March 24, 2026

An Open Letter to the Health Care Affordability Working Group: How to Save $43 Billion in Health Care Costs by 2035

Dear Chairpersons Walsh and Murray:

In Massachusetts, health care spending continues to grow at a rapid clip, outpacing wages and inflation. Massachusetts now has the highest health care premiums in the nation, with family premiums outpacing the national average by more than $3,500, and our deviation from the national average is growing.[1] As employers and consumers, we grapple with rising costs at the pharmacy counter, doctor's office and in the emergency room.

The Working Group's charge to find ways to address the health care affordability crisis in this Commonwealth could not be more urgent or serious. Without action, continued high growth in the cost of health care eats away at employee and consumer finances, makes Massachusetts less competitive, and contributes to health inequities. We are very supportive of these efforts and ready to assist you, as your success is critically important to us.

To jumpstart your efforts, please find below six recommendations for reducing health care costs for your consideration. Each of these recommendations comes from a state regulatory agency, uses MA-specific data, and offers sizable savings. Using publicly available data from the Massachusetts Attorney General's Office, the Massachusetts Center for Health Information (CHIA) and Analysis, the Betsy Lehman Center, and the Massachusetts Health Policy Commission (HPC), we have identified these six opportunities for savings, resulting in over $4 billion in annual savings across the health care system and more than $40 billion in savings over the next decade.

Please note that the savings recommendations below are reflective of the most recent analyses available, although in some instances the data is several years old. Updated analyses would likely garner greater savings.

Recommendation	Annual Savings
Eliminate health insurance coverage mandates	$158 million to $4.1 billion
Require site neutral payment and limit facility fees	$1.6 billion
Constrain excessive provider prices	$1.14 billion
Prohibit surprise billing	$801 million
Improve patient safety and address medical errors	$617 million
Eliminate low value care	$13 million to $80 million
Total Annual Savings:	**$4.4 - $8.3 billion annually**

[1] Massachusetts Health Policy Commission (via Massachusetts Retirees Association summary), "Annual family premiums in Massachusetts exceed the national average by more than $3,500" (2025). https://massretirees.com/2025/11/were-at-a-breaking-point-health-insurance-premiums-just-keep-going-up-worsening-affordability-crisis/.

ISSUE	SOLUTION	POTENTIAL SAVINGS
State-imposed health insurance mandates on the fully insured	**Allow the sale of insurance products without the mandated benefits**	**From $158 million t $4.1 billion annually**

Recommendation #1: Eliminate or Greatly Reduce the Number of Mandated Benefits

Massachusetts requires that fully insured health insurance products sold in the Commonwealth cover 59 health services or providers, 18 of which have been added since 2018. This rich coverage exceeds the minimum creditable coverage requirement at the state level and the essential health benefit requirement at the federal level. Companies and purchasers that self-insure are not subject to these mandates due to federal ERISA law preemption, therefore, the burden of paying for these added benefits falls largely on small employers and individuals purchasing in the merged market. The legislature has exempted MassHealth and the GIC from these requirements in many instances.

Often, these mandated benefits are enacted without completion of the statutorily required cost-benefit analysis or a full analysis of the medical efficacy/necessity; rather, these laws are often passed based on the advocacy of special interest groups or the emotional plea of constituents. But these mandates add greatly to the cost of health insurance. According to a Center for Health Information and Analysis (CHIA) report[2], state mandated benefits now account for more than 24% of every premium dollar. CHIA estimates the required direct costs of providing mandated benefits at $4.147 billion. This figure is comprised of two components: (1) base costs, defined as the cost that would be incurred in the absence of a mandate due to voluntary coverage or other state and federal requirements; and (2) marginal costs that represent additional expenditures directly attributable to the mandate itself. The CHIA report assumes that a large portion of the cost of mandated benefits would be incurred even without the mandate, but that premise calls into question the necessity of the mandates. As costs continue to rise at unsustainable rates, employers would appreciate the ability to determine what benefits beyond minimum creditable coverage and essential health benefits they can afford to offer.

Proposed Solution:

The Working Group should conduct a comprehensive review of all the mandates to determine if they are medically necessary, the best treatment option and add sufficient value to justify the costs to the insured population. Reducing the number of mandated benefits would provide immediate relief to the fully insured market. Alternatively, the Working Group should support allowing employers to offer a mandate-free benefit package alongside an insurance product with all the mandated benefits so that consumers can decide which level of coverage is right for them. The Working Group should also support a moratorium on the imposition of additional mandated benefits for a three- year period. This provision is particularly important given the many other cost challenges – high energy costs, high labor costs, tariffs, rising unemployment insurance premiums – confronting Massachusetts small employers.

