American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

October 7, 2026

**To:** Commissioner Michael T. Caljouw, Massachusetts Department of Insurance

**From:** Ryan A. Stanton, MD, FACEP
President, American College of Emergency Physicians
**Subject:** Division of Insurance Listening Session on Out-of-Network Costs

Dear Commissioner Caljouw,

On behalf of the American College of Emergency Physicians, the leading organization representing emergency physicians, I am writing to express our concern with the Massachusetts Department of Insurance (MA DOI) plan to establish an out of network (OON) default formula and believe such action will have unintended consequences for emergency physicians and our patients.

Currently, 22 states have their own specified state laws that replace or govern payment disputes instead of the standard federal Independent Dispute Resolution (IDR) process under the No Surprises Act (NSA). Massachusetts falls near the bottom of the median IDR Emergency Service Qualified Payment Amount (QPA), and payment amounts relative to median in-network rates. While MA DOI believes cost savings can be achieved through changes to the formula that determines OON payment, OON disputes accounted for only $2 of the total increase in insurance premiums in the Commonwealth in 2025.

The outlier awards MA DOI is most concerned with are not hospital-based physicians. Emergency medicine awards are two times the QPA and have not risen in three years, which is well below the national average. Furthermore, MA ranks 39th in utilization of the IDR process, with only 900 IDR claims initiated in the second quarter of 2025.

Importantly, the QPA has matched what insurers pay in-network emergency physicians. Insurers have consistently offered at least 2 times of their own QPA in arbitration. Since arbitration pays out-of-network emergency groups a multiple of the in-network rate, ACEP believes the cost savings for MA DOI is in the process of disputing claims, and that realistic offers from both insurers and physicians decrease the need for arbitration.

ACEP is increasingly concerned that insurers are not engaging in the NSA's IDR process. Even when arbitrators decide in favor of emergency physicians, insurers have not been paid under statutory requirements. Nearly a third of all IDR awards have not been paid at all by insurers.

We respectfully ask that MA DOI consider the limited scope of the issue with the state IDR utilization issue being tied to a select group of several insurers and physician groups. ACEP is working with Congressional leaders to ensure that the transparency and enforcement issues with the NSA can be resolved.

If I can answer any questions, please contact Adam Krushinskie, Senior Director of State Government Relations at akrushinskie@acep.org.

Sincerely,



Ryan A. Stanton, MD, FACEP
President

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October 16, 2026

Michael Caljouw, Commissioner
Massachusetts Division of Insurance
One Federal Street, Suite 700
Boston, MA 02110-2012

RE: BCBSMA Comments Regarding Setting a Default Out-of-Network Rate

Dear Commissioner Caljouw,

Blue Cross Blue Shield of Massachusetts (BCBSMA) appreciates the opportunity to provide written comments to the Massachusetts Division of Insurance (DOI) as it considers design options for establishing a default out-of-network (OON) rate and accompanying consumer protections. We commend the Division for convening interested stakeholders through listening sessions to explore balanced, predictable pathways forward.

As a community-focused, not-for-profit health plan serving nearly three million members across the Commonwealth, BCBSMA strongly supports establishing a clear, standardized default OON rate applicable to both emergency and non-emergency services. A thoughtfully designed default rate mechanism—coupled with a clear prohibition on balance billing—is essential to protecting Massachusetts consumers from unexpected medical expenses while safeguarding network integrity and commercial market affordability.

A predictable default OON reimbursement rate is critical to maintaining a functioning healthcare marketplace. While the federal No Surprises Act (NSA) achieved an important milestone by shielding patients from surprise medical bills, capping cost-sharing at in-network levels, and removing patients from carrier-provider payment disputes, its reliance on an Independent Dispute Resolution (IDR) arbitration framework has introduced unintended market impacts:

1. **Arbitration Volume and Administrative Burden:** The federal IDR process has experienced high case volumes, exceeding expectations. The IDR process has led to substantial backlogs, administrative burden, and high operational overhead.

2. **Financial Consequence:** Prevailing IDR determinations have heavily favored provider-submitted amounts. In BCBSMA's experience, the decision has landed in favor of the provider in over 70% of the cases. For 2025 and the first half of 2026, BCBSMA has received adverse IDR determinations that have added over $6.5 M in costs. In addition to the costs for payers, the higher amounts awarded through the IDR process adversely impact member cost-sharing amounts.

3. **Impacts on Networking:** When an arbitration system repeatedly awards out-of-network payments higher than negotiated contracted rates, it disincentivizes providers from participating in commercial insurance networks, jeopardizing network adequacy and increasing premium costs for Massachusetts employers and families. This carries particular

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risk when considering limited or tiered network plans. Further, trends have shown that some recent acquisitions of practices by private equity firms have resulted in providers terminating their in-network status to leverage higher out-of-network reimbursement. This trend undermines health care affordability for members and accounts.

By enacting a defined, statutory or regulatory default rate the DOI can promote cost containment consistent with the Commonwealth's goals.

BCBSMA recommends that the DOI establish a standard default out-of-network reimbursement rate set at **135% of Medicare allowable charges**. For clinical services or billing codes where Medicare has not established a set rate, the Division should establish a default rate tied to a **carrier-specific median in-network rate**.

Using Medicare's public, transparent, and non-proprietary payment schedules and relative value units (RVUs) simplifies administration and eliminates data integrity disputes. By incorporating the state's two existing geographic payment localities (Locality 01: Greater Boston and Locality 02: Rest of Massachusetts), a Medicare-indexed formula naturally adjusts for regional cost differences without requiring the DOI to design separate calculations.

Additionally, indexing to a fixed percentage of Medicare removes the need to calculate annual inflation factors. The rate updates in tandem with Medicare prices and annual RVU revaluations. Ultimately, this approach is familiar, as the Massachusetts health care community is already experienced in administering payments tied to a percentage of Medicare from to the COVID-19 emergency orders.

In instances where a service lacks an active Medicare reimbursement rate, the default should default to each carrier's own median in-network rate. This secondary benchmark should be *payer-specific* rather than aggregated across all commercial health plans. Payer-specific calculations consider distinct provider contracting structures, prevent disruption to high-performing network arrangements, and ensure that cost-containment and affordability initiatives pioneered by specific plans are not undercut by higher-cost market competitors.

To ensure that the default reimbursement rate achieves its core objective of patient protection, it should be paired with stringent safeguards:

1. **Comprehensive Prohibition on Balance Billing:** Providers receiving the DOI default OON rate should be prohibited from billing patients for any residual charges exceeding the applicable cost-sharing.

2. **In-Network Cost-Sharing:** For all services subject to the default OON rate, member cost-sharing (copayments, coinsurance, and deductibles) should be calculated based on the in-network benefit level, ensuring patients are not penalized financially for out-of-network scenarios beyond their control*.

3. *** Notice-and-Consent Exception:** Consistent with federal consumer protection principles; balance billing exceptions should be narrow and strictly limited to elective, non-emergency procedures. This exception should require:

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a. **Timely Advance Notice:** Provided well in advance of the scheduled service date to allow genuine consideration.

b. **Actionable Alternatives:** A verifiable, accessible option to receive the service from an available in-network provider.

c. **Language and Formatting Accessibility:** Comprehensive disclosure documents presented in plain language, and in the patient's primary language.

Establishing a clear default OON rate at 135% of Medicare—supplemented by a carrier-specific median in-network benchmark and a comprehensive balance billing ban—offers Massachusetts a balanced, predictable, and sustainable solution for determining a default rate. This framework protects patients from financial harm and supports long-term healthcare affordability across the Commonwealth.

BCBSMA appreciates the Division's leadership on this issue and remains available to provide additional insights to support the Division's approach.

Sincerely,

Sarah A. Stanton
Sarah A. Stanton (Oct 16, 2026 14:59:11 EDT)

Sarah Stanton
Vice President
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October 8, 2026

VIA ELECTRONIC SUBMISSION

Massachusetts Division of Insurance
Attn: Cara Libman, Senior Regulatory Advisor to the Commissioner
One Federal Street, Suite 700
Boston, MA 02110

**RE: Listening Session on Out-of-Network Costs Testimony**

Dear Attorney Libman:

On behalf of Global Medical Response, Inc. (GMR), we respectfully submit these comments regarding out-of-network ground ambulance services and the potential establishment of a default out-of-network payment rate by the Division of Insurance.

GMR is the nation's largest provider of EMS and out-of-hospital care, serving urban and rural communities across the United States. GMR has approximately 34,000 employees, operates more than 7,200 ground vehicles and 500 air medical aircraft, and supports approximately 5.5 million patient encounters annually across 50 states. Among the communities we serve in the Commonwealth, we are proud to provide 911 service to the Cities of Springfield and Greenfield.

GMR supports protecting Massachusetts patients from unexpected costs associated with emergency ambulance services. However, establishing a single, government-determined default payment rate for EMS would be problematic. Ground ambulance services are fundamentally different from other healthcare services, and a one-size-fits-all rate would not adequately account for the costs, obligations, and operational realities of maintaining a reliable 24/7 emergency response system. GMR has supported legislative efforts in Massachusetts, including S.799 and H.1261, to protect patients from surprise bills related to emergency ambulance services while establishing a sustainable reimbursement framework.

When a patient calls 911, an ambulance provider cannot determine the patient's insurance status before responding, choose patients based on their coverage, negotiate payment at the time of service, or decline a response because reimbursement may ultimately be out-of-network. The appropriate provider is generally determined by the patient's location, medical needs, and the availability of the nearest appropriate EMS resource. Unlike elective healthcare services, patients have no meaningful opportunity to compare ambulance providers, negotiate prices, or select an in-network provider during an emergency.

These circumstances should be central to any consideration of out-of-network EMS reimbursement.

**A default rate established by the Division could fail to reflect the actual cost of providing emergency ambulance services.** EMS providers must maintain personnel, ambulances, medical equipment, communications infrastructure, facilities, training, and operational readiness 24 hours a day, seven days a week—regardless of the insurance status of the next patient requiring assistance. Those costs vary based on geography, labor, call volume, response requirements, equipment, and other operating conditions. A single rate cannot reasonably capture these differences.

There is also a risk that an administratively established rate would become a de facto benchmark or ceiling for reimbursement, regardless of whether it reflects the actual cost of maintaining EMS readiness. Existing commercial rates should not automatically be viewed as evidence of the appropriate or sustainable value of emergency ambulance services. Providers may accept negotiated rates because they offer predictability, even when those rates do not fully cover the cost of providing emergency services. Likewise, Medicare reimbursement is an important reference point but should not automatically be assumed to represent the cost of providing EMS in Massachusetts.

At the same time, patients should not bear the burden of disputes between insurers and EMS providers. GMR supports a framework that protects patients from unexpected and burdensome out-of-network costs. However, patient protections should not simply shift those costs to EMS providers that are required to respond regardless of a patient's insurance status.

This is particularly important as EMS providers face ongoing challenges related to workforce recruitment and retention, rising operating costs, vehicle and equipment needs, and maintaining adequate emergency coverage. Inadequate or unpredictable reimbursement can ultimately affect staffing, investment, and the ability to maintain reliable emergency response throughout the Commonwealth.

For these reasons, GMR respectfully encourages the Division **not to establish a one-size-fits-all default out-of-network payment rate for ground ambulance services.** Instead, Massachusetts should pursue a reimbursement framework that protects patients while recognizing the unique costs and obligations of EMS and providing reasonable, predictable, and sustainable reimbursement for medically necessary emergency services.

Federal surprise-billing protections generally do not extend to ground ambulance transportation, giving the Commonwealth an important opportunity to address this gap. That policy should protect patients without inadvertently undermining the EMS infrastructure on which Massachusetts communities depend.

GMR appreciates the opportunity to provide this perspective and looks forward to working with the Division and other stakeholders on an approach that protects Massachusetts patients while preserving a financially sustainable and reliable EMS system.

Thank you for your consideration.

Sincerely,

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October 8, 2026
Honorable Michael T. Caljouw
Commissioner, Massachusetts Division of Insurance
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**Re: Out-Of-Network Default Rate**

Dear Commissioner Caljouw,

On behalf of Health Care For All, we appreciate the opportunity to provide comments in support of establishing an out-of-network (OON) default rate that can lower health care costs for consumers and increase access to in-network care.

Surprise billing and high OON rates are one facit of a broader health care affordability crisis we are facing in Massachusetts (MA). They are also a function of the market power that enables certain provider groups or health systems to leverage the threat of high out-of-network rates to command higher in-network prices. These cost increases stem from multiple factors, but two significant and connected contributors are the rise in hospital outpatient spending and the variation in prices associated with this spending. Hospital outpatient spending represents the second highest category of health care growth in the state, and there is enormous variation in prices that can be two and a half times higher at the most expensive system than the least expensive one.[1] [2]

At Health Care For All, we operate a HelpLine that takes over 20,000 calls a year in five languages and we partner with community-based organizations in eastern Massachusetts that are helping hundreds of clients a year with medical debt. Through these channels we hear about the difficulties that growing premiums and out-of-pocket costs are placing on families and the ways that OON care can cause financial harm to consumers.

