she cannot afford. She says that making changes to Medicaid, such as block granting would be devastating. Julie says, "Those of us with disabilities are always blamed for costing the most in the system---but prevention with us costs more. Instead of a $30 vaccination preventing $1000 ER visit for the flu, it might be a $15,000 wheelchair with complex rehab seating systems preventing $1 million in pressure sores. People with disabilities are the canaries in the coal mines of health care."

1. **Home and Community Based Services.** As Graham-Cassidy would impose deep cuts to Medicaid, states will have to make difficult choices in their budgets between absorbing costs, cutting non-health related state services (such as education) or cutting Medicaid. Some of the services most at risk for cuts are Medicaid-funded Home and Community Based Services (HCBS), including personal care services, employment supports, residential supports, and specialized therapies. HCBS are cost-efficient when compared to institutional care, but HCBS are optional for states to provide while institutional care, like nursing facilities, is often mandatory. Severe federal Medicaid cuts put HCBS services directly in the crosshairs of state budget cuts. **We oppose per capita caps in Medicaid that will lead to cuts in HCBS.**

2. **Waitlists.** Many HCBS services are delivered via Medicaid waivers. Waivers let states limit the number of people getting services and set special income limits to provide eligibility above regular Medicaid eligibility limits. Unlike regular Medicaid, states can set up a "waitlist" for some waivers. Thus, individuals who meet the waiver program requirements may still have to wait for services until one of a limited number of slots

becomes available. In fact, over half a million individuals are already on these waiting lists. Graham-Cassidy would cut Medicaid by hundreds of billions, likely leading to even longer waitlists as states struggle to provide required services to eligible individuals before providing optional waiver services. **We oppose per capita caps in Medicaid that will lead to increase in waiting lists.**

3. **Home and Community-Based Attendant Supports.** Graham-Cassidy takes direct aim at the "Community First Choice Option" (CFC), which provides states enhanced federal funding for home and community-based services and supports under State Medicaid Plans. CFC services assist individuals with Activities of Daily Living (ADLs) and habilitative services. Graham-Cassidy repeals the 6% enhanced funding to cover these services, which CBO predicts will reduce federal supports to participating states by $19 billion. Instead, Graham-Cassidy proposes $8 billion in demonstration funds, lasting just four years and limited to 15 states, with a preference for more rural states. A limited, short-term demonstration program is no substitute for the CFC option. **We oppose cuts to the Community First Choice funding.**

4. **Institutional Care.** Medicaid traditionally does not fund services in large (more than 16 beds) psychiatric facilities for adults under age 65, such as state long-term hospitals, but it does fund community-based rehabilitation services. In this way, Medicaid's structure encourages states to limit the use of large, congregate facilities--the trend has been to develop smaller, more community-based facilities instead. Graham-Cassidy could reverse this trend—first by offering funding to states for medium-length stays in these institutions (30 days or less in a six month period), and then mandating that states accepting this funding maintain the same number of licensed beds at psychiatric hospitals owned, operated or contracted by the state. By forcing states to maintain a specific number of "beds," whether or not the demand exists, this provision creates an incentive for states to fill such beds, even if people can be served in less restrictive, more integrated environments. Not only does this raise Medicaid concerns, but it also creates conflict with the state and provider obligations under Olmstead to ensure people receive services in the most integrated setting appropriate to their needs. **We oppose provisions that incentivize institutional care.**

5. **Pathways to Coverage for Children with Disabilities.** Nearly all states disregard parental income for children with significant disabilities living at home to provide them Medicaid coverage. This option, called the "Katie Beckett program," saves parents from the unbearable dilemma of having to place their child in institutional care, where parental income is automatically disregarded, so their child can qualify for Medicaid. The Katie Beckett program allows these children to get the care they need while living at home. However, these children tend to have expensive health needs and the coverage is optional for states. Graham-Cassidy gives states an incentive to reduce Medicaid enrollment and costs. In response, states may severely curtail or eliminate their Katie Beckett programs. **We oppose per capita caps that could lead states to curb their Katie Beckett programs.**

6. **Parents and Home Care Workers.** Juggling doctors' appointments, therapies, and school meetings may mean parents of children with disabilities cannot work full time. Medicaid expansion helps low-income parents by making health care available to them, so they can keep themselves healthy and take care of their children. Similarly, the home care workers that actually provide HCBS for individuals with disabilities often rely on Medicaid for their own care. One-in-three home care workers live in households that qualify for Medicaid expansion. Medicaid expansion indirectly supports individuals with disabilities by making health care available to their parents and the workers who provide HCBS. Converting Medicaid expansion into a block grant and competing with other state health care funding needs will likely result in decreased coverage for these parents and home care workers. **We oppose repeal of Medicaid expansion.**

