MAHP
MASSACHUSETTS ASSOCIATION of HEALTH PLANS

March 14, 2025

Ms. Deborah Devaux, Chair
Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

Senator Cindy Friedman
Chair, Joint Committee on
Health Care Financing
State House, Room 313
Boston, MA 02133

Representative John Lawn
Chair, Joint Committee on
Health Care Financing
State House, Room 236
Boston, MA 02133

RE: Health Policy Commission's Public Hearing on the Potential Modification of the 2026 Health Care Cost Growth Benchmark

Dear Chair Devaux, Senator Friedman, and Representative Lawn:

On behalf of the Massachusetts Association of Health Plans (MAHP), which represents 13 member health plans and one behavioral health organization that provide coverage to nearly 3 million Massachusetts residents, I am writing to offer testimony to the Health Policy Commission (HPC) as you consider modification of the health care cost growth benchmark for 2026. We appreciate the HPC engaging with stakeholders and the opportunity to offer our comments in support of maintaining a strong cost growth benchmark set at 3.6%.

The cost growth benchmark is a vital part of the HPC's cost containment mission, and is an important reminder that health care cost growth is a shared responsibility. In recent years, however, it seems that commitment to the benchmark has been lost, with calls from hospitals and health systems to suspend and replace the benchmark's existing framework or set the benchmark at the rate of inflation, while routinely seeking double digit rate increases from health plans. At the same time, pharmaceutical spending continues to rise unabated with limited accountability to the benchmark for drug manufacturers. Despite these challenges, the benchmark remains an important tool that should not be abandoned or weakened.

Indeed, the very same factors that challenged our collective ability to meet the state's cost growth benchmark prior to the COVID-19 pandemic continue to exist today:

- Persistent increases in the prices that doctors, hospitals, and other providers charge, often driven by market leverage rather than quality of care,
- Care largely being delivered by high-cost providers in high-cost settings, and
- Continued excessive spending growth for prescription drugs.

High health care premiums are a direct reflection of these underlying cost drivers. Unfortunately, for too long, the responsibility for controlling health care costs has predominantly rested with the state's health plans, while other stakeholders in the health care sector have faced minimal, if any, accountability. In the absence of cost constraints on providers and the pharmaceutical industry, health care expenses have continued to rise at unsustainable levels. We believe we are currently at a critical juncture, and it is essential for the state to take decisive action to ensure that all entities within the health care ecosystem are held accountable for escalating costs.

We urge the Health Policy Commission and Legislature to consider the policy recommendations below in any discussion of health care costs and cost containment. These proposals, which target the root causes of cost growth, have been proven to garner significant savings in other states and will increase affordability for consumers while ensuring stability in the merged market.

**1) Moratorium on legislation or regulations that raise health care premiums**

Massachusetts has among the highest health care costs in the nation and one of the most extensive sets of state-mandated insurance benefits. Fully-insured commercial plans are required to cover more than 50 specific services, treatments, and providers – far exceeding the already comprehensive benefits mandated by the Affordable Care Act. These coverage requirements account for over 17.3% of commercial premium spending.

Despite this, legislative efforts continue to threaten key cost-containment tools, such as benefit design, cost-sharing mechanisms, and utilization management. Seven recent mandates enacted in the 2023-2024 legislative session—including coverage for fertility preservation, donor milk and donor milk-derived products, universal postpartum home visits, and caps on copayments for certain branded drugs and high-cost imaging—are projected to increase premiums by more than $750 million over the next five years.

To mitigate further cost escalation, the state should implement a moratorium on any new legislative or regulatory measures that would increase health insurance premiums. Such measures would include, but not be limited to, expanding coverage mandates, eliminating cost-sharing, restricting utilization management, or imposing reimbursement requirements. This pause should remain in effect until overall health care expenditures align with the state's health care cost growth benchmark. The moratorium should not only apply to the commercial market, but to the Group Insurance Commission and MassHealth, as well. Legislative actions that mandate coverage, remove utilization management tools or dictate plan design drive up costs for employers, individuals and the state's already stressed state budget.