[2] https://www.chiamass.gov/assets/docs/r/pubs/2025/Comprehensive-Mandated-Benefit-Review_2025.pdf

Potential Savings: $158 million to $4.15 billion.

ISSUE	SOLUTION	POTENTIAL SAVINGS
Significant variation in price based on site of care and the imposition of facility fees	**Require site neutral payments, limit facility fees and require disclosure of them prior to providing service**	**$1.6 billion annually**

Recommendation #2: Require Site-Neutral Payments, Limit Facility Fees and Increase Transparency

Facility fees contribute to excessive health care spending growth and persistent price variation in Massachusetts. A facility fee is a charge from a provider of outpatient services delivered in a hospital-owned or a freestanding facility away from a hospital's campus that is separate from the bill for actual medical care. In most cases, a patient is unaware that they will be responsible for the payment of a facility fee. Patients are being charged facility fees of up to hundreds of dollars out-of-pocket without warning and without the ability to contest them. Elimination of facility fees from the state's health care system will result in dramatic cost savings for consumers.

Facility fees have become much more prevalent as large hospital systems buy physician practices. Originally intended to help hospitals offset overhead costs, facility fees are now charged for a much broader list of outpatient services performed by physicians who work in an office that is owned by a hospital. As care is largely shifting from hospital inpatient to outpatient settings, this imposition of facility fees adversely impacts more state residents and increases overall health care spending. Facility fees provide a non-service-related revenue source to hospitals, incentivizing them to acquire independent provider practices, imaging centers and outpatient services and convert them to off-campus hospital outpatient departments (HOPDs).

Historically, Medicare permitted reimbursement for the same health care service to vary depending on the site of care and paid a higher rate for services delivered in HOPDs than services delivered in an office setting. Medicare payments to hospital-owned facilities reflect two components: the professional component (reimbursement for the provider's services based on the Medicare Physician Fee Schedule), and a facility payment to compensate a hospital or health system for a portion of the operational expenses incurred to make emergency services available 24 hours a day and to deliver complex services in an inpatient environment.

Beginning in 2017, Medicare no longer pays a facility fee for non-emergency services delivered by newly created off-campus HOPDs and prohibits facility fees for other common services, including office visits, labs, and mammograms in recognition that most HOPDs are identical to physician office settings and do not require additional resources.[3] And many routine health care services can be provided safely and effectively in settings other than hospitals at reduced

[3] Massachusetts Health Policy Commission. Board Meeting Presentation. September 2023. Available at: https://www.mass.gov/doc/presentation-board-meeting-september-13-2023/download

cost.[4] The Medicare Payment Advisory Commission (MedPAC) has recommended reimbursement should not vary by site for health care services that are safe and appropriate to provide in a lower-cost setting, such as imaging and endoscopies.[5]

Facility fees are a primary cause of excessive health care spending growth in Massachusetts and substantially increase the price of health care services in the state. Commercial prices and patient spending on health care services are twice as expensive or greater when delivered in a HOPD setting rather than an office, due to the addition of a facility fee. According to HPC data, facility fees account for 80% of all HOPD spending,[6] often exceeding the professional charge for a health care service. Facility fees increased 6.7% between 2019 and 2021 while spending on the professional component grew at a more reasonable 1.5%.[7] Because care has shifted dramatically away from doctors' offices and into outpatient facilities, hospitals can capitalize on referral relationships and increase facility fee revenue by directing service delivery to HOPDs instead of a lower cost alternate site. MedPAC estimates that site-neutral payments would have saved Medicare $6.6 billion in 2019 and Medicare beneficiaries would have paid $1.7 billion less out of pocket. A more recent Congressional Budget Office report estimates that site-neutral payments for both off-campus and on-campus HOPDs for services commonly performed in a physician's office would save Medicare $156 billion over the next decade.

Proposed Solution:
The HPC 's 2023 *Annual Health Care Cost Trends Report* recommended that policymakers in the Commonwealth take action to equalize payments between HOPDs and physician offices for the same health care services to reduce inappropriate health care spending and consumer liability. Specifically, the HPC endorses limits on both newly licensed and existing sites that can bill as HOPDs and supports site-neutral payments for ambulatory services that are commonly provided in office-based settings, including office visits, lab tests, basic imaging and diagnostic services, and drug administration.

