MAHP
MASSACHUSETTS ASSOCIATION of HEALTH PLANS

April 3, 2026

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 2027 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 2027. 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% or below.

The cost growth benchmark remains a vital part of the Commonwealth's cost containment framework and serves as an important reminder that health care affordability is a shared responsibility across the system. However, Massachusetts has continued to move further away from that goal, as health care cost growth has reached an unsustainable level, with the consequences increasingly borne by employers and consumers in the form of higher premiums, rising cost sharing, and reduced access to affordable coverage.

The drivers of health care spending growth are not new, nor unexpected. Over the past decade, over forty state reports from the HPC, the Center for Health Information and Analysis (CHIA), the Attorney General, and others have consistently identified the primary contributors to rising health care costs in Massachusetts, together challenging our collective ability to meet the state's cost growth benchmark: ever-increasing unit prices for prescription drugs, hospital inpatient, and hospital outpatient services.

These cost pressures have not abated. Instead, they have intensified, with hospital and pharmaceutical spending continuing to account for a substantial share of total health care expenditures. The most recent data from CHIA makes clear that health care spending continues to rise at unsustainable levels, increasing 5.7% in 2024 to a total of $83.3 billion, exceeding the state's cost growth benchmark for the fourth consecutive year. From 2023 to 2024, total health care spending increased by more than $5.2 billion in Massachusetts. Pharmacy spending alone accounted for 23% of that growth, while hospital spending, combining inpatient and outpatient services, accounted for approximately 36%. Together, these two categories account for nearly 60% of total spending growth in the system. This growth continues to outpace both wage growth and regional inflation, further compounding affordability

challenges for consumers and employers. Utilization has remained relatively stable, underscoring that spending growth is primarily driven by prices, not increased use of services. These trends reflect a new baseline, not a temporary spike. As the health care system has stabilized following COVID-19, ongoing cost growth is driven by structural factors, not extraordinary conditions.

The Commonwealth's ongoing challenges in meeting the cost growth benchmark are not unexpected. Rather, they reflect a structural imbalance in accountability. Hospitals, health systems, and pharmaceutical manufacturers continue to exert significant pricing power, often driven by market consolidation and leverage, with limited mechanisms to ensure that pricing growth aligns with the state's affordability goals. These pressures are evident across the system, as providers from specialist physicians to personal care attendants, continue to seek and often receive significant rate increases. Prescription drug spending continues to rise, driven by the introduction of new high-cost therapies and pricing strategies that outpace existing controls. In addition, new state-mandated benefits contribute incrementally to overall system costs.

The impact of these dynamics is reflected directly in premiums. While health plans are subject to rigorous state and federal oversight, including medical loss ratio requirements that ensure nearly 90% of premium dollars in Massachusetts are spent on medical care, other sectors of the health care system are not held to comparable standards. As a result, when underlying costs increase, particularly in hospital and pharmaceutical spending, those increases are ultimately borne by employers and consumers. In the absence of meaningful cost constraints across all sectors, health care spending has continued to rise at unsustainable levels.

The Commonwealth is now at a critical juncture. Ensuring long-term affordability will require a more balanced approach to accountability, with all stakeholders held responsible for the cost of care. We urge the Health Policy Commission and the Legislature to prioritize and advance the policy solutions that have been consistently identified to address these challenges. These approaches target the root causes of cost growth, have demonstrated savings in other states, and offer a path toward improved affordability while maintaining stability and access across the health care system.

Implement targeted limits on excessive provider prices. A number of factors contribute to excessive health care spending, including the increased utilization of services in high-acuity, high-cost settings that could have been provided in lower cost settings, the overprovision of services that clinical guidelines and researchers agree do not improve health, and services that could have been avoided, prevented or are otherwise unnecessary. However, the primary contributor to excessive spending in Massachusetts is unit price, or the prices charged by providers for services and treatments.

In many cases, higher prices reflect market leverage rather than higher-value care. Other states have taken targeted action to address this issue. 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 DOI 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.

Prohibit provider practices that unnecessarily raise health care costs.

Establish 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. The absence of a standardized reimbursement framework for out-of-network (OON) services allows certain providers, particularly radiologists, anesthesiologists, pathologists, emergency physicians, and ambulance providers, to command significantly higher prices, contributing to increased costs across the system. Without the counterbalance of patient volume, these providers may remain out of network and bill at inflated rates, driving up spending for consumers and employers alike.

To address this, the Commonwealth should establish a default reimbursement rate for OON services, set at the health plan's median in-network rate for similar providers. This approach has been endorsed by the Health Policy Commission, the Executive Office of Health and Human Services, and the Office of the Attorney General. In conjunction with this policy, the state should prohibit balance billing and limit patient cost-sharing for OON services to in-network levels, protecting consumers from unexpected financial liability and reducing a significant source of medical debt. Establishing a clear and predictable payment standard would reduce incentives for providers to remain out of network, moderate upward pressure on negotiated rates, and improve overall affordability.

