MASSACHUSETTS Health & Hospital ASSOCIATION

2025-2026 Legislative Package

WORKFORCE

H.2655 | S.1718

An Act Requiring Health Care Employees to Develop & Implement Programs to Prevent Workplace Violence

Rep. John Lawn (D-Watertown) | Sen. Joan Lovely (D-Salem)
Referred to Joint Committee on Public Safety and Homeland Security

Supported in partnership with MHA, the Massachusetts Nurses Association, and 1199SEIU, this legislation takes comprehensive steps to address the worsening trend of workplace violence in healthcare settings. The bills require all Massachusetts hospitals to develop a facility-specific risk assessment to identify potential risks of workplace violence. Based on this assessment, hospitals must implement a comprehensive program aimed at reducing such risks. The program must involve hospital staff in its development, including worker training, and provide a formal written violence prevention plan that is available upon request to all employees and labor organizations. The bill also establishes strong enforcement measures through DPH licensing, regular reporting, and job protections for workers affected by violence. Workers who are assaulted will be entitled to additional paid leave as part of these protections.

H.359 | S.251

An Act Relative to Health Equity and Community Health Workers

Rep. Marjorie Decker (D-Cambridge) | Sen. Robyn Kennedy (D-Worcester)
Referred to Joint Committee on Consumer Protection and Professional Licensure

Requiring insurers and MassHealth to reimburse for the covered services provided by community health workers would allow healthcare providers, including community health centers and hospital systems, to pay them more equitably, assist in efforts to diversify care teams to be more reflective of the populations they serve, and professionalize a role with an ever-increasing importance in safety net communities. Additionally, this legislation would also add behavioral health, mental health, and substance use disorder services to the core competencies of community health workers and establish a task force to examine the availability and long-term sustainability of community health workers in the commonwealth.

H.3218 | S.1960

An Act Establishing Tax Credits for Healthcare Preceptorship

Rep. Sean Reid (D-Lynn) | Sen. Sal DiDomenico (D-Everett)
Referred to Joint Committee on Revenue

This language would establish tax credits, with limitations, for doctors, nurses, and physician assistants (PAs) that serve as unpaid preceptors to medical, nursing, and PA students during their clinical rounds. It is modeled after the steps Maine, Maryland, and other states have taken in an

effort to boost the healthcare workforce in areas experiencing shortages by enticing licensed professionals to serve as preceptors.

ADMINISTRATIVE SIMPLIFICATION

H.1136 | S.1403
An Act to Improve Health Insurance Prior Authorization
An Act Relative to Reducing Administrative Burden
Rep. Marjorie Decker (D-Cambridge) | Sen. Cindy Friedman (D-Arlington)
Referred to Joint Committee on Financial Services
Referred Joint Committee on Mental Health, Substance Use and Recovery

Supported in partnership with MHA, Massachusetts Medical Society, and Healthcare For All, both bills address timely patient access by reducing administrative burdens relative to prior authorization. These bills prohibit carriers and utilization review entities from retrospectively denying, revoking, or limiting admissions, procedures, treatments, or services when authorization has already been granted unless approval was based on inaccurate information. The bills require a minimum 90-day grace period for any prior authorization protocols for patients already stabilized on a treatment upon enrollment in a plan. The bills also require continuous approval and utilization review requirements, and increases transparency by requiring the HPC, in consultation with the Department of Insurance and CHIA, to make public available statistics, including services and or medications subject to prior authorization, prior authorization requests per category, percentages of approvals/denials, and percentages of approval upon appeal, including internal and external appeals. In addition, they require the HPC to consult with the Massachusetts Collaborative, CHIA, and DOI to produce an annual report that includes a breakdown of prior authorization data collected and corresponding recommendations, among other provisions.