Additionally, the HPC calls for increased consumer transparency, requiring outpatient sites that charge facility fees to conspicuously and clearly disclose potential financial liability to patients prior to delivering care and to include on claims submitted to payers and reported to CHIA's Massachusetts All-Payer Claims Database the location where the visit occurred, specifying whether it was an on- or off-campus hospital outpatient department.

Potential Savings: $1.6 billion annually.[8]

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[4] Massachusetts Health Policy Commission. 2023 Annual Health Care Cost Trends Report and Policy Recommendations. Sept. 2023. Available at: https://www.mass.gov/doc/2023-health-care-cost-trends-report/download
[5] MedPac. Report to Congress: Medicare and the Health Care Delivery System. June 2023. Available at: https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch8_MedPAC_Report_To_Congress_SEC.pdf
[6] Massachusetts Health Policy Commission. 2023 Annual Health Care Cost Trends Report and Policy Recommendations. Sept. 2023. Available at: https://www.mass.gov/doc/2023-health-care-cost-trends-report/download https://www.mass.gov/doc/2023-health-care-cost-trends-report/download
[7] Id.
[8] Committee for a Responsible Federal Budget. Moving to Site Neutrality in Commercial Insurance Payments. February 2023. Available at: https://www.crfb.org/papers/moving-site-neutrality-commercial-insurance *Estimated that mandating commercial site-neutral payments would reduce total national healthcare*

ISSUE	SOLUTION	POTENTIAL SAVINGS
Excessive Prices	**Price Benchmark at 200% of Medicare**	$1.14 billion annually

Recommendation #3: Constrain Excessive Provider Prices

Several factors contribute to excessive health care spending. Among them are the overutilization of services in high-acuity, high-cost settings that could have been provided in lower cost settings; the provision of services that exceed clinical guidelines without improving health; and services that could have been avoided, prevented or are otherwise unnecessary. However, the primary contributor to excessive spending in Massachusetts is unit price, or the prices charged by providers for services and treatments.[9]

In 2023, the Health Policy Commission found that nearly 27% of health care spending in Massachusetts is excessive, amounting to $3 billion in excess costs each year, or twelve percent of all commercial medical expenditures. Of that amount, $1.14 billion or almost half of excessive spending can be attributed to hospital inpatient and outpatient settings, including lab services, imaging, endoscopy, specialty services, inpatient stays, and clinician administered drugs.

To conduct this analysis, the HPC compared prices charged by hospitals to commercially insured patients to prices paid for those same services by the Medicare fee-for-service program or MassHealth as appropriate.
Using the Medicare fee-for-service rates as a comparator, the HPC then set a generous threshold above which prices would be considered excessive. For a majority of the services outlined in Figure 1 below, the benchmark sits at 200% of the Medicare rate or 200% of the MassHealth rate. In the case of prescription drugs, the comparator is 120% of international prices. In each of the areas examined, the HPC found significant spending in excess of the benchmark, with variation in the level of excessive pricing impacted by site of care.

expenditures by $548 billion and reduce commercial premiums by $386 billion over the next decade. Massachusetts' annual figure is based on CHIA's Enrollment Data – September 2023.

[9] Beginning with the Attorney General's 2010 Examination of Cost Trends and Drivers, successive state reports from the Massachusetts Office of the Attorney General, Health Policy Commission, and Center for Health Information and Analysis have reached this conclusion. See: Danielle DiCenzo MS, MPH and John Freedman MD, MBA. Re-examining the Health Care Cost Drivers and Trends in the Commonwealth: A Review of State Reports (2008-2018). April 2019. Available at: https://mahp.com/wp-content/uploads/2019/05/freedman-report-2018-final.pdf

Exhibit 3.12. Estimated commercial excessive spending using example benchmark for seven service categories, 2021

Service category	Modeled spending (millions), 2021	Price benchmark	Percent of spending in the category over the price benchmark	Excessive spending (millions)	Excessive spending (percent of TME)
Labs (1,132 services performed in office, HOPD, and independent labs)	$970M	200% of Medicare	22.9%	$220M	0.9%
Imaging (571 services performed in office and HOPD)	$1,380	200% of Medicare–HOPD	18.8%	$260	1.0%
Endoscopy (all endoscopies)	$340	200% of Medicare	4.4%	$10	0.06%
Specialty Services (149 services performed in office and HOPD)	$620	200% of Medicare–Office	35.4%	$220	0.9%
Inpatient Stays (all inpatient stays)	$3,620	200% of MassHealth	10.7%	$390	1.4%
Clinician-Administered drugs (top 15 drugs by spending)	$650	200% of Medicare	5.8%	$40	0.2%
Prescription Drugs (all retail drugs)	$3,580	120% of international prices	51.9%	$1,860	7.5%
Total	**$11,150 (45% of TME)**		**26.9%**	**$3,000 (12.0% of TME)**	**12.0%**

Note: All spending estimates in this table are based on analysis of claims data processed by the HPC from the All-Payer Claims Database. These data account for roughly 40% of the commercial market in 2021. The figures in the table have been extrapolated to represent the full Massachusetts commercial market. Numbers may not add to total due to rounding.

