MAHP
MASSACHUSETTS ASSOCIATION of HEALTH PLANS

June 10, 2025

Senator Paul Feeney, Chair
Joint Committee on Financial Services
State House, Room 112
Boston, MA 02133

Representative James Murphy, Chair
Joint Committee on Financial Services
State House, Room 254
Boston, MA 02133

RE: 4/29 Joint Committee on Financial Services Legislative Hearing

Dear Chairmen Feeney and Murphy,

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.

Pharmacy

House No. 1326 / Senate No. 827, An act to ensure access to prescription medications – Oppose

H1326 and S827 would impose restrictions on pharmacy benefits programs designed to use maximum allowable cost (MAC) benchmarks to ensure a fair reimbursement to pharmacies for generic drugs. These restrictions will increase costs for individuals, employers and small businesses.

The purpose of MAC pricing is to standardize the reimbursement amount for identical products from various manufacturers, regardless of each manufacturer's price. A MAC list is a common cost management tool that is developed from a survey of wholesale prices existing in the marketplace, taking into account market share, existing inventory, expected inventories, reasonable profits margins, and other factors. The purpose of a MAC list is to incentivize pharmacies to negotiate more competitive rates for generic drugs with manufacturers and wholesalers in order to keep overall prices down.

While MAC pricing laws have passed in several states, none are as restrictive as these bills proposed in Massachusetts. For example, the mandate to release proprietary pricing lists would have an anti-competitive effect on insurers and employers, as well as PBMs. According to the Federal Trade Commission, this would drive up drug prices for employers and consumers. Moreover, requiring PBMs or health plans to make retroactive adjustments would create difficult administrative burdens and add administrative cost. A reasonable process for a pharmacy to appeal the listed MAC for a particular drug is appropriate, but these are individual appeals, and it is not appropriate to require the PBM or health plan to also have to make that adjustment for other pharmacies in the network. The administrative burdens and increases in the cost of drug benefits caused by this bill will increase costs for employers and consumers by individuals and small businesses at a time when health care affordability continues to remain a significant concern.

House No. 1091 / Senate No. 800, An Act relative to pharmacists as healthcare providers – Oppose

H1091 and S800 would permit pharmacists to test or screen for and initiate treatment for health conditions and would also expand prescribing authority in Massachusetts to permit pharmacists to prescribe and dispense certain prescription drugs. Expanding pharmacists' scope of practice to prescribe medication and treat members is

unnecessary and presents patient safety concerns. Today, pharmacist prescribing authority is appropriately limited under the Board of Registration in Medicine's Collaborative Drug Therapy Management Agreement, which permits certain pharmacists and physicians to enter into a collaborative practice agreement, under which the pharmacist may then initiate, monitor, modify or discontinue a patient's drug therapy. Additionally, pharmacists with appropriate training may administer vaccines. These requirements allow enough flexibility for pharmacists to modify prescriptions without practicing medicine.

H1091 and S800 would not require pharmacists to either record a medical history of the patient or carry out a physical or mental status exam before testing or screening or initiating treatment. This could lead to adverse reactions to prescription drugs by the patient resulting in potential harm to individuals, liability and malpractice issues, and increased medical costs for consumers due to hospitalizations. To prohibit plans from denying reimbursement for services and procedures performed by a pharmacist and mandate reimbursement at the standard contracted rate will increase health care spending without regard for patient safety.

House No. 1101 / Senate No. 698, An Act relative to consumer deductibles – Oppose
H1101 and S698 would require health plans to apply cost-sharing assistance amounts, including drug manufacturer coupons, towards a member's required contribution to deductible and annual out-of-pocket maximum. This provision would permanently assist drug companies in selling high-cost brand name drugs at the expense of more cost-effective generics. Copayment assistance programs and drug coupons may seem like a good deal for consumers; however, drugmakers use coupons as an incentive for patients to use branded drugs instead of less expensive generics, even though a less expensive and equally effective alternative may be available, insulating patients from the true cost of a drug. But while the consumer may pay a lower copayment for a short amount of time, health plans pay significantly more for the higher-cost drug covered by the coupon. Therefore, limiting consumer exposure to cost-sharing will only shift the waived costs charged by pharmaceutical manufacturers to employers and consumers through increased monthly health insurance premiums. Coupons have reduced the use of generic drug competitors and increased branded drug sales by more than 60%, and increased brand drug makers' revenue by $700 million to $2.7 billion, an average windfall of $30 to $120 million per drug. Restricting out-of-pocket expenses on broad categories of drugs or allowing coupons and cost-sharing assistance from drug manufacturers to count towards a member's deductible removes the patient's incentive to choose the lower cost alternative and increases premiums for employers and consumers.

