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HEALTHCARE VALUE HUB

Massachusetts Healthcare Affordability: A Closer Look

November 2022

CONTENTS

All materials produced as part of the Healthcare Affordability State Policy Scorecard project, including the methodology report and scorecards for individual states, are available on our website at: www.HealthcareValueHub.org/Affordability-Scorecard

INTRODUCTION

As of 2021, 51% of Massachusetts adults experienced healthcare affordability burdens according to the Healthcare Value Hub's CHESS survey. In addition, Massachusetts continues to have some of the highest healthcare spending per person out of all states, at $9,876 per person in 2021.[1] In the 2022 Healthcare Affordability State Policy Scorecard, Massachusetts scored only 61.9 out of 80 possible points, equivalent to a C+ letter grade. While Massachusetts has enacted many policies intended to contain healthcare costs, their outcomes continue to lag, especially in reducing low-value care and making out-of-pocket costs affordable. Ultimately, the execution and effectiveness of the state's policies need significant improvement, alongside new interventions that will address the state's unique healthcare landscape.

Overall, Massachusetts has much work to do to improve healthcare affordability for its residents. This memo is intended to capture and critique Massachusetts' current healthcare affordability policies and outcomes, with specific recommendations for how to improve execution.

CURB EXCESS PRICES

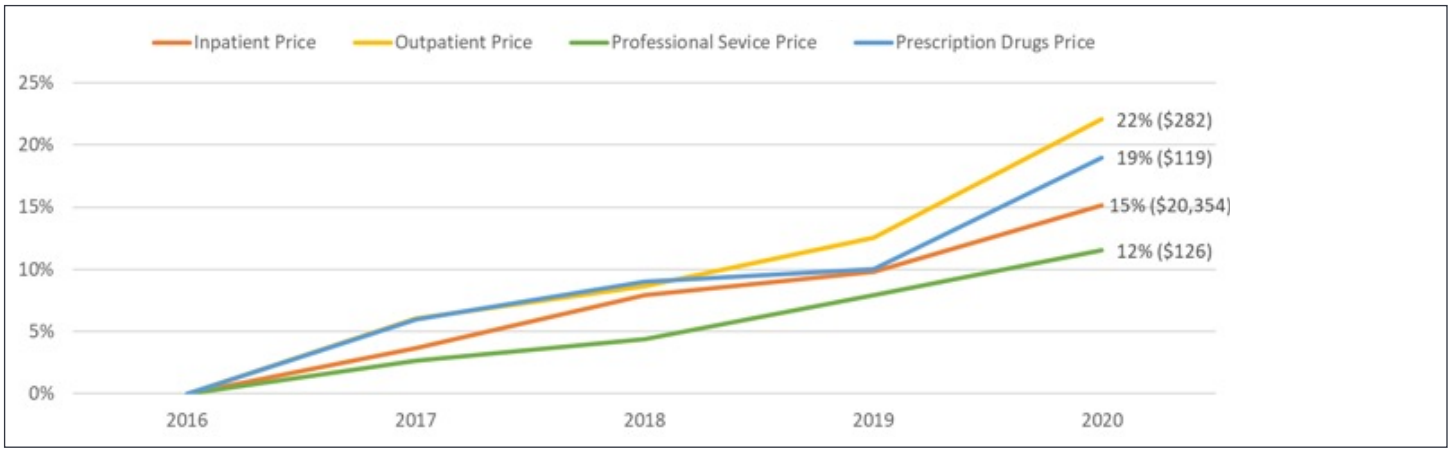
Commercial healthcare spending growth in Massachusetts is primarily driven by increases in prices paid per service, not by utilization. Internal analyses showed that price increases accounted for more than half of overall commercial spending growth in Massachusetts from 2015 to 2018.[2] External analysis by the Health Care Cost institute found that commercial healthcare prices grew 15.6% from 2014 to 2018, accounting for two-thirds of total spending growth, compared to only a 7% increase in utilization.[3]

Notably, price growth was highest in hospital inpatient settings (9.1% increase from 2016 to 2018), followed by hospital outpatient services (6.6% increase) and office-based services (4.4% increase) (see Figure 1).[4] Looking further at hospital inpatient prices, Massachusetts' inpatient private payer prices were 200% of Medicare prices, on average, for a basket of the top 25 most frequent private inpatient Diagnostic Related Groups* (DRGs), placing them in the upper middle range of all states (ranked 28 out of 48 states, plus D.C.).[5] While is it debated whether Medicare prices are too low or too high for different services, high and growing private prices remain a significant driver of cost increases over time. Further analysis of revenues and costs of specific hospitals using the National Academy for State Health Policy (NASHP) Hospital Cost Tool shows that almost all Massachusetts hospitals receive prices paid by commercial payers that exceed the payment level required to cover their maximum expenses with no profit (i.e. commercial breakeven) (see Figure 1).[6]

The Massachusetts Health Policy Commission has also noted that some spending increases can be attributed to shifts away from lower-priced care settings (community hospitals, community high payer public hospitals and teaching hospitals) to higher-priced care settings (academic medical centers and specialty hospitals).[7] Hospital upcoding also contributes to higher spending, with hospitals coding admissions at increasingly higher severity levels, which correspond to higher spending regardless of the type of care ultimately administered. Finally, increases in the average price per person have increased across inpatient, outpatient and professional services as well as prescription drugs since 2016, although it is worth noting that inpatient prices per person remain the highest by a substantial amount (see Figure 2).[8]

FIGURE 1: HOSPITAL COMMERCIAL BREAKEVEN POINT TO PRIVATE PAYER PRICES CHARGED FOR SELECT MASSACHUSETTS HOSPITALS

FIGURE 2: PERCENT CHANGE IN AVERAGE PRICE PER PERSON PER SERVICE FROM 2016 TO 2020 IN MASSACHUSETTS (AVERAGE PRICE IN 2020)[9]



HEALTH SPENDING OVERSIGHT ENTITY & ALL-PAYER SPENDING BENCHMARKS

Massachusetts' Health Policy Commission (HPC) is a permanent health spending oversight entity—established in 2012—that targets all spending, using All-Payer Claims Database (APCD) data to review market transactions and to monitor healthcare cost growth. They conduct regulatory reviews of proposed mergers, acquisitions and affiliations and have the ability to recommend approval, denial or terms of agreement. They also conduct Annual Health Care Cost Trends Reports, examining state trends in healthcare spending and delivery to inform the next year's statewide target for growth in Total Health Care Expenditures (THCE). The HPC can then require individual health plans, hospitals and medical groups charging above the THCE benchmark to submit Performance Improvement Plans (PIP) and is authorized to levy penalties of up to $500,000 for noncompliance with PIPs.[9] In February 2022, the Commission issued its first ever PIP request in its ten years of operation, requiring the Mass General Brigham health system to submit a PIP.[10,11,12] In September 2022, the HPC approved Mass General Brigham's revised PIP, which cut around $128 million in annual costs, a nearly $60 million increase from their original plan submitted in May 2022. Spending reductions will be achieved primarily through price reductions accounting for a majority $90 million in

spending cuts, including cutting outpatient rates charged to insurers and converting pricing at one facility to a community hospital rate schedule, as well as reducing utilization and moving care to lower-cost settings.[13]

In the field of prescription medications, the state can directly negotiate supplemental rebate agreements with manufacturers for MassHealth Medicaid, and the HPC can review manufacturer prices to determine whether they are unreasonably or excessively high.[14] This process has reportedly saved the state's Medicaid program $171 million since 2019.[15] In 2021, Governor Baker's office issued a fiscal 2022 budget proposal that would have penalized drug manufacturers who increase prices above the consumer price index plus 2 percent each year, but it did not pass.[16,17]

Despite HPC advancements, Total Health Care Expenditures increased above the benchmark in 2018 and 2019. This may be due, in part, to providers becoming dismissive of the benchmarks, particularly in the wake of COVID-19 and the increased administrative and financial burdens it placed on some hospitals, as well as continued consolidation, despite the HPC's regulatory efforts. Specifically, the HPC rejected Partners HealthCare's proposed acquisition of community hospitals, and Partners then captured the same assets through other avenues and began investing in costly developments. In response, multiple Boston hospitals and health plans merged, furthering consolidating across Eastern Massachusetts and ostensibly driving up prices to fund revenues for expansions.[18] In response to the shifting healthcare and hospital landscape, the HPC has affirmed its interest in new approaches to curbing healthcare spending and improving affordability, notably strengthening accountability for the cost growth benchmarks and increasing penalties for hospitals that are consistently over the benchmark.[19,20]

Recommendations:

- **Improve PIP and Increase Penalties:*** Improve the Performance Improvement Process (PIP) by allowing the Center for Health Information and Analysis (CHIA) to (1) use stronger metrics beyond primary care spending alone to identify entities driving spending and (2) increase financial penalties for above-benchmark spending or non-compliance, so that it will be impactful for hospitals of different sizes. Potential metric improvements include adding all-patient spending beyond primary care, hospitals and other provider types beyond primary care groups and robust medical coding analysis (see Massachusetts Health Policy Commission's 2021 Cost Trends Report).[21] Massachusetts might consider using the NASHP Hospital Cost Tool[22] as a component of these stronger metrics by using the commercial breakeven point for hospitals with high spending as a reference point for setting new spending goals for individual hospitals or health systems during the PIP.
- **Constrain Excessive Provider Prices:*** Implement limits on excess prices by establishing price caps for the highest-priced providers, limiting facility fees, increasing monitoring of provider expansions and ambulatory care and adopting default out-of-network payment rates (see Massachusetts Health Policy Commission's 2021 Cost Trends Report).
- **Investigate Medical Coding Changes and Improve Patient Risk Adjustment:*** The HPC encourages Massachusetts to further investigate high-intensity medical coding and take action to mitigate this practice, such as aligning payments with actual resource use rather than diagnosis exclusively and implementing mechanisms to offset coding-related spending impacts (see Massachusetts Health Policy Commission's 2021 Cost Trends Report). Given that increased coding intensity appears to be a deliberate, acknowledged strategy among some Massachusetts hospitals,[23] Massachusetts should carefully consider whether penalties or incentives will be more effective in addressing this issue.