H.1126
An Act to Streamline Patient Disclosure Requirements
Rep. Mike Day (D-Stoneham)
Referred to Joint Committee on Financial Services

This bill proposes amendments to Chapter 111 of the General Laws to enhance transparency regarding providers' participation in patients' health benefit plans and related cost information. It requires providers to disclose their participation status in a patient's health plan upon scheduling non-emergency medical services, or upon the patient's request. Providers must update patients if their participation status changes during ongoing treatment. Participating providers are obligated to supply a good faith estimate of expected billing and diagnostic codes, enabling health insurance carriers to inform patients about their estimated financial responsibility. The notification must adhere to specific timelines based on service scheduling.

For providers not participating in a patient's plan, or for uninsured patients, providers are required to disclose anticipated costs and facility fees, along with guidance on potentially lower-cost options with participating providers. Non-compliance results in billing restrictions, limiting charges to only copayment, coinsurance, or deductible amounts. The bill provides the DOI Commissioner with authority to enforce these provisions and impose penalties up to $2,500 for violations not covered by federal penalties. Some sections of the bill depend on the

implementation of federal regulations. *Note: while there is a companion bill (SD.2182) in the Senate, this draft includes a provision not included in the House bill that would impose new provider non-compliance penalties at the state level – a measure that MHA strongly opposes.*

CLINICAL AFFAIRS & PATIENT ACCESS

H.1130 | S.763

An Act Relative to Telehealth and Digital Equity for Patients

Rep. Marjorie Decker (D-Cambridge) | Sen. Adam Gomez (D-Springfield)

Referred to Joint Committee on Financial Services

The bill continues to support reimbursement parity for all telehealth services on par with in-person visits. It seeks to expand access to telehealth services, including e-consults, e-visits, remote patient monitoring, and remote therapeutic monitoring requiring insurance coverage and reimbursement for these services. This bill also prohibits insurers from imposing prior authorization requirements on medically necessary telehealth visits that would not apply to in-person visits. To address issues surrounding continuity of care and interstate licensure, this bill establishes two task forces: one to study interstate licensure of physicians and another to study interstate licensure of other healthcare providers, including advanced practice registered nurses, physician assistants, and behavioral and allied health professions.

From a digital equity perspective, this bill requires health insurers to develop and maintain procedures to identify and offer digital health education to enrollees with low digital health literacy to assist with accessing any medically necessary covered telehealth benefits. It further requires insurers to cover interpreter services for patients with limited English proficiency and for those who are deaf or hard of hearing. Also, it would require the Executive Office of Health and Human Services (EOHHS) and Executive Office of Housing and Economic Development (EOHED) to use the new common application portal that is being developed for state services like MassHealth and other low-income services to determine a method to also allow individuals to simultaneously apply to internet service providers' affordable broadband plans. This bill further directs the Health Policy Commission to establish two programs: — a Digital Bridge Pilot Program and a Digital Health Navigator Tech Literacy Pilot Program — to support expanded access to telehealth technologies and technological literacy. The bill also establishes a special commission to address the inequity of health outcomes and digital access through the recruitment and implementation of digital health navigators to assist patients with accessing telehealth services.

S.777

An Act Relative to Specialty Medications and Patient Safety

Sen. Jason Lewis (D-Winchester)

Referred to Joint Committee on Financial Services

This legislation mirrors recommendations outlined in the HPC's report and would prohibit insurers, including the Group Insurance Commission (GIC), MassHealth, and commercial carriers, from utilizing brownbagging practices. Additionally, the bill promotes reasonable guardrails for whitebagging: creating patient-specific exceptions for the use of this practice by insurers; requiring a 60-day notification requirement to providers and patients when an insurer intends implement whitebagging of medications; establishing clear safety guidelines to ensure that the

integrity of the supply chain is not compromised; and prohibiting insurer-mandated whitebagging for drugs that require sterile compounding or patient-specific dosages depending on same day test results. Insurers would also be required to offer site-neutral payment for whitebagged medications to the healthcare provider administering the medication, and payment must include the cost for providers to intake, store, and dispose of the medication.