**2) Address the High Cost of Prescription Drugs**

The Health Policy Commission (HPC) has identified the high cost of prescription drugs as one of the primary drivers of health care spending in Massachusetts, rising by $1 billion between 2022 and 2023 alone according to the Center for Health Information and Analysis (CHIA). As in previous years, spending growth has been driven by the prices charged for branded and specialty drugs. Brand name drugs make up only 15% of commercial pharmacy

volume but account for the majority of prescription drug costs on a gross basis; similarly, specialty drugs, though comprising just 2–3% of prescriptions, represent 50% of total pharmacy spending in the state. Many newly approved drugs fall into this high-cost specialty category. The rising use and cost of GLP-1 drugs illustrate this trend. A survey of MAHP member plans found a 57% increase in fully insured per member per month (PMPM) costs for GLP-1 drugs across all uses—from $23 in January 2024 to $36 in August 2024. With approvals for new indications expected in 2025, costs will likely keep rising. The state must allow carriers to manage utilization for those with a demonstrated need and consider limiting coverage for certain uses.

Given the significant impact of prescription drug prices on overall health care costs, it is essential for the state to implement strong policies that control prices and hold drug manufacturers accountable. Efforts to alleviate prescription drug cost pressures for consumers, through copayment caps or elimination of cost sharing, have done nothing to address the underlying cost of prescription drugs and have instead, increased premium costs for employers and consumers.

In order to make prescription drugs affordable for consumers, we recommend the following state actions:

- **Expand HPC Oversight of Pharmaceutical Manufacturers –** Health care cost containment and affordability should be a shared responsibility among all players in the health care system. Pharmaceutical manufacturers should be subject to the very same reporting requirements and accountability to the health care cost growth benchmark as providers and payers are today.
- **Expand HPC Drug Pricing Review Authority -** We strongly support the HPC's recommendation from the 2022 and 2023 Cost Trends Reports that the Legislature authorize the expansion of the HPC's drug pricing review authority to include drugs with a financial impact on the commercial market in Massachusetts.
- **Establish a Prescription Drug Affordability Board:** To address unwarranted prices and price increases by pharmaceutical manufacturers the state should establish a new Prescription Drug Affordability Board charged with reviewing the prices and price increases of prescription drugs that impact health care affordability in Massachusetts and take targeted enforcement actions to lower prices charged in the state by setting an upper payment limit or implement a penalty on manufacturers for excessive price increases that make health care less affordable.

Further, as the state works to control health care costs and improve affordability, it must avoid policies that limit health plans' ability to manage expenses. Tools like promoting generics and biosimilars, prior authorization, step therapy, formulary tiers, and cost sharing help ensure quality care at lower costs. However, legislation backed by the pharmaceutical industry continues to threaten these cost-saving measures. Some proposals seek to restrict utilization management, eliminate cost sharing or favor higher rebates tied to increased drug volume. To keep pharmacy benefits affordable, the state must protect the tools that help control costs effectively.

3) **Prohibit providers from charging excessive prices**

As identified in dozens of state reports by the HPC, CHIA, and the Attorney General's Office, the prices charged by hospitals, providers, and the pharmaceutical industry are the primary drivers of health care spending in the state. These excessive prices drive our state's health care affordability challenges and divert resources away from smaller community providers, primary care, and behavioral health. Other states have taken action to limit excessive prices; for example, Oregon instituted a cap on hospital prices for Oregon's state health plan enrollees – at 200% of Medicare for in-network providers and at 185% for out-of-network providers. Rhode Island has set rate caps for hospitals that limit how much health plans can increase hospital rates annually, set at inflation plus 1% for both inpatient and outpatient hospital services. Both states have seen significant savings from implementing caps – in the first two years, Oregon reduced spending on hospital prices by $107.5 million, while Rhode Island has seen an over 8% reduction in spending per commercially insured adult in the state.

In Massachusetts, the HPC has modeled the potential savings associated with capping the prices charged by hospitals, providers, and provider organizations at 200% of Medicare. The HPC estimates the Commonwealth would immediately garner at least $3 billion in savings with such a change. If the state were to consider adopting such a proposal, the HPC, working with CHIA and Division of Insurance, should model various attachment points. Any cap adopted should yield the greatest savings for employers and consumers, while ensuring a strong likelihood that the health care sector will meet the cost growth benchmark. Likewise, any cap on provider prices must be coupled with a cap on out of network provider services to ensure that if providers leave the network, they cannot pass on excessive charges to our members. This default rate could be tied to Medicare or the health plan's average in-network rate for similar providers.