- **Authorize the HPC to Prohibit or Penalize Private Insurer Excess Prices for Prescription Drugs:** While Massachusetts' Medicaid negotiation authority has accrued savings for the state, it has not directly addressed high prescription drug prices driving spending in the commercial market, which is critical to addressing affordability for residents who rely on private insurance. Since a negotiation model cannot be applied to private markets where the state is not a buyer, authorizing the HPC to prohibit or penalize payment for excess prescription drug prices among all payers could be a viable alternative. This approach could potentially serve to reduce hospital medication prices as well.

**These recommendations have been drawn from the Massachusetts Health Policy Commission's 2021 Cost Trends Report.*

Lessons from Colorado – Setting Upper Payment Limits for All Plans: While Colorado's Prescription Drug Affordability Board is still in development (beginning April 2022), their Upper Payment Limit model[24] presents an opportunity to address prescription drug prices for commercial plans. The law achieves this by referring to all purchases of and payer reimbursements for drugs dispensed or administered to individuals in Colorado.[25] Massachusetts should watch the Colorado PDAB progress closely to assess how they establish their payment limits, any lawsuits they may face related to employer-sponsored insurance and whether the program yields the intended reductions in prescription drug payments/spending.

ALL-PAYER CLAIMS DATABASE

Massachusetts' All-Payer Claims Database (APCD) is comprised of medical, pharmacy and dental claims, as well as information about member eligibility, providers and insurance coverage.[26] Massachusetts also offers an Acute Hospital Case Mix Database for detailed inpatient, outpatient and emergency department data, cost reports for hospitals and other health providers such as nursing facilities, statewide payment/expenditure data and insurance cost/coverage data. Information on the share of the state's population captured in the APCD was not readily available. However, Massachusetts has reported that around 75% of self-insured enrollees in the state, including enrollees in non-ERISA self-funded plans, were missing from the APCD as of 2017 after the *Gobeille v. Liberty Mutual* Supreme Court decision (previously 2.3 million self-insured beneficiaries before 2016 to 563,000 beneficiaries in 2018, with a 27% drop in medical claims volume). Post-*Gobeille*, the percent difference between the Massachusetts APCD and U.S. Census estimates was 24%.[27,28] The Center for Health Information and Analysis (CHIA) is "actively working with payers and employers to maintain as much self-insured data as possible."[29]

Recommendations:

- **Encourage Voluntary Data Submission from Employers/Self-Insured Plans**: To further support CHIA's efforts to encourage private employers and purchasing coalitions to submit self-insured data, Massachusetts might consider disseminating opt-in forms, educating employer groups on the value of participation and offering specific resources targeted toward employers.[30]

Lessons from Colorado: Colorado's APCD offers pre-made reports for employers, including a "Cost Driver Analysis" report to determine which services are driving highest healthcare cost among employees, and design benefits that incentivize employees to use high-quality, low-cost facilities, as well as a report on "Medicare Reference-Based Pricing" to help negotiate lower rates with providers.[31]

PRICE TRANSPARENCY TOOL

Massachusetts' Compare Care[32] tool shows negotiated prices paid by insurers and consumers for nearly 300 unique procedures by provider. There are ten service categories, including colonoscopy/endoscopy, maternity and others. The tool consistently directs consumers to contact their individual insurance plan for personalized quotes. However, some procedures have limited data that reduce the tool's usefulness. For example, the vaginal delivery childbirth page includes only professional fees, not hospital fees, which are often a substantial cost associated with childbirth.

Recommendations:

- **Provide Both Negotiated and Chargemaster Rates:** Providing only the negotiated rates can be a disadvantage for the small number of Massachusetts residents without insurance, who are often responsible for paying the chargemaster rate. Therefore, including both the chargemaster rate and the negotiated rate would be helpful for the uninsured.
- **Display More Robust Data for Select Services:** For pages where information is limited, such as the childbirth page, CompareCare might consider either displaying more robust data on procedures that accompany medical events like childbirth or providing sample itemized bills. This may further assist consumers trying to understand or estimate their costs, especially those who cannot get estimates from their insurer in advance or those trying to negotiate a fair price after they have received a bill. The state might start by estimating hospital fees in addition to the professional fees already captured and publishing them through the tool.

REDUCE LOW-VALUE CARE

Low-value care is defined as patient care that does not provide a net health benefit in clinical scenarios. Low-value care includes care that is clinically inappropriate for particular clinical cases, services that provide little to no clinical benefit and are against patient preferences, services that are done out of habit rather than scientific evidence and services that actively harm patients.[33]

A groundbreaking 2019 study conducted by the Institute of Medicine and Berwick and Hackbarth found that approximately one-quarter of healthcare spending is wasted, or roughly 25% of healthcare spending does not result in better health. Researchers estimated that one category of healthcare waste—overtreatment/low-value care—drives $75.7 billion to $101.2 billion in health expenditures each year. The estimated annual savings from the implementation of measures to eliminate overtreatment/low-value care ranges from $12.8 billion to $28.6 billion. Failure to curtail this "waste" raises premiums and causes patients to endure unnecessary cost-sharing for services, inconvenience and, occasionally, medical harm.[34]

MEASURE LOW-VALUE CARE IN CLAIMS AND/OR ELECTRONIC HEALTH RECORDS DATA

In 2018, the Massachusetts Health Policy Commission released a report looking at 19 low- or no-value tests, imaging services and procedures. The report found that one in five people covered by three major health insurers received low-value service from 2013-2015, with costs totaling $80 million, including more than $12 million paid out-of-pocket by patients.[35,36]

Recommendations:

- **Replicate Analysis with Larger Sample, More Low-Value Care Services and Recent Data:** The HPC might replicate their study using a larger sample covering more low-value care services and using more recent data. To determine the list of low-value care services to evaluate, consider drawing from the Choosing Wisely Campaign Clinician List[37] and/or services evaluated in other state studies below.

  Lessons from Other States:

  - Washington State Report: Found that 36% of spending on the healthcare services examined went to low value treatments and procedures, totaling an estimated $282 million in wasteful spending.[38]
  - Oregon Report: Found that the top 15 most utilized services accounted for 97% of all low-value services identified, affecting 2.9 million people, with $293,561,410 spent.[39]
  - Virginia Report: Found that 1,573,514 individuals received a low-value care service across a variety of service types with a total proxy cost of $706,504,304.[40]

- **Enact a Multi-Stakeholder Campaign to Reduce Low-Value Care:*** According to the Massachusetts HPC, "payers, providers, and purchasers should convene to develop strategies, incentives, and action steps to eliminate low-value care. Employers can also play a role in assisting employees and their families in accessing information useful in making high-value treatment decisions."[41] The HPC might draw on strategies implemented by Atrius Health, a network of primary and specialty care providers, such as

continuous education for physicians and other clinicians about low-value care, decision-support tools built into electronic medical records[42] and drawing on research about effective communication with physicians drawn from the Choosing Wisely campaign.[43]

**These recommendations have been drawn from the Massachusetts Health Policy Commission's 2021 Cost Trends Report.*

> **Lessons from Virginia**: After identifying low-value care services in a 2014 report, the nonprofit Virginia Center for Health Innovation (VCHI) received a $2.2 million grant from Arnold Ventures to create a statewide pilot, Smarter Care Virginia, aimed at reducing the provision of seven key low-value care services by creating a large-scale health system learning community and employer task force, as well as developing a set of consumer-driven low-value care measures.[44]

REQUIRE VALIDATED PATIENT SAFETY REPORTING IN HOSPITALS

One critical aspect of reducing spending on low-value care is reducing care that harms patients. Recent research found that nearly 62,000 incidents of medical error in inpatient facilities produced over $617 million in excess costs in a single year in Massachusetts.[45] Hospital/Healthcare-Acquired Infections (HAIs) are a prominent type of medical error, which include Central line-associated bloodstream infections (CLABSI) and catheter-associated urinary tract infections (CAUTI). Nationwide, research shows that CLABSI and CAUTI are estimated to cost hospitals roughly $48,100 and $13,800 per case, respectively.[46] The costs of medical harm can also impact consumers, particularly if a medical error requires a patient to seek additional care to repair damage caused by the error.[47,48]

In 2010, the Massachusetts Department of Public Health developed a comprehensive statewide plan to address HAIs.[49] Within that framework, Massachusetts mandated patient safety reporting and validation for CLABSIs and CAUTIs in acute care hospitals as of 2019 in an effort to reduce the prevalence of these costly incidents.[50] However, recent data showed that Massachusetts did not complete validation of CLABSIs or CAUTIs in acute care hospitals (ACH) in 2020, possibly as a result of strain on health systems during the COVID-19 pandemic.[51] States are designated as performing validation if they performed regular data cleaning/quality checks on at least 6 months of 2020 data prior to June 1, 2021 and contacted hospitals if data errors, outliers or missing information were found. States that perform more vigorous data validation activities are more likely to find hospital records of infections, and therefore these states may have higher SIRs compared to states that do not perform validation.[52] Between 2019 and 2020, Massachusetts acute care hospitals reported an increase in CLABSIs, and 10% of the 49 ACHs with sufficient data have rates higher than the national infection ratio. While there was no notable change in CAUTIs, 17% of the 53 ACHs with sufficient data still had higher rates than the national infection ratio.[53,54]

In addition to patient safety reporting, Massachusetts has also established the Betsy Lehman Center for Patient Safety[55] (launched 2004) and the Massachusetts Healthcare Safety and Quality Consortium[56] (launched in 2019), which are dedicated to improving patient safety reporting compliance, working with providers to implement patient safety programs and identifying policy strategies to incentivize best practices.