Increasing costs are becoming more and more unaffordable for consumers and causing them to avoid care altogether. Merged market premiums had a double digit increase this year, on top of significant increases last year and CHIA measured health care cost growth at 5.7% which

[1] MA Health Policy Commission 2024 Annual Health Care Cost Trends Report and Policy Recommendations. October 2024 https://masshpc.gov/sites/default/files/2024_Cost_Trends_Report.pdf
[2] MA Health Policy Commission 2024 Annual Health Care Cost Trends Report and Policy Recommendations Chartpack. October 2024. https://masshpc.gov/sites/default/files/2024%20CTR%20Chartpack.pdf

exceeded the benchmark for the 4th year in a row, and once again grew faster than wages, requiring consumers to pay more with less. Consumers are also facing years of growing out-of-pocket costs most clearly displayed in the increase in enrollment in high-deductible health plans.

In 2025, over 1 in 8 MA residents have family medical debt and 90% incurred it while they and their families were fully insured. While the causes of medical debt are multifaceted, OON care is a significant contributor, exposing patients to balance billing and higher cost sharing, leaving them with unaffordable and unexpected out-of-pocket costs. Ground ambulances are one illustration of this. The No Surprises Act (NSA) protects against surprise billing in emergencies but excludes ground ambulances. In a 2023 report from the Attorney General's Office, they report that 67% of ambulance rides in MA are OON and recent GBH reporting tied ambulance-related medical debt in MA to balance billing.[3] [4] However, ambulances are not the only service that is frequently OON and leading to medical debt.

Surprise billing represents one significant, but narrow cost challenge that consumers face, but the market power that drives the issue has much broader effects on in-network costs. Therefore, Health Care For All encourages the Division to interpret the Governor's directive broadly and consider ways to establish default out-of-network rates to make progress toward the urgent goal of health care cost containment. We believe this can be done in a way that not only reduces overall costs but increases access to in-network care for consumers which is a similarly important goal.

*Metric & Index Selection*

Health Care For All believes the best approach for the default out-of-network rate is to tie it to Medicare rates to encourage administrative simplicity, while selecting the percentage of Medicare rates based on extensive research and modeling regarding median in-network rates. The goal should be to ensure that the default OON rate puts downward, rather than upward pressure on in-network rates while enabling broader network participation.

Fully loaded Medicare rates consider a variety of factors which would help the Division minimize the need for future adjustments to the rate and that already adjust for geographic wage differences based on metropolitan statistical areas removing the need to adjust based on geographical differences. Medicare rates also adjust for inflation and market basket updates eliminating the need to reset the rate in the future and preventing market based median rates from

[3] The Office of Attorney General Andrea Joy Campbell, Examination of Health Care Cost Trends. 2023. https://www.mass.gov/doc/examination-of-health-care-cost-trends-report-2023/download

[4] GBH. Need an ambulance in Massachusetts? It could leave you thousands in debt. November 24, 2025. https://www.wgbh.org/news/health/2025-11-24/need-an-ambulance-in-massachusetts-it-could-leave-you-thousands-in-debt

inappropriately pulling rates upward. Finally, Medicare rates adjust for case mix ensuring providers are treated fairly.

This approach has been used in other state efforts regarding OON default rates and reference prices including California and Oregon.[5] [6] While Medicare rates exist for most services, a separate anchor would be needed to set an OON default rate for pediatric services. There are several alternative options for establishing OON default rates for pediatric services including, for example, tying them to a percentage of Medicaid rates or median in-network rates.

*Scope*

We believes that all OON medical services should be subject to default out of network rates. Including unplanned care, such as emergency and urgent care, as well as pre-scheduled non-emergency care. Similarly to the scope of California's law, we also recommend that the default rate should also apply to all care delivered by an OON provider at an in-network facility. While we believe a broad scope is the best option for protecting consumers and lowering health care costs, we also understand the concerns for small, rural providers and providers of historically under reimbursed services such as behavioral health and primary care. Therefore, we suggest that the Division consider exemptions for small provider entities with limited market power and that either narrow exemptions or higher, adjusted rates be used for historically under-reimbursed specialties such as primary care and certain behavioral health services.

*Network Impacts*

Health Care for All believes that setting an out-of-network rate can protect consumers, rein in costs, and encourage, rather than discourage, in-network participation. About 3 years after passage of their default rate, California reported broader networks, with 80% of their hospitals reporting no OON billing.[7] However, proper data collection and reporting is critical to this goal. On top of regular tracking of premiums and cost-sharing, we believe the Division should collect information on the default rate's impact on average in-network rates, provider participation, and network status. There may need to be a process laid out for evaluating and responding to any concerning shifts in networks. Lastly, MA general law protects residents with limited network HMO and PPO plans, allowing them to receive OON care at in-network cost sharing in instances

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[5] California Law AB72. 2016. https://legiscan.com/CA/text/AB72/id/1424636

[6] Oregon Law SB1067. 2017. https://olis.oregonlegislature.gov/liz/2017R1/Downloads/MeasureDocument/SB1067/A-Engrossed#:~:text=Modifies%20state%20government%20employment%20cap,administrative%20costs%20and%20transfer%20rates.

[7] Patients Protected, Providers Paid: Data From Three Years of California's Compromise to Stop Surprise Medical Bills, Health Access California (September 2019): https://health-access.org/wp-content/uploads/2019/09/hafactsheet-AB72report-final.pdf

of network inadequacy.[8] We recommend that this right be preserved to appropriately protect residents.

*Consumer Protections*

We believe that strong consumer protections and notice and consent requirements are essential to establishing a default rate. It is important that cost savings associated with a default rate are translated to reduced premium and out-of-pocket costs for consumers and that consumers understand their protections and obligations to help avoid medical bills they cannot afford and to help them seek in-network care when possible.

We believe that there should continue to be a ban on balance billing that holds consumers fully harmless and prevents medical debt. We also believe that there should be a cap on cost sharing for OON services because it is a leading driver of medical debt. Over 70% of residents with medical debt reported that it was due to their plan deductible payments, and about half reported that it was due to copayments or coinsurance.[9] Nevertheless, we understand that cost-sharing is an important tool to help preserve network distinction and encourage consumers to utilize in-network providers when available. Therefore, we recommend that cost sharing for unplanned OON services and in cases of network inadequacy be capped at in-network cost sharing rates and that the Division also establish a cap on cost sharing for planned OON services, though at a higher-rate than in network services based on appropriate market research.

Health Care For All recommends utilizing the federal NSA notice and consent requirements[10] [11] as a framework for notice and consent related to a state OON default rate. From a consumer perspective, the federal NSA was successful and Health Care For All is not aware of any large-scale problems with its notification or consent tactics. However, we have a couple of suggestions that we believe could improve upon the NSA requirements and ensure consumer understanding.

First, the NSA requires notice and consent documents be provided in the 15 most common languages in the State in which facility is located and that if the individual does not speak one of those 15 languages, that the facility obtain a qualified interpreter to assist the individual with understanding the information. In order to avoid instances in which a person does not understand the documents, we urge the Division to require written notice and consent be provided in the

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[8] Massachusetts General Law chapter 1760 section 6(a)(4). https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXXII/Chapter176O/Section6

[9] CHIA. Massachusetts Health Insurance Survey. 2025. https://www.chiamass.gov/insights-analysis/access/massachusetts-health-insurance-survey/

[10] 45 CFR 149.420. https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-149/subpart-E/section-149.420

[11] No Surprises Act Toolkit for Consumer Advocates. Updated June, 2026. https://www.cms.gov/files/document/nsa-toolkit-combined.pdf

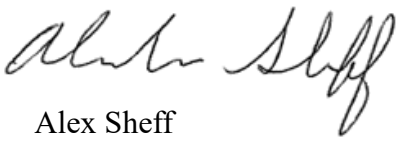
patient's primary language and that the signed consent document be void in instances where the patient signs but does not understand the language.

Second, we believe that consumers should have adequate time to review notices about an OON provider, digest any good faith cost estimates, conduct research about available in-network providers, and ask questions to their insurer. The NSA requires that notice and consent documents be provided at least 72 hours before the service is furnished or at the time of scheduling when the appointment is scheduled less than 72 hours before services are to be furnished. Many planned services are scheduled well in advance, often times they are scheduled weeks to months in advance. We suggest that all notice and consent documents be provided shortly after scheduling and then again 72 hours before the service to provide enough time for patients, though we are open to alternative noticing timelines.

Finally, we recommend that the Division require that notice and consent documents include all of the relevant information needed for the consumer to make an informed decision. Similarly to the NSA requirements, this should include information about the OON providers that are relevant to the specific service and the costs to the consumer should they agree to receive care from an OON provider. In addition to this, we recommend that the Division ensure consumers have access to fully accurate and up-to date provider directories at the point of notice so they can utilize directories to find available in-network providers in the area.

Overall, Health Care For All supports the creation of an OON default rates that adhere to the following parameters: 1) they should apply to the broadest possible set of services and be tied to rates that meaningfully reduce overall cost, 2) they should ensure that in-network participation is improved upon, and 3) they should be inclusive of strong consumer protections to prevent costs from being shifted to patients. Thank you for the opportunity to provide feedback and please feel free to reach out with any questions.

Thank you,



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health law advocates
Lawyers Fighting for Health Care Justice | HLA

MAMH
Massachusetts Association for Mental Health

October 14, 2026

Mr. Michael T. Caljouw, Commissioner
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Kevin Beagan, Deputy Commissioner
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Cara Libman, Senior Regulatory Policy Advisor to the Commissioner
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**Re: Behavioral Health Consumer Protections and Network Impacts of an Out-of-Network Default Rate**

Dear Commissioner Caljouw, Deputy Commissioner Beagan, and Attorney Libman:

On behalf of Health Law Advocates (HLA) and the Massachusetts Association for Mental Health (MAMH), thank you for prioritizing consumer protections and adequate provider networks as the Division of Insurance (DOI) explores a potential out-of-network default rate for the Commonwealth. We urge the Division to please consider the following points from the behavioral health perspective as it engages in this important work:

***Default out-of-network rates for outpatient behavioral health office visits would add little in the way of consumer protections for health plan members. What would really make a difference for individuals and families would be for the DOI to enforce state and federal mental health parity laws and ensure there are adequate outpatient behavioral health provider networks and parity in reimbursement rates.***

Compared to other states, commercial health plan members in Massachusetts are much more likely to go out-of-network for behavioral health treatment than for medical/surgical treatment. Alarmingly, our Commonwealth ranks the worst across all 50 states for individuals going out-of-network for behavioral health office visits (commercial plan members in Massachusetts went out-of-network 14.1 times more often for behavioral health office visits than for medical/surgical office visits). These disparities in out-of-network utilization are greater by clinician type:

- Commercial plan members in Massachusetts went out-of-network 42.1 times more often for psychiatrist office visits than for medical/surgical specialist physician office visits; commercial plan members across all states were 8.9 times more likely to do this.
- Commercial plan members in Massachusetts went out-of-network 39.0 times more often for psychologist office visits than for medical/surgical specialist physician office visits; commercial plan

members across all states were 10.6 more likely to do this.
- Commercial plan members in Massachusetts went out-of-network 24.7 times more often for therapist office visits than for physician assistant office visits; commercial plan members across all states were 4.1 times more likely to do this.[1]

These stark contrasts are not the product of Massachusetts residents' proclivity for pursuing preferences in provider selection. The reason why so many individuals and families are going out-of-network is because their health plan behavioral health provider networks are inadequate. People cannot find timely access to appropriate care, that is, by geography, age of patients served (e.g., children, adolescents, adults, and/or older adults), specialty (e.g., eating disorders, obsessive compulsive disorder, post traumatic stress disorder, etc.), and cultural competency (e.g., race, ethnicity, language, gender, sexuality, etc.).