4) **Prohibit provider practices that unnecessarily raise health care costs**

   a. **Set a default out-of-network reimbursement rate at the health plan's median in-network rate for emergency services, ambulance services, and non-emergency services delivered at an in-network facility –** Health care spending on services provided by out-of-network (OON) radiologists, anesthesiologists, pathologists, emergency doctors, and ambulance providers far exceeds the average health plan spending on in-network claims. Without the threat of losing patient volume for charging higher prices, OON providers can avoid contracting directly with health plans and instead bill insurers and their members at an inflated rate.

   The state can protect Massachusetts' insured residents from financial liability to OON providers, most often the source of medical debt, by prohibiting OON providers from balance billing patients and limiting cost sharing for OON services to the in-network amount. In recognition of the opportunity for considerable health care cost savings, the Executive Office of Health and Human Services, the HPC, and the Attorney General have endorsed the establishment of a default OON reimbursement rate for emergency services, ambulance services, and non-emergency services

delivered at an in-network facility. We recommend that this rate be set at the health plan's median in- network rate for similar providers.

b. **Limit the scope of facilities permitted to charge facility fees –** Additionally, facility fees have become more prevalent as independent provider practices are increasingly bought up by large hospital systems and care is largely shifting to outpatient settings. Originally intended to help hospitals offset overhead costs, facility fees adversely impact state residents and overall health care spending. MAHP supports a prohibition on facility fees in certain circumstances and notice requirements for providers who continue to charge facility fees.

c. **Adopt site neutral payment policies –** Today, Medicare allows providers to charge higher prices for the same services depending on the site of care. This raises costs for employers and consumers, while creating an additional financial incentive for hospitals to buy physician practices. In the commercial market, differential pricing based on site of service has resulted in continued increased spending on hospital outpatient department services. MAHP supports the HPC's 2023 Annual Health Care Cost Trends Report recommendation that the Commonwealth take action to reduce inappropriate health care spending and consumer costs by equalizing payments for ambulatory services commonly provided in office-based settings, including laboratory tests, basic imaging and diagnostic services, and drug administration.

d. **Take steps to mitigate provider market dominance in contract negotiations –** To curb the rising costs of health care by preventing providers that expand outside their primary service area from charging the same and often substantially higher rates as those charged in Boston, hospitals, ambulatory surgical centers, and outpatient facilities in the community should be directed to bill public and private health plans using the specific facility where services were provided. These secondary facilities should be paid at a separate negotiated rate from the facility of primary licensure, reflective of the community rate and not the higher, academic medical center rate. This will help to limit the market leverage used by systems to obtain higher prices. Further, facilities should be prohibited from conditioning the availability of a price or a term for a contract on the carrier entering into an agreement with another individual facility within the system, unless they can demonstrate they are truly integrated.

e. **Prohibit contracted providers from opting out of lower cost product offerings -** Health plans in Massachusetts are required by state law to offer health insurance products with either a limited or tiered provider network at a 14% premium discount. A key component to developing more affordable products that are attractive to employers and consumers is the ability to contract with providers at rates that support the price point for these offerings. We encourage the Division to prohibit providers who are contracted with a health plan from opting out of limited and tiered network products. Increased provider participation will allow health plans to develop products that ensure members have access to a broad range of more affordable providers, achieving cost savings for consumers.

f. **Reduce the provision of unnecessary, duplicative, or harmful care –** Unnecessary utilization of health care services, including those deemed to be avoidable, also drives excess medical spending, increasing challenges with premium affordability. The HPC has identified nearly $80 million in unnecessary health care spending on low-value care – care that, according to the best available evidence, provides little to no benefit to patients, is likely to cause more harm than benefit, and is too costly given its benefits. The overprovision of health care services and treatments is often the result of variation in care delivery, driven largely by financial self-interest, the influence of pharmaceutical and medical device industries, and fear of malpractice litigation. Physicians themselves report that more than 20% of medical care is not needed, including about a quarter of tests, more than a fifth of prescriptions, and more than a tenth of procedures. Yet, there is little incentive for hospitals and providers to eliminate the provision of low-value care.