Figure 1: Health Policy Commission Excessive Pricing Analysis

In other words, employers and employees with commercial insurance routinely overpay for a wide array of services at a rate that is more than double the reimbursement rate of Medicaid or MassHealth without any discernible improvement in patient outcomes.

Proposed Solutions:
By simply capping prices for the identified services at the benchmark used for analysis – 200% of Medicare or MassHealth – policymakers could garner significant annual savings.

Potential Savings: Up to $1.14 billion in savings annually.

ISSUE	SOLUTION	POTENTIAL SAVINGS
Surprise Billing	**Set a statutory out-of-network default rate and prohibit surprise billing in Massachusetts.**	**$801.4 million annually across the Massachusetts commercial population**

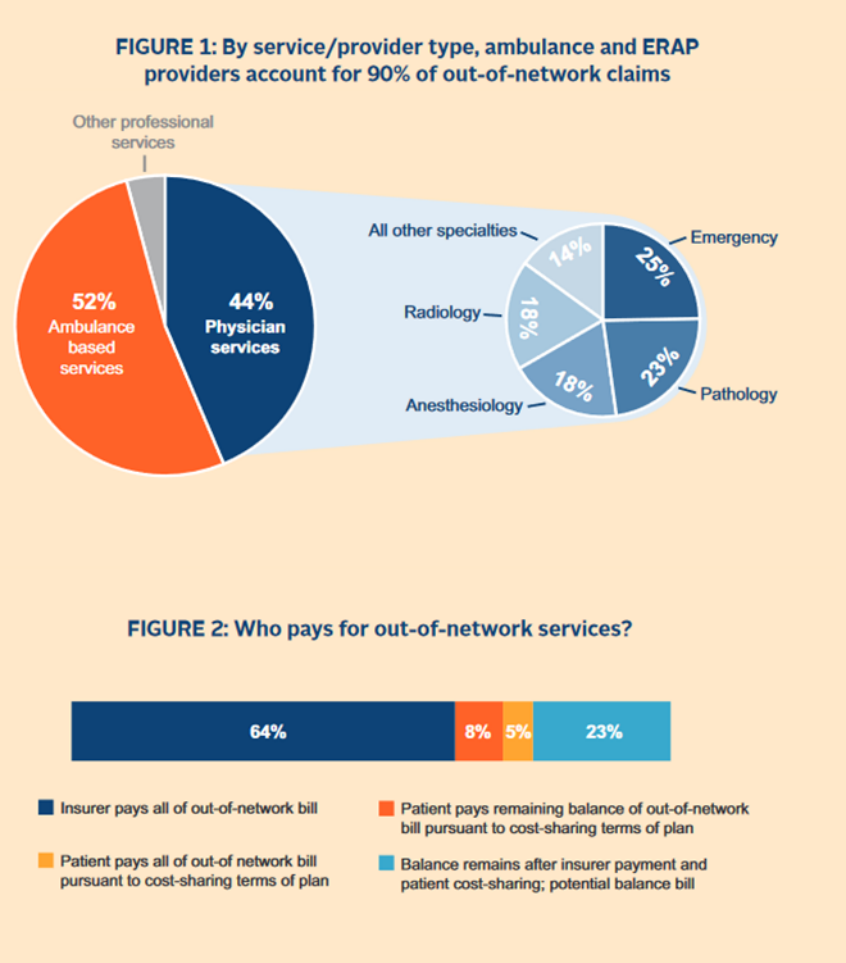
<u>Recommendation #4: Eliminate Surprise Medical Billing</u>

A surprise medical bill is an unexpected bill, often for services received from a health care provider or facility that a patient did not know was out-of-network (e.g., had not negotiated a reimbursement rate with your insurance company) until he/she was billed. Health care spending resulting from surprise billing is on the rise in Massachusetts.