Health plan members that seek out-of-network outpatient behavioral health treatment face exorbitant cost sharing. Below is an excerpt from an actual Explanation of Benefits (EOB) for the child of a staff member at MAMH. For five office visits with an out-of-network licensed social worker, the family paid $891.85. This is after the out-of-network deductible was met ($1,000/member), which is double the plan's in-network deductible ($500/member). The out-of-pocket maximums are also higher for out-of-network care than in-network care, exposing the family to additional financial vulnerability. Please see the table below:

**Actual Case Example - Except from Explanation of Benefits (EOB):**
**Out-of-Network 45-minute office visits with a licensed social worker (child)**

| Massachusetts Clinical Social Worker, Patient Name: (Child), Claim #: Out-of-Network | | | | | |
|---|---|---|---|---|---|
| **Date** | **Amount Your Health Care Provider Charged** | **Health Plan Discount** | **Allowed Amount** | **Amount Covered** | **What You Owe (30% Co-Insurance + Not Covered*)** |
| 05/08/26 | $275.00 | $0.00 | $138.05 | $96.63 | $178.37** |
| 06/05/26 | $275.00 | $0.00 | $138.05 | $96.63 | $178.37 |
| 06/12/26 | $275.00 | $0.00 | $138.05 | $96.63 | $178.37 |
| 06/19/26 | $275.00 | $0.00 | $138.05 | $96.63 | $178.37 |
| 06/25/26 | $275.00 | $0.00 | $138.05 | $96.63 | $178.37 |
| **TOTAL** | **$1375.00** | **$0.00** | **$690.25** | **$483.15** | **$891.85** |
| * SERVICES MAY BE PAID AT A LOWER RATE IF YOUR PROVIDER WAS NOT PART OF THE PPO NETWORK | | | | | |

** $178.37 = $41.42 co-insurance + $136.95 balance billing

In the same family, one of the parents also receives outpatient behavioral health therapy with a licensed social worker. The difference is that this clinician is in the health plan's network. After the in-network deductible was reached for the parent, the cost to the family per visit is only the $35.00 co-pay. So, the cost to the family for the parent's in-network behavioral health treatment for five visits was **$175.00** ($35.00 * 5 visits) compared to $891.85 for the child's out-of-network behavioral health treatment. The actual course of therapy was much longer for both the child and parent; five visits were chosen to illustrate the much higher costs for families and individuals when they are forced to go out-of-network to access the behavioral health services they need.

In the interest of exploring out-of-network rates, let's consider a scenario where DOI sets a methodology for

[1] Mark, T. L., & Parish, W. J. (2024). Behavioral health parity – Pervasive disparities in access to in-network care continue. RTI International. Retrieved 2 October 2026 at: https://www.rti.org/publication/behavioral-health-parity-pervasive-disparities-access-network-care-continue/fulltext.pdf

determining out-of-network default rates. The current Amount Allowed for the child above is $138.05 per 45-minute visit with the out-of-network social worker. Let's assume that under a new DOI methodology for determining out-of-network default rates, the new Amount Allowed is $150.00 per visit:

**Fictional Case Example – Assuming New OON Allowed Amount is $150.00 Per Visit**
**Out-of-Network 45-minute office visits with a licensed social worker (child)**

| Massachusetts Clinical Social Worker, Patient Name: (Child), Claim #: Out-of-Network | | | | | |
|---|---|---|---|---|---|
| **Date** | **Amount Your Health Care Provider Charged** | **Health Plan Discount** | **Allowed Amount** | **Amount Covered** | **What You Owe (30% Co-Insurance + Not Covered*)** |
| 05/08/26 | $275.00 | $0.00 | $150.00 | $105.00 | $170.00** |
| 06/05/26 | $275.00 | $0.00 | $150.00 | $105.00 | $170.00 |
| 06/12/26 | $275.00 | $0.00 | $150.00 | $105.00 | $170.00 |
| 06/19/26 | $275.00 | $0.00 | $150.00 | $105.00 | $170.00 |
| 06/25/26 | $275.00 | $0.00 | $150.00 | $105.00 | $170.00 |
| **TOTAL** | **$1375.00** | **$0.00** | **$750.00** | **$525.00** | **$850.00** |
| * SERVICES MAY BE PAID AT A LOWER RATE IF YOUR PROVIDER WAS NOT PART OF THE PPO NETWORK | | | | | |

** $170.00 = $45.00 co-insurance + $125.00 balance billing

In this fictional scenario with a default out-of-network rate that results in a higher Allowed Amount, the family would save a little bit of money ($891.85 - $850.00 = $41.85). Interestingly, when the Allowed Amount is increased, the balance billing decreases for the health plan member (difference between Health Care Provider Charge and Allowed Amount), but the co-insurance increases (because it is applied to a higher Allowed Amount). Of course, the exact numbers would vary depending on how the default out-of-network rate is set. For this fictional scenario, an Allowed Amount of $150.00 was chosen because it is higher than the current, actual Allowed Amount, yet still quite a bit lower than the Amount Charged by the Provider.

Additional cost-sharing for using out of network care is designed to incentivize members to use in-network providers and dissuade plan members from using out-of-network care. Because networks for behavioral health outpatient care are not adequate in many cases, the burden of the additional cost-sharing falls unfairly to plan members who have no choice when they need treatment but to seek care outside their inadequate provider network.

With respect to consumer protections needed when accessing out-of-network care, the scenarios above show that paying co-pays for in-network behavioral health visits is far more affordable for health plan members than the high costs for balanced billing for out-of-network behavioral health visits, with or without a default out-of-network rate. It's also critical to note that many families simply cannot afford to pay these kinds of out-of-pocket costs to access out-of-network behavioral health treatment. In these instances, people are unable to get the care they need due to inadequate health plan behavioral health provider networks, further exacerbating health disparities. The people of the Commonwealth have the right to access behavioral health networks that are adequate. And they have the right under state and federal mental health parity laws to have access to behavioral health provider networks that are equivalent in adequacy to medical/surgical provider networks. The most important strategy at this point for building such adequate behavioral health provider networks is facilitating reimbursement rate parity for behavioral health providers compared to medical/surgical providers.

In sum, increasing default out-of-network rates for behavioral health outpatient visits will provide a very small

benefit to individuals and families. *What would really make a difference for health plan members is to enforce state and federal mental health parity laws and address the problem of inadequate behavioral health provider networks in Massachusetts***.** Again, Massachusetts ranks worse than every other state for the percent of individuals and families going out-of-network for behavioral health office visits compared to medical/surgical office visits.

**Before exploring the possibility of a default out-of-network rate for outpatient behavioral health visits, we urge DOI to first investigate the alarming findings raised by the MA Health Policy Commission regarding the lack of parity in reimbursement rates to behavioral health providers.**

We strongly oppose the establishment of default rates to reimburse behavioral health providers that are based upon any formula that relies upon current in-network reimbursement rates (such as the median in-network rate) unless and until the Commonwealth of Massachusetts ensures that the current reimbursement rates used by commercial carriers for behavioral health services are not illegal violations of federal and state parity laws.

As recently as May 2026, the Massachusetts Health Policy Commission (HPC) issued an alarming report documenting the gross disparities between how much behavioral health providers are paid, as compared to medical providers, when they are billing for the same billing codes and comparable services. This HPC study found that "For the same work time (30 minutes), the average commercial payment to physicians in office-based settings for a composite of specialty services was 6 times higher than the average payment [to physicians for] psychotherapy. The average commercial payment to a physician for an evaluation and management visit was 2.6 times as high as the average payment [to physicians for] psychotherapy."[2]

This HPC study follows upon two earlier studies by leading experts in parity enforcement noting these disparities. An RTI International study documented that in 2021, the average commercial reimbursement for all medical/surgical clinician office visits in Massachusetts was 44.8% higher than for all behavioral health clinicians (170.5% of Medicare as compared to 117.8% of Medicare, respectively). This compares to a 21.7% higher rate for medical/surgical office visits across all 50 states (124.8% of Medicare as compared to 102.5% of Medicare, respectively).[3]

The RTI study built upon an earlier landmark study by Milliman, which documented that average in-network reimbursement rates for behavioral health office visits were lower than for primary care office visits in Massachusetts. Accordining to the Milliman study, primary care reimbursements were 59.6% higher than behavioral health reimbursements in Massachusetts in 2017 (157.0% of Medicare as compared to 98.4% of Medicare, respectively). Massachusetts was one of the poorest performing states; across all 50 states, primary care reimbursements were 23.8% higher than behavioral health reimbursements.[4]

The DOI has been asked to look at this issue during numerous listening sessions with providers, and in meetings with, and comments submitted by, our organizations as well. Since both the enactment of state and federal parity laws, and the comprehensive studies by the HPC, RTI, and Milliman researchers, no examination

[2] MA Health Policy Commission. Examination of Payments for Behavioral Health Care Services. May 2026. Retrieved 4 October 2026 at: https://masshpc.gov/sites/default/files/BHWC-Rates-Analysis_Chartpack_Final.pdf

[3] Mark, T. L., & Parish, W. J. (2024). Behavioral health parity – Pervasive disparities in access to in-network care continue. RTI International. Retrieved 2 October 2026 at: https://www.rti.org/publication/behavioral-health-parity-pervasive-disparities-access-network-care-continue/fulltext.pdf

[4] Davenport, Gray, & Melek. (2019). Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement. Milliman. Retrieved 4 October 2026 at: https://www.milliman.com/en/insight/addiction-and-mental-health-vs-physical-health-widening-disparities-in-network-use-and-p

of this increasingly well documented disparity in reimbursement rates has been conducted by DOI, despite the fact that it is almost certain to be a violation of state and federal parity laws.

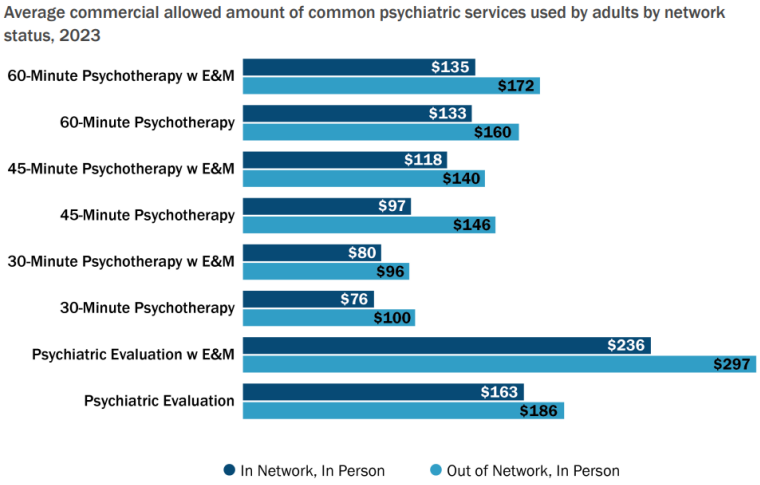
In addition, HLA has recently worked with a behavioral health provider in Massachusetts to file a parity complaint with the DOI regarding the fact that the reimbursement rates by one large commercial plan for a set of commonly needed evaluation and management services had remained stagnant for the four-year period from September 2022 to August 2026. This was true despite a 2022 state parity law that requires Massachusetts carriers and the DOI to ensure that behavioral health providers are paid no less than medical providers for that same set of evaluation and management services that are critical for routine care.

Without first investigating the alarming findings raised by the May HPC study regarding the lack of parity in reimbursement to behavioral health providers, and the concerns in this complaint, we feel it would be grossly irresponsible for the state to adopt a default rate for out-of-network payments for behavioral health services that is based in any manner upon the current rates for in-network *behavioral health* providers. Current reimbursement rates for behavioral health providers in Massachusetts have been thoroughly and consistently documented by the HPC and numerous prior independent research studies to be out of compliance with parity law. Adopting current in-network rates as a benchmark would risk extending these alarming inequities and likely parity violations to an even broader range of behavioral health providers, especially at a time when Massachusetts consumers still routinely struggle to find and access the behavioral health care that they need.

**Before exploring the possibility of a default out-of-network rate for outpatient behavioral health visits, DOI must also consider that commercials insurers in Massachusetts are already paying higher Allowed Amounts for out-of-network outpatient behavioral health treatment than in-network behavioral health treatment.**

As noted above, the RTI study shows that currently Massachusetts residents are going out-of-network for behavioral health services more often than they do for medical care, a pattern that is widely recognized to indicate that behavioral health provider networks are inadequate. In addition, the May 2026 HPC report also showed that commercial insurers in Massachusetts are applying Allowed Amounts for out-of-network behavioral health providers that are 114%-150% more than the Allowed Amounts they are applying for in-network behavioral health providers. (See Figure below).

**Allowed Amounts for Common Psychiatric Services for Adults were Higher for Out-of-Network than In-Network Commercial Health Plan Allowed Amounts in Massachusetts, 2023**[5]




[5] MA Health Policy Commission. Examination of Payments for Behavioral Health Care Services. May 2026. Retrieved 4 October 2026 at: https://masshpc.gov/sites/default/files/BHWC-Rates-Analysis_Chartpack_Final.pdf

What's worrisome here is that if DOI sets an out-of-network default rate for outpatient behavioral health services based on a median in-network rate, as discussed as a possibility during the October 1 DOI Listening Session, this would significantly reduce the Allowed Amounts that plans currently pay for out-of-network care. Reducing reimbursement in this manner would expose health plan members that must seek care outside of provider networks – for lack of access to timely and appropriate in-network care – to higher balance billing, increasing the financial burden on consumers, which could in some cases force them to make the choice of foregoing needed care altogether, or to try to enroll in MassHealth CommonHealth for supplemental coverage, which would increase health care spending under the State budget.