H.1296 | S.779

An Act to Protect 340B Providers

Rep. Sean Reid (D-Lynn) | Sen. Jason Lewis (D-Winchester)

Referred to Joint Committee on Financial Services

This legislation would follow the approach enacted in other states, creating protections against pharmacy benefit managers' (PBMs') discriminatory practices in the commercial market. It would prohibit health insurers and PBMs from imposing requirements, exclusions, reimbursement terms, or other conditions that differ from those applied to non-340B-covered entities. The bill restores the intent of the 340B program and returns savings to the safety net, versus the bottom line of for-profit companies.

H.779 | S.845

An Act to Protect 340B Providers in the MassHealth Program

Rep. Kate Lipper Garabedian (D-Melrose) | Sen. Brendan Crighton (D-Lynn)

Referred to Joint Committee on Elder Affairs

Referred to Joint Committee on Health Care Financing

This language would prohibit further erosion of this critical component of hospital and health system financing related to 340B drugs provided to MassHealth patients.

On January 31, 2024, EOHHS issued Bulletin 109 to its Managed Care Entities (MCEs) directing those managed care plans not to reimburse certain drugs prescribed to MassHealth members if the drugs were purchased through the 340B Drug Pricing Program. In the bulletin, EOHHS permits MassHealth managed care plans to pay for the listed drugs only when providers use non-340B stock. Seven drugs are listed in Bulletin 109 that are new innovative GLP-1 drugs such as Ozempic and Wegovy. The drugs that are identified in Bulletin 109 do not meet the high-cost drug exception defined in the pharmacy regulations. MassHealth MCE Bulletin 114 delayed the effective date of the GLP-1 payment restriction to July 1, 2024.

Based on feedback from hospitals, this policy has serious negative implications to hospital health system finances and operations, which in turn will negatively affect patient access to these drugs and other services. The impact of the proposed MassHealth policy will be greater than the loss of 340B margins that eligible hospitals currently receive. Of greater concern, we believe EOHHS will seek to expand on this policy in the future.

The discounts achieved through the 340B program provide needed financial benefits to hospital health systems, yielding a margin for a portion of their operations that would otherwise operate at a loss in many cases. These savings allow hospitals and providers to stretch their resources to, among other things, subsidize underpayment by MassHealth and Medicare for medical services.

H.1412 | S.903

An Act Improving Access to Post Acute Services

Rep. Thomas Stanley (D-Waltham) | Sen. Pavel Payano (D-Lawrence)

Referred to Joint Committee on Health Care Financing

This legislation aims to streamline healthcare transitions, enhance support for post-acute care, improve patient protections, and strengthen the long-term care system in the commonwealth. It includes initiatives to optimize community discharge processes for patients in non-acute care hospitals, provides support for patients transitioning to independent living, and establishes a complex care ombudsman program to assist with discharge planning.

Additionally, the bill seeks to improve Medicaid reimbursement rates for non-acute care hospitals, eliminate prior authorization requirements for transitions from acute or non-acute hospitals to home health agencies, and create a regional pilot program to increase the availability of long-term care and dementia care beds. It also establishes an Office of Adult Guardianship and Conservatorship Oversight to safeguard vulnerable adults from abuse, with a focus on improving court oversight and appointing guardians and conservators.

The legislation fosters collaboration between healthcare facilities and academic institutions by providing opportunities for skilled nursing facilities to serve as teaching hubs, thereby enhancing the quality of care for residents. It also addresses the need to expand telehealth services and medical care within skilled nursing facilities while promoting workforce development and recruiting guardians and conservators for individuals without representation.

H.1141 | S.806

An Act Increasing Access to Acute Hospital at Home Services

Rep. Daniel Donahue (D-Worcester) | Sen. Patrick O'Connor (R-Weymouth)

Referred to Joint Committee on Financial Services

Mandating Hospital at Home coverage for commercial plans would enable more hospitals across the commonwealth to offer and expand these valuable services, ultimately improving patient outcomes and reducing healthcare costs. Both Medicare and MassHealth are currently covering Hospital at Home Programs, with coverage flexibility currently extended through March 31, 2025. However, there is no clear guidance on coverage for commercial insurance plans at this time. Thess programs have proven effective in keeping patients out of traditional hospital settings, reducing the risk of hospital-acquired infections, and promoting a more comfortable recovery environment at home. Additionally, Hospital at Home offers greater convenience for patients and helps alleviate hospital capacity issues.