Adopt site-neutral payment policies and limit facility fee practices that drive unnecessary cost growth. Facility fees and site-based payment differentials are a significant driver of excessive health care spending and persistent price variation in Massachusetts. As independent physician practices are increasingly acquired by hospital systems, services that were previously delivered in lower-cost office settings are shifted to higher-cost hospital outpatient departments (HOPDs), where additional facility fees are charged. These charges increase total spending for both patients and payers and create incentives for further provider consolidation.

Evidence demonstrates that these higher prices are not associated with improved quality or additional resources for many routine services. In many cases, HOPDs function similarly to physician offices but are reimbursed at substantially higher rates. According to HPC data, facility fees account for approximately 80% of all HOPD spending, and services delivered in these settings can cost twice as much as those provided in office-based settings.

To address these disparities, the Commonwealth should adopt site-neutral payment policies that equalize reimbursement for clinically equivalent services across care settings, consistent with recommendations from the HPC. This includes commonly provided ambulatory services such as office visits, laboratory

services, imaging, and drug administration. In addition, the state should limit the scope of facilities permitted to charge facility fees and require clear, advance notice to patients when such fees apply. Together, these policies would reduce unnecessary spending, limit incentives for provider consolidation, and improve affordability for consumers and employers.

Take steps to mitigate provider market dominance in contract negotiations. To curb rising health care costs and address provider market dominance in contract negotiations, providers that expand beyond their primary service area should not be permitted to charge the same, often substantially higher, rates as those charged by Boston-based academic medical centers. Hospitals, ambulatory surgical centers, and outpatient facilities should be required to bill public and private health plans based on the specific facility where services are delivered. 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.

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 of Insurance 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.

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 $50 million in unnecessary health care spending on just 17 low-value care services – 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.

Address the high cost of prescription drugs. The HPC has identified the high cost of prescription drugs as one of the primary drivers of health care spending in Massachusetts, rising by $1.4 billion

between 2023 and 2024 alone according to CHIA. As in previous years, spending growth has been driven by the prices charged for branded and specialty drugs. Since 2014, prescription drug prices have risen 39%, 20 times faster than the rate of inflation and outpacing price increases for any other medical commodity or service. In addition to price increases for existing generic and specialty medications, the median launch price of newly launched prescription drugs increased 51% over just two years, from 2022 to 2024. Median launch prices increased from $2,115 per year in 2008 to $308,749 per year in 2024. In the first two weeks of 2026 alone, pharmaceutical manufacturers hiked the prices of 872 prescription drugs.

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 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.

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 60 specific services, treatments, and providers – far exceeding the already comprehensive benefits mandated by the Affordable Care Act. These coverage requirements account for over 24.16% of commercial premium spending, totaling $4.147 billion.

Despite this, legislative efforts continue to threaten key cost-containment tools, such as benefit design, cost-sharing mechanisms, and utilization management. In the 2025-2026 legislative session alone, 188 state mandated benefit bills have been filed.

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, removes utilization management tools or dictates plan design drive up costs for employers, individuals and the state's already stressed state budget.

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, which, 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.

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 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.

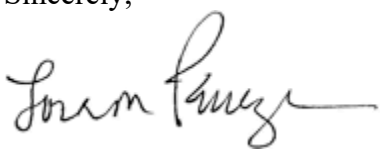
Other states have taken meaningful steps to implement policies that directly address the underlying drivers of health care cost growth and are beginning to see measurable improvements in affordability. In Massachusetts, however, many of these approaches remain unimplemented, and the consequences are evident in continued cost growth that outpaces the state's benchmark, wages, and inflation. As other states advance targeted cost containment strategies, the Commonwealth risks falling behind in its longstanding position as a national leader in health care quality, access, and innovation.

MAHP is encouraged by the Administration's focus on affordability, including the Governor's affordability workgroup, and the attention it is bringing to these longstanding challenges. While this focus is both necessary and timely, it must translate into concrete and sustained policy action to meaningfully address the primary drivers of cost growth. Until such action is taken, the cost growth benchmark remains the Commonwealth's primary mechanism for promoting system-wide accountability and must be maintained as a strong and credible standard. Achieving meaningful affordability, however, will require coordinated action across the entire health care system. Health plans alone cannot solve the affordability crisis, hospitals, providers, and the pharmaceutical industry must be held accountable for the cost of care.

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 2027, 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 2027 benchmark. Please feel free to contact me directly should you have any questions or need additional information on our comments.

Sincerely,



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