Furthermore, reducing out-of-network default rates for out-of-network behavioral health services to current, median in-network rates is unlikely to incentivize providers to join health plan networks. As discussed above, the in-network rates for behavioral health services are so low that Massachusetts lags considerably behind other states in providing comparable reimbursement for behavioral and medical/surgical services. Again, the fundamental problem is failure to comply with state and federal mental health parity laws. Addressing low reimbursement rates is foundational to strengthening health plan behavioral health provider networks. Likewise, more robust provider networks are essential for plan members to access more timely care and to have the financial protections associated with receiving in-network versus out-of-network outpatient behavioral health care.

**Any default rate should be limited in scope to exclude out-of-network care driven by network inadequacies**

A default rate should not apply to an out-of-network provider who is seen in response to the inadequacy of a carrier's provider network -- i.e. when a plan member is in a limited network HMO or PPO plan, and they cannot find an in-network provider who is both qualified and available.

This important right to access out-of-network care when your network is inadequate is firmly enshrined in current Massachusetts law. Under current M.G.L. chapter 176O section 6(a)(4), "whenever a proposed admission, procedure or service that is a medically necessary covered benefit is not available to an insured within the carrier's network, the carrier ***shall cover the out-of-network admission, procedure or service*** and the insured will not be responsible to pay more than the amount which would be required for similar admissions, procedures or services offered within the carrier's network[.]" That is, a plan member is entitled to in-network level cost sharing in such instances, and their carrier must ensure that the provider is paid for the medically necessary, covered services that the carrier failed to make available through an in-network provider. Such network adequacy is so important that additional Section 7(a)(7) of Chapter 176O reiterates this point, stating that "the carrier, if necessary, shall obtain out-of-network services if they are unavailable within the network."

Conversely, allowing a default rate to apply to instances of network inadequacies would create a powerful incentive for plans to fail to build or maintain adequate networks of providers. It could also create a significant barrier to providers accepting patients for non-emergency care in such instances. Even under this law, getting access to out-of-network non-emergency care is an arduous process, forcing the consumer to contact numerous in-network providers, gather and document information on whether the provider is available to see them, convey this information to their health plan and ask the plan to help them find an available provider, and then wait for the plan's response. Even if they accomplish these steps, they must then find an out-of-network provider who is willing to see them, and if the consumer cannot afford to pay for their care up front, out of pocket, this provider must also be willing to enter into a single case agreement with the plan, including possibly committing themselves to the onerous processes of expedited credentialling, submitting claims, and dealing with possible reimbursement problems. The only incentive for the provider to do so is that they have leverage to ask to be paid an acceptable rate. Allowing carriers to try to apply a default out-of-network rate in this instance would remove all incentive for out-of-network providers to accept new patients in such instances,

likely leading to all the harms associated with unreasonable delays in accessing timely, medically necessary care.

Please let us know if we can answer any questions or provide additional information. Thank you very much for your consideration and your efforts to improve access to care for consumers and families.

Sincerely,

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Senior Supervising Attorney
Health Law Advocates (HLA)

Danna Mauch, PhD
President and CEO
Massachusetts Association for Mental Health (MAMH)

Monica Luke
Mental Health Advocate

Cc: Colby Dillon, First Deputy Commissioner, Division of Insurance

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Southcoast Behavioral Health

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Newton Wellesley Hospital
North Shore Medical Center
Pembroke Hospital
St. Anne's Hospital
St. Vincent Hospital
Sunrise Detox Centers
TaraVista Behavioral Health
Tufts Medical Center
U Mass Memorial Health Care
Valley Springs BH Hospital
Walden Behavioral Care
Westborough Behavioral Hospital

**Comments on Consumer Protections on Out of Network Rates**
**Division of Insurance**
**Submitted by David Matteodo, Executive Director**
**Massachusetts Association of Behavioral Health Systems**
**October 5, 2026**

Thank you for the opportunity to offer these comments and suggestions on the Out of Network Provider Rates that the Division of Insurance (DOI) is reviewing. I offer these comments on behalf of our statewide organization consisting of 53 Behavioral Health Inpatient Providers. We are hopeful that our recommendations are adopted by the DOI.

Our major concerns in the Out of Network Provider area revolve around Partial Hospital (PHP) and Intensive Outpatient Programs (IOP) services. In Massachusetts we have seen many new Out of Network PHP and IOP programs come into the state in recent years. The programs are able to charge exorbitant rates, which has led to a competitive imbalance with our MABHS longstanding PHPs and IOPs. Our PHP/IOPs are delivered within a DPH and Medicare licensed program or a DMH licensed hospital and these Out of Network Programs are largely outside of that purview.

The Out of Network providers have functioned under the radar screen of both DPH and DMH for several years. We have highlighted this issue to DPH and recently DPH is providing much more scrutiny in this area. However, the problem still exists, and the Out of Network providers are charging rates that can be three or four times higher than the usual contracted rates. Our programs are losing staff to these providers as a result of this competitive disadvantage.

Also, access is absolutely not an issue in this area. We have numerous high quality, in Network PHP/IOP providers in Massachusetts that are able to provide these services. Services are provided both remotely and in-person. These programs successfully allow consumers to remain in their own homes while getting regular treatment, as opposed to the Out of Network providers that require overnight stays in their Sober House collaboration.

DOI can help address this unfair situation in Partial Hospital and Intensive Outpatient Programs by setting the Out of Network rates at no more than the Average Contracted Rate for In-Network providers: this would be a critical step forward to address this unfair situation.

By establishing a fair and equitable Out of Network rate in for these services, we are confident that the proliferation of these Out of Network PHP/IOPs will rapidly diminish in Massachusetts. As such, it will help create a more level playing field with high-quality programs able to provide very needed Behavioral Health services.

Thank you and we are available to answer and questions DOI may have in this area.

MAHP
MASSACHUSETTS ASSOCIATION of HEALTH PLANS

October 9, 2026

Michael Caljouw, Commissioner
Massachusetts Division of Insurance
One Federal Street, Suite 700
Boston, MA 02110-2012

Re: Healey-Driscoll Health Care Affordability Workgroup Recommendations – Out of Network Reimbursement Listening Sessions

Dear Commissioner Caljouw:

On behalf of the Massachusetts Association of Health Plans (MAHP), representing 13 health plans and one behavioral health organization that together provide coverage to nearly 3 million Massachusetts residents, thank you for the opportunity to review and provide feedback on the Division of Insurance's approach to out-of-network (OON) reimbursement. We appreciate the Division's thoughtful consideration of these issues and your focus on policies that protect consumers while supporting affordable and sustainable health insurance markets.

Massachusetts has been examining the challenges associated with OON care for more than a decade, and that work provides an important foundation for the Division's current consideration. The Health Policy Commission (HPC) has documented both the consumer consequences of unexpected OON care and the significant variation that can result depending on the methodology used to determine reimbursement. In its analysis of commercial claims, the HPC found that 7.2 percent of emergency department visits resulted in at least one potential surprise claim and identified the potential for balance billing in more than 90 percent of surprise professional-service claims. The average potential balance bill was $167, with substantially greater exposure for some consumers.

The HPC's work also demonstrated the importance of the reimbursement methodology itself. For a high-severity emergency department visit, for example, the HPC found that a payment based on the 80th percentile of provider charges would have been $842, compared with a median allowed amount of $241 and $233 at 125 percent of Medicare. The significant difference among these amounts shows why the methodology used to set a default rate matters. Where that rate is set will affect not only what plans pay for OON care, but also overall health care spending and premiums, and the incentives for plans and providers to negotiate and maintain network contracts.

More recently, the Attorney General's examination of emergency ground ambulance services demonstrated how these dynamics can affect consumers in a market characterized by significant OON utilization. The AGO found that 67 percent of emergency ground ambulance transports for commercially insured members in 2022 were OON, and nearly 80 percent of municipal ambulance providers responding to its survey reported that they did not participate in any commercial health plan network. For members subject to a deductible, the average deductible when a plan allowed an OON ambulance provider's full charge was $971. The AGO also documented significant balance billing and collection activity, including

approximately 31,000 accounts totaling nearly $27.5 million sent to collections by four private ambulance providers in 2022.

These findings highlight an important distinction in considering the appropriate policy response. OON care is not, in itself, the problem. PPO products are intentionally designed to give members the flexibility to seek care from nonparticipating providers, with different cost-sharing and other benefit requirements reflecting that choice. The concern arises when a consumer has little or no meaningful ability to choose whether the care they receive is in network; for example, during an emergency, when an OON clinician provides services at an in-network facility, or when an ambulance provider is selected by circumstance rather than by the patient. In those situations, consumers should not bear the financial consequences of a network decision they did not make, and the reimbursement framework should not create incentives that make it more advantageous for providers to remain outside plan networks. At the same time, any state reimbursement standard should preserve the role of network contracting as a key tool for promoting access, affordability, quality, and coordinated care.

Massachusetts has previously considered how best to address that problem. In its 2021 report to the Legislature, EOHHS, in consultation with the HPC, CHIA and the Division, recommended establishing a default payment rate for unintentional OON emergency and non-emergency services. The report identified a median in-network rate calculated by the payer as a reasonable approach that balances payer and provider interests, is administratively feasible, and is generally consistent with the methodology underlying the federal qualifying payment amount. The report also recognized that using a health plan's median contracted rate can mitigate cost increases and promote payer-provider contracting, while emphasizing the importance of evaluating the impact of any policy on costs, quality, patient access, network breadth and federal arbitration activity.

MAHP believes that work provides a strong starting point for the Division's current discussion and offers the following comments in response to the issues raised during the listening sessions.

**Consumer Protections**

MAHP supports a clear prohibition on balance billing when a consumer does not meaningfully choose to receive OON care. A member receiving emergency services, unexpected OON services at an in-network facility, or other care for which there was no meaningful opportunity to select an in-network provider should be held harmless beyond the cost-sharing that would have applied had the service been furnished in network. The member's cost-sharing should count toward the applicable in-network deductible and out-of-pocket maximum, and the provider should accept the plan payment together with the member's applicable cost-sharing as payment in full.

This approach removes the consumer from a payment dispute between the provider and the health plan and builds on the consumer protections already established through the federal No Surprises Act. To the extent Massachusetts establishes additional notice and consent requirements, MAHP recommends aligning those requirements as closely as possible with the federal framework, including the circumstances in which a consumer may waive OON protections and the ancillary services for which federal law does not permit such a waiver. A separate Massachusetts process with different forms, definitions or timelines would add administrative complexity without necessarily providing additional protection to consumers.

The treatment of a consumer who knowingly and voluntarily selects an OON provider presents a different policy question. For PPO products, the ability to receive care from a nonparticipating provider is an intentional component of the benefit design, and the applicable OON deductible and coinsurance reflect that choice. MAHP believes that distinction should be preserved in any state framework.

**Scope of a Default OON Reimbursement Requirement**

MAHP has supported a targeted approach that applies the default payment framework to emergency and other unforeseen OON services, including unexpected OON clinicians at participating facilities, services where an in-network provider is unavailable, certain OON services resulting from an in-network referral, and ground ambulance. This approach focuses the protection on circumstances in which the member did not meaningfully choose to receive OON care, while preserving the existing rules that apply when a member knowingly chooses to use an OON provider. The Division's consideration of whether to apply a default more broadly to all covered OON services, including scheduled care where a member deliberately selects an OON provider, raises different questions. While a broader framework may provide greater consistency and predictability, it could also make the statutory default an alternative to network contracting rather than a mechanism for resolving claims when a negotiated rate does not exist.

That distinction matters because provider networks are an important part of how health plans manage both access and affordability, reflecting negotiated agreements not only on reimbursement, but also on quality, utilization management, value-based payment, data exchange and other expectations that support coordinated care. A default that is broadly available, particularly if it provides reimbursement comparable to or above what a provider could negotiate through a network contract, could reduce the incentive to participate in networks in the first place. If OON reimbursement becomes more attractive than negotiated in-network reimbursement, providers may have less incentive to contract, increasing leverage in negotiations and placing additional upward pressure on premiums. Any expansion beyond emergency and unforeseen OON care should therefore preserve a meaningful incentive for providers and plans to negotiate network agreements rather than rely on the statutory payment as an alternative to contracting.

Ground ambulance also warrants particular consideration within this discussion. Consumers generally have no meaningful ability to select the ambulance provider responding to an emergency, making strong balance-billing protections especially important. At the same time, the AGO's findings demonstrate that the Massachusetts ambulance market has a particularly high level of OON participation, especially among municipal providers. That market structure may make a payer-specific median contracted rate less representative for ambulance services than it is for physician or facility services. We recommend that ground ambulance be included within the Commonwealth's consumer protections but that the Division consider separately whether the general OON reimbursement methodology is appropriate for ambulance services. Any alternative methodology should provide predictable and reasonable reimbursement without allowing the provider's own charges to determine the amount a health plan is required to pay or creating a financial incentive to remain outside plan networks.