BEHAVIORAL HEALTH

H.1131 | S.773

An Act Expanding Access to Mental Health Services

Rep. Marjorie Decker (D-Cambridge) | Sen. John Keenan (D-Quincy)
Referred to Joint Committee on Financial Services

The legislation takes steps to reduce financial barriers by waiving application fees for mobile integrated health services focused on behavioral health. It updates coverage requirements for behavioral health crisis services, ensuring these services are aligned with the recent updates from the Roadmap for Behavioral Health Reform. A critical aspect of this change is the extension of commercial coverage to include behavioral health evaluations performed in emergency departments. In addressing existing challenges, the legislation removes regulatory barriers stemming from Chapter 177's previous elimination of prior authorization for inpatient psychiatric services. It also enhances access by expanding the number of behavioral health services that must be covered without requiring prior authorization, thus simplifying the process for patients in need. To further prioritize patient care, the legislation ensures that medical necessity is determined by the patient's treating clinician, with this determination documented in the medical record. Additionally, it allows qualified physician assistants to admit psychiatric patients, broadening the scope of those who can provide essential care. The bill also codifies regulations from the Department of Public Health, expanding the definition of licensed mental health professionals to include master's-level clinicians working towards licensure. These changes are designed to strengthen the behavioral health system, improve access to care, and ensure more comprehensive coverage for those in need.

H.213 | S.111

An Act to Ensuring Access to Behavioral Health Services for Children Involved with State Agencies

Rep. Marjorie Decker (D-Cambridge) | Sen. Brendan Crighton (D-Lynn)
Referred to Joint Committee on Children, Families and Persons with Disabilities

This bill seeks to improve access to mental health services for children involved with state agencies, including the Department of Mental Health (DMH), the Department of Developmental Services (DDS), and the Department of Children and Families (DCF). It requires DCF to create and support an emergency response plan for congregate care settings and creates presumption that a child would return to a DCF group home after a leave of absence, with accountability for denied readmissions. DCF would coordinate care through an emergency team and reimburse programs for holding beds during treatment in other settings. Additionally, DCF and DDS must develop a comprehensive plan to address access to behavioral health services, evaluate alternative placements, and enhance coordination with local education agencies. A commission would be established to explore alternative placements for children not adequately served by existing psychiatric or treatment models. DMH would also take primary responsibility for facilitating specialized mental health services for individuals involved with both DMH and DDS. The bill ultimately works to streamline services and ensure that children receive the appropriate mental healthcare and placements they need.

H.1337

An Act Relative to Opioid Use Disorder Treatment and Rehabilitation Coverage

Rep. Andy Vargas (D-Haverhill) | Rep. Kate Don Donaghue (D-Westborough)

Referred to Joint Committee on Financial Services

This language expands access to opioid use disorder treatment. It requires that the GIC, MassHealth, and commercial health plans reimburse for medication for opioid use disorder regardless of whether these medications are filled by prescription, are over the counter, are dispensed directly to the patient without needing to go to a pharmacy, as is best practice, or are administered to the patient. This language explicitly requires that payer coverage of these lifesaving medications include reimbursement for the medications to ensure facilities have the resources to provide these medications to patients. Currently, while health plans may "cover" these medications, they do not provide any reimbursement for them; this language would require that healthcare facilities are reimbursed for the medications dispensed directly to patients, much as health plans reimburse pharmacies if a patient took a prescription for these same medications to be filled.

TRANSPORTATION

H.1198 | S.746

An Act to Improve Patient Access to Non-Emergency Medical Transportation

Rep. Dan Hunt (D-Boston) | Sen. Paul Feeney (D-Foxborough)

Referred to Joint Committee on Financial Services

This bill work to address growing emergency medical services (EMS) challenges by ensuring insurance prior authorization for patient transportation is valid for three business days to take into account any transport delays, while ensuring that EMS providers are adequately reimbursed by MassHealth for non-emergency medical transportation for behavioral health, dialysis, and post-acute care transportation.

