2024 Health Care Affordability State Policy Snapshot

MASSACHUSETTS

CURB EXCESS PRICES IN THE SYSTEM	**PREMIUM RATE REVIEW**	**HEALTH CARE SPENDING BENCHMARKS**	**HOSPITAL PRICE REGULATION**	**PUBLIC OPTION**
IMPROVE OVERSIGHT, ACCOUNTABILITY AND TRANSPARENCY	**HEALTH SPENDING OVERSIGHT ENTITIES**	**ALL-PAYER OR MULTI-PAYER CLAIMS DATABASE**	**PRICE TRANSPARENCY**	**MEDICAL DEBT COLLECTION REGULATIONS**
ADDRESS CONSOLIDATION AND PROMOTE COMPETITION	**CONSOLIDATION ASSESSMENT AND AUTHORIZATION**	**BALANCE BILL PROTECTIONS**	**FACILITY FEE LIMITS**	**ANTI-COMPETITIVE CONTRACT PROVISIONS**
MAKE OUT-OF-POCKET COSTS AFFORDABLE	**REDUCED COST-SHARING: PRESCRIPTION DRUGS**	**REDUCED COST-SHARING: HIGH VALUE SERVICES**	**MEDICAL DEBT PREVENTION**	**EXPANDED COVERAGE**

State Has Active Legislation

State Does Not Have Active Legislation

HEALTHCARE VALUE HUB

The Health Care Value Hub ("the Hub") is proud to launch the 2024 Health Care Affordability Policy Snapshot ("Affordability Snapshot") which replaces the annual Healthcare Affordability Scorecard ("Scorecard"). The Affordability Snapshot provides legislators, consumer advocates, regulators and other stakeholders a tool to compare their state's health policies across other states.

The categories examined in this resource explore a variety of policy options that have previously appeared in the Scorecard, as well additional policies that impact health care affordability. Policies were selected based on whether they have the potential to impact health care affordability or access to health care at the state level, whether a reputable source was available for review, and whether evidence was current within the past ten years.

Policies were examined for whether they were active, implemented to a limited degree, or not active as of July 1, 2024. Sources for this information can be found in the downloadable Data and Source Document available on the **Dashboard** page.

The Hub offers both online and hands-on support, with a staff dedicated to monitoring, translating, and disseminating evidence and connecting advocates, researchers, and policymakers to build communities and galvanize action around creating a patient-centered, high-value healthcare system. As a research-based organization, the Hub takes a comprehensive approach to improving affordability through policy analysis, translation, visualization, and collaborative engagement. We encourage advocates, legislators, and other stakeholders to share our findings to improve consumer health care affordability across the states.

Curb Excess Prices in the System

Premium Rate Review

States can control excessive health insurance premium increases through premium rate review, where state insurance regulators scrutinize proposed rate hikes for the upcoming year to ensure that the increases are based on accurate data and realistic projections of health care costs and utilization. The Affordable Care Act (ACA) set standards for these efforts, and states meeting these standards are recognized by the Centers for Medicare and Medicaid Services (CMS) as having an effective rate review process. States may also establish the authority to approve or deny rate increases and incorporate affordability criteria into their evaluations. This section examines whether a state has an effective rate review program, as defined by CMS, the power to approve or deny rate increases, and if affordability criteria are integrated into the rate review process.

Health Care Spending Benchmarks

Health spending benchmarks aim to limit annual health care spending growth by establishing a maximum limit, or "benchmark." Benchmarks may examine overall spending or spending for specific hospitals or insurers. If the benchmark is surpassed, the overseeing state entity will often collaborate with providers to curtail spending, and some states authorize the entity to mandate performance improvement plans or impose penalties. This section examines whether a state has established a benchmark, and if so, whether the state has statutory authority to enforce the benchmark.

Hospital Price Regulation

This section assesses state efforts to reduce hospital service costs through reference-based pricing, global budgets, or a comparable program that regulates hospital pricing. Unlike reference-based benefits, which set a maximum allowed benefit for specified drugs or services, reference-based pricing establishes set service costs based on a predetermined reference rate. As of publication, each state that has implemented this model has set reimbursement as a multiple of the Medicare reimbursement rate.

Similarly, global budgeting involves setting a fixed prospective payment for a specified range of services over a defined period, rather than being paid for each service. By establishing a limit on annual spending, this model shifts the financial responsibility to providers and payers and encourages managing service delivery within the set budget. Some states have established state-specific insurance models which mirror select aspects of these strategies, which are also highlighted under "alternative hospital price regulation strategies."

