MAHP
MASSACHUSETTS ASSOCIATION of HEALTH PLANS

September 16, 2025

Senator James Eldridge, Chair
Joint Committee on Revenue
State House, Room 511-C
Boston, MA 02133

Representative Adrian Madaro, Chair
Joint Committee on Revenue
State House, Room 34
Boston, MA 02133

RE: 9/16 Joint Committee on Revenue Legislative Hearing
MAHP Oppose: House No. 3196 and Senate No. 2047 / House No. 3159 and Senate No. 1938

Dear Chairs Eldridge and Madaro,

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.

House No. 3196 / Senate No. 2047, An Act to reform the healthcare cost benchmark - Oppose
House No. 3196 and Senate No. 2047 would fundamentally alter Massachusetts' nation-leading health care cost growth benchmark by replacing the existing benchmark, set annually at a rate equal to potential gross state product (PGSP), or 3.6%, with the historical growth rate in gross state product calculated annually by the Secretary of Administration and Finance as the average annual growth rate of actual state product for the most recent ten-year period.

The cost growth benchmark is a cornerstone of the Commonwealth's health care cost containment framework. Established in Chapter 224 of the Acts of 2012, the benchmark is set annually through a transparent, public process, and has served as a model for at least eight other states. The benchmark is not a cap on provider reimbursement, or even on spending growth, but rather a statewide accountability target that links health care cost growth to long-term economic growth. In seeking to align the health care ecosystem to a shared goal, the cost growth benchmark is intended to help moderate spending increases and preserve affordability for employers and consumers.

Replacing the prospective benchmark with a backward-looking measure undermines accountability and affordability, while ignoring the very real cost drivers hamstringing our ability to meet the benchmark. Moving to a historical average will weaken, if not eliminate, the tool's function at precisely the wrong time, locking in unaffordable trends, reducing accountability, and eroding affordability. Historical spending patterns include years when total health care expenditures far exceeded the benchmark; using these inflated trends would bake in unaffordable growth moving forward, as seen in the chart below.

Year	GSP (Massachusetts, All Industries) in millions of dollars	% Change from Previous Year	Cost Growth Benchmark	Performance Against Benchmark from Previous Year
2014	469,824.9 (FRED)	+3.80 %	3.6%	4.2%
2015	497,767.0 (FRED)	+5.88 %	3.6%	4.8%
2016	514,108.0 (FRED)	+3.26 %	3.6%	3.0%
2017	530,129.4 (FRED)	+3.14 %	3.6%	2.8%
2018	559,605.0 (FRED)	+5.57 %	3.1%	3.6%
2019	588,069.5 (FRED)	+5.06 %	3.1%	4.3%
2020	592,653.0 (FRED)	+0.78 %	3.1%	-2.4%
2021	649,511.4 (FRED)	+9.58 %	3.1%	9.0%
2022	695,612.1 (FRED)	+7.10 %	3.1%	5.8%
2023	736,296.3 (FRED)	+5.85 %	3.6%	8.6%
2024	780,666.2 (FRED)	+5.97 %	3.6%	

Further, a forward-looking benchmark sets a clear target for providers, insurers, and policymakers. Shifting to a historical mission will reduce the ability of the Health Policy Commission to hold the system accountable when actual costs outpace economic growth. Massachusetts already has among the highest health care costs in the nation. Diluting the benchmark will only accelerate premium growth and further erode affordability for employers and consumers.

Leading health policy scholars agree that benchmarks tied to prospective state gross product are most effective when they remain forward-looking, are periodically calibrated, and paired with robust enforcement tools. While benchmarks alone cannot bend the cost curve, a strong benchmark paired with complementary policies such as the performance improvement plan process, price oversight, and prescription drug reform, can address health care cost concerns.

Massachusetts needs stronger, not weaker, tools to contain health care costs and make health care affordable for employers and consumers. The Center for Health Information and Analysis' most recent Annual Report on the Performance of the Massachusetts Health Care System showed that per capita spending grew by a whopping 8.6% in 2023, well above the 3.6% benchmark. Families, employers, and state programs cannot absorb this growth. This underscores the need to **strengthen the benchmark's enforceability, not weaken it by adopting a higher, retrospective target.**

Massachusetts has led the nation by linking health care spending growth to the economy. H.3196 / S.2047 would undo more than a decade of progress, undermine accountability, and jeopardize affordability. We respectfully urge the Committee to reject this legislation and instead focus on policies that bolster the benchmark's effectiveness, such as enhanced enforcement authority and stronger oversight of high-cost providers and pharmaceuticals.

For these reasons, **we oppose House Bill 3196 and Senate Bill 2047**.

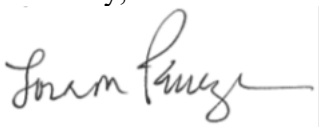
House No. 3159 / Senate No. 1938, An Act supporting family caregivers – Oppose

In addition to allowing spouses to be compensated as caregivers under MassHealth, H.3159 and S.1938 would require health plans to provide an automatic 30-day additional supply of prescription drugs during a declared state of emergency. While we support ensuring that members have timely access to critical medications in emergencies, a blanket mandate poses significant cost, operational, and safety challenges. Massachusetts law already provides statutory and regulatory frameworks to ensure patient access to prescription drugs during emergencies, while balancing cost and safety. For example, 130 CMR 406.411 establishes a 30-day supply limit with defined exceptions, including emergency 72-hour fills and designated 90-day supply lists; and 247 CMR 9.00 requires pharmacists to exercise professional judgment and comply with state dispensing standards. In addition, during emergencies such as the COVID-19 pandemic, the State issued guidance and bulletins which permitted early refills, extended 90-day supplies, and emergency pharmacy override. These laws ensure that patients can access needed medications, while avoiding unnecessary stockpiling, waste, and diversion.

Health plans already work closely with providers and pharmacies to ensure continuity of care during emergencies, and flexibilities such as early refills, extended day supplies, and emergency pharmacy overrides can be activated as needed. Codifying an across-the-board mandate risks unnecessary stockpiling, increased waste, and higher pharmacy spending, without improving patient safety. For these reasons, **we oppose House Bill 3159 and Senate Bill 1938.**

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

Sincerely,



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