Recommendations:

- **Improve Validation of CLABSI and CAUTI:** Improve validation for CLABSI, CAUTI and all other healthcare-associated infections in all care settings. As part of broader efforts to improve patient safety reporting, Massachusetts should invest in their validation infrastructure, including data cleaning/quality checks and capacity to contact hospitals to correct data errors. This can help identify which hospitals may need additional supports to address CLABSI and CAUTI.
- **Establish State-Based Patient Safety Authority:** Massachusetts might consider establishing a state-based Patient Safety Authority modeled after the Pennsylvania Patient Safety Authority (PSA). The Pennsylvania PSA is an independent, non-regulatory entity that takes in information gathered by Department of Health and organizes liaisons to work directly with care providers to facilitate improvements in patient safety.

HOSPITAL ANTIBIOTIC STEWARDSHIP

Overuse of antibiotics contributes to the problem of healthcare-associated infections (HAIs), a form of medical harm, by encouraging antibiotic resistant organisms to thrive, thereby making HAIs more difficult to treat, limiting treatment options and potentially prolonging a patient's length of stay in a healthcare facility. In turn, the CDC estimates that antibiotic resistant infections result in $20-35 billion in excess direct healthcare costs.[57]

Ninety-nine percent of Massachusetts hospitals had adopted the CDC's Core Elements of Antibiotic Stewardship—a set of key principles to guide providers' efforts to improve antibiotic use and advance patient safety and improve outcomes—in 2019, but the share decreased to 93% in 2020. It is possible that some of this decrease may have come about due to the COVID-19 pandemic and the strain it put on the healthcare system. Among outpatient pharmacies, Massachusetts reported an all-antibiotic prescription rate of 696 prescriptions per 1,000 population in 2019 and 548 out of 1,000 in 2020. This places them in the middle 50% of states, suggesting that there are further stewardship opportunities for providers, facilities and other partners interested in improving how antibiotics are used.[58,59,]

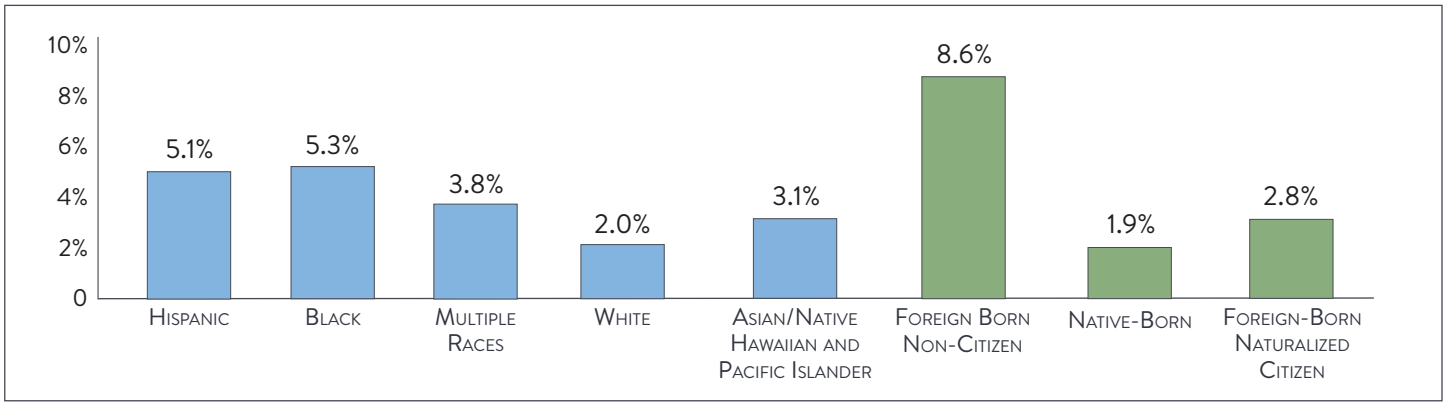
Recommendations:

- **Increase Hospital Adoption of CDC Antibiotic Stewardship:** Encourage universal adoption of the CDC's 7 Core Elements by working with remaining hospitals to complete the Antibiotic Stewardship Program Assessment Tool. Identify senior hospital leaders to champion efforts and secure resources, particularly the chief medical officer, chief nursing officer and director of pharmacy.[60]
- **Target Providers Outside of Hospitals:** Consider promoting the CDC Antibiotic Stewardship model to additional providers beyond hospitals, such as nursing homes (which have their own CDC Antibiotic Stewardship model), retail health and urgent care settings, community clinic physicians, community pharmacists and public health clinics. This promotion may require modified campaigns based on the unique organizational structure and decision-makers of the target provider.

EXTEND COVERAGE TO ALL RESIDENTS

Massachusetts has the lowest overall uninsurance rate of any state—roughly 3.0% to 3.6%, depending on the source.[61,62] However, state rates of uninsurance are higher among people of color and non-citizens. Black and Hispanic residents had uninsurance rates over 5%[63] and foreign-born non-citizens had an uninsurance rate of 8.6%, far higher than native-born and naturalized citizens (see Figure 3).[64] The uninsured population remains at risk for experiencing restricted access to crucial healthcare services and uncompensated care costs when using emergency services.

FIGURE 3: MASSACHUSETTS UNINSURANCE RATE BY RACE/ETHNICITY AND BY CITIZENSHIP STATUS (2021)



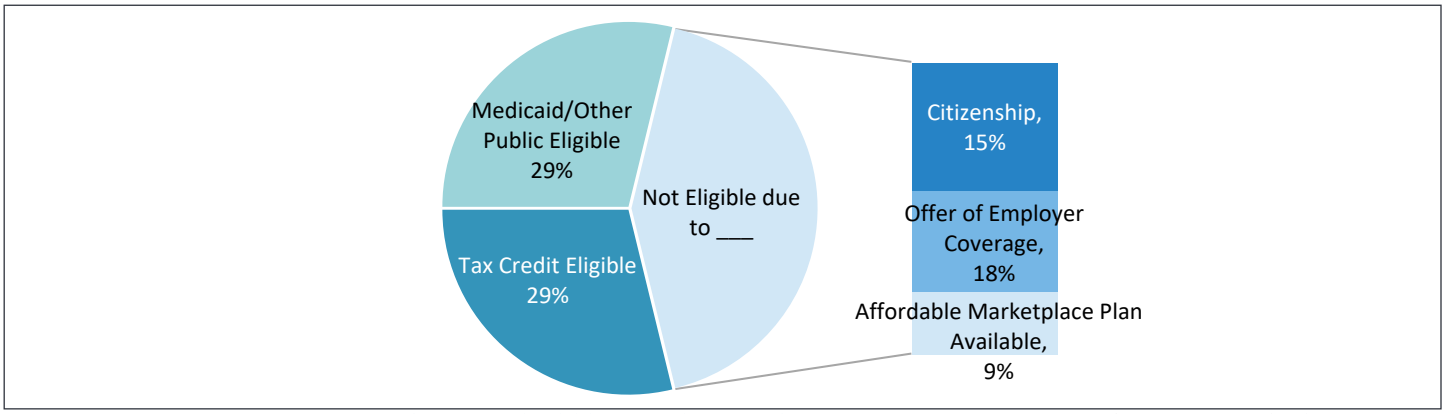
Sources: Kaiser Family Foundation, *Uninsured Rates for the Nonelderly by Race/Ethnicity*, Washington, D.C. (Accessed Nov. 1, 2022) and United States Census Bureau, *B27020 Health Insurance Coverage Status and Type by Citizenship Status. 2021, 1-year estimate*.

Roughly 15% of all uninsured Massachusetts residents are ineligible for Medicaid or ACA Marketplace health coverage due to their citizenship (see Figure 4).[65] An additional 18% of uninsured residents are ineligible for ACA Marketplace coverage due to an offer of 'affordable' employer coverage, and 9% are ineligible because the Marketplace calculates that, based on their income, they have access to an 'affordable' Marketplace plan without subsidies (the federal government defines 'affordable' as a plan with premiums costing up to 8.5% of household income). These data suggest that these employer or ACA Marketplace plans are, in reality, unaffordable or undesirable for this population.

In addition, over half of uninsured Massachusetts residents are eligible for subsidized coverage but remain uninsured. Roughly 29% are Medicaid-eligible and another 29% are tax credit eligible (including American Rescue Plan Subsidies), totaling roughly 114,000 residents as of 2021. While coverage may, in theory, be extended to this population, barriers remain that may have prevented them from getting coverage, including difficulty enrolling, healthcare plans being too expensive despite subsidies, lack of insurance carriers in rural areas and churn in and out of the program.

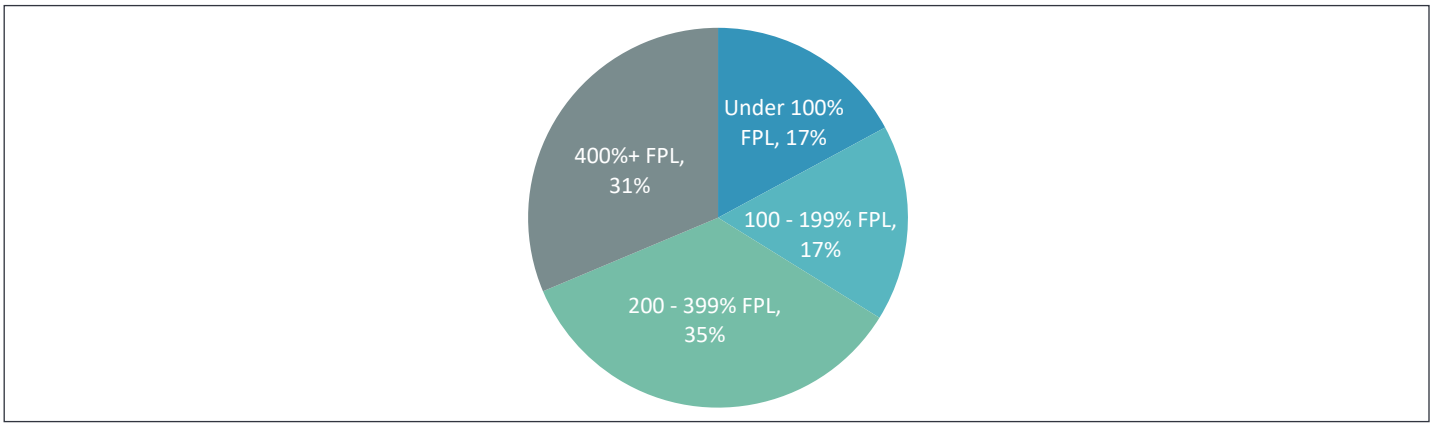
While a large share of Massachusetts' total uninsured population is middle-income and white, economic and racial/ethnic disparities persist in the state. Slightly less than half of Massachusetts' remaining uninsured population is white (48.4%),[66] but Hispanic and Black residents continue to face higher rates of uninsurance (5.1% and 5.3%, respectively) compared to white residents (2.0%) (see Figure 3). Low-income households earning less than 200% of the Federal Poverty Level (FPL) make up just 37% of the state's uninsured population (see Figure 5)[67] but face higher rates of uninsurance (6.5%) compared to middle-income households making 200–399% FPL (5.2%) and high-income households making 400% FPL or more (1.9%) (see Figure 6).[68]