Public Option

A Public Option is a state-managed health insurance model designed to enhance competition and control costs through negotiated rates. States possess a degree of flexibility in designing these coverage options, resulting in variations in cost-containment measures and provisions related to network adequacy and reimbursement. This section highlights states that have an active Public Option and those with provider participation mandates to ensure consistent access to in-network providers.

Policy	Status as of July 1, 2024	Summary
Premium Rate Review	● Has an effective rate review process. ● Has the authority to modify or reject premium rate increases. ● Incorporates affordability criteria into premium rate review.	Massachusetts has the authority to approve or deny proposed premium rate increases in the individual and small group markets, with authority to hold public hearings to solicit stakeholder engagement in the process. In the large group market, the state has the authority to approve or deny for HMO's only. The Health Policy Commission reviews whether rate increases will result in a significant impact on the commonwealth's ability to meet the health care cost growth benchmark or the competitive market. If so, they may conduct a cost and market impact review.
Health Care Spending Benchmarks	● Has health care spending benchmark for providers and/or insurers. ● Has enforcement mechanism for healthcare spending benchmark.	Massachusetts's Cost Growth Benchmark was set at 3.6% in 2017, 3.1% from 2018-2022, and 3.6% from 2023-2025. The statewide health spending target is applied to a broad range of health care entities, including health insurance payers, hospitals, clinics, and medical groups. Entities whose spending grows faster than the target growth rate are subject to detailed reviews, may be required to submit Performance Improvement Plans (PIPs) designed to bring their spending growth in line with the target, and face financial penalties of up to $500,000 for noncompliance with PIPs.
Hospital Price Regulation	⊗ Has not implemented hospital reference-based pricing or rate-setting. ⊗ Has not implemented hospital global budgets. ⊗ Has not implemented alternative hospital price regulation strategies.	
Public Option	⊗ Does not have an active Public Option. ⊗ Does not offer a state-wide Public Option, with or without a provider participation mandate.	

● State Has Active Policy or Program ◉ Policy or Program Partially Implemented ⊗ State Does Not Have an Active Policy or Program ✱ No Source, or Limited Information Found

Improve Oversight, Accountability, and Transparency

Health Spending Oversight Entities

Health Spending Oversight Entities monitor and track health care spending systematically, offering data and research support to ensure efficient resource use. While many states set population health priorities, few have established oversight entities with enforcement powers. This section examines whether a state has a health spending oversight entity reviewing primary care, hospital, or prescription drug spending, and if upper payment limits for prescription drugs have been implemented.

All-Payer or Multi-Payer Claims Database

All-payer claims databases (APCDs) compile diverse health care data, that may include health, dental, and pharmacy claims from private insurers, state employee health programs, Medicare, and Medicaid. In instances where a database includes only some of these payers, it is referred to as a multi-payer claims database. Typically created through legislation, APCDs are often subject to state oversight and regulation. However, some claims databases have been voluntarily developed by independent entities, limiting oversight.

This section examines whether a state has an active all-payer or multi-payer claims database, if the database is facilitated and managed by the state or by third-party entities, if the data is free and accessible without institutional review board approval, and if the database is required to capture race and ethnicity demographic information.

Price Transparency

This section evaluates state efforts to provide access to health care price data through a publicly available and easily accessible tool. To be credited, the tool must show negotiated prices for various services and be accessible without fees, IRB approval, or legislative restrictions. Additionally, this section reviews whether a state requires prescription drug price data to be reported to a state entity and if a state has another form of price transparency regulation.

Medical Debt Collection Regulations

This section examines how a state regulates providers' ability to collect medical debt once it has been incurred. It reviews whether a state: prohibits providers from sending debts to collections while a patient is actively pursuing efforts to address the bill (e.g., appealing to insurance, applying for financial assistance, negotiating the bill, in a payment plan); prohibits spouses or other persons from being held liable for another adult's debt; limits collections' ability to garnish wages; prohibits collections from initiating home foreclosure; prohibits collections from initiating actions that would lead to an individual's arrest due to medical debt; prohibits collections from seizing a bank account.