More providers are opting to avoid contracting directly with a health plan and instead bill plans and their insured members at a higher, non-negotiated rate. These out-of-network (OON) providers charge more for their services without fear of losing patient volume because demand for their services is constant and patients have no opportunity to choose an in-network provider.

As the chart below indicates, the most common OON providers are in emergency, radiology, anesthesiology and pathology.

The average balance potentially billed to patients for OON professional claims from ERAP providers in 2017 was $167 per claim.[10]



However, the amount of the bill varied widely, ranging from $5 to $749 depending on the specialty; anesthesiology claims had the highest average potential balance bill at $588, emergency claims at $249, pathology at $85, and radiology claims having the lowest at $58.[11]

Charges billed by OON ED physicians rose substantially between 2015 and 2017. For example, the cost of a moderate severity ED evaluation and monitoring visit grew 11 percent from $294 to $325.[12]

OON providers bill patients for the difference between the provider's total charge and the amount the health plan pays, subjecting insured residents to unexpected financial liability and debt collection. Both the charges billed by out-of-network (OON) providers and the amounts paid to OON providers have risen substantially.[13] The average spending on health care services provided by OON radiologists, anesthesiologists, pathologists, emergency doctors, and ambulance providers far

[10] Health Policy Commission, Out-of-Network Billing in Massachusetts Chart pack (2020), *available at* https://www.mass.gov/doc/out-of-network-billing-in-massachusetts-chartpack/download.
[11] Id.
[12] Id.
[13] Health Policy Commission, Out-of-Network Billing in Massachusetts Chart pack (2020), *available at* https://www.mass.gov/doc/out-of-network-billing-in-massachusetts-chartpack/download.

exceeds the average spending on in-network claims.[14] 91% of OON claims for professional services delivered in hospital outpatient departments in Massachusetts by radiologist, pathologists, and anesthesiologists have the potential to be balance billed to consumers.[15]

In Massachusetts, ambulance-based services represent the largest share of OON claims paid by health plans.[16] In 2023, the Office of the Attorney General's *Examination of Health Care Cost Trends Report* identified balance billing by OON ambulance providers as a primary factor associated with high health care costs in the Commonwealth. The vast majority of commercial health plan members transported by municipal ambulance providers are at risk of receiving a balance bill, and a large share of these claims are sent to collection agencies for nonpayment.[17]These higher prices for OON providers cause premiums paid by employers and consumers to increase.

While the 2020 *No Surprises Act* holds individuals harmless from balance billing in certain instances, ground ambulances are explicitly carved out. In addition, the *No Surprises Act* uses an arbitration process to address out-of-network bills, adding costly bureaucracy to an already costly problem. Early observations share these concerns "Data from early implementation of the arbitration process established by the federal *No Surprises Act* (to resolve out-of-network provider payment disputes) demonstrate significant administrative challenges and disadvantages of relying on the federal arbitration process."[18]

Multiple state agencies have recommended legislative action to establish reasonable default reimbursement rates for health care services delivered by OON providers, in combination with a ban on surprise billing, to make health care more affordable for enrollees in the Massachusetts fully insured market.

The Executive Office of Health and Human Services (EOHHS) issued a report to the Legislature in September 2021 that recommended the establishment of default reimbursement rates for OON providers at a health plan's median in-network contracted rate.[19] The EOHHS report found the use of contracted rates ensures fair reimbursement because they reflect the current, competitively negotiated agreements between health plans and in-network providers, and account for a provider's specialty, geographic market conditions, and business expenses. "In-network rates are market-driven and can more accurately reflect relative costs of providing services. They represent actual payments to providers by a payer in a particular market."[20] This approach was endorsed by EOHHS as a targeted solution for the fully insured market that will protect residents from surprise

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[14] Id.

[15] Rose Kerber, MPP and David Auerbach, PhD. Out-of-Network Billing in Massachusetts: Implications for Patients, Payers, and Market Dynamics. Available at: https://www.mass.gov/doc/out-of-network-billing-in-massachusetts/download

[16] Massachusetts Health Policy Commission. Board Meeting Presentation. November, 2017. Available at: https://www.mass.gov/files/documents/2017/11/14/20171101%20-%20Commission%20Document%20-%20Presentation%20FINAL.pdf

[17] AGO, 2023.

[18] Massachusetts Health Policy Commission. 2023 Annual Cost Trends Report and Recommendations (Sept. 2023), available at: www.mass.gov/doc/2023-health-care-cost-trends-report/download

[19] Massachusetts Executive Office of Health and Human Services. Report to the Massachusetts Legislature: Out-of-Network Rate Recommendations (September 8, 2021), available at https://www.mass.gov/out-of-network-rate-recommendations

[20] Id.

billing and excessive cost sharing, lower OON costs, promote payer-provider contracting, and provide greater transparency on OON health care spending.

