MAHP
MASSACHUSETTS ASSOCIATION of HEALTH PLANS

August 6, 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: 7/15 Joint Committee on Financial Services Legislative Hearing
MAHP Support: House No. 1144
MAHP Oppose: House Nos. 1120, 1156, 1196, 1126, 1140, 1142, and 1168, and Senate Nos. 758, 762, 801, 783, and 818.

Dear Chairs 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. In addition, we support one bill that addresses the issue of out-of-network billing, reducing health care costs and protecting patients. 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. 1144, An Act to protect health care consumers from surprise billing – Strongly Support
Health care spending as a result of surprise billing has continued to increase in Massachusetts. Both the charges billed by out-of-network (OON) providers and the amounts paid by health plans and consumers to OON providers have risen substantially. The average spending on health care services provided by OON radiologists, anesthesiologists, pathologists, emergency doctors, and ambulance providers far exceeds the average spending on in-network claims. For instance, the 2020 Health Policy Commission study found that the OON Payment rates for ambulance services in the state were significantly higher than the health plans' in-network reimbursement rates ranging from 112% to 430%; for professional services including anesthesia, CT and pathological services by 37% to 189%; and for ED E&M procedures by 102% to 158%.

H1144 would protect Massachusetts' insured residents from being billed by OON providers for health care treatment, limit member cost sharing for OON services to the in-network amount and restrict facility fees to services provided on a hospital's campus or a facility that includes a hospital emergency department, or emergency services provided at a licensed satellite emergency facility. Additionally, the bill would reduce health care spending in the state through the establishment of appropriate

reimbursement rates for health care services delivered by OON providers in the fully insured market at a carrier's median contracted rate. The establishment of a default OON reimbursement rate has been endorsed by the state's Executive Office of Health and Human Services, the Health Policy Commission (HPC), and the Attorney General in recognition of the opportunity for savings of over $1.6 billion annually, as estimated in MAHP's policy brief. If these savings were measured in potential premium reductions, the average Massachusetts resident could see about $225 in annual savings, or roughly $900 for a family of four. That amounts to a 3.1% reduction in total annual health care costs. These are meaningful savings that would benefit consumers, employers, and the Commonwealth alike.

Many routine health care services are safely provided in both hospital outpatient departments and non-hospital settings such as physician offices, however commercial prices and patient cost-sharing are generally substantially higher (often twice as high or more) at hospital outpatient sites due to the addition of a hospital payment component or facility fee. H1144 would require site neutral payments for services delivered by an off-campus facility and services commonly provided in office-based settings, including laboratory tests, imaging, diagnostic services, and clinician-administered drugs identified by the HPC. Requiring site-neutral payments will address increased costs to employers and consumers that access the same care in alternative settings and ensure the cost of care is tied to its value and not to the site where the care is delivered. **For these reasons, we strongly SUPPORT House Bill 1144.**

House No. 1120, An Act relative to patient access to primary care services – Oppose
H1120 would increase health care costs and undermine health plan networks by authorizing direct primary care (DPC) arrangements, contractual agreements between individuals and primary care providers for a monthly or annual fee. DPC is a reformulation of concierge medicine in which patients pay providers directly, outside of the insurance system. These providers do not participate in health plan networks, thereby weakening established provider networks that offer consumers access to high-quality, credentialed primary care.

By removing health plans from the care delivery model, DPC arrangements eliminate critical oversight functions that plans provide, such as credentialing, quality assurance, and ensuring value for patients and purchasers. H1120 would not only fragment care but also increase costs for consumers and employers. Massachusetts law requires that health insurance include coverage for primary care services. As a result, patients who engage in DPC arrangements would still be subject to minimum creditable coverage requirements and continue paying premiums for insurance that already includes primary care, effectively paying twice.