Policy	Status as of July 1, 2024	Summary
Health Spending Oversight Entity	● Has a Prescription Drug Affordability Board reporting on prescription drug prices. ⊗ Does not enforce prescription drug prices through upper payment limits. ● Monitors and reports on hospital spending. ● Monitors and reports on primary care spending.	Massachusetts' Health Policy Commission and Center for Health Information and Analysis (CHIA) monitor hospital and primary care spending. Massachusetts Executive Office of Health and Human Services can negotiate with drug manufacturers and they can be referred to the Health Policy Commission for review. The HPC can identify a proposed value of the drug and propose a supplemental rebate. The Health Policy Commission manages drug spending and assessing if the pricing is reasonable, and acts the same as a Prescription Drug Affordability Board under a different name.
All-Payer or Multi-Payer Claims Database	● Has a(n) all-payer or multi-payer claims database. ● Database is operated by the state. ● Database does not include access restrictions. ● Database is required to capture demographic information.	Massachusetts's APCD data is available by formal request and payment. Data includes age and sex.
Price Transparency	● Has a price transparency tool showing negotiated rates. ⊗ Does not have a Prescription Drug price transparency reporting requirement.* ⊗ Does not have any other price transparency regulation.	Massachusetts's CompareCare shares average negotiated cost information for services within 28 different service categories. Beginning January 1, 2025, health care providers are required to notify patients if the provider is in- or out-of-network for the patient's health benefit plan. When a provider is out-of-network, they may be required to tell patients how much certain services will cost based on their health insurance plan. This requirement only applies to in-network providers when the patient requests the information.
Medical Debt Collection Regulations	● Prohibits providers from sending debts to collections while patient is actively pursuing means to pay the bill. ⊗ Does not prohibit other persons being held liable for another adult's medical debt.* ⊗ Does not prohibit collections from initiating home lien or foreclosure due to medical debt. ● Exceeds federal wage garnishment protections. ⊗ Does not prohibit actions that would lead to an individual's arrest due to medical debt.* ⊗ Does not prohibit collections from initiating bank account seizure due to medical debt.	Massachusetts grants homestead exemptions up to $1,000,000 in certain circumstances, which exceeds the median home value in the state.

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Address Consolidation and Promote Competition

Consolidation Assessment and Authorization

This section examines whether relevant parties are required by law or statute to notify the state of hospital consolidation transactions beyond the federal requirements, and whether the state has the authority to review these transactions; to approve, reject, or modify conditions of the transaction; and if consumer affordability or price growth are included in the review criteria

Balance Bill Protections

The federal No Surprises Act (NSA) protects patients from balance bills, which are unexpected costs from out-of-network providers. Under the federal legislation, patients receiving emergency care or who are unknowingly treated by out-of-network providers during an in-network procedure are only required to pay the in-network cost-sharing amount for services provided. Effective January 1, 2022, the No Surprises Act applies to most health plans but not all care sites and services. States can legislate additional protections for balance bills not covered under the NSA, such as for ground ambulances, or services provided at urgent care locations, hospice facilities, and birthing centers.

Facility Fee Limits

Facility fees are charges for services provided in outpatient and physician office settings that hospitals own. These fees increase the out-of-pocket costs for care and are becoming increasingly more common as the rate of health system consolidation has accelerated. This section explores whether a state prohibits facility fees under certain circumstances, if they have imposed regulations to protect consumers against out-of-pocket costs from facility fees, and if they require hospitals to report facility fee data.

Anti-Competitive Contract Provisions

Anti-competitive contracting is a pattern of contracting between health care providers and insurers where one party gains unfair advantages over potential competitors. States can enact regulations that limit dominant health systems from abusing their market power in ways that increase prices. This section evaluates whether states prohibit four types of anti-competitive contracting practices in the health system:

- Most Favored Nation Clauses: Health systems agree not to offer lower prices to competing insurers, preventing them from offering the same service at a lower price. These provisions may allow insurers and providers to collude to raise prices.
- All-or-Nothing Clauses: Health systems require plans to contract with all providers in their system or none of them, even if those providers are low-value or high-cost.
- Non-Compete Clauses: Doctors are prohibited from working at competing hospitals within a certain distance for a certain period of time.
- Anti-Tiering or Anti-Steering Clauses: Insurers must place favored providers in higher tiers regardless of cost or quality (anti-tiering) and restrict directing patients to higher value care from competitors (anti-steering).