H.2491 | S.1513

An Act Establishing a Task Force to Study the Sustainability of Emergency Medical Services

Rep. Jon Mahoney (D-Worcester) | Sen. Bill Driscoll (D-Milton)

Referred to Joint Committee on Public Health

This bill establishes an EMS task force to ensure the stability of EMS in the commonwealth, and to issue a report and recommendations on ways to ensure that the commonwealth's emergency medical services capabilities are met.

The lack of availability of EMS providers has created a significant bottleneck for hospitals in discharging patients from acute care settings to home, behavioral health treatment, skilled nursing facilities (SNFs), and long-term care facilities. It has also created issues in moving patients that do not require an acute level of care to necessary preventative outpatient and other treatments/services that minimize the need for hospitalizations.

H.2234 | S.1397

An Act Establishing Alternative Models for Behavioral Health Transport

Rep. Adam Scanlon (D-North Attleboro) | Sen. Paul Feeney (D-Foxboro)

Referred to Joint Committee on Mental Health, Substance Use and Recovery

This legislation would require the Executive Office of Health and Human Services to establish a pilot program to evaluate alternative models of transport for behavioral health patients and would require MassHealth reimburse for these services. The behavioral health crisis and its impact on hospital emergency department operations continue to endure, creating a sustained demand for a range of healthcare services that are difficult to access. Traditional EMS models, primarily designed for acute medical emergencies, are not designed to address the nuances of behavioral health diagnoses or the statewide behavioral health system, leading to long response times, overcrowded facilities, and a lack of specialized care during transport. These limitations highlight the need for alternative transportation models to ensure individuals receive timely and appropriate care that is tailored to their needs. Such alternatives improve outcomes, reduce strain on EMS systems, and offer a more humane, effective response to behavioral health transport.

DATA, OVERSIGHT, and FINANCE

H.1354 | S.917

An Act to Address the Financial Stability of the Health Safety Net

Rep. Dan Cahill (D-Lynn) | Sen. John Velis (D-Westfield)

Referred to Joint Committee on Health Care Financing

This bill addresses the Health Safety Net program's financial instability in two ways. First, commercial health insurance companies would be required to share in the cost of the Health Safety Net Trust Fund shortfalls, similar to their initial surcharge contribution to the program. Second, it updates the state's statutory requirement to meaningfully support the program by increasing the state funding amount to $60 million and adds language to reinforce the current statutory funding requirement. The state's $30 million contribution amount can be traced back to 2011; however, in recent years the state has only funded half that amount.

The commonwealth Health Safety Net program is in jeopardy. Monetary deficiencies in the Health Safety Net program are now exceeding levels not experienced since prior to the state's historic 2006 healthcare reform law, with the shortfall anticipated to exceed $200 million in FY2025. Today, hospitals alone must make up any funding shortfall. Without additional resources, hospitals — which are already struggling with their own financial challenges — are charged with financing the funding shortfall alone. At these deficiency levels, many hospitals will not receive any monies for care provided to low-income uninsured patients even though they pay an assessment into the fund.

H.1156 | S.758

An Act Relative to Uncollected Co-pays, Co-insurance, and Deductibles

Rep. Carole Fiola (D-Fall River) | Sen. Barry Finegold (D-Andover)

Referred to Joint Committee on Financial Services

Thes bills require carriers who design and sell "consumer-directed" plans to share accountability with providers for uncollectible patient obligations after insurance payment. This legislation would require insurers to reimburse healthcare providers 65% of an uncollected co-payment, co-insurance, and/or deductible that exceeds $250 if the provider does not receive payment after the provider has made reasonable collection efforts. The process for reasonable collection efforts outlined in the bill is similar to the processes that Medicare and the state's Health Safety Net use, with the 65% reimbursement metric modeled on the Medicare methodology.