**Appropriate Metric for Establishing a Default OON Rate**

MAHP supports an OON default rate set at the carrier's median in-network contracted rate. We believe this is the fairest approach because it reflects reimbursement that plans and providers have actually negotiated and preserves the incentive to participate in contracted networks. It also recognizes that carriers build different networks and products to serve different populations, including negotiated rates that make more affordable coverage possible. This approach builds on the Commonwealth's 2021 EOHHS recommendation.

We oppose an all-payer median because it combines rates negotiated by different carriers for different networks and products into a common benchmark. For a carrier that has negotiated lower rates to offer affordable coverage, that benchmark could pay an OON provider more than its participating providers receive. That would weaken the value of network participation and could undermine the contracting arrangements that support affordable premiums. A carrier's success in negotiating affordable rates should not be overridden by other carriers' higher reimbursement.

We are open to considering a default set at a percentage of Medicare, but would need updated modeling to understand whether its affordability benefits justify the additional implementation complexity and administrative expense for carriers. That analysis should examine differences across services and products, address services without a readily applicable Medicare rate, and assess effects on in-network contracting and prices, not simply reprice existing OON claims. The Division's objective should be reasonable reimbursement that supports network participation and affordable premiums for employers and consumers, using a methodology carriers can administer consistently and update without unnecessary expense.

**Network Impact**

The effect of a default rate on provider networks should be a central consideration in determining both its scope and its level. A default that is sufficiently attractive relative to contracted reimbursement may reduce the incentive for providers to participate in networks, while an appropriately calibrated rate can preserve contracting incentives by requiring providers seeking different reimbursement or contractual terms to negotiate directly with health plans. This consideration is particularly important in Massachusetts, where network design is one of the tools available to health plans and purchasers seeking to manage health care costs. It is also relevant in the merged market and ConnectorCare, where the ability to offer affordable products depends in part on plans' ability to build and maintain cost-effective provider networks. The Commonwealth should be careful that a policy intended to address OON reimbursement does not inadvertently make it easier to rely on statutory reimbursement in place of meaningful network participation.

MAHP supports establishing a baseline before implementation and monitoring the impact of any new policy over time. That evaluation should include OON utilization and spending; changes in in-network and OON reimbursement; provider contracting and network participation; network adequacy; voluntary OON utilization in PPO products; member complaints and appeals; premiums and total medical expense; and impacts on merged-market and ConnectorCare products. The Commonwealth should also consider whether the effects differ materially by provider type, geography, carrier, network design or product.

**Implementation and Interaction with Federal Requirements**

Finally, the effectiveness of any Massachusetts framework will depend significantly on how it interacts with the federal No Surprises Act and how it is implemented operationally. MAHP supports aligning state requirements with federal requirements wherever possible, including notice and consent standards, and avoiding duplicative reporting or administrative processes. A Massachusetts framework should build on the federal protections already in place rather than create a separate set of requirements that increases administrative burden for plans, providers, and consumers.

The federal experience with independent dispute resolution is particularly relevant. Implementation of the No Surprises Act's IDR process has involved substantially greater dispute volume than federal agencies originally anticipated, along with significant administrative demands and delays in resolving disputes. The process also requires providers and plans to devote resources to fees, claims review and dispute resolution that do not directly contribute to patient care. Massachusetts should learn from that experience, and prioritize a clear, predictable default payment methodology that minimizes the need for dispute resolution rather than creating a parallel state process. A clear and predictable default payment methodology should resolve most OON claims without requiring another layer of arbitration. If the Commonwealth determines that some form of dispute resolution is necessary, it should be structured as a limited mechanism for circumstances in which the default methodology cannot reasonably resolve the claim rather than as a routine second step in determining OON reimbursement.

A Massachusetts framework must also provide sufficient information for plans to determine which rules apply to a claim. If the treatment of a claim depends on whether the member voluntarily selected an OON

provider or provided valid consent, for example, plans will need a reliable mechanism for receiving the documentation necessary to make that determination. Similarly, any new methodology should include a workable transition for existing contracts and claims systems and clearly address its relationship to federal payment and dispute-resolution requirements.

**Conclusion**

Massachusetts has already done significant work to understand the impact of unexpected OON care and the tradeoffs associated with different approaches to reimbursement. That work provides a strong foundation for a policy that protects consumers when they do not have a meaningful choice of provider, while preserving the role of contracted networks in supporting access and affordability. It also provides an opportunity to advance the Governor's broader goal of making coverage more affordable for individuals, families, employers, and small businesses.

MAHP supports clear protections from balance billing for emergency and unforeseen OON care, appropriate in-network cost-sharing for affected members, and a predictable default payment that is grounded in negotiated rates and does not create an incentive to remain outside plan networks. As the Division considers the scope and methodology of that framework, we encourage continued attention to its impact on network participation, health care spending, premiums and consumer access.

We appreciate the Division's thoughtful approach to these issues and the opportunity for plans and other stakeholders to inform its work. We look forward to continuing to work with the Division to develop a framework that provides meaningful protections for consumers while supporting a stable and affordable health care market.

Sincerely,



Liz Leahy, Esq.
Chief of Staff and Senior Vice President of Advocacy & Engagement
Massachusetts Association of Health Plans

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October 8, 2026

Commissioner Michael Caljouw
Division of Insurance
One Federal Street Suite 700
Boston, MA 02110

**Re: DOI Listening Sessions on Out-of-Network Costs**

Dear Commissioner Caljouw:

On behalf of the Massachusetts Health & Hospital Association (MHA) and our member hospitals and health systems, thank you for the opportunity to participate in this ongoing dialogue regarding out-of-network (OON) healthcare costs.

Massachusetts hospitals strongly support protecting patients from unexpected out-of-network costs and advancing healthcare affordability. We commend the Healey-Driscoll administration's and the Division of Insurance's (DOI's) commitment to these goals and share the urgency of addressing healthcare cost concerns. With those shared goals in mind, it is essential that any policy changes be carefully designed to benefit patients while avoiding unintended consequences that could further undermine care access, destabilize provider networks, or further weaken an already fragile healthcare delivery system.

**For these reasons, MHA respectfully requests that DOI first carefully defines the OON problem it is proposing to address prior to offering specific solutions.** This will ensure Massachusetts is positioned to proceed with a collaborative, data-driven approach to address the specific issues.

## MHA's Core Principles

MHA and our members believe any proposal involving out-of-network services should be evaluated against five core principles:

- First, any **policy changes must ensure that patients are meaningfully protected** from unexpected OON costs.
- Second, it is critical to **protect access and network adequacy**, particularly for specialty care, safety-net hospitals, trauma services, academic medical centers, community hospitals, and regional referral programs.
- Third, we must **preserve meaningful payer-provider negotiations** and the ability of contracts to reflect unique patient complexity, community needs, quality of care, and provider capabilities.
- Fourth, **the cumulative financial pressures facing hospital health systems must be recognized.** Historic federal policy changes, reductions in public financing, persistent inflation, and rapidly rising labor and supply costs are already placing essential services at risk. Hospitals and their affiliated providers cannot absorb significant, unnecessary reductions in commercial reimbursement on top of these pressures without harming patients and communities through

reduced access, diminished quality, or service cutbacks. Any policy proposal should be evaluated carefully to avoid these consequences.

- Finally, any major policy change (including consideration of a default payment benchmark) must require **comprehensive and transparent data to define the problem it is attempting to address**. We encourage the state to quantify current out-of-network spending and **assess whether the Federal No Surprises Act (NSA) protects consumers** who may face these unexpected costs. Following this evaluation, DOI should then seek further input and explain how any benchmark would be calculated and updated, identify the projected effect on premiums and provider revenues, and establish mechanisms to monitor access and unintended consequences.

Protecting patients and determining provider reimbursement are related but distinct policy questions. Massachusetts can strengthen patient protections without adopting a broad government-established payment methodology for OON services.

## 1. Define the Problem We Are Trying to Solve

Before pursuing specific legislative or regulatory changes, DOI should clearly identify the specific out-of-network issue(s) requiring intervention.

The federal NSA already provides substantial consumer protections for emergency services and for care delivered by out-of-network providers at in-network facilities. As a result, it is important to understand what remaining gap exists in Massachusetts, who is affected, and the magnitude of any remaining problem before developing a new policy framework.

A 2021 report issued by the Massachusetts Executive Office of Health and Human Services, in consultation with the Health Policy Commission, the Center for Health Information and Analysis, and the Division of Insurance, recommended a default OON rate. It is important to note that this report and its findings predate the implementation of the NSA, and therefore the conclusions and recommendations do not incorporate the federally required patient protections and OON payment processes that are now available in 2026.

To help define the problem, MHA encourages DOI to collect and publicly analyze data that addresses:

- Service categories that continue to be provided out-of-network at significant volume and are not otherwise covered by the federal NSA;
- Trends in utilization and spending associated with those services;
- Availability and adequacy of in-network alternatives;
- Geographic variation across the commonwealth;
- The extent to which insurance product design, including narrow or limited networks, contributes to out-of-network utilization; and
- The proportion of spending and covered lives that would be affected by state intervention, recognizing the limits of state authority over self-funded ERISA plans.

Any policy response should be tailored to a clearly documented problem and supported by objective evidence.

## 2. Preserve Provider-Plan Contracting Incentives

Massachusetts benefits when providers and health plans negotiate contracts that reflect local market conditions, patient needs, service complexity, quality expectations, and community resources. Strong incentives to maintain provider networks ultimately benefit patients, as consumers rely on robust networks and accurate provider directories when making coverage decisions and seeking care. Market-based negotiations also foster payment innovations focused on quality outcomes, population health, and value-based arrangements.

As described below, government-established default payment levels may unintentionally weaken incentives for providers and health plans to enter or maintain negotiated contracts, or pursue innovative payment arrangements focused on outcomes. Rates that are seen as either too high or too low could lead to network instability and reduced patient access.

## 3. Avoid Unintended Consequences of Mandated Payment Benchmarks

Massachusetts should carefully evaluate whether a mandated OON payment rate could create unintended consequences for healthcare access, specialty services, and overall network stability. As noted below, these unintended consequences are magnified if DOI considers expanding OON default rates to all OON services.

***Fairness In Reimbursement Rates***

MHA is particularly concerned about proposals that would establish a fixed out-of-network payment benchmark or default reimbursement rate. A single benchmark should not be presumed to represent an appropriate reimbursement level for every provider or service as it does not account for meaningful differences among providers, including:

- Differences in patient acuity and clinical complexity;
- Specialized services and programs;
- Teaching and workforce training responsibilities;
- Trauma and regional referral services;
- Safety-net obligations; and
- Geographic cost variation.

***Cost Increases***

We believe a mandated OON default rate could potentially raise costs in the market, based on dynamics associated with both lower-paid and higher-paid providers.

- Providers who are currently paid below any mandated level will have an economic incentive to terminate their existing contracts and accept a higher out-of-network mandated rate, or they will be incentivized to leave the network so that payers will increase their negotiated rate of payment. With fewer lower-paid providers, members may have to receive their care from higher-paid providers.
- At the same time, providers paid above any mandated level will likely find it more difficult to accept any material decrease in payment. One of three scenarios is likely to result from this refusal: (i) insurers will maintain existing contracted rates with these providers to avoid network disruption; (ii) providers will see patients out-of-network, shifting costs from insurers to consumers rather than reducing the underlying cost of care; or (iii) providers will not see patients for elective services if they are not in a plan's network.

***Market Confusion***
If OON default rates are applied to all OON services, consumers could experience significant disruption in their access to care.

- Providers who were previously available as in-network may no longer be available for care. (This applies to both "lower cost" and "higher cost" providers, for different reasons as discussed above). If consumers go to these out-of-network providers, they may be subject to new out-of-pocket expenses, which will be even more confusing given that the federal NSA prohibits this for only a subset of care.
- Consumers will have extreme difficulty in understanding what is driving an out-of-network mandated rate that is creating potential unexpected out-of-pocket expense exposure; this could vary based on what product they have selected, whether their employer is insured or self-insured, which insurer they select, and which provider they see.
- 211 CMR 52.12, Network Adequacy states that "In any case where the Carrier has an inadequate number or type of Participating Provider(s) to provide services for a Covered Benefit, the Carrier shall ensure that the Insured receives the Covered Benefit at the same benefit level as if the Benefit was obtained from a Participating Provider or shall make other arrangements acceptable to the Commissioner." The DOI must take care not to diminish the rights of consumers under this regulation nor give carriers a loophole to shrink networks.

In summary, insurers will need to determine whether they reimburse members for this potential consumer exposure and, if so, to what degree. The importance of having a provider network will also be put into question if consumers are able to go anywhere and the provider receives an OON default rate.