The HPC has also repeatedly recommended the legislative establishment of a default OON rate in Massachusetts and endorsed the methodology supported by EOHHS in the most recent *Health Care Cost Trends* report, stating:[21]

> *"As a constraint on the spending and market impact of excessive prices charged by out-of-network providers, the Legislature should enact the default out-of-network payment rate for 'surprise billing' situations recommended by the Executive Office of Health and Human Services in its Report to the Massachusetts Legislature."*[22]

The HPC agreed with the EOHHS analysis, concluding that a default rate based on median contracted rates "would provide predictability, transparency and simplicity, and reduce health care spending in Massachusetts. Establishing a default out-of-network rate is also a critical component of a policy response to unwarranted provider price variation."[23] Finally, the HPC and EOHHS have recommended extending protections against surprise bills to ground ambulance transports for Massachusetts residents with commercial health insurance.

Proposed Solution:

Recommend a default reimbursement rate for out-of-net network providers based on median contracted rates and prohibit balanced billing.

Potential Savings: $801,399,220 annually.[24]

ISSUE	SOLUTION	POTENTIAL SAVINGS
Medical Errors and Patient Safety	**Implement the Betsy Lehman Center for Patient Safety's Roadmap to Health Care Safety for Massachusetts**	**$617 million annually**

[21] Massachusetts Health Policy Commission. 2023 Annual Cost Trends Report and Recommendations (Sept. 2023), available at: https://www.mass.gov/doc/2023-health-care-cost-trends-report/download

[22] Massachusetts Health Policy Commission. 2022 Annual Cost Trends Report and Recommendations (Sept. 2022), available at: https://www.mass.gov/doc/2022-health-care-cost-trends-report-and-policy-recommendations/download

[23] Massachusetts Health Policy Commission. 2023 Annual Cost Trends Report and Recommendations (Sept. 2023), available at: https://www.mass.gov/doc/2023-health-care-cost-trends-report/download

[24] Policies to Address Surprise Billing Can Affect Health Insurance Premiums, September 11, 2020. Erin L. Duffy, PhD, MPH, Bich Ly, BA, Loren Adler, MS, Erin Trish, PhD, The American Journal of Managed Care, September 2020, Volume 26, Issue 09. *Estimated that eliminating provider leveraging stemming from the ability to surprise bill could reduce commercial insurance premiums by $212 per member per year. Figure is based on CHIA's Enrollment Data – September 2023.*

Recommendation #5: Eliminate Medical Errors

While there has been considerable progress towards improving patient safety, medical errors and adverse patient safety events continue to cause hundreds of thousands of deaths and injuries every year in the United States. Approximately 400,000 hospitalized patients experience some sort of preventable harm each year, costing close to $20 billion in excess costs annually. [25]

In Massachusetts, the Betsy Lehman Center for Patient Safety found that, in a single year, there were over 62,000 medical errors, accounting for $617 million in excess costs.[26]

While it is challenging, if not impossible, to find a consistent cause of errors, the Betsy Lehman Center (the Center) took a twofold approach to understanding the instances of medical errors in the Commonwealth. First, the Center utilized the Massachusetts All Payer Claims Database to identify patients for whom insurance claims had been submitted using any of 98 identified diagnostic codes known to be associated with preventable harm events. The Center then calculated the probability that these claims were related to preventable error, and estimated the additional health care costs resulting from the event. For preventable harm events that aren't identifiable through health insurance claims data, the Center used data derived from peer-reviewed literature and incident reporting systems.

