Joint Committee on Health Care Financing
2025-2026 (194th) Bill Summary

Bill Number: House, No. 1361

Title: AN ACT TO ADDRESS HEALTH CARE COSTS THROUGH THE COST BENCHMARK AND RATE REVIEW PROCESS

Sponsor: Representative Patricia A. Duffy (Holyoke)

Hearing Date: June 2, 2025

Reporting Deadline: August 1, 2025

Prior History: New Bill

Similar Matters: S904 (Rausch – Similar, Health Care Financing)

Current Law:

M.G.L. Ch. 6D § 10 directs the center for health information and analysis (CHIA) to notify the Health Policy Commission (HPC) of any health care entity identified by the center as exceeding the health care cost growth benchmark for any given year. The HPC may require that entity to file and implement a performance improvement plan to improve efficiency and reduce cost growth. In addition, if the HPC finds that the percentage change in total health care expenditures exceeded the health care cost growth benchmark in the previous calendar year, the HPC may require any entity to file a performance improvement plan. A violation of the section may result in a civil penalty of not more than $500k.

M.G.L. Ch. 12C § 18 directs the CHIA to perform an ongoing analysis of payers, providers or provider organizations whose increase in health status-adjusted total medical expense is excessive, and who threaten the Commonwealth's ability to meet the health care cost growth benchmark. CHIA is directed to identify such health care entities and confidentially provide a list to the HPC such that the authority may pursue further action under section 10 of chapter 6D.

M.G.L. Chapter 176B § 4 authorizes the commissioner of insurance to disapprove medical service plans filed by a nonprofit medical service corporation if the benefits provided therein are unreasonable in relation to the rate charged, nor if the rates are excessive, inadequate or unfairly discriminatory

M.G.L. Chapter 176G § 16 authorizes the commissioner of insurance to disapprove subscriber contracts filed by a HMO if the benefits provided therein are unreasonable in relation to the rate charged, nor if the rates are excessive, inadequate or unfairly discriminatory.

M.G.L. Chapter 176J § 6 authorizes the commissioner of insurance to approve health insurance policies submitted to the division of insurance for the purpose of being provided to eligible individuals or eligible small businesses [Merged Market]. Carriers offering small group health insurance plans, including carriers licensed under chapters 175, 176A, 176B or 176G, shall file with the division small group product base rates and any changes to small group rating factors that are to be effective on January 1 of each year, on or before July 1 of the preceding year. The commissioner shall disapprove any proposed changes to base rates that are excessive, inadequate or unreasonable in relation to the benefits charged.

Summary Prepared by the House Staff of the Joint Committee on Health Care Financing

M.G.L. Ch. 176K § 7 establishes regulations for Medicare supplement and Medicare select insurance policies. These policies must adhere to a community rating system, ensuring premiums are the same for all policyholders regardless of individual health status. Insurers are allowed to apply certain adjustments to premiums, such as surcharges or discounts, but these must be filed with the commissioner and are subject to public hearings for transparency.

Summary:

SECTION 1 of the proposed legislation amends section 10 of chapter 6D by adding a new subsection (c), which authorizes the Health Policy Commission (HPC) to require performance improvement plans from clinics, hospitals, ambulatory surgical centers, physician organizations, carriers, and accountable care organizations. These entities must be identified by CHIA as having excessive cost growth. It is important to note that this addition does not modify or eliminate the existing subsection (c).

SECTION 2 replaces subsection (q) of section 10 of chapter 6D with a new version that institutes a structure of escalating penalties for noncompliance. A first violation results in a $500,000 fine, a second in $750,000, and any third or subsequent violation may be fined up to the full amount of the spending that exceeded the health care cost growth benchmark. If an entity commits different types of violations (such as failing to submit a plan versus falsifying data), each violation type will be treated independently as a first offense. In addition to monetary penalties, the new subsection introduces non-monetary consequences. These include the HPC pausing any consideration of material change notices (e.g., mergers or expansions) for the noncompliant entity or its affiliates and allowing the HPC to notify the Department of Public Health (DPH) if a noncompliant entity applies for a determination of need. Civil penalties collected under this section will be deposited into the Healthcare Payment Reform Fund established under section 100 of chapter 194 of the acts of 2011.

SECTION 3 eliminates and replaces section 18 of chapter 12C. The updated language shifts the focus from "payers, providers, or provider organizations" to the broader term "health care entities," explicitly including clinics, hospitals, ambulatory surgical centers, physician organizations, carriers, and accountable care organizations. While still relying on health status-adjusted total medical expense as a benchmark for identifying excessive cost growth, the new section also considers other contributing factors, such as baseline spending, pricing levels, and payer mix. Additionally, failure to submit data accurately, completely or on time is added as a trigger for identification. Lastly, this section clarifies that referrals to HPC do not limit CHIA's own authority to assess penalties for noncompliance under section 11 of chapter 12C.

SECTIONS 4–7 of the proposed legislation require the commissioner of insurance to approve, modify, or disapprove proposed changes to rates, but modifications or disapprovals would be limited to situations where rates are excessive, inadequate or unfairly discriminatory.