H.1181 | S.759

An Act to Redirect Excessive Health Insurance Reserves to Support Health Care Needs

Rep. Danielle Gregoire (D-Marlborough) | Sen. Barry Finegold (D-Andover)

Referred to Joint Committee on Financial Services

This legislation requires carriers to pay an assessment based on a portion of their reserves that is far greater than the amount that carriers are required to maintain to cover their risk. This assessment funding would be used to support the commonwealth's behavioral health delivery system and financially strained healthcare systems.

H.1357 | S.840

An Act Relative to Insurer Responsibility to the Operating Budgets of Health Care Oversight Entities

Rep. Michael Day (D-Stoneham) | Sen. Nick Collins (D-Boston)

Referred to Joint Committee on Health Care Financing

This legislation would add language to both updated CHIA and HPC funding statutes relative to the surcharge payers' responsibility to these oversight entities' budgets. The language makes clear thar surcharge payers are one of the entities that bear funding responsibility and references the MCO assessment set under Section 66 of Chapter 118E, ensuring that the intention of Chapter 224 is clear and that insurers will continue to fund the work of CHIA and the HPC if the MCO assessment is ever updated or altered.

Under Chapter 224 of the Acts of 2012, the law that established the Center for Health Information and Analysis (CHIA) and the Health Policy Commission (HPC), hospitals, ambulatory surgical centers, and insurers shared responsibility for the funding of both agencies' oversight budgets. Through language adopted in Outside Sections 124 through 126 of the FY2025 state budget, insurers will now pay their proportion of the agencies' costs through a bundled assessment on managed care organization (MCO) services. Additionally, Chapter 343 of the Acts of 2024 established a new funding mechanism for CHIA and the HPC, and added pharmaceutical manufacturers, pharmacy benefit managers, and non-hospital provider organizations – now also subject to CHIA and HPC oversight under Chapter 343 – to the cohort of assessed entities. However, the law removed all references to insurers – defined as surcharge payers – in the sections of the CHIA and HPC statutes that outline all healthcare entities' assessment requirements.

H.1376 | S.864

An Act Relative to The Operating Budgets of Health Care Oversight Agencies

Rep. Hannah Kane (R-Shrewsbury) | Sen. Barry Finegold (D-Andover)

Referred to Joint Committee on Health Care Financing

This legislation would set a limit on the amount that the agencies can increase their respective operating budgets over the previous year. The limit would be equal to the same year's cost growth benchmark – the metric used by the HPC and CHIA to control healthcare spending.

The intent of Chapter 224 was that that hospitals, ambulatory surgical centers (ASCs), insurers, and the commonwealth's general fund would share equal responsibility for funding CHIAand theHPC , as both agencies serve a broad healthcare mission from which the commonwealth benefits. In prior years, only hospitals/ASCs and insurers had been responsible for funding the CHIA and HPC operating budgets. Both agencies' budgets have continued to increase year over year, often exceeding the healthcare cost benchmark. For example, the HPC's FY25 budget is 5.2% more than its FY24 allotment, and its FY24 budget was 5.1% more than FY23.

Chapter 343 of the Acts of 2024 effectively eliminated the commonwealth's obligation to the CHIA and HPC budgets through its newly established funding mechanism, and added pharmaceutical manufacturers, pharmacy benefit managers, and non-hospital provider organizations – now also subject to CHIA and HPC oversight under Chapter 343 – to the cohort of assessed entities. Surcharge payers fund the costs of CHIA and HPC through an insurer tax bundle adopted through the FY2025 state budget.

H.1385 | S.865

An Act Expanding the Moral Obligation Bond Program to Acute Hospitals

Rep John Lawn (D-Watertown) | Sen. Barry Finegold (D-Andover)

Referred to Joint Committee on Health Care Financing

This language expands the use of moral obligation bonds in existing statue to include all nonprofit acute care hospitals, broadening the scope of the program. Moral obligation bonds are bonds issued by state governments to raise money for projects that may not have enough capital to completely cover their debts. They are secured by a non-binding covenant and do not require voter approval, and the legislature may vote to fund any shortfalls when bond issuers are unable to pay back a bond. Chapter 288 of the Acts of 2010 expanded Massachusetts' moral obligation bond eligibility to nonprofit acute care community hospitals and community health centers.