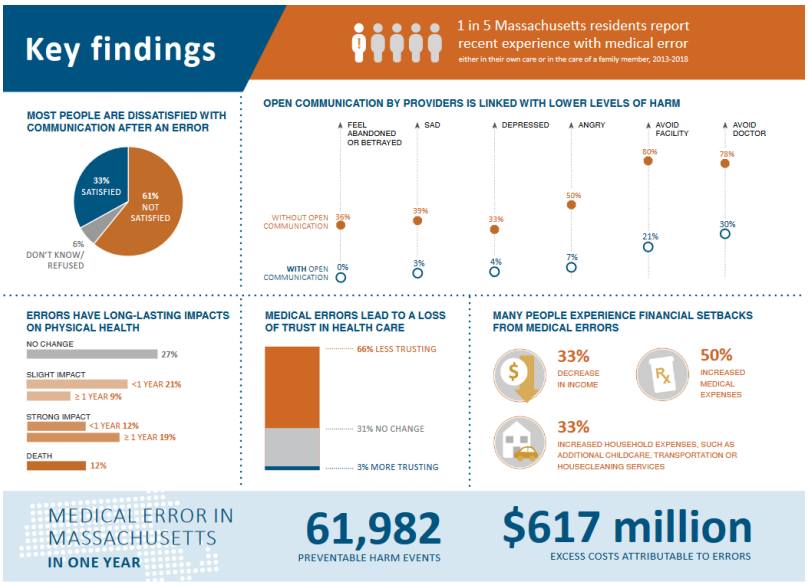

Figure 2: Betsy Lehman Center. The Financial and Human Cost of Medical Error.

Next, the Center conducted a large, randomized survey of a cross-section of Massachusetts residents to collect qualitative data on patient experience of medical error. A total of 988 individuals reported medical error experiences, providing information on the physical, emotional, behavioral,

[25] Rodziewicz TL, Houseman B, Hipskind JE. Medical Error Reduction and Prevention. 2023 May 2. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2024 Jan–. PMID: 29763131.
[26] The Betsy Lehman Center for Patient Safety. The Financial and Human Cost of Medical Error… and How Massachusetts Can Lead the Way on Patient Safety. June 2019. Available at: https://betsylehmancenterma.gov/assets/uploads/Cost-of-Medical-Error-Report-2019.pdf

and financial impact of the errors as well as the post-error communication and support offered by providers.

Overall, the Center found 612,982 preventable harm events and over $617 million in excess health insurance claims, representing approximately 1% of the state's total health care expenditures. Of the 98 types of errors found, the top 10 most frequent errors accounted for 71% of all errors, with seven of the top 10 most frequent errors also being the costliest errors. Interestingly, patients' experience of medical error provided insight into the cause of the error, with about 60% of respondents describing an error or delay in diagnosis resulting from process breakdowns. The Center also found that medical errors happen across all health care settings and across all age groups.

In conjunction with the Massachusetts Health Care Safety and Quality Consortium which is comprised of health care leaders from provider groups, hospitals, and payers, as well as patient advocates, policymakers and other experts, the Betsy Lehman Center has developed a *Roadmap to Health Care Safety* to root out medical errors and improve health care safety.[27]

Potential Solutions:
Implementation of the Roadmap will move our health care system towards a mindset of zero tolerance for deficiencies that can result in harm to patients, while creating a continuous, proactive approach to patient safety that breaks down the silos inherent in our health care system, results in better patient outcomes and saves money.

Potential Savings: $617 million annually.

ISSUE	SOLUTION	POTENTIAL SAVINGS
Low-Value Care and Unnecessary Care	**Engage all health care stakeholders through a multi-pronged approach in the elimination of low value and unnecessary services**	**$13 million to $80 million annually**

Recommendation #6: Minimize the Provision of Low-Value and Unnecessary Services

In 2023, the Commonwealth Fund ranked Massachusetts the 7th worst performing state on "avoidable use and costs."[28] While the primary driver of health care costs in Massachusetts is unit price, unnecessary utilization of health care services, including those deemed to be avoidable, also drives excess medical spending. The overprovision of health care services and treatments is often

[27]The Betsy Lehman Center. Roadmap to Health Care Safety. April 2023. Available at: https://betsylehmancenterma.gov/assets/uploads/04-2023_Roadmap.pdf
[28] C. Radley et al., *The Commonwealth Fund 2023 Scorecard on State Health System Performance: Americans' Health Declines and Access to Reproductive Care Shrinks, But States Have Options* (Commonwealth Fund, June 2023). https://doi.org/10.26099/fcas-cd24

the result of variation in care delivery, driven largely by financial self-interest, the influence of the pharmaceutical and medical device industry, and fear of malpractice litigation.[29]

The American Board of Internal Medicine's *Choosing Wisely* initiative, launched in 2012, produced a list of over 550 services they defined as "low value", meaning they offer little to no benefit for patients, and may even cause harm. These ineffective treatments can be procedures, lab testing, imaging, and medications, and are very commonplace. In some instances, an initial low-value screening or test can cause a chain reaction, or a "cascade of care," which results in a series of ill-advised tests or treatments that may cause avoidable, adverse effects and/or morbidity. Indeed, a 2019 survey of physicians in the U.S. found that 398 out of 400, or 99.5%, of the physicians surveyed have seen cascades of care following incidental findings that did not lead to clinically meaningful outcomes yet caused harm to patients.[30]

This problem is not unique to Massachusetts providers, nor does it impact a small subset of patients. All patients are at risk of being subjected to low-value care, regardless of their income, race, class or insurance status.[31] Nationally, estimates of spending on low-value care range from $100 billion to $700 billion annually.

