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,

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