***Administrative Complexity***
The health plans appear to support development of separate rates based on carrier and product. Assuming that DOI agrees that any OON default rate should be specific to each carrier (and then within each carrier, to each product that they offer), there will need to be an entity responsible for administering this complexity and determining answers to a long list of questions, including, but not limited to:

- Who validates that an insurer is calculating any payer-specific mandated rate accurately?
- How will any product variation within an insurer be accommodated and who defines what products are "sufficiently different" to merit a different mandated out-of-network payment level?
- How will there be market transparency regarding expected rate levels if there is variability by payer and by product?
- How will a mandated rate change over time, acknowledging inflation and unpredictable market dynamics?
- If the net effect of this policy is inflationary, which we strongly believe it will be, will insurers be allowed by DOI to raise their rates in response?

***Legal Uncertainty***
We seek to better understand the statutory versus regulatory authority concerning the scope and implementation of any potential mandated OON default rates. If DOI promulgates a regulation

mandating that carriers adopt mandated OON default rates, how does this regulation affect consumer out-of-pocket expenses? Would the NSA prevail at least for those services covered by that law?
We appreciate the concerns raised by Health Law Advocates regarding OON behavioral health providers. We agree that establishing a default OON rate – and requiring providers to accept it without first addressing parity concerns in carrier reimbursement – would further strain an already challenging environment and harm both providers and the patients they serve.

## 4. Recognize the Current Financial Environment

Any proposed out-of-network policy should be evaluated in the broader context confronting Massachusetts hospitals and health systems. Providers continue to face rising supply and labor costs, workforce shortages, increasing patient acuity, inflation, and persistent public-payer reimbursement challenges.

Recent financial data underscores the fragility of many providers across the commonwealth. In September, the Center for Health Information and Analysis (CHIA) reported that the statewide median operating margin for hospital health systems – including affiliated physician organizations – was 0.2% in FY25. Conditions have deteriorated in FY26; CHIA's most recent data shows the statewide median hospital health system operating margin falling to *negative* -1.5%, with two-thirds of hospital health systems reporting negative operating margins. At the same time, sweeping federal Medicaid policy changes are projected to expose hospitals to more than $1 billion in losses, placing immense pressure on operations and threatening the commonwealth's healthcare safety net.

Given these realities, policymakers should carefully consider whether proposed out-of-network payment policies could reduce commercial reimbursement, weaken provider networks, or add pressure on providers already struggling to sustain essential services. Particular attention should be paid to the effects on safety-net and community hospitals, rural providers, trauma centers, teaching hospitals, and specialty care providers.

## 5. Alternative Considerations for OON Situations

We support efforts to protect consumers who are facing OON challenges and believe that providers and payers can work together to improve the current environment without creating inflationary pressure, consumer confusion, burdensome regulations, and diminishing network adequacy.

***Notice and Consent***

- **Member Education.** Educating members about health plan networks and participating providers is a shared responsibility of health plans and providers. Health plans must maintain accurate, current provider directories so patients can identify where to receive in-network care. Providers must inform health plans of any provider directory changes and inform patients of their network status. Robust networks and clear participation information are essential to minimizing unexpected out-of-network care. The federal NSA further supports informed decision-making through notice, consent, and good-faith estimate requirements in specified circumstances.
- **Need for a unified approach.** MHA generally supports notice and consent protections but overlapping state and federal requirements could increase administrative and operational burdens while creating confusion for patients. A coordinated framework would minimize administrative burden and provide patients with the information needed to make informed

choices more effectively than separate, duplicative compliance regimes designed to achieve the same goal.

***Support for Improved Independent Dispute Resolution***

When payment disputes occur, MHA believes any out-of-network reimbursement should be determined through a fair, transparent, and administratively workable independent review process rather than through a predetermined government-set payment rate.

An effective dispute resolution process should:

- Consider objective market information;
- Account for the circumstances of the provider and service involved;
- Encourage reasonable submissions by both parties;
- Discourage frivolous disputes; and
- Promote equitable outcomes without creating market distortions.

Such an approach more appropriately balances competing interests while preserving incentives for providers and health plans to negotiate sustainable contracts.

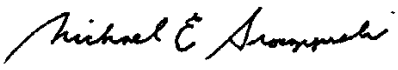
## Conclusion: MHA Seeks to be a Committed Partner

MHA appreciates the opportunity to provide input as a committed partner on this important issue.

We share the commonwealth's strong commitment to protecting patients from unexpected out-of-network costs. As DOI evaluates potential policy options, we urge it to first focus on objective data and clearly define any remaining gaps in consumer protection prior to pursuing any proposed solutions. Ultimately, it will be critical for the commonwealth to preserve incentives for robust provider networks and to carefully assess the unintended consequences that may result from any mandated out-of-network payment benchmarks.

Our shared goal should be a targeted, evidence-based policy that protects patients and advances affordability without undermining access to care, essential healthcare services, or the long-term stability of Massachusetts' healthcare system – particularly at this critical moment. MHA welcomes the opportunity to further discuss these comments. Please do not hesitate to reach out to us.

Sincerely,



Michael Sroczynski
Interim President & CEO

MASSACHUSETTS MEDICAL SOCIETY
*Every physician matters, each patient counts.*

Massachusetts Society of Anesthesiologists
860 Winter Street Waltham MA 02451

October 8, 2026

Michael T. Caljouw
Commissioner, Massachusetts Division of Insurance
One Federal Street
Suite 700
Boston, MA 02110-2012

Dear Commissioner Caljouw:

On behalf of the Massachusetts Medical Society and the undersigned specialty medical societies, we write collectively to urge the Division of Insurance to pause regulatory efforts to establish a default payment rate for out-of-network (OON) health care services. We support evidence-based solutions grounded in meaningful data. Absent compelling, current data reflecting both the scope of the problem in Massachusetts and the need for state-specific intervention, it is premature to determine that a default rate is warranted or represents an appropriate policy solution for the Commonwealth.

The Medical Society and the undersigned specialty societies together share the goal of making health care more affordable for patients. Every day, our physicians see the consequences when patients cannot afford medications or recommended treatment. We appreciate the Division's efforts to gather stakeholder input and value the opportunity to partner with the Division and the Healey-Driscoll administration on policies that promote affordability while preserving access to high-quality care

The physician community supports a policy framework that holds patients harmless, provides meaningful transparency on cost and network information, and maintains a marketplace where physicians and insurers are incentivized to negotiate in good faith. Patients benefit when physicians and health plans enter contracts that ensure quality, accountability, coordination of care, and administrative efficiency and timely billing and payment. Should the current, Massachusetts-specific data indicate a need for state-level policy intervention, we think this would

most effectively be achieved through a legislative process. That approach would allow for a comprehensive consideration of robust patient protections, appropriate disclosure requirements, a fair payment mechanism, and the interaction between state and federal law.

Since the passage and implementation of the federal No Surprises Act (NSA), the Medical Society has consistently recommended that Massachusetts allow the NSA framework to govern in lieu of adopting a separate state-level process. The NSA comprehensively regulates all fully- and self-funded plans and reflects a carefully negotiated, bipartisan compromise informed by individual states' experiencing and addressing surprise billing. Most importantly, it provides comprehensive patient protections against surprise medical bills while establishing a process for resolving payment disputes between health plans and providers.

As the Division reflects on the comments offered throughout these listening sessions, we urge particular attention to two principles.

**First, any policy solution relative to OON billing should be evaluated not only for potential premium savings, but also for its impact on access to care, network adequacy, physician practice stability, and fair contracting.**

A default rate that is set too low or too high could significantly alter the balance of negotiations between insurers and physician practices. A rate substantially below market value gives insurers undue leverage in contract negotiations by reducing the incentive to negotiate in good faith with physician practices, knowing that any resulting out-of-network scenario would be reimbursed at a significantly lower default OON rate. This could quickly become a "take it or leave it" proposition and put downward pressure on in-network rates each year without a meaningful avenue for physicians to seek recourse.

Strong network-adequacy standards — particularly for specialties commonly involved in surprise-billing situations — are essential to maintain access to care. After California enacted AB 72, physician groups reported contract terminations and demands for significant rate reductions, in some cases up to 40%. California subsequently strengthened its network-adequacy requirements to include certain specialists addressing access concerns and restoring some balance in contract negotiations.

We also caution that a low default rate intended to constrain high-cost outliers would apply broadly to lower-cost providers as well and could threaten the sustainability of independent physician practices. Payments that do not adequately reflect the cost of delivering care could further pressure independent physician practices already facing rising administrative and practice expenses. Policies intended to promote affordability should not unintentionally accelerate consolidation, diminish competition, or reduce patient choice.

Notably, AMA's 2024 Physician Practice Benchmark Survey shows that physicians increasingly work in practices owned by hospitals or other organizations and not by physicians. Physicians reported that the lack of negotiating leverage is a longstanding and important driver of this change. Consolidation in the health care industry exacerbates the vulnerability of independent physician practices, which historically have provided personalized and locally responsive health care services.

**Second, consideration of any state policy intervention must be grounded in current data specific to Massachusetts.** Before fundamentally changing the reimbursement framework and creating a separate, parallel system alongside the existing federal framework, we need to understand the problem Massachusetts is trying to solve today.

The 2021 OON report provided valuable data and insight into the prevalence of surprise medical bills, their impact on patients, and the relationship between out-of-network payment rates and the efficiency, accessibility, and cost of the health care delivery system in the Commonwealth. However, much of the underlying data predated implementation of the NSA — a major federal policy change that has since successfully protected patients from surprise medical bills and transformed the care delivery landscape.

We cannot predicate policy decisions today on data collected and assessed prior to the passage and implementation of the NSA. An informed policy discussion requires updated information on the prevalence of out-of-network billing; the specialties and services most commonly involved; the efficacy of existing patient protections under the NSA; changes in network participation and contracting; and the actual use and cost associated with the federal independent dispute resolution (IDR) process in Massachusetts.

We appreciate that the Division has asked for data submissions by November 1. However, no single organization can provide the data needed to assess whether additional state intervention is warranted or how such a policy should be structured. The 2021 EOHHS report relied on CHIA's All-Payer Claims Database (APCD) and custom payment benchmark data from FAIR Health, Inc. We urge the Commonwealth to update that analysis and make the resulting data available to stakeholders to determine the need for a policy intervention.

Accordingly, we strongly caution against an early 2027 timeline for final regulations because that timeline does not allow sufficient opportunity to collect, analyze, and publicly evaluate these data. Fundamental legal and operational questions also remain, including the full scope of the Division's regulatory authority; whether legislation is required to address key patient protections; and how a state default rate would interact with the NSA if Massachusetts does not enact all elements necessary to qualify as a specified state law. The NSA holds patients harmless, limits cost-sharing

to in-network rates, and prohibits balanced billing – all of which are essential and should be preserved.

**Beyond the need for updated data to rationalize state action, as a matter of policy, we do not believe a default payment rate alone is an adequate or appropriate mechanism for compensating care delivered out-of-network.**

Negotiation opportunities and an independent dispute resolution process are necessary for backstops when physicians and health plans cannot agree on appropriate reimbursement, particularly in outlier cases. At the same time, we agree with the 2021 EOHHS report that Massachusetts avoid establishing its own separate dispute resolution process, as it would result in considerable confusion for payers and providers, as well as duplicative administrative costs.

Implementation of the federal IDR process under the NSA has not been without its challenges. Greater guidance, transparency, and enforcement are needed to ensure that claims are resolved fairly and payment is made promptly. We acknowledge concerns nationally about the unanticipated volume and cost associated with the federal IDR process. However, the national experience is not representative of the Massachusetts market. CMS data show that Massachusetts ranks relatively low in use of the IDR process, ranking 42nd among states for claims initiated. In the fourth quarter of 2025, only 1,211 claims were initiated in Massachusetts, compared with a state average of more than 12,400 nationally.[1] From 2023-2025, Massachusetts accounted for just 0.15% of all IDR claims initiated nationwide.

To our knowledge, federal data does not provide a state-by-state calculation of total administrative costs. We continue to work with national partners to obtain the most accurate data possible and may submit additional data regarding costs associated with IDR in Massachusetts. However, any costs associated with the federal program should be carefully weighed against the administrative costs associated with developing, implementing, and enforcing a separate state framework, especially for providers navigating dueling payment resolution processes for fully-insured or self-insured plans.