The Health Policy Commission first examined the cost impact of low value care In Massachusetts in its 2018 Health Care Cost Trends Report, selecting 19 measures of low-value care identifiable in the Massachusetts All-Payer Claims Database (APCD). The HPC found that more than 20% of patients received at least one instance of low-value care, with patients bearing nearly 15% of the unnecessary spending or close to $12 million in higher out-of-pocket costs. In total there were nearly 800,000 low-value services identified over the study time period, accounting for nearly $80 million in health care spending.[32]

The following year, the HPC refined its study of low-value care to focus on seven measures across three domains (screening, pre-operative, and procedure) and identify variation in provision of low value care services by provider organization. The HPC identified $13 million in unnecessary health care spending across more than 100,000 patients in a single year and found substantial variation across organizations in provision of these low-value services.[33]

Since 2019, the HPC has continued to track the provision of low-value care across these domains, identifying consistent variation in spending and provision of low-value care across provider

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[29] Verkerk EW, Van Dulmen SA, Born K, Gupta R, Westert GP, Kool RB. Key factors that promote low-value care: views of experts from the United States, Canada, and the Netherlands. *Int J Health Policy Manag*. 2022;11(8):1514– 1521. doi:10.34172/ijhpm.2021.53

[30] Ganguli I, Simpkin AL, Lupo C, Weissman A, Mainor AJ, Orav EJ, Rosenthal MB, Colla CH, Sequist TD. Cascades of Care After Incidental Findings in a US National Survey of Physicians. JAMA Netw Open. 2019 Oct 2;2(10):e1913325. doi: 10.1001/jamanetworkopen.2019.13325. Erratum in: JAMA Netw Open. 2019 Nov 1;2(11):e1916768. PMID: 31617925; PMCID: PMC6806665.

[31] Add Lown Institute reference.

[32] Massachusetts Health Policy Commission. 2018 Cost Trends Report. Sept. 2018. Available at: https://www.mass.gov/doc/2018-report-on-health-care-cost-trends/download

[33] Massachusetts Health Policy Commission. 2019 Cost Trends Report Chart pack. Sept. 2019. Available at: https://www.mass.gov/doc/2019-cost-trends-report-chartpack/download

organizations.[34] These services which can be identified in claims, rather than in medical records, likely represent a small fraction of all low-value care according to the HPC.

Reducing low-value care is vital in addressing rising health care costs in Massachusetts and has the added benefit of ensuring residents of the Commonwealth have better access to more efficient, high quality, affordable, and safe health care.

Proposed Solutions:
To reduce the provision of low-value health care, the Working Group can offer a number of recommendations that involve providers, insurers, the government and consumers.

- Providers must better utilize clinical decision support tools to incorporate evidence-based clinical guidelines into practice with the rapid growth of AI expanding the opportunity and the savings associated.

- Insurers should use financial incentives for both providers and consumers to ensure care is consistent with value-based and evidence-based guidelines.

- Government should broadly disseminate research findings about low-value care through public service announcements to inform the public about clinical value prior to seeking services while also designing public health insurance programs to reward high-value providers.

- Employers can utilize direct employer contracts with preferred providers and/or offer incentives for employees to seek care from high-value providers (reduced premiums and lower deductibles.)

- Consumers should be informed about the care they seek and ask questions of providers to determine if the care is appropriate and necessary.

Potential Savings: Between $13 million and $80 million annually, based on conservative estimates.

We appreciate your serious consideration of these recommendations. While not an exhaustive list, they are well-vetted ideas that other states have implemented to realize material savings, can be implemented rather quickly, and meaningfully address the health care affordability challenges confronting the residents, businesses and taxpayers of this Commonwealth.

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[34] Massachusetts Health Policy Commission. 2021 Cost Trends Report Chart pack. Sept. 2021. Available at: https://www.mass.gov/doc/2021-cost-trends-report-chartpack/download; Massachusetts Health Policy Commission. 2022 Cost Trends Report Chart pack. Sept. 2022. Available at: https://www.mass.gov/doc/2022-cost-trends-report-chartpack/download

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