FIGURE 4: DISTRIBUTION OF ELIGIBILITY FOR ACA HEALTH COVERAGE AMONG THE REMAINING UNINSURED (2021)



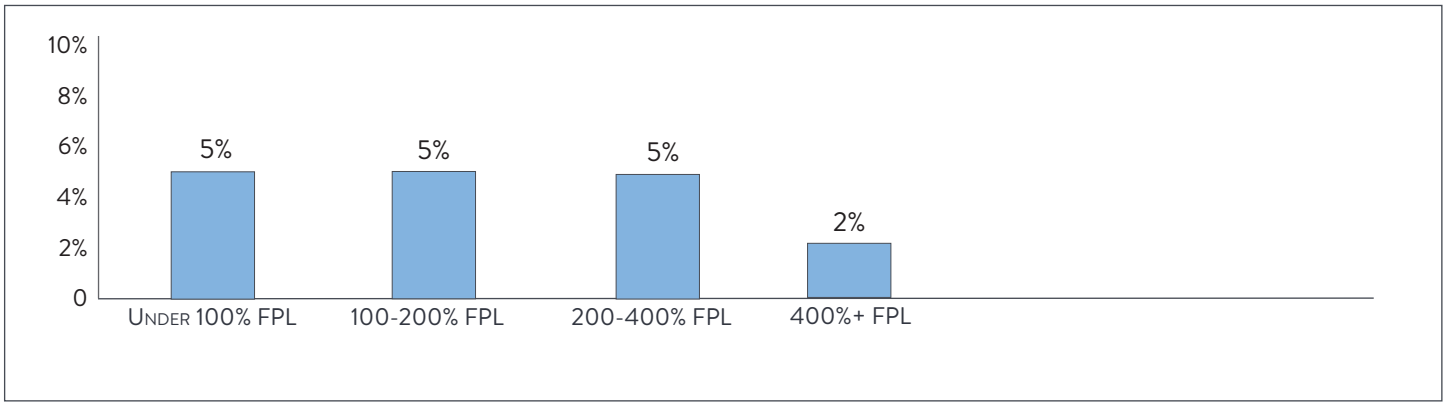
Kaiser Family Foundation, *Distribution of Eligibility for ACA Health Coverage Among the Remaining Uninsured*, Washington, D.C. (Accessed Nov. 1, 2022).

FIGURE 5: DISTRIBUTION OF UNINSURED BY FEDERAL POVERTY LEVEL (2021)



Source: Kaiser Family Foundation, *Distribution of the Nonelderly Uninsured by Federal Poverty Level (FPL)*, Washington, D.C. (Accessed on Nov. 29, 2022).

FIGURE 6: MASSACHUSETTS UNINSURED RATE BY FEDERAL POVERTY LEVEL (2021)



Kaiser Family Foundation, *Uninsured Rates for the Nonelderly by Federal Poverty Level (FPL)*, Washington, D.C. (Accessed Nov. 1, 2022).

MEDICAID EXPANSION

Massachusetts adopted the ACA Medicaid expansion to cover low-income adults with incomes under 138% FPL in 2014. To reduce state budgets, Governor Baker and the Massachusetts Department of Health and Human Services (DHHS) advocated for moving people earning 100-138% FPL off of MassHealth Medicaid and onto ConnectorCare marketplace plans with subsidies in 2017. Governor Baker also proposed prohibiting people from enrolling in MassHealth if they had access to employer-sponsored insurance plans with premiums less than 5% of their income, but neither of these proposals moved forward. Instead, the state increased Employer Medical Assistance Contributions and started charging employers an additional assessment if employees received benefits through MassHealth or ConnectorCare.[69]

While Medicaid expansion has certainly benefited Massachusetts residents, there are still those struggling to maintain their coverage. Notably, Massachusetts appears to have issues with churn (the process of enrollees repeatedly losing and regaining Medicaid coverage), which can disrupt care, resulting in unnecessary administrative costs for states and delays in care for beneficiaries, which may increase health costs in the long run.[70] It can also indirectly make Medicaid expansion less effective at providing stable coverage if low-income beneficiaries are churning in and out of the program and delaying or foregoing care during coverage disruptions. According to a 2021 MACPAC study, 12% of Massachusetts enrollees disenrolled and re-enrolled within 12 months (i.e., churn) in the Medicaid program, among the highest of the states studied.[71] Notably, Massachusetts has not enacted 12-month continuous eligibility for children's Medicaid and CHIP, which may contribute to churn.[72] While the state has taken some steps to streamline eligibility determination, such as re-determining eligibility using electronic data matches before requiring enrollees to complete a renewal form, more improvements can be made.[73]

Recommendations:

- **Maintain Medicaid Eligibility for Residents Under 138% FPL**: Massachusetts should consider continuing to allow residents under 138% FPL to remain on Medicaid, rather than switching them to ConnectorCare. The default Medicaid expansion structure has many affordability benefits, such as protecting patients from the high cost-sharing and enrollment barriers of marketplace plans, such as complex cost-sharing structures and confusion about plan selection. In addition, residents face a shortage of affordable dental care within ConnectorCare compared to Medicaid.
- **Enact 12-month Continuous Medicaid Eligibility**: Massachusetts should consider enacting continuous Medicaid eligibility for children through a state plan amendment and for adults through a 1115 waiver.[74] Although adopting continuous eligibility does come with increased costs from additional coverage months and initial implementation, reductions in healthcare costs over time and administrative savings can help offset these costs.[75] See this resource from Georgetown Center for Children and Families (CCF) for a comprehensive guide to improving Medicaid retention.
- **Expand Enrollment Assistance and Simplify Renewal Process**: Massachusetts can consider a variety of strategies to keep Medicaid-eligible people from losing their coverage, including: policies that streamline enrollment (relying on client statements for certain eligibility factors; sending both paper AND digital renewal forms if electronic verification fails, rather than only paper mail;[76] post-enrollment verification; expanded presumptive eligibility) and improved communication strategies (through text/email outreach;

updating enrollee contact information with data from Medicaid providers; giving enrollees 30 days to verify their new address).[77] These improvements require investments in health insurance navigator staffing, capacity and training. See this resource from Georgetown Center for Children and Families (CCF) for a comprehensive guide to improving Medicaid retention.

ADDITIONAL COVERAGE FOR PEOPLE ABOVE THE MEDICAID ELIGIBILITY THRESHOLD

The Massachusetts Health ConnectorCare Program provides additional state subsidies to individuals earning up to 300% FPL. Enrollees have access to zero- or low-dollar premium plans, zero-or low-dollar copays and do not have deductibles or coinsurance.

In 2018, Massachusetts published a study assessing the feasibility of allowing small employers to share premiums with or "buy into" MassHealth Medicaid.[78] Public option legislation was introduced in 2019 and 2021 but all bills thus far have died in committee.[79]

Recommendations:

- **Offer a Public Option Plan:** To reach the remaining uninsured population and ensure access to affordable coverage, Massachusetts might consider exploring a publicly funded health insurance plan. A 'public option' policy may allow states more freedom to pursue tailored subsidies and payment rate limits for commercial plans available to residents ineligible for Medicaid, especially if the state allows employers to offer public insurance instead of private plans.

  Massachusetts might even consider building on its existing Employer Medical Assistance Contributions infrastructure to allow residents with an offer of employer-sponsored coverage to instead choose the state public plan option if it is more affordable for them, while off-setting the costs with the additional assessment fees levied on employers. As a first step, Massachusetts could fund a study on how such a program could be created, including assessing how different program structures would affect the number of residents served, gathering input from employer stakeholders and estimating affordability for those earning above the Medicaid eligibility threshold.[80]

Lessons from Washington: Washington's Cascade Care is a hybrid public-private plan whereby the state contracts with private insurers to provide the plans, rather than creating a state-run insurance company. While this method saves on costs, it limits the state's control over plans. Legislation originally capped provider reimbursement at 100% of Medicare rates in an effort to keep premiums lower than other private coverage options, but pushback from industry stakeholders on rate setting caused legislators to increase the cap to 160%.[81]

Thus far, Washington public option plans are not as affordable as expected and have struggled with network adequacy. Cascade Care Bronze plan premiums are 2% more expensive than the lowest non-standard Bronze plan on the marketplace in plan year 2022, though many carriers report that the public option plan is their lowest priced plan in several counties. Although Cascade Care plans were more likely to be offered in counties where the marketplace was larger and more competitive, plan premiums were lower in smaller, less competitive counties.[82,83] In addition, public option plans were available in only 25 of Washington's 39 counties, due, in part, to hospitals refusing to participate in public option plan networks. Washington has since passed legislation requiring hospitals in large healthcare systems to participate in at least one public option plan.[84]

Lessons from Colorado: In 2021, Colorado passed legislation to establish a public option plan available for purchase on the marketplace by 2023 for individuals and small businesses with less than 100 employees. Similar to Washington, Colorado will contract with private issuers to provide public option plans, requiring it in counties where the issuers offer marketplace plans. Notably, the public option premiums offered must be 15% lower by 2025 than they were in 2021 for the same carrier and county. Colorado has also submitted a Section 1332 waiver to get federal pass-through funding. Colorado's legislation also includes several health equity components, such as efforts to improve perinatal healthcare coverage and pre-deductible high-value services. Moreover, plans must offer a culturally responsive network of providers that reflects the diverse nature of its enrollees in an effort to address health equity and reduce health disparities.[85]