Importantly, many of the issues with the federal IDR system have either been addressed through regulation or can be addressed as part of prevailing, bipartisan legislation currently before Congress. A much-anticipated new federal rule addresses front-end eligibility screening and is expected to standardize information exchanged between physicians and health plans before

[1] Data sourced from CMS' Independent Dispute Resolution Reports

disputes proceed to arbitration.[2] These changes will reduce the frequency of ineligible claims entering the IDR process and improve the information provided to all parties at the outset.[3]

**The Division should also review relevant federal data to assess whether the NSA is affecting network participation and cost savings as intended.**

Recent federal Government Accountability Office data shows that physicians did not leave networks or increase rates after implementation of the NSA. Moreover, the report found that the percentage of in-network claims increased after implementation of the NSA for three of the four specialties studied (anesthesiology, emergency medicine, air ambulance).[4] For example, according to the GAO study:

- The percentage of in-network professional claims for anesthesiology increased from 96.1 percent in 2021 to 97.5 percent in 2023.
- The percentage of in-network professional claims for radiology increased from 98.6 percent in 2021 to 98.8 percent in 2023.
- The percentage of in-network professional claims for emergency medicine increased from 90.8 percent in 2021 and 93.5 percent in 2023.

The same GAO report also found that changes in in-network payment largely reflected continuations of trends that predated implementation of the NSA. For anesthesiology, allowed amounts fell approximately 4 percent during the two years preceding the NSA and another 7 percent between 2019 and 2021. For emergency medicine, allowed amounts fell approximately 9 percent during the two years before the law took effect and another 12 percent during the subsequent two years.

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[2] Independent Dispute Resolution Operations final rule

[3] For example, the rules: (1) Require more complete information from disputing parties before arbitration begins, making it easier to identify claims that are clearly eligible—or clearly not; (2) Health plans will now be required to use claim adjustment reason codes (CARCs) and remittance advice remark codes (RARCs) on paper or electronic remittance advice in response to a claim for payment for health care items or services furnished by an entity with which it does not have a direct or indirect contractual relationship. (Takes effect January 1, 2027); (3) More information must now be disclosed with the initial payment or notice of denial of payment; (4) Streamline the efficiency and increase the formality of the Open Negotiation process by placing the initiation and response in the federal IDR portal; (5) Require plans and issuers to register in a new Federal IDR portal so that their information is available to physicians and other parties; (6) Allow for more flexibility in batching items or services into a single dispute, including extending the number of allowed line items from 25 to 50, reducing improper batching. (Takes effect November 1, 2026); and (7) Shortens the "cooling off period" for batched disputes from 90 business days to 30 business days. (Takes effect November 1, 2026).

[4] GAO, 2026

These findings underscore why Massachusetts should first understand how the federal framework is functioning in our market before replacing or supplementing it with a fundamentally different state reimbursement policy.

For these reasons, we respectfully urge the Division to pause development of a default OON payment rate until updated Massachusetts-specific data are compiled and made available to assess whether additional state action is warranted. Thank you for your consideration of these comments. We appreciate the Division's continued engagement and look forward to reviewing the relevant data and providing additional input as this process continues.

Sincerely,



Rebecca W. Brendel, MD, JD
President, Massachusetts Medical Society



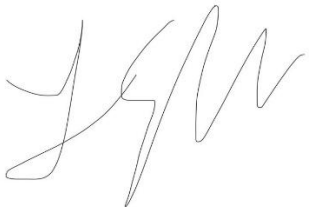
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Ami M. Karkar, MD
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Commissioner Michael Caljouw
Division of Insurance
1000 Washington Street
Boston, MA 02118

October 7, 2026

**RE: Opposition to Default Out-Of-Network Payment Rate**

Dear Commissioner Caljouw,

On behalf of the Massachusetts Society of Anesthesiologists (MSA), we are writing to express our opposition to the consideration of a default out-of-network (OON) payment rate.

Anesthesiologists strongly support protecting patients from unexpected medical bills. Patients should not be placed in the middle of payment disputes between health plans and physicians, and their financial responsibility for covered out-of-network services should generally be limited to the cost-sharing obligation that would apply to in-network care. These principles are central to the federal No Surprises Act, which removed patients from payment disputes while establishing an independent process for resolving disagreements between clinicians and health plans.

At the same time, a default payment rate established by the Commonwealth could have significant and unintended consequences for the state's leading academic medical centers and the physician practices that support them. If set too low, a default rate could effectively establish a payment ceiling that allows payers to offer unreasonably low payments for complex, hospital-based services, weakening physician networks and making it more difficult for major teaching hospitals to recruit and retain highly qualified clinicians. This is particularly concerning because these institutions often care for the state's most ill and medically complex patients and must maintain the specialized physician workforce necessary to provide that care.

The Division's public notice appropriately identifies access, affordability, provider networks, administrative burden, and costs as factors that must be considered. We respectfully urge the Division to delay further consideration of a default payment rate in order to compile the required data to evaluate if this is an appropriate solution. It is critical for the state to conduct a comprehensive and transparent analysis of these potential effects before advancing a specific payment methodology.

## A default payment rate should not be adopted without Massachusetts-specific evidence

A default rate would not operate only as a mechanism for resolving occasional out-of-network claims. It could become the practical ceiling for in-network negotiations. If a health plan knows that it can pay a predetermined amount whenever negotiations fail, the plan may have less incentive to offer reasonable contract terms or maintain adequate physician networks.

This concern is especially important for hospital-based specialties, including anesthesiology. Anesthesiologists provide essential services in operating rooms, obstetrical units, trauma centers, intensive care units, and other hospital settings. They often must be available around the clock regardless of the number, complexity, or payer mix of the cases that ultimately occur. A payment

benchmark that does not recognize these staffing and readiness obligations could destabilize coverage arrangements and impair access to surgical, obstetrical, and emergency care.

Before establishing a default rate, the Division should examine, at a minimum:

- The frequency and distribution of out-of-network anesthesia services in Massachusetts.
- Whether those services are concentrated in particular hospitals, geographic regions, specialties, or health plans.
- Current network participation and contracting trends.
- The potential effect of alternative benchmarks on clinician recruitment, retention, and hospital coverage.
- Whether a proposed rate would affect network adequacy differently in rural, community, academic, safety-net, and specialty hospitals.
- Whether insurer contracting practices or narrow networks contribute to out-of-network utilization.

The information presently available does not establish that a default payment rate is necessary or that it would lower premiums without harming access. The Division should therefore pause and develop a public evidentiary record before selecting a benchmark.

### Medicare should not be used as the benchmark

MSA strongly opposes tying commercial out-of-network payment to a percentage of Medicare rates.

By any measure, Medicare rates are deeply flawed. These rates are administratively established and are influenced by federal budget-neutrality rules and broader fiscal policy. They are not designed to measure the cost of maintaining commercially insured hospital coverage or the fair-market value of anesthesia services in Massachusetts. Existing data is clear, long-term stagnation and decline of the Medicare anesthesia conversion factor relative to inflation and commercial payment levels illustrate that such rates are unreasonable and unsustainable.

Using Medicare as the basis for a commercial default rate would import federal payment inadequacies into the Massachusetts commercial market. It could also create a particularly significant problem for anesthesiology because Medicare's anesthesia payment methodology and conversion factor are distinct from the general Medicare physician fee schedule.

A Medicare-based benchmark could consequently:

- Undervalue the clinical and standby resources necessary to furnish anesthesia services safely.
- Make participation in commercial networks less sustainable.
- Intensify recruitment and retention challenges.
- Place additional pressure on hospitals to subsidize essential anesthesia coverage.
- Disproportionately affects community, rural, safety-net, and lower-volume facilities.

If the Division proceeds with any payment framework, it should expressly reject Medicare as a proxy for commercial market value.

### The QPA should not become a default payment rate

MSA also urges the Division not to adopt the insurer-calculated Qualifying Payment Amount (QPA) as a presumptively appropriate out-of-network rate.

The QPA was developed under the No Surprises Act primarily to determine patient cost sharing and to serve as one of several factors available to an independent dispute-resolution entity. It was not intended to dictate the final payment in every case.

There are substantial concerns about the accuracy, transparency, and representativeness of QPAs. The American Society of Anesthesiologists (ASA) and other national medical organizations have documented concerns involving "ghost rates," out-of-specialty rates, unweighted contracted rates, and the exclusion of certain incentive-based payments. ASA's recent materials recommend that contracted rates associated with no actual claims or payments be excluded and that QPAs be based on clinicians in the same or similar specialty who actually furnish the service.

Research cited in ASA's No Surprises Act materials found that 60 percent of examined QPAs were below the actual median in-network rate and that actual median contracted rates were, on average, nearly three times the reported QPAs. These findings counsel strongly against treating the QPA as an independently verified market rate.

The United States Court of Appeals for the Fifth Circuit has also affirmed a decision rejecting aspects of the federal QPA methodology, including the inclusion of non-negotiated "ghost rates" and the exclusion of certain bonus and incentive payments.

Converting an opaque, insurer-calculated amount into a binding Massachusetts payment standard could therefore compound the very deficiencies that have produced federal litigation and regulatory uncertainty.

### Independent, claims-based data would be preferable to insurer-generated benchmarks

If the Division determines that it must evaluate payment benchmarks, it should rely on independent data reflecting actual services and payments rather than solely on amounts reported or calculated by health plans.

An independent commercial claims database may provide a more credible starting point because it can reflect the amounts associated with services that were actually furnished. However, any such database must be carefully evaluated for representativeness, specialty-specific accuracy, geographic sufficiency, timeliness, and susceptibility to outliers.

For anesthesia services, the methodology must also account for the distinctive anesthesia payment structure, including base units, time units, conversion factors, physical-status modifiers, and other factors relevant to patient complexity. A generic percentage of a procedure code or a benchmark developed for other specialties may not accurately measure anesthesia services.

Any data source and methodology should be published for stakeholder review, independently auditable, and based on a sufficiently recent period. The Division should not rely on proprietary calculations that physicians, employers, patients, and regulators cannot independently validate.

### Any payment framework must preserve a neutral dispute-resolution process

A single mandatory payment rate cannot account for every clinical circumstance, geographic market, hospital coverage arrangement, or patient need. If the Commonwealth ultimately establishes a default rate, it should function only as an initial payment or presumptive amount, not as the final payment in every case.

Physicians and health plans should retain access to a neutral, baseball-style independent dispute-resolution process in which each party submits an offer and the arbitrator selects the more

reasonable amount. ASA has consistently supported such an approach because it protects patients while encouraging both parties to submit reasonable offers and negotiate in good faith.

The arbitrator should be permitted to consider relevant information beyond the default amount, including:

- The clinician's training and experience.
- Patient acuity and case complexity.
- The circumstances and location in which care was furnished.
- The parties' good-faith contracting history.
- The market share of the plan and physician practice.
- The clinician's teaching or specialized responsibilities.
- The resources needed to maintain continuous hospital coverage.
- Valid independent commercial payment information.

The process must also include firm deadlines for payment and meaningful enforcement. ASA's experience under the federal No Surprises Act demonstrates that a favorable determination has limited value when an insurer delays or fails to make the required payment. ASA has therefore advocated stronger enforcement, transparency, and accountability for delayed or missing payments.

### National IDR volume does not, by itself, justify rate setting

The volume of federal Independent Dispute Resolution (IDR) disputes should not be interpreted in isolation as evidence that physicians are misusing the process or that a government-set payment rate is necessary.

ASA, the American College of Emergency Physicians, and the American College of Radiology recently analyzed federal data showing that, during 2025, insurers failed to submit an offer and lost by default on 24.5 percent of IDR line items. Insurer offers of one dollar or less occurred in 8.2 percent of line items, and nearly 40 percent of insurers offers, excluding defaults, were at or below the QPA.

These figures demonstrate why policymakers should examine initial payment practices, QPA calculations, network contracting, and insurer participation before attributing IDR volume solely to provider conduct. High dispute volume may reflect a payment or contracting problem occurring before the dispute is initiated.

The available national data also should not be assumed to describe Massachusetts. The Division should determine whether Massachusetts-specific utilization and payment data support regulatory action and should publish that analysis before selecting a remedy.

### Scope and consumer protections

MSA supports holding patients harmless when they unknowingly receive covered out-of-network care at an in-network facility. In those circumstances, patients should generally owe no more than the applicable in-network deductible, copayment, or coinsurance.

However, the same payment restrictions should not automatically apply when a patient knowingly and voluntarily selects an out-of-network physician for scheduled, non-emergency care after receiving appropriate notice. The Division should distinguish between care in which the patient has no meaningful choice of clinician and care in which the patient affirmatively chooses an out-of-network professional.

Any notice-and-consent framework must be clear and workable, but it should not impose administrative requirements on anesthesiologists when they do not control scheduling, registration, benefit verification, or patient communications.

### Geographic and inflation adjustments

If a payment methodology is adopted, it must recognize meaningful geographic differences within Massachusetts. A statewide amount could obscure variations in labor costs, hospital characteristics, clinician supply, and the resources necessary to furnish continuous coverage.

The Division should also establish a transparent annual update. Any benchmark should reflect changes in the actual cost of operating a physician practice, including staffing, professional liability coverage, technology, equipment, and other inputs required to deliver care. An update limited to a general consumer inflation measure may not reflect changes in the costs of furnishing medical services.