Administrative Costs
House No. 1321 / Senate No. 685, An Act relative to transparency of consumer health insurance rights – Oppose
H1321 and S685 would unnecessarily increase health plan administrative costs, despite the fact that robust consumer transparency is already firmly established through existing state and federal regulations. Health plans are required to provide members with clear, comprehensive information on covered benefits, cost-sharing responsibilities, and coverage limits—details that are easily accessible through user-friendly tools on health plan websites, member portals, and federally mandated disclosures on insurance ID cards.

Provider Contracting / OON Billing
House No. 1162 / Senate No. 810, An Act to reduce inequities in access to medical procedures – Oppose
H1162 and S810 would prohibit negotiated reimbursement rates for evaluation and management or procedural services, undermining efforts to keep costs down and allowing providers to bypass contractual rates. Increases in reimbursement should remain tied to services provided and performance. Higher mandated payments would force premiums for employers and consumers to rise, particularly impacting individuals and small businesses, as large employers increasingly self-insure and are exempt under ERISA. State reports repeatedly show that rising prices, not utilization, drive health care costs, with the Health Policy Commission highlighting significant price growth in recent years.

State-Mandated Benefits
Massachusetts state law mandates that fully insured health plans provide coverage for 50 specific services, treatments, supplies and practitioners. These mandated benefits increase the cost of health insurance coverage in the merged market and remove flexibility in employer product design. In January 2022, CHIA calculated that **existing state mandated benefits account for $2.5 billion in health care spending annually, representing**

17% of total commercial premiums paid. State mandates apply to fully insured policies only, specifically individuals who purchase coverage on their own or receive it through a small or medium-sized business. Due to preemption of ERISA, self-insured plans are not required to provide state mandated benefits. Thus, the addition of new mandates encourages more employers to self-insure to avoid benefits required by the state, drawing membership from the small group market. As more employers self-insure, state laws mandating specific types of services and the associated costs impact an increasingly smaller portion of the privately insured marketplace. As the state works to make health care affordable for individuals and small businesses, passing mandates into law undermines that objective and will raise premiums for these subscribers. Seven mandates became law last session and are estimated to cost over $1 billion over 5 years. Rather than pass more mandates, the legislature should pass a moratorium on further mandating additional coverage.

Specifically:

House No. 1151 / Senate No. 742, An Act relative to cognitive rehabilitation for individuals with an acquired brain injury – Oppose
Under the Affordable Care Act, health plans are already required to cover rehabilitative and habilitative services, including medically necessary acute and ongoing care for individuals with acquired brain injuries (ABI). Most ABI patients are treated in emergency or inpatient settings, with necessary follow-up care provided in rehabilitation centers, skilled nursing facilities, and through continued services by occupational therapists, physical therapists, speech-language pathologists, neuropsychologists, and physicians. These treatments are covered when medically necessary. However, certain interventions—such as neurofeedback—remain investigational and are not universally supported by clinical evidence or covered by plans. As the Center for Health Information and Analysis (CHIA) noted, cognitive rehabilitation therapy encompasses a wide range of services that vary in effectiveness depending on the patient's condition and recovery needs. An outdated 2016 CHIA estimate suggested this mandate would add $5 million to premiums annually, driven primarily by increased utilization of post-acute stays that are custodial rather than restorative, which are not medically necessary. If health insurance is required to cover custodial services in perpetuity for members who are not also receiving rehabilitative treatment, this would be a broad expansion of health insurance coverage that would significantly drive up costs. We recommend an updated review of the potential costs and medical efficacy of each of the services included in the mandate be conducted.