Policy	Status as of July 1, 2024	Summary
Consolidation Assessment & Authorization	● Requires certain healthcare providers to notify the state of consolidation transactions. ● Has authority to approve, set conditions, or disapprove consolidation transactions. ● Includes consumer affordability and/or price growth in review criteria or approval conditions.	Massachusetts requires the state's Certificate of Need program be notified of transfers of hospital ownership, and has authority to approve or disapprove transactions. The Attorney General and state Health Policy Commission (HPC) must also be notified of provider material change transactions for both nonprofit or for-profit entities, but they do not have approval authority. However, if the state Health Policy Commission (HPC) finds that the percentage change in total health care expenditures exceeded the health care cost growth benchmark in the previous calendar year, the commission may conduct a cost and market impact review of any provider organization identified by the center. In addition, the state can go to court to challenge the transaction if they find that the parties involved engaged in price fixing.
Balance Bill Protections	⊗ Does not prohibit balance billing for out-of-network ground ambulance services. ⊗ Does not prohibit balance billing for out-of-network services at specific facilities not included in the NSA.	
Facility Fee Limits	⊗ Does not prohibit facility fees for specified procedures and/or care settings.* ⊗ Does not have codified protections against out-of-pocket costs from facility fees.* ⊗ Does not require hospitals to report facility fee data.*	
Anti-Competitive Contract Provisions	● Law restricts Most Favored Nation contract provisions. ● Law restricts all-or-nothing contract provisions in all or some situations. ● Law restricts anti-tiering or anti-steering contract provisions. ● Non-competes generally unenforceable or prohibited.	Massachusetts bans contract provisions that allow an insurer to establish reimbursement rates based on the price paid to a provider in a contract with another insurer. In practice, this prohibits Most Favored Nation clauses, which guarantee one insurer the best rate. Massachusetts bars the execution of contracts that include an All-or-Nothing, Anti-Steering, or Anti-Tiering clause, prohibiting provisions that require an insurer to include all members of a provider group in a select network plans; require a provider to participate in a select network or tiered network plan; or require the carrier to place all members of a provider group in the same tier of a tiered network plan. Massachusetts also has stringent restrictions on noncompete agreements, explicitly banning them in physician employment contracts.

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Make Out-of-Pocket Costs Affordable

Reduced Cost Sharing: Prescription Drugs

This section examines whether states have passed legislation reduce the amount a consumer pays out-of-pocket for select prescriptions drugs including insulin, epinephrine, oral oncology medications and asthma inhalers. This section also examines state-level legislation prohibiting copay accumulator programs, which are payer strategies that limit the impact of manufacturer cost-sharing assistance programs on consumer out-of-pocket costs.

Reduced Cost-Sharing: High Value Services

This section provides an overview of state efforts aimed at reducing consumer cost burdens for high-value services. Specifically, it identifies states which have enacted legislation mandating coverage without cost-sharing for: primary care services recommended by the United States Preventive Services Task Force (USPSTF); various cancer screening and diagnostic services; and annual mental health exams. It also evaluates state efforts to expand access to affordable maternal and reproductive health care by highlighting the states that mandate private insurers cover in-vitro fertilization, fertility preservation, doula services and abortion care. The section concludes with a review of whether a state has incorporated equity-focused initiatives in their state-regulated insurance design.

Medical Debt Prevention

This section reviews state laws aimed at preventing medical debt, including mandates for hospitals and health care providers to offer financial assistance policies, screen patients for insurance and charity care eligibility, and inform patients of charity care policies before collecting payment. It also assesses whether states have extended Medicaid benefits retroactively for 90 days; expanded general presumptive eligibility for Medicaid to all adults; prohibited short-term, limited duration health plans; and if the state has established annual reporting requirements on community benefit spending.

Expanded Coverage

This section evaluates policies aimed at expanding access to and improving the affordability of health insurance, including whether a state has expanded Medicaid eligibility to adults with incomes up to 138% of the federal poverty level (FPL); authorized 12-month continuous Medicaid eligibility for all adults; extended postpartum Medicaid coverage to 12 months following delivery; established a Basic Health Plan; initiated a program providing state-funded premium subsidies for residents ineligible for Medicaid; explicitly authorizes coverage for gender-affirming care under Medicaid; has authorized the provision of Medicaid coverage to individuals transitioning from incarceration; and if the state has extended Medicaid coverage to include dental, hearing, and vision benefits, including eye exams and glasses, beyond what is deemed medically necessary following injury or surgery. Beyond these policy options, this section also reviews state efforts to extend coverage to children, pregnant residents, and non-pregnant adults regardless of immigration status. This includes waiving the five-year required waiting period for immigrant children and legally residing pregnant residents (the "five-year bar"); offering alternative coverage options regardless of citizenship status; and opting into the From-Conception-to-End-of-Pregnancy (FCEP) option under the Children's Health Insurance Program (CHIP), previously known as the CHIP Unborn Child option.