Lessons from Nevada: In 2021, Nevada passed legislation to establish a public option plan available for purchase on the marketplace in 2026.[86] While the full details of the program are still in development, notably, the "bidder" model will require that any insurers who bid on Managed Care Organization contracts and public employee insurance contracts are required to make a good faith bid on the public option plans. The state will also prioritize bids from plans that integrate reducing health disparities into their proposals.[87]

COVERAGE FOR IMMIGRANTS

Massachusetts offers Medicaid coverage to lawfully residing immigrant pregnant women and children without a 5-year wait, and provides some services not covered through Emergency Medicaid for income-eligible pregnant or postpartum women who would otherwise be ineligible due to immigration status. Massachusetts also provides some coverage for undocumented children through the Children's Medical Security Plan, but it is restricted to primary and preventive care and excludes behavioral health for those with disabilities, among other crucial services. Massachusetts does not offer any coverage options for undocumented adults, who make up over 77% of the state's unauthorized population.[88]

Recommendations:

- **Consider Expanding Coverage for Undocumented Children:** Expanding coverage for undocumented children beyond basic primary/preventive care and including behavioral health services would drastically improve the policy's effectiveness. This could be achieved in several ways, including: (1) expanding the Children's Medical Security plan to include more comprehensive services such as behavioral health, pharmacy benefits, outpatient surgical services and treatment of chronic conditions; (2) allowing undocumented children to access MassHealth Medicaid/CHIP coverage; and/or (3) expanding MassHealth CommonHealth for people with disabilities to cover undocumented immigrant children.
- **Offer Coverage Options for Undocumented Adults:** Offering comprehensive coverage options for undocumented adults will help Massachusetts achieve 100% insurance coverage among its residents. Because undocumented adults are not eligible for Medicaid and are not allowed to purchase plans on the exchange, Massachusetts would need to pursue strategies to provide affordable, off-exchange coverage for undocumented adults. See Table 1 for examples from other states.

TABLE 1: STATE COVERAGE OPTIONS FOR UNDOCUMENTED ADULTS

State	Program	Eligibility	Benefits	Cost Sharing
California[89]	Young Adult Expansion	Ages 19 – 25 and 50+ with incomes <138% FPL, effective 2022 **Upcoming expansion to age 26–49 effective 2024*[90]	Full scope Medicaid equivalent	No copays No premiums
Illinois	Health Benefits for Immigrant Seniors[91]	Ages 65+ with income <100% FPL, includes asset test	Comprehensive medical benefits (*does not cover long-term care*)	No copays No premiums
	Health Benefits for Immigrant Adults[92]	*Ages 42-64 with incomes <138% FPL*	Comprehensive medical benefits (*does not cover long-term care*)	No copays No premiums
D.C.[93,94,95]	DC Health Care Alliance	Ages 21+ with income <215% FPL, includes asset test	Limited scope medical benefits (*does not cover vision, mental health or substance use services, long-term care over 30 days, medical transportation, open heart surgery, organ transplant, out of network care*)	No copays No premiums
	Cover All DC	Ages 21+ with no income or asset limits	Purchase private health insurance with no financial assistance	Private market rates
Colorado	Colorado's OmniSalud policy is available for purchase by undocumented residents and other groups starting in fall 2022.[96] State-subsidized 'public option' insurance is available for purchase through a public benefit corporation separate from ACA Marketplace. Undocumented residents earning up to 150% FPL are eligible for SilverEnhanced savings, which are zero premium plans with limited cost-sharing, while higher income groups can purchase OmniSalud plans without SilverEnhanced savings.[97] Premium subsidies for undocumented immigrants will be funded by a Health Insurance Affordability Enterprise bolstered by passthrough funds from ARPA subsidies and reinsurance.[98,99]			
Washington	Washington's policy, currently in development, passed during the 2022 legislative session. The policy's budget allocation will be set to launch 2 health coverage programs for immigrants by January 2024, including: (1) a Medicaid-equivalent program for those earning up to 138% FPL; and (2) an Exchange-based program for those above 138% FPL (1332 waiver pending), with Cascade Savings premium assistance for those up to 250% FPL.[100]			

RATE REVIEW

Rate review is the process by which insurance regulators review health carriers' proposed insurance premiums to ensure they are based on accurate, verifiable data and realistic projections of healthcare costs and utilization. Using a rigorous, multidimensional review process with input from the public and consumer advocates has been shown to lower rates for consumers.

Massachusetts is an 'active purchaser,' which means that the state-run exchange sets criteria for participating health plans, negotiates with insurers and ultimately decides which health plans will be sold through the exchange.[101] This has traditionally kept premiums on the exchange lower than those in other states.[102] However, over the past few years, Massachusetts's exchange premiums have increased relative to national trends, though they remain below the national average. For example, in 2018 Massachusetts's average benchmark premium was $316 compared to $481 nationwide, and in 2022 Massachusetts's average benchmark premium is $389 compared to $438 nationwide.[103]

The Department of Insurance (DOI) conducts premium rate review for their merged market, which includes all plans sold to individuals and all small group plans sold to businesses with fewer than 50 employees,[104] both on and off the exchange. The merged market review has clear statutory and regulatory standards, including Medical Loss Ratio, administrative expenses and other factors. The DOI can require issuers to provide a detailed description of the basis on which they reimburse different rates to similarly situated providers and require them describe efforts to reduce such variation. The DOI can also request descriptions of cost containment programs the carrier will use to address healthcare delivery costs, and the savings gained from such cost containment programs. If the DOI does decide to reject a rate increase, the process requires hearings on the rejected rate before the rates become effective.[105] The DOI also conducts a separate, less comprehensive rate review of all HMO plans and Blue Cross Blue Shield plans, which make up most of the employer-sponsored plans in the large group market. The DOI can disapprove these commercial plan rates, but they generally do not take that course of action, focusing instead on rate changes in the small group market to ensure they are comparable to the large group market and to identify discriminatory behavior.[106] Finally, Massachusetts's Health Policy Commission can request and review issuer-provider contracts as part of its mandate to reduce healthcare cost growth.

The rate review process is conducted privately between insurers and the DOI and happens four times a year with short review periods. The DOI has only fully rejected one rate increase in the last decade. In , they rejected most requests for higher rates from multiple carriers.[107] There were no additional rejections until 2021, when they rejected an average 15% rate increase request for Allways health plans, later approving an 11.5% increase after the required hearings and negotiations. The initial increase was rejected because Allways did not demonstrate adequate steps taken to renegotiate reimbursement rates to limit the grown in claims cost, especially with higher cost provider groups and inpatient hospitals (likely a reference to Mass General Brigham's hospital network).[108]

Beyond outright rejection, in 2020 the DOI negotiated rate increases down by one percent across the board, ultimately approving rates that increased by an average of 7.9% beginning in 2021, including a 12.2% increase for Tufts Health Plan, which provides low-cost healthcare on the Massachusetts Health Connector. These high rates were due, in part, to uncertainty in the market caused by the COVID-19 pandemic.[109] The DOI has acknowledged that they did not challenge the 2020 increase or hold a hearing because it would have prevented plans from being available in time for October's open enrollment period.[110]

In May 2022, the DOI drafted regulations that would reduce the number of chances insurers have to file rate increases for small businesses and would require insurers to provide information to the public to support their rates for individuals and small businesses, including a public hearing as part of an annual review process.[111] Governor Baker also proposed healthcare legislation (S. 2774) that would enhance the DOI's ability to modify and disapprove proposed rates that are unjustified.[112]

Recommendations:

- **Create Affordability Standards and Factor into Rate Review:*** Massachusetts might consider developing health plan affordability standards that prioritize consumers' ability to afford proposed rates. These affordability standards could then be added to the factors that the DOI considers in reviewing and approving health plan rate filings (see Massachusetts Health Policy Commission's 2021 Cost Trends Report for full recommendation).[113] Massachusetts might also consider developing their own affordability standard. See the NASHP rate review toolkit for model legislation and examples of affordability standards, including specific calculations.[114]
- **Explore Robust Negotiation with Large Group Market Carriers:** In order to reach a large share of the state's population, Massachusetts might consider strengthening the DOI's authority to include rate negotiation with HMOs and Blue Cross Blue Shield plans in the large group market so that it more closely resembles the rigorousness of the merged market review.
- **Explore Increasing Duration of the Rate Review Process:** In order to accommodate more robust review of consumer affordability in rate review, Massachusetts might also consider lengthening the rate review process for both the merged market and the large group market to last more than 45 days. Massachusetts might also consider adjusting the timeline to allow for sufficient time for the rejection and re-negotiation process without jeopardizing the effective date for the eventual rate increase. At the same time, carriers have expressed that the quarterly review window allows them more flexibility to respond to market trends, suggesting a compromise between quarterly and annual review could be beneficial.