H.1154 | S.726

An Act Relative to Insurance Coverage of Mobile Integrated Health

Rep. Michael Finn (D-West Springfield) | Sen. Bill Driscoll (D-Milton)

Referred to Joint Committee on Financial Services

This legislation would disallow public and private health plans from refusing to cover healthcare services on the basis that they were delivered by a state-approved mobile integrated health (MIH) program, requires that said services be covered to the same extent as they would have had they been provided in a healthcare facility, and would lift application and registration fees for MIH programs that are focused on delivering behavioral health services.

H.1267 | S.699

An Act Relative to Unilateral Contract Changes

Rep. Frank Moran (D-Lawrence) | Sen. Brendan Crighton (D-Lynn)

Referred to Joint Committee on Financial Services

This bill prohibits the Group Insurance Commission and commercial carriers from entering into contracts with healthcare providers that allow them to make unilateral changes to a material term or condition of such contract other than a change expressly required by law or unless the effective date of such unilateral change is after the then-current term of such contract. Currently, carriers may unilaterally change the terms of the contract while it is in force, causing operational, financial, and medical consequences for both patients and providers.

H.1138 | S.782

An Act to Increase Health Insurer Reporting Transparency

Rep. Mindy Domb (D-Amherst) | Sen. Joan Lovely (D-Salem)

Referred to Joint Committee on Financial Services

This bill enhances the transparency of data for healthcare consumers and stakeholders by requiring the CHIA to periodically report on and include in its annual report the information it receives from insurance carriers as well as data available from the Division of Insurance regarding medical expenses, administrative expenses, medical loss ratios, reserves, and surpluses. This bill does not create any new reporting requirements on insurers. It simply requires CHIA to evaluate data metrics that insurers already submit to CHIA and to the Division under current law and to incorporate this information as part of its annual evaluation and regular reporting of Massachusetts healthcare financing. It is important to note that CHIA is funded by an assessment on hospitals and health plans, not the general fund, and therefore any administrative expenses related to reporting this information are not borne by the commonwealth.

H.3196 | S.2047

An Act to Reform the Healthcare Cost Benchmark

Rep. Frank Moran (D-Lawrence) | Sen. Mike Moore (D-Millbury)

Referred to Joint Committee on Revenue

This bill reforms the reference benchmark that is used to inform HPC's healthcare cost growth benchmark to base it on historical state economic growth rather than an arbitrary process. A historical growth rate in gross state product would be calculated using the most recent 10-year period and would serve as the default healthcare cost benchmark subject to HPC modification and approval. Each year, the Health Policy Commission board establishes a healthcare cost growth benchmark for the next calendar year. Unless modified by the HPC, the benchmark is equal to the growth rate of the "potential gross state product" established under section 7H 1/2 of chapter 29 of the General Laws. While that process involves input from economists and other experts, the Secretary of Administration and Finance and House and Senate committees on Ways and Means jointly ultimately determine the growth rate of the potential gross state product. For more than a decade since the law's inception in 2012, the potential gross state product has always been determined to be 3.6% despite varying future and past measures of the state's gross domestic product.

H.85 | S.1553

An Act Relative to Determination of Need for New Technology

Rep. Meghan Kilcoyne (D-Northborough) | Sen. John Keenan (D-Quincy)

Referred to Joint Committee on Advanced Information Technology, the Internet and Cybersecurity

Referred to Joint Committee on Public Health

This bill excludes the acquisition of both computerized tomography (CT) equipment, as well as any equipment widely used as standard diagnostic, treatment, or therapeutic technology from the Department of Public Health's (DPH's) determination of need process. Healthcare facilities would be able to acquire said technology without DPH approval.