Policy	Status as of July 1, 2024	Summary
Reduced Cost-Sharing: Prescription Drugs	⊗ Does not prohibit copay accumulator programs. ⊗ Does not cap the price of insulin or diabetes supplies. ⊗ Does not cap the price of other prescription drugs or medical devices.	
Reduced Cost-Sharing: High Value Services	● Mandates private insurers cover USPSTF recommended preventive services without cost-sharing. ● Waives or reduces cost-sharing for an annual mental health exam in private health plans. ● Provides coverage and/or waives or reduces cost-sharing for select maternal and reproductive health services. ● Mandates coverage for some cancer screening services without cost-sharing. ● Insurance design includes cost-saving measures to mitigate health disparities.	Massachusetts Medicaid covers doula services for enrollees. Massachusetts also requires health benefit plans to cover in-vitro fertilization, but not fertility preservation, and mandates coverage for abortions and related services without cost-sharing. HMOs in Massachusetts are mandated to cover cytologic screenings and mammograms without cost-sharing. Massachusetts' ConnectorCare plans eliminate cost-sharing for primary care sick visits, mental health outpatient services, and certain medications for conditions that disproportionately impact communities of color, such as diabetes, asthma, coronary heart disease, and hypertension. To address disparities in mental health by race and LGBTQ+ status, plans are required to contract with Community Behavioral Health Centers and have limited or no cost-sharing for outpatient behavioral health and substance use disorder services. Additionally, the Health Policy Commission has launched the HEART-BP program, which uses remote blood pressure monitoring to address severe maternal morbidity (SMM) conditions and continues research in this area.
Medical Debt Prevention	⊗ Does not mandate hospitals and other health care providers provide free or discounted care for low-income patients. ⊗ Does not mandate health care providers screen patients for insurance eligibility or charity care. ● Mandates health care providers notify patients of charity care options before collecting payment. ◉ Retroactively extends Medicaid benefits less than 90 days prior to application date or for select enrollees (see notes). ⊗ Has not authorized all qualified entities to provide presumptive eligibility for all adults in Medicaid. ● Has prohibited or effectively eliminated short-term, limited duration health plans. ⊗ Does not require transparency in spending for community benefit programs.	Massachusetts doesn't require health care facilities to provide charity care to low-income residents, but does operate a "Health Care Safety Net" program to reimburse hospitals for care provided to individuals earning up to 300% FPL. Pregnant women and children are offered retroactive Medicaid coverage up to three months. Contingent on continued federal approval, no later than January 2026, all Medicaid-eligible residents will be provided three months of retroactive coverage. STLD health plans aren't explicitly banned in the state, but strict regulations have effectively removed them from the market.

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Expanded Coverage—Medicaid	Expanded Medicaid income eligibility to 138% FPL. Does not offer a basic health plan or other affordable coverage option for residents with incomes below 200% FPL.* Authorized 12-month continuous eligibility for adult Medicaid enrollees. Includes 12 months of postpartum care in Medicaid benefits. Provides select Medicaid services to justice-involved people up to 90 days before release. Medicaid policy explicitly includes coverage for gender-affirming services. Offers some, but not an extensive amount of dental, vision, or hearing coverage in Medicaid benefits (see notes). Offers state-based premium subsidies.	Massachusetts' ConnectorCare offers plans with zero premiums through state-based premium subsidies, as well as $0 deductibles, and low co-pays for residents earning up to 150% FPL. The state originally offered premium subsidies to those earning up to 300% FPL, and starting 2024, a two-year ConnectorCare pilot program expanded state-based subsidies to those 500% FPL. Massachusetts' Medicaid covers eye exams and eyeglasses for adults; covers hearing aids and other hearing devices for adults; and offers some dental coverage for dentures, root canals, restorative (fillings and crowns), preventive, and diagnostic services. Under the MassHealth Section 1115 Demonstration, incarcerated residents in Massachusetts are eligible to receive select Medicaid benefits, including case management and counseling, three-months prior to release. The regulations governing Massachusetts' Medicaid program clearly state that a comprehensive range of gender affirming care is included in the benefits package. Massachusetts provides 12-month continuous eligibility to adults following release from a correctional setting and 24 months continuous eligibility for adults under age 65 experiencing homelessness for at least 6 months. The state also has a pending waiver to extend continuous eligibility to all adults 19+ which would become effective January 2025 if approved.
Expanded Coverage—Immigrant Coverage	Offers coverage for lawfully residing immigrant children or pregnant people without a five-year bar. Covers pregnancy-related services through the CHIP "From-Conception-to-End-of-Pregnancy" (FCEP) Option. Offers an affordable coverage option for undocumented immigrant children. Offers an affordable coverage option for some, but not all, undocumented immigrant adults (see notes).	Massachusetts's Children's Medical Security Plan offers limited Medicaid-like benefits (excludes emergency services, ambulance services, medical transportation, inpatient care, and cosmetic or orthodontic dentistry) for children under 19 with income at or below 250% FPL regardless of immigration status. The state also offers comprehensive Medicaid-like coverage for up to 60 days post -pregnancy for people regardless of immigration status.

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