House No. 1227 / Senate No. 809, An Act relative to patient access to biomarker testing to provide appropriate therapy – Oppose
H1227 and S809 would mandate health plan coverage for biomarker testing of enrollees and would require a 72-hour turnaround time for prior authorization decisions. Biomarker tests that are conducted as a component of routine patient care are included in the Commonwealth's Essential Health Benefit (EHB) benchmark plan and are already broadly covered. The Affordable Care Act (ACA) requires coverage, without cost-sharing, of biomarker tests that receive a grade A or B by the United States Preventive Services Task Force. Human Leukocyte Antigen (HLA) testing, conducted for transplant recipients and/or transplant donors, is a state-required benefit. While MAHP member plans cover certain types of biomarker testing today, we will be working with proponents of the bill to understand the scope of the term biomarker, the intended clinical use cases, and the evidence-base for expansion of such testing and work on alternative language of the bill that supports medically appropriate policies and leads to safe and effective treatment. A 2024 mandated benefit review conducted and issued by CHIA on a prior version of the bill concluded that legislation expanding coverage would increase health insurance premiums by **$168 million over five years**. The current version of the bill includes a more expansive definition of biomarker and biomarker testing, which may lead to even greater cost implications.

House No. 1154 / Senate No. 726, An Act relative to insurance coverage of mobile integrated health – Oppose
Pursuant to state regulation 105 CMR 173, mobile integrated health (MIH) programs approved by the Department of Public Health (DPH) are required to identify gaps in service delivery, and provide improvements in quality, access, and cost effectiveness through reduction in avoidable emergency department visits, a decrease in total health care expenditures, or a decrease in costs to patients. Mandating health plan coverage of MIH programs at **the same payment rate as in-person services** would undermine the state's goals of the program to improve cost effectiveness, as reimbursement should be commensurate with the services provided. Furthermore, the MIH program is already partially funded by the DPH, which provides financial assistance to participating MIH

providers for startup costs. Health plans in Massachusetts currently reimburse MIH providers based on negotiated payment rates, reflecting the cost, quality, and efficacy of the services provided. We are deeply concerned about efforts to mandate payment rates, particularly if those rates are tied to high-priced hospital and facility rates.

House No. 1288 / Senate No. 716, An Act relative to telehealth parity for nutrition counseling – Oppose
Telehealth was intended to create cost savings for providers, health plans, and members by serving as a lower-cost alternative to urgent care or physician office visits. Savings resulting from reduced labor and physical facility costs can be passed on to insured members through decreased premiums, but this cannot be accomplished if health plans are required to reimburse telehealth at the same rate as an in person visit.

House No. 1289, An Act requiring reimbursement for the costs of competent interpreter services – Oppose
H1289 is unnecessary as hospitals and licensed health care facilities in Massachusetts are already required under both federal and state law to provide competent interpreter services for patients with limited English proficiency and those who are deaf or hard of hearing. Pursuant to the Americans with Disabilities Act and M.G.L. Chapter 66 of the Acts of 2000, hospitals are already required to provide interpreter services at no cost to patients as a condition of their licensure and receipt of federal funds. Mandating separate reimbursement, as proposed in House Bill 1289, would pay hospitals again for services they are already obligated to provide, push additional costs onto consumers and employers, and add unnecessary administrative complexity by requiring new billing systems for services that are already part of standard patient care.

House No. 1309 / Senate No. 764, An Act ensuring prompt access to health care – Oppose
H1309 and S764 would mandate coverage of outpatient office and clinic visits, without cost sharing. MAHP member plans already provide extensive coverage for medically appropriate health care services in outpatient settings in compliance with both state and federal regulations. However, the elimination of cost-sharing for these services will significantly increase premiums for insured members. We recommend that this legislation not advance before CHIA calculates an accurate cost estimate.