**This recommendation have been drawn from the Massachusetts Health Policy Commission's 2021 Cost Trends Report.*

Lessons from Rhode Island: Rhode Island's affordability standard requires a cap of inflation plus 1% in insurers' negotiated prices with hospitals in order to have their premium rates approved.[115] This rate review process applies to large group market plans as well as the individual and small group markets.[116] See this report for an overview of RI affordability standards.[117]

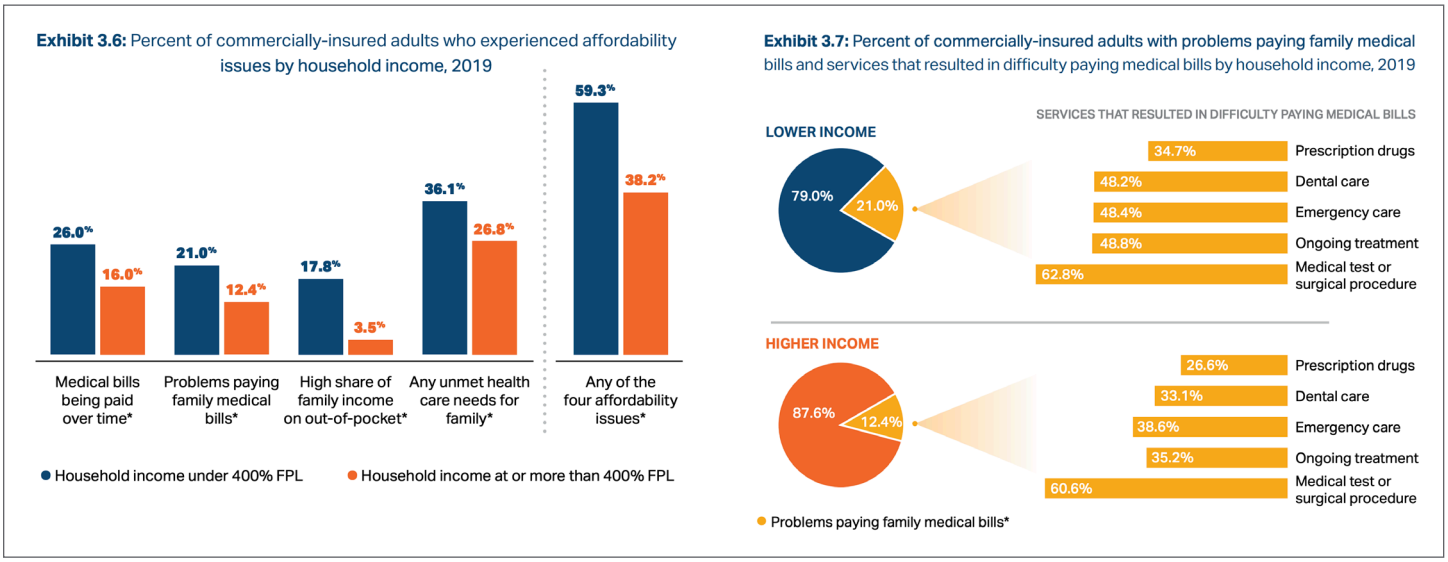
Lessons from Connecticut: CT is had developed their own affordability standard called the CT Healthcare Affordability Index, which factors in cost of living alongside healthcare expenses, to identify affordable premium and cost-sharing rates.[118]

MAKE OUT-OF-POCKET COSTS AFFORDABLE

Premiums and out-of-pocket costs for Massachusetts households are higher than those in most states and are rising faster than earnings. According to a Commonwealth Fund analysis, combined household premium contributions and out-of-pocket costs for those with employer-sponsored insurance totaled $4,578 per year from 2016 to 2017—11th highest of any state, and almost $1,000 more than the national median.[119]

Increasing out-of-pocket costs are an important driver of healthcare affordability burdens, with lower-income households facing higher burdens. The 2019 Massachusetts Health Insurance Survey (MHIS) found that 59.3% of households with incomes below 400% of FPL faced affordability burdens (defined as: medical bills being paid overtime; problems paying medical bills; high share of family income spent on out-of-pocket costs; any unmet healthcare needs), as well as 38.2% of households above 400% FPL (see Figure 7).[120]

FIGURE 7: AFFORDABILITY BURDENS FOR MASSACHUSETTS RESIDENTS



Source: Figures taken from Massachusetts Health Policy Commission 2021 Health Care Cost Trends Report (September 2021).

In a separate analysis, the HPC estimated that 33% of middle-class families in Massachusetts saw more than a quarter of all earnings go to healthcare spending based on 2016-2018 data, up from 23% in their 2019 report using 2013-2015 data.[121]

High deductible health plans (HDHP) are a notable barrier to care for Massachusetts's lower-income workers. The MHIS survey found that 29% of low-income adults with high deductible health plans went without care due to cost compared to 21% of low-income adults without high deductible plans. Among adults with low incomes in high-deductible plans, the percentage was still greater for people of color (33% among Black, Hispanic, or reported other or multiple races) compared to White adults (28%).[122] High deductible plans are becoming more prevalent nationwide and in Massachusetts. According to SHADAC, roughly 46% of Massachusetts households enrolled in an HDHP in 2020, and the average family deductible among employer

insurance plans in Massachusetts rose 36% between 2013 and 2019, totaling $3,151 in 2019. This may place an even greater burden on Massachusetts low-income workers: a CHIA analysis found that HDHPs comprise "more than 60 percent of plans held by employees of small- and mid-sized firms [in Massachusetts] (which tend to employ workers with lower incomes)."[123]

STANDARD PLAN DESIGN ON STATE EXCHANGE

Massachusetts has a state-based exchange, the Massachusetts Health Connector, where they offer both standardized and non-standardized plans. A standard plan design is where several features of the insurance plan design have been standardized, and typically affect cost-sharing requirements. Standardization enables consumers to make an "apples to apples" comparison amongst plans and simplifies plan shopping. Massachusetts's standardized plans have the same out-of-pocket costs (within each metal level) for various benefit categories (such as deductibles, out-of-pocket maximums, office visits and emergency room visits), but can vary in terms of premiums, provider networks and cost-sharing for benefits outside of the standardized categories. Massachusetts carriers also offer non-standardized plan designs on the Health Connector that have different cost-sharing requirements from the standardized plans.[124]

> **Lessons from California**: It is worth noting that some states have gone beyond offering standardized plans. For example, in California, insurers cannot offer non-standardized plans on the exchange.[125,126]

Massachusetts should enact the following recommendations to build on their success with standardized plan design.

Recommendations:

- **Develop Affordability Standards and Monitor Whether Exchange Plans Meet Standards:*** Massachusetts might consider developing affordability standards and ensure that all standard plans offered on the exchanges meet affordability standards (potentially consider extending to all plans). See Rate Review section recommendations for details on affordability standards.[127]
- **Partner with Employers to Investigate Alternatives to High-Deductible Health Plans:*** While standard plan designs benefit consumers purchasing on the state exchange, the majority of residents get their insurance through employer-sponsored plans, many of which are increasingly relying on high-deductible structures that do not align with the values and benefits of standard plan design. The state exchange and/or individual health plans could provide valuable insight by partnering with employers to study alternatives to HDHPs. One example of this could be structures that allow premium contributions based on different employee wage levels, as the exchange currently does with income-based subsidies (see Massachusetts Health Policy Commission's 2021 Cost Trends Report for details).

**These recommendations have been drawn from the Massachusetts Health Policy Commission's 2021 Cost Trends Report.*

WAIVE OR REDUCE COST-SHARING FOR HIGH-VALUE SERVICES

Failure to receive high-value care like flu vaccines, certain cancer screenings and other select services not only worsens health outcomes but can result in higher future medical spending.[128] Reducing financial barriers by waiving or reducing cost-sharing for specific high-value services is one-way states can encourage the utilization of high-value care. Massachusetts's standardized benefit plans offer some services pre-deductible for those purchasing Platinum, Gold, and certain Silver plans, including primary care, mental health visits, urgent care, and certain prescription drugs (see Figure 8). However, those purchasing Bronze plans and HSA-compatible Silver plans are required to first meet their deductibles for many high-value services apart from the lowest tier prescription medications, with deductibles ranging from $2,000 to $6,400.[129] In contrast, ConnectorCare plans (special state-based plans for individuals who earn up to 300% FPL and are ineligible for other government healthcare programs like Medicaid or Medicare) limit deductibles and include pre-deductible services with low to moderate copay amounts based on income tier, including non-preventive primary care, specialty care, mental health and substance use disorder treatment, urgent care and prescription drugs (see Figure 9).[130]

FIGURE 8: MASSACHUSETTS STANDARD QUALIFIED HEALTH PLAN DESIGN

Plan Feature/ Service *Note: "Deductible then..." means the member must first meet the plan's deductible; then, the member pays only the copay as listed for in-network services.*		Platinum	High Gold	High Silver	Low Silver (HSA compatible, Small Group Only)	Bronze #1	Bronze #2 (HSA compatible)
Annual Deductible – Combined		$0	$0	$2,000	$2,000	**$2,750**	**$3,200**
		$0	$0	$4,000	$4,000	**$5,500**	**$6,400**
Annual Deductible – Medical		N/A	N/A	N/A	N/A	N/A	N/A
		N/A	N/A	N/A	N/A	N/A	N/A
Annual Deductible – Prescription Drugs		N/A	N/A	N/A	N/A	N/A	N/A
		N/A	N/A	N/A	N/A	N/A	N/A
Annual Out-of-Pocket Maximum		$3,000	$5,000	**$8,700**	**$7,050**	**$8,700**	**$7,050**
		$6,000	$10,000	**$17,400**	**$14,100**	**$17,400**	**$14,100**
Primary Care Provider (PCP) Office Visits and Mental/Behavioral Health Outpatient Services		$20	$25	$25	Deductible then $30	**Deductible then $35**	Deductible then $100
Specialist Office Visits		$40	$50	$50	Deductible then $60	**Deductible then $75**	Deductible then $150
Urgent Care		$40	$50	$50	Deductible then $60	**Deductible then $75**	Deductible then $150
Emergency Room		$150	$300	Deductible then $300	Deductible then $300	Deductible then $750	Deductible then $1,750
Emergency Transportation		$0	$0	Deductible then $0	Deductible then $0	Deductible then $0	Deductible then $0
Inpatient Hospitalization		$500	$750	**Deductible then $750**	Deductible then $750	Deductible then $1,200	Deductible then $2,000
Skilled Nursing Facility		$500	$750	**Deductible then $750**	Deductible then $750	Deductible then $1,200	Deductible then $2,000
Durable Medical Equipment		20 percent	20 percent	Deductible then 20 percent	Deductible then 20 percent	Deductible then 20 percent	Deductible then 20 percent
Rehabilitative Occupational and Rehabilitative Physical Therapy		$40	$50	$50	Deductible then $60	**Deductible then $75**	Deductible then $150
Laboratory Outpatient and Professional Services		$0	$50	**Deductible then $45**	Deductible then $60	Deductible then $75	Deductible then $55
X-rays and Diagnostic Imaging		$0	$75	Deductible then $75	Deductible then $75	Deductible then $100	Deductible then $140
High-Cost Imaging		$150	$400	**Deductible then $375**	Deductible then $500	**Deductible then $800**	Deductible then $1,000
Outpatient Surgery: Ambulatory Surgery Center		$250	$500	Deductible then $500	Deductible then $500	Deductible then $500	Deductible then $500
Outpatient Surgery: Physician/Surgical Services		$0	$0	Deductible then $0	Deductible then $0	Deductible then $0	Deductible then $0
Prescription Drug	Retail Tier 1	$10	$25	$25	Deductible then $30	$30	Deductible then $30
	Retail Tier 2	$25	$50	$50	Deductible then $60	Deductible then $100	Deductible then $150
	Retail Tier 3	$50	$75	Deductible then $75	Deductible then $105	Deductible then $150	Deductible then $225
	Mail Tier 1	$20	$50	$50	Deductible then $60	$60	Deductible then $60
	Mail Tier 2	$50	$100	$100	Deductible then $120	Deductible then $200	Deductible then $300
	Mail Tier 3	$150	$225	Deductible then $225	Deductible then $315	Deductible then $450	Deductible then $675
Federal Actuarial Value Calculator		89.25 percent	81.40 percent	71.97 percent	**68.85 percent**	**64.97 percent**	**64.96 percent**

Bold indicates changes from 2021.