Moreover, on the federal level, the recently enacted "One Big Beautiful Bill Act" (OBBA) already addresses the role of DPC arrangements in a way that is more appropriate and consumer protective. Under which, DPC arrangements are explicitly clarified as not constituting health insurance and are therefore not subject to insurance regulation. OBBA establishes a fixed, periodic fee structure for DPC agreements, capping fees at $150 per month per individual or $300 per month for arrangements covering more than one individual. It also allows DPC fees to be treated as qualified medical expenses eligible for payment through Health Savings Accounts (HSAs), further aligning DPC with broader federal tax policy. This statutory framework strikes a better balance by providing clear parameters for DPC without undermining regulated insurance markets or duplicating coverage. **For these reasons, we OPPOSE House Bill 1120.**

House No. 1156 / Senate No. 758, An Act relative to uncollected co-pays, co-insurance and deductibles – Oppose
House No. 1196, An Act relative to unpaid health insurance deductibles – Oppose
H1156, H1196, and S758 would significantly increase health insurance premiums by requiring health plans to reimburse providers for copayments, coinsurance and deductibles billed by a health care provider when unpaid by an insured. Traditionally, providers are responsible for collecting these payments at the point of service. These amounts are outside the contractual obligations of the health plan, and current systems are not designed to support such collections, and as such, complying with this mandate would require substantial business and IT infrastructure overhauls, increasing administrative costs and premiums for consumers and employers. Furthermore, if plans are required to pay providers for unrecovered cost sharing, it eliminates the financial incentives built into plan designs like deductibles and coinsurance, tools intended to promote value-based care and consumer engagement. Importantly, H1156, H1196, and S758 would not apply to self-insured plans, which are governed by the Federal Employee Retirement Income Security Act (ERISA) and not subject to regulation by the state. As a result, the costs associated with payments to providers for unpaid member cost sharing would only apply to fully insured health plans, creating a major inequity within the commercial market. Large, self–insured employers will continue to be free to design cost effective benefit plans that suit the needs of their employees, but small businesses will face much more limited and more expensive options. The result would be disproportionately higher costs for the fully insured small to mid-sized employers. The Affordable Care Act (ACA) already tightly regulates out-of-pocket spending and actuarial value. Mandating health plans to absorb patient cost sharing would push products into higher actuarial value tiers, increasing premiums and limiting product flexibility. Additionally, as H1156, H1196 and S758 do not apply to self-insured plans, these bills would add complexity and confusion for both health plans and providers, who would be required to navigate inconsistent administrative requirements across markets. Rather than imposing new administrative mandates on health plans, efforts should focus on addressing the root causes of health care cost growth. **For these reasons, we strongly OPPOSE House Bills 1156 and 1196, and Senate Bill 758.**

House No. 1126, An Act to streamline patient disclosure requirements – Oppose
Senate No. 762, An Act relative to streamlining notice and disclosure – Oppose
MAHP strongly supports efforts to increase health care cost transparency and ensure patients have access to timely, accurate information about their out-of-pocket costs. Health plans already offer robust, user-friendly cost estimate tools on their websites as required under Massachusetts law, Chapter 176O Section 7, which mandates that health plans provide itemized, good-faith cost estimates to members. We encourage the Committee to review health plans' pre-filed testimony for the Health Policy Commission's Cost Trends Hearings for detailed data on the utilization and performance of these tools.

However, we are concerned that H1126 and S762 place disproportionate responsibility on health plans for delivering cost estimates to patients, while relying on providers to supply critical information that is often incomplete, delayed, or inaccurate. The bill effectively shifts the operational and compliance burden from providers to health plans, while imposing rigid timelines and significant penalties that fail to account for these dependencies. H1126 and S762 require providers to submit good faith estimates of billing and diagnostic codes for scheduled, non-emergency services. Health plans would then be required to produce

cost-sharing estimates for patients within one to three business days, depending on the timing of the appointment. While we understand and support the intent to give patients meaningful information before they receive care, health plans cannot produce accurate estimates without reliable and timely data from providers. Any breakdown in communication, such as missing codes, scheduling changes, or data entry errors, would still expose the health plan to enforcement actions and penalties of up to $5,000 per violation under S762 and up to $2,500 under H1126. In addition, this proposal would codify in state law certain elements of the federal No Surprises Act (42 U.S.C. §300gg-136), while potentially introducing inconsistencies with federal timelines, definitions, and enforcement mechanisms. The resulting dual regulatory structure could create confusion for patients and duplicative compliance obligations for plans, especially given the ongoing implementation of federal rules. Finally, the bill's compliance timeframes and administrative requirements will require health plans and their vendors to make costly and complex systems upgrades. These expenses, ultimately borne by employers and consumers in premium costs, would be better invested in tools and partnerships that help patients understand their coverage and navigate to high-quality, cost-effective care. **For these reasons, we OPPOSE House Bill 1126 and Senate Bill 762.**

