MAHP
MASSACHUSETTS ASSOCIATION of HEALTH PLANS

July 7, 2025

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: 7/1 Joint Committee on Health Care Financing Legislative Hearing
MAHP Support: Senate No. 902
MAHP Oppose: House No. 1412 and Senate No. 903

Dear Chairs Friedman and Lawn,

On behalf of the Massachusetts Association of Health Plans (MAHP), representing 13 member health plans and one behavioral health organization covering nearly 3 million Massachusetts residents, thank you for the opportunity to comment on several proposals before the Joint Committee on Health Care Financing. Ensuring access to high-quality, affordable care is the shared goal of the Commonwealth's health care system and the top concern for the employers, working families, and consumers our member plans serve. As the Committee considers proposals that will shape the future of health care affordability in Massachusetts, we respectfully offer our strong support for Senate Bill 902 and our opposition to House Bill 1412 and Senate Bill 903.

Senate No. 902, An Act lowering health care prices for patients – Support
S902 addresses one of the most pressing issues in our health care system: the unsustainable growth in hospital and provider prices, which continue to drive higher premiums and out-of-pocket costs for Massachusetts families and small businesses. By capping the allowed amount that can be charged by hospitals, providers, and provider organizations at a set percentage of the Medicare rate, policymakers can eliminate both excessive prices and provider price variation, while still providing for generous and appropriate reimbursement levels.

Over the past two decades, the Massachusetts provider landscape has experienced significant consolidation, with large health systems acquiring community hospitals, physician practices, and post-acute facilities. While often justified as a means of improving care coordination, this market consolidation has also resulted in wide and unjustified variation in provider prices, with certain large systems commanding two to three times more than others for the same services, even after adjusting for quality, patient acuity, or service complexity. These price disparities are not benign; they drive up premiums and out-of-pocket costs for families and small businesses, while undermining competition and exacerbating health care access challenges. The Health Policy Commission (HPC) has documented time after time that these wide price differences are, in fact, not correlated with better quality and that they place significant pressure on public programs, commercial payers, and the state budget.

Senate Bill 902 would take a critical step forward by capping the allowed amount that hospitals, providers, and provider organizations can charge at a set percentage of Medicare. This approach uses Medicare's evidence-based payment structure as a reasonable benchmark, one that is grounded in provider costs and takes into account cost differences across provider types and service areas. The HPC has estimated that adopting a cap at 200% of Medicare would garner over $3 billion in annual system-wide savings. Medicare rates are designed to reflect the costs of an efficient provider; a 200% cap offers a 90+% markup over that cost, ensuring stability for most

providers while eliminating the most egregious outliers. More importantly, by tying payment rates to a transparent and consistent benchmark, the legislation would eliminate unjustified price variation that is currently baked into the commercial market and bring much-needed relief to employers and consumers.

We recognize that 200% of Medicare may not be the perfect number. Policymakers should explore whether that percentage best balances the dual goals of meaningful cost containment and preserving network adequacy. If we want to create a more affordable and sustainable health care system, it is time to establish reasonable limits on how much providers can charge. **For these reasons, we SUPPORT Senate Bill 902.**

House No. 1412 / Senate No. 903, An Act improving access to post acute services – Oppose
H1412 and S903 outline a number of reforms to address challenges identified by hospitals in moving patients from the acute care setting to post-acute care. The reasons for these challenges are multifaceted, ranging from legal and decision-making barriers to post-acute care capacity constraints to fragmentation across the care continuum. MAHP and our member plans share the goal of improving patient flow across care settings and ensuring that patients are receiving the right care, in the right place, at the right time. However, we strongly oppose provisions in Section 3 and Section 5 of these bills that would restrict or eliminate the use of utilization and care management tools, like prior authorization.

Section 5 of the bills would prohibit health plans from requiring prior authorization for the transition of any inpatient to a CMS-certified home health agency. Prior authorization is an important clinical and cost management tool that helps ensure patients receive appropriate, high-quality care in the right setting. Eliminating this oversight removes an essential checkpoint for care coordination and may inadvertently lead to fragmented or unsafe discharges, particularly for medically complex patients. When health plans voluntarily lifted prior authorization for admissions to post-acute care facilities during periods of heightened COVID-19 and respiratory virus infections, instances of inappropriate placement, out of network care, and increased costs for patients grew significantly, while post-acute care facilities continued to request pre-approvals for admissions from health plans. Eliminating prior authorization is not a solution.

The existing expedited prior authorization pilot, enacted in Chapter 197 of the Acts of 2024, strikes a more appropriate balance by streamlining approvals while retaining essential clinical safeguards. Repealing its sunset, as proposed in Section 3 of the bill, would preempt a meaningful evaluation of the pilot's effectiveness and undermine the evidence-based approach legislators put in place just last year. We urge the Committee to allow the pilot to continue as planned, with a robust review of outcomes before considering permanent changes. **For these reasons, we OPPOSE House Bill 1412 and Senate Bill 903.**

As the health care system faces rising prices, workforce constraints, and growing strain on public and private budgets, it is critical that we pursue targeted, evidence-based reforms. Senate Bill 902 provides a meaningful step toward curbing excessive provider price growth, while preserving patient access and supporting a competitive, sustainable marketplace. Conversely, House Bill 1412 and Senate Bill 903 risk weakening essential care management tools before the Commonwealth has had an opportunity to evaluate existing reforms.

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