House No. 1161, An Act regarding cervical cancer and women's preventative health – Oppose
H1161 would mandate coverage of cytological and HPV screenings without cost sharing at an interval that does not align with clinical guidelines. In compliance with the ACA and state law, health plans in Massachusetts already provide comprehensive coverage for cytological screenings every 3 years and for high-risk HPV testing every 5 years. These standards are developed by health care professionals who undertake a rigorous process to review and assess evidence to protect patients and ensure that clinicians deliver high-quality, safe and appropriate care. House Bill 1161 would go far beyond current federal guidelines by mandating health plans to cover yearly screenings without cost-sharing, which would encourage inappropriate and unnecessary care and drive up costs for consumers and employers. A 2014 mandated benefit review conducted by CHIA concluded that the bill would increase health insurance premiums by $10.6 million annually, or **$53.06 million over five years**.

House No. 1317 / Senate No. 682, An Act improving access to breast pumps – Oppose
H1317 and S672 are unnecessary as the ACA already requires health plans to cover prenatal and postnatal lactation support, counseling, and the rental or purchase of breastfeeding equipment, without the imposition of cost sharing. The lactation services mandate was implemented by Massachusetts health plans almost ten years ago, in accordance with Bulletin 2016-05 issued by the Division of Insurance. A 2024 mandated benefit review conducted and issued by CHIA concluded that legislation expanding coverage would increase health insurance premiums by **$10.5 million over five years**.

House No. 1311 / Senate No. 761, An Act ensuring access to full spectrum pregnancy care – Oppose
H1311 and S761 seek to eliminate cost sharing for coverage of prenatal care, childbirth, and postpartum care. Health insurance in Massachusetts already provides robust coverage for pregnancy and maternal health care services, without cost sharing, as required by state and federal law. Notably, the ACA requires coverage of routine prenatal care including office visits with no copays or coinsurance, even if a member has a deductible that she hasn't yet reached. Further, the ACA and state law prohibit cost sharing for countless preventive services based on clinical recommendations made by expert medical and scientific bodies. For perinatal women in Massachusetts, this includes no-cost depression and anxiety screenings and interventions, gestational diabetes screenings and healthy weight counseling, screenings for hypertension and sexually transmitted infections, and breastfeeding interventions for postpartum women. CHIA estimates that the elimination of cost sharing for childbirth and the

corresponding hospital stay for the mother will significantly increase premiums for insured members by approximately **$50 million every year**.

House No. 1127 / Senate No. 697, An Act to increase access to nurse-midwifery services – Oppose
This legislation would increase health insurance premiums by **$14 million over the next five years** by requiring health plans to reimburse services provided by certified nurse midwives (CNMs) at the same level as licensed physicians. Health plans appreciate the value that CNMs add to the health care system. Massachusetts law already mandates insurance coverage of services delivered by CNMs to the full extent that such services are performed by any other duly licensed practitioner and within their lawful scope of practice. The rate of reimbursement established during contract negotiations between plans and providers reflects the technical skill, educational background, and clinical experience of health care professionals. CHIA estimates the mandate will increase health care spending on all services by CNMs by 18%. Higher costs negate any savings that can be achieved by directing perinatal care to CNMs. Mandating higher reimbursement will impede efforts to control health care costs at a time when employers and residents across the state are struggling to afford premiums.

House No. 1312, An Act relative to insurance coverage for doula services – Oppose
MAHP also opposes increasing health insurance premiums for individuals and small businesses by mandating coverage of doula services. As MassHealth implements coverage and reimbursement of doula services, we look forward to learning from their experience in terms of the impact on maternal health outcomes, member access and satisfaction, and costs. We ask that the Legislature review available evaluations from the first year of the MassHealth program's experience before requiring health insurance enrollees in Massachusetts to pay for doula services.

For the above reasons, we urge the Committee to **oppose the following bills: House Nos. 1091, 1101, 1127, 1151, 1154, 1161, 1162, 1227, 1288, 1289, 1309, 1311, 1312, 1317, 1321, 1326, and Senate Nos. 682, 685, 697, 698, 716, 726, 742, 761, 764, 800, 809, 810, 827.**

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