MAHP
MASSACHUSETTS ASSOCIATION of HEALTH PLANS

July 3, 2025

William J. Driscoll, Jr., Chair
Joint Committee on Public Health
State House, Room 507
Boston, MA 02133

Marjorie C. Decker, Chair
Joint Committee on Public Health
State House, Room 130
Boston, MA 02133

RE: 6/23 Joint Committee on Public Health Legislative Hearing

Dear Chairs Driscoll and Decker,

On behalf of the Massachusetts Association of Health Plans and our 13-member health plans and one behavioral health organization, providing health insurance coverage to nearly 3 million Massachusetts residents, we appreciate the opportunity to share feedback on the following bills before your committee that will raise costs for small businesses and their employees. Health care affordability is the number one challenge facing individuals and small businesses in this state, driven by ever-increasing prices for prescription drugs, hospitals and providers. Without action to address the key cost drivers, the Commonwealth cannot make health care more affordable. We offer our feedback below.

House No. 2537, An Act relative to primary care access – Oppose / Amend
MAHP strongly supports increased investment in primary care as a critical strategy to improve care coordination, patient outcomes, and access to high-quality, team-based care across the Commonwealth. Primary care serves as the foundation of our health care delivery system, and we support efforts to realign resources toward this essential component of care. While we continue to have concerns with several provisions in this bill, MAHP looks forward to working with the Committee and stakeholders to further refine the bill to support our shared goals of enhancing primary care without increasing overall health care costs.

H2537 establishes primary care expenditure targets and authorizes the Health Policy Commission (HPC) to monitor and enforce compliance. MAHP supports this policy direction, provided that increases in primary care spending occur within the bounds of the state's cost growth benchmark. This principle is explicitly recognized in H2537 and aligns with longstanding HPC recommendations. To be effective, however, the legislation must include clear and enforceable language empowering the HPC to ensure that any shift in spending toward primary care is offset by reductions elsewhere preventing an unsustainable increase in total health care expenditures. States like Rhode Island and Oregon have shown that increased investment in primary care, when coupled with controls on spending growth in other service lines, can reduce avoidable emergency room visits, hospitalizations, and excessive specialty care, all while improving patient outcomes and system efficiency.

Health care affordability remains a top concern for Massachusetts residents and employers. As such, increased investment in primary care must be coupled with offsets in other spending areas to avoid upward pressure on premiums and overall health costs. MAHP supports a gradual, phased-in approach to increasing primary care investment, allowing time for health plans and providers to update contracts, adjust rates, and adapt care delivery models accordingly.

We also urge caution regarding the proposal to move toward uniform capitation. While global and sub-capitated payment models can support coordinated, team-based care, a one-size-fits-all mandate is not appropriate at this time. Not all providers are positioned to assume financial risk or operate under prospective payment arrangements, and any shift toward capitation must meet providers where they are in terms of infrastructure and readiness. In our experience with the MassHealth Primary Care Sub-Capitation Program, flexibility and provider engagement have been essential to success. We do not believe a task force, as proposed, is the appropriate mechanism to design such a complex payment system, particularly without the technical and actuarial expertise required.

Finally, we oppose the provisions in the legislation that would mandate commercial coverage of services at federally qualified community health centers (FQHCs) and set the rates that private health plans must pay for those services in statute. This provision will add administrative complexity and increase the cost of coverage for Massachusetts employers and consumers. Health care affordability continues to be a significant challenge for Massachusetts employers and consumers. The provisions discussed herein will add to the underlying cost of coverage and will disproportionately fall on individuals and small employers.