Other Provisions

1. **Pre-Existing Conditions***.* Prior to passage of the ACA, insurers regularly charged women higher premiums, or outright denied them coverage, based on preexisting condition exclusions such as being cancer survivors, having had a cesarean section, having received medical treatment from domestic violence or sexual assault, or for being pregnant.[5] The ACA changed this by prohibiting health plans from either denying coverage or charging higher premiums to people with pre-existing conditions. In addition to the issues specifically related to maternity and newborn care above, health plans in states that choose to modify or eliminate EHBs would likely offer less comprehensive plans that lack the specific services people with pre-existing conditions need. People with pre-existing conditions would be forced to pay higher premiums for more comprehensive coverage that includes their needed services. The result would be an end run around the ACA's prohibition on discriminating against people with pre-existing conditions. Elimination of this ACA protection could prevent women with chronic and other pre-existing conditions from obtaining health insurance that meets their needs, or indeed from obtaining health insurance at all. This also effectively excludes individuals with disabilities from plans, as many disabilities are, by definition, pre-existing conditions. **We oppose provisions weakening protections for individuals with pre-existing conditions.**

2. **Essential Health Benefits (EHBs).** Currently, insurers in the small group and individual market must provide coverage in at least 10 "essential health benefit" categories. Graham-Cassidy allows states to waive this requirement. This has direct implications for people with disabilities and for women's health. If a state waives EHBs such that mental health benefits are excluded altogether from plans, mental health parity protections are rendered meaningless because mental health parity only applies if plans offer mental health benefits. Similarly, insurers could choose not to provide habilitative services. Even if plans include mental health or habilitative services, the prohibition on lifetime and annual limits only applies to EHBs. If states waive EHB requirements, any insurers that still cover these important services could impose lifetime and annual limits. Habilitation services are likely to be necessary in the long term for families with children with I/DD. EHBs also includes maternity and newborn care, as well as other services essential to basic reproductive health such as preventive and wellness services, mental health and

substance use disorder services, and prescription drugs. One study found that if a state eliminated the EHB requirement to cover maternity care, the premium for a maternity care rider would cost a woman an additional $17,320 in 2026.[6] Prior to passage of the ACA, only 12% of individual health plans across the country covered maternity care, resulting in high out-of-pocket costs for pregnant women.[7] Elimination of the EHB requirement would again leave many women without adequate maternity care or force them to incur debt to obtain care. It would also effectively allow plans to practice gender discrimination by requiring women to pay more for plans that do include maternity care. **We oppose waivers of EHB requirements.**

If you have any questions about this statement, please contact Mara Youdelman, Managing Attorney of the National Health Law Program's DC office, (202) 289-7661, Youdelman@healthlaw.org.

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[1] Graham-Cassidy's growth rate from the state's base year through 2019 is the medical component of the Consumer Price Index (CPI-M). For 2019-2025, the growth rate would be CPI-M plus 1% for elderly enrollees and enrollees with disabilities and CPI-M for adults and children. Beginning in 2025, the growth rate would lower to the "regular" CPI which grows even slower than CPI-M and does not include long term care costs.

[2] U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, HEALTH INSURANCE MARKETPLACES 2016 OPEN ENROLLMENT PERIOD: FINAL ENROLLMENT REPORT (March 2016) https://aspe.hhs.gov/system/files/pdf/187866/Finalenrollment2016.pdf.

[3] CENTER ON BUDGET AND POLICY PRIORITIES, LIKE OTHER ACA REPEAL BILLS, CASSIDY-GRAHAM PLAN WOULD ADD MILLIONS TO UNINSURED, DESTABILIZE INDIVIDUAL MARKET (Sep. 2017), https://www.cbpp.org/research/health/like-other-aca-repeal-bills-cassidy-graham-plan-would-add-millions-to-uninsured.

[4] The Hyde exceptions are abortions that are necessary to save the life of the mother, or to terminate pregnancies that are the result of rape or incest.

[5] *Id*.

[6] SAM BERGER & EMILY GEE, CENTER FOR AMERICAN PROGRESS, SENATE HEALTH CARE BILL COULD DRIVE UP COVERAGE COSTS FOR MATERNITY CARE AND MENTAL HEALTH AND SUBSTANCE USE DISORDER TREATMENT (Jun. 2017), https://www.americanprogress.org/issues/healthcare/news/2017/06/20/434670/senate-health-care-bill-drive-coverage-costs-maternity-care-mental-health-substance-use-disorder-treatment.

[7] NATIONAL WOMEN'S LAW CENTER, WOMEN AND THE HEALTH CARE LAW IN THE UNITED STATES (May 2013), https://nwlc.org/wp-content/uploads/2015/08/us_healthstateprofiles.pdf.