House No. 1140 / Senate No. 801, An Act to remove barriers to patient care – Oppose
While we greatly value the contributions of advanced practice registered nurses (APRNs) to the Commonwealth's health care workforce, H1140 and S801 would undermine health plan utilization management tools that are designed to ensure patients receive clinically appropriate, evidence-based, affordable care. These bills would require health plans to accept diagnostic evaluations, medical necessity determinations, certifications, written orders, prescriptions, and treatment recommendations from APRNs in all instances where current statute requires those decisions to be made by a physician. Although the bill states that it does not expand the scope of practice for APRNs, it effectively changes how clinical authority is recognized under Massachusetts law. Requiring health plans to treat APRN determinations the same as those of physicians across all lines of business would force significant and costly changes to utilization management systems, clinical review protocols, and provider contracts. Moreover, the bill would remove an important layer of clinical oversight, as physician review is essential within health plan benefit structures, especially for complex or high-risk services. By statutorily eliminating the requirement for physician-level review, the bill could lead to an increase in service utilization, ultimately raising premiums for consumers and employers. **For these reasons, we OPPOSE House Bill 1140 and Senate Bill 801.**

House No. 1142 / Senate No. 783, An Act to promote increased access to patient care through equitable reimbursement – Oppose
H1142 and S783 would mandate health plans to reimburse certified registered nurse anesthetists (CRNAs) at the same rate as physicians for the same services, regardless of differences in training, licensure, scope, or clinical responsibility. Health plans appreciate the value that CRNAs add to the health care system. However, these bills would require health plans to increase payment for services delivered by CRNAs without demonstrating a corresponding increase in care or quality. Though the bills allow for rate variation based on quality or performance measures, they establish a statutory rate floor for CRNAs that undermines health plans' ability to design reimbursement structures that reflect provider type, scope of practice, and negotiated agreements to preserve affordability for members and purchasers. Higher costs negate any savings that can be achieved by directing care to lower cost providers. The rate of

reimbursement established during contract negotiations between health plans and providers reflects the technical skill, educational background, and clinical experience of health care professionals. Therefore, any increases in reimbursement and compensation rates should remain linked to both the services provided and performance. Mandating higher reimbursement for health care services delivered by CRNAs would undermine health plans' efforts to keep costs down for consumers and employers. **For these reasons, we OPPOSE House Bill 1142 and Senate Bill 783.**

House No. 1168 / Senate No. 818, An Act relative to eliminating the PCP referral requirement for specialty gynecological care – Oppose

H1168 and S818 would increase health care costs and undermine essential care management tools by prohibiting health plans from requiring a referral or prior authorization from a primary care provider for certain specialty services provided by an obstetrician, gynecologist, certified nurse-midwife, or family practitioner. Prior authorization is a critical tool that helps ensure members receive the right care at the right time and in the most appropriate setting. It supports evidence-based care, reduces unnecessary or duplicative services, and protects patients from avoidable harm or overutilization. Similarly, coordinated referral processes support the integrity of health plan networks—networks that are carefully structured to deliver high-quality, cost-effective care through credentialed providers who meet rigorous standards. Disrupting these mechanisms would diminish care coordination, reduce value, and contribute to rising health care costs for consumers, employers, and the Commonwealth. **For these reasons, we OPPOSE House Bill 1168 and Senate Bill 818.**

For the reasons above, we **support House No. 1144.**

Conversely, we **oppose the following bills: House Nos. 1120, 1156, 1196, 1126, 1140, 1142, and 1168, and Senate Nos. 758, 762, 801, 783, and 818.**

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