   In order to ensure health care spending is directed towards the most effective treatments, we recommend the state update requirements associated with the Determination of Need review process to require consideration of whether care is delivered in the most appropriate setting and requiring hospitals to file plans designed to reduce the duplication of unnecessary diagnostic services, reduce readmissions, and eliminate HPC-identified low-value care.

**5) Streamline administrative requirements through implementation of electronic tools, including automated prior authorization and fully integrated medical records**

Emerging technologies like electronic prior authorization and fully integrated electronic medical records offer tremendous opportunities to streamline administrative requirements and eliminate unnecessary or duplicative testing, treatment and services. A recent report from the Council for Affordable Quality Healthcare (CAQH) estimates that moving to electronic prior authorization could save the medical industry up to $515 million. With more automated prior authorization processes, that include health plan access to the electronic medical record for medical necessity determinations, there is great opportunity to achieve administrative savings associated with manual prior authorization processes, as well as opportunities to eliminate costs associated with low-value care. Automation, paired with integrated medical records across systems, will allow for better quality of care, safety, and allow patients to truly shop for services.

We also caution against efforts to eliminate prior authorization legislatively. Each legislative session there are dozens of bills seeking to eliminate prior authorization for certain high-cost treatments, services, and prescription drugs, and more recently bills have been filed to make changes to health plan processes around prior authorization. These efforts are a blunt instrument, unnecessary in light of the progress towards automation, and costly. In fact, legislation to wholly eliminate health plans' ability to conduct prior authorization, according to a 2023 study by Milliman, will result in commercial premium increases ranging from 9.1% to 23.3% annually, or between $2.2 billion and $5.6 billion in additional premium costs for employers and consumers every year. Likewise, efforts to reduce prior authorizations must be

done thoughtfully and artificial percentage targets may be harmful to quality of care and cost containment. The likelihood of a "sentinel effect," that being the inappropriate or overuse of services once prior authorization is removed, is a significant factor as reported in dozens of academic literature reports.

**6) Increase accountability for hospitals and health systems**

Unlike health plans which are subject to a public hearing if reserve levels exceed 700% and disapproval of rates if a health plan's contribution to surplus exceeds 1.9%, hospitals and health systems are not subject to any similar cap on surplus or profits. Rather, the only mechanism to understand the financial status of hospitals and health systems is through mandated reporting to the CHIA. We recommend that the state establish statutory or regulatory requirements for hospitals with margins exceeding the cost growth benchmark to report to the state and testify at a public hearing regarding their financial condition, the need to sustain such a margin, and any efforts aimed at reducing costs. This commensurate level of accountability for hospitals and health systems is a much needed mechanism to hold providers accountable for the prices charged.

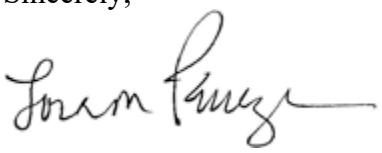
Furthermore, MAHP and our member plans are deeply concerned that legislative and regulatory efforts to constrain health care spending have focused on policies to limit out-of-pocket spending for consumers. These proposals only shift costs from cost-sharing to premium and do nothing to lower the prices charged by pharmaceutical manufacturers and providers. They may also have the unintended consequence of driving employers to self-insure or to adopt federally regulated high deductible health plans as a way to preserve cost sharing options.

In closing, it is important to note that Chapter 343 of the Acts of 2024 granted the Division of Insurance authority to consider "affordability" for consumers and purchasers of health care products when reviewing premium rate submissions, provided that the review adheres to principles of solvency and actuarial soundness. MAHP and our member plans are committed to working with the Division as it implements this important provision of the law, but caution that any accountability on affordability for health plans must be paired with tools to address the underlying drivers of health care costs.

In closing, MAHP and our member plans are committed to ensuring access to high-quality, affordable, and equitable health care services. We urge the HPC to set a strong cost growth benchmark at 3.6% for 2026, an aggressive, but achievable goal, as a strong signal that health care cost containment remains a priority in the Commonwealth.

We appreciate the opportunity to offer these comments as you consider the 2026 benchmark. Please feel free to contact me directly should you have any questions or need additional information on our comments.

Sincerely,



Lora M. Pellegrini,
President & CEO, Massachusetts Association of Health Plans