### Recommended next steps

Before proposing a default payment rate, the Society respectfully recommends that the Division:

- Pause the current rate-setting initiative while collecting Massachusetts-specific evidence.
- Publish data concerning out-of-network utilization, initial insurer payments, network participation, and any available dispute-resolution activity.
- Conduct a formal network and patient-access impact analysis.
- Evaluate the effect of alternative benchmarks on hospital-based and on-call specialties.
- Reject Medicare payment as a commercial payment benchmark.
- Avoid treating the insurer-calculated QPA as an independently verified market rate.
- Preserve access to neutral independent dispute resolution.
- Establish clear insurer disclosure, participation, and payment requirements.
- Protect patients by limiting cost sharing without converting patient protections into insurer rate setting.
- Provide stakeholders with the proposed methodology, underlying data, and sufficient opportunity for public review before issuing a regulation.

MSA shares the Commonwealth's commitment to affordable health care and stable insurance markets. A durable policy, however, must protect patients without creating incentives for narrower networks, below-market contracting, or reduced access to essential hospital-based services.

We appreciate the Division's willingness to receive stakeholder input and would welcome the opportunity to provide anesthesia-specific expertise as this work continues.

Sincerely,

Ami M. Karkar, MD
President
Massachusetts Society of Anesthesiologists

Donna Kucharski, MD
Chair, Economics Committee
Massachusetts Society of Anesthesiologists

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Harvard Pilgrim Health Care | TUFTS Health Plan

Point32Health companies

October 13, 2026

Michael Caljouw
Commissioner
Massachusetts Division of Insurance
One Federal Street, Suite 700
Boston, MA 02110-2012

Re: Out-of-Network Costs

Dear Commissioner Caljouw:

On behalf of Point32Health, I appreciate the opportunity to provide comments on the Division of Insurance's (Division) efforts to implement recommendations from the Governor's Health Care Affordability Work Group (Work Group) related to reducing out-of-network costs.

As you are aware, Point32Health is a regional nonprofit organization that offers insured products under both our Harvard Pilgrim Health Care and Tufts Health Plan brands, covering approximately 400,000 fully insured members in the Massachusetts market.

We share the concern that care provided outside of a carrier's network can raise healthcare costs and expose consumers to large, unexpected bills. While the federal "No Surprises Act" was intended to address many situations in which consumers receive bills from out-of-network providers, it has become clear that the law is not working as intended, leading to more disputes between providers and payors, and increasing costs for out-of-network care.

Therefore, we support the efforts of both the Work Group and the Division to identify meaningful reforms that will protect consumers and lower the cost of health care in Massachusetts. We appreciate the collaborative approach the Division is taking in reviewing the methodology for setting a default reimbursement rate and how the scope of such a rate could impact costs, contract negotiations and plan design.

Rather than setting a new benchmark or creating a new reimbursement methodology, we recommend setting the out-of-network default reimbursement rate at the carrier-specific median in-network rate as calculated by each licensed healthcare entity. We believe this method is the most fair and accounts for fundamental differences in the contracted rates for carriers with more limited networks and lower overall costs (i.e. carriers that primarily service the subsidized population on the Massachusetts Health Connector). Using a payer-wide average rate or some other benchmark could increase costs for those limited network plans rather than lower them. Carriers are also already familiar with this reimbursement methodology as it is what is required under the No Surprises Act and it will, therefore, be simple and easy for carriers to implement. It is also the rate recommended by the Executive Office of Health and Human Services in their 2021 *Report to the Massachusetts Legislature: Out-of-Network Rate Recommendations*. Utilizing a different methodology, such as a percentage of Medicare, would be operationally challenging and costly for carriers to implement as claims systems are not currently configure to pay this way.

We recommend that this rate methodology be utilized in instances where members have the greatest exposure to out-of-network bills, such as with emergency, radiology, anesthesiology and pathology providers and ambulance providers. These two scenarios – members who visit in-network facilities but are treated by non-contracted specialists and members who receive emergency ambulance transports

constitute the majority of out of network care that our members experience. Moreover, members do not have meaningful choice in selecting these providers and contracting with them has proven to be the most challenging. For these reasons, applying a default out-of-network rate in these circumstances would be the most beneficial to consumers and to mitigating costs.

As the Division considers options for setting an out-of-network reimbursement methodology, it is important that the solution preserves the incentive for providers to contract with carriers. Out-of-network reimbursement rates play an important role in provider negotiating leverage. An out-of-network rate higher than the carrier-specific median in-network rate will increase provider's leverage in requesting higher contracted rates or give providers less of an incentive to contract with carriers, ultimately eroding the value carrier's network offers to both members and providers.

Finally, members need to be protected from large out-of-network bills, especially in instances where they have no meaningful choice in provider. In situations where an out-of-network reimbursement rate exists, providers should be prohibited from balance billing members for any costs over the default amount. And members should not be responsible for cost sharing beyond what would be required had the service been provided by an in-network provider.

Thank you for the opportunity to provide comments. Please do not hesitate to contact me if you have any questions.

Sincerely,



Adam Martignetti
Vice President
State Government Affairs & Advocacy
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Beth Israel Lahey Health Performance Network

PhysicianPerformance
Empowering Physicians. Elevating Healthcare.

October 8, 2026

Michael Calijouw
Massachusetts Commissioner of Insurance
One Federal Street
Suite 700
Boston, MA 02110-2012

Dear Commissioner Caljouw and Members of the Division of Insurance:

On behalf of Beth Israel Lahey Health Performance Network, Physician Performance, and Lahey Clinical Performance Network, we thank you for the opportunity to provide comments regarding the Division's ongoing review of potential out-of-network (OON) reimbursement policies. We appreciate the Administration's commitment to advancing healthcare affordability, strengthening consumer protection, and promoting stable insurance markets. We share the goal of ensuring patients have access to affordable, high-quality care without being exposed to unexpected financial burdens.

Any contemplation of OON should be guided by the goals of protecting access to care and avoiding undue financial burden. Examination of OON policies should focus on alignment of beneficiary policies developed by payers that today may result in high out of pocket costs for patients. The Division of Insurance (DOI) must use caution to avoid broader care reimbursement policies that could fundamentally alter and cause harm to the healthcare market. As noted during the DOI listening sessions, the ultimate impact of any OON policy will depend heavily on the specific services, providers, and circumstances included within its scope.

## Support for Strong Consumer Protections

Our organizations strongly support protections for patients who unknowingly receive out-of-network services or who are placed in the middle of payment disputes between insurers and providers. Federal protections under the No Surprises Act already prohibit balance billing in many circumstances and establish an independent dispute resolution process to resolve payment disagreements while

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holding patients harmless. As you are aware, the Patient First Act providing additional protection for patients goes into effect in January. We would recommend waiting for full implementation of this law. Any further state policies should build upon these protections and remain focused on ensuring patients maintain access to medically necessary and emergency services without financial hardship.

### OON rate setting can harm patient access and the healthcare market

Massachusetts has benefited from a market-based approach in which physicians, hospitals, and insurers negotiate reimbursement arrangements that reflect local market conditions, patient complexity, quality expectations, and value-based care initiatives. The introduction of a state-mandated OON default payment rate is akin to across-the-board rate setting which can exacerbate underfunding, reduce patient access to services, and distort true market metrics by decoupling patient demand, service availability, and real provider costs.

A benchmark tied to Medicare rates or median in-network rates may reduce incentives for insurers to negotiate in good faith or develop contracts at all and could undermine efforts that payers and providers engage in to negotiate and drive, not only reimbursement rates, but also collaborative reimbursement policies and efficiency and care management practices.

For physician organizations already facing increasing operating costs, workforce shortages, and expanding administrative requirements, abrupt changes in reimbursement could impair the ability to recruit clinicians, maintain services, and invest in innovative care delivery models.

### Protect Patient Access and Network Adequacy

Any OON reimbursement policy should be evaluated through the lens of patient access. Many physician specialties provide highly specialized services that are not uniformly available across all regions of the Commonwealth. Reimbursement methodologies that fail to account for clinical complexity, specialty-specific practice expenses, geographic variation, and workforce challenges may have adverse consequences for access to care.

If the DOI considers a default reimbursement framework, we encourage careful evaluation of its potential impact on:

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- Specialty physician services;
- Academic and tertiary referral programs;
- Behavioral health services;
- Emergency and on-call physician coverage;
- Rural and underserved communities; and
- Recruitment and retention of physicians in high-demand specialties.

Addressing affordability in healthcare will take collaboration and a willingness to accept that solutions are unlikely to come in easy one-size fits all measures. Solutions will have greater long-term impact if they balance patient care needs, efficient delivery across the system and sustainability.

## Importance of Data and Transparency

Before adopting any default reimbursement methodology, we encourage the DOI to provide transparent analyses regarding:

- The specific problem being addressed;
- The volume and types of OON claims involved;
- The providers and services subject to the proposal;
- The proposed benchmark methodology and update process;
- Estimated savings to consumers and premium payers;
- Financial effects on physician practices and healthcare providers; and
- Mechanisms to monitor and report on network adequacy, access, and unintended consequences.

Policymaking in this area should be guided by objective data and careful evaluation of anticipated outcomes rather than assumptions regarding market behavior.

## Conclusion

We appreciate the Division's thoughtful engagement with stakeholders on this critical issue. Our organizations support efforts to protect patients from unexpected healthcare costs and improve affordability. However, any proposal involving state-

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established OON reimbursement rates should be carefully evaluated to ensure it supports patient access to care, maintains adequate provider networks, preserves meaningful contracting and care delivery, and reflects the significant financial challenges currently facing healthcare providers.

We look forward to continuing to work collaboratively with the Division as it evaluates potential policy options and welcome the opportunity to provide additional information as the process moves forward.

Sincerely,

**Susan Chapman Moss, MPH, President**
**Beth Israel Lahey Health Performance Network**

Signed by:
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October 8, 2026

Michael T Caljouw
Commissioner of Insurance
Massachusetts Division of Insurance
One Federal Street, Suite 700
Boston, MA 02110

RE: Request for Comments on Out-of-Network Rate Setting

Dear Commission Caljouw,

On behalf of UMass Memorial Health (UMMH), the largest nonprofit health care system and employer in Central Massachusetts, thank you for your leadership in addressing the key drivers of healthcare affordability in the Commonwealth. UMMH applauds the efforts of the Affordability Work Group and Division of Insurance (DOI) to make healthcare more affordable for Massachusetts' residents.

UMass Memorial Health agrees that protecting patients from unexpected out-of-network (OON) costs is essential to ensuring affordability of healthcare. However, the mechanisms for protecting consumers must also properly align incentives for payers and providers to ensure fair reimbursement.

Alison Kuznit's September 9, 2026 article (attached) acknowledges EOHHS and Massachusetts Association of Health Plans' concerns regarding the "perverse incentive" that would be created if OON rates are set too high such that providers may have no incentive to participate in health plan networks, but does not consider the other side of the equation such that if OON rates are set too low or below a provider's in-network rates, insurance companies will have no incentive to include certain providers in-network.

As you know, a provider can be in-network for some insurance products and not others offered by an insurer (select network or employer specific EPO products). In these cases, a provider and insurer may have already negotiated OON rates to apply to products in which a provider is not offered in-network participation.

Such OON rates are generally higher than the provider's in-network rates in recognition that the payer will redirect elective services but offers some level of discount for emergency services and specialty care services not otherwise available in the payer's network for that product. This model accounts for differences in patient populations and will provide for savings v. the current state in which a provider is entitled to 100% of its billed charges, subject to surprise billing legislation; and will not create additional barriers to access.

**This rate structure (an inflator or premium over a provider's in-network rates) properly aligns incentives for patients, payers, and providers and should be the model the DOI uses as the basis for establishing out-of-network rates.**

**Conversely, setting OON rates at a statewide median (especially without regard to provider type/cohort) will create a perverse incentive** whereas Academic Medical Centers whose in-network rates are above a statewide median inclusive of community hospitals, would be forced to accept OON rates below its in-network rates creating a disincentive for insurance companies to contract with such providers.

Additionally, it may be unaffordable for hospitals to provide certain services at a statewide median rate, potentially causing program closures or other barriers to access. A median rate will also not solve for the concerns raised by the Massachusetts Hospital Association with respect to consideration of differences in case mix and "unique patient populations, community investments, quality, and provider capabilities."

**Therefore, establishing a threshold or maximum inflator over each provider's in-network rates as described above (or in the absence of an agreement, above a providers in-network rates with all other like payers) is a more reasonable and balanced solution which will lower costs, not create additional barriers to access, and provides a meaningful incentive for the use of lower cost in-network providers.**

Thank you for your consideration of these points and for your leadership in improving healthcare affordability across the Commonwealth. Please feel free to reach out to me at (508) 334-8487 should you have questions.

Sincerely,



Catherine M. Rossi
SVP, Health System Contracting
UMass Memorial Health

cc: Tim Foley
Vice President, Government Relations