MAHP supports legislation to increase investment in primary care, but such policies must be implemented in a way that is financially sustainable, operationally feasible, and aligned with existing provider-payer relationships. Any reform should support both payers and providers in meeting expenditure targets while adhering to the state's cost growth benchmark. **For these reasons, if the committee moves forward with the bill, we would support amending House Bill 2537 as outlined above.**

House No. 1358, An Act advancing health care research and decision-making centered on patients and people with disabilities – Oppose

H1358 would prohibit the Health Policy Commission (HPC) and MassHealth, from developing or employing a dollars per-quality adjusted life year (QALY) measure to assess the cost-effectiveness of a particular treatment, service, or medication. This would undermine the important, data-driven work of independent non-partisan research organizations, like the Institute for Clinical and Economic Review (ICER), that conduct rigorous analyses of clinical data to establish value-based price benchmarks for prescription drugs. At a time when Massachusetts and the nation are struggling with the high costs of prescription drugs, eliminating this tool would be a step backward. 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 billion between 2022 and 2023 alone according to the Center for Health Information and Analysis.

While proponents of this bill have claimed that the use of cost-effectiveness analyses are inconsistent with Americans with Disabilities Act protections for individuals with disabilities, this is not the case. The QALY measures are utilized to determine the appropriate cost for a particular treatment or drug by evaluating how the treatment or drug adds value and benefits patients. Cost-effectiveness analysis has long been a part of academic research in the United States and internationally. In fact, it is the cornerstone of research

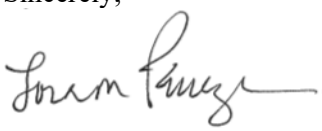
comparing the value of different drugs and other health care interventions. While not the sole factor in making coverage determinations, it is an important metric for consideration used by federal researchers at the Centers for Disease Control and Prevention and the National Institutes of Health. Therefore, the state should embrace the use of such measures to determine the safety, coverage, reimbursement, value, and efficacy of prescription drugs. Leveraging tools like comparative effectiveness and value-based pricing strengthen market competition and align drug costs with clinical value. For example, in 2018, Sanofi and Regeneron's value-based agreement with Express Scripts for Praluent, guided by ICER analysis, led to lower prices and greater patient access. State Medicaid programs, including New York, have also used ICER reports to negotiate drug prices, saving nearly $300 million. A 2022 JAMA study estimated that applying ICER's value-based pricing could save up to $57.5 billion annually. This bill would eliminate this possibility. **For these reasons, we OPPOSE House Bill 1358.**

Senate No. 1637, An Act wiring medical facilities, nursing homes, and medical training to support safer electromagnetic radiation exposures and to support reduction of other environmental hazards – Oppose

S1637 seeks to mandate coverage of new benefits or set a mandated payment rate for services, which will increase health care premiums for insured members. Massachusetts law requires fully insured health plans to cover 50 specific services, treatments, supplies, and practitioners—mandates that increase costs in the fully-insured merged market and limit employer flexibility in plan design. In January 2022, CHIA estimated these mandates accounted for $2.47 billion in annual health care spending, or 17.3% of total commercial premiums paid in 2018. State mandates apply only to fully insured plans, affecting individuals and employees of small and mid-size businesses. Since ERISA exempts self-insured plans, adding new costly mandates incentivizes employers to self-insure, shrinking the small group market and concentrating the impact of state mandates on a diminishing share of the privately insured population. S1637 mandates coverage for a number of non-ionizing radiation reduction services, including nutritional supplementation in pathological conditions, and diagnosis and treatment for digital addiction. S1637 would mandate coverage for services that are not in line with evidence-based, nationally recognized standards of care as nutritional supplementation for pathological conditions, diagnosis and treatment of "digital addiction," and mitigation of electromagnetic hypersensitivity, are conditions not formally recognized by the American Psychiatric Association, the U.S. Preventive Services Task Force, or other nationally recognized authorities. The bill also requires coverage for environmental testing, safer technology installations, and other non-health care services that are not within the purview of health plans. These expansive and ambiguously defined mandates could lead to significant, unpredictable premium increases, especially in the absence of a cost impact analysis by CHIA. **For these reasons, we OPPOSE Senate Bill 1637.**

Thank you for the opportunity to share our concerns. Please do not hesitate to contact me for additional information or to discuss these bills further.

Sincerely,



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