Source: Massachusetts Health Connector (October 2021).

FIGURE 9: MASSACHUSETTS CONNECTORCARE FEE SCHEDULE 2022

Lowest-cost ConnectorCare Plan Premiums in 2020					
	Plan Type 1	Plan Type 2A	Plan Type 2B	Plan Type 3A	Plan Type 3B
Lowest Cost Plan	$0	$0	$45	$87	$130

ConnectorCare Benefits & Co-pays				
Plan Type		Plan Type 1	Plan Types 2A & 2B	Plan Types 3A & 3B
Medical Maximum Out-of-Pocket (Individual/ Family)		$0	$750/$1,500	$1,500/$3,000
Prescription Drug Maximum Out-of-Pocket (Individual/ Family)		$250/$500	$500/$1,000	$750/$1,500
Preventive Care/Screening/Immunization		$0	$0	$0
Primary Care visit to treat injury or illness (exc. Well Baby, Preventive and X-rays)		$0	$10	$15
Specialist Office Visit		$0	$18	$22
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services		$0	$10	$15
Rehabilitative Speech Therapy		$0	$10	$20
Rehabilitative Occupational and Rehabilitative Physical Therapy		$0	$10	$20
Emergency Room Services		$0	$50	$100
Urgent Care		$0	$18	$22
Outpatient Surgery		$0	$50	$125
All Inpatient Hospital Services (including Mental/Behavioral Health and Substance Abuse Disorder Services)		$0	$50	$250
High Cost Imaging (CT/PET Scans, MRIs, etc.)		$0	$30	$60
Laboratory Outpatient and Professional Services		$0	$0	$0
X-Rays and Diagnostic Imaging		$0	$0	$0
Skilled Nursing Facility		$0	$0	$0
Retail Prescription Drugs:	Generics Preferred Brand Drugs Non-Preferred Brand Drugs Specialty High Cost Drugs	$1 $3.65 $3.65 $3.65	$10 $20 $40 $40	$12.50 $25 $50 $50

Source: Massachusetts Health Connector (Accessed Nov. 1, 2022).

Of the 26 states that have passed policies to reduce financial barriers to high-value care as of Dec. 31, 2021, the most common area of action was capping costs for prescription drugs, particularly insulin.[131] While the Massachusetts legislature has attempted to cap prices for specific drugs, such as insulin, in the wider market, these efforts have not yet succeeded. The most recent attempt took place in February 2022, with an insulin price cap that died in the state House.[132]

Recommendations:

- **Waive or Reduce Cost-Sharing for High-Value Services Across all Plan Types**: Massachusetts should consider a suite of measures to ease consumer burdens, including waiving or reducing cost-sharing for high-value services beyond prescription drugs and those services already offered pre-deductible. For example, for ConnectorCare plans, the state might aim to offer $0 copays for primary care, emergency room services and mental/behavioral health visits across all plan types (rather than $10 and $15 for Plan Types 2 and 3, respectively). For standard sarketplace plans, the state might offer primary care and mental/behavioral health outpatient visits pre-deductible and with a reduced copay, rather than requiring enrollees in certain Silver and Bronze Plans to meet their deductible and then pay copays ranging from $60 to $150.
- **Investigate Tying Consumer Out-of-Pocket Costs Increases to Healthcare Spending**: To directly address healthcare affordability burdens, Massachusetts might commission a study of potential methods to tie consumer out-of-pocket costs in standard Marketplace and ConnectorCare plans to the healthcare spending benchmark. For example, if annual healthcare spending totals 3%, the advisory board in charge of plan design might aim to keep the growth of deductibles and copays between years to 3%.
- **Explore Other Avenues to Subsidize High-Value Prescription Drugs for ALL Residents, Not Exclusively Through the Marketplace:** While Massachusetts's Marketplace prescription drug schedule is an excellent start, its benefits are limited to the small population purchasing on the exchange. For example, one estimate assessing state marketplace-level insulin price cap programs suggested that only roughly 25% of people with diabetes in the states with these programs would be able to take advantage of a $100 copay cap on insulin.[133] Massachusetts should pursue additional opportunities to improve prescription drug affordability for all residents, including those in the private market and the uninsured, by way of discounts or wholesale purchasing.

Utah's Insulin Savings Program allows any resident to purchase insulin at wholesale prices through the state and public employee plan.[134,135]

New Mexico passed legislation to cap copays and out-of-pocket expenses for insulin at $25 for a 30-day supply (the lowest price cap in the country) and established an advisory group to study the cost of prescription drugs for New Mexico consumers and make recommendations on increasing accessibility.[136]

Texas passed a law in 2021 that caps the cost-sharing of a 30-day supply of insulin to $25, regardless of the amount or type of insulin needed to fill an enrollee of a state-regulated health plan's prescription.[137] Another Texas law instructs state officials to develop a drug savings program that would give uninsured individuals a discounted rate on insulin purchases.[138]

In 2021, **Oregon** passed a law to limit cost-sharing of insulin for health plans offered on the state exchange to $75 for a 30-day supply or $225 for a 90-day supply.[139] The law further excludes such coverage from deductibles imposed by health plans.[140]

Delaware, Louisiana and **Maryland** cap cost-sharing for specialty drugs—such as those to treat HIV and hepatitis—at $150 for a 30-day supply.[141]

Beginning in 2023, **Massachusetts** ConnectorCare plans (available to residents earning up to 300% FPL) will eliminate cost-sharing for medications used to treat conditions that disproportionately affect communities of color, including diabetes, asthma, coronary artery disease and hypertension.[142] Also beginning in 2023, the **District of Columbia** will eliminate cost-sharing for prescription drugs and other medical services required for the treatment and maintenance of conditions that disproportionately affect District residents of color in standard marketplace plans. Plan year 2023 will eliminate cost-sharing for diabetes services, with other conditions under consideration for future plan years.[143]

- **Consider Establishing Spending Targets for High-Value Care:** In addition to improving the affordability of high-value care for patients, Massachusetts should also consider setting targets for spending on high-value care for service categories like primary care and behavioral healthcare. Research shows that primary care-oriented health systems produce better patient outcomes, lower costs and improve patient experience of care, compared to specialist-oriented care.[144] The HPC recommends payers and providers increase spending on primary and behavioral health and prioritize non-claims-based spending, such as capitation, infrastructure and workforce investments. Massachusetts can enact these spending targets either within their cost growth benchmark or as an independent program.

Part of **Connecticut's** cost growth benchmark includes spending targets for increasing primary care spending to account for 10% of total healthcare expenditures by 2025.[145] The Office of Health Care Strategy develops these cost benchmarks, as well as quality benchmarks, across all public and private payers that include clinical quality, over/under utilization and patient safety measures. The 2022-2025 Quality Benchmark Measures can be found here.[146] Importantly, the Executive Order creating the benchmarks charges the technical team overseeing their development with prioritizing health equity in their recommendations.[147]

Rhode Island's affordability standards (enacted in 2010) require commercial insurers to invest more in primary care providers and services and encourage primary care practices to transform into patient-centered medical homes. A 2019 study found that quarterly primary care coordination spending increased by $21 per commercially insured enrollee, total spending growth decreased (the reduction in fee-for-service spending on patient care was greater than the increase in non-fee-for-service spending related to primary care) and that quality measures were either unaffected or improved.[148]

SURPRISE OUT-OF-NETWORK MEDICAL BILL PROTECTIONS

Surprise medical bills (SMB), also known as balance bills, include any medical bill for which a health insurer paid less than the patient expected. One form of SMB receiving a lot of attention is when a patient receives a bill from an out-of-network provider that would have been difficult for them to avoid; for example, in emergency situations or when care is provided by an out-of-network provider at an in-network hospital.

A 2020 report from the Massachusetts HPC observed the potential for balance billing in more than 90% of out-of-network claims for professional services, with claims ranging from $5 to $749 and an average of $167 per claim. In addition to consumer affordability burdens, surprise medical bills pose a real problem for controlling spending—across a range of procedures and ambulance services, the average spending on out-of-network claims far exceeded the average spending on in-network claims.[149]

Massachusetts has partial state protections against surprise medical billing. The state requires insurers to hold enrollees harmless for amounts beyond in-network cost-sharing, specifically for HMO and PPO enrollees and services provided by out-of-network professionals at in-network facilities.[150] In 2021, Governor Baker signed legislation prohibiting providers from billing insured patients for more than the allowed in-network amount.[151] However, Massachusetts protections do not apply to self-insured plans, which cover the majority of consumers.[152]

The federal No Surprises Act is a landmark law intended to shield consumers from many aspects of SMBs—beginning on Jan. 1, 2022, providers for most plan types, including self-insured plans, may not bill patients for more than the in-network cost-sharing due under patients' insurance for "emergency services provided at hospitals, free-standing emergency departments and urgent care centers that are licensed to provide emergency care." The No Surprises Act also covers non-emergency services provided at certain in-network facilities, as well as air ambulance services, along with ancillary services for both emergency and non-emergency situations.[153,154]

However, there are a few crucial elements that the No Surprises Act does not cover:

1. **Ground Ambulances:** The lack of coverage for ground ambulance services presents challenges for Massachusetts consumers. According to an estimate from Johns Hopkins University, 40% of ground ambulance rides in Massachusetts charged to commercial insurance plans had the potential for surprise medical billing, while a separate 2020 study cites a median cost of $450 nationwide per ground ambulance ride.[155]
2. **Emergency Services Provided at Urgent Care Centers Not Licensed for Emergency Care**: The No Surprises Act does not cover emergency services provided at Urgent Care facilities that are not licensed to provide emergency care.[156]
3. **Non-Emergency Services Provided at Certain In-Network Facilities:** The No Surprises Act covers non-emergency services received at specific types of in-network facilities, including hospitals, hospital outpatient departments and ambulatory surgical centers. However, it does NOT cover non-emergency care received at in-network urgent care centers, birthing centers, hospices, addiction treatment facilities and nursing homes.
4. **Certain Laboratory Services:** The No Surprises Act does not apply when an in-network provider sends a test to an out-of-network lab for a non-emergency service, such as a doctor requesting a blood test during an annual primary care visit. In this case, the lab can balance bill the patient.[157]

Notably, if a hospital or an insurer declares that the care provided wasn't an emergency, the No Surprises Act doesn't necessarily apply. In addition, disputes over lack of documentation demonstrating that the services provided were emergency services can result in claims being rejected and costs passed on to consumers, who must either pay or go through a burdensome appeal process.[158]

The No Surprises Act also allows certain out-of-network providers to give patients a form waiving their SMB protections. The provider can refuse to treat a patient if they refuse to waive the protections; however, certain providers are prohibited from giving this form to patients, including emergency room doctors, anesthesiologists, radiologists, assistant surgeons and hospitalists. There is a risk that some facilities (including prohibited ones) will simply include this waiver in their general admission paperwork, potentially violating federal law or at least making it difficult for patients to identify the protections they are waiving.[159]

The No Surprises Act defers to state law when resolving payment disputes between insurers and out-of-network providers. For states without their own arbitration process, the No Surprises Act creates a federally operated Independent Dispute Resolution Process (IDRP) to determine how much a patient's health plan must pay an out-of-network provider, primarily based on the insurer's median in-network rate (Qualified Payment Amount), among some other factors. The IDRP must eventually select one party's offer, called baseball-style arbitration, which is then binding for both parties.[160] However, if a state law already sets a payment amount for the out-of-network services covered by the federal law, the state's law will govern.[161] Massachusetts's 2021 legislation does not create any dispute resolution process or similar mechanism for providers and insurers to determine what additional amount, if any, an out-of-network provider may be reimbursed for services rendered to an insured patient. Nor does the state have a process dictating that such patient's financial responsibility is limited to the applicable in-network coinsurance amount. However, the 2021 state law directed multiple state agencies to collaborate and recommend a default rate for out-of-network billing, and they issued a report in September 2021.[162,163]

Recommendations:

- **Enact Protections Filling in Gaps in the No Surprises Act for State-Regulated Plans:** Massachusetts should consider enacting state-level SMB protections for services and situations not covered by the No Surprises Act outlined in the section above. *It is important to note that additional state SMB protections cannot by default apply to self-insured, employer-sponsored health insurance plans, which are federally regulated.*[164] *However, Massachusetts can still enact additional protections for consumers with state-regulated insurance plans and simultaneously allow self-funded plans to opt into the state surprise medical billing protections*, a practice permitted under ERISA[165] and currently in practice in a handful of states (Maine, New Jersey, Nevada, Virginia and Washington). This document explores additional considerations for adopting state SMB protections beyond the No Surprises Act, while this *Health Affairs* report contains details on opt-in programs.[166]
  - Enact an SMB protection for state-regulated plans prohibiting balance billing for **ground ambulance services.** Eight states currently offer some protection for out-of-network ambulance charges: Colorado, Delaware, Maine, Maryland, New York, Ohio, Vermont and West Virginia.
  - Enact an SMB protection for state-regulated plans covering **emergency services provided at all urgent care facilities**, regardless of whether they're licensed to provide emergency care.
  - Enact SMB protections for state-regulated plans covering **non-emergency care** received at in-network urgent care centers, birthing centers, hospices, addiction treatment facilities and nursing homes.
  - Enact a protection for state-regulated plans prohibiting balance billing by out-of-network **laboratories** for services requested by in-network providers.

> **Colorado** law prohibits privately-owned ambulance services from billing insured patients for amounts other than for the in-network cost sharing rate. However, the law does not apply to publicly funded fire departments or county emergency medical services. In addition, Colorado requires state-regulated health plans to reimburse out-of-network private ground ambulances at 325% of Medicare payment rates and limits the amount patients pay out-of-pocket to the in-network rate.[167]
>
> **Delaware** has regulations on the out-of-network payment dispute resolution process for health plans and providers of emergency services, which specifically include ground ambulances.[168]
>
> **New York** prohibits ground ambulance service providers from billing enrollees in certain plan types (HMOs, PPOs, EPOs) more than the in-network cost sharing.[169]

- **Allow Self-Funded Plans to "Opt Into" State Balance Billing Protections**: Massachusetts should consider allowing self-funded plans to opt into state balance billing protections to provide additional balance billing protections for those consumers.

Several states with surprise medical bill protections enable self-funded plans to opt into the protections. According to a 2021 publication from *Health Affairs*, 20 entities had opted into **Nevada's** law (for emergency services only), 137 entities had opted into **New Jersey's** law, 351 entities had opted into **Virginia's** law and about 350 entities had opted into **Washington's** law. Maine also allows self-funded entities to opt into their 2020 law (for emergency services only), though data on how many have chosen to do so is not yet available.[170]

- **Outline Dispute Resolution Process for Misidentified Emergency Services**: Massachusetts might also consider outlining an additional dispute resolution process between insurers and hospitals when one or both entities miscodes or misidentifies emergency services as non-emergency services, or there is missing documentation causing the claim to be rejected. This process could be applied to both self-insured and fully insured plans, since the No Surprises Act defers to state laws on dispute resolution and arbitration. Such a resolution process should protect consumers from being charged and from the burden of managing the appeal process.[171]
- **Explore Regulating Waivers**: Massachusetts might explore (1) prohibiting SMB protection waivers, (2) prohibiting providers from rejecting patients that refuse to waive their SMB rights or (3) requiring providers to present the waiver to patients as a separate document with clear language explaining the rights they are waiving. The first two options could likely only apply to state-regulated plans, since their application to federally-regulated plans would undermine the No Surprises Act. The third option, however, could likely be applied to all plan types, including federally-regulated plans, since additional notice requirements simply exceed the No Surprises Act and do not directly undermine it.[172] Once enacted, these approaches could involve auditing provider intake forms, conducting a patient and provider education campaign on SMB protections and the No Surprises Act and designating an office responsible for receiving patient waiver violation complaints and resolving disputes.

In **New York,** patients with fully-insured, state-regulated[173] health insurance coverage cannot give written consent to waive balance billing protections for certain services, including post-stabilization services after emergency care and services referred by an in-network doctor. In addition, if an in-network doctor refers a patient to an out-of-network provider without their consent (including lab and pathology services), the provider cannot balance bill the patient.[174,175]

- **EOHHS Recommendation—Consider Enacting Recommended Payment Limits:*** Massachusetts should use data from the state's APCD to calculate a median in-network rate for each individual payer in alignment with the federal Qualified Payment Amount (QPA) standard.[176] This would preemptively resolve any potential disputes of the QPA in the federal arbitration process.

**This recommendations comes from Massachusetts Executive Office of Health and Human Services' 2021 Out-of-Network Rate Recommendations report.*

Initial analysis suggests that **California**'s payment benchmark (greater of the average contracted rate or 135% of Medicare) protected patients, reduced spending and maintained or increased patient access.[177]

In contrast, the baseball-style arbitration systems in **New York** and **New Jersey** base their determination on the 80th percentile of provider charges, which is much higher than in-network prices. This has led to prices higher than those that would have been paid without surprise billing legislation.[178,179]

- **State-Level Surprise Medical Billing Protections that Mirror the No Surprises Act**: While it may seem unnecessary to enact state-level protections given the new federal law, the Act may be repealed in the future, especially if there is a desire to undo perceived 'big government' regulations enacted under the Biden Administration. While Massachusetts may not be able to enact protections for the large share of residents with self-insured employer-sponsored insurance, it can still insulate those who buy coverage on the state exchanges and who have fully-insured employer-sponsored insurance plans from this potential federal policy change.

PROTECTIONS AGAINST SHORT-TERM, LIMITED DURATION HEALTH PLANS

In response to rising insurance costs, some people turn to Short-Term, Limited-Duration (STLD) health plans, which offer lower monthly premiums compared to ACA-compliant plans. However, these policies offer poor coverage, can discriminate against people with pre-existing conditions and pose significant financial risks for consumers. Massachusetts laws are inhospitable to short-term plans, and as a result, no carriers sell STLD plans in the state. Massachusetts requires guaranteed issue (no rejections for pre-existing conditions), and short-term plans do not meet state-based individual health insurance mandate requirements, so individuals with short-term plans would be charged a penalty fee.[180]

Recommendation:

- While Massachusetts could enact an outright ban on STLD plans, the current level of regulation has achieved the goal of eliminating their impact on Massachusetts residents, suggesting further regulation is not needed.

CONCLUSION

Massachusetts has an evolving healthcare policy landscape and has pursued many innovative strategies to address healthcare spending and affordability. However, affordability challenges persist for residents of the state. Massachusetts should consider enacting many of the policy strategies outlined in this report to address serious